FISCAL YEAR 2013

Annual Performance Report and Performance Plan

Released February, 2012

U.S. Department of Health & Human Services

HHS.GOV

Message from HHS Performance Improvement Officer

Managing performance to achieve desired results is a responsibility that HHS takes very seriously. Thousands of HHS staff, grantees, contractors, volunteers and community members contributed to the results reflected in this report and should take pride in the outcomes that HHS can demonstrate from the investments made by US taxpayers. From the Head Start classroom where low income children receive high quality education to the NIH lab where scientific breakthroughs contribute to advances in medical science, HHS is working every day to improve the lives of Americans.

This report reflects a new, more holistic approach to HHS performance reporting which meets Government Performance Results Modernization Act requirements for an annual performance report and performance plan. Previously, each of the HHS Operating Divisions and many of the Staff Divisions prepared performance reports separately, documenting more than 1,000 measures and more than 1,800 pages of performance reporting. This year, HHS has consolidated performance reports organization-wide, selected a representative set of measures highlighting key programs and priorities, and aligned these measures to the HHS Strategic Plan. Each HHS component has reviewed their submissions and I confirm, to the best of my ability, that the data is reliable and complete. When results are not available because of delays in data collection, the date when the results will be available is noted in the report.

Performance reporting improvements are a small part of what HHS has done this year to improve the outcomes of services, research, and administration. In addition to formalizing the role of the Performance Improvement Officer, HHS has instituted quarterly data-driven reviews with HHS senior staff and counselors to monitor progress on achieving key performance objectives. Priority Goals for the period of FY 2010 – 2011 were managed, all demonstrating improved results, while Priority Goals for FY 2012 – 2013 were developed. A network of performance professionals throughout HHS components was strengthened and supported through improved tools like performance tracking software, best practice discussions through webinars, and regular meetings with HHS performance leaders.

HHS staff in the most recent Employee Viewpoint Survey demonstrated a high commitment to achieving the HHS mission to enhance the health and well-being of Americans. The following pages should provide you with illustrative examples of the great work done in FY 2011 and what accomplishments we expect for the future.

Ellen Murray
Assistant Secretary for Financial Resources
Health and Human Services

Table of Contents

Mission Statement

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

Strategic Plan Overview

The U.S. Department of Health and Human Services (HHS) developed a new strategic plan in 2010, and made minor updates to the plan in the Fall of 2011. The plan, available at http://www.hhs.gov/secretary/about/priorities.html , identifies five strategic goals and 25 related objectives. The five strategic goals are:

Goal 1: Strengthen Health Care

Goal 2: Advance Scientific Knowledge and Innovation

Goal 3: Advance the Health, Safety, and Well-being of the American People

Goal 4: Increase the Efficiency, Transparency and Accountability of HHS Programs

Goal 5: Strengthen the Nation's Health and Human Services Infrastructure and Workforce

HHS Organizational Structure

HHS is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

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

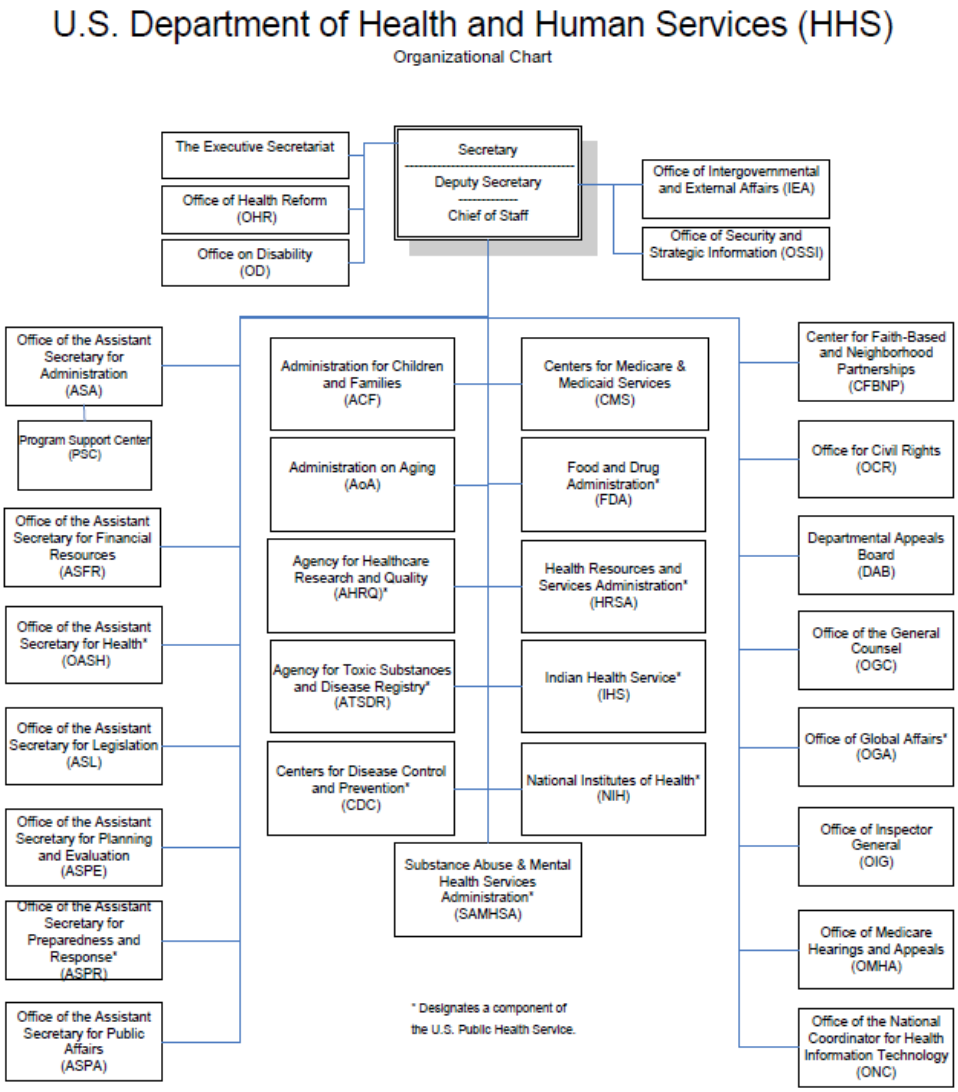
- Administration for Children and Families (ACF)
- Administration on Aging (AoA)
- Agency for Healthcare Research and Quality (AHRQ)
- Agency for Toxic Substances and Disease Registry (ATSDR)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Food and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

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

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

Throughout this document the operating divisions and staff divisions will be collectively referred to as HHS components.

Organizational Chart Department of Health and Human Services (Text Version)



Performance Management

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

Responding to opportunities afforded by the Government Performance Modernization Act, HHS has instituted significant improvement in performance management during Fiscal Year 2011 including:

- Implementation of a new, streamlined HHS performance plan more clearly focused on HHS priorities and organized around the new HHS Strategic Plan.
- Systematic review, analysis, reporting and management of nine Priority Goals to be achieved by the end of FY 2011, and the development of a new set of Priority Goals for FY 2012-2013.
- Implementation of quarterly performance reviews between HHS component staff and HHS leadership to monitor progress to achieving key performance objectives identified by each division.
- Performance Improvement Officer visits with leadership at each HHS component to encourage and better understand efforts to improve performance management efforts across HHS.
- Development and support of a network of Performance Officers who support, coordinate and implement performance management efforts across HHS.
- Sharing of best practices in performance management at HHS through webinars and other media.

HHS Priority Goals

HHS, along with other Federal agencies, uses priority goals to improve performance and accountability. HHS established a set of near-term (18 – 24 months) High Priority Performance Goals (Priority Goals) in the FY 2011 President's Budget which were to be accomplished by the end of FY 2011. HHS began holding quarterly data-driven reviews to monitor progress towards its Priority Goals in FY 2011, and is currently working to improve the effectiveness of those reviews. A new set of Priority Goals has been established for FY 2012 - FY 2013.

A summary of the initial FY 2010 - FY 2011 Priority Goals and HHS's accomplishments related to those goals is provided below, followed by a listing of the new FY 2012-FY 2103 Priority Goals. Significant progress was made for all the 2010 - 2011 goals including those that were not fully achieved, despite encountering challenges such as funding cuts, legislative barriers, data lags and other challenges.

HHS Priority Goals FY 2010 – FY 2011

Access to Early Care and Education Programs for Low-Income Children: By the end of 2010, increase the number of low-income children receiving Federal support for access to high quality early care and education settings including an additional 61,000 children in Head Start and Early Head Start and an average of 10,000 additional children per month through the Child Care and Development Fund (CCDF) over the number of children who were enrolled in 2008.

RESULT REPORTED: As of September 30, 2011 59,696 additional Head Start and Early Head Start children were served, achieving 98 percent of the target and substantially increasing the number of children served.

Quality in Early Care and Education Programs for Low-Income Children: Take actions in 2010 and 2011 to strengthen the quality of early childhood programs by advancing re-competition, implementing improved performance standards and improving training and technical assistance systems in Head Start; promoting community efforts to integrate early childhood services; and by expanding the number of states with Quality Ratings Improvement Systems that meet high quality benchmarks for Child Care and other early childhood programs developed by HHS in coordination with the Department of Education.

RESULT REPORTED: ACF made progress on its goal of improving quality in early care and education programs for low-income children. HHS implemented a new training and technical assistance framework for Head Start and Child Care to support this goal. A Final Rule that requires low performing Head Start grantees to recompete for continued funding was enacted. HHS also piloted draft Quality Rating Improvement System (QRIS) high quality benchmarks for Child Care programs in 10 states and territories, and developed supportive tools to help all states assess the quality of child care and provide easy-to-understand quality information to parents so that they can assess the child care choices available in their community.

Medicaid and Children's Health Insurance Program: Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in the Children's Health Insurance Program (CHIP) and Medicaid.

RESULT REPORTED: Though CMS fell short of its interim FY 2010 target to increase children's enrollment in CHIP by 5 percent over the FY 2008 baseline, CMS achieved a 4.6 percent increase in CHIP enrollment. Children's enrollment in Medicaid increased by 15 percent between FY 2008 and FY 2010, which may have been in part due to a shift from CHIP to Medicaid for families impacted by the economic downturn. In total, combined CHIP and Medicaid enrollment has increased since FY 2008.

Food Safety: By the end of 2011, decrease by 10 percent from the 2007-2009 average baseline, the rate of sporadic Salmonella Enteritidis (SE) illnesses in the population.

RESULT REPORTED: In spite of the high level of compliance that has been confirmed by FDA in large egg firms, the rate of SE illnesses in the population is not on track to meet the target. This is likely due to a number of factors. For example, small firms, which produce almost 18% of the eggs consumed in the United States, are not required to comply with the rule until July 2012. In addition, many foods other than eggs can cause SE illness. The SE rates could also include transmission of SE from non-food sources, such as reptiles.

The final result for this goal uses data from FoodNet, a surveillance system in 10 sites throughout the United States. The rate of illness in 2011 is calculated by dividing the total

number of SE illnesses that were laboratory-confirmed in FoodNet sites by the total population in those sites. Work is being undertaken in 2012 to improve the ability to estimate the number of illnesses that can be attributed to specific food commodities. This will improve the ability to monitor the impact of a specific intervention (e.g., the Egg Rule) on the rate of illness.

Tobacco - Supportive Policy and Environments: By the end of 2011, increase to 75 percent the percentage of communities funded under the Communities Putting Prevention to Work (CPPW) program that have enacted new smoke-free policies and improved the comprehensiveness of existing policies.

RESULT REPORTED: This goal, based on CDC's Communities Putting Prevention to Work program, focused on providing the support and evidence base for strengthening smoke-free indoor air policies at the community level. CDC reported four out of the 11 (36 percent) communities pursuing smoke-free policies enacted new smoke-free policies or improved the comprehensiveness of existing policies. CDC anticipates that additional communities will enact improved policies before their grant funding period ends, but recognizes that change is a lengthy and complex process. To support this goal, CDC implemented regular performance reviews to identify gaps in grantee resources/capacity, as well as tailor technical assistance to meet various and unique needs of the funded communities.

Primary Care: By the end of 2011, increase access to primary health care by increasing the Field Strength of the National Health Service Corps (NHSC) to 10,500 primary care providers. This is in contrast to the 2008 field strength of 3,601.

RESULT REPORTED: The field strength of the National Health Service Corp is at its highest levels in 40 years. Though there was an 82 percent funding cut in the base appropriation, the program succeeded in increasing the number of clinicians to 10,279, achieving 98 percent of the target.

Emergency Preparedness - Incident Command Structure: By 2011, increase the percentage of State public health agencies that can convene within 60 minutes of notification a team of trained staff that can make decisions about appropriate response and interaction with partners to 90 percent.

RESULT REPORTED: Improving from a 2009 baseline of 70 percent, the FY 2010 result of 84 percent exceeded the target by four percent. Although final data for FY 2011 will not be available until March 2012, CDC's review of awardees' interim reports indicates that State public health agencies will meet the FY 2011 target of 90 percent.

Health Information Technology: By the end of FY 2011, establish the infrastructure necessary to encourage the adoption and meaningful use of Health Information Technology by:

- Establishing a network of Regional Extension Centers covering 100 percent of the United States Population by the end of FY 2010.
- Registering 30,000 providers to receive services from Regional Extension Centers by the end of FY2010.

- Registering 100,000 providers to receive services from Regional Extension Centers by the end of FY2011.

- Achieving 40 percent adoption of EHRs among providers who have been registered with a Regional Extension Centers for at least 10 months, by the end of FY2011.

  RESULT REPORTED: HHS/ONC successfully established a network of Regional Extension Centers covering 100 percent of the target population by the end of FY 2010. The program's primary care provider registration drive began in April, 2010 and had 11,875 providers signed up by September 2010, with nearly 98,000 providers signed up by September 2011. Regional Extension Centers are actively providing intensive technical assistance for implementing electronic health records. Forty-six percent of registered providers have adopted electronic health records within 10 months, exceeding the target for this goal.

Biomedical Research: By 2011, reduce the fully-loaded cost of sequencing a human genome to $25,000.

RESULT REPORTED: NIH exceeded their target and reduced the cost of sequencing a human genome to $10,497. Quarterly calls among NIH staff, sequencing center staff, and external consultant's panel, as well as annual meetings, provided a rigorous evaluation of progress and a strong capacity for program management. To understand the genetic basis of common, complex diseases such as cancer, diabetes, heart disease, and Alzheimer's, it will be necessary to sequence the genomes of many thousands, or even tens of thousands, of people per study to understand the genomic variants that contribute to these disorders. While NIH has achieved the initial Priority goal of reducing the cost below $25,000, in the next few years, NIH aims to continue reducing sequencing costs which will enable more studies to be conducted.

HHS Priority Goals FY 2012 – FY 2013

The following new Priority Goals have been established for FY 2012 - 2013. HHS will actively monitor progress and manage towards achievement of these goals through quarterly data-driving reviews and other mechanisms. These Priority Goals are largely cross-cutting in nature, requiring active management across HHS components for success. Per the GPRA Modernization Act, P.L. 111-352, requirement to address Federal Goals in the Strategic Plan an Annual Performance Plan. Please refer to Performance.gov for information on Federal Priority Goals and the agency's contributions to those goals.

Increase the number of health centers certified as Patient Centered Medical Homes (PCMH): By September 30, 2013, the quality of care provided by health centers will be improved by increasing the proportion of health centers that are nationally recognized as Patient Centered Medical Homes (PCMH) from 1 percent to 25 percent.

Improve patient safety: By September 30, 2013, reduce the national rate of healthcare-associated infections (HAIs) by demonstrating significant, quantitative and measurable reductions in hospital-

acquired central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI).

Improve health care through meaningful use of health information technology: By September 30, 2013, increase the number of eligible providers who receive an incentive payment from the CMS Medicare and Medicaid EHR Incentive Programs for the successful adoption or meaningful use of certified EHR technology to 140,000.

Improve the quality early childhood education: By September 30, 2013, improve the quality of early childhood programs for low-income children through implementation of the Quality Rating and Improvement Systems (QRIS) in the Child Care and Development Fund (CCDF), and through implementation of the Classroom Assessment Scoring System (CLASS: Pre-K) in Head Start.

Reduce cigarette smoking: By December 31, 2013, reduce annual adults' cigarette consumption in the United States from 1,281 cigarettes per capita to 1,062 cigarettes per capita, which represents a 17.1 percent decrease from the 2010 baseline.

Reduce foodborne illness in the population: By December 31, 2013, decrease the rate of Salmonella Enteritidis (SE) illness in the population from 2.6 cases per 100,000 (2007-2009 baseline) to 2.1 cases per 100,000.

In addition to these Priority Goals, HHS is working to improve the health of millions of Americans through implementation of the Affordable Care Act. To provide transparency to the public with regard to the Affordable Care Act, HHS launched www.HealthCare.gov on July 1, 2010. The website is the first of its kind to bring information and links to health insurance plans and other coverage options into one place, to make it easy for consumers to learn about their insurance choices.

About This Report

Prior to FY 2011, HHS Operating Divisions and Staff Divisions (components) produced their own performance plan and reports, known as On-line Performance Appendices (OPA). As part of HHS' effort to meet new requirements from the Government Performance and Results Modernization Act of 2010 (GPRA Modernization Act), HHS is producing a consolidated and streamlined report to replace the 18 OPAs produced in previous years similar to other Cabinet-level Departments. The Department is working to direct limited resources toward performance management, while ensuring that the transparency and accountability needs of the American people are met. This report, which is focused on key HHS programs and priorities, is organized around the HHS Strategic Plan goals and objectives and includes:

- A representative set of measures that reflect the priorities of HHS and its components
- Performance measures which are used by the Department and its components to guide management decisions and achieve results
- Introductory narrative for each set of objectives that provides context and outlines the intent of HHS in addressing issues of importance to the American people
- Performance targets and reported results from 2008 through 2011
- Performance targets for 2012 and 2013
- Analysis of the trends associated with the related performance measures
- Plans for achieving targets through 2013

This report has additional sections including:

- Discussion on Performance Management
- Summary of Evaluations
- Discussion of GAO High Risk Items
- Data validation and data sources for included performance measures

The GPRA Modernization Act, 31 U.S.C. 1115(b)(10), requires the identification of lower-priority program activities in the Annual Performance Plan. The public can see this information in "Cuts, consolidations and Savings Volume" of the President's Budget at: *http://www.whitehouse.gov/omb/budget*.

Performance Detail

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

Today, millions of Americans lack access to affordable health insurance. Many who do have health insurance have gaps in coverage such as exclusions for pre-existing conditions, or they may be one step away from losing coverage because of a change in employment. Individuals with health insurance face increasingly high premiums and medical costs that drive some to bankruptcy or force choices between maintaining health insurance coverage and paying for other household essentials. HHS has been identified as the lead Federal entity responsible for implementing the Affordable Care Act, which contained many new health insurance market reforms and programs to address these and other issues.

Starting in 2010 and continuing in 2011, HHS has implemented new regulations aimed at increasing consumer protections and at creating a more competitive insurance market to both lower cost and improve quality. These new protections and increased oversight of the insurance industry helps ensure that individuals are getting what they pay for; this oversight also will make the healthcare system more responsive to the needs of its patients, providers, and other stakeholders.

Within HHS, agencies and offices such as CMS, HRSA, IHS, and ONC work to implement the reforms prescribed in the law to make affordable coverage more accessible.

Objective 1.A Table of Related Performance Measures

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	90%	90%	90%	90%	90%	90%
Result	90%	90%	90%	92%	Dec 31, 2012	Dec 31, 2013
Status	Target Met	Target Met	Target Met	Target Exceeded	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	90%	90%	90%	90%	90%	90%
Result	90%	90%	91%	92%	Dec 31, 2012	Dec 31, 2013
Status	Target Met	Target Met	Target Exceeded	Target Exceeded	Pending	Pending

Number of young adults ages 19 to 25 who are covered as a dependent on their parent's employer-sponsored insurance policy (Lead Agency - CMS; Measure ID - PHI2)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target		N/A	N/A	8.4 million	8.7 million	8.8 million
Result		7.3 million	8.3 million	Jul 1, 2012	Jul 1, 2013	Jul 1, 2014
Status		Historical Actual	Historical Actual	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target			N/A	N/A	58.0%	55.0%
Result			100.0%	Jan 31, 2013	Jan 31, 2014	Jan 31, 2015
Status			Historical Actual	Pending	Pending	Pending

Increase the proportion of legal residents under age 65 covered by health insurance by establishing affordable insurance Exchanges and implementing Medicaid expansion (Lead Agency - CMS; Measure ID - PHI4)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target				Number of States in which stakeholder consultation has been performed to gain public input into Exchange planning process (50 States and DC)	Award all qualifying applications for Establishment Grants within 60 days of receiving the application	1. Release national Federal risk adjustment model
Result				45 States plus DC	Aug 30, 2012	Jan 1, 2013
Status				Target Not Met	In Progress	In Progress
Target						2. Release 2014 payment notice
Result						Jan 1, 2013
Status						In Progress
Target						3. Data sharing agreements for hub use in place with every State
Result						Sep 30, 2013
Status						In Progress

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target						4. Health plans certified in all Federally-facilitated Exchange States
Result						Sep 30, 2013
Status						In Progress

Analysis of Results

Historically, Medicare has been committed to assuring high levels of health care access and health care satisfaction. Both Medicare Fee-for-Service and Medicare Advantage programs have demonstrated success in achieving access to care for their beneficiaries. Because of CMS' leadership in health insurance coverage, it has risen to the challenge of tracking some of the changes related to making coverage more secure, more available to uninsured individuals and more affordable. New measures have been developed to track progress in expanding coverage for the uninsured including the number of young adults covered as dependents on their parents' employer-sponsored insurance plans and tracking the progress of implementation of Affordable Insurance Exchanges (Exchanges). In the future, Exchanges will be a keystone for expanding coverage options for individuals who are uninsured by providing an organized marketplace to help consumers and small businesses buy health insurance and compare plan options based on price, benefits, services and quality.

In terms of making coverage more affordable, the Affordable Care Act included changes that reduce the costs Medicare Part D enrollees are required to pay for their prescription once they reach the coverage gap (commonly known as the donut hole). According to CMS, 3.6 million seniors and individuals with disabilities reached the coverage gap and saved more than $2.1 billion in brand name medications. These savings averaged about $604 per person.

Plans for the Future

In both 2012 and 2013 HHS will continue to pursue high levels of access for both Medicare Fee-for-Service and Medicare Advantage. In order to achieve these goals CMS has committed to analyzing and communicating subgroup and geographic levels of enrollment to assist plans in developing interventions that are both actionable and targeted to achieve the desired results.

In terms of increasing coverage for uninsured individuals CMS will continue to work collaboratively with states, to build the foundation for implementation of Exchanges and to include new populations in the Medicaid program beginning in 2014. These efforts include:

- Providing enhanced funding to states as they plan for and implement needed improvements to their existing Medicaid eligibility systems to ensure the capacity to enroll newly eligible individuals and to coordinate with the Exchange eligibility process.
- Develop an enrollment strategies guide, a communication toolkit and an applications training module to help states effectively target enrollment strategies toward newly eligible individuals.

In order to extend affordable coverage to the uninsured by 2014, CMS is working with states to help them to achieve key milestones necessary to establish Exchanges in each state.

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

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

Several HHS components are committed to and focused on achieving goals that improve health care quality. FDA protects the Nation's health by ensuring the safety, effectiveness, and security of human and veterinary drugs, vaccines, and other biological products and medical devices. HHS also ensures quality of care and patient safety through surveillance activities at FDA and CDC. Additionally, CDC's HAI program protects patients receiving care in all U.S. healthcare settings through establishing prevention guidelines and supporting staffing to improve practice. AHRQ develops strategies to strengthen quality measurement and improvement and promotes improved practices through Patient Safety Organizations. IHS improves the quality of care in the clinical, public health, and preventive services it provides to American Indians and Alaska Natives by providing training and support for innovative uses of paraprofessionals to make available a wider range of culturally and linguistically appropriate services. IHS is demonstrating its commitment to quality by striving to have 100 percent of their hospitals and clinics maintain accreditation. CMS is currently transforming itself from a claims payment agency into an agency that positively promotes and incentivizes the quality of care for its beneficiaries. Examples include the development of physician- and hospital-quality reporting systems that will support linking payments to the quality and efficiency of care while also reducing healthcare-associated infections. CMS also has quality reporting systems in several other provider areas such as home health, skilled nursing facilities, and hospice. OMHA enforces applicant rights and enables eligible individuals to obtain services more quickly by striving to promptly review and decide cases related to patients' benefits and care.

Within HHS, CDC, CMS, FDA, HRSA, AHRQ, IHS, and OMHA are working together to improve healthcare quality and patient safety for all Americans. Below are some related key performance measures.

Objective 1.B Table of Related Performance Measures

Voluntary electronic Medical Device Reporting (Lead Agency - FDA; Measure ID - 252202)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	55.0%	67.0%	87.0%	93.0%
Result	13.0%	46.0%	53.0%	80.0%	Dec 31, 2012	Dec 31, 2013
Status	Historical Actual	Historical Actual	Target Not Met but Improved	Target Exceeded	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	1780	1900	1900	2000	2000	2000
Result	1934	2006	2079	2276	Nov 30, 2012	Nov 26, 2013
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	8.5%	8.2%	8.1%	Set Baseline	TBD	TBD
Result	8%	7.6%	7.4%	Feb 28, 2012	Feb 28, 2013	Feb 28, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Target Not In Place	Target Not In Place

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target				Publish recommended core set of adult quality measures in the Federal Register.	Publish initial core set of adult quality measures in the Federal Register.	Work with States to ensure that 60 percent of States report on at least three quality measures in the Affordable Care Act Adult Medicaid core set of quality measures
Result				Target Met	Target Met	Mar 31, 2014
Status				Target Met	Target Met	In Progress

Increase percentage of dialysis patients with fistulas as their vascular access for hemodialysis (Lead Agency - CMS; Measure ID - QIO5)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	51%	54%	57%	58%	60.5%	61%
Result	51%	54%	56.8%	59.8%	Nov 30, 2012	Nov 29, 2013
Status	Target Met	Target Met	Target Not Met but Improved	Target Exceeded	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	100%	100%	100%	100%	100%	100%
Result	100%	100%	100%	100%	Oct 30, 2012	Oct 31, 2013
Status	Target Met	Target Met	Target Met	Target Met	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target			Set Baseline	5,000	6,500	10,000
Result			2,619	5,000	Jun 30, 2013	Jun 30, 2014
Status			Baseline	Target Met	Pending	Pending

Increase percentage of timely antibiotic administration (Lead Agency - CMS; Measure ID - QIO4)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	85%	89%	92%	95.5%	98%	98.5%
Result	91.6%	95.6%	97%	Jun 30, 2012	Jun 30, 2013	Jul 31, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target				Work with States to ensure that 70 percent of States report on at least one quality measure in the CHIPRA core set of quality measures.	Work with States to ensure that 80 percent of States report on at least five quality measures in the CHIPRA core set of quality measures	Work with States to ensure that 90 percent of States report on at least seven quality measures in the CHIPRA core set of quality measures.
Result				Mar 31, 2012	Mar 31, 2013	Mar 31, 2014
Status				In Progress	In Progress	In Progress

Increase the number of Benefits Improvement and Protection Act of 2000 (BIPA) cases closed within 90 days. (Lead Agency - OMHA; Measure ID - 1.1.1)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	86%	87%	88%	88%	56%	44%
Result	95%	94%	95%	73%	Nov 15, 2012	Nov 15, 2013
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending

Increase the number of U.S. healthcare organizations per year using AHRQ-supported tools to improve patient safety culture. (Lead Agency - AHRQ; Measure ID - 1.3.38)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	450 Research users	500 Research users	580 Research users	900 Research users	1200 Research users	1300 Research users
Result	519 Research users[1]	622 Research users	885 Research users	1032 Research users	Sep 30, 2012	Sep 30, 2013
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Analysis of Results

Improving current medical products and medications and creating new ones is crucial to improving health care and patient safety. FDA's voluntary electronic medical device reporting enables improved electronic reporting of adverse events which help FDA maintain its safety surveillance. Information obtained from these reports may prompt modification in the use or design of the product, improve the safety profile of devices and lead to increased patient safety. The number of enrollees participating voluntarily in this program has increased from 13 percent in 2008 to 53 percent in 2010. FDA's Center for Drug Evaluation and Research has been on an upward trend on acting on applications for review of generic drugs, exceeding targets for taking action since 2008.

