FISCAL YEAR 2017

Annual Performance Plan and Report

Released February 2016

U.S. Department of Health & Human Services

HHS.GOV

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 2017 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 2015, HHS monitored five 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 144 performance measures that illustrate progress toward achieving the Department's strategic goals. The information provided spans many of HHS's eleven Operating Divisions and fifteen 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 continues to improve the lives of many. Millions have 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 plans to examine a number of health challenges facing the public through a new set of priority goals over the next two years, including serious mental illness, opioid abuse, antibiotic resistant bacteria, tobacco use, and food safety, while also exploring improvements to early childhood education and paying for 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
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U.S. Department of Health and Human Services

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Overview

The U.S. Department of Health and Human Services 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, urban Indian organizations and other tribal organizations to facilitate greater consultation and coordination between state and tribal governments on health and human services.

HHS also has strong partnerships with the private sector and nongovernmental organizations. The Department works with 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:

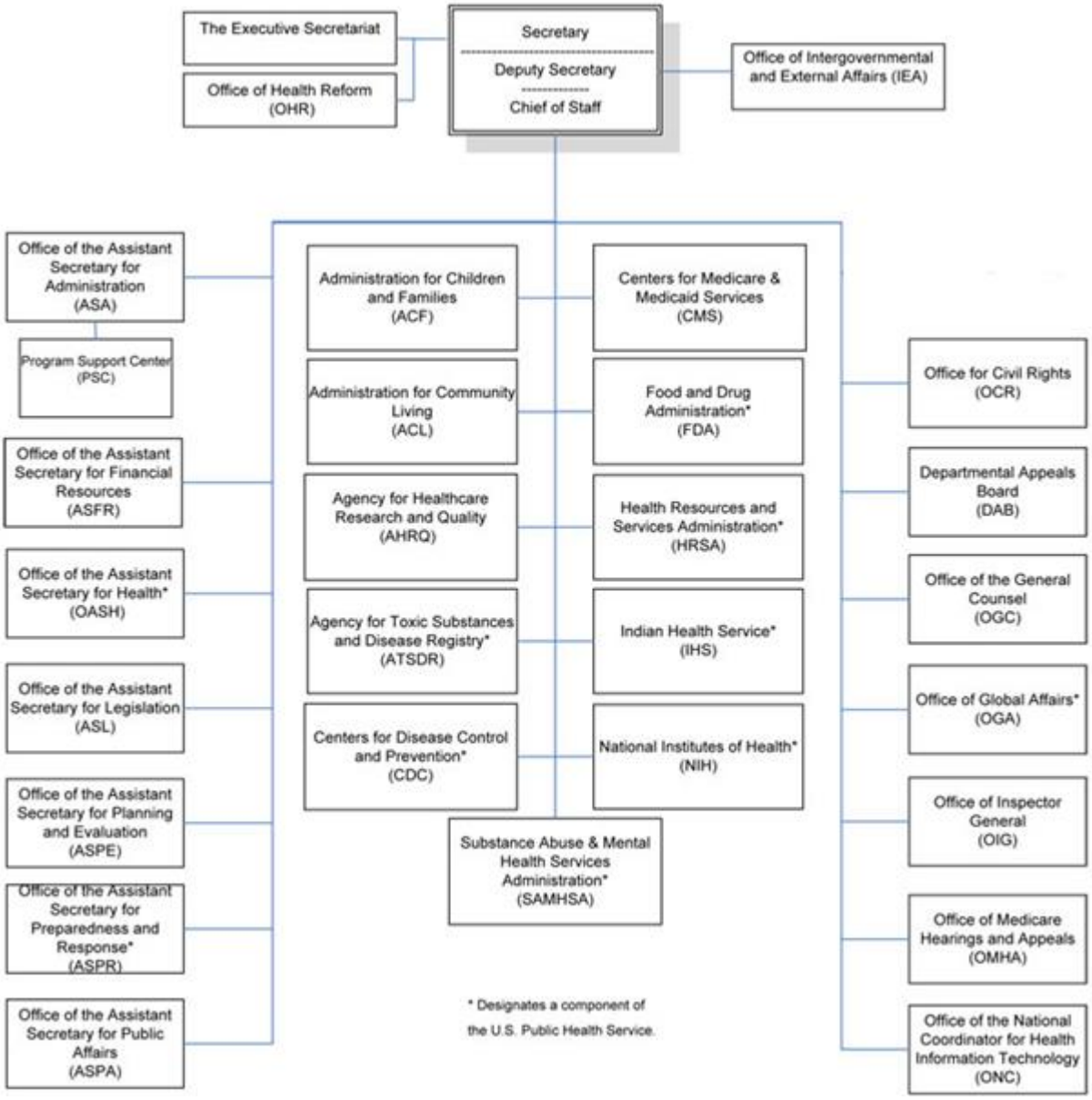
- Administration for Children and Families (ACF)
- Administration for Community Living (ACL)
- Agency for Healthcare Research and Quality (AHRQ)
- Agency for Toxic Substances and Disease Registry (ATSDR)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- 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 efforts can be found in the Goal 4 section of 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 strives to achieve meaningful progress and find lower-cost ways to achieve positive impacts, in addition to sustaining and spreading information on effective and efficient government programs.

Responding to opportunities afforded by GPRAMA, HHS continues to institute significant improvements in performance management 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 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 Agency Priority Goals

HHS, along with other federal agencies, uses Agency Priority Goals to improve performance and accountability for priorities of agency leadership and the Administration. In FY 2014, HHS established a set of near-term (18 – 24 month) Agency Priority Goals, each aligned to a HHS Strategic Plan Goal, and began holding quarterly data-driven reviews to monitor progress towards the achievement of these Priority Goals. These goals reached the completion of their two year cycle in FY 2015 and the final progress summaries are available below.

The Department has developed new Agency Priority Goals for the FY 2016-2017 cycle, described below. Working groups collaborated across the Department to identify those activities that would reflect HHS priorities and benefit from the focus and communication of the Agency Priority Goal process. Some of these Goals are continuations from the previous set from FY 2014-2015, reflecting their continued importance across the Department. These Agency Priority Goals are largely cross-cutting in nature, requiring active management across HHS components for success. Please refer to www.Performance.gov for additional information on Agency Priority Goals and the HHS components' contributions to those goals.

HHS Agency 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 2015, over 478,379 providers had received their first incentive payment. CMS recently presented the following data on early provider progress from stage 1 to stage 2 attestation milestones:
>
> > 57,726 Medicare eligible professionals (EPs) successfully attested to stage 2.
> > 1,553 Medicare eligible hospitals (EHs) successfully attested to stage 2.

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, 2015 was 2.9 illnesses per 100,000. This is a decrease from the 2010 rate (3.5 cases per 100,000) but is higher than the 2007-2009 baseline rate of 2.6 cases per 100,000 population. In support of this reduction, as of September 30, 2015, FDA has conducted a total of 136 inspections or investigations of small and large registered egg producers. The emergence of Highly Pathogenic Avian Influenza (HPAI) at commercial egg producing operations impacts FDA's ability to monitor compliance with the Egg Rule. On May 5, 2015, FDA temporarily suspended

physical inspections of egg laying facilities to safeguard against possible spread of HPAI. The FDA is working closely with USDA and other federal, state, and local agencies to track and manage the effects of recent outbreaks of HPAI. Prior to resuming inspection, the Agency will be providing enhanced biosecurity training to all food safety staff in FDA and states performing inspections on egg farms. All 10 FoodNet sites are transmitting exposure information to CDC. Information about the exposures of 979 people with domestically-acquired, sporadic SE illness in 2013 and 2014 has been mapped to exposures included in the attribution model and has been evaluated for quality.

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: The annual per capita adult cigarette consumption fell to 1,216; missing the FY 2014 target of 1,212 by only four cigarettes. This reduction represents an approximate 9 percent decrease from the FY 2012 baseline of 1,342. Additionally, the current smoking rate for adults is 16.8 percent (National Health Interview Survey 2014); showing progress toward the Healthy People 2020 goal, which aims to reduce adult prevalence to less than 12 percent by 2020.

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: CDC changed the CAUTI definition in response to input from stakeholders and scientific data, which went into effect January 1, 2015. Because the baseline CAUTI SIR was calculated using the old CAUTI definition, a strategy to ensure continuity and validity of new SIR data across this goal has been established. The CDC constructed a new SIR by applying the new CAUTI definition to the current baseline SIR and data points. Under the new definition, the most current NHSN data for the time period through March 31, 2015 shows a CAUTI SIR of 0.69. This is a reduction from the previous quarters' CAUTI SIR of 0.80. Analysis of the CAUTI data continues to reveal marked difference in reductions between intensive care and non-intensive care units. Non-ICUs achieved a 23.4 percent relative reduction in CAUTI rates, whereas ICUs achieved a 5.9 percent reduction in CAUTI rates. The CAUTI rate reduction in non-ICUs is greater than in ICUs in part because ICUs have higher rates of catheter utilization than non- ICUs.

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, making progress to improve the quality of Early Childhood Education programs. In FY 2014, 29 states had a Quality Rating and Improvement System (QRIS) that met high quality benchmarks, meeting the previously established target. States expanded from pilot programs to statewide-systems and increased availability to quality information, leading them to meet more components of the QRIS measure. States were also supported by targeted technical assistance

through state specific benchmarks and goals. The FY 2014 results show that states continue to make progress toward implementing QRIS that meet high-quality benchmarks. The FY 2015 (CLASS: Pre-K) result is a continued improvement over the previous FY 2014 result, further reducing the number of grantees scoring below a 2.5 from 23 to 22 percent. The ACF Office of Head Start continues to provide targeted technical assistance to grantees scoring in the low range, particularly for the Instructional Support domain, and develop strategies for improvement.

HHS Agency Priority Goals FY 2016 – FY 2017

HHS developed new Agency Priority Goals for FY 2016 - FY 2017. The goal statements and performance indicators for these are listed below:

Improve Early Childhood Education: Improve the quality of early childhood programs for low-income children. By September 30, 2017, HHS will improve the quality of early childhood programs for low-income children by increasing the number of states with Quality Rating and Improvement Systems (QRIS) that meet high quality benchmarks from a baseline of 17 states in FY 2011 to 37 states in FY 2017, reducing the proportion of grantees receiving a score in the low range on the basis of the Classroom Assessment Scoring System (CLASS) from a baseline of 25 percent (FY 2012) to 24 percent in FY 2017, and increasing the percent of teachers in Head Start and Early Head Start that have a Bachelor's Degree (BA) or higher by 2 percentage points each year from a baseline of 52 percent (FY 2012).

Indicators

- Increase the number of states with Quality Rating and Improvement Systems (QRIS) that meet high quality benchmarks for child care and other early childhood programs developed by HHS.
- 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).
- Increase the percent of teachers in Head Start and Early Head Start that have a BA or higher.

Healthcare Payment Reform: A critical step toward better care, smarter spending, and healthier people is to use payment incentives to motivate higher-value care by increasingly tying payment to alternative payment models that reward value over volume. By December 31, 2017, increase the percentage of Medicare Fee-for-Service (FFS) payments tied to quality and value through alternative payment models (APMs) to 40 percent.

Indicator

- Percent of Medicare Fee For Service payments tied to Quality and Value in Alternative Payment Models

Treat Serious Mental Illness: Improve the timeliness of initiation into treatment for individuals with serious mental illness. By September 30, 2017, expand the availability of evidence-based early intervention services for individuals with serious mental illness (SMI) funded through the SAMHSA Community Mental Health Services Block Grant by increasing the number of states with at least one evidence-based early intervention program that provides a team-based approach to treatment including services such as case management, recovery-oriented cognitive and behavioral skills training, supported

employment, supported education services, family education and support, and low doses of medications when indicated. The goal is to increase by 50 percent from a baseline of 13 states in 2015.

Indicator

- Increase access to early intervention services by increasing the number of states with early intervention programs by 50 percent.

Combating Antibiotic-Resistant Bacteria: Combat antibiotic-resistant bacteria to save lives. By September 30, 2017, HHS will increase the percent of hospitals that report implementation of antibiotic stewardship programs that comply with all of the CDC Core Elements for Hospital Antibiotic Stewardship Programs by 50 percent from a baseline of 39.2 percent.

Indicator

- Increasing the percent of hospitals that report implementation of antibiotic stewardship programs that comply with all of the CDC Core Elements for Hospital Antibiotic Stewardship Programs by 50 percent

Reduce Opioid Abuse: Reduce opioid-related morbidity and mortality. By September 30, 2017, opioid-related overdose death and opioid use disorder will be addressed through the three priority areas of reforming opioid prescribing practices, increasing the use of naloxone, and expanding access to and use of medication-assisted treatment (MAT) for opioid use disorders.

Indicators

- Decrease by 10 percent the total morphine milligram equivalents (MME) dispensed.
- Increase by 15 percent the number of prescriptions dispensed for naloxone.
- Increase by 10 percent the number of unique patients receiving prescriptions for buprenorphine and naltrexone in a retail setting.

Reduce Tobacco Use: By December 31, 2017, reduce the annual adult combustible tobacco consumption in the United States from 1,277 cigarette equivalents per capita to 1,127 cigarette equivalents per capita, which will represent an approximate 12 percent decrease from the 2013 baseline.

Indicator

- Annual per capita adult combustible tobacco consumption in the United States (cigarette equivalents)

Improve Food Safety: By December 31, 2017, working with federal, state, local, tribal, and industry partners, improve preventive controls in food production facilities and reduce the incidence rate (reported cases per 100,000 population per year) of Listeria monocytogenes (Lm) infections by 8 percent.

Indicator

- Reduce the incidence rate of Listeria

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 2015 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 faced increasingly high premiums and medical costs that drove some to bankruptcy or forced 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 17.6 million previously uninsured Americans have gained health coverage since the enactment of the Affordable Care Act. In part due to the affordable coverage available through the Marketplace, the uninsured rate among nonelderly, civilian, non-institutionalized adults has declined from 18.2 percent in 2010 to 13.3 percent in 2014 (see measure PHI7 below). This huge increase in coverage comes along with other significant improvements and policy developments by CMS, including requirements for comprehensive essential health benefits, preventive services with no cost-sharing, and guaranteed ability to obtain coverage regardless of pre-existing conditions as well as the expansion of Medicaid.

Starting in 2010 and continuing in 2016, HHS implemented new regulations aimed at increasing consumer protections and at creating a more competitive insurance market to both lower cost and improve quality. These 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 patients, providers, and other stakeholders.

Within HHS, divisions such as ACL, AHRQ, CDC, CMS, IHS, OASH, ONC, 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

Track the Number of Individuals who have Confirmed Enrollment through the Health Insurance Marketplaces (Lead Agency - CMS; Measure ID - PHI5)

	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017
Target			Set Baseline	9,000,000 enrollees	10,000,000 enrollees	TBD[1]
Result			6,337,860 enrollees	Apr 30, 2016	Apr 1, 2017	N/A
Status			Baseline	Pending	Pending	Target Not In Place

[1]The CY 2017 target will likely be set before the 2017 open enrollment period.

Percentage of the Nonelderly United States Population Who are Uninsured (Civilian, Noninstitutionalized) (Lead Agency - CMS; Measure ID - PHI7)

	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017
Target	N/A	N/A	N/A	Contextual Indicator	Contextual Indicator	Contextual Indicator
Result	16.9 %	16.6 %	13.3 %	May 31, 2016	May 31, 2017	May 31, 2018
Status	Historical Actual	Historical Actual	Historical Actual	Pending	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	43,212,512 children	45,592,385 children	46,617,385 children	47,642,385 children	45,271,662[2] children	46,062,581 children
Result	44,453,639 children	45,292,410 children[3]	43,689,824 children	Mar 31, 2016	Mar 31, 2017	Mar 31, 2018
Status	Target Exceeded	Target Not Met but Improved	Target Not Met	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	90 %	90 %	90 %	90 %	Contextual Indicator[4]	Contextual Indicator
Result	90 %	91 %	91 %	91 %	Dec 31, 2016	Dec 31, 2017
Status	Target Met	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	90 %	90 %	90 %	90 %	Contextual Indicator[5]	Contextual Indicator
Result	91 %	91 %	90 %	90 %	Dec 31, 2016	Dec 31, 2017
Status	Target Exceeded	Target Exceeded	Target Met	Target Met	Pending	Pending

[2]The FY 2016 target, originally reported in the FY 2016 CJ as 48,667,385, was reduced to 45,271,662.

[3]The FY 2013 results reflect enrollment at a "point in time", but States may subsequently revise their current and/or historical data at any time. For example, the FY 2013 enrollment total that was reported as of 3/2014 was 45,292,420, but as of 4/2015, enrollment was 42, 919,432, a difference of nearly 2.4 million children. This change is due primarily to improvements to data quality.

[4,5]After FY 2015, CMS will no longer set targets for this measure, but will report the annual result as a Contextual Indicator.

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	58.0%	55.0%	53.0%	50.0%	48.0%	43.0%
Result	57.0%	52.0%	Feb 28, 2016	Feb 28, 2017	Feb 28, 2018	Feb 28, 2018
Status	Target Exceeded	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	6 months	6 months	6 months	6 months	6 months	6 months
Result	6 months	6 months	6 months	6 months	Sep 30, 2016	Sep 30, 2017
Status	Target Met	Target Met	Target Met	Target Met	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	47 %	50 %	47 %	66 %	66 %	66 %
Result	66 %	66 %	64 %	Jul 31, 2016	Jul 31, 2017	Jul 31, 2018
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Analysis of Results

The Heath Insurance Marketplaces are designed to make buying health coverage easier and more affordable. Starting in 2014, Marketplaces brought new transparency to the market and allow individuals to compare health plans, get answers to questions, find out if they are eligible for premium tax credits to reduce the cost of their monthly premiums, and enroll in a health plan that meets their needs. CMS is reporting a new measure tracking the number of qualified individuals who have confirmed enrollment through the Marketplaces. Consumers can enroll in a Marketplace operated by the federal government or by a state. The target enrollment number reflects the total enrollment across all states. Baseline data for Calendar Year (CY) 2014 for the first year of enrollment was 6,337,860 at the end of December. CMS set an ambitious CY 2015 target before the open enrollment period that began on November 15, 2014 (9 million) and set a CY 2016 target (10 million) before the open enrollment period that began on November 1, 2015.

HHS is securing and extending health insurance to the previously uninsured by implementing provisions created by the Affordable Care Act of 2010, such as working with States to set up Health Insurance Marketplaces, expanding Medicaid coverage to low-income Americans, and prohibiting insurance companies from dropping people when they get sick. Through this coordinated effort, partners have made significant progress in a short amount of time toward extending affordable coverage to the uninsured. According to NHIS data, the affordable coverage available through Medicaid expansion and Marketplace coverage contributed to a six percentage point drop in the uninsured rate between 2013,

the year of the first Open Enrollment Period in October 2013, and the second quarter of 2015.[6] CMS is providing a new contextual indicator in this report that tracks the percentage of the United States civilian nonelderly noninstitutionalized population who are uninsured. The substantial increase in coverage comes along with other significant improvements and policy developments including requirements for comprehensive essential health benefits, preventive services with no cost-sharing, and guaranteed ability to obtain coverage regardless of pre-existing conditions as well as the expansion of Medicaid.

CMS is tracking progress toward improving the availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and Medicaid. States submit quarterly and annual statistical forms, which report the number of children under age 19 who are enrolled in Medicaid, separate CHIP programs, and Medicaid expansion CHIP programs. The most recent combined enrollment figure was reported for 2014, when 43,689,824 children were enrolled in Medicaid and CHIP, falling short of the 2014 target of 46,617,385 children. The paper attached to the 2014 children's enrollment report on Medicaid.gov is helpful in explaining the decrease. It is available here: http://www.medicaid.gov/chip/downloads/fy-2014-childrens-enrollment-report.pdf. The FY 2016 target has been reduced to reflect this updated data.

CMS has monitored fee for service and Medicare Advantage access to care and prescription drugs as measures of beneficiary satisfaction since the enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. CMS met or exceeded FY 2015 targets reflecting beneficiary experience in FFS and MA 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 2013, CMS exceeded its target for reductions.

The Medical Expenditure Panel Survey (MEPS)-Insurance Component (IC) 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-month 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 and/or co-occurring substance use disorder who experience homelessness or are at risk of homelessness. Many people experiencing homelessness also 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

[6] http://www.cdc.gov/nchs/data/nhis/earlyrelease/Quarterly_estimates_2010_2015_Q12.pdf, Table 1.

treatments to reduce anxiety. In FY 2014, 64 percent of homeless enrolled in the Projects to Assist in the Transition from Homelessness (PATH) received mental health services, exceeding the target.

Plans for the Future

Through a multitude of communications and outreach efforts aimed at consumers, the CMS Office of Communications provides the information needed to make informed decisions about obtaining affordable coverage through the Health Insurance Marketplace. CMS plans to undertake a number of analysis and enhancement initiatives over the coming year to improve the effectiveness of communications and outreach. Plans include building a model to measure effectiveness of outreach on enrollment to inform future efforts, conducting consumer research to improve the consumer experience on Healthcare.gov, and documenting lessons learned.

CMS will continue working with states toward full compliance with the provisions of the Affordable Care Act and implementing regulations. This will include completion of systems development; implementation of fully compliant application, verification, and renewal policies and practices; and improved coordination with Marketplaces to achieve the vision of coverage of all eligible beneficiaries.

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; CMS recently received an additional $40 million through the Medicare Access and CHIP Reauthorization Act to fund general outreach and enrollment grants, outreach grants that focus on American Indian and Alaska Native children, and the National Enrollment Campaign in FY 2016 and FY 2017.

In addition, CMS is working closely with States to implement Affordable Care Act provisions related to eligibility, enrollment, benefits, and cost sharing in Medicaid and CHIP.

CMS will continue to monitor beneficiary satisfaction with access to care for Medicare Fee for Service and Medicare Advantage using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. CMS will also analyze Medicare Advantage 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.

The Affordable Care Act requires that the Medicare Part D Prescription Drug Benefit coverage gap be closed completely by 2020 and CMS is working to reduce out-of-pocket costs for Medicare coverage for prescription drugs. Prior to the passage of the Affordable Care Act, a Medicare beneficiary was responsible for paying 100 percent of the prescription costs between the initial coverage limit and the catastrophic limit. CMS will aim to continue to reduce the coverage gap, using a combination of manufacturers' discounts and enhanced Medicare benefits.

SAMHSA's PATH program identifies and connects those experiencing chronic homelessness to primary medical and behavioral health services and housing. Many of those served suffer from serious mental illness. The services provided by the PATH program fill gaps in existing community resources and play a crucial role in communities' strategic plans to end homelessness. For example, the need for standardized definitions is addressed through the PATH's Administrative Workgroup. PATH helps recipients address issues relating to retention, staff shortages, and funding at the local level as well.

FY 2014 Strategic Review Objective Progress Update Summary

Please note that this section summarizes the result of the FY 2014 HHS Strategic Review process, limiting the scope of content to that available prior to spring of 2015. Due to this constraint, the following may not be the most current information available.

Conclusions: Noteworthy Progress

Analysis: At the time of this review, HHS has made significant progress in a short amount of time toward our objective to extend affordable coverage to the uninsured. Since the enactment of the Affordable Care Act, nearly 18 million Americans have gained coverage. In part due to the affordable coverage available through Marketplace, the uninsured rate among nonelderly adults has declined by more than seven percentage points since the beginning of open enrollment in 2013.

This huge increase in coverage comes along with other significant improvements and policy developments including changes in application, verification, eligibility determination, coordination, and renewal of coverage, as well as expansion of Medicaid. In particular, the single, streamlined application for all insurance affordability programs has allowed consumers a more coordinated and consistent process for obtaining coverage.

Coverage has not only expanded to more people but it has also become more secure for beneficiaries, particularly those who have Medicaid and CHIP, due to the development of regulations that ensure these beneficiaries remain enrolled in coverage for as long as they are eligible. In addition, consumers have also gained broader access to coverage – at least one issuer offered coverage in each service area of the Marketplaces, ensuring that all consumers would have qualified health plan access.

HHS will continue to work to secure coverage for hard-to-reach populations. Now that a significant number of previously uninsured individuals have enrolled in health coverage programs, growing total enrollment further will require the Department to update its previous tactics, as the remaining uninsured are often hard-to-reach. Additional content and sample size increase was achieved for FYs 2014 and 2015 for the National Health Interview Survey, although not to the level that could have been achieved with the full Prevention and Public Health Fund request. The uncertainty of the availability of these funds impacts HHS' ability to effectively plan for inclusion of the additional sample and content on the 2017 survey. HHS will also continue to explore ways to promote a full continuum of behavioral health services as part of Qualified Health Plans.

HHS is exploring opportunities to update and improve performance indicators for this strategic objective. HHS will work to improve the customer experience by examining Call Center staffing options and starting open enrollment with better data personalization in emails so that consumers have the most helpful information. HHS will work with state-based Marketplaces to move from current workarounds to improve the efficiency of their application, verification, and renewal of policies.

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 tools and strategies to strengthen quality and patient safety practices 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 facilities to more continuous quality improvement and a greater focus on improvement through the use of performance measurement.

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 value based purchasing programs 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 core sets of measures related to quality of 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

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target			Set Baseline		50.0 %	59.0 %
Result			39.2 %		Jul 31, 2017	Jul 31, 2018
Status			Baseline		Pending	Pending

Decrease by 10 percent the total morphine milligram equivalents (MME) dispensed (Lead Agency - FDA; Measure ID - TBD)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target					TBD	TBD
Result					TBD	TBD
Status					TBD	TBD

Increase by 15 percent the number of prescriptions dispensed for naloxone (Lead Agency - FDA; Measure ID - TBD)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target					TBD	TBD
Result					TBD	TBD
Status					TBD	TBD

Increase by 10 percent the number of unique patients receiving prescriptions for buprenorphine and naltrexone in a retail setting (Lead Agency - FDA; Measure ID - TBD)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target					TBD	TBD
Result					TBD	TBD
Status					TBD	TBD

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	0.6	0.5	0.4	0.35	0.33[7]	0.31
Result	0.56	0.54	0.50[8]	Nov 30, 2016	Nov 30, 2017	Nov 30, 2018
Status	Target Exceeded	Target Not Met but Improved	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	6,500	12,000	13,500	17,000	19,000	20,000
Result	10,900	12,400	14,450	18,300	Jan 1, 2017	Jan 31, 2018
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

[7] CLABSI baseline will not be re–established in the HHS HAI Action Plan. However, future targets will be adjusted accordingly to align with the Plan.

[8] The Standardized Infection Ratio (SIR) is calculated by dividing the actual (observed) infections by the expected infections using data gathered through the CDC National Healthcare Safety Network (NHSN).

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)[9]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	10 %[10]	20 %[11]	5 %	10 %[12]	5 %[13]	10 %[14]
Result	-17 %	-12 %[15]	-4.9 %[16]	Mar 31, 2016	Mar 31, 2017	Mar 31, 2018
Status	Target Not Met	Target Not Met but Improved	Target Not Met but Improved	Pending	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	6.9 %	6.9 %	6.7 %[17]	5.7 %[18]	5.5 %	5.5 %
Result	6.5 %	6.1 %	5.9 %	Feb 28, 2016	Feb 28, 2017	Feb 28, 2018
Status	Target Exceeded	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)

	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017
Target	N/A	N/A	19.1%[19]	17.9%[20]	16.7%	16%
Result	19.8%	20.3%	19.1%	Jan 31, 2016	Jan 31, 2017	Jan 31, 2018
Status	Historical Actual	Historical Actual	Target Met	Pending	Pending	Pending

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[9] 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).

[10,11] The Standardized Infection Ratio (SIR) for FY 2010 is 0.94. SIR is calculated by dividing the actual (observed) infections by the expected infections using data gathered through the CDC National Healthcare Safety Network (NHSN). Projected FY 2012 SIR calculation (0.94 x 0.9). Projected FY 2013 calculation (0.94 x 0.8).

[12] The final FY 2014–15 CAUTI target will be 10% reduction in the national CAUTI SIR from baseline of 1.03 to target SIR of 0.93. The end period for this goal is September 2015 and the final goal data will be reported in March of 2016.

[13] CDC is resetting the national CAUTI SIR baseline back to 1.0 at the end of FY 2015. The FY 2016 CAUTI SIR midpoint target calls for a 5% reduction in the national CAUTI SIR which equates to a SIR of 0.95 (from 1.0 to 0.95).

[14] CDC is resetting the national CAUTI SIR baseline back to 1.0 at the end of FY 2015. The FY 2017 target goal is a 10% reduction equating to a national CAUTI SIR of 0.90 (from 1.0 to 0.90).

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

[16] The national CAUTI SIR data, which was reported in March of 2015, reflects a SIR of 0.98, a 4.9% reduction just shy of target goal.

[17] FY 2014 Target was originally 6.9% in the CMS CJ. The target was reduced to 6.7% when 2012 results were received.; For internal purposes, the FY 2014 target was reduced to 5.9% in 2014, but the target could not be reduced for external reporting purposes.

[18] FY 2015 Target was reduced from 6.6% to 5.7% in FY 2016 CJ.

[19] 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 CY 2014 target was reduced from 20.3 percent to 19.1 percent.

[20] Due to the significant progress made toward achieving this measure, the CY 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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	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	Work with states to ensure that 90 percent of states report on at least eleven quality measures in the CHIPRA core set of quality measures
Result	92% of states reported on at least five quality measures	88% of states reported on at least seven quality measures[21]	88% of states reported on at least eight quality measures.	Mar 31, 2016	Mar 31, 2017	Mar 31, 2018
Status	Target Exceeded	Target Exceeded	Target Not Met but Improved	In Progress	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	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 Medicaid 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	Work with states to ensure that 75 percent of states report on at least eleven quality measures in the Affordable Care Act Adult Medicaid core set of measures.
Result	Target Met	59% of states reported on at least three quality measures.[22]	67% of states reported on at least five quality measures.	Mar 31, 2016	Mar 31, 2017	Mar 31, 2018
Status	Target Met	Target Not Met	Target Exceeded	In Progress	Pending	Pending

[21] "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%.

[22] "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%.

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	13%	25%	40%	60%	65%	70%
Result	13%	33%	58%	65%	Dec 31, 2016	Dec 31, 2017
Status	Target Met	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	N/A	N/A	N/A	60% within 15 months	75% within 15 months	90% within 10 months
Result	N/A	N/A	N/A	Feb 28, 2017	Feb 28, 2018	Feb 28, 2019
Status				In Progress	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	1032 users of research	1300 users of research	1350 users of research	2050 users of research	2200 users of research	2275 users of research
Result	1128 users of research	1627 users of research	1851 users of research	2106 users of research	Oct 30, 2016	Sep 30, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	100 %	100 %	100 %	100 %	100 %	100 %
Result	100 %	100 %	100 %	99 %	Jan 15, 2017	Jan 15, 2018
Status	Target Met	Target Met	Target Met	Target Not Met	Pending	Pending

Analysis of Results

Antibiotics have been a critical public health tool since the discovery of penicillin in 1928, saving the lives of millions of people around the world. Today, however, the emergence of drug resistance in bacteria is reversing the miracles of the past eighty years, with drug choices for the treatment of many bacterial infections becoming increasingly limited, expensive, and, in some cases, nonexistent. The CDC estimates that drug-resistant bacteria cause two million illnesses and approximately 23,000 deaths each year in the United States alone. Thus, combatting antibiotic resistance has become a priority for both the White House and the HHS Secretary. In response to President Barack Obama's Executive Order: Combating Antibiotic-Resistant Bacteria (CARB), and the National Strategy, the National Action Plan for CARB was developed to provide a roadmap to guide the nation in rising to this challenge. One of the core strategies within the action plan is improving the use of antibiotics, also known as antibiotic

stewardship, in hospitals where complications of and risk factors for antibiotic resistance are most concentrated. In pursuit of this goal, CDC will track the percentage of hospitals that report having an antibiotic stewardship program that complies with all CDC Core Elements for Hospital Antibiotic Stewardship Programs. CDC is collecting this data annually as a part of the National Healthcare Safety Network (NHSN) facility survey. In 2014, only about 40 percent of U.S. acute care hospitals report having an antibiotic stewardship program that incorporates all of the CDC Core Elements for Hospital Antibiotic Stewardship Programs.

