U.S. Department of Health and Human Services

FY 2019 Annual Performance Plan and Report

Message from the HHS Performance Improvement Officer

The U.S. Department of Health and Human Services (HHS) supports and implements programs that contribute to the health, safety, and well-being of the American people. In accordance with the Government Performance and Results Act (GPRA) of 1993, as amended in the GPRA Modernization Act (GPRAMA) of 2010, I am pleased to present the Fiscal Year 2019 Annual Performance Plan and Report, documenting the Department's performance during the past year. Further information detailing HHS performance is available at Performance.gov.

In FY 2017, HHS monitored over 1,000 performance measures to manage departmental programs and activities and improve the efficiency and effectiveness of these programs. This report includes a representative set of performance measures to illustrate progress toward achieving the Department's strategic goals. The information provided spans the Department's 11 operating divisions and 14 staff divisions and includes work across the country and throughout the world. Each HHS division has reviewed its submission and I confirm, based on certifications from the divisions, that the data are reliable and complete. When results are not available because of delays in data collection, the report notes the date when the results will be available.

HHS is working to keep America healthy, advance science and research, serve our citizens at key stages of life, and continuously improve the Department's administration and operations. The results presented here demonstrate that HHS is performing well across a wide range of activities.

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Table of Contents

Overview

The U.S. Department of Health and Human Services is the United States government's principal agency for protecting the health of all Americans and providing essential human services.

Operating divisions (OpDivs), including agencies in the United States Public Health Service and human service agencies, administer HHS programs. Staff divisions (StaffDivs) provide leadership, direction, and policy and management guidance to the Department. Throughout this document, the operating divisions and staff divisions will be collectively referred to as HHS components.

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

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

Mission Statement

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

HHS Organizational Structure

The Department includes 11 operating divisions that administer HHS programs:

- Administration for Children and Families (ACF)

- Administration for Community Living (ACL)
- Agency for Healthcare Research (AHRQ)[1]
- Agency for Toxic Substances and Disease Registry (ATSDR)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health and (NIH)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

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

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

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

[1] In FY 2019, AHRQ's activities will be consolidated within NIH as the National Institute for Research Safety and Quality.

Cross-Agency Priority Goals

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

Agency Priority Goals

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

Strategic Goals Overview

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

Goal 1: Reform, Strengthen, and Modernize the Nation's Health Care System.

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

Goal 3: Strengthen the Economic and Social Well-Being of Americans across the Lifespan.

Goal 4: Foster Sound, Sustained Advances in the Sciences.

Goal 5: Promote Effective and Efficient Management and Stewardship.

Performance Management

Performance goals and measures are powerful tools to advance an effective, efficient, and productive government. HHS regularly collects and analyzes performance data to inform decisions, to achieve meaningful progress, and to identify more cost-efficient ways to achieve results.

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

- Developing, analyzing, reporting, and managing priority goals and conducting quarterly performance reviews between HHS component staff and HHS leadership to monitor progress towards achieving key performance objectives.
- Coordinating the Strategic Reviews process to support decision-making and performance improvement across the Department.

- Overseeing performance measurement, budgeting, strategic planning, and program integrity activities within the Department.
- Fostering a network of component Performance Officers who support, coordinate, and implement performance management efforts across HHS.
- Sharing best practices in performance management at HHS through webinars and other media.

Annual Performance Plan and Report

The Annual Performance Plan and Report provides information on the Department's progress towards achieving the goals and objectives described in the HHS Strategic Plan FY 2018-2022. This report is organized according to that strategic plan and the information in the report reflects results available at the end of FY 2017.

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

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

In 2016, the Federal Government accounted for 28 percent of health care spending; households, 28 percent; private businesses, 20 percent; and State and local governments, 17 percent. National Health Expenditure data show that growth in spending is due to expanded coverage and increased utilization of health care.

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

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

Objective 1.1 Table of Related Performance Measures

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	58.0%	55.0%	53.0%	50.0%	48.0%	43.0%	37.0%	32.0%
Result	57.0%	52.0%	53.0%	49.0%	April 30, 2018	Feb 28, 2019	Feb 28, 2020	Feb 28, 2021
Status	Target Exceeded	Target Exceeded	Target Met	Target Exceeded	Pending	Pending	Pending	Pending

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) amends Title XVIII (Medicare) of the Social Security Act by adding a Voluntary Prescription Drug Benefit Program (Medicare Part D). Since its inception, Medicare Part D has significantly increased the number of

beneficiaries with comprehensive drug coverage, and enhanced access to medicines.

While Medicare Part D offers substantial insurance coverage for prescription drugs, it does not offer complete coverage. Prior to 2010, a beneficiary was responsible for paying 100 percent of the prescription costs between the initial coverage limit and the out-of-pocket threshold (or catastrophic limit). Only once the beneficiary reached the catastrophic limit, did Medicare coverage recommence. This is known as the coverage gap (or "donut hole"). For 2017, this "gap" in coverage was above $3,700 in total drug costs until a beneficiary spent spends $4,950 out-of-pocket.

Since 2011, brand-name pharmaceutical manufacturers have been required to provide a 50 percent discount on the negotiated price of their drugs while a beneficiary is in the coverage gap. The discount is applied at the point of sale, and 100 percent of the negotiated price counts toward the annual out-of-pocket threshold (known as True Out-of-Pocket Costs or TrOOP). Since 2013, Part D Plans have been required to cover a portion of the costs of brand drugs in the coverage gap as well, with this coverage increasing over time from 2.5 percent in 2013 to 25 percent for 2020 and beyond. Since 2011, Part D Plans have also been required to cover a portion of the costs for generic drugs in the coverage gap, starting with 7 percent in 2011 and increasing to 75 percent for 2020 and beyond.

This performance measure reflects CMS' effort to reduce the average out- of-pocket costs paid by non-Low Income Subsidy (LIS) Medicare beneficiaries while in the coverage gap and to ensure that the coverage gap is closed completely by 2020 as required by law. For 2020 and beyond, the beneficiary, on average, will only be responsible for 25 percent of the costs of both generic and brand name drugs while in the coverage gap, making this coverage equivalent to coverage prior to reaching the gap.

CMS' implementation and management of the coverage gap discount program has, in most years, meant that non-LIS OOP costs have decreased beyond what is required by statute. This has occurred without any meaningful decreases in plan participation in the Part D market. As generic utilization in the Part D program has remained static, and very high, that is not a strong contributor to the success of this goal. Rather, CMS' application and management of the coverage gap discount program, coupled with the strong incentives for manufacturers to participate in the Part D program, are the primary drivers of this goal's success.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	Set Baseline	26%	30%	40%	50%	TBD
Result	N/A	N/A	22%	26%	31%	Nov 30, 2018	Nov 30, 2019	Nov 30, 2020
Status	N/A	N/A	Baseline	Target Met	Target Exceeded	Pending	Pending	Pending

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 and CMS, through the Center for Medicare and Medicaid Innovation (CMMI), identifies, tests, evaluates, and expands, as appropriate, innovative payment and service delivery models that can reduce program expenditures for Medicare, Medicaid, and Children's Health Insurance Program, 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 a lower cost. In addition, CMS is implementing payment reforms that increasingly reward quality and efficiency of care.

These alternative payment models and payment reforms that increasingly tie 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 uses the following framework to describe and measure health care payments through the stages of transition from pure FFS to more advanced alternative payment models. This framework classifies payment models into the following four categories according to how clinicians and organizations are paid:

- Category 1—fee-for-service with no link of payment to quality;
- Category 2—fee-for-service with a link of payment to quality;
- Category 3—alternative payment models built on fee-for-service architecture; and

- Category 4—population-based payment.

To encourage alignment between public and private payers and to help move payment reform along the continuum described above, CMS set a target for Medicare to have 40 percent and 50 percent of Medicare FFS payments tied to alternative payment models by the end of Calendar Years 2017 and 2018, respectively.

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

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

Health care safety is a national priority. When the Office of Inspector General examined the health records of hospital inpatients in 2008, it determined that hospital care contributed to the deaths of 15,000 Medicare beneficiaries each month. Health care-associated infections are infections people get while they are receiving medical treatment or undergoing surgery. At any given time, about 1 in 25 patients have an infection related to hospital care. Infections lead to the loss of tens of thousands of lives and cost the U.S. health care system billions of dollars each year. Adverse drug events—injuries resulting from medical intervention related to a drug—result in more than 3.5 million physician office visits, 1 million emergency department visits, and 125,000 hospital admissions each year.

HHS investments in prevention have yielded both human and economic benefits. From 2010 to 2014, efforts to reduce hospital-acquired conditions and infections have resulted in a decrease of 17 percent nationally, translating to 87,000 lives saved, $19.8 billion in unnecessary health costs averted, and 2.1 million instances of harm avoided.

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

Objective 1.2 Table of Related Performance Measures

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	Set Baseline	N/A	50.0 %	61.3 %	68.8 %	84.4 %
Result	N/A	N/A	40.9 %	N/A	64%	Nov 30, 2018	Nov 30, 2019	Nov 30, 2020
Status	N/A	N/A	Baseline	N/A	Target Exceeded	Pending	Pending	Pending

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. CDC estimates that drug-resistant bacteria cause two million illnesses and approximately 23,000 deaths each year in the United States alone. In 2016, about 64% of U.S. acute care hospitals reported having an antibiotic stewardship program that incorporates all of the CDC Core Elements for Hospital Antibiotic Stewardship Programs. Thus, CDC exceeded its 2016 target and is on track to meet its 2017 target. In FY 2018 and 2019, CDC will continue to work with public and private partners to encourage hospitals to continue implementing antibiotic stewardship programs that are fully compliant with CDC Core Elements for Hospital Antibiotic Stewardship Programs to improve health care, decrease health consequences (e.g., C. difficile infections), and ultimately prevent antibiotic resistance.

Reduce all-cause hospital readmission rate for Medicare-Medicaid Enrollees (Lead Agency - CMS; Measure ID - MMB2)[2]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	Set Baseline	N/A	N/A	N/A	N/A	N/A	Prior Result -1.0%	Prior Result -1.0%
Result	92.7	85.7	83.4	84.0	Apr 30, 2018	Apr 30, 2019	Apr 30, 2020	Apr 30, 2021
Status	Baseline	Historic Actual	Historic Actual	Historic Actual	Pending	Pending	Pending	Pending

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

While many studies have pointed to opportunities for improving hospital readmission rates, the rate of readmissions for individuals who are dually eligible for both Medicare and Medicaid (also referred to as Medicare-Medicaid Enrollees) is often higher than for Medicare beneficiaries overall. In 2016 an estimated 11.7 million beneficiaries were dually eligible for Medicare and Medicaid.

[2] This goal was publicly reported in the FY 2018 Congressional Justification with a goal identifier of MMB1.

Compared to non-dually eligible Medicare beneficiaries, Medicare-Medicaid enrollees have higher rates of chronic and co-morbid conditions and higher rates of institutionalization, as well as challenges posed by socioeconomic issues. As a result, we seek to assess the impact of interventions on this sub-population.

In calendar year (CY) 2013, CMS implemented two demonstrations focused on improving care for Medicare-Medicaid enrollees. The first and larger demonstration is the Financial Alignment Initiative, in which CMS partners with state Medicaid agencies to test models for integrated, coordinated care for this population. The second demonstration is the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents.

This measure is calculated using the number of readmissions per 1,000 eligible beneficiaries. This is a more sensitive measure for dual-eligible beneficiaries than the rate of readmissions (numerator) divided by admissions (denominator) used in other hospital readmissions measures. There has been concern that such a ratio does not accurately capture quality improvement outcomes of decreased readmissions and admissions at any given hospital. For example, such a ratio can remain unchanged if admissions decline at the same rate as readmissions due to hospital quality improvement efforts to reduce both.

Based on national trends reflecting a slowing in readmissions reductions for all Medicare beneficiaries, CMS now proposes a relatively modest target reduction rate of 1 percent from the prior year's actual result for both CY 2018 and CY 2019.

Patient Safety Cluster

Improve hospital patient safety by reducing preventable patient harms (Lead Agency – CMS; Measure ID – QIO11)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	N/A	106 harms per 1,000 discharges	101 harms per 1,000 discharges	97 harms per 1,000 discharges
Result	132	121	121	115	Mar 31, 2018	Dec 31, 2018	Dec 31, 2019	Dec 31, 2020
Status	N/A	Historic Actual	Historic Actual	Historic Actual	Pending	Pending	Pending	Pending

The purpose of this measure is to determine the national impact of patient safety efforts by counting the number of preventable patient harms that take place per 1,000 inpatient discharges. Examples of some of the preventable patient harms included in this measure are:

- Adverse Drug Events (ADEs);
- Catheter-Associated Urinary Tract Infections (CAUTI);
- Central Line-Associated Bloodstream Infections (CLABSI);
- Falls;
- Pressure Ulcers (PrUl);
- Surgical Site Infections (SSI);
- Ventilator-Associated Pneumonia/Events (VAP/VAE);
- Venous Thromboembolism (VTE); and
- Hospital Readmissions.

These preventable harms can cause additional pain, stress, and costs to the patient and their family during intended treatment, as well as increased spending on the part of payers. This measure utilizes the AHRQ National Scorecard, which includes abstraction from a nationally representative sample of approximately 30,000 hospital charts per year that yields clinical relevant yet highly standardized national hospital safety metrics. This system is in active operation, and was originally put into place to measure the impact of the Partnership for Patients (PfP) Center for Medicare & Medicaid Innovation (CMMI) model test. By itself however, it represents an enormous contribution to the government's ability to measure, monitor, and improve patient safety at a national scale. As a composite of many different harms, the AHRQ National Score Card also includes data from the CDC's National Health care Safety Network (NHSN) and AHRQ's Health care Cost and Utilization Project (HCUP) databases.

The results of this dataset thus far demonstrate a reduction in harm from 145 harms per 1,000 discharges in the baseline year of CY 2010 (defined prior to the PfP model test), to 115 harms per 1,000 discharges in CY 2015, the latest year for which preliminary data are available at this time. These data demonstrate a reduction in harm to patients of approximately 21 percent over five years.

Calendar Year	# Harms per 1,000 Discharges	Percent decrease from baseline
2015	115	21%
2014	121	17%
2013	121	17%
2012	132	9%
2011	142	2%

2010 – Baseline	145	Baseline

The proposed 2019 target is a 20 percent reduction in patient harms, compared to the 2014 baseline (annualized reduction [-4.4 percent] applied for 5 years). Given the progress to date, the active interventions of Hospital Innovation and Improvement Networks (HIINs) currently in the field under PfP 3.0, CMS and AHRQ believe that this is a challenging, yet achievable goal.