Several HHS components have approached improving quality of care from multiple perspectives. CMS continues to track the prevalence of pressure ulcers in nursing homes. Since 2007 there has been a steady decrease in the reported prevalence in pressure ulcers. The results have dropped from 8.1 percent in 2007 to 7.4 percent in 2010. A decrease of even 0.1 percent represents more than 1,000 fewer nursing home residents with pressure ulcers, not only reducing the cost of care but also improving nursing home residents' quality of life. Another quality initiative at CMS aims to increase the percentage of end stage renal disease patients who have arteriovenous fistula as vascular access for hemodialysis, which improves patient quality of life by improving adequacy of dialysis and decreasing complications from other methods of vascular access. CMS continues to track timely antibiotic administration which benefits Medicare beneficiaries. Targets related to this performance measure have been exceeded since 2008.

IHS uses outside accrediting bodies like the Joint Commission and the Accreditation Association for Ambulatory Health Care to develop national standards of quality of care and then manages IHS operated hospitals and ambulatory centers to meet these standards.

CDC's National Healthcare Safety Network (NHSN) is a surveillance system used for tracking and prevention of Healthcare Associated Infections across healthcare settings, including hospitals in all 50 states, and non-hospital settings (e.g. hemodialysis and long-term acute care facilities). As of December 2011, more than 5,000 healthcare facilities were using NHSN for HAI reporting. Approximately, 420

[1] 12/31/09_Data is available at this time.

hemodialysis facilities and 240 long-term acute care facilities were enrolled in NHSN as of December 2011.

AHRQ is disseminating information and tools for professionals to become aware of and integrate treatments and techniques that enhance patient safety and care. For example, the administration of appropriate preventative antibiotics just prior to surgery is effective in preventing infection.

Plans for the Future

FDA plans to continue to increase the number of new drug applications that have actions taken, and to have continued expansion of voluntary electronic medical device reporting. IHS will continue its focus on improving healthcare quality by striving to meet nationally recognized health care standards. CMS will not only track several key quality indicators, but will expand mechanisms that reward patient quality of care. CMS, as outlined in the Affordable Care Act, has developed and published in the Federal Register a core set of quality performance measures for Medicaid. These will serve as the groundwork for creating a structure to improve how care is measured and provided. Making these measures public will lay the groundwork for future efforts to work with states to meet quality standards.

AHRQ plans to expand tools that improve patient safety. OMHA continues to implement improvements to increase efficiency in case processing such as the recent establishment of a centralized docketing division. Despite these gains in efficiency, OMHA is over capacity for the number of manageable claims each Administrative Law Judge can adjudicate while still maintaining program integrity. OMHA has updated its targets to reflect the increasing caseload.

CDC plans to expand HAI reporting in NHSN to additional healthcare settings including long-term acute care facilities and rehabilitation centers to meet health reform requirements and maintain support to 5,000 hospitals and to 5,000 dialysis facilities. CDC will also expand the types of infections reported to NHSN by increasing the number of hospitals reporting surgical site infections, including: C. difficile; methicillin-resistant Staphylococcus aureus; and catheter-associated urinary tract infections.

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

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

Within HHS AHRQ, AoA, CDC, CMS, FDA, HRSA, IHS, NIH, and SAMHSA are committed to continuing their emphasis on primary and preventive care, with a focus on community prevention services. NIH research enables identification of the services that have the greatest potential to be effective in community settings. HRSA programs deliver healthcare services to millions of Americans, including vulnerable and underserved populations. CMS programs provide payment for recommended preventive services through Medicare, Medicaid, and CHIP.

Below are a representative set of measures that demonstrate HHS' targets and results for primary and preventative care linked with community prevention services. Key features of the Affordable Care Act focus on preventative care and several of these newer measures were developed to focus managers' attention and expand opportunities to achieve preventative care results.

Objective 1.C Table of Related Performance Measures

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target			Set Baseline		13%	25%
Result			1%		Aug 30, 2013	Aug 31, 2014
Status			Baseline		Pending	Pending

By 2015, identify three (3) key factors influencing the scaling up of research-tested interventions across large networks of services systems such as primary care, specialty care and community practice. (Lead Agency - NIH; Measure ID - SRO-8.7)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	Identify three (3) implementation mechanisms, strategies, or techniques to improve the uptake of effective interventions in healthcare settings.	Identify and test at least three (3) key variables for measuring implementation to improve the uptake of effective interventions in healthcare settings.	Identify at least three systemic (or services) intervention studies which utilize implementation mechanisms, strategies or techniques to improve the uptake of effective interventions in healthcare settings	Identify at least 3 mechanisms for tracking successful implementation within studies to improve the uptake of research-tested interventions in health care settings.	Complete target by identifying three effective implementation strategies that enhance the uptake of research-tested interventions in service systems such as primary care, specialty care and community practice.	Identify three key factors influencing the sustainability of research-tested interventions in service systems such as primary care, specialty care, and community practice.
Result	Three mechanism, strategies, or techniques, were identified to improve the uptake of effective interventions in healthcare settings, including community-based models, evidenced-based care framework, and collaborative frameworks.	Variables for measuring implementation include organizational culture and climate, capacity for organizational change, dimensions of supervisory adherence to treatment principles, and adherence to clinical guidelines.	Three intervention studies that utilize implementation mechanisms, strategies, or techniques were identified to improve the uptake of effective interventions for mental health services, HIV and drug use disorders, and alcohol screening and treatment in healthcare or community settings.	Three mechanisms for tracking successful implementation within studies were identified to improve the uptake of research-tested interventions in health care settings.	N/A	N/A
Status	Target Met	Target Met	Target Met	Target Met		

Increase percent of pregnant women who received prenatal care in the first trimester. (Lead Agency - HRSA; Measure ID - 10.III.A.3)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	85%	86%	86.5%	69%	70%	71%
Result	71%[2]	Nov 30, 2012	Nov 30, 2013	Nov 30, 2014	Nov 30, 2015	Nov 30, 2016

[2] The target is not applicable. This result is based on the Revised Standard Birth Certificate, while the target was set when the unrevised certificate was in use.

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Status	Target Not Met but Improved	Pending	Pending	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	90%	90%	90%	90%	90%	90%
Result	92%	90%	92%	Sep 30, 2012	Sep 30, 2013	Sep 30, 2014
Status	Target Exceeded	Target Met	Target Exceeded	Pending	Pending	Pending

Number of persons who learn their serostatus from Ryan White HIV/AIDS Programs. (Lead Agency - HRSA; Measure ID - 16.II.A.2)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	572,397	572,397	572,397	583,730	872,565	877,525
Result	739,779	871,696	Feb 28, 2012	Feb 28, 2013	Feb 28, 2014	Feb 28, 2015
Status	Target Exceeded	Target Exceeded	Pending	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	N/A	64.2 %	68 %	68.3 %
Result	63.8 %	67.5 %	67.4 %	Dec 30, 2012	Dec 30, 2013	Dec 31, 2014
Status	Historical Actual	Historical Actual	Historical Actual	Pending	Pending	Pending

Increase the Number of Medicare Beneficiaries Who Receive an Annual Wellness Visit (Lead Agency - CMS; Measure ID - MCR25)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target					Set Baseline	TBD
Result					Jun 30, 2012	N/A
Status					Pending	Target Not In Place

Analysis of Results

HHS components are committed to improving primary and preventive care. The new Priority Goal to increase the number of health centers with at least one site recognized as a patient centered medical

home demonstrates this commitment. Patient centered medical homes are a new model of care that focuses on coordinated care and quality outcomes. HRSA is working with its health centers to improve coordination of care by increasing the number of sites that are recognized as patient center medical homes.

Rising to the challenge of translating research into healthcare practice, NIH has broadened its portfolio in implementation research by working with scientists, health care providers and other stakeholders to develop innovative approaches for identifying, understanding, and overcoming barriers to implementation of research-tested interventions in service settings. In FY 2011, NIH researchers identified mechanisms for tracking successful implementation within studies to improve the uptake of research-tested interventions in health care settings. This includes using a web-based data platform to gather information on the implementation of a child welfare intervention and developing tools which help researchers understand the attitudes of providers about evidence-based practices and to understand the quality of service implementation. These and additional efforts are increasing the capacity of researchers to better track the key outcomes of research-tested interventions.

In 2009, 18.1 percent more people learned of their HIV status through the Ryan White program than did so in 2007. HRSA's Ryan White HIV/AIDS Program enables uninsured or underinsured individuals to determine their HIV status so that the spread of HIV can be slowed, and treatment can start earlier. Early care vastly improves the quality and length of the HIV positive patient's life.

Similarly, prenatal care is one of the most important interventions for ensuring the health of pregnant women and their newborn babies. HRSA contributes to the national receipt of prenatal care through support of the State Maternal and Child Health Program that, among other objectives seeks to ensure access to comprehensive prenatal and postnatal care. HRSA also supports a national network of Health Centers and other service delivery sites that strive to ensure that low-income and medically underserved women have early prenatal care. The prenatal care in the first trimester measure examines data from birth certifications. The FY 2011 - FY 2013 targets and the 2008 results are based on the Revised Standard Birth Certificate, while FY 2008 – FY 2010 targets are based on the unrevised birth certificate.

Routine immunizations represent a cost-effective public health measure that significantly improves the health of children by preventing a number of serious illnesses and associated treatment costs. Overall, an estimated $10.20 in medical costs are saved for every $1 invested in childhood immunizations. CDC focuses on sustaining appropriate coverage levels for routinely recommended childhood vaccines to prevent the spread of disease. From 2006-2008, Measles, Mumps and Rubella (MMR) coverage among children 19-35 months of age was 92 percent, but declined to 90 percent in 2009. In 2010, coverage was 92 percent, which exceeded the CDC target and the national health objective for MMR coverage targets for this measure.

Obesity increases the risk of many health conditions, including heart disease, stroke, high blood pressure and cancer. Obesity accounts for more than 300,000 deaths per year and is associated with more than $147 billion in annual medical care expenditures. More than 35 percent of US adults, 14.7 percent of low income children ages two to five, and 17 percent of US children ages 2-19 are obese. Physical

activity plays an important role, in maintaining a healthy body weight. In 2010, only 67.4 percent of adults engaged in leisure-time physical activity. To combat these trends, CDC provides strategies and interventions to improve nutrition and physical activity and promote healthy lifestyles. These strategies include developing and disseminating guidelines/standards, advancing environmental strategies to support healthy eating and active living, and implementing a coordinated approach to community-based and statewide nutrition and physical activity programs.

Medicare beneficiaries now have a variety of screening procedures that are available with no out-of-pocket costs to the beneficiary. As of January 1, 2011, beneficiaries may have an Annual Wellness Visit to outline what steps are recommended to protect or improve their health. CMS will be tracking the number of Annual Wellness Visits to determine the utilization of this new benefit, and ways it can be improved.

Plans for the Future

The goal of increasing the percentage of recognized patient centered medical homes is an HHS priority goal and will have the unrelenting focus of HRSA and HHS leadership staff. Quarterly, data-driven reviews will enable managers to identify performance issues and provide the best possibility of goal achievement.

CDC works closely with state and local organization to achieve community-based public health investments designed to reduce the risk factors for the leading causes of death and prevent and control chronic disease. The Community Transformation Grants (CTG) program will create healthier communities by demonstrating changes in weight, nutrition, physical activity and tobacco use. In addition, the Consolidated Chronic Disease Prevention Grant Program supports state, tribal and territorial health department coordination to improve nutrition and physical activity, achieve and maintain a healthy weight, reduce and control of tobacco use, and improve effective delivery of preventive services. These efforts will help to patients manage and prevent conditions such as arthritis, diabetes, obesity, heart disease and stroke, and the leading preventable cancers.

Annual Wellness Visit data will enable CMS to track the implementation of this new benefit. Data for calendar year 2011 will be available June 2012, and will enable CMS to set up baseline and additional targets for out year performance. NIH plans to continue to identify factors influencing sustainability of research-tested interventions. HRSA is expecting modest growth in the national percentage of pregnant women receiving prenatal care in their first trimester and in the number of individuals learning their HIV status through HRSA's HIV/AIDS Program.

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

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

As part of health reform implementation, HHS is lowering costs for American families and individuals through insurance market reforms that ensure that preventive care is available for all Americans and builds on its experience in improving the quality of care. HHS is transforming Medicare from a system that rewards volume of service to one that rewards efficient, effective care; reduces delivery system fragmentation; and better aligns reimbursement rates with provider costs. Within HHS, AHRQ, CDC, CMS, FDA, HRSA, IHS, and SAMHSA each play a distinct role in realizing this objective. HHS has identified the following measures as indicators for reducing healthcare costs while promoting high-value, effective care.

Objective 1.D Table of Related Performance Measures

Reduce by 25 percent hospital-acquired central-line associated bloodstream infections (CLABSI) by the end of FY 2013. (Lead Agency - CMS; Measure ID - MCR28.1)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target			N/A	N/A	12.5%[1] (SIR=0.60)	25% (SIR=0.51)
Result			SIR=0.68	Oct 31, 2012	Oct 31, 2013	Oct 31, 2014
Status			Historical Actual	Pending	Pending	Pending

Reduce by 20 percent hospital-acquired catheter-associated urinary tract infections (CAUTI) by the end of FY 2013. (Lead Agency - CMS; Measure ID - MCR28.2)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target			N/A	N/A	10%[2] (SIR=0.85)	20% (SIR=0.75)
Result			SIR=0.94	Oct 31, 2012	Oct 31, 2013	Oct 31, 2014
Status			Historical Actual	Pending	Pending	Pending

[1] The CLABSI rate is the number of infections per 1,000 central line days. The Standardized Infection Ratio (SIR) for FY 2010 is 0.68. SIR is calculated by dividing the actual (observed) infections by the expected infections using data gathered through the CDC National Healthcare Safety Network (NHSN). Projected FY 2012 SIR calculation (0.68 x 0.875). Projected FY 2013 SIR calculation (0.68 x 0.75).

[2] The CAUTI rate is the number of infections per 1,000 urinary catheter days. The Standardized Infection Ratio (SIR) for FY 2010 is 0.94. SIR is calculated by dividing the actual (observed) infections by the expected infections using data gathered through the CDC National Healthcare Safety Network (NHSN). Projected FY 2012 SIR calculation (0.94 x 0.9). Projected FY 2013 calculation (0.94 x 0.8).

Reduce all-cause hospital readmission rate (Lead Agency - CMS; Measure ID - MCR26)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target					Set Baseline	5.0%
Result					Feb 29, 2012	Feb 28, 2013
Status					Pending	Pending

Improve the accuracy of Medicare Physician Fee Schedule (PFS) payments by identifying, reviewing, and appropriately valuing potentially misvalued codes (i.e. high expenditure or high cost) under the Medicare PFS through the potentially misvalued code analysis process. (Lead Agency - CMS; Measure ID - MCR22)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target					20%	40%
Result					Dec 31, 2012	Dec 31, 2013
Status					Pending	Pending

Analysis of Results

The Affordable Care Act provides the framework to make healthcare safer by reducing harm to patients, and includes provisions to reduce unnecessary all-cause hospital readmissions in order to reduce Medicare payments, while ensuring patient quality. HHS is dedicated to improving the quality of health care by reducing healthcare-acquired conditions, including healthcare associated infections (HAI), which are among the leading causes of death in the United States. There were an estimated 1.7 million infections in hospital patients, and 99,000 associated deaths in 2002; hospital-acquired infections alone were responsible for an estimated $28-$33 billion dollars in excess healthcare expenditures. Central line-associated bloodstream infections (CLABSI) are among the most serious HAIs, resulting in death in 12-25 percent of affected patients. They are also among the most costly to the healthcare system. Catheter-associated urinary tract infections (CAUTI) are the most common, making up almost 40 percent of all HAIs. Evidence-based guidelines exist that, when applied correctly and consistently, have been shown to prevent most of these events, thus preventing or lessening patient suffering and saving lives, while avoiding excess costs.

While the HHS Priority Goal to reduce CLABSI and CAUTI rates is new, CDC has reported comparable historical data for both. The National Healthcare Safety Net (NHSN) shows a reduction in the CLABSI Standardized Infection Ratio (SIR) from .8 in 2009 to .68 in 2010 and a decline of CAUTI SIR from 1.0 in 2009 to 0.94 in 2010. NHSN data also show reductions of 58 percent in CLABSI in hospital intensive care units from 2001-2009, saving up to 27,000 lives and $1.8 billion in excess medical costs. In 2010 CDC's nationwide HAI prevention efforts demonstrated a 15 percent reduction in CLABSI, and a seven percent reduction in CAUTI. AHRQ's Comprehensive Unit-based Safety Program (CUSP) was shown to be a highly effective approach for HAI prevention in the Michigan Keystone Project, in which hospital-acquired CLABSIs were reduced by two-thirds within three months and many intensive care units sustained a zero level of CLABSI for the duration of a three-year observation period. Building on its

knowledge and experience, HHS has developed a cross-cutting Priority Goal coordinated by CMS in partnership with AHRQ, CDC, and OASH to significantly reduce hospital-acquired CLABSI and CAUTI events by the end of FY 2013.

Another mechanism to reduce the growth of healthcare costs is to appropriately value services. CMS is in the process of procuring analytic contractors to identify and analyze potentially misvalued payment codes in the Medicare Physician Fee Schedule. After conducting surveys or collecting data, the contractors will make recommendations on the review and appropriate adjustment of potentially misvalued physician services, thus enhancing the current process of reviewing codes, and helping to ensure accurate reimbursement for services rendered.

Plans for the Future

During the next 18 months, CMS will coordinate a Priority Goal focused on the reduction of CLABSI and CAUTI which reflects programmatic efforts across HHS and those of the public and private stakeholders to achieve demonstrable improvements in healthcare quality and patient safety through reduction in hospital-acquired CLABSI and CAUTI rates. Among efforts to reduce these rates, are those of CMS' Quality Improvement Organizations in the 10th Statement of Work, nationwide implementation of CLABSI and CAUTI prevention through AHRQ's initiative to spread the use of CUSP, CDC-sponsored State-based HAI initiatives, and the combined use of CDC's web-based NHSN for tracking HAIs. The CLABSI and CAUTI Priority Goal is consistent with the OASH-originated HHS "Action Plan to Prevent Healthcare-Associated Infections" as well as CLABSI and CAUTI measures included in the Partnership for Patients, launched by Secretary Sebelius in April 2011.

In 2012, CMS expects to set a baseline for the all-cause hospital readmission rate using CY 2010 data. The readmission rate, based on readmission for heart attack, pneumonia and congestive heart failure, will be updated annually through FY 2015. Evidence-based practice guidelines, when applied correctly and consistently, have been shown to prevent hospital readmissions. By expanding efforts by HHS components to disseminate quality practices and pay for quality services, HHS expects to reduce the growth of health care costs while promoting high-value effective care. Reduction of hospital readmissions is also consistent with the priorities of the HHS Partnership for Patients.

Also in 2012, CMS will review and appropriately value at least 20 percent of the potentially misvalued codes identified through the current and new practices recommended by the contractor. CMS plans to review an additional 20 percent of misvalued codes in FY 2013. Currently, there are approximately 7,500 codes payable under the Medicare Physician Fee Schedule, but only a sub-set of codes will ultimately be identified as misvalued after further analysis.

Goal 1. Objective E: Ensure access to quality, culturally competent care for vulnerable populations

With the growing diversity of the U.S. population, healthcare providers are increasingly called on to address their patients' unique social and cultural experience and language needs. Provision of culturally competent care can increase quality and effectiveness, increase patient satisfaction, improves patient compliance, and reduces racial and ethnic health disparities. A number of HHS programs help make health care more accessible to people whose circumstances call for special attention, including older adults; children; people with disabilities; uninsured populations; persons with Limited English Proficiency; low income individuals; and those who live in remote areas. The 2010 National Healthcare Disparities Report issued by AHRQ finds that many racial and ethnic minorities have more limited access to care and receive lower quality care. Data from some HRSA supported Health Centers indicates that disparity gaps exist for racial and ethnic minorities regardless of economic status.

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

Within HHS AHRQ, AoA, CMS, HRSA, IHS, and SAMHSA have significant roles to play in realizing this objective.

Objective 1.E Table of Related Performance Measures

Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in Medicaid (Lead Agency - CMS; Measure ID - CHIP 3.2)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	N/A	33,236,910 children	35,033,500 children	35,332,931 children
Result	29,943,162 children	32,292,253 children	34,441,217 children	Mar 31, 2012	Mar 31, 2013	Mar 31, 2014
Status	Historical Actual	Historical Actual	Historical Actual	Pending	Pending	Pending

Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP. (Lead Agency - CMS; Measure ID - CHIP 3.1)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	6,732,000 children	7,442,164 children	7,736,903 children	8,031,642 children	8,179,012 children	8,333,750 children
Result	7,368,479 children	7,717,317 children	7,705,723 children	Mar 31, 2012	Mar 31, 2013	Mar 31, 2014
Status	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	16.75 million	18.95 million	20.15 million	19.7 million	20.6 million[3]	20.9 million
Result	17.1 million	18.8 million	19.5 million	Jan 31, 2012	Aug 31, 2013	Aug 31, 2014
Status	Target Exceeded	Target Not Met but Improved	Target Not Met but Improved	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target		Set Baseline	380,000	385,000	390,000	395,000
Result		375,000	383,776	Oct 31, 2012	Oct 31, 2013	Oct 31, 2014
Status		Baseline	Target Exceeded	Pending	Pending	Pending

Increase the number of children receiving Maternal and Child Health Block Grant services who are enrolled in and have Medicaid and CHIP coverage. (Lead Agency - HRSA; Measure ID - 10.I.A.2)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	11 M	11.2 M	12 M	13 M	14 M	15 M
Result	14.7 M	15.2 M	14.3 M	Nov 30, 2012	Nov 30, 2013	Nov 30, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	28 M	29 M	30 M	31 M	33 M	30 M
Result	35 M	33.3 M	34.5 M	Nov 30, 2012	Nov 30, 2013	Nov 30, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

[3] Target reflects impact of Affordable Care Act funding. The FY 2011target differs from that in the FY 2011 Congressional Justification to reflect Affordable Care Act funding.

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	1,352,000	1,348,000	1,413,000	1,324,000	1,296,300	1,340,300
Result	1,408,886	1,407,691	1,417,219	Oct 31, 2012	Oct 31, 2013	Oct 31, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Increase the percentage of children receiving Systems of Care mental health services who report improved functioning (Lead Agency - SAMHSA; Measure ID - 3.2.26)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	Set Baseline	49.6 %	50.2 %	50.2 %	50.2 %	50.2 %[4]
Result	49.6 %	50.2 %	51.3 %	53.0 %	Dec 31, 2012	Dec 31, 2013
Status	Baseline	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	23.6 %	25.6 %	25.6 %	25.6 %	25.6 %
Result	23.6 %	24.6 %	29.4 %	33 %	Oct 31, 2012	Oct 31, 2013
Status	Historical Actual	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Increase the percentage of adults receiving services who had no past month substance use (Lead Agency - SAMHSA; Measure ID - 1.2.33)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	80%	81%	82%	82%	83%	83%
Result	82.3%	81%	82.9%	82.1%	Oct 31, 2012	Oct 31, 2013
Status	Target Exceeded	Target Met	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	24%	35%	53%	51.9%	56.5%	53.2%
Result	35%	44%	52%	56.5%	Oct 31, 2012	Oct 31, 2013
Status	Target Exceeded	Target Exceeded	Target Not Met but Improved	Target Exceeded	Pending	Pending

[4] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY13 performance targets reflect FY 12 funding levels. To see SAMHSA'S FY14 performance targets reflecting FY13 funding levels, please see SAMHSA'S FY13 Congressional Justification submission.

American Indian and Alaska Native patients with diagnosed diabetes achieve Ideal Glycemic Control (A1c Less than 7.0%). (Lead Agency - IHS; Measure ID - 2)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	31%	30%	33%	30.2%	32.7%	31.3%
Result	32%	31%	32%	31.9%	Oct 31, 2012	Oct 31, 2013
Status	Target Exceeded	Target Exceeded	Target Not Met but Improved	Target Exceeded	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target				3 recommendations	3 recommendations[5]	3 recommendations[6]
Result				7 recommendations	Sep 30, 2012	Sep 30, 2013
Status				Target Exceeded	Pending	Pending

Amount of savings by State ADAPs participation in cost-savings strategies on medications. (Lead Agency - HRSA; Measure ID - 16.E)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	$267.9 M	$374.2 M	$487.3 M	Prior Result +0	Prior Result +0	Prior Result +0
Result	$374.2 M	$487.3 M	Apr 30, 2012	Apr 30, 2013	Apr 30, 2014	Apr 30, 2015
Status	Target Exceeded	Target Exceeded	Pending	Pending	Pending	Pending

Analysis of Results

HHS components are committed to ensuring access to quality care. CMS is tracking the number of children covered under the Children's Health Insurance Program (CHIP) and Medicaid. Though CMS fell short of its FY2010 target for a 5 percent increase in the number of children enrolled in CHIP, a 4.6 percent increase was obtained. Nonetheless, FY 2010 CHIP and Medicaid enrollment has increased since FY 2008. By March 2012, CMS expects to have results on the number of children enrolled in both CHIP and in Medicaid in FY 2011.

HRSA's focus on increasing the number of patients served through Health Centers, is important because these organizations serve populations lacking access to high quality cost-effective primary health care. HRSA has steadily increased the number of patients served by Health Centers, reaching 19.5 million in 2010. As part of its mission to assure access and continuity of care, HRSA supports State Maternal and

[5] FY 2012 target is to implement at least 3 recommendations annually

[6] FY 2013 target is to implement at least 3 recommendations annually

Child Health programs, which have increased the number of children served and facilitated the enrollment of a growing number of these children in Medicaid and CHIP. Working with young women to screen them for Chlamydia and reduce the likelihood of pelvic inflammatory disease and sterility is another example HHS' support for providing care to a vulnerable population.

