U.S. Department of Health and Human Services

FY 2025 Annual Performance Plan and Report

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

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

In accordance with the Government Performance and Results Act (GPRA) of 1993, as amended in the GPRA Modernization Act (GPRAMA) of 2010, I am pleased to present the Fiscal Year 2025 Annual Performance Plan and Report, documenting the Department's performance during the past year, as well as the plans for continued progress towards achieving the Strategic Goals and Objectives. Further information detailing HHS performance is available at Performance.gov, including descriptions of the Department's 2024 – 2025 Agency Priority Goals on Behavioral Health and Customer Experience.

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

Lisa Molyneux
Acting Performance Improvement Officer
U.S. Department of Health and Human Services

Table of Contents

Table of Contents 2
Overview 4
Mission Statement 4
HHS Organizational Structure 4
Cross-Agency Priority Goals 5
Strategic Goals Overview 5
Agency Priority Goals 6
Strategic Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare 7
Objective 1.1: Increase choice, affordability, and enrollment in high-quality healthcare coverage 7
Objective 1.2: Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs 10
Objective 1.3: Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services, while addressing social determinants of health 16
Objective 1.4: Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families 20
Objective 1.5: Bolster the health workforce to ensure delivery of quality services and care 25
Strategic Goal 2: Safeguard and Improve National and Global Health Conditions and Outcomes 28
Objective 2.1: Improve capabilities to predict, prevent, prepare for, respond to, and recover from disasters, public health and medical emergencies, and threats across the nation and globe 28
Objective 2.2: Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices, and vaccines 32
Objective 2.3: Enhance promotion of healthy behaviors to reduce occurrence of and disparities in preventable injury, illness, and death 37
Objective 2.4: Mitigate the impacts of environmental factors, including climate change, on health outcomes 40
Strategic Goal 3: Strengthen Social Well-being, Equity, and Economic Resilience 43
Objective 3.1: Provide effective and innovative pathways leading to equitable economic success for all individuals and families 43
Objective 3.2: Strengthen early childhood development and expand opportunities to help children and youth thrive equitably within their families and communities 47

Objective 3.3: Expand access to high-quality services and resources for older adults and people with disabilities, and their caregivers to support increased independence and quality of life 51

Objective 3.4: Increase safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have experienced trauma or violence 56

Strategic Goal 4: Restore Trust and Accelerate Advancements in Science and Research for All 62

Objective 4.1: Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion 62

Objective 4.2: Invest in the research enterprise and the scientific workforce to maintain leadership in the development of innovations that broaden our understanding of disease, healthcare, public health, and human services resulting in more effective interventions, treatments, and programs 66

Objective 4.3: Strengthen surveillance, epidemiology, and laboratory capacity to understand and equitably address diseases and conditions 71

Objective 4.4: Improve data collection, use, and evaluation, to increase evidence-based knowledge that leads to better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience 74

Strategic Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability 76

Objective 5.1: Promote effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices. 76

Objective 5.2: Sustain strong financial stewardship of HHS resources to foster prudent use of resources, accountability, and public trust 77

Objective 5.3: Uphold effective and innovative human capital resource management resulting in an engaged, diverse workforce with the skills and competencies to accomplish the HHS mission 84

Objective 5.4: Ensure the security and climate resiliency of HHS facilities, technology, data, and information, while advancing environment-friendly practices. 85

Major Management Priorities 88

Cross-Agency Collaborations 88

Lower-Priority Program Activities 89

Evidence Building Efforts 89

Overview

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

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

HHS also has strong partnerships with the private sector and nongovernmental organizations. The Department works with industries, academic institutions, trade organizations, and advocacy groups to leverage resources from organizations and individuals with shared interests. By collaborating with these partners, HHS accomplishes its mission in ways that are the least burdensome and most beneficial to the American public. Private sector grantees, such as academic institutions and faith-based and neighborhood partnerships, often provide HHS-funded services at the local level.

The Annual Performance Plan and Report (APPR) details the Department's progress towards achieving the goals and objectives described in the HHS Strategic Plan for FY 2022–2026. This APPR includes an overview of the Department's contributions to its Cross-Agency Priority Goals, Strategic Goals, Agency Priority Goals, Performance Management, and Strategic Reviews. Additionally, this document provides historical results and upcoming targets for the performance measures that support each HHS Strategic Objective, as well as an explanation for how the program will accomplish each target for FYs 2024 and 2025. Also included is a summary of evidence building efforts at HHS, cross-government collaborations, and major management priorities.

Mission Statement

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

HHS Organizational Structure

The Department includes 13 OpDivs that administer HHS programs:

- Administration for Children and Families (ACF)
- Administration for Community Living (ACL)
- Agency for Healthcare Research and Quality (AHRQ)
- Administration for Strategic Preparedness and Response (ASPR)
- Advanced Research Projects Agency for Health (ARPA-H)
- Agency for Toxic Substances and Disease Registry (ATSDR)
- Centers for Disease Control and Prevention (CDC)

- Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Substance use And Mental Health Services Administration (SAMHSA)

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

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

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

Cross-Agency Priority Goals

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

Strategic Goals Overview

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

The five strategic goals are:

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

Agency Priority Goals

The FY 2022–2023 Agency Priority goals are:

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

The FY 2024–2025 Agency Priority goals are:

- **Behavioral Health:** HHS is committed to improving health outcomes for those affected by behavioral health conditions. HHS will continue to improve these outcomes by increasing access and utilization of prevention, crisis intervention, treatment and recovery services. By September 30, 2025, HHS will reduce emergency department visits for acute alcohol use, mental health conditions, suicide attempts, and drug overdose by 10 percent compared to the FY 2023 baseline.
- **Customer Experience:** HHS builds trust and improves customer experience by simplifying its procedures, saving people time, and delivering results while maintaining program integrity. By September 30, 2025, HHS will enhance foundational CX capacity by reporting on trust and other service-level experience measures for HHS operating divisions.

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

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

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

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

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

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACL, AHRQ, ASPE, CMS, HRSA and OASH. In consultation with OMB, HHS has determined that performance toward this objective is making noteworthy progress, as the national uninsured rate has continued to drop to historic lows and HRSA Health Centers continue to serve increasing numbers of patients. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 1.1 Table of Related Performance Measures

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	46,440,401[1]	46,556,502[2]	46,672,893[3]	46,672,893[4]	44,650,216[5]	44,538,869[6]	44,538,869[7]	43,982,544[8]

[1] Medicaid - 7,152,321/CHIP - 9,288,080
[2] Medicaid - 37,245,202/CHIP - 9,311,300
[3] Medicaid - 37,338,314/CHIP - 9,334,579
[4] Medicaid - 37,338,314/CHIP - 9,334,579
[5] Medicaid - 35,720,173/ CHIP - 8,930,043
[6] Medicaid - 35,391,786/CHIP - 9,147,083
[7] Medicaid - 35,391,786/CHIP - 9,147,083
[8] Medicaid - 34,835,461/CHIP - 9,147,083

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Result	45,919,430 [9]	44,745,129 [10]	44,098,421 [11]	46,000,408 [12]	46,418,101 [13]	Jul 31, 2024	Jul 31, 2025	Jul 31, 2026
Status	Target Not Met	Target Not Met	Target Not Met	Target Not Met	Target Exceeded	Pending	In Progress	-

This measure assesses the progress of the Children's Health Insurance Program (CHIP) and Medicaid in providing affordable health coverage for low-income children and families by monitoring child enrollment trends for these programs over time. States are required to report child enrollment data for Medicaid and CHIP on a quarterly basis. These enrollment data are an important indicator of access to health coverage for children because over half of the nation's children obtain health coverage through Medicaid and CHIP. As such, this measure supports the CMCS Blueprint objective of increasing access to coverage and aligns with the CMS Strategic Plan Pillar to Expand Access to quality, affordable health coverage and care.

The FY 2022 result is largely attributed to temporary state policy changes in response to the Families First Coronavirus Response Act (FFCRA; P.L. 116-127), which enacted a 6.2 percentage point increase to the federal matching rate tied to the continuous enrollment condition in Medicaid through March 31, 2023. This resulted in significant growth in Medicaid child enrollment, as children that became ineligible for Medicaid during this period were not terminated from coverage. This continuous enrollment condition did not apply to CHIP, though some states opted to extend this policy to CHIP. Most states continued to terminate coverage for ineligible children from CHIP at renewal during this period, resulting in decreased CHIP enrollment for FY 2022.

CMS's future targets for this measure account for residual impacts of states returning to routine operations after the end of the continuous enrollment condition on March 31, 2023. CMS developed the enrollment targets for FYs 2023 and 2024 prior to the end of the continuous enrollment condition. We now expect smaller enrollment totals for FYs 2023 and 2024 that will be lower than the targets set for these years. We adjusted our FY 2025 projection to account for anticipated enrollment losses from terminations following the end of the FFCRA continuous enrollment condition. The FY 2025 target also accounts for enrollment targets prior to FY 2022 not being met since FY 2017. For this reason, we propose a more modest and attainable target for FY 2025. Additionally, with most eligible children already enrolled in Medicaid and CHIP, we do not expect significant levels of growth in child enrollment for these programs going forward.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	9,199	9,627	10,136	10,707	11,431	12,735	56,300	58,600

[9] Medicaid - 36,287,063/CHIP - 9,632,367
[10] Medicaid - 35,090,387/ CHIP - 9,654,742
[11] Medicaid - 35,055,383/ CHIP - 9,043,038
[12] Medicaid - 37,371,414/ CHIP - 8,628,994
[13] Medicaid - 38,135,461/ CHIP - 8,282,640

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Result	9,377	9,886	10,457	11,181	12,485	56,000	TBD	-
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	In Progress	-

The Medical Expenditure Panel Survey (MEPS) Interactive Data Tools and The MEPS Tables Compendia are sources of important data that is easily accessed by users. Expanding the content and coverage of these tools furthers the utility of the data for conducting research and informing policy. Currently data are available from 1996 through 2021 for MEPS-IC and from 1996-2020 for MEPS-HC. This represents over twenty-five years of data for both the Household and Insurance Components, enabling the user to follow trends on a variety of topics.

The MEPS collects data on the specific health services that Americans use, how frequently they use them, the cost of these services, and how they are paid for, as well as data on the cost, scope, and breadth of health insurance held by and available to U.S. workers. The MEPS HC Tables Compendia has recently been updated moving to a more user friendly and versatile platform (https://datatools.ahrq.gov/meps-hc). Interactive dashboards are provided for the following: use, expenditures and population; health insurance, accessibility and quality of care; medical conditions and prescribed drugs. The new platform greatly expands the number of tables that can be generated based on parameters entered by the user. This transition resulted in an exponential increase in the number of tables provided by the MEPS-HC and MEPS-IC projects. Whereas the old tables were released as consolidated PDFs, the new Data Tools platform allows users greater flexibility to create custom views of the tables, including a new feature that allows data to be viewed across time. This change resulted in for FY 2023 56,000 tables released and therefore AHRQ has re-baselined this measure. The number of tables will be increased by 2,300 each year in the new platform.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	26	27.2	28.6	29.8	29.8	30.4	33.5	37.4
Result	28.4	29.8	28.6	30.2	30.5	Aug 1, 2024	Aug 1, 2025	Aug 1, 2026
Status	Target Exceeded	Target Exceeded	Target Met	Target Exceeded	Target Exceeded	Pending	In Progress	-

For more than 50 years, HRSA funded health centers have delivered affordable, accessible, high-quality, and cost-effective primary health care to patients regardless of their ability to pay. During that time, health centers have become an essential primary care provider for millions of people across the country, using a coordinated, comprehensive, and patient-centered approach. Today, approximately 1,400 health centers operate nearly 15,000 service delivery sites that provide care in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin. Historically, success in increasing the number of patients served by health centers has been due in large part to the development of new health centers, new satellite sites, and expanded capacity at existing clinics. In 2022, health centers served 30.5 million patients, an increase of approximately 300,000 patients from 2021.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	91%	91%	91%	91%	91%	90%	90%	91%
Result	91%	91%	91%	90%	90%	Aug 1, 2024	Aug 1, 2025	Aug 1, 2026
Status	Target Met	Target Met	Target Met	Target Not Met	Target Not Met	Pending	In Progress	-

HRSA funded health centers deliver affordable, accessible, quality, and cost-effective primary health care to patients regardless of their ability to pay. Health centers emphasize coordinated primary and preventive services that promote reductions in health disparities for low-income individuals, racial and ethnic minorities, rural communities, and other underserved populations. In 2022, approximately 90 percent of health center patients were individuals or families living at or below 200 percent of the Federal Poverty Guidelines, as compared to approximately 27.6 percent of the U.S. population as a whole. HRSA set the FY 2025 target based on historical program trends of the composition of health center patients. HRSA will continue to work in collaboration with technical assistance partners to ensure health centers are optimizing access to services for all populations in their respective service areas.

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

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

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

Objective 1.2 Table of Related Performance Measures

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	37%	28%	25%	25%	25%	25%	25%	Discontinued

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Result	36.7%	27%	25%	25%	Apr 30, 2024	Apr 30, 2025	Apr 30, 2026	N/A
Status	Target Exceeded	Target Exceeded	Target Met	Target Met	Pending	Pending	In Progress	N/A

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

The Inflation Reduction Act of 2022 (IRA) makes significant changes to the current Part D benefit design. Due to changes enacted by the IRA, the current goal will no longer be consistent with current law in 2025. Beginning in 2025, the IRA eliminates the coverage gap benefit phase, introduces manufacturer discounts in the initial and catastrophic coverage phases, changes enrollee and plan liability in the initial coverage phase, and changes plan and government reinsurance liability in the catastrophic phase.

Prior to the IRA, there were other changes to the Part D benefit that aimed to improve prescription drug coverage for Medicare beneficiaries. Before 2010, a beneficiary was responsible for paying 100 percent of the prescription costs between the initial coverage limit and the out-of-pocket threshold (or catastrophic limit). Only once the beneficiary reached the catastrophic limit, did Medicare coverage recommence. This was known as the coverage gap (or "donut hole").

The Affordable Care Act began closing the coverage gap through a combination of manufacturer discounts and gradually increasing federal subsidies until it closed in 2020. For CY 2020 and beyond, this means that non-LIS beneficiaries who reach this phase of Medicare Part D coverage will pay no more than 25 percent of costs for all covered Part D drugs. For 2024, beneficiaries reach this phase when total drug costs amount to $5,030 and stay in this phase until they pay $8,000 in qualified out-of-pocket costs. CMS' tracking of this measure has shown that that in most years non-LIS out-of-pocket costs have decreased beyond the targets required by statute. As generic utilization in the Part D program has remained static, and very high (over 75 percent since 2012), that is not a strong contributor to the success of this goal. Rather, CMS' application and management of the Coverage Gap Discount Program, coupled with the strong incentives for manufacturers to participate in the Part D program, are the primary drivers of this goal's success.

Increase the percentage of Medicare health care dollars tied to Alternate Payment Models (APMs) incorporating downside risk (Lead Agency - CMS; Measure ID - MCR36)

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	-	Set Baseline	30%	40%	40%	47%	55%	60%
Result	-	20.21%	24.2%	24.8%	30.4%	Dec 15, 2024	Dec 15, 2025	Dec 15, 2026
Status	-	Baseline	Target Not Met but Improved	Target Not Met but Improved	Target Not Met but Improved	Pending	In Progress	-

The Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS), through the Center for Medicare and Medicaid Innovation (CMMI), identifies, tests, evaluates, and expands, as appropriate, innovative payment and service delivery models. The Medicare Shared Savings Program Accountable Care Organizations (ACOs) also play an integral role in moving Medicare toward value-based payment models and person-centered care, with almost 11 million people with Medicare receiving care from a health care provider in a Shared Savings Program ACOs as of January 2023. These efforts drive innovative payment and service delivery models, which can reduce program expenditures for Medicare, Medicaid, and the Children's Health Insurance Program, while improving or preserving beneficiary health and quality of care.

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

While CMS did not meet its FY 2022 target, it did demonstrate significant improvement towards the goal, making the largest annual jump in recent years (5.6 percentage points increase). Several factors contribute to CMS falling short of the designated goal, including lingering effects of the COVID-19 pandemic, such as practice staffing issues and comfort with risk-based arrangements, a limited number of new CMMI models in recent years, and stabilization of enrollment in the Medicare Shared Savings Program.

In order to continue working towards the goal of shifting Traditional Medicare dollars into Alternative Payment Methods (APMs) that include downside risk, CMMI announced several new innovative payment models in 2023. In June 2023, the Making Care Primary (MCP) model was announced, which aims to move primary care practices towards accepting prospective, population-based payments. Additionally, in September 2023 the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) was announced, which is a state-based total cost of care model. CMMI plans to continue to develop and test new alternative payment models in FY 2023 and beyond. The targets for FY 2023, FY 2024, and FY 2025 are 47%, 55%, and 60% respectively. These were set to align with CMMI's Strategic Refresh and the Health Care Payment Learning & Action Network (HCPLAN) goals for the percentage of health care spending tied to Alternative Payment Models (APMs) that incorporate downside risk.