CMS will leverage the momentum and lessons learned from the model test in aligning PfP with the Quality Innovation Networks-Quality Improvement Organizations (QIN-QIO) improvement efforts. The Center for Clinical Standards and Quality (CCSQ) has made patient safety an essential component of both the QIN-QIOs and PfP, the alignment of these programs will permit the systematic use of innovative patient safety practices at a national scale. Integration presents unique opportunities to leverage scope and scale in achieving the goals of the 11th SOW (e.g., Hospital Acquired Condition (HAC) reduction in hospitals).

The goal of the integrated PfP and QIN-QIO patient safety effort is to directly work with recruited hospitals to implement evidence-based interventions and best practices, track improvement using a data driven approach (e.g. using CDC's NHSN system), and establish a culture of safety and quality improvement to make care safer for Medicare beneficiaries. This work does not directly involve payment incentives or penalties as participation with HIINs and/or QIOs is completely voluntary on the part of the hospital. The quality programs that CMS operates through the Inpatient Prospective Payment System (IPPS) also contribute to the aims of this goal, to increase patient safety and reduce harms.

It is important to note that the data obtained from the AHRQ National Scorecard experiences a lag of approximately one year between service delivery and the collection, analysis, and delivery of preliminary results and a second year between delivery of preliminary and final results. The preliminary data that will be used to obtain confirmation of CMS's achievement of this CY 2019 target is expected to be available in the December CY 2020 and final data in CY 2021.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	0.6	0.5	0.4	0.35	0.33	0.31	0.29	0.27
Result	0.56	0.54	0.5	0.6	Jun 30, 2018	Jun 30, 2019	Jun 30, 2020	Jun 30, 2021
Status	Target Exceeded	Target Not Met but Improved	Target Not Met but Improved	Target Not Met	Pending	Pending	Pending	Pending

Reducing HAIs across all health care settings supports the HHS mission to prevent infections and its complications as well as reduce excess health care costs in the U.S. These efforts also align with the National Action Plan to Prevent Health care Associated Infections: Roadmap to Elimination (National HAI Action Plan),[5] and Healthy People 2020 Goals.[6] Between CY 2008 and CY 2015, CLABSIs decreased 40 percent nationally in U.S. hospitals. While the overall Standardized Infection Ratio of 0.60 falls short of the 2015 target, CDC continues to move forward to meet the goals in the National HAI Action Plan. In 2015, CDC developed a new baseline for all HAIs including CLABSI to better assess national and local prevention progress and identify gaps for tailored prevention. Beginning with 2015 data, HAI prevention progress will be measured to the new baseline. CDC will shift the national CLABSI targets for Measure 3.3.3 to incorporate these changes in future performance documents.

Reduce standardized infection ratio for hospital-onset Clostridium difficile infections (Lead Agency - CDC; Measure ID - 3.2.4b)[7]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	Set Baseline	Set Baseline	0.84	0.76	0.75	0.70
Result	N/A	N/A	1.00	1.00	Mar 31, 2018	Mar 31, 2019	Mar 31, 2020	Mar 31, 2021
Status	N/A	N/A	Baseline	Baseline	Pending	Pending	Pending	Pending

Clostridium difficile infection (CDI)[8] is a preventable, life-threatening bacterial infection that can occur in both inpatient and outpatient health care settings. CDC provides data-driven strategies and tools for targeted intervention to the health care community to help prevent CDI, as well as

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3 The baseline for this measure was updated in FY 2015 and will affect future targets and data reporting for FY 2016 onward.

4 The FY 2018 CLABSI target is based on an FY 2006-2008 baseline; revisions to update this target are pending.

5 https://health.gov/hcq/prevent-hai-action-plan.asp.

6 https://www.healthypeople.gov/2020/topics-objectives/topic/healthcare-associated-infections.

7 FY 2018 and FY 2019 targets for measures 3.2.4a and 3.2.4b reflect proposed changes to program resources for antibiotic resistance.

8 http://www.nejm.org/doi/full/10.1056/NEJMoa1408913.

resources to help the public safeguard their own health. CDI prevention is a national priority, with a 2020 target to reduce CDI by 50 percent in the National Action Plan for CARB and the 2015 National HAI Action Plan.[9] To better identify and make improvements to prevention efforts for CDI nationwide, CDC created a new CDI metric that consists of two sub-measures, one of which is hospital-onset CDI. Starting at an initial baseline of 1.00 for this measure in 2014, progress in the CDI measure will assist CDC in targeting resources to where there is the greatest need to make the most impact. The baseline year for this measure changed from 2014 to 2015 to align to changes in the 2015 HHS HAI Action Plan.

[9] https://health.gov/hcq/prevent-hai-action-plan.asp.

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

The Department defines access to health services as "the timely use of personal health services to achieve the best health outcomes." It involves gaining entry into the health care system, usually through payment; gaining access to diverse options for receiving treatment, services, and products, including physical locations and online options; and having a trusted relationship with a health care provider. Efforts to improve access to care are not limited to physical health care. Improving access to behavioral and oral health care, including through innovative solutions that use health information technology, also is critical, especially for populations experiencing disparities in access.

To improve outcomes in this objective, HHS is working to address the high cost of care, lack of availability of services, and lack of culturally competent care. Strategies related to promoting affordability and strengthening the workforce are addressed in Strategic Objectives 1.1 and 1.4. This Strategic Objective focuses on how HHS, rather than instituting government mandates, is giving people more control over how they access care, through increasing the spectrum of consumer options and expanding competition among health care providers, including by removing barriers to participation in the health care sector for religious, faith-based, and other providers.

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

Objective 1.3 Table of Related Performance Measures

Track the number of individuals who receive direct services through Federal Office of Rural Health Policy (FORHP) Outreach grants, subject to the availability of resources (Lead Agency - HRSA; Measure ID - 29.IV.A.3) [10]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	390,000 people	395,000 people	400,000 people	400,000 people	410,000 people	415,000 people	420,000 people	230,000 people
Result	747,952 people	703,070 people	820,176 people	837,511 people	993,187 people	Oct 31, 2018	Oct 31, 2019	Oct 31, 2020
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

[10] A new cohort of FORHP Outreach grants is awarded for 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.

Outreach grants of the Federal Office of Rural Health Policy focus on improving access to care in rural communities through the work of community coalitions and partnerships. These grants often focus on disease prevention and health promotion, but can also support expansion of services such as primary care, mental and behavioral health care, and oral health services. Nearly 1 million people received direct services supported through Outreach grants in FY 2016, up from about 748,000 in FY 2012. In FY 2018 and 2019, FORHP will continue to fund non-categorical grants that allow rural communities to respond to health care challenges and issues unique to rural areas.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	Set Baseline	N/A	N/A	76 %	TBD	TBD
Result	N/A	N/A	74.6 %	75.2 %	75.4 %	Jul 31, 2018	July 31, 2019	July 31, 2020
Status	N/A	N/A	Baseline	Historic Actual	Historic Actual	Pending	Pending	Pending

The purpose of this performance goal is to help assess an important component of patient experience of care with their provider. Specifically, shared decision making between patient, caregiver and provider is considered to be a fundamental component of a patient-centered health care system that leads to improved health outcomes for patients. The Shared Decision Making section of the Summary Survey Measures (SSM) asks beneficiaries questions such as when they talked to their provider about starting or stopping a prescription medicine, did the provider ask what they thought was best for them. It also asks beneficiaries whether they and their provider talked about how much of their personal health information they wanted shared with family or friends. As beneficiaries become more empowered to actively participate in their care, we would expect better performance in the Shared Decision Making section of the SSM, as this section of the Consumer Assessment of Health care Providers System (CAHPS) survey focuses on beneficiary engagement related to their care. And as more beneficiaries actively participate in their care decisions, CMS should also see improved health outcomes for beneficiaries.

The Shared Decision Making section of the SSM is collected and reported through the CAHPS survey for Physician Quality Reporting programs, the Merit-Based Incentive Program beginning in 2017 and the CAHPS for ACOs Survey administered by Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program (Shared Savings Program). Congress created the Shared Savings Program to facilitate coordination and cooperation among providers to improve

the quality of care for Medicare Fee-For- Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an ACO.

The performance target set for this measure was established using Shared Savings Program's quality measure performance benchmark distribution. Prior to the start of a performance year, CMS publishes quality measure performance benchmarks that are set using all available Medicare FFS quality data. These data-driven benchmarks are used to assess quality attainment (and more recently, quality improvement) and ultimately translated into points used in the program's financial performance calculations. The 76 percent target set for the Shared Decision Making measure in 2017 (available for reporting in 2018) was set using the 2015 Shared Savings Program quality measure benchmarks, assuming continued improvement in measure performance over the next two years.

Specifically, the performance target focuses on measuring continued improvement of the scores related to beneficiary responses to the Shared Decision Making section of the SSM. The performance on this measure was 75.40 in CY 2016. For CY 2018 CMS would like to delay setting a target, as the OpDiv anticipates implementing a revised shortened version of the survey in 2018. The revised shortened version of the survey results in substantive changes to the Shared Decision Making SSM. Specifically, the number of questions contained in this SSM is reduced from eight to two questions.

To ensure ACOs attain high measure performance, and improve measure performance, CMS provides training webinars, dedicated resource webpages and materials including a CAHPS toolkit to support ACOs and group practices to improve their CAHPS scores. In an effort to streamline the CAHPS for ACO survey, CMS is currently reviewing potential survey revisions. Revisions to the survey will likely shorten the survey, but maintain or strengthen the reliability and validity of the survey. While the potential survey revisions being considered could impact the ability to compare data from the old survey to the new survey, over time CMS will again be able to calculate trend data on the revised survey. Additionally, CMS believes that the revised survey will be less burdensome to complete for beneficiaries and may increase response rates. The revised shortened survey was piloted tested with ACOs from November 2016 – February 2017. Results from the pilot study suggest that administration of the shortened version of the survey (i.e., the pilot survey) is likely to result in improvements in overall response rates. Findings show that the response rate to

the pilot survey was 3.4 percentage points higher than the response rate to the FY 2016 CAHPS for ACOs survey among ACOs participating in the pilot study. Increases in response rates tended to be larger among ACOs that had lower response rates in the prior year.

In addition, after accounting for survey questions that were removed from the pilot survey, the average survey responses for ACOs who participated in the pilot study were mostly similar across the two survey versions (pilot and FY 2016).

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	8,600	8,901	10,359	11,600	TBD
Result	N/A	7,397	8,298	9,773	10,388	12,212	Dec 31, 2019	Dec 31, 2020
Status	N/A	Historic Actual	Historic Actual	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

The IHS has increased efforts to expand access to care through the integration of telemedicine with community-based services. An important specialty care delivered through this telehealth option includes behavioral health services. The FY 2017 target was 10,359 and the FY 2017 result was a total of 12,212 encounters; IHS exceeded its FY 2017 target by 18%. From FY 2013 to FY 2017 results for this measure have increased by 65%.

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

Whether people access health care in a doctor's office, in a health center, in a pharmacy, at home, or through a mobile device, they depend on a qualified, competent, responsive workforce to deliver high-quality care.

Yet population growth and the aging U.S. population, among other factors, are generating increasing demand for physicians, with demand among the older population expected to grow substantially. From 2014 to 2025, the U.S. population age 65 and older is expected to grow 41 percent, compared with 8.6 percent for the population as a whole and 5 percent for those younger than age 18. Because the elderly have higher health care use per capita, compared with younger populations, the increase in demand for health care services for older adults is projected to be much greater than the increase in demand for pediatric health care.

HHS regularly produces reports projecting growth or deficits in the supply and demand of various occupations in the health care workforce. At a national level, by 2025, demand is expected to exceed supply for several critical health professions, including primary care practitioners, geriatricians, dentists, and behavioral health providers, including psychiatrists, mental health and substance abuse social workers, mental health and substance use disorder counselors, and marriage and family therapists. At a State level, the picture is more complex, with some States projected to experience greater deficits in certain health care occupations. For example, rural areas experience greater shortages in the oral and behavioral health workforces.

HHS works in close partnership with academic institutions, advisory committees, research centers, and primary care offices. These collaborations help HHS make informed decisions on policy and program planning to strengthen and expand the workforce.

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

Objective 1.4 Table of Related Performance Measures

Support field strength of the National Health Service Corps (NHSC) through scholarship and loan repayment agreements (Lead Agency - HRSA; Measure ID - 4.I.C.2)[11]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	9,193 persons	7,128 persons	7,522 persons	8,495 persons	9,153 persons	9,219 persons	8,705 persons	8,810 persons
Result	9,908 persons	8,899 persons	9,242 persons	9,683 persons	10,493 persons	10,179 persons	Dec 31, 2018	Dec 31, 2019
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

As of September 30, 2017, 10,179 primary care medical, dental, and mental and behavioral health practitioners were providing service nationwide through the following programs: NHSC Scholarship Program, NHSC Loan Repayment Program, NHSC Students to Service Loan Repayment Program, and the State Loan Repayment Program. These programs collectively serve the immediate needs of underserved communities and support the development and maintenance of a pipeline of health care providers capable of meeting the needs of these communities in the future. In FY 2018 and 2019, NHSC will continue to assist students through scholarships and loan repayments and professionals through loan repayment awards as incentives to practice in underserved communities.

[11] NHSC field strength data include awards made from the FY 2017 Zika Supplemental, which supported providers in the U.S. territories.

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

Health promotion and wellness activities involve providing information and education to motivate individuals, families, and communities to adopt healthy behaviors, which ultimately can improve overall public health. However, the lack of access to and understanding of health information can lead people to make uninformed decisions and engage in risky behavior.

By supporting healthy choices and expanding access to healthier living supports, HHS is helping to curb threats to public health, promote a healthier population, and avoid the economic and human costs of poor health. HHS is working with partners, including faith-based and community organizations, to help people and communities take steps to identify and address priority health issues. The Department supports a series of programs and initiatives aimed at improving nutrition; increasing physical activity; reducing environmental hazards; increasing access to preventive services; and reducing the use of tobacco, alcohol, and illicit drugs and prescription drug abuse. These outcomes are achieved through culturally competent and linguistically appropriate health education, services, and supports made possible through strategic partnerships.

