U.S. Department of Health and Human Services
FY 2024 Annual Performance Plan and Report

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

The U.S. Department of Health and Human Services (HHS) supports and implements programs that enhance the health, safety, and well-being of the American people. HHS strives to provide all Americans with high-quality healthcare and social services. With its skilled, dedicated, and diverse workforce, HHS is well-positioned to fulfill its mission and achieve the goals and objectives in the FY 2022-2026 Strategic Plan.

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 2024 Annual Performance Plan and Report, documenting the Department's performance during the past year. Further information detailing HHS performance is available at Performance.gov.

HHS monitors over 900 performance measures to manage departmental programs and activities and improve the efficiency and effectiveness of these programs. As required by GPRAMA, this report includes a representative set of performance measures to illustrate progress toward achieving the Department's strategic goals in the FY 2022- 2026 Strategic Plan. The information in this report spans the Department's 12 operating divisions and 13 staff divisions and includes work done across the country and throughout the world. Each HHS division has reviewed its submission and I confirm, based on certifications from the divisions, that the data are reliable and complete. When results are not available because of delays in data collection, the report notes the date when the results will be available. As additional data becomes available, HHS will continue to update the information on those impacts in future reports. The results presented here demonstrate that HHS is performing well across a wide range of activities.

Robert Gordon
Performance Improvement Officer
U.S. Department of Health and Human Services

Table of Contents

Overview

The U.S. Department of Health and Human Services (HHS) is the United States government's principal agency for protecting the health of all Americans and providing essential human services. HHS is tackling major challenges facing our country today, including the spread of disease, climate change, substance use disorders and mental health, health inequality between this country's diverse populations, and more.

HHS works closely with other federal departments and international partners to coordinate efforts and ensure the maximum benefit for the public throughout its work. HHS also works with state, local, and U.S. territorial governments to achieve its mission. The Federal Government has a unique legal and political government-to-government relationship with tribal governments and provides health services for American Indians and Alaska Natives consistent with this special relationship. HHS works with tribal governments, urban Indian organizations, and other tribal organizations to facilitate greater consultation and coordination between state and tribal governments on health and human services.

HHS also has strong partnerships with the private sector and nongovernmental organizations. The Department works with industries, academic institutions, trade organizations, and advocacy groups to leverage resources from organizations and individuals with shared interests. By collaborating with these partners, 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, often provide HHS-funded services at the local level.

The Annual Performance Plan and Report details the Department's progress towards achieving the goals and objectives described in the HHS Strategic Plan for FY 2022-2026. This includes an overview of Cross-Agency Priority Goals, Strategic Goals, Agency Priority Goals, Performance Management, and Strategic Reviews. Additionally, this document provides historical results and upcoming targets for the performance measures that illustrate each Strategic Objective, as well as an explanation for how the program will accomplish each target for FY's 2023 and 2024. Also included is a summary of evidence building efforts at HHS, cross-government collaborations, and major management priorities.

Mission Statement

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

HHS Organizational Structure

The Department includes 12 OpDivs that administer HHS programs:

- Administration for Children and Families (ACF)
- Administration for Community Living (ACL)
- Agency for Healthcare Research and Quality (AHRQ)
- Administration for Strategic Preparedness and Response (ASPR)
- Agency for Toxic Substances and Disease Registry (ATSDR)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)

- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Substance use And Mental Health Services Administration (SAMHSA)

In addition, 13 StaffDivs and the Immediate Office of the Secretary (IOS) coordinate Department operations and provide guidance to the operating divisions:

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

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

Cross-Agency Priority Goals

Per the GPRA Modernization Act's requirement to address Cross-Agency Priority Goals in the agency strategic plan, the annual performance plan, and the annual performance report, please refer to Performance.gov for the agency's contributions to those goals and progress, where applicable. The Department of Health and Human Services currently contributes to the following CAP Goals: Managing the Business of Government (co-lead); Strengthening and Empowering the Federal Workforce; and Delivering Excellent, Equitable, and Secure Federal Services and Customer Experience.

Strategic Goals Overview

The strategic goals and strategic objectives HHS Strategic Plan FY 2022-2026 are included in this document and posted here: https://www.hhs.gov/about/strategic-plan/index.html.

The five strategic goals are:

Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare.
Goal 2: Safeguard and Improve National and Global Health Conditions and Outcomes.
Goal 3: Strengthen Social Well-being, Equity and Economic Resilience.
Goal 4: Restore Trust and Accelerate Advancements in Science and Research for All.
Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability.

Agency Priority Goals

The FY 2022-2023 Agency Priority goals are:

- **Behavioral Health:** Increase equitable access to and utilization of prevention, treatment, and recovery services to improve health outcomes for those affected by behavioral health conditions.
    - By September 30, 2023, increase by 15% over a baseline of 1,015,386 the number of unique patients dispensed prescriptions for buprenorphine from retail pharmacies in the U.S. and 15% over a baseline of 324,126 the number of prescriptions dispensed for naloxone in U.S. outpatient retail and mail-order pharmacies.
    - By September 30, 2023, increase by 20% the number of individuals referred for behavioral health services by SAMHSA grantees engaged in screening and assessment.
- **Child Well-Being:** By September 30, 2023, HHS will improve child well-being, especially in underserved or marginalized populations and communities.
- **Emergency Preparedness:** While promoting equitable access, strengthen the systems for domestic and global health, human services, and public health to protect the nation's well-being before, during, and after disasters and public health emergencies. By September 30, 2023, HHS will complete 4 projects, establish a new ASPR office, and increase by at least 10% key deliverables to increase resources that develop and improve the national capacity of public health, human services, and global health disaster management entities to respond equitably to emerging threats and emergency incidents above FY 2020.
- **Equity:** Advance progress towards equity in health and human services by optimizing opportunities and access for underserved and marginalized populations and addressing drivers of inequities throughout the life course in order to remove barriers, reduce disparities, and improve outcomes. By September 30, 2023, initiate at least 10 equity assessments on HHS policies and activities and identify potential actions for improvement.
- **Maternal Health:** Improve maternal health and advance health equity across the life course by assuring the equitable provision of evidence-based high-quality care and addressing racism, discrimination, and other biases. By September 30, 2023, HHS will:
    - increase by 10% the number of hospitals participating in Perinatal Quality Collaboratives engaged in data-informed quality improvement efforts to address the drivers of maternal mortality and achieve equity;
    - increase by 10% the number of birthing facilities that are participating in the Alliance for Innovation on Maternal Health; and
    - increase by 20% the number of pregnant and postpartum people, their support networks, and providers reached by HHS messages about urgent maternal warning signs.

For current progress updates, please go to Performance.gov.

Strategic Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare

HHS works to protect and strengthen equitable access to high quality and affordable healthcare. Increasing choice, affordability and enrollment in high-quality healthcare coverage is a focus of the Department's efforts in addition to reducing costs, improving quality of healthcare services, and ensuring access to safe medical devices and drugs. HHS also works to expand equitable access to comprehensive, community-based, innovative, and culturally- and linguistically-appropriate healthcare services while addressing social determinants of health. The Department is driving the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families. HHS also bolsters the health workforce to ensure delivery of quality services and care.

Objective 1.1: Increase choice, affordability, and enrollment in high-quality healthcare coverage

HHS supports strategies to increase choice, affordability, and enrollment in high-quality healthcare coverage. HHS promotes available and affordable healthcare coverage to improve health outcomes in our communities and empowers consumers with high quality healthcare coverage choices. The Department also leverages knowledge and partnerships to increase enrollment in health insurance coverage.

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

Objective 1.1 Table of Related Performance Measures

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

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	46,062,581 children[1]	46,440,401 children[2]	46,556,502 children[3]	46,672,893 children[4]	46,672,893 children[5]	44,650,216 children[6]	44,538,869 children[7]	44,538,869 children[8]
Result	46,322,217 children[9]	45,919,430 children[10]	44,745,129 children[11]	44,098,421 children[12]	46,000,408 children	Mar 31, 2023	Mar 31, 2024	Mar 31, 2025
Status	Target Exceeded	Target Not Met	Target Not Met	Target Not Met	Target Not Met	Pending	Pending	Pending

[1]Medicaid 36,850,065/CHIP 9,212,516
[2]Medicaid 37,152,321/CHIP 9,288,080
[3]Medicaid 37,245,202/CHIP 9,311,300
[4]Medicaid 37,338,314/CHIP 9,334,579
[5]Medicaid 37,338,314/CHIP 9,334,579
[6]Medicaid 35,720,173/CHIP 8,930,043
[7]Medicaid 35,391,786/CHIP 9,147,083
[8]Medicaid 35,391,786/CHIP 9,147,083
[9]Medicaid 36,862,057/CHIP 9,460,160
[10]Medicaid 36,287,063/CHIP 9,632,367
[11]Medicaid 35,090,387/CHIP 9,654,742
[12]Medicaid 35,055,383/CHIP 9,043,038

The purpose of this measure is to increase enrollment in CHIP and Medicaid from 43,542,385 children in FY 2011 to 44,538,869 children by the end of FY 2024. Our enrollment target for FY 2024 takes into consideration that the prior FY enrollment targets have not been met since FY 2017, and that the majority of eligible children are enrolled in Medicaid and CHIP. Additionally, the FY 2024 Medicaid and CHIP enrollment target accounts for potential declines in Medicaid and CHIP child enrollment that may result from states resuming normal operations after the end of the continuous enrollment condition initially authorized in section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA), which required states to maintain enrollment for most individuals enrolled in Medicaid since March 2020, as a condition of receiving a 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP). For example, state renewal processing after the end of the continuous enrollment condition will impact individuals that have retained their coverage during the COVID-19 PHE in Medicaid because of the FFCRA continuous coverage requirement and in CHIP for states that elect the optional flexibilities to temporarily delay acting on changes in circumstances that would impact eligibility, and delay timely processing of renewals in CHIP. These changes will lead to terminations of coverage for children that are determined to be ineligible for Medicaid or CHIP at renewal during the eligibility period after the continuous enrollment condition ends. The FY 2024 enrollment target is set at the same enrollment projections for FY 2023. We anticipate this to be a reasonable goal for FY 2024 given that states will continue to process renewals from the COVID-19 Public Health Emergency (PHE) at the start of FY 2024, which will result in terminations of enrollees that do not complete renewals or are otherwise no longer eligible for Medicaid and CHIP. These terminations will likely be reflected in the FY 2024 results as a decline in Medicaid and CHIP enrollment. After the continuous enrollment condition ends, there will be a great focus on retention of child enrollment in Medicaid and CHIP, however, we do not expect to see returns to pre-pandemic levels of Medicaid and CHIP child enrollment until FY 2025. Additionally, a 2021 analysis by the Urban Institute reveals that 91.9% of eligible children were enrolled in Medicaid and CHIP in 2019. The remaining 4 million, or 8.1% of uninsured children are the hardest to reach.

The data for this goal comes from state's submission of required quarterly and annual child enrollment data, which include the number of children who are enrolled in Medicaid, separate CHIP programs, and Medicaid expansion CHIP programs. The enrollment counts reflect an unduplicated number of children ever enrolled during each year and are not reflective of point-in-time enrollment.

Measurement and reporting on this measure align with the CMS Strategic Plan pillar to expand access to quality, affordable health coverage and care, and supports the CMCS Blueprint objectives of ensuring all youth have access to a full breadth of physical and behavioral health services, and maximizing coverage retention across CMS programs as the COVID-19 PHE unwinds.

CMS' strategy to increase the availability and accessibility of health insurance coverage for children includes collaborating with its State and Federal partners, continuing to implement statutory provisions that encourage program simplification, supporting CHIP outreach grantees, and bolstering its data collection activities.

CHIP, including the Connecting Kids to Coverage Outreach and Enrollment Program, is currently funded through FY 2029. The HEALTHY KIDS Act, as included in P.L. 115-120, extended CHIP funding for six years through FY 2023, and the Advancing Chronic Care, Extenders and Social Services Act (referred to as the ACCESS Act and included in Pub. L. No. 115-123), provides CHIP funding for an additional four years, for FY 2024 through FY 2027. The Consolidated Appropriations Act of 2023 further extends CHIP funding through FY 2029. These laws also included provisions related to the extension and reduction of federal financial participation for CHIP, maintenance of effort for children's Medicaid and CHIP coverage, and the extension of express lane eligibility. The Connecting Kids to

Coverage Outreach and Enrollment grants and National Campaign received $120 million in funding for outreach and enrollment activities through FY 2023, $48 million for FY 2024 to FY 2027, and $48 million for FY 2028 to FY 2029.

The Connecting Kids to Coverage grants and the National Campaign fund activities that are aimed at reducing the number of children who are eligible for Medicaid and CHIP but are not enrolled and improving retention of eligible children who are currently enrolled. Most recently, on July 19, 2022, CMS awarded 36 new cooperative agreements, with awarded amounts ranging from $664,179 to $1,500,000. These grants have a 3-year period of performance which began on July 19, 2022. On October 17, 2022, CMS published a Notice of Funding Opportunity for an additional $6 million of HEALTHY KIDS Act funding that is available to enroll and retain American Indian/Alaska Native (AI/AN) children in Medicaid and CHIP. The award date for these cooperative agreements is scheduled for April 2023. Eligible entities for this funding opportunity include Indian Health Service providers, Tribes and Tribal organizations operating a health program under a contract or compact with the Indian Health Service under the Indian Self Determination and Education Assistance Act, and Urban Indian organizations operating a health program under the Indian Health Care Improvement Act.

Increase the number of tables per year added to the MEPS table series (Lead Agency - AHRQ; Measure ID - 1.3.19)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	8,609 total tables in MEPS table series	9,199 total tables in MEPS table series	9,627 total tables in MEPS table series	10,136 total tables in MEPS table series	10,707 total tables in MEPS table series	11,431 total tables in MEPS table series	12,735 total tables in MEPS table series	12,985 total tables in MEPS table series
Result	8,949 total tables in MEPS table series	9,377 total tables in MEPS table series	9,886 total tables in MEPS table series	10,457 total tables in MEPS table series	11,181 total tables in MEPS table series	12,485 total tables in MEPS table series	N/A	N/A
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Not Collected	Not Collected

The Medical Expenditure Panel Survey (MEPS) collects data on the specific health services that Americans use, how frequently they use them, the cost of these services, and how they are paid for, as well as data on the cost, scope, and breadth of health insurance held by and available to U.S. workers. The Household Component (MEPS HC) Tables Compendia has recently been updated moving to a more user friendly and versatile format (https://meps.ahrq.gov/mepstrends/home/index.html). Interactive tables are provided for the following: use, expenditures, and population; health insurance, accessibility, and quality of care; medical conditions and prescribed drugs. The new format greatly expands the number of tables generated dependent on the parameters entered by the user.

The MEPS Tables Compendia is scheduled to be expanded by a minimum of 250 tables per year. Tables can be used to produce nationally representative estimates of medical conditions, health status, use of medical care services, charges and payments, access to care, experience with care, health insurance coverage, income, employment and other important information. For the Insurance Component there are a total of 3,982 national level tables and 7,207 state and metro area tables. Additionally, there are 1,296 tables available for the MEPS Household Component. The total number of tables available to the user population is currently 12,485.

The MEPS Tables Compendia is a source of important data that is easily accessed by users. Expanding

the content and coverage of these tables furthers the utility of the data for conducting research and informing policy. Currently data are available in tabular format for the years 1996 – 2021. This represents over twenty years of data for both the Household and Insurance Components, enabling the user to follow trends on a variety of topics.

Number of patients served by health centers (Lead Agency - HRSA; Measure ID - 1010.01)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	25.7 million	26 million	27.2 million	28.6 million	29.8 million	29.8 million	30.4 million	33.5 million
Result	27.2 million	28.4 million	29.8 million	28.6 million	30.2 million	Aug 1, 2023	Aug 1, 2024	Aug 1, 2025
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Met	Target Exceeded	Pending	Pending	Pending

For more than 50 years, HRSA funded health centers have delivered affordable, accessible, quality, and cost-effective primary health care to patients regardless of their ability to pay. During that time, health centers have become an essential primary care provider for millions of people across the country. Health centers advance a model of coordinated, comprehensive, and patient-centered primary health care, integrating a wide range of medical, dental, behavioral health, and patient support/enabling services. Today, approximately 1,400 health centers operate nearly 15,000 service delivery sites that provide care in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin. Historically, success in increasing the number of patients served by health centers has been due in large part to the development of new health centers, new satellite sites, and expanded capacity at existing clinics. In 2021, health centers served 30.2 million patients, an increase of approximately 1.6 million patients from 2020, or 6 percent.

Percentage of health center patients who are at or below 200 percent of poverty (Lead Agency - HRSA; Measure ID - 1010.10)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	91%	91%	91%	91%	91%	91%	90%	91%
Result	91%	91%	91%	91%	90%	Aug 1, 2023	Aug 1, 2024	Aug 1, 2025
Status	Target Met	Target Met	Target Met	Target Met	Target Not Met	Pending	Pending	Pending

HRSA funded health centers deliver affordable, accessible, quality, and cost-effective primary health care to patients regardless of their ability to pay. Health centers emphasize coordinated primary and preventive services that promote reductions in health disparities for low-income individuals, racial and ethnic minorities, rural communities, and other underserved populations. In FY 2021, approximately 90 percent of health center patients were individuals or families living at or below 200 percent of the Federal Poverty Guidelines, as compared to approximately 27.5 percent of the U.S. population as a whole. HRSA set the FY 2024 target based on historical program trends of the composition of health center patients.

Objective 1.2: Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs

HHS supports strategies to reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs for everyone. HHS develops and implements payment models in partnership with healthcare providers and establishes other incentives to improve quality care while reducing healthcare spending. HHS implements and assesses approaches to improve healthcare quality, and address disparities in healthcare quality, treatment, and outcomes. The Department also improves patient safety, strengthens access to safe and effective medical products and devices, and expands approaches to safely exchange information among patients, providers, and payers.

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

Objective 1.2 Table of Related Performance Measures

Reduce 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 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	43%	37%	28%	25%	25%	25%	25%	25%
Result	42%	36.7%	27%	25%	Apr 30, 2023	Apr 30, 2024	Apr 30, 2025	Apr 30, 2025
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Met	Pending	Pending	Pending	Pending

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

While Medicare Part D offers substantial insurance coverage for prescription drugs, it does not offer complete coverage. Prior to 2010, a beneficiary was responsible for paying 100 percent of the prescription costs between the initial coverage limit and the out-of-pocket threshold (or catastrophic limit). Only once the beneficiary reached the catastrophic limit, did Medicare coverage recommence. This is known as the coverage gap (or "donut hole"). The Affordable Care Act began closing the coverage gap through a combination of manufacturer discounts and gradually increasing federal subsidies until it closed in 2020. For CY 2020 and beyond, this means that non-LIS beneficiaries who reach this phase of Medicare Part D coverage will pay no more than 25 percent of costs for all covered Part D drugs. For 2023, beneficiaries reach this phase when total drug costs amount to $4,660 and stay in this phase until they pay $7,400 in qualified out-of-pocket costs. CMS' tracking of this measure has shown that that in most years non-LIS out-of-pocket costs have decreased beyond the targets required by statute.

The statute which established the Coverage Gap Discount Program gave CMS the authority to authorize exceptions to the requirement that manufacturers have their applicable drugs be covered under a Coverage Gap Discount Program agreement (Section 1860D-43 (C)) in extenuating circumstances. However, CMS successfully encourages all manufacturers of applicable drug products to participate in the program, which results in the consistent application of discounts for all branded products. Furthermore, the infrastructure which has been put in place treats manufacturers fairly, which has resulted in manufacturers choosing to stay in the Part D program. Specifically, it: 1) allows public access to information about which manufacturers are participating in the program, and 2) offers an equitable process for manufacturers to dispute invoiced amounts. This has occurred without any meaningful decreases in manufacturer participation in the Part D market. As generic utilization in the Part D program has remained static, and very high (over 75 percent since 2012), 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 healthcare dollars tied to Alternate Payment Models (APMs) incorporating downside risk (Lead Agency - CMS; Measure ID - MCR36)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target			Set Baseline	30%	40%	40%	47 %	55 %
Result			20.21%	24.2%	24.8	Dec 15, 2023	Dec 15, 2024	Dec 15, 2025
Status			Baseline	Target Not Met but Improved	Target Not Met	Pending	Pending	Pending

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. The Medicare Shared Savings Program Accountable Care Organizations (ACOs) also play an integral role in moving Medicare toward value-based payment models and person-centered care, with over 11 million people with Medicare receiving care from a health care provider in a Shared Savings Program ACOs as of January 1, 2022. These innovative payment and service delivery models can reduce program expenditures for Medicare, Medicaid, and the Children's Health Insurance Program, while improving or preserving beneficiary health and quality of care.

To further accelerate movement away from paying for volume and towards paying for value and outcomes, CMS lauched a bold new strategy with the goal of achieving equitable outcomes through high quality, affordable, person-centered care. On October 20, 2021, CMS published a white paper detailing CMS's vision for the next 10 years (Innovation Strategy Refresh). In November 2022, CMS published a one-year update on progress made achieving this vision, including measures for success against key objectives (Person-Centered Innovation - An Update on the Implementation of the CMS Innovation Center's Strategy). As part of this strategic refresh, CMS set a new 10-year Medicare goal and target to have all beneficiaries in a care relationship with accountability for quality and total cost of care by 2030 (see newly developed measure CMMI6).

CMS did not meet its FY 2021 target because of the unprecedented impact of the COVID-19 pandemic, more limited opportunities for enrollment in new CMMI models, and a plateauing of participation in the Medicare Shared Savings Program.

Review and act on 90 percent of standard original Abbreviated New Drug Application (ANDA) submissions within 10 months of receipt. (Lead Agency - FDA; Measure ID - 223215)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	90%	90%	90%	90%	90%	90%	90%	90%
Result	96%	96%	97%	95%	96%	Feb 29, 2024	Feb 28, 2025	Feb 28, 2026
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

The goal of GDUFA III is to build on the successes GDUFA I and II, with a focus on maximizing the efficiency of and utility of each assessment cycle with the intent to reduce the number of assessment cycles for ANDAs and facilitate timely access to quality, affordable, safe, and effective generic medicines. Certain new enhancements in GDUFA III are specifically designed to foster the development, assessment and approval of ANDAs for complex generic products. GDUFA III also assures a sound financial foundation to support the vital activities of the Generic Drug Program. The value of this investment in the Generic Drug Review program is reflected by FDA's performance on its goals under GDUFA, including the review of standard submissions reflected in this performance measure, as well as FDA's commitment to meet shorter review goals (8 months) for priority submissions under GDUFA II and GDUFA III. Despite the unforeseen challenges due to the COVID-19 pandemic, including having to transition to a remote work environment with an increased workload due to the expedited development and review of generic drug submissions for products that could help address the public health emergency, FDA rose to the challenge and maintained its high level of performance in meeting GDUFA's goals and initiatives. HHS is confident that the new processes introduced through GDUFA III, and activities taken under FDA's Drug Competition Action Plan will continue to help reduce assessment cycles, improve approval times, and boost competition, helping to ensure that quality, affordable, safe and effective generic drug products are available to the American public.

Increase the cumulative number of evidence-based resources and tools available to improve the quality of healthcare and reduce the risk of patient harm. (Lead Agency - AHRQ; Measure ID - 1.3.41)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	177 tools	187 tools	200 tools	225 tools	250 tools	275 tools	300 tools	325 tools
Result	180 tools	191 tools	204 tools	225 tools	250 tools	275 tools	N/A	N/A
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Met	Target Met	Target Met	Not Collected	Not Collected

A major output of the Patient Safety Portfolio is the availability of evidence-based resources and tools that can be utilized by healthcare organizations to improve the care they deliver, and, specifically, patient safety. An expanding set of evidence-based tools is available as a result of ongoing investments to generate knowledge through research and synthesize and disseminate this new knowledge in the optimal format to facilitate its application.

The Agency continues provide many and a large variety of resources and tools to improve patient safety. Examples include:

- AHRQ Patient Safety Network (AHRQ PSNet) & Web M&M (Morbidity and Mortality Rounds);
- AHRQ Question Builder App;

- AHRQ's Safety Program for Nursing Homes: On-Time Pressure Ulcer Prevention;
- Common Formats (standardized specifications for reporting patient safety events);
- Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families;
- Healthcare Simulation Dictionary, Second Edition;
- Making Healthcare Safer III Report; Primary Care-Based Efforts To Reduce Potentially Preventable Readmissions;
- *Reducing Diagnostic Errors in Primary Care Pediatrics* (Project RedDE!);
- Re-Engineered Discharge (RED) Toolkit;
- Toolkit To Improve Antibiotic Use in Acute Care Hospitals;
- Understanding Omissions of Care in Nursing Homes.

The Patient Safety Portfolio is projecting that the number of evidence-based resources and tools will continue to increase with a projected cumulative number of 275 in FY 2022 and 300 in FY 2023, and 325 in FY 2024.

Percentage of health centers with at least one site recognized as a patient centered medical home (Lead Agency - HRSA; Measure ID - 1010.11)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	65%	65%	65%	70%	75%	75%	75%	76%
Result	67%	75%	76%	76%	77%	Aug 1, 2023	Dec 15, 2023	Dec 15, 2024
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

HRSA funded health centers improve health outcomes by emphasizing the care management of patients with multiple health care needs and the use of key quality improvement practices, including health information technology. HRSA's Health Center Program Patient Centered Medical Home (PCMH) Initiative supports health centers to achieve national PCMH recognition, an advanced model of primary care using a team-based approach to improve quality through coordination of care and patient engagement. Currently, 77 percent of health centers are recognized by national accrediting organizations as Patient Centered Medical Homes.