Opioid abuse and overdose present a nationwide public health challenge. Death by drug overdose is the leading cause of injury death in the United States, with deaths from opioids in particular increasing precipitously in the twenty-first century. Overdose deaths from prescription opioids, such as oxycodone, hydrocodone, and morphine, have quadrupled over the period 1999-2013. Overdose deaths involving heroin have increased significantly in recent years, with an 88 percent increase between 2011 and 2013. Agencies across HHS recognize the urgency of halting the rise of opioid use disorder and overdose, and are working to develop and implement the most effective interventions, from prevention through treatment.

In March of 2015, HHS Secretary Burwell introduced the Secretary's Opioid Initiative to accelerate progress toward two broad goals: 1) decreasing opioid overdoses and overall overdose mortality and 2) decreasing the prevalence of opioid use disorder. This unifying strategy is designed to focus implementation efforts on action steps most likely to yield rapid and meaningful results. Specifically, the Initiative focuses on the three areas of reforming of opioid prescribing practices to reduce excess prescribing; improving naloxone development, access, and distribution; and expanding access to medication-assisted treatment (MAT). This new Agency Priority Goal for FY 2016 and accompanying metrics align with the three emphasis areas of the Initiative. Further, this opioid APG represents targeted assessment of the near-term progress that will be essential for achieving the broader Initiative goals of overall reduction in the morbidity and mortality associated with opioid use.

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 2015, CDC extended tracking capacity to more than 18,000 facilities. Although CDC did not meet its 2014 CLABSI target, between CY 2008 and CY 2014, CLABSIs decreased 50% to a 0.50 Standardized Infection Ratio (SIR) nationally in U.S. hospitals. .

The CDC changed the CAUTI definition in response to input from stakeholders and scientific data. The new definition is designed to improve the clinical relevance while remaining objective. The national CAUTI SIR data, which was reported in March of 2015, reflects a SIR of 0.98, a 4.9 percent reduction just shy of target goal. 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.

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 2014 result is 5.9 percent, which exceeds the target of 6.7 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). For FY 2014 CMS met its target of 19.1 percent, an improvement over the previous year's result.

CMS continues to work closely with states to improve children's health care quality across Medicaid and CHIP, as required by the Children's Health Insurance Program 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 2014, 88 percent of states reported on at least eight quality measures in the Child Core Set, falling just short of the target of 90 percent. 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 67 percent of states reporting on at least five quality measures in FY 2014, CMS exceeded its target of 65 percent.

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 2015 65 percent of HRSA health centers had at least one site recognized as a patient centered medical home, exceeding the 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 Generic Drug Review performance measure focuses on process enhancements resulting from the GDUFA program. The goal of the GDUFA program is to enhance efficiency in the generic drug review process, promote transparency between FDA and generic drug sponsors, and enhance access to high-quality, lower cost generic drugs. This investment in the Generic Drug Review program is reflected in the performance target which increases from 75 percent of Abbreviated New Drug Application (ANDA) submissions reviewed in 15 months in FY 2016 to 90 percent.

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 2015, 2,106 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.

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. 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 or certification. As of September 30, 2015, 75 IHS federal facilities are fully accredited, 3 are certified by CMS, and 1 is a new facility currently seeking accreditation. In 2015, one facility status changed to without deeming status by the Det Norske Veritas Accrediting Body (DNV), meaning CMS does not deem the survey as a certifying survey. The FY 2015 result is 99 percent.

Plans for the Future

HHS will highlight the problem of antibiotic-resistant bacteria and work toward improved antibiotic stewardship in hospitals in part through the establishment of a new Agency Priority Goal for FY 2016 – 2017. HHS has established a working group to support the priority goal and analyze challenges to antibiotic stewardship. HHS will hold quarterly meetings to review progress toward the goal.

There have been significant investments in the expansion of the NHSN and HAI prevention by the CDC. CDC will expand NHSN's Antibiotic Use and Resistance reporting to additional hospital and non-hospital settings for rapid detection of antibiotic resistant pathogens causing HAIs, develop a new surveillance definition for sepsis that is based on automated data collection, and promote innovation through collaboration with academic research centers in CDC's Prevention EpiCenters network, which conducts applied research on interventions for infection prevention.

CDC plans to increase the number of health care organizations reporting into the National Healthcare Safety Network to 20,000 facilities by FY 2017. CLABSI reporting from hospital wards and other non-ICU locations is still growing with mostly voluntary reporting from facilities (CMS IPPS facilities began required CLABSI reporting from wards in January 2015), and existing prevention efforts are being refined for use outside of ICUs. CDC is further working to prevent CLABSI in all locations by using HAI data to identify specific hospitals and locations that can benefit from enhanced infection control practices and expertise.[23]

CMS has established FY 2016-2017 targets for national CAUTI SIR reductions in hospitals. CDC reset the national CAUTI SIR baseline back to 1.0 at the end of FY 2015, which affected the FY 2016 and FY 2017 targets. The 2016 CAUTI SIR target calls for a 5 percent reduction in the national CAUTI SIR which equates to a SIR of 0.95 (from 1.0 to 0.95) and the 2017 target goal is a 10 percent reduction equating to a national CAUTI SIR of 0.90.

[23] http://www.health.gov/hai/prevent_hai.asp#hai_plan

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 Children's Health Insurance Program 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 April 2015, President Obama signed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which provides an additional $20 million in funding for the Pediatric Quality Measures Program for use in FY 2016 and FY 2017. This funding will help CMS achieve its FY 2017 target of 90 percent of states reporting on at least eleven of the quality measures. As the technical assistance program continues to mature, CMS is also expanding the scope of CMS's technical assistance to help states understand how to use the data they collect to drive quality improvement. CMS seeks also to understand the quality of care that adults in Medicaid receive, improve how this care is measured, and create opportunities to impact health quality. It plans to work with states to ensure that 75 percent of states report on at least eleven quality measures from the Medicaid Adult Core Set in FY 2017. CMS will continue to provide technical assistance and analytic support to states collecting and reporting the measures. As with the Child Core Set, CMS is creating a foundation for a national system of quality measurement, reporting, and improvement for adults in Medicaid.

The FY 2017 target for the reduction of pressure ulcers in nursing homes is set at 5.5 percent. CMS' 11th Scope of Work for the Quality Improvement Organizations has established the *National Nursing Home Quality of Care Collaborative* and has a specific task related to reducing healthcare acquired conditions in nursing homes, including pressure ulcers. CMS is also collaborating with the *Advancing Excellence in America's Nursing Homes* campaign which lists pressure ulcer reduction and improved mobility as two of its five clinical goals. All of these efforts should help continue the momentum.

CMS staff has been working with partners, including state coalitions, provider associations, nursing home resident advocates, and stakeholders to decrease the use of antipsychotic medications in nursing homes. Some of this work includes developing and conducting trainings for nursing home providers, surveyors, and consumers; conducting research, raising public awareness, using regulatory oversight, improving surveyor guidance, conducting focused dementia care surveys in selected states, and by public reporting to increase transparency. A number of evidence-based non-pharmacological interventions and approaches have been reviewed by national scientists and thought leaders through the *National Partnership to Improve Dementia Care*. These have been incorporated into clinical practice guidelines and various tools and resources and are now posted on the *Advancing Excellence* website (in the public domain) at www.nhqualitycampaign.org. State coalitions are reaching out to providers in every state and encouraging the use of these resources, as well as Hand in Hand, the training for nursing home staff developed by CMS. A number of meta-analyses have reviewed the use of non-pharmacological approaches to behaviors in people with dementia. Studies have shown that these interventions may be effective in reducing behaviors associated with dementia that may be distressing to residents or families.

HRSA is continuing its Patient Centered Medical Home (PCMH) Initiative to improve the quality of care in health centers and support health center efforts to achieve national PCMH recognition. The Initiative has included funding to cover health center costs associated with surveys for PCMH recognition, technical assistance, and other quality improvement supports to help health centers in the

transformation of their practices needed to receive recognition as a PCMH. The IHS Office of Information Technology is working toward implementation of a patient portal and a secure messaging platform between patients, providers, and care teams. These two platforms will greatly enhance communications between patients and caregivers via HIPAA secure mechanisms. They will also assist facilities in achieving a critical milestone of the Patient Centered Medical Home and meeting recognition standards for such.

SAMHSA will continue to help adults with serious mental illness and youth with severe emotional disturbances by helping states and communities to develop capacity and deliver effective treatment services. SAMHSA will accomplish this by leveraging its grant portfolio and technical assistance capabilities to provide funding and policy direction which helps grantees to make the necessary changes to policies, organizational structure, and delivery methods needed to realize the possibilities created through the Affordable Care Act. SAMHSA will actively monitor the effectiveness of these efforts.

In FY 2016, IHS plans to work with The Joint Commission to assist facilities in meeting full accreditation. The FY 2016 target is to maintain 100 percent accreditation or certification at IHS-operated hospitals and outpatient clinics (excluding tribally operated facilities).

FY 2014 Strategic Review Objective Progress Update Summary

Please note that this section summarizes the result of the FY 2014 HHS Strategic Review process, limiting the scope of content to that available prior to spring of 2015. Due to this constraint, the following may not be the most current information available.

Conclusions: Progressing

Analysis: HHS continues to make progress in strengthening health care by guiding and supporting national efforts to improve health care quality and patient safety, but opportunities for improvement remain, and the need for this work continues. Health care quality and disparities have improved in some areas, but additional focus and attention are necessary in order to achieve improvements in many other areas. Though the rate of uninsurance among adults 18-64 substantially decreased, racial differences in rates persist.

Federal efforts that provide local support for health care quality and patient safety improvement seem to be yielding some of the most impactful results. An initiative to improve dementia care and reduce antipsychotic medication use in nursing homes has reduced antipsychotic use for long-stay nursing home residents by 15.1 percent from the fourth quarter of 2011 to the end of 2013. Quality improvement efforts have resulted in some sites reporting statistically significant reductions in avoidable hospital readmissions and hospital-acquired conditions. Quality Innovation Network-Quality Improvement Organizations worked with hospitals across the country that reported high rates of central-line blood stream infections and catheter-associated urinary tract infections, results showed a 53 percent relative improvement rate.

Patient safety and quality improvement efforts ranging from the local to the national level require valid, standard measures and efficient systems for collecting information about patient safety and quality. For example, CDC is developing guidelines for opioid prescribing for chronic pain outside the setting of end-of-life care; and ONC is exploring ways to convert these guidelines into health IT-enabled clinical decision support interventions.

While progressing, the fact that in 2013 patients are still impacted at a rate of 121 hospital-acquired conditions per 1,000 discharges highlights the need for continued diligence in making health care safer. The shifting landscape in clinical quality measurement, including the drive to develop composite measures, measure relationship between value and cost, and capture the patient experience, continues to be a challenge. In addition, automating quality measurement to improve efficiency and drive improvement was identified as a challenge. Further, clinical quality measurement can be more challenging in rural communities because data collection is based on a small volume of patients.

Highlighting the importance or patient safety, the Department is in the process of implementing a priority goal related to combating opioid abuse as well as antibiotic stewardship in multiple health care settings.

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 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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	68 %	68.3 %	71 %	72.5 %	73.2 %	73.9 %
Result	70.4 %[24]	69.7 %	70 %	Dec 30, 2016	Dec 30, 2017	Dec 31, 2018
Status	Target Exceeded	Target Exceeded	Target Not Met but Improved	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	64 %	64 %	65 %	66 %	67 %	68 %
Result	70 %	72 %	72 %	Aug 31, 2016	Aug 31, 2017	Aug 31, 2018
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

[24] 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

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 barely missed its FY 2014 target for increasing the proportion of adults that engage in leisure-time physical activity, but the result was an improvement over the previous year.

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 2014, 72 percent of those patients began care in the first trimester, exceeding the target. Health Centers serve a higher risk prenatal population than seen nationally, making progress on this measure a particular accomplishment.

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 73.9 percent of adults will be participating in at least 150 minutes of physical activity a week by FY 2017 through its efforts to increase the availability of safe environments for physical activity.

HRSA's Health Center Program will continue to be a critical element of the health system, providing an accessible and dependable source of primary care services in underserved communities. HRSA will continue to support efforts to improve access to comprehensive primary health care services, including prevention services. In FY 2017, the program will continue to assess both quality of care and health center outreach efforts through monitoring timely entry into prenatal care.

FY 2014 Strategic Review Objective Progress Update Summary

Please note that this section summarizes the result of the FY 2014 HHS Strategic Review process, limiting the scope of content to that available prior to spring of 2015. Due to this constraint, the following may not be the most current information available.

Conclusions: Progressing

Analysis: Integrating primary health care services and public health efforts, including linking to community prevention services, can promote efficiency, positively affect individual well-being, and improve population health. The Affordable Care Act provides a unique opportunity to maximize the value of America's health investment by integrating public health approaches and health care service delivery. For example, as a result of delivery system reform efforts, healthcare providers are looking beyond traditional clinical services to address other determinants that impact individuals' health and well-being, healthcare quality and cost. Rather than reinventing the wheel, providers and payers have begun looking to community-based social services for their expertise in supporting seniors and people with disabilities. Through a collaborative learning experience community-based organizations

developed bundled “packages” that integrated care providers can purchase to reduce unnecessary hospital and nursing facility admissions and support community living. To date, 15 contracts have been completed with integrated care entities (such as health plans, physician practices and health systems) to provide care transitions, evidence-based programs, and other services.

In 2014, the Million Hearts® Learning Collaborative assisted state and local health agencies in implementing evidence-based strategies to identify, control and improve blood pressure. In the first year, 10 states implemented high-impact strategies including standardization of hypertension screenings, use of electronic health records, and development of disease self-management tools. During this rapid scale-up of services, which included over 150 partners, 89,187 individuals were reached.

The Title X Program has greatly contributed to preventive services by decreasing unintended pregnancy among women and families, as well as significantly reducing unintended pregnancy rates among teens and young adults. According to the most recent data (CY 2013), of the more than 4.5 million individuals served in Title X clinics, approximately 18 percent were under 20 years of age and more than 2.31 million (51 percent) were in their 20’s. In addition, Title X centers have also made an impact by screening for chlamydia infection to reduce infertility. Title X centers screened a total of 1,181,534 clients under the age of 25 for Chlamydia.

The review identified some potential challenges such as the roll-out of the Dietary Guidelines for Americans especially as it relates to sodium reduction. Access to timely and reliable data within a complex and fluid health care environment is a significant challenge because there are statutory obligations to test and expand models that demonstrate positive results. If adequate and timely data necessary to conduct evaluation are not available, then no determination about the success of a model can ultimately be made. In addition, as a greater number of individuals become insured through private plans, Title X providers have to contract with private health plans, a challenge for small providers. These providers are struggling to ensure high quality care while adapting to new health care technologies.

HHS will continue to analyze the implications of the Affordable Care Act on federally funded public health programs. It will continue to build capacity and infrastructure of community based human service organizations so they can partner and obtain better outcomes in cooperation with health providers.

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. In 2011, Medicare made almost no payments to providers through alternative payment models (APMs), but by the end of 2014 such payments represented approximately 22 percent of Medicare payments. For the first time in history of the Medicare program, HHS has explicitly set goals for tying payments to APMs that reward quality and value over volume. 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

Alternative Payment Models: Increase the percentage of Medicare Fee-for-Service (FFS) Payments Tied to Quality and Value through Alternative Payment Models (Lead Agency - CMS; Measure ID - MCR30.1)

	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017
Target			Set Baseline	26%	30%	40%
Result			22%	Nov 30, 2016	Nov 30, 2017	Nov 30, 2018
Status			Baseline	Pending	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	N/A	18.5 %[25]	18.3 %[26]	17.9 %[27]	17.4 %[28]	17.2 %
Result	18.7 %[29]	18.6 %[30]	18.1 %	17.6 %	Mar 1, 2016	Mar 31, 2017
Status	Historical Actual	Target Not Met but Improved	Target Exceeded	Target Exceeded	Pending	Pending

[25,30] Based on CY 2011 data.

[26] Based on CY 2012 data.

[27] Based on CY 2013 data.

[28] The FY 2016 target was reduced to 17.4% from 17.7% as reported in the FY 2016 Congressional Justification.

[29] Based on CY 2010 data.

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	$616.1 million	$989.8 million	$896 million	Prior Result +0	Prior Result +0	Prior Result +0
Result	$989.8 million	$896 million	Apr 30, 2016	Apr 30, 2017	Apr 30, 2018	Apr 30, 2019
Status	Target Exceeded	Target Not Met	Pending	Pending	Pending	Pending

Analysis of Results

Health care costs consume a significant amount of our nation's resources. In the United States, one source of inefficiency is a payment system that rewards medical inputs rather than outcomes, has high administrative costs, and lacks focus on disease prevention. HHS, through the Innovation Center at CMS, established by the Affordable Care Act, identifies tests, evaluates, and expands, as appropriate, innovative payment and service delivery models that can reduce program expenditures for Medicare, Medicaid, and CHIP, while improving or preserving beneficiary health and quality of care. Under this authority, CMS is testing a variety of alternative payment models that create new incentives for clinicians to deliver better care at lower cost. This measure will help track progress toward the achievement of the Healthcare Payment Reform FY 2016 – 2017 Priority Goal.

In addition, CMS is implementing payment reforms that increasingly reward quality and efficiency of care (such as the readmissions/hospital acquired condition reduction program). These alternative payment models and payment reforms that increasingly tie Fee-for-Service (FFS) payments to value are currently moving the health care system in the right direction, but increased alignment across payers would be beneficial. To encourage alignment, Medicare is leading the way by publicly tracking and reporting payments tied to alternative payment models. Moving payments to more advanced payment models in an aligned fashion and on an aligned timeframe increases the overall likelihood that new payment models will succeed. CMS has established a baseline of 22 percent of Medicare FFS payments tied to alternative payment models in CY 2014.

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 FY 2015 target for this goal, with readmission rates reduced to 17.6 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. Cost savings in FY 2013 decreased from the previous year to $896 million. Across the Ryan White HIV/AIDS Program, grantees are encouraged to maximize resources and leverage efficiencies. Within Part B state ADAPs use a variety of strategies to maximize resources, which results in a more effective use of funding and potentially enables ADAPs to serve more people. Cost

savings strategies used by states include approaches such as recovering costs when another payor was primary, coordinating benefits with Medicare Part D, improving drug purchasing models, and participating in manufacturer rebate programs.

Plans for the Future

To encourage alignment between public and private payers and to help move health care payment reform forward, HHS has set a target for Medicare to have 30 percent of Medicare FFS payments tied to quality and value through alternative payment models by the end of 2016 and have 40 percent of Medicare FFS payments tied to quality and value through alternative payment models by the end of 2017. The Department's key strategies to achieve these targets include growing and enhancing the *Medicare Shared Saving Program* and testing; expanding new payment and service delivery models; and establishing the *Health Care Payment Learning and Action Network.*

Over the last several years, CMS has undertaken several initiatives to reduce hospital readmissions in the Medicare program. These include publicly reporting hospital readmission rates through the Hospital Compare website, funding hospital-level improvements through the *Partnership for Patients* program, changing payment policies through the Hospital Readmissions Reduction Program and the Medicare Physician Fee Schedule, and CMS' many shared savings initiatives. CMS will continue with these successful efforts and also seek additional ways to reduce unnecessary readmissions.

HRSA will continue to provide technical assistance to state AIDS Drug Assistance Programs (ADAPs) on strategies to contain cost of medications, which can result in more effective use of funding and enable ADAPs to potentially serve more people living with HIV.

FY 2014 Strategic Review Objective Progress Update Summary

Please note that this section summarizes the result of the FY 2014 HHS Strategic Review process, limiting the scope of content to that available prior to spring of 2015. Due to this constraint, the following may not be the most current information available.

Conclusions: Noteworthy Progress

Analysis: HHS, as a whole, is strengthening the health system. Programs directed at reducing costs and improving the quality and safety of health care are well underway and targeted at areas of most opportunity and need. Indicators to date suggest that the nation is achieving historic progress in reducing growth in health care costs and improving quality even while the largest expansion in insurance coverage since the launch of Medicare and Medicaid is underway.

The Department is transforming the health system to achieve better care, smarter spending, and healthier people. For example, Accountable Care Organizations have demonstrated over $380 million in savings. HHS has estimated from 2010 to baseline to 2013, the health system has achieved a 17 percent decrease in hospital-acquired conditions, representing an estimated 50,000 deaths averted, 1.3 million patient harm events such as infections and adverse events avoided and $12 billion in savings overall.

The Department's implementation of the Affordable Care Act has made a meaningful contribution to recent trends by introducing payment reforms in Medicare, Medicaid, and other public programs as well as aligning with the private sector. National health expenditures rose just 1.4 percent in real per capita terms in 2013, slower than the 1.5 percent increase in real per capita GDP in 2013. The last three

years—2011, 2012, and 2013—are the three slowest years of growth in real per capita national health expenditures since record-keeping began in 1960.

HHS will continue to monitor influences on health care. AHRQ is a valuable resource for tracking health care costs and quality as well as providing supportive training and services to enhance quality. Recent efforts to defund the agency would threaten the progress being made to reduce the growth of healthcare costs while promoting high-value effective care. Another challenge in this area is that some consumers have had difficulty understanding the full scope of benefits from the Affordable Care Act.

In the coming year HHS plans to improve results and better manage progress by implementing the newly developed Delivery System Reform Priority Goal with related performance indicators. CMS is working to enhance transparency for consumers through rules and information collections including publishing the Medicare Shared Savings Program Final Rule.

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 and tribal communities. The 2014 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

By September 30, 2017, expand the availability of evidence-based early intervention services for individuals with serious mental illness (SMI) funded through the SAMHSA Community Mental Health Services Block Grant by increasing the number of states with at least one evidence-based early intervention program by 50 percent. (Lead Agency - SAMHSA; Measure ID - TBD)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target				Set Baseline	N/A	20 States
Result				13 States	Sep 30, 2016	Sep 30, 2017
Status				Baseline	Pending	Pending

Proportion of American Indian and Alaska Native adults 18 and over who are screened for depression (Lead Agency - IHS; Measure ID - 18)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	56.5 %	58.6 %	66.9 %	64.3 %	67.2 %	68.5 %
Result	61.9 %	65.1 %	66 %	67.4 %	Sep 30, 2016	Sep 30, 2017
Status	Target Exceeded	Target Exceeded	Target Not Met but Improved	Target Exceeded	Pending	Pending

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	32.7 %	Set Baseline	48.3 %	47.7 %	49.5 %	50.4 %
Result	33.2 %	48.3 %[31]	48.6 %	47.4 %	Sep 30, 2016	Sep 30, 2017
Status	Target Exceeded	Baseline	Target Exceeded	Target Not Met	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	3 recommendations	3 recommendations	3 recommendations	3 recommendations	3 recommendations	3 recommendations
Result	4 recommendations	4 recommendations	9 recommendations	9 recommendations	Sep 30, 2016	Sep 30, 2017
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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	62 weighted average	63 weighted average	62 weighted average	62.5 weighted average	63 weighted average	63.25 weighted average
Result	63 weighted average	64.2 weighted average	63.8 weighted average	Dec 31, 2016	Dec 31, 2017	Dec 31, 2018
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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	1,535	5,734[32]	3,891	3,000[33]	2,580[34]	2,580
Result	6,593	6,437	3,507[35]	Aug 31, 2016	Aug 31, 2017	Aug 31, 2018
Status	Target Exceeded	Target Exceeded	Target Not Met	Pending	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%.

[32] Target has been revised from previously reported. Target has been changed to include Cohorts VII, VIII, IX, and X. The FY 2014 actual reflects the closeout of HIV Cohort 7, which was comprised of 55 grants.

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

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

[35] The FY 2014 actual results reflect the closeout of HIV Cohort 7, which is comprised of 55 grants.

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	63.1 %	64.2 %	64.2 %	62.7 %	62.7 %	62.7 %
Result	64.2 %	62.7 %	62.7 %	64.5 %	Dec 31, 2016	Dec 31, 2017
Status	Target Exceeded	Target Not Met	Target Not Met	Target Exceeded	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	9,193 persons	7,128 persons[36]	7,522 persons	8,495 persons	9,153 persons	10,155 persons
Result	9,908 persons	8,899 persons	9,242 persons	9,683 persons	Dec 31, 2016	Dec 31, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	43 %[37]	43 %	33 %[38]	34 %[39]	34 %[40]	40 %
Result	43 %[41]	43 %[42]	46 %[43]	Dec 30, 2016	Dec 26, 2017	Dec 31, 2018
Status	Target Met	Target Met	Target Exceeded	Pending	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	20.6 million	22.2 million	24.3 million	27.5 million	27.0 million	27.0 million
Result	21.1 million	21.7 million	22.9 million	Aug 31, 2016	Aug 31, 2017	Aug 31, 2018
Status	Target Exceeded	Target Not Met but Improved	Target Not Met but Improved	Pending	Pending	Pending

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

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

[38,39,40]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.

[41,42,43]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.

Number of unique individuals receiving direct services through the Federal Office of Rural Health Policy (FORHP) Outreach Grants (Lead Agency - HRSA; Measure ID - 29.IV.A.3)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	390,000 people	395,000 people	400,000 people	405,000 people	410,000 people[44]	415,000 people[45]
Result	747,952 people	703,070 people[46]	820,176 people	Oct 31, 2016	Oct 31, 2017	Oct 31, 2018
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	2.66 Million	2.85 Million	3.18 Million	3.26 Million	3.49 Million	3.74 Million
Result	2.88 Million	3.05 Million	3.25 Million	3.35 Million	Dec 31, 2016	Dec 31, 2017
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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	1,296,300	1,340,300	1,196,600	1,155,500	1,195,000	1,032,500
Result	1,247,525	1,164,140	996,379	Oct 31, 2016	Oct 31, 2017	Oct 31, 2018
Status	Target Not Met	Target Not Met	Target Not 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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	5 percentage points above CDC data	5 percentage points above CDC data	5 percentage points above CDC data	Within 3 percentage points of CDC.[47]	Within 3 percentage points of CDC data[48]	Within 3 percentage points of CDC data
Result	72.6% (CDC= 67.1%)	72.4% (CDC= 68.2%)	Oct 31, 2016	Oct 31, 2017	Oct 31, 2018	Oct 31, 2019
Status	Target Met	Target Not Met	In Progress	In Progress	In Progress	In Progress

[44,45,46] A new cohort of FORHP Outreach grants is awarded a 3–year project period. During the 1st year of the project period, the number of people receiving direct services through the FORHP Outreach grants tends to be lower due to program start up. The numbers generally increase throughout the project period as outreach efforts are implemented.

[47] 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.

[48] This is a new target set in FY 2015 "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 the 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.

Analysis of Results

The National Institute of Mental Health (NIMH) at the National Institutes of Health (NIH) estimates that the direct and indirect financial costs of serious mental illness (SMI)—including health expenditures, disability benefits, and loss of earnings—exceed $300 billion per year in the United States. Individuals with SMI often experience barriers to treatment, including difficulty accessing and initiating treatment. Significant delays in the identification and treatment of SMI are common; for example, research has repeatedly found that individuals with psychosis in the U.S. often do not receive appropriate treatment for that condition for one to three years. HHS is starting a new Agency Priority Goal for FY 2016 - 2017 to address the challenges of SMI in the U.S. The new measure provided above tracks one aspect of this effort, whether evidence-based early intervention services are available for individuals with SMI. This key indicator specifically focuses on early intervention programs that are funded through the SAMHSA Community Mental Health Services Block Grant. Specifically, the indicator measures the number of states with at least one evidence-based early intervention program that provides a team-based approach to treatment including services such as case management, recovery-oriented cognitive and behavioral skills training, supported employment, supported education services, family education and support, and low doses of medications when indicated. The goal for FY 2017 is to increase the number of states by 50 percent from a baseline of 13 in 2015.

IHS focuses on some key health related issues for vulnerable tribal members. These include helping patients with diabetes maintain good glycemic control and increasing the number of adults screened for depression when visiting IHS facilities. 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 2014, IHS implemented new clinical standards of care, changing the glycemic control measure threshold. The FY 2015 result is IHS missing the FY 2015 target of 47.7 percent by 0.3 percent.

IHS uses depression screening to help fulfill its mission of raising the physical, mental, social, and spiritual health of American Indian and Alaska Native people to the highest level. Depression is often an underlying component contributing to suicide, accidents, domestic/intimate partner violence, and alcohol and substance abuse. Early identification of depression allows providers to plan interventions and treatment options which positively impact the mental health and overall well-being of American Indian and Alaska Native people experiencing depression. 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 67.4 percent in FY 2015, exceeding its target.

To strengthen the federal/tribal partnership, IHS engages American Indian and Alaska Native Tribes in open, continuous, and meaningful consultation. IHS incorporates tribal consultation to improve services for American Indians and Alaska Natives, setting a goal of implementing three recommendations from tribes per year to improve the consultation process. IHS exceeded this goal in FY 2015 by implementing nine recommendations. These included budgeting, contracting, health, fitness, and tax filing improvements, as well as enhanced communication and deliberation opportunities.

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 $80,300 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. For FY 2014, the result score of 63.8 is a decline over the previous year, but remains a 37 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. 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 2014, 3,507 program participants received substance abuse prevention education services, substantially missing the target. The result was affected by the more recent active grantees providing different services and data than earlier cohorts, e.g. recent grantees offered fewer direct services options, which are captured in this measure, and more indirect service options, which are not captured in this measure.

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 2015, the percentage of children reporting positive functioning increased to 64.5 percent, exceeding the target. 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.

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. 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 2015, the Corps field strength was 9,683. 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’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 46 percent in FY 2014.

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 22.9 million patients in FY 2014. This is 1.2 million more than the 21.7 million patients served in FY 2013 and represents a 75 percent increase within a ten year period. Success in increasing the number of patients served has been due in large part to the development of new health centers, new satellite sites, and expanded capacity at existing clinics. Through the Office of Rural Health Policy, HRSA improves access to care in rural communities by utilizing Outreach grants that focus on community coalitions and partnerships. In FY 2014, 820,176 persons received direct services supported by these grant programs.

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 2015, 3.35 million persons on the donor registry self-identified as belonging to racial/ethnic minority populations, compared to 3.25 million in FY 2014. Increases in potential donors of minority race and ethnicity will lead to more minority patients receiving unrelated donor cell transplants, ensuring more equitable access to this potentially life-saving treatment.

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. For more than 40 years, Title X family planning clinics have played a critical role in ensuring access to a broad range of family planning and related preventive health services for millions of low-income or uninsured individuals and others. 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 996,379 in FY 2014.

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 2013, 72.4 percent of Ryan White program clients were racial/ethnic minorities. This compares to 68.2 percent of CDC-reported AIDS cases.

Plans for the Future

The Special Diabetes Program for Indians (SDPI) has contributed substantially to improved clinical outcomes since its inception in 1997. SDPI provides funds at the national and Area levels for diabetes clinical care. SDPI will continue to support AI/AN patients by providing clinical training (including Advancements in Diabetes Seminars), clinical tools, such as treatment algorithms, Standards of Care, Best Practices, and performance data feedback to sites via the Diabetes Audit.

IHS will screen for depression in all patients 18-years-old and older. The screening will be standardized across all IHS sites and will use a valid and reliable screening tool (PHQ-2). Screening will be documented in the EHR accurately and in a timely manner. To accomplish this, IHS will develop and provide online training addressing depression, screening, documentation, and treatment. This training will be targeted to nursing staff and primary care support staff, who are the primary staff that will be

implementing this measure. Training will be provided bi-annually and be available via recordings. In FY 2017, IHS is proposing a measure name change to specify the American Indian and Alaska Native (AI/AN) population is measured and IHS is developing a separate measure for depression screening among AI/AN youth ages 12-17 years.

ACL will continue to provide high quality technical assistance, work with program resource centers to support the Aging Network 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 serious mental illness through collaboration across agencies and providers. A Systems of Care (SoC) 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. National program evaluation data reported annually to Congress indicate that the SoC approach is successful, resulting in many favorable outcomes for children, youth, and their families, including sustained mental disorder improvements for youth and children who participate for as little as six months, reductions in suicide-related behaviors, and cost reductions based on fewer days in residential care.

HRSA will continue to support the National Health Service Corps (NHSC) to address health professional shortages in high-need rural and urban communities across the country. HRSA will continue to seek to increase the scope and presence of the program.

The Health Center Program will continue to emphasize coordinated primary and preventive services to promote reductions in health disparities for low income individuals, racial and ethnic minorities, rural community, and other underserved populations through an emphasis on the coordinated and comprehensive care, the ability to manage patients with multiple health care needs, and the use of key quality improvement practices.