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

Objective 2.1 Table of Related Performance Measures

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	Set Baseline	N/A	N/A	N/A	1,145	1,128	967	903
Result	1,342	1,277	1,216	1,211	1,164	Jul 31, 2018	Jul 31, 2019	Jul 31, 2020
Status	Baseline	Historic Actual	Historic Actual	Historic Actual	Target Not Met but Improved	Pending	Pending	Pending

Although cigarette smoking remains the leading cause of tobacco-related disease, tobacco users are increasingly shifting consumption to other tobacco products and dual use with other combusted tobacco, including cigars, cigarillos and little cigars, pipe tobacco, roll-your-own tobacco, and hookah. This has resulted in a slowing of the decline in the consumption of all

combustible tobacco, and indicates that the use of non-cigarette combustible products has become more common in recent years and that some smokers may be switching to other combustible tobacco products rather than quitting smoking cigarettes completely. Per capita combustible tobacco product consumption declined from 1,216 cigarette equivalents in FY 2014 to 1,164 cigarette equivalents in FY 2016, though slightly above the FY 2016 target. In FY 2018 and 2019, CDC will continue to monitor combustible tobacco consumption to inform its strategies on reducing tobacco-related disease.

Reduce the age-adjusted proportion of adults (age 20 years and older) who are obese (Lead Agency - CDC; Measure ID - 4.11.10a)[12]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	35.1 %	N/A	34.4 %	N/A	33.2 %	N/A	33 %	N/A
Result	34.9 %	N/A	37.7 %	N/A	39.6 %	N/A	Oct 31, 2019	N/A
Status	Target Exceeded	N/A	Target Not Met	N/A	Target Not Met	N/A	Pending	N/A

In adults, 2015-2016 National Health and Nutrition Examination Survey (NHANES) data show 39.6% had obesity, an increase in the proportion of obese adults reported in FY 2014 (37.7%). There are some community factors that affect diet and physical activity. This includes the affordability and availability of healthy food options (e.g. fruits and vegetables), peer and social supports, marketing and promotion, and policies that determine whether a community is designed to support physical activity. In FY 2018 and 2019, CDC will continue to implement evidence-based strategies and increase healthy eating and active living through its support for states and communities throughout the U.S.

[12] Data for this measure is collected and reported every other year.

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

Communicable diseases and chronic conditions affect the lives of millions of Americans every day. The emergence and spread of infectious diseases—such as HIV/AIDS, hepatitis, tuberculosis, measles, and human papillomavirus (HPV)—can quickly threaten the stability of public health for communities and place whole populations at risk. The rise of globalization and ease of travel also has made it easier for domestic and international outbreaks—such as recent outbreaks of measles, pandemic influenza A (H1N1), Ebola, Zika, and chikungunya—to create public health challenges. Moreover, the prevalence of chronic conditions—such as diabetes, heart disease, stroke, and cancer—in the United States continues to contribute to the daily struggles of Americans. The occurrence of multiple chronic conditions also exacerbates the adverse health impacts and health care costs associated with chronic conditions and their associated health risks.

The prevention and management of communicable diseases require strategic coordination, collaboration, and mobilization of resources among governmental and nongovernmental partners within and outside of the United States. Similarly, managing chronic conditions requires support for affected individuals, families, caregivers, health professionals, and service providers. HHS programs and initiatives focus on promoting partnerships, educating the public, improving vaccine development and uptake, advancing early detection and prevention methods, and enhancing surveillance and response capacity.

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

Objective 2.2 Table of Related Performance Measures

Increase the percentage of Ryan White HIV/AIDS Program clients receiving HIV medical care and have had at least one viral load test demonstrating suppression of the virus (Lead Agency - HRSA; Measure ID - 16.III.A.4)[13]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	N/A	N/A	83%	83%
Result	N/A	N/A	N/A	83%	85%	Dec 15, 2018	Dec 15, 2019	Dec 15, 2020
Status	N/A	N/A	N/A	Historic Actual	Historic Actual	Pending	Pending	Pending

The Ryan White HIV/AIDS Program (RWHAP) works to improve health outcomes by preventing disease transmission or slowing disease progression for disproportionately impacted communities. One way RWHAP accomplishes this is through the provision of medications that help patients reach HIV viral suppression. People living with HIV who use medications designed to virally suppress the disease are less infectious, reducing the risk of transmitting HIV to others. In FY 2018 and 2019, RWHAP will continue to play a central role in ending the HIV epidemic by ensuring that persons living with HIV have access to regular care, receive antiretroviral medications, and adhere to a regular schedule for taking their medications.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	Set Baseline	47 %	50 %	53 %	56 %	59 %	62 %	62 %
Result	41 %	42 %	44 %	42 %	43%	Sep 30, 2018	Sep 30, 2019	Sep 30, 2020
Status	Baseline	Target Not Met but Improved	Target Not Met but Improved	Target Not Met	Target Not Met but Improved	Pending	Pending	Pending

In the United States, on average 5-20 percent of the population contracts the flu, more than 200,000 people are hospitalized from seasonal flu-related complications, and approximately 36,000 people die from seasonal flu-related causes. This measure reflects the universal influenza vaccination recommendation and aligns with the Advisory Committee on Immunization Practices' (ACIP) updated recommendation (as of 2010) for the seasonal influenza vaccine. Seasonal influenza vaccinations increased slightly by two percentage points from FY 2013 (42%) to FY 2014 (44%), then varied from 42% in FY 2015 to 43% in FY 2016. CDC's efforts to improve adult

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

vaccination coverage rates include:

- Increasing patient and provider education to improve demand and implement system changes in practitioner office settings to reduce missed opportunities for vaccinations
- Funding 10 state and local health departments to implement the Standards for Adult Immunization Practice in large health systems, community health centers, and pharmacies.
- Enhancing evidence-based communication campaigns to increase public awareness about adult vaccines and recommendations. CDC routinely conducts literature reviews and surveys of the general public and health care providers to provide a deeper understanding of the target audiences for development of adult immunization communication messages and campaigns.
- Expanding the reach of vaccination programs including new venues such as pharmacies and other retail clinics. CDC has existing partnerships to implement adult immunization practice standards, HPV vaccination, and pandemic vaccine program planning efforts to expand access to pandemic vaccine. As of 2016-2017 influenza season, nearly 1 in 4 adults who got an influenza vaccine were vaccinated in a pharmacy or retail setting.

In FY 2018 and 2019, CDC will continue to monitor the percentage of adults aged 18 and older who are vaccinated annually against seasonal influenza to inform its strategies for improving adult vaccination coverage rates.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	N/A	Set Baseline	2.0 programs	2.0 programs
Result	N/A	N/A	N/A	N/A	N/A	2.0 programs	Dec 31, 2018	Dec 31, 2019
Status	N/A	N/A	N/A	N/A	N/A	Baseline	Pending	Pending

The mission of ASPR is to lead the country in preparing for, responding to, and recovering from the adverse health effects of emergencies and disasters by supporting our communities' ability to withstand adversity, strengthening our health and response systems, and enhancing national health security. The Biomedical Advanced Research and Development Authority (BARDA), within the Office of the Assistant Secretary for Preparedness and Response, provides an integrated, systematic approach to the development and purchase of the necessary vaccines, drugs, therapies, and diagnostic tools for public health medical emergencies. This performance measure monitors the number of programs supported through ASPR's advanced research and development initiatives

as they pursue more effective influenza vaccines and the development of safe and broad-spectrum therapeutics for use in seriously ill and/or hospitalized patients, including pediatric patients. In FY 2017, the FDA approved the use of Rapivab (manufactured by BioCryst) to treat acute uncomplicated influenza in pediatric patients two years and older. The FY 2017 result is 2 programs. The data supports the goal to develop more effective influenza vaccines and to develop novel antivirals that have the potential to overcome resistance mechanisms. Resistance is a critical concern related to the emergence of H7N9 in Asia. The initial baseline is now set at 2 programs. Two is also the target for FY 2018 and FY 2019. The targets were set based on resource expectations and overall priorities. In FY 2018 and 2019, ASPR will continue to monitor progress towards an agile, robust and sustainable U.S. infrastructure capable of rapidly producing influenza vaccines against pandemic flu.

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

Mental illness and substance abuse create health risks and place a heavy burden on affected individuals and their families. Substance use disorders arise from the recurring use of alcohol and/or drugs, which lead to clinically and functionally significant impairments. Mental disorders are health conditions that involve significant changes in thinking, emotion, and/or behavior and lead to distress and/or problems functioning in social, work, or family activities. Mental and substance use disorders are illnesses that impact people's ability to go about their daily lives in family, social, and professional settings and place individuals at risk of additional health problems.

HHS works closely with Federal, State, Tribal, local, territorial, and community partners and stakeholders, including faith-based and community organizations, to help identify and address mental health problems and substance use disorders. The Department invests in programs and interventions focused on prevention, screening, and early detection of serious mental illness and substance abuse, including those related to opioid abuse.

Other HHS activities involve improving the provision of comprehensive, coordinated, and evidence-based community recovery supports for affected individuals and improving access to treatment options. Continuing to advance research and work in these areas raises awareness and facilitates the adoption of best practices across communities to minimize the negative health impacts caused by mental and substance use disorders.

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

Objective 2.3 Table of Related Performance Measures

Opioid Cluster

Reduce the age-adjusted annual rate of overdose deaths involving prescription opioids per 100,000 population among states funded through Prescription Drug Overdose Prevention for States program (Lead Agency - CDC; Measure ID - 7.2.6) [14]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	11.9 per 100,000 residents	11.8 per 100,000 residents	11.8 per 100,000 residents	11.8 per 100,000 residents	10.8 per 100,000 residents
Result	N/A	N/A	13.3 per 100,000 residents	N/A	N/A	Feb 28, 2018	Feb 28, 2019	Feb 28, 2020
Status	N/A	N/A	N/A	Not Collected	Baseline	Pending	Pending	Pending

CDC has been tracking the rise of opioid overdose deaths and using the data to pivot to prevention activities to curb this alarming epidemic. Opioids were involved in over 42,249 deaths in 2016, and opioid overdoses were five times higher in 2016 than 1999. In response to this growing public health crisis, CDC has launched its Overdose Prevention in States (OPIS)[15] effort as means to equip states with resources and expertise needed to reverse this epidemic. As a part of OPIS, CDC's Prescription Drug Overdose Prevention for States (PfS) program funds 29 state health departments to advance and evaluate comprehensive state-level interventions for preventing opioid-related overdose, misuse, and abuse. This measure tracks progress in reducing overdose deaths involving all opioids among the 29 states funded specifically for PfS. In FY 2016 the baseline, age-adjusted annual rate of opioid overdoses was 11.8 per 100,000 residents among states funded for the PfS program. In FY 2018 and 2019, CDC will continue to track the rise of opioid overdose deaths to monitor the impact of its prevention activities.

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

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

Increase the number of persons receiving outpatient Medication-Assisted Treatment (MAT) for Opioid Use Disorder from a substance use disorder treatment facility (Lead Agency - SAMHSA; Measure ID - 2.3.19K) [16]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	N/A	N/A	200,000.0	220,000.0
Result	N/A	N/A	N/A	163,787	N/A	N/A	Dec 31, 2019	Dec 31, 2020
Status	N/A	N/A	N/A	Historic Actual	N/A	N/A	Pending	Pending

SAMHSA monitors this data to track advances in opioid surveillance pertaining to prevention, diagnosis, intervention, treatment, and recovery. This includes advances in access to services and supports for adults with SMI and children with SED. As the states further develop their systems with increased resources from the state targeted response grants and Medication-Assisted Treatment Prescription Drug and Opioid Addiction (MAT-PDOA) grants; Medicaid systems increase their focus on opioids; and technical assistance and outreach efforts from across HHS promote MAT, SAMHSA expects to see increases in the number of people receiving outpatient MAT for opioid use disorder from a substance use disorder treatment facility. MAT consists of provision of Methadone, Buprenorphine and Extended-release Naltrexone. MAT helps people manage their opioid addiction and supports their engagement in positive activities; while also greatly reducing the risk of overdose death. The most recent available data reported indicated that in FY 2015, 163,787 people received outpatient Medication-Assisted Treatment (MAT) for Opioid Use Disorder from a substance use disorder treatment facility. The next available data report for FY 2016, is expected in December 2018. In FY 2018 and 2019, SAMHSA will continue to monitor the use of MAT and its impact on SMI.

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

Fiscal Year	Target	Result	Status
FY 2012	N/A	N/A	N/A
FY 2013	N/A	N/A	N/A
FY 2014	N/A	N/A	N/A
FY 2015	N/A	N/A	N/A
FY 2016	N/A	N/A	N/A
FY 2017	N/A	N/A	N/A
FY 2018	Develop at least one new electronic clinical	Sep 30, 2018	In Progress

[16] MAT includes provision of Methadone, Buprenorphine, and extended-release Naltrexone.

Fiscal Year	Target	Result	Status
	decision support tool related to safe pain management and opioid prescribing		
FY 2019	1) Test, revise, and disseminate at least one new electronic clinical decision tool related to safe pain management and opioid prescribing and 2) Partner with stakeholders to identify additional evidence-based electronic clinical decision tools related to safe pain management and opioid prescribing and make them publicly available	Sep 30, 2019	In Progress

In FY 2017, AHRQ's Health Services Research, Data, and Dissemination portfolio made substantial contributions to the Department's comprehensive opioids strategy through public dissemination of systematic evidence reviews on non-opioid pain management and the use of naloxone by emergency medical service personnel, in addition to publishing a collection of over 250 field-tested tools to support the delivery of Medication Assisted Treatment (MAT) in primary care settings. Using AHRQ data platforms, AHRQ produced a series of analyses which documented trends in health care utilization fueled by the opioid epidemic at state and national levels and which uncovered the diverse ways the opioid crisis is manifesting itself across the country. In FY 2017, AHRQ also continued to support investigator-initiated health services research on the prevention and treatment of opioid addiction by health care delivery organizations, as well as targeted health services research expanding access to MAT in rural communities through primary care.

In FY 2018, AHRQ will develop new electronic clinical decision support (CDS) CDS in the clinical domain of safe pain management and opioid prescribing, an initiative that began in FY 2017. The CDS will include shareable, interoperable specifications for integration into electronic health records as well as implementation guidance. The CDS will be developed with input from a CDS Connect work group consisting of stakeholders from multiple perspectives, including patients, providers, health IT developers, and others.

In FY 2018 and continuing in FY 2019, the CDS for safe pain management and opioid prescribing will be tested, revised, and disseminated through the CDS Connect platform. All resources developed within the project will be publicly-available at https://cds.ahrq.gov. In addition, AHRQ plans to

work with stakeholders to disseminate other safe pain management and opioid prescribing CDS tools and resources developed elsewhere. For example, CDC and ONC will continue to develop opioid-related CDS that may be suitable for dissemination through CDS Connect.