PCMH recognition assesses a health center's approach to patient-centered care and evaluates health centers against national standards for primary care that emphasize care coordination and on-going quality improvement. PCMH recognition also increases health outcomes, improves health equity, and lowers costs for patients and health centers, and has become a standard of care for HRSA funded health centers. HRSA set the FY 2024 target based on data trends.

Increase the number of communities that have access to tele-behavioral health services where access did not exist in the community prior to Telehealth Network Grant Program (TNGP) grant (Lead Agency - HRSA; Measure ID - 6070.01)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	--	--	N/A	N/A	N/A	N/A	N/A	40
Result	--	--	176[13]	74[14]	39	Dec 31, 2023	Dec 31, 2024	Dec 31, 2025
Status	--	--	Historical Actual	Historical Actual	Pending	Pending	Target Not In Place	Target not in place

HRSA's Office for the Advancement of Telehealth has several programs that allow grantees to focus entirely, or in part, on expanding access to telebehavioral services in rural and underserved communities. This measure reflects programs with different focus areas and cohorts. As such, measure results will vary from year-to-year due to expected turnover in grantee cohorts and focus areas, and targets will need to be evaluated on an ongoing basis. In addition, recent data represents results from FY 2021 and was collected between September 2021 through August 2022, aligning with the program period. The targets for FY 2024 have been established based on the current cohorts for TNGP—the Telehealth Network Grant program for emergency services and the Evidence-Based Telehealth Network program for Direct-to-Consumer services—for which tele-behavioral health is not the primary focus. Past Telehealth Network Grant programs such as the Evidence-based Tele-behavioral Health Network Program (FY 2018 – FY 2020) did allow for grantees to focus solely on telebehavioral health.

For the Title X program, # of unduplicated clients receiving high-quality services through the program. (Lead Agency – OASH; Measure ID – 8000.01)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	4,259,000	4,000,000	3,991,000	4,018,000	3,300,000	3,500,000	4,250,000	4,462,500
Result	4,004,246	3,939,749	3,095,666	1,536,743	1,662,466	Sep 30, 2023	Sep 30, 2024	Sep 30, 2025
Status	Not Met	Not Met	Not Met	Not Met	Not Met	Pending	Pending	Pending

The Title X Family Planning program is the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. Enacted in 1970 as part of the Public Health Service Act, the Title X program is designed to provide access to contraceptive services, supplies, and information to all who want and need them. By law, priority is given to persons from low-income families.

The program's performance measures focus on increasing access to high-quality care and serving individuals and families from underserved, vulnerable and low-income populations, gauging the extent to which Title X expands the availability of quality healthcare to the public. Performance measurement guides program strategies, establishes directions for technical assistance, and directs revisions to program

[13] Baseline data includes school-based TNGP and Substance Abuse Treatment (SAT) TNGP which were discontinued after FY 19. This data and out year data from the Emergency Department (ED) TNGP and Evidence-based (EB) Evidence-based Tele-behavioral Network Program (TNP) programs will be used to identify trending over a three-year period, as the measure is developmental. Once HRSA analyzes a trend, appropriate targets will be identified. HRSA expects that with turnover in cohorts and focus areas, the target will need to be evaluated on an ongoing basis.
[14] This data represents FY 20 reporting involving the ED TNGP and EB TNP programs which will be used to identify trending over a three-year period, as the measure is developmental. Once HRSA analyzes a trend, appropriate targets will be identified. HRSA expects that with turnover in cohorts and focus areas, the target will need to be evaluated on an ongoing basis.

policies. This enables Title X to better address program performance and facilitates methods to increase efficiency in the delivery of preventive healthcare services.

Of particular importance, Title X service grantees provide high-quality contraceptive counseling and care, recommended chlamydia screening, screening for undiagnosed cervical tissue abnormalities, preconception care and counseling, basic infertility services, pregnancy testing and counseling, adolescent services and related education and counseling. These services, along with community-based education and outreach, assist individuals and families with pregnancy leading to healthy birth outcomes and prevention of unintended pregnancy. The target and data collection efforts around unduplicated clients served through the Title X program helps track core performance aligned with Title X's mission.

The marked decrease in Title X performance between 2021 and 2019 is attributable to two main factors: the 2019 Final Rule and the COVID-19 pandemic. On March 3, 2019, HHS issued a Final Rule that revised Title X regulations governing several aspects of how Title X-funded projects deliver family planning care. The implementation of the 2019 Title X Final Rule led to 19 grantees (and their networks) immediately withdrawing from the program; 18 other grantees reported losses to their service networks. These departures significantly reduced the Title X service network. While supplemental awards were made to compensate for these departures; the program experienced a net decrease of more than 1,000 service sites. Additionally, the emergence of the novel coronavirus in 2020 created a public health emergency that affected all aspects of healthcare delivery, which varied in both scope and duration, severely disrupting Title X clinical operations.

In October 2021, the Department amended the Title X Family Planning regulations to restore access to equitable, affordable, client-centered, quality family planning services for more Americans. Aligned with the new program policies, performance targets have been established to restore the breadth of client access that is central to Title X's mission.

Objective 1.3: Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services, while addressing social determinants of health

HHS invests in strategies to expand equitable access to comprehensive, community-based, innovative, and culturally- and linguistically-appropriate healthcare services while addressing social determinants of health. HHS supports community-based healthcare services to meet the diverse healthcare needs of underserved populations while removing barriers to access to advance health equity and reduce disparities. The Department also works to understand how to best address social determinants of health in its programs.

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

Objective 1.3 Table of Related Performance Measures

Public Health Nursing (PHN): Total number of IHS public health activities captured by the PHN data system; emphasis on primary, secondary, and tertiary prevention activities to individuals, families, and community groups. (Lead Agency - IHS; Measure ID - 23)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	381,314	381,314	381,314	381,314	330,000	411,325	415,438	415,438
Result	362,358	329,980	324,391	391,738	428,476	385,356	Jan 31, 2024	Jan 31, 2025
Status	Target Not Met	Target Not Met	Target Not Met	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending

The Indian Health Service (IHS) Public Health Nursing (PHN) Program provides critical support for health care services in the tribal communities served. PHNs are licensed, professional nursing staff that support population-focused services to promote healthier communities through community based direct nursing services, community development, and health promotion and disease prevention activities. The PHN Program expands access to comprehensive, community-based, innovative, and culturally-competent healthcare services. One way the PHN Program measures this intervention is through monitoring the total number of individual public health encounters documented in the electronic health record and reported by the PHN data mart system with an emphasis on primary, secondary, and tertiary prevention activities to individuals, families, and community groups. The FY 2022 target for the PHN Program measure was 411,325 encounters. The final FY 2022 result of 385,356 patient encounters did not meet the target by 25,969 enounters, a 6 percent decrease. During the IHS COVID-19 pandemic response, PHNs reported critical patient encounters for communicable disease, surveillance, contact tracing, testing, patient monitoring, and vaccination activities. These efforts resulted in an overall increase in the number of PHN activities reported for community nursing services to address the COVID-19 crisis in FY 2020 and 2021. PHNs worked tirelessly with local community partners and public health officials in AI/AN communities to address the pandemic crisis, but in FY 2022 expanded their focus on the growing concern in the public health and health promotion arena which resulted from delays or avoidance of medical care because of COVID-19 including urgent, routine, and preventive health care services. To support prevention and control of comorbid conditions, PHNs joined agency activities such as the pediatric immunization improvement project, ongoing childhood obesity prevention and breastfeeding promotion, and sexual transmitted infection treatment and prevention. This shift in service away from hosting massive immunization, vaccination clinics and the overall pandemic activity resulted in a decrease in FY 2022 PHN patient encounters. As new COVID-19 variants emerged, triggering local outbreaks, and with unpredictable implications for prevention and treatment strategies, PHN staff shortages challenged efforts to administer vaccines, support case investigation, and monitor individuals for adverse events. Prior to FY 2020, the PHN program did not meet the established targets due to anticipated Tribal programs migrating away from reporting to the IHS Resource and Patient Management System. The PHN Program shares data, such as provider productivity and the number of health care delivery services provided, to inform I/T/U decision-making and promote data reporting. In 2022, the IHS enhanced the PHN data mart to include updated health promotion and disease prevention reports to support staff to access critical program performance data.

The PHN program uses key evidence-based strategies in delivering services. PHNs improve care transitions by providing patients with tools and support that promote self-management of their condition as they transition from the hospital/clinical setting to home. The PHN expertise in communicable disease assessment, outreach, investigation, and surveillance, aids in the management and prevention of the spread of communicable diseases. PHNs contribute to several primary prevention efforts such as

providing community immunization clinics, administering immunizations to homebound AI/AN individuals, and through public health education, encouraging AI/AN people to engage in healthy lifestyles and ultimately live longer lives. PHNs provide nurse home visiting services via referral for such activities as follows: maternal and pediatric populations, including childhood obesity prevention through breastfeeding promotion, screening for early identification of developmental problems, and parenting education; elder care services including safety assessment and health maintenance care; chronic disease care management; and communicable disease investigation and follow up. The PHN program works to improve the overall wellness of AI/AN people by using a variety of methods to educate the AI/AN population such as, individual and group patient education sessions, screening activities and referring high-risk patients, and immunizing individuals to prevent illnesses. PHNs provide valuable preventative health care service to the AI/AN population by promoting healthy lifestyles and providing early treatment for illnesses.

Percentage of underserved population accessing mental health and substance use services. (Lead Agency – SAMHSA; Measure ID –3.4.15)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	66%	54%	65%	64%	64%	64%	64%	64%
Result	55%	65%	64%	64%	44%	July 31, 2023	April 30, 2024	April 30, 2025
Status	Target Not Met	Target Exceeded	Target Not Met	Target Met	Target Not Met	Pending	Pending	Pending

The PATH program serves individuals with serious mental illness (SMI), or with SMI and a co-occurring substance use disorder, who are homeless or at risk of homelessness. The PATH program offers an array of essential services and supports, including community mental health services. A significant aspect of the PATH program that may not be supported by traditional mental health programs or funding is extensive outreach activity to build relationships with hard-to-reach homeless populations and link them to needed services. PATH providers ensure that the PATH-eligible clients receive treatment and recovery services either through the PATH program, Medicaid, or other funding sources. SAMHSA encourages PATH providers at the local level to work with HUD continuums of care to ensure PATH eligible clients will be prioritized for HUD housing vouchers. SAMHSA will encourage grantees (states) to provide supportive services for those who are at risk of housing instability. The combination of linkage to essential services, such as community mental health, and housing supportive services is important for the attainment and maintenance of housing stability for the people served by this program

Targets were set for FY 2023 based on the FY 2020 target. The number of people experiencing homelessness has remained steady over the years.

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

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	63.25 weighted average	63.25 weighted average	63.6 weighted average	64 weighted average	64.7 weighted average	64.3 weighted average	63.3 weighted average	64.9 weighted average
Result	63.7 weighted average	66.7 weighted average	66.89 weighted average	66.95 weighted average	61.4 weighted average	Dec 31, 2023	Dec 31, 2024	Dec 31, 2025
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending	Pending

The FY 2021 result for ACL Measure ID - 2.10 is calculated using data from the State Program Report and the 2021 National Survey of Older Americans Act Participants[15]. ACL collaborates with the Aging Network to target services to those at high risk of losing their independence. ACL has consistently strived to exceed this goal by ensuring the most vulnerable participants receive home- and community-based services and caregiver support by collaborating with the Aging Network, promoting community living, and providing person centered services. These successes reflect ACL's collaboration with the Aging Network and efforts to target services to those at high risk of losing their independence and thereby promote and enhance community living. Since FY 2012, ACL had been successful in exceeding this goal. Unfortunately, with annual rises in expenditures per unit of service, the target for Fiscal Year 2021 was not met. While many of our targets are being met or exceeded, ACL's most recent performance measure results are demonstrating that our current methodology does not have the ability to account for outlier years such as 2021 for measures that are sensitive to fluctuations in the per unit cost increase or decrease due to unforeseen events like the COVID-19 pandemic. Programs are finding new and innovative ways to demonstrate their adaptability, and ACL is monitoring these trends through performance, monitoring, and assessment to understand the impact of changing norms on our programs as well as how our performance measures stand up to severe outliers.

Percentage of pregnant health center patients beginning prenatal care in the first trimester (Lead Agency - HRSA; Measure ID - 1010.09)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	70%	70%	73%	73%	73%	73%	73%	74%
Result	74%	74%	74%	73%	74%	Aug 1, 2023	Aug 1, 2024	Aug 1, 2025
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Met	Target Exceeded	Pending	Pending	Pending

Timely entry into prenatal care is an indicator of both access to and quality of care. Identifying maternal disease and risks for complications of pregnancy or birth during the first trimester can also help improve birth outcomes. At HRSA funded health centers, results over the past few years demonstrate improved performance as the percentage of pregnant health center patients that began prenatal care in the first

[15] This is a composite measure that utilizes data from multiple sources. One source is the State Program Report. Another source is the National Survey. The State Program Report data is submitted annually by grantees (states and territories). The web-based submissions include multiple data checks for consistency. The National Survey draws a sample of Area Agencies on Aging to obtain a random sample of clients receiving selected Older Americans Act (OAA) services. Since the National Survey draws a sample of Area Agencies on Aging to obtain a random sample of clients it is not possible to measure the actual number of vulnerable people who continue to live in their homes after receiving these services.

trimester grew from 57.8 percent in 2011 to 74.0 percent in 2021, meeting the program target. HRSA set the FY 2024 target based on data trends.

In collaboration with FEMA and DHS, OCR (Agencies) will conduct compliance reviews of select state COVID-19 vaccine provider programs to determine whether their services are being provided free of discrimination on the basis of race or national origin (including limited English proficient (LEP) persons and communities). (Lead Agency - OCR; Measure ID - TBD)

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	N/A	N/A	N/A	Coordinate with the DHS Office for Civil Rights and Civil Liberties and FEMA's Office of Equal Rights to plan state LEP compliance reviews.	Meet quarterly with the DHS Office for Civil Rights and Civil Liberties and FEMA's Office of Equal Rights to review 19 states' responses and issue supplemental data requests or communications to obtain missing information.	Analyze information received from states regarding their efforts to provide meaningful access to LEP persons in responding to COVID-19. Identify themes for potential technical assistance.	
Result	Issued guidance: HHS OCR Guidance on Ensuring Language Access and Effective Communication During Response and Recovery - A Checklist for Emergency Responders; Collaborated to develop: HHS ASPR Blog - Four Ways to Enhance	Issued guidance and checklist: HHS OCR Ensuring Effective Emergency Preparedness, Response and Recovery for Individuals with Access and Functional Needs – A Checklist for Emergency Managers; Collaborated to develop: HHS ACL	Issued bulletins: HHS OCR Bulletin on Civil Rights Protections Prohibiting Race, Color and National Origin Discrimination During COVID-19, Application of Title VI of the Civil Rights Act of 1964; HHS OCR Bulletin on Civil Rights, HIPAA, and the	Completed. Initiated compliance reviews in 19 states in September 2021. Issued guidance: New Guidance to Boost Accessibility and Equity in COVID-19 Vaccine Programs Collaborated to develop: HHS CDC's Guidance	Completed. OCR, DHS, and FEMA dispatched data requests to the 19 states on September 29, 2021, and, based upon responses received, issued supplemental requests to particular states on May 24, 2022. As of December 1, 2022, all states had	OCR, DHS, and FEMA are developing a webinar based upon the responses from the 19 states that highlights best practices among the states and common areas for improvement. The webinar will initially be presented to the 19 states at issue, but will again be	

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
	Language Access during Disaster Response and Recovery	Webpage: Helping Community-Based Organizations Be Prepared for Emergencies; and HHS ACL Webpage - New Resource Available: Emergency Planning Toolkit for the Aging and Disability Networks	Coronavirus Disease (COVID-19); HHS OCR Bulletin on Ensuring the Rights of Persons with Limited English Proficiency in Health Care During COVID-19. Collaborated to develop: HHS SAMHSA Webpage - Disaster Preparedness, Response, and Recovery	Access and Functional Needs Toolkit for Integrating a Community Partner Network to Inform Risk Communication Strategies	provided responses to the initial or supplemental data requests and the agencies had completed their reviews and analyses of the responses Issued Guidance on Nondiscrimination in Telehealth: Federal Protctions to Ensur Accessibility to People with Disabilities and Limited English Proficiency.	provided to all 50 states and other interested stakeholder.	
Status	Historic Result	Historic Result	Historic Result	Historic Result	Complete	Pending	

In light of the disproportionate impact of COVID-19 on communities of color, OCR launched an initiative to partner with the Department of Homeland Security's Office of Civil Rights and Civil Liberties and FEMA to conduct compliance reviews to evaluate their compliance with Title VI of the Civil Rights Act of 1964, focusing on whether states' COVID-19 response efforts provide meaningful access to persons with limited English proficiency (LEP) to health care programs and services. The scope of states' COVID-19 related programs included in this initiative is testing, treatment, and vaccination. By conducting compliance reviews in a nationwide sample of states, OCR identifiedgaps in states' efforts and best practices. These observations informed discussions with HHS, DHS and FEMA on themes for possible technical assistance. Under Title VI of the Civil Rights Act of 1964 and the HHS implementing regulation, states receiving federal financial assistance were required to provide services free of discrimination on the basis of national origin, among other bases. Nondiscrimination on the basis of national origin includes the provision of language assistance services to LEP persons. These compliance reviews created baseline results to be used in strengthening this measure going forward to provide guidance to providers about non-discriminatory practices and information to consumers about their rights. These compliance reviews and the guidance stemming from them will build upon HHS efforts to expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services, while addressing social determinants of health, and will supplement non-discrimination guidance documents that OCR has issued since the beginning of the COVID-19 pandemic.

Objective 1.4: Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families

HHS supports strategies to drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families across all settings. HHS is enhancing the ability to serve those in need of behavioral health services by exchanging data, information, and resources while expanding evidence-based integrated systems of behavioral and physical healthcare to improve equitable access to quality care. HHS is also engaging and educating healthcare providers, healthcare professionals, paraprofessionals, other health workforce professionals, and students in these professions to build their practice competence and capacity to address the behavioral and physical health needs of individuals, families, caregivers, and communities.

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

Objective 1.4 Table of Related Performance Measures

Number of people trained for the support of the recovery community organizations and peer support networks (Lead Agency – SAMHSA; Measure ID – 1.1.0)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	N/A	N/A	N/A	Set Baseline	875	5,000	2,100	2,500
Result	N/A	N/A	N/A	Dec 31, 2021	4,766	1,925	Dec 31, 2023	Dec 31, 2024
Status	Not Collected	Not Collected	Not Collected	Not Collected	Target Exceeded	Target Not Met	Pending	Pending

The number of people trained for the support of the recovery community organizations and peer support networks was above the initial target for this program. Because of the COVID-19 pandemic the Peer Recovery Center of Excellence adjusted their activities to mainly virtual training and technical assistance which provided the environment for many additional participants to attend their trainings and activities. Over 4,700 participants attended events during this period however only 541 responded to the post event data collection form. This program was funded on August 2020 and the training and events center around focus areas: Clinical Integration of Peers into Non-Traditional Settings, Recovery Community Organization Capacity Building, Peer Workforce Development, and Evidence-Based Practice and Practice-Based Evidence Dissemination. Early 2021 this program started accepting Technical Assistance (TA) requests from anyone in need of support related to substance use disorder peer support services. As the pandemic emergency continues, the majority or training and technical assistance will be delivered virtually. The Peer Recovery Center of Excellence target for FY 2022 increased slightly to account for supplemental funds that were awarded to provide technical assistance to support infrastructure development, training, and other supports to SAMHSA's Minority AIDS Initiative grantees, including the Prevention Navigators, and other grantees and recipients who are interested in integrating peer recovery strategies into their prevention approaches.

Increase the cumulative amount of publicly available data on 1) Opioid-Related Hospital Use, 2) Neonatal Abstinence Syndrome (NAS), and 3) outpatient use of opioids. (Lead Agency – AHRQ; Measure ID – 2.3.9)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target						Opioid Related Hospital Use - create interactive map with 2018 data	Opioid-Related Hospital Use - update interactive maps using 2019 data	Opioid-Related Hospital Use - update interactive maps using 2020 data
Result						Created an Opioid Related Hospital Use interactive map with 2018 data	N/A	N/A
Status						Target Met	Pending	
Target						NAS - create interactive maps using 2019 data	NAS - update interactive maps using 2019 data	
Result						NAS– updated interactive maps using 2018 data	N/A	
Status						Target Met	Pending	
Target								
Result						Opioid-Related Hospital Use updated interactive maps using 2018 data	N/A	
Status						Target Met	Pending	

This measure supports AHRQ's ongoing work to create accurate data for monitoring and responding to the opioid crisis. AHRQ maintains two large databases capable of monitoring data relevant to the opioid overdose epidemic – the Healthcare Cost and Utilization Project (HCUP) and the Medical Expenditure Panel Survey-Household Component (MEPS-HC).

HCUP includes the largest collection of longitudinal hospital care data in the United States and HCUP Fast Stats displays that information in an interactive format that provides easy access to the latest HCUP-based statistics for healthcare information topics. More information on HCUP can be found on the HCUP

website at https://hcup-us.ahrq.gov/. HCUP is able to produce national estimates on Opioid-Related Hospital Use based on data from the HCUP National Inpatient Sample (NIS) and the HCUP Nationwide Emergency Department Sample (NEDS). HCUP is able to produce State-level estimates on Opioid-Related Hospital Use based on data from the HCUP State Inpatient Databases (SID) and HCUP State Emergency Department Databases (SEDD). HCUP is also able to produce data on the rate of births diagnosed with NAS (newborns exhibiting withdrawal symptoms due to prenatal exposure to opioids) by State. State-level statistics on newborn NAS hospitalizations are from the HCUP State Inpatient Databases (SID). National statistics on newborn hospitalizations are from the HCUP National (Nationwide) Inpatient Sample (NIS).

The MEPS-HC collects nationally representative data on health care use, expenditures, sources of payment, and insurance coverage for the U.S. civilian noninstitutionalized population. The MEPS-HC is cosponsored by the Agency for Healthcare Research and Quality (AHRQ) and the National Center for Health Statistics (NCHS). More information about the MEPS-HC can be found on the MEPS Web site at http://www.meps.ahrq.gov/. MEPS-HC data can be used to produce Statistical Briefs that examine a wide range of measures of opioid use and expenditures including the percentages of adults with any use and frequent use of outpatient opioids during the year.

For the outpatient use of opioid measure, in FY 2022 MEPS has produced two Briefs on outpatient opioid use, one for non-elderly and one for elderly adults overall, looking at socioeconomic characteristics including sex, race-ethnicity, income, insurance status, perceived health status, Census region and Metropolitan Statistical Area (MSA) status. In FY 2023, that Brief will be updated and, if relevant, new analyses of trends or using additional data sources may be added.

AHRQ updated the website interactive maps that provide trends in opioid-related inpatient stays and emergency department visits at the national and State levels and a Neonatal Abstinence Syndrome (NAS) Among Newborn Hospitalizations interactive heat map that visualizes the rate of births diagnosed with NAS by State with 2018 data.

Number of providers who have provided Medication-Assisted Treatment (Lead Agency - HRSA; Measure ID - 6090.03)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	--	--	--	N/A	2,750	2,000	2,100	2,150
Result	--	--	--	2,676	2,872	Nov 30, 2023	Nov 30, 2024	Nov 30, 2025
Status	--	--	--	Historical Actual	Target Exceeded	Pending	Pending	Pending

The Rural Communities Opioid Response Program (RCORP) is a multi-year initiative administered by HRSA that funds community-based grants and technical assistance to reduce the morbidity and mortality of substance use disorder (SUD), including opioid use disorder (OUD), in rural communities. Since its inception in FY 2018, RCORP has served over 1,800 counties in 47 states and two territories. Given the initiative's initial focus on OUD, and the limited availability of DATA 2000-waivered providers in rural communities, increasing the number of providers willing and able to provide Medication-Assisted Treatment (MAT) was a key focus area and objective of RCORP's inaugural grant awards. In FY 2021, 2,872 providers provided MAT in areas served by RCORP grant recipients, an increase of nearly 200 providers over the previous year. HRSA has expanded the scope of the RCORP initiative to include other substances of concern (e.g., methamphetamine) as well as broader behavioral health challenges in rural

communities. Consequently, HRSA expects that the number of RCORP grant recipients focused solely on MAT provision will decrease and has set targets that reflect that change.