HRSA's Federal Office of Rural Health Policy Outreach Grants will continue to support demonstrations of collaborative models to deliver basic health care services that are uniquely designed to meet local rural health needs. A particular focus is on improving the coordination of health services in rural communities and strengthening the rural healthcare system as a whole.

HRSA's C.W. Bill Young Cell Transplantation Program will continue to engage in a number of critical functions related to stem cell transplantation including the ongoing recruitment and tissue-typing of new donors. In FY 17, the program will continue to serve a diverse patient population with a focus on increasing the number of blood stem cell transplants facilitated for patients from racially and ethnically diverse backgrounds by adding to the pool of potential adult volunteer blood stem cell donors from these groups.

In 2014, the Office of Population Affairs, in collaboration with the Division of Reproductive Health, CDC, published an MMWR, "Providing Quality Family Planning Services, Recommendations of CDC and US Office of Population Affairs." This document, along with the release of updated screening guidance in the prior years regarding screening for Chlamydia infection emphasized the need for and the criteria around screening sexually active females 15-25 for Chlamydia. The proportion of those screened has increased to approximately 60 percent, most likely the result of improved adherence to the guidelines. Though the actual decrease in females screened has occurred, a reflection of the decrease in the

number of clients in general as well as those in this age group, it is promising to see the increase in the proportion of the target population screened.

The Ryan White HIV/AIDS Program will continue to work to improve access to health care by addressing the disparities in access, treatment, and care for populations disproportionately affected by HIV/AIDS including racial/ethnic minorities.

FY 2014 Strategic Review Objective Progress Update Summary

Please note that this section summarizes the result of the FY 2014 HHS Strategic Review process, limiting the scope of content to that available prior to spring of 2015. Due to this constraint, the following may not be the most current information available.

Conclusion: Progressing

Analysis: Important progress has been made for this objective; data from the HHS Action Plan to Reduce Racial and Ethnic Health Disparities shows that progress has been made in implementing more than 90 percent of the plan's action steps. For example, the Department of Health and Human Services leads the dissemination and implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care, to date awarding more than 1 million continuing education credits to providers who have completed e-learning programs designed to improve the competency of providers to deliver culturally and linguistically appropriate care to diverse populations. Numerous studies have also shown racial and ethnic minority practitioners are more likely to practice in medically underserved areas. Currently nearly 30 percent of the 9,200 clinicians serving in the National Health Service Corps are from minority groups, while more than half of the 1,100 Corps scholars in the training pipeline are from minority groups. Grantees are building networks with community health care facilities to promote effective, culturally appropriate, trauma-informed services that improve the safety and well-being of victims of human trafficking. Another example of culturally appropriate services is the Tribal Home Visiting program which is designed to utilize home visiting approaches to strengthen tribal capacity to support and promote the health and well-being of American Indian and Alaska Native families.

Though many people served by federally funded health centers are sicker and more frequently at risk than the national average progress has been made in serving a variety of conditions. The Ryan White HIV/AIDS Program provides HIV primary medical care, treatment, and supportive services to 56 percent of the people who have been diagnosed with HIV in the United States. Data show that 75 percent of these patients are virally suppressed, while overall in the U.S. only 30 percent of people living with HIV are virally suppressed. In another example, the rate of low birth weight babies born to health center patients has declined to 7.29 percent, lower than the national average of 7.99 percent. Sixty-three percent of health center patients with hypertension had their blood pressure controlled, exceeding the national average of 48.9 percent. Rural providers and patients experiencing depression in Indian country have benefitted from using televideo services for a range of behavioral health services and training and technical assistance. More than 100 rural communities were awarded grants to support access to care including grants that improve emergency medical services, provide resources for implementing telehealth solutions, or help communities build networks of care.

Surveys and focus groups were used by Medicare and Marketplace programs to understand perceptions and behaviors of consumers and guide messaging to support outreach and enrollment efforts. Through segmented analysis, CMS knows that about 25 percent of the uninsured are active seekers of health

care information but need additional support to enroll in health care. In 2014 the Medicare language line handled 63,644 calls in 193 different languages, while the Marketplace Call Center handled 279,538 calls in 246 different languages.

The review identified a challenge related to refugee health. There is the lack of institutionalized shared resources supporting domestic refugees. There are gaps in health literacy and culturally appropriate care; mainstream service providers can approach clients with messages that may not resonate with refugees due to lack of familiarity with Western medicine concepts and care. Another challenge relates to the Veterans Administration which has been using Provider Agreements to pay the Aging and Disability Network for veterans' long term services and supports. Recently the VA has ceased using Provider Agreements until the statute is amended. Approximately 400 Veterans and their families in 13 states are at risk of losing service. Another group that is affected by limitations to high quality health care includes individuals that live in states that have not expanded Medicaid. Adults may fall into a "coverage gap" of having incomes above Medicaid eligibility but below the Marketplace premium tax credit income eligibility. Health centers in these states may provide services that may not be fully reimbursed. High quality care is based on having well-trained providers and National Health Service Corps Scholarship program was only able to fund 10 percent of applicants, indicating high demand for this program.

In the coming year, HHS plans to improve results and better manage progress by developing a Priority Goal related to improving access for those affected by serious mental illness. HHS is working to provide states an option to eliminate the assignment of court ordered medical support as a requirement of receiving Medicaid. In addition, HHS will solicit applications for a second phase of an initiative to reduce preventable inpatient hospitalizations among residents of nursing facilities while identifying the impact of a new payment model.

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	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	Discontinued
Result	156,758 eligible professionals and hospitals	325,124 eligible professionals and hospitals	414,914 eligible professionals and hospitals	471,561 eligible professionals and hospitals	Dec 31, 2016	
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	45% of office-based primary care physicians	55% of office-based primary care physicians	65% of office-based primary care physicians	67% of office-based primary care physicians	70% of office-based primary care physicians	75% of office-based primary care physicians
Result	49% of office-based primary care physicians	53% of office-based primary care physicians	56% of office-based primary care physicians	Dec. 2016	Dec. 2017	Dec. 2018
Status	Target Exceeded	Target Not Met but Improved	Target Not Met but Improved	Pending	Pending	Pending

Percent of office-based physicians who are electronically sharing patient information with any providers outside their organization (Lead Agency - ONC; Measure ID - 1.E.4)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	Set Baseline	N/A	40% of office-based physicians	40% of office-based physicians	50% of office-based physicians	55% of office-based physicians
Result	10% of office-based physicians	14% of office-based physicians	26% of office-based physicians	Dec. 2016	Dec. 2017	Dec. 2018
Status	Baseline	Historical Actual	Target Not Met but Improved	Pending	Pending	Pending

Percent of non-federal acute care hospitals that are electronically exchanging patient health information with any providers outside their organization (Lead Agency - ONC; Measure ID - 1.E.7)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	Set Baseline	N/A	75% of non-federal acute care hospitals	78% of non-federal acute care hospitals	80% of non-federal acute care hospitals	85% of non-federal acute care hospitals
Result	58% of non-federal acute care hospitals	62% of non-federal acute care hospitals	76% of non-federal acute care hospitals	Dec. 2016	Dec. 2017	Dec. 2018
Status	Baseline	Historical Actual	Target Exceeded	Pending	Pending	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	Set Baseline	33 %	54 %	54 %	72%	80%
Result	18 %	46 %	70 %	Mar 31, 2016	Mar 31, 2017	Mar 31, 2018
Status	Baseline	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	Award research grants to identify key design principles	Gather first year report from grantees	Gather second year report from grantees.	Continue gathering reports from grantees.	2 additional reports from PHIM grantees	3 additional reports from PHIM grantees
Result	Awarded research grants to identify key design principles.	Gathered first year reports from grantees.	Gathered second year reports from grantees.	3 preliminary findings for PHIM healthit.ahrq.gov	Sep 30, 2016	Sep 30, 2017
Status	Target Met	Target Met	Target Met	In Progress	In Progress	In Progress
Target		Report preliminary results of grantees in Health IT's Annual Report	Report preliminary results of grantees in Health IT's Annual Report and summarize any early findings from PA-11-99 identifying key design principles for PHIM.	Report preliminary results of grantees in Health IT's Annual Report and summarize any ongoing findings from PA-11-99 identifying key design principles for PHIM in preparation for final report in FY 2016.		
Result		Preliminary results will be posted on healthit.ahrq.gov and in Health IT's Annual report (under development).	Preliminary results posted on healthit.ahrq.gov	3 preliminary findings for unique personal health information management needs and preferences based on 1) condition, setting, health information management activity; 2) age; and 3) how health information is shared between elderly patients and their caregivers.		
Status		Target Met	Target Met	Target Met		

Analysis of Results

To promote the use of health information technology, 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 was one of HHS's recently completed FY 2014 - 2015 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 2015 of 450,000 providers, making payments to 464,634 eligible professionals and hospitals. 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.

The wide scale adoption of appropriate health information technology 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 2014, 56 percent of office-based primary care physicians had systems that met the basic EHR standard, falling short of the target but improving over the previous year's result.

Electronic exchange of patient health information is a core component of Stage 2 Meaningful Use of electronic health records. Measure 1.E.4 estimates nation-wide office-based physicians' electronic sharing of any patient information with providers outside of the physician's organization. The information for this measure is gathered in partnership between the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS) and the Office of the National Coordinator for Health IT (ONC). Each year since 2008, NCHS has included in its National Ambulatory Medical Care Survey (NAMCS) questions pertaining to electronic health record (EHR) adoption. Office-based physicians' electronic exchange of patient health information with external providers continued to grow as FY 2014 witnessed a near tripling of the rate to 37 percent of office-based physicians, not meeting the target but improving. Through FY 2014, 76 percent of non-federal acute care hospitals electronically exchange patient health information with external providers. This exceeds the goal of 75 percent.

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 & 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 2014, 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 continues to grow, with an increase from 46 percent in FY 2013 to 70 percent in FY 2014.

Individuals are the end users of consumer health information technology; however, there is still a lack of basic research around these end users' personal health information management (PHIM) practices and needs and how these methods are influenced by a multitude of other contextual factors (e.g., care settings, demographics, motivations, user capabilities and limitations, informal care-giving networks, technology sophistication, and access to Internet) that, typically, represent a mixture of facilitators or barriers to adequate PHIM. The potential of health information technology to improve the quality of health care lies in providing information to people about their health in ways that are meaningful and useful to them. AHRQ's health information technology portfolio will build the evidence on what works

for people when they manage their health information. Preliminary results are revealing key principles for useful health IT design. Innovative researchers are using consumer gaming devices to capture doctor's workflow, and are discovering what happens to clinical care when electronic health records "go down" temporarily.

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. CMS will continue to work to develop electronically specified measures that can be used to collect clinically relevant quality data for patient safety and improvement and will use available regulatory vehicles such as the inpatient prospective payments system rule and the physician fee schedule rule to continually improve upon data collection that supports the meaningful use of electronic health information.

CDC is partnering with the Association of State and Territorial Health Officers (ASTHO) to assess the feasibility of a Public Health Community Platform (PHCP), intended to be a shared infrastructure for common information exchange and development of innovative and interoperable systems to support state and local public health departments. A platform is a common architecture that is a base upon which other synergistic applications, processes, or technologies are developed. As the amount of data and expectation to use that data increase, informatics solutions are needed at the state and local level to efficiently transform data into public health action, ultimately improving health outcomes by providing decision makers with timely, accurate, and complete information. The PHCP will provide a space to generalize solutions to common public health informatics problems.

CDC is also partnering with Association of State and Territorial Health Officials (ASTHO) on an assessment state policy and practices to better understand the barriers and facilitators to health department access to healthcare facilities EHR in responding to a public health emergency, such as an infectious disease outbreak. The information and lessons learned from this study will be compiled in a report and toolkit to provide states with a list of barriers, suggestions to mitigate those barriers, best practices and policies that support EHR access, a menu of legal options, and may include practical tools such as templates for cooperative agreements, memorandums of understanding (MOUs) or policies.

In FY 2015, HRSA supported two national cooperative agreements to provide specialized training and technical assistance to health centers with health information technology and data. The cooperative agreement(s) will help health centers: adopt, optimize, and implement meaningful use of electronic health records and related information technology; develop and improve data quality, aggregation, and analytic capacity; use data to support clinical and operational quality improvement; and support effective recruitment and retention strategies of informatics and information management staff.

FY 2014 Strategic Review Objective Progress Update Summary

Please note that this section summarizes the result of the FY 2014 HHS Strategic Review process, limiting the scope of content to that available prior to spring of 2015. Due to this constraint, the following may not be the most current information available.

Conclusion: Progressing

Analysis: HHS has made progress improving health care and population health through meaningful use of health IT since the release of the HHS Strategic Plan. As of March 2015 more than 447,000 health care providers have received an incentive payment from the Medicare and Medicaid Electronic Health Records (EHR) incentive Programs. Seventy-six percent of hospitals have adopted a basic EHR system, and 48 percent of office-based physicians have adopted a basic EHR system. This progress has laid a strong base for health IT adoption and created a growing demand for its interoperability that not only supports the care continuum, but also supports health generally.

Electronic health information is not yet sufficiently standardized to allow seamless interoperability, as it is still inconsistently expressed through technical and medical vocabulary, structure, and format, thereby limiting the potential uses of the information to improve health and care. Additionally, health IT adoption remains a lower priority among providers that are not eligible for incentive payments under the Medicare and Medicaid EHR Incentive Programs, such as long-term care, post-acute care, and behavioral health settings. Effective communication and information sharing across all health care providers is essential for improving care quality and community health.

Issues identified during the review include observations that costs and workload are expected to increase going forward because of ever-growing and more complex requirements for health information technology. In addition, how the Electronic Health Records incentives sunset could potentially impact participation by new providers in EHR needs to be better understood. Finally, new models for collecting patient information could help to reduce data collection time, increase uniformity, and garner provider enthusiasm.

HHS plans to pivot the focus of the review in upcoming years to assess progress on interoperable electronic health information exchange in support of the HHS Delivery System Reform initiative. It will use available regulatory vehicles such as inpatient prospective payment system rule to improve upon data collection that supports meaningful use of electronic health information. HHS will assess the feasibility of a Public Health Community Platform to support state and local health departments. In addition, HHS will implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), particularly Title 1, to help providers use data and certified health IT so they can successfully participate in alternative payment models.

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 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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	N ≥ 12%	N ≥ 10%	N ≥ 10%	N ≥10%	N ≥ 10%	N ≥ 10%
Result	Award rate to comparison group reached 11%.	Award rate to comparison group reached 11%.	Award rate to comparison group reached 10%	Award rate to comparison group reached 10%	Dec 31, 2016	Dec 31, 2017
Status	Target Not Met	Target Met	Target Met	Target Met	In Progress	In Progress

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	N ≥ 12%	N ≥ 10%	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 3%.	Award rate to comparison group reached 14% and exceeded the target by 4%.	Award rate to comparison group reached 14% and exceeded the target by 4%.	Dec 31, 2016	Dec 31, 2017
Status	Target Met	Target Met	Target Exceeded	Target Exceeded	In Progress	In Progress

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	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	Discontinued
Result	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.	The Molecular Libraries Program (MLP) completed 448 HTS assays screened against a library of 300,000 compounds and generated 382 small molecule probes. The information on the probes and assays was deposited in PubChem.	N/A	N/A
Status	Target Exceeded	Target Exceeded	Target Met	Target Exceeded		

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	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.	Design a clinical study testing an agent for a disorder of the immune system in children.
Result	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).	Researchers have completed a compassionate use study to evaluate treatment with Janus Kinase (JAK) inhibitors in pediatric patients with the immune disorder CANDLE.	Dec 31, 2016	Dec 31, 2017
Status	Target Met	Target Met	Target Met	Target Met	In Progress	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	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	Discontinued
Result	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*).	A formal process for evaluating HTS results for use in prioritization of compounds for additional testing has been developed, and a model was developed to evaluate the estrogenic potential of chemicals and has been proposed for use.	N/A	N/A
Status	Target Met	Target Met	Target Met	Target Met		

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	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 data for the first 1000 five year follow-up visits to identify 1-3 predictors of disease progression.	Complete exome chip genotyping of 10,171 COPDGene subjects and identify 1 to 5 new rare and common genetic determinants of COPD.
Result	N/A	N/A	A meta-analysis was published FY 2014 using COPDGene as well as other studies to identify three known loci and three new loci marking genetic risk factors.	Identified four clusters that show robust associations with clinical characteristics of COPD and known COPD-associated genetic variants.	Dec 31, 2016	Dec 31, 2017
Status			Target Met	Target Met	In Progress	In Progress

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	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.	Support research on continued development of one or two prototype devices that will begin to initiate the regulatory process.
Result	N/A	N/A	Six technologies were identified that have potential for clinically focused solutions to improve primary care.	Identified and established the feasibility of 3 technologies through preliminary testing for potential use as point of care technology in the primary care setting.	Dec 31, 2016	Dec 31, 2017
Status			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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	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	Discontinued
Result	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.	Identified and characterized two molecular pathways of potential clinical significance that may serve as the basis for discovering new medications for preventing and treating asthma exacerbations.	N/A	N/A
Status	Target Met	Target Met	Target Met	Target Met		

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	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.	Identify morphological and functional neuroplastic modifications due to drugs at the level of dendritic spines and electrophysiological indices and their persistence during the development of drug dependence (or during repeated intermittent drug administration).
Result	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.	NIH-funded researchers defined circuits and portions of circuits that are important for the perception of reward that are activated in the presence or absence of drugs of abuse.	Dec 31, 2016	Dec 31, 2017
Status			Target Met	Target Met	In Progress	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 2015, 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.

NIH also routinely monitors the career outcomes of former postdoctoral fellows. In FY 2015, 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. Former NIH-trained postdoctoral fellows are more likely to remain in research careers and are better able to compete for funding. Kirschstein-NRSA fellows from 1994 to 2004 were nearly twice as likely to receive NIH research project grant support within ten years of completing their training as compared to other postdoctoral fellows who did not received 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 exceptional progress and exceeded the annual performance target during the closeout period of the program. In FY 2015 the results of 448 high-throughput biological assays screened against a library of 300,000 unique compounds, including the assay results and the detailed information about the 382 molecular probes that were developed through that screening process, were made publicly available in PubChem by the MLP. 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 2015, researchers completed a compassionate use study to evaluate treatment with Janus Kinase (JAK) inhibitors in pediatric patients with the immune disorder CANDLE, meeting the target.

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 met its target in FY 2015 by developing a formal process for evaluating high throughput screening (HTS) results for use in prioritization of compounds for additional testing, which consists of a data analysis pipeline and a protocol developed for evaluating HTS results. A model was developed to use 18 of the HTS assays to evaluate the estrogenic potential of chemicals and has been proposed for use in Endocrine Disruptor Screening Program (EDSP) evaluations. Furthermore, NIH met expectations in FY 2015 by screening the Tox21 10K library in 30 quantitative high throughput screening (qHTS) assays with a subset of the 10K library evaluated in a validation mode in an additional 54 assays that focused on measuring agonism/ antagonism in nuclear receptor assays and the activation of various stress response pathways. In addition, data obtained on 22 sets of possible high risk chemicals were screened for activity in a variety of mid to high throughput screens utilizing stem cell derived tissue models 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. NIH met its target in FY 2015 by identifying four clusters that can be characterized as 1) relatively resistant smokers; 2) mild upper zone emphysema predominant; 3) airway disease predominant; and 4) severe emphysema. These clusters show robust associations with clinical characteristics of COPD and known COPD-associated genetic variants.

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 FY 2015 NIH met its target by identifying and establishing the feasibility of three technologies through preliminary testing for potential use as point-of-care technology in the primary care setting: a microchip for diagnosing multiple infectious agents, a rapid fluorescence-based determination of antibiotic susceptibility, and an optical device for diagnosing otitis media (middle ear infection).

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 2015 NIH achieved its milestone, with investigators in the Centers for Advanced Diagnostics and Experimental Therapeutics Program (CADET II) identifying and characterizing two molecular pathways of potential clinical significance (smooth muscle myosin polymerization and YKL-40), that may serve as the basis for discovering new medications for preventing and treating asthma exacerbations.

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 scientists 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). Scientists 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. In FY 2015, NIH-funded researchers defined

circuits and portions of circuits that are important for the perception of reward that are activated in the presence or absence of drugs of abuse, meeting the target.

Plans for the Future

NIH expects to maintain the retention targets of both pre- and post-doctoral trainees and fellows in FY 2016 and 2017, despite challenges. 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.

FY 2014 Strategic Review Objective Progress Update Summary

Please note that this section summarizes the result of the FY 2014 HHS Strategic Review process, limiting the scope of content to that available prior to spring of 2015. Due to this constraint, the following may not be the most current information available.

Conclusion: Noteworthy Progress

Analysis: Significant scientific progress has been achieved by the Department and its Divisions. Accomplishments in 2014 included Ebola research. The Ebola outbreak that began in 2014 in West Africa is the largest such outbreak in history. More than 20,000 cases and almost 8,000 deaths were reported by the end of the year. Scientists used genomic sequencing technologies to identify the origin and track transmission of the Ebola virus. Research intensified efforts to develop a protective vaccine. A clinical trial to assess two experimental vaccines to prevent Ebola virus infection opened to volunteers in Liberia.

Sickle cell disease in adults was reversed by stem cell transplants. Sickle cell is an inherited blood disorder that affects more than 90,000 Americans. In 2014 researchers successfully treated adults using a modified stem cell transplant approach that does not require extensive immune-suppressing drugs. A drug candidate to treat Sickle Cell that was developed in part by HHS researchers was acquired by Baxter International's BioScience business for further clinical development. The compound is the first specifically developed to target the underlying molecular mechanism of sickle cell disease.

Paralyzed men regain movement with spinal stimulation. Four young men paralyzed below the chest because of spinal cord injuries were able to regain control of some movement after receiving an experimental spinal stimulation therapy. The fact that all 4 patients were able to regain voluntary movement suggests that a large number of patients with paralysis might benefit from spinal stimulation.

Another indicator of scientific accomplishment is the award of the Nobel Prize. An HHS grantee, Dr. William E. Moerner, shared the Nobel Prize in Chemistry for work on optical microscopy that enable scientist to visualize structures in living cells beyond the resolution of conventional light microscopy.

HHS is exploring opportunities to strengthen health disparities research efforts including using community-based participatory research (CBPR). The implementation of CBPR projects requires building strong relationships between academic institutions and community partners. It can take considerable time and effort, and progress is difficult to measure. A key need in health disparities research is the

necessity of consistent measurement tools. Non-standardized methodologies for measuring differences between and within populations make it very challenging to compare across population and studies to measure progress to reduce health disparities. The current health environment emphasizes team based care which can include health care practitioners who are geographically dispersed. The training and development needs of these "virtual teams" could benefit from further discussion.

Currently being evaluated by HHS, the implementation of a single institutional review board (IRB) for multi-site research has the potential to enhance and streamline the process of IRB review and reduce inefficiencies so that research can proceed efficiently without compromising protections. The Department is developing a Priority Goal related to Combating Antibiotic-Resistant Bacteria. The Accelerating Medicines Partnership is exploring the utility of tau imaging and fluid biomarkers for tracking responsiveness to treatment and/or disease progress in Alzheimer's disease in three large ongoing clinical trials.

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 governments, urban Indian organizations and other tribal organizations, 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 the number of opportunities for the public to co-create solutions through open innovation (Lead Agency - IOS; Measure ID - 1.4)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target			N/A	31.0	20.0	20.0
Result			16.0	22.0	Sep 30, 2016	Sep 23, 2017
Status			Historical Actual	Target Not Met but Improved	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target			N/A	180.0	90.0[49]	90.0[50]
Result			157.0	198.0	Sep 30, 2016	Aug 30, 2017
Status			Historical Actual	Target Exceeded	Pending	Pending

Analysis of Results

In FY 2015, 16 challenges were completed and 6 new challenges were launched at HHS, not meeting the target of 31 but improving over the previous year's result. The four major trends across these

[49,50]The HHS Innovates Awards program is being discontinued, therefore the awards for this program are no longer included in the target calculation.

challenges are: 1) HHS challenges are becoming more ambitious and sophisticated (i.e., more multi-phase competitions, better problem statements); 2) HHS challenges are more collaborative (public-private partnerships, interagency collaborations); 3) the purse prize is higher and more staff time is being dedicate to design and execution; and 4) more challenges are developing not only solutions but providing a structure to pilot and test them.

The HHS Innovation, Design, Entrepreneurship, and Action (IDEA) Lab received 198 innovative solutions in FY 2015, representing participation from all of the Operating and Staff Divisions, exceeding the target. The HHS Innovates program received 70 submissions, of which 7 were personally recognized at the HHS Innovates Awards Ceremony. The HHS Ignite Accelerator received 115 proposals across two rounds of Ignite, of which 24 were selected for scale-up and training. The Ventures program received 10 applications of which 3 were selected for financial support. The Entrepreneur-in-Residence Program, which has moved to a rolling basis, received three final submissions and recruit for 5 Entrepreneurs-in-Residence. All three of the EIRs have been asked to extend their stays, which speaks to the satisfaction of their work.

Plans for the Future

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. 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 2016. The HHS Open Innovation Challenge Manager plans to expand the network and capability of agency heads within HHS to manage the policy and guidance of prizes and challenges; build on the two-week pilot accelerator run in 2015 to support HHS in the design and launch of a prize (anticipate hosting another one in 2016); and expand the offering of prize/vendor platforms through the HHS strategic sourcing vehicle.

The IDEA Lab anticipates making several changes to its innovation offerings in FY16. The IDEA Lab will work closely with the HHS Innovation Council, comprised of HHS leadership, to determine the types of offerings that will be most relevant to the innovation needs of the HHS Operating Divisions. In FY 16, the IDEA Lab will focus its efforts on providing seed funding and entrepreneurial training through the HHS Ignite and HHS Ventures. For example, the HHS Ignite Accelerator will provide design-thinking training to all the finalists before selecting a cohort (this is intended to allow more teams to receive training). The HHS Ventures Program will focus on high areas of need (e.g. re-engineering core processes, strengthening the Department's workforce, increasing citizen engagement with the government, improving energy usage and water operations, and promoting security and innovation). The Entrepreneur-In-Residence program is spending more time up front with operating and staff divisions to ensure that this pathway best meets their need; thus, while the number of submissions may be reduced, the quality of projects in expected to improve. The HHS Innovates Awards program, which has been led by IOS for eight rounds will sunset, and Operating Divisions will be encouraged to develop their own awards programs.

FY 2014 Strategic Review Objective Progress Update Summary

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Conclusion: Progressing

Analysis: HHS is utilizing open innovation strategies to enhance how it collaborates with other federal, state, local, and private sector partners to develop innovative responses to the range of health, public health, and human services challenges. For example mobile technology is being used to increase the reach of resources. In August, 2014 the "Know Bullying" app was released empowering parents, caregivers and educators with the tools they need to start the conversation with children about bullying. Know Bullying received a Bronze Award in the Mobile category from the Web Health Awards.

The Accelerating Medicines Partnership is a public-private partnership that is working to transform the current model for developing new diagnostics and treatments. A critical component of the partnership is that all partners have agreed to make the data and analyses publicly accessible to the broad biomedical community.

The Department continues to invest in longitudinal databases to create research-based knowledge about the outcomes experienced by people as they live with spinal cord injuries, traumatic brain injuries, or burn injuries. By working in cooperation with the American Spinal Injury Association interventions and outcomes measures that support recovery of functions are being developed.

In 2014 there were 31 jurisdictions operating child waiver demonstrations. These waivers provide states with an opportunity to use federal funds more flexibly in order to test innovative approaches to child welfare service delivery and financing. Priority consideration is provided to applications focusing on promoting social and emotional well-being and addressing trauma.

HHS is working to translate innovations into practical, scalable applications to improve outcomes, but that work is not without challenges including delays in reauthorization for several programs have limited opportunities for legislative changes to foster or allow innovation. While technological advances have produced a wealth of data on the biological causes of disease, translating these discoveries into treatments has been far more difficult. As smartphones become more ubiquitous and health related applications gain acceptance there will be challenges to compete for consumers' attention.

In the coming year HHS will work with the Accelerating Medicines Partnership is supporting the development of a Type 2 Diabetes Knowledge Portal incorporating datasets including DNA sequences, functional genomic and clinical data from studies on type 2 diabetes and its heart and kidney complications. In addition, the Department will work to increase adoption of mobile apps in the behavioral health space.

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	6.0 working days	5.0 working days	4.0 working days	4.0 working days	3.0 working days	3.0 working days
Result	6.0 working days	5.0 working days	4.0 working days	3.0 working days	Dec 31, 2016	Dec 31, 2017
Status	Target Met	Target Met	Target Met	Target Exceeded	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
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	99.8% w/in 180 days	98.3% w/in 180 days	Jan 31, 2017	Jan 31, 2018	Jan 31, 2019
Status	Target Exceeded	Target Exceeded	Target Exceeded	In Progress	In Progress	In Progress

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	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	Complete initial phase of research to Identify drugs that have differential toxicological effects depending on age and/or sex of an individual in an effort to develop a bioinformatics-based safety assessment
Result	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.	Research generated a mutational profile of Triple Negative Breast cancer to aid in personalized medicine approaches to treat breast cancer. Initial evaluation of biomarkers completed via Nuclear Magnetic Resonance	Dec 31, 2017	Dec 31, 2018
Status	Target Met	Target Met	Target Met	Target Met	In Progress	In Progress

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 and integrating commercially available instrumentation into its microbiological testing workflow that is vastly improving the ability of FDA to more quickly and effectively detect and characterize foodborne pathogens such as Salmonella directly from the food supply. Improvements in sample throughput, along with the high degree of sensitivity and specificity built into new pathogen detection technologies, will dramatically improve FDA's foodborne response and traceback capabilities. When fully deployed, technologies such as next-generation whole-genome sequencing (WGS) and others will reduce the time to conduct these analyses from 14 days originally to just a few days. One updated technology which provides highly accurate and rapid Salmonella serotype results for FDA, known as the flow cytometry/fluorescence platform, has been validated extensively and is now deployed in nearly all FDA field laboratories, as well as in CFSAN and CVM laboratories. In FY 2015, FDA exceeded the target of four working days, reducing the average number of days to serotype priority pathogens in foods to three working days, which is the minimum amount of time required.

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 2014 FDA exceeded its ADUFA performance goal for the twelfth year in a row, completing review and action on 98.3 percent of original NADAs within 180 days.

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 2015, the FDA met its goal when 1) research generated a mutational profile of Triple Negative Breast cancer to aid in personalized medicine approaches to treat breast cancer; and 2) the initial evaluation of biomarkers was completed via Nuclear Magnetic Resonance.

Plans for the Future

In the area of food safety, HHS established a method development, validation, and implementation program for FDA and state laboratories to ensure the highest standards of analytical laboratory practices needed to support outbreak, compliance and surveillance testing; launched the 2014 FDA Food Safety Challenge, a prize competition to advance breakthroughs in foodborne pathogen detection, specifically with the goal of accelerating the detection of Salmonella in fresh produce; and in collaboration among FDA, CDC, USDA, and academic institutions, HHS created a network of 18 state and federal laboratories equipped with desktop DNA sequencers and expert staff to collect genomic data

from foodborne pathogens, greatly enhancing the ability to rapidly and precisely identify patterns and isolate sources of foodborne illness.

FY 2014 Strategic Review Objective Progress Update Summary

Please note that this section summarizes the result of the FY 2014 HHS Strategic Review process, limiting the scope of content to that available prior to spring of 2015. Due to this constraint, the following may not be the most current information available.

Conclusion: Progressing

Analysis: HHS made progress in advancing regulatory science in 2014 across a broad spectrum of food safety, medical product development, tobacco regulation responsibilities. In the area of food safety, HHS established a method development, validation, and implementation program for state laboratories to ensure the highest standards of analytical laboratory practices needed to support outbreak, compliance, and surveillance testing. The Food Safety Challenge was launched in 2014 which was a prize competition to advance breakthrough in foodborne pathogen detection, with the goal of accelerating the detection of Salmonella in fresh produce. HHS created a network of 18 state and federal laboratories equipped with desktop DNA sequencers and expert staff to collect genomic data from foodborne pathogens, greatly enhancing the ability to rapidly and precisely identify patterns and isolate sources of foodborne illness.