Several HHS components focus efforts on enabling accessible services for special populations including individuals with behavioral or emotional health concerns, Native Americans, HIV positive individuals, and others. For example, SAMHSA provides support services to homeless individuals with or at risk of substance abuse and mental illness and has successfully worked to increase the percentage of clients who have a permanent residence. Stable housing is associated with improved functioning, positive health outcomes and higher earning potential. Those with a permanent home are expected to have better mental health and fewer substance abuse problems. SAMHSA works with many other special populations, including children and adolescents who have serious emotional disorders. Results since 2008 show steady improvements in the percentage of children receiving services through the Children's Mental Health Services Program who report improved functioning. SAMHSA has kept stable the percentage of adults who have had no substance use within the past month. Significant periods of sobriety are associated with improved health outcomes.

The Indian Health Service, which incorporates tribal consultation to improve services for American Indians and Alaska Natives, has focused on some key health related issues for tribal members. These include increasing the number of adults who visit IHS facilities to be screened for depression, and enabling diabetic patients to maintain ideal glycemic control. Results for depression screening and Tribal consultations showed improvement in FY 2011, while ideal glycemic control among diabetic patients maintained stable results. IHS has increased accountability for achieving targets at the regional and local levels. IHS is increasing the use of electronic health records across the Indian health delivery system with screening tools becoming more integrated with the electronic records system.

Plans for the Future

HHS plans for more children to have access to health insurance with an estimated 35 million children being enrolled in Medicaid by 2013. By 2013 HRSA expects 1.4 million more individuals to be served through health centers than were served in FY 2010. Approximately 1.2 million fewer young women will be able to receive screening for Chlamydia and will be at greater risk of infertility due to budget reductions. SAMHSA commits to maintaining the level of results that they have currently been achieved with children who report improved functioning, adults who have a permanent place to live, and adults who have had no substance about in the last month. IHS will continue to expand depression screening through the use of health IT, but the percentage of adults who achieve ideal glycemic control is expected to decline from 32 percent in 2010 to 30 percent by 2013.

Goal 1. Objective F: Promote the adoption and meaningful use of health information technology

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

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

Objective 1.F Table of Related Performance Measures

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target				Set Baseline	80,000	140,000
Result				10,700	Oct 31, 2012	Oct 31, 2013
Status				Baseline	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	23.0%	35.0%	45.0%	55.0%
Result	20.0%	21.0%	30.0%	39.0%	Dec 31, 2012	Dec 31, 2013
Status	Historical Actual	Historical Actual	Target Exceeded	Target Exceeded	Pending	Pending

Analysis of Results

The American Recovery and Reinvestment Act of 2009 (P.L. 111-5) created an incentive to encourage medical providers who serve Medicare and Medicaid patients to adopt electronic health records and become "meaningful users" of health IT. The incentive program, administered by CMS, provides payments between 2011 and 2012 to eligible providers that meet established criteria during each of the three stages of the meaningful use incentive payment program. To earn meaningful use incentive payments during stage 1, providers are required to use the electronic health record technology to:

- improve care coordination,
- reduce healthcare disparities,
- engage patients and their families,
- improve population and public health, and
- ensure adequate privacy and security.

Plans for the Future

ONC will continue to play a leadership role in advancing the national strategy for health system delivery and payment reform by implementing HITECH programs and by undertaking targeted activities that improve the nation's health care capacity to address priority issues such as disease prevention, early detection, and chronic condition using health information technologies. To this end, ONC and its partners will continue to seek out, demonstrate, and increase IT-infused health care reforms that enable measurable improvements in patient care and population health, including supporting CMS operation of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

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

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

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

HHS will continue to support ethical and responsible research practices, including ensuring the protection of the humans and animals participating in health research. AHRQ, FDA, and NIH have significant roles to play in advancing science to improve health and well-being for Americans. Below is a sample of performance measures that HHS will use to guide activities and achieve improved results for patient care.

Objective 2.A Table of Related Performance Measures

By 2012, reduce the fully loaded cost of sequencing a human genome to $15,000. (Lead Agency - NIH; Measure ID - CBRR-12)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target			New sequencing machines in routine production at centers.	Reduce the fully-loaded cost of sequencing a human genome to $25,000.	Reduce the fully-loaded cost of sequencing a human genome to $15,000.	
Result			New sequencing machines are in routine production at centers and are on track to meet sequencing targets.	The current cost of a fully-loaded human genome was reduced to $10,497.	The current cost of a fully-loaded human genome was reduced to $10,497.	
Status			Target Met	Target Exceeded	Target Exceeded	

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target			Begin accrual of two patient cohorts presenting in childhood, one with a monogenic autoinflammatory disorder and one with a genetically complex autoinflammatory disorder.	Complete phenotypic characterization of a patient cohort.	Complete genetic, biochemical, or cellular studies aimed at identifying a molecular pathway underlying the disease in the patient cohort.	Identify at least one molecular pathway suitable for targeting in the patient cohort.
Result			Two cohorts are being accrued by NIH investigators – one with neonatal-onset multisystem inflammatory disease and another with systemic-onset juvenile idiopathic arthritis.	NIH researchers completed recruitment of a cohort of well-characterized patients with systemic-onset juvenile idiopathic arthritis through an international consortium of investigators.	N/A	N/A
Status			Target Met	Target Met		

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	Use advanced radiological and molecular imaging techniques to increase understanding of changes in pulmonary physiology associated with asthma exacerbations.	Identify single nucleotide polymorphisms (SNPs) in DNA that may be associated with AE in children.	Describe phenotypic characteristics of a group of asthma patients prone to exacerbations.	Characterize cellular and molecular inflammation in the distal lung that may contribute to severe disease with frequent exacerbations.	Investigate the role of mucus gel formation in healthy controls and asthma patients.	Conduct investigations to elucidate the dynamic, pathophysiologic phenotypes of severe asthma.

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Result	Advanced imaging techniques such as multiple detector (MD) CT, 3He-MRI, and FDG-PET have been performed on approximately 40 subjects with AE.	A SNP(-251) in the Interleukin-8 gene was identified and found to be associated with exacerbations of asthma in children.	Histoblood group antigens were explored as susceptibility factors for asthma exacerbations. O-secretor mucin glycan phenotype was identified as a risk factor for asthma exacerbations.	Scientists characterized the molecular pathways in fibroblasts (the principal active cells of connective tissue) from two regions of the lung. Their findings suggest that fibroblasts from the distal lung may be the more important fibroblast cell type in processes that contribute to disease progression and severity in asthma.	N/A	N/A
Status	Target Met	Target Met	Target Met	Target Met		

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target			Establish a >7000 compound library for testing in quantitative high throughput screens (qHTS) and test in >20 qHTS, test >50 compounds (a subset of the main library) in at least 50 mid-throughput assays.	Identify an additional 3,000 compounds to the library for testing, complete compound analytical analysis, and test 50 compounds in mid-throughput assays.	Test 10,000 compound main library in 50 qHTS and test 50 compounds in mid-throughput assays.	Test 10,000 compound main library in 25 qHTS and test 180 compounds in densely sequenced human lymphoblastoid cell lines to assess genetic diversity in response to toxicants.

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Result			7,000 compounds were selected and collected as an establishment of the compound library. A subset of this library, "the 1408 compound library," has screened an additional 20 qHTS assays. 50 compounds were identified for testing in 50 mid-throughput assays but testing was not conducted and was rescheduled for 2011.	The 10K library was completed. Performance on mid- throughput assays surpassed the target. Analytical or chemical analysis is in progress but not yet completed.	N/A	N/A
Status			Target Not Met	Target Not Met		

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target		Establish repository of 300,000 compounds.	Establish 35 new assays in the Molecular Libraries Program (MLP) Portfolio.	Increase depositions of bioassays in PubChem to a rate of five (5) per month.	Deposit chemical structure and biological data for 200 new small molecule probes in PubChem.	Establish 400 primary biochemical, cell-based or protein-protein interaction assays that can be miniaturized and automated as high throughput screens in the Molecular Libraries Program (MLP) Portfolio.
Result		The Molecular Libraries Small Molecule Repository (MLSMR) contains 341,830 unique compounds.	98 new high-throughput assays were added to the MLP Portfolio.	NIH increased the assay deposition into PubMed to a rate greater than eight HTS assays per month, resulting in a total deposit of 103 assays.	N/A	N/A
Status		Target Exceeded	Target Exceeded	Target Exceeded		

Develop an animal model for the full spectrum of clinical complexities of human Hansen's Disease. (Lead Agency - HRSA; Measure ID - 3.III.A.1)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	BRM 3, CM 2, 3	BRM 4, CM 4	Demonstrate defective nerve function in infected armadillos.	Use DNA evidence to link leprosy transmission from armadillos to humans[7]	Pursue the integration of BRM, CM and molecular reagent breakthroughs	Produce relevant animal model for human leprosy.
Result	BRM 3, CM 2,3	BRM 4, CM 4	Defective nerve function demonstrated	Mar 31, 2012	Mar 31, 2013	Mar 31, 2014
Status	Target Met	Target Met	Target Met	In Progress	In Progress	In Progress

Increase the number of Effective Health Care (EHC) Program products available for use by clinicians, consumers, and policymakers. (Lead Agency - AHRQ; Measure ID - 4.4.5)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	15 EHC products	32 EHC products	23 EHC products	65 EHC products	26 EHC products	65 EHC products
Result	19 EHC products	35 EHC products	51 EHC products	68 EHC products	Sep 30, 2012	Sep 30, 2013
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Analysis of Results

The pathway to discovery is not linear -- the history of human genome sequencing cost reduction is a good example. Improvements in process and technology have enabled decreases in sequencing costs that have gone beyond linear and NIH highlighted this research as a priority goal for FY 2010 – FY 2011. The cost of sequencing a human genome was approximately $50,000 at the beginning of 2010, and NIH has reduced the cost to $10,497 by the end of FY 2011. Recent advances in genomic sequencing technologies have gone hand-in-hand with parallel achievements in nucleotide chemistry, fluorescence detection, microfluidics, algorithm development and computational processing, and other enabling scientific areas. The key challenges are to extract the most efficient operation of current technologies and to stimulate the new field-altering leaps that will be necessary to continue to drive down the cost of human genome sequencing. However, the costs of human genome sequencing are not solely determined by the performance of instrumentation. Costs at very high throughput centers are optimized for efficiency, much like in a production factory. This is different than, for example, a laboratory using a single research instrument, where costs will be higher. High-throughput work requires highly standardized methods, robust laboratory information management systems, and other features not present in a small lab.

[7] This target is different from that shown in the FY 2011 Congressional Justification due to the pace of advances made in this research endeavor.

NIH has several measures that are related to advancing health sciences and supporting improved patient care. For example, in FY 2011, scientists supported by NIH characterized molecular pathways in cells from two different regions of the lung—increasing understanding of processes that contribute to disease progression and severity in asthma. Another program, called Tox21, is a collaboration between NIH, EPA and FDA to develop, validate, and translate innovative chemical testing methods that characterize toxicity pathways to help predict how chemicals will affect human health and the environment. In FY 2011, the Tox21 assembled a large library of ten thousand chemicals to be tested, and over 300 compounds were chemically analyzed. Additionally, thousands of compounds were screened to help prioritize which chemicals need more extensive toxicological evaluation. The NIH Molecular Libraries Program (MLP) is a collaborative research network of centers that will advance our understanding of basic biology and disease mechanisms, and will allow the development of new strategies and therapeutics for diagnosing, treating, and preventing diseases. In FY2011, the MLP exceeded annual performance targets and made the results of 103 High Throughtput Screening assays screened against 300,000 compounds freely available to researchers through PubChem, along with detailed information on the probes developed through the screening process.

Meanwhile, HRSA-supported research has made progress toward developing an animal model for Hansen's Disease, commonly known as leprosy. Once the model is developed, potential advances in scientific knowledge related to questions associated with pathogenesis, early diagnosis, vaccine development, and transmission of the disease can be further explored.

AHRQ's Effective Health Care Program products such as Research Reviews summarize studies on the outcomes, effectiveness, safety, and usefulness of medical treatments and services. These products serve to inform and facilitate evidence-based decision-making on treatments and health care services as well as identify knowledge gaps and future research needs.

Plans for the Future

In 2013 HHS plans to build upon the successes of 2011 by continuing conduct further investigations in the genetic makeup and environmental influences of asthma, continue to do more in-depth testing of the toxicology of thousands of compounds, and distribute results to enhance patient care and treatment options.

Goal 2. Objective B: Foster innovation to create shared solutions

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

Innovation is a key element of HHS's intra-agency Open Government initiative. Through this initiative, the administration is promoting agency transparency, public participation, and public-private collaboration across Federal departments. Every part of the Department contributes to making HHS more open and innovative.

Objective 2.B Table of Related Performance Measures

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target			311	317	340	346
Result			311	334	Sep 30, 2013	Sep 30, 2014
Status			Target Met	Target Exceeded	Pending	Pending

Increase number of high-value data sets and tools that are published by HHS (Lead Agency - IOS; Measure ID - 1.2)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target			117	122	285	288
Result			179	282	Sep 30, 2013	Sep 30, 2014
Status			Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target			7	8	10	12
Result			6	8	Sep 30, 2013	Sep 30, 2014
Status			Target Not Met	Target Met	Pending	Pending

Analysis of Results

Enhancing opportunities for public participation and collaboration in HHS activities is a key priority for the HHS Open Government efforts. It is widely understood that to effectively deliver on our mission, we must leverage the collective creativity and wisdom of our stakeholders. Federal Advisory Committees are one key way of ensuring public and expert involvement and advice in Federal decision-making. Another way to involve the public in helping HHS to solve pressing national problems is through the use of challenges and competitions in which members of the public can participate. Other opportunities include mechanisms such as feedback websites and open listening sessions.

In order to create shared solutions the HHS Open Government Plan makes HHS data more available to the public. The HHS Data Council is working with the Chief Information Officer Council to enhance opportunities for publishing data and tools. This information can be used to increase agency accountability and responsiveness, improve public knowledge of the agency and its operations, further the core mission of the agency, create economic opportunity, and used by researchers and analysts to add knowledge and understanding to existing health and human service issues.

Plans for the Future

HHS plans to continue to increase the number of high value data sets and tools that are made available to the public. HHS will continue to lead collaborative activities and encourage growth in public engagement options including public-facing challenges with purse prizes, improvements of data visualization for large data sets, mobile health messaging and other mechanisms.

Goal 2. Objective C: Invest in the regulatory sciences to improve food and medical product safety

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

Advancing regulatory science and innovation is an objective shared by a number of agencies within HHS. FDA and NIH are collaborating on an initiative to fast-track medical innovation to the public. Other agencies promoting regulatory science and innovation include AHRQ, and HRSA. Below are several performance measures that are indicative of the types of achievements that HHS and its components expect to achieve related to improving regulatory science and food and medical product safety.

Objective 2.C Table of Related Performance Measures

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	N/A	9.0 working days	6.0 working days	5.0 working days
Result	14.0 working days	14.0 working days	10.0 working days	7.0 working days	Dec 26, 2012	Dec 26, 2013
Status	Historical Actual	Historical Actual	Historical Actual	Target Exceeded	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	Identify patterns in serum biomarkers to use in monitoring dietary intervention protocols to reduce obesity	Identify target genes that can predict potential for obesity and type 2 diabetes to provide individually tailored therapeutic treatment and dietary guidelines for use in improving health	1) Develop analytical methods to assess drug-induced heart damage 2) Identify target genes for obesity and the consequent development of metabolic syndrome diseases and heart disease	1) Analyze urine, blood , and tumor tissues samples to identity biomarkers that will facilitate early detection in new cases and in the reemergence of pancreatic cancer. 2) Develop a new targeted therapeutic approach to improve clinical management of breast cancer.
Result	N/A	Incorporate the linkage between physical responses to a healthier diet and genetic analyses via the Community Based Participatory Research project resulting in 45 blood samples and approx. 660,000 genotypes (genetic makeup) identified for each participant. (Historical Baseline)	Patterns were identified from analysis of 2009 CBPR data and preliminary analysis of 2010 CBPR data in serum biomarkers that can be used to monitor dietary intervention protocols to reduce obesity. (Target Met)	Statistical analyses of gene-phenotype interactions and nutrient levels were conducted and target genes identified, further results are pending a final analysis and publication (Target Met)	N/A	N/A
Status	Target Not In Place	Target Not In Place	Target Met	Target Met		

Promote innovation and predictability in the development of safe and effective nanotechnology-based products by establishing scientific standards and evaluation frameworks to guide nanotechnology-related regulatory decisions. (Lead Agency - FDA; Measure ID - 293206)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target				Initiate multi-year studies on safety issues (1) for evaluating nanoparticles that cross multiple product areas and (2) surrounding use of nanoparticles in cosmeticproducts.	Continue regulatory science studies on evaluating nanomaterials from 2011.	Continue regulatory science studies on evaluating nano-materials from 2011.
Result				FDA implemented the Collaborative Opportunities for Research Excellence in Science (CORES) Program to promote cross-center and external collaborative regulatory science research opportunities, focusing on studies evaluating nano-materials. (Target Met)	N/A	N/A
Status				Target Met	In Progress	In Progress

Analysis of Results

FDA Foods Program scientists are evaluating commercially available instrumentation that can be adapted to support FDA's objectives to analyze biological materials more quickly and thoroughly. Two of these technology platforms have been advanced to Field laboratories. The application can simultaneously identify and characterize bacterial, viral, fungal, and other infectious organisms. The technology can analyze thousands of samples a week. Further research through the next year will evaluate the ability to detect Salmonella genus.

FDA Nanotechnology Task Force published the agency's FY 2011 regulatory science research plan for nanotechnology enabling regulatory science studies relevant for the development of safe and effective nanotechnology-based products. In FY 2011, FDA implemented its proposed nanotechnology research plan including building laboratory capacity to assess nanotechnology products, and investing in training and staff development.

Plans for the Future

FDA plans to continue to reduce the average number of days to serotype pathogens in food. The need for rapid, accurate response was highlighted in the recent international incidence between Spain and Germany over potentially contaminated food. Though initial news reports were eventually corrected to show the pathogen started in Germany rather than Spain, in addition to the 38 deaths that were reported, some estimate as much as €450 million of canceled orders affected Spanish farmers. Rapid testing for pathogens saves money and lives. FDA believes that further improvements in sample throughput, along with the high degree of specificity built into this technology platform, will dramatically improve our response and traceback capabilities. When fully deployed, this technology holds the promise of reducing the time to conduct these analyses from 14 days to 7 days or fewer.

FDA will continue to evaluate nanomaterials as well as continue to use the samples collected from the Mississippi Delta Region of Arkansas community-based participator research to identify target genes for obesity that can lead to the development of metabolic syndrome diseases and heart disease. The study uses standard statistical approaches and well as novel methods to assess individual responses.

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

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

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

A number of HHS agencies promote the adoption of evidence-based programs and practices including ACF, AHRQ, AoA, CDC, HRSA, IHS, NIH, and SAMHSA. Below are representative measures which HHS and its components will use to guide performance.

Objective 2.D Table of Related Performance Measures

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	33%	40%	52%	60%	Prior Result +3PP	Prior Result +3PP
Result	37%	49%	57%	Oct 31, 2012	Oct 31, 2013	Oct 31, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target				Set Baseline	973,724	1,032,147
Result				927,357	Sep 30, 2012	Sep 30, 2013
Status				Baseline	Pending	Pending

Analysis of Results

The most efficient and effective programs often use evidence-based and evidence-informed practices. The Community-Based Child Abuse Prevention program (CBCAP) developed an efficiency measure to gauge progress towards programs' use of these types of practices. In order to demonstrate meaningful improvement, ACF has selected a target of increasing by 3 percentage points annually the funds devoted to evidence-based practices. Each year since FY 2007 ACF has exceeded this target.

CDC contributes to this objective by providing scientific expertise for the Guide to Community Preventive Services (Community Guide) and technical assistance to decision makers and public health practitioners who want help in selecting and implementing evidence-based recommendations. The Community Guide builds the scientific evidence base by conducting and updating reviews to address significant public health problems. In FY 2011, CDC developed a measure focused on awareness and use of the Community Guide findings and recommendations, using page views as a proxy. There were 927,357 page views in 2011 (baseline). Nine reviews were completed by CDC in FY 2011, including updates of previous reviews.

Plans for the Future

ACF is committed to continuing to work with CBCAP grantees to invest in known evidence-based practices, while continuing to promote evaluation and innovation, so as to expand the availability of evidence-informed and evidence-based practice over time. CDC will expand the number of page views of the Community Guide in FY 2012

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

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

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

A wide range of HHS agencies support these activities, including ACF, CDC, CMS, HRSA, IHS, NIH, OASH, and SAMHSA. Below is a list of several performance measures which will be used by HHS agencies to manage performance and ensure the safety and well-being of children and youth:

Objective 3.A Table of Related Performance Measures

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target					Set Baseline	TBD
Result					Sep 30, 2012	N/A
Status					Pending	Target Not In Place

Reduce the proportion of 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 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target					Set Baseline	TBD
Result					Sep 30, 2012	Jan 31, 2014
Status					Pending	Target Not In Place

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	80%	80%	80%	80%	80%	80%
Result	83.8%	85%	85.1%	Oct 31, 2012	Oct 30, 2013	Oct 30, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	Set Baseline	N/A	N/A	Prior Result +0.2PP	Prior Result +0.2PP
Result	91.8 %	91.3 %	91.5 %	Oct 30, 2012	Oct 30, 2013	Oct 30, 2014
Status	Historical Actual	Baseline	Historical Actual	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	Set Baseline	N/A	N/A	Prior Result +0.5PP	Prior Result +0.5PP
Result	71.9 %	72.4 %	72.5 %	Oct 30, 2012	Oct 30, 2013	Oct 30, 2014
Status	Historical Actual	Baseline	Historical Actual	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	85%	85%	85%	85%	86%	86%
Result	86%	86%	87%	87%	Dec 31, 2012	Dec 30, 2013
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	20.0 %	20.0 %	20.0 %	20.0 %[8]
Result	20.0 %	19.0 %	24.0 %	21.5 %	Dec 31, 2012	Dec 31, 2013
Status	Historical Actual	Historical Actual	Target Not Met	Target Not Met but Improved	Pending	Pending

Increase the percentage of children receiving trauma informed services showing clinically significant improvement (Lead Agency - SAMHSA; Measure ID - 3.2.02)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	37%	69%	69%	43%	43%	43%
Result	42%	47%	43%	34%[9]	Dec 31, 2012	Dec 31, 2013
Status	Target Exceeded	Target Not Met but Improved	Target Not Met	Target Not Met	Pending	Pending

Decrease the number of antibiotic courses prescribed for ear infections in children under five years of age per 100 children. (Lead Agency - CDC; Measure ID - 3.2.1)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	57	55	50	49	48	49
Result	58.5	59.2	Dec 31, 2012	Dec 31, 2013	Dec 31, 2014	Dec 31, 2014
Status	Target Not Met	Target Not Met	Pending	Pending	Pending	Pending

Analysis of Results

Strengthening the quality of early childhood programs can provide a sound basis for each child's future. ACF's commitment to the Priority Goal of improving Head Start and the Child Care Development Fund will help to achieve a solid foundation for children's future. ACF is committed to implementing the Final Rule regarding Head Start recompetition to ensure high-quality and comprehensive early childhood programs as announced in November 2011, as well as an improved training and technical assistance system for Head Start.

[8] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY13 performance targets reflect FY 12 funding levels. To see SAMHSA'S FY14 performance targets reflecting FY13 funding levels, please see SAMHSA'S FY13 Congressional Justification submission.

[9] Analysis of the FY2011 GPRA result revealed that one of three measures that contributes to the overall result was used at a significantly lower level in FY 2012. The measure had the highest percentage of youth demonstrating improvement in previous years and was unavailable for a significant portion of FY 2011 due to license issues which are now resolved. We anticipate that the result for this GPRA measure will increase as grantee use of the measure with lower utilization in FY2011 moves closer to historic levels in FY 2012.

ACF is also committed to establishing permanency for some of our most vulnerable citizens, children who are in foster care and runaways. ACF has a suite of performance measures focused on ensuring positive permanent living situations for children in foster care and ensuring children are placed in safe living arrangements. Since trauma can be aggravated further when a child is moved from one placement setting to another, ACF measures and strives to have no more than two placements setting during the first 12 months of foster care. Establishing permanency for children who are in foster care is a priority for ACF since children who remain in care for longer periods of time are less likely to exit to permanency and less likely to benefit from connection to family. These measures show positive trends, from fiscal years 2004 – 2010.

SAMHSA is leading change to create communities where individuals, families, schools and other organizations take action to promote emotional health and reduce mental illness and substance abuse. Between FY2007 to FY 2009 there were decreases in the number of middle and high school students reporting current substance abuse. In FY 2010 the reported rate of substance abuse increased, to 24 percent. SAMHSA reports that 60 new grantees are now fully implementing services and expects to achieve the 20 percent target in 2013. SAMHSA's National Child Traumatic Stress Initiative has also shown progress in showing clinically significant improvements since 2008. This Initiative is a critical outlet to develop, test and implement evidence-based practices in trauma-related care for children.

The over usage of antibiotics can have a profound effect on children and their future, as more drug-resistant strains of infection develop. Ear infections (acute otitis media) are the most common reason children under age five receive antibiotics, and antibiotic prescribing for ear infections remains high with a rate of 59.2 prescriptions per 100 children in this age group. The American Academy of Pediatrics published guidelines for the treatment of ear infections in children which recommend watchful waiting instead of antibiotic therapy for infections meeting certain criteria. Antibiotic prescription rates for children less than age 15 years of age seen in physician offices declined from 300 antibiotic courses per 1,000 physician office visits in 1993-1994 to 229 antibiotic courses per 1,000 visits in 2007-2008, which represents a change in physician prescribing behavior. CDC's Get Smart: Know When Antibiotics Work Program, which educates parents and health-care providers about the importance of appropriate antibiotic use, likely contributed to this decline.

Plans for the Future

CDC and ACF plan to improve results for children in foster care, improve the quality of Head Start and Child Care programs, as well as decrease the number of antibiotic courses prescribed for children. CDC will further enhance national, regional, state and local surveillance capacity to better characterize both the incidence of specific infections and antimicrobial use. It will also conduct research to more precisely define the relationships between the emergence and the spread of antimicrobial resistant microorganisms and antimicrobial drug use in humans and animals. SAMHSA is committed to maintaining improvements for traumatized children and the percentage of middle and high school students who report substance abuse.

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

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

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

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

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

Objective 3.B Table of Related Performance Measures

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	122	122	110[10]	110	Prior Result +2%	Prior Result +2%

[10] Adjustments to the performance target index scores were made in order to reflect the trend in actual index scores over recent years for low income elderly and young child households.

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Result	109[11]	116[12]	118	Sep 30, 2012	Sep 30, 2013	Sep 30, 2014
Status	Target Not Met	Target Not Met but Improved	Target Exceeded	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	96	96	78	74	Prior Result +2%	Prior Result +2%
Result	76	76[13]	73	Nov 30, 2012	Nov 30, 2013	Nov 30, 2014
Status	Target Not Met	Target Not Met	Target Not Met	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	61%	62%	62%	61%	62%	62%
Result	62%	62%	62%	Nov 30, 2012	Nov 29, 2013	Nov 30, 2014
Status	Target Exceeded	Target Met	Target Met	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	37%	38%	38.4%	26.8%[14]	Prior Result +0.3PP	Prior Result +0.3PP
Result	34.6%[15]	26.5%[16]	25.1%	Oct 31, 2012	Oct 31, 2013	Oct 30, 2014
Status	Target Not Met	Target Not Met	Target Not Met	Pending	Pending	Pending

[11] The FY 2008 actual result for this measure was updated as a result of further editing of the state data for the LIHEAP Report to Congress for FY 2009.