Number of outreach events to provide training and technical assistance to healthcare providers, healthcare professionals, and paraprofessionals on providing healthcare services free of disability discrimination against persons receiving medication assisted treatment (MAT) for substance abuse disorder and on protecting the confidentiality and care coordination of behavioral health through HIPAA. (Lead Agency - OCR; Measure ID - TBD)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	No Target	N/A	N/A	N/A	N/A	1	1	1
Result	N/A	1	4	1+	3 Launch of OCR new video series on federal disability rights protections that apply to some individuals in recovery from an Opioid Use Disorder on 4/19/21. This video series is reaching thousands of personnel in the child welfare system and Opioid Treatment Providers. This video series lives on Opioids.gov, OCR's child welfare page, SAMHSA's YouTube page, and the National Center for Substance Abuse and Child Welfare website and has had over 31,000 views.	1 – Presentation at New Mexico Children's Law Institute on 1-13-22; Attendees: 50 social service providers, attorneys, and judges 2 – Presentation at SAMHSA Virtual Tribal Consultation of Substance Use Disorder Patient Records on 3-10-22; Attendees: 100 representatives from advocacy organizations 3 – Presentation at American Bar Association Parent Representation Conference on 4-7-22; Attendees: 60+ attorneys, social workers, judges, advocates (Recorded for future viewing) 4 – Presentation at Indiana Public Defender Conference on 8-12-22; Attendees: 55 attorneys. 5-Presentation at the National Association of Counsel for Children Conference on 8-22-22; Attendees: 100	TBD	

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
						attorneys, judges and social workers 6 – American Association of Health and Human Services Attorneys Conference on 10-11-22; Attendees: 50 attorneys 7 – American Association for the Treatment of Opioid Dependence Conference on 11-3-22; Attendees: 65 opioid treatment providers 8 – Presentation to Disability Rights Pennsylvania on 10-27-2021; Attendeesare part of a national network of disability rights non-profit organizations that protect and advocate for the rights of children and adults with disabilities to live free from abuse, neglect and discrimination. 9– Presentation to Disability Rights Maryland on 11-9-21; National network of disability rights non-profit organizations that protect and advocate for the rights of children and adults with disabilities to live free from abuse, neglect and discrimination. 10 – Presentation to Center for Disabilities Studies		

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
						at the Univ. of Delaware on 11-8-2021; facilitated a lunchtime learning series to the disability community. The University intended to videorecord the presentation and put it on YouTube.		
Status	Not Collected	Historic Result	Historic Result	Historic Result	Historic Result	Target Exceeded	Pending	

Outreach events are an effective way to proactively address civil rights and HIPAA compliance in provider communities. As part of HHS efforts to integrate behavioral health into the health care system, OCR is training and providing technical assistance to health care providers, health care professionals, and paraprofessionals to increase awareness of civil rights protections for individuals in recovery from substance use disorder, including individuals receiving medications for Opioid Use Disorders. The outreach events also provide technical assistance and training on protecting the confidentiality and care coordination of behavioral health through HIPAA. Information provided during these events will help to eliminate discriminatory barriers and expand access to mental health and substance use disorder treatment and recovery services for individuals and families. OCR is exceeding its target goals and providing outreach to hundreds of health care providers and attorneys across the country, along with child welfare system personnel who are trained through a video series.

Objective 1.5: Bolster the health workforce to ensure delivery of quality services and care

HHS supports strategies to bolster the health workforce to ensure delivery of quality services and care. HHS is committed to facilitating coordinated efforts to address long-standing barriers to strengthening the health workforce. HHS efforts focus on developing professional development opportunities to learn and use new skills to improve the delivery of quality services and care. HHS is also strengthening the integration of culturally- and linguistically-appropriate and effective care into the services delivered by the health workforce.

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

Objective 1.5 Table of Related Performance Measures

Percentage of clinical training sites that provide interprofessional training to individuals enrolled in a primary care training program. (Lead Agency – HRSA; Measure ID – 2000.04)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	19%	24%	45%	50%	50%	55%	65%	68%
Result	59%	64%	71%	74%[16]	77%[17]	Dec 31, 2023	Dec 31, 2024	Dec 31, 2025
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

HRSA's health professions programs strengthen the health workforce by developing, expanding, and enhancing training for health care professionals, particularly primary care providers, through grants awarded to health professions schools and training programs. These programs prepare trainees to deliver quality, team-based patient care by offering interprofessional training experiences at clinical sites across the U.S. This measure calculates the percent of active clinical training sites at which individuals from more than one profession or discipline train together.

According to annual grantee performance report data, the percentage of sites providing interprofessional training experiences has increased by 18 percentage points from FY 2017 to FY 2021. The rapid increase in this outcome is primarily due to HRSA's efforts to increase interprofessional training across more than 40 health professions training programs. HRSA increased the FY 2024 target to 68 percent to reflect this upward trend.

In 2021, HRSA implemented a new grantee scorecard, and in 2022, HRSA reached grantees from nearly all grant programs with a demonstration of the scorecard's use. The scorecard allows program staff and grantees to determine whether individual grant programs and awardees are meeting the interprofessional training target. Increasing staff and grantee access to the results of this measure is one strategy HRSA developed to ensure it can continue to meet its targets.

Percentage of individuals supported by the Bureau of Health Workforce who completed a primary care training program and are currently employed in underserved areas (Lead Agency - HRSA; Measure ID - 2000.03)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	40%	40%	40%	40%	40%	40%	40%	40%
Result	43%	47%	43%	40%[18]	40%[19]	Dec 31, 2023	Dec 31, 2024	Dec 31, 2025
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Met	Target Met	Pending	Pending	Pending

[16] Most recent results are for Academic Year 2020-2021 (FY2022) and for clinical training sites funded in FY 2020.

[17] Most recent results are for Academic Year 2021-2022 and for sites funded in FY 2021.

[18] Service location data are collected on students who have been out of the HRSA program for one year. The results are from programs that have the ability to produce clinicians with one-year post program graduation. Most recent results are for Academic Year 2020-2021 (funded in FY 2020) based on graduates from Academic Year 2019-2020).

[19] Service location data are collected on students who have been out of the HRSA program for one year. The results are from programs that have the ability to produce clinicians with one-year post program graduation. Most recent results are for Academic Year 2021-2022 (funded in FY 2021) based on graduates from Academic Year 2020-2021 (funded in FY 2020).

HRSA's health professions programs strengthen the health workforce by developing, expanding, and enhancing training for health care professionals, particularly primary care providers, through grants awarded to health professions schools and training programs. These programs improve access to health care in our Nation's communities by training individuals who go on to work in medically underserved areas after completing their HRSA primary care training program. This measure indicates the percent of individuals who report being employed in an underserved area one-year after they complete a HRSA Bureau of Health Workforce training program. According to annual grantee performance reports, the number of individuals who completed a HRSA primary care training program and then found employment in medically underserved areas has remained relatively stable from FY 2017 to FY 2021, fluctuating by zero to four percentage points each year. Given the lack of a clear trend and the potential impact of COVID-19 on program completers' employment decisions, HRSA is maintaining the FY 2023 target for FY 2024.

In 2021, HRSA implemented a new grantee scorecard that allows program staff and grantees to identify individual grant programs or awardees that may have best practices to share or may need additional assistance to increase program completers' employment in medically underserved areas. In 2022, HRSA reached grantees from nearly all grant programs with a demonstration of the scorecard's use. Increasing staff and grantee access to the results of this measure is one strategy HRSA developed to ensure it can continue to meet its targets.

Percent growth of USPHS Ready Reserve Officers Year-over-Year (or total officers). (Lead Agency – OASH; Measure ID –6.1.8

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	N/A	N/A	N/A	N/A	200	200	200	400
Result	N/A	N/A	N/A	N/A	15	66[20]	N/A	N/A
Status	Not Collected	Not Collected	Not Collected	Not Collected	Target Not Met	Target Not Met but Improved	Not Collected	Not Collected

On March 27, 2020, the President signed H.R. 748, the Coronavirus Aid, Relief, and Economic Security (CARES) Act into law. This historic legislation provided the necessary legislative changes to reinstate/implement the Ready Reserve Corps as well provided the initial funding to build the infrastructure for the program and begin the recruitment and training of the initial cohort.

All USPHS Ready Reserve officers are part-time officers; paid when on Active Duty (such as training or deployment). Reservists are required to train (drill') for a minimum of 2 weekends/month (on average) and 14 days/year for annual training. Reservists are called to active duty for deployment or for training. Based on critical specialized skill sets, reservists can also be placed on Active Duty (temporary/part-time) to support personnel shortages in HHS/or non-HHS agencies (e.g. the Indian Health Service or other hard to fill positions). The Ready Reserve ensures the USPHS has trained, ready and equipped surge capacity to respond to any public health emergency. Recruitment is focused for high-demand, already-trained clinical professionals. When not activated, Reservists work in their respective civilian jobs in their communities.

Commissioned Corp Headquarters' s (CCHQ) Division of Commissioned Corps Services and Ready Reserve Affairs are leading the development and implementation of a comprehensive recruitment strategy and accompanying operations plan to reach the recruitment goals for the Ready Reserve Program. The

[20]ARP Funded

framework for this new strategy consists of three key areas of focus: Communication and Stakeholder Engagement, CCHQ Infrastructure, and Performance Management. Each focus area contains a series of activities with high impact on the overall strategy as well as a detailed plan of operation. In addition, the strategy includes a performance management plan that consists of important milestones, key performance indicators, and a risk management plan.

As a new program, upon release of the CARES Act money in July of 2020, many policies and infrastructure related needs had to be created. While some efforts for this are ongoing, HHS is pleased that OASH has been able to complete many of these endeavors which have provided the structural foundation that has allowed HHS to onboard a quickly growing number of Ready Reserve Officers. However, in FY 2021, a discrepancy did exist between targets and results. As described above, the infrastructural needs of a new program limited the agency's ability to onboard officers to meet initial target goals. HHS looks forward to meeting the FY 2023 target with the new strategy described above.

Strategic Goal 2: Safeguard and Improve National and Global Health Conditions and Outcomes

HHS is dedicated to safeguarding and improving health conditions and health outcomes for everyone. The Department improves capabilities to predict, prevent, prepare for, respond to, and recover from disasters, public health and medical emergencies, and threats, domestically and abroad. The Department protects individuals, families, and communities from infectious disease and prevent non-communicable disease through the development and equitable delivery of effective, innovative, readily available, treatments, therapeutics, medical devices, and vaccines. HHS enhances the promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death. The Department also mitigates the impacts of environmental factors, including climate change, on health outcomes.

Objective 2.1: Improve capabilities to predict, prevent, prepare for, respond to, and recover from disasters, public health and medical emergencies, and threats across the nation and globe

HHS invests in strategies to predict, prevent, prepare for, respond to, and recover from emergencies, disasters, and threats. HHS leverages opportunities to improve collaboration and coordination, to build capacity and foster readiness for effective emergency and disaster response. HHS advances comprehensive planning for mitigation and response. HHS also applies knowledge gained from the effective and efficient use and application of technology, data, and research to improve preparedness and health and human services outcomes during emergencies and disasters.

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

Objective 2.1 Table of Related Performance Measures

Increase the number of new licensed medical countermeasures across BARDA programs (Lead Agency - ASPR; Measure ID - 2.4.13a)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	3 medical counter-measures	3 medical counter-measures	3 medical counter-measures	3 medical counter-measures	3 medical counter-measures	3 medical counter-measures	3 medical counter-measures	4 medical counter-measures
Result	5 medical counter-measures	9 medical counter-measures	7 medical counter-measures	3 medical counter-measures	6 medical counter-measures	3 medical counter-measures	Dec 31, 2023	Dec 31, 2024
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Met	Target Exceeded	Target Met	Pending	Pending

ASPR leads the nation's medical and public health preparedness for, response to, and recovery from disasters and public health emergencies. ASPR constantly scans the horizon to prepare for whatever emergency may come next, whether natural or manmade. Within ASPR, the Biomedical Advanced Research and Development Authority (BARDA) is the premier advanced research and development office within the United States Government. BARDA invests in the innovation, advanced research and development, FDA approval, acquisition, and manufacturing of medical countermeasures (MCMs) – including the vaccines, drugs, therapeutics, diagnostic tools needed to combat health security threats. The data inform the public about BARDA's capacity to provide an integrated, systematic approach to developing MCMs for public health medical emergencies such as chemical, biological, radiological, and nuclear (CBRN) accidents, incidents and attacks, pandemic influenza, and emerging infectious diseases. The targets for this measure were met or exceeded each year. The data sources are stable with no gaps or delays in reporting. The data reported reflect ASPR's efforts to prepare for, response to, and recover from disasters and public health emergencies. Together with industry partners, BARDA's support spans early development into advanced development and FDA approval. As of February 2023, BARDA-supported products have achieved 69 FDA approvals, licensures, or clearances. ASPR also oversees the procurement of MCMs for storage in the Strategic National Stockpile to ensure their availability during a public health emergency.

Number of cumulative Field Epidemiology Training Program (FETP) - Frontline graduates (Lead Agency - CDC; Measure ID - 10.F.1c)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	N/A	N/A	11,015	12,315	12,435	12,555	15,974	16,786
Result	8,021	10,906	12,197	12,534	13,537	Jun 30, 2023	Jun 30, 2024	June 30, 2025
Status	Historical Actual	Historical Actual	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

International Field Epidemiology Training Programs (FETP) are recognized worldwide[21] as an effective means to strengthen countries' capacity in surveillance, epidemiology, and outbreak response. These graduates strengthen public health capacity so individual countries are able to transition from U.S.-led global health investments to more long-term host country ownership. Frontline is a three-month program that aims to increase the number of capable public health workers in a community setting. This program is part of three tiers in the FETP program which all help countries meet International Health Regulation guidelines. In FY 2021, there were 13,537 Frontline program graduates, an increase over FY 2020 and exceeding the FY 2021 target. By tracking the number of people who graduate from FETP – including the Frontline program every year, CDC can better gauge its impact on developing other countries' abilities to prevent, detect, and respond to disease outbreaks.

By 2026, establish a formalized funding pathway for the development, validation, and regulatory review of diagnostic technologies to enhance surveillance and pandemic preparedness. (Lead Agency – NIH; Measure ID – SRO-5.19)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target						Receive FDA authorization for marketability for three home, point-of-care, or lab-based diagnostics.	Receive FDA authorization or approvals for two home, point-of-care, or lab-based diagnostics, at least one of which addresses accessibility needs of people with disabilities.	Receive FDA authorization or approval (including updated authorization or approval) for at least two home, point-of-care, or lab-based diagnostics, at least one of which is fully accessible to people with disabilities.
Result						NIH supported the	Dec. 2023	Dec. 2024

[21] Traicoff D et al. 2015. Strong and flexible: Developing a three-tiered curriculum for the Regional Central America Field Epidemiology Training Program. Pedagogy in Health Promotion 1(2): 74–82. http://php.sagepub.com/content/1/2/74.full.pdf+html.

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
						development of technologies that led to two at-home COVID-19 tests, five point-of-care COVID-19 tests, and two lab-based COVID-19 tests. All nine tests received an FDA emergency use authorization for marketability.		
Status						Target Exceeded	Pending	Pending

NIH is aiming to accelerate the innovation of new technologies using a design, build, test, and deploy approach to improve future pandemic preparedness and surveillance. In response to the COVID-19 pandemic, NIH launched the Rapid Acceleration of Diagnostics (RADx®) initiative to speed up innovation in the development and deployment of COVID-19 testing approaches and strategies. To inform approaches and specific capabilities needed for infectious disease surveillance and preparedness, NIH continues to build on the research funding mechanisms used and the lessons learned through RADx®.

In FY 2022, NIH. supported the development of technologies that led to two at-home COVID-19 tests, five point-of-care COVID-19 tests, and two lab-based COVID-19 tests. All nine tests received an FDA emergency use authorization for marketability. In one representative example, developers created an at-home test that uses a nasal swab to collect viral particles and a lateral flow assay to test for the presence of a COVID-19 protein. This simple test, which uses lateral flow technologies similar to those found in at-home pregnancy tests, delivers results in 15 minutes. In another example, developers created a high-throughput, point-of-care test that detects the genetic material found in SARS-CoV-2, the virus that causes COVID-19. This type of test is beneficial for large-scale testing in settings like nursing homes or schools and is capable of providing results in 15 minutes. In a final example, developers created a high-throughput, lab-based test that also detects the genetic material found in SARS-CoV-2. This test is intended for use by qualified laboratory personnel, especially in small hospitals and laboratories. It has a simpler workflow and can deliver results much faster than conventional lab-based tests. This type of test can expand the testing capacity of commercial laboratories.

In FY 2023, NIH aims to receive FDA authorization or approvals for two home, point-of-care, or lab-based diagnostics, at least one of which addresses accessibility needs of people with disabilities. In FY 2024, NIH aims to receive FDA authorization or approval (including updated authorization or approval)

for at least two home, point-of-care, or lab-based diagnostics, at least one of which is fully accessible to people with disabilities.

By 2026, advance the preclinical or clinical development of 10 antivirals for current or future infectious disease threats. (Lead Agency – NIH; Measure ID – SRO-5.20)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target						Advance preclinical or clinical development of one antiviral therapeutic	Advance preclinical or clinical development of two antiviral therapeutics	Advance preclinical or clinical development of 2 antiviral therapeutics
Result						NIH-funded researchers advanced the preclinical development of multiple antiviral therapeutic candidates.	Dec. 2023	Dec. 2024
Status						Target Exceeded	Pending	Pending

The development of antiviral drugs to combat harmful viruses can take 10-15 years. When SARS-CoV-2, the coronavirus that causes COVID-19, first emerged, there were no approved treatments or vaccines for treating any coronavirus infection. However, NIH was able to build on existing research on other coronaviruses that had caused earlier outbreaks or pandemics and actively contribute to the Federal response to COVID-19. To prepare for future threats posed by known and unknown viruses, NIH is taking a proactive approach by drawing on existing research and investing in antiviral drug discovery and development. The goal is to generate a pool of new antiviral drugs and increase the availability of antiviral drug candidates that might be used to address future outbreaks or pandemics. In FY 2022, NIH-funded efforts advanced the preclinical development of multiple antiviral therapeutic candidates. For example, two separate groups of researchers used lab-based screening tools to identify ways to inhibit the growth of SARS-CoV-2 in host cells. Other researchers determined that flavanols, a type of flavonoids – natural substances found in fruits, nuts, vegetables, seeds and spices that have been shown to have antiviral effects – more effectively inhibited SARS-CoV-2 than other types of flavonoids that were previously tested. In addition, another group of researchers created the Small Molecule Antiviral Compound Collection (https://smacc.mml.unc.edu), a public database with curated scientific data to support scientists working on the development of antiviral drugs targeting a broad range of viruses. . In FY 2023 and FY 2024, NIH aims to advance the preclinical or clinical development of two antiviral therapeutics each year.

Objective 2.2: Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices, and vaccines

HHS is working on strategies to protect the public from known and emerging infectious diseases and prevent non-communicable diseases, including cardiovascular diseases, cancer, diabetes, and other chronic conditions. HHS advances the development and delivery of safe and effective, and innovative diagnostics, treatments, therapeutics, medical devices, and vaccines. HHS invests in innovative technology and development to ensure the supply and availability of diagnostics, treatments, therapeutics, medical devices, and vaccines while leveraging resources and collaborations to support and apply research, evaluation, and data insights about non-communicable and infectious disease.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: AHRQ, ASPR, CDC, CMS, FDA, HRSA, IHS, NIH, OASH, and OGA. In consultation with OMB, HHS has determined that performance toward this objective has made noteworthy progress. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 2.2 Table of Related Performance Measures

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

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	59%	62%	66%	70%	70%	70%	70%	70%
Result	38%	45%	48%	50%	49%	Sep 30, 2023	Sep 30, 2024	Sep 30, 2025
Status	Target Not Met	Target Not Met but Improved	Target Not Met but Improved	Target Not Met but Improved	Target Not Met	Pending	Pending	Pending

In the United States, on average 5 to 20 percent of the population contracts the flu, more than 200,000 people are hospitalized from seasonal flu-related complications, and approximately 36,000 people die from seasonal flu-related causes. It is important that everyone over 6 months old receives an annual flu shot. This measure reflects the universal influenza vaccination recommendation and aligns with the Advisory Committee on Immunization Practices' updated recommendation (as of 2010) for the seasonal influenza vaccine. Seasonal influenza vaccination rates for adults aged 18 and older increased slightly over the past few years from 45 percent in FY 2018 to 49 percent in FY 2021, with FY 2021 vaccination rates seeing little change from FY 2020 . Targets for this measure have remained level for several years as CDC works to achieve the current level of seasonal flu vaccination. Interpretation of these results should take into account limitations of the survey, which include reliance on self-reporting of vaccination status and a decrease in response rates.

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

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

- Increasing patient and provider education to improve demand and implement system changes in practitioner office settings to reduce missed opportunities for vaccinations.
- Funding state and local health departments to implement the Standards for Adult Immunization Practice in large health care systems, community health centers, pharmacies, and other settings.
- Partnering with professional organizations (e.g., F1.3 American Pharmacists Association, American College of Physicians, American Academy of Family Physicians, American College of Obstetricians and Gynecologists) and other organizations (e.g., National Association of Chain Drug Stores, National Association of Community Health Centers, American Immunization Registry Association) to develop and implement strategies to improve adult immunization at provider, practice, and systems levels.
- Enhancing evidence-based communication campaigns to increase public awareness about adult vaccines and recommendations. CDC routinely conducts literature reviews and surveys of the general public and healthcare providers to provide a deeper understanding of the target audiences for development of adult immunization communication messages and campaigns.
- Partnering with the National Adult and Influenza Immunization Summit, a national coalition of partners and stakeholders represented by clinicians, public health, industry, government, and other entities with the common goal to promote immunization for adults.
- Expanding the reach of vaccination programs including new venues such as pharmacies and other retail clinics. CDC has existing partnerships to implement adult immunization practice standards, HPV vaccination, and pandemic vaccine program planning efforts to expand access to pandemic vaccine. As of 2016-2017 influenza season, nearly one in four adults who got an influenza vaccine were vaccinated in a pharmacy or retail setting.
- Designing and funding investigations into the factors associated with disparities in adult vaccination among racial and ethnic minority populations and projects designed to expand the evidence base for interventions to increase vaccination among adults with chronic medical conditions and underserved populations.
- Collaborating with numerous existing and new partners to expand flu vaccine coverage, with specific efforts to address racial and ethnic disparities for the 2021-2022 influenza season. For example, CDC is working with the National Association for Community Health Centers to implement evidence-based strategies to increase adult vaccination coverage among underserved priority populations. CDC has developed a large portfolio of new partnerships to promote COVID-19 and flu vaccination in high-risk populations, including communities of color, those living in rural settings, adults with chronic medical conditions (cardiovascular, diabetes, chronic lung conditions, etc.) and those in congregate settings (i.e., long-term care facilities, homeless shelters, and prisons).

Percentage of Ryan White HIV/AIDS Program clients who are virally suppressed. (Lead Agency – HRSA; Measure ID –4000.03)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	N/A	83%	83%	83%	83%	83%	84%	85%
Result	86%	87%	88%	89.4%	89.7%	Dec 1, 2024	Dec 31, 2024	Dec 31, 2025
Status	Target Not In Place	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

Continue advanced research and development initiatives for more effective influenza vaccines manufactured using modern, flexible, agile technologies, and the development of influenza therapeutics for use in outpatient and hospital settings, including pediatric patients (Lead Agency - ASPR; Measure ID - 2.4.15b)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	Set Baseline	2 programs	2 programs	2 programs	2 programs	2 programs	3 programs	3 programs
Result	2 programs	7 programs	6 programs	2 programs	2 programs	2 programs	Dec 31, 2023	Dec 31, 2024
Status	Baseline	Target Exceeded	Target Exceeded	Target Met	Target Met	Target Met	Pending	Pending

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

Influenza vaccination rates among adult American Indian and Alaska Native patients 18 years and older (Lead Agency - IHS; Measure ID - 68)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target		18.8 %	18.8 %	25.4 %	24.4 %	28 %	19.7 %	19.7 %
Result		23.3 %	23.6 %	24.3 %	18.1 %	20.0%	Jan 31, 2024	Jan 31, 2025
Status		Target Exceeded	Target Exceeded	Target Not Met but Improved	Target Not Met	Target Not Met	Pending	Pending

Influenza is a serious disease that causes significant morbidity and mortality, especially in the AI/AN population. Influenza and resulting sequelae such as pneumonia are among the top 10 leading causes of death for AI/ANs, and influenza-related mortality is significantly higher among AI/AN populations compared with non-Hispanic Whites. Influenza vaccination remains the best strategy for reducing influenza-related illness. The IHS offers influenza vaccinations to eligible AI/ANs to support public health strategies for preventing influenza illnesses while also reducing influenza-related hospitalizations and deaths.

Monitoring influenza vaccination uptake is critical to ensure that the AI/AN population is sufficiently protected from primary influenza infections as well as severe health outcomes such as pneumonia and influenza-related death. The influenza vaccination rate measures the proportion of individuals receiving seasonal influenza vaccine among AI/AN adult patients.

Beginning in FY 2018, the IHS transitioned measure reporting from the Clinical Reporting System to the Integrated Data Collection System Data Mart and measure targets, including the influenza vaccination rate, were reset. The IHS FY targets are set based on prior year performance and projected funding. From FY 2018 through FY 2020, the IHS seasonal influenza vaccination rate for AI/AN adults 18 years of age and older improved. During FY 2021, the influenza vaccination rate was 18.1% and increased to 20.0% in FY 2022. These results did not meet the established FY targets. IHS results are likely impacted by changes in healthcare-seeking behavior related to the COVID-19 pandemic and compounded by diversion of resources to stand up the COVID-19 immunization efforts. Additionally, the IHS results are impacted by reliance on patients' self-report of vaccinations completed outside IHS, tribal, or urban Indian health care facilities, which may result in incomplete capture of true vaccination status among patients.