Review and act on 90 percent of standard original Abbreviated New Drug Application (ANDA) submissions within 10 months of receipt. (Lead Agency - FDA; Measure ID - 223235)[14]

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	90%	90%	90%	90%	90%	90%	90%	90%
Result	96%	97%	95%	96%	93%	Feb 28, 2025	Feb 28, 2026	Feb 28, 2027

[14] FDA measure ID 223235 was previously measure ID 223215.

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	In Progress	-

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

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	187	200	225	250	275	300	325	350
Result	191	204	225	250	275	305	Sep 30, 2024	Sep 30, 2025
Status	Target Exceeded	Target Exceeded	Target Met	Target Met	Target Met	Target Met	In Progress	-

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

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

- AHRQ Patient Safety Network (AHRQ PSNet) & Web M&M (Morbidity and Mortality Rounds);
- AHRQ Question Builder App;
- AHRQ's Safety Program for Nursing Homes: On-Time Pressure Ulcer Prevention;
- Common Formats (standardized specifications for reporting patient safety events);

- Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families;
- Healthcare Simulation Dictionary, Second Edition;
- Making Healthcare Safer III Report; Primary Care-Based Efforts To Reduce Potentially Preventable Readmissions;
- Reducing Diagnostic Errors in Primary Care Pediatrics (Project RedDE!);
- Re-Engineered Discharge (RED) Toolkit;
- Toolkit To Improve Antibiotic Use in Acute Care Hospitals;
- Understanding Omissions of Care in Nursing Homes.

In FY 2023, the Patient Safety Portfolio reported the number of evidence-based resources and tools was 305. The Portfolio is projecting that the number of evidence-based resources and tools will continue to increase with a projected cumulative number of 325 in FY 2024 and 350 in FY 2025.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	65%	65%	70%	75%	75%	75%	76%	77%
Result	75%	76%	76%	77%	78%	78%	Dec 15, 2024	Dec 15, 2025
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	In Progress	-

HRSA funded health centers improve health outcomes by emphasizing the care management of patients with multiple health care needs and the use of key quality improvement practices, including health information technology. HRSA's Health Center Program Patient Centered Medical Home (PCMH) Initiative supports health centers to achieve national PCMH recognition, an advanced model of primary care using a team-based approach to improve quality through coordination of care and patient engagement. Currently, 78 percent of health centers are recognized by national accrediting organizations as Patient Centered Medical Homes. PCMH recognition assesses a health center's approach to patient-centered care and evaluates health centers against national standards for primary care that emphasize care coordination and on-going quality improvement. PCMH recognition also increases health outcomes, improves health equity, and lowers costs for patients and health centers, and has become a standard of care for HRSA funded health centers. HRSA set the FY 2025 target based on data trends. HRSA will continue to work in collaboration with technical assistance partners to encourage health centers to pursue PCMH recognition.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	-	Not Defined	Not Defined	Not Defined	Not Defined	Not Defined	40	65

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Result	-	176[15]	74	39	56	Dec 31, 2024	Dec 31, 2025	Dec 31, 2026
Status	-	Historical Actual	Historical Actual	Historical Actual	Historical Actual	Pending	In Progress	-

HRSA's Office for the Advancement of Telehealth supports the Telehealth Network Grant Program (TNGP) and Evidence Based Telehealth Network Program (EB TNP), which allows grantees to focus entirely, or in part, on expanding access to tele-behavioral services in rural and underserved communities. The TNGP provides grants that demonstrate how telehealth can (a) expand access to, coordinate, and improve the quality of health care services; (b) improve and expand the training of health care providers; and (c) expand and improve the quality of health information available to health care providers, and patients and their families, for decision-making. The EB TNP program aligns with the TNGP program goals with the additional requirement of data collection to allow outcomes from this program to be published, expanding the evidence base for telehealth.

Both programs have had different focus areas depending on the needs for rural and underserved communities. This measure reflects programs with different focus areas and cohorts. The current TNGP cohort supports networks that are providing tele-emergency services. The current EB TNP cohort supports direct consumer telehealth services to patients in rural and frontier communities within established telehealth networks.

Measure results will vary from year to year due to expected turnover in grantee cohorts and focus areas, and HRSA will re-evaluate targets on an ongoing basis. In addition, recent data represent results from FY 2022 and were collected between September 2022 through August 2023, aligning with the program funding period. HRSA established targets for FY 2024 based on the current cohorts for TNGP and EB TNP for which tele-behavioral health is not the primary focus. Past programs such as the Evidence-based Tele-behavioral Health Network Program (FY 2018 – FY 2020) did allow grantees to focus on tele-behavioral health.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	4,000,000	3,991,000	4,018,000	3,300,000	3,500,000	4,250,000	3,300,000	3,600,000
Result	3,939,749	3,095,666	1,536,743	1,662,466	2,600,663	Sep 30, 2024	Sep 30, 2025	Sep 30, 2026
Status	Not Met	Not Met	Not Met	Not Met	Not Met	Pending	In Progress	-

The Title X Family Planning program is the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. Enacted in 1970 as part of the Public Health Service Act, the Title X program is designed to provide access to

[15]Baseline data includes school-based TNGP and SAT TNGP which were discontinued after FY 19. This data and out year data from the ED TNGP and EB THNP programs will be used to identify trending over a three-year period, as the measure is developmental. Once a trend is analyzed, appropriate targets will be identified. It is expected that with turnover in cohorts and focus areas, the target will need to be evaluated on an ongoing basis.

contraceptive services, supplies, and information to all who want and need them. By law, priority is given to persons from low-income families.

The program's performance measures focus on increasing access to high-quality care and serving individuals and families from underserved, vulnerable and low-income populations, gauging the extent to which Title X expands the availability of quality healthcare to the public. Performance measurement guides program strategies, establishes directions for technical assistance, and directs revisions to program policies. This enables Title X to better address program performance and facilitates methods to increase efficiency in the delivery of preventive healthcare services.

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

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

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

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

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

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

Objective 1.3 Table of Related Performance Measures

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	381,314	381,314	381,314	330,000	411,325	415,438	400,000	350,000
Result	329,980	324,391	391,738	428,476	385,356	292,426	Jan 31, 2025	Jan 31, 2026
Status	Target Not Met	Target Not Met	Target Exceeded	Target Exceeded	Target Not Met	Target Not Met	In Progress	-

The Indian Health Service (IHS) Public Health Nursing (PHN) Program provides critical support for health care services in the tribal communities served. PHNs are licensed, professional nursing staff that support population-focused services to promote healthier communities through community based direct nursing services, community development, and health promotion and disease prevention activities. One way the PHN Program measures this intervention is through monitoring the total number of individual public health encounters documented in the electronic health record and reported by the PHN data mart system with an emphasis on primary, secondary, and tertiary prevention activities to individuals, families, and community groups.

In FY 2023, the PHN measure target was 415,438 encounters and the final result of 292,426 did not meet the target by 123,012 encounters. The decrease in PHN patient encounters is attributed to a shift in services away from pandemic activity, e.g. hosting mass COVID-19 testing, vaccination and immunization clinics, contact tracing and investigation efforts. During the IHS COVID-19 pandemic response, PHNs reported critical patient encounters for communicable disease, surveillance, contact tracing, testing, patient monitoring, and vaccination activities, resulting in a total increase in the number of PHN encounters reported to address the COVID-19 crisis in FY 2020 and FY 2021. The current PHN staff shortages create challenges to administer, support, and provide services. Additionally, the PHN program is impacted by Tribal programs migrating away from using the IHS Resource and Patient Management System (RPMS), as Tribal programs are no longer able to report PHN data. IHS anticipates this will continue to impact performance reporting for this measure. The FY 2024 target is a decrease compared to FY 2023 as the performance spike in FY 2020 and FY 2021 is a result of the increased PHN activity related to the COVID-19 pandemic and the current plan is to analyze FY 2022, FY 2023, and FY 2024 data to predict future performance targets.

In FY 2023, PHNs continued to strive to meet Agency goals and to manage an adaptable strategic and long-term plan for health promotion and disease prevention PHN activities for childhood immunizations and sexually transmitted infection prevention. PHN programs continue to participate in the IHS National E3 Vaccine Strategy – ensuring EVERY patient at EVERY encounter receives EVERY recommended vaccine, when appropriate. The PHN program aligns with the E3 strategy by supporting efforts to include implementation of quality improvement cycles and encouraging innovation and replicating PHN best practices across the health care system.

In FY 2024, a PHN leadership development, training, and mentorship/ preceptorship program will be established to improve placement rates for recently graduated BSN-prepared nurses, PHNs, and newly hired PHNs. The focus will be on PHNs to provide rapid, creative, and effective solutions to public health

problems in American Indian/Alaska Native (AI/AN) communities. Additional plans for FY 2024 are to secure strategic partnerships with Bureau of Indian Affairs schools and the health care facilities that are associated with each of the schools in pursuit of upstream changes that enhance AI/AN student health, safety, and education.

Percentage of enrolled homeless persons who receive community mental health services (Lead Agency – SAMHSA; Measure ID –3.4.15a)

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	54%	65%	64%	64%	64%	64%	64%	64%
Result	65%	64%	64%	44%	35%	July 31, 2024	July 31, 2025	-
Status	Target Exceeded	Target Not Met	Target Met	Target Not Met	Target Not Met	Pending	In Progress	-

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

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	63.25	63.6	64	64.7	64.3	63.3	63.3	63.3
Result	66.7	66.89	66.95	61.4	60.2	Dec 31, 2024	Dec 31, 2025	Dec 31, 2026
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met	Target Not Met	Pending	In Progress	-

The FY 2021 result for ACL Measure ID - 2.10 is calculated using data from the State Program Report and the 2021 National Survey of Older Americans Act (OAA) Participants. ACL collaborates with the Aging Network to target services to those individuals at high risk of losing their independence. This is a composite measure that indicates the proportion of older adults served at greatest need that are able to stay in their homes and communities as a result of OAA services provided. This measure combines multiple indicators of vulnerability such as mobility impairment, functional limitations, and OAA services provided. ACL has consistently strived to exceed this goal by ensuring the most vulnerable

participants receive home- and community-based services and caregiver support by collaborating with the Aging Network, promoting community living, and providing person centered services. Unfortunately, our programs are re-normalizing post-pandemic, and the target for Fiscal Year 2022 was not met. While many of our targets are being met or exceeded, ACL's most recent performance measure results are demonstrating that our current methodology does not have the ability to account for outlier years such as 2021 and 2022. Programs are finding new and innovative ways to demonstrate their adaptability, and ACL is monitoring these trends through performance, monitoring, and assessment to understand the impact of changing norms on our programs as well as how our performance measures stand up to severe outliers. ACL is going to revisit this measure in FY 2024 to align with new program definitions and to incorporate lessons learned during the pandemic.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	70%	73%	73%	73%	73%	73%	72%	73%
Result	74%	74%	73%	74%	72%	Aug 1, 2024	Aug 1, 2025	Aug 1, 2026
Status	Target Exceeded	Target Exceeded	Target Met	Target Exceeded	Target Not Met	Pending	In Progress	-

Timely entry into prenatal care is an indicator of both access to and quality of care. Identifying maternal disease and risks for complications of pregnancy or birth during the first trimester can also help improve birth outcomes. HRSA set the FY 2025 target based on data trends. HRSA will continue to work in collaboration with technical assistance partners to optimize access to prenatal care in health centers. A summary of Health Center Program data trends can be found at the following link: https://data.hrsa.gov/tools/data-reporting/program-data/national.

In collaboration with FEMA and DHS, OCR (Agencies) will conduct compliance reviews of select state COVID-19 vaccine provider programs to determine whether their services are being provided free of discrimination on the basis of race or national origin (including limited English proficient (LEP) persons and communities). (Lead Agency - OCR; Measure ID -1.3)

-	Target	Results	Status
FY 2018	N/A	N/A	N/A
FY 2019	N/A	N/A	N/A
FY 2020	N/A	N/A	N/A
FY 2021	Coordinated with the DHS Office for Civil Rights and Civil Liberties and FEMA's Office of Equal Rights to plan state LEP compliance reviews	Initiated compliance reviews by dispatching data requests to 19 states in September 2021. Issued guidance to bolster accessibility and equity in COVID-19 Vaccine Programs**.**	Historic Actual
FY 2022	Conduct a compliance review of 19 states to ensure that they were conducting public health programs consistent with federal civil rights laws.	Provided support for states completing the initial data request and issued supplemental requests to states on May 24, 2022.	Target Met
FY 2023	Through a compliance review, analyzed information received from states regarding their efforts to provide meaningful access to LEP persons in responding to COVID-19	As of December 1, 2022, all states had provided responses to the initial and supplemental data requests and the agencies had completed their reviews and analyses of the responses. From the results of the compliance review analysis, HHS/OCR, DHS, and FEMA developed a webinar based that highlighted best practices. The webinar was presented three times and all 19 of the states included in compliance reviews attended. Additional materials were developed, including a presentation on Language Access During Covid-19 Pandemic & Other Health Emergencies, and the first Annual Language Access Progress Report.	Target Met
FY 2024	Update the 2013 HHS Language Access Plan.	-	In Progress
FY 2025	Establish a centralized language access unit to coordinate language access services across HHS.	-	-

*Prior year targets and results have been updated for this measure. For the previous version of this measure, please see the FY 2024 HHS Annual Performance Plan and Report.

The HHS Office for Civil Rights (OCR) enforces federal civil rights laws, conscience and religious freedom laws, the Health Insurance Portability and Accountability Act (HIPAA) Privacy, Security, and Breach Notification Rules, and the Patient Safety Act and Rule, which together protect the fundamental rights of nondiscrimination, conscience, religious freedom, and health information privacy. OCR protects rights by teaching health and social service workers about relevant laws, educating communities about civil rights, conscience and religious freedom rights, and health information privacy rights, and investigating civil rights, conscience and religious freedom, health information privacy, and patient safety confidentiality complaints to identify discrimination or violation of the law and taking action to correct problems.

In 2021, HHS/OCR partnered with the Department of Homeland Security's Office of Civil Rights and Civil Liberties and FEMA to conduct compliance reviews to evaluate 19 states' compliance with Title VI of the Civil Rights Act of 1964, focusing on whether the states' COVID-19 response efforts provide meaningful access to persons with limited English proficiency (LEP). Under Title VI of the Civil Rights Act of 1964 and the HHS implementing regulation, states receiving federal financial assistance must provide services free of discrimination on the basis of national origin, among other bases. Nondiscrimination on the basis of national origin includes the provision of language assistance services to LEP persons. These compliance reviews provided baseline results to provide guidance to providers about non-discriminatory practices and information to patients and consumers about their rights. These compliance reviews identified gaps in the 19 states' efforts and best practices. These observations informed themes for technical assistance that HHS/OCR, DHS, and FEMA provided in 2023.

HHS/OCR is using the lessons learned during the COVID-19 pandemic to expand language access technical assistance and tools as the COVID-19 public health emergency ended. On April 5, 2023, OCR dispatched a letter to state health officials reminding states of their language access and effective communication obligations under federal civil rights laws to ensure that individuals and families continue to have access to information about Medicaid and CHIP coverage upon the expiration of the Families First Coronavirus Response Act continuous enrollment condition.

Pursuant to the HHS 2022 Equity Action Plan and the November 21, 2022, Attorney General memorandum entitled Strengthening the Federal Government's Commitment to Language Access, OCR, in coordination with the reconstituted HHS Language Access Steering Committee, is updating the Department's language access plan for the first time since 2013. The updated plan will provide strategic guidance to HHS Operating and Staff Divisions to ensure meaningful access by persons with Limited English Proficiency (LEP) to HHS programs and activities. OCR is also taking steps to establish a centralized language access unit, which will provide a coordinated approach to the Department's language access obligations. The position of language access coordinator, the first such position in OCR's history, was filled in 2023.

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

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

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

Objective 1.4 Table of Related Performance Measures

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	-	-	Set Baseline	875	5,000	2,100	2,500	2,500
Result	-	-	-	4,766	1,925	4,511	Dec 31, 2024	-
Status	-	-	-	Target Exceeded	Target Not Met	Target Exceeded	In Progress	-

Over the course of FY 2023, the Peer Recovery Center of Excellence (PRCoE) has conducted trainings, provided 1-on-1 technical assistance, and developed products that align with each of the outlined focus areas (DEI, Evidence-Based Practices, Recovery Community Organization (RCO) Capacity Building, Peer Workforce Development, and Peer Services Integration). This included 78 total trainings/webinars that trained a total of 4,511 participants. Specific examples include a training on harm reduction and peer support (92 peers/non-clinical professionals trained), Supervisors of peer recovery support specialists (PRSS)—Supporting Staff Navigating Work-Related Loss (mix of 48 non-clinical and clinical professionals trained), and PRSS—Exploring and Defining Lived Experience (68 non-clinical professionals trained). The PRCoE also added a new focus area (DEI) and added an additional advisory group member to lead related efforts.