The medical product pre-market programs are consistently meeting or exceeding their performance goals for assuring timely access to safe and effective products. More than 30 guidance documents on topics such as Biosimilarity; expedited programs for rare diseases and serious conditions; cellular and gene therapy were published. HHS responded to the Ebola Virus in a variety of ways including rapidly evaluating investigational new drug applications, enabling access to investigational products for Ebola under appropriate regulatory mechanisms, and monitoring for fraudulent products that claim to prevent or treat Ebola.

One focus area for the Tobacco Regulatory Science Program included research on the role and impact of flavors in cigarettes, cigars, e-cigarettes and smokeless tobacco. "Tobacco Use among Middle and High School Students – United States, 2011-2014" was published in *Morbidity and Mortality Weekly*. The article highlighted the alarming trend of e-cigarette use among high school and middle school students which increased from 4.5 percent in 2013 to 13.4 percent in 2014.

HHS will continue to investigate the impact of e-cigarette use. It is a challenge to provide scientific evidence needed to inform tobacco regulation by conducting research at a pace that can keep up with a rapidly changing tobacco product market. Recruiting and retaining a talented scientific workforce and maintaining and modernizing aging scientific facilities, field laboratories and equipment are essential to supporting such research. The Department will perform manufacturing, production, and supply chain oversight using enhanced hand-held instrumentation, remote sensing, and well as implementation of prevention controls regulation and quality system standards. In addition, collaboration on studies that address e-cigarettes use will include measuring harmful and potentially harmful constituents in e-cigarettes vapor and e-juice; addictive compound in e-cigarette vapor; and biomarkers of these harmful addictive constituents in blood and urine of users. The Department will also explore methods to improve our measures of regulatory science progress and outcomes.

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	65.3 %	76.7 %	71.4 %	92.4 %	Prior Result +3PP	Prior Result +3PP
Result	73.7 %	68.4 %	89.4 %	Oct 31, 2016	Oct 31, 2017	Oct 31, 2018
Status	Target Exceeded	Target Not Met	Target Exceeded	Pending	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	973,724	1,032,147	1,400,000	1,400,000	1,420,000	1,420,000
Result	1,220,956	1,359,772	1,339,561	1,301,832	Oct 31, 2016	Oct 31, 2017
Status	Target Exceeded	Target Exceeded	Target Not Met	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	Complete target by identifying three effective implementation strategies that enhance the uptake of research-tested interventions in service systems such as primary care, specialty care and community practice.	Identify three key factors influencing the sustainability of research-tested interventions in service systems such as primary care, specialty care, and community practice.	Identify three effective implementation strategies that enhance the sustainability of research-tested interventions in service systems such as primary care, specialty care and community practice.	Identify three (3) key factors influencing the scaling up of research-tested interventions across large networks of services systems such as primary care, specialty care and community practice.	Initiate testing of hypothesized mechanism of treatment effect of one novel intervention, and determine whether the intervention should progress further to clinical testing.	Establish one research-practice partnerships to improve dissemination, implement-ation, and continuous improvement of evidence-based mental health care services.
Result	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: 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 implementation strategies that enhance the sustainability of research-tested interventions in service systems 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.	NIH researchers identified three key factors that influence the scaling up of research-tested interventions across large services systems including: the utilization of technological approaches to enhance validation and scale-up; optimization of treatment fidelity in the delivery of research-based treatment; and the development of research community partnerships to promote research-tested interventions.	Dec 31, 2016	Dec 31, 2017
Status	Target Met	Target Met	Target Met	Target Met	In Progress	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 2017. 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. In FY 2014, the percentage of total funding increased significantly to 89.4 percent. This increase is due to significantly more funding being used for programs on the higher continuum of evidence, especially in the "supported" category.

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 2015, CDC received 1,301,832 page views on the Community Guide website, a decline over the previous year's result and missing the target. CDC maintained the majority of expected page views (~96 percent) from its high in FY 2013 by utilizing processes, strategies, and web-based products developed and tested during 2011-2013. CDC expects modest growth in page views in FY 2016 with a likely plateau in FY 2017 due to the release and promotion of enhancements to the Community Guide website, which provide customized decision and implementation support for a range of user audiences.

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 2015 NIH researchers identified three key factors that influence the scaling up of research-tested interventions across large services systems such as child welfare, primary care, specialty care, and community practice. These key factors include the utilization of technological approaches to enhance validation and scale-up; optimization of treatment fidelity in the delivery of research-based treatment; and the development of research community partnerships to promote research-tested interventions. As documented in the past several decades, many barriers exist to the successful

implementation of effective clinical practices, and sustainability of those practices over time is even more difficult to achieve. These barriers exist at individual, organizational, system, and policy levels. NIH-funded investigators have developed a number of strategies to overcome these barriers and to enhance the sustainability of research-tested interventions.

Plans for the Future

Over time, the ACF Community-Based Child Abuse Prevention (CBCAP) program expects to increase the number of effective programs and practices that are implemented, maximizing the impact and efficiency of CBCAP funds. ACF is committed to continuing to work with CBCAP grantees to invest in known evidence-based practices, while continuing to promote evaluation and innovation, so as to expand the availability of evidence-informed and evidence-based practice over time.

CDC will continue to conduct systematic reviews of the evidence on the effectiveness of community preventive programs, services, and policies. It will also expand the reach of the Community Guide website, improve users' satisfaction with the usefulness of the website, multiply options for technical assistance in implementing Task Force findings, and increase dissemination of Task Force findings in public health practice through partnerships and collaborations. CDC will expand the reach and usefulness of the Community Guide website including the release and promotion of enhancements to the 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.

FY 2014 Strategic Review Objective Progress Update Summary

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Conclusion: Progressing

Analysis: HHS is committed to improving the quality of public health and human services practice by conducting applied, translational, and operations research and evaluations as well as using data for decision-making. Accomplishments related to furthering this objective included the publication of an ACF evaluation policy which identifies five important principles to guide evaluation: rigor, relevance, transparency, independence, and ethics. Notable examples of recent publications include findings from Head Start CARES, a randomized trial of the effectiveness of three approaches to improving preschoolers' social and emotional competence; data from the three-year follow-up survey of the National Survey of Child and Adolescent Well-Being, a paper on integrating human services and health programs under the Affordable Care Act, and a journal article on "Sustained Effects of the Communities That Care System on Prevention Service System Transformation."

Early outcomes from the Partnership in Employment (PIE) Systems Change grant have shown improvements in a variety of approaches within states including California's Program for Transition Age Youth no longer permitting sub-minimum wages for transitioning youth as well as efforts in Missouri which led to increases in Business Partnerships and the number of businesses providing employment opportunities for youth and young adults with I/DD. The Bridgespan Group released in November 2013

a report entitled, “What Does It Take to Implement Evidence-based Practices? A Teen Pregnancy Prevention Program Shows the Way,” in which they identified the Teen Pregnancy Prevention program as a model for implementing evidence-based programs with fidelity and quality. In addition, several HHS Divisions partnered to host the 2014 HHS Teen Pregnancy Prevention (TPP) Conference, Bridging the Gaps: Eliminating Disparities in Teen Pregnancy and Sexual Health. This collaborative effort brought together close to 1,000 people, sparked previously unavailable opportunities for coordination of state and local efforts to prevent teen pregnancy, reduced duplication, and demonstrated good stewardship of federal funds.

The Minority AIDS Initiative addresses the disproportionate impact of HIV/AIDS on communities of color. In FY 2014, HRSA funded seven new or ongoing MAI projects that increase understanding of what works in the delivery of comprehensive, culturally, and linguistically appropriate HIV/AIDS care and treatment. Examples include: Reaching Low Volume Clinician Providers Through Telehealth Training Centers; UCARE4 (The Use of Mobile Texting to Improve Retention in Care and Medication Adherence in Youth and Adult Minorities Living with HIV in Southern States); and Health Literacy Project Targeting Adult and Young Black MSM.

HHS is working to build evidence about what works though available procurement vehicles, which lack the flexibility needed to match the dynamic nature of the high-quality evaluations and statistical surveys that are essential to building evidence about what works. Barriers exist that prevent the adoption and implementation of newly devised and research-tested interventions into service systems. These barriers may occur at the individual level, practice level, or broader organizational level. For example, an evidence-based program may require extensive clinical training, the cost of which may be prohibitive for a provider. Other financial barriers may exist such as the inability to get reimbursed for providing a specific intervention.

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 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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	179	255	430	430	430	430
Result	280	300	402	Jun 30, 2016	Jun 30, 2017	Jun 30, 2018
Status	Target Exceeded	Target Exceeded	Target Not Met but Improved	Pending	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	2,660	2,846	3,101	3,500	3,700	4,100
Result	2,881	3,130	3,618	Jun 30, 2016	Jun 30, 2017	Jun 30, 2018
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	237	248	401	430	487	487
Result	335	401	310[51]	288[52]	Dec 31, 2016	Dec 31, 2017
Status	Target Exceeded	Target Exceeded	Target Not Met	Target Not Met	Pending	Pending

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	31	33	36	40[53]	43	43
Result	33	36[54]	40[55]	42[56]	Feb 1, 2017	Feb 28, 2018
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Analysis of 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. In FY 2014, CDC did not meet its target for new residents. However, the number of new residents increased by more than 33% over FY 2013 results. Since 1980, CDC has developed international Field Epidemiology Training Programs (FETPs) serving more than 60 countries that have graduated over 3,600 epidemiologists, exceeding its cumulative target for FY 2014. 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.-led global health investments to long-term host-country ownership. In FY 2014, FETP graduates and residents participated in approximately 424 outbreak investigations, over 340 planned investigations, and approximately 500 surveillance activities. CDC is planning for a level number of new residents in FY 2017 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 future number of FETPs supported, which may require adjustments to targets.

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

[51]The FY 2014 number of fellows is much lower than previous years because the start date for the new class of Public Health Associates transitioned from summer 2014 (FY 2014) to fall 2014 (FY 2015). FY 2014 was considered a "gap year" (no new associates) to accommodate this transition to a later start date; 145 new PHAP associates began in fall 2014 (FY 2015). CDC expects performance levels similar to previous years in FY 2015.

[52]Results reflect FY 2014 PHAP class due to a "gap year" resulting from a change made to PHAP class starting date, beginning with the FY 2014 class.

[53,54]36 Plus D.C.

[55]40 + D.C.

[56]42 + D.C

epidemiologists, public health nurses, managers, disease investigation specialists, laboratorians, environmental scientists, sanitarians, and informaticians. CDC's fellowship programs promote service while learning; fellows fill critical workforce needs at CDC and in the field while they are in-training for careers in the field of public health. Targets are set based on the typical, annual class size for each of the fellowship programs included in the measure. CDC's Public Health Associates Program (PHAP) transitioned from a summer start date to a fall start-date for the incoming FY 2014 class, creating a "gap-year" that resulted in fewer PHAP trainees reported for FY 2014. The PHAP "gap year" also affected the 2015 class because of the later start date, Therefore, only the 2014 class that started in October 2014 is reflected in the results. CDC will report two PHAP classes in the FY 2017. Therefore, CDC expects performance levels to increase in FY 2016 and increase in FY 2017.

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. CDC works in collaboration with state and local health departments to better monitor the effects of HIV medical care through expanded reporting of CD4 and viral load test results. For FY 2015, 42 states and Washington, D.C. required reporting of all CD4 and viral load values, an increase of two states from FY 2014, exceeding the FY 2015 target while continuing a steady increase in states meeting reporting requirements (Measure 2.2.4).

Plans for the Future

In response to the Ebola epidemic, in 2014/2015, CDC initiated the FETP Surveillance Training for Ebola Preparedness (STEP) program in several countries in West Africa. Community health workers participating in the STEP program were trained in basic principles of disease epidemiology and reporting and have served as an important node in supplying local data to national networks, enabling quicker response in these countries, and faster recognition and resolution of community outbreaks. CDC is now implementing a shorter FETP Basic Level Training for surveillance personnel at the lower levels of the health system in nearly 25 new countries in order to build surveillance response capacity more broadly. This work should significantly improve countries' ability to detect the next important disease outbreaks within their borders as well as developing common surveillance epidemiology skills across borders to improve information sharing and earlier disease reporting and control. CDC is also 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.

FY 2014 Strategic Review Objective Progress Update Summary

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Conclusions: Progressing

Analysis: Progress has been made in a variety of surveillance and epidemiologic areas which are clearly tied to public health outcomes. The National Healthcare Safety Network continues to demonstrate how

surveillance can drive prevention at the facility, state, regional and national levels. CMS is using National Healthcare Safety Network data in its pay for performance programs and posting data on the Hospital Compare website.

In 2014 a “Mini-Sentinel” pilot program demonstrated proof of principle in conducting 17 medical product assessments across multiple vaccine classes. The now-established full Sentinel System uses innovative electronic methods to rapidly assess the safety of drugs and other medical products.

Progress has been made in the laboratory sphere, especially with respect to outbreak detection including incorporating new tools like Advanced Molecular Detection. In the area of Food Safety Advanced Molecular Detection methods of whole genome sequencing have improved the laboratory-based foodborne outbreak detection system, PulseNet. A successful pilot project involving Listeria samples has resulted in detecting outbreaks faster and savings lives. Food safety experts within HHS are building on this success to extend to other pathogens and to the states. Advanced Molecular Detection also achieved improvements in the high priority area of antibiotic resistant Neisseria gonorrhea that have the potential to lead to the development of point of care tests, providing real time results and revolutionizing gonorrhea treatment.

There were numerous outbreaks where laboratory testing and new diagnostics played a pivotal role. The Novel Coronavirus RT-PCR assay for the presumptive detection of Middle Eastern Respiratory Syndrome (MERS) and its dissemination to qualified laboratories in the US and around the world formed a cornerstone of efforts to control the spread of MERS. In another example, laboratory analysis was critical in investigating multiple clusters of infections from multidrug resistant E. coli infections from duodenoscopes.

Training at the state and local level is focused on filling gaps and creating the next generation of public health specialist. Recent efforts include building IT capacity in states, utilizing e-learning, and informatics training. Building electronic laboratory capacity is bearing fruit with a steady increase in the proportion of laboratories that report nationally notifiable diseases electronically.

Further, HHS is exploring options for harmonizing electronic health record systems with public health surveillance systems as well as continuing to expand public health applications of Advanced Molecular Detection methods.

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, CDC, 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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	20 states	25 states	29 states	32 states	35 states	37 states
Result	19 states	27 states	29 states	Jun 30, 2016	Jun 30, 2017	Jun 30, 2018
Status	Target Not Met but Improved	Target Exceeded	Target Met	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	Set Baseline	23 %	27 %	26 %	25 %	24 %
Result	25 %	31 %	23 %	22 %	Jan 31, 2017	Jan 31, 2018
Status	Baseline	Target Not Met	Target Exceeded	Target Exceeded	Pending	Pending

Increase the percentage of Head Start and Early Head Start teachers that have a BA or higher. (Lead Agency - ACF; Measure ID - 3D)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	N/A	N/A	N/A	N/A	62 %	Prior Result +2PP
Result	52 %	55 %	58 %	60 %	Jan 31, 2017	Jan 31, 2018
Status	Historical Actual	Historical Actual	Historical Actual	Historical Actual	Pending	Pending

Maintain the proportion of youth living in safe and appropriate settings after exiting ACF-funded Transitional Living Program (TLP) services.[57] (Lead Agency - ACF; Measure ID - 4.1LT and 4A)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	86 %	86 %	86 %	86 %	87 %	87 %
Result	89.4 %	87.7 %	87.8 %	Jan 31, 2016	Dec 30, 2016	Dec 31, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	91.9 %	91.7 %	92.4 %	91.8 %	Prior Result +0.2PP	Prior Result +0.2PP
Result	91.5 %	92.2 %	91.6 %	Oct 31, 2016	Oct 31, 2017	Oct 31, 2018
Status	Target Not Met	Target Exceeded	Target Not Met	Pending	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	73.3 %	75.3 %	75.4 %	75.5 %	Prior Result +0.5PP	Prior Result +0.5PP
Result	74.8 %	74.9 %	75 %	Oct 31, 2016	Oct 31, 2017	Oct 31, 2018
Status	Target Exceeded	Target Not Met but Improved	Target Not Met but Improved	Pending	Pending	Pending

[57] 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.

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	80 %	80 %	80 %	84 %	84 %	84 %
Result	85.3 %	85.5 %	85.2 %	Oct 31, 2016	Oct 31, 2017	Oct 31, 2018
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	4,930	6,457	4,846	6,610	13,595	13,595
Result	6,357	6,610	6,280	13,595	Dec 31, 2016	Dec 31, 2017
Status	Target Exceeded	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	N/A	76.1%	76.1%	65.9%	65.9%	77%
Result	76.1%	65.9%	77.9%	74%	Dec 31, 2016	Dec 31, 2017
Status	Historical Actual	Target Not Met	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target				18.1%	25.0%	25.0%
Result				25%	Dec 31, 2016	Dec 31, 2017
Status				Target Not Met	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	33 million	30 million	31 million	32 million	34 million	34 million
Result	35.9 million	34.3 million	June 30, 2016	Nov 1, 2016	Nov 30, 2017	Nov 30, 2018
Status	Target Exceeded	Target Exceeded	Pending	Pending	Pending	Pending

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 made this initiative a Priority Goal for the FY 2014 – 2015 period and continued for FY 2016 –2017: 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. As of FY 2014, 29 states had a QRIS that met high quality benchmarks, meeting the previously established target. States expanded from pilot programs to statewide-systems and increased availability to quality information, leading them to meet more components of the QRIS measure. States were also supported by targeted technical assistance through state specific benchmarks and goals. The FY 2014 results show that states continue to make progress toward implementing QRIS that meet high-quality benchmarks. Currently, many states meet some, but not all seven, of the outlined benchmarks – for example, as of FY 2014, at least six states have incorporated six quality benchmarks and at least six states have incorporated five quality benchmarks. In addition, targeted technical assistance provided by the new National Center on Early Childhood Quality Assurance, as well as other technical assistance partners funded by OCC, helps states work toward their goals to improve their QRIS through small group peer-to-peer interactions, national webinars, and topical learning tables related to 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 2015 indicates that 22 percent of grantees scored in the low range, exceeding the target of 26 percent. All grantees scoring in the low range did so on the Instructional Support domain. All seven FY 2015 implementation milestones for this program were also completed.

In addition to looking at classroom quality through the CLASS measure, the ACF Office of Head Start (OHS) is also emphasizing the credentials of classroom teachers by striving to increase the percent of Head Start and Early Head Start teachers with a Bachelor's Degree (BA) degree. In doing so, OHS is prioritizing a distinct but complementary goal in boosting the quality of Head Start programs. This measure is distinct in that it looks at credentials for both Head Start and Early Head Start teachers, rather than focusing on the credentials of Head Start pre-school teachers. The most recent results for this performance measure indicate that in FY 2015, 60 percent of Head Start and Early Head Start teachers have a BA or higher.

ACF is committed to establishing permanency for some of our most vulnerable citizens—children who are in foster care and runaways. The ACF Transitional Living Program (TLP) seeks to foster a safe and appropriate exit rate of children from the program by monitoring 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, the TLP 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 fell short of its target in FY 2014 (92.4 percent) for those children in care less than 24 months, finding permanency for 91.6 percent. ACF also fell slightly short of its target for FY 2014 (75.4 percent) on the complementary performance measure examining the placement rate for children who have been in care 24 months or longer, realizing permanency in 75.0 percent of exits, but nonetheless demonstrated improvement over the previous year's rate. 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 2014, performance on this measure declined slightly from the previous year (85.5 percent), but still exceeded its target with 85.2 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. In FY 2015, the number of children with severe emotional disturbance that are receiving services from the CMHI increased and the measure 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 2015, SAMHSA exceeded the performance target with 74.4 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.

SAMHSA's Safe Schools Healthy Students (SS/HS) seeks to create healthy learning environments that help students thrive, succeed in school and build healthy relationships. The program addresses key public health priorities associated with youth in the US. This program implements and continually improves a coordinated and comprehensive plan of activities, programs, and services that promote healthy childhood development, prevent violence, and prevent unhealthy behaviors. Grantees are required to develop local strategic plans that address five required elements: (1) safe school environments and violence prevention activities; (2) alcohol, tobacco, and other drug prevention activities; (3) student behavioral, social, and emotional supports; (4) mental health services; and (5) early childhood social and emotional learning programs. This measure includes both middle school and high school students that reported having used alcohol within the past 30 days. For this measure, lower numbers reflect higher performance. In FY 2015, 25 percent of middle and high school students who report current alcohol use, exceeding the target.

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 continues to invest in building its Classroom Assessment Scoring System (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. ACF will conduct more analysis on the specific dimensions that are particularly challenging for those grantees, such as concept development and language modeling, and tailor the technical assistance for grantees based on their specific needs. With respect to increasing the number of teachers with a Bachelor's Degree (BA) or higher, ACF is investing in an initiative called Early EdU, which is a higher education alliance working to advance early childhood teaching by providing online courses for early childhood educators so they can pursue a BA. ACF is also working within states to strengthen early care and education professional development systems and promote articulation agreements within and across institutions of higher education. Articulation agreements allow students to apply credits earned in one program toward another program, which facilitates them moving along their educational pathway toward a BA. The ACF Office of Child Care (OCC) is gathering information about Quality Rating and Improvement System (QRIS) implementation through the Child Care and Development Fund (CCDF) Plan and the annual quality performance report, as well as providing states with targeted technical assistance through state specific technical assistance plans and goals. The National Center for Child Care Quality Improvement, funded by OCC, helps states work toward their goals to improve their QRIS through small group peer-to-peer interactions, national webinars, and topical learning tables related to quality benchmarks.

ACF will continue to support state agencies as they work to move children to permanent homes. 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.

As part of the Maternal and Child Health (MCH) Block Grant Program, HRSA will continue to address states' efforts to strengthen the capacity and quality of health systems to serve women, infants, and children support of health systems infrastructure development, public information and education, screening and counseling, and other services (including direct care services as payer of last resort). In addition, the Program will continue to monitor emerging issues, provide needed technical assistance , and share promising models and effective strategies that promote improved maternal and child health outcomes.

The Safe Schools Healthy Students (SS/HS) initiative addresses key public health priorities associated with youth in the US. This program includes Project Aware. SS/HS is designed to implement and continually improve a coordinated and comprehensive plan of activities, programs, and services that promote a healthy learning environment where students thrive, succeed in school, and build healthy relationships. SAMHSA is taking this effective model to scale through the Safe Schools/Healthy Students State Planning, Local Education Agency, and Local Community Cooperative Agreements. The State Education Agency and the State Mental Health Authority are partners in the oversight. The intent is to build cross system capacity to utilize effectively the growing body of knowledge learned from prevention

and implementation science for the purpose of supporting expanded adoption of similar approaches in states.

In FY 2014, in response to the tragedy at Sandy Hook Elementary School and as part of the President's *Now is the Time* initiative, SAMHSA provided resources to support Project AWARE (Advancing Wellness and Resilience in Education) in order to increase awareness of mental health issues and connect young people who have behavioral health issues and their families with needed services. SAMHSA collaborates with the Departments of Education and Justice in the development, implementation, and management of this initiative to maximize coordination and avoid duplication of efforts. Project AWARE has multiple components. The first component, Project AWARE State Educational Agency (SEA) grants, is built on the highly successful SS/HS model. This model seeks to create safe and supportive schools and communities. SAMHSA has awarded these grants to 20 SEAs to promote comprehensive, coordinated, and integrated state efforts to make schools safer and increase access to mental health services.

FY 2014 Strategic Review Objective Progress Update Summary

Please note that this section summarizes the result of the FY 2014 HHS Strategic Review process, limiting the scope of content to that available prior to spring of 2015. Due to this constraint, the following may not be the most current information available.

Conclusion: Progressing

Analysis: HHS collaborates with state, local, tribal, urban Indian, nongovernmental, and private sector partners to sustain an essential safety net of services that protect children and youth, promote their emotional health and resilience in the face of adversity or trauma, and ensure their healthy development from birth through the transition to adulthood. In a number of cases there was substantial evidence of important innovation and impact, with systematic evaluation of efforts and outcomes. Significant trends include increased attention to specific causal areas of risk --for example, early identification of developmental delay and increased attention to the biopsychosocial effects of trauma and adverse childhood experience. There was evidence of major policy development efforts, and substantial evidence of serious engagement in evaluation.

The Institute of Medicine has highlighted many opportunities for improving adolescent health. Adolescent Health: Think, Act, Grow (TAG) was developed to build awareness of the adolescent years as opportunities to increase delivery of recommended screening, immunizations, and other recommended preventive services; to intervene promptly when risky behavior, mental health, substance use, or other issues emerge; and to set the course for healthy, productive adulthood.

In 2014, the President signed into the law the first statutory reauthorization of the Child Care and Development Block Grant (CCDBG) program since 1996, which aims to move children receiving subsidies into high-quality child care settings. Among a comprehensive array of reforms, the new statute includes an increased focus on improving the quality of child care through systemic quality investments, which will helps states toward meeting the Priority Goal. In addition, the statute includes provisions requiring states to evaluate the measurable outcomes of their quality improvement activities.

Several key changes have been made to the Teen Pregnancy Prevention (TPP) Program based on experiences during the last five years, lessons learned, and feedback from experts in the field. Changes in the new funding for grantees includes, but is not limited to, ensuring inclusivity of all youth served, applying Positive Youth Development practices when interacting with youth, and using a trauma-informed approach.

As HHS increasingly focuses on preventive interventions, the problem of how to measure and demonstrate success will require additional attention. For example, there are 50,000 Head Start and Early Head Start classrooms across the country in diverse settings ranging from New York City to the bottom of the Grand Canyon. Changing teacher behavior and practices at the ground level to improve the quality of the classroom is a formidable challenge, particularly in highly rural areas, American Indian and Alaska Native programs, and Migrant and Seasonal Head Start programs where finding qualified staff can be difficult due to more limited access to higher education.

Among the major planned efforts for the Department is the continued implementation of an action plan for the Priority Goal for improving Early Childhood Care and Education. In addition, the Department will be working among Divisions to identify reimbursement mechanisms for trauma-informed and trauma-focused care interventions with children.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	792,000 caregivers	796,000 caregivers	790,000 caregivers	790,000 caregivers	825,000 caregivers	900,000 caregivers
Result	867,546 caregivers	1,046,159 caregivers	934,096 caregivers	Dec 31, 2016	Dec 31, 2017	Dec 31, 2018
Status	Target Exceeded	Target Exceeded	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	71.75 %	71.77 %	69.76 %	76.84 %	83.01 %	Prior Result +1%
Result	71.06 %	69.07 %	76.08 %	82.19 %	Nov 30, 2016	Nov 30, 2017
Status	Target Not Met but Improved	Target Not Met	Target Exceeded	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	51.02 %	52.5 %	54 %	54.5 %	54.75 %	55 %
Result	52.91 %	49.33 %	47.28 %	Dec 30, 2016	Dec 29, 2017	Dec 31, 2018
Status	Target Exceeded	Target Not Met	Target Not Met	Pending	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target[58]	80 targeting index score	85 targeting index score	84 targeting index score	80 targeting index score	Prior Result +0	Prior Result +0
Result	83 targeting index score	84 targeting index score	80 targeting index score	Nov 30, 2016	Nov 30, 2017	Nov 30, 2018
Status	Target Exceeded	Target Not Met but Improved	Target Not Met	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target[59]	124 targeting index score	116 targeting index score	117 targeting index score	112 targeting index score	Prior Result +0	Prior Result +0
Result	114 targeting index score	117 targeting index score	112 targeting index score	Nov 30, 2016	Nov 30, 2017	Nov 30, 2018
Status	Target Not Met	Target Exceeded	Target Not Met	Pending	Pending	Pending

[58] From FY 2014 – 2017 the target is to maintain the prior year result.

[59] From FY 2014 – 2017 the target is to maintain the prior year result.

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	89.7 %	90 %	90 %	90 %	90 %	90 %
Result	90.3 %	92.3 %[60]	92.6 %[61]	May 31, 2016	Mar 31, 2017	Mar 31, 2018
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	62 %	62 %	62 %	63 %	65 %	67 %
Result	63 %	64 %	64 %	Nov 30, 2016	Nov 30, 2017	Nov 30, 2018
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	30.6 %	30.7 %	32.5 %	Prior Result +0.1PP	Prior Result +0.1PP	Prior Result +0.1PP
Result	30.4 %[62]	32.4 %	31.4%	Jan 31, 2017	Jan 31, 2018	Jan 31, 2019
Status	Target Not Met but Improved	Target Exceeded	Target Not Met	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	32.7 %	32.7 %	31.7 %	31.7 %	31.7 %	30%
Result	32.7 %	31.7 %	31.7 %	30.2%	Oct 31, 2016	Oct 31, 2017
Status	Target Met	Target Not Met	Target Met	Target Not Met	Pending	Pending

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

[61] The FY 2013 data includes corrected data from two grantees that may have been collecting/reporting data incorrectly for prior fiscal years. In FY 2014, grantees were able to update their FY 2013 numbers if an error was found and two grantees did so.

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

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	25.6 %	25.6 %	24.6 %	33 %	33 %	33%
Result	35.7 %	44.9 %	45.8 %	46.1 %	Oct 31, 2016	Oct 31, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Analysis of Results

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 by supporting 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 2014, over 900,000 caregivers received services exceeding the target of serving 790,000 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 (e.g. respite versus caregiver training) then fewer caregivers can be served with a given amount of resources). In addition to the program's increasing reach to serve more caregivers, several specific indicators of program outcomes are also high. Nearly three-quarters of caregivers receiving services report that the services have "helped them provide care longer"; 74 percent of caregivers report experiencing less stress as a result of services; and nearly 40 percent of caregivers report that without services their care recipients would be unable to maintain their current living arrangements.

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 2015, 82.19 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 76.84 percent, an increase of 7.01 percentage points over the previous year's result. All grantees showed year over year performance increases on this performance measure, which represents a return to program achievements not seen since before the recession. In addition to robust economic conditions, several grantees attributed the increases to the ongoing focus on performance improvement plan process.

In FY 2014, the percentage of refugees entering employment through ACF-funded refugee employment services was below the target of 54.00 percent with an actual result of 47.28 percent. This is a result of various 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. Lower performance by the three largest programs: Florida, Texas, and California significantly affected the overall outcome. Many recent arrivals have spent protracted periods of time in refugee camps in countries of first asylum, have experienced intense trauma, and have limited work skills.

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 U.S. population of eligible clients. The recipiency targeting index decreased to 80 for FY 2014, falling short of the established target of 84 for FY 2014. The index score still indicates that elderly households receiving heating assistance were served at a level below their representation in the income eligible population of elderly households. Families with young children also experienced challenges with recipiency. In FY 2014, the recipiency score for households with children fell short of the FY 2014 target of 117.

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 2014, the result for this measure increased by 0.3 percentage points.

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 2014 of 64 percent exceeded the target for this measure for a fourth 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) measure assesses the extent to which recipients transition from cash assistance to employment. 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. However, in FY 2014, the rate of newly employed decreased slightly to 31.4 percent, missing the FY 2014 target of 32.5 percent, which was based off the previous year's result. 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 2015 target for homeless clients receiving services who were currently employed or engaged in productive activities was not 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 45.8 percent in FY 2014. In FY 2015, 46.1 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.

Plans for the Future

The ACL data collection for the "process evaluation" of the National Family Caregiver Support Program (NFCSP) is expected to be completed in FY 2015. The results from that portion of the evaluation will be useful in helping ACL and the Aging Services Network understand how the program has developed over the past 15 years, including the challenges being faced at the state and local levels. This information will be disseminated broadly and will likely be an invaluable tool in guiding future program implementation decisions at the federal, state, and local levels. Additionally, evaluation results will help inform guidance and technical assistance to the Aging Services Network as it implements any changes to the program that occur as a result of reauthorization and to more efficiently and effectively meet the growing demand for caregiver supports as the population of older adults increases dramatically.