[12] The FY 2009 actual result for this measure excludes nonuniform data from one state. The FY 2009 actual result for this measure was updated as a result of further editing of the state data for the LIHEAP Report to Congress for FY 2009.

[13] The FY 2009 actual result for this measure excludes nonuniform data from one state.

[14] The FY 2011 target is calculated as the FY 2009 actual result plus 0.3 percentage points.

[15] Although the sample size used for federal reporting is adequate for program purposes, the subsamples used for the job entry, job retention, and earnings gain measures are not large enough to ensure comparability of FY 2008 data with FY 2007 data for some states that switched from universe data in one period to sample reporting in the other (or vice versa). As a result, these states have been excluded from the calculation of the national rates for FY 2008.

[16] The FY 2009 actual result for this performance measure has been updated based on a technical correction.

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	80%	80.5%	67.88%	68.79%	71.75%	Prior Result +1%
Result	78.3%	67.21%	68.11%	71.04%	Apr 30, 2013	Apr 30, 2014
Status	Target Not Met	Target Not Met	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	54.06%	49.98%	40.87%	42.97%	Prior Result +2%	46.5%
Result	49%	40.07%	42.13%	Dec 31, 2012	Dec 31, 2013	Dec 30, 2014
Status	Target Not Met	Target Not Met	Target Exceeded	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target		N/A	Set Baseline	89.4 %	89.7 %	89.8 %
Result		89.1 %	89.3 %	May 30, 2012	May 30, 2013	May 30, 2014
Status		Historical Actual	Baseline	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	54.5	56	61	61	62	63
Result	60.6	61	60.53	May 31, 2013	May 31, 2014	May 31, 2015
Status	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	762,000	731,545	560,000	790,000	792,000	796,000
Result	675,243	855,000	761,000	Sep 30, 2012	Sep 30, 2013	Sep 30, 2014
Status	Target Not Met	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Analysis of Results

Promoting economic security is an essential component for stable families and communities. ACF uses several approaches including enforcing child support payments, encouraging TANF recipients to become employed, and supporting refugees to become independent. Over the last decade, the child support program has nearly doubled the amount of total distributed collections, going from $14.3B in FY 1998 to $26.6B in FY 2010. Fiscal year 2009 and 2010 data suggest that outcomes in this area weakened, most likely as a result of the slow economic recovery. States continue to help TANF adult recipients enter employment, and these efforts have been augmented by other factors including the employment focus of Personal Responsibility and Work Opportunity Reconciliation Act. While these approaches have been helpful in the past, it is now clear the weak economy has affected performance on this measure. The ACF Office of Refugee Resettlement strives to improve grantees abilities to assist refugees in entering employment. In addition to the challenge of the difficult economic climate, the changing demographics of the refugee population makes the process of refugee employment and placement more complex. Many recent arrivals have spent protracted periods of time in refugee camps in countries of first asylum, have experienced intense trauma, and have limited work skills.

In addition to promoting economic security, assuring a safe home environment is a key component to well-being. Enabling families to have heating during cold months, or appropriate cooling in hotter parts of the United States is not just an issue of comfort, but of health for individuals with multiple chronic conditions like senior citizens, and safety for young children. Between FY 2008 and FY 2010 there was a statistically significant increase in the ratio of households that had young children that were served by ACF's Low Income Home Energy Assistance Program (LIHEAP), while the service level for households with one elderly member slightly declined. The Administration on Aging recruits and supports caregivers to enable more frail elderly to remain at home. More than 80 percent of caregivers receiving services report that the services have helped them provide care longer, while 43 percent of caregivers say that without services their care recipients would be unable to maintain their current living arrangements. ACF is also committed to the protection of vulnerable populations such as domestic violence victims; ACF continues to monitor domestic violence program participants' improved knowledge of safety planning, which is correlated with other indices of longer-term client safety and well-being.

Plans for the Future

ACF will continue to have aggressive targets and improve results for achieving income security, despite the challenging economic environment. ACF plans to increase the current child support collection rate by working with parents to ensure that they have the tools and resources they need to provide for their children by focusing on new and improved enforcement techniques, and preventing and addressing accumulated child support debt. The Administration on Aging is also targeting increases in the number of caregivers served and the proportion of vulnerable seniors served, based on the continued integration of home and community based services.

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

HHS is committed to strategies that streamline access to a full complement of integrated services across the lifespan of elderly and disabled individuals. Over the past decade, a number of policy reforms and initiatives have improved the effectiveness of efforts to promote home and community-based services and to decrease unnecessary reliance on institutional care. The Supreme Court's landmark 1999 Olmstead ruling requires states to place qualified individuals with disabilities in community settings whenever such placements are appropriate. AoA provides a number of services to older adults including those with disabilities; services include, for example, transportation, personal care, meals, supportive services for family caregivers and senior rights protective services. Through grants, technical assistance, and information-sharing, the Administration on Developmental Disabilities (ADD) within ACF works with a network of State Developmental Disabilities Councils, State Protection and Advocacy Systems, National University Centers on Excellence in Developmental Disabilities, and Projects of National Significance to ensure that individuals with developmental disabilities and their families have access to culturally competent services and supports that promote independence, productivity, integration, and inclusion in the community. SAMHSA has been working with homeless clients who have mental health and/or substance abuse problems to overcome these conditions and improve their living situation.

Among the agencies and offices contributing to the achievement of this objective are ACF, AHRQ, AoA, CMS, HRSA, IHS, OCR, and SAMHSA. The following performance measures exemplify how HHS is improving the quality and accessibility of supportive services for seniors and people with disabilities.

Objective 3.C Table of Related Performance Measures

Reduce the percent of caregivers who report difficulty in getting services. (Lead Agency - AoA; Measure ID - 2.6)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	35%	35%	30%	30%	28%	28%
Result	32%	30%	29%	May 31, 2013	May 31, 2014	May 29, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

90% of Family Caregiver Support Services clients rate services good to excellent. (Lead Agency - AoA; Measure ID - 2.9c)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	90%	90%	90%	90%	90%	90%
Result	95.4%	95.3%	94%	May 31, 2013	May 31, 2014	May 31, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

90% of transportation clients rate services good to excellent. (Lead Agency - AoA; Measure ID - 2.9b)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	90%	90%	90%	90%	90%	90%
Result	96.7%	96.6%	98%	May 31, 2013	May 31, 2014	May 30, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

90% of home delivered meal clients rate services good to excellent. (Lead Agency - AoA; Measure ID - 2.9a)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	90%	90%	90%	90%	90%	90%
Result	91.03%	91.1%	90.08%	May 31, 2013	May 31, 2014	May 31, 2015
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Increase the number of older persons with severe disabilities who receive home-delivered meals. (Lead Agency - AoA; Measure ID - 3.2)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	364,590	378,613	325,000	297,000	311,000	297,000
Result	349,934	342,084	348,669	Dec 31, 2012	Dec 31, 2013	Dec 31, 2014
Status	Target Not Met	Target Not Met	Target Exceeded	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	Set Baseline	4,927	4,927	5,420	5,420	5,420[17]
Result	4,927	5,104	5,163[18]	4,459	Dec 31, 2012	Dec 31, 2013
Status	Baseline	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending

[17] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY13 performance targets reflect FY 12 funding levels. To see SAMHSA'S FY14 performance targets reflecting FY13 funding levels, please see SAMHSA'S FY13 Congressional Justification submission.

[18] This result has been updated from previously reported due to an error that caused a cumulative number to be reported which was incorrect.

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	87.0 %	87.0 %	87.0 %	87.0 %
Result	87.0 %	88.0 %	90.0 %	Jul 31, 2012	Jul 31, 2013	Jul 31, 2014
Status	Historical Actual	Historical Actual	Target Exceeded	Pending	Pending	Pending

Analysis of Results

In April, 2011 the President released an executive order on "Streamlining Service Delivery and Improving Customer Service" which included establishing mechanisms to solicit customer feedback and setting clear customer service standards. Many HHS components have incorporated mechanisms for soliciting customer feedback including AoA which has customer service targets for caregivers, home delivered meal recipients, and transportation users. For example, in 2003 64 percent of caregiver service recipients reported difficulty in getting services for a loved one with a disability. Through nation-wide implementation of the National Family Caregiver support program by 2010 the percentage of caregivers reporting difficulty getting service substantially declined to 29 percent. Customer service reports on quality for meal clients and transportation remain very high with 90 percent or more reporting good to excellent services.

Another vulnerable population is individuals who have serious mental illness who may also experience a co-occurring substance use disorder and who are homeless or at risk of homelessness. SAMHSA's work to restore clients' rights has shown improvement between 2008 –2010. In 2010, because of Protection and Advocacy for Individuals with Mental Illness program (PAIMI) involvement, 90 percent of complaints of alleged abuse, neglect and rights violations substantiated and not withdrawn by the client resulted in positive change for the client. Because as many as 15 percent of homeless individuals have Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI), SAMHSA providers are trained to better assist clients in applying for and receiving the income benefits for which they are eligible, such as housing, mental health and/or substance abuse services, case management, and other supportive services.

Plans for the Future

Both SAMHSA and AoA are committed to targeting services to those most in need and in maintaining high levels of customer service. AoA expects to continue to achieve 90 percent or higher customer satisfaction. AoA expects a decline in the number of severely disabled people provided home delivered meals due to economic challenges at the state and local levels. Funding for meals are highly leveraged, with the majority of service funding coming from state and local sources.

SAMHSA will be maintaining the percentage of clients who have a restoration of rights through the PAIMI program. SAMHSA will also maintain, the number of PATH providers that are trained in SSI/SSDI Outreach, Access, and Recover (SOAR). SOAR is a good example of SAMHSA working to assist a vulnerable population with getting access to a variety of services, including income support, to meet patient needs. The SOAR Technical Assistance Center has made a concerted effort to selectively train only those who commit to assisting applicants using the SOAR method when assisting applicants with SSI/SSDI applications as well as commit to tracking their outcomes. In addition, due to the poor economy, even when trainings are free, the PATH TA Center has found that many agencies will not allow their staff the time to attend, resulting in a reduced number trained.

Goal 3. Objective D: Promote prevention and wellness

Over the next several years, HHS will focus on creating environments that promote healthy behaviors to prevent chronic diseases and health conditions including tobacco use, being overweight or obese, and mental and substance use disorders. These conditions result in the most deaths, disability, and substantial human and fiscal costs for Americans. HHS works to promote prevention and wellness across its programs, with CDC identified as the Nation's principal prevention agency. CDC's goals for chronic disease prevention and health promotion are to increase the use of proven interventions to prevent and control chronic diseases, reduce rates of morbidity, disability and premature mortality from chronic disease and provide science-based interventions to address the leading causes of death and their associated risk factors., especially among populations at greatest risk.

Across HHS agencies including AoA, CDC, FDA, HRSA, IHS, and SAMHSA contribute to these efforts. For example, FDA has committed to increasing compliance with tobacco products regulations. SAMHSA is working to reduce underage drinking, while IHS is striving to reduce heart disease among American Indians and Alaska Native patients.

Objective 3.D Table of Related Performance Measures

Reduce annual adult's cigarette consumption in the United States (per capita) (Lead Agency - OASH; Measure ID - 1.4)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	Set Baseline	1,232.0	1,150.0	1,062.0
Result	1,507.0	1,367.0	1,281.0	Feb 28, 2012	Feb 28, 2013	Feb 28, 2014
Status	Target Not In Place	Target Not In Place	Baseline	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	N/A	20.5%	20%	19%
Result	20.6%	20.6%	19.4%	Jun 30, 2012	Jun 30, 2013	Jun 30, 2014
Status	Historical Actual	Historical Actual	Historical Actual	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target		N/A		18.9%	18.6%	18.2%
Result		19.5%		Jun 30, 2012	Jun 30, 2013	Jun 30, 2014
Status		Historical Actual		Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target				N/A	84,000	150,000
Result				24,419	Jan 31, 2013	Jan 31, 2013
Status				Historical Actual	Pending	Pending

Increase the percentage of adults receiving homeless support services who report improved functioning (Lead Agency - SAMHSA; Measure ID - 3.4.02)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	Set Baseline	68.4 %	68.4 %	68.4 %	68.4 %	63.1 %
Result	68.4 %	54.8 %	63.9 %	63.1 %	Dec 31, 2012	Dec 31, 2013
Status	Baseline	Target Not Met	Target Not Met but Improved	Target Not Met	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	Set Baseline	538,963	555,132	555,132	555,132	555,132[19]
Result	513,298	619,813	664,932	765,638	Dec 31, 2012	Dec 31, 2013
Status	Baseline	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target			N/A	N/A	N/A	32.3%
Result			29%	32.8%	Oct 31, 2012	Oct 31, 2013
Status			Historical Actual	Historical Actual	Pending	Pending

[19] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY13 performance targets reflect FY 12 funding levels. To see SAMHSA'S FY14 performance targets reflecting FY13 funding levels, please see SAMHSA'S FY13 Congressional Justification submission.

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	51.8%	50.4%	50.4%	50.4%[20]	55.9%	50%
Result	55.9%	70.2%	56%	Dec 31, 2012	Dec 31, 2013	Dec 31, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Reduce motor vehicle deaths per 100 million vehicle miles traveled (Lead Agency - CDC; Measure ID - 7.2.4)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	Set Baseline	1.09	1.06	1.03	1
Result	1.26	1.13	1.09[21]	Oct 31, 2012	Oct 31, 2013	Oct 31, 2014
Status	Historical Actual	Baseline	Target Met	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	1.94 Million	2.06 Million	2.35 Million	2.48 Million	2.66 Million	2.85 Million
Result	2.03 Million	2.22 Million	2.46 Million	2.67 Million	Dec 31, 2012	Dec 31, 2013
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Analysis of Results

Premature death due to tobacco use is preventable. The preventable loss of life and the high cost of treating people with tobacco-related disease are the reasons that this was chosen as an HHS priority goal for FY 2012 - 2013. OASH, CDC and FDA have measures related to reducing tobacco use. OASH developed and now leads the Department's comprehensive tobacco control strategy, *Ending the Epidemic – A Tobacco Control Strategic Action Plan*. The plan is designed to mobilize HHS's expertise and resources in support of proven, pragmatic, achievable actions that can be aggressively implemented not only at the federal level, but also within states and communities. Additionally, OASH has created a Tobacco Control Implementation Committee co-chaired by OASH, CDC, FDA and NIH and with participation from the HHS agencies integral to tobacco control (CMS, SAMHSA, HRSA, and IHS). CDC focuses on both adult and youth smoking prevention efforts and interventions. Over the last decade, in the United States the percentage of adult smokers has fluctuated between approximately 23 percent and 19 percent. As of 2010, about 19 percent of adults reported that they were current smokers. More

[20] SAMHSA'S grant awards are made late in the fiscal year; therefore performance targets and results for any given fiscal year primarly reflect the outputs and outcomes associated with activities supported from the prior fiscal year. For example, these FY13 performance targets reflect FY12 funding levels. To see SAMHSA'S FY14 performance targets reflecting FY13 funding levels, please see SAMHSA'S FY13 Congressional Justification submission.

[21] Result is based on preliminary data.

than 80 percent of adult smokers began smoking before 18 years of age. Over the last decade youth smoking rates have also fluctuated. Since 2007, they have stabilized between 19 percent and 20 percent. CDC leads a comprehensive, broad-based approach to reducing tobacco use which involves: preventing people from initiating smoking; eliminating exposure to secondhand smoke; promoting quitting; and, identifying and eliminating disparities in tobacco use among population groups. A key element in deterring youth access to tobacco will be compliance checks to assure that retailers refuse sales of tobacco to adolescents under the age of 18. FDA is striving to reduce the sale, access, and the allure of tobacco products to minors. It exceeded the FY 2010 target of contracting with U.S. states for the purpose of conducting retail inspections. IHS met or exceeded its target for screening patients 22 years and older for Coronary Heart Disease from FY 2008 – FY 2010. One of the components of this screening includes tobacco use.

The National Center for Health Statistics (CDC) reported in 2008 there were 34,598 suicides, ranking as the 11th leading cause of death nationally. Suicide is preventable, and SAMHSA's support of the suicide prevention hotline shows an increasing number of calls answered from 2008 through 2010.

Reducing death and disability by reducing unsafe behaviors is represented by additional performance measures of SAMHSA and CDC. SAMHSA is working to sustain the ongoing decline in underage drinking as evidenced by several national studies. Consistent with other HHS programs addressing underage drinking and its precursors, it is expected that SAMHSA prevention programs will further reduce the prevalence of underage drinking in America. As the leading cause of death for persons from ages five to 34, motor vehicle crashes account for more than 30,000 deaths per year. CDC works to reduce the rate of fatal motor vehicle crashes by identifying and promoting the effectiveness of traffic safety interventions including the promotion of child restraint systems, primary seat belt laws, ignition interlocks for prevention of impaired driving, Graduated Drivers Licensing programs for new teen drivers, and traffic safety programs for tribal communities. Traffic fatalities have been declining for several years now. Between 2007 and 2008, the rate of traffic fatalities per 100 million vehicle miles traveled declined by more than 7 percent (from 1.36 to 1.26). This same rate decreased by more than 10 percent between 2008 and 2009 (from 1.26. to 1.13) and by another 3.5 percent between 2009 and 2010 (from 1.13 to 1.09).

HRSA has committed to increase the number of adult volunteer potential donors of minority race and ethnicity. Increasing minority race donors will enable more minority patients to receive unrelated donor transplants.

Plans for the Future

In FY13 SAMHSA is planning to maintain prevention activities at close to the same level as FY 2011. FDA expects to increase compliance with tobacco regulation by working to increase the number of retail compliance checks to assure that tobacco is not being sold to underage customers. CDC plans to support and expand smoking cessation services through its national network of tobacco cessation

quitlines as well as providing funding to states to expand quitline capacity. In addition, CDC will launch a national media campaign to promote tobacco cessation and reduce smoking initiation.

To reduce motor vehicle-related death and disability, CDC will evaluate ignition interlock programs throughout the United States in partnership with the National Highway Traffic Safety Administration (NHTSA) and Governors Highway Safety Association (GHSA). CDC will assist states in improving seat belt policies to reduce the number and severity of motor vehicle crash-related injuries.

HRSA intends to increase the number of minority stem-cell donors by nearly 40,000 over 2010 levels to 2.85 million by 2013.

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

Infectious diseases continue to be a significant health threat in the US and around the world because microbes evolve and develop resistance to drugs over time, rapid global travel, importation of foods, and changing demographics have increased the ability of infectious agents to spread quickly. Infectious diseases include vaccine-preventable diseases, foodborne illnesses; HIV and AIDS ; tuberculosis; infections acquired in healthcare settings; and infections transmitted by animals and insects.

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

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

Within HHS, components such as CDC, FDA, and NIH have primary responsibility for reducing the occurrence of infectious diseases. Other HHS agencies and offices that contribute to efforts to combat infectious diseases include HRSA, IHS, OASH, and SAMHSA. HHS will use a variety of approaches to reduce the occurrence of infectious diseases. The table below includes representative measures.

Objective 3.E Table of Related Performance Measures

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target		N/A	N/A	2.3 cases/100,000	2.2 cases/100,000	2.1 cases/100,000[22]
Result		2.6 cases/100,000	3.5 cases/100,000	Jul 31, 2012	Jul 31, 2013	Jul 26, 2014
Status		Historical Actual	Historical Actual	Pending	Pending	Pending

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

American Indian and Alaska Native patients, aged 19-35 months, receive childhood immunizations. (Lead Agency - IHS; Measure ID - 24)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	78%	78%	80%	74.6%	77.8%	74.5%
Result	78%	79%	79%[23]	75.9%[24]	Oct 30, 2012	Oct 31, 2013
Status	Target Met	Target Exceeded	Target Not Met	Target Exceeded	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	1.9 /100,000	1.8 /100,000	1.9 /100,000	1.8 /100,000	1.7 /100,000	1.7 /100,000
Result	2 /100,000	1.7 /100,000	1.6 /100,000	Sep 30, 2012	Sep 30, 2013	Sep 30, 2014
Status	Target Not Met but Improved	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Increase the rate of influenza vaccination among adults ages 18 to 64. (Lead Agency - CDC; Measure ID - 1.3.2a)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target		Set Baseline	30%	33%	36%	40%
Result		27%	28%	Jan 31, 2013	Jan 31, 2014	Jan 31, 2015
Status		Baseline	Target Not Met but Improved	Pending	Pending	Pending

Increase the percentage of people diagnosed with HIV infection at earlier stages of disease (not CDC stage 3: AIDS) (Lead Agency - CDC; Measure ID - 2.1.4)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target		N/A	43.5	44.5	46.0	47.5
Result		42.5	Mar 31, 2012	Mar 31, 2013	Mar 31, 2014	Mar 31, 2015
Status		Historical Actual	Pending	Pending	Pending	Pending

Proportion of racial/ethnic minorities in Ryan White HIV/AIDS-funded programs served. (Lead Agency - HRSA; Measure ID - 16.I.A.1)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	5 percentage points above CDC data	5 percentage points above CDC data	5 percentage points above CDC data	5 percentage points above CDC data	5 percentage points above CDC data	5 percentage points above CDC data
Result	73% (CDC=65.9%)	73% (CDC = 66.4%)	72% (CDC data not available for comparison yet.)	Oct 31, 2012	Oct 31, 2013	Oct 31, 2014
Status	Target Exceeded	Target Exceeded	In Progress	In Progress	In Progress	In Progress

[23] Varicella vaccination added to the series of childhood immunizations the agency reports on in FY 2010.

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

Reduce the estimated number of cases of healthcare associated invasive Methicillin-resistant Staphylococcus aureus (MRSA) infections. (Lead Agency - CDC; Measure ID - 3.3.2)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	N/A	52,000 cases	46,000 cases	40,000 cases
Result	79,463 cases	71,828 cases	64,158 cases	Nov 30, 2012	Nov 30, 2013	Nov 30, 2014
Status	Historical Actual	Historical Actual	Historical Actual	Pending	Pending	Pending

Increase the proportion of children under five years old who slept under an insecticide treated net the previous night PMI target countries. (Lead Agency - CDC; Measure ID - 10.C.1)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	3rd 6 of 8 countries - Baseline			85% (median) in 2006 countries	85% (median) in 2007 countries	85% (median) in 2008 countries
Result	13.1%			44.8%[25]	Dec 31, 2012	Dec 31, 2013
Status	Target Met			Target Not Met	In Progress	In Progress

Analysis of Results

Decreasing the rate of Salmonella Enteritidis (SE) illness in the population is an HHS Priority Goal for FY 2012 – 2013. In 2011 FDA published a final egg rule that requires shell egg producers to implement controls to prevent SE from contaminating eggs on the farm and from further growth during storage and transportation. CDC is a critical HHS partner in this effort by providing surveillance, epidemiology, laboratory, and analytic services that will measure progress toward the goal. Specifically, CDC will use data from FoodNet, a national surveillance network that includes 10 participating state health departments working in collaboration with CDC, FDA, and USDA. FoodNet data covers about 15 percent of the population of the United States and is considered representative of the population as a whole.

IHS is measuring a combined series of immunizations that includes coverage for Diphtheria, tetanus, whooping cough, polio, measles, mumps and rubella, Hepatitis B, influenza, chicken pox and pneumonia consistent with the CDC's Advisory Committee on Immunization Practices standards and schedule. In 2008 the result was 78 percent of children served by IHS received the combined series. This result increased one percentage point to 79 percent in 2009 and 2010, but declined to 76 percent immunization rate in 2011.

Other conditions that CDC is actively addressing include tuberculosis, HIV infection, and influenza. Due to the effectiveness of TB prevention and control programs, the U.S. consistently has one of the lowest TB incidence rates in the world. Effective control efforts by CDC and its 68 state and local partners have led to the lowest number of overall U.S. TB cases (preliminary estimates are 11,182 cases in 2010, or 3.6 per 100,000 population) since national reporting began in 1953. CDC monitors key aspects of TB control including completion of treatment within one year, timely laboratory reporting and testing of all TB

[25] FY 2011 results reflect reporting from 2 of the 3 countries reflected in the measure. Results from the third country will be available in April 2012

patients for HIV to ensure coordinated care and other prevention activities. Regarding HIV, persons who learn their HIV status have been shown to reduce their HIV risk behaviors and thus the likelihood of transmitting HIV to their sex and drug using partners. In 2009, 42.5 percent of patients diagnosed with HIV infection were identified early (before Stage 3). Persons who learn their HIV status earlier in the course of the disease are able to access medical care and antiretroviral therapy that reduces HIV-related morbidity and mortality. These medications also reduce HIV viral load, lowering the likelihood of HIV transmission. HRSA has exceeded its targets in serving racial/ethnic minorities to address healthcare disparities for HIV- infected individuals. Influenza is a major public health problem in the United States and globally. Current levels of coverage among adults 18 to 64 years of age are lower than for children and adults 65 and older. In 2010, the rate of influenza vaccination among adults ages 18 to 64 was 28 percent. Although the target of 30 percent was not met, the rate of vaccination showed slight improvements over the 2009 baseline of 27 percent.

In alignment with HHS Action Plan to Prevent Healthcare Associated Infections, CDC has developed guidelines and plans to reduce infections associated with healthcare settings, including but not limited to MRSA. The most recent data (2010) from CDC's Emerging Infection Program demonstrated a 6 percent decrease in the national estimates of health-care associated invasive MRSA.

Through the President's Malaria Initiative (PMI), CDC procured more than 17 million long-lasting, insecticide-treated mosquito nets, protected more than 27 million residents by spraying their houses with residual insecticides, and procured more than 41 million artemisinin-based combination therapies in 2010. Scale-up of these interventions through PMI and other program efforts have already led to reductions in all case mortality in children less than five years of age by 23–36 percent in PMI countries surveyed and contributed to saving more than 200,000 lives over the past nine years. However, the FY 2011 target was not met due to delays in improvements of the national distribution systems and delays in procurement. CDC is working to address the procurement delays so that programmatic scale-up is not delayed in the future.

Plans for the Future

The goal to decrease the rate of SE illness in the population will be managed like other Priority Goal with quarterly, data-driven reviews that enable managers to identify performance issues and provide the best possibility of goal achievement. CDC will supply quarterly updates of the incidence of SE infections using FoodNet data to monitor progress toward the Priority Goal, and will conduct analyses to continue to understand the role of contaminated eggs in the SE illness rate. CDC will also support this measure in their primary roles in foodborne outbreak detection, investigation, and response.

Both CDC and IHS will continue to promote immunization schedule in order to prevent childhood illnesses. CDC will scale up purchase and distribution of insecticide-treated nets to prevent malaria in young children. It also proposes improving results for other conditions including early stage HIV infection, tuberculosis, influenza immunization, and MRSA.

Goal 3. Objective F: Protect Americans' health and safety during emergencies and foster resilience in response to emergencies

Over the past decade, our Nation has renewed its efforts to address large-scale incidents that have threatened human health, such as natural disasters, disease outbreaks, and terrorism. Working with its Federal, State, local, tribal, and international partners, HHS has improved and exercised response capabilities and developed plans for medical countermeasures.