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

-	Target	Result	Status
FY 2018	-	-	-
FY 2019	-	-	-
FY 2020	-	-	-
FY 2021	-	-	-
FY 2022	Opioid Related Hospital Use - create interactive map with 2018 data	Opioid-Related Hospital Use - updated interactive maps using 2018 data	Target Met
	NAS - create interactive maps using 2019 data	Updated interactive maps using 2019 data	Target Met
	Outpatient use of opioids - post a Brief on outpatient opioid use for non-elderly and elderly adults.	Updated Brief	Target Met
FY 2023	Opioid-Related Hospital Use - update interactive maps using 2020 data	Opioid-Related Hospital Use – updated interactive maps using 2020 data	Target Met
	NAS - update interactive maps using 2020 data	NAS– updated interactive maps using 2020 data	Target Met

	Outpatient use of opioids - update Brief and/or do new analysis addressing trends or other measures	Posted two updated briefs on outpatient opioid use, one for non-elderly and on for elderly adults, using 2020-2021 data.	Target Met
FY 2024	Opioid-Related Hospital Use - update interactive maps using 2021 data	-	In Progress
	NAS-update interactive maps using 2021 data	-	In Progress
	Outpatient use of opioids - update Brief and/or do new analysis addressing trends or other measures	-	In Progress
FY 2025	Opioid-Related Hospital Use - update interactive maps using 2022 data	-	-
	NAS-update interactive maps using 2022 data	-	-
	Outpatient use of opioids – retiring this portion of the measure	-	-

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

HCUP includes the largest collection of longitudinal hospital care data in the United States and HCUP Fast Stats displays that information in an interactive format that provides easy access to the latest HCUP-based statistics for healthcare information topics. More information on HCUP can be found on the HCUP website. HCUP is able to produce national estimates on Opioid-Related Hospital Use based on data from the HCUP National Inpatient Sample (NIS) and the HCUP Nationwide Emergency Department Sample (NEDS). HCUP is able to produce State-level estimates on Opioid-Related Hospital Use based on data from the HCUP State Inpatient Databases (SID) and HCUP State Emergency Department Databases (SEDD). HCUP is also able to produce data on the rate of births diagnosed with NAS (newborns exhibiting withdrawal symptoms due to prenatal exposure to opioids) by State. State-level statistics on newborn NAS hospitalizations are from the HCUP State Inpatient Databases (SID). National statistics on newborn hospitalizations are from the HCUP National (Nationwide) Inpatient Sample (NIS).

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

For the outpatient use of opioid measure, in FY 2022 MEPS has produced two Briefs on outpatient opioid use, one for non-elderly and one for elderly adults overall, looking at socioeconomic characteristics including sex, race-ethnicity, income, insurance status, perceived health status, Census region and Metropolitan Statistical Area (MSA) status. In FY 2023, the Opioid related hospital use and NAS interactive website maps were updated using 2020 data. In FY 2024, the plan is to continue to keep these

resources updated with subsequent year data. This portion of the measure will be discontinued in FY 2025.

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

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	-	-	Not Defined	2,750	2,000	2,100	2,150	1,615
Result	-	-	2,676	2,872	5,587	Nov 30, 2024	Nov 30, 2025	Nov 30, 2025
Status	-	-	Historical Actual	Target Exceeded	Target Exceeded	Pending	In Progress	-

The Rural Communities Opioid Response Program (RCORP) is a multi-year initiative administered by HRSA that funds community-based grants and technical assistance to reduce the morbidity and mortality of substance use disorder, including opioid use disorder, in rural communities More than 1,900 counties across 47 states and two territories have taken part in the RCORP initiative. Given the initiative's initial focus on opioid use disorder, increasing the number of providers willing and able to provide Medication-Assisted Treatment is a key focus area and objective of RCORP's grant awards.

In FY 2022, 5,587 providers provided Medication-Assisted Treatment in areas served by RCORP grant recipients, an increase of 2,715 providers over the previous year. To increase the likelihood of sustaining these services and enhance community buy-in, RCORP award recipients have engaged with approximately 3,400 state and local agencies and organizations representing a diverse array of sectors, including school systems, health centers, hospitals, law enforcement agencies, community-based organizations, and others to implement their programs.

HRSA has expanded the scope of the RCORP initiative to include other substances of concern (e.g., methamphetamine) as well as broader behavioral health challenges in rural communities. Consequently, HRSA expects that the number of RCORP grant recipients focused solely on Medication-Assisted Treatment provision will decrease and has set targets that reflect that change.

Number of outreach events to provide training and technical assistance to healthcare providers, healthcare professionals, and paraprofessionals on providing healthcare services free of disability discrimination against persons receiving medication assisted treatment (MAT) for substance abuse disorder and on protecting the confidentiality and care coordination of behavioral health through HIPAA. (Lead Agency - OCR; Measure ID – 1-4)

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	N/A	N/A	N/A	N/A	1	1	10	10

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Result	1	4	1	12	12	13	TBD	-
Status	Historic Result	Historic Result	Historic Result	Historic Result	Target Exceeded	Target Exceeded	Pending	-

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

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

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

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

Objective 1.5 Table of Related Performance Measures

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	40%	40%	40%	40%	40%	40%	40%	40%

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Result	47%	43%[16]	40%	40%	43%	Dec 31, 2024	Dec 31, 2025	Dec 31, 2026
Status	Target Exceeded	Target Exceeded	Target Met	Target Met	Target Exceeded	Pending	In Progress	-

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	24%	45%[17]	50%	50%	55%	65%	68%	70%
Result	64%	71%	74%	77%	83%	Dec 31, 2024	Dec 31, 2025	Dec 31, 2026
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	In Progress	-

HRSA's health professions programs strengthen the health workforce by developing, expanding, and enhancing training for health care professionals, particularly primary care providers, through grants awarded to health professions schools and training programs. These programs improve access to health care in our Nation's communities by training individuals who go on to work in medically underserved areas after completing their HRSA primary care training program. Additionally, an increasing number of clinic training sites across the U.S. prepare trainees to deliver quality, team-based patient care by offering interprofessional training experiences.

The percentage of individuals supported by the Bureau of Health Workforce who completed a primary care training program and are currently employed in underserved areas (Measure 2000.03) indicates the percent of individuals who report being employed in an underserved area one-year after they complete a HRSA Bureau of Health Workforce training program. According to annual grantee performance reports, the number of individuals who completed a HRSA primary care training program and then found employment in medically underserved areas decreased by seven percentage points from FY 2018 to FY 2020, held steady at 40% in FY 2021, and increased to 43% in FY 2022. Given the lack of a clear trend and the potential impact of COVID-19 on program completers' employment decisions, HRSA is maintaining the FY 2024 target for FY 2025.

The percentage of clinical training sites that provide interprofessional training to individuals enrolled in a primary care training program (Measure 2000.04) calculates the percent of active clinical training sites at which individuals from more than one profession or discipline train together. According to annual grantee performance report data, the percentage of sites providing interprofessional training experiences increased by 19 percentage points from FY 2018 to FY 2022. The rapid increase in this outcome is primarily due to HRSA's efforts to increase interprofessional training across more than 40 health

[16]Service location data are collected on students who have been out of the HRSA program for one year. The results are from programs that have the ability to produce clinicians with one-year post program graduation. Most recent results are for Academic Year 2022-2023 (funded in FY 2021) based on graduates from Academic Year 2021-2022.
[17]Most recent results are for Academic Year 2022-2023 and funded in FY 2022.

professions training programs (e.g., by emphasizing the importance of such training in Notices of Funding Opportunities). HRSA increased the FY 2025 target to 70 percent to reflect this upward trend.

HRSA employs multiple strategies to help programs meet performance targets. In 2021, HRSA implemented a new grantee scorecard that allows program staff and grantees to identify individual grant programs or awardees that may have best practices to share or may need additional assistance to increase program completers' employment in medically underserved areas. In 2022, HRSA reached grantees from nearly all grant programs with a demonstration of the scorecard's use. In 2023, HRSA began annual meetings with program staff from each health professions training program to discuss performance results. During these sessions, HRSA discusses program-specific challenges related to meeting targets and strategizes how programs can improve performance if they did not meet recent targets.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	-	-	-	200	200	250	Retire	Retire
Result	-	-	-	15	66[18]	96[21]	N/A	N/A
Status	-	-	-	Target Not Met	Target Not Met but Improved	Target Not Met but Improved	-	-

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

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

Commissioned Corp Headquarters' (CCHQ) Division of Commissioned Corps Services and Ready Reserve Affairs are leading the development and implementation of a comprehensive recruitment strategy and accompanying operations plan to reach the recruitment goals for the Ready Reserve Program. The framework for this new strategy consists of three key areas of focus: Communication and Stakeholder Engagement, CCHQ Infrastructure, and Performance Management. Each focus area contains a series of activities with high impact on the overall strategy as well as a detailed plan of operation. In addition, the

[18]ARP Funded.
[22]ARP Funded.

strategy includes a performance management plan that consists of important milestones, key performance indicators, and a risk management plan.

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

This measure is being retired in FY 2024 as the program is being ramped down.

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

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

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

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

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

Objective 2.1 Table of Related Performance Measures

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	3	3	3	3	3	3	7	6
Result	9	7	3	6	3[19]	20	Dec 31, 2024	Dec 31, 2025
Status	Target Exceeded	Target Exceeded	Target Met	Target Exceeded	Target Met	Target Exceeded	In Progress	-

ASPR leads the nation's medical and public health preparedness for, response to, and recovery from disasters and public health emergencies. ASPR constantly scans the horizon to prepare for whatever emergency may come next, whether natural or manmade. Within ASPR, the Biomedical Advanced Research and Development Authority (BARDA) is the premier advanced research and development office within the United States Government. BARDA invests in the innovation, advanced research and development, U.S. Food and Drug Administration (FDA) approval, acquisition, and manufacturing of medical countermeasures (MCMs) – including the vaccines, therapeutics, diagnostic tools, and devices needed to combat health security threats. The data inform the public about BARDA's capacity to provide an integrated, systematic approach to developing MCMs for public health medical emergencies such as chemical, biological, radiological, and nuclear (CBRN) accidents, incidents and attacks, pandemic influenza, and emerging infectious diseases. The targets for this measure were met or exceeded each year. The data sources are stable with no gaps or delays in reporting. The data reported reflect ASPR's efforts to prepare for, respond to, and recover from disasters and public health emergencies. Together with industry partners, BARDA's support spans early development into advanced development and FDA approval. As of September 2023, BARDA-supported products have achieved 84 FDA approvals, licensures, or clearances. ASPR also oversees the transition of procurement of MCMs for storage in the Strategic National Stockpile to ensure their availability during a public health emergency.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	N/A	11,015	12,315	12,435	12,555	15,974	16,786	17,122
Result	10,906	12,197	12,534	13,537	15,314	Jun 30, 2024	Jun 30, 2025	Jun 30, 2026
Status	Historical Actual	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	In Progress	-

[19]Results based on both supplemental and base appropriations

International Field Epidemiology Training Programs (FETP) are recognized worldwide[20] as an effective means to strengthen countries' capacity in surveillance, epidemiology, and outbreak response. These graduates strengthen public health capacity so individual countries are able to transition from U.S.-led global health investments to more long-term host country ownership. Frontline is a three-month program that aims to increase the number of capable public health workers in a community setting. This program is part of three tiers in the FETP program which all help countries meet International Health Regulation guidelines. In FY 2022, there were 15,314 Frontline program graduates, an increase over FY 2021 and exceeding the FY 2022 target. By tracking the number of people who graduate from FETP – including the Frontline program every year, CDC can better gauge its impact on developing other countries' abilities to prevent, detect, and respond to disease outbreaks.

By 2026, establish a formalized funding pathway for the development, validation, and regulatory review of diagnostic technologies to enhance surveillance and pandemic preparedness. (Lead Agency – NIH; Measure ID – SR-NIBIB-001)[21]

-	Target	Result	Status
FY 2018	-	-	-
FY 2019	-	-	-
FY 2020	-	-	-
FY 2021	-	-	-
FY 2022	Receive FDA authorization for marketability for three home, point-of-care, or lab-based diagnostics.	NIH supported the development of technologies that led to two at-home COVID-19 tests, five point-of-care COVID-19 tests, and two lab-based COVID-19 tests. All nine tests received an FDA emergency use authorization for marketability.	Target Exceeded
FY 2023	Receive FDA authorization or approvals for two home, point-of-care, or lab-based diagnostics, at least one of which addresses accessibility needs of people with disabilities.	NIH supported the development of six at-home COVID-19 tests, one of which addresses the accessibility needs of people with disabilities, one point-of-care (POC) COVID-19 test, and two POC multiplex tests for COVID-19 and flu. All nine tests received an FDA emergency use authorization for marketability.	Target Exceeded
FY 2024	Receive FDA authorization or approval (including updated authorization or approval) for at least two home, point-of-care, or lab-based diagnostics, at least one of which is more accessible to people with disabilities.	Dec. 2024	In Progress

[20] Traicoff D et al. 2015. Strong and flexible: Developing a three-tiered curriculum for the Regional Central America Field Epidemiology Training Program. Pedagogy in Health Promotion 1(2): 74–82. http://php.sagepub.com/content/1/2/74.full.pdf+html.
[21] SR-NIBIB-001 was previously SRO-5.19. NIH has realigned the Measure ID numbers to the NIH-Wide Strategic Plan.

FY 2025	Submit for FDA authorization or approval two home, point-of-care, or lab-based diagnostics, at least one of which detects multiple pathogens.	Dec. 2025	-

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

In FY 2023, NIH supported the development of technologies that led to six at-home COVID-19 tests, one point-of-care (POC), or bedside testing, COVID-19 test, and two POC multiplex tests for simultaneous detection of COVID-19 and flu. All nine tests received an FDA emergency use authorization for marketability. In one example, developers created the first at-home test that conforms to accessible design principles. As a result of the COVID-19 pandemic, infectious disease testing has seen a fundamental shift from lab-based testing to self-testing at home, necessitating the need for tests that everyone can use. This extremely simple test has only two parts, its use requires far fewer steps than other at-home tests, and there is no need to transfer liquids, manipulate small parts, or understand complex instructions. Results are still available within 15 minutes. In another example, developers created a multiplex POC test that simultaneously detects COVID-19 and flu. It is designed to be performed by a healthcare provider and uses a nasal swab for sample collection. The ability to detect both COVID-19 and flu using a single test saves time and money and is less of a hassle to patents as only one nasal swab is necessary.

In FY 2024, NIH aims to receive FDA authorization or approval (including updated authorization or approval) for at least two home, point-of-care, or lab-based diagnostics, at least one of which is more accessible to people with disabilities. In FY 2025, NIH aims to submit for FDA authorization or approval two home, point-of-care, or lab-based diagnostics, at least one of which detects multiple pathogens.

By 2026, advance the preclinical or clinical development of 10 antivirals for current or future infectious disease threats. (Lead Agency - NIH; Measure ID - SR-NIAID-001)[22]

-	Target	Result	Status
FY 2018	-	-	-
FY 2019	-	-	-
FY 2020	-	-	-
FY 2021	-	-	-
FY 2022	Advance preclinical or clinical development of one antiviral therapeutic	NIH-funded researchers advanced the preclinical development of multiple antiviral therapeutic candidates.	Target Exceeded

[22]SR-NIAID-001 was previously SRO-5.20. NIH has realigned the Measure ID numbers to the NIH-Wide Strategic Plan.

FY 2023	Advance preclinical or clinical development of two antiviral therapeutics	NIH-funded researchers advanced the preclinical development of three antiviral therapeutic candidates and supported two Phase 3 clinical studies that are evaluating antiviral therapeutics.	Target Exceeded
FY 2024	Advance preclinical or clinical development of two antiviral therapeutics	Dec. 2024	In Progress
FY 2025	Advance preclinical or clinical development of two antiviral therapeutics	Dec. 2025	-

The development of antiviral drugs to combat harmful viruses can take several years. When SARS-CoV-2, the coronavirus that causes COVID-19, first emerged, there were no approved treatments or vaccines for treating any coronavirus infection. However, NIH was able to build on existing research on other coronaviruses that had caused earlier outbreaks or pandemics and actively contribute to the Federal response to COVID-19. To prepare for future threats posed by known and unknown viruses, NIH is taking a proactive approach by drawing on existing research and investing in antiviral drug discovery and development. The overall goal is to generate a pool of new antiviral drugs and increase the availability of antiviral drug candidates that might be used to address future outbreaks or pandemics.

In FY 2023, NIH-funded efforts contributed to further development of three drug candidates that show promise against SARS-CoV-2, other coronaviruses, and/or influenza A viruses. NIH also continued to support two clinical studies to test the effectiveness of two antiviral drugs. One study is investigating whether ensitrelvir fumaric acid, which prevents a virus from making more copies of itself, can shorten the duration of COVID-19 symptoms and reduce the risk of developing long COVID. The other study is evaluating whether tecovirimat, which is used for treating smallpox, can safely and effectively treat monkeypox. These advancements, along with other NIH investments in antiviral drug discovery and development, are critical steps in positioning the U.S. to respond to future outbreaks and pandemics.