The ACF refugee employment program aims to continue to increase performance by improving Office of Refugee Resettlement (ORR)'s collaboration with states and Wilson-Fish agencies to better communicate ORR priorities and to share knowledge of best practices that can be transferred across programs. This endeavor includes increasing ORR monitoring activities in which program challenges are followed up with technical assistance and further monitoring. ORR is working closely with ACF's Office of Family Assistance to increase collaboration between TANF and refugee service providers. ORR is also intending to work more closely with technical assistance providers to ensure effective guidance to states and Wilson-Fish agencies. ORR plans to work with states and Wilson-Fish agencies to improve engagement through a new regional structure and expects positive trends to continue in FY 2017 thus reaching the goal of 55.00 percent of refugees entering employment through ACF-funded refugee employment services.

ACF is committed to assisting states with helping TANF adult recipients enter employment by 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. Through these efforts, the ACF Office of Family Assistance (OFA) supports state, tribal, and community partners to design and implement programs that focus simultaneously on parental employment and child and family well-being. In August 2015, OFA convened state TANF administrators and human services commissioners/secretaries at the Gateway to Opportunity national conference to explore how state TANF programs can incorporate job-driven and career pathways training, two-generation approaches, and more innovative practices to improve family economic security. Tribal TANF leaders also convened at this time, creating an opportunity for shared learning and relationship-building across state and tribal programs. OFA launched the Systems to Family Stability National Policy Academy (the Academy) in FY 2015. The Academy will continue to engage eight teams of key leaders, administrators, and stakeholders from a select group of TANF jurisdictions to develop and implement TANF program improvements over an 18 month period. The Academy will support state and local TANF programs to improve employment outcomes and strengthen service delivery. In FY 2015 OFA also initiated facilitation of a year-long peer exchange designed to help eight state teams explore strategies for successful integration of TANF and Workforce Innovation and Opportunity Act (WIOA) programs.

Grants for the Benefit of Homeless Individuals (GBHI) grants are designed to expand and strengthen treatment services for those experiencing homelessness, with substance use and co-occurring mental and substance use disorders. This program seeks to provide treatment and recovery support services for individuals experiencing homelessness. In addition to strengthening access to treatment and housing support, grantees are linked to primary health care services. 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.

FY 2014 Strategic Review Objective Progress Update Summary

Please note that this section summarizes the result of the FY 2014 HHS Strategic Review process, limiting the scope of content to that available prior to spring of 2015. Due to this constraint, the following may not be the most current information available.

Conclusion: Progressing

Analysis: Strong individuals, families, and communities are the building blocks for a strong America. Promoting economic and social well-being requires attention to a complex set of factors. With its partners, HHS is working to provide a path of opportunity to help families leave poverty, to enter the middle class, and to revitalize communities. While some progress has been made on this Strategic Objective more could be done. There are significant challenges of HHS work in this area. One challenge is that many of the factors that influence economic and social well-being are out of HHS's control (i.e. the economy and the availability of jobs that pay a family-supporting wage). Another is the nature of block grants and the variation in the programs that are implemented at the state and local level.

Recent accomplishments include work expanding knowledge about effective programs to promote employment, family economic security, and child and family well-being. HHS has partnered with the Department of Labor to encourage the use of Temporary Assistance for Needy Families (TANF) and the Community Services Block Grant (CSBG) funds to support subsidized employment programs, including summer youth employment, as a pathway to unsubsidized employment and economic security. In addition, HHS collaborated with the Departments of Labor and Education on WIOA guidance and technical assistance, as well as to encourage engagement of human services agencies in WIOA implementation to help ensure that TANF and CSBG participants and other individuals with significant employment barriers are well served in the one-stop system.

HHS continued to make progress in supporting the prevention of, and effective intervention into, abuse, neglect, and exploitation of older adults and adults with disabilities. The Lifespan Respite Program in cooperation with ARCH National Respite Network and Resource Center completed and disseminated a document entitled *Measuring Systems Change and Consumer Outcomes: Recommendations for Developing Performance Metrics for State Lifespan Respite Programs*. This document can serve as a guide to developing Lifespan Respite Programs for how to measure performance of new and developing programs for family caregivers across the lifespan.

Performance data shows that HHS criminal justice related programs are effective in improving the lives of participants. The drug court program served 7,357 individuals in 2014. The percentage of those receiving services that were employed or engaged in productive activities increased to 55.8 percent compared to 34.7 percent at intake. The percentage of individuals receiving services who had a permanent place to live in the community increased to 40.8 percent compared to 29.5 percent at intake. The percentage of adults receiving services who had no past month substance use increased to 81.9 percent compared to 50.2 percent at intake.

Though HHS is working to increase economic and social well-being, there are many influences outside of HHS's control. For example, the TANF program has not been fully reauthorized in many years. The flexibility that is inherent in TANF as a block grant has enabled states to use their TANF dollars in a

variety of ways, including filling budget gaps for human services programs that are not part of their welfare program. In FY 2013, states spent less than 30 percent of their federal TANF and state maintenance-of-effort dollars on cash assistance to families and only six percent on work activities. Further, between 1995 and 2011, the share of eligible families receiving TANF declined from 84 percent to 34 percent. Another challenging example is adult protective services (APS) which are state-based systems and which can vary widely across states. A number of challenges exist that impede the Department's ability to achieve the biggest impact with program efforts to address abuse neglect and exploitation of older adults and adults with disabilities. There is a lack of information about the risk and protective factors for being a victim or perpetrator of abuse. In addition, there is a lack of information about effective and evidence-based prevention, intervention, and remediation practices.

The Department continues to provide intensive technical assistance oriented towards strengthening TANF programs to create better outcomes for families. TANF administrators and state commissioners/secretaries will meet to explore how state TANF programs can more effectively assist parents in their efforts to achieve economic security in a 21st century economy, while also supporting child and family well-being. The first report of data submitted using the National Adult Maltreatment Reporting System (NAMRS) is expected by June, 2017. This report will be the first systematic look at the experience of abuse, neglect, and exploitation of older adults and adults with disabilities, as reported to state Adult Protective Service programs across multiple states.

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	28%	28%	28%	27%	27%	26.8%
Result	26%	31.6%	36%	Dec 31, 2016	Dec 31, 2017	Dec 31, 2018
Status	Target Exceeded	Target Not Met	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	90%	90%	90%	90%	90%	90%
Result	88%	89%	88%	Dec 31, 2016	Dec 31, 2017	Dec 31, 2018
Status	Target Not Met	Target Not Met but Improved	Target Not Met	Pending	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	90%	90%	90%	90%	90%	90%
Result	98.5%	97%	95.1%	Dec 31, 2016	Dec 31, 2017	Dec 31, 2018
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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	90%	90%	90%	90%	90%	90%
Result	93.8%	94.6%	93.6%	Dec 31, 2016	Dec 31, 2017	Dec 31, 2018
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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	N/A	39%	44.3%	44.8%	45%	45.1%
Result	43.5%	43.5%	42%	Dec 31, 2016	Dec 31, 2017	Dec 31, 2018
Status	Historical Actual	Target Exceeded	Target Not Met	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	87.0 %	87.0 %	87.0 %	87.0 %	87.0 %	88.0 %
Result	87.0 %	88.3 %	72.6 %	Jul 31, 2016	Jul 31, 2017	Jul 31, 2018
Status	Target Met	Target Exceeded	Target Not Met	Pending	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	5,420	5,420	4,591	4,360	2,296	2,296
Result	4,781	4,360	2,296	1,676	Dec 31, 2016	Dec 31, 2017
Status	Target Not Met but Improved	Target Not Met	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 36 percent of caregivers in FY 2014, missing the target of 28 percent. While results in FY 2013 and FY 2014 reflect a significant improvement since the beginning of the National Family Caregiver Support Program, the increasing challenges faced by family caregivers may be a reflection of the impact of sequester and stagnant budgets.

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. Performance for FY 2014 was 88 percent reporting “good” to “excellent” service quality, falling just short of the target, but consistent with previous year’s results. Of the other 12 percent of respondents, the majority rated specific indicators positively, e.g. nearly 60 percent report liking the meals they receive. AoA expects the slight drop in positive rating of program quality to be transient 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 95 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 served by the National Family Caregiver Support Program reported a 93.6 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 2014 result is 42 percent. This unexpected decline was partially due to at least one state losing all ADL assessment data for clients during the transition to a new data system.

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.

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. This has had short term performance implications. Overall, performance for this program has been stable and improving. FY 2015 was a challenging year but program improvements are expected during 2016. The targets are being increased starting in 2017 to be more ambitious.

Plans for the Future

National Family Caregiver Support 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). Longer term efforts include dissemination of results from the 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 ensure 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.

SAMHSA fills gaps in community resources in ways that address the complex issues surrounding mental illness, substance use disorders, and housing. SAMHSA's PATH program funds community-based outreach, mental and substance use disorder treatment services, case management, assistance with accessing housing and support services to vulnerable individuals in need of sustainable stable housing as well as social connections and other services and supports. 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.

The PAIMI Program continues to pursue excellence in assuring that the most vulnerable individuals with mental illness, especially those residing in public and private residential care and treatment facilities are free from abuse. PAIMI addresses such issues as inappropriate restraints and seclusion, neglect, and rights violations. A PAIMI Program Peer Review process is in place for the Annual Program Performance Report which assesses and provides specific feedback regarding strengths and weaknesses of the program as well as specific recommendations for ongoing quality improvement. The PAIMI Programs within each State Protection & Advocacy (P&A) agency are monitored via on-site reviews on a regular schedule. These on-site monitoring reviews are conducted by independent consultants and provide SAMHSA with an assessment of key areas: governance, legal, fiscal and consumer/constituent services/activities of the State's PAIMI Program. Following these site visits, the consultants issue a report that summarizes its program findings and when appropriate, may include recommendations for technical assistance and/or corrective action. These steps are expected to improve performance so that annual and long-term targets can be met.

FY 2014 Strategic Review Objective Progress Update Summary

Please note that this section summarizes the result of the FY 2014 HHS Strategic Review process, limiting the scope of content to that available prior to spring of 2015. Due to this constraint, the following may not be the most current information available.

Conclusion: Progressing

Analysis: At a national population level, progress on this objective is being made. The primary driver for accessibility and quality of long-term services and supports is the Medicaid program. In 2008, 42 percent of Medicaid long-term services and supports expenditures were for home and community-based services (HCBS). The most recent data from 2012 indicates that this has increased to nearly 50 percent. Nearly half of the states expend 50 percent or more of their Medicaid long-term service and supports on home and community-based services. The activities driving change in access to care include Money Follows the Person, Balancing Incentives Program, and Community First Choice – 1915(k) waivers. The primary quality drivers in long-term care services and supports include HCBS final rule and the National Quality Forum quality measure initiative.

Nearly every state is implementing Money Follows the Person and while the most recent target was missed, more than 10,000 individuals transitioned in 2013. Currently 21 states are approved under BIP, which is targeted at the states that have a low percent of long-term services and supports expenditures compared to institutional services. Over a 4-year period $3 billion is available to these states and will likely have a significant impact in rebalancing long term care. The 1915 (k) waiver is small with five states approved but growing as six additional states are in the planning stage.

The National Quality Forum quality measure initiative is an early milestone in the Department’s efforts to improve quality. The lack of standard, reliable and valid measures is a primary barrier to quality improvement. While each of the above accomplishments may be making a difference or are a milestone with great potential there are challenges and areas for improvement that can be identified for each.

HHS is working to strengthen quality measures, disseminate evidence-based interventions, and evaluate programs to improve our ability to serve seniors and people with disabilities. A challenge facing the future development and endorsement of HCBS quality measures is the lack of organizational capacity for measures stewards to foster measures through the rigorous process. Another challenge is the difficulty of dissemination of evidence-based interventions in nursing homes. It is difficult for a number of reasons: there is high turnover of staff and leadership, nursing homes have a number of quality deficits that need to be dealt with, and it is difficult to engage in more than one or two interventions at one time. Consequently, interventions need to compete with other interventions for attention. In addition, delays in availability of Medicaid data required for the evaluation of the Financial Alignment Initiative for Medicare-Medicaid Enrollees may impact the timeframe for access to a complete, preliminary set of results necessary to comprehensively evaluate and disseminate best practices associated with the expanded services provided under the capitated financial alignment model demonstration. In addition, states are working to transition from submitting Medicaid Statistical Information System (MSIS) data to instead submitting data through the new, transformed-MSIS (tMSIS) process. During this transition period, some states are currently not submitting Medicaid data in either format, which may result in significant delays in data availability for evaluation purposes.

In the near term, the HCBS final rule has the potential to significantly impact quality of long-term service and supports in the community. Challenges persist around implementation but federal partners are working with states to ensure the regulation results in improvements for beneficiaries. With the dissemination of the On-Time pressure ulcer prevention intervention in 50 nursing homes the Department will assess the success of the new training materials, the ability to recruit nursing homes, successfully implement the intervention, and show that the intervention continues to prevent pressure ulcers and is sustainable. Upcoming findings on the Financial Alignment Initiative will include the first state-specific annual reports for the three state demonstrations implemented in 2013.

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	Set Baseline	1,259.0 per capita	1,212.0 per capita	1,174.0 per capita	1,145.0 per capita	1,127.0 per capita
Result	N/A	1,277.0 per capita	1,216.0 per capita	Jul 31, 2016	Jul 31, 2017	Jul 31, 2018
Status	Not Collected	Target Not Met	Target Not Met but Improved	Pending	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	20 %	19 %	18 %	17 %	16 %	15 %
Result	18.1 %	17.8 %	16.8 %	Nov 30, 2016	Nov 30, 2017	Nov 30, 2018
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	84,000	75,000	100,000	105,000	110,000	125,000
Result	87,455	109,908	124,296	162,873	Dec 31, 2016	Dec 31, 2017
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	18.6 %	18.2 %	N/A	15.7 %	N/A	11.9 %
Result	14 %[63]	15.7 %[64]	N/A	Jun 30, 2016	N/A	Jun 30, 2018
Status	Target Exceeded	Target Exceeded		Pending		Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	555,132	555,132	765,638	989,994	1,308,825	1,308,825
Result	884,536	1,061,204	1,308,825	1,502,573	Dec 31, 2016	Dec 31, 2017
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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	68.4 %	63.1 %	63.1 %	66.1 %	66.1 %	66.1 %
Result	66.7 %	66.1 %	66.0 %	70.8 %	Dec 31, 2016	Dec 31, 2017
Status	Target Not Met	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	N/A	Set Baseline	5,911	5,911	8,850	9,177
Result	3,760	7,389	8,219	5,588	Dec 31, 2016	Dec 31, 2017
Status	Historical Actual	Baseline	Target Exceeded	Target Not Met	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	93 %	93 %	93 %	93 %	93 %	93 %
Result	85.9 %	84.3 %	83.1 %	80.7%	Jan 31, 2017	Jan 31, 2018
Status	Target Not Met but Improved	Target Not Met	Target Not Met	Target Not Met	Pending	Pending

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

[64] 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

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	N/A	32.3 %	51 %	47.3 %	53.3 %[65]	Discontinued
Result	37.5 %	46.7 %	52.3 %	55 %	Sep 30, 2016	N/A
Status	Historical Actual	Target Exceeded	Target Exceeded	Target Exceeded	Pending	

Statin Therapy for the Prevention and Treatment of Cardiovascular Disease among American Indians and Alaska Natives. (Lead Agency - IHS; Measure ID - 51)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target						Set Baseline
Result						Sep 30, 2017
Status						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 established this effort as a Priority Goal for FY 2014 – 2015 and will continue to address the challenge as a Priority Goal for FY 2016 – 2017. In FY 2014, the annual adult combustible tobacco consumption in the United States failed to meet the target of 1,212 cigarette equivalents per capita, falling just short.

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 16.8 percent in FY 2014, 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 2015, under contracts with 45 states and territories, FDA conducted 162,873 compliance check inspections of retail establishments, substantially exceeding its target. Although this

[65] In FY 2015 the CVD measure included five risk factors. In FY 2016 the measure will include four risk factors.

was a much higher number than expected, it reflects the high level of variability inherent in this goal requiring the estimation of the number of compliance checks that each state will be able to conduct.

Another significant cause of early death in the U.S. is suicide. The National Center for Health Statistics (CDC) reported in 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 1,502,573 calls answered in FY 2015, an increase of almost 200,000 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 2015, 70.8 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 20143-2015 program year, 80.7 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 2013 program year while others experienced most of the impact from the reductions during the FY 2014 program year. That said, when analyzing the data at enrollment compared with at the end of enrollment, the percentage of children who were up-to-date on medical screenings increased 18 percent. This result demonstrates that Early Head Start program are making a significant progress in assisting children get age-appropriate medical screenings during the program year.

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 2015 the target was 47.3 percent of coronary heart disease patients receiving all 5 assessments and the result was 55 percent, exceeding that target by 7.7%. IHS used national webinars to highlight each of the five assessments to improve the 2015 results. In FY 2016, the measure numerator does not include "Patients with LDL completed during the report period, regardless of result." The new American College

of Cardiology/American Heart Association (ACC/AHA) cholesterol guidelines no longer recommend treating to LDL targets. Statin medication therapy is recommended instead.

Plans for the Future

The ACF Office of Head Start is also doing more to analyze the data regarding medical screenings to understand which programs and geographic areas are struggling with this particular measure and determine a strategy to provide targeted support. In the interim, the Office of Head Start has completed a toolkit for Head Start and Early Head Start programs to assist them in the tailored use of an online, web-based Well Visit Planner (WVP), 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 WVP helps parents and caregivers to customize the well-child visit to their family's needs by helping them identify and prioritize their health risks and concerns before the well-child appointment. This means that parents and health care professionals are better able to communicate and address the family's needs during the well-child visit.

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.

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.

SAMHSA's suicide prevention activities provide states, colleges, consumer groups and other organizations with resources that build national capacity for preventing suicides. For example, SAMHSA supports statewide or tribal youth suicide early intervention and prevention services through the Suicide Prevention Resource Center (SPRC) and other programs. SPRC builds national capacity for preventing suicide through research, technical assistance, and policy development. One important aspect of this program is referring individuals for proper mental health intervention following prevention screening.

CDC is continuing to conduct applied research on the health effects and patterns of use of emerging tobacco products to inform the American public as well as decision makers. CDC is also modifying its surveillance systems to ensure it is able to capture relevant data on new products and shifting patterns of use. CDC will continue to communicate about these evolving issues to the American public, through media, such as the Tips from Former Smokers national education campaign.

Based on clinical practice and new treatment guidelines, the IHS has elected to discontinue the CVD risk factors measure after September 30, 2016. The comprehensive CVD measure evaluates 5 data elements related to cardiovascular disease risk, prevention, and treatment. New guidelines from the American College of Cardiology and the American Heart Association no longer recommend yearly LDL assessment as a basis for cardiovascular disease prevention. In 2016, LDL assessment will be dropped from the current measure. Starting in 2017, the IHS will begin to report on a new measure that aligns with new national guidelines by evaluating the management of cholesterol. This measure, Statin Therapy for the Prevention and Treatment of Cardiovascular Disease, will assess the number of patients who are at risk of cardiovascular disease and prescribed statin therapy during the reporting period or have a documented contraindication against receiving it.

FY 2014 Strategic Review Objective Progress Update Summary

Please note that this section summarizes the result of the FY 2014 HHS Strategic Review process, limiting the scope of content to that available prior to spring of 2015. Due to this constraint, the following may not be the most current information available.

Conclusion: Progressing

Analysis: Progress has occurred in this objective in the areas of smoking rates, physical activity, and the rate of rise of obesity. HHS is working to help programs incorporate evidence-based and evidence-informed models into their settings, using an expanded body of scientific literature. There are challenges posed by infectious threats (e.g. Ebola, MERS), electronic nicotine delivery systems, prescription opioid abuse, and legalization of marijuana in more states. HHS also faces a changing communication landscape which requires us to modernize our approach to public education.

To achieve positive results HHS needs to overcome some obstacles. Although there is a growing body of research on evidence-based prevention models, programs may need additional resources, training and technical assistance to incorporate evidence-based or evidence informed practices into their settings. Local adaptations to existing programs may be necessary, but also may influence the effectiveness of programs in unknown ways. It is difficult to balance the need for scientific rigor and the constantly expanding body of published scientific literature, with the public's demand for rapid and up-to-date reviews of the literature.

The introduction of emerging products, such as electronic nicotine delivery systems, and shifting patterns of tobacco use are presenting challenges to tobacco prevention and control. The Department has modified its surveillance systems to better capture shifting patterns of tobacco use among both youth and adults. While the overall tobacco use rate in the US has been decreasing, rates for individuals with behavioral health disorders, who comprise approximately 25 percent of the US population, have not decreased. A major effort for the Department is the continuation of the Agency Priority Goal focused on combustible tobacco consumption with a focus on reducing youth smoking and e-cigarettes. The Department plans to conduct applied research on the health effects and patterns of use of emerging tobacco products to inform the American public as well as decision makers. A State Policy Academy for Tobacco Control in Behavioral Health will provide an opportunity for behavioral health leadership teams in five states to build a collaborative action planning process to address the high rate of tobacco use by persons with behavioral health disorders.

In collaboration with the White House Conference on Aging, the Go4Life Month is launching in September 2015. Activities nationwide will encourage older adults to include exercise and physical activity as part of their daily routine. Healthfinder.gov has established a partnership with CVS Health in

2015 that could increase the uptake of clinical preventive services and increase the continuity of prevention care. CVS is encouraging its customers to get preventive services their Minute Clinic offers and to get other recommended preventive services at their primary care provider.

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. Other HHS components and offices that contribute to combatting infectious diseases include ASPR, FDA, HRSA, IHS, NIH, 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 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017
Target	2.2 cases/100,000	2.1 cases/100,000[66]	2.0 cases/100,000	1.9 cases/100,000	Discontinued	Discontinued
Result	2.6 cases/100,000	2.6 cases/100,000	2.9 cases/100,000	Jul 31, 2016	N/A	N/A
Status	Target Not Met but Improved	Target Not Met	Target Not Met	Pending	Not Collected	Not Collected

[66] 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.

Reducing foodborne illness in the population. By December 31, 2017, working with federal, state, local, tribal, and industry partners, improve preventive controls in food production facilities and reduce the incidence rate (reported cases per 100,000 population per year) of Listeria monocytogenes (Lm) infections by 8 percent. (Lead Agency - FDA; Measure ID - TBD)

	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017
Target	Set Baseline	Set Baseline	Set Baseline	N/A	N/A	.22 cases/100,000
Result	.26 cases/100,000	.25 cases/100,000	.24 cases/100,000	March 31, 2016	March 31, 2017	March 31, 2018
Status	Baseline	Baseline	Baseline	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	Set Baseline	47 %	50 %	53 %	56 %	59 %
Result	39 %	42 %	44 %	Sep 30, 2016	Sep 30, 2017	Sep 30, 2018
Status	Baseline	Target Not Met but Improved	Target Not Met but Improved	Pending	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	90 %	90 %	90 %	90 %	90 %[67]	90 %[68]
Result	91 %	92 %	92 %	Sep 30, 2016	Sep 30, 2017	Sep 30, 2018
Status	Target Exceeded	Target Exceeded	Target Exceeded	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	26.3 %	22.7 %	21 %	19.1 %	18.9 %	18.9 %
Result	24 %	23.6 %	Nov 30, 2016	Nov 30, 2017	Nov 30, 2018	Nov 30, 2019
Status	Target Exceeded	Target Not Met but Improved	Pending	Pending	Pending	Pending

[67,68] Targets are maintained at 90% to align with HP2020 targets.

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	N/A	2,813,684	3,310,618	4,796,000	6,600,000	7,200,000
Result	2,620,177	3,623,255	4,292,400	5,841,700	Dec 31, 2016	Dec 31, 2017
Status	Target Not In Place	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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)[69]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	Set Baseline	13.53	12.18	Discontinued[70]	Discontinued	
Result	18.74	18.28[71]	17.30	N/A	N/A	
Status	Baseline	Target Not Met but Improved	Target Not Met but Improved	Not Collected	Not Collected	

Reduce invasive healthcare-associated Methicillin-resistant Staphylococcus aureus (MRSA) infections. (Lead Agency - CDC; Measure ID - 3.3.2b)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target				Set Baseline	36,900	32,800
Result				41,000[72]	Nov 30, 2017	Nov 30, 2018
Status				Baseline	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	1.7 %	1.7 %	1.5 %	1.4 %	1.2 %	1.2 %
Result	1.4 %[73]	1.2 %	1.2 %	Sep 30, 2016	Sep 30, 2017	Sep 30, 2018
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

[70] 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

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

[72] Estimated baseline is provided and subject to change per forthcoming data.

[73] Preliminary

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	77.8 %	Set Baseline	74.8 %	73.9 %	76.8 %	78.3 %
Result	76.8 %	74.8 %[74]	75.4 %	73.3 %	Sep 30, 2016	Sep 30, 2017
Status	Target Not Met but Improved	Baseline	Target Exceeded	Target Not Met	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). This challenges HHS's ability to reduce Salmonella by limiting FDA's regulatory authority over infection producing foods. To attempt to decrease foodborne illness and death, the FDA and CDC have joined forces and made the reduction of SE infections attributable to shell eggs a Priority Goal for FY 2014 - 2015. CDC reported that the illness rate during the 12-month period ending June 30, 2015 was 2.9 illnesses per 100,000. This is a decrease from the 2010 rate (3.5 cases per 100,000) but is higher than the 2007-2009 baseline rate of 2.6 cases per 100,000 population.

FDA's new Agency Priority Goal to reduce foodborne illness is a long-term outcome goal that reflects FDA's efforts, along with our partners in CDC and NIH, to decrease the rate of Listeria monocytogenes (L.m.). Listeria monocytogenes infections are one of the leading causes of death from foodborne illness in the United States, resulting in an estimated 1,600 illnesses and 260 deaths each year. With enactment of the 2011 Food Safety Modernization Act (FSMA), Congress mandated a paradigm shift to prevention – to establishing a modern system of food safety protection based not on reacting to problems, but on preventing them from happening in the first place. Over the next two years, concentrated efforts to 1) improve preventative controls through inspections and technical guidance to industry, 2) improve surveillance and detection using whole genome sequencing of L.m. isolates, and 3) improve response by more accurately linking illnesses and outbreaks to the food that caused the illness, should lead to a reduction in the overall L.m. rate.

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

[74] 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.

the new standards of vaccinations for everyone 6 months and older. In FY 2014 the number of adults that received a flu vaccination increased to 44 percent, however CDC did not meet its goal.

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 in FY 2014 with 92 percent of children 19 to 35 months of age receiving MMR vaccination.

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. In FY 2013, 23.6% of persons diagnosed with HIV were diagnosed late in the course of infection, an improvement over 2012 results. Internationally, CDC is also focused on providing life-saving ART to adults and children to help control the HIV epidemic. In FY 2015, CDC collaborated with CDC supported partners in 23 PEPFAR countries to provide life-saving ART for 5,841,700 HIV-infected adults and children, about 61% of all ART provided by PEPFAR. Over four million (4,041,000) of these individuals are receiving direct service delivery support and an additional 1,800,700 are benefiting from essential technical support provided by CDC. This represents a 36% increase compared to FY 2014 in adults and children with advanced HIV infection receiving ART and a 43% increase compared to FY 2013.

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 Aureus (MRSA) infections. In FY 2014, there were just over 55,000 cases of MRSA with an incidence of 17.30 per 100,000 population. This represents a 36% decrease from 2007-2008 baseline. CDC replaced Measure 3.3.2a with a more nationally representative measure in FY 2015. This new measure is an estimate of the overall number of healthcare-associated MRSA bacteremia cases (healthcare onset and healthcare-associated community onset), the most common type of invasive MRSA infections in the U.S. Preliminary baseline data demonstrate 41,000 cases in 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 there were 9,421 TB cases in 2014, representing 3.0 per 100,000 population and 1.2 for U.S. born population, exceeding the target. 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 FY 2015 result of 73.3% narrowly missed the target of 73.9%.

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. CDC's efforts to improve adult influenza vaccination coverage rates include: increasing patient and provider education to improve demand implementing system changes in practitioner office settings to reduce missed opportunities for vaccinations enhancing evidence-based communication campaigns to increase public awareness about adult vaccines and recommendations expanding the reach of vaccination programs including new venues such as pharmacies and other retail clinics. This effort toward Salmonella infection reduction ended as a Priority Goal in FY 2015 and will be replaced by a focus on Listeria infection reduction for the FY 2016 – 2017 foodborne illness Priority Goal.

CDC will continue infection prevention and control efforts to reducing HAIs across healthcare settings, supporting national progress toward the HHS National Action Plan to Prevent Healthcare Associated Infections: Roadmap to Elimination. CDC continues to support PEPFAR's Impact Action Agenda, which is driven by the need to do the right things in the right places at the right time. In close alignment with the Office of the U. S. Global AIDS Coordinator (S/GAC) and other U.S. Government (USG) agencies collaborating in PEPFAR, CDC will maximize the impact of USG-supported ART programs worldwide by focusing resources in key geographic areas, reaching the most vulnerable populations, completing Site Improvement through Monitoring System (SIMS) assessments at all CDC-supported sites, and actively participating in the Interagency Collaboration for Program Improvement (ICPI).

The IHS supports the delivery of all routine childhood immunizations by providing clinical decision support and reminders for providers in the IHS Electronic Health Record. For FY 2016, IHS will update the reminders as needed, and will provide at least 2 web-based trainings for providers on the rationale for and use of these reminders. In addition, IHS will collect quarterly childhood immunization coverage reports in FY 2016 and disseminate coverage data to Area Immunization coordinators to identify sites with low coverage. The Area Immunization Coordinators in each of the 12 IHS regions use these data to provide feedback to facilities and identify sites in need of additional assistance. IHS will also continue to expand and support the electronic exchange of immunization data with state immunization information systems to support immunization efforts and continue to provide technical assistance and immunization education to IHS and tribal immunization programs. Other IHS programs, such as Public Health Nursing, also support this measure by conducting outreach for maternal-child health initiatives including parenting education on childhood immunizations during postpartum visits.

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Please note that this section summarizes the result of the FY 2014 HHS Strategic Review process, limiting the scope of content to that available prior to spring of 2015. Due to this constraint, the following may not be the most current information available.

Conclusion: Progressing

Analysis: Infectious diseases response consumed significant HHS effort and resources in 2014. At a time when MERS has replaced measles in the headlines and Ebola is just below the fold, review of HHS progress is timely and fraught with the enormity of the task. Because infectious diseases know no borders the capabilities and capacity of local public health have a large impact on the occurrence of infectious diseases. HHS works on many fronts to improve these capabilities globally. Domestically, there is a disparity of state/local capacities and capability that alone and together impact the goal of reducing the occurrence of infectious diseases.

HHS' impact on reducing the occurrence of variety of infectious diseases helps to illustrate progress on this objective. For example, measles is a perfect indicator disease for the nation's vaccine program. While much attention was given to the outbreak of measles associated with Disneyland earlier this year as an indicator for the pockets of unimmunized children and adults in the country, had population immunity been significantly less, the outbreak would have been far more widespread and severe. One lesson from the Disney-associated outbreak was that when many people are potentially exposed and need to be traced, it is an expensive and time-consuming process that diverts state and local health department resources from other priorities. HHS staff played a significant role in the identification, containment, treatment and prevention of Ebola and Ebola Fighters were recognized as Time Magazine's Person(s) of the Year.

The Department's historic and continuing contributions to reducing HIV have contributed to the downward trajectory of the number of people who are dying from AIDS. As President Obama said "This is a global fight and it's one that America must continue to lead….no other country has done more that this country… But we can't be complacent," PEPFAR's impact far exceeds the reduction of suffering, death and despair caused by AIDS. PEPFAR has built infrastructure, strengthened local health systems, and provided invaluable lessons and experience that will continue to inform and improve responses to unforeseen health crisis in the future.

HHS is working to address persistent challenges, especially in adult vaccination coverage, safe drinking water, and public health capacity. Vaccination for seasonal influenza has improved, but not achieved desired levels. Vaccination coverage levels among adults are low, and for those 65 and older the rate of vaccination has not substantially improved between 2000 and 2014. Without concerted effort, especially given the aging of the US population, vaccine preventable disease in the adult population is unlikely to improve. Approximately 13 percent of U.S. Households about 43 million people, use private drinking water systems that are unregulated under the federal Safe Drinking Water Act. These systems are primarily private wells but may also include springs, cisterns, and hauled water systems. From 1971 through 2006, there was significant increase in the annual outbreaks reported in individual water systems. Public health resources are diminishing at multiple levels. When state and local public health jobs are cut, the country loses important state and local capacity to track Healthcare Associated Infections or Antimicrobial Resistance, reduce our ability to assess prevention progress, provide infection control training, and effectively respond to outbreaks. Staffing cuts also affect the capacity of

public health laboratories to assist hospitals and test patient samples, and subsequently, the capacity of state and local public health to rapidly detect and respond to outbreaks.