By 2020, evaluate the efficacy of new or refined interventions to treat opioid use disorders (OUD) (Lead Agency - NIH; Measure ID - SRO-4.9)

Fiscal Year	Target	Result	Status
FY 2012	N/A	N/A	N/A
FY 2013	N/A	N/A	N/A
FY 2014	N/A	N/A	N/A
FY 2015	N/A	N/A	N/A
FY 2016	N/A	N/A	N/A
FY 2017	N/A	N/A	N/A
FY 2018	Initiate at least one study to improve identification of OUD or evaluate the comparative effectiveness of available pharmacotherapies for OUD treatment	Dec 31, 2018	In Progress
FY 2019	Conduct 1 preclinical study and 1 clinical trial to develop non-opioid based medications to treat OUD that may avoid the risks of opioid dependence and overdose	Dec 31, 2019	In Progress

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

Mental Illness Cluster

Increase the percentage of youth ages 12-17 who experienced major depressive episodes in the past year receiving mental health services (Lead Agency - SAMHSA; Measure ID - 2.3.19O)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	N/A	N/A	43.0 %	45.0 %
Result	N/A	N/A	N/A	N/A	40.9%	Dec 31, 2018	Dec 31, 2019	Dec 31, 2020
Status	N/A	N/A	N/A	N/A	Historic Actual	Pending	Pending	Pending

As states and the Federal Government strengthen their implementation and enforcement efforts related to parity and the Interagency Serious Mental Illness Coordinating Committee (SMICC) coordinates and drives Federal efforts to address the needs of children and youth with serious emotional disturbances, we will see reductions in the percentage of youth with major depressive episodes in the past year who are not receiving mental health services. This measure reports percentage of youth ages 12-17 who experienced major depressive episodes in the past year receiving mental health services. The data supports evaluations of the effect Federal programs related to SMI have on public health, including public health outcomes. There are effective medications and psychosocial interventions which can improve functioning and control the symptoms of depression, making receipt of these services critical. The most recent available data reported shown that in FY 2016, 40.9 percent of youth ages 12-17 who experienced major depressive episodes in the past year receiving mental health services. The next available data report for FY 2017 is expected in December 2018.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	N/A	N/A	66.0 %	68.0 %
Result	N/A	N/A	N/A	N/A	64.8 %	Dec 31, 2018	Dec 31, 2019	Dec 31, 2020
Status	N/A	N/A	N/A	N/A	Historic Actual	Pending	Pending	Pending

As states and the Federal Government strengthen their implementation and enforcement efforts related to parity and the Interagency Serious Mental Illness Coordinating Committee coordinates and drives Federal efforts to address SMI, SAMHSA expects to see reductions in the percentage of people with SMI who are not receiving mental health services. It is important for people with SMI to receive treatment so that they can better control their symptoms and improve their level of functioning. This measure reports percentage of adults with SMI receiving mental health

services. The data can support recommendations for actions that agencies can take to better coordinate the administration of mental health services for adults with SMI and children with Serious Emotional Disturbance (SED). The most recent available data reported shown that in FY 2016, 64.8 percent of adults with SMI received mental health services. The next available data report for FY 2017 is expected in December 2018.

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

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

HHS is working to ensure that a national disaster health care system is integrated within the health care delivery infrastructure—hospitals, emergency medical services, emergency management, and public health agencies—to provide safe and effective health care during emergencies and other disasters. In addition, National Disaster Medical System teams and the U.S. Public Health Service Commissioned Corps complement non-Federal efforts during incidents. HHS supports local Medical Reserve Corps units, which supplement the capacity of States, Tribes, localities, and territories. Through direct services and partnerships with State, Tribal, local, and territorial governments, with faith-based and community organizations, and with the private sector, HHS works to strengthen the Nation's emergency preparedness, response, and recovery efforts.

HHS is engaged in the research, development, and procurement of medical countermeasures, including vaccines, drugs, therapies, and diagnostic tools. HHS collaborates with others to ensure that the appropriate number of safe and effective medical countermeasures are developed and stockpiled and can be easily distributed and used to save lives during an incident.

HHS invests in building the capacity of other countries to detect, prevent, and respond to incidents—thus providing early warning to or reducing the impact to the United States. The international public health professionals trained by the Global Disease Detection Operations Center monitor 30 to 40 public health events each day, and can deploy within 24 hours of learning about an outbreak.

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

Objective 2.4 Table of Related Performance Measures

Increase the percentage of CDC-funded Public Health Emergency Preparedness state and local public health agencies that can convene, within 60 minutes of notification, a team of trained staff that can make decisions about appropriate response and interaction with partners (Lead Agency - CDC; Measure ID - 13.5.3) [17]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	91 %	94 %	95 %	95 %	96 %	96 %	96 %	96 %
Result	89 %	96 %	96 %	100 %	Feb 1, 2018	Dec 31, 2018	Dec 31, 2019	Dec 31, 2020
Status	Target Not Met but Improved	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending	Pending

Public health agencies must be able to rapidly convene key management staff (within 60 minutes of being notified) to appropriately respond to an emergency. This effort includes the integration of information and the prioritization of resources to ensure timely and effective coordination within the public health agency and key response partners. In FY 2015, 100% of PHEP-funded public health agencies convened trained staff within 60 minutes of notification to make decisions regarding partner engagement and incident response, exceeding the FY 2015 target and representing an 11 percentage point increase from FY 2012. In FY 2018 and 2019, CDC will continue to work with awardees to improve results and achieve future targets.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	3.0	3.0	3.0	3.0
Result	N/A	N/A	N/A	N/A	3.0	5.0	Dec 31, 2018	Dec 31, 2019
Status	N/A	N/A	N/A	N/A	Target Met	Target Exceeded	Pending	Pending

In support of HHS strategies for public health emergency preparation and response, ASPR reports the number of new licensed medical countermeasures, which are regulated products (biologics, drugs, devices) that may be used in the event of a potential public health emergency stemming from a terrorist attack with a biological, chemical, or radiological/nuclear material, a naturally occurring emerging disease, or a natural disaster. For FY 2017, BARDA reported 5 new medical countermeasures. In addition to chemical, biological, radiological, and nuclear defense, the new countermeasures address influenza, broad spectrum antimicrobials, and Zika. The FY 2017 target

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

for this measure was 3. The FY 2017 was exceeded. The FY 2018 and FY 2019 targets are 3 for each respective year. The targets were set based on resource expectations and overall priorities. In FY 2018 and 2019, ASPR will continue to monitor progress towards an agile, robust and sustainable U.S. manufacturing infrastructure capable of rapidly producing vaccines and other biologics against pandemic influenza and other emerging threats.

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

Strong, economically stable individuals, families, and communities are integral components of a strong America. Many Americans currently experience or are at risk for economic and social instability. The social and health impacts of poverty can include reduced access to nutritious food; fewer educational opportunities and poor educational outcomes; a lack of access to safe and stable housing; increased risk of poor health outcomes including obesity and heart disease; and difficulty obtaining work opportunities.

In 2016, a family of three was considered to be living in poverty if they earn less than $19,105 per year. According to the Census Bureau, the poverty rate in 2016 was 12.7 percent, with 40.6 million people living in poverty; this number was down 0.8 percentage points from 2015. For most demographic groups, the number of people in poverty decreased from 2015, with adults older than 65 the only population group experiencing an increase in the number of people living in poverty. By providing opportunities for work and work supports, the Department is dedicated to improving the education, skills, health, and resources of low-income individuals and families to help them expand their productivity, achieve economic independence, and enhance their economic and health outcomes.

To reach this goal, the Department coordinates safety-net programs across the Federal Government; State, local, Tribal, and territorial governments; and faith-based and community organizations. One of the Department's primary programs for families in need is the Temporary Assistance for Needy Families (TANF) program. TANF provides States with block grants to design and operate programs that help needy families reach self-sufficiency, with a focus on preparing parents for work. The Department coordinates with the U.S. Departments of Labor and Education to implement the Workforce Innovation and Opportunity Act, which is designed to help young job seekers and people with disabilities access employment education, training, and support services and match employers with skilled workers.

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

Objective 3.1 Table of Related Performance Measures

Increase the percentage of adult TANF recipients and former recipients who are newly employed (Lead Agency - ACF; Measure ID - 22B) [18]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	30.6 %	30.7 %	32.5 %	31.5 %	Prior Result +0.1PP	Prior Result +0.1PP	Prior Result +0.1PP	Prior Result +0.1PP
Result	30.4 %	32.4 %	31.4 %	Jan 31, 2018	Jan 31, 2019	Jan 31, 2020	Jan 31, 2021	Jan 31, 2022
Status	Target Not Met but Improved	Target Exceeded	Target Not Met	Pending	Pending	Pending	Pending	Pending

TANF measures assess how effectively recipients transition from cash assistance to employment. Full success requires not only that recipients be employed, but also that they remain and increase their earnings, demonstrating a reduction in dependency on cash assistance.

ACF is committed to finding innovative and effective employment strategies through research, identifying and disseminating information on promising employment and skill-building strategies, and providing a range of targeted technical assistance efforts to states. Through these efforts, ACF supports state, tribal, and community partners' efforts to design and implement programs that focus simultaneously on adult employment and family well-being.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	71.75 %	71.77 %	69.76 %	76.84 %	83.01 %	85.26 %	Prior Result +1%	Prior Result +1%
Result	71.06 %	69.07 %	76.08 %	82.19 %	84.42 %	84%	Nov 1, 2018	Nov 1, 2019
Status	Target Not Met but Improved	Target Not Met	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending

In FY 2017, performance decreased slightly by 0.38 percentage points, with an actual result of 84 percent. Decreasing and uneven arrival numbers created unusual challenges for grantees. ACF expects to see an increase in FY 2018 and expects that goals will be met or exceeded through FY 2019 as arrival patterns and funding levels become more predictable.

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

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

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

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

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

Objective 3.2 Table of Related Performance Measures

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	89.7 %	90 %	90 %	90 %	90 %	90 %	90 %	90 %
Result	90.3 %	92.3 %	93 %	91.9 %	89.6 %	May 31, 2018	May 31, 2019	May 29, 2020
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending	Pending

Data collected from Family Violence Prevention and Services Act (FVPSA) grantees for fiscal years 2012 through 2015 show that more than 90 percent of domestic violence program clients reported improved knowledge of safety planning as a result of work done by FVPSA grantees and subgrantees. For FY 2016, the actual result fell slightly below the target of 90 percent; this will continue to be an area of focus for training. Since many program participants receive short-term crisis assistance and would not be expected to report significant change, a higher number of clients responding that they increased their knowledge above the 90 percent benchmark is unrealistic. In FY 2018 and 2019, ACF will continue to implement its improved data quality checks to ensure data

accuracy as well as work with the grantees to identify ways to promote domestic violence safety.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	6.5%	6.3%	6.1%	6.3%	6.2%	5.2%	Prior Result -0.2PP	Prior Result -0.2PP
Result	6.5%[19]	6.3%	6.5%	6.4%	5.4%	Oct 31, 2018	Oct 31, 2019	Oct 30, 2020
Status	Target Met	Target Met	Target Not Met	Target Not Met but Improved	Target Exceeded	Pending	Pending	Pending

In FY 2010, states reported that 6.5 percent of children with a substantiated or indicated report were found to be victims of another substantiated or indicated report within six months. In FY 2011 there was a slight increase in the rate from 6.5 percent to 6.7. The percentage then declined to 6.5 percent in FY 2012 and to 6.3 percent in FY 2013, meeting targets for those years. In FY 2014, the percentage of victims experiencing repeat maltreatment again rose to 6.5 percent which did not meet the target of 6.1 percent. In FY 2015 there was a decrease in the percent of children who experienced repeat maltreatment to 6.4 percent, falling just short of the target of 6.3 percent. In FY 2016, there was improved performance on this measure with 5.4 percent of children experiencing repeat maltreatment in FY 2016. In FY 2018 and 2019, ACF will continue to identify and implement ways to support states in their efforts to care for children and families in crisis, while ensuring the safety of children.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	N/A	N/A	41.6%	41.6%
Result	N/A	N/A	N/A	N/A	N/A	N/A	Jan 31, 2019	Jan 31, 2020
Status	N/A	N/A	N/A	N/A	N/A	N/A	Pending	Pending

Domestic and intimate partner violence has a disproportionately large impact on AI/AN communities with AI/AN women experiencing intimate partner violence at higher rates than any other single race or ethnicity in the U.S. The Intimate Partner (Domestic) Violence (DV) screening

[19] The FY 2012 actual result was updated as a result of updated state data submissions. As such, the FY 2013 target was also recalculated accordingly.

measure is designed to support improved processes for identification, referral, and treatment for victims of domestic assault. It is critical that these individuals are referred for services aimed at reducing the prevalence and impact of domestic violence. In FY 2018, IHS will begin reporting the Intimate Partner (Domestic) Violence screening measure using the IHS Integrated Data Collection System Data Mart (IDCS DM). Since FY 2018 is the first IDCS DM report year, data trends and analysis for this measure are unavailable.

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

Families are the cornerstone of America's social fabric. A strong family can lead to many positive outcomes for the health, social, and economic status of both adults and children. People live longer, have less stress, and are more financially stable in a healthy family environment where both parents are present, share the responsibility of the household, and raise the children. Additionally, in these households, children tend to be healthier, both mentally and physically, and are better able to have their fundamental needs met.

The Department supports healthy families and youth development through collaborations across the Federal Government and with States, territories, community partners, Tribal governments, and faith-based organizations. Head Start served 1.1 million children from birth to age 5 and pregnant women in 2015–2016, and approximately 1.4 million children per month received child care assistance in 2015. Recommendations for best practices for early child development are shared with partners across the country. Transitions from youth to adulthood are supported through the promotion of strength-based approaches, multisector engagement, and youth engagement efforts.

Through programs like the Healthy Marriage and Relationship Education Grant Program, the Department funds organizations (including faith-based and community organizations) across the country to provide comprehensive healthy relationship and marriage education services, as well as job and career advancement activities to promote economic stability and overall improved family well-being.