IHS reviews evidence-based recommendations to inform strategies to increase influenza vaccination coverage among AI/AN populations. Each fiscal year the Influenza Vaccination Action Plan is updated with current recommendations and issued as the framework to increase vaccination coverage across the health care system. The IHS continues to apply evidence-based approaches, including co-administration of COVID-19 and influenza vaccines and combining with other targeted vaccination efforts to maximize opportunities for influenza vaccination. The IHS regularly incorporates strategies that improve influenza vaccination rates, such as use of standing orders that promote vaccine administration, proper documentation of vaccines given to aid tracking, and automated point-of-care reminders generated through electronic health record alerts to prompt vaccination when a patient is due. In May 2021 the IHS implemented a pediatric immunization improvement initiative called “Safeguard our Future: Protect Tomorrow, Vaccinate Today”. This quality improvement project targeting changes in immunization workflow resulted in improved and sustained pediatric vaccination coverage rates. Additionally, in November 2022, the IHS initiated a call to action to increase vaccine coverage and protection against vaccine-preventable illness through a vaccine strategy called E3. The E3 approach focuses on offering

Every patient, Every recommended vaccine, at Every encounter. The IHS has also implemented data-driven interventions targeted to specific, highly susceptible patient populations to improve their specific influenza vaccination rates and related health outcomes.

Objective 2.3: Enhance promotion of healthy behaviors to reduce occurrence of and disparities in preventable injury, illness, and death

HHS supports strategies to promote healthy behaviors to reduce the occurrence of and disparities in preventable injury, illness, and death. The Department develops, communicates, and disseminates information to improve health literacy about the benefits of healthy behaviors. HHS leverages resources, partnerships, and collaborations to support healthy behaviors that improve health conditions and reduce disparities in health outcomes. HHS also advances and applies research and data insights to inform evidence-based prevention, intervention, and policy approaches to address disparities in preventable injury, illness, and death.

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

Objective 2.3 Table of Related Performance Measures

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

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024[22]
Target	1,128	967	903	838	817	755	693	631
Result	1,114	1,061	1,004	1,004	967	Jul 31, 2023	Jul 31, 2024	July 31, 2025
Status	Target Exceeded	Target Not Met but Improved	Target Not Met but Improved	Target Not Met	Target Not Met but Improved	Pending	Pending	Pending

Although cigarette smoking remains the leading cause of preventable disease and death in the United States, the tobacco[23] product use landscape continues to diversify to include multiple combustible tobacco products, including cigars, cigarillos and little cigars, pipe tobacco, roll-your-own tobacco, and hookah. Per capita combustible tobacco product consumption decreased from 1,004 cigarette equivalents in FY 2020 to 967 cigarette equivalents in FY 2021. CDC will continue to work to decrease combustible tobacco consumption in the U.S.

CDC recommendations to help reduce tobacco consumption include: raising the price of tobacco products, providing access to cessation services, protecting everyone's right to breathe clean air, and

[22] This measure uses the CDC's National Center for Health Statistics (NCHS)-provided trend setting tool for the Healthy People 2030 targets. It uses a linear trend to calculate at least 5 options. Specifically, ordinary least-squares was fit. The targets were selected from Option 3, there is a 50% chance that the target value will meet or exceed. 2018 was selected as the baseline year since that is the year with the most recent data available.

[23] References to tobacco refer to commercial tobacco and not the sacred and traditional use of tobacco by some American Indian communities.

mass-reach media campaigns warning about the dangers of tobacco use. CDC strategies to promote these interventions include providing funding to 50 states, Washington, DC, 8 U.S territories and 12 tribal organizations for comprehensive tobacco control efforts through the National Tobacco Control Program, and supporting grantees to implement Best Practices for Comprehensive Tobacco Control Programs. CDC also funds the Tips From Former Smokers Campaign,® a national campaign profiling real people who live with serious health effects due to smoking and secondhand smoke exposure.

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

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	73.5 %	73.8 %	N/A: Biannual data	N/A	N/A: Biannual data	74.7 %	N/A: Biannual data	75.5%
Result	74.1 %	74.6 %	N/A: Biannual data	73.9 %	N/A: Biannual data	Dec 31, 2023	N/A: Biannual data	Dec 31, 2025
Status	Target Exceeded	Target Exceeded	N/A: Biannual data	Baseline	N/A: Biannual data	Pending	N/A: Biannual data	Pending

The proportion of adults who engage in leisure-time physical activity increased from 63.8% in FY 2008 to 74.6% in FY 2018. After FY 2018, the National Health Interview Survey (NHIS) changed the survey question and methodology used for the measure's data. As a result, new data cannot be compared to previous results, and a new baseline of 73.9% was established in FY 2020. CDC's Active People, Healthy Nation^{SM} is a national initiative to help 27 million Americans become more physically active by 2027. CDC used percent improvement target setting methodology to set a goal of a 0.4% increase per year for the proportion of adults (age 18 and older) that engage in leisure-time physical activity. This translates to a 0.8% increase every two years and is consistent with administration of the NHIS, the survey used to collect this data, which is administered every two years instead of annually.

CDC funds states, communities, and organizations with national reach to design communities that are safe and easy for people of all ages and abilities to be physically active. In addition, CDC trains states and communities to implement strategies to improve the walkability of communities. For example, the CDC funded Walkability Action Institute has trained teams in 79 jurisdictions in 32 states and two territories. As a result, the jurisdictions cumulatively achieved over 850 outcomes related to improving walkability with a focus on community and transportation design for over 41 million people. CDC will continue to promote the critical need for safe and easy places for physical activity to take place and help implement high impact strategies for walking and walkable communities like Complete Streets and Safe Routes to Schools. As of April 2022, over 1,670 Complete Streets policies, including those adopted by 35 state governments plus the Commonwealth of Puerto Rico, and Washington D.C., have been reported to the National Complete Streets Coalition.

Percentage of adult health center patients with diagnosed hypertension whose blood pressure is under adequate control (less than 140/90) (Lead Agency - HRSA; Measure ID - 1010.07)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	63%	63%	63%	63%	63%	63%	61%	62%
Result	63%	63%	65%	58%	60%	Aug 1, 2023	Aug 1, 2024	Aug 1, 2025
Status	Target Met	Target Met	Target Exceeded	Target Not Met	Target Not Met But Improved	Pending	Pending	Pending

Percentage of adult health center patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9 percent) (Lead Agency - HRSA; Measure ID - 1010.08)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	69%	69%	69%	67%	67%	67%	67%	68%
Result	67%	67%	68%	64%	68%	Aug 1, 2023	Aug 1, 2024	Aug 1, 2025
Status	Target Not Met	Target Not Met	Target Not Met but Improved	Target Not Met	Target Exceeded	Pending	Pending	Pending

Health centers continue to be a critical element of the health system, largely because they can provide an accessible and dependable source of high quality, affordable, and cost-effective primary health care services in underserved communities. In particular, health centers emphasize coordinated primary and preventive services that promote reductions in health disparities for low-income individuals, racial and ethnic minorities, rural communities, and other underserved populations. Health centers emphasize coordinated and comprehensive care, the ability to manage patients with multiple health care needs, and the use of key quality improvement practices. Health center patients, including low-income individuals, racial/ethnic minority groups, and persons who are uninsured, are more likely to suffer from chronic diseases such as hypertension and diabetes. Clinical evidence indicates that access to appropriate care can improve the health status of patients with chronic diseases and thus reduce or eliminate health disparities.

HRSA set the FY 2024 targets based on historical data trends. Recovery efforts from COVID-19, including significant use of telemedicine, are expected to bring measure performance back to previous levels.

Objective 2.4: Mitigate the impacts of environmental factors, including climate change, on health outcomes

HHS invests in strategies to mitigate the impacts of environmental factors, including climate change, on health outcomes. HHS detects, investigates, forecasts, monitors, responds to, prevents, and aids in recovery from environmental and hazardous public health threats and their health effects. HHS promotes cross-disciplinary and multi-stakeholder coordination to improve the outcomes of climate change and environmental exposures on workers, communities, and domestic and international systems. Additionally, HHS expands awareness and increases knowledge of environmental hazards and actions that individuals and communities can take to reduce negative health outcomes.

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

Objective 2.4 Table of Related Performance Measures

Number of public health actions undertaken (using Environmental Health Tracking data) that prevent or control potential adverse health effects from environmental exposures (Lead Agency - CDC; Measure ID - 6.C)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	21	21	40	40	45	45	60	60
Result	57	97	87	66	80	45	Oct 31, 2023	Oct 31, 2024
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Met	Pending	Pending

The Environmental and Health Outcome Tracking Network covers over 185 million people, which made up about 57% of the population in the U.S. in 2021. The Tracking Network serves as a source of information on environmental hazards and exposures, population data, and health outcomes. CDC exceeded expectations for the number of data-driven actions to improve public health using the Tracking Network which is in keeping with previous years. CDC is refining how public health actions are captured and anticipates that the total number of actions may be reduced or remain flat. Performance for this measure is dependent on Environmental Health Tracking recipients reporting on the actions they undertake which may vary from year to year. FY 2024 targets remain level with FY 2023 but are increased slightly over previous year targets as a result. From FY 2005 to FY 2022, state and local public health officials have used the Tracking Network to implement over 850 data-driven public health actions to save lives and prevent adverse health effects that are due to environmental exposures.

For example, in 2022 45 public health actions were reported, with COVID, heat stress illness, environmental justice, radon, and lead poisoning as the most common environmental health topics addressed. Policies included developing county Strategic Plan for Equity and Social Justice based on Tracking's Environmental Health disparities map, and a clean air standard to reduce vehicle emissions and expand the market for electric vehicles. Programs or interventions described by Tracking recipients included developing a map used by the state's Oil and Gas Health Information and Response Program to identify new sites for collecting air quality measurements, identifying counties at high-risk of childhood lead poisoning and testing their drinking water, and providing guidelines and recommendations for establishing cooling centers in at-risk communities. The Tracking Network also serves as a source of information for health professionals, elected officials, researchers, parents, and the public on environmental hazards and exposures, population data, and health outcomes.

Increase training and resources to address the access and functional needs of electricity and healthcare service-dependent at-risk individuals who live independently and are impacted by incidents, emergencies, and disasters (Lead Agency - ASPR; Measure ID - 1.3)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target			Set Baseline	81,720 trained	88,826 trained	110,322 trained	102,150 trained	102,150 trained
Result			71,061 trained	234,802 trained	130,610 trained	152,461	Dec 31, 2023	Dec 31, 2024
Status			Baseline	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

ASPR's mission is to lead the country through public health emergencies. ASPR measure 1.3 is part of ASPR's National Disaster Medical System (NDMS) support of nationwide communities. When disaster strikes, NDMS is important because States, Localities, Territories, and Tribes (SLTT) may have medical infrastructure that becomes overwhelmed and requires assistance with their critical services. At that point, they can request NDMS help for their communities as they respond and recover. NDMS capabilities and tools deliver essential medical and emergency management services and subject matter expertise when requested by an SLTT agency. As a tool within NDMS, the HHS emPOWER Program's federal health data are used to advance SLTT and community partner capabilities to anticipate and plan for healthcare system surge, including pre-emptively taking action to protect health and save the lives of at-risk populations that may be rapidly and adversely impacted during an emergency or disaster. The HHS emPOWER Program is a mission-critical partnership between ASPR and the Centers for Medicare and Medicaid Services (CMS) that provides public health agencies and their partners with Medicare datasets, mapping, rest service and artificial intelligence tools, training, informational resources, technical assistance and best practices to protect the health of 4.3 million at-risk individuals who live independently in the community and rely on life-maintaining electricity-dependent equipment (including ventilators) and or essential healthcare services (such as dialysis and oxygen tank services). These tools and technical assistance have advanced preparedness and community mitigation activities nationwide and have directed informed and supported over 250 local to national emergencies and disasters. Baseline data was collected in 2019 and the target exceeded in 2020 and 2021. The nationwide use of emPOWER data represents the rapid scientific advancement of data-driven mitigation strategies that help during a broad array of disasters, including the Covid-19 pandemic and events associated with climate change.

By FY 2026, OCR will conduct a Title VI Environmental Justice/Public Health compliance review and undertake any needed steps for resolution. (Lead Agency - OCR; Measure ID - TBD)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	N/A	N/A	N/A	N/A	N/A	Conduct Title VI/Section 504 compliance review through on-site inspections, interviews, and data analysis.	Coordinate comprehensive public health response by HHS partners, including CDC and HRSA. Provide technical assistance to the covered entity based on analysis of collected data to establish safe and effective sewage management and nondiscriminatory policies and practices.	Additional environmental justice compliance reviews are under consideration for FY 2024.
Result	N/A	N/A	N/A	N/A	Background investigation completed; joint meetings held with other partner federal agencies, including USDA, DOJ, and Office of Climate Change and Health	Onsite investigation completed in April of 2022; approximately 50 witness interviews conducted, data request letters submitted and responses received.	Interim Voluntary Resolution Agreement (VRA) drafted formalizing public health response, federal coordination efforts, and changes to policies and procedures. The interim	Pending

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
					Equity; follow-up interviews conducted with Complainants; compliance review opened September 2021.		CRA is currently being negotiated with the Alabama Department of Public Health (ADPH).	
Status	Not Collected	Not Collected	Not Collected	Not Collected	Baseline	Completed	Pending	

This initiative supports the HHS objective of mitigating the impacts of environmental factors on health outcomes by addressing the health impact of environmental hazards, such as inadequate sanitation systems, that result from discriminatory practices. As part of this initiative, OCR is conducting an environmental justice/public health compliance review under Title VI of the Civil Rights Act and Section 1557 of the Affordable Care Act. Through on-site investigation, interviews, and document reviews, OCR will identify corrective actions, if needed, and provide technical assistance to ensure that federally assisted health programs and activities are accessible to underserved racial and ethnic minority communities. OCR will coordinate with HHS partner agencies to develop and implement a comprehensive public health response to improve community health outcomes and partner with other federal agencies involved in environmental justice. This compliance review will provide baseline results to use in strengthening this measure going forward.

Strategic Goal 3: Strengthen Social Well-being, Equity, and Economic Resilience

HHS works to strengthen the economic and social well-being of Americans across their lifespan. HHS provides effective and innovative pathways leading to equitable economic success for all individuals and families. The Department strengthens early childhood development and expands opportunities to help children and youth thrive equitably within their families and communities. HHS expands access to high-quality services and resources for older adults and people with disabilities, and their caregivers to support increased independence and quality of life. HHS also increases safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have experienced trauma or violence.

Objective 3.1: Provide effective and innovative pathways leading to equitable economic success for all individuals and families

HHS invests in strategies to provide effective and innovative pathways that lead to equitable economic success for all individuals and families. HHS facilitates system enhancements and partnerships across the federal government to coordinate resources and technical assistance to individuals and families hoping to achieve and sustain economic independence.

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

Objective 3.1 Table of Related Performance Measures

Reduce energy burden among the most energy burdened households (Lead Agency - ACF; Measure ID - 1D (new))

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	N/A	N/A	N/A	90	86	86	Prior Result +0[24]	Prior Result +0[25]
Result	83[26]	87	90	86	86	Nov 30, 2023	Nov 30, 2024	Nov 30, 2025
Status	Historical Actual	Historical Actual	Historical Actual	Target Not Met	Target Met	Pending	Pending	Pending

By design, LIHEAP targets energy assistance to low-income households with the highest energy needs. It does so as part of Congress' statutory mandate, as expressed in 42 U.S.C. 8624(b)(5). ACF measures the extent to which LIHEAP meets this mandate through targeting indices, which show the extent to which the program reaches selected households over others, specifically households with (a) elderly members, (b) young children, and (c) high energy burdens. ACF also measures the extent to which LIHEAP reduces energy-burdens among high-energy burden households. A household's energy burden is the household's energy costs as a share of its income. Reducing a household's energy burden prevents the household from suffering adverse outcomes—including hypothermia, heat stroke, etc.—due to extreme indoor temperatures. It also prevents the household from forgoing essential items; like food, medication, etc.; in order to pay for energy. The index score that measures the targeting of energy burden reduction shows the extent to which high energy burden recipients receive more benefits than other recipients. ACF computes this score by dividing the percent reduction, attributable to LIHEAP, in the median individual energy burden for *high energy burden recipients* by the equivalent type of reduction for *all recipients* and multiplying the result by 100.

The Benefit Targeting Index (measure 1C) score for FY 2021 based on all states with usable data was 111, indicating that LIHEAP provided 11 percent higher benefits to those households with the highest energy burden compared to average recipient households. The Burden Reduction Targeting Index (measure 1D) score for FY 2021 based on all states with usable data was 86, indicating that LIHEAP paid about 14 percent less of the energy bill for households with the highest energy burden compared to average recipient households. Under funding provided by the Consolidated Appropriations Act of 2012, which increased training and technical assistance funds to $3 million, ACF has invested in increased grantee training and technical assistance to improve performance management and monitoring activities by states. In FY 2022, Congress appropriated $4.6 million for the same purposes. The President's FY 2023 Budget proposed to increase this amount to $20.5 million to substantially enhance our efforts around administrative support, training and technical assistance, equity, and environmental justice. ACF plans to continue its support for the LIHEAP Performance Management Workgroup (PMIWG), which is comprised of selected state directors; make each year's Report to Congress available for publication,

[24]The FY 2023 target is to maintain the previous actual result.
[25]The FY 2024 target is to maintain the previous actual result.
[26]The preliminary result for FY 2017 is based on result for 46 states that submitted usable data.

continue to make LIHEAP household and performance management preliminary data available for public consumption through the LIHEAP Performance Management website; and develop evidence-based more precise training and technical assistance tools to support LIHEAP grantees. In FY 2022, LIHEAP formed an Application Streamline and Electronic Verification Workgroup with a selected number of state directors to create technical assistance tools that will improve customer experience and verify data through third party systems. This workgroup will continue in FY 2023. In fiscal year 2022, LIHEAP made several online dashboards publicly available on topics such as extreme heat and disaster management, as well as published quarterly LIHEAP reports, which included assisted households, performance management, use of LIHEAP funds, and implementation and support data. Additional tools will include grant recipient performance management profiles, a completely redesigned energy-assistance locator www.energyhelp.us website, and several program-specific fact sheets.

Increase the percent of cash assistance terminations due to earned income from employment for those clients receiving cash assistance at employment entry. (outcome) (Lead Agency - ACF; Measure ID - 15A)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	54.5%	55%	55.5%	56%	56.5%	56.75%	56.75%	56.75%
Result	56.2%	50.99%	43.47%	42.45%	40.58%	Dec 1, 2023	Dec 1, 2024	Dec 1, 2025
Status	Target Exceeded	Target Not Met	Target Not Met	Target Not Met	Target Not Met	Pending	Pending	Pending

The Transitional and Medical Services (TAMS) program provides refugees and other eligible populations with time-limited assistance to purchase food and clothing, pay rent, use public transportation, and secure medical care. Additionally, this program provides a path to economic self-sufficiency by supplying resources for employment training and placement, case management services, and English language training in order to facilitate economic self-sufficiency and effective resettlement as quickly as possible. A cash assistance termination is defined as the closing of a cash assistance case due to earned income in an amount that is predicted to exceed the state's payment standard for the case based on family size, rendering the case ineligible for cash assistance. The FY 2021 actual result of 40.58 percent was below the target of 56.50 percent by 15.92 percent. Many refugees are placed into full-time jobs with reduced work hours, thus not always producing termination. A few large programs had lower termination rates which negatively affected national termination rate. COVID 19 also contributed to delays in employments and extended benefits period due to COVID 19 eligibility extensions. ACF plans to continue to work with states to increase the ratio of full-time job placements and to increase terminations to 56.75 percent in FY 2024.

Increase the percentage of refugees who are self-sufficient (not dependent on any cash assistance) within the first eight months (240 days) of the service period.[27] (Lead Agency - ACF; Measure ID - 16C)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	85.24%	84.84%	82.88%	81.76%	76.05%	78.58%	76.76%	Prior Result +1%
Result	84%	82.06%	80.95%	75.3%	77.8%	76.0%	Nov 30, 2023	Nov 30, 2024
Status	Target Not Met	Target Not Met	Target Not Met	Target Not Met	Target Exceeded	Target Not Met	Pending	Pending

The Matching Grant program is an alternative to traditional cash assistance that provides participants with services such as case management, job development, job placement and placement follow-up, and interim housing and cash assistance through grants awarded to participating national refugee resettlement agencies. These agencies provide a match (in cash and/or in-kind services) of one dollar for every two dollars of federal contribution to client direct assistance funding. The purpose of the program is to help participants become self-sufficient within 240 days from the date of eligibility for the program. This is a shift from the previous client support period of 180 days, which was implemented starting in FY 2022. The extension of the client service period will enable grant recipients to further emphasize basic integration services such as English language acquisition and to provide more equitable employment services. The actual result for the refugee self-sufficiency rate in FY 2022 indicates that 76 percent of program participants were self-sufficient at the end of the 240-day program service period, falling just short of the FY 2022 target of 78.58 percent. This result also remains below the pre-pandemic level of performance in FY 2019. ORR expects positive growth to continue in FY 2024 as grant recipients continue to refine their pandemic era methodologies and the U.S. economy recovers.

Increase the percentage of IV-D (child support) cases having support orders. (outcome) (Lead Agency - ACF; Measure ID - 20B)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	85%	86%	87%	88%	90%	90%	90%	90%
Result	87%	88%	88%	87%	88%	Nov 30, 2023	Nov 30, 2024	Nov 30, 2025
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met	Target Not Met, but Improved	Pending	Pending	Pending

The Social Services Amendments of 1975 (P.L. 93-647) established the federal child support enforcement program as part of Part D of title IV of the Social Security Act. Child support is one of the most significant financial resources available to children living apart from a parent. Child support receipt promotes family self-sufficiency, child well-being, and health from birth through adulthood, thereby reducing costs in other government programs. The annual performance measure regarding child support orders compares the number of IV-D child support cases with support orders established (which are required to collect child support) with the total number of IV-D cases. Despite the ongoing impact of the COVID-19 pandemic on program operations, states continue to show strong performance with respect to this measure as the total number of cases with an order established was 11.1 million in FY 2021. The

[27] The language of this performance measure has been updated as a result of the change to client service period from 180 to 240 days total.

percent of cases with support orders was 88 percent, which is slightly below the target of 90 percent for FY 2021. The target for FY 2024 will remain at 90 percent.

Increase the median state share of federal TANF and state maintenance-of-effort (MOE) funds used for work, education, and training activities. (Lead Agency - ACF; Measure ID - 22F)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	N/A	6.6 %	7.8 %	7.4 %	6.8 %	Prior Result +0.1PP	Prior Result +0.1PP	Prior Result +0.1PP
Result	6.5 %	7.7 %	7.3 %	6.7 %	7.4%	Oct 30, 2023	Oct 30, 2024	Oct 30, 2025
Status	Historical Actual	Target Exceeded	Target Not Met	Target Not Met	Target Exceeded	Pending	Pending	Pending

The Temporary Assistance for Needy Families (TANF) program provides state flexibility in operating programs designed to help low-income families achieve independence and economic self-sufficiency. The performance measures for the TANF program assess the extent to which TANF work-eligible individuals and families transition from cash assistance to employment. Full success requires not only that recipients get jobs, but also that they stay in employment and increase their earnings in order to reduce dependency and enable families to support themselves. The state spending requirement of matching funds for the federal TANF payment is referred to as "maintenance-of-effort" or MOE. This performance measure reports on the median state share of federal TANF and state MOE funds used for work, education, and training activities. The most recent actual result increased from 6.7 percent in FY 2020 to 7.4 percent in FY 2021, exceeding the target of 6.8 percent. Through intentional technical assistance, ACF encourages states to invest more resources towards engaging TANF work-eligible individuals in work and work preparation activities so that families with barriers to employment can reach the ultimate outcome of a stable, unsubsidized job.

Objective 3.2: Strengthen early childhood development and expand opportunities to help children and youth thrive equitably within their families and communities

HHS invests in strategies to strengthen early childhood development opportunities to help children and youth thrive equitably within their families and communities. HHS fosters the physical, emotional, intellectual, language, and behavioral development of children and youth while supporting their families and caregivers. HHS implements interventions and multidisciplinary programs to enhance and support early childhood development and learning. HHS also focuses its efforts to improve early childhood development programs, systems, and linkages through the application of data, evidence, and lessons learned.

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

Objective 3.2 Table of Related Performance Measures

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

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	24 %	15 %	17 %	15 %	16 %	16 %	Prior Result -1PP	Prior Result -1PP
Result	16 %	18 %	16 %	17 %	N/A[28]	N/A	Jan 31, 2024	Jan 31, 2025
Status	Target Exceeded	Target Not Met	Target Exceeded	Target Not Met	N/A	N/A	Pending	Pending

ACF strives to increase the percentage of Head Start children in high quality classrooms. Progress is measured by reducing the proportion of Head Start grant recipients 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. ACF began data collection using random samples for the CLASS: Pre-K in the first quarter of FY 2012. ACF assesses each Head Start grantee using the CLASS instrument during onsite monitoring reviews. This performance measure was developed to track the proportion of grant recipients receiving a score in the low range on the basis of the CLASS with the goal of decreasing that proportion over time.