A major area of effort for HHS will be the development of an Agency Priority Goal to combat antimicrobial resistance and including prevention activities related to antibiotic stewardship**.** In terms of controlling the HIV epidemic, to the extent possible the Department will pivot to a data-driven approach, especially using sub-national and sub-population epidemiologic data that strategically targets geographic areas and populations where HIV/AIDS is most prevalent and has the greatest HIV incidence.

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) medical countermeasures (MCM) under Emergency Use Authority (EUA) or licensed (Lead Agency - ASPR; Measure ID - 2.4.13)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	**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= +2; **Pan Flu/EID Licensed**= +2; EUA= +0	**CBRN Licensed**= +4; EUA= +2 (Cumulative 2010-2015) **Pan Flu/EID Licensed**= +5; EUA= +3 (Cumulative 2010-2015)	**CBRN Licensed**= +2; EUA = +1. **Pan Flu Licensed**= +1; EUA = 0	**CBRN New BLA and NDA approvals** = 2; **Pan Flu Licensed**= +1; new EUA = 0.

Result	**CBRN EUAs= 1;** CBRN EUA= 1 anti-neutropenia cytokine drug for acute radiation treatment (Neupogen) Pan Flu Licensed = 1 (Simplexa diagnostics device) BLA Submissions = 2 (vaccines) Awarded 3 contracts for Centers for Innovation in Advanced Development and Manufacturing (CIADM)	**CBRN EUA= 2;** ST-246 antiviral for smallpox approved by FDA for EUA and Neupogen an anti-neutropenia cytokine for radiation treatment. 2 other packages were submitted but not acted on during the performance period. **Pan Flu licensed=3**; Licensed by FDA are: 1) Flucelvax, the first cell0based seasonal influenza vaccine, 2) FluBlØk, the first recombinant-based seasonal influenza vaccine, and 3) Aura, a next generation portable ventilator for adults. While not part of the goal, BARDA saw the first anthrax antitoxin and the first botulinum antitoxin licensed by FDA. Both projects were supported by Project BioShield and approved under the FDA's Animal Efficacy Rule.	**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) 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	**CBRN EUA= 4:** New in FY 15: OraSure Ebola rapid diagnostic **CBRN Licensed= 5**: New in FY 15: Neupogen anti-neutropenia cytokine (Amgen) approved by for ARS treatment indication (March 2015); AIG anthrax antitoxin (Emergent) approved by FDA for treatment of inhalation anthrax (March 2015). **Pan Flu licensed=11**; New in FY 15: Rapivab antiviral drug (BioCryst) for treatment of influenza (December 2014); Cobas liat PCR system (Roche) for diagnostic detection of influenza A/B was CLIA-waived by FDA (September 2015). **Pan Flu EUA=3**	Dec 31, 2016	Dec 31, 2017

Status	Target Met	Target Not Met but Improved	Target Exceeded	Target Met	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	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.	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
Result	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	In FY 2013, CBER met the target to develop and evaluate new methods to produce high-yield influenza vaccine reference strains. Activities to meet this target include: • Multiple assays were evaluated to determine the best methods for assessing vaccine reference strain yield. This is a critical issue for comparing different virus reference strains that might be available to manufacturers for vaccine production. The growth and HA yield of eight H5N1 influenza reference strains, representing 8 distinct H5 sub-clades, were compared for HA yield (enzyme activity and HA protein), total infectious virus titer, total viral protein, and HA/ nucleoprotein ratio in eggs. The results indicated that a single method was	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. FDA developed a H7N9 influenza vaccine candidate virus. The vaccine candidate virus was optimized by introduction of targeted mutations in the viral genome	In FY 2015, FDA met the target to continue evaluation of new methods to produce high-yield influenza vaccine reference strains. Activities to meet this target included the following: • FDA continued efforts to develop new methods for determining influenza vaccine potency, an important component in the evaluation of high-yield influenza vaccine viruses. An international collaborative study, involving multiple manufacturers and regulatory agencies, was initiated to compare several alternative methods. The study will continue in FY 2016. In addition, improvements were made to the alternative potency assays under development at FDA	Dec 31, 2017	Dec 31, 2018

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
	the potential of each method and indicated that further development and evaluation was warranted.	insufficient for an accurate assessment of a candidate vaccine's potential for vaccine manufacturing and that multiple methods should be utilized.	to increase its protein yield, measured using the methods described above.	that included the ability to accurately measure the potency of influenza B vaccines in addition to influenza A vaccines. Assay development and evaluation will continue in FY 2016.		
Result		• 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. Increased hemagglutinin (HA) content of the reference virus was achieved by modification of the viral neuraminidase (NA) gene to include portions of the A/Puerto Rico/8/34 donor NA trans-membrane and stalk regions. Further increases in HA yield were obtained for this influenza reference strain by genetic modification of the virus PB1gene. HA yield is important to produce the needed quantity of vaccine and helps to ensure rapid availability of vaccines. • One new influenza reference strain was developed as a possible vaccine candidate for the H7N9 influenza virus that emerged in China during 2013. This		• FDA continued evaluation of methods to assess the relative yields of candidate vaccine viruses. FDA participated in an international collaborative study that compared the influenza virus yields and virus hemagglutinin (HA) production from several candidate vaccine strains. This study is ongoing and will continue in FY 2016. Studies at FDA, designed to increase the yields of candidate vaccines by targeted manipulation of the virus genome, demonstrated the feasibility of improving virus yields for H1N1 vaccine viruses. These studies will continue in FY 2016.		

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
		reference strain has passed all tests for attenuation and has been shared with the WHO collaborating centers.				
Status	Target Met	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
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, 2016	Dec 31, 2017
Status	Target Met	Target Met	Target Met	Target Met	In Progress	In Progress

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	91 %	94 %	95 %	95 %	96 %	96 %
Result	89 %	96 %[75]	96 %	Dec 31, 2016	Dec 31, 2017	N/A
Status	Target Not Met but Improved	Target Exceeded	Target Exceeded	Pending	Pending	Not Collected

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 2015, the program exceeded its target its target,

[75] The 98% result previously reported in the 2016 Congressional Justification was based on preliminary data. The result has been updated to reflect final data.

producing an additional 2 EUA and 4 licensed medical countermeasures in the CBRN area and an additional 3 EUA and 5 licensed products in the pandemic influenza portfolio.

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. FDA achieved its FY 2015 target to continue evaluation of new methods to produce high-yield influenza vaccine reference strains. Activities to meet this target include the following: FDA continued efforts to develop new methods for determining influenza vaccine potency, an important component in the evaluation of high-yield influenza vaccine viruses. An international collaborative study, involving multiple manufacturers and regulatory agencies, was initiated to compare several alternative methods. In addition, improvements were made to the alternative potency assays under development at FDA that included the ability to accurately measure the potency of influenza B vaccines in addition to influenza A vaccines. FDA also continued evaluation of methods to assess the relative yields of candidate vaccine viruses. FDA participated in an international collaborative study that compared the influenza virus yields and virus hemagglutinin (HA) production from several candidate vaccine strains. Studies at FDA, designed to increase the yields of candidate vaccines by targeted manipulation of the virus genome, demonstrated the feasibility of improving virus yields for H1N1 vaccine viruses. 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 96 percent in FY 2014, exceeding the target. CDC will continue to work with grantees to improve results and achieve future targets.

Plans for the Future

For FY 2016, 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.

FDA will continue evaluation of new methods to produce high-yield influenza vaccine reference strains.

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 sustain the percentage of grantees who can convene key staff within 60 minutes of notification.

FY 2014 Strategic Review Objective Progress Update Summary

Please note that this section summarizes the result of the FY 2014 HHS Strategic Review process, limiting the scope of content to that available prior to spring of 2015. Due to this constraint, the following may not be the most current information available.

Conclusion: Progressing

Analysis: HHS's submission to Congress in 2014 of the statutorily required *National Health Security Strategy (2015 – 2018)* provides overarching national guidance on enhancing our nation's health security. However, there are three themes from 2014 that best characterize HHS's achievements and support the above rating for Objective 3F of the HHS Strategic Plan:

1) The frequency and variety of public health and medical emergency incidents/events for which HHS responds demonstrates an expanding mission and near constant emergency posture for some components;
2) HHS has built a national public health and medical emergency response core infrastructure and capabilities by developing state and local public health capacity, building regional coalitions of healthcare providers, and preparing the National Disaster Medical System (NDMS) to respond; and
3) HHS demonstrated a model interagency collaboration and public private partnership in mobilizing the medical countermeasures (MCM) enterprise in response to Ebola.

While Ebola response efforts were the most highly visible in 2014, HHS prepared for, responded to, and supported recovery from a range of public health threats and emergencies. These investments helped Bellevue hospital develop and maintain its quarantine and isolation unit and exercise their clinical procedures, protocols, and plans which prepared Bellevue to receive and monitor a suspected Ebola case in a doctor who was exposed in West Africa while maintaining regular, day-to day-care in the facility. Likewise, a HPP funded healthcare coalition in West Virginia was poised to respond to a large chemical spill and the coalition's hospitals, long-term care facilities, poison centers, and behavioral health facilities came together to share resources and ensure that clean water, behavioral health, and other services were made available. The frequency of these incidents and events means that some components of HHS are in a near constant emergency posture.

Although HHS's emergency resources and expertise can augment services during emergencies, the success with which these needs are met during and after an emergency largely relies on the strength of the systems in communities that provide these services in routine, day-to-day settings. Emergency care requirements should be aligned with efforts to strengthen the healthcare, public health, human services and emergency management systems that provide routine care day-to-day so that these systems are able to provide appropriate care during emergencies. HHS plans to continue to invest in federal, state and local response tools such as such as public health emergency response core infrastructure, regional coalitions of healthcare providers, and the National Disaster Medical System to ensure capabilities to meet national disaster response needs. In addition, the Department will continue to invest in and enhance the Medical Counter Measure enterprise – a model of interagency collaboration and public-private partnership.

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 accuracy. 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

Unprivileged Users 2 Factor Authentication (Lead Agency - ASA; Measure ID - 3.1)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target					89%	92%
Result				87%	Dec 31, 2016	Dec 31, 2017
Status				Historical Actual	Pending	Pending

Privileged Users 2-Factor Authentication (Lead Agency - ASA; Measure ID - 3.2)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target					98%	98%
Result				97%	Dec 31, 2016	Dec 30, 2017
Status				Historical Actual	Pending	Pending

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	8,600 clients	8,700 clients	8,600 clients	9,250 clients	8,700 clients	9,000 clients
Result	9,206 clients	9,753 clients	8,930 clients	Dec 31, 2016	Dec 31, 2017	Dec 31, 2018
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Retain 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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	3.6	3.6	3.6	3.4	3.4	3.4
Result	4.1	4	3.9	3.9	Nov 8, 2016	Nov 8, 2017
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 – 3E)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	0.7 %	0.7 %	0.6 %	0.8 %	1.2 %	1.1 %
Result	0.8 %	0.7 %	0.9 %	1.84 %	Jan 31, 2017	Jan 31, 2018
Status	Target Not Met	Target Met	Target Not 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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	4.5 %	6 %	5.1 %	5.3 %	3.6 %[76]	3.55 %[77]
Result	6.2 %	5.3 %	5.5 %	3.65 %	Oct 31, 2016	Oct 31, 2017
Status	Target Not Met	Target Exceeded	Target Not Met	Target Exceeded	Pending	Pending

[76] The revised target for FY 2016 is based on the actual FY 2015 improper payment rate and was updated to reflect improved performance in this area.

[77] The revised target for FY 2017 is based on the actual FY 2015 improper payment rate and was updated to reflect improved performance in this area.

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	17 %	16 %	16 %	16 %	16 %	16 %
Result	16.07 %	15.85 %	15.23 %	Oct 31, 2016	Oct 31, 2017	Oct 31, 2018
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	5.4 %	8.3 %	9.9 %	12.5 %	11.5 %	10.4 %
Result	8.5 %	10.1 %	12.7 %[78]	12.09 %	Nov 15, 2016	Nov 15, 2017
Status	Target Not Met but Improved	Target Not Met	Target Not Met	Target Exceeded	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	10.4 %	10.9 %	9 %	8.5 %	9.14 %	8.79 %
Result	11.4 %	9.5 %	9 %	9.5 %	Nov 15, 2016	Nov 15, 2017
Status	Target Not Met	Target Exceeded	Target 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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	3.2%	3.1%	3.6%	3.5%	3.4%	3.3%
Result	3.1%	3.7%	3.3%	3.6%	Nov 15, 2016	Nov 15, 2017
Status	Target Exceeded	Target Not Met	Target Exceeded	Target Not Met	In Progress	In Progress

[78] 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.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016[79]	FY 2017
Target	Set Baseline	31 %	36 %	42 %	45 %[80]	TBD[81]
Result	27 %[82]	31.8 %	41.15 %	43.63 %	Nov 30, 2016	N/A[83]
Status	Baseline	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Target Not In Place

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	7.4 %[84]	6.4 %[85]	5.6 %	6.7 %	11.53 %	10.48 %
Result	7.1 %	5.8 %	6.7 %	9.78 %	Nov 15, 2016	Nov 15, 2017
Status	Target Exceeded	Target Exceeded	Target Not Met	Target Not Met	Pending	Pending

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
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%	6.81%	6.23%
Result	8.2%	7.1%	6.5%	6.8%	Nov 15, 2016	Nov 15, 2017
Status	Target Met	Target Met	Target Met	Target Not Met	In Progress	Pending

Increase the number of innovative acquisitions for IT services throughout the Department in collaboration with the HHS IDEA Lab (Lead Agency - IOS; Measure ID - 1.7)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target				Set Baseline	10.0	10.0
Result				4	Sep 30, 2016	Sep 30, 2017
Status				Historical Actual	Pending	Pending

[79,80] The FY 2015 results will be available in November 2015, at which time the FY 2016 target will be determined.

[81] The FY 2016 results will be available in November 2016, at which time the FY 2017 target will be determined.

[82] 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.

[83] Target and Date will be provided in November 2015.

[84] 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).

[85] 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).

Analysis of Results

HHS's enterprise-wide information security and privacy program was launched in FY 2003 to help protect HHS against potential IT threats and vulnerabilities. The HHS Cybersecurity Program ensures compliance with federal mandates and legislation, including the Federal Information Security Management Act (FISMA) and the President's Management Agenda. The Program also plays an important role in protecting HHS's ability to provide mission-critical operations, and is an enabler for e-government success. ASA leads the management and sets policy for HHS information technology systems. In conjunction with the Federal Sprint and Marathon Team initiatives, the HHS components have been focused on the implementation of two-factor authentication (LOA-4) for privileged and unprivileged users. In this case, two-factor authentication involves the use of a physical PIV card as well as a pin to access hardware and secure systems. ASA is reporting two new measures tracking the rate of two-factor authentication usage, reaching 87 percent for unprivileged network users and 97 percent for privileged network users.

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 2014, the Aging Services Network served 8,930 clients per million dollars of OAA funding exceeding the target of 8,600. While results for FY 2014 declined from FY 2013's exceptionally high performance, the results are more consistent with performance prior to FY 2013 and may also reflect a delayed effect of sequester. Performance has trended upward over the last ten years and performance targets have been consistently achieved. This reflects the success of ongoing initiatives to improve program management and expand options for home and community-based care. Aging and Disability Resource Centers (ADRCs) and increased commitments and partnerships at the state and local levels have all had a positive impact on program efficiency.

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 2015, OMHA achieved a 3.9 level of appellant satisfaction nationwide, exceeding the 3.4 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 hearing formats used to adjudicate their cases. Despite a growing backlog of cases, OMHA will continue to strive to meet customer expectations and maintain customer satisfaction levels.

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 2014-2015 program year, Head Start grantees had, on average, not enrolled 1.84 percent of the children they were funded to serve, missing the FY 2015

target of 0.8 percent. This represents approximately 16,700 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 2015 Foster Care estimated national payment error rate is 3.65 percent, exceeding the target of 5.3 percent.

ACF also 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 15 and 22 percent on administrative expenses. In FY 2014, 15.23 percent of CSBG sub-grantee funds were used for administrative costs, a slight decrease from the previous year's result and exceeding the FY 2014 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 2015 result, an error rate of 12.09 percent, was below the targeted level of 12.5 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 a payment recovery and appeal mechanism to be applied when CMS identifies erroneous payment data submitted by an MA organization. In FY 2015 results show that CMS fell short of the measure target with an improper payment rate of 9.5 percent. CMS has implemented two key initiatives to improve payment accuracy in the Part C program: contract-level audits and new regulatory provisions. Additional information about these initiatives is available in the "Plans for the Future" section below and in the 2015 HHS AFR.

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 3.6 percent in FY 2015, falling just short of the target of 3.5 percent. The root cause of many improper payments in the Part D program reported in FY 2015 is administrative and documentation errors, particularly related to long term care facility medication orders. 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 2015, the FPS exceeded its target, with 43.63 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 developed systems 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 9.78 percent payment error rate estimated, an increase from the previous year. CHIP also did not meet its target for the CHIP performance indicator, with 6.8 percent estimate of payment errors, missing the 6.5 percent target. These increases were due to state difficulties getting systems into compliance with new requirements that were put in place to strengthen program integrity.

Plans for the Future

There are three factors that contributed to the increased rate of under-enrollment in Head Start in FY 2015: a period of under-enrollment as more programs become Birth-to-Five through competition and renovate facilities, train staff and recruit infants and toddlers; 2) competitive transitions which can result in a period of under-enrollment as programs become fully operational; and 3) under-enrollment within some very large grantees. The ACF Office of Head Start (OHS) is following up and providing technical assistance to ensure these grantees become fully enrolled as soon as possible. Per the 2007 reauthorization of the Head Start Act, ACF now collects online enrollment data on a monthly basis from all Head Start grantees through the Head Start Enterprise System (HSES). HSES provides a system-generated alert when grantees are under-enrolled, and Regional Offices have procedures in place, consistent with the Head Start Act, to begin technical assistance and to establish improvement plans with clear timetables if the under-enrollment persists. In such cases, Regional Offices have worked with grantees to address under-enrollment by considering, for example, conversion of Head Start slots to Early Head Start slots if it support community need or enrollment reductions depending on the circumstances. Very few Head Start grantees trigger the designation of chronically under-enrolled in the Head Start Act, which requires being at 97 percent of funded enrollment after receiving 12 months of technical assistance, but in a small subset of cases, ACF has reduced the grantee's base funding.

ACF is developing strategies to implement Enterprise Risk Management (ERM) throughout the agency; currently, ACF is developing a planning and scoping document that will facilitate implementation of the key principles of ERM. The intent of this program, in part, is reducing erroneous payments in the title IV-E Foster Care program.

ACL expects the targeted number of clients served for home and community-based services to vary in the future 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.

Historical trend data for the ACF Community Services Block Grant (CSBG) administrative funds expended performance measure have fluctuated, with sub-grantees spending between 15 and 22 percent on administrative expenses. 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.

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. CMS is continuing to apply the risk-based approach to payment and provider oversight, which increases contractors' efficiency. This approach also reduces the burden on legitimate providers by focusing the majority of fraud detection and prevention resources on those posing higher risk of fraud. CMS's goal is to increase the percentage of Medicare providers and suppliers identified as high risk that receive an administrative action.

The factors contributing to improper payments are complex and vary from year to year, and CMS strives to reduce improper payments in the Medicare FFS program. Improper payment data garnered from the CERT program and other sources isI.A.1 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.

Of particular importance are five corrective actions that CMS believes will have a considerable effect in preventing and reducing improper payments: 1) HHS implemented corrective actions to address program payment vulnerabilities related to home health services; 2) proposed an update to the "Two Midnight" rule CMS-1633-P regarding when hospital admissions are appropriate for payment under Medicare Part A; 3) issued a proposed rule that would build on a successful demonstration program to establish a Master List of Durable Medical Equipment, Prosthetic, Orthotics, and Supplies (DMEPOS) items that are frequently subject to unnecessary utilization and potentially could be subject to prior authorization, as well as a Required Prior Authorization List of certain DMEPOS items that would be subject to a prior authorization process, 4) expanded the use of prior authorization in the Medicare FFS program by instituting a prior authorization demonstration program with the expectation of reducing improper payments for power mobility devices; and 5) implemented two demonstration projects to test whether prior authorization in Medicare FFS reduces expenditures while maintaining quality of care for certain non-emergent services. Detailed information on corrective actions can be found on pages 184 and 185 of the 2015 HHS AFR. Future targets are 11.50 percent for FY 2016 and 10.40 percent for FY 2017.

CMS has implemented two key initiatives to improve payment accuracy in the Part C program: contract-level audits and new regulatory provisions. Contract-level audits are conducted to recover over-payments and to verify the accuracy of enrollee diagnoses submitted by (MA) organizations for risk adjusted payments. In new regulatory provisions, CMS codified the Affordable Care Act requirement that MA organizations must report and return overpayments that they identify. CMS also established a payment recovery and appeal mechanism to be applied when CMS identifies erroneous payment data

submitted by an MA organization. Accordingly, in FY 2015, approximately $650 million in overpayments have been reported and returned. This recovery appears to be the result of the sentinel effect of the RADV audits, as well as the 'report and pay' requirement.

To improve program integrity in the Part D program, CMS conducts national training sessions for Part D plan sponsors on Part D payment and data submission. In addition, CMS continues to provide additional guidance to Part D sponsors to improve data accuracy and validity. HHS also codified the Affordable Care Act requirement that Part D sponsors must report and return overpayments that they identify. HHS also established a payment recovery and appeal mechanism to be applied when HHS identifies erroneous payment data submitted by a Part D sponsor. Accordingly, in FY 2015, approximately $11.6 million in overpayments have been reported and returned. This recovery of Part D risk adjustment related overpayments appears to be the result of the "report and return" requirement.

In order to reduce the national Medicaid and CHIP improper payment 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, provider communication and education to reduce errors related to missing or insufficient documentation and also target eligibility errors through the leveraging of technology and available databases to obtain eligibility verification information without client contact; providing caseworker training; and providing additional eligibility policy resources through a consolidated manual and web-based training.

In addition to the development, execution, and evaluation of the state-specific CAPs, CMS has implemented additional efforts to lower improper payments rates including provider outreach, mini-PERM audits, best practice calls, and various other methods of state outreach. For more information on corrective actions see the FY 2015 HHS AFR.

The IDEA Lab supports innovative approaches to achieving the HHS mission by assisting all 11 Operating Divisions in addition to Staff Divisions within the Office of the Secretary. An area of focus for the IDEA Lab is the acquisition of IT services. IT acquisition can be ineffective and inefficient, resulting in high failure rates[86] that are attributable to many factors, including but not limited to lack of stakeholder collaboration with acquisitions; miscommunication and failure to identify needs, gaps, and problems; poor project management; and the lack of end user involvement with frequent feedback loops throughout implementation. Given the $50 billion annual spend on IT services government-wide[87], and the growing complexity of IT and health IT needs, it is important for HHS to address this high-impact area by investing in and experimenting with solutions to mitigate risk of failure through new approaches.

The goal is to create a more effective and efficient government by transforming how HHS acquires information technology and digital services in order to improve stakeholder outcomes. This HHS-wide approach involves creating awareness of potential issues with IT acquisitions, introduction of more effective methods as well as extensive training to master them, and broadening the evidence base to iteratively improve, learn, and share best practices. Established baseline and target measures will yield important information to help acquire IT in a more effective and efficient way, resulting in better systems and reduced costs.

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[86] 2013 Chaos Manifesto by The Standish Group

[87] General Services Administration. Based on category management data analysis derived from certain Product Service Codes (PSCs) from the Federal Procurement Data System (FPDS).

An innovative IT services acquisition is one that utilizes any of the following approaches to mitigate risk, deliver required end-user outcomes, and increase stakeholder collaboration by aligning incentives. The below approaches tend to lead to on-time or early delivery, increased end user satisfaction, and reduction in total cost of ownership:

- Early and frequent collaboration between acquisition stakeholders;
- Use of agile, iterative, modular implementation methods;
- Frequent feedback loops with end users and stakeholders;
- Utilization of new or rarely-used acquisition approaches, such as incentive prize tools, multi-stage acquisitions (down-selects), rapid-prototyping, and prototype-based proposals that more effectively prove contractor capability.

Innovative acquisitions also include evaluating contractor capabilities based on the established requirements in order to yield better value to the government by mitigating risk of failure. For example, evaluating IT service contractors through submission of coding, prototypes, and/or other associated work product as opposed to strictly text-based proposal submissions mitigates risk of failure because the requisite contractors are evaluated based on their capability to perform the government's requirements. The IDEA Lab has created a new measure to track the number of innovative acquisitions and set a target of 10 for FY 2016 and FY 2017.

FY 2014 Strategic Review Objective Progress Update Summary

Please note that this section summarizes the result of the FY 2014 HHS Strategic Review process, limiting the scope of content to that available prior to spring of 2015. Due to this constraint, the following may not be the most current information available.

Conclusions: Progressing

Analysis: HHS has made progress in addressing improper payments. HHS has established new risk-based screening requirements to ensure that only legitimate providers are enrolling in and billing the Medicare program. The Department has instituted a number of new policies and demonstrations to strengthen program integrity within (FFS), such as requiring physicians to document face-to face-encounters with a patient prior to certifying eligibility for the home health benefit and instituting a prior authorization demonstration program for power mobility devices. This demonstration has reduced improper payments and overall Medicare expenditures and was expanded in FY 2015 from the initial seven states to include an additional 12 states.

Other areas of progress include the implementation of revisions to the financial reporting form in the Temporary Assistance for Needy Families (TANF) program, which will require states to provide more accurate information about the ways they are using their TANF block grants and meeting Maintenance-of-Effort obligations, as well as the continuation of the Senior Medicare Patrol program to empower Medicare beneficiaries, their families, and caregivers to prevent Medicare fraud, waste, and abuse through outreach, counseling and education.

HHS still faces challenges in reducing improper payments, as the FY 2014 improper payment rates for both the Medicare FFS and Medicaid programs increased from previous years. The factors contributing to improper payments are complex and vary from year to year. Insufficient documentation for home health claims was the major driver of the increase in the Medicare Fee-For-Service improper payment rate, increasing from 17 percent in FY 2013 to 51 percent in FY 2014 due to the implementation of new

face-to-face encounter requirements to support the medical necessity of the billed services. Another contributing factor was medical necessity errors that are common for inpatient hospital claims, particularly short stays found to not be medically necessary because services should have been billed as outpatient (i.e., patient status errors).

During the review, a weakness identified was the statutory limitations in the TANF program, which prohibit HHS from requiring states to participate in a TANF improper payment measure. As a result, the TANF program has not reported an improper payment error rate. In addition, Medicare Advantage and state Medicaid programs face challenges with managed care due to the program integrity responsibilities largely being delegated to the managed care organizations as part of the capitated payment. The Department is seeking to take a more active role in program integrity oversight and guidance.

HHS is working to revisit and revise performance measures to track new developments, specifically related to cybersecurity. HHS and its individual Operating and Staff Divisions are developing and implementing Enterprise Risk Management principles to better address risk. In addition, the Department is looking at integrating the Medicare and Medicaid program integrity work to provide cooperative benefits in fraud, waste, and abuse oversight.

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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	10 months	10 months	9.5 months	9.5 months	9.5 months	9 months
Result	10 months	10 months	9.5 months	9.5 months	Sep 30, 2016	Sep 30, 2017
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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	6,000,300	1,792,523[88]	1,882,149[89]	2,390,402	1,700,000	1,700,000
Result	1,707,165[90]	2,298,464[91]	1,745,133[92]	N/A[93]	Dec 31, 2016	Dec 31, 2017
Status	Target Not Met	Target Exceeded	Target Not Met	Not Collected[94]	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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	285	288	1,200	1,800	2,000	2,025
Result	366	1,025	1,657	1,900	Sep 30, 2016	Sep 30, 2017
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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	1,169,208	1,215,976	2,924,842	3,858,339	6,875,000	7,500,000
Result	1,829,111	2,924,842	3,507,581	6,551,159	Oct 31, 2016	Oct 31, 2017
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 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	144 Million	145 Million	145 Million	146 Million	147 Million	148 Million
Result	143 Million	143 Million	143 Million	143 Million	Dec 30, 2016	Dec 30, 2017
Status	Target Not Met	Target Not Met	Target Not Met	Target Not Met	Pending	Pending

[88] Reduction in target reflects a change in the data collection methodology.

[89] Reduction in target reflects a change in the data collection methodology.

[90] There is no delay between fiscal year funding and the performance year.

[91] There is no delay between fiscal year funding and the performance year.

[92] There is no delay between fiscal year funding and the performance year.

[93] There is no delay between fiscal year funding and the performance year.

[94] Due to technical and programmatic changes associated with the website, 2015 data was not collected

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target			N/A	3,250,000	4,000,000	4,500,000
Result			3,000,000	3,600,000	Sep 30, 2016	Aug 30, 2017
Status			Historical Actual	Target Exceeded	Pending	Pending

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. In FY 2015, it maintained a two week reduction achieved in FY 2014 of 9.5 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. Due to technical and programmatic changes associated with the website, FY 2015 data was not collected.

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 2015, HHS continued executing its Health Data Initiative Strategy and Execution plan. Currently, 1900 datasets are available on healthdata.gov, exceeding the measure target. A major focus of activity this year has been on enhancing the capabilities and functionalities of the healthdata.gov portal. A new contractor was hired and the site has been re-launched in beta as the IDEA Lab seeks to improve the look and feel of the site, improve performance including better sort and search, data preview capabilities with charts and maps, links to other datasets users might be interested in.

CDC Vital Signs is a monthly communications program that 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). 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. 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 6.5 million potential viewings in FY 2015 due to print, broadcast and cable media interest, and continued promotion to add subscribers to its social and email dissemination channels. As a result of the continued use of mechanisms such as the CDC website and social media outlets, CDC expects the number of potential viewers for *CDC Vital Signs* to continually increase through FY 2017.

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 2015, the CAHPS program missed its goal of 146 Million for whom CAHPS survey data is collected, with a result of 143 million, the same as the previous four years.

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 total number of articles in Pub Med Central as of September 30, 2015 was over 3.6 million, exceeding its target. Weekday usage of PMC continues to increase, with an average of over 1 million unique users/weekday in September 2015. In FY 2015, the National Library of Medicine (NLM) undertook a redesign of the NIH Manuscript Submission (NIHMS) system to support the public access policies of new agencies who are using PMC as a public access repository for funded research. The redesign streamlined the authentication and manuscript submission processes and provide updated, relevant help information for new users directly on each screen. As part of this redesign, a new interface was also added to the NIHMS to allow agency funding administrators to track manuscript submissions associated with support from their agency. In conjunction with changes to the NIHMS system, PMC also expanded the available documentation on public access policies and PMC submission methods to help funded authors determine how to submit papers in compliance with public access. Agency-branded PMC portals / storefronts were also set up for participating funding agencies. These agencies are also being provided with access to PMC usage statistics for all of their funded papers in PMC to view the impact of their policies. PMC continues to accept and review applications from new journals wishing to participate (Note: Current number of journals that archive their complete contents in PMC is over 1700 as of October 2015).

Plans for the Future

AHRQ is seeking to reduce the amount of time from the point when MEPS Household Component data is collected to when the data is made available for public use. From FY 2015 through FY 2017, the MEPS will continue to take steps to accelerate data release, including batch processing, processing data sets concurrently, and combining similar processes. Starting in FY 2017 and beyond, MEPS data will be available two weeks earlier than previous fiscal years.

HHS expects the number of datasets published to increase in the coming years. Federation of datasets continues as HHS began acquiring health data from USDA 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. HHS is exploring, through an Innovator-in-Residence initiative titled "Demand-Driven Open Data" an infrastructure for requesting and discussing data that our community of data users can rely on while supporting one another in understanding and more efficiently using the available data resources.

AHRQ believes the CAHPS 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, which items need updating, and how data can be collected in the most cost-effective way.

CDC's active provider outreach has stimulated reporting of clinically-focused Vital Signs issues in widely read medical journals and web material such as The Journal for the American Medical Association (JAMA), American Academy of Family Physicians (AAFP) News, American Association of Nurse Practitioners (AANP) SmartBrief, and Medscape. CDC will continue to actively engage with the medical community to increase dissemination and use among health care providers.