In FY 2024 and FY 2025, NIH aims to advance the preclinical or clinical development of two antiviral therapeutics each year.

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

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

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

Objective 2.2 Table of Related Performance Measures

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	62%	66%	70%	70%	70%	70%	70%	70%
Result	45%	48%	50%	49%	50%	Sep 30, 2025	Sep 30, 2025	Sep 30, 2026
Status	Target Not Met but Improved	Target Not Met but Improved	Target Not Met but Improved	Target Not Met	Target Not Met but Improved	Pending	In Progress	-

In the United States, on average 5 to 20 percent of the population contracts the flu, more than 200,000 people are hospitalized from seasonal flu-related complications, and approximately 36,000 people die from seasonal flu-related causes. It is important that everyone over 6 months old receives an annual flu shot. This measure reflects the universal influenza vaccination recommendation and aligns with the Advisory Committee on Immunization Practices' updated recommendation (as of 2010) for the seasonal influenza vaccine. Seasonal influenza vaccination rates for adults aged 18 and older increased slightly over the past few years from 42 percent in FY 2015 to 50 percent in FY 2022, with FY 2022 vaccination rates seeing little change from FY 2021. Targets for this measure have remained level for several years as CDC works to achieve the current level of seasonal flu vaccination. Interpretation of these results should take into account limitations of the survey, which include reliance on self-reporting of vaccination status and a decrease in response rates.

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

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

- Addressing pandemic-related declines in routine immunizations, through the launch of the CDC **Let's RISE** initiative, which stands for Routine Immunizations on Schedule for Everyone. Let's RISE is an effort to equip partners and health care providers with actionable strategies, resources, and data to support getting all Americans back on schedule with their routine immunizations. Let's RISE provided technical assistance to 20 jurisdictions resulting in improved Immunization Information Systems (IIS), vaccine confidence, and school vaccination data collection.
- Strengthening vaccine confidence and preventing outbreaks of vaccine-preventable diseases in the US by establishing the Vaccinate with Confidence strategic framework. CDC has developed Vaccine Confidence and Demand partnerships with healthcare and community-based organizations to build vaccine confidence and generate demand.
- Collaborating with numerous existing and new partners to develop and implement strategies to improve adult immunization at provider, practice, and systems levels. These partnerships with professional organizations, pharmacy partners, and other entities help to promote immunization for adults and allow for increased access to vaccination programs through new venues.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	83%	83%	83%	83%	83%	84%	85%	85%
Result	87%	88%	89.4%	89.7%	89.6%	Dec 31, 2024	Dec 31, 2025	Dec 31, 2026
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	In Progress	-

HRSA's Ryan White HIV/AIDS Program (RWHAP) works to improve health outcomes by preventing disease transmission or slowing disease progression for disproportionately affected communities. The RWHAP accomplishes its mission through the provision of medications that help patients reach HIV viral suppression. An overwhelming body of clinical evidence has established that a person with HIV who is in treatment and has an undetectable viral load (otherwise known as viral suppression) cannot sexually transmit HIV. This is also referred to as Undetectable Equals Untransmittable, or U=U. Improved viral suppression rates reduce the transmission of HIV and result in significant health benefits for individuals and cost-savings to the health care system.

FY 2022 results show that 89.6 percent of RWHAP patients receiving RWHAP medical care are virally suppressed, far exceeding the 69.8 percent rate of viral suppression for the general population of people with diagnosed HIV − an outcome measure that demonstrates the success of the program and results in major public health benefits. These results align with a study published in Clinical Infectious Diseases, which found that clients receiving care and support at RWHAP-funded facilities are associated with improved outcomes (such as viral suppression), compared to those not served by the RWHAP. Furthermore, RWHAP patients are more likely to reach viral suppression regardless of other health care coverage (e.g., uninsured, Medicaid, Medicare, or private insurance).

Today, with advances in antiretroviral therapy, people with HIV are living longer and healthier lives. However, even with these positive outcomes, fully ending the HIV epidemic domestically continues to be a challenge as CDC estimates that 1.2 million people in the United States have HIV, and one in eight are unaware of their HIV status. In addition, over 36,000 HIV diagnoses occur every year.

The successive steps or stages that people with HIV go through from diagnosis to achieving and maintaining viral suppression through care and treatment with HIV medicine called antiretroviral therapy or ART, is known as the HIV care continuum. The HIV care continuum is crucial in ensuring optimal health outcomes for people with HIV. It also helps policymakers and service providers better pinpoint where gaps in services might exist, develop strategies to better support people with HIV to achieve the treatment goal of viral suppression, and prevent further transmission of the virus, advancing the public health goal of ending the HIV epidemic in the United States.

To meet the FY 2024 and 2025 viral suppression targets of 85 percent, the RWHAP will continue to ensure low-income people with HIV have access to a wide range of services aimed at early diagnosis of HIV, linkage to care, retention in care, medically appropriate treatment, and sustained viral suppression. The RWHAP will support recipients in prioritizing people with HIV who are disconnected from care and

treatment and individuals not achieving optimal viral suppression through person-centered approaches supporting treatment adherence and addressing behavioral health needs and other factors to improve health outcomes.

The RWHAP aims to continue to achieve high viral suppression rates for clients in medical care that far exceed the national average and to reduce the health disparity in viral suppression rates among racial and ethnic minorities. The following helped inform the methodology for establishing this target:

- People with HIV who are not engaged in care tend to have more complex needs than those that remain engaged. Multiple studies indicate that those retained in care are more likely to achieve viral suppression compared to those not engaged in regular care.
- Viral suppression can take up to three months to achieve based on viral dynamics while a person establishes routine engagement in care and maintains adherence to HIV medications. The RWHAP and EHE focuses on people with HIV unaware of their diagnosis or not in routine care. The programs have been highly successful in engaging and re-engaging people in care and treatment. Due to these efforts, there is a potential impact that new clients may have on overall viral suppression rates as people who are not diagnosed or in care have lower viral suppression rates.
- Despite the improved rates of durable viral suppression in the RWHAP overall, populations with multiple needs, including clients who have been out of care and who have co-morbidities such as mental health challenges, substance use disorders, or are unhoused, remain at increased risk of not meeting optimal viral suppression.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	2	2	2	2	2	3	3	2
Result	7	6	2	2	2	3	Dec 31, 2024	Dec 31, 2025
Status	Target Exceeded	Target Exceeded	Target Met	Target Met	Target Met	Target Met	In Progress	-

Within ASPR, the Biomedical Advanced Research and Development Authority (BARDA) uses an end-to-end strategy to prepare for the next influenza pandemic by supporting development, licensure, and manufacturing of better products to detect, treat, and prevent seasonal and pandemic influenza. This strategy relies on the development of improved influenza diagnostics, treatments, and vaccines that can be rapidly manufactured. BARDA continues to focus on developing capabilities to recognize potential pandemic influenza viruses in point-of-care settings, thus quickly recognizing a potential new pandemic and increasing the speed of vaccine availability when a new pandemic influenza vaccine is needed. BARDA also focuses on developing new therapeutics to treat viral infections, including investment in host-directed therapeutics for the treatment of acute respiratory distress syndrome (ARDS). This measure is specific to the development of influenza vaccines and therapeutics. The products reported for this measure include those from new awards or contract modifications supporting clinical trials and

manufacturing campaigns related to Pandemic Influenza. The targets have been met or exceeded each year. There are no missing or delayed data. The data source is stable and quality assurance procedures are routinely conducted. The measure reflects that ASPR uses a comprehensive portfolio approach to develop and acquire a broad array of medical countermeasures for pandemic influenza. The ASPR investments reflected through this data highlight support for advanced research and development, stockpiling, procurement, and capacity expansion. Important context is that previous and ongoing investments in addressing the pandemic influenza threat proved invaluable to accelerate the COVID-19 response by jump-starting therapeutic and vaccine development using platform technologies for more rapid production and increased fill/finish capability. By continuing to widen availability of enhanced influenza medical countermeasures, BARDA promotes effective, timely management and treatment of seasonal and pandemic influenza, and reduces its impact on health, communities, the Nation, and internationally. Targets are set based on ongoing active projects specifically related to complex advanced research and development projects that are on the product development pathway to FDA licensure.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	18.8%	18.8%	25.4%	24.4%	28%	19.7%	19.7%	21.0%
Result	23.3%	23.6%	24.3%	18.1%	20%	19.9%	Jan 31, 2025	Jan 31, 2026
Status	Target Exceeded	Target Exceeded	Target Not Met but Improved	Target Not Met	Target Not Met but Improved	Target Exceeded	In Progress	-

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

Various components of the IHS and tribal health care enterprise work collaboratively and collectively to improve influenza vaccination among AI/AN people as reflected by the measure. IHS seeks to reduce the burden of all vaccine-preventable diseases among AI/AN people across the lifespan through strategies and activities that promote vaccination among AI/AN communities. Overall, strategies and activities that promote the uptake of recommended vaccines preempt infectious disease threats that can further exacerbate health disparities impacting AI/AN populations. The influenza vaccination rate measures the proportion of individuals receiving seasonal influenza vaccines among AI/AN adults.

From FY 2018 through FY 2020, the IHS seasonal influenza vaccination rate for AI/AN adults 18 years of age and older improved. In FY 2021, the influenza vaccination rate was 18.1 percent and increased to 20.0 percent in FY 2022. These results did not meet the established FY targets. In FY 2023, the influenza vaccination rate was 19.9 percent, exceeding the target of 19.7 percent. IHS results are likely impacted by effects of the COVID-19 pandemic and the subsequent refocus of resources prioritizing immunizations in the post-pandemic era. The IHS has implemented data-driven interventions targeted to specific, highly

susceptible patient populations to improve their specific influenza vaccination rates and related health outcomes.

Each fiscal year the IHS reviews and applies evidence-based approaches, including co-administration of COVID-19 and influenza vaccines and combining with other targeted vaccination efforts to maximize opportunities for influenza vaccination. The IHS incorporates strategies such as use of standing orders that promote vaccine administration, proper documentation of vaccines given to aid tracking, and automated point-of-care reminders to prompt vaccination when a patient is due to receive immunization. In November 2022, the IHS launched the National E3 Vaccine Strategy - ensuring EVERY patient at EVERY encounter receives EVERY recommended vaccine, when appropriate – which sets vaccination as the Agency's clinical and public health prevention priority. During FY 2023, IHS collaborated with key stakeholders to operationalize the E3 strategy; efforts included implementing quality improvement cycles, encouraging innovation, and incentivizing efforts towards success and best practices developed in and for Indian Country. In FY 2024, the E3 Strategy will continue to influence vaccination rates for all recommended vaccines, including influenza. As part of the influenza preparation for season 2023 -2024, the IHS is communicating the national and local immunization trends among AI/AN patients and strategies that could improve vaccination uptake to include influenza vaccines.

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

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

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

Objective 2.3 Table of Related Performance Measures

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	967	903	838	817	755	693	631	570
Result	1,061	1,004	1,004	967	847	Jul 31, 2024	Jul 31, 2025	Jul 31, 2026
Status	Target Not Met but Improved	Target Not Met but Improved	Target Not Met	Target Not Met but Improved	Target Not Met but Improved	Pending	In Progress	-

Although cigarette smoking remains the leading cause of preventable disease and death in the United States, the tobacco[23] product use landscape continues to diversify to include multiple combustible tobacco products, including cigars, cigarillos and little cigars, pipe tobacco, roll-your-own tobacco, and hookah. Per capita combustible tobacco product consumption decreased from 967 cigarette equivalents in FY 2021 to 847 cigarette equivalents in FY 2022. CDC will continue to work to decrease combustible tobacco consumption in the U.S.

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

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	73.8%	-	Set Baseline	-	74.7%	-	75.5%	-
Result	74.6%	-	73.9%	-	73.7%	-	Dec 31, 2025	-
Status	Target Exceeded	-	Baseline	-	Target Not Met	-	In Progress	-

The proportion of adults who engage in leisure-time physical activity increased from 63.8% in FY 2008 to 74.6% in FY 2018. After FY 2018, the National Health Interview Survey (NHIS) changed the survey question and methodology used for the measure's data. As a result, new data cannot be compared to previous results, and a new baseline of 73.9% was established in FY 2020. In FY 2022, there was a slight decrease from the FY 2020 baseline, however additional years of data are needed to confirm if this is a true decline. CDC's Active People, Healthy Nation[SM] is a national initiative to help 27 million Americans become more physically active by 2027. CDC used percent improvement target setting methodology to set a goal of a 0.4% increase per year for the proportion of adults (age 18 and older) that engage in leisure-time physical activity. This translates to a 0.8% increase every two years and is consistent with administration of the NHIS, the survey used to collect this data, which is administered every two years instead of annually.

CDC funds states, communities, and organizations with national reach to design communities that are safe and easy for people of all ages and abilities to be physically active. In addition, CDC trains states and communities to implement strategies to improve the walkability of communities. For example, the CDC funded Walkability Action Institute has trained teams in 79 jurisdictions in 32 states and two territories. As a result, the jurisdictions cumulatively achieved over 850 outcomes related to improving walkability with a focus on community and transportation design for over 41 million people. CDC will continue to promote the critical need for safe and easy places for physical activity to take place and help implement

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

high impact strategies for walking and walkable communities like Complete Streets and Safe Routes to Schools.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	63%	63%	63%	63%	63%	61%	62%	63%
Result	63%	65%	58%	60%	63%	Aug 1, 2024	Aug 1, 2025	Aug 1, 2026
Status	Target Met	Target Exceeded	Target Not Met	Target Not Met but Improved	Target Met	Pending	In Progress	-

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	69%	69%	67%	67%	67%	67%	68%	69%
Result	67%	68%	64%	68%	70%	Aug 1, 2024	Aug 1, 2025	Aug 1, 2026
Status	Target Not Met	Target Not Met but Improved	Target Not Met	Target Exceeded	Target Exceeded	Pending	In Progress	-

Health centers continue to be a critical element of the health system, largely because they can provide an accessible and dependable source of high quality, affordable, and cost-effective primary health care services in underserved communities. In particular, health centers emphasize coordinated primary and preventive services that promote reductions in health disparities for low-income individuals, racial and ethnic minorities, rural communities, and other underserved populations. Health centers emphasize coordinated and comprehensive care, the ability to manage patients with multiple health care needs, and the use of key quality improvement practices. Health center patients, including low-income individuals, racial/ethnic minority groups, and persons who are uninsured, are more likely to suffer from chronic diseases such as hypertension and diabetes. Clinical evidence indicates that access to appropriate care can improve the health status of patients with chronic diseases and thus reduce or eliminate health disparities. HRSA set the FY 2025 targets based on historical data trends. HRSA will continue to work in collaboration with technical assistance partners to promote high quality hypertension and diabetes care in

health centers. A summary of Health Center Program data trends can be found at the following link: https://data.hrsa.gov/tools/data-reporting/program-data/national.

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

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

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

Objective 2.4 Table of Related Performance Measures

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	21	40	40	45	45	60	60	60
Result	97	87	66	80	45	73	Oct 31, 2024	Oct 31, 2025
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Met	Target Exceeded	In Progress	-

The Environmental and Health Outcome Tracking Network covers over 185 million people, which made up about 57% of the population in the U.S. in 2021. The Tracking Network serves as a source of information on environmental hazards and exposures, population data, and health outcomes. CDC exceeded expectations for the number of data-driven actions to improve public health using the Tracking Network which is in keeping with previous years. CDC is refining how public health actions are captured and anticipates that the total number of actions may be reduced or remain flat. Performance for this measure is dependent on Environmental Health Tracking recipients reporting on the actions they undertake which may vary from year to year. FY 2025 targets remain level with FY 2024 but are increased slightly over previous year targets as a result. From FY 2005 to FY 2023, state and local public health officials have used the Tracking Network to implement over 900 data-driven public health actions to save lives and prevent adverse health effects that are due to environmental exposures.