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

Within HHS, improving health security is a shared responsibility. The Assistant Secretary for Preparedness and Response (ASPR) serves as the Secretary's principal advisor on matters related to bioterrorism, public health emergencies, and also coordinates interagency activities between HHS, other Federal partners, State, local, and tribal officials responsible for emergency preparedness and protection of the civilian population. OASH leads the U.S. Public Health Service Commissioned Corps (Corps), which maintains a system of Corps Officer response teams that rapidly respond to emerging public health emergencies. Other agencies and offices supporting emergency preparedness include ACF, CDC and FDA. The table below includes performance measures that are indicative of HHS activities to improve the health and safety of Americans during emergencies.

Objective 3.F Table of Related Performance Measures

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	Facilitated development and evaluation of one new pandemic influenza vaccine and one new trivalent vaccine; demonstrated an improved method for evaluating the safety, potency or immunogenicity of influenza vaccines; and participated in one international workshop.	Started a pilot program to develop and evaluate new methods to detect possible adverse effects, both pre-specified and non-pre-specified, of newly licensed vaccines, including pandemic influenza vaccines, in large population databases. Participated in at least one international workshop or conference.	Complete and evaluate the pilot vaccine adverse-effects program and participate in at least one international workshop or conference.	Apply novel technologies, including mass spectrometry, to quantify the absolute amount of hemagglutinin in the reference standards that are used to determine influenza vaccine potency.	Evaluate and compare new methods to determine the potency of influenza vaccines.	Develop and optimize one new method to produce high-yield influenza vaccine reference strains

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Result	Accomplished targets. See goal-by-goal section below.	Nov 30, 2009	Nov 30, 2010	The studies were delayed in FY 2011 awaiting the delivery of required equipment. In FY 2011, CBER did complete preliminary studies to evaluate the use of mass spectrometry to determine the absolute amount of hemagglutinin in reference standards and define initial sample conditions. (Target not met but improved)	N/A	N/A
Status	Target Met	Target Met	Target Met	Target Not Met but Improved		

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	87 %	Set Baseline[26]	75 %	83 %	91 %	94 %
Result	85 %	68 %	92 %	Mar 31, 2012	Mar 31, 2013	Mar 31, 2014
Status	Target Not Met but Improved	Baseline	Target Exceeded	Pending	Pending	Pending

Enhance the Department's capability to rapidly and appropriately respond to medical emergencies and urgent public health needs, through maintaining operational response teams. (Lead Agency - OASH; Measure ID - 6.1.5)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	26	36	46	46	41	46
Result	26	41	41	41	Sep 30, 2012	Sep 30, 2013
Status	Target Met	Target Exceeded	Target Not Met	Target Not Met	Pending	Pending

[26] This measure was enhanced as of 2009, which resulted in a re–baselining of the data

2.4.13: Increase the number of new CBRN and emerging infectious disease medical countermeasures under EUA or licensed (Lead Agency - ASPR)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target			N/A	Awards contracts for advanced development of recombinant-based influenza vaccines. Initiate clinical study to determine the safety of an anthrax vaccine. Issue RFP to establish Centers of Innovation for Advanced Development and Manufacturing Issue RFP to establish a network of domestic vaccine and biologics manufacturers	CBRN Licensed= 0; EUA= +1; Pan Flu/EID Licensed= +1; EUA= 0	CBRN Licensed= +0; EUA= +3; Pan Flu/EID Licensed= +3; EUA= +0
Result			Baseline	Awarded contract for Recombinant-based flu vaccines. Started large clinical studies to evaluate safety H5N1 vaccines. Issued RFP to establish Centers of Innovation for Advanced Development and Manufacturing. Proposals received and are under evaluation. Issued RFI issued to discern the capabilities of US vaccines and biologics manufacturing which will inform the subsequent RFP.	N/A	N/A
Status			Target Met	Target Met		

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	2,500 rad & 1,200 chem	2,500 rad & 1,650 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem
Result	2,500 rad & 1,200 chem	2,500 rad & 1,650 chem	2,500 rad & 2,100 chem	2,500 rad & 2,100 chem	Sep 30, 2012	N/A
Status	Target Met	Target Met	Target Met	Target Met	In Progress	

Analysis of Results

HHS is expanding diagnostic, preparation, response and treatment options to deal with both natural and man-made disasters. FDA and ASPR are striving to have more options available to handle a crisis. FDA is diversifying flu vaccine production and increasing laboratory surge capacity for testing of foods. ASPR is working to increase the development of medical countermeasures for chemical, biological, radiological, and nuclear agents. CDC is helping public health agencies rapidly convene key management staff (within 60 minutes of being notified of an emergency) so that they can integrate information, prioritize resources, and effectively coordinate with key response partners. In FY 2009 68 percent of the 62 CDC grantees convened necessary staff within 60 minutes. By FY 2010 92 percent were able to convene staff within 60 minutes, exceeding their target.

Plans for the Future

FDA is planning to maintain laboratory surge capacity for potentially contaminated foods in FY2013 to be able to perform analysis on 2,500 radiological samples and 2,100 chemical samples per week. FDA will be examining new ways to maximize flu production and evaluate vaccine potency. ASPR plans to increase the number of medical countermeasures available. CDC will be increasing the percentage of public health agencies that can assemble, make key decisions and quickly respond during an emergency.

Goal 4. Objective A: Ensure program integrity and responsible stewardship of resources

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

All agencies and offices in HHS, including ACF, AoA, CMS, OMHA and OIG are focused on ensuring the efficiency and integrity of HHS programs. In the table below are performance measures which focus on HHS plans for responsible stewardship.

Objective 4.A Table of Related Performance Measures

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	1.5%	1.4%	0.8%	0.6%	0.7%	Prior Result - 0.1PP
Result	1.3%	0.9%	0.7%	0.8%	Jan 31, 2013	Jan 31, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	19%	19%	19%	17%[27]	16%
Result	18.42%	16.96%	16.04%	Oct 31, 2012	Oct 31, 2013	Oct 30, 2014
Status	Historical Actual	Target Exceeded	Target Exceeded	Pending	Pending	Pending

[27] The FY 2012 performance target for this measure has been updated to maintain rigor in light of the most recent data trend.

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	3.1	3.2	3.2	3.4	3.6	3.2
Result	4.36	4.3	4.3	4.2	Nov 15, 2012	Nov 15, 2013
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	8,300	8,422	7,742	8,350	8,600	8,600
Result	8,301	8,544	8,438	Sep 30, 2012	Sep 30, 2013	Sep 30, 2014
Status	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Analysis of Results

Managing performance for program efficiency is one of the stewardship principles that HHS staff regularly evaluate. As an example, Head Start has a goal to ensure that the maximum number of children are served and that federal funds are used appropriately. In the Head Start program, an un-enrolled space is defined as a funded space that is vacant for more than 30 days. Head Start has had substantial success in keeping un-enrolled spaces low by requiring programs to maintain a waiting list so vacant positions can be filled quickly. ACF is also tracking the proportion of CSBG funds are used for administrative purposes. ACF wants to assure there is sufficient administrative capacity to carry out the program, the goal of this measure is to ensure that the majority of CSBG funds are being spent on direct services to support low income individuals and families. AoA is measuring the performance efficiency of the National Aging Services Network in the provision of home and community-based services. Historically, performance has exceeded targets with increasing number of seniors served per million dollars of Older American's Act funding for this measure from 2004 – 2009.

In addition to using funds wisely, HHS also needs to assure that the expected results come from expenditures. The measure from OMHA demonstrates the importance of regularly evaluating customer service and obtaining feedback from appellants and related parties on their satisfaction with appeals. OMHA has exceeded this target FY 2008 – FY 2011.

Plans for the Future

ACF and OMHA expect to maintain close to the same level of performance in FY 2013 as compared with FY 2011 expected performance. In light of the most recent results for the CSBG performance measure the performance targets for this goal have been updated to a 17 percent target for FY 2012 and a 16 percent target for FY 2013. AoA projects to improve efficiency nearly 3 percent over FY 2011 levels.

Goal 4. Objective B: Fight fraud and work to eliminate improper payments

HHS strives to allocate resources in the most efficient manner possible by preventing inappropriate payments, targeting emerging fraud schemes by provider and by type of service, and establishing safeguards to correct programmatic vulnerabilities. Reducing fraud, waste, and abuse in HHS program spending for health care, social services, and scientific research is a top priority for the Department. These activities are not one-time efforts to reduce fraud and improper payments; rather, the activities reflect our long-term commitment to continuously reduce system waste and inefficiencies.

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

HHS is monitoring and assisting the efforts of states, territories, and tribes to prevent and control error and improper payments in Head Start, Temporary Assistance to needy families (TANF), Low Income Heating and Energy Assistance Program (LIHEAP), Foster Care, and Child Care. For example, TANF agencies use employment data from the National Directory of New Hires (maintained by ACF's Office of Child Support Enforcement) to identify unreported and underreported income, thereby reducing improper assistance payments. In addition, ACF uses Title IV-E Foster Care Eligibility Reviews to ensure that children for whom Federal foster care payments are claimed are placed with eligible foster care providers. In addition to CMS and ACF, every agency and office in the Department is focused on improving efficiency, fighting fraud and eliminating abuse and improper payments. Below is a sample of performance measures that are used to manage HHS progress toward eliminating improper payments.

Objective 4.B Table of Related Performance Measures

Estimate the Payment Error Rate in the Medicaid Program (Lead Agency - CMS; Measure ID - MCD1.1)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	Report national error rates in the FY 2009 AFR based on 17 States reported in FY 2009.	Report baseline rolling average error rate in the 2010 AFR based on States measured in 2008-2010. Develop baseline and future targets.	Report rolling average error rate in the 2011 AFR based on States reported in 2009-2011. Meet or exceed the target error rate of 8.4%.	Report rolling average error rate in the 2012 AFR based on States reported in 2010-2012. Meet or exceed the target error rate of 7.4%.	Report rolling average error rate in the 2013 AFR based on States reported in 2011-2013. Meet or exceed the target error rate of 6.4%.	Report rolling average error rate in the 2014 AFR based on States reported in 2012-2014. Meet or exceed the target error rate of 6.0%.

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Result	FY 2008 PERM Rates reported in the FY 2009 AFR	9.4%	8.1%	Nov 30, 2012	Nov 30, 2013	Nov 30, 2014
Status	Target Met	Target Met	Target Met	In Progress	In Progress	In Progress

Estimate the Payment Error Rate in CHIP (Lead Agency - CMS; Measure ID - MCD1.2)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	Report national error rates in the FY 2009 AFR based on 17 CHIP States reported in FY 2009.	Publish Final Regulation in accordance with Section 601 of CHIPRA	Publish Final Regulation in accordance with Section 601 of CHIPRA	Report national error rates in the FY 2012 AFR based on 17 CHIP States.	Report rolling average error rate in the 2013 AFR based on States reported in 2012-2013.	Report rolling average error rate in the 2014 AFR based on States reported in 2012-2014. Develop baseline and future targets.
Result	Due to legislation, calculation of error rates suspended pending publication of final regulation	Regulation delayed until FY 2010	Final Regulation published 8/11/2010.	Nov 30, 2012	Nov 30, 2013	Nov 30, 2014
Status	Target Not Met	Target Not Met	Target Met	In Progress	In Progress	In Progress

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	3.8%	3.5%	9.5%	8.5%	5.4%	5%
Result	3.6%	10.8%[28]	9.1%	8.6%[29]	Nov 30, 2012	Nov 30, 2013
Status	Target Exceeded	Target Not Met	Measure Method Changed	Target Not Met but Improved	Pending	Pending

[28] The HHS 2009 Agency Financial Report (AFR) reported the Medicare FFS error rate as 7.8 percent, or $24.1 billion in improper payments. This rate reflected a combination of two different review methodologies to determine errors: 1) the old review process, accounting for the majority of the FY 2009 reviews and 2) the new review process that implemented a more stringent review methodology. Since the new review process was to be used going forward, HHS estimated an adjustment to the FY 2009 error rate for comparison purposes. Based on new estimation methodology outlined in FY2011 AFR, HHS calculated and adjusted 2009 error rate to 10.8% and 2010 error rate from 10.5% to 9.1%.

[29] Beginning with the FY 2011 Agency Financial Report (AFR), HHS refined its error rate estimation methodology to reflect activity related to the receipt of additional documentation and the outcome of appeals decisions that routinely occur after the cut–off date for the published AFR. The error rates and targets for FY 2011 and future years have been adjusted to reflect this revised methodology. Without this adjustment, the FY 2011 error rate would have been 9.9 percent. The targets for FY 2012 and FY 2013 have been adjusted from 6.2 percent and 5.8 percent respectively, as reported in the FY 2011 AFR, to 5.4 percent and 5.0 percent, respectively.

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target		Set Baseline	14.3%	13.7%	10.4%	9.8%
Result		15.4%	14.1%	11%	Nov 15, 2012	Nov 15, 2013
Status		Baseline	Target Exceeded	Target Exceeded	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target			Further develop component measures of payment error for the Part D program	Report Composite Error Rate for the Part D program.	3.2%	3.1%
Result			Additional component measure reported. (Target met)	Baseline 3.2% (Target met)	Nov.15, 2012	Nov 15, 2013
Status			Target Met	Target Met	In Progress	In Progress

Increase the percentage of administrative actions taken for Medicare providers and suppliers identified as high risk. (Lead Agency - CMS; Measure ID - MIP8)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target				Set Baseline	15%	TBD[30]
Result				Mar 31, 2012	Nov 30, 2012	N/A
Status				Pending	Pending	Target Not In Place

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	3.25%	6%	4.5%	4.7%	4.5%	4.3%
Result	6.42%[31]	4.7%	4.9%	5.25%	Oct 31, 2012	Oct 30, 2013
Status	Target Not Met	Target Exceeded	Target Not Met	Target Not Met	Pending	Pending

[30] No target has yet been established for 2013. In 2011, we are developing the baseline for this Goal to determine whether the 2012 goal is appropriate and how to set the target for 2013.

[31] The FY 2007 Foster Care error rate is not comparable to previous years' rates due to a change in the estimation methodology requested by OMB.

Analysis of Results

Nearly $800 billion is spent annually by the Federal government on Medicare and Medicaid. These expenditures comprise 85 percent of the HHS budget. Focusing on fighting fraud, waste and abuse with Medicare and Medicaid is not only efficient but also has the greatest likelihood of significant savings. CMS must ensure that correct Medicare payments are made to legitimate providers for covered, appropriate and reasonable services for eligible beneficiaries. Since there is a link between billing fraud and enrollment fraud, CMS will perform enhanced provider enrollment reviews to prevent and detect Medicare fraud and to reduce waste, abuse and other improper payments. Although CMS expects to reduce the number of fraudulent providers that enroll in Medicare, it will also identify high risk providers and suppliers through comprehensive claims-based predictive analytics that are focused on fraud indicators and which are continuously strengthened.

One of CMS' key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. Paying correctly the first time saves resources required to recover improper payments (commonly referred to as "pay and chase") and ensures the proper expenditure of valuable Medicare Trust Fund dollars. CMS improved performance in reducing improper payments for Fee-for–Service and Medicare Advantage; as well as continuing work on properly measuring improper payments for Medicare Prescription Drug Program. Reduction of improper payments is a priority initiative of this Administration, and particularly important in large programs like Medicaid that grant hundreds of millions of dollars to states. CMS performs payment error rate measurement (PERM) reviews in 17 states in any given year, reviewing all states on a three year cycle. The PERM process allows for corrective actions to address errors detected in the process, as well as provide education and outreach to reduce payment errors in the first place. CMS met its FY 2010 Medicaid target with a rate of 8.1 percent. CMS also met its CHIP target to publish the Final Regulation in accordance with Section 601 of the Children's Health Insurance Program Reauthorization Act.

ACF calculates a national payment error rate and develops an improvement plan to strategically reduce, or eliminate where possible, improper payments under the Foster Care program. Although in 2010 and 2011 the program error rate increased, the IV-E Foster Care program continues to maintain a payment error rate that is about half the 2005 baseline rate. In comparison to the baseline rate of 10.33 percent, the 2011 payment error rate is 5.25 percent (90 percent confidence interval: 4.90 percent to 5.60 percent). Examination of the relative contributions of overpayments and underpayments indicates that the overall program improper payments error rate of 5.25 percent is comprised of 4.58 percent overpayment rate and 0.67 percent underpayment rate. Of the 16 states for which updated information was included in the 2011 estimated error rate, 10 demonstrated improved performance, and one remained constant (with a 0 percent error rate). However, five other states declined in their most recent review performance and this had the effect of increasing the national error rate slightly. Results between FY 2008 through FY 2010 have fluctuated with only FY 2009 meeting the respective performance targets.

Plans for the Future

ACF, in consultation with OMB, has adjusted out-year targets for foster care improper payments for fiscal years 2011 through 2013 (4.7 percent, 4.5 percent and 4.5 percent respectively). By FY 2015, ACF expects to reach the goal of 3.7 percent.

CMS will continue to reduce improper payments for Medicare, Medicaid and CHIP services. CMS will develop baselines and future CHIP targets in FY 2013.

Goal 4. Objective C: Use HHS data to improve the health and well-being of the American people

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

Several core principles guide HHS's plan for leveraging its data, including publishing more government information online in ways that are easily accessible and usable; developing and disseminating accurate, high-quality, and timely information; fostering the public's use of the information HHS provides; and advancing a culture of data sharing at HHS.

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

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

The HHS Data Council coordinates health and human services data collection and includes the following HHS components: ACF, AHRQ, AoA, ASPE, CDC, CMS, FDA, HRSA, IHS, NIH, ONC, OASH, and SAMHSA. Below are performance measures related to use of data to improve health outcomes and well-being.

Objective 4.C Table of Related Performance Measures

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	11 months	11 months	10.8 months	10 months	10 months	10 months
Result	11 months	11 months	10.8 months	10 months	Oct 31, 2012	Oct 31, 2013
Status	Target Met	Target Met	Target Met	Target Met	Pending	Pending

Increase the electronic media reach of CDC Vital Signs through the use of mechanisms such as CDC.gov and social media outlets (Lead Agency - CDC; Measure ID - 8.B.2.2)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target		Set Baseline	N/A	350,000	1,169,208	1,215,976
Result		0	256,243	1,113,531	Oct 31, 2012	Oct 31, 2013
Status		Baseline	Historical Actual	Target Exceeded	Pending	Pending

Analysis of Results

Both AHRQ and CDC use a variety of methods to distribute information to improve health and well-being. The Medical Expenditures Panel Survey (MEPS) data is being used to increase the awareness of health and human service issues and generate insights into how to improve health and well-being. The MEPS Household Component fields questionnaires to individual household members to collect nationally representative data on demographic characteristics, health conditions, health status, use of medical care services and other characteristics. AHRQ has succeeded in reducing the data delay over the past 3 years for MEPS files which are used by policy makers, researchers, and service providers. CDC Vital Signs, which was first published in July, 2010, is an innovative project at the intersection of science, policy, and communications. The public health indicators addressed in the monthly issues of CDC Vital Signs are related to the leading causes of morbidity and mortality in the United States. The audience for Vital Signs has expanded tremendously due to growing print, broadcast, and cable media interest, and in FY 2011, over 1 million people were reached, outpacing expectations.

Plans for the Future

HHS components plan to expand the number of people reached through electronic media as represented by CDC Vital Signs targets. Further, planned releases of CDC Vital Signs include important health topics such as cancer screening, obesity, alcohol and tobacco use, and foodborne disease. AHRQ plans to maintain gains in turning data around more quickly for users.

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

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

HHS efforts to reduce greenhouse gas emissions will protect our environment and the public's health. Our operations produce greenhouse gases that are associated with negative health impacts resulting from alterations of our climate, ecosystems, food and water supplies, and other aspects of the physical environment. These gases and other air, water, and land contaminants are generated from energy production and use, employee travel and commuting, facility construction and maintenance, and mission activities, such as patient care and laboratory research.

The Senior Sustainability Officer in the Office of the Secretary helps ensure that HHS operations promote sustainability and comply with Executive Order 13514. However, meeting sustainability goals is a shared responsibility, underpinning the functions offices throughout HHS. It is also the responsibility of the individuals directly employed by HHS as well as its grantees and contractors. To integrate sustainability into the HHS mission HHS agencies and offices are using a variety of techniques, the following measures illustrate some of the ways the HHS will be tracking progress to support sustainability.

Objective 4.D Table of Related Performance Measures

Increase the percent employees on telework or AWS (Lead Agency - ASA; Measure ID - 1.1)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target				12.0%	14.0%	16.0%
Result				13.0%	Dec 3, 2012	Dec 2, 2013
Status				Target Exceeded	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target			N/A	100.0%	100.0%	100.0%
Result			32.0%	85.0%	Dec 3, 2012	Dec 2, 2013
Status			Historical Actual	Target Not Met but Improved	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	13,232 MTCO2e	12,968 MTCO2e	12,708 MTCO2e	12,454 MTCO2e
Result	13,778 MTCO2e	12,549 MTCO2e	11,750 MTCO2e	9,375 MTCO2e	Dec 3, 2012	Dec 2, 2013
Status	Historical Actual	Historical Actual	Target Exceeded	Target Exceeded	Pending	Pending

Analysis of Results

The President's Executive Order 13514 mandates the reduction of the federal government's carbon footprint by 28 percent in the next decade. HHS' Strategic Sustainability Performance Plan uses a variety of approaches with related performance measures to manage toward achieving that goal. Reducing fleet emissions, reducing electricity used by equipment in HHS offices, and encouraging employees to telework are all strategies that are outlined and tracked in the plan. In 2011 all these measures improved. Both the HHS fleet emissions and the telework targets were exceeded, with the fleet emission performance indicator measuring the reduction in the number of metric tons of carbon dioxide reduced.

Plans for the Future

HHS plans to implement the Strategic Sustainability Performance Plan and increase the energy savings that have already begun.

Goal 5. Objective A: Invest in the HHS workforce to help meet America's health and human service needs today and tomorrow

Objective B: Ensure that the Nation's healthcare workforce can meet increased demands

Goal 5. Objective C: Enhance the ability of the public health workforce to improve public health at home and abroad

Goal 5. Objective D: Strengthen the Nation's human service workforce

Goal 5. Objective E: Improve national, State, local and tribal surveillance and epidemiology capacity

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

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

Improvements in health practices rely on three critical elements: surveillance, epidemiology, and laboratory services. Carrying out these activities requires quality data and specimen collection, evidence-based epidemiology, and adequate laboratory services across the Nation. The skill set required to detect emerging threats, monitor ongoing health issues and their risk factors, and identify and evaluate the impact of strategies to prevent disease is specialized and technical.

These challenges play out against a backdrop of persisting problems. Our health professions workforce is not well-distributed geographically, racially or ethnically. Rural areas face the difficulties of low population density and long distances to care, which are especially problematic in Indian Country.

Despite the need for greater primary care capacity, physicians are apt to choose other specialties—in part, because educational debt levels have grown and primary care practitioners have lower incomes compared with most specialists.

HHS supports health workforce training efforts across the educational spectrum. CMS makes substantial financial investment in the health professions workforce by supporting the graduate medical education of physicians. CMS also uses various payment incentives to help encourage providers to practice in underserved areas. NIH is committed to meeting the nation's needs for biomedical, behavioral, and clinical investigators by providing research training for pre- and post-doctoral trainees and fellows. HRSA and IHS offer programs that provide scholarships and loan repayment in exchange for service in underserved areas. HRSA provides support to medical, nursing, and other health professional schools to improve the supply, diversity, quality, and specialty and geographic distribution of health care providers. IHS supports programs to increase the numbers of AI/AN health professionals through scholarship program and grants to educational institutions. CDC's public health workforce programs help to ensure a prepared, diverse, sustainable public health workforce through experiential fellowships and high-quality training programs, which fill critical gaps in key areas such as epidemiology, informatics, prevention effectiveness (health economics and decision sciences), preventative medicine, program management, and policy analysis. Routine placement of fellows in the field also strengthens the ability of state and local health departments to respond to public health problems and emergencies.

HHS components are committed to investing and strengthening the health and human service workforce and improving the quality of training and technical assistance; strategic use of data, monitoring, and evaluation efforts; collaboration with other agencies; and the promotion of evidence-based practices. Below are examples of performance measures from selected components designed to meet the demands for a well-trained health and human service workforce.

Objective 5 Table of Related Performance Measures

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target			N/A	80 Average Number of Days	61 Average Number of Days	60 Average Number of Days
Result			65 Average Number of Days	61 Average Number of Days	Dec 3, 2012	Dec 2, 2013
Status			Historical Actual	Target Exceeded	Pending	Pending

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 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N ≥ 12%	N ≥ 12%	N ≥ 12%	N ≥ 12%	N ≥ 12%	N ≥ 10%
Result	Award rate to comparison group reached 14% and exceeded the target by at least 2%.	Award rate to comparison group reached 13% and exceeded the target by at least 1%.	Award rate to comparison group reached 12%.	Award rate to comparison group reached 12%.[32]	N/A	N/A
Status	Target Met	Target Met	Target Met	Target Met		

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N ≥ 12%	N ≥ 12%	N ≥ 12%	N ≥ 12%	N ≥ 12%	N ≥ 10%
Result	Award rate to comparison group reached 13% and exceeded the target by at least 1%.	Award rate to comparison group reached 14% and exceeded the target by at least 2%.	Award rate to comparison group reached 14% and exceeded the target by at least 2%.	Award rate to comparison group reached 13% and exceeded the target by 1%.[33]	N/A	N/A
Status	Target Met	Target Met	Target Met	Target Met		

Percentage of health professionals supported by Bureau of Health Professions programs who enter practice in underserved areas. (Lead Agency - HRSA; Measure ID - 6.I.C.2)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	35%	35%	43%	43%	47%	43%
Result	47%	43%	Dec 31, 2012	Dec 31, 2013	Dec 31, 2014	Dec 31, 2015
Status	Target Exceeded	Target Exceeded	Pending	Pending	Pending	Pending

[32] At least 12% more NIH Kirschstein-NRSA predoctoral trainees and fellows remained in research relative to two comparison groups of Ph.D.s: (A) other doctoral students at the same institutions over the same time period. and (B) doctoral students at institutions not receiving Kirschstein-NRSA support (as indicated by the greater percentage applying for and receiving NIH research project grant support within 10 years of completing their Ph.D.s.).

[33] At least 13% more NIH post-doctoral fellows receiving research training through the Kirschstein-NRSA program remained in research relative to a comparison group of postdoctoral fellows that applied for, but did not receive Kirschstein-NRSA research fellowship support during the same time period (as indicated by the greater percentage applying for and receiving NIH research project grant support within 10 years of completing their training).

Number of primary care physicians who complete their education through HRSA's Bureau of Health Professions programs supported with Prevention and Public Health funding. (Lead Agency - HRSA; Measure ID - 6.I.C.3.a)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target						172
Result						Dec 31, 2014
Status						Pending

Number of physician assistants who complete their education through HRSA's Bureau of Health Professions programs supported with Prevention and Public Health funding. (Lead Agency - HRSA; Measure ID - 6.I.C.3.b)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target					140[34]	280[35]
Result					Dec 31, 2013	Dec 31, 2014
Status					Pending	Pending

Number of nurse practitioners who complete their education through HRSA's Bureau of Health Professions programs supported with Prevention and Public Health funding. (Lead Agency - HRSA; Measure ID - 6.I.C.3.c)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target					110	150
Result					Dec 31, 2013	Dec 31, 2014
Status					Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	3,558	4,674[36]	7,358[37]	9,203[38]	9,193[39]	7,128[40]

[34] Includes nurse midwives.