Data from the FY 2014 CLASS reviews indicated that 23 percent of grant recipients are in the low range on any domain, exceeding the revised target. The most recent data from the FY 2020 CLASS reviews indicate that 17 percent of grant recipients scored in the low range, not meeting the target of 15 percent. The target set for FY 2021 is 16 percent, a one percent improvement from the FY 2020 result. However, there are no results for this performance measure in FY 2021 and FY 2022 since CLASS reviews were not conducted due to the COVID-19 pandemic. The targets for FY 2023 and 2024 are also set to a one percentage decrease from the prior year result. In response to data from CLASS reviews, ACF is providing more intentional targeted assistance to those grant recipients that score in the low range on CLASS. ACF is flagging grant recipients that score in the low range, conducting more analysis on the specific dimensions within the Instructional Support domain that are particularly challenging for those grant recipients, and working more directly with those grant recipients on strategies for improvement.

Increase the percentage of Head Start preschool teachers with an AA, BA, or Advanced degree in early childhood education or a related field. (Lead Agency - ACF; Measure ID - 3C)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	100%	100%	100%	N/A	100%	100%	100%	100%
Result	95.6%	94.9%	94.8%	N/A[29]	94.8%	94%	Jan 31, 2024	Jan 31, 2025
Status	Target Not Met	Target Not Met	Target Not Met	Pending	Target Not Met	Target Not Met	Pending	Pending

[28]Due to health concerns with the COVID-19 pandemic, the FY 2021 and FY 2022 CLASS® reviews were not conducted.
[29]Due to health concerns during the COVID-19 pandemic, there are no results to report for this performance measure in FY 2020.

Head Start grant recipients are required to develop plans to improve the qualifications of staff. Head Start has shown a steady increase in the number of Head Start teachers with an Associate Degree (AA), Bachelor's Degree (BA), or advanced degrees in early childhood education. The Head Start reauthorization requires that all Head Start preschool center-based teachers have at least an AA degree or higher with evidence of the relevance of their degree and experience for early childhood education by October 1, 2011, thus the goal for each fiscal year through 2023 is to reach 100 percent. The most recent FY 2022 data indicates that 94 percent of Head Start teachers had an AA degree or higher, slightly missing the target, but remaining stable compared to the FY 2019 and FY 2021 actual resultx. Of the 38,692 Head Start preschool teachers in FY 2022, 34,506 had an AA degree or higher. Of these degreed teachers, 8,775 have an AA degree, 21,190 have a BA degree, and 4,541 have an advanced degree. Not included in these numbers are 1,181 teachers with a Child Development Associate (CDA) or state credential and 946 teachers who do not have a degree or CDA. About 22 percent of teachers without a BA or advanced degree are enrolled in a BA degree. ACF continues to provide training and technical assistance funds directly to grant recipients to increase the qualifications of teachers.

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 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	90 %	90 %	90 %	90 %	91 %	91 %	91 %	91 %
Result	90.7 %	90 %	90 %	92 %	91.5%	Mar 31, 2023	Mar 31, 2024	Mar 31, 2025
Status	Target Exceeded	Target Met	Target Met	Target Exceeded	Target Exceeded	Pending	Pending	Pending

This annual performance measure pertains to safe and appropriate exit rates for youth from the Transitional Living Program (TLP). The TLP program provides shelter and services to meet the needs of homeless youth to promote long-term economic independence in order to ensure the well-being of the youth. All youth between the ages of 18 and 21 are eligible for up to 18 months of TLP services. This performance measure captures the percentage of TLP youth who are discharged from the program into an immediate living situation that is both safe and appropriate. This goal is achieved through the promotion and support of innovative strategies that help grantees to: 1) encourage youth to complete the program and achieve their developmental goals instead of leaving the program prior to completion; 2) stay connected with youth as they transition out of program residencies and provide preventive, follow-up, and aftercare services; 3) track exiting youth more closely; 4) report accurate data and maintain updated youth records to reduce the number of youth whose exit situations are unknown; and 5) analyze data to discover patterns of participation and opportunities for improved services. During FY 2021, the program exceeded the 91 percent target for this measure by attaining a 91.5 percent safe and appropriate exit rate. Because safe and stable housing is one of the core outcome areas, ACF proposes to maintain the target of 91 percent for FY 2024. ACF will continue to work to ensure appropriate service delivery and technical assistance systems are in place to support continued high performance on this performance measure.

Number of 0-8-year-old children screened for mental health or related interventions (Lead Agency - SAMHSA; Measure ID - 2.4.00)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	44,775	18,554	18,554	11,497	8,700	8,500	22,000	29,000
Result	18,554	27,922	12,390	8,788	8,573	25,427	Dec 31, 2024	N/A
Status	Target Not Met	Target Exceeded	Target Not Met	Target Not Met	Target Not Met	Target Exceeded	Pending	Not Collected

Established in 2008, Project LAUNCH is a national grant program that seeks to promote the wellness of young children from birth to eight years of age by addressing the physical, social, emotional, cognitive, and behavioral aspects of their development. In 2018, SAMHSA funded a cohort of 14 Indigenous LAUNCH grants. This cohort includes sites of varying population size and capacity in Indian Country, two large Alaskan Native Organizations, and the Virgin Islands. A required activity for Project LAUNCH is to conduct screening and assessment to ensure the early identification of behavioral and developmental concerns using validated screening instruments; to include screening for other behavioral health issues, such as perinatal/maternal depression and substance misuse among parents (including opioid use), as appropriate. Each Project LAUNCH local pilot community implements a set of "5 Core Strategies" that bring evidence-based mental health practices and expertise into the natural settings of early childhood. Grantees identify the evidence-based practices to implement for their population of focus.

The grantee reviews data on the number of children screened from previous years. For the following year, the grantee establishes a target of numbers of children that will be screened during each project year. The COVID-19 pandemic influenced the LAUNCH grantees' ability to reach and engage participants in the program. This impacted the grantee's ability to meet their expected targets in 2020.

Number of participants served by the State/Jurisdiction Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. (Lead Agency - HRSA; Measure ID - 3110.08)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	N/A	N/A	N/A	N/A	N/A	N/A	164,470	188,067
Result	156,297[30,31]	150,291	154,496	140,606[32]	140,674[33]	137,802[34]	Available January 2024	Available January 2025
Status	N/A	N/A	N/A	N/A	N/A	Pending	Pending	Pending

[30] Reflects changes HRSA made to reporting definitions beginning in FY 2017 clarifying that only participants whose services were directly supported with federal funds should be included in MIECHV reports.
[31] Does not include data from Puerto Rico and the U.S. Virgin Islands due to reporting delays caused by Hurricanes Maria and Irma.
[32] FY 2020 results were impacted by funding reductions due to sequestration, the impacts of COVID-19 on enrollment and service delivery, and a reporting error in one state.
[33] FY 2021 results were impacted by funding reductions due to sequestration and the impacts of COVID-19 on enrollment and service delivery.
[34] FY 2022 results were impacted by funding reductions due to sequestration, the impacts of COVID-19 on enrollment and service delivery, and significant issues with workforce recruitment and retention across the early childhood care and education field.

Number of participants served by the Tribal Maternal, Infant, and Early Childhood Home Visiting Program. (Lead Agency - HRSA; Measure ID - 3110.09)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	N/A	N/A	N/A	N/A	N/A	N/A	3,871	4,427
Result	3,456	3,751	3,428	3,315	3,508	3,498	Available January 2024	Available January 2025
Status	N/A	N/A	N/A	N/A	N/A	Pending	Pending	Pending

HRSA's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program supports voluntary, evidence-based home visiting services during pregnancy and to parents with young children up to kindergarten entry living in at-risk communities.

Despite the negative influence of COVID-19 on enrollment of families in 2021, and issues with home visitor workforce recruitment and retention, states reported serving more than 137,000 parents and children in over 1,000 counties across all 50 states, the District of Columbia, and five territories, representing more than a 300 percent increase in the number of participants served since FY 2012. MIECHV state and jurisdictional grantees provided more than 8.8 million visits from FY 2012 through FY 2022. In FY 2024, HRSA is increasing its target. The new requirement for matching grants beginning in FY 2024, as included in the Consolidated Appropriations Act, 2023 (Public Law 117-328, Section 6101), may influence performance measure targets and results. HRSA will reevaluate performance measures in FY 2025.

Objective 3.3: Expand access to high-quality services and resources for older adults and people with disabilities, and their caregivers to support increased independence and quality of life

HHS is investing in several strategies to expand access to high-quality services and resources for older adults, people with disabilities, and their caregivers. HHS enhances system capacity to develop processes, policies, and supports that are person centered and provide quality care for older adults and individuals with disabilities across settings, including home and community-based settings. HHS ensures the availability and equitable access and delivery of evidence-based interventions that focus on research, prevention, treatment, and care to older adults and individuals with disabilities. HHS also supports development and implementation activities to better understand and address the needs of all caregivers across the age and disability spectrum.

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

Objective 3.3 Table of Related Performance Measures

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

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	26.8%	30%	30%	30%	Discontinued	Discontinued	Discontinued	Discontinued
Result	31%	31%	31.2%	31.2%	N/A	N/A	N/A	N/A
Status	Target Not Met but Improved	Target Not Met	Target Not Met	Target Not Met	Not Collected	Not Collected	Not Collected	Not Collected

ACL retired several measures that no longer accurately reflect the work of its programs. One of these measures was Measure ID - 2.6, which includes factors outside of the program's control.

Increase the percentage of individuals with developmental disabilities whose rights were enforced, retained, restored, or expanded. (Lead Agency - ACL; Measure ID - 8F)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	N/A	N/A	N/A	79.55%	78.73%	Prior Result +1%	Prior Result +1%	Prior Result +1%
Result	78.1%	78.9%	78.76%	77.95%	78.75%	Jan 1, 2024	Jan 1, 2025	Jan 1, 2026
Status	Historical Actual	Historical Actual	Historical Actual	Target Not Met	Target Exceeded	Pending	Pending	Pending

Under the Developmental Disabilities Assistance and the Bill of Rights Act of 2000 (DD Act), each state and territory has a Developmental Disabilities Protection and Advocacy (P&A) program designated by the state's governor. The DD Act and other authorizing statutes give the P&A program the authority to advocate for the rights of individuals with disabilities. The DD Act states that each P&A program has the authority to "pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of, and advocacy for, the rights of such individuals within the State."[35] P&A programs provide a range of legal services and use a range of remedies, including self-advocacy assistance, negotiation, investigation, and litigation, to advocate for traditionally unserved or underserved individuals with developmental disabilities. P&A authorities are critical to preventing abuse and neglect of people with disabilities and safeguarding individuals' right to live with dignity and self-determination.

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

[35] 42 U.S.C. 15043

Increase the age-adjusted percentage of adults (age 18+) diagnosed with arthritis who were counseled by a doctor or other health professional to be physically active or exercise to help arthritis or joint symptoms, in states funded by the CDC Arthritis Program (Lead Agency - CDC; Measure ID - 4.10.1)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	N/A	N/A	Set Baseline	N/A: Data Biennial	70.3 %	N/A: Data Biennial	71 %	N/A: Data Biennial
Result	N/A	N/A	70 %	N/A: Data Biennial	68.2%	N/A: Data Biennial	Sep 30, 2024	N/A: Data Biennial
Status	N/A	N/A	Baseline	N/A: Data Biennial	Target Not Met	N/A: Data Biennial	Pending	N/A: Data Biennial

Recent projections indicate that arthritis prevalence and arthritis-associated limitations are increasing and confirm that arthritis remains a top cause of morbidity, work limitations, and compromised quality of life. Arthritis affects more than 58.5 million adults, almost 60% of whom are working aged adults (< 65) and is projected to affect 78.4 million adults by 2040. There is strong evidence that physical activity can reduce joint pain, improve function, and halt or delay physical disability among adults with arthritis, but physical activity levels are lower for adults with arthritis than adults without arthritis. Adults with arthritis are more likely to engage in physical activity and self-management education programs when recommended by a health care provider. This strategy and an emphasis on provider recommendations are reflected in CDC's new state arthritis program and will be reflected in other, future activities of the arthritis program.

Among states funded by the CDC Arthritis Program in 2021, 68.2% of adults diagnosed with arthritis were counseled by a doctor or other health professional to be physically active to help arthritis or joint symptoms. The 2021 target was not met and was lower than the 2019 baseline of 70%. Funded states indicated the pandemic significantly impacted their efforts to reach healthcare professionals and that many providers' ability to provide physical activity counseling to patients with arthritis were limited due to pandemic-related demands. However, over the last 4 years, funded states reached more than 40,000 adults with low-cost community-based physical activity and self-management education programs that have been effective in improving arthritis symptoms, management, and quality of life for people living with arthritis.

The future targets are consistent with an outcome measure in CDC's State Public Health Approaches to Addressing Arthritis Notice of Funding Opportunity,

Decrease the prevalence of hemophilia treatment inhibitors among Community Counts - Health Outcomes Monitoring System for People with Bleeding Disorders at HTCs (Lead Agency - CDC; Measure ID - 5.3.2)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	Set Baseline	5.7 %	5.6 %	5.5 %	5.4 %	4.8 %	4.4 %	4.2%
Result	7 %[36]	6.4 %	5.8 %	5.1 %	5.0%	Mar 31, 2023	Mar 31, 2024	Mar 31, 2025
Status	Baseline	Target Not Met but Improved	Target Not Met but Improved	Target Exceeded	Target Exceeded	Pending	Pending	Pending

[36]CDC established a new data source in FY 2017. Results cannot be compared to previous years.

CDC protects people and prevents complications of blood disorders by reducing the prevalence of inhibitors among hemophilia patients and increasing the proportion of very young hemophilia patients receiving early prophylaxis treatment. Through Community Counts, CDC collects data on health issues and medical complications for people living with bleeding disorders, incorporates screening for inhibitors, and monitors treatment use, including prophylaxis, to facilitate best practices that help prevent or eradicate complicated, costly, and debilitating health conditions.

Approximately 15-20% of people with hemophilia develop an inhibitor, a condition where the body stops accepting the factor treatment product (which helps the blood clot properly) as a normal part of blood. The body treats the "factor" as a foreign substance and mounts an immune system response to destroy it with an inhibitor. When people develop inhibitors, treatments to prevent and stop bleeding episodes are less effective. Special treatment is required until the body stops making inhibitors, which can increase hospitalizations, compromise physical function, and exceed $1,000,000 a year for a single patient.

Discovering an inhibitor as soon as possible helps improve outcomes and reduce costs. Although hemophilia care providers widely accept that development of an inhibitor is a serious issue, routine screening for inhibitors is not current practice for local laboratories because of the high cost and the inability to perform the proper tests.

In FY 2021, the prevalence of hemophilia treatment inhibitors was 5.0% which surpassed the FY 2021 target by seven and a half percent. For the second consecutive year, the measure has been exceeded and the continued decrease in inhibitor prevalence demonstrates marked improvement for the population's management of complications.

Increase the percentage of older adults who receive appropriate clinical preventive services (Lead Agency - AHRQ; Measure ID - 2.3.7)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	Continue to analyze MEPS pilot data to determine if the data can be used to provide national estimates of receipt of high-priority clinical preventive services. Use MEPS data and data from the evaluation of the USPSTF's recommendations implementation project in order to identify specific preventive services that can be targeted for improvement.	Prepare for and collect PSAQ data again in FY 2018	Continue PSAQ data collection through 2019. The panel design of the survey features several rounds of interviewing covering two full calendar years. Data should be available in 2020.	New data for the PSAQ prevention items available	2021 PSAQ data collection continues. Administer another round of the PSAQ.	Complete analysis of FY 2018/2019 data; New data from FY 2020/2021 will be available: Begin collecting FY 2022/2023 data	Maintain 6%	5%
Result	Pilot data was found to be reliable and valid to provide national estimates of receipts of high-priority clinical preventive services. Survey	PSAQ data collection began and is underway.	Collected and began analysis of PSAQ data	Collected new data	Continued data analysis of the PSAQ 2018/2019 data. Complete administration of another round (2020/2021) of the PSAQ.	6% Baseline		

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
	results found that 8 percent of adults (35+) received all of the high priority, appropriate clinical preventive services (95% confidence interval: 6. 5% to 9.5%). Ana lyses are underway to identify specific preventive services that can be targeted for improveme nt.							
Status	Target Met	Target Met	Target Met	Target Met	Target Met	In Progress	Pending	
Target				Begin analysis on the FY 2018 and 2019 data collected				
Result				Continued analysis of FY 2018 and 2019 data				
Status				Target Met				
Target				FY 2020 PSAQ data collection will begin				
Result				Began collecting FY 2020 PSAQ data				
Status				Target Met				

In FY 2021, AHRQ continued to provide ongoing scientific, administrative and dissemination support to the U.S. Preventive Services Task Force (USPSTF). The Task Force makes evidence-based recommendations about clinical preventive services to improve the health of all Americans (e.g., by improving quality of life and prolonging life). By supporting the work of the USPSTF, AHRQ helps to identify appropriate clinical preventive services for adults, disseminate clinical preventive services recommendations, and develop methods for understanding prevention in adults.

For several years, AHRQ has invested in creating a national measure of the receipt of appropriate clinical preventive services by adults (measure 2.3.7). A necessary first step in creating quality improvement within health care is measurement and reporting. Without the ability to know where HHS is and the direction HHS is heading, it is difficult to improve quality. This measure will allow AHRQ to assess where improvements are needed most in the uptake of clinical preventive services. It will help AHRQ support the USPSTF by targeting its recommendations and dissemination efforts to the populations and preventive services of greatest need. Thus, making sure the right people get the right clinical preventive services, in the right interval. The data from this measure can also identify gaps in the receipt of preventive services and therefore inform the Department's and the public health sector's prevention strategies.

AHRQ now has a validated final survey to collect data on the receipt of appropriate clinical preventive services among adults (the Preventive Services Self-Administered Questionnaire (PSAQ) in the AHRQ Medical Expenditure Panel Survey (MEPS)). The survey was fielded in a pilot test in 2015. It is a self-administered questionnaire that will be included as part of the standard MEPS starting in 2018. Additional years of data will allow for AHRQ to track and compare receipt of high priority, appropriate clinical preventive services over time.

The panel design of the survey, which will include the PSAQ in even years, makes it possible to determine how changes in respondents' health status, income, employment, eligibility for public and private insurance coverage, use of services, and payment for care are related. Once data are collected, they are reviewed for accuracy and prepared to release to the public.

In FY 2022, AHRQ completed analysis of the CY2018 (FY 2018/2019) data. It also anticipates the CY2020 (FY 2020/2021) preventive items data will become available, and data collection for the CY2022 (FY2022/2023) will begin. In addition, AHRQ began a project to update the list of high priority clinical preventive services based on the latest available evidence.

In FY 2023, AHRQ anticipates it will begin analysis of the CY2020 (FY2020/2021) data and continue data collection for the CY 2022 (FY 2022/2023) data. The target of 6% (baseline from FY2022) will be maintained. AHRQ will convene an expert panel to update the list of high priority clinical preventive services and a series of technical expert panels to identify strategies to improve uptake of these services.

Objective 3.4: Increase safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have experienced trauma or violence

HHS increases safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have experienced trauma or violence. The Department continues its efforts to promote coordination across the government to address the full range and multiple forms of neglect, violence, trauma, and abuse across the life span. HHS is building a resource infrastructure to ensure equitable delivery of high-quality services to support affected individuals,

families, and communities. HHS also leverages data to inform the development of effective and innovative prevention and intervention models to address neglect, abuse, and violence.

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

Objective 3.4 Table of Related Performance Measures

Increase the capacity of the National Domestic Violence Hotline to respond to increased call volume (as measured by percentage of total annual calls to which the Hotline responds). (Lead Agency - ACF; Measure ID - 14A)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	84 %	82 %	82 %	75 %	75 %	75 %	75 %	75 %
Result	75 %	74 %	62 %	56 %	62%	Mar 1, 2023	Mar 31, 2024	Mar 31, 2025
Status	Target Not Met	Target Not Met	Target Not Met	Target Not Met	Target Not Met, but Improved	Pending	Pending	Pending

The staff and volunteers of the National Domestic Violence Hotline (Hotline) provide victims of family violence, domestic violence, and dating violence; family and household members; and other persons such as advocates, law enforcement agencies and the general public with crisis intervention, emotional support, safety planning, domestic violence information, and referrals to local service providers as well as national resources. Measurement of the Hotline's performance has historically focused on the percentage of total annual responses to calls in relation to the number of calls received. This performance measure acknowledges that tracking the answers or responses to calls is a better determinant of the Hotline's usefulness than reporting the number of calls received (as previously reported).

In FY 2021, the Hotline answered 396,803 total contacts across platforms. The Hotline and loveisrespect (LIR), the helpline targeted towards young people, which is 49,322 more contacts than the Hotline answered in FY 2021. The Hotline's FY 2021 our overall answer rate was sixty-seven percent (67 percent). On average, callers waited 5 minutes and 37 seconds for a connection to a Phone Services Advocate. Direct connect, which allows an Advocate to connect and transfer a caller to a local provider, was offered by Phone Services Advocates 16,740 times. In FY 2021, the Hotline experienced a significant increase in digital contacts compared to phone contacts. The Hotline's Digital Services Advocates answered a total of 107,399 Hotline chats in FY 2020, in FY 2021, Digital Services Advocates answered 151,671 Hotline chats. In FY 2021, the Hotline saw an increase in average talk time and wait times during this reporting period, which results in a decrease in advocate availability. The Hotline's advocates provide survivors with in-depth advocacy, lethality assessment, support, and safety planning which leads to longer interaction times. Less advocate availability does ultimately impact the Hotline's answer rate and wait times. More survivors are choosing to reach out for the Hotline's services digitally (for safety reasons, especially during the continued COVID-19 pandemic), and the launch of Hotline text services provided an additional method to do so. On May 13, 2021, the Hotline launched text services by text-enabling the Hotline's toll-free phone number. On June 14th, the SMS short code- text Start to 88788- for Hotline text services became active. Previously, text services were only available through LIR. The success for answering more contacts can be attributed to efficiencies created through effective scheduling,

technological enhancements, and training initiatives for advocates. It is not feasible for 100 percent of calls received to be answered due to unanticipated spikes resulting from media coverage promoting the Hotline phone number and increases in call volume during the rollover of state or local program crisis lines during an emergency or disaster. In addition, some situations require a caller to disconnect before an advocate can answer (e.g. the abuser enters the room). Given the expected continual rise in callers contacting the Hotline, increased hours of training for new advocates, and increased programmatic and financial support to StrongHearts Native Helpline, the Hotline is projected to have a performance rate of 75 percent through FY 2024.

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. (CAPTA) (Lead Agency - ACF; Measure ID - 7B)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	6.3%	6.7%	6.5%	6.4%	6%	6.3%	Prior Result -0.2PP	Prior Result -0.2PP
Result	6.9%	6.7%	6.6%	6.2%	6.5%	Oct 30, 2023	Oct 31, 2024	Oct 31, 2025
Status	Target Not Met	Target Met	Target Not Met but Improved	Target Exceeded	Target Not Met	Pending	Pending	Pending

The annual performance measure regarding repeat child maltreatment evaluates the trend in the percentage of children with substantiated or indicated reports who experience repeat maltreatment. ACF has set a target of decreasing the percentage of child victims who experience repeat maltreatment by 0.2 percentage points per year. For FY 2019, the rate of recurrence decreased to 6.6 percent, just missing the target of 6.5 percent. For FY 2020, the rate of recurrence decreased to 6.2 percent, exceeding the target of 6.4 percent. For FY 2021, the rate of recurrence increased slightly to 6.5 percent, missing the target of 6 percent. ACF will continue to support states in their efforts to support children and families who are experiencing a crisis, while ensuring the safety of children. The CAPTA State Grant program provides formula grants to states to improve child protective service systems through a range of prevention activities, including addressing the needs of infants born with prenatal drug exposure, referring children not at risk of imminent harm to community services, implementing criminal record checks for prospective foster and adoptive parents and other adults in their homes, training child protective services workers, protecting the legal rights of families and alleged perpetrators, and supporting citizen review panels. The renewed emphasis on prevention efforts, in tandem with funding for the Community-Based Child Abuse Prevention (CBCAP) program that also assists states in their efforts to prevent child abuse and neglect while promoting healthy parent-child relationships, may also assist in improving performance in this area. By FY 2024, the program expects to work with states in again reducing the rate of repeat maltreatment by 0.2 percent from the previous year's actual result.