For example, in 2023 there were 73 public health actions reported, with air quality, climate change, lead poisoning, cancer, and environmental justice as the most common environmental health topics addressed. Programs or interventions described by Tracking recipients included using their Cooling Center Finder to

offer real-time cooling center availability information; adding acute and chronic health outcomes related to environmental exposures to the state public health accountability metrics; and implementing a policy requiring the state to use health disparity mapping tools to plan urban tree planting and reforestation efforts. The Tracking Network also serves as a source of information for health professionals, elected officials, researchers, parents, and the public on environmental hazards and exposures, population data, and health outcomes.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	-	Set Baseline	81,720	88,826	110,322	102,150	102,150	102,150
Result	-	71,061	234,802	130,610	152,461	515,797	Dec 31, 2024	Dec 31, 2025
Status	-	Baseline	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	In Progress	-

ASPR's mission is to lead the country through public health emergencies. ASPR Measure 1.3 is part of ASPR's National Disaster Medical System (NDMS) support of nationwide communities. When disaster strikes, NDMS is important because states, localities, tribes, and territories (SLTT) may have medical infrastructure that becomes overwhelmed and requires assistance with their critical services. At that point, they can request NDMS help for their communities as they respond and recover. NDMS capabilities and tools deliver essential medical and emergency management services and subject matter expertise when requested by an SLTT agency. As a tool within NDMS, the HHS emPOWER Program's federal health data are used to advance SLTT and community partner capabilities to anticipate and plan for health care system surge, including pre-emptively taking action to protect health and save the lives of at-risk populations that may be rapidly and adversely impacted during an emergency or disaster. The HHS emPOWER Program is a mission-critical partnership between ASPR and the Centers for Medicare and Medicaid Services (CMS) that provides public health agencies and their partners with Medicare datasets, mapping, Representational State Transfer (REST) service and artificial intelligence (AI) tools, training, informational resources, technical assistance, and best practices to protect the health of over 4.5 million at-risk individuals who live independently in the community and rely on life-maintaining electricity-dependent equipment (including ventilators) and or essential health care services (such as dialysis and oxygen tank services). These tools and technical assistance have advanced preparedness and community mitigation activities nationwide and have informed and supported hundreds of local-to-national emergencies and disasters.

Baseline data was collected in 2019 and the targets have been exceeded each year from 2020 through 2023. The nationwide use of emPOWER data represents the rapid scientific advancement of data-driven mitigation strategies that help during a broad array of disasters, including the COVID-19 pandemic, power and infrastructure failures, and numerous events associated with climate change.

By FY 2026, OCR will conduct a Title VI Environmental Justice/Public Health compliance review and undertake any needed steps for resolution. (Lead Agency - OCR; Measure ID – 2-4)

-	Target	Result	Status

FY 2017	-	-	-
FY 2018	-	-	-
FY 2019	-	-	-
FY 2020	-	-	-
FY 2021	N/A	Background investigation completed; joint meetings held with other partner federal agencies, including USDA, DOJ, and Office of Climate Change and Health Equity (OCCHE); follow-up interviews conducted with Complainants; compliance review opened September 2021.	Baseline
FY 2022	Conducted Title VI/Section 1557compliance review through on-site inspections, interviews, and data analysis.	Onsite investigation completed in April of 2022; approximately 50 witness interviews conducted, data request letters submitted, and responses reviewed.	Target Met
FY 2023	Coordinated comprehensive public health response by HHS partners, including CDC and HRSA. Provided technical assistance to the covered entity, Alabama Department of Public Health (ADPH) based on analysis of collected data to establish safe and effective sewage management and nondiscriminatory policies and practices.	Interim Voluntary Resolution Agreement executed by HHS, DOJ, and ADPH on May 3, 2023. HHS and DOJ are currently implementing the terms of the agreement and will be monitoring ADPH's compliance for three years. HHS and DOJ met monthly with stakeholders in Lowndes County to increase awareness of the Agreement and to stay abreast of ADPH's engagement with the community. HHS and DOJ also regularly met with ADPH officials to provide technical assistance on civil rights compliance and to share information about new federal funding opportunities to improve wastewater infrastructure and rural public health services.	Target Met
FY 2024	Continue collaboration with OCCHE, OEJ, and other partner federal agencies involved in environmental justice policy and enforcement. Review local and/ state agency policies and practices that may implicate environmental justice concerns	-	In Progress

	under OCR's jurisdiction for possible investigation.		
FY 2025	Continue collaboration with OCCHE, OEJ, and other partner federal agencies involved in environmental justice policy and enforcement. Review local and/ state agency policies and practices that may implicate environmental justice concerns under OCR's jurisdiction for possible investigation.	-	-

This initiative supports the HHS objective of mitigating the impacts of environmental factors on health outcomes by addressing the health impact of environmental hazards, such as inadequate sanitation systems, that result from discriminatory practices. OCR coordinates with HHS partner agencies to develop and implement a comprehensive public health response to improve community health outcomes and partner with other federal agencies involved in environmental justice. As part of this initiative, OCR reviews local and/ state agency policies and practices that may implicate environmental justice concerns under OCR's jurisdiction for possible investigation and may conduct environmental justice/public health compliance reviews under Title VI of the Civil Rights Act and Section 1557 of the Affordable Care Act. Through on-site investigations, interviews, and document reviews, OCR will identify corrective actions, and best practices, if needed. OCR may also provide technical assistance to ensure that state and local governments and federally assisted health programs and activities are accessible to underserved racial and ethnic minority communities. Based on OCR's reviews to date, these results include, but are not limited to, the execution of an Interim Voluntary Resolution Agreement, ongoing community stakeholder engagement, and collaboration with HHS partner agencies such as the Centers for Disease Control with the goal of advancing public health, and will include future abatement of public health threats.

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

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

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

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

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

Objective 3.1 Table of Related Performance Measures

Increase energy burden reduction index score for high burden households. (Lead Agency - ACF; Measure ID - 1D)

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	N/A	N/A	90	86	86	95	Prior Result +0[24]	Prior Result +0
Result	87	90	86	86	95	Nov 30, 2024	Nov 30, 2025	Nov 30, 2026
Status	Historical Actual	Historical Actual	Target Not Met	Target Met	Target Exceeded	Pending	In Progress	-

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

The Benefit Targeting Index (measure 1C) score for FY 2022 based on all states with usable data was 116, indicating that LIHEAP provided 16 percent higher benefits to those households with the highest energy burden compared to average recipient households. The Burden Reduction Targeting Index (measure 1D) score for FY 2021 based on all states with usable data was 95, indicating that LIHEAP paid about 5 percent less of the energy bill for households with the highest energy burden compared to average recipient households. Under funding provided by the Consolidated Appropriations Act of 2012, which increased training and technical assistance funds to $3 million, ACF has invested in increased grantee training and technical assistance to improve performance management and monitoring activities by states. In FY 2023, Congress appropriated $9.6 million for the same purposes.

LIHEAP continued to prioritize enhancing efforts around administrative support, training and technical assistance, equity, and environmental justice. In FY 2023, LIHEAP continued to work with the Application Streamline and Electronic Verification Workgroup with a selected number of state directors to create technical assistance tools that will improve customer experience and verify data through third

[24]The FY 2024 target is to maintain the previous actual result.

party systems. This workgroup will continue in FY 2024. In FY 2023, LIHEAP made updates to existing online data dashboards publicly available on topics such as extreme heat and disaster management, as well as continued to publish LIHEAP quarterly performance reports, which included assisted households, performance management, use of LIHEAP funds, and implementation and support data. Additional tools have included grant recipient performance management profiles, ongoing work on a completely redesigned energy-assistance locator (www.energyhelp.us) website, and several program-specific fact sheets.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	55%	55.5%	56%	56.5%	56.75%	56.75%	41.5%[25]	42.5%
Result	50.99%	43.47%	42.45%	40.58%	40.28%	Dec 1, 2024	Dec 1, 2025	Dec 1, 2026
Status	Target Not Met	Target Not Met	Target Not Met	Target Not Met	Target Not Met	Pending	In Progress	-

The Transitional and Medical Services (TAMS) program provides refugees and other eligible populations with time-limited assistance to purchase food and clothing, pay rent, use public transportation, and secure medical care. Additionally, this program provides a path to economic self-sufficiency by supplying resources for employment training and placement, case management services, and English language training in order to facilitate economic self-sufficiency and effective resettlement as quickly as possible. A cash assistance termination is defined as the closing of a cash assistance case due to earned income in an amount that is predicted to exceed the state's payment standard for the case from employment based on family size, rendering the case ineligible for cash assistance. The FY 2021 actual result of 40.58 percent was below the target of 56.50 percent by 15.92 percent. The FY 2022 actual result of 40.28 percent was also below the target of 56.75 percent by 16.47 percentage points. Many refugees are placed into full-time jobs with reduced work hours, for example, jobs in the service industry that have varying hours, thus termination from assistance may not occur. A few large programs had lower termination rates which negatively affected national termination rate. For example, some larger states had a significant influx of clients, with barriers to getting employment, some due to challenges in receiving employment authorization. Some states had higher employment outcomes; however, the threshold for termination from cash assistance is higher, thus resulting in a lower termination rate. COVID-19 also contributed to delays in employments and extended benefits period due to COVID-19 eligibility extensions. ACF plans to continue to work with states to increase the ratio of full-time job placements and to increase terminations to a revised target of 42.55 percent in FY 2025, based on recent trend data.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	84.84%	82.88%	81.76%	76.05%	78.58%	76.76%	79.06%	Prior Result +1%

[25]This performance target has been revised in light of the most recent trend data.

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Result	82.06%	80.95%	75.3%	77.8%	76%	78.28%	Nov 30, 2024	Nov 30, 2025
Status	Target Not Met	Target Not Met	Target Not Met	Target Exceeded	Target Not Met	Target Exceeded	In Progress	-

The Matching Grant program is an alternative to traditional cash assistance that provides participants with services such as case management, job development, job placement and placement follow-up, and interim housing and cash assistance through grants awarded to participating national refugee resettlement agencies. These agencies provide a match (in cash and/or in-kind services) of one dollar for every two dollars of federal contribution to client direct assistance funding. The purpose of the program is to help participants become self-sufficient within 240 days from the date of eligibility for the program. This is a shift from the previous client support period of 180 days, which was implemented starting in FY 2022. The extension of the client service period will enable grant recipients to further emphasize basic integration services such as English language acquisition and to provide more equitable employment services. The actual result for the refugee self-sufficiency rate in FY 2023 indicates that over 78 percent of program participants were self-sufficient at the end of the 240-day program service period, exceeding the FY 2023 target of 76.76 percent. ORR expects positive growth to continue in FY 2025 as grant recipients continue to refine their pandemic era methodologies and the U.S. economy recovers.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	86%	87%	88%	90%	90%	90%	88%[26]	88%
Result	88%	88%	87%[27]	88%	87%	Nov 30, 2024	Nov 30, 2025	Nov 30, 2026
Status	Target Exceeded	Target Exceeded	Target Not Met	Target Not Met but Improved	Target Not Met	Pending	In Progress	-

The Social Services Amendments of 1975 (P.L. 93-647) established the federal child support services program as part of Part D of title IV of the Social Security Act. Child support is one of the most significant financial resources available to children living apart from a parent. Child support receipt promotes family self-sufficiency, child well-being, and health from birth through adulthood, thereby reducing costs in other government programs. The annual performance measure regarding child support orders compares the number of IV-D child support cases with support orders established (which are required to collect child support) with the total number of IV-D cases. In FY 2022, child support services programs nationwide continued to grapple with the impacts of the COVID-19 pandemic. Even though there have been some improvements, returning to pre-pandemic performance levels remains a challenging endeavor. The total number of cases with an order established was 10.7 million in FY 2022. The percent of cases with support orders was 87 percent, which is slightly below the target of 90 percent for FY 2022.

[26] The FY 2024 target has been updated as a result of the most recent trend data.
[27] The FY 2020 actual result has been updated as a result of final data validation.

The target for FY 2025 was reduced to 88 percent based on the most recent results and anticipated trends.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	6.6%	7.8%	7.4%	6.8%	7.5%	8.4%	Prior Result +0.1PP	Prior Result +0.1PP
Result	7.7%	7.3%	6.7%	7.4%	8.3%	Oct 30, 2024	Oct 30, 2025	Oct 31, 2026
Status	Target Exceeded	Target Not Met	Target Not Met	Target Exceeded	Target Exceeded	Pending	In Progress	-

The Temporary Assistance for Needy Families (TANF) program provides state flexibility in operating programs designed to help low-income families achieve independence and economic self-sufficiency. The performance measures for the TANF program assess the extent to which TANF work-eligible individuals and families transition from cash assistance to employment. Full success requires not only that recipients get jobs, but also that they stay in employment and increase their earnings in order to reduce dependency and enable families to support themselves. The state spending requirement of matching funds for the federal TANF payment is referred to as "maintenance-of-effort" or MOE. This performance measure reports on the median state share of federal TANF and state MOE funds used for work, education, and training activities. The most recent actual result increased from 7.4 percent in FY 2021 to 8.3 percent in FY 2022, exceeding the target of 7.5 percent. Through intentional technical assistance, ACF encourages states to invest more resources towards engaging TANF work-eligible individuals in work and work preparation activities so that families with barriers to employment can reach the ultimate outcome of a stable, unsubsidized job.

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

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

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

Objective 3.2 Table of Related Performance Measures

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	15%	17%	15%	N/A	N/A	N/A	16%	Prior Result - 1PP
Result	18%	16%	17%	N/A	N/A	N/A	Jan 31, 2025	Jan 31, 2026
Status	Target Not Met	Target Exceeded	Target Not Met	N/A	N/A	N/A	In Progress	-

ACF strives to increase the percentage of Head Start children in high quality classrooms. Progress is measured by reducing the proportion of Head Start grant recipients scoring in the low range, below 2.5, in any domain of the Classroom Assessment Scoring System (CLASS: Pre-K). This research-based tool measures teacher-child interaction on a seven-point scale in three broad domains: Emotional Support, Classroom Organization, and Instructional Support. ACF began data collection using random samples for the CLASS: Pre-K in the first quarter of FY 2012. ACF assesses each Head Start grantee using the CLASS instrument during onsite monitoring reviews. This performance measure was developed to track the proportion of grant recipients receiving a score in the low range on the basis of the CLASS with the goal of decreasing that proportion over time.

Data from the FY 2014 CLASS reviews indicated that 23 percent of grant recipients are in the low range on any domain, exceeding the revised target. The most recent data from the FY 2020 CLASS reviews indicate that 17 percent of grant recipients scored in the low range, not meeting the target of 15 percent. The target set for FY 2021 is 16 percent, a one percent improvement from the FY 2020 result. However, there are no results for this performance measure in fiscal years 2021, 2022, and 2023 since CLASS reviews were not conducted due to the COVID-19 pandemic. The targets for FY 2024 and 2025 are also set to a one percentage decrease from the prior year result. In response to data from CLASS reviews, ACF is providing more intentional targeted assistance to those grant recipients that score in the low range on CLASS. ACF is flagging grant recipients that score in the low range, conducting more analysis on the specific dimensions within the Instructional Support domain that are particularly challenging for those grant recipients, and working more directly with those grant recipients on strategies for improvement.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	100%	100%	N/A	100%	100%	100%	100%	100%
Result	94.9%	94.8%	N/A	94.8%	94%	92.9%	Jan 31, 2025	Jan 31, 2026
Status	Target Not Met	Target Not Met	Pending	Target Not Met	Target Not Met	Target Not Met	In Progress	-

Head Start grant recipients are required to develop plans to improve the qualifications of staff. Head Start has shown a steady increase in the number of Head Start teachers with an Associate Degree (AA), Bachelor's Degree (BA), or advanced degrees in early childhood education. The Head Start reauthorization requires that all Head Start preschool center-based teachers have at least an AA degree or higher with evidence of the relevance of their degree and experience for early childhood education by October 1, 2011, thus the goal for each fiscal year through 2025 is to reach 100 percent. The most recent FY 2023 data indicates that approximately 93 percent of Head Start teachers had an AA degree or higher, slightly missing the target, but remaining relatively stable compared to previous years actual results. Of the 34,904 Head Start preschool teachers in FY 2023, 32,443 had an AA degree or higher. Of these degreed teachers, 8,637 have an AA degree, 19,491 have a BA degree, and 4,351 have an advanced degree. Not included in these numbers are 1,420 teachers with a Child Development Associate (CDA) or state credential and 1,024 teachers who do not have a degree or CDA. About 23 percent of teachers without a BA or advanced degree are enrolled in a BA degree. ACF continues to provide training and technical assistance funds directly to grant recipients to increase the qualifications of teachers.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	90%	90%	90%	91%	91%	91%	90%[28]	90%
Result	90%	90%	92%	91.5%	91.1%	Mar 31, 2024	Mar 31, 2025	Mar 31, 2026
Status	Target Met	Target Met	Target Exceeded	Target Exceeded	Target Exceeded	Pending	In Progress	-

This annual performance measure pertains to safe and appropriate exit rates for youth from the Transitional Living Program (TLP). The TLP program provides shelter and services to meet the needs of homeless youth to promote long-term economic independence in order to ensure the well-being of the youth. All youth between the ages of 18 and 21 are eligible for up to 18 months of TLP services. This performance measure captures the percentage of TLP youth who are discharged from the program into an immediate living situation that is both safe and appropriate. This goal is achieved through the promotion and support of innovative strategies that help grantees to: 1) encourage youth to complete the program and achieve their developmental goals instead of leaving the program prior to completion; 2) stay connected with youth as they transition out of program residencies and provide preventive, follow-up, and aftercare services; 3) track exiting youth more closely; 4) report accurate data and maintain updated youth records to reduce the number of youth whose exit situations are unknown; and 5) analyze data to discover patterns of participation and opportunities for improved services. During FY 2022, the program exceeded the 91 percent target for this measure by attaining a 91.1 percent safe and appropriate exit rate. Because safe and stable housing is one of the core outcome areas, ACF will maintain the target of 90 percent through FY 2025. ACF will continue to work to ensure appropriate service delivery and technical assistance systems are in place to support continued high performance on this performance measure.