[35] Includes nurse midwives.

[36] Reflects Recovery Act funding.

[37] Reflects Recovery Act funding.

[38] Reflects Amercian Recovery and Reinvestment funding. Reflects Affordable Care Act funding.

[39] Reflects Affordable Care Act. Reflects Recovery Act Funding.

[40] Reflects Amercian Recovery and Reinvestment funding. Reflects Affordable Care Act funding.

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Result	3,601	4,808[41]	7,530[42]	10,279	Dec 31, 2012	Dec 31, 2013
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Increase the number of individuals trained by SAMHSA's Science and Services Program (Lead Agency - SAMHSA; Measure ID - 1.4.09)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	N/A		37,896	37,049[43]
Result	48,415	45,462	51,415[44]		Dec 31, 2012	Dec 31, 2013
Status	Historical Actual	Historical Actual	Historical Actual		Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	73%	75%	85%	100%[45]	100%[46]	100%
Result	80.4%	83.2%	85%	88.2%[47]	Jan 31, 2013	Jan 30, 2014
Status	Target Exceeded	Target Exceeded	Target Met	Target Not Met but Improved	Pending	Pending

[41] Reflects Recovery Act funding. This is final audited Field Strength which differs from the 4,760 shown in the FY 2011 Congressional Justification.

[42] Reflects Recovery Act funding.

[43] SAMHSA's grant awards are made late in the fiscal year; therefore, performance targets and results for any given fiscal year primarily reflect the output and outcomes associated with activities supported by funding from the prior fiscal year. For example, these FY13 performance targets reflect FY 12 funding levels. To see SAMHSA'S FY14 performance targets reflecting FY13 funding levels, please see SAMHSA'S FY13 Congressional Justification submission.

[44] All component programs have now reported; therefore, data are revised from previously reported.

[45] The FY 2011 target for this measure reflects the requirement of the 2007 Reauthorization of Head Start that, by October 1, 2011, all Head Start teachers must have at least an AA degree in early childhood education or a related field with pre–school teaching experience or have a BA degree and been admitted into the Teach for America program.

[46] The FY 2012 target for this measure reflects the requirement of the 2007 Reauthorization of Head Start that, by October 1, 2011, all Head Start teachers must have at least an AA degree in early childhood education or a related field with pre–school teaching experience or have a BA degree and been admitted into the Teach for America program.

[47] The data reported for FY 2011 reflects teachers in the 2010–2011 program year, before the statutory mandate was in place.

Maintain the number of new CDC trainees who join public health fellowship programs in epidemiology, preventive medicine, public health leadership and management, informatics, or prevention effectiveness, and participate in training at federal, state, tribal, local, and territorial public health agencies. (Lead Agency - CDC; Measure ID - 8.B.4.3)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target	N/A	N/A	N/A	185	176	176
Result	161	134	212	197	Dec 31, 2012	Dec 31, 2013
Status	Historical Actual	Historical Actual	Historical Actual	Target Exceeded	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target			Set Baseline	26.0	31.0	36.0
Result			25.0	Feb 1, 2012	Feb 1, 2013	Feb 1, 2014
Status			Baseline	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target		Set Baseline	149	164	179	255
Result		134	192	Jun 30, 2012	Jun 30, 2013	Jun 30, 2014
Status		Baseline	Target Exceeded	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target		Set Baseline	2,316	2,486	2,660	2,846
Result		2,166	2,351	Jun 30, 2012	Jun 30, 2013	Jun 30, 2014
Status		Baseline	Target Exceeded	Pending	Pending	Pending

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

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Target		Set Baseline	N/A	198	237	248
Result		119	182	309	Dec 31, 2012	Dec 31, 2013
Status		Baseline	Historical Actual	Target Exceeded	Pending	Pending

Analysis of Results

HHS has a number of activities that contribute to strengthening of the human service workforce. The Assistant Secretary for Administration (ASA) has committed to reducing the number of days from when an HHS recruitment request is made to when an employee is hired. In FY 2011 ASA reported an average hiring time of 61 days, exceeding the target of 80 days.

Increasing the number of medical personnel and public health professionals receiving training and education helps to build high quality and cost-effective clinical care and public health services. NIH, HRSA and CDC all have initiatives to improve and expand on the number of health professionals in areas key to achieving their missions. Graduate students and postdoctoral fellows receiving research training through NIH's Ruth L. Kirschstein National Research Service Award program are more likely to be retained in research careers and be successful in competing for subsequent research grants than their peers.

CDC has increased support to state, tribal, local and territorial public health agencies through the placement of field trainees. CDC made significant progress with 309 trainees in in state, tribal, local and territorial public health agencies in 2011, relative to the 2009 baseline of 119 trainees. HRSA is not just supporting the education of physicians, nurse practitioners and physician assistants but also is measuring the percentage of health professionals supported by its programs who enter practice in underserved areas. Assuring appropriate care in medically underserved areas throughout the country is a key HHS priority.

The public health workforce has shrunk by least 45,000 since 2008 state and local health departments report shortages of personnel in critical disciplines such as epidemiologists, public health nurses, managers, disease investigation specialists, laboratorians, environmental scientists, sanitarians, and informaticians. CDC's fellowship programs promote service while learning; fellows fill critical workforce needs at CDC and in the field while they are training for public health careers. In FY 2011, CDC exceeded its target for new trainees (CDC Measure 8.B.4.3) by supporting 197 fellows. CDC surveillance, epidemiology and laboratory services and skilled public health workforce are key resources nationally and around the world in detecting emerging health threats and monitoring ongoing health issues and their risk factors. Through its Field Epidemiology Training Program CDC has exceeded its goal to train and graduate more applied epidemiologists to equip Ministries of Health (MOH) in a range of areas, such as epidemiology, outbreak investigation, health surveillance systems and laboratory management. Since 1980, the program has trained and graduated 2,351 people. Through its HIV/AIDS prevention efforts, CDC has established a baseline for tracking state-based report of CD4 viral load, a population-level marker for HIV transmission risk. Routine reporting of viral load facilitates case finding and follow-up on new cases.

SAMHSA funds trainings, meetings and provides technical assistance that are designed to disseminate best-practice information to grantees and other prevention practitioners. The training opportunities are a cost-effective mechanism to increase capacity within communities while advancing the field of substance abuse and mental illness prevention and treatment.

ACF improved results for the percentage of Head Start grantees that have AA, BA or Advanced degrees. ACF believes achieving this goal will help it to achieve other goals in improving Head Start programs, including the Priority Goal for improved Head Start quality.

Plans for the Future

HHS plans to continue to improve hiring time and epidemiological and laboratory capacities. SAMHSA plans to maintain current capacities for training and education of their workforce. By 2013 all Head Start center-based teachers will have at least an AA degree or higher with relevant experience in early childhood education. HRSA expects to continue to have 43 percent of health professionals supported through its programs to enter practice in underserved areas. NIH plans to strengthen the Kirschstein-NRSA program's ability to attract and retain new scientists in biomedical research by increasing its research training stipends. CDC plans to continue strengthening capacity to detect and respond to emerging health threats and outbreaks, including HIV and increase the number of public health trainees to fill public health workforce gaps.

Summary of Evaluations completed during the fiscal year

HHS administers the largest number of assistance programs of any Federal department. Evaluating the effectiveness and benefits of services are an integral part of improving health and human services.

HHS maintains online electronic report libraries and distributes information on evaluation results as an important component of HHS evaluation management. The Department's information and reports on major evaluations are available through the HHS Policy Information Center web site, located at: http://aspe.hhs.gov/pic/performance. This web site offers users an opportunity to search – by key word, selected program, or policy topics.

The results of HHS evaluations are also disseminated on agency and office websites through targeted distribution of printed reports and research briefs, as well as presentations at professional meetings and conferences. HHS evaluators participate in the broader research community through articles in specialist publications and refereed journals.

To search the list of more than 8,000 evaluation products from HHS evaluations go to http://aspe.hhs.gov/pic/login/dataentry/index.cfm

To review the most recent Performance Improvement reports go to http://aspe.hhs.gov/pic/perfimp/index.html

GAO High Risk Items

The Government Accountability Office (GAO) has placed four HHS programs (listed below) on its "High Risk List," which lists programs that may have greater vulnerabilities to fraud, waste, abuse and mismanagement. As a responsible steward to taxpayer resources, HHS is committed to making improvements related to these challenges and high risk areas.

The programs identified by GAO are:

CMS - Medicare Program

CMS - Medicaid Program

FDA - Revamping Federal Oversight of Food Safety

FDA - Protecting Public Health through Enhanced Oversight of Medical Products

A copy of the CMS plan for addressing risk within these programs is available at:
http://www.cms.gov/apps/files/2012_CMS_GAO_High_Risk_Program_Report.pdf

A copy of the FDA plan for addressing risk within these program is available at:
http://www.fda.gov/AboutFDA/ReportsManualsForms/Reports/BudgetReports/ucm290769.htm

Data Sources and Validation

Administration for Children and Families (ACF)

Measure ID	Data Source	Data Validation
1.1LT and 1A (ACF)	State *LIHEAP Household Report* and Census Bureau's Annual Social and Economic Supplement (ASEC) to the Current Population Survey	ACF obtains weighted national estimated numbers of LIHEAP income eligible (low income) households from the Census Bureau's Annual Social and Economic Supplement (ASEC) to the Current Population Survey. The estimates are subject to sampling variability. The Census Bureau validates ASEC data. ACF aggregates data from the states' annual *LIHEAP Household Report* to furnish national counts of LIHEAP households that receive heating assistance (including data on the number of LIHEAP recipient households having at least one member who is 60 years or older and the number of LIHEAP recipient households having at least one member who is five years or younger). The aggregation and editing of state-reported LIHEAP recipiency data for the previous fiscal year are typically completed in September of the following fiscal year. Consequently, the data are not available in time to modify ACF interventions prior to the current fiscal year (i.e. there is at least a one-year data lag). There are no federal quality control or audit requirements for the data obtained from the *LIHEAP Household Report*. However ACF provides to states an electronic version of the *LIHEAP Household Report* that includes formulae that protect against mathematical errors. ACF also cross checks the data against LIHEAP benefit data obtained from the states' submission of the annual *LIHEAP Grantee Survey* on sources and uses of LIHEAP funds.
1.1LT and 1B (ACF)	State *LIHEAP Household Report* and Census Bureau's Annual Social and Economic Supplement (ASEC) to the Current Population Survey	ACF obtains weighted national estimated numbers of LIHEAP income eligible (low income) households from the Census Bureau's Annual Social and Economic Supplement (ASEC) to the Current Population Survey. The estimates are subject to sampling variability. The Census Bureau validates ASEC data. ACF aggregates data from the states' annual *LIHEAP Household Report* to furnish national counts of LIHEAP households that receive heating assistance (including data on the number of LIHEAP recipient households having at least one member who is 60 years or older and the number of LIHEAP recipient households having at least one member who is five years or younger). The aggregation and editing of state-reported LIHEAP recipiency data for the previous fiscal year are typically completed in September of the following fiscal year. Consequently, the data are not available in time to modify ACF interventions prior to the current fiscal year (i.e. there is at least a one-year data lag). There are no federal quality control or audit requirements for the data obtained from the *LIHEAP Household Report*. However ACF provides to states an electronic version of the *LIHEAP Household Report* that includes formulae that protect against mathematical errors. ACF also cross checks the data against LIHEAP benefit data obtained from the states' submission of the annual *LIHEAP Grantee Survey* on sources and uses of LIHEAP funds.

Measure ID	Data Source	Data Validation
2B (ACF)	ACF has revised the biennial CCDF State Plan Preprint and established a new quality performance report which states and territories will be required to submit on an annual basis.	ACF Federal Regional Office staff will review and validate the plans and quality performance reports from CCDF Lead Agencies.
3A (ACF)	Classroom Assessment Scoring System (CLASS)	CLASS: Pre-K is a valid and reliable tool that uses observations to rate the interactions between adults and children in the classroom. Reviewers, who have achieved the standard of reliability, assess classroom quality by rating multiple dimensions of teacher-child interaction on a seven point scale (with scores of one to two being in the low range; three to five in the mid-range; and six to seven in the high range of quality). ACF will implement ongoing training for CLASS: Pre-K reviewers to ensure their continued reliability. Periodic double-coding of reviewers will also be used, a process of using two reviewers during observations to ensure they continue to be reliable in their scoring.
3C (ACF)	Program Information Report (PIR)	The PIR is a survey of all grantees that provides comprehensive data on Head Start, Early Head Start and Migrant Head Start programs nationwide. Data collection for the PIR is automated to improve efficiency in the collection and analysis of data. Head Start achieves a 100 percent response rate annually from 2,600 respondents. The automated data system provides trend data so that the team can examine strengths and weaknesses in all programs.
3F (ACF)	Program Information Report (PIR)	The PIR is a survey of all grantees that provides comprehensive data on Head Start, Early Head Start and Migrant Head Start programs nationwide. Data collection for the PIR is automated to improve efficiency in the collection and analysis of data. Head Start achieves a 100 percent response rate annually from 2,600 respondents. The automated data system provides trend data so that the team can examine strengths and weaknesses in all programs.
4.1LT and 4A (ACF)	The Runaway and Homeless Youth Management Information System (RHYMIS)	RHYMIS incorporates numerous business rules and edit checks, provides a hot-line/help desk and undergoes continuous improvement and upgrading. Extensive cleanup and validation of data take place after each semi-annual transfer of data from grantee systems into the national database. Historically, the reporting response rate of grantees has exceeded 97 percent every year.
7D (ACF)	State Annual Reports	States are required to submit an Annual Report addressing each of the CBCAP performance measures outlined in Title II of CAPTA. One section of the report must "provide evaluation data on the outcomes of funded programs and activities." The 2006 CBCAP Program Instruction adds a requirement that the states must also report on the OMB performance measures reporting requirements and national outcomes for the CBCAP program. States were required to report on this new efficiency measure starting in December 2006. The three percent annual increase represents an ambitious target since this is the first time that the program has required programs to target their funding towards evidence-based and evidence-informed programs, and it will take time for states to adjust their funding priorities to meet these new requirements.

Measure ID	Data Source	Data Validation
7P1 (ACF)	Adoption and Foster Care Analysis Reporting System (AFCARS)	States report child welfare data to ACF through AFCARS. All state semi-annual AFCARS data submissions undergo extensive edit-checks for validity. The results of the AFCARS edit-checks for each of the six-month data submissions are automatically generated and sent back to each state, to help the state to improve data quality. Many states submit revised data to ensure that accurate data are submitted, often for more than one prior submission period. The Children's Bureau conducts several AFCARS compliance reviews each year, which typically result in a comprehensive AFCARS Improvement Plan (AIP). States' Statewide Automated Child Welfare Information Systems (SACWIS) are undergoing reviews to determine the status of their operation and the system's capability of reporting accurate AFCARS data. To speed improvement in these data, the agency funds the National Resource Center for Child Welfare Data and Technology. This Resource Center provides technical assistance to states to improve reporting to AFCARS, improve statewide information systems, and to make better use of their data. All of these activities should continue to generate additional improvements in the data over the next few years.
7P2 (ACF)	Adoption and Foster Care Analysis Reporting System (AFCARS)	States report child welfare data to ACF through AFCARS. All state semi-annual AFCARS data submissions undergo extensive edit-checks for validity. The results of the AFCARS edit-checks for each of the six-month data submissions are automatically generated and sent back to each state, to help the state to improve data quality. Many states submit revised data to ensure that accurate data are submitted, often for more than one prior submission period. The Children's Bureau conducts several AFCARS compliance reviews each year, which typically result in a comprehensive AFCARS Improvement Plan (AIP). States' Statewide Automated Child Welfare Information Systems (SACWIS) are undergoing reviews to determine the status of their operation and the system's capability of reporting accurate AFCARS data. To speed improvement in these data, the agency funds the National Resource Center for Child Welfare Data and Technology. This Resource Center provides technical assistance to states to improve reporting to AFCARS, improve statewide information systems, and to make better use of their data. All of these activities should continue to generate additional improvements in the data over the next few years.
7Q (ACF)	Adoption and Foster Care Analysis Reporting System (AFCARS)	States report child welfare data to ACF through AFCARS. All state semi-annual AFCARS data submissions undergo extensive edit-checks for validity. The results of the AFCARS edit-checks for each of the six-month data submissions are automatically generated and sent back to each state, to help the state to improve data quality. Many states submit revised data to ensure that accurate data are submitted, often for more than one prior submission period. The Children's Bureau conducts several AFCARS compliance reviews each year, which typically result in a comprehensive AFCARS Improvement Plan (AIP). States' Statewide Automated Child Welfare Information Systems (SACWIS) are undergoing reviews to determine the status of their operation and the system's capability of reporting accurate AFCARS data. To speed improvement in these data, the agency funds the National Resource Center for Child Welfare Data and Technology. This Resource Center provides technical assistance to states to improve reporting to AFCARS, improve statewide information systems, and to make better use of their data. All of these activities should continue to generate additional improvements in the data over the next few years.

Measure ID	Data Source	Data Validation
7S (ACF)	Regulatory title IV-E Foster Care Eligibility Reviews conducted by the Children's Bureau in each of the 50 states, the District of Columbia, and Puerto Rico	Data validation occurs on multiple levels. Information collected during the onsite portion of the review is subject to quality assurance procedures to assure the accuracy of the findings of substantial compliance and reports are carefully examined by the Children's Bureau Central and Regional Office staff for accuracy and completeness before a state report is finalized. Through the error rate contract, data is systematically monitored and extensively checked to make sure the latest available review data on each state is incorporated and updated to reflect rulings by the Departmental Appeals Board and payment adjustments from state quarterly fiscal reports. This ensures the annual program error rate estimates accurately represent each state's fiscal reporting and performance for specified periods. The Children's Bureau also has a database (maintained by the contractor) that tracks all key milestones for the state eligibility reviews.
12B (ACF)	CSBG Information System (CSBG/IS) survey administered by the National Association for State Community Services Programs (NASCSP)	The Office of Community Services (OCS) and NASCSP have worked to ensure that the survey captures the required information. The CSBG Block Grant allows states to have different program years; this can create a substantial time lag in preparing annual reports. States and local agencies are working toward improving their data collection and reporting technology. In order to improve the timeliness and accuracy of these reports, NASCSP and OCS are providing states training, and better survey tools and reporting processes.
14D (ACF)	SF-PPR, Family Violence Prevention and Services Program Progress Report Form	Submission of this report is a program requirement. The outcome measures and the means of data collection were developed with extensive input from researchers and the domestic violence field. The forms, instructions, and several types of training have been given to states, tribes and domestic violence coalitions.
16.1LT and 16C (ACF)	Matching Grant Progress Report forms	Data are validated with methods similar to those used with Performance Reports. Data are validated by periodic desk and on-site monitoring, in which refugee cases are randomly selected and reviewed. During on-site monitoring, outcomes reported by service providers are verified with both employers and refugees to ensure accurate reporting of job placements, wages, and retentions.
18.1LT and 18A (ACF)	Performance Report (Form ORR-6)	Data are validated by periodic desk and on-site monitoring, in which refugee cases are randomly selected and reviewed. During on-site monitoring, outcomes reported by service providers are verified with both employers and refugees to ensure accurate reporting of job placements, wages, and retentions.

Measure ID	Data Source	Data Validation
20C (ACF)	Office of Child Support Enforcement (OCSE) Form 157	States currently maintain information on the necessary data elements for the above performance measures. All states were required to have a comprehensive, statewide, automated Child Support Enforcement system in place by October 1, 1997. Fifty-three states and territories were Family Support Act-certified and Personal Responsibility and Work Opportunity Reconciliation Act-certified (PRWORA) as of July 2007. Certification requires states to meet automation systems provisions of the specific act. Continuing implementation of these systems, in conjunction with cleanup of case data, will improve the accuracy and consistency of reporting. As part of OCSE's audit of performance data, OCSE Auditors review each state's and territory's ability to produce valid data. Data reliability audits are conducted annually. Self-evaluation by states and OCSE audits provide an on-going review of the validity of data and the ability of automated systems to produce accurate data. Each year OCSE Auditors review the data that states report for the previous fiscal year. The OCSE Office of Audit has completed the FY 2010 data reliability audits. Since FY 2001, the reliability standard has been 95 percent.
22.2LT and 22B (ACF)	National Directory of New Hires (NDNH)	Beginning with performance in FY 2001, the above employment measures – job entry, job retention, and earnings gain – are based solely on performance data obtained from the NDNH. Data are updated by states, and data validity is ensured with normal auditing functions for submitted data. Prior to use of the NDNH, states had flexibility in the data source(s) they used to obtain wage information on current and former TANF recipients under high performance bonus (HPB) specifications for performance years FY 1998 through FY 2000. ACF moved to this single source national database (NDNH) to ensure equal access to wage data and uniform application of the performance specifications.

Agency for Healthcare Research and Quality – (AHRQ)

Measure ID	Data Source	Data Validation
1.3.21 (AHRQ)	MEPS website	Data published on website. A number of steps are taken from the time of sample selection up to data release to ensure the reliability and accuracy of MEPS data including: • Quality control checks are applied to the MEPS sample frame when it is received from NCHS as well as to the subsample selected for MEPS. • Following interviewer training, performance is monitored through interview observations and validation interviews. • A variety of materials and strategies are employed to stimulate and maintain respondent cooperation. • All manual coding and data entry tasks are monitored for quality by verification at 100 percent until an error rate of less than 2 percent is achieved for coding work or less than 1 percent for data entry. • All specifications developed to guide the editing, variable construction and file creation are monitored through data runs that are used to verify that processes are conducted correctly and to identify data anomalies. • Analytic weights are developed in a manner that reduces nonresponse bias and improves national representativeness of survey estimates. • The precision of survey estimates are reviewed to insure they are achieving precision specifications for the survey. • Prior to data release, survey estimates on health care utilization, expenditures, insurance coverage, priority conditions and income are compared to previous year MEPS data and other studies. Significant changes in values of constructed variables are investigated to determine whether differences are attributable to data collection or variable construction problems that require correction. • Expenditure data obtained from the MEPS medical provider survey are used to improve the accuracy of household reported data.
1.3.38 (AHRQ)	Surveys/case studies	AHRQ staff (OCKT) and evaluation contractor (TBD) to develop methods to validate survey data and conduct case studies
4.4.5 (AHRQ)	All AHRQ systematic reviews are entered into a database, which is used to populate the AHRQ Effective Health Care Program Web site http://effectivehealthcare.ahrq.gov/	Effective Health Care Program staff will develop and document a methodology that will be used annually to check data

Assistant Secretary for Administration – (ASA)

Measure ID	Data Source	Data Validation
1.1 (ASA)	HHS personnel records	

Measure ID	Data Source	Data Validation
1.2 (ASA)	FAST (Fleet Automated Statistical Tool)	
1.3 (ASA)	HHS administrative data.	
2.1 (ASA)	HHS personnel records	

Assistant Secretary For Preparedness and Response – (ASPR)

Measure ID	Data Source	Data Validation
2.4.13 (ASPR)	ASPR contract files	Contracts awarded and draft Request for Proposal for industry comment are negotiated and issued, respectively, in accordance with Federal Acquisition Regulations (FAR) and the HHS Acquisition Regulations (HHSAR). Interagency Agreements are developed with federal laboratories to address specific advanced research questions.

Administration on Aging – (AoA)

Measure ID	Data Source	Data Validation
1.1 (AoA)	State Program Report data is annually submitted by States.	The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by AoA and State staff. AoA staff follow-up with States to assure validity and accuracy. After revisions, States certify the accuracy of their data.
2.6 (AoA)	National Survey of Older Americans Act Participants.	The National Survey draws a sample of Area Agencies on Aging to obtain a random sample of clients receiving selected services. Trained staff administers telephone surveys. Results are analyzed and compared to client population to assure representative sample.

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

Measure ID	Data Source	Data Validation
2.10 (AoA)	State Program Report and National Survey of Older Americans Act Participants.	This is a composite measure that utilizes data from multiple sources. One source is the State Program Report. Another source is the National Survey. State Program Report data is annually submitted by States. The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by AoA and State staff. AoA staff follow-up with States to assure validity and accuracy. After revisions, States certify the accuracy of their data. The National Survey draws a sample of Area Agencies on Aging to obtain a random sample of clients receiving selected services. Trained staff administers telephone surveys. Results are analyzed and compared to client population to assure representative sample.
3.1 (AoA)	State Program Report data is annually submitted by States.	The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by AoA and State staff. AoA staff follow-up with States to assure validity and accuracy. After revisions, States certify the accuracy of their data.
3.2 (AoA)	State Program Report data is annually submitted by States.	The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by AoA and State staff. AoA staff follow-up with States to assure validity and accuracy. After revisions, States certify the accuracy of their data.

Centers for Disease Control and Prevention (CDC)

Measure ID	Data Source	Data Validation
1.2.1c (CDC)	Childhood data are collected through the National Immunization Survey (NIS) and reflect calendar years.	The NIS uses a nationally representative sample and provides estimates of vaccination coverage rates that are weighted to represent the entire population, nationally, and by region, state, and selected large metropolitan areas. The NIS, a telephone-based survey, is administered by random-digit-dialing to find households with children aged 19 to 35 months. Parents or guardians are asked about the vaccines, with dates, that appear on the child's "shot card" kept in the home; demographic and socioeconomic information is also collected. At the end of the interview with parents or guardians, survey administrators request permission to contact the child's vaccination providers. Providers are then contacted by mail to provide a record of all immunizations given to the child. Examples of quality control procedures include 100% verification of all entered data with a sub-sample of records independently entered. The biannual data files are reviewed for consistency and completeness by CDC's National Center for Immunization and Respiratory Diseases, Immunization Services Division - Assessment Branch and CDC's National Center for Health Statistics' Office of Research and Methodology. Random monitoring by supervisors of interviewers' questionnaire administration styles and data entry accuracy occurs daily. Annual methodology reports and public use data files are available to the public for review and analysis.

Measure ID	Data Source	Data Validation
1.3.2a (CDC)	National Health Interview Survey (NHIS)	NHIS is a cross-sectional household interview survey. Households chosen for interviews are a probability sample representative of the target population. The annual response rate is more than 90 percent of eligible households in the sample. NHIS has three modules: 1) The basic module remains largely unchanged from year to year and allows for trend analysis. Data from more than one year can also be pooled to increase the sample size for analytic purposes. The basic module contains a family core, a sample adult core, and a child core through which data are collected on the family unit and from one randomly selected adult and child. 2) Periodic modules collect more detailed information on some of the topics included in the basic module. 3) Topical modules respond to new data needs as they arise. Data are collected through a personal household interview conducted by staff employed and trained by the U.S. Census according to procedures delineated by CDC. Data are reviewed and analyzed extensively to ensure their validity and reliability. The survey sample is designed to yield estimates that are representative and that have acceptably small variations. Before the actual survey, cognitive testing is performed by CDCs Questionnaire Design Research laboratory, and pretests are conducted in the field. Once collected, data are carefully edited, checked, and compared to data from earlier surveys and/or independent sources. Staff members calculate descriptive statistics and perform in-depth analyses, which result in feedback on the analytic usefulness of the data.
2.1.4 (CDC)	National HIV surveillance system	CDC conducts validation and evaluation studies of the data systems which monitor HIV to determine the quality of data generated by them. Data for 2010 are from 46 states with mature, confidential name-based HIV surveillance systems. These states are: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. The period of time between a diagnosis of HIV or AIDS and the arrival of a case report at CDC is called the "reporting delay". In order to provide the best estimates of recent trends, HIV and AIDS surveillance data are analyzed by date of diagnosis and are statistically adjusted for reporting delays and incomplete information on some cases. CDC requires a minimum of 12 months after the end of a calendar year to provide accurate trend data.