Increase the number of potential trafficking victims identified by the hotline. (Lead Agency - ACF; Measure ID - 17D)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	19,434 cases	16,255 cases	23,123 cases	26,322 cases	27,825 cases	27,306 cases	Prior Result +5%[37]	TBD (avg of previous 4 actual results)
Result	21,644 cases	34,753 cases	30,684 cases	19,186 cases	17,460 cases	Feb 28, 2023	Feb 28, 2024	Feb 28, 2025
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met	Target Not Met	Pending	Pending	Pending

This performance measure demonstrates the continued work of the National Human Trafficking Hotline (NHTH) in identifying potential victims of human trafficking and increasing the number of incoming communications from victims and survivors. In FY 2019, the program funding level was increased by 100 percent and the hotline grantee launched an enhanced Interactive Voice Recognition system to prioritize calls directly from victims and those close in proximity to the potential trafficking situation. That year, the hotline identified 30,684 potential victims of trafficking[38]. In FY 2020, the total number of potential victims identified decreased to 19,186, a 37 percent decrease from the prior year. However, the total number of potential cases identified (each case could have one or more victims) only decreased by six percent from the prior year (11,852 potential cases identified in FY 2019 and 11,193 potential cases identified in FY 2020). The total number of signals from potential victims increased by 27 percent (10,362 signals in FY 2019 and 13,129 signals in FY 2020). This result indicates that while more signals came in directly from potential victims of trafficking, the cases of potential trafficking may have involved fewer victims per case than in prior years. Some of these results may have also been impacted by challenges related to the COVID-19 pandemic, including quarantine and social-distancing measures. Other pandemic-related challenges that impacted the operation of the hotline included the move to remote operations that may have limited in-person supervisory support, staff wellness and increased turnover attributed to pandemic and/or secondary trauma on calls, increased mental health calls from the public requiring more time per call, and the spread of viral misinformation on human trafficking increasing overall call volume (which increased from 136,990 total signals in FY 2019 to 15,100 signals in FY 2020). While ACF did not meet this particular target for FY 2020, it increased the number of signals received directly from potential victims and responded to a record number of overall signals. In FY 2021, ACF provided supplemental funding for the hotline to increase staffing capacity, recruitment and retention, and mental health and wellness resources.

By FY 2024, ACF aims to increase incoming communications to the hotline from victims and survivors and the number of potential trafficking victims identified by the hotline by ten percent over the average of the previous four years of actual results. This growth is anticipated, at least in part, due to the award of a $1 million contract in September 2021 for Look Beneath the Surface Public Awareness and Outreach Campaign Strategy and Materials. The campaign reflects the diversity of the anti-trafficking community, and messages will be targeted to reach marginalized populations and encourage those experiencing human trafficking to seek help, which will hopefully translate to increased communications to the NHTH.

[37]The FY 2023 target is to meet the average of the previous four years of actual results.

[38] It is important to note that federal funding represents only 72 percent of the total operating cost of hotline services.

Increase the percentage of placement designation of referrals of Unaccompanied Children (UC) from Department of Homeland Security within 24 hours of referral. (Lead Agency - ACF; Measure ID - 19A)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	99 %	99 %	99 %	99 %	99 %	99 %	99 %	99 %
Result	98.67 %	69.3 %	64.9 %	99.27 %	64%	Mar 1, 2023	Mar 1, 2024	Mar 1, 2025
Status	Target Not Met	Target Not Met	Target Not Met	Target Exceeded	Target Not Met	Pending	Pending	Pending

Since 2014, ACF has expanded its network of care to be able to continue increasing the percentage of placement designation of referrals of unaccompanied children (UC) from the Department of Homeland Security (DHS) within 24 hours of referral. Although the statutory requirement is 72 hours, ACF aims for UC to enter the Office of Refugee Resettlement (ORR) care as soon as possible, recognizing that border facilities are not designed to meet the needs of children). In FY 2017, ACF was able to designate placement within 24 hours of referral to 98.67 percent of the UC referred by DHS. This performance measure is calculated by taking the number of UC who were designated for placement within 24 hours of referral divided by the total number of referrals per fiscal year. In FY 2017, due to a lower number of referrals and a surplus of bed capacity unoccupied, the program was directed to reduce bed capacity by approximately 30 percent. Changes to the overall bed capacity were insufficient in FY 2018 to accommodate the increase in referrals, and ORR was not able to meet this measure. In FY 2021, ORR received an unprecedented increase in UC referrals. There were 122,731 UC referred in FY 2021, compared to 15,381 referrals in FY 2020. This historically large influx, combined with added challenges from the COVID-19 pandemic, placed a strain on existing systems, and ORR was not able to meet the measure of designating 99 percent of referrals for placement within 24 hours.

In order to meet the number of referrals of UC and to ensure the best placement based on the medical and/or mental health needs and safety of the children, ACF has brought on additional bed capacity as needed. The program's ability to avoid a buildup of children waiting in border patrol stations for placement in shelters is accommodated through the expansion of existing programs through the supplemental grant award process and emergency contracts that will be replaced with competitive multiple-award indefinite delivery indefinite quantity contracts allowing ORR to increase capacity beyond standard beds in the event of an influx without maintaining influx capacity during periods of low referrals. In order to meet targets, ACF continues its efforts in streamlining operations and making changes to existing policies and procedures to decrease the program's length of stay. The program also continues to experience a higher volume of referrals and is engaged in increasing the overall program capacity needs. ACF will continue to collect grantee-related performance information including: monthly statistical reports, daily programmatic electronic updates and case file information related to admissions, discharges, and length of stay. The ORR Intakes team also tracks the daily number of UC referrals and the number of UC pending placement in excess of 24 hours.

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

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target		41.6 %	41.6 %	41.5 %	37.5 %	36.3 %	29.6 %	29.6 %
Result		38.1 %	36.3 %	30.2 %	27.2 %	28.3%	Jan 31, 2024	Jan 31, 2025
Status		Target Not Met	Target Not Met	Target Not Met	Target Not Met	Target Not Met	Pending	Pending

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

Although some IHS Areas met or exceeded the FY 2022 target, IHS did not meet the national target of 36.3 percent. The IHS COVID-19 pandemic response and the transition from in person primary care to virtual care at several sites, may have impacted screening women for IPV. To avoid potential coronavirus exposure risk, there have been fewer in-person visits and many health care services for prevention and health maintenance were postponed by patients during the pandemic. While patients with acute illness or the need for emergency care were still seen at IHS facilities, the COVID-19 pandemic response limited healthcare provider-patient IPV interactions and reduced opportunities to screen women. Due to the sensitivity of the IPV screening, proper administration requires the health care provider to ensure the patient is comfortable responding without external influence. Therefore, the increased use of telehealth visits within a patient's home is not necessarily meeting the safety and security recommendations for IPV assessments.

Due to COVID-19 response efforts, opportunities for facilities to participate and complete trainings were limited. As in-person office visits resume, IHS anticipates an increase in IPV screening rates. Successful staff training will focus on enhanced communications, frequent data reviews, preparation with specific screening tools, and inclusion of the measure in facility quality improvement projects. In April and May 2022, the IHS Domestic Violence Prevention program awarded 40 new projects for a five-year period that will increase access to forensic healthcare services and support the development of tribal community-based projects to prevent domestic and sexual violence. The projects are culturally appropriate, evidence-based, practice-based models of violence prevention and treatment among American Indians and Alaska Natives. IHS provides outreach and assistance to tribal sites upon request with a virtual training made available in FY 2020 regarding a specific IPV lethality risk screening tool. Additionally, in FY 2022 IHS updated and released two webinars focused on improving the healthcare infrastructure to support victims of violence. IHS will continue to build upon these efforts during FY 2023 and FY 2024.

Increase the number of prevention and response strategies from CDC's resource Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence being implemented by state and local health departments funded through the multistate ACEs cooperative agreement. (Lead Agency - CDC; Measure ID – 7.F (new))

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	N/A	N/A	N/A	N/A	15	15	15	16
Result	N/A	N/A	N/A	11	15	15	Dec 31, 2023	Dec 31, 2024
Status	Not Collected	Not Collected	Not Collected	Baseline	Target Met	Target Met	Pending	Pending

Strategies drawn from the Preventing ACEs Best Available Evidence resource are being implemented by each of the funded Preventing Adverse Childhood Experiences: Data to Action (PACE: D2A) recipients. This indicator tracks trends associated with implementing evidence-based strategies to prevent and respond to adverse childhood experiences (ACEs) and addresses the effectiveness of CDC's actions to translate science into action. CDC's mission with respect to ACEs is to prevent, identify, and respond to them using evidence-based strategies, and this indicator is the most direct measure of CDC success in that regard. The PACE: D2A initiative helps ensure states and intrastate partners have access to the best available evidence for ACEs prevention and response. In FY 2022 15 prevention and response strategies were being implemented by funded recipients. Future targets were set based on an assessment of what realistic growth may look like and recipients capacity to increase strategy implementation.

Expand the number of evidence-based resources on best practices and core components of trauma-informed care for clinical practice that are available on the National Center for Injury Prevention and Control website. (Lead Agency - CDC; Measure ID – 7.G (new))

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	N/A	N/A	N/A	N/A	Set Baseline	2.0	5.0	7.0
Result	N/A	N/A	N/A	N/A	0.0	0	Dec 31, 2023	Dec 31, 2024
Status	Not Collected	Not Collected	Not Collected	Not Collected	Baseline	Target Not Met	Pending	Pending

CDC is leading efforts to prevent violence before it begins and reaching out to audiences with new prevention strategies. CDC adapts and disseminates actionable resources based on rigorous science to equip every available partner with the tools they need to build trauma-informed systems and infrastructure. Equipping partners with the tools and resources they need to move from principle to practice of trauma-informed care in school, healthcare, housing, justice-serving, and other behavioral and mental health service spaces will help amplify CDC's impact and equip its partners to do the same. This measure ensures CDC continues to push to generate and disseminate resources on trauma-informed care for clinical settings (and other partners), to ensure that its systems responses to people who have experienced trauma is not harmful. Progress on this measure has been slower than expected and the target was not met for FY 2022, however, CDC expects an upward trend in FY 2023. Our perspective on trauma-informed care (TIC) and trauma-informed systems has broadened to recognize that while clinical settings are an essential setting from which to provide TIC, we can also build capacity of all systems (first responders, educational settings, businesses, for example) to operate from a trauma-informed perspective.

Future targets were set based on the products and deliverables expected in relation to CDC's adverse childhood experiences (ACEs) and trauma informed care work that is underway.

Strategic Goal 4: Restore Trust and Accelerate Advancements in Science and Research for All

HHS is dedicated to restoring trust and accelerating advancements in science and research. The Department is prioritizing science, evidence, and inclusion to improve the design, delivery, and outcomes of HHS programs. It is investing in the research enterprise and the scientific workforce to maintain leadership in the development of innovations that broaden our understanding of disease, healthcare, public health, and human services resulting in more effective interventions, treatments, and programs. Strengthening surveillance, epidemiology, and laboratory capacity is another major focus to better understand and equitably address diseases and conditions. HHS is also increasing evidence-based knowledge through improved data collection, use, and evaluation efforts to achieve better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience.

Objective 4.1: Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion

HHS works on strategies to improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion. The Department leverages stakeholder engagement, communication, and collaboration to build and implement evidence-based interventions and approaches for stronger health, public health, and human services outcomes.

The Office of the Secretary leads this objective. All divisions are responsible for implementing programs under this strategic objective. In consultation with OMB, HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 4.1 Table of Related Performance Measures

By 2026, enhance understanding of how five health information technologies can be applied effectively to improve minority health or to reduce health disparities. (Lead Agency - NIH; Measure ID - SRO-5.18)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	N/A	N/A	N/A	N/A	Develop an adaptive smoking cessation intervention targeting adolescents of health disparity populations using the QuitStart mobile application.	Determine if a mobile phone app is effective in promoting physical activity or reducing weight among racial and ethnic minority populations.	Assess the feasibility of using data mining, natural language processing (NLP), and/or other technological advances to improve the health or healthcare for individuals who experience health disparities. .	Identify barriers and enhancers to adoption of health information technologies, such as clinical decision aids, from the perspective of physicians who care for populations who

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
								experience health disparities.
Result	N/A	N/A	N/A	N/A	NIH investigators developed a new smoking cessation mobile application, QuitJourney, based on QuitGuide (not QuitSTART, which is for adolescents) and conducted acceptability and usability testing with 48 young adults.	The app *¡Hola Bebé, Adiós Diabetes!* was successfully launched, but completion of effectiveness testing has been delayed due to the COVID-19 pandemic	Dec 2023	Dec. 2024
Status	Not Collected	Not Collected	Not Collected	Not Collected	Target Met	Target Not Met	Pending	Pending

Health information technology (health IT) refers to a variety of electronic methods that can be used to manage information about people's health and health care. Although health IT holds much promise for reducing disparities in populations that are medically underserved by facilitating behavior change and improving quality of health care services and health outcomes, few studies have examined the impact of health IT adoption on improving health outcomes and reducing health disparities among racial and ethnic minority individuals, people of less privileged socioeconomic status, underserved rural populations, and sexual and gender minority populations. Thus, NIH is investing in research to explore the potential of health IT for improving the health of underserved populations and reducing health disparities using technologies such as decision support tools, mobile apps, and new technologies such as artificial intelligence and natural language processing.

In the U.S., Hispanic or Latina women have one of the highest rates of gestational diabetes mellitus (GDM), a major risk factor for developing type 2 diabetes. In FY 2022, NIH-funded investigators launched and began testing the effectiveness of *¡Hola Bebé, Adiós Diabetes!*, a mobile app intended to help reduce risk factors for type 2 diabetes in Hispanic or Latina women who experienced GDM in the past five years. Phase 1 of the study offered promising results: Through the eight-week pilot program, participants showed increased self-efficacy for physical activity and reduced their weight. They also provided positive feedback on the app's personalized action plans, motivational text messages, at-home exercise videos, and recipes. During Phase II, the study experienced delays in recruiting participants due to the COVID-19 pandemic, which prevented the investigators from finishing the study in a timely manner. They are now in the final stage of testing the effectiveness of the app, with 97 participants (out of 150) having completed the study. If successful, the app will offer a culturally-tailored, user-centered, low-cost, and evidence-based intervention to reduce risk factors for developing type 2 diabetes among Hispanic or Latina women with a recent history of GDM.

In FY 2023, NIH willassess the feasibility of using data mining, natural language processing (NLP), and/or other technological advances to improve the health or healthcare for individuals who experience health disparities. In FY 2024, NIH will identify barriers and enhancers to adoption of health information technologies, such as clinical decision aids, from the perspective of physicians who care for populations who experience health disparities.

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 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	57.3 %	56.4 %	64.5 %	65.8 %	69.3 %	Prior Result +3PP	Prior Result +3PP	Prior Result +3PP
Result	53.4 %	61.5 %	62.8 %	66.3 %	61.4%	Oct 30, 2023	Oct 31, 2024	Oct 31, 2025
Status	Target Not Met	Target Exceeded	Target Not Met but Improved	Target Exceeded	Target Not Met	Pending	Pending	Pending

The most efficient and effective programs often use evidence-based and evidence-informed practices. ACF developed an efficiency measure to gauge progress towards programs' use of these types of practices. ACF is working closely with the states to promote more rigorous evaluations of their funded programs. Over time, ACF expects to increase the number of effective programs and practices that are implemented, thereby maximizing the impact and efficiency of Community-Based Child Abuse Prevention (CBCAP) funds. For the purposes of this efficiency measure, ACF 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. Programs determined to fall within specified program parameters will be considered to be implementing "evidence-informed" or "evidence-based" practices (collective referred to as "EBPs"), as opposed to programs that have not been evaluated using any set criteria. The funding directed towards these types of programs (weighted by EBP level) will be calculated over the total amount of CBCAP funding used for direct service programs to determine the percentage of total funding that supports evidence-based and evidence-informed programs and practices. A baseline of 27 percent was established for this measure in FY 2006. The target of a three percentage point annual increase in the amount of funds devoted to evidence-based practice was selected as a meaningful increment of improvement that takes into account the fact that this is the first time that the program has required grantees to target their funding towards evidence-based and evidence-informed programs, and it will take time for states to adjust their funding priorities to meet these new requirements.

In general, the majority of CBCAP funding is directed toward EBPs. Fiscal year 2018 represented an increase with grantees reporting 61.5 percent of funds being directed at EBPs. Fiscal year 2019 also saw an increase with grantees reporting 62.8 percent of funds directed toward EBPs. Despite this increase, it did not meet the target of 64.5 percent. In FY 2020, however, the percentage spent on EBPs increased to 66.3 percent, exceeding the target of 65.8 percent. In FY 2021, the target of 69.3 was not met, as states reported 61.4 percent of funds were used for evidence-informed and evidence-based programs. Based on report narratives and engagement with grant recipients, ACF believes that impacts of the public health pandemic have influenced this decrease. For example, ACF experienced increased requests from grant recipients to use CBCAP funds to address concrete needs (e.g. housing, food, clothing, child care assistance, etc.), which often do not have as much research demonstrating effectiveness. States further

reported decreased administration of evidence-informed and evidence-based programs during the pandemic due to restrictions with in-person interactions, as well as limited capacity, resulting from increased resignations from personnel. While CBCAP programs were able to carry out many evidence-informed and evidence-baesd programs virtually, they reported that it still had decreased from pre-pandemic levels. Moreover, ACF has worked to tailor training and technical assistance activities to address these challenges and increase state capacity to use funds for evidence-based and evidence-informed programs. Efforts will further continue to promote evaluation and innovation, so as to expand the availability and use of evidence-informed and evidence-based programs over time and continue to set the target of an annual three percentage point increase over the prior year.

Objective 4.2: Invest in the research enterprise and the scientific workforce to maintain leadership in the development of innovations that broaden our understanding of disease, healthcare, public health, and human services resulting in more effective interventions, treatments, and programs

HHS is investing in strategies to support the research enterprise and the scientific workforce. HHS works to build public trust by upholding scientific integrity and quality. HHS is also working to recruit, retain, and develop a diverse and inclusive scientific workforce to conduct basic and applied research in disease, healthcare, public health, and human services. HHS supports innovation in how research is supported, conducted, and translated into interventions that improve health and well-being.

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

Objective 4.2 Table of Related Performance Measures

By 2025, develop or evaluate the efficacy or effectiveness of new or adapted prevention interventions for substance use disorders (SUD). (Lead Agency - NIH; Measure ID - SRO-5.2)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	N/A	N/A	N/A	Conduct 3-5 pilot studies to test the efficacy of promising prevention interventions for SUD.	Launch 1-2 clinical trials, based on pilot study results, to test the effects of a prevention intervention for opioid use disorder.	Conduct 1-2 studies to test the effectiveness of prevention interventions focused on electronic nicotine delivery systems	Launch 1-2 clinical trials testing approaches to prevent opioid and other substance misuse by intervening on social determinants of health.	Launch 1-2 pilot studies to develop novel strategies to prevent substance use among youth and young adults informed by epidemiological research.

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
						(including vaping).		
Result	N/A	N/A	N/A	Nine prevention pilot studies were conducted as part of the Helping to End Addiction Long-term (HEAL[SM]) Initiative.	Two clinical trials were launched as part of the Helping to End Addiction Long-term (HEAL) Initiative®.	NIH-funded researchers conducted two studies to test the effectiveness of prevention interventions focused on electronic nicotine delivery systems in schools, via social media and electronic cigarette advertising restrictions.	Dec. 2023	Dec. 2024
Status	Not Collected	Not Collected	Not Collected	Target Exceeded	Target Met	Target Met	Pending	Pending

Preventing the initiation of substance use and minimizing the risks of harmful consequences of substance use are essential parts of addressing SUD. NIH's prevention research portfolio encompasses a broad range of research on how biological, social, and environmental factors operate to enhance or lessen an individual's propensity to begin substance use, or to escalate from use to misuse to SUD. This line of research, along with rapidly growing knowledge about substance use and addiction (including tobacco, alcohol, illicit, and nonmedical prescription drug use), is helping to inform the development of evidence-based prevention strategies.

Vaping continues to be the predominant method of nicotine consumption among youth, and early nicotine use is associated with subsequent drug use and dependence.In FY 2022, NIH-funded researchers conducted two studies to test the effectiveness of prevention interventions focused on electronic nicotine delivery systems in schools, via social media and electronic cigarette advertising restrictions. In the first study, the researchers have been evaluating the effectiveness of culturally-tailored, anti-vaping social media messages for sexual and gender minority (SGM) youth ages 13-18. Available data indicate that SGM youth are more likely to initiate and continue vaping than non-SGM youth. This study, along with related NIH-funded studies, is building an evidence base to inform efforts to reduce vaping-related health disparities in this vulnerable population. In the interim, the researchers have called for a more nuanced approach to discussions about vaping: They pointed out in a scientific commentary that (1) discussions that lump the scientific/public health community into "supporters" and "opponents" of e-cigarettes are not productive because they ignore the areas of agreement, and (2) that discussions of potential harms and benefits of e-cigarettes need to be grounded in the characteristics of the products themselves, which are quite variable. In the second study, the researchers have been identifying features of e-cigarette advertisements that influence young adults' susceptibility toward vaping and to determine if restricting those features impacts attitudes, initiation, and continued use of vaping products. Their recent findings

highlight the importance of advertisement source messaging – specifically, expert messaging, compared with peer messaging, was seen by young adults as more credible and was associated with increased perceptions of e-cigarette harm. As the FDA has the authority to regulate e-cigarette advertisement features, these results may inform real-world policy decisions aimed at vaping prevention.

In FY 2023, NIH will launch 1-2 clinical trials to test approaches to prevent opioid and other substance misuse by intervening on social determinants of health. (Social determinants of health refer to the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.) In FY 2024, NIH will launch 1-2 pilot studies to develop novel strategies to prevent substance use among youth and young adults informed by epidemiological research.

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

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	N ≥ 10%	N ≥ 10%	N ≥ 10%	N ≥ 10%	N ≥ 10%	N ≥ 10%	N ≥ 10%	N ≥ 10%
Result	Award rate to comparison group reached 12%	Award rate to comparison group reached 11%	Award rate to comparison group reached 11%	Award rate to comparison group reached 11%	Award rate to comparison group reached 10%	Award rate to comparison group reached 9.8%	Dec. 2023	Dec. 2024
Status	Target Met	Target Met	Target Met	Target Met	Target Met	Target Not Met	Pending	Pending

A critical part of the NIH mission is the education and training of the next generation of biomedical, behavioral, and clinical scientists. The overall goal of the NIH research training program is to maintain a population of scientists that is well educated, highly trained, and dedicated to meeting the Nation's future health-related research needs. Success of NIH predoctoral research training programs can be measured, in part, by the number of trainees and fellows that go on to apply for and receive subsequent NIH career development and research awards. Subsequent support is an indicator of retention success in the research arena and reflects the impact of NIH-funded training on the ability of trainees and fellows to be competitive and sustain a research career with independent funding.

Each year, NIH assesses the degree to which predoctoral trainees and fellows who received NIH-funded training through a National Research Service Award (NRSA) are more likely to remain in research careers and successfully compete for NIH funding after the completion of their degrees. A 2001 assessment of the early progress of NRSA predoctoral trainees and fellows showed that the percentage of NRSA-funded individuals who applied for funding from NIH or the National Science Foundation was typically 10 percentage points higher than those who graduated from NIH-funded training institutions but who were not direct recipients of NRSA predoctoral funding. As part of the current assessment, NIH determines the difference in percentage points of receiving a research project grant mentored career development award between NRSA-funded individuals and other doctoral students at the same institutions who did not receive NRSA support. Tracking this measure annually serves as an indicator of the impact of NRSA support on ability of trainees and fellows to remain competitive and sustain a research career with independent funding.

In FY 2022, NIH-funded predoctoral trainees and fellows were 9.8 percentage points more likely to remain active in biomedical research than non-NIH trainees and fellows. This number falls just short of

meeting the annual target of equal to or greater than 10 percentage points set in 2001. In recent years, early career researchers have been experiencing a highly dynamic and uncertain research environment. For example, the lingering impact of COVID-19 has added uncertainty to the already changing funding landscape for early career investigators. Increasingly, recent trends indicate that an investigator's first or initial NIH award tends to be a mentored career development (K) or fellowship (F) award rather than an NIH research project grant. NIH has evaluated this recent pattern and will update its methodology to better reflect the current funding landscape and opportunities (e.g., incorporating research training fellowships in NIH's analysis criteria). With proposed update in analysis methodology, as mentioned above, NIH will maintain the current target in FY 2023 and FY 2024 and continue to assess differences between NIH-funded and non-NIH trainees and fellows as an indicator of programmatic impact.

Increase the total number of mentored research career development experiences for trainees from diverse backgrounds, including groups underrepresented in biomedical research, to promote individual development and to prepare them for a range of research-related careers. (Lead Agency - NIH; Measure ID - CBRR-25)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target		3505 career experiences across all career stages.	3,522 career experiences across all career stages.	3,539 career experiences across all career stages	3,540 career experiences across all career stages	3,545 career experiences across all career stages	3,550 career experiences across all career stages	3,600 career experiences across all career stages
Result		3706 mentored research career development experiences for trainees from underrepresented backgrounds to promote individual development and to prepare them for a range of research-related careers were supported across all training related stages,	Trainees from diverse backgrounds received a total of 3797 career experiences across all career stages.	Trainees from diverse backgrounds received a total of 3,779 career development experiences across all career stages.	Trainees from diverse backgrounds received a total of 3,779 career development experiences across all career stages.	Trainees from diverse backgrounds received a total of 3,972 career development experiences across all career stages.	Dec. 2023	Dec. 2024

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
		exceeding the target.						
Status		Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

NIH is committed to diversifying the Nation's biomedical research workforce. It funds numerous programs – at the undergraduate, graduate, postdoctoral, and faculty levels – that foster research training and the development of a strong and diverse workforce. The National Institute of General Medical Sciences, a component of NIH, develops and manages many of these programs. A key focus of the Institute is to provide trainees with mentored research training and career development experiences that help them acquire important knowledge and skills to drive scientific discovery and innovation.