[28] The FY 2024 target has been revised in light of the most recent trend data.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	18,554	18,554	11,497	8,700	8,500	22,000	29,000	29,000
Result	27,922	12,390	8,788	8,573	25,427	30,743	Dec 31, 2024	N/A
Status	Target Exceeded	Target Not Met	Target Not Met	Target Not Met	Target Exceeded	Target Exceeded	In Progress	-

Established in 2008, Project LAUNCH (Linking Actions to Unmet Needs in Children's Health) promotes the wellness of young children from birth to eight years of age by addressing the physical, social, emotional, cognitive, and behavioral aspects of their development. Project LAUNCH is designed to build the capacities of adult caregivers of young children to promote healthy social and emotional development; to prevent mental, emotional, and behavioral disorders; and to identify and address behavioral concerns before they develop into serious emotional disturbances. A required activity for Project LAUNCH is to conduct screening and assessment to ensure the early identification of behavioral and developmental concerns using validated screening instruments; to include screening for other behavioral health issues, such as perinatal/maternal depression and substance misuse among parents (including opioid use), as appropriate. Each Project LAUNCH local pilot community implements a set of "5 Core Strategies" that bring evidence-based mental health practices and expertise into the natural settings of early childhood. Grantees identify the evidence-based practices to implement for their population of focus. For FY 2024 and FY 2025, it is expected that approximately 29,000 young children will be screened for mental health disorders each year.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	N/A	N/A	N/A	N/A	Not Defined	164,470	167,096	189,498
Result	150,291	154,496	140,606[29]	140,674[30]	137,802[31]	139,695[32]	Jan 31 2025	Jan 31 2026
Status	Historical Actual	Historical Actual	Historical Actual	Historical Actual	Historical Actual	Not Met	In Progress	-

[29] FY 2020 results were impacted by funding cuts due to sequestration, the impacts of COVID-19 on enrollment and service delivery, and a reporting error in one state.
[30] FY 2021 results were impacted by funding cuts due to sequestration and the impacts of COVID-19 on enrollment and service delivery.
[31] FY 2022 results were impacted by funding cuts due to sequestration, the impacts of COVID-19 on enrollment and service delivery, and significant issues with workforce recruitment and retention across the early childhood care and education field.
[32] FY 2023 results were impacted by funding cuts due to sequestration and significant issues with workforce recruitment and retention across the early childhood care and education field.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	N/A	N/A	N/A	N/A	Not Defined	3,871	4,427	6,500
Result	3,751	3,428	3,315	3,508	3,498	3,432[33]	Jan 31 2025	Jan 31 2026
Status	Historical Actual	Historical Actual	Historical Actual	Historical Actual	Historical Actual	Not Met	In Progress	-

HRSA's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program supports voluntary, evidence-based home visiting services during pregnancy and to parents with young children up to kindergarten entry living in at-risk communities. Additional information on the MIECHV program can be found in the FY 2025 HRSA Congressional Justification as well as the HRSA MIECHV Program website which includes a MIECHV Program Brief.

In FY 2023, states reported serving more than 139,000 parents and children in over 1,000 counties across all 50 states, the District of Columbia, and five territories, representing more than a 300 percent increase in the number of participants served since FY 2012. MIECHV state and jurisdictional grantees provided over 9.7 million home visits from FY 2012 through FY 2023.

In FY 2025, HRSA is increasing its target using projections based on an appropriation of $600 million, reduced by sequestration at a rate of 5.7%. The increased funding may be used by states and jurisdictions to expand services to additional communities and families. Funding will also support the recruitment and retention of the home visiting workforce, including increasing home visitor training and supports, and hiring a diverse workforce. Additionally, up to 6 new awards will be made to tribal entities to expand services to additional tribal communities. This expansion of services will be key to achieve set targets. FY 2025 targets reflect both the increased appropriation levels included in the most recent authorization of the MIECHV Program (Consolidated Appropriations Act, 2023 (Public Law 117-328, Section 6101)), as well as new program requirements that establish base grants beginning in FY 2023 and matching grants beginning in FY 2024.

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

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

[33] FY 2023 results were impacted by factors such as challenges with family and staff recruitment and retention.

development and implementation activities to better understand and address the needs of all caregivers across the age and disability spectrum.

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

Objective 3.3 Table of Related Performance Measures

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	N/A	N/A	79.55%	78.73%	79.54%	79.62%	Prior Result +1%	Prior Result +1%
Result	78.9%	78.76%	77.95%	78.75%	78.83%	Jan 1, 2025	Jan 31, 2026	Jan 31, 2027
Status	Historical Actual	Historical Actual	Target Not Met	Target Exceeded	Target Not Met but Improved	Pending	In Progress	-

Under the Developmental Disabilities Assistance and the Bill of Rights Act of 2000 (DD Act), each state and territory has a Developmental Disabilities Protection and Advocacy (P&A) program designated by the state's governor. The DD Act and other authorizing statutes give the P&A program the authority to advocate for the rights of individuals with disabilities. The DD Act states that each P&A program has the authority to "pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of, and advocacy for, the rights of such individuals within the State."[34] P&A programs provide a range of legal services and use a range of remedies, including self-advocacy assistance, negotiation, investigation, and litigation, to advocate for traditionally unserved or underserved individuals with developmental disabilities. P&A authorities are critical to preventing abuse and neglect of people with disabilities and safeguarding individuals' right to live with dignity and self-determination.

The formula for determining the percentage of individuals with developmental disabilities whose rights were enforced, retained, restored or expanded is the number of closed cases in which client's objective was partially or fully met plus the number of closed group cases or projects concluded successfully, divided by the total number of valid closed cases plus the total number of group cases or projects. The Administration on Disabilities program staff is continuing to work with ACL's Office of Performance and Evaluation to develop or improve logic models and performance measures for this program. ACL staff are piloting methods for collecting data and working on developing standard methods for analyzing the data to identify trends and results.

[34] 42 U.S.C. 15043

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	-	Set Baseline	-	70.3%	-	71%	-	71%
Result	-	70%	-	68.2%	-	Sep 30, 2024	-	Sep 30, 2026
Status	-	Baseline	-	Target Not Met	-	Pending	-	-

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

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

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

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	5.7%	5.6%	5.5%	5.4%	N/A	10.8%	10.6%	10.4%
Result	6.4%	5.8%	5.1%	5%	11%	Mar 31, 2024	Mar 31, 2025	Mar 31, 2026

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Status	Target Not Met but Improved	Target Not Met but Improved	Target Exceeded	Target Exceeded	Baseline	Pending	In Progress	-

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

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

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

Recently, CDC scientists were able to include multiple data sources to detect inhibitors among participants in the Community Counts program, including new cases, history of an inhibitor, and lab specimens. This more accurate representation of the population yields a new baseline where 11% of the sample population had an inhibitor as of FY 2022. Preliminary data indicates continuation of a decrease in cumulative prevalence in FY 2023. By continuing to monitor the prevalence of inhibitors in people with hemophilia subject matter experts aim to better understand factors that may contribute to the trends and assess the impact of CDC's programs and partnerships to reduce complications from bleeding disorders.

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

-	Target	Result	Status
FY 2018	Prepare for and collect PSAQ data again in FY 2018	PSAQ data collection began and is underway.	Target Met
FY 2019	Continue PSAQ data collection through 2019. The panel design of the survey features several rounds of interviewing covering two full calendar years. Data should be available in 2020.	Collected and began analysis of PSAQ data	Target Met
FY 2020	New data for the PSAQ prevention items available, Begin analysis on the FY 2018 and 2019 data collected, FY 2020 PSAQ data collection will begin	Collected new data, Continued analysis of FY 2018 and 2019 data, Began collecting FY 2020 PSAQ data	Target Met

FY 2021	2021 PSAQ data collection continues. Administer another round of the PSAQ.	Continued data analysis of the PSAQ 2018/2019 data, Complete administration of another round (2020/2021) of the PSAQ.	Target Met
FY 2022	Complete analysis of FY 2018/2019 data; New data from FY 2020/2021 will be available: Begin collecting FY 2022/2023 data	6% Baseline	Target Met
FY 2023	6%	Future results will be displayed in a quantitative performance table (below)	See below

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	-	-	-	-	Baseline	6%	5%	5%
Result	-	-	-	-	6%	6%	-	-
Status	-	-	-	-	Baseline	Target Met	In Progress	-

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

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

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

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

In FY 2023, AHRQ analyzed the CY2020 (FY2020/2021) data and completed data collection for the CY 2022 (FY 2022/2023) data. The target of 6% was maintained in FY 2023. AHRQ convened an expert

panel to provide input into an updated list of high priority clinical preventive services and a series of technical expert panels to identify strategies to improve uptake of these services.

In FY 2024, AHRQ will report estimates of the percentage of older adults who received high-priority, appropriate preventive services based on CY 2020 (FY 2020/2021) data. It is expected that rates will be reduced to 5% due to the impact of the COVID-19 pandemic on use of health care, in particular the postponement of preventive care. AHRQ expects to finalize the updated list of high priority clinical preventive services in FY 2024. AHRQ and HHS efforts in FY 2024 are expected to result in increased use of preventive services in coming years which may be reflected in the CY 2024 nationally representative survey results. AHRQ anticipates that data collection for CY 2024 (FY 2024-2025) will begin.

In FY 2025, AHRQ anticipates it will begin analysis of the CY 2022 (FY 2022/2023) data and continue data collection for the CY 2024 (FY 2024/2025). The target of 5% (from FY 2024) will be maintained. AHRQ will have completed the list of high priority clinical preventive services for measurement, which will inform future analysis and targets.

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

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

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

Objective 3.4 Table of Related Performance Measures

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	82%	82%	75%	75%	75%	75%	75%	75%
Result	74%	62%	56%	62%	42%	47%	Mar 31, 2025	Mar 31, 2026
Status	Target Not Met	Target Not Met	Target Not Met	Target Not Met but Improved	Target Not Met	Target Not Met, but Improved	In Progress	-

The staff and volunteers of the National Domestic Violence Hotline (Hotline) provide victims of family violence, domestic violence, and dating violence; family and household members; and other persons such as advocates, law enforcement agencies and the general public with crisis intervention, emotional support, safety planning, domestic violence information, and referrals to local service providers as well as national resources.

In FY 2023, the Hotline answered 419,923 total contacts across all platforms, including 257,768 calls, 70,386 chats, and 91,769 texts. This represents an overall 2023 answer rate of 47 percent, missing the target for that year, but improving over the previous year's actual result of 42 percent. In March 2022, a queue management system for digital services to optimize survivor experience on chat and text was implemented. In addition, an in-queue messaging directing survivors to the database was implemented during long waitlist, in case waiting was unsafe.

It is not feasible for 100 percent of calls received to be answered due to unanticipated spikes resulting from media coverage promoting the Hotline phone number and increases in call volume during the rollover of state or local program crisis lines during an emergency, disaster, or a national public health emergency, such as the pandemic. In addition, some situations require a caller to disconnect before an advocate can answer (e.g., the abuser enters the room). Given the expected continual rise in callers and online "chatters" contacting the Hotline, piloting a volunteer recruitment program, increased hours of training for new advocates, and increased programmatic and financial support to StrongHearts Native Helpline, the Hotline is projected to have a performance rate of 75 percent through FY 2025.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	6.7%	6.5%	6.4%	6%	6.3%	6.1%	Prior Result - 0.2PP	Prior Result - 0.2PP
Result	6.7%	6.6%	6.2%	6.5%	6.3%	Oct 31, 2024	Oct 31, 2025	Oct 31, 2026
Status	Target Met	Target Not Met but Improved	Target Exceeded	Target Not Met	Target Met	Pending	In Progress	-

The annual performance measure regarding repeat child maltreatment evaluates the trend in the percentage of children with substantiated or indicated reports who experience repeat maltreatment. ACF has set a target of decreasing the percentage of child victims who experience repeat maltreatment by 0.2 percentage points per year. For FY 2020, the rate of recurrence decreased to 6.2 percent, exceeding the target of 6.4 percent. For FY 2021, the rate of recurrence increased slightly to 6.5 percent, missing the target of 6 percent. For FY 2022, the rate of recurrence decreased to 6.3 percent, meeting the target for that year. ACF will continue to support states in their efforts to support children and families who are experiencing a crisis, while ensuring the safety of children. The CAPTA State Grant program provides formula grants to states to improve child protective service systems through a range of prevention activities, including addressing the needs of infants born with prenatal drug exposure, referring children not at risk of imminent harm to community services, implementing criminal record checks for prospective foster and adoptive parents and other adults in their homes, training child protective services workers, protecting the legal rights of families and alleged perpetrators, and supporting citizen review panels. The

renewed emphasis on prevention efforts, in tandem with funding for the Community-Based Child Abuse Prevention (CBCAP) program that also assists states in their efforts to prevent child abuse and neglect while promoting healthy parent-child relationships, may also assist in improving performance in this area. By FY 2025, the program expects to work with states in again reducing the rate of repeat maltreatment by 0.2 percent from the previous year's actual result.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	16,255	23,123	26,322	27,825	27,306	21,026[35]	10% below avg of prev 4 results	10% below avg of prev 4 results
Result	34,753	25,597	19,186	17,460	16,775	Jan 31, 2024	Jan 31, 2025	Jan 31, 2026
Status	Target Exceeded	Target Exceeded	Target Not Met	Target Not Met	Target Not Met	Pending	In Progress	-

This performance measure demonstrates the continued work of the National Human Trafficking Hotline (NHTH) in identifying potential victims of human trafficking and increasing the number of incoming communications from victims and survivors. In FY 2022, total signals to the NHTH fell by 3 percent from the all-time high observed in FY 2021, and the number of potential victims identified fell by 4 percent. ACF aims to increase incoming communications to the hotline from victims and survivors by the average of the previous four years of actual results for performance measure 17D. In FY 2021, the NHTH observed a modest increase (3 percent) in incoming communications to the hotline from victims and survivors, despite the decrease in victims identified. In FY 2022, the number of incoming signals to the hotline from potential victims and survivors fell by 25 percent. Through engagement with stakeholders and ongoing performance monitoring, OTIP has identified opportunities to strengthen the hotline's queuing system to better elevate signals from potential victims as the total number of signals to the hotline increases overall, among other operational improvements. Additional growth is anticipated in FY 2022 due to OTIP awarding a $1 million contract in September 2021 for renewal of its Look Beneath the Surface Public Awareness and Outreach Campaign. The renewed LBS Campaign is focused on improving foundational knowledge about human trafficking and education service providers and members of the public on what constitutes an actionable report to the hotline, so that hotline advocates are better able to direct their time and resources. The LBS contractors is currently developing a new strategy, including conducting formative research on audience segmentation and targeting, scalability, dissemination strategies, and metrics for evaluation of results, and accompanying anti-trafficking public awareness and outreach materials for the next iteration of the LBS Campaign. The Campaign is expected to reflect the diversity of communities impacted by human trafficking, and messages will be tailored for hard-to-reach populations and encourage those experiencing human trafficking to seek help, which will hopefully translate to increased communications to the NHTH into FY 2023 and FY 2024.

By FY 2025, ACF aims to increase incoming communications to the hotline from victims and survivors and the number of potential trafficking victims identified by the hotline by ten percent below the average

[35] The FY 2024 target is the average of the previous four years of actual results. The hotline continues to experience performance impacts from staffing shortages and a substantial increase in communications, including communications related to misinformation campaigns that hinders their ability to identify potential victims.

of the previous four years of actual results. This growth is anticipated, at least in part, due to the award of a $1 million contract in September 2021 for Look Beneath the Surface Public Awareness and Outreach Campaign Strategy and Materials. The campaign reflects the diversity of the anti-trafficking community, and messages will be targeted to reach marginalized populations and encourage those experiencing human trafficking to seek help, which will hopefully translate to increased communications to the NHTH.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	99%	99%	99%	99%	99%	99%	99%	99%
Result	69.3%	64.9%	99.27%	64%	99%	99%	Mar 1, 2025	Mar 1, 2026
Status	Target Not Met	Target Not Met	Target Exceeded	Target Not Met	Target Met	Target Met	In Progress	-

Since 2014, ACF has expanded its network of care to be able to continue increasing the percentage of placement designation of referrals of unaccompanied children from the Department of Homeland Security (DHS) within 24 hours of referral. Although the statutory requirement is 72 hours, ACF aims for UC to enter the Office of Refugee Resettlement (ORR) care as soon as possible, recognizing that border facilities are not designed to meet the needs of children. This performance measure is calculated by dividing the number of unaccompanied children who were designated for placement within 24 hours of referral by the total number of referrals per fiscal year. In FY 2017, due to a lower number of referrals and a surplus of bed capacity unoccupied, the program was directed to reduce bed capacity by approximately 30 percent. Changes to the overall bed capacity were insufficient in FY 2018 to accommodate the increase in referrals, and ORR was not able to meet this measure. In FY 2021, ORR received an unprecedented increase in unaccompanied child referrals. There were 122,731 unaccompanied children referred in FY 2021, compared to 15,381 referrals in FY 2020. This historically large influx, combined with added challenges from the COVID-19 pandemic, placed a strain on existing systems, and ORR was not able to meet the measure of designating 99 percent of referrals for placement within 24 hours. In response to continued higher volume of unaccompanied children referrals in FY 2022, the ORR Intakes Team increased its staffing footprint and implemented a new overnight team, ensuring placements for incoming referrals are continuous 24 hours a day, 7 days a week. Despite record high referrals in FY 2022 of 128,094 children and youth, and in FY 2023 of 119,123 unaccompanied children, ACF achieved the 99 percent placement designation target in both FY 2022 and FY 2023.