Measure ID	Data Source	Data Validation
2.2.4 (CDC)	Legal Assessment Project -The Legal Assessment Project is a legal research and policy analysis project led by CDC's Division of HIV/AIDS Prevention, Office of the Director. The project is conducting a series of 50 state legal surveys (including both statutory and regulatory law) across a number of legal domains, using standard legal research methods. The laws are described as characteristics of policy environments that may facilitate or hinder effective HIV prevention.	CDC conducts legal research to assess policy, statutory and regulatory changes that affect the states' ability to conduct effective HIV prevention.
2.8.1 (CDC)	The National TB Surveillance System	TB morbidity data and related information submitted via the national TB Surveillance System are entered locally or at the state level into CDC-developed software which contains numerous data validation checks. Data received at CDC are reviewed to confirm their integrity and evaluate completeness. Routine data quality reports are generated to assess data completeness and identify inconsistencies. Problems are resolved by CDC staff working with state and local TB program staff. During regular visits to state, local, and territorial health departments, CDC staff review TB registers and other records and data systems and compare records for verification and accuracy. At the end of each year, data are again reviewed before data and counts are finalized and published.
3.2.1 (CDC)	National Ambulatory Medical Care Survey (NAMCS), CDC, NCHS; and National Hospital Ambulatory Medical Care Survey (NHAMCS), CDC, NCHS	A 10% quality control sample of survey records was independently keyed and coded.
3.3.2 (CDC)	Emerging Infections Program / Active Bacterial Core Surveillance/Emerging Infections Program Surveillance for Invasive MRSA Infections	Surveillance Site personnel trained in methodology, updates annually; laboratory audits performed by Site staff
3.3.4 (CDC)	National Healthcare Safety Network (NHSN)	Extensive cross-field edit checks are used for validation and incomplete records cannot be reported. Detailed instructions for completion of report forms ensure consistency across sites. Process and quality improvements occur through email updates and annual meetings.
4.6.3 (CDC)	National Health Interview Survey, NCHS	NCHS validates the data

Measure ID	Data Source	Data Validation
4.6.5 (CDC)	The primary data source for setting and reporting targets is the Youth Risk Behavior Surveillance System (YRBSS), which monitors priority health-risk behaviors and is conducted every other year (odd years). Beginning in FY 2011, the National Youth Tobacco Survey (NYTS) was added as an additional data source, which tracks closely with YRBSS. To obtain data on an annual basis, CDC will conduct the NYTS in the intervening years.	Validity and reliability studies of YRBSS and NYTS attest to the quality ofthe data. CDC conducts quality control and logical edit checks on each record
4.11.9 (CDC)	National Health Interview Survey (NHIS), CDC, NCHS	Data are reported from a national surveillance system and follows predetermined quality control standards.
7.2.4 (CDC)	National Highway Traffic Safety Administration Fatal Analysis Reporting System (FARS)	Data are from police accident reports for any crash on a public road that resulted in a fatality within 30 days of the crash. Each police accident report of an eligible crash is then entered into the national "Fatal Analysis Reporting System" database (FARS). The quality of the data is reviewed by state FARS data coordinator.
8.B.2.2 (CDC)	Electronic media reach of CDC Vital Signs is measured by CDC.gov web traffic and actual followers and subscribers of CDC's social media, e-mail updates and texting service The data source for this measure is Omniture® web analytics, which is a software product that provides consolidated and accurate statistics about interactions with CDC.gov and social media outlets as individuals seek and access information about *CDC Vital Signs.*	Monthly review of Omniture data by CDC Office of the Associate Director for Communication (OADC) and Vital Signs staff.
8.B.2.5 (CDC)	Omniture	Ongoing review of Omniture reports by Community Guide staff.

Measure ID	Data Source	Data Validation
8.B.4.2 (CDC)	Data are compiled annually at the end of the fiscal year to count the total number of fellows in field assignments in state, tribal, local, and territorial public health agencies. In 2009, this measure included the Epidemic Intelligence Service (EIS), Preventive Medicine Residency/Fellowship (PMR/F), Public Health Prevention Specialists (PHPS), and the Public Health Associate Program (PHAP), formerly known as the Public Health Apprentice Program; the Public Health Informatics Fellowship Program (PHIFP) was added in 2010; the CDC-supported Emerging Infectious Diseases (EID) Laboratory Fellowships, CDC/Council of State and Territorial Epidemiologists' (CSTE) Applied Epidemiology Fellowship, Post-EIS Practicum, PHPS Residency, and Applied Public Health Informatics Fellowship were added to the measure for FY 2011. Fellows funded by other federal agencies are excluded.	Staff reviews and validates data through the fellowship programs' personnel system.
8.B.4.3 (CDC)	Data are compiled annually at the end of the fiscal year to count the number of new trainees entering classes in the Epidemic Intelligence Service (EIS), Preventive Medicine Residency/Fellowship (PMR/F), Public Health Prevention Service (PHPS), Public Health Informatics Fellowship (PHIF), Prevention Effectiveness Fellowship (PEF), Presidential Management Fellows (PMF) program, and the Public Health Associate Program (PHAP). Fellows funded by other federal agencies are excluded.	Staff reviews and validates data through the Fellowship Management System and through the Public Health Workforce Development program's personnel system.

Measure ID	Data Source	Data Validation
10.C.1 (CDC)	Demographic and Health Surveys (DHS), Multiple Indicator Surveys (MICS), and Malaria Indicator Surveys (MIS).	In sub-Saharan Africa, nationally representative household surveys, like the UNICEF Multiple Indicator Cluster Surveys (MICS) or the MEASURE Demographic and Health Surveys (DHS) conducted by MACRO/Measure Evaluation measure mortality of children less than five as a complement to decadal censuses. These surveys give robust estimates of mortality that can be used to track improvements in survival in populations without strong systems of vital registration. In PMI countries, malaria indicator surveys at baseline, midpoint and after four full years of implementation will be used to obtain nationally representative estimates of coverage with ITNs, ACTS, and IPTp. In addition, a nationally representative mortality survey will provide baseline mortality data and a similar survey will provide follow-up data after at least three years of implementation. These surveys will most often be scheduled independently of PMI but may be supported by PMI funding. A fifty percent drop in malaria mortality would be evident through these surveys even if deaths together for children under five were considered together from all causes. The Demographic and Health Surveys are conducted and funded largely by USAID. They cover multiple programs such as HIV, Reproductive Health, etc. Each program module has a set of questions and in some cases laboratory tests. Countries decide what program modules they would like to add to the survey. The sample sizes are dependent on the population of the country. The surveys are designed to be representative of the country and vary by country. The methodologies are sound and widely accepted; the results are used by the MOHs and the global public health community for planning and evaluating. These surveys are designed to be repeated over time for consistency. More information is available at http://www.measuredhs.com/
10.F.1a (CDC)	FELTP Annual Program Reports	Reports from Countries are submitted to CDC annually. These reports are confirmed by program directors in each Country.
10.F.1b (CDC)	FELTP Annual Program Reports	Reports from Countries are submitted to CDC annually. These reports are confirmed by program directors in each Country.
13.5.3 (CDC)	Self-reported grantee data as part of required progress reports	Quality assurance reviews with follow-up with grantees

Centers for Medicare & Medicaid Services (CMS)

Measure ID	Data Source	Data Validation
CHIP 3.1 (CMS)	States are required to submit quarterly and annual CHIP statistical forms to CMS through the automated Statistical Enrollment Data System (SEDS). Using these forms, States report quarterly and annually on unduplicated counts of the number of children under age 19 who are enrolled in separate CHIP programs and Medicaid expansion CHIP programs. The enrollment counts presented reflect an unduplicated number of children ever enrolled during the year in separate CHIP and Medicaid expansion CHIP programs.	Each State must assure that the information is accurate and correct when the information is submitted to SEDS by certifying that the information shown on the CHIP forms is correct and in accordance with the State's child health plan as approved by the Secretary. CMS staff populates the data into various SEDS reports and verifies each of the enrollment measures. Each form has the following seven measures that are reported by service delivery system: 1: Unduplicated Number Ever Enrolled During the Quarter. 2: Unduplicated Number of New Enrollees in the Quarter. 3: Unduplicated Number of Disenrollees in the Quarter. 4: Number of Member-Months of Enrollment in the Quarter. 5: Average Number of Months of Enrollment (item 4 divided by item 1). 6: Number Enrolled At Quarter's End (point in time). 7: Unduplicated Number Ever Enrolled in the Year" (4th Quarter Only). CMS compares these enrollment measures to past quarters and trends over the life of each program to ensure that there aren't any anomalies in the data, and if apparent errors are detected, CMS corresponds with the State staff who are responsible for reporting enrollment statistics. If there are major increases or decreases, CMS investigates the causes of the changes in enrollment patterns.
CHIP 3.2 (CMS)	States are required to submit quarterly and annual CHIP statistical forms to CMS through the automated Statistical Enrollment Data System (SEDS). Using these forms, States report quarterly and annually on unduplicated counts of the number of children under age 19 who are enrolled in separate CHIP programs and Medicaid expansion CHIP programs. The enrollment counts presented reflect an unduplicated number of children ever enrolled during the year in separate CHIP and Medicaid expansion CHIP programs.	Each State must assure that the information is accurate and correct when the information is submitted to SEDS by certifying that the information shown on the CHIP forms is correct and in accordance with the State's child health plan as approved by the Secretary. CMS staff populates the data into various SEDS reports and verifies each of the enrollment measures. Each form has the following seven measures that are reported by service delivery system: 1: Unduplicated Number Ever Enrolled During the Quarter. 2: Unduplicated Number of New Enrollees in the Quarter. 3: Unduplicated Number of Disenrollees in the Quarter. 4: Number of Member-Months of Enrollment in the Quarter. 5: Average Number of Months of Enrollment (item 4 divided by item 1). 6: Number Enrolled At Quarter's End (point in time). 7: Unduplicated Number Ever Enrolled in the Year" (4th Quarter Only). CMS compares these enrollment measures to past quarters and trends over the life of each program to ensure that there aren't any anomalies in the data, and if apparent errors are detected, CMS corresponds with the State staff who are responsible for reporting enrollment statistics. If there are major increases or decreases, CMS investigates the causes of the changes in enrollment patterns.

Measure ID	Data Source	Data Validation
MCD1.1 (CMS)	As part of a national contracting strategy, adjudicated claims data and medical policies are gathered from the States for purposes of conducting medical and data processing reviews on a sample of the claims paid in each State.	CMS and our contractors are working with the 17 States to ensure that the Medicaid universe data and sampled claims are complete and accurate and contain the data needed to conduct the reviews.
MCD1.2 (CMS)	As part of a national contracting strategy, adjudicated claims data and medical policies are gathered from the States for purposes of conducting medical and data processing reviews on a sample of the claims paid in each State.	CMS and our contractors are working with the 17 States to ensure that the Medicaid universe data and sampled claims are complete and accurate and contain the data needed to conduct the reviews.
MCD6 (CMS)	The core set of measures was published in December 2009. CMS will initially use the automated web-based system - CHIP Annual Reporting Template System for the reporting of quality measures developed by the new program.	Developmental. CMS will monitor performance measurement data related to the core set of measures through CARTS.
MCD8 (CMS)	Developmental. For FY 2011 and FY 2012, the data source will be the links to the Federal Register. The link to the recommended core set is: http://federalregister.gov/a/2010-32978. The link to the published core set is http://federalregister.gov/a/2011-33756. By January 1, 2013, CMS will provide States with technical specifications for reporting information on the adult quality core measures set, coupled with technical assistance to increase the feasibility of reporting. Information voluntarily reported to CMS by the end of 2013, will serve as the data source for assessing States' progress in reporting standardized adult quality measurement data to CMS.	Developmental. For FY 2011 and FY 2012, the data validation will be the link to the core set in the Federal Register. The link to the recommended core set is: http://federalregister.gov/a/2010-32978. The link to the published core set is http://federalregister.gov/a/2011-33756

Measure ID	Data Source	Data Validation
MCR1.1a (CMS)	The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a set of annual surveys of beneficiaries enrolled in all Medicare Advantage plans and in the original Medicare fee-for-service plan.	The Medicare CAHPS are administered according to the standardized protocols as delineated in the CAHPS 4.0 Survey and Reporting Kit developed by the Agency for Healthcare Research and Quality (AHRQ). This protocol includes two mailings of the survey instruments to randomized samples of Medicare beneficiaries in health plans and geographic areas, with telephone follow-up of non-respondents with valid telephone numbers. CAHPS data are carefully edited and cleaned prior to the creation of composite measures using techniques employed comparably in all surveys. Both non-respondent sample weights and managed care-FFS comparability weights are employed to adjust collected data for differential probabilities of sample selection, under-coverage, and item response.
MCR1.1b (CMS)	The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a set of annual surveys of beneficiaries enrolled in the original Medicare fee-for-service plan and in all Medicare Advantage plans.	The Medicare CAHPS are administered according to the standardized protocols as delineated in the CAHPS 4.0 Survey and Reporting Kit developed by the Agency for Healthcare Research and Quality (AHRQ). This protocol includes two mailings of the survey instruments to randomized samples of Medicare beneficiaries in health plans and geographic areas, with telephone follow-up of non-respondents with valid telephone numbers. CAHPS data are carefully edited and cleaned prior to the creation of composite measures using techniques employed comparably in all surveys. Both non-respondent sample weights and managed care-FFS comparability weights are employed to adjust collected data for differential probabilities of sample selection, under-coverage, and item response.
MCR22 (CMS)	The PFS rules and regulations; the Relative Value Scale Update Committee (RUC) database; relevant PFS utilization data available at the time of analysis.	Developmental. We will devise a process to compare the values from multiple data sources and incorporate clinical review to check the appropriate valuation of the codes identified as potentially misvalued.
MCR23 (CMS)	The Prescription Drug Event (PDE) data	CMS has a rigorous data quality program for ensuring the accuracy and reliability of the PDE data. The first phase in this process is on-line PDE editing. The purpose of on-line editing is to apply format rules, check for legal values, compare data in individual fields to other known information (such as beneficiary, plan, or drug characteristics) and evaluate logical consistency between multiple fields reported on the same PDE. On-line editing also enforces business order logic which ensures only one PDE is active for each prescription drug event. The second phase of our data quality program occurs after PDE data has passed all initial on-line edits and is saved in our data repository. We conduct a variety of routine and ad hoc data analysis of saved PDEs to ensure data quality and payment accuracy.

Measure ID	Data Source	Data Validation
MCR25 (CMS)	The Common Working File (CWF) will be the primary data source for this analysis; the claims will undergo final-action to be consistent with the data available in the Integrated Data Repository (IDR) database. The claims will be used to identify Annual Wellness Exams for Original Medicare beneficiaries, using HCPCS code G0438 for Part B FFS initial AWV claims as well as the HCPCS code G0439 for subsequent AWVs. The baseline will consist of the total number of initial AWV in 2011 (the first year of the benefit), and will help inform future target estimates. Targets are based on a cumulative number of initial AWV services estimated in total by the end of each year since CY 2011. CMS will monitor subsequent Part B beneficiary AWV utilization through the CWF (HCPCS G0439) over time and can adjust the calculation to factor in repeat service utilization if most beneficiaries are using the service each year after first receiving it.	The CWF contains claims that are submitted by providers to Medicare and are from Systems of Record or other authoritative data sources. AWV utilization rates for Part B beneficiaries will be calculated and compared to previous months' or years' data to check for any unusual changes in data values.
MCR26 (CMS)	Medicare claims data. The data used to calculate the performance measures are administrative claims data submitted by hospitals and Medicare Advantage plans. Administrative claims data is a validated data source and is the data source for public reporting of hospital readmission rates on the Hospital Compare website. As stated on the Hospital Compare website, research conducted when the measures were being developed demonstrated that the administrative claims-based models perform well in predicting readmission compared with models based on chart reviews.	The claims processing systems have validation methods to accept accurate Medicare claims into the claims database. CMS uses national administrative inpatient hospital claims data to calculate the readmission rate measure. The claims processing systems have validation methods to accept accurate Medicare claims into the claims database. Inpatient hospital claims information is assumed to be accurate and reliable as presented in the database.

Measure ID	Data Source	Data Validation
MCR28.1 (CMS)	National Healthcare Safety Network	Extensive cross-field edit checks are used for validation and incomplete records cannot be reported. Detailed instructions for completion of report forms ensure consistency across sites. Process and quality improvements occur through email updates and annual meetings.
MCR28.2 (CMS)	National Healthcare Safety Network	Extensive cross-field edit checks are used for validation and incomplete records cannot be reported. Detailed instructions for completion of report forms ensure consistency across sites. Process and quality improvements occur through email updates and annual meetings.
MIP1 (CMS)	Comprehensive Error Rate Testing (CERT) Program.	The CERT program is monitored for compliance by CMS through monthly reports from the contractors. In addition, the OIG periodically conducts reviews of CERT and its contractors.
MIP5 (CMS)	The Part C Composite Error Rate is made up of two components: Medicare Advantage Prescription Drug (MARx) payment system error (MPE): The MPE measures errors in the system which issues payments to Medicare Advantage Plans. Source data come from CMS' monthly Beneficiary Payment Validation (BPV) analyses, which are employed by CMS to ensure the accuracy of the monthly Part C payments calculated by MARx. Risk Adjustment Payment Error (RAE) Estimate: The RAE measures errors in diagnostic data submitted by plans to Medicare. The diagnostic data is used to determine risk adjusted payments made to plans.	Data used to determine the Part C composite payment error rate is validated by several contractors. The Part C MPE estimate is based on data from CMS' monthly payment validation process, beneficiary payment validation (BPV), and is confirmed and analyzed by multiple contractors. The Part C RAE estimate is based on data obtained from a rigorous Risk Adjustment Data Validation process in which medical records are reviewed by two independent coding entities in the process of confirming discrepancies for a national random sample of beneficiaries.

Measure ID	Data Source	Data Validation
MIP6 (CMS)	The components of payment error measurement in the Part D program are: A rate that measures payment errors in the system that issues payments to Part D plan sponsors. A rate(s) that measures payment errors related to low income subsidy (LIS) payments for beneficiaries dually-eligible for Medicare and Medicaid and non-duals also eligible for LIS status. A rate that measures payment errors due to errors in Prescription Drug Event (PDE) records. A rate that measures payment errors due to incorrect assignment of Medicaid status to beneficiaries who are not dually eligible for Medicare and Medicaid. A rate that measures payment errors due to errors in Direct and Indirect Remuneration (DIR) amounts reported by Part D sponsors to CMS.	For the Part D component payment error rates, the data to validate payments comes from multiple internal and external sources, including CMS' enrollment and payment files. Data are validated by several contractors. Data for the payment system error measure come from CMS' monthly Beneficiary Payment Validation (BPV) process, which is employed by CMS to ensure the accuracy of the monthly Part D payments calculated by the payment system; this data is confirmed and analyzed by several contractors. Data for the LIS payment error measure come from CMS' internal payment and enrollment files for all Part D plan beneficiaries. Data for the PDE error measure come from CMS' PDE Data Validation process, which validates PDE data through contractor review of supporting documentation submitted to CMS by a national sample of Part D plans. The data element for incorrect Medicaid status is the PERM eligibility error rate, which is validated by the Medicaid program for the entire Medicaid population and is used by the Part D program as a proxy for incorrect Medicaid status. From the population of Part D beneficiaries who are eligible for Medicare and Medicaid, we randomly assign a subset, equal to the PERM rate, to be ineligible for Medicaid, resulting in payment error. Data for the DIR error measure come from audit findings for a national sample of Part D plans; the audits are conducted by contractors as part of the CMS Financial Audit process.

Measure ID	Data Source	Data Validation
MIP8 (CMS)	Developmental. CMS proposes to identify high risk providers in two ways: 1. according to provisions included in *CMS-6028-FC: Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers*, the Final Rule with Comment, published in the Federal Register on February 2, 2011, and 2. as a part of the analytics supporting the National Fraud Prevention Program announced by the Secretary on June 17, 2011. In the February regulation, CMS finalized three levels of risk, Limited, Moderate and High. Provider types were assigned to these risk levels based on findings in reports from the HHS Inspector General, the Government Accountability Office, and CMS's own analytic work and experience. The provider types assigned to these risk levels receive oversight and review that increases with the level of risk of fraud—the greater the level of risk, the greater the level of oversight and review. As a part of the National Fraud Prevention Program announced by Secretary Sebelius on June 17, 2011, CMS is engaged in predictive analytics that will identify providers and suppliers that exhibit behavior that poses a high risk of fraud in the Medicare program. The analytic tools assess claims that have passed initial edits but that have not yet been paid. The algorithms assess many different variables and assign composite scores that indicate relative risk of fraud. The results of the analytics become Alerts that are made available to program integrity contractors for rapid review and development and recommendation for administrative actions. Medicare contractors have been given CMS-developed reporting requirements for data on implementation and operational activities associated with these two different sets of requirements. As a part of this reporting, contractors will track and report the results of the administrative actions as defined in the goal description.	Developmental. Enrollment contractors have been instructed in the data required to monitor the implementation of the provider screening rule published on February 2, 2011. CMS will review the processes employed by the contractors and will develop procedures to validate the data reported to CMS' by the MACs, ZPICs and NSC. As civil monetary penalties are one of the interventions included in the analysis, CMS will be working with the Office of the Inspector General to obtain the data regarding imposition of such penalties. With regard to administrative actions taken in the universe of providers and suppliers identified via predictive analytics as posing a high risk of fraud, we will capture the same level of detailed information from our fraud prevention contractors as for the administrative actions taken in the enrollment screening component of the goal.

Measure ID	Data Source	Data Validation
MSC1 (CMS)	Nursing homes submit this information to the State Minimum Data Set database, which is linked to the national Minimum Data Set database.	The MDS is the source of the data used to calculate this measure. The MDS is considered to be part of the medical record. The nursing home must maintain the MDS and submit it electronically to CMS for every resident of the certified part of the nursing home. However, MDS data are self-reported by the nursing home. MDS data quality assurance currently consists of onsite and offsite reviews by surveyors and by CMS contractors to ensure that MDS assessments are reported in a timely and complete manner. Beginning in FY 2011, the data source is changing from MDS version 2.0 to MDS version 3.0.
PHI2 (CMS)	Current Population Survey	Current Population Survey
PHI4 (CMS)	Exchange IT system metrics	Operational standard operating procedures will include audit and verification of system metric output.
QIO4 (CMS)	Baseline State-level performance rates calculated using self-reported and validated data abstracted from hospitals participating in the CMS Hospital Inpatient Quality Reporting (IQR) program.	The accuracy and reliability of data from the QIO Clinical Warehouse are monitored constantly through reabstraction of a sample of approximately 48 medical records per year by the CMS Data Abstraction Center (CDAC) for a random sample of 800 hospitals per year.
QIO5 (CMS)	Data is self reported by the dialysis facilities. Dialysis facilities submit directly to the 18 ESRD Networks who then submit directly to CMS through a file transfer.	Prior to monthly ESRD Network dashboard publishing, edit checks are programmed to ensure that only eligible facilities are reporting. A further check is conducted using a trend report comparing over 70% of all reported data with historical trends to ensure that missing case rates and case counts are in line with monthly annual trends.

Food and Drug Administration (FDA)

Measure ID	Data Source	Data Validation
212409 (FDA)	CDC/FoodNet	FoodNet Annual Reports are summaries of information collected through active surveillance of nine pathogens. A preliminary version of this report becomes available in the spring of each year and forms the basis of each year's Morbidity and Mortality Weekly Report (MMWR) FoodNet Surveillance. The FoodNet Final Report becomes available later in the year when current census information becomes available. The illness rates calculated for this Priority Goal use the same data and same methodology as the illness rates in the MMWR.. CDC's FoodNet system reports pathogen-specific illness data based on the calendar year, not the fiscal year. Therefore, achievement of the annual targets reported here is evaluated based on the calendar year data, not fiscal year data.

Measure ID	Data Source	Data Validation
214305 (FDA)	Field Data Systems	These maximum capacities are extrapolated to estimate for times of emergency with the laboratory operating under abnormal conditions that are variable and uncertain. FDA and FERN work to maximize capabilities by continually improving methods and training along with increasing automated functionality and available cache of supplies. Through using these laboratories, with known instrumentation and methods, after examining the sample throughput during emergencies, and after consultation with the laboratories and FDA subject matter experts, the listed sample totals are the estimates reached. The surge capacity estimates provided in the performance measures for these laboratories have been examined under the stress of emergencies and outbreaks such as the melamine contamination, Deepwater Horizon oil spill, and the Japan nuclear event.
214306 (FDA)	BioPlex and ibis Biosensor systems	CFSAN scientists have developed the means to evaluate and adapt commercially available instruments to develop and validate more rapid, accurate, and transportable tests to stop the spread of foodborne illness and cases of chemical contamination. Using one such system, known as Bioplex, CFSAN scientists are using the device to rapidly serotype pathogens such Salmonella. The Bioplex system can serotype 48 different samples in 3 to 4 hours, which vastly improves response time in foodborne illness outbreaks. CFSAN scientists also are using the ibis Biosensor system to speed the identification of Salmonella, E. coli, and other pathogens, toxins, and chemical contaminants.
223205 (FDA)	Review performance monitoring is being done in terms of cohorts, e.g., FY 2009 cohort includes applications received from October 1, 2008, through September 30, 2009. CDER uses the Document Archiving, Reporting, and Regulatory Tracking System (DARRTS). FDA has a quality control process in place to ensure the reliability of the performance data in DARRTS.	The Document Archiving, Reporting, and Regulatory Tracking System (DARRTS) is CDER's enterprise-wide system for supporting premarket and postmarket regulatory activities. DARRTS is the core database upon which most mission-critical applications are dependent. The type of information tracked in DARRTS includes status, type of document, review assignments, status for all assigned reviewers, and other pertinent comments. CDER has in place a quality control process for ensuring the reliability of the performance data in DARRTS. Document room task leaders conduct one hundred percent daily quality control of all incoming data done by their IND and NDA technicians. Senior task leaders then conduct a random quality control check of the entered data in DARRTS. The task leader then validates that all data entered into DARRTS are correct and crosschecks the information with the original document.
234101 (FDA)	CBER's Office of Vaccines Research and Review; and CBER's Emerging and Pandemic Threat Preparedness Office	The data are validated by the appropriate CBER offices and officials.