HHS expects the number of journal articles in the NLM's PubMed Central Database to grow in 2017 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. Starting in FY16, PMC will also be serving as the public access repository for non-HHS agencies, e.g., NASA. Staff are working to continue to improve documentation to help authors new to NIHMS and PMC in the coming year.

FY 2014 Strategic Review Objective Progress Update Summary

Please note that this section summarizes the result of the FY 2014 HHS Strategic Review process, limiting the scope of content to that available prior to spring of 2015. Due to this constraint, the following may not be the most current information available.

Conclusions: Progressing

Analysis: HHS has made progress in enhancing access to and use of HHS data to improve programs, promote improvements in health and health care, and enhance information for decision making in health and human services. Improvements are evident in increasing timeliness, quality, and public and internal access and dissemination of survey data, administrative and programmatic data, and public access to scientific and research data.

HHS statistical and programmatic and administrative data systems are not only essential to the success of the HHS mission, but they also provide most of the national statistical capacity to monitor the health and wellbeing of the population, the performance of the public health, health care and human services systems and progress on HHS priorities and initiatives.

Most of the major HHS survey programs have taken steps to shorten the turnaround time from data collection to availability through technology and other efficiencies while maintaining high standards of data quality. As a result of Open Data Initiatives and the Health Data Initiative, HHS agencies have posted links to over 1800 data sets and tools on healthcare.gov. Data.gov includes over 3000 health

related datasets and tools. In addition, HHS makes statistical and administrative data available for research and statistical analysis through a continuum of data access mechanisms while protecting the confidentiality of the information.

HHS is working to balance its goals for making data available, promoting electronic health record adoption and meaningful use, with other important priorities, such as protecting the privacy and confidentiality of individuals and organizations. It is a challenging balance to identify and apply the complex and multi-faceted safeguards and security controls necessary to protect privacy while still making useful data available publicly to support program improvement and enhancement. Challenges in electronic health record adoption and meaningful use attainment limits the extent and quality of data that the health center program is able to collect. Data reporting presents an administrative burden on health centers and results in a delay in having data readily available for program planning and evaluation. Administrative and programmatic data is largely a byproduct of program operations and management, and significant continuing resources are often needed to prepare the data for public access and utility. Statistical programs face increasing costs of field work as well as data documentation, curation and data access mechanisms.

HHS is considering reaching out to stakeholders to develop cost-effective ways of collecting Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data that do not compromise validity or reliability. In addition, the Department is exploring options for making additional high value de-identified administrative data like Marketplace enrollment data or Marketplace plan offerings data available for research and evaluation in a privacy protected manner both internally within HHS and in a public research access venue. In another approach, HHS is organizing a challenge for software developers to create a semi-automated MS Word and Adobe Acrobat document conversion and remediation tool that would allow HHS to quickly and at low cost ensure all documents are accessible to individuals with disabilities and in compliance with Section 508 of the Rehabilitation Act.

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

Increase the top talent at HHS through recruitment, training and retention. (Lead Agency - ASA; Measure ID - 2.5)[95]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target			Set Baseline	50% of supervisors and managers	51% of supervisors and managers	52% of supervisors and managers
Result			49% of supervisors and managers	50% of supervisors and managers	Dec 31, 2016	Dec 31, 2017
Status			Baseline	Target Met	Pending	Pending

[95] Percentage of positive responses of HHS managers and supervisors to the annual Office of Personnel Management Employee Viewpoint Survey question "My work unit is able to recruit people with the right skills."

Increase HHS employee engagement (Lead Agency - ASA; Measure ID - 2.6)[96]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target			Set Baseline	67% employee engagement index	68% employee engagement index	69% employee engagement index
Result			66% employee engagement index	68% employee engagement index	Dec 31, 2016	Dec 31, 2017
Status			Baseline	Target Exceeded	Pending	Pending

Attract, hire, develop and retain a diverse and inclusive HHS workforce (Lead Agency - ASA; Measure ID - 2.7)[97]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target			Set Baseline	69% of employees	70% of employees	71% of employees
Result			68% of employees	69% of employees	Dec 31, 2016	Dec 31, 2017
Status			Baseline	Target Met	Pending	Pending

Increase hiring speed; i.e., the percentage of hires made within 80 day. (Lead Agency - ASA; Measure ID - 2.8)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target		N/A	N/A	N/A	N/A	44%
Result		56%	49%	43%	Dec 31, 2016	Dec 31, 2017
Status		Historical Actual	Historical Actual	Historical Actual	Historical Actual	Pending

Analysis of Results

Starting in FY 2015, the Department is tracking new performance measures, targeting three areas of emphasis: (1) Workforce Management, (2) Employee Engagement, 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. These metrics will be measured through responses to the Office of Personnel Management Annual Employee Viewpoint survey of federal employees.

To help determine if HHS is achieving its workforce management goals, analysis will be conducted on the responses of HHS managers and supervisors to the question "My work unit is able to recruit people with the right skills."

The employee engagement index is calculated from the annual Office of Personnel Management Employee Viewpoint Survey and, specifically, is derived from questions related to leadership, supervisor behaviors, and intrinsic experience. A successful agency fosters an engaged working environment to ensure each employee can reach their full potential and contribute to the success of their agency and

[96] The employee engagement index is calculated from the annual Office of Personnel Management Employee Viewpoint Survey.

[97] Percentage of positive responses of HHS employees to the annual Office of Personnel Management Employee Viewpoint Survey question, "My supervisor is committed to a workforce representative of all segments of society."

the entire federal government. Historically HHS has performed above the government norm, and future targets reflect HHS's continuing efforts to improve employee engagement.

HHS strives to have a workforce that is reflective of America and of the population that it serves. In addition to using hiring and retention data to evaluate its recruitment processes, HHS will look at the most recent results from the Office of Personnel Management's Employee Viewpoint Survey. Specifically, HHS will track the percentage of employees who positively report, "My supervisor is committed to a workforce representative of all segments of society."

HHS is committed to improving the federal recruitment and hiring process and is part of the End to End hiring initiative which was established by the Office of Personnel Management (OPM). Hiring speed will be measured through data gathered from the HHS Human Resources Enterprise Personnel System (HREPS) by tracking the percentage of hiring actions that are completed within 80 days. This measure is prescribed within the OPM End to End hiring process and would increase the percentage of hiring actions completed within 80 days, end-to-end, to bring new staff on board. In FY 2015, 43 percent of all hiring transactions were completed within 80 days.

Plans for the Future

The Washington HR Services Center (WHRSC) continues to provide staffing and administrative services to the currently serviced Operating and Staff Divisions. This year, following the selection of a new HR Director and Deputy Director, OHR conducted a business process improvement review to further identify gaps in service delivery, staffing requirements, and overall workload management.

Additionally, to improve operations and address hiring challenges, the Acting Deputy Assistant Secretary established a tiger team to thoroughly examine the WHRSC's operations including structure, staffing, contracts, and funding. This remediation team developed a strategic performance management plan that contained four critical work streams requiring data review: validation and reporting; process and technology improvement; capacity building; and change management and communications.

HHS has also developed another three-year strategic performance management plan with four focus areas. Work plans were developed for each area with specific activities defined for the three time-driven waves, or "horizons" of execution. The four focus areas are:

- Recruitment Processes: Workforce analysis and development of an execution framework to achieve full capability in mission critical occupations.
- People and Organization Development: A robust, comprehensive talent development system.
- Performance Culture: A top-down, mission-driven performance management system focusing on employee engagement and top tier organization performance.
- HR Capability: A step change improvement in HR capability for successfully driving the above three areas.

Some of the initiatives outlined in these four focus areas are:

- Develop and execute workforce plan for mission-critical organizations by developing a 5 year trend analysis (e.g., assessing hiring and attrition rates) key positions with high attrition rates.
- Enhance HHS diversity by assessing applicant flow data, reviewing barrier analysis, develop action plans to eliminate any identified barrier(s), and coordinate implementation of action plans.

- Conduct and analyze strategic employee engagement efforts to determine those that promote diversity within the workforce.
- Increase the percentage all hiring transactions from 30 percent to 31 percent by the end of FY 2017.
- Automate (i.e., design and implement ePMAP) the PMAP through OPM Pilot Program
- Foster an organizational culture that supports employee engagement by improving SES performance to generate high levels of employee motivation and commitment.

Other initiatives (e.g., Career SES Development, HHS Pathways Programs) in progress or planned will enhance employee engagement, the overall recruitment and hiring process, recruitment and retention in mission critical occupations (including STEM), workforce diversity, and employee performance. HHS is committed to recruiting and retaining top talent to meet America's health and human service needs.

FY 2014 Strategic Review Objective Progress Update Summary

Please note that this section summarizes the result of the FY 2014 HHS Strategic Review process, limiting the scope of content to that available prior to spring of 2015. Due to this constraint, the following may not be the most current information available.

Conclusions: Focus Area for Improvement

Analysis: HHS continues to experience significant challenges in hiring and maintaining its workforce. For example, the number of days to hire performance measure missed the target this year and in each of the preceding two years. While the re-baselining of the Hire-to-Retire (or HR Solutions) initiative may have been disruptive to operations, the gap between the target and measure outcome is much greater than the corresponding gap from each of the two preceding years. The current plan is to revise the days to hire measure to begin reporting in FY 2017 – as well as continue to include measures related to employee engagement, supervisor assessment of staff capacity, and a diversity measure from the Employee View Point Survey.

HHS has implemented a number of new initiatives around training, diversity, targeted recruiting, work-life balance, employee engagement, and retention. However, recruitment remains the key issue for the majority of HHS components. Many Divisions identified the time it takes to fill vacancies as the primary challenge. In particular, small Operating Divisions with limited staff in specific programs experience significant risks to effectively manage when hiring is delayed. The HHS Deputy Secretary recently chartered a team that is currently evaluating the challenges with hiring and onboarding processes.

In addition, several new issues deal with the growing number of retirement-eligible employees, particularly around knowledge transfer and succession planning. Another challenge is the recruitment of people in their 20s and 30s and how HHS effectively engages this audience in order to recruit, train and provide advancement opportunities. HHS also experiences challenges in identifying high quality, experienced professionals for positions which require a very specific level and type of expertise (e.g. Information Technology Specialist, Medical Technologists, Nurse Consultants, Safety Engineers, etc.). Many of these professionals are able to demand a higher salary in the private sector.

The new Pathways Programs provide HHS Hiring Officials with some flexibility to recruit and hire students into entry-level positions to meet succession planning needs. OHR continues to partner with OPM to address Pathways Programs recruitment challenges, consult with components on ways to

leverage the various Pathways Programs hiring authorities, and continuously improve the program's hiring process HHS-wide.

During the review, quickly capturing and reporting lessons learned from hiring pilots and other initiatives were identified as an area for improvement. In addition, Divisions are working on succession planning and knowledge management strategies to address the agency's aging workforce. Another strategy is the development of a new web-based system to house and distribute resumes of candidates who are eligible for non-competitive hiring authorities.

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

Reduce HHS fleet emissions (Lead Agency - ASA; Measure ID - 1.2)[98]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	1,285 Gasoline Gallon Equivalent (GGE)	1,184 Gasoline Gallon Equivalent (GGE)	1,360 Gasoline Gallon Equivalent (GGE)	1,635 Gasoline Gallon Equivalent (GGE)	1,602 Gasoline Gallon Equivalent (GGE)	1,570 Gasoline Gallon Equivalent (GGE)
Result	1,360 Gasoline Gallon Equivalent (GGE)	1,184 Gasoline Gallon Equivalent (GGE)	1,086 Gasoline Gallon Equivalent (GGE)	1,603 Gasoline Gallon Equivalent (GGE)	Dec 31, 2016	Dec 31, 2017
Status	Target Not Met	Target Met	Target Exceeded	Target Exceeded	Pending	Pending

[98] 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.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Target	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Result	94.0%	90.0%	99.0%	95.0%	Dec 31, 2016	Dec 31, 2017
Status	Target Not Met but Improved	Target Not Met	Target Not Met but Improved	Target Not Met	Pending	Pending

Analysis of Results

HHS has surpassed the Executive Order 13514 and EISA 2007 petroleum-use reduction targets of reducing FY 2005 usage 20 percent by FY 2015. The FY 2005 baseline usage was 2.04 million gasoline gallon equivalent (GGE) and FY 2014 total usage was 1.36 million GGE, meeting the target. In general, the HHS fleet's overall cost has gone down more than 25 percent compared to its FY 2005 baseline. The fleet size, about 4,890 vehicles, has changed to meet evolving regulatory demands. The HHS fleet is among the top performers in the United States in the Executive fleet cadre for performance and compliance. HHS best practices include rapid deployment of high efficiency sedans, empirical studies focused on safety and operator behavior, and flexibility for internal customers in the United States and 35 countries worldwide. The FY 2015 value is preliminary - data collection for the year is not closed until January 15th 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 percent of HHS eligible computers, laptops, and monitors to have power management. HHS set aggressive goals to move from the 2010 level of 32 percent of devices with power management enabled to 100 percent of devices with power management by 2013 and to maintain that level continuing through 2015. In 2011, 85 percent of eligible devices were reported in compliance across the department, while in 2012 this increased to 94 percent. The 2013 department-wide Electronic Stewardship Report showed that 90 percent of computers, laptops, and monitors were covered by power management. The 2014 Electronic Stewardship Report showed this value increased to 99 percent. For FY 2015 the percentage of PC and laptops with power management was 90.65 percent and for monitors it was 98.53 percent. This averages to approximately 95 percent, missing the target of 100 percent. Historically, there have been issues with data collection, verification, and validation, which likely has contributed to fluctuation in trends, particularly with regards to the PC and laptops. With the introduction of clearer definitions and criteria as well as better data collection methods, this metric should have less fluctuation in the future.

Plans for the Future

HHS will continue to support initiatives toward the achievement of the goals in the Executive Order 13693 and the Sustainability Performance Plan. HHS is replacing conventionally (petroleum based) powered vehicles with alternative fuel vehicles as possible, reducing the amount of HHS greenhouse gas emissions. ASA staff members plan to assist OASH in the development of a Climate Adaptation Planning Workshop to include mission-related programmatic planners, emergency coordinators, continuity of operations planners, occupant emergency planners, chief sustainability officers, and climate change experts. This first-of-its-kind workshop will discuss the contents of an adaptation plan, share tools to

conduct risk/vulnerability assessments, review component mission essential functions, and identify adaptation activities for each component to consider. ASA will also continue to explore policies and technologies that will help to expand telework, a primary strategy to reduce scope 3 emissions associated with commuting.

FY 2014 Strategic Review Objective Progress Update Summary

Please note that this section summarizes the result of the FY 2014 HHS Strategic Review process, limiting the scope of content to that available prior to spring of 2015. Due to this constraint, the following may not be the most current information available.

Conclusions: Progressing

Analysis: HHS has made progress improving environmental, energy, and economic performance to promote sustainability, as demonstrated by performance measures.

The performance measure focused on reducing HHS fleet emissions continued to exceed the target. In addition to reducing overall fleet emissions, HHS also reduced its vehicle inventory by an additional 8 percent overall, and also added two plug-in electric vehicles to the fleet while placing alternative fuel vehicles in locations where alternative fuel is more readily available. The performance measure focused on ensuring power management being enabled in 100 percent of HHS computers, laptops, and monitors improved from the previous measuring period. The performance measure focused on increasing the percent of employees on telework or on an alternate work schedule seemed to have a substantial decline with inconsistent trends over the past three years. However, further study revealed that the methodology behind the measurement was adjusted for this year. If prior years had been adjusted to use this methodology, this year would have shown a small but measureable increase over prior years.

Organizations within HHS also excelled in this area. The CMS Headquarters Complex achieved 64 percent waste diversion, exceeding an Executive Order that targeted 50 percent reduction. IHS has met its target for FY 2020 greenhouse gas emissions. During 2014, SAMHSA experienced a 12.6 percent decrease in annual electricity usage.

HHS will continue to explore opportunities to reduce the HHS footprint by consolidating office space, expanding telework, and seeking to recycle or reduce energy usage. A challenge for some HHS Divisions which are part of larger federal efforts to consolidate office space is that these efforts are sometimes delayed. These delays lead to additional costs in supporting multiple locations, and delay the reduction of the HHS footprint. Some HHS Divisions are challenged in adhering to the “Freeze the Footprint” mandate while also adding FTE resources to meet new mandates. There are sometimes challenges maintaining compatibility with applicable state and local recycling.

HHS will continue to explore policies and technologies that will help to expand telework, a primary strategy to reduce scope 3 emissions associated with commuting. In addition an HHS Division is currently pursuing a LEED Silver rating for new construction of its central office, to include a geothermal system, a photo-voltaic array, and a green rooftop reduce the use of carbon based energy and waste.

Evidence Building Efforts

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 2015 Top Management and Performance Challenges

The HHS OIG has identified the top management and performance challenges for FY 2015. 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 and is developing an enterprise-wide risk management process. For further information about these challenges, please read the *HHS Fiscal Year 2015 Top Management and Performance Challenges Facing the Department of Health and Human Services* report located at http://oig.hhs.gov/reports-and-publications/top-challenges/2015/2015-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 - Improving 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 2015 GAO High-Risk Series Update here: http://www.gao.gov/assets/670/668415.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/2015_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	3D (Head Start)	Add	N/A	Add the following new outcome measure: "Increase the percentage of Head Start and Early Head Start teachers that have a Bachelor's Degree (BA) or higher."	This new outcome measure supports the FY 2016-17 Priority Performance Goal on Early Childhood Education to track progress on increasing the credentials of both Head Start and Early Head Start teachers. This measure is distinct from outcome measure 3C in that it looks at credentialing for both Head Start and Early Head Start, rather than focusing on solely the Head Start teachers.
ACF	7S (Foster Care)	Target Change	FY 2016 Target: 4.7%	Revise FY 2016 Target to 5.1%.	In light of the most recent (FY 2014) actual result, which shows an increase, ACF proposed reducing the FY 2016 target in the Annual Financial Report, which OMB has approved.
AHRQ	1.3.39	Retire	Increase the number of patient safety events (e.g. medical errors) reported to the Network of Patient Safety Databases (NPSD) from baseline.	Retire measure at the end of FY 2015.	Program requests retirement of the measure, as it is no longer meaningful. Submission to the NPSD is voluntary, and in the past years none of the data transmitted to the PSO PPC have been of sufficient quality and volume. This performance measure is no longer meaningful to report as a GPRA measure and will be retired at the end of FY 2015.
ASA	1.1	Retire	Increase the percent employees on telework or on Alternative Work Schedule	Retire	Goal is difficult to measure and subject to reporting error given current reporting mechanisms.
ASA	2.8	New	Increase hiring speed; i.e., the percentage of hires made within 80 day	New, FY17 increase to 44%, end-to-end hiring actions completed in 80 days	OMB request
ASA	3.1	New	Unprivileged Users 2 Factor Authentication	New, HHS will increase two-factor authentication (LOA-4) for unprivileged users to 92% in FY2017	ASFR request
ASA	3.2	New	Privileged Users 2-Factor Authentication	New, HHS will increase two-factor authentication (LOA-4) for privileged users to 98% in FY2017	ASFR request

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2015 REPORT Released 3/2014	PROPOSED MEASURE CHANGE	REASON FOR CHANGE
ASPR	2.4.13	Correcting error	Targets for Chemical, Biological, Radiological, and Nuclear countermeasures: Licensed= 2 new; Emergency Use Authority = 5 new. Targets for Pandemic Influenza or Emerging Infectious Disease: Licensed=+2; Emergency Use Authority= +3.	Targets for Chemical, Biological, Radiological, and Nuclear countermeasures: Licensed= 2 new; EUA = 1 new. Targets for Pandemic Influenza or Emerging Infectious Disease: Licensed=1 new EUA = 0.	Originally was input into PPTS with an error. It erroneously stated targets as "new" when those numbers were actually cumulative numbers. New wording states the actual new product numbers.
CDC	3.3.2a	Retire and replace	Reduce the incidence (per 100,000 population) of healthcare associated invasive MRSA infections (per 100,000 person)	Replace with 3.3.2b: Reduce invasive* healthcare-associated Methicillin-resistant Staphylococcus aureus (MRSA infections) *All invasive infections manifesting as bacteremia	This measure is being revised to provide more useful data, depicting a more accurate and focused national estimated rate of healthcare associated MRSA bacteremia infections, which is the most common type of invasive MRSA infection. The revised measure will incorporate National Healthcare Safety Network (NHSN) data into the reporting and is consistent with the measures and targets that have been put forth in the HHS Action Plan to Prevent Healthcare-Associated Infections (HAIs).
CDC	3.3.2b	New		Reduce invasive* healthcare-associated Methicillin-resistant Staphylococcus aureus (MRSA infections) *All invasive infections manifesting as bacteremia Replaces 3.3.2a	This measure is being revised to provide more useful data, depicting a more accurate and focused national estimated rate of healthcare associated MRSA bacteremia infections, which is the most common type of invasive MRSA infection. The revised measure will incorporate National Healthcare Safety Network (NHSN) data into the reporting and is consistent with the measures and targets that have been put forth in the HHS Action Plan to Prevent Healthcare-Associated Infections (HAIs)

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2015 REPORT Released 3/2014	PROPOSED MEASURE CHANGE	REASON FOR CHANGE
CDC	3.2.5	New		Increase the percentage of hospitals reporting implementation of antibiotic stewardship programs fully compliant with CDC Core Elements for Hospital Antibiotic Stewardship Programs (Outcome, HHS Agency Priority Goal)	This is the FY 2016-2017 Agency Priority Goal
CMS	CHIP3: Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in the Children's Health Insurance Program (CHIP) and Medicaid	Revise 2016 target.	48,667,385 children (CHIP 8,909,064/ Medicaid 39,758,322)	45,271,662 children (CHIP – 9,054,332/ Medicaid – 36,217,330)	CMS has invested considerable effort in improving the quality of the data reported by states in the last two years, which has uncovered a number of systems-related challenges that have resulted in both increases and decreases in reported enrollment. Some of the issues have included duplication of enrollment counts between Medicaid and CHIP and incorrect reporting of children in Medicaid Expansion CHIP Programs. Based on these factors, the FY 2016 target has been reduced to reflect revised data .
CMS	CMMI2: Identify, test, and improve payment and service delivery models:	Revise measure title for CMMI2.1	CMMI2.1 Increase the number of model tests that demonstrate : 1) cost savings while maintaining or improving quality, and/or 2) improving quality while maintaining or reducing cost.	CMMI2.1 Increase the number of model tests that currently indicate : 1) cost savings while maintaining or improving quality, and/or 2) improving quality while maintaining or reducing cost.	This measure has been reworded re-worded for the sake of consistence consistency with the other measures included in this goal.
CMS	MCR26 Reduce All-Cause Hospital Readmissions Rates	Revise 2016 target.	17.7%	17.4%	Target was adjusted downward to be more aggressive.
CMS	MIP9 Estimate the Improper Payment Rate in the Medicaid and Children's Health Insurance Programs	Goal title change.	Estimate the Payment Error Rate in the Medicaid and Children's Health Insurance Programs	Estimate the Improper Payment Rate in the Medicaid and Children's Health Insurance Programs	CMS wants to be consistent across the board by stating "improper payment rate" for all improper payment rate measurement programs.

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2015 REPORT Released 3/2014	PROPOSED MEASURE CHANGE	REASON FOR CHANGE
CMS	MCR30:Shift Medicare health care payments from volume to value	Revised measure title	MCR30 Delivery System Reform: Provide Better Care at Lower Cost across the Health Care System by Improving the Way Providers are Incentivized	MCR30: Shift Medicare health care payments from volume to value	MCR30 is a proposed Agency priority goal. The measure title has been changed to more accurately reflect the outcomes CMS hopes to achieve through this initiative.
CMS	MCR30: Health Care Payment Reform: Setting clear goals and timeline for shifting health care reimbursements from volume to value	Discontinued measure 30.2	MCR30.2 Increase the Percentage of Medicare FFS Payments Linked to Quality and Value	Discontinue	CMS will focus efforts on measure MCR30.1 Increase the Percentage of Medicare FFS Payments Tied to Quality and Value through Alternative Payment Models.
FDA	212409	Drop	Reducing foodborne illness in the population. By December 31, 2015, decrease the rate of Salmonella Enteritidis (SE) illness in the population from 2.6 cases per 100,000 (2007-2009 baseline) to 1.9 cases per 100,000.	NA	Previous SE Annual Priority Goal (APG) was completed in 2015.
FDA	212410	New	NA	Reducing foodborne illness in the population. By December 31, 2017, working with federal, state, local, tribal, and industry partners, improve preventive controls in food production facilities and reduce the incidence rate (reported cases per 100,000 population per year) of *Listeria monocytogenes (Lm)* infections by 8%.	New Listeria Annual Priority Goal (APG).

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2015 REPORT Released 3/2014	PROPOSED MEASURE CHANGE	REASON FOR CHANGE
FDA	293206	Revised	Promote innovation and predictability in the development of safe and effective nanotechnology- based products by establishing scientific standards and evaluation frameworks to guide nanotechnology-related regulatory decisions. Target: 30 CORES projects completed	Promote innovation and predictability in the development of safe and effective nanotechnology-based products by establishing scientific standards and evaluation frameworks to guide nanotechnology-related regulatory decisions. Target: 30 CORES projects with completed annual milestones	Target wording was revised to reflect the fact that some of these projects are multi-year, although the expected annual milestones have all been met.
HRSA	4.I.C.2 NHSC	FY 2016 target change	Field Strength of the NHSC through scholarships and loan repayment agreements	FY 2016 target change	The targets for the NHSC are directly related to the NHSC budget.
HRSA	29.IV.A.3. ORHP	Revise Wording	Increase the number of people receiving direct services through Outreach grants	The number of unique individuals who receive direct services through ORHP Outreach grants	Wording changed to indicate that individuals are counted only once in this measure.
IHS	18	Revise Measure Name	Proportion of adults ages 18 and over who are screened for depression	Proportion of American Indian and Alaska Native adults 18 and over who are screened for depression	Specify that the screening population is American Indian and Alaska Native, not the U.S. adult population
IHS	20	Revise measure type	100 percent of hospitals and outpatient clinics operated by the Indian Health Service are accredited or certified (excluding tribal and urban facilities)	Change the performance measure type from Annual Performance Plan measure to budget measure beginning in 2017	Requested by HHS.
IHS	24	Revise name after 2016	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 influenza type b); 3 HepB (hepatitis B); 1 Varicella (chicken pox); 4 Pneumococcal conjugate	Revise measure title 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 diseases.	Replace budget measure with a different title in 2017 label all vaccines included.

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2015 REPORT Released 3/2014	PROPOSED MEASURE CHANGE	REASON FOR CHANGE
IHS	30	Revise FY 2016 measure and retire after 2016 report year	American Indian and Alaska Native patients, 22 and older, with Coronary Heart Disease are assessed for five cardiovascular disease (CVD) risk factors	Remove the following numerator from the measure: "Patients with LDL completed during the report period, regardless of result." Replace measure with ID 51 in 2017.	The new ACC/AHA cholesterol guidelines no longer recommend treating to LDL targets. Instead, they recommend statin medication therapy. For 2016, IHS would report on a composite result of the 4 remaining numerators of the CVD Comprehensive Assessment representative set measure.
IHS	51	New Indicator in CRS for 2017 to replace ID 30	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease among American Indians and Alaska Natives	Measure will focus on statin medication therapy.	IHS will develop a new CVD measure based upon the new ACC/AHA standards of care to replace the current measure 30: Comprehensive CVD-related Assessment.
IOS	1.7	New Measure for FY16	N/A	N/A	New measure to document the number of innovative acquisitions for IT services throughout the Department in collaboration with the HHS IDEA Lab
NIH	SRO-5.13	Retire (Measure will discontinue in FY 2016)	By 2015, establish and evaluate a process to prioritize compounds that have not yet been adequately tested for more in-depth toxicological evaluation.	N/A	Measure was achieved in FY 2015.
NIH	SRO-6.4	Retire (Measure will discontinue in FY 2016)	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.	N/A	Measure was achieved in FY 2015.

OPDIV	UNIQUE IDENTIFIER	CHANGE TYPE	ORIGINAL MEASURE IN FY 2015 REPORT Released 3/2014	PROPOSED MEASURE CHANGE	REASON FOR CHANGE
NIH	CBRR-10	Retire (Measure will discontinue in FY 2016)	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.	N/A	Measure was achieved in FY 2015.
NIH	SRO-8.2	Retire (Measure will discontinue in FY 2018)	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.	N/A	Measure is expected to be achieved in FY 2017.
SAMHSA	3.2.02a	Target Changes	Increase the percentage of children receiving trauma informed services who report positive functioning at 6 month follow-up (Outcome)	FY17 and FY18 targets were increased to 77%.	SAMHSA establishes ambitious targets. This change aligns the targets with recent actual results.

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. Starting with FY 2016 actual result, the State Plans will be reported on a triennial basis per Child Care Reauthorization.
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.
3D (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
3E (ACF)	Program Information Report (PIR)	The PIR is a survey of all grantees that provides comprehensive data on Head Start, Early Head Start and Migrant Head Start programs nationwide. Data collection for the PIR is automated to improve efficiency in the collection and analysis of data. Head Start achieves a 100 percent response rate annually from 2,600 respondents. The automated data system provides trend data so that the team can examine strengths and weaknesses in all programs.
4.1LT and 4A (ACF)	The Runaway and Homeless Youth Management Information System (RHYMIS)	RHYMIS incorporates numerous business rules and edit checks, provides a hot-line/help desk and undergoes continuous improvement and upgrading. Extensive cleanup and validation of data take place after each semi-annual transfer of data from grantee systems into the national database. Historically, the reporting response rate of grantees has exceeded 96 percent every year for the past five years.
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 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 requirements.

Measure ID	Data Source	Data Validation
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 has conducted AFCARS compliance reviews in all states. All states reviewed were required to undertake 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 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.
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 has conducted AFCARS compliance reviews in all states. All states reviewed were required to undertake 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 provides technical assistance to states to improve reporting to AFCARS, improve statewide information systems, and to make better use of their data. All of these activities should continue to generate additional improvements in the data over the next few years.

Measure ID	Data Source	Data Validation
7Q (ACF)	Adoption and Foster Care Analysis Reporting System (AFCARS)	States report child welfare data to ACF through AFCARS. All state semi-annual AFCARS data submissions undergo extensive edit-checks for validity. The results of the AFCARS edit-checks for each of the six-month data submissions are automatically generated and sent back to each state, to help the state to improve data quality. Many states submit revised data to ensure that accurate data are submitted, often for more than one prior submission period. The Children's Bureau has conducted AFCARS compliance reviews in all states. All states reviewed were required to undertake 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 provides technical assistance to states to improve reporting to AFCARS, improve statewide information systems, and to make better use of their data. All of these activities should continue to generate additional improvements in the data over the next few years.
7S (ACF)	Regulatory Title IV-E Foster Care Eligibility Reviews	Data validation occurs on multiple levels. Information collected during the onsite portion of the review is subject to quality assurance procedures to assure the accuracy of the findings of substantial compliance and reports are carefully examined by the Children's Bureau Central and Regional Office staff for accuracy and completeness before a state report is finalized. Through the error rate contract, data is systematically monitored and extensively checked to make sure the latest available review data on each state is incorporated and updated to reflect rulings by the Departmental Appeals Board and payment adjustments from state quarterly fiscal reports. This ensures the annual program error rate estimates accurately represent each state's fiscal reporting and performance for specified periods. The Children's Bureau also has a database (maintained by the contractor) that tracks all key milestones for the state eligibility reviews.
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 the National Association for State Community Service Programs (NASCSP) worked to ensure that the survey captures the required information. The 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 provide states with training, and better survey tools and reporting processes.

Measure ID	Data Source	Data Validation
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. All of the grantees use database systems (online or manual) for data collection and monitoring of their program service locations.
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.
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. The remaining state is in systems development. 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 data reliability audit standard for reliable data has been 95 percent.