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

Objective 3.3 Table of Related Performance Measures

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	Set Baseline	23 %	27 %	26 %	25 %	24 %	15 %	Prior Result -1PP
Result	25 %	31 %	23 %	22 %	24 %	16 %	Jan 31, 2019	Jan 31, 2020
Status	Baseline	Target Not Met	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

The ACF Office of Head Start (OHS) is striving to increase the percentage of Head Start children in high-quality classrooms. Progress is measured by reducing the proportion of Head Start grantees scoring in the low range (below 2.5) in any domain of the Classroom Assessment Scoring System (CLASS: Pre-K). This research-based tool measures teacher-child interaction on a seven-point scale in three broad domains: Emotional Support, Classroom Organization, and Instructional Support. Research findings underscore the importance of teacher-child interactions as a demonstrated measure of classroom quality. Now OHS assesses each Head Start grantee using the CLASS instrument during onsite monitoring reviews. Data from the FY 2017 CLASS reviews indicates that 16 percent of grantees scored in the low range, greatly exceeding the target of 24 percent. In FY 2018 and 2019, ACF plans to reduce the proportion of grantees scoring in the low range by at least one percentage point, year over year.

Reduce the proportion of children and adolescents ages 2 through 19 who are obese (Lead Agency - CDC; Measure ID - 4.11.10b)[20]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	Set Baseline	N/A	N/A	N/A	15.7 %	N/A	15.2 %	N/A
Result	16.9 %	N/A	17.2 %	N/A	18.5 %	N/A	Oct 31, 2019	N/A
Status	Baseline	N/A	Historic Actual	N/A	Target Not Met	N/A	Pending	N/A

CDC funds a number of interventions that target obesity as well as related chronic diseases. The percentage of all children and adolescents (ages two to 19 years) that have obesity increased from 16.8% in FY 2008 to 18.5% in FY 2016. In children ages 2 to 5, the prevalence of obesity has fluctuated over time. Following a significant decrease from 13.9% in 2003-2004 to 8.9% in 2011-

[20] The data for this performance goal is collected and reported every other year.

2014, the prevalence of obesity increased to 13.9% in 2015-2016. Research shows behaviors that influence excess weight gain include eating high-calorie, low-nutrient foods and beverages, not getting enough physical activity, sedentary activities such as watching television or other screen devices, medication use, and sleep routines. Public health practitioners can educate individuals about healthy lifestyle choices and ways to improve their diet and increase physical activity. However, it can be difficult for children and parents to make healthy food choices and get enough physical activity when they live, work and play in environments that do not support healthy habits. Places such as childcare centers, schools, or communities can affect diet and activity through the foods and drinks offered and the opportunities provided for physical activity. In FY 2018 and 2019, CDC will continue promoting good nutrition and physical activity in children and adolescents to help prevent childhood obesity.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	86 %	86 %	86 %	86 %	86 %	87 %	90 %	90 %
Result	89.4 %	87.7 %	87.8 %	88.2 %	91.6 %	Jan 31, 2018	Jan 31, 2019	Jan 31, 2020
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

The Transitional Living Program (TLP) supports community-based, adult-supervised residences for youth ages 16 to under 22 who cannot safely live with their own families, or for whom living with their families provides undue hardships. This long-term shelter program offers otherwise homeless youth housing for up to 18 months and provides the educational, employment, health care and life skills necessary for youth to transition into self-sufficient living. The TLP safe and appropriate exit rate is the percentage of TLP youth (aged 16-21) discharged during the year who find immediate living situations that are consistent with independent living. The vast majority of youth (72 percent) were between the ages of 18 and 20 when they entered the program. Nearly 25 percent of these youth had been in the child welfare system and almost 12 percent had been involved in the juvenile justice system. During FY 2016, TLP programs exceeded the 87 percent target for this measure by attaining a 91.6 percent safe exit rate. Because safe and stable housing is one of the core outcomes for the TLP program, ACF proposes to keep this performance standard and increase the annual target to 90 percent. In FY 2018 and 2019, ACF will continue to work with grantees to

ensure that appropriate service delivery and technical assistance systems are in place to provide increased support to at-risk youth.

Increase the number of participants in ACF-funded healthy marriage and relationship education services (Lead Agency – ACF) [21]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	N/A	Pending	Pending	Pending
Result	N/A	N/A	N/A	N/A	N/A	Mar 31, 2018	Mar 31, 2019	Mar 31, 2020
Status	N/A	N/A	N/A	N/A	N/A	Pending	Pending	Pending

This is a new measure. ACF will report the first full year of actual results in FY 2018; once trend data is established, ACF will set future year targets and develop its performance plan.

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

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

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

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

The Department also supports caregivers of older Americans and Americans living with disabilities. At least 90 percent of older adults receiving help with daily activities receive some form of unpaid care, and about two-thirds receive only unpaid care. In 2011, an estimated 18 million unpaid caregivers provided 1.3 billion hours of care on a monthly basis to Medicare beneficiaries age 65 and over.

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

Objective 3.4 Table of Related Performance Measures

Demonstrate improvement in health care quality of participating Medicare and Medicaid one-star nursing homes (Lead Agency - CMS; Measure ID - QIO7.2)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	Set Baseline	N/A	6.0	5.0
Result	N/A	N/A	N/A	N/A	8.0%	Oct 31, 2018	Oct 31, 2019	Oct 31, 2020
Status	N/A	N/A	N/A	N/A	Baseline	Historic	Pending	Pending

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
						Actual		

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

In December 2008, CMS added a star rating system to the Nursing Home Compare website. This rating system serves three purposes: 1) to provide residents and their families with an assessment of nursing home quality, 2) to make a distinction between high and low performing nursing homes, and 3) to provide incentives for nursing homes to improve their performance. The one-star rating is the lowest rating and the five star rating is the highest. CMS tracks nursing home care quality using this rating system.

The Quality Innovation Network-Quality Improvement Organization (QIN-QIO), via recruitment of nursing homes and other activities, shall support the creation of a National Nursing Home Quality Care Collaborative (NNHQCC). The purpose of the NNHQCC is to ensure, along with its partners, that every nursing home resident receives the highest quality of care. Specifically, the QIN-QIO shall support the Collaborative' s objective to "instill quality and performance improvement practices, eliminate health care acquired conditions, and improve resident satisfaction." Although the QIN-QIO recruited nursing homes with an existing star status, all nursing homes or facilities providing long-term care services to Medicare beneficiaries are eligible and encouraged to participate in the Collaborative.

One-star nursing homes face specific challenges, including lack of understanding of quality improvement processes; lack of resources to implement the processes; poor understanding of the data for use in improvement; lack of consistent leadership; and perhaps lower resident and family engagement. Participation in the NNHQCC entails peer-to-peer learning activities in an "all \teach/all learn" environment involving virtual, face-to-face meetings, and quality improvement activities which help guide the nursing home to engage in the use of facility- specific data for rapid-cycle quality improvement activities, such as Plan-Do-Study Act (PDSA) cycles, to instill systems-

level improvement in the individual nursing home. There are two collaborative time periods, and recruitment goals are measured at the start of each collaborative. Continued engagement in collaborative activities is monitored throughout the life of each collaborative via the facilities' individual quality and outcome measures, such as the decreased use of antipsychotic medication in residents with dementia.

The one-star recruitment measure will assess the ability of the QIN-QIO to gain participation in peer-to-peer quality improvement activities, measured by the percentage increase of one-star nursing homes participating in the NNHQCCs through 2018. Participation would therefore ensure safer care received by Medicare beneficiaries residing in the lowest performing nursing homes. While CMS plans to begin with measuring participation in the early years of the project, the goal is to move toward measuring improvement utilizing the Quality domain of the Five Star Rating system of each participating nursing home as the project matures.

The QIN-QIOs exceeded the recruitment goal of 50 percent by recruiting 72 percent of the total One-Star Category Target Number (SCTN) in the Collaborative I time period. With the re-balancing of the Medicare.gov 5-Star Rating system effective February 20, 2015, one-star homes continued to be recruited by QIN-QIOs as part of Collaborative II in the NNHQCC. For both Collaborative I and II combined, the QIN-QIOs recruited more than 100 percent of the SCTN for the 11th Statement of Work (SOW).

The measure "quality improvement in one star nursing homes" (C.7.2) tracks the change in the percentage of nursing homes with a one-star quality rating over time. CMS monitors quality improvement progress generated at the national, QIN-QIO, and nursing home levels using the quality domain of the Five Star Rating system. The total quality score is one of three domains within CMS' Five Star Rating system, which also rates facilities based on inspections and staffing ratios. As of January 2017, the total quality score is based on data for 13 quality measures for short and long-stay residents derived from the Minimum Data Set and 3 claims based measures for short-stay residents, Nursing Home Compare Five-Star Quality Rating System: Technical User's Guide. The QIO program is focusing on the quality domain because of its capacity to influence this specific domain most effectively.

Nursing homes participating in the NNHQCC focus on processes that improve their systems and measure individual tests of change. Specifically, nursing homes look at their PDSA improvement

cycle results, clinical outcomes measures such as falls with major trauma, and measures of quality improvement. Nursing homes participating in the NNHQCC are encouraged to improve quality as a whole rather than focus on anyone measure. Therefore, the 16 measure total quality score appropriately reflects general quality improvement. A reduction in the percentage of homes that receive the lowest quality score would indicate progress in the hardest to reach nursing homes.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	20.3%	19.1%	17.9%	16.7%	16%	16%	15.5%
Result	19.8%	20.3%	19.1%	17.1%	16.7%	Mar 31, 2018	Feb 28, 2019	Feb 28, 2020
Status	Historic Actual	Target Met	Target Met	Target Exceeded	Target Met	Pending	Pending	Pending

The purpose of including this measure as a CMS performance measure is to decrease the use of antipsychotic medications in nursing homes with emphasis on improving dementia care. These medications have common and dangerous side effects when used for the behavioral and psychological symptoms of dementia.

In 2012, CMS began a nationwide initiative - the Partnership to Improve Dementia Care in Nursing Homes – to improve dementia care and reduce the use of antipsychotic medications. CMS staff have been working with partners, including state coalitions, provider associations, nursing home resident advocates, and stakeholders to decrease the use of these drugs. 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. CMS hopes to enhance person-centered care for all nursing home residents, particularly those with dementia-related behaviors.

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.[22]

Person-centered care is an approach to care that focuses on residents as individuals and supports caregivers working most closely with them. It involves a continual process of listening, testing new approaches, and changing routines and organizational approaches in an effort to individualize and de-institutionalize the care environment. Person-centered care is the central theme of the Hand in Hand training.

In July 2012, CMS began posting on the Nursing Home Compare website quality measures of antipsychotic use in long-stay and short-stay nursing home residents, excluding residents with schizophrenia, Tourette's syndrome, or Huntington's disease. In 2015, CMS added the quality measures to the Five-Star Quality Rating System on the website.

CMS reports the prevalence of antipsychotic use in the last three months of the fiscal year. The numerator consists of long-stay residents receiving an antipsychotic medication on the most recent assessment. The denominator is all long-stay nursing home residents, excluding residents with schizophrenia, Tourette's syndrome, or Huntington's disease. Residents are considered to be long-stay residents if they have resided in the nursing home for 101 or more days. The baseline number reflects the prevalence of use in the last quarter of CY 2011. It was selected because it was the last quarter in the pre-intervention period.

The CY 2012-2013 goal represented approximately a 15 percent reduction in prevalence from the baseline. The goals for succeeding years represent an additional 5 percent reduction each year. The resulting CY 2016 goal represents a 30 percent reduction from the baseline, for a prevalence rate of 16.7 percent or lower by the end of the CY. Prior to the CMS and National Partnership intervention in CY 2012, the prevalence rates had consistently risen each quarter. In January 2015 the Government Accountability Office affirmed that CMS had made clear progress in reducing antipsychotic use in nursing homes, and recommended that HHS undertake similar efforts in settings beyond nursing homes (such as assisted living and home and community-based environments). CMS met its CY 2016 goal.

[22] Gitlin LN, Kales HC, Lyketsos CG. Nonpharmacologic Management of Behavioral Symptoms in Dementia.JAMA, November 21, 2012; 308(19): 2020-2029.

CMS continues to have quarterly national calls with the public on aspects of good dementia care and the use of non-pharmacological approaches. CMS is conducting focused dementia care surveys on those facilities that continue to have high rates of antipsychotic use, and has modified the regulations limiting the use of antipsychotic medications on an as needed basis.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	N/A	Baseline	N/A	TBD
Result	N/A	N/A	N/A	N/A	N/A	January 1, 2019	January 1, 2020	January 1, 2021
Status	N/A	N/A	N/A	N/A	N/A	Pending	Pending	Pending

The effects of Alzheimer's Disease and Related Dementias (ADRD) are devastating for individuals living with the disease and their family caregivers. Serving people with ADRD typically requires significant levels of health care as well as the provision of person-centered, dementia-capable home and community-based services (HCBS). Of the community dwelling individuals with ADRD, approximately one-third live alone, exposing them to numerous risks, including unmet needs, malnutrition and injury and various forms of neglect and exploitation.[23] As the number of people with ADRD is projected to grow by almost 300% by 2050[24] from an estimated 5.3 million individuals, it is important to develop effective and coordinated service delivery and health care systems that are responsive to these individuals and their caregivers.

Establishing enhanced dementia capable HCBS systems designed to meet the needs of formal and informal caregivers of individuals with ADRD is critical to helping caregivers to continue to provide care and improving the care that individuals with ADRD receive. ACL's Alzheimer's Disease Program provides funding for the development and implementation of these person-centered systems of services and supports partnerships with public and private entities to identify and address the unique needs of persons with ADRD and their caregivers.

ACL has developed a new indicator to measure the Program's success at improving the dementia capability of long term services and support systems. Baseline data collected in FY 2017 will be used to set targets and develop a performance plan for improving results.

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[23] Gould, E., Maslow, K., Yuen, P., Wiener, J. *Providing Services for People with Dementia Who Live Alone: Issue Brief.* Accessed April 14, 2014 at *http://www.adrc-tae.acl.gov/tiki-index.php?page=adsspkey&filter=key* .

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

As a result of the Protection and Advocacy Program's individual or systemic advocacy, the percentage of individuals with developmental disabilities whose right to be safe, receive an appropriate education, live in the community, be economically self-sufficient and/or participate in their communities is enforced, retained, restored or expanded (Lead Agency ACL; Measure ID – 8F)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	N/A	Baseline	N/A	TBD
Result	N/A	N/A	N/A	N/A	N/A	January 1, 2019	January 1, 2020	January 1, 2021
Status	N/A	N/A	N/A	N/A	N/A	Pending	Pending	Pending

People with developmental disabilities are significantly more likely to experience abuse or neglect than their peers without disabilities. Specifically, with regard to abuse, research indicates that they are four to ten times more likely to be abused than their peers without disabilities. ACL's Developmental Disabilities Protection and Advocacy (P&As) programs provide a range of legal services to traditionally unserved or underserved individuals with developmental disabilities to ensure they are protected from abuse and neglect and are able to exercise their rights to make choices, contribute to society, and live independently. The purpose of this new measure is to increase the success of P&As to promote the rights of individuals with developmental disabilities through individual or systemic advocacy. ACL will use baseline data collected in FY 2017 to set targets and develop its performance plan.