This measure highlights a critical component – career development experiences – in the development of trainees from underrepresented backgrounds and tracks that data across different career stages. Underrepresented backgrounds include historically underrepresented racial/ethnic minorities (e.g., Blacks or African Americans, Hispanics or Latinos, American Indians or Alaska Natives, Native Hawaiians, and other Pacific Islanders), individuals with disabilities, and individuals from disadvantaged backgrounds (through the undergraduate stage). In FY 2022, the Institute supported 3,972 career development experiences across all career stages for trainees from diverse backgrounds. In FY 2023 and FY 2024, the Institute aims to support 3,550 and 3,600 career development experiences across all career stages for trainees from diverse background.

Maintain the yearly number of undergraduate students with mentored research experiences through the IDeA (Institutional Development Award) Networks of Biomedical Research Excellence (INBRE) program in order to sustain a pipeline of undergraduate students who will pursue health research careers. (Lead Agency - NIH; Measure ID - CBRR-26)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target		Sustain the number of undergraduate mentored research experiences from 2017 level.	Sustain the number of undergraduate mentored research experiences from 2018 level.	Sustain the number of undergraduate mentored research experiences from 2019 level.	Sustain the number of undergraduate mentored research experiences from 2020 level.	Sustain the number of undergraduate mentored research experiences from FY 2021 level.	Sustain the number of undergraduate mentored research experiences from FY 2022 level.	Sustain the number of undergraduate mentored research experiences from FY 2023 level
Result		Approximately 1,450 undergraduate students participated in mentored research experiences, consistent with 2017 level.	Approximately 1,450 undergraduate students participated in mentored research experiences, consistent with 2018 level.	Approximately 1,450 undergraduate students participated in mentored research experiences, consistent with 2019 level.	An estimated 1,450 undergraduate students participated in mentored research experiences, consistent with 2020 level.	An estimated 1,490 undergraduate students participated in mentored research experiences, consistent with 2021 level.	Dec. 2023	Dec. 2024

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Status		Target Met	Target Met	Target Met	Target Met	Target Met	Pending	Pending

Established by Congress in 1993, the goal of the Institutional Development Award (IDeA) program is to broaden the geographic distribution of NIH funding. The program supports faculty development and institutional research infrastructure enhancement in states that have historically received low levels of support from NIH. The purpose of the IDeA Networks of Biomedical Research Excellence (INBRE) is to augment and strengthen the biomedical research capacity of IDeA-eligible states. The INBRE represents a collaborative effort to sponsor research between research-intensive institutions and primarily undergraduate institutions (PUIs), community colleges, and tribally controlled colleges and universities (TCCUs).

A primary goal of the INBRE is to provide research opportunities for students from PUIs, community colleges, and TCCUs, and to serve as a "pipeline" for these students to continue in biomedical research careers within IDeA states. Offering these students mentored research experiences is crucial in developing their foundation in biomedical research and their interest in pursuing health research careers. Different types of mentored research experiences are available to these students. Examples include participating in INBRE-supported internship programs that provide hands-on research experience; attending research seminars, laboratory meetings, and journal clubs; and preparing oral or poster presentations of individual research projects and presenting them to the scientific community during the state's annual summer research conference. In FY 2022, an estimated 1,490 undergraduate students participated in mentored research experiences, consistent with the FY 2021 level. In future years, NIH aims to sustain the number of undergraduate mentored research experiences at the same level as previous years.

Percentage of scientists retained at FDA after completing Fellowship or Traineeship programs. (Lead Agency - FDA; Measure ID - 291101)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	40%	50%	50%	50%	20%	20%	20%	20%
Result	72%	53%	86%	80%	66%	23%	Feb 28, 2024	Feb 28, 2025
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

To support the Department's mission and FDA's scientific expertise, FDA is launching a new FDA Traineeship Program while continuing other Fellowship programs. This performance goal focuses on FDA's efforts to retain a targeted percentage of the scientists who complete these programs. Additionally, it is important to realize that whether "graduates" from these programs continue to work for FDA or choose to work in positions in related industry and academic fields, they are trained in using an FDA-presented understanding of the complex scientific issues in emerging technologies and innovation, which furthers the purpose of this strategic objective. FDA reset the retention target to 20% in FY 2021 to reflect the new expanded program's expected baseline. Although the Traineeship program has not yet been fully implemented, and additional programs will come online over the next few years, FDA has met the initial target of 20% in FY 2022. FDA will continue to monitor and adjust the target for retention moving forward as necessary. For now, the target will remain at 20% in FY 2023 and 2024.

Number of rural health research products released during the fiscal year. (Lead Agency - HRSA; Measure ID - 6010.01)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022[39]	FY 2023	FY 2024
Target	39	14	39	39	43	47	47	47
Result	61	67	56	107	77	81	Oct 31, 2023	Oct 31, 2024
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

HRSA's Federal Office of Rural Health Policy (FORHP) has a statutory charge to advise the HHS Secretary on rural health and telehealth policy issues across the Department, including interactions with the Medicare and Medicaid programs, and support policy-relevant research on rural health issues, consistent with HRSA's broader focus on access and underserved populations. HRSA provides funding for the only Federal research programs specifically designed to provide publicly available, policy relevant research on rural health issues. The Rural Health Research Center (RHRC) Program funds eight core research centers to conduct policy-oriented health services research to assist providers and decision/policymakers at the federal, state, and local levels to better understand the healthcare-related challenges faced by rural communities and provide information that can be applied in ways that improve health care access and population health. HRSA supports four research projects per RHRC per year. The RHRCs produce policy briefs and peer-reviewed journal manuscripts based on their funded research projects. These publications are made available through the HRSA-funded Rural Health Research Gateway (www.ruralhealthresearch.org). The Rural Health Research Gateway disseminates and promotes the work of the RHRCs to rural health stakeholders with the goal of informing and raising awareness of key policy issues important to rural communities. HRSA has repositioned the program to develop more robust technical research products vs. the shorter research briefs; HRSA anticipates that this adjustment will result in a decrease in the total number of research products.

Objective 4.3: Strengthen surveillance, epidemiology, and laboratory capacity to understand and equitably address diseases and conditions

HHS supports strategies to strengthen surveillance, epidemiology, and laboratory capacity to understand and equitably address diseases and health conditions. HHS is focused on expanding capacity to improve laboratory safety and quality, monitor conditions, understanding the needs of various sub-groups of people, and establishing the pipeline for future professionals. HHS is working to modernize surveillance systems for timeliness, accuracy, and analytic reporting while engaging and learning from partners and stakeholders to inform improvements and innovation.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: CDC, FDA, IHS, OASH, NIH, OGA, and SAMHSA. In consultation with OMB, HHS has determined that performance toward this objective is a focus area for improvement. Although HHS continues to find success in this objective, the scope and risk of the ongoing pandemic highlights the continued importance of additional progress. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

[39] FORHP has repositioned the RHRC to develop more fulsome, technical research products vs. the shorter research briefs completed prior to FY22. As such, FORHP anticipates the total number of research products will decrease from the previous trends.

Objective 4.3 Table of Related Performance Measures

Percentage of isolates of priority PulseNet pathogens (Salmonella, Shiga toxin-producing E. coli, and Listeria monocytogenes) sequenced and uploaded to the PulseNet National Database (Lead Agency - CDC; Measure ID - 3.D)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target		Set Baseline	65.0	70.0	75.0	80.0	85.0	85
Result		59.0	77.0	87.0	98	Dec 31, 2023	Dec 31, 2024	Dec 31, 2025
Status		Baseline	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

CDC estimates the burden of foodborne disease in the U.S. to be approximately 48 million cases per year (one out of every six Americans), 128,000 hospitalizations, and 3,000 deaths per year. Foodborne disease is mostly preventable, but controlling and preventing outbreaks requires that HHS understands the foods and settings that cause illness. Fast and effective outbreak investigations are needed to identify and remove contaminated food from the market to prevent additional illnesses and improve the safety of the nation's food supply.

In 2019, the standard method for outbreak detection in PulseNet changed to whole-genome sequencing (WGS) of bacteria in food that cause human illness. Tracking the progress of this new method is important because the degree to which it is adopted affects the sensitivity of outbreak detection, and multiple trends could affect PulseNet's ability to detect outbreaks in a positive or negative direction. Data indicates in FY 2021, 98% of isolates of priority PulseNet pathogens (*Salmonella*, *Shiga* toxin-producing *E. coli*, and *Listeria monocytogenes*) were sequenced and uploaded to the PulseNet National Database (Measure 3.D). These data exceeded the FY 2021 target, in part, because COVID-19 impacted the overall volume of isolates received by state laboratories. Lower isolate volume, combined with changes in state public health laboratories' workflows, has allowed labs to improve efficiencies to sequence most of their PulseNet organisms.

With the change in PulseNet to use WGS to detect foodborne outbreaks, CDC expects to see an increase in suspected clusters of foodborne disease, which, in turn, will need to be interviewed in order to determine if they are part of an outbreak. CDC invests in improving interview capacity in state and local health departments in order to also improve the availability of data for multistate foodborne outbreak investigations. Tracking state epidemiologic interview capacity is also important to help identify and address challenges in the availability of epidemiologic data critical for multistate foodborne outbreak investigations.

The percentage of laboratory test results reported within the expected turn-around time (two weeks) upon receipt by CDC labs (Lead Agency - CDC; Measure ID - 10.C.4)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	90%	90%	90%	90%	90%	90%	90%	90%
Result	96%	96%	98%	97%	96%	Apr 30, 2023	Apr 30, 2024	Apr 30, 2025
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

As a significant health concern in the U.S., malaria, and other parasitic diseases have a tremendous impact on global morbidity and mortality, due to increased international travel, importations, and domestically acquired infections. CDC's parasitic disease labs serve as global and national resources for ensuring efficient and high-quality analyses, which are essential to timely and accurate diagnosis and treatment.

In FY 2021, CDC labs tested 3,682 specimens from U.S. residents and overseas government staff for parasitic diseases and analyzed and reported results for 96% of submitted specimens in a timely manner (within the expected turnaround times posted in the CDC test directory for each test), exceeding the target. A target of 90% for this measure helps ensure accountability for consistent, timely reporting. Meeting or exceeding 90% each year represents ideal performance and the flexibility to respond to unforeseen challenges, such as those associated with the COVID pandemic. While the COVID pandemic did not directly impact CDC's ability to meet this performance target, it did initially affect CDC's laboratory operations. This includes having fewer people working in labs together at the same time and social distancing. FY 2021 results reflect 11 months of diagnostic testing (October 1, 2020—August 31, 2021). In September 2021, CDC's Parasitic Diseases Laboratory paused all diagnostic testing operations for parasitic diseases to implement laboratory system improvements. CDC is utilizing a phased, prioritized approach for bringing tests back online. CDC webpages are routinely updated to reflect the list of tests that have resumed to date.

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

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	N/A	N/A	50	55	60	65	65	65
Result	N/A	74	68	79	86	76	Jan 31, 2024	Jan 31, 2025
Status	Not Collected	Historical Actual	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

The Sentinel Initiative is FDA's medical product surveillance program. The Initiative is comprised of multiple components including: the Sentinel System, and its Active Risk Identification and Analysis (ARIA) program; FDA Catalyst; and the Biologics Effectiveness and Safety System. The goal of the Sentinel Initiative is to provide high quality real-world evidence to support regulatory decision-making about the performance of medical products, and this performance measure provides an estimate for the program's impact on FDA's public health mission. This performance measure captures the quantity of analyses conducted in the Sentinel System by FDA investigators to monitor the safety of drugs and therapeutic biologics. The number of analyses is a function of multiple factors beyond FDA's control, such as the nature and number of medical product safety issues, which can vary year-to-year. FDA will continue reporting the total number of analyses conducted by the Sentinel Initiative to show the scientific productivity of the system and describe its impact on public health. Prior to 2018, the Sentinel performance measure captured the number of people for whom FDA was able to evaluate product safety, based on benchmarks outlined in the Food and Drug Administration Amendments Act of 2007. FDA consistently exceeded these benchmarks, and in 2018 FDA changed the performance measure to reflect Sentinel's role as a vital source of safety information that informs regulatory decision-making and expands FDA's knowledge of how medical products perform once they are widely used in medical practice. In 2019, Congress required that FDA build on Sentinel's core successes by establishing a new Real-World Evidence Medical Data Enterprise with access to at least 10 million electronic medical records. In 2020 the performance measure was updated to capture not only Sentinel's ARIA system, which is comprised of pre-defined, parameterized, reusable routine querying tools and the electronic data

in the Sentinel Common Data Model, but also activities from these other components of the Sentinel Initiative, including those conducted in response to the COVID-19 pandemic.

Number of Tribal Epidemiology Center-sponsored trainings and technical assistance provided to build tribal public health capacity. (Lead Agency - IHS; Measure ID - EPI-5)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	89	89	89	89	89	89	89	200
Result	210	216	242	137	937	1,197	Jan 31, 2024	Jan 31, 2025
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

The Indian Health Service (IHS) provides core funding support to twelve Tribal Epidemiology Centers (TECs) across Indian Country. The TECs provide critical support to the tribal communities they serve by using epidemiological data to support local Tribal disease surveillance and control programs, producing a variety of reports annually or bi-annually that describe activities and progress towards public health goals, and providing support to Tribes who self-govern their health programs. This measure reports the number of completed trainings and technical support to Tribes and Tribal organizations and demonstrates the sustained efforts of the TECs to engage, support, train, and collaborate with the Tribes in their service area. In fiscal year (FY) 2016, the TEC program launched the training and technical assistance measure to coincide with the 5-year funding and cooperative agreement cycle and, as a way to strengthen and simplify performance tracking of TEC efforts to engage, support, train, and collaborate with Tribes in their service area. The TECs' direct support to Tribes translates emerging public health strategies, resources, and information to reduce the burden on the overall Indian health system through prevention. In FY 2022, TECs completed 1,197 TEC-sponsored trainings, largely driven by the Tribal demand for technical assistance with the COVID-19 pandemic. This represents a shift in focus from in-person trainings to more tailored technical support.

The measure target is informed by input from TEC partners. Actual performance among the TECs varies but overall performance has exceeded the target consistently. Because training and technical assistance events are driven largely by Tribal requests, which can vary greatly year-to-year in their frequency and complexity, the target was unchanged to support consistency throughout the 5-year funding and cooperative agreement period during FY 2016 – FY 2020. The 2021 Notice of Funding Opportunity announcing the current TEC funding cycle from FY 2021 – FY 2025 instituted a more robust and comprehensive evaluation plan, supported in part by this measure, which IHS proposes to increase in FY 2024 to better reflect the increased core resources and robust Tribal demands on the program. This plan provides TECs with the flexibility to meet the training and technical assistance needs of their Tribal partners while also responding to the broader evaluation goals of the IHS. The IHS is committed to supporting TEC performance through partnership and direct technical assistance, performance metric tracking and feedback, as well as by providing resources sufficient to meet the training and technical assistance needs of supported Tribes through available appropriations.

Objective 4.4: Improve data collection, use, and evaluation, to increase evidence-based knowledge that leads to better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience

HHS invests in strategies to improve data collection, use, and evaluation, to increase evidence-based knowledge that leads to better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience. HHS leverages different types of data, such as administrative data and research data, to guide its actions. HHS is establishing a Department-wide approach to improve data collection, close data gaps, transform data, and share data for better HHS analysis and evaluation. HHS also fosters collaborations to expand data access and sharing to create more opportunities to use HHS data to increase knowledge of health, public health, and human service outcomes. HHS is improving data collection and conducting evaluations to understand the drivers for inequities in health outcomes, social well-being, and economic resilience while working to increase capacity and the use of evaluations at HHS to inform evidence-based decision making.

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

Objective 4.4 Table of Related Performance Measures

Sustain the percentage of Federal Power Users (key federal officials involved in health and healthcare policy or programs) that indicate that data quality is good or excellent (Lead Agency - CDC; Measure ID - 8.A.1.1b)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	100% Good or Excellent	100% Good or Excellent	100% Good or Excellent	100% Good or Excellent	100% Good or Excellent	100% Good or Excellent	100% Good or Excellent	100% Good or Excellent
Result	100% Good or Excellent	100% Good or Excellent	80% Good or Excellent	100% Good or Excellent	100% Good or Excellent	Feb 28, 2023	Feb 28, 2024	Feb 28, 2025
Status	Target Met	Target Met	Target Not Met	Target Met	Target Met	Pending	Pending	Pending

CDC uses several indicators to measure its ability to provide timely, useful, and high-quality data. CDC is improving access to NCHS online data sources, including integrating and simplifying existing points of access. Projects underway include developing a scalable data query system and a single data repository with standard and searchable metadata - with the goal of improving user experiences in accessing and using NCHS data. The number of visits to the NCHS website is nearly three times more than the average number of visitors since 2015, likely due to the increased focus on available data during the pandemic. CDC interviews Federal Power Users (key federal officials involved in health and health care policy or programs) to assess their satisfaction with CDC's Health Statistics products and services, including data quality, ease of data accessibility and use, professionalism of staff, relevance of data to major health

issues, and relevance of data to user needs. One hundred percent of federal power users rated NCHS as "good" or "excellent" in data quality – meeting the target for the second consecutive year.

Strategic Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability

HHS is dedicated to advancing strategic management across the Department to build trust, transparency, and accountability. A major focus of the Department is promoting effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices. HHS sustains strong financial stewardship of resources to foster prudent use of resources, accountability, and public trust. HHS works to uphold effective and innovative human capital resource management resulting in an engaged, diverse workforce with the skills and competencies to accomplish the HHS mission. The Department also ensures the security of HHS facilities, technology, data, and information, while advancing environment-friendly practices.

Objective 5.1: Promote effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices.

HHS is supporting strategies to promote effective enterprise governance and ensure programmatic goals are achieved. HHS is strengthening governance, enterprise risk management, and strategic decision making across the Department to better pursue opportunities and address risks while creating a culture of change to support continuous improvement in program and mission delivery.

Because this is a new objective, HHS will not include performance measures for Goal 5 Objective 1. In 2021, HHS had an independent Enterprise Risk Management maturity assessment completed by the American Productivity and Quality Center (APQC) and St. John's University Center for Excellence in Enterprise Risk Management. HHS was assessed as "world-class" with a "systematic" capability. With this assessment, APQC and St. John's noted that HHS is among leading organizations who use Enterprise Risk Management to "lower an organization's risk exposure and drive value through benefits like better decision-making, highly targeted business strategies, and faster responses to disruption." During 2022, HHS continues to use Enterprise Risk Management governance to identify and promote adoption of management best practices and lessons learned during the COVID pandemic. HHS plans to incorporate derived insights into its next update of its own internal Enterprise Risk Management organizational maturity model, once the COVID public health emergency has ended and post-COVID management reviews are completed.

The Office of the Secretary leads this objective. All divisions are responsible for implementing programs under this strategic objective. In consultation with OMB, HHS has determined that performance toward this objective has made noteworthy progress.

Objective 5.2: Sustain strong financial stewardship of HHS resources to foster prudent use of resources, accountability, and public trust

HHS supports strategies to sustain strong financial stewardship of resources. The Department continues to strengthen the financial management environment to prevent and mitigate deficiencies. HHS is focused on upholding accountability, transparency, and financial stewardship of HHS resources to ensure

program integrity, effective internal controls, and payment accuracy. The Department is also building an enhanced financial management workforce that is better able to keep pace with changing contexts.

The Office of the Secretary leads this objective. All divisions are responsible for implementing programs under this strategic objective. In consultation with OMB, HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 5.2 Table of Related Performance Measures

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

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	6.6 %[40]	7 %[41]	7 %[42]	6 %	N/A[43]	N/A	N/A	TBD
Result	7.1 %	7.56 %	4.85 %	3.36 %	N/A	N/A	N/A	N/A
Status	Target Not Met	Target Not Met	Target Exceeded	Target Exceeded	Target Not in Place[44]	Target Not in Place	Target Not in Place	Target Not in Place

The Foster Care program provides matching reimbursement funds for foster care maintenance payments, costs for comprehensive child welfare information systems, training for staff, as well as foster and adoptive parents, and administrative costs to manage the program. Administrative costs that are covered include the work done by caseworkers and others to plan for a foster care placement, arrange therapy for a foster child, train foster parents, and conduct home visits to foster children, as well as more traditional administrative costs, such as automated information systems and eligibility determinations. ACF estimates the national Foster Care payment error rate and develops an improvement plan to strategically reduce, or eliminate where possible, improper payments under the program. State-level data generated from the title IV-E eligibility reviews are used to develop a national error rate estimate for the program. Eligibility reviews are routinely and systematically conducted by ACF in the states, the District of Columbia, and Puerto Rico to ensure that foster care maintenance payments are made only for program-eligible children in eligible placements. The fiscal accountability promoted by these reviews has contributed to a general trend of reductions in case errors and program improvements.

The FY 2019 foster care error rate was 4.85 percent, which exceeded the target of 7 percent. In FY 2020, ACF set an error rate target of 6.00 percent, recognizing that changes in Title IV-E Foster Care eligibility requirements made by the Family First Prevention Services Act may contribute to increased improper payments as states adjusted to changes in law affecting eligibility, particularly for children placed in child care institutions. Due to the COVID-19 pandemic, ACF made the decision to postpone IV-E reviews beginning in the Spring of 2020 until it is again safe to travel and meet onsite. Therefore, ACF has not yet conducted reviews for states subject to the updated child care institution safety check requirements.

[40]The FY 2017 target for this performance measure was updated as the result of IPIA reporting process as approved by HHS and OMB.
[41]The FY 2018 target for this performance measure was updated as the result of the IPIA reporting process as approved by HHS and OMB.
[42]The FY 2019 target for this performance measure was updated as part of the Annual Financial Report process with the Office of Management and Budget (OMB).
[43]In response to COVID-19, HHS postponed Title IV-E reviews beginning in the spring of FY 2020 to protect the health and safety of state and federal staff. Because the reviews provide data normally used to calculate the Foster Care error rate, the postponement of reviews results in HHS having no new data for FY 2021 or FY 2022. Therefore, HHS is not reporting data for this measure in FY 2021 or FY 2022. HHS anticipates resuming reviews in 2023, but does not expect to have information needed to calculate an error rate until FY 2024.
[44] HHS has chosen not to set a target for this performance measure for 2021 due to policy changes and the unknown impact of the COVID-19 public health emergency.

The error rate for FY 2020 was, therefore, based on updated review data for six states as well as previous years' data for other states. Encouragingly, the improper error rate decreased from 4.85 percent in FY 2019 to 3.36 percent in FY 2020 because five out of the six states that were newly reviewed had decreases in error rates. In particular, two states with large programs (and thus more impact) had substantial decreases of more than 13 percent in their state-level error rates.

ACF chose not to set an improper payment reduction target for FY 2021 and FY 2022 given the ongoing COVID-19 public health emergency as it is uncertain when it will be safe to resume conducting onsite Title IV-E Reviews. In light of this uncertainty, as well as the unknown impact of the programmatic changes in title IV-E foster care eligibility made by the Family First Prevention Services Act on the improper payment rate, ACF will not report on the improper payment reduction rate in FY 2021 and FY 2022, and the targets for FY 2023 and FY 2024 will be determined at a later date. ACF will continue to work with all states to ensure that they have a clear understanding of changes in federal eligibility requirements and are prepared to successfully manage Title IV-E eligibility determinations for their Foster Care programs.

Increase the cost-effectiveness ratio (total dollars collected per $1 of expenditures). (OMB approved efficiency) (Lead Agency - ACF; Measure ID - 20.2LT and 20E)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	$5.20	$5.20	$5.20	$5.20	$5.20	$5.20	$5.20	$5.20
Result	$5.15	$5.14	$5.06	$5.51	$5.27	Nov 30, 2023	Nov 30, 2024	Nov 30, 2025
Status	Target Not Met	Target Not Met	Target Not Met	Target Exceeded	Target Exceeded	Pending	Pending	Pending

The purpose of the Child Support Enforcement program is to provide funding to states to support state-administered programs of financial assistance and services for low-income families to promote their economic security, independence, and self-sufficiency. This performance measure calculates efficiency by comparing total IV-D dollars collected and distributed by states with total IV-D dollars expended by states for administrative purposes; this is the Child Support Performance and Incentive Act (CSPIA) cost-effectiveness ratio (CER). The formula for determining the CER is the total collections distributed, plus the collections forwarded to other states and countries for distribution, and fees retained by other states, divided by the administrative expenditures, less the non-IV-D administrative costs. In FY 2021 the national CER ratio was $5.27. While this performance exceeded the target for FY21, it is important to note that there are many programmatic and economic variables that this measure does not account for. For example, we saw significant improvement last year due to the surge in collections primarily due to offsets from increased unemployment insurance benefits and economic impact payments because of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. In FY 2021, the CER declined from $5.51 (previous year) to $5.27 when collection surges leveled off. Similarly, increases in total IV-D dollars expended on program investments may decrease the CER initially, even though the investment may ultimately lead to increased program performance. Since continued fluctuations are expected, the $5.20 target is maintained through FY 2024.

ACF will continue to focus on increased efficiency of state programs through approaches such as automated systems of case management and enforcement techniques, administration simplifications, improving collaboration with families and partner organizations, and building on evidence-based innovations. The Child Support Program has continued to promote and advance key priorities that have a direct and positive impact on states, territories, and tribes and, most importantly, families. Maintaining investments in vital programs that serve to reduce poverty and improve families' economic stability are

effective ways to avoid public assistance costs and save money long-term. Furthermore, the Child Support Program serves mostly families with modest incomes who are more likely to spend the child support money quickly to meet basic household needs.