Measure ID	Data Source	Data Validation
22B (ACF)	National Directory of New Hires (NDNH)	Beginning with performance in FY 2001, the above employment measures – job entry, job retention, and earnings gain – are based solely on performance data obtained from the NDNH. Data are updated by states, and data validity is ensured with normal auditing functions for submitted data. Prior to use of the NDNH, states had flexibility in the data source(s) they used to obtain wage information on current and former TANF recipients under high performance bonus (HPB) specifications for performance years FY 1998 through FY 2000. ACF moved to this single source national database (NDNH) to ensure equal access to wage data and uniform application of the performance specifications.

Administration for Community Living (ACL)

Measure ID	Data Source	Data Validation
1.1 (ACL)	State Program Report data is annually submitted by States.	The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by ACL's Administration on Aging (AoA) and State staff. AoA staff follow-up with States to assure validity and accuracy. After revisions, States certify the accuracy of their data.
2.6 (ACL)	National Survey of Older Americans Act Participants.	ACL's Administration on Aging's (AoA) national survey uses a range of quality assurance procedures to validate data on OAA participants and services which covers all the steps in the survey process. The surveys have consistently achieved a cooperation rate of over 80% for the sampled Area Agencies on Aging and over 90% for the sample of clients who are currently participating in OAA programs. These high cooperation rates occur because of several important steps in the quality assurance process, including intensive follow-up to contact and interview as many service participants as possible, and calling back at times that are convenient for respondents. After the surveys are complete, range and consistency checks and edits, in conjunction with the CATI software applications, ensure that only correct responses appear in the data files. The data is weighted during three post-survey steps to ensure accuracy. This includes using the inverse of the probability of selection to weight the sample of agencies and clients, adjusting for any non-response patterns and bias that might otherwise occur, and post-stratification of control totals to ensure consistency with official administrative records.

Measure ID	Data Source	Data Validation
2.9a (ACL)	National Survey of Older Americans Act Participants	ACL's Administration on Aging's (AoA) national survey uses a range of quality assurance procedures to validate data on OAA participants and services which covers all the steps in the survey process. The surveys have consistently achieved a cooperation rate of over 80% for the sampled Area Agencies on Aging and over 90% for the sample of clients who are currently participating in OAA programs. These high cooperation rates occur because of several important steps in the quality assurance process, including intensive follow-up to contact and interview as many service participants as possible, and calling back at times that are convenient for respondents. After the surveys are complete, range and consistency checks and edits, in conjunction with the CATI software applications, ensure that only correct responses appear in the data files. The data is weighted during three post-survey steps to ensure accuracy. This includes using the inverse of the probability of selection to weight the sample of agencies and clients, adjusting for any non-response patterns and bias that might otherwise occur, and post-stratification of control totals to ensure consistency with official administrative records.
2.9b (ACL)	National Survey of Older Americans Act Participants	ACL's Administration on Aging's (AoA) national survey uses a range of quality assurance procedures to validate data on OAA participants and services which covers all the steps in the survey process. The surveys have consistently achieved a cooperation rate of over 80% for the sampled Area Agencies on Aging and over 90% for the sample of clients who are currently participating in OAA programs. These high cooperation rates occur because of several important steps in the quality assurance process, including intensive follow-up to contact and interview as many service participants as possible, and calling back at times that are convenient for respondents. After the surveys are complete, range and consistency checks and edits, in conjunction with the CATI software applications, ensure that only correct responses appear in the data files. The data is weighted during three post-survey steps to ensure accuracy. This includes using the inverse of the probability of selection to weight the sample of agencies and clients, adjusting for any non-response patterns and bias that might otherwise occur, and post-stratification of control totals to ensure consistency with official administrative records.

Measure ID	Data Source	Data Validation
2.9c (ACL)	National Survey of Older Americans Act Participants	ACL's Administration on Aging's (AoA) national survey uses a range of quality assurance procedures to validate data on OAA participants and services which covers all the steps in the survey process. The surveys have consistently achieved a cooperation rate of over 80% for the sampled Area Agencies on Aging and over 90% for the sample of clients who are currently participating in OAA programs. These high cooperation rates occur because of several important steps in the quality assurance process, including intensive follow-up to contact and interview as many service participants as possible, and calling back at times that are convenient for respondents. After the surveys are complete, range and consistency checks and edits, in conjunction with the CATI software applications, ensure that only correct responses appear in the data files. The data is weighted during three post-survey steps to ensure accuracy. This includes using the inverse of the probability of selection to weight the sample of agencies and clients, adjusting for any non-response patterns and bias that might otherwise occur, and post-stratification of control totals to ensure consistency with official administrative records.
2.10 (ACL)	State Program Report and National Survey of Older Americans Act Participants.	This is a composite measure that utilizes data from multiple sources. One source is the State Program Report. Another source is the National Survey. State Program Report data is annually submitted by States. The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by ACL's Administration on Aging (AoA) and State staff. AoA staff follow-up with States to assure validity and accuracy. After revisions, States certify the accuracy of their data. The National Survey draws a sample of Area Agencies on Aging to obtain a random sample of clients receiving selected Older Americans Act (OAA) services. Trained staff administers telephone surveys. Results are analyzed and compared to client population to assure representative sample.
3.1 (ACL)	State Program Report data is annually submitted by States.	The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by ACL's Administration on Aging (AoA) and State staff. AoA staff follow-up with States to assure validity and accuracy. After revisions, States certify the accuracy of their data.
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. http://meps.ahrq.gov/mepsweb/communication/whats_new.jsp, see Tabular Data.	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 at What's News http://meps.ahrq.gov/mepsweb/communication/whats_new.jsp, see Data.	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, AHRQ has 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, AHRQ has 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.
1.3.60 (AHRQ)	Ongoing findings from PA-11-99	Information on PHIM projects: https://healthit.ahrq.gov/events/national-web-conference-assessing-patient-health-information-needs-developing-consumer-hit-tools http://www.ncbi.nlm.nih.gov/pubmed/26147401 https://healthit.ahrq.gov/ahrq-funded-projects/infosage-information-sharing-across-generation-and-environments https://healthit.ahrq.gov/ahrq-funded-projects/patient-reminders-and-notifications http://www.ncbi.nlm.nih.gov/pubmed/26173040

Assistant Secretary for Administration (ASA)

Measure ID	Data Source	Data Validation
1.1 (ASA)	The Office of Human Resources Telework Liaisons collect telework data from the components using spreadsheets. For all components except NIH and CDC, the Integrated Time and Attendance System is used for AWS data.	Data review and verification are completed during the GHG inventory process.

Measure ID	Data Source	Data Validation
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). The FY 2014 value is preliminary—data collection for the year is not closed until January 15th and the analysis will not be final until the fleet emission report is released January 30th. Note: 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 constrains of regulating and enforcing US standards abroad and the intent of the metric.	Both the FAST and MVMIS have internal validation processes
1.3 (ASA)	OCIO HHS Electronic Stewardship report.	Third party verification is used (i.e., reviewed by another office with ASA)
2.5 (ASA)	Office of Personnel Management Employee Viewpoint Survey. Question #21, My work unit is able to recruit people with the right skills.	This federal survey is a self-administered web survey that is offered to all full-time and part-time employees by the Office of Personnel Management.
2.6 (ASA)	Office of Personnel Management Employee Viewpoint Survey. https://www.unlocktalent.gov/employee-engagement. Question 69. Considering everything, how satisfied are you with your job?	This federal survey is a self-administered web survey that is offered to all full-time and part-time employees by the Office of Personnel Management. Data collected from the 2014 survey respondents were weighted to produce survey estimates that accurately represent the agency population.
2.7 (ASA)	Office of Personnel Management Employee Viewpoint Survey. Question 45. My supervisor is committed to a workforce representative of all segments of society.	This federal survey is a self-administered web survey that is offered to all full-time and part-time employees by the Office of Personnel Management. Data collected from the 2014 survey respondents were weighted to produce survey estimates that accurately represent the agency population.
2.8 (ASA)	The results will be captured from the HHS HREPS tracking system and tracking systems at Indian Health Service (IHS) and the National Institutes of Health (NIH).	Data on staff hiring actions is captured within the HREPS and reported on a weekly basis. This weekly data report is sent for review to each of the HHS HR Centers. The report distribution group consists of each of the HR Directors, their Deputies and staff team leads and supervisors.

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 NCCDPHP 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 NCCDPHP by August (e.g. August 2012 for the 2011-12 influenza season). Persons with unknown, refused or missing status for flu vaccination in the past 12 months are excluded.	Data validation methodology: Estimates from BRFSS are subject to the following limitations. First, influenza vaccination status is based on self or parental report, was not validated with medical records, and thus is subject to respondent recall bias. Second, BRFSS is a telephone-based survey and does not include households without telephone service (about 2% of U.S. households) and estimates prior to the 2011-12 influenza season did not include households with cellular telephone service only, which may affect some geographic areas and racial/ethnic groups more than others. Third, the median state CASRO BRFSS response rate was 54.4% in 2010, and nonresponse bias may remain after weighting adjustments. Fourth, the estimated number of persons vaccinated might be overestimated, as previous estimates resulted in higher numbers vaccinated than doses distributed.

Measure ID	Data Source	Data Validation
2.1.8 (CDC)	National HIV surveillance system	CDC conducts validation and evaluation studies of the data systems which monitor HIV to determine the quality of data generated by them. HIV data for 2010 and after include data from all 50 states. The period of time between a diagnosis of HIV or AIDS and the arrival of a case report at CDC is called the "reporting delay". CDC requires a minimum of 12 months after the end of a calendar year to provide accurate trend data. Data from the National HIV Surveillance System are available and the latest annual surveillance report was published November 24, 2015. Plans are for annual surveillance reports to be published on Dec 1st of upcoming years which would include data collected from the previous year.
2.2.4 (CDC)	DHAP Legal Assessment Project	The Legal Assessment Project (LAP) is a legal research and policy analysis project led by CDC's Division of HIV/AIDS Prevention, Office of the Director. Using standard legal research methods, the LAP researches state statutes, regulations, and policies that affect states' ability to conduct effective HIV prevention.
2.8.1 (CDC)	The National TB Surveillance System	TB morbidity data and related information submitted via the national TB Surveillance System are entered locally or at the state level into CDC-developed software which contains numerous data validation checks. Data received at CDC are reviewed to confirm their integrity and evaluate completeness. Routine data quality reports are generated to assess data completeness and identify inconsistencies. Problems are resolved by CDC staff working with state and local TB program staff. During regular visits to state, local, and territorial health departments, CDC staff review TB registers and other records and data systems and compare records for verification and accuracy. At the end of each year, data are again reviewed before data and counts are finalized and published.
3.2.5 (CDC)	National Healthcare Safety Network (NHSN) facility survey	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.
3.3.2b (CDC)	CDC's Emerging Infections Program (EIP) Active Bacterial Core Surveillance (ABCs) invasive MRSA Surveillance System, and CDC's National Healthcare Safety Network (NHSN).	NHSN data is validated by the Centers for Medicare & Medicaid Services (CMS) and state/local health departments. EIP data undergoes annual audits to ensure accuracy.

Measure ID	Data Source	Data Validation
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
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.

Measure ID	Data Source	Data Validation
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.
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 & Medicaid Services (CMS)

Measure ID	Data Source	Data Validation
CHIP 3.3 (CMS)	Statistical Enrollment Data System	Each State must assure that the information is accurate and correct when the information is submitted to SEDS by certifying that the information shown on the CHIP forms is correct and in accordance with the State's child health plan as approved by the Secretary. CMS staff populates the data into various SEDS reports and verifies each of the enrollment measures. Each form has the following seven measures that are reported by service delivery system: 1: Unduplicated Number Ever Enrolled During the Quarter. 2: Unduplicated Number of New Enrollees in the Quarter. 3: Unduplicated Number of Disenrollees in the Quarter. 4: Number of Member-Months of Enrollment in the Quarter. 5: Average Number of Months of Enrollment (item 4 divided by item 1). 6: Number Enrolled At Quarter's End (point in time). 7: Unduplicated Number Ever Enrolled in the Year" (4th Quarter Only). CMS compares these enrollment measures to past quarters and trends over the life of each program to ensure that there aren't any anomalies in the data, and if apparent errors are detected, CMS corresponds with the State staff who are responsible for reporting enrollment statistics. If there are major increases or decreases, CMS investigates the causes of the changes in enrollment patterns.
MCD6 (CMS)	The core set of measures required under CHIPRA was published in December 2009. CMS initially used the automated web-based system, CHIP Annual Reporting Template System (CARTS), for voluntary reporting of quality measures. This is the same system that was used for the CHIP Quality GPRA goal that was discontinued after FY 2010 (MCD2). Starting with FFY 2015 reporting, CMS will use the MACPro system as the data source for this measure.	For Child Core Set reporting between FFY 2011 and FFY 2014, CMS monitored performance measurement data related to the Child Core Set through CARTS. Starting with FFY 2015 reporting, CMS will monitor data reported on the Child Core Set through the MACPro system.
MCD8 (CMS)	The initial Adult Core Set was published in January 2012. CMS initially used the automated web-based system, the Medicaid Adult Quality Measures Template in CARTS for voluntary reporting of quality measures. Starting with FFY 2015 reporting, CMS will use the MACPro system as the data source for this measure.	For FY 2011 and FY 2012, the data validation was 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. For Adult Core Set reporting for FFY 2013 and FFY 2014, CMS monitored performance measurement data related to the core set of measures through CARTS. Starting with FFY 2015 reporting, CMS will monitor data reported on the Child Core Set through the MACPro system.

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. CMS conducts 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 and Medicare Advantage plans. Administrative claims data is a validated data source and is the data source for public reporting of hospital readmission rates on the Hospital Compare website (www.hospitalcompare.hhs.gov). ; As stated on the Hospital Compare website, research conducted when the measures were being developed demonstrated that the administrative claims-based model performs well in predicting readmissions compared with models based on chart reviews.	The claims processing systems have validation methods to accept accurate Medicare claims into the claims database. CMS uses national administrative inpatient hospital claims data to calculate the readmission rate measure. The claims processing systems have validation methods to accept accurate Medicare claims into the claims database. Inpatient hospital claims information is assumed to be accurate and reliable as presented in the database.
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.
MCR30.1 (CMS)	A combination of data pulls from Integrated Data Repository (IDR), Master Data Management (MDM) warehouse, Chronic Conditions Data Warehouse (CCW), Centers for Medicare & Medicaid Services (CMS) Office of the Actuary (OACT) reports, Center for Medicare and Medicaid Innovation interim payment and reconciliation reports, and so on. *Numerator*: The total amount of FFS payments made under alternative payment models and population-based payments (i.e. categories 3 and 4), such as Pioneer Accountable Care Organizations (ACOs), Shared Savings Program (SSP) ACOs, Comprehensive Primary Care Initiative (CPC), Comprehensive End Stage Renal Disease (ESRD), Bundles, and so on) during a given performance year/calendar year. *Denominator:* The total amount of FFS payments during a given calendar year as determined by OACT.	CMMI will work closely with OACT, program staff, and contractors to ensure data are accurate and reliable.
MIP1 (CMS)	The Comprehensive Error Rate Testing (CERT) Program selects a random sample of Medicare Fee-for Service (FFS) claims from a population of claims submitted for Medicare FFS payment. Complex medical review is performed on the sample of Medicare FFS claims to determine if the claims were properly paid under Medicare coverage, coding, and billing rules.	The CERT program is monitored for compliance by CMS through monthly reports from the contractors. In addition, the HHS Office of the Inspector General (OIG) conducts annual reviews of the CERT program and its contractors.

Measure ID	Data Source	Data Validation
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.
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, CMS randomly assigns 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)	CMS's predictive analytics work, using the Fraud Prevention System (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 alert summary record (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.

Measure ID	Data Source	Data Validation
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.
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, CMS reports 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.
PHI5 (CMS)	Enrollment Data Store (EDS)	Data will be generated based on effectuated enrollments; CMS will have internal controls and oversight mechanisms to ensure validity.
PHI7 (CMS)	The Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) reports data on a quarterly basis from the National Health Interview Survey (NHIS), which provides for prompt monitoring of health insurance coverage as the Affordable Care Act provisions are implemented and go into effect. The numerator for the proposed measure is the estimated number of individuals with no health coverage (individuals who reported IHS or single-service plans only are treated as uninsured). The denominator is the total civilian noninstitutionalized nonelderly population.	The National Health Interview Survey (NHIS) is the principal source of information on the health of the civilian noninstitutionalized population of the United States and is one of the major data collection programs of the CDC's National Center for Health Statistics (NCHS.) Data are collected through a personal household interview conducted by interviewers employed and trained by the U.S. Census Bureau according to procedures specified by the NCHS. http://www.cdc.gov/nchs/nhis/about_nhis.htm NHIS estimates will be compared with estimates from the American Community Survey and Current Population Survey Annual Social and Economic Supplement, which are released later than NHIS.

Food and Drug Administration (FDA)

Measure ID	Data Source	Data Validation
212406 (FDA)	FoodNet	The proactive use of food safety surveillance information and scientific data and tools to prevent illness and injury from foods is a significant focus of FDA. FDA collects data from the FoodNet Data Base to assess and communicate the specific risks associated with specific food products to American consumers and to industry on a routine basis as well as during foodborne illness outbreaks to reduce the incidence of infection with key foodborne pathogens.
212409 (FDA)	CDC/FoodNet	FoodNet Annual Reports are summaries of information collected through active surveillance of nine pathogens. A preliminary version of this report becomes available in the spring of each year and forms the basis of each year's Morbidity and Mortality Weekly Report (MMWR) FoodNet Surveillance. The FoodNet Final Report becomes available later in the year when current census information becomes available. The illness rates calculated for this Priority Goal use the same data and same methodology as the illness rates in the MMWR. CDC's FoodNet system reports pathogen-specific illness data based on the calendar year, not the fiscal year. Therefore, achievement of the annual targets reported here is evaluated based on the calendar year data, not fiscal year data.
214305 (FDA)	Field Data Systems	These maximum capacities are extrapolated to estimate for times of emergency with the laboratory operating under abnormal conditions that are variable and uncertain. FDA and FERN work to maximize capabilities by continually improving methods and training along with increasing automated functionality and available cache of supplies. Through using these laboratories, with known instrumentation and methods, after examining the sample throughput during emergencies, and after consultation with the laboratories and FDA subject matter experts, the listed sample totals are the estimates reached. The surge capacity estimates provided in the performance measures for these laboratories have been examined under the stress of emergencies and outbreaks such as the melamine contamination, Deepwater Horizon oil spill, and the Japan nuclear event.

Measure ID	Data Source	Data Validation
214306 (FDA)	BioPlex and ibis Biosensor systems	CFSAN scientists have developed the means to evaluate and adapt commercially available instruments to develop and validate more rapid, accurate, and transportable tests to stop the spread of foodborne illness and cases of chemical contamination. Using one such system, known as BioPlex, CFSAN scientists are using the device to rapidly serotype pathogens such Salmonella. The BioPlex system can serotype 48 different samples in 3 to 4 hours, which vastly improves response time in foodborne illness outbreaks. CFSAN scientists also are using the ibis Biosensor system to speed the identification of Salmonella, E. coli, and other pathogens, toxins, and chemical contaminants.
223215 (FDA)	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.
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.

Measure ID	Data Source	Data Validation
262401 (FDA)	NCTR Project Management System; peer-review through FDA/NCTR Science Advisory Board (SAB) and the NTP Scientific Board of Counselors; presentations at national and international scientific meetings; use of the predictive and knowledge-based systems by the FDA reviewers and other government regulators; and manuscripts prepared for publication in peer-reviewed journals.	NCTR provides peer-reviewed research that supports FDA's regulatory function. To accomplish this mission, it is incumbent upon NCTR to solicit feedback from its stakeholders and partners, which include FDA product centers, other government agencies, industry, and academia. The NCTR SAB —composed of non-government scientists from industry, academia, and consumer organizations, and subject matter experts representing all of the FDA product centers—is guided by a charter that requires an intensive review of each of the Center's scientific programs at least once every five years to ensure high quality programs and overall applicability to FDA's regulatory needs. Scientific and monetary collaborations include Interagency Agreements with other government agencies, Cooperative Research and Development Agreements that facilitate technology transfer with industry, and informal agreements with academic institutions. NCTR also uses an in-house strategy to ensure the high quality of its research and the accuracy of data collected. Research protocols are often developed collaboratively by principal investigators and scientists at FDA product centers and are developed according to a standardized process outlined in the "NCTR Protocol Handbook." NCTR's Project Management System tracks all planned and actual expenditures on each research project. The Quality Assurance Staff monitors experiments that fall within the Good Laboratory Practices (GLP) guidelines. NCTR's annual report of research accomplishments, goals, and publications is published and available on FDA.gov. Research findings are published in peer-reviewed journals and presented at national and international scientific conferences.
280005 (FDA)	CTP's Tobacco Inspection Management System (TIMS) is a database that contains the tobacco retail inspection data submitted by state and territorial inspectors commissioned by FDA.	CTP/OCE has in place a process for ensuring the quality of the data in TIMS. OCE staff conduct random quality control checks of inspection data submitted for tobacco retail inspections where no violations were found. OCE staff conduct quality control checks for all tobacco retail inspections where potential violations were found.

Health Resources and Services Administration (HRSA)

Measure ID	Data Source	Data Validation
1.I.A.1 (HRSA)	HRSA Bureau of Primary Health Care's Uniform Data System	Validated using over 1,000 edit checks, both logical and specific. These include checks for missing data and outliers and checks against history and norm.
1.I.A.3 (HRSA)	HRSA/Bureau of Primary Health Care contractors that perform PCMH surveys.	Data validated by Health Center program staff.
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 performance reports submitted by BHW grantees through the BHW Performance Management Handbook 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 BHW's National Center for Health Workforce Analysis (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)	MCH Block Grant's Title V Information System (TVIS) that contains data on grantee performance from grantee annual reports	Data are validated by project officers and program staff.
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.

Measure ID	Data Source	Data Validation
29.IV.A.3 (HRSA)	Reported by grantees through the Program's Performance Improvement Measurement System	Validated by project officers
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 and AAAHC, non-governmental organizations, maintain lists of certified and accredited facilities at their public websites. Visit the Joint Commission website at http://www.qualitycheck.org/CertificationList.aspx. Visit the Accreditation Association for Ambulatory Health Care at http://www.aaahc.org/eweb/dynamicpage.aspx?site=aaahc_site&webcode=find_orgs.
24 (IHS)	Clinical Reporting System (CRS)	CRS software testing; quality assurance review of site submissions; Immunization program reviews

Measure ID	Data Source	Data Validation
30 (IHS)	Clinical Reporting System(CRS)	CRS software testing; quality assurance review of site submissions
51 (IHS)	Clinical Reporting System (CRS)	CRS software testing, quality assurance review of the site submission
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
1.2 (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
1.4 (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/
1.7 (IOS)	The HHS IDEA Lab Buyers Club Program Manager's Database	The HHS IDEA Lab Buyer's Club tracks IT acquisitions that have utilized Buyer's Club

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.	Information on the Molecular Libraries Program (MLP) can be found here: http://commonfund.nih.gov/molecular libraries/ MLP research resources that are available: - NCATS Small Molecule Resource's public access to compounds of the MLI (http://ncats.nih.gov/preclinical/core/compound) - NIH Clinical Collection (http://nihsmr.evotec.com/evotec/sets/ncc) - NCGC Assay Guidance Manual and HTS Guidance Criteria (http://www.ncbi.nlm.nih.gov/books/NBK53196/) - Probe Reports and Probe Report abstracts in PubChem (http://www.ncbi.nlm.nih.gov/books/NBK47352/; https://pubchem.ncbi.nlm.nih.gov/) - Probes available from ML Centers and commercial vendors (http://www.ncbi.nlm.nih.gov/books/NBK47352/?term=molecular%5BAll%20Fields%5D%20AND%20(%22libraries%22%5BAll%20Fields%5D%20OR%20%22libraries%22%5BAll%20Fields%5D)) - PubChem (https://pubchem.ncbi.nlm.nih.gov/) - BioAssay Research Database (BARD) (https://bard.nih.gov/)

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. Specific data sources for this measure are provided below. A contact is listed if administrative records are included as a data source. For additional information contact: NIAMS SPPB (Reaya Reuss, 301-496-8271, reussa@mail.nih.gov) 1. Preliminary Response to Janus Kinase Inhibition with Baricitinib in Chronic Atypical Neutrophilic Dermatosis with Lipodystrophy and Elevated Temperatures (CANDLE) Gina A Montealegre Sanchez, Adam Reinhardt, Paul Brogan, Yackov Berkun, Abraham Zlotogorski, Diane Brown, Peter Chira, Ling Gao, Jason Dare, Susanne Schalm, Rosa Merino, Dawn Chapelle, Hanna Kim, Samantha Judd, Michelle O'Brien, Adriana Almeida de Jesus, Yun J. Kim, Bahar Kost, Yan Huang, Scott Paul, Robert Colbert, Alessandra Brofferio, Chyi-chia Lee, Colleen Hadigan, Theo Heller, Caterina P. Minniti, Kristina I. Rother, Raphaela Goldbach-Mansky. Abstract and oral presentation by Dr. Montealegre with preliminary data were presented at the ISSAID meeting in Dresden, Germany on October 4th 2015. 2. Additive Loss-of-Function Mutations in Proteasome-Subunit-Genes induce Type-I-interferon production in CANDLE/PRAAS. Anja Brehm, Yin Liu, Afsal Sheikh, Bernadette Marrero, Ebun Omoyinmi, Qing Zhou, Gina Montealegre Sanchez, Angelique Biancotto, Adam Reinhardt, Adriana de Jesus, Martin Pelletier, Wanja Tsai, Elaine Remmers, Lena Kardava, Suvimol Hill, Hanna Kim, Helen Lachmann, Andres Megarbane, Jae Chae, Jilian Brady, Rena Castillo, Diane Brown, Angel Casano, Lng Gao, Dawn Chapelle, Yan Huang, Deborah Stone, Yongjing Chen, Frauke Sotzny, Chia Lee, Daniel Kastner, Antonio Torrelo, Abraham Zlotogorski, Susanne Moir, Massimo Gadina, Phil McCoy P, Robert Wesley, Kristina Rother, Peter Hildebrand, Paul Brogan, Elke Krüger, Ivona Aksentijevich, Raphaela Goldbach-Mansky R. J Clin Invest. October 2015.
SRO-5.2 (NIH)	Publication, databases, administrative records and/or public documents	Cluster analysis in the COPDGene study identifies subtypes of smokers with distinct patterns of airway disease and emphysema. Castaldi PJ et al. Thorax. 2014 May;69(5):415-22. doi: 10.1136/thoraxjnl-2013-203601. Epub 2014 Feb 21. For additional information contact: Dr. Lisa Postow, NHLBI, NIH (lisa.postow@nih.gov).

Measure ID	Data Source	Data Validation
SRO-5.5 (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. Specific data sources for this measure are provided below. A contact is listed if administrative records are included as a data source. For additional information, contact: NIBIB OSPC (Christine Cooper, 301-594-8923, cooperca2@mail.nih.gov). Selected publications: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4234275/ http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4444489/
SRO-5.13 (NIH)	Publication, databases, administrative records and/or public documents	Relevant results are reported in peer-reviewed journals: 1. Hsieh *et al.* (2015). A data analysis pipeline accounting for artifacts in Tox21 quantitative high-throughput screening assays. *J Biomol. Screen.* **20(7):** 887-897. 2. Browne *et al.* (2015). Screening Chemicals for Estrogen Receptor Bioactivity Using a Computational Model. *Environ. Sci. Technol.* **49(14):** 8804-8814. 3. Judson *et al.* (2015). Integrated Model of Chemical Perturbations of a Biological Pathway Using 18 In Vitro High-Throughput Screening Assays for the Estrogen Receptor. *Toxicol. Sci.* **148(1):** 137-154. Information about Tox21 can be found at http://www.epa.gov/ncct/Tox21/.
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. The Role of Type 2 inflammation in the Pathogenesis of Asthma Exacerbations; Dunican E and Fahy J; Annals ATS, 12 (supp 2): S144-149; November 2015. Vitamin D Supplementationand the Risk of Colds in Patients with Asthma; Denlinger L et al; AJRCCM; November 2015. For additional information contact: Dr. Gail Weinmann, NHLBI, NIH at Gail.Weinmann@nih.hhs.gov

Measure ID	Data Source	Data Validation
SRO-8.2 (NIH)	Publications, databases, administrative records and/or public documents	1. Papers identified by the August mini-review. 2. a. Jennings, JH, Rizzi, G, Stamatakis, AM, Ung, RL, Stuber, GD, 2013, Science, 341:1517-1518. The inhibitory circuit architecture of the lateral hypothalamus orchestrates feeding. b. Nieh, EH, et al, 2015, Cell 160:528-541. Decoding neural circuits that control compulsive sucrose seeking. c. Jennings, JH, et al, 2015, Cell 160:516-527. Visualizing hypothalamic network dynamics for appetitive and consummatory behaviors. d. Myers, MG, Olson, DP, 2014, Cell Metabolism 19:732-733. SnapShot: Neural pathways that control feeding. 3. Cruz,F.C.,etal.,Using c-fos to study neuronal ensembles in corticostriata lcircuitry of addiction. Brain Research(2014), http://dx.doi.org/10.1016/j.brainres.2014.11.005

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. Specific data sources for this measure are provided below. A contact is listed if administrative records are included as a data source. Cowart-Osborne M, Jackson M, Chege E, Baker E, Whitaker D, Self-Brown S. Technology-Based Innovations in Child Maltreatment Prevention Programs: Examples from SafeCare® Social Sciences (Basel). 2014 Aug 15;3(3):427-440. Forsberg S, Fitzpatrick KK, Darcy A, Aspen V, Accurso EC, Bryson SW, Agras S, Arnow KD, Le Grange D, Lock J. Development and evaluation of a treatment fidelity instrument for family-based treatment of adolescent anorexia nervosa. The International journal of eating disorders; 2015 Jan;48(1):91-9. Brookman-Frazee L, Stahmer A, Stadnick N, Chlebowski C, Herschell A, Garland AF. Characterizing the Use of Research-Community Partnerships in Studies of Evidence-Based Interventions in Children's Community Services. Adm Policy Ment Health. 2015 Jan 13. [Epub ahead of print] 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	The Commerce data is actual sales of tobacco and the Census data is the early adult population calculation.

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 2015. 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).

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.
1.E.4 (ONC)	National Electronic Health Records Survey (NEHRS), which is a supplemental mail survey to the National Ambulatory Medical Care Survey (NAMCS). The NERHS was formerly called the NAMCS EMR Supplement. ONC partially funds the supplement through interagency agreements with the CDC National Center for Health Statistics, which fields the broader survey.	The NAMCS is nationally representative of office-based physicians. Historically, the response rate is approximately 68%. Beginning with survey year 2010, the survey allows ONC to evaluate trends in electronic health record adoption by region, provider specialty, and state. Estimates for FYs 2008-11 for this measure derive from the mail supplement to the NAMCS.
1.E.7 (ONC)	Hospital measures: American Hospital Association (AHA) Information Technology (IT) Supplement to the AHA Annual Survey, which ONC partially funds through cooperative agreement.	Data are from the American Hospital Association (AHA) Information Technology (IT) Supplement to the AHA Annual Survey. Since 2008, ONC has partnered with the AHA to measure the adoption and use of health IT in U.S. hospitals. The chief executive officer of each U.S. hospital was invited to participate in the survey regardless of AHA membership status. The person most knowledgeable about the hospital's health IT (typically the chief information officer) was requested to provide the information via a mail survey or secure online site. Non-respondents received follow-up mailings and phone calls to encourage response. The FY 2014 estimates are derived from the survey that was fielded from November 2014 to the end of February 2015.

Substance Abuse and Mental Health Services Administration (SAMHSA)

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 providing 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. This is to be part of CDP Phase 1 data collection and reporting.	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.	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. The NCTSI began using a web-based GPRA data collection system called Transformation Accountability (TRAC) System in FY 2008 and only source for its performance monitoring data.
3.2.16 (SAMHSA)	TRAC	For the data collected in TRAC, 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.	For the TRAC data, 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.
3.2.37 (SAMHSA)	TRAC	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

Measure ID	Data Source	Data Validation
3.2.50 (SAMHSA)	The data will be collected and tabulated by hand on a 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.	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)	This measure was never part of phase one in the CDP. This data is from the mental health block grants. It is hand-collected and reported by CMHS for input into TRAC and then PPTS.	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 never part of CDP.	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 (SAMHSA)	Services Accountability Improvement System.	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
3.4.25 (SAMHSA)	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
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.