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

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

As response rates to surveys fall and primary data collection costs increase, the need to use and leverage new sources of data for public health surveillance becomes critical. Within the Department, efforts are underway to use electronic health records for infectious disease surveillance and to facilitate coding of causes of death on death certificates. At the National Center for Health Statistics, linkages between survey data, mortality data, hospital administrative data, electronic health records, Medicare data, and housing data have been created and should greatly expand public health surveillance opportunities. In addition, HL7 Continuity of Care Document specifications have been published to facilitate the submission of standardized electronic health information to the National Health Care Surveys, enhancing their usability for surveillance.

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

Objective 4.1 Table of Related Performance Measures

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	Set Baseline	65 %	70 %	75 %	80 %	82 %	90 %
Result	54 %	62 %	69 %	69 %	75 %	80%	Dec 31, 2018	Dec 31, 2019
Status	Historic Actual	Baseline	Target Exceeded	Target Not Met	Target Met	Target Met	Pending	Pending

Advancing national implementation of Electronic Laboratory Reporting (ELR) is a priority in CDC's efforts to protect the public's health. ELR replaces paper-based reporting, which accelerates reporting to public health labs; reduces the reporting burden on clinicians, hospitals, and commercial laboratories; and decreases errors and duplicate reporting. As of FY 2017, electronic laboratory reports accounted for nearly 80% of laboratory reports for reportable conditions received, which exceeds FY 2016 results and continues the upward trend since FY 2012. As of the end of 2017, the national average for ELR is expected to be very close to 90%. There are diminishing returns if trying to push the ELR volume number higher than 90%, therefore the program considers moving from 62% in 2013 to 90% as a success. In FY 2018 and 2019, CDC will continue to monitor the implementation of ELR as part of its efforts to protect the public health.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	Set Baseline	10 %	40 %	40 %	40 %
Result	N/A	N/A	1 %	1 %	3 %	5%	Dec 31, 2018	Dec 31, 2019
Status	N/A	N/A	Historic Actual	Baseline	Target Not Met but Improved	Target Exceeded	Pending	Pending

During FY 2017, CDC advanced the modernization of infectious disease surveillance by producing technology upgrades to the Message Validation, Processing and Provisioning System , which receives production data from the states using the new HL7-based messages. This system streamlines data processing to more efficiently provide the data to CDC programs for analysis and action. When new HL7 messages have been implemented for all diseases, the new strategy will allow the retirement of older, less efficient legacy systems, and will increase the number of HL7 messages received at CDC. Although CDC did not meet its FY 2017 target, the five percent achievement represents an increase over the proportion in FY 2016 and the FY 2015 baseline. The FY 2017 accomplishments demonstrate increasing momentum toward achieving the targets in outlying years. In FY 2018 and 2019, CDC will continue to increase its use of HL7 formatting to receive surveillance data from the states.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	100 million	100 million	150 million	180 million	185 million	195 million	233 million	243 million
Result	126 million	149 million	178 million	182 million	193 million	223 million	Jan 31, 2019	Jan 31, 2020
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

The FDA's Sentinel Initiative provides significant public health benefits by developing new approaches and methods to actively monitor the safety of marketed medical products to complement existing FDA surveillance capabilities. Through the Sentinel System, the FDA is able to evaluate drug safety issues that may require regulatory action. In FY 2017, the Sentinel System expanded surveillance to 223 million members, which is an increase of 30 million members from FY 2016. FDA held the Ninth Annual Sentinel Initiative Public Workshop in February 2017 to bring together stakeholder communities to discuss a variety of topics on active medical product surveillance and emerging Sentinel projects. To date, the Sentinel Initiative has contributed to multiple safety communications and labeling changes to better inform patients and providers about safe use of drugs and vaccines. The Sentinel System ensures FDA will continue to have the tools necessary to conduct active safety surveillance work.

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

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

Through various initiatives and programs, HHS recruits and trains students, recent graduates, and other professionals to conduct rigorous and reproducible research. HHS provides research training and career development opportunities to ensure that highly trained investigators will be available across the range of scientific disciplines necessary to address the Nation's biomedical and scientific research needs.

HHS invests in Federal statistical units responsible for national surveys that provide reliable, timely, and policy-relevant information for policymakers and researchers. HHS also invests in strengthening the research infrastructure, ensuring that research facilities are constructed, modernized, and equipped with state-of-the-art tools and resources to support the scientific community.

Scientific integrity is a priority for the Department. Divisions responsible for research have developed policies and procedures to ensure the highest degree of scientific integrity in the research HHS conducts, funds, and supports—to ensure that our research is credible and worthy of the public's confidence.

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

Objective 4.2 Table of Related Performance Measures

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

Fiscal Year	Target	Result	Status
FY 2012	N/A	N/A	N/A
FY 2013	N/A	N/A	N/A
FY 2014	N/A	N/A	N/A
FY 2015	N/A	N/A	N/A
FY 2016	N/A	N/A	N/A
FY 2017	N/A	N/A	N/A
FY 2018	Develop four novel neurotechnologies for stimulating/recording in the brain to enable basic studies of neural activity at the cellular level.	Dec 31, 2018	In Progress
FY 2019	Test new and/or existing brain stimulation devices for 2 new therapeutic indications in humans through the BRAIN Public-Private Partnership.	Dec 31, 2019	In Progress

The Brain Research Through Advancing Innovative Neurotechnologies (BRAIN) Initiative® was launched to accelerate the development and application of new neurotechnologies that will enable researchers to gain deeper understanding of how the human brain functions in normal conditions as well as states of disease or dysfunction. These new technologies will provide unprecedented opportunities to explore how individual cells and whole circuits interact in both time and space. Ultimately, the scientific advances that emerge through this initiative are expected to lead to new ways to treat, cure, or prevent brain disorders. This measure reflects the short-term goals identified in the BRAIN 2025 report, with a specific focus on development and validation of cutting edge tools and technologies that can later be applied to answer critical and complex research questions about the human brain.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	50%	50%	45%	40%	40%	40%	50%	50%
Result	69%	63%	78%	80%	81%	N/A	Sep 30, 2018	Sep 30, 2019
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	N/A	Pending	Pending

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

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

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

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

Objective 4.3 Table of Related Performance Measures

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

Fiscal Year	Target	Result	Status
FY 2012	N/A	N/A	N/A
FY 2013	N/A	N/A	N/A
FY 2014	N/A	N/A	N/A
FY 2015	N/A	N/A	N/A
FY 2016	N/A	N/A	N/A
FY 2017	N/A	N/A	N/A
FY 2018	Optimize properties of 3 nanoformulations for effective delivery and antigen-specific response in immune cells.	Dec 31, 2018	In Progress
FY 2019	Further optimize top 2 candidate nanoformulations for co-delivery of multiple antigens to enhance anti-tumor response in one animal model.	Dec 31, 2019	In Progress

Immunotherapy approaches have shown potential to overcome some of the limitations associated with standard treatments for advanced cancers (e.g., toxicity in high-dose chemotherapy). However, treatment resistance, relapse, and low response rates limit the utility of current immunotherapies and/or hinder the development of new immunotherapies. Nanotechnology drug delivery methods have been shown to alleviate some of the current limitations of

immunotherapies. Therefore, NIH has launched several lines of research aiming to enhance existing immunotherapies with nanotechnologies or to facilitate the development of new, more efficacious nano-immunotherapies. In recent years, NIH-funded investigators designed various nano-carriers capable of: more effective delivery of antigens and other biomolecules, controlling drug distribution within a patient's body, and enabling co-delivery of immunotherapies with treatment modulators to improve efficacy. It is important to develop and test multiple nano-approaches to realize the effectiveness of nano-enabled immunotherapy.

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

Fiscal Year	Target	Result	Status
FY 2012	N/A	N/A	N/A
FY 2013	N/A	N/A	N/A
FY 2014	N/A	N/A	N/A
FY 2015	N/A	N/A	N/A
FY 2016	N/A	N/A	N/A
FY 2017	Strategy 1: Continue enrolling participants into two studies to test the safety, tolerability, and effectiveness of VRC01 as an intravenous prevention strategy.	Enrollment of participants continued for both studies.	Target Met
FY 2018	Strategy 2: Analyze primary results of a Phase 2a study examining the long-acting injectable, cabotegravir, for the prevention of HIV	Dec 31, 2018	In Progress
FY 2019	Strategy 3: Complete final analysis of an open-label extension study that builds on the findings of an earlier trial and aims to assess the continued safety of the dapivirine vaginal ring in a more real-world context and study participants' adherence	Dec 31, 2019	In Progress

NIH-funded research has led to the identification of highly effective, non-vaccine prevention strategies that have the potential to significantly reduce HIV infection rates around the world, including: 1) treatment as prevention or TasP, in which antiretroviral drugs (ARVs) are used to treat HIV-infected individuals and reduce the possibility that they transmit HIV to an uninfected heterosexual partner; and 2) pre-exposure prophylaxis (PrEP), a strategy in which healthy people routinely take one or more antiretroviral drugs to reduce their risk of getting HIV.

Current oral ARV formulations require adherence to daily or near-daily dosing strategies for both

HIV treatment and prevention, and this has proved challenging for both HIV-infected and uninfected individuals. Sustaining adherence over time also becomes increasingly challenging. Furthermore, research studies have found adherence to PrEP regimens particularly challenging for women, especially young women in sub-Saharan Africa, who in 2014, accounted for more than half of the 25.8 million people living with HIV in that region. PrEP may only reach its full potential with agents that do not depend on daily or near-daily pill taking.

Therefore, the development of alternative agents for PrEP, more adherence-friendly schedules for currently available agents, and long-acting injectable agents, as well as alternative interventions for women, such as an intravaginal ring, could go a long way in increasing the acceptability and adoption of prevention strategies and in reducing the number of new HIV infections.

By 2020, identify risk and protective alleles that lead to one novel therapeutic approach, drug target, or pathway to prevention for late-onset Alzheimer's disease (Lead Agency - NIH; Measure ID - SRO-5.3)

Fiscal Year	Target	Result	Status
FY 2012	N/A	N/A	N/A
FY 2013	N/A	N/A	N/A
FY 2014	Complete Discovery Phase whole genome sequencing and analysis of 582 family members from 111 families with late onset AD to identify genomic regions associated with increased risk of AD; sequencing of the coding regions of the DNA (whole exome sequencing) of 5,000 cases / 5,000 controls for both risk raising and protective loci; and whole exome sequencing and analysis of one individual from ~1,000 additional AD families to identify regions associated with increased risk or protection from AD.	Sequencing and an initial level of analysis were completed.	Target Met
FY 2015	Initiate Replication Phase to validate genes / regions of interest identified from case-control and family sequencing in ~50,000 samples from well phenotyped individuals by targeted sequencing and/or genotyping.	Sample selection for whole genome sequencing on additional multiply affected families was initiated. Planning of the Replication Phase has begun.	Target Met
FY 2016	Begin confirmation of genomic regions of interest identified in the Discovery Phase using samples from the Replication phase. Begin harmonization of data from Discovery phase datasets with data from Replication Phase for confirmation of regions of interest.	Sample selection/sequencing Discovery Extension phases completed (4,000 additional whole genomes). Data analysis for Extension Phase initiated. Genomic Center for Alzheimer's Disease funded (all ADSP quality control and data harmonization).	Target Met
FY 2017	Continue confirmation of genomic regions of interest in the Discovery and Replication	NIH met its target of confirming genomic regions of interest in the	Target Met

Fiscal Year	Target	Result	Status
	phase datasets. Continue harmonization of Discovery Phase and Replication Phase datasets.	Discovery and Replication phase data sets and continues to harmonize the Discovery Phase and Replication Phase data sets.	
FY 2018	Continue confirmation of genomic regions of interest in the Discovery using samples from the Replication phase. Continue harmonization of Discovery Phase and Replication Phase datasets. Begin analysis of genomic regions of interest in the genomes of minority cohorts.	Dec 31, 2018	In Progress
FY 2019	Begin analysis of genomic regions of interest in the ADSP Discovery Follow-Up Phase using whole genome sequence data from ethnically diverse cohorts. Continue confirmation of genomic regions of interest in the Discovery Phase using samples from the Follow-Up phase. Continue harmonization of Discovery Phase and Follow-Up Phase datasets.	Dec 31, 2019	In Progress

Effective interventions to prevent, delay, and treat Alzheimer's disease (AD) are urgently needed. Today, research reports estimate that as many as 5.1 million Americans may have the disorder, and the number is expected to rise as the population ages. Drugs currently in use for AD provide symptomatic relief and may slow symptoms of cognitive decline for some people for a limited time, but they neither halt nor reverse disease progression because they do not target the underlying molecular pathways believed to be involved in AD.

The advent of genome wide association studies (GWAS) and other high throughput technologies have facilitated the recent identification of risk factor genes for AD. This measure highlights the work of the NIH-funded Alzheimer's Disease Sequencing Project (ADSP), the overall goal of which is to identify genetic variants associated with risk and protection for AD.

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

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

Evaluation and evidence can support the Department's efforts to improve program performance by applying existing evidence about what works, generating new knowledge, and using experimentation and innovation to test new approaches to program delivery. HHS is committed to integrating evidence into policy, planning, budget, operational, and management decision making. HHS funds multiple types of evaluation and evidence-generating activities; these activities may examine how well a program is implemented, whether it achieves intended outcomes, the overall impact of a program, or all three. Results of these types of activities may be used to plan programs, assess program performance, understand how to improve a program, and inform policy decisions.

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

Objective 4.4: Table of Related Performance Measures

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	65.3 %	76.7 %	71.4 %	64.1 %	62.4 %	Prior Result +3PP	Prior Result +3PP	Prior Result +3PP
Result	73.7 %	68.4 %	61.1 %	59.4 %	53.4%	Oct 31, 2018	Oct 31, 2019	Oct 30, 2020
Status	Target Exceeded	Target Not Met	Target Not Met	Target Not Met	Target Not Met	Pending	Pending	Pending

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

- Emerging and Evidence Informed;
- Promising;
- Supported; and
- Well-Supported.