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

information related to admissions, discharges, and length of stay. The ORR Intakes team also tracks the daily number of unaccompanied children referrals and the number of unaccompanied children pending placement in excess of 24 hours.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	41.6%	41.6%	41.5%	37.5%	36.3%	29.6%	29.6%	30.5%
Result	38.1%	36.3%	30.2%	27.2%	28.3%	28.9%	Jan 31, 2025	Jan 31, 2026
Status	Target Not Met	Target Not Met	Target Not Met	Target Not Met	Target Not Met but Improved	Target Not Met but Improved	In Progress	-

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

Although seven of the twelve IHS Areas met or exceeded the FY 2023 target, as a whole IHS did not meet the national target of 29.6 percent, but improved performance compared to FY 2022. IHS awarded grants to 41 Tribal partners to develop IPV protocols and improve services, with four sites increasing their capacity to process forensic services. In FY 2024, the IHS Domestic Violence Prevention (DVP) program's grantees will enter into their third year of a five-year funding cycle. Thirty-seven (37) projects focus on culturally appropriate, evidence-based and practice-based models of prevention within the community. Grantees tailor prevention efforts to meet the needs of their communities and are provided with guidance on models, trainings, and resources. The four (4) Forensic Healthcare (FHC) program grantees focus on the development and/or expansion of FHC services to provide treatment, intervention, and prevention in order to address the needs of victims impacted by sexual assault and domestic violence.

Additionally, IHS encourages all 113 Tribal partners that are increasing service capacity to also report on any IPV screening and services that they experience. The first-year review of the partners' work suggests that IPV screening is increasing with the additional IHS grant support even in those communities that were initially planning on other services, such as screening for substance use disorders. Due to the sensitivity of the IPV screening, proper administration requires thorough education and trauma informed care training, ensuring health care providers know how to properly screen their patients, and that patients are comfortable in responding and without external influences. As such, the increased use of telehealth visits within a patients' homes are not necessarily meeting the safety and security recommendations for IPV assessments.

In 2023, the IHS created a guidebook titled *Forensic Health Care and Caring for American Indian and Alaska Native Patients*. This resource for providers may help ensure providers are screening patients and

includes educational information related to domestic and intimate partner violence, why screening patients is important, screening considerations, and multiple examples of validated, evidence-based screening tools.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	-	-	Set Baseline	15	15	15	16	17
Result	-	-	11	15	15	15	Dec 31, 2024	Dec 31, 2025
Status	-	-	Baseline	Target Met	Target Met	Target Met	In Progress	-

Strategies drawn from the Preventing ACEs Best Available Evidence resource are being implemented by each of the funded Preventing Adverse Childhood Experiences: Data to Action (PACE: D2A) recipients. This indicator tracks trends associated with implementing evidence-based strategies to prevent and respond to adverse childhood experiences (ACEs) and addresses the effectiveness of CDC's actions to translate science into action. CDC's mission with respect to ACEs is to prevent, identify, and respond to them using evidence-based strategies, and this indicator is the most direct measure of CDC success in that regard. The PACE: D2A initiative helps ensure states and intrastate partners have access to the best available evidence for ACEs prevention and response. In FY 2023, 15 prevention and response strategies were being implemented by funded recipients. The new Essentials for Childhood (EfC): Preventing Adverse Childhood Experiences through Data to Action programmatic initiative is planned for FY 2024. Twelve recipients will enhance state-level surveillance infrastructure and implement data-driven prevention strategies to prevent adverse childhood experiences (ACEs) and promote positive childhood experiences (PCEs). Future targets were set based on an assessment of what realistic growth may look like and recipients' capacity to increase strategy implementation.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	-	-	-	Set Baseline	2	5	7	7
Result	-	-	-	0	0	1	Dec 31, 2024	Dec 31, 2025
Status	-	-	-	Baseline	Target Not Met	Target Not Met but Improved	In Progress	-

CDC is leading efforts to prevent violence before it begins and reaching out to audiences with new prevention strategies. CDC adapts and disseminates actionable resources based on rigorous science to equip every available partner with the tools they need to build trauma-informed systems and

infrastructure. Equipping partners with the tools and resources they need to move from principle to practice of trauma-informed care in school, healthcare, housing, justice-serving, and other behavioral and mental health service spaces will help amplify CDC's impact and equip its partners to do the same. This measure ensures CDC continues to push to generate and disseminate resources on trauma-informed care for clinical settings (and other partners), to ensure that its systems responses to people who have experienced trauma is not harmful. Progress on this measure has been slower than expected which led us to not meet our goal for 2023; and we have concerns about new requirements regarding our web presence that may impact the feasibility of our future targets. Our work to generate publicly facing resources to support implementation of trauma-informed care in all settings continues, and we will ensure availability to the public. However, the venue for dissemination may include partner outlets rather than including content on the CDC's NCIPC web page. CDC is also deeply engaged in the Interagency Task Force on Trauma-Informed Care, which helps ensure that our resources reach a broader audience and are incorporated into the emerging federal strategy for a coordinated approach to TIC. That task force recently submitted a report to Congress detailing the impact of our efforts thus far and proposing next steps for continued interagency collaboration.

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

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

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

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

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

The Office of the Secretary leads this objective. All divisions are responsible for implementing programs under this strategic objective. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 4.1 Table of Related Performance Measures

By 2026, enhance understanding of how five health information technologies can be applied effectively to improve minority health or to reduce health disparities. (Lead Agency - NIH; Measure ID - SR-NIMHD-001)[36]

-	Target	Result	Status
FY 2018	-	-	-
FY 2019	-	-	-
FY 2020	-	-	-
FY 2021	Develop an adaptive smoking cessation intervention targeting adolescents of health disparity populations using the quitStart mobile application.	NIH investigators developed a new smoking cessation mobile application, QuitJourney, based on QuitGuide (not QuitSTART which is for adolescents) and conducted acceptability and usability testing with 48 young adults.	Target Met
FY 2022	Determine if a mobile phone app is effective in promoting physical activity or reducing weight among racial and ethnic minority populations.	The app *¡Hola Bebé, Adiós Diabetes!* was successfully launched, but completion of effectiveness testing has been delayed due to the COVID-19 pandemic.	Target Not Met
FY 2023	Assess the feasibility of using data mining, natural language processing (NLP), and/or other technological advances to improve health or healthcare for individuals who experience health disparities.	NIH-funded investigators leveraged natural language processing and informatics to build and pilot test the Rosie the Chatbot mobile app. The investigators assessed the application's ability to provide information that meets the maternal health and infant care needs of racial and ethnic minority mothers who experience health disparities.	Target Met
FY 2024	Identify barriers and enhancers to adoption of health information technologies, such as clinical decision aids, from the perspective of physicians who care for populations who experience health disparities.	Dec. 2024	In Progress
FY 2025	Identify barriers and enhancers to adoption of chronic disease self-management support enhanced by health IT, from the perspective of racial or ethnic minority, rural, sexual and gender minority, or socioeconomically disadvantaged patients.	Dec. 2025	-

Health information technology (health IT) refers to a variety of electronic methods that can be used to manage information about people's health and health care. Although health IT holds much promise to reduce disparities in populations that are medically underserved by facilitating behavior change and improving quality of health care services and health outcomes, few studies have examined the impact of health IT adoption on improving health outcomes and reducing health disparities among racial and ethnic

[36] SR-NIMHD-001 was previously reported as SRO-5.18. NIH has realigned the Measure ID numbers to the NIH-Wide Strategic Plan.

minority individuals, people of less privileged socioeconomic status, underserved rural populations, and sexual and gender minority populations. To better understand the potential of health IT to improve the health of populations who are medically underserved and reduce health disparities, NIH is investing in research on the use of technologies such as decision support tools, mobile apps, and natural language processing and other forms of artificial intelligence.

In FY 2023, NIH assessed the feasibility of using natural language processing to meet the maternal health and infant care needs of racial and ethnic minority mothers who experience health disparities. An NIH-supported research team developed and pilot-tested Rosie the Chatbot, a mobile application that provides pregnant and new mothers with timely information on a range of topics, such as postpartum symptoms and complications, infant health and safety (e.g., safe sleep), and baby development milestones. Mothers can access the chatbot on their computers or cell phones, in English and Spanish. Users can ask Rosie a question, and the chatbot will return an appropriate response from its extensive knowledge bank containing information from trusted sources (e.g., children's hospitals, health organizations). Building on the promising results of a three-month pilot test, the research team will begin a randomized clinical trial in FY 2024 to examine whether the use of Rosie the Chatbot by racial and ethnic minority mothers during the pregnancy and postpartum period will improve their health-seeking behavior and their and their babies' health outcomes. If proven successful, Rosie the Chatbot will provide a scalable tool that can have widespread reach across geographies and can be personalized to serve an individual's specific health information needs.

In FY 2024, NIH plans to identify barriers and enhancers to adoption of health information technologies, such as clinical decision aids, from the perspective of physicians who care for populations who experience health disparities. In FY 2025, NIH aims to identify barriers and enhancers to adopting health IT support for the self-management of chronic disease, from the perspective of racial or ethnic minority, rural, sexual and gender minority, or socioeconomically disadvantaged patients.

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 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	56.4%	64.5%	65.8%	69.3%	64.3%	66.7%	Prior Result +3PP	Prior Result +3PP
Result	61.5%	62.8%	66.3%	61.4%	63.7%	Oct 31, 2024	Oct 31, 2025	Oct 31, 2026
Status	Target Exceeded	Target Not Met but Improved	Target Exceeded	Target Not Met	Target Not Met, but Improved	Pending	In Progress	-

The most efficient and effective programs often use evidence-based and evidence-informed practices. ACF developed an efficiency measure to gauge progress towards programs' use of these types of practices. ACF is working closely with the states to promote more rigorous evaluations of their funded programs. Over time, ACF expects to increase the number of effective programs and practices that are implemented, thereby maximizing the impact and efficiency of Community-Based Child Abuse

Prevention (CBCAP) funds. For the purposes of this efficiency measure, ACF defines evidence-based and evidence-informed programs and practices along a continuum, which includes the following four categories of programs or practices: Emerging and Evidence Informed; Promising; Supported; and Well-Supported. Programs determined to fall within specified program parameters will be considered to be implementing "evidence-informed" or "evidence-based" practices (collective referred to as "EBPs"), as opposed to programs that have not been evaluated using any set criteria. The funding directed towards these types of programs (weighted by EBP level) will be calculated over the total amount of CBCAP funding used for direct service programs to determine the percentage of total funding that supports evidence-based and evidence-informed programs and practices. A baseline of 27 percent was established for this measure in FY 2006. The target of a three percentage point annual increase in the amount of funds devoted to evidence-based practice was selected as a meaningful increment of improvement that takes into account the fact that this is the first time that the program has required grantees to target their funding towards evidence-based and evidence-informed programs, and it will take time for states to adjust their funding priorities to meet these new requirements.

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

In FY 2022, states reported 63.7 percent of funds supported EBP programs. While this was an improvement, it did not meet the target of 64.4 percent. This aligned with reports from states noting they were able to resume some of the services and programs as prior restrictions were lifted yet were not back to pre-pandemic levels. Reasons reported by states included continued hesitation by some families to return to funded activities, as well as decreased capacity due to ongoing workforce challenges. Moreover, ACF has worked to tailor training and technical assistance activities to address these challenges and increase state capacity to use funds for evidence-based and evidence-informed programs. Efforts will further continue to promote evaluation and innovation, so as to expand the availability and use of evidence-informed and evidence-based programs over time and continue to set the target of an annual three percentage point increase over the prior year.

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

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

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: AHRQ, ASPE, ASPR, CDC, FDA, HRSA, NIH, OASH, OCR, and OGA. In consultation with OMB, HHS has determined that performance toward this objective is Noteworthy Progress. Work done across the department, including NIH grant-funded research, FDA Fellowships, and HRSA's Rural Health research products all exceeded their FY 2023 targets for measures to build the scientific workforce. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 4.2 Table of Related Performance Measures

By 2025, develop or evaluate the efficacy or effectiveness of new or adapted prevention interventions for substance use disorders (SUD). (Lead Agency - NIH; Measure ID - SR-NIDA-002)[37]

-	Target	Result	Status
FY 2018	-	-	-
FY 2019	-	-	-
FY 2020	Conduct three to five pilot studies to test the efficacy of promising prevention interventions for SUD.	Nine prevention pilot studies were conducted as part of the Helping to End Addiction Long-term (HEAL[SM]) Initiative.	Target Exceeded
FY 2021	Launch one to two clinical trials, based on pilot study results, to test the effects of a prevention intervention for opioid use disorder.	Two clinical trials were launched as part of the Helping to End Addiction Long-term (HEAL) Initiative®.	Target Met
FY 2022	Conduct one to two studies to test the effectiveness of prevention interventions focused on electronic nicotine delivery systems (including vaping).	NIH-funded researchers conducted two studies to test the effectiveness of prevention interventions focused on electronic nicotine delivery systems in schools, via social media and electronic cigarette advertising restrictions.	Target Met
FY 2023	Launch one to two clinical trials testing approaches to prevent opioid and other substance misuse by intervening on social determinants of health.	NIH-funded researchers conducted two clinical trials testing approaches to prevent opioid and other substance misuse by intervening on social determinants of health.	Target Met

[37] SR-NIDA-002 was previously reported as SRO-5.2. NIH has realigned the Measure ID numbers to the NIH-Wide Strategic Plan.

FY 2024	Launch preliminary epidemiological research studies to inform pilot studies that will develop novel strategies to prevent substance use among youth and young adults.	Dec. 2024	In Progress
FY 2025	Continue preliminary epidemiological research studies to inform pilot studies that will develop novel strategies to prevent substance use among youth and young adults.	Dec. 2025	-

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

In FY 2023, NIH-supported researchers launched two clinical trials testing approaches to prevent opioid and other substance misuse by intervening on social determinants of health (SDOH). While evidence-based prevention strategies exist, they are not widely implemented, and most do not address underlying socio-environmental factors that confer risk for substance use. Two studies directly target SDOH as an approach to prevent substance use and improve outcomes for youth. One clinical trial is evaluating a multi-component intervention that provides services to address multiple SDOH including economic stability, housing, educational attainment, health and social services, community context, and social support. The trial will assess whether and how the intervention improves substance use and mental health outcomes for youth experiencing homelessness. Another trial is exploring the effects of the Inclusive Skill-building Learning Approach, a school-wide intervention to reduce exclusionary discipline. By addressing educational access and school climate, SDOH domains that can significantly influence long-term outcomes for youth, including drug use and future justice system involvement, this trial aims to improve substance use and related outcomes. By evaluating upstream interventions, these studies will fill critical gaps in the field of substance use prevention.

In FY 2024, NIH will launch preliminary epidemiological research studies to inform pilot studies that will develop novel strategies to prevent substance use among youth and young adults.

Provide research training for predoctoral trainees and fellows that promotes greater retention and long-term success in research careers. (Award rate to comparison group reached) (Lead Agency - NIH; Measure ID - RC-OER-001)[38]

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	N ≥ 10%	N ≥ 10%	N ≥ 10%	N ≥ 10%	N ≥ 10%	N ≥ 10%	N ≥ 10%	N ≥ 10%
Result	11%	11%	11%	10%	9.8%	15%	Dec. 2024	Dec. 2025
Status	Target Met	Target Met	Target Met	Target Met	Target Not Met	Target Exceeded	In Progress	-

[38] RC-OER-001 was previously reported as CBRR-1.1. NIH has realigned the Measure ID numbers to the NIH-Wide Strategic Plan.

A critical part of the NIH mission is the education and training of the next generation of biomedical, behavioral, and clinical scientists. The overall goal of the NIH research training program is to maintain a population of scientists that is well educated, highly trained, and dedicated to meeting the Nation's future health-related research needs. Success of NIH predoctoral research training programs can be measured, in part, by the number of trainees and fellows that go on to apply for and receive subsequent NIH career development and research awards.