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

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	9.50 %	8.08 %	7.90 %	7.77 %	N/A	9.69 %	5.77%	TBD[45]
Result	8.31 %	8.10 %[46]	7.87 %	6.78 %	10.28 %	5.42%	Nov 15, 2023	Nov 15, 2024
Status	Target Exceeded	Target Met	Target Exceeded	Target Exceeded	Historical Actual	Target Exceeded	Pending	Target Not In Place

In FY 2022, CMS reported an actual improper payment estimate of 5.42 percent or $13.94 billion. CMS finalized a policy regarding treatment of spontaneous "additionals" in the improper payment rate calculation. Diagnoses that were not submitted to CMS for payment have been excluded from the payment error calculation to get a true measure of payment error. In previous years, these potential payments were reflected in the underpayment rate and overall payment error calculation; however, including the spontaneous "additionals" in the gross underpayment portion resulted in an overstatement of the overall improper payment rate. The implemented policy contributed to a decrease in the projected Part C improper payment rate, representing a new baseline improper payment rate for Part C and is not directly comparable with prior reporting years. Moreover, FY 2021 also represented a new baseline due to various methodology changes, most significantly, a refined denominator calculation.

The Part C Improper Payment Measurement (IPM) methodology estimates improper payments resulting from errors in beneficiary risk scores. The primary component of most beneficiary risk scores is clinical diagnoses (the CMS Hierarchical Condition Category [CMS-HCC]) submitted by the MA Organizations. To calculate the projected error rate, CMS selects a random sample of enrollees with one or more CMS-HCCs and requests medical records to support each condition. If medical records do not support the diagnoses submitted to HHS the risk scores may be inaccurate and result in payment errors.

In FY 2022, CMS selected a stratified random sample of beneficiaries with a risk adjusted payment in Payment Year 2020 (where the strata are high, medium, and low risk scores) and reviewed medical records of the diagnoses submitted by plans for the sample beneficiaries. CMS establishes improper payment rate targets only for the next fiscal year; therefore, the FY 2024 target will be established in the FY 2023 HHS AFR.

The primary error type of Medicare Part C improper payments consists of medical record discrepancies (4.74 percent in overpayments and 0.49 percent in underpayments), with a smaller portion of improper payments resulting from insufficient documentation to determine whether proper or improper (0.19 percent). Improper payments due to medical record discrepancies occur when medical record documentation submitted by the MA Organization does not substantiate the CMS-HCC for which it received payment. The underpayment component is comprised of risk scores identified during the medical review process that the MA Organization did not submit for payment.

[45]The FY 2024 target will be established in the FY 2022 HHS AFR and FY 2023 HHS AFR, respectively

[46]CMS uses Payment Integrity Information Act (PIIA) standards, rather than GPRAMA standards, for performance reporting on improper payments. Programs with established valid and rigorous estimation methodologies should count reduction targets as being met if the 95% confidence interval includes the reduction target.

The factors contributing to improper payments are complex and vary from year to year. Each year, CMS outlines actions the agency will implement to prevent and reduce improper payments in Medicare Part C. Detailed information on corrective actions can be found in the 2022 HHS AFR.

Reduce the Percentage of Improper Payments Made Under the Part D Prescription Drug Program (Lead Agency - CMS; Measure ID - MIP6)[47]

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	3.3 %	1.66 %	1.65 %	0.74 %	1.14 %	1.20 %	1.64%	TBD[48]
Result	1.67 %	1.66 %	0.75 %	1.15 %	1.33 %	1.54%	Nov 15, 2023	Nov 15, 2024
Status	Target Exceeded	Target Met	Target Exceeded	Target Not Met	Target Met	Target Met	Pending	Pending

In FY 2022, CMS reported an improper payment estimate of 1.54 percent of total outlays or $1.36 billion. The improper payment estimate due to missing or insufficient documentation is 1.21 percent or $1.07 billion, representing 78.49 percent of total improper payments. The increase from the prior year's estimate of 1.33 percent is due to year-over-year variability and is not statistically different from the prior year. As the rate is already low, variation in sampled error types and amounts can cause minor shifts in the total estimated error rate. Per OMB guidance, CMS establishes improper payment rate targets only for the next fiscal year, therefore the FY 2024 target will be established in the FY 2023 HHS AFR.

The Part D program payment error estimate measures the payment error related to Prescription Drug Event (PDE) data, where most errors for the program exist. CMS measures inconsistencies between information reported on PDEs and supporting documentation submitted by Part D sponsors: prescription record hardcopies (or medication orders as appropriate) and detailed claims information. Based on these reviews, each PDE in the audit sample is assigned a gross drug cost error. A representative sample of beneficiaries undergoes a simulation to determine the Part D improper payment estimate.

The FY 2022 Medicare Part D improper payment error categories are drug or drug pricing discrepancies (0.29 percent in Overpayments and 0.04 percent in Underpayments) and insufficient documentation to determine whether proper or improper (1.21 percent). Improper payments due to drug or drug pricing discrepancies occur when the prescription documentation submitted indicates that an overpayment occurred. Underpayments result when prescription record hard copies (or medication orders) indicate that CMS should have paid more.

The factors contributing to improper payments are complex and vary from year to year. Each year, CMS outlines actions the agency will implement to prevent and reduce improper payments in Medicare Part D. Detailed information on corrective actions can be found in the FY 2022 HHS AFR.

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

[48] Starting in FY 2017, per OMB guidance, CMS establishes improper payment rate targets only for the next fiscal year. Therefore, the FY 2024 target will be established in the FY 2023 HHS AFR.

Reduce the Improper Payment Rate in the Medicare Fee-for- Service (FFS) Program (Lead Agency - CMS; Measure ID - MIP1)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	10.40 %	9.40 %	8.00 %	7.15 %	6.17 %	6.16 %	7.36%	TBD[49]
Result	9.51 %	8.12 %	7.25 %	6.27 %	6.26 %[50]	7.46%	Nov 15, 2023	Nov 15, 2024
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Met	Target Not Met	Pending	Target Not In Place

The Medicare Fee-for-Service (FFS) improper payment rate is calculated by the Comprehensive Error Rate Testing (CERT) program and reported in the Department of Health and Human Services (HHS) Agency Financial Report (AFR) on an annual basis. Information on the Medicare FFS improper payment methodology can be found in the FY 2022 HHS AFR. Starting in FY 2017, per OMB guidance, CMS establishes improper payment rate targets only for the next fiscal year. Therefore, the FY 2024 target will be established in the FY 2023 HHS AFR.

In August 2020, CMS resumed CERT program activities that had been paused due to COVID-19, thus impacting the FY 2022 reporting period. As a result, the improper payment rate reflects processes that had a 2-month delay in contacting providers and suppliers for documentation and an adjusted sample size. In addition, the waivers and flexibilities provided by CMS for providers and suppliers during COVID-19 apply to all claims in the FY2022 reporting period.

The Medicare FFS improper payment estimate for FY 2022 is 7.46 percent, or $31.46 billion. While the factors contributing to improper payments are complex and vary by year, the primary causes of improper payments continue to be insufficient documentation and medical necessity errors as described in the following four driver service areas:

- Skilled Nursing Facilities (SNF): Insufficient documentation continues to be the major error reason for SNF claims. The improper payment estimate for SNF claims increased from 7.79 percent in FY2021 to 15.10 percent in FY2022. The primary reasons for these errors are missing documentation to support the level of care requirements and missing documentation to support the required components for the billed code.
- Hospital Outpatient: Insufficient documentation continues to be the major error reason for hospital outpatient claims. The improper payment estimate for hospital outpatient claims increased from 4.57 percent in FY2021 to 5.43 percent in FY2022; however, this change is not statistically significant. The primary reason for these errors is missing documentation to support the order, or the intent to order for certain services.
- Hospice: Both insufficient documentation and medically unnecessary were the major error reasons for hospice claims. The improper payment estimate for hospice claims increased from 7.77 percent in FY2021 to 12.04 percent in FY2022. The primary reasons for these errors are missing or insufficient documentation to support the certification or recertification and the hospice coverage criteria for medical necessity was not met.
- Home Health: Medically unnecessary was the major error reason for home health claims. The improper payment estimate for home health claims decreased from 10.24 percent in FY 2021 to 10.15 percent in FY 2022; however, this change is not statistically significant.

[49]The FY 2024 target will be established in the FY 2023 HHS AFR

[50]CMS uses Payment Integrity Information Act (PIIA) standards, rather than GPRAMA standards, for performance reporting on improper payments. Programs with established valid and rigorous estimation methodologies should count reduction targets as being met if the 95% confidence interval includes the reduction target.

The primary reason for these errors is that the home health coverage criteria for medical necessity was not met.

CMS develops and refines multiple preventive and detective measures for specific service areas with high improper payment estimates, such as hospital outpatient, SNF, home health, hospice, and other areas. CMS believes implementing targeted corrective actions will prevent and reduce improper payments in these areas and reduce the overall improper payment estimate. Detailed information on corrective actions can be found in the 2022 HHS AFR.

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

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	9.57 %	7.93 %	N/A[51]	N/A[52]	N/A[53]	18.94 %	12.68%	TBD[54]
Result	10.10 %	9.79 %	14.90 %[55]	21.36 %[56]	21.69 %[57]	15.62%	Nov 15, 2023	Nov 15, 2024
Status	Target Not Met but Improved	Target Not Met but Improved	Historical Actual	Historical Actual	Historical Actual	Target Exceeded	Pending	Target Not In Place

[51]2019 is the first year the eligibility component measurement is resumed. Targets will not be established until all three cycles have been measured for eligibility.
[52]2019 is the first year the eligibility component measurement is resumed. Targets will not be established until all three cycles have been measured for eligibility.
[53]2019 is the first year the eligibility component measurement is resumed. Targets will not be established until all three cycles have been measured for eligibility.
[54]Starting in FY 2017, per OMB guidance, CMS establishes improper payment rate targets only for the next fiscal year. Therefore, the FY 2024 target will be established in the FY 2023 HHS AFR.
[55]2019 is the first year the eligibility component measurement is resumed, therefore results in FY 2019 do not reflect all states under the new eligibility methodology.
[56]2019 is the first year the eligibility component measurement is resumed, therefore results in 2020 do not reflect all states under the new eligibility methodology.
[57]2019 is the first year the eligibility component measurement is resumed, therefore results in FY 2021 may not reflect all states under the new eligibility methodology.

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

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	7.38 %	8.2 %	N/A[58]	N/A[59]	N/A[60]	27.88 %[61]	21.04%	TBD[62]
Result	8.64 %	8.57 %	15.83 %[63]	27 %[64]	31.84 %[65]	26.75%	Nov 15, 2023	Nov 15, 2024
Status	Target Not Met	Target Not Met but Improved	Historical Actual	Historical Actual	Historical Actual	Target Exceeded	Pending	Target Not In Place

The Payment Error Rate Measurement (PERM) program measures improper payments for the FFS, managed care, and eligibility components of both Medicaid (MIP9.1) and CHIP (MIP9.2). CMS measures improper payments in 17 states each year to calculate a rolling, three-year national improper payment rate for both Medicaid and CHIP. The national Medicaid and CHIP improper payment rates reported in the FY 2022 HHS AFR are based on measurements that were conducted in FYs 2020, 2021, and 2022. Information on the Medicaid and CHIP statistical sampling process and review period can be found in the FY 2022 HHS AFR. Per OMB guidance, CMS establishes improper payment targets only for the next fiscal year, therefore the FY 2024 target will be established in the FY 2023 HHS AFR.

The national Medicaid improper payment estimate for FY 2022 is 15.62 percent or $80.57 billion. The national Medicaid component rates are 10.42 percent for Medicaid FFS, 0.03 percent for Medicaid managed care, and 11.89 percent for the Medicaid eligibility component.

The national CHIP improper payment estimate reflects reviews that accounted for certain flexibilities afforded to states during COVID-19, such as postponed eligibility determinations and reduced requirements around provider enrollment or revalidations. CMS will publish supplemental information related to the Medicaid results on the CMS website following AFR publication.

The areas driving the Medicaid improper payment estimate are:

- **Insufficient Documentation:** Represents situations where the required verification of eligibility data, such as income, was not done at all and where there is an indication that eligibility verification was initiated but the state provided no documentation to validate that the verification process was completed. This includes situations where medical records were either not submitted or were missing required documentation to support the medical necessity of the claim.
- **State Non-Compliance:** Represents noncompliance with federal eligibility redetermination requirements; enrolled providers not appropriately screened by the state; providers not

[58]2019 is the first year the eligibility component measurement is resumed. Targets will not be established until all three cycles have been measured for eligibility.
[59]2019 is the first year the eligibility component measurement is resumed. Targets will not be established until all three cycles have been measured for eligibility.
[60]2019 is the first year the eligibility component measurement is resumed. Targets will not be established until all three cycles have been measured for eligibility.
[61]The FY 2021 AFR will report a target established for 2022.
[62]The FY 2024 target will be established in the FY 2023 HHS AFR.
[63]2019 is the first year the eligibility component measurement is resumed, therefore results in FY 2019 do not reflect all states under the new eligibility methodology.
[64]2019 is the first year the eligibility component measurement is resumed, therefore results in FY 2020 do not reflect all states under the new eligibility methodology.
[65]2019 is the first year the eligibility component measurement is resumed, therefore results in FY 2021 do not reflect all states under the new eligibility methodology.

appropriately rescreened at revalidation; providers not enrolled; and/or providers without the required National Provider Identifier on the claim. State compliance with provider enrollment or screening requirements has improved as the Medicaid FFS component improper payment estimate decreased from 13.90 percent in RY 2021 to 10.42 percent in RY 2022. COVID-19 review flexibilities afforded to states should also be considered in the identified decrease in the Medicaid FFS and eligibility components between RY 2021 and RY 2022.

The national CHIP improper payment estimate for FY 2022 is 26.75 percent or $4.30 billion. The national CHIP component rates are 11.23 percent for CHIP FFS, 0.62 percent for CHIP managed care, and 24.01 percent for the CHIP eligibility component.

The national CHIP improper payment estimate reflects reviews that accounted for certain flexibilities afforded to states during COVID-19, such as postponed eligibility determinations and reduced requirements around provider enrollment or revalidations. CMS will publish supplemental information related to the CHIP results on the Payment Error Rate Measurement page of the CMS website following AFR publication.

The areas driving the CHIP improper payment estimate are as follows:

- **Insufficient Documentation:** Represents situations where the required verification of eligibility data, such as income, was not done at all and where there is an indication that eligibility verification was initiated but the state provided no documentation to validate that the verification process was completed. This includes situations where medical records were either not submitted or were missing required documentation to support the medical necessity of the claim.
- **Improper Determinations:** Represents situations where the beneficiary was inappropriately claimed under Title XXI (CHIP) rather than Title XIX (Medicaid), mostly related to incorrect state calculations based on beneficiary income, the presence of third-party insurance, household composition, or tax filer status. Improper Determinations accounted for 14.68 percent or $0.63 billion of total errors cited in CHIP FFS, CHIP managed care and CHIP eligibility.
- **State Non-Compliance:** Represents noncompliance with federal eligibility redetermination requirements; enrolled providers not appropriately screened by the state; providers not appropriately rescreened at revalidation; providers not enrolled; and/or providers without the required National Provider Identifier on the claim. State compliance with provider enrollment or screening requirements has improved as the CHIP FFS component improper payment estimate decreased from 13.67 percent in RY 2021 to 11.23 percent in RY 2022. COVID-19 review flexibilities afforded to states should also be considered in the identified decrease in the CHIP FFS and eligibility components between RY 2021 and RY 2022.

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 states-specific Corrective Action Plans (CAPs) to CMS. Each year, CMS also outlines actions the agency will implement to prevent and reduce improper payments for all error categories on a national level. Detailed information on corrective actions can be found in the FY 2022 HHS AFR.

Objective 5.3: Uphold effective and innovative human capital resource management resulting in an engaged, diverse workforce with the skills and competencies to accomplish the HHS mission

HHS supports strategies to uphold effective and innovative human capital resource management. HHS is focused on building and sustaining a strong workforce through improved recruitment, hiring, and

retention efforts. The Department is leveraging training and professional development opportunities to develop and manage a high-performing workforce while providing leaders and managers with the insight and tools to effectively carry out change management, organizational learning, and succession planning.

The Office of the Secretary leads this objective. All divisions are responsible for implementing programs under this strategic objective. In consultation with OMB, HHS has determined that performance toward this objective is a focus area for improvement due to the challenges of return-to-work and future-of-work activities and the many associated risks and opportunities. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 5.3 Table of Related Performance Measures

The Office of Human Resources (OHR) is leading efforts to improve the different aspect of the workplace conditions that lead to engagement. OHR is focusing these activities in three key strategic areas for employees: (1) Intrinsic Work Experience, (2) Opportunities for Professional Development and Growth and (3) Engagement, which are aligned to the HHS Strategic Plan, OMB planning, and OPM human capital initiatives as well as unique HHS organizational priorities. The intent of these efforts is:

- To increase the Department's conditions conducive to engagement
- Develop opportunities for employees to improve skills and enhance professional development.
- Improve employees' feelings of motivation and competency relating to their role in the workplace.

Intrinsic Work Experience. (Lead Agency - ASA; Measure ID – 2.8)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target						80%	80.5%	81.0%
Result						79.5 %	Dec 31, 2023	Dec 31, 2024
Status						Target Not Met	Pending	Pending

One of the five key drivers of employee engagement, Intrinsic Work Experience, considers employees' feelings of motivation and competency related to their role in the workplace, such as sense of accomplishment and their perception of their skill usage. Compared to other very large and large federal agencies, HHS continues to excel in this area despite barely missing its target by 0.5%[66].

[66] Office of Personnel Management *Federal Employee Viewpoint Survey Results 2022* https://www.opm.gov/fevs/reports/governmentwide-reports/governmentwide-reports/governmentwide-management-report/2022/2022-governmentwide-management-report.pdf

Employee Satisfaction with Opportunities for Professional Development and Growth. (Lead Agency - ASA; Measure ID – 2.9)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target						68%	68.5%	69.0%
Result						71.9%	Dec 31, 2023	Dec 31, 2024
Status						Target Exceeded	Pending	Pending

Employee Satisfaction with Opportunities for Professional Development and Growth reflects the employees' perceptions as to the opportunities they have to improve their skills in their organization and if their talents are used well in the workplace. The HHS Learning Management System (LMS) is used across the Department for the administration, documentation, tracking, and reporting of training programs, classroom and online events, e-learning programs, and training content. In FY 2022, employees reported high levels of course satisfaction for all courses taken in the LMS.

Employee Engagement Index. (Lead Agency - ASA; Measure ID – 2.6)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target	69% employee engagement index	72.5% employee engagement index	73% employee engagement index	75% employee engagement index	73% employee engagement index	77% employee engagement index	77.5% employee engagement index	78.0% employee engagement index
Result	72% employee engagement index	72.8% employee engagement index	73.5% employee engagement index	76.5% employee engagement index	77.4%	77.9% employee engagement index	Dec 31, 2023	Dec 31, 2024
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Employee engagement is foundational to achieving the level of active strategic management needed for building and sustaining the 21st century workforce. The OPM Federal Employee Viewpoint Survey (FEVS) measures employee engagement because it drives performance. Engaged employees look at the whole of the organization and understand their purpose within the agency's mission. This understanding leads to better decision-making. The 2021 FEVS was administered from November 8, 2021 – December 10, 2021. FY 2022 results indicate that HHS continues to improve its Department-wide Employee Engagement Index score, rising to 77.9% for the FY 2022.

Objective 5.4: Ensure the security and climate resiliency of HHS facilities, technology, data, and information, while advancing environment-friendly practices.

HHS supports strategies to ensure the security of HHS facilities, technology, data, and information, while advancing environment-friendly practices. HHS is focused on shifting the culture of data use across the enterprise to maximize the power of data. The Department is leveraging modernization as a gateway to strengthened cybersecurity and enhanced risk management. HHS also captures and applies lessons learned from real-world experiences to strengthen operational resilience.

The Office of the Secretary leads this objective. All divisions are responsible for implementing programs under this strategic objective. In consultation with OMB, HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 5.4 Table of Related Performance Measures

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

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target		Set Baseline	96.5 %	97 %	100 %	100 %	100 %	100 %
Result		96 %	95 %	98 %	99 %	99 %	Dec 31, 2023	Dec 31, 2024
Status		Baseline	Target Not Met	Target Exceeded	Target Not Met but Improved	Target Not Met	Pending	Pending

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

It is the responsibility of the OpDiv Chief Information Officers, Chief Information Security Officers, and StaffDiv system owners to maintain their system ATOs. HHS has made continued improvements toward meeting the ATO compliance target and will continue to implement proactive initiatives to meet the 100% target.

Phishing Test Success Rate. (Lead Agency - ASA; Measure ID – 3.7)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target						95 %	95 %	95 %
Result						96 %	Dec 31, 2023	Dec 31, 2024
Status						Target Exceeded	Pending	Pending

Phishing is a fraudulent attempt to obtain sensitive information (e.g., usernames and passwords) to access a system or network. Per various threat analyses, phishing attacks remain one of the main threat vectors targeting HHS and the healthcare industry. HHS trains and educates its personnel to reduce the likelihood of staff mistaking phishing email attempts for legitimate communications through a combination or training, education, and tools. The response rates to phishing training drills is 96% (i.e., only 4% of personnel take the "bait.")

Reduce HHS GHG emissions (Metric Tons CO2 Equivalent) from prior FY (Lead Agency - ASA; Measure ID – 1.4)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target						2 %	2 %	2 %
Result						8.73%	Jan 31, 2024	Jan 31, 2025
Status						Target Exceeded	Pending	Pending

HHS uses the DOE Federal Energy Management Program greenhouse gas emissions (GHG) emissions report to identify and target high emission categories and implement specific actions to address the identified high emission areas. For HHS, the highest focus is on Scope 1 and 2 GHG emissions generated by energy use in building and laboratory operations. HHS also continues to focus on promoting green commuting habits for employees to reduce GHG emissions. Public transportation, car and van pools, and teleworking are emphasized through the promotion of transit subsidies, enhanced access to public transportation, and employee outreach.

Increase HHS owned facilities municipal solid waste (MSW) diversion rate (Lead Agency - ASA; Measure ID – 1.5)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target						44 %	46 %	48 %
Result						72.6%	Jan 31, 2024	Jan 31, 2025
Status						Target Exceeded	Pending	Pending

HHS continues to prevent and reduce waste and pollution by diverting waste to landfill and eliminating single use plastic through the promotion and establishment of closed loop recycling processes.

Reduce energy intensity (MMBtu/kSF) from prior FY (Lead Agency - ASA; Measure ID – 1.6)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target						2 %	2 %	2 %
Result						-0.58%	Jan 31, 2024	Jan 31, 2025
Status						Target Not Met	Pending	Pending

HHS focuses on improving facility energy efficiency through dedicated energy reduction projects, renovations and upgrade projects, and new construction. Facility evaluations identify projects that can be bundled into performance contracts or with scheduled upgrades and renovations. Employee energy efficiency awareness and outreach is another strategy used to engage the HHS workforce in the effort to improve facility energy efficiency.

Reduce water intensity (Gal/kSF) from prior FY (Lead Agency - ASA; Measure ID – 1.7)

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Target						2 %	2 %	2 %
Result						-11.38%	Jan 31, 2024	Jan 31, 2025
Status						Target Not Met	Pending	Pending

HHS focuses on improving water efficiency through infrastructure upgrades, leak detection and prevention, metering, and implementing no-cost or low-cost water conservation measures (WCMs). WCMs are primarily implemented through performance contracts or bundled in HHS-funded upgrade projects. HHS also works to improve the efficiency of research water use in laboratories.

Major Management Priorities

The HHS OIG has identified the top management and performance challenges for 2022. HHS management is committed to working toward resolving these challenges. The performance measures in this document track such challenges safeguarding public health, ensuring the financial integrity of HHS programs, delivering value, quality and improved outcomes in Medicare and Medicaid, protecting the health and safety of HHS beneficiaries, harnessing data to improve the health and well-being of individuals, and improving collaboration to better serve our Nation. In addition, HHS employs a robust program integrity process. For further information about these challenges, please read the HHS 2022 Top Management and Performance Challenges.

Cross-Agency Collaborations

The Federal Government has a unique legal and political government-to-government relationship with tribal governments and provides health services for American Indians and Alaska Natives consistent with that special relationship. HHS works with tribal governments, urban Indian organizations, and other tribal organizations to facilitate greater consultation and coordination between states and tribes on health and human services issues. The HHS Office of Intergovernmental and External Affairs (IEA) facilitates Regional Tribal Consultations, Annual Tribal Budget Consultation, and regular meetings of the Secretary's Tribal Advisory Council (STAC). The Indian Health Service (IHS) also regularly consults and confers with Tribes and Urban Indian Organizations on funding allocations and policy decisions that impact Indian Country.

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

Lower-Priority Program Activities

The President's Budget identifies the lower-priority program activities, where applicable, as required under the GPRA Modernization Act of 2010, 31 U.S.C. 1115(b)(10). The public can access the volume at: http://www.whitehouse.gov/omb/budget.

Evidence Building Efforts

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

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

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

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

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

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