States that receive ACF CBCAP funding are required to use that funding for evidence-based and evidence-informed programs. Although this measure shows a downward trend, ACF anticipates a year-over-year increase of 3 percent from FY 2017 through FY 2019. In FY 2018 and 2019, ACF is committed to continuing to work with CBCAP grantees to invest in known evidence-based practices, while continuing to promote evaluation and innovation, so as to expand the availability of evidence-informed and evidence-based practice over time. In addition, ACF continues to focus one-on-one and peer learning technical assistance on increased accuracy of data reporting for this measure.

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

Fiscal Year	Target	Result	Status
FY 2012	N/A	N/A	N/A
FY 2013	N/A	N/A	N/A
FY 2014	N/A	N/A	N/A
FY 2015	N/A	N/A	N/A
FY 2016	N/A	N/A	N/A

Fiscal Year	Target	Result	Status
FY 2017	Develop 2 strategies for translating validated basic knowledge, clinical interventions, or behavioral interventions to diverse communities and clinical practice through establishing the Partnerships to Advance Cancer Health Equity (PACHE) program between Minority Serving Institutions (MSI) and NCI-designated Cancer Centers (CC).	Several U54 PACHE Partnerships have developed and/or validated evidence-based interventions and tools to help reduce the burden of cancer disparities in underserved communities across the United States. They are working with various community-based organizations (including faith-based organizations and community-based clinical practices and organizations) to disseminate/translate the interventions and tools in the diverse communities.	Target Met
FY 2018	Develop and support 2 partnerships to test validated basic cancer knowledge, clinical or behavioral interventions to diverse communities in clinical practice.	Dec 31, 2018	In Progress
FY 2019	Finalize testing and validating the strategies to translate basic cancer knowledge, clinical or behavioral interventions to underserved communities and into clinical practice.	Dec 31, 2019	In Progress

Disparities persist in cancer incidence rates, care, and survival rates. Unequal benefit from state-of-the-art diagnostics and treatment care for cancer (i.e., lack of access to quality care for segments of the U.S. population) and providers without adequate skills or knowledge to offer the state-of-the-art care are among the reasons for these disparities. Whereas biomedical research makes discoveries and develops these discoveries into new standards for care, studies have identified systematic inefficiencies to delivering these new standards to settings where everyone could have equitable access and benefit. Timely (targeted) dissemination of evidence-based state-of-the-art advancements in cancer diagnostics and treatment modalities to clinicians who work with underserved populations and in underserved communities could help alleviate existing disparities. Thus, NIH is supporting projects to develop and test dissemination strategies that will shed light on how new interventions can be effectively adopted by communities and clinicians serving various populations with various cancer types.

Goal 5. Objective 1: Ensure responsible financial management

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

All divisions contribute to the achievement of this objective. The Office of the Secretary leads this objective and the Department's response to the HHS Major Management Priority and Challenge: Improper payment rates for Medicare and Medicaid.

Objective 5.1 Table of Related Performance Measures

Improper Payment Cluster

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	10.4 %	10.9 %	9 %	8.5 %	9.14 %	9.5 %	8.08 %	TBD
Result	11.4 %	9.5 %	9 %	9.5 %	10 %	8.3%	Nov 15, 2018	N/A
Status	Target Not Met	Target Exceeded	Target Met	Target Not Met	Target Not Met	Target Exceeded	Pending	Pending

In FY 2017, CMS exceeded its Part C Medicare Advantage (MA) error rate target of 9.50 percent, reporting an actual improper payment rate of 8.31 percent, or $14.35 billion. The decrease from the prior year's estimate of 9.99 percent was driven primarily by submission of more accurate diagnoses by MA organizations for payment.

The FY 2018 target is 8.08 percent. The FY 2019 target will be established in the FY 2018 Agency Financial Report (AFR); per OMB starting with FY 2017 CMS will now establish a target for only the next fiscal year.

The Part C program payment error estimate reflects the extent to which plan-submitted diagnoses for a national sample of enrollees are substantiated by medical records.

Validation of diagnoses in medical records for sampled beneficiaries is performed during CMS'

annual Medical Record Review process, where medical records are reviewed by two separate coding entities in the process of confirming discrepancies for sampled beneficiaries. To calculate the Part C program's error rate, the dollars in error are divided by the overall Part C payments for the year being measured.

CMS has implemented four key initiatives to improve payment accuracy in the Part C program:

Contract-Level Audits: Contract-level Risk Adjustment Data Validation (RADV) audits are CMS's primary corrective action to recoup overpayments. RADV verifies, through medical record review, the accuracy of enrollee diagnoses submitted by MA organizations for risk adjusted payment. CMS expects that payment recovery will have a sentinel effect on the quality of risk adjustment data submitted by plans for payment, as contract-level RADV audits increase the incentive for MA organizations to submit valid and accurate diagnosis information, and encourage MA organizations to self-identify, report, and return overpayments they have received. Payment recovery for the pilot audits has been completed, totaling $13.7 million recovered in FYs 2012 through 2014. After completing the pilots, contract-level RADV audits of payment years 2011 through 2013 are in various stages of the audit process. For example, payment year 2013 audits continued in FY 2017, and CMS will initiate payment year 2014 audits in FY 2018. Furthermore, CMS expects to conduct recoveries for the 2011 and 2012 contract-level RADV audits (which began in FY 2014 and FY 2015, respectively) in FY 2018, which will be the first reviews to recoup funds based on extrapolated estimates.

Regulatory Provision (Overpayment Recoveries): As required by the Social Security Act, CMS regulations specify MA organizations report and return overpayments that they identify. In FY 2017, MA organizations reported and returned approximately $78.71 million in self-reported overpayments. CMS believes that this requirement will reduce improper payments by encouraging MA organizations to submit accurate payment information.

Part C RAC: Section 1893(h) of the Social Security Act required the implementation of a Medicare Part C Recovery Audit Contractor (RAC) program. CMS is currently exploring how to fit the Medicare Part C RAC program into the larger Medicare Part C program integrity efforts, including examining refinements that can be made to RAC operations that won't result in activities that excessively burden plans.

Training: Historically, CMS has conducted fraud, waste, and abuse in-person and webinar training sessions for MA plans. Only one training session for MA plans was conducted in FY 2017 due to procurement activities that were underway and the termination of contractor support in mid-FY 2017. In late FY 2017, CMS procured a new contractor to support this initiative and will resume training in FY 2018.

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	FY 2018	FY 2019
Target	3.2%	3.1%	3.6%	3.5%	3.4%	3.3%	1.66%	TBD
Result	3.1%	3.7%	3.3%	3.6%	3.41%	1.67%	Nov 15, 2018	N/A
Status	Target Exceeded	Target Not Met	Target Exceeded	Target Not Met	Target Met	Target Exceeded	In Progress	Pending

The purpose of this measure is to reduce the percentage of improper payments in the Part D Prescription Drug program. Measuring Part D payment errors protects the integrity of the Part D program by ensuring that CMS has made correct payments to contracting private health plans for coverage of Medicare-covered prescription drug benefits.

The Medicare Part D payment error estimate reported in FY 2017 represents payment error related to Prescription Drug Event (PDE) data.

The estimate for FY 2017 is 1.67 percent, or $1.30 billion. The decrease from the prior year's estimate of 3.41 percent was driven primarily by submission of more accurate data by Part D sponsors for payment. The target for FY 2018 is 1.66 percent. The FY 2019 target will be established in the FY 2018 Agency Financial Report (AFR); per OMB, starting with FY2017 CMS will establish a target for only the next fiscal year.

CMS has implemented three key initiatives, described below, to improve payment accuracy in the Part D program:

Training: Historically, CMS has also conducted fraud, waste, and abuse in-person and webinar training sessions for Part D sponsors on payment and data submissions. Only one fraud, waste, and abuse training session for Part D sponsors was conducted in FY 2017 due to procurement activities that were underway and the termination of contractor support in mid-FY 2017. In late FY 2017, CMS procured a new contractor to support this initiative, and will resume trainings in FY 2018.

Outreach: CMS continued formal outreach to plan sponsors for invalid/incomplete documentation. CMS distributed Plan Sponsor Summary Reports to all plans participating in the national payment error estimate. This report provided feedback on their submission and validation results against an aggregate of all participating plan sponsors.

Regulatory Provision (Overpayment Recoveries): As required by the Social Security Act, CMS requires that Part D sponsors report and return overpayments that they identify (Section 11.22). CMS believes that Part D sponsors pay more attention to ensuring their data is accurate because of the overpayment statute and regulation. In FY 2017, Part D sponsors reported and returned approximately $2.83 million in self-reported overpayments.

Reduce the improper payment rate in the Medicare Fee-for-Service (FFS) Program (Lead Agency - CMS; Measure ID - MIP1) [25]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	5.4 %	8.3 %	9.9 %	12.5 %	11.5 %	10.4 %	9.4 %	9.3 %
Result	8.5 %	10.1 %	12.7 %	12.1 %	11.0 %	9.5 %	Nov 15, 2018	Nov 15, 2019
Status	Target Not Met but Improved	Target Not Met	Target Not Met	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

The Medicare Fee-for-Service (FFS) improper payment estimate is calculated under the Comprehensive Error Rate Testing (CERT) program and reported in the Department of Health and Human Services (HHS) Agency Financial Report (AFR). The CERT program was initiated in FY 2003 and has produced a national Medicare FFS improper payment rate for each year since its inception. Information on the Medicare FFS improper payment methodology can be found in the FY 2017 HHS AFR.[26]

CMS exceeded its FY 2017 target. The Medicare FFS improper payment estimate for FY 2017 is 9.51 percent or $36.21 billion. The decrease from the prior year's reported improper payment estimate of 11.00 percent or $41.08 billion was driven by a reduction in improper payments for home health and Inpatient Rehabilitation Facility (IRF) claims. Although the improper payment rate for these

[25] 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.

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

services and the overall Medicare FFS improper payment rate decreased, improper payments for home health, Skilled Nursing Facility (SNF), and IRF claims were the major contributing factors to the FY 2017 Medicare FFS improper payment rate. While the factors contributing to improper payments are complex and vary from year to year, the primary causes of improper payments continue to be insufficient documentation and medical necessity errors.

Home Health Claims: Insufficient documentation for home health claims continues to be prevalent, despite the improper payment rate decrease from 42.01 percent in FY 2016 to 32.28 percent in FY 2017. The primary reason for these errors was that the documentation to support the certification of home health eligibility requirements was missing or insufficient. Medicare coverage of home health services requires physician certification of the beneficiary's eligibility for the home health benefit (42 CFR 424.22).

SNF Claims: Insufficient documentation was the major error reason for SNF claims. The improper payment rate for SNF claims increased from 7.76 percent in FY 2016 to 9.33 percent in FY 2017. The primary reason for these errors was that the certification/recertification statement was missing or insufficient (e.g., one required element was missing). Medicare coverage of SNF services requires certification and recertification for these services (42 CFR 424.20).

IRF Claims: Medicare necessity (i.e. services billed were not medically necessary continues to be the major error reason for IRF claims, despite the improper payment rate decrease from 62.39 percent in FY 2016 to 39.74 percent in FY 2017. The primary reason for these errors was that the IRF coverage criteria for medical necessity were not met. Medicare coverage of IRF services requires that there must be a reasonable expectation that the patient meets all of the coverage criteria at the time of admission to the IRF (42 CFR 412.622(a) (3)).

CMS uses data from the CERT program and other sources of information to address improper payments in Medicare FFS through various corrective actions. CMS has developed a number of preventive and detective measures for specific service areas with high improper payment rates such as home health, SNF, and IRF claims. CMS believes implementing targeted corrective actions will continue to prevent and reduce improper payments in these areas and reduce the overall improper payment rate. Detailed information on corrective actions can be found in the FY 2017 HHS AFR.

Reduce 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	FY 2018	FY 2019
Target	7.4 %	6.4 %	5.6 %	6.70 %	11.53 %	9.57 %	7.93 %	TBD
Result	7.1 %	5.8 %	6.7 %	9.78 %	10.48 %	10.10 %	Nov 15, 2018	N/A
Status	Target Exceeded	Target Exceeded	Target Not Met	Target Not Met	Target Exceeded	Target Not Met but Improved	Pending	Pending

Reduce 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	FY 2018	FY 2019
Target	N/A	N/A	N/A	6.50 %	6.81 %	7.38 %	8.20 %	TBD
Result	N/A	N/A	N/A	6.80 %	7.99 %	8.64 %	Nov 15, 2018	Nov 15, 2019
Status	N/A	N/A	N/A	Target Not Met	Target Not Met	Target Not Met	Pending	Pending

The Payment Error Rate Measurement (PERM) program measures improper payments in the Fee-For-Service (FFS), managed care, and eligibility components of both Medicaid (MIP9.1) and CHIP (MIP9.2). CMS measures improper payments in 17 states each year as a means to contain cost, reduce the burden on states, and make measurement manageable. In this way, states can plan for the reviews and CMS can complete the measurement on time for HHS and AFR reporting. At the end of a three-year period, each state will have been measured once and will rotate in that cycle in future years, (e.g., the states measured in the 2014 AFR were also measured again in the 2017 AFR). Information on the Medicaid and CHIP statistical sampling process and review period can be found in the FY 2017 HHS AFR.

The national Medicaid improper payment rate (MIP9.1) reported in the 2017 AFR is based on measurements that were conducted in FYs 2015, 2016, and 2017. The FY 2019 target will be established in the FY 2018 AFR. Per OMB, starting with FY 2017, CMS will now establish a target for only the next fiscal year.

The current national Medicaid improper payment rate is 10.10 percent. The national Medicaid component rates are: Medicaid FFS: 12.87 percent and Medicaid managed care: 0.30 percent. The Medicaid eligibility component is held constant at the FY 2014 reported rate of 3.11 percent.

For FYs 2015 through 2018, CMS will not conduct the eligibility measurement component of PERM. In place of these PERM eligibility reviews, all states are required to conduct eligibility review pilots that provide more targeted, detailed information on the accuracy of eligibility determinations. The

pilots use targeted measurements to: provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility, identify strengths and weaknesses in operations and systems leading to errors, and test the effectiveness of corrections and improvements in reducing or eliminating those errors. During this time, for the purpose of computing the overall national improper payment rates, the Medicaid and CHIP eligibility component improper payment rates are held constant at the FY 2014 national rate of 3.11 percent and 4.22 percent, respectively.