Measure ID	Data Source	Data Validation
252202 (FDA)	CDRH Adverse Events Reports	FDA's adverse event reporting system's newest component is the Medical Device Surveillance Network (MedSun) program. MedSun is an initiative designed both to educate all health professionals about the critical importance of being aware of, monitoring for, and reporting adverse events, medical errors and other problems to FDA and/or the manufacturer, and to ensure that new safety information is rapidly communicated to the medical community thereby improving patient care.
262401 (FDA)	NCTR Project Management System; peer-review through FDA/NCTR Science Advisory Board (SAB) and the NTP Scientific Board of Counselors; presentations at national and international scientific meetings; use of the predictive and knowledge-based systems by the FDA reviewers and other government regulators; and manuscripts prepared for publication in peer-reviewed journals.	NCTR provides peer-reviewed research that supports FDA's regulatory function. To accomplish this mission, it is incumbent upon NCTR to solicit feedback from its stakeholders and partners, which include FDA product centers, other government agencies, industry, and academia. The NCTR SAB —composed of non-government scientists from industry, academia, and consumer organizations, and subject matter experts representing all of the FDA product centers—is guided by a charter that requires an intensive review of each of the Center's scientific programs at least once every five years to ensure high quality programs and overall applicability to FDA's regulatory needs. Scientific and monetary collaborations include Interagency Agreements with other government agencies, Cooperative Research and Development Agreements that facilitate technology transfer with industry, and informal agreements with academic institutions. NCTR also uses an in-house strategy to ensure the high quality of its research and the accuracy of data collected. Research protocols are often developed collaboratively by principal investigators and scientists at FDA product centers and are developed according to a standardized process outlined in the "NCTR Protocol Handbook." NCTR's Project Management System tracks all planned and actual expenditures on each research project. The Quality Assurance Staff monitors experiments that fall within the Good Laboratory Practices (GLP) guidelines. NCTR's annual report of research accomplishments, goals, and publications is published and available on FDA.gov. Research findings are published in peer-reviewed journals and presented at national and international scientific conferences.
280005 (FDA)	CTP's Office of Compliance and Enforcement	The data are validated by the appropriate CTP offices and officials.
293206 (FDA)	FDA Nanotechnology Task Force; National Nanotechnology Initiative (NNI); Science Board to the FDA; FDA staff presentations at public meetings; and manuscripts and other written materials for publication in peer-reviewed journals and other communication forums.	FDA will validate its efforts in promoting innovation and predictability in the development of safe and effective nanotechnology-based products by assessing outcomes and other progress in five areas related to nanotechnology including science, research, policy, communication, and planning. Information from several data sources and relevant FDA activities will provide measures in the five areas related to nanotechnology. Information will be gathered and documented from multiple data sources, which may include agency source data, agency guidance and other written materials, the NNI, cooperation and coordination with other regulatory agencies, public meetings, publications, and other areas.

Health Resources and Services Administration (HRSA)

Measure ID	Data Source	Data Validation
1.I.A.1 (HRSA)	HRSA Bureau of Primary Health Care's Uniform Data System	Validated using over 1,000 edit checks, both logical and specific. These include checks for missing data and outliers and checks against history and norm.
1.I.A.3 (HRSA)		
3.III.A.1 (HRSA)	Program research records	Validated by program staff and research presentations.
4.I.C.2 (HRSA)	HRSA Bureau of Clinician Recruitment Service's Management Information Support System (BMISS)	BMISS is internally managed with support from the NIH which provides: Data Management Services, Data Requests and Dissemination, Analytics, Data Governance and Quality, Project Planning and Requirements Development, Training, and Process Improvement.
6.I.C.2 (HRSA)	Annual grantee data submitted through the Bureau of Health Profession's Performance Management System.	Data are entered through a web-based system that incorporates extensive validation checks. Grantees are also required to describe methods and systems they use to collect and submit data. Those with deficient systems are required to submit a corrective action plan.
6.I.C.3.a (HRSA)	Grantee reports submitted through HRSA's Electronic Hand Book.	Validated by project officers.
6.I.C.3.b (HRSA)	Grantee reports submitted through HRSA's Electronic Hand Book.	Validated by project officers.
6.I.C.3.c (HRSA)	Grantee reports submitted through HRSA's Electronic Hand Book.	Validated by project officers.
10.I.A.1 (HRSA)	The Title V Information System (TVIS) collects data on grantee performance from grantee annual reports.	TVIS allows each State to enter data on performance. TVIS provides preformatted and interactive data entry. Calculations are done automatically and the system performs immediate checks for errors. Data are validated by project officers and program staff.
10.I.A.2 (HRSA)	The Title V Information System (TVIS) collects data on grantee performance from grantee annual reports.	TVIS allows each State to enter data on performance. TVIS provides preformatted and interactive data entry. Calculations are done automatically and the system performs immediate checks for errors. Data are validated by project officers and program staff.
10.III.A.3 (HRSA)	Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC).	Data are validated by CDC.
16.E (HRSA)	ADAP Quarterly Report data provided by State ADAPs.	Web-based data checked through a series of internal consistency/validity checks. Also HIV/AIDS program staff review submitted Quarterly reports, and provide technical assistance on data-related issues.

Measure ID	Data Source	Data Validation
16.I.A.1 (HRSA)	HRSA HIV/AIDS Bureau's Ryan White HIV/AIDS Program Services Report	This web-based data collection method communicates errors and warnings in the built in validation process. To ensure data quality the Program conducts data verification for all CADR submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.
16.II.A.2 (HRSA)	The Ryan White CARE Act Data Report (CADR) [now called The Ryan White HIV/AIDS Program Annual Data Report (RDR) and beginning January 2009 it will be called The Ryan White HIV/AIDS Program Services Report (RSR)] is completed by all Ryan White HIV/AIDS Program Part A, B, C, and D-funded grantees and service providers.	This web-based data collection method communicates errors and warnings in the built in validation process. To ensure data quality the Program conducts data verification for all CADR submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.
24.II.A.2 (HRSA)	Data are captured within the National Marrow Donor Program's computerized system, containing information pertaining to registered volunteer adult donors willing to donate blood stem cells to patients in need. Monthly reports generated from the computerized system to indicate the number of registered donors (broken down by self-reported race and ethinicity).	Validated by project officers analyzing comprehensive monthly reports broken down by recruitment organization. To decrease the likelihood of data entry errors, the program contractor utilizes value protected screens and optical scanning forms.
29.IV.A.3 (HRSA)	Reported by grantees through the Program's Performance Improvement Measurement System	Validated by project officers
36.II.B.1 (HRSA)	Family Planning Annual Report (FPAR). The FPAR consists of 14 tables in which grantees report data on user demographic characteristics, user social and economic characteristics, primary contraceptive use, utilization of family planning and related health services, utilization of health personnel, and the composition of project revenues. For this measure, FPAR Table 11: "Unduplicated number of Users Tested for Chlamydia by Age and	The responsibility for the collection and tabulation of annual service data from Title X grantees rests with the Office of Population Affairs (OPA), which is responsible for the administration of the program. Reports are submitted annually on a calendar year basis (January 1 - December 31) to the regional offices. Grantee reports are tabulated and an annual report is prepared summarizing the regional and national data. The annual report describes the methodology used both in collection and tabulation of grantee reports, as well as the definitions provided by OPA to the grantees for use in completing data requests. Also included in the report are lengthy notes that provide detailed information regarding any discrepancies between the OPA requested data and what individual grantees were able to provide. Data inconsistencies are first identified by the Regional Office and then submitted back to the grantee for correction. Additionally, discrepancies found by the contractor compiling the FPAR data submits these to the Office of Family Planning (OFP)

Measure ID	Data Source	Data Validation
	Gender," is the data source.	FPAR data coordinator who works with the Regional Office to make corrections. All data inconsistencies and their resolution are noted in an appendix to the report. These are included for two reasons: (1) to explain how adjustments were made to the data, and how discrepancies affect the analysis, and (2) to identify the problems grantees have in collecting and reporting data, with the goal of improving the process.

Indian Health Service (IHS)

Measure ID	Data Source	Data Validation
2 (IHS)	Clinical Reporting System (CRS); yearly Diabetes care and outcome audit	Comparison of CRS and audit results; CRS software testing; quality assurance review of site submissions
18 (IHS)	Clinical Reporting System (CRS)	CRS software testing; quality assurance review of site submissions
20 (IHS)	IHS operated hospitals and clinics report the accrediting body, the length of accreditation, and other significant information about their accreditation status to the IHS Headquarters, Office of Public Health Support, Statistics Branch, which maintains a List of Federal Facilities - Status of Accreditation.	The Joint Commission and AAAHC, non-governmental organization, maintain lists of certified and accredited facilities at their public websites. Visit the Joint Commission ;website at http://www.qualitycheck.org/CertificationList.aspx. Visit the Accreditation Association for Ambulatory Health Care at http://www.aaahc.org/eweb/dynamicpage.aspx?site=aaahc_site&webcode=find_orgs.
24 (IHS)	Clinical Reporting System (CRS)	CRS software testing; quality assurance review of site submissions; Immunization program reviews
30 (IHS)	Clinical Reporting System(CRS)	CRS software testing; quality assurance review of site submissions
TOHP-SP (IHS)	Routine IHS Tribal consultation documentation for HHS consultation report and IHS Director's Activities database	Routine IHS Tribal consultation documentation for HHS consultation report and IHS Director's Activities database

Immediate Office of the Secretary (IOS)

Measure ID	Data Source	Data Validation
1.1 (IOS)	"Get Involved" website http://www.hhs.gov/open/getinvolved/index.html and HHS-sponsored challenges listed on the Challenge.Gov website at http://challenge.gov/HHS	Collection on annual basis and updates on Open.Gov; quarterly updates requests through HHS Innovation Council

Measure ID	Data Source	Data Validation
1.2 (IOS)	www.healthdata.gov	Quarterly reports on data on Data.Gov submissions posted on HHS.Gov/Open
1.3 (IOS)	HHS Innovation Council Administrative records	Community of Practice Website (www.hhs.gov/open/opengovernmentplan/participation/strategic.html)

National Institutes of Health (NIH)

Measure ID	Data Source	Data Validation
CBRR-1.1 (NIH)	Doctorate Records File and the NIH IMPAC II database	Analyses of career outcomes for predoctoral Kirschstein-NRSA participants, compared to individuals that did not receive Kirschstein-NRSA support. For additional information contact: OER/OD (Jennifer Sutton, 301-435-2686, suttonj@od.nih.gov)
CBRR-1.2 (NIH)	NIH IMPAC II database	Analyses of career outcomes for postdoctoral Kirschstein-NRSA participants, compared to individuals that did not receive Kirschstein-NRSA support. For additional information contact: OER/OD (Jennifer Sutton, 301-435-2686, suttonj@od.nih.gov)

Measure ID	Data Source	Data Validation
CBRR-10 (NIH)	Publications, databases, administrative records and/or public documents	NIH staff review relevant publications, databases, administrative records, and public documents to confirm whether the data sources support the scope of funded research activities. The most common data sources are articles from peer-reviewed journals, as well as presentations and progress reports. Scientific journals use a process of peer review prior to publishing an article. Through this rigorous process, other experts in the author's field or specialty critically assess a draft of the article, and the paper may be accepted, accepted with revisions, or rejected. Specific data sources for this measure are provided below. A contact is listed if administrative records are included as a data source. NIH Roadmap Molecular Libraries Program: http://mli.nih.gov/mli/mlp-overview Notice of Opportunity for Fast Track Entry of Assay Projects for High Throughput Screening into the NIH Roadmap Molecular Libraries Probe Production Centers Network http://grants.nih.gov/grants/guide/notice-files/NOT-RM-09-011.html **Identification of Metabotropic Glutamate Receptor Subtype 5 Potentiators Using Virtual High-Throughput Screening.** Mueller R, Rodriguez AL, Dawson ES, Butkiewicz M, Nguyen TT, Oleszkiewicz S, Bleckmann A, Weaver CD, Lindsley CW, Conn PJ, Meiler J. *ACS Chem Neurosci.* 2010 Apr 21;1(4):288-305. Epub 2010 Jan 28. http://www.ncbi.nlm.nih.gov/pubmed/20414370 **Synthesis and SAR of novel, 4-(phenylsulfamoyl)phenylacetamide mGlu4 positive allosteric modulators (PAMs) identified by functional high-throughput screening (HTS).** Engers DW, Gentry PR, Williams R, Bolinger JD, Weaver CD, Menon UN, Conn PJ, Lindsley CW, Niswender CM, Hopkins CR. *Bioorg Med Chem Lett.* 2010 Sep 1;20(17):5175-8. Epub 2010 Jul 8. http://www.ncbi.nlm.nih.gov/pubmed/20667732 **Chronic active B-cell-receptor signalling in diffuse large Bcell lymphoma.** Davis, R.E., Ngo, V.N., Lenz, G., Tolar, P., Young, R.M., Romesser, P.B., Kohlhammer, H., Lamy, L., Zhao, H., Yang, Y., Xu,W., Shaffer, A.L., Wright, G., Xiao, W., Powell, J., Jiang, J-, Thomas, C.J., Rosenwald, A., Ott, G., Muller-Hermelink, H.K., Gascoyne, R.D., Connors, J.M., Johnson, N.A., Rimsza, L.M., Campo, E., Jaffe, E.S., Wilson, W.H., Delabie, J., Smeland, E.B., Fisher, R.I., Braziel, R.M., Tubbs, R.R., Cook, J.R., Weisenburger, D.D., Chan, W.C., Pierce, S.K., Staudt, L.M.*Nature*, 2010, 463(7277):88-92. http://www.ncbi.nlm.nih.gov/pubmed/20054396 **HTS-driven discovery of new chemotypes with West Nile Virus inhibitory activity.** Chung, D.H., Jonsson, C.B., Maddox, C., McKellip, S.N., Moore, B.P., Heli, M., White, E.L., Ananthan, S., Li, Q., Feng, S., Rasmussen, L. *Molecules,* 2010, 15(3): 1690-1704. http://www.ncbi.nlm.nih.gov/pubmed/20336008 **A Novel and Specific NADPH Oxidase-1 (Nox1) Small-Molecule Inhibitor Blocks the Formation of Functional Invadopodia in Human Colon Cancer Cells.** Gianni D, Taulet N, Zhang H, Dermardirossian C, Kister J, Martinez L, Roush WR, Brown SJ, Bokoch GM, Rosen H. *ACS Chem Biol.* 2010 Oct 15;5(10):981-93. http://www.ncbi.nlm.nih.gov/pubmed/20715845 **Synthesis and characterization of iodinated tetrahydroquinolines targeting the G protein-coupled estrogen receptor GPR30.** Ramesh, C., Nayak, T.K., Burai, R., Dennis, M.K., Hathaway, H.J., Sklar, L.A., Prossnitz, E.R., Arterburn, J.B. *Journal of Medicinal Chemistry,* 2010*,* 53:1004-1014. http://www.ncbi.nlm.nih.gov/pubmed/20041667 **Identification of known drugs that act as inhibitors of NF-κB signaling and their mechanism of action.** Miller, S.C., Huang, R., Sakamuru, S., Shukla, S.J., Attene-Ramos, M.S. Shinn, P., Van Leer, D., Leister, W., Austin, C.P., Xia, M. *Biochem Pharmacol,* 2010, 79:1272-1280. http://www.ncbi.nlm.nih.gov/pubmed/20067776

Measure ID	Data Source	Data Validation
CBRR-12 (NIH)	Reports from Large Scale sequencing centers	The Large Scale sequencing centers submitted quarterly reports, which were evaluated by the administrators of large-scale sequencing program according to an established cost analysis methodology. For additional information contact: NHGRI/OD (Kris Wetterstrand, 301-435-5543, wettersk@mail.nih.gov)
SRO-3.9 (NIH)	Publications, databases, administrative records and/or public documents	NIH staff review relevant publications, databases, administrative records, and public documents to confirm whether the data sources support the scope of funded research activities. The most common data sources are articles from peer-reviewed journals, as well as presentations and progress reports. Scientific journals use a process of peer review prior to publishing an article. Through this rigorous process, other experts in the author's field or specialty critically assess a draft of the article, and the paper may be accepted, accepted with revisions, or rejected. Specific data sources for this measure are provided below. A contact is listed if administrative records are included as a data source. Data provided directly by intramural primary investigators. For additional information contact: NHGRI/OPPA (Sanja Basaric, 301-594-3516, basarics@mail.nih.gov)

Measure ID	Data Source	Data Validation
SRO-5.13 (NIH)	Publications, databases, administrative records and/or public documents	NIH staff review relevant publications, databases, administrative records, and public documents to confirm whether the data sources support the scope of funded research activities. The most common data sources are articles from peer-reviewed journals, as well as presentations and progress reports. Scientific journals use a process of peer review prior to publishing an article. Through this rigorous process, other experts in the author's field or specialty critically assess a draft of the article, and the paper may be accepted, accepted with revisions, or rejected. Specific data sources for this measure are provided below. A contact is listed if administrative records are included as a data source. Huang R, Cho M-H, Sakamuru S, Shinn P, Houck KA, Dix DJ, Judson RS, Witt KL, Kavlock RJ, Tice RR, Austin CP. Chemical genomics profiling of environmental chemical modulation of human nuclear receptors. Environ Health Perspect 2011: 119:1142-1148 http://www.ncbi.nlm.nih.gov/pubmed/21543282 Xia M, Shahane S, Huang R, Titus SA, Shum E, Zhao Y, Southall N, Zheng W, Witt KL, Tice RR, Austin CP. Identification of quaternary ammonium compounds as potent inhibitors of hERG potassium channels. Environ Health Perspect 2011; http://dx.doi.org/10.1016/j.taap.2011.02.016 Yamamoto KN, Hirota K, Kono K, Takeda S, Sakamuru S, Xia M, Huang R, Austin CP, Witt KL, Tice RR. Characterization of environmental chemicals with potential for DNA damage using isogenic DNA repair-deficient chicken DT40 cell lines. 2011; DOI 10.1002/em.20656. http://www.ncbi.nlm.nih.gov/pubmed/21538559
SRO-6.4 (NIH)	Publications, databases, administrative records and/or public documents	NIH staff review relevant publications, databases, administrative records, and public documents to confirm whether the data sources support the scope of funded research activities. The most common data sources are articles from peer-reviewed journals, as well as presentations and progress reports. Scientific journals use a process of peer review prior to publishing an article. Through this rigorous process, other experts in the author's field or specialty critically assess a draft of the article, and the paper may be accepted, accepted with revisions, or rejected. Specific data sources for this measure are provided below. A contact is listed if administrative records are included as a data source. AJRCMB (American Journal of Respiratory Cell and Molecular Biology) Articles in press. Published online on July 14, 2011 as doi:10.1165/rcmb.2011-0065OC. http://ajrcmb.atsjournals.org/cgi/reprint/2011-0065OCv1

Measure ID	Data Source	Data Validation
SRO-8.7 (NIH)	Publications, databases, administrative records and/or public documents	NIH staff review relevant publications, databases, administrative records, and public documents to confirm whether the data sources support the scope of funded research activities. The most common data sources are articles from peer-reviewed journals, as well as presentations and progress reports. Scientific journals use a process of peer review prior to publishing an article. Through this rigorous process, other experts in the author's field or specialty critically assess a draft of the article, and the paper may be accepted, accepted with revisions, or rejected. Specific data sources for this measure are provided below. A contact is listed if administrative records are included as a data source. Mechanisms: Web-based data platform and Measure for understanding attitudes of providers Aarons GA, Glisson C, Hoagwood K, Kelleher K, Landsverk J, Cafri G. (2010). "Psychometric properties and U.S. National norms of the Evidence-Based Practice Attitude Scale (EBPAS)." Psychol Assess. 356-65. http://www.ncbi.nlm.nih.gov/pubmed/20528063 Mechanism: Measure of Stages of Implementation Completion Saldana, L., Chamberlain, P., Wang, W., & Brown, C.H. (2011). "Predicting Program Start-Up Using the Stages of Implementation Measure." *Administration and Policy in Mental Health and Mental Health Services Research. 1-7.* 2011 Jun 28. [Epub ahead of print] http://www.ncbi.nlm.nih.gov/pubmed/21710257

Office of the Assistant Secretary for Health (OASH)

Measure ID	Data Source	Data Validation
1.4 (OASH)	The data sources are the Department of Treasury's Alcohol and Tobacco Tax and Trade Bureau (TTB), and the U.S. Census Bureau. Per capita cigarette consumption can be calculated annually from these data sources approximately 45 days after the end of the calendar year.	The goal is calculated using publicly available data from the Department of Treasury and the U.S. Census Bureau by the scientific and policy staff at CDC's Office of Smoking and Health.
6.1.5 (OASH)	OFRD web-based database	Project officer oversight and validation

Office of Medicare Hearings and Appeals (OMHA)

Measure ID	Data Source	Data Validation
1.1.1 (OMHA)	The Medicare Appeals System (MAS) is the sole appeals tracking and reporting system supporting Medicare Parts A, B, C, and D, Entitlement, and Income Related Monthly Adjustment Amount (IRMAA) appeals across Levels 2 and 3 of the appeals process. MAS allows users to track the processing of appeals electronically and facilitates the transfer of appeal data records throughout the various levels.	The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) included direction for development of a plan transitioning work from SSA to HHS. An element specifically included was "CASE TRACKING.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the Medicare program."[§931(a)(2)(E)] The Medicare Appeals System (MAS) was developed in response to this and implemented with the opening of the new Office of Medicare Hearings and Appeals on July 1, 2005. MAS is the sole appeals tracking and reporting system supporting Medicare Parts A, B, C, and D, Entitlement, and Income Related Monthly Adjustment Amount (IRMAA) appeals across Levels 2 and 3 of the appeals process. MAS allows users to track the processing of appeals electronically and facilitates the transfer of appeal data records throughout the various levels. MAS is able to import scanned documents, produce reports for analysis, reporting, and workflow management, and ensure consistency of information across the levels of Medicare Appeal. Throughout the adjudication process, MAS provides workflow management through team-specific task sharing – allowing all adjudicatory team members access to information on tasks that have been completed and those yet to be accomplished. The entire adjudicatory process, from the initial request for hearing to the decision, is tracked in MAS. The system's data collection includes appeal request information, case file location, claims information, parties to the appeal, and appeal dispositions. Processing appeals using MAS improves timeliness, assists in meeting required processing deadlines, and minimizes paper utilization. In addition to supporting case processing and workload balancing, data derived from MAS has been used for replies to Congressional queries, the OIG audit of the OMHA program, appellant satisfaction surveys, and tracking performance measures.
1.1.5 (OMHA)	The most recent version of the survey was administered by a third party contractor using a stratified random sample of appellants whose cases were closed within fiscal year 2011.	The most recent version of the survey was administered by a third party contractor using a stratified random sample of appellants whose cases were closed within fiscal year 2011 The survey was designed to collect appellant: demographic information, overall satisfaction, satisfaction with hearing format, satisfaction with other aspects (e.g., scheduling, clarity of case processing documents, interaction with the ALJ team after the scheduling and prior to the hearing, and use of the OMHA website) and possible predictors of satisfaction (e.g., case fully heard and considered, ALJ behavior, etc).

Office of the National Coordinator for Health Information Technology (ONC)

Measure ID	Data Source	Data Validation
1.A.2 (ONC)	The information for this measure is gathered in partnership between the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS) and ONC. Each year since 2008, NCHS has included in its National Ambulatory Medical Care Survey (NAMCS) questions pertaining to electronic health record adoption.	The CDC National Ambulatory Medical Care Survey (NAMCS) survey is a nationally representative survey of office-based physicians with a response rate of approximately 68%. The survey allows ONC to examine electronic health record adoption by provider specialty and region in detail. Estimates of performance for FYs 2008-2011 for this measure derive from the mail supplement to the NAMCS.
1.B.4 (ONC)	Centers for Medicare & Medicaid Services, National Level Repository (NLR).	The National Level Repository (NLR) contains information on eligible providers who receive Medicare and Medicaid EHR incentive payments. Information from the NLR will be populated from other CMS systems, including the Provider Enrollment, Chain, and Ownership System (PECOS) and the National Plan and Provider Enumeration System (NPPES). See Final Rule for further detail (http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf).

Substance Abuse & Mental Health Services Administration (SAMHSA)

Measure ID	Data Source	Data Validation
1.2.33 (SAMHSA)	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
1.4.09 (SAMHSA)	SAMHSA Performance Measure Measurement System(s) (TRAC, SAIS, PMART)	To be determined
2.3.21 (SAMHSA)	State Estimates from the National Survey on Drug Use and Health	Performance results are based on state-level estimates obtained via the NSDUH. State estimates are entered by each SPF SIG grantee into the Prevention Management and Reporting Tool (PMRTS). The SPF SIG cross-site evaluation team verifies, cleans, and analyzes data to calculate annual performance results. Information about methodology for the NSDUH is available at http://www.oas.samhsa.gov/nhsda/methods.cfm. Standard errors and detailed estimate tables obtained from the NSDUH can be found at http://oas.samhsa.gov/NSDUH/2k10NSDUH/tabs/TOC.htm.

Measure ID	Data Source	Data Validation
2.3.61 (SAMHSA)	The number of calls answered is reported in the National Suicide Prevention LifeLine Monthly Report	Specialists in information technology at the National Suicide Prevention LifeLine evaluation center validate phone records received from Sprint to determine the number of calls received and answered at 1-800-273-TALK.
3.2.02 (SAMHSA)	Baseline and follow-up data are collected by the NCTSI cross-site evaluator, ICF Macro, using the Core Data Set (CDS), a secure web-based system. Three standardized behavioral/symptomology measures (CBCL, TSCC, and PTSD-RI) are used to assess improvement in children's outcomes.	The NCTSI cross-site evaluator, ICF Macro, performs significant validation on data reported by the NCTSI Centers for the eSUF and Core Data Set and the systems used to collect that data. ("Validation" includes, but is not limited to, data integrity checks, validation and quality control of the batch loading processes and databases, extracts used to produce analysis data sets and reports that are generated from the data collected.) Evaluation coordinators at ICF Macro have built multiple types of data validation techniques into the architecture of the Web-based General Adoption Assessment Survey (GAAS) to ensure the collection of clean, correct and meaningful data, and avoid data corruption or security vulnerabilities as well as missing, incomplete or inappropriate data.
3.2.26 (SAMHSA)	TRAC on-line data reporting and collection system.	All TRAC data are automatically checked as they are input into TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
3.2.30 (SAMHSA)	Data on children's outcomes were reported in the grantees' ED524 Bi-Annual Report submitted to their GPO every six months. The methods for collecting these measures varied by grantee, but were generally student self-report for the violence and substance use measures and school records for attendance and mental health services.	Grantees implement various forms of data validation as part of their local evaluations. To establish the accuracy and reliability of data used to measure the outcome performance, local evaluators require double entry of data; range checks coded into the data entry program; or assessing concurrent validity with other measure of the same indicator among other things.
3.4.02 (SAMHSA)	Data are collected through standard instruments and submitted through the TRAC on-line data reporting and collection system.	All TRAC data are automatically checked as they are input into TRAC. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.
3.4.20 (SAMHSA)	Data are submitted annually to SAMHSA by States, which obtain the information from local human service agencies that provide services.	SAMHSA's CMHS has developed additional error checks to screen data and contacts States and local providers concerning accuracy when data is reported outside expected ranges. CMHS has also issued guidance to all States and localities on data collection and monitors compliance with data collection through increased site visits to local PATH-funded agencies.

Measure ID	Data Source	Data Validation
3.4.21 (SAMHSA)	Data are derived from standardized annual Program Performance Reports in which grantees estimate the potential number of individuals impacted through a pre-defined list of 7 possible interventions (e.g., group advocacy non-litigation, facility monitoring services, class litigation).	The information provided in the annual reports is checked for reliability during on-site PAIMI Program visits, annual reviews, and budget application reviews.
3.4.25 (SAMHSA)	Services Accountability Improvement System	All data are automatically checked as they are input to SAIS. Validation and verification checks are run on the data as they are being entered. The system will not allow any data that are out of range or violate skip patterns to be saved into the database.