CMS used the eligibility review pilots to test updated PERM eligibility processes, and prepare states for the resumption of the PERM eligibility component measurement. Based on the pilots, CMS updated the eligibility component measurement methodology and published a final rule (82 FR 31158, July 5, 2017) to update the methodology for the PERM eligibility component. CMS will resume the eligibility component measurement under this final rule and report an updated national eligibility improper payment estimate in FY 2019.

Since FY 2014, the Medicaid improper payment estimate has been driven by errors due to state non-compliance with provider screening, enrollment, and National Provider Identifier (NPI) requirements. First, all referring/ordering providers are required to be enrolled in Medicaid or CHIP and claims must contain the referring/ordering provider NPI. Second, states are required to screen providers under a risk-based screening process prior to enrollment. Finally, the attending provider NPI is required to be submitted on all electronically filed institutional claims. CMS began reviewing against these requirements for FY 2014 improper payment reporting. Therefore, in FY 2014, CMS saw the first ever increase in the Medicaid improper payment rate when the first cycle of states was reviewed against the new requirements. The Medicaid rate increased in FY 2015 when CMS reviewed the second cycle of states against the new requirements. FY 2016 represented the first "baseline" improper payment rate reflecting the new requirements because all 50 states and the District of Columbia were measured under the same requirements. FY 2017 represents the first cycle of states that has been measured a second time.

Compliance with provider screening, enrollment, and NPI requirements for the 17 states measured in FY 2017 improved, and the improper payment rate related to non-compliance decreased. The Medicaid FFS improper payment rate for non-compliance with these requirements decreased for these states from 5.74 percent in FY 2014 to 4.03 percent in FY 2017. Although the 17 states reviewed this year had better compliance results compared to their previously measured cycle,

non-compliance with the provider screening, enrollment, and NPI requirements is still a major contributor to the improper payment rate. Additionally, improper payments due to no or insufficient medical documentation increased in FY 2017.

The national CHIP improper payment rate (MIP 9.2) reported in the 2017 AFR is based on measurements conducted in FYs 2015, 2016, and 2017. The current national CHIP improper payment rate is 8.64 percent. The national CHIP component rates are: CHIP FFS: 10.29 percent and CHIP managed care: 1.62 percent. The CHIP eligibility component is held constant at the FY 2014 reported rate of 4.22 percent. Additional detail about Medicaid and CHIP improper payment rates and underlying components is available in the FY 2017 HHS AFR.

Similar to Medicaid, CMS began reviewing against provider screening, enrollment, and NPI requirements for FY 2014 improper payment reporting. In FYs 2014 and 2015, the CHIP improper payment estimate increased when CMS reviewed the first two cycles of states against the new requirements. FY 2016 represented the first "baseline" improper payment rate reflecting the new requirements because all 50 States and the District of Columbia were measured under the same requirements. FY 2017 represents the first cycle of states that has been measured a second time.

The CHIP improper payment estimate increased due to continued state difficulties coming into compliance with the provider screening, enrollment, and NPI requirements. The CHIP FFS improper payment rate for non-compliance with these requirements increased for these states from 4.69 percent in FY 2014 to 5.73 percent in FY 2017. A higher percentage of CHIP providers are not enrolled in Medicare. Therefore, there are more CHIP providers where states cannot rely on Medicare's screening in lieu of conducting state screening. Additionally, managed care improper payments increased in FY 2017 due to recipients that aged out of CHIP.

The factors contributing to improper payments are complex and vary from year to year. 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. Each year CMS outlines actions the agency will implement to prevent and reduce improper payments for all error categories. Detailed information on corrective actions can be found in the FY 2017 HHS AFR.

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

As the Department looks to FY 2022 and beyond, it imagines all the achievements that can be reached when workforce performance is heightened, efficiencies achieved, and accountability strengthened. The Department must continue to create a flexible and agile workforce that responds and adapts to change: change in technology, change in society, change in expectations, and change in scientific findings. HHS needs the leaders of tomorrow today. To this end, the Department will build a world-class Federal management team and a workforce ready to collaborate with colleagues within the Department, among other Federal departments, and outside the Federal Government, to seek change that improves and enhances the health and well-being of Americans.

Management will need to help build and maintain the workforce in a way that retains current knowledge, anticipates advances in medicine and technology, and prepares internal staff for future leadership positions. To fulfill the Department's mission, there is a need to recruit, hire, and retain talent with STEM (science, technology, engineering, and math) skills. Targeted recruitment efforts will become more important as mission-critical positions are vacated. Competition from private industry for new employees will continue to be a challenge in recruitment efforts.

An improved and engaged workforce is enhanced by a world-class management team. HHS will strengthen its management team by providing the tools, training, skill development, and empowerment needed to encourage its workforce to work to its highest potential, accountable for its efficiency and effectiveness toward meeting the HHS mission. To keep abreast of advances and lead change in these fields, HHS will continue to bring together the best expertise and talent—to serve the American people the best way possible.

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

Objective 5.2 Table of Related Performance Measures

Increase HHS employee engagement through Federal Employee Viewpoint Survey (FEVS) (Lead Agency - ASA; Measure ID - 2.6)

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	Set Baseline	67% employee engagement index	68% employee engagement index	69% employee engagement index	72.5% employee engagement index	75% employee engagement index
Result	N/A	N/A	66% employee engagement index	68% employee engagement index	70% employee engagement index	72% employee engagement index	Dec 31, 2018	Dec 31, 2019
Status	N/A	N/A	Baseline	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Among very large Federal agencies (greater than 75,000 employees), HHS had the highest employee engagement score for FY 2017 (72%). In FY 2017, HHS senior executives focused on achieving a minimum of 70 percent in each of the five areas of HHS FEVS performance: participation; employee engagement; satisfaction; belief that action will be taken based on survey results; and effective communication. The FEVS places emphasis on organizations taking local action to support enterprise improvement in the above five areas of focus, as well as other areas for improvement as appropriate. In FY 2018 and 2019, HHS will continue to use FEVS data to monitor the impact of its efforts to support enterprise improvement.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	N/A	N/A	80 days	80 days
Result	N/A	N/A	N/A	N/A	108 days	101 days	Dec 31, 2018	N/A
Status	N/A	N/A	N/A	N/A	Historic Actual	Historic Actual	Pending	Pending

Outcomes for this measure are strongly influenced by the ongoing hiring freeze. In FY 2018, ASA will review the hiring process to identify bottlenecks and potential efficiencies. In FY 2019, ASA will implement any necessary changes.

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

HHS information technology investments help achieve the Department's mission by acquiring and managing the technology infrastructure and systems for its health care and human services programs and mission-support programs. From externally facing websites like HHS.gov to internal applications that manage programs and resources, HHS needs information technology solutions to be modernized, secure, and responsive to customer demands.

The HHS Information Technology Strategic Plan 2017–2020 and the HHS Implementation Plan for the Federal Information Technology Acquisition Reform Act (FITARA) guide information technology decision making across the Department. The Department's current modernization investments include cloud computing, data center consolidation and improvements, information technology portfolio reviews, shared services, and a digital strategy that makes it easier to access information using HHS websites and tools. HHS is working to increase partnerships with industry, academia, and other organizations to leverage their technology expertise as well.

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

Objective 5.3 Table of Related Performance Measures

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	N/A	N/A	Set Baseline	TBD
Result	N/A	N/A	N/A	N/A	N/A	N/A	Sep 30, 2018	N/A
Status	N/A	N/A	N/A	N/A	N/A	N/A	Pending	Pending

The purpose of this measure is to increase the total percentage of identified systems that have a formal authorization to operate on HHS networks. The baseline for this measure will be set by September 30, 2018 and targets will be developed from data collected from reports. This measure links directly to measure 3.4.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	N/A	N/A	90 %	90%
Result	N/A	N/A	N/A	N/A	64 %	64 %	Dec 31, 2018	Dec 31, 2019
Status	N/A	N/A	N/A	N/A	Historic Actual	Historic Actual	Pending	Pending

HHS has developed plan to capture cost savings through portfolio review, data center optimization, and software licensing. In FY 2018 and 2019, HHS will establish a software inventory to drive decision-making in that area.

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

Protecting the privacy of personally identifiable information—such as birthdates and Social Security numbers—and securing Federal information systems and critical infrastructure are challenges for Federal agencies. HHS is working to improve how it protects the security and privacy of electronic health information and to consistently address controls that prevent unauthorized use and unauthorized changes to information system resources, monitor building and access control systems, and ensure that all HHS staff and contractors are vetted properly and understand cybersecurity risks. Keeping personal information safe increases trust and confidence in HHS and its information and reporting systems.

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

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

Objective 5.4 Table of Related Performance Measures

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	N/A	N/A	Set Baseline	TBD
Result	N/A	N/A	N/A	N/A	N/A	N/A	Sep 30, 2018	N/A
Status	N/A	N/A	N/A	N/A	N/A	N/A	Pending	Pending

Through the combination or training, education, and tools (e.g., email add-in), the purpose of the measure is to reduce the likelihood of staff falling for fake email attempts over time. A baseline will

be established using data collected through OCIO's enterprise Phishme solution and a target will be set with a goal of negative responses decreasing over time.

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

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	N/A	N/A	Set Baseline	TBD
Result	N/A	N/A	N/A	N/A	N/A	N/A	Sep 30, 2018	N/A
Status	N/A	N/A	N/A	N/A	N/A	N/A	Pending	Pending

This measure serves as an enterprise-wide countdown measure since the last day of a major PII incident in the Department as well as a gauge for the number of major PII incidents. The baseline will be set by September 30, 2018. The number of days will continue to increase unless there is a major incident, at which point the count resets.

Evidence Building Efforts

Evaluation and analysis provide essential evidence for HHS to understand how its programs work, for whom, and under what circumstances. HHS builds evidence through evaluation and analysis in order to inform decisions in budget, legislative, regulatory, strategic planning, program, and policy arenas. Given the breadth of work supported by HHS, many evaluations and analyses are conducted each year. These efforts range in scope, scale, design, and methodology, but all aim to understand how the effect of programs and policies and how they can be improved.

Evaluation at HHS: Across HHS evaluation comes in many forms including 1) formal program evaluations using the most rigorous designs appropriate; 2) capacity-building initiatives to improve administrative data collection, accessibility, and use for management; 3) exploratory and preliminary quantitative and qualitative analysis to build evidence; 4) pilots and demonstrations; and 5) statistical analysis of factors related to health and human services programs and policies. Findings from a variety of evaluations and analyses are disseminated to the public on HHS agency websites such as Office of Planning, Research, and Evaluation (ACF) and the Innovation Center at the Centers for Medicare & Medicaid (CMS). HHS coordinates the evaluation community by regularly convening the HHS Evaluation & Evidence Policy Council, which builds capacity by sharing best practices and promising new approaches across HHS.

Disseminating Evidence: In addition to building evidence through a broad range of rigorous empirical studies, analysis, and evaluations, HHS supports multiple clearinghouses that catalog, review, and disseminate evidence related to programs such as the ACF Research and Evaluation Clearinghouses on Self-Sufficiency, Employment Strategies, Strengthening Families, Home Visiting, and Child Care and Early Education; the AHRQ United States Preventive Services Task Force; the CDC Community Guide; or the SAMHSA National Registry of Evidence-based Programs and Practices.

Cross-Government Collaborations

The Federal Government has a unique legal and political government-to-government relationship with tribal governments and provides health services for American Indians and Alaska Natives consistent with that special relationship. HHS works with tribal governments, urban Indian organizations, and other tribal organizations to facilitate greater consultation and coordination

between states and tribes on health and human services issues.

Major Management Priorities and Challenges

According to OMB Circular A-11, an agency's APP/R must include a section on major management priorities and challenges, to describe management and programmatic issues and risks or areas that have greater vulnerability to waste, fraud, abuse, and mismanagement where a failure to perform could seriously affect the agency's mission delivery and ability to achieve its goals. The OIG has identified ten top management and performance challenges facing the Department as it strives to fulfill its mission. The OIG notes that challenges can arise in the Department's responsibilities and functions, sound fiscal management; efforts to strengthen these functions are described in *Strategic Objective 5.1: Ensure Responsible Financial Management.* The Department's efforts to ensure sound fiscal management are ongoing. A description of the challenge and actions taken towards progress can be found on pages 71-79 of this report.

The Office of the Inspector General reports annually on HHS Top Management and Performance Challenges. The OIG report for FY 2017 can be found at: https://oig.hhs.gov/reports-and-publications/top-challenges/2017/. The HHS response to these OIG-identified challenges can be found at: https://www.hhs.gov/about/agencies/asfr/finance/financial-policy-library/agency-financial-reports/index.html.

Regulatory Reform

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

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

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	44	TBD
Result	N/A	N/A	N/A	N/A	Oct 31, 2018	Oct 31, 2019
Status	N/A	N/A	N/A	N/A	Pending	Pending

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

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	19	TBD
Result	N/A	N/A	N/A	N/A	Oct 31, 2018	Oct 31, 2019
Status	N/A	N/A	N/A	N/A	Pending	Pending

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

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	4	TBD
Result	N/A	N/A	N/A	N/A	Oct 31, 2018	Oct 31, 2019
Status	N/A	N/A	N/A	N/A	Pending	Pending

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

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	6	TBD
Result	N/A	N/A	N/A	N/A	Oct 31, 2018	Oct 31, 2019
Status	N/A	N/A	N/A	N/A	Pending	Pending

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

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	16	TBD
Result	N/A	N/A	N/A	N/A	Oct 31, 2018	Oct 31, 2019
Status	N/A	N/A	N/A	N/A	Pending	Pending

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

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Target	N/A	N/A	N/A	N/A	-$28.7 million	TBD
Result	N/A	N/A	N/A	N/A	Oct 31, 2018	Oct 31, 2019
Status	N/A	N/A	N/A	N/A	Pending	Pending

Management Objectives and Priorities

The structure of the HHS Strategic Plan FY 2018-2022 aligns Strategic Goals 1 through 4 to mission-focused efforts, while Strategic Goal 5 aligns to management objectives. The emphasis on the efficiency, transparency, accountability, and effectiveness of HHS programs in Goal 5 highlights efforts across the Department to strengthen program integrity, create innovations for data access and use, and invest in the HHS workforce.

Lower-Priority Program Activities

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

Changed Performance Goals

Information on performance goal changes can be found at: https://www.hhs.gov/about/budget/fy2019/performance/performance-plan-changes-in-performance-measures/index.html?language=es.

Data Sources and Validation

Supporting information on HHS FY 2019 Agency Performance Plan and Report performance measures and data can be found at: https://www.hhs.gov/about/budget/fy2019/performance/performance-plan-data-sources-and-validation/index.html?language=es.