Each year, NIH assesses the degree to which predoctoral trainees and fellows who received NIH-funded training through a National Research Service Award (NRSA) are more likely to remain in research careers and successfully compete for NIH funding after the completion of their degrees. The annual target of equal to or greater than 10 percentage points is informed by a 2001 assessment showing that the percentage of NRSA-funded individuals who applied for research funding from NIH or the National Science Foundation was typically 10 percentage points higher than those who graduated from NIH-funded training institutions but who were not direct recipients of NRSA predoctoral funding. However, after evaluating recent trends indicating that an investigator's first or initial NIH award tends to be a mentored career development (K) or fellowship (F) award rather than an NIH research project grant, NIH updated its methodology to better reflect the current funding landscape and opportunities (e.g., incorporating research training fellowships in NIH's analysis criteria). Using the updated methodology in FY 2023, NIH-funded predoctoral trainees and fellows in the biomedical and behavioral sciences were 15 percentage points more likely to remain active in biomedical research than non-NIH trainees and fellows, exceeding the target of 10 percentage point difference. In FY 2024 and FY 2025, NIH will maintain the current target as an indicator to assess the impact of NRSA support on the ability of predoctoral trainees and fellows to remain competitive and sustain a research career with independent funding.

Increase the total number of National Research Service Award (NRSA) slots for high-quality research training awarded to Historically Black Colleges and Universities (HBCUs), Tribal Colleges and Universities (TCUs), Tribal Organizations (TOs), and institutions in Institutional Development Award (IDeA) states, to develop a diverse pool of well-trained scientists with the skills necessary to conduct rigorous, reproducible research and transition into careers in the biomedical research workforce. (Lead Agency - NIH; Measure ID - RC-NIGMS-002)[39]

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	-	-	-	-	-	424	498	503
Result	-	-	-	-	-	483	Dec. 2024	Dec. 2025
Status	-	-	-	-	-	Target Exceeded	In Progress	-

Research training programs are an integral part of NIH's efforts to build a strong, diverse scientific workforce. National Research Service Awards (NRSAs), authorized in 1974, are a family of fellowships and institutional training grants provided by NIH for training researchers in biomedical, behavioral, and clinical sciences. The National Institute of General Medical Sciences (NIGMS) is the only NIH institute that supports undergraduate research training programs through NRSAs, as most NIH institutes and centers fund NRSAs to support predoctoral and postdoctoral trainees. Each training program provides high-quality research training, mentored research experiences, and additional training opportunities that equip trainees with the technical, operational, and professional skills required for careers in the

[39] RC-NIGMS-002 was previously reported as CBRR-31. NIH has realigned the Measure ID numbers to the NIH-Wide Strategic Plan.

biomedical research workforce. NIGMS seeks to enhance the diversity of the biomedical research workforce by expanding the types of institutions that receive NRSA training support. Historically Black Colleges and Universities (HBCUs) and Tribal Colleges and Universities (TCUs), originally designated in the Higher Education Act of 1965, have a longstanding and current commitment to educating students with interests in studying health disparities as well as population/region specific conditions and health challenges. In addition, Institutional Development Award (IDeA)-eligible institutions in the 23 IDeA states plus Puerto Rico are in areas that have distinct populations, such as rural, low socioeconomic status, and medically underserved communities. Supporting the research training of individuals at these institutions is expected to increase the impact of NIGMS-funded biomedical research training and clinician-scientist programs across the country.

In FY 2023, NIGMS supported approximately 483 NRSAs at HBCUs, TCUs, Tribal Organizations (TOs), or institutions in IDeA states, exceeding the target of 424. In FY 2024 and FY 2025, NIGMS aims to support 498 and 503 NRSAs, respectively at the target institutions.

Maintain the yearly number of undergraduate students with mentored research experiences through the IDeA (Institutional Development Award) Networks of Biomedical Research Excellence (INBRE) program in order to sustain a pipeline of undergraduate students who will pursue health research careers. (Lead Agency - NIH; Measure ID - RC-NIGMS-001)[40]

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	Sustain Program Levels	Sustain Program Levels	Sustain Program Levels	Sustain Program Levels	Sustain Program Levels	Sustain Program Levels	Sustain Program Levels	Sustain Program Levels
Result	1,450 (estimated)	1,450 (estimated)	1,450 (estimated)	1,450 (estimated)	1,490 (estimated)	1,450 (estimated)	Dec. 2024	Dec. 2025
Status	Target Met	Target Met	Target Met	Target Met	Target Met	Target Met	In Progress	-

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

A primary goal of the INBRE is to provide research opportunities for students from PUIs, community colleges, and TCCUs, and to serve as a "pipeline" for these students to continue in biomedical research careers within IDeA states. Since each IDeA-eligible state can only hold one state-wide INBRE award, the number of students participating in the program usually remains relatively stable at around 1450-1500 students in any given year. Offering these students mentored research experiences is crucial in developing their foundation in biomedical research and their interest in pursuing health research careers. Different types of mentored research experiences are available to these students. Examples include participating in INBRE-supported internship programs that provide hands-on research experience; attending research seminars, laboratory meetings, and journal clubs; and preparing oral or poster presentations of individual research projects and presenting them to the scientific community during the

[40] RC-NIGMS-001 was previously reported as CBRR-26. NIH has realigned the Measure ID numbers to the NIH-Wide Strategic Plan.

state's annual summer research conference. In FY 2023, more than 1,450 undergraduate students participated in mentored research experiences, consistent with the FY 2022 level. In future years, NIH aims to sustain the number of undergraduate mentored research experiences at the same level as previous years.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	50%	50%	50%	20%	20%	20%	20%	20%
Result	53%	86%	80%	66%	23%	55%	Feb 28, 2025	Feb 28, 2026
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	In Progress	-

To support the Department's mission and FDA's scientific expertise, FDA is launching a new FDA Traineeship Program while continuing other Fellowship programs. This performance goal focuses on FDA's efforts to retain a targeted percentage of the scientists who complete these programs. FDA uses various strategies to attract and retain fellows by offering training in writing resumes and applying for federal jobs, as well as promoting and building affiliation with FDA by sponsoring the FDA Fellows Association, hosting the annual FDA Fellows Appreciation Day, including Fellows in FDA Scientific Achievement Group Awards, and showcasing Fellows' research at FDA's Annual Student Research Day. FDA is also working to streamline the hiring process to make it easier to convert Fellows to employees after completing the Traineeship Program. Additionally, it is important to realize that whether "graduates" from these programs continue to work for FDA or choose to work in positions in related industry and academic fields, they are trained in using an FDA-presented understanding of the complex scientific issues in emerging technologies and innovation, which furthers the purpose of this strategic objective. FDA reset the retention target to 20% in FY 2021 to reflect the new expanded program's expected baseline. Although the Traineeship program has not yet been fully implemented, and additional programs will come online over the next few years, FDA has met the initial target of 20% in FY 2023. FDA will continue to monitor and adjust the target for retention moving forward as necessary. For now, the target will remain at 20% in FY 2024 and 2025.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	14	39	39	43	43	47	47	47
Result	67	56	107	77	81	81	Oct 31, 2024	Oct 31, 2025
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	In progress	-

HRSA's Federal Office of Rural Health Policy has a statutory charge to advise the HHS Secretary on rural health policy issues across the Department, including interactions with the Medicare and Medicaid programs, and support policy-relevant research on rural health issues, consistent with HRSA's broader

focus on access and underserved populations. HRSA provides funding for the only Federal research programs specifically designed to provide publicly available, policy relevant research on rural health issues. The Rural Health Research Center Program funds eight core research centers to conduct policy-oriented health services research to assist providers and decision/policymakers at the federal, state, and local levels to better understand the healthcare-related challenges faced by rural communities and provide information that can be applied in ways that improve health care access and population health.

Through the Rapid Response Rural Data Analysis and Issue Specific Rural Research Studies Program, HRSA continues to monitor and track the number of rural hospitals across the country that have closed completely or converted to another type of facility that provides only non- inpatient care. From January 1, 2010 to December 31, 2023, 148 rural hospitals have closed completely or converted to another facility type that does not provide inpatient hospital services. HRSA has funded a number of grants that focus on addressing hospital closures, particularly mitigating the loss of services due to hospitals closing or facing financial distress.

Current research funded under these programs includes studies examining rural hospital finance, maternal health, post-acute care utilization, the extent and coverage of the Program of All-Inclusive Care for the Elderly (PACE) on rural communities and the impacts of insurance coverage changes among topic areas.

In FY 2023, these federally-funded research programs conducted and disseminated 81 research reports, including policy briefs. This was significantly above the FY 2023 target of 47 research products because several studies resulted in multiple publications. In recent years, HRSA repositioned the program to develop more robust technical research products instead of shorter research briefs. Targets for this measure in future years remain consistent to reflect the requirement of one publication per research project.

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

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

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: CDC, FDA, IHS, OASH, NIH, OGA, and SAMHSA. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 4.3 Table of Related Performance Measures

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	Set Baseline	65	70	75	80	85	85	90
Result	59	77	87	98	84	Dec 31, 2024	Dec 31, 2025	Dec 31, 2026
Status	Baseline	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	In Progress	-

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

In 2019, the standard method for outbreak detection in PulseNet changed to whole-genome sequencing (WGS) of bacteria in food that cause human illness. Tracking the progress of this new method is important because the degree to which it is adopted affects the sensitivity of outbreak detection, and multiple trends could affect PulseNet's ability to detect outbreaks in a positive or negative direction. Data indicates in FY 2022, 84% of isolates of priority PulseNet pathogens (Salmonella, Shiga toxin-producing E. coli, and Listeria monocytogenes) were sequenced and uploaded to the PulseNet National Database (Measure 3.D). These data exceeded the FY 2022 target, in part, because changes in state public health laboratories' workflows, has allowed labs to improve efficiencies to sequence most of their PulseNet organisms. With the change in PulseNet to use WGS to detect foodborne outbreaks, CDC expects to see an increase in suspected clusters of foodborne disease, which, in turn, will need to be interviewed in order to determine if they are part of an outbreak. CDC invests in improving interview capacity in state and local health departments in order to also improve the availability of data for multistate foodborne outbreak investigations. Tracking state epidemiologic interview capacity is also important to help identify and address challenges in the availability of epidemiologic data critical for multistate foodborne outbreak investigations.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	90%	90%	90%	90%	90%	90%	90%	92%
Result	96%	98%	97%	96%	97.5%	Apr 30, 2024	Apr 30, 2025	Apr 30, 2026
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	In Progress	-

As a significant health concern in the U.S., malaria, and other parasitic diseases have a tremendous impact on global morbidity and mortality, due to increased international travel, importations, and domestically

acquired infections. CDC's parasitic disease labs serve as global and national resources for ensuring efficient and high-quality analyses, which are essential to timely and accurate diagnosis and treatment.

In FY 2022, CDC labs analyzed and reported results for 97.5% of submitted specimens in a timely manner (within the expected turnaround times posted in the CDC test directory for each test), exceeding the target. A target of 90% for this measure helps ensure accountability for consistent, timely reporting. Meeting or exceeding 90% each year represents ideal performance and the flexibility to respond to unforeseen challenges, such as those associated with the COVID pandemic. While the COVID pandemic did not directly impact CDC's ability to meet this performance target, it did initially affect CDC's laboratory operations. This includes having fewer people working in labs together at the same time and social distancing. FY 2022 results reflect 8 months of diagnostic testing (February 2022-September 2022). In September 2021, CDC's Parasitic Diseases Laboratory paused all diagnostic testing operations for parasitic diseases to implement laboratory system improvements. CDC is utilizing a phased, prioritized approach for bringing tests back online. As of August 1, 2023, 18 tests have been resumed at CDC representing the vast majority (more than 90%) of historical testing volume.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	N/A	50	55	60	65	65	65	65
Result	74	68	79	86	76	65	Jan 31, 2025	Jan 31, 2026
Status	Historical Actual	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Met	In Progress	-

The Sentinel Initiative is FDA's medical product surveillance program. The Initiative is comprised of multiple components including: the Sentinel System, and its Active Risk Identification and Analysis (ARIA) program; FDA Catalyst; and the Biologics Effectiveness and Safety System. The goal of the Sentinel Initiative is to provide high quality real-world evidence to support regulatory decision-making about the performance of medical products, and this performance measure provides an estimate for the program's impact on FDA's public health mission. This performance measure captures the quantity of analyses conducted in the Sentinel System by FDA investigators to monitor the safety of drugs and therapeutic biologics. The number of analyses is a function of multiple factors beyond FDA's control, such as the nature and number of medical product safety issues, which can vary year-to-year. FDA will continue reporting the total number of analyses conducted by the Sentinel Initiative to show the scientific productivity of the system and describe its impact on public health. Prior to 2018, the Sentinel performance measure captured the number of people for whom FDA was able to evaluate product safety, based on benchmarks outlined in the Food and Drug Administration Amendments Act of 2007. FDA consistently exceeded these benchmarks, and in 2018 FDA changed the performance measure to reflect Sentinel's role as a vital source of safety information that informs regulatory decision-making and expands FDA's knowledge of how medical products perform once they are widely used in medical practice. In 2019, Congress required that FDA build on Sentinel's core successes by establishing a new Real-World Evidence Medical Data Enterprise with access to at least 10 million electronic medical records. In 2020 the performance measure was updated to capture not only Sentinel's ARIA system, which is comprised of pre-defined, parameterized, reusable routine querying tools and the electronic data in the Sentinel Common Data Model, but also activities from these other components of the Sentinel Initiative, including those conducted in response to the COVID-19 pandemic.

In FY 2023, the Sentinel System completed 65 medical product analyses, including 14 related to COVID-19 themes. In FY 2024 and FY 2025, FDA plans to leverage the knowledge acquired through the work of the Sentinel Innovation Center to develop more efficient mechanisms to access information from electronic healthcare data, such as leveraging advances in Natural Language Processing (NLP) to introduce efficiency in the chart validation process and developing de novo or adapting existing NLP. These projects, in combination with the prior Sentinel System tools and methods development work, will contribute towards the creation of a query-ready system of linked EHR-claims data and will assess the feasibility, efficiency, and accuracy of using EHR data for safety surveillance and causal inference to support FDA's postmarket safety surveillance.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	89	89	89	89	89	89	200	200
Result	216	242	137	937	1197	Feb 29, 2024	Jan 31, 2025	Jan 31, 2026
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	In Progress	-

The Indian Health Service (IHS) provides core funding support to twelve Tribal Epidemiology Centers (TECs) across Indian Country. The TECs provide critical support to the tribal communities they serve by using epidemiological data to support local Tribal disease surveillance and control programs, producing a variety of reports annually or bi-annually that describe activities and progress towards public health goals, and providing support to Tribes who self-govern their health programs. The TECs provide essential epidemiology and public health functions, including monitoring of and reporting on progress made toward meeting health status objectives and highlighting AI/AN health disparities, e.g. COVID-19 health disparities, the opioid crisis in Indian country, and the epidemic of HIV/AIDS, HCV, and sexually transmitted infections in AI/AN communities. Independent TEC goals are set as directed by their constituent Tribes and health boards.

This measure reports the number of completed trainings and technical support to Tribes and Tribal organizations and demonstrates the sustained efforts of the TECs to engage, support, train, and collaborate with the Tribes in their service area. In FY 2022, TECs completed a total of 1,197 instances of technical assistance and TEC-sponsored trainings. IHS maintains an overview of the IHS TEC program at https://www.ihs.gov/epi/tecs/ and more detail of the TEC budget is available in the IHS Congressional Justification https://www.ihs.gov/budgetformulation/congressionaljustifications/. The awardees maintain a public-facing website at https://tribalepicenters.org/.

The current TEC funding cycle (FY 2021 – FY 2025) instituted new, robust evaluation measures across the program. This evaluation structure provides TECs with the flexibility to meet the training and technical assistance needs of their Tribal partners while providing IHS with enhanced qualitative data in addition to the core quantitative measures. In FY 2023, the TEC awardees coordinated and authored a special supplemental issue to the journal *Public Health Reports*, "Public Health Matters: Insights From Tribal Epidemiology Centers." The TECs provided examples of their best practice work in a Tribal setting, described data collection activities, outlined their methods for demonstrating the value of TEC collaboration networks, and brought attention to data access issues and gaps in the current understanding of AI/AN health disparity surveillance.

During FY 2024 and FY 2025, the TECs will continue to focus on tribal public health department technical assistance. This includes building data portals, sponsoring trainings for Tribes to track service delivery, identify program sustainability resources, investing in Tribal staff capacity in grant writing and COVID-19 response, and maintaining partnerships to identify community needs. Collectively, TECs continue to identify lack of timely access to public health data sources as a significant barrier to their successful support of AI/AN communities. In the interest of responsible data stewardship, the TECs are expanding collaborations to appropriately access, manage, and work with new and existing data sources.

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

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

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, AHRQ, ASPE, CDC, CMS, FDA, HRSA, IHS, NIH, OASH, OCR, OGA, ONC, and SAMHSA. In consultation with OMB, HHS has determined that performance toward this objective is a focus area for improvement. In FY 2023, the Department developed the 2023 – 2028 HHS Data Strategy, which outlines the Department's priorities and initiatives to safely and effectively harness data to enhance the health and well-being of all Americans. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 4.4 Table of Related Performance Measures

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	100%	100%	100%	100%	100%	100%	100%	100%
Result	100%	80%	100%	100%	83.3%	100%	Feb 28, 2025	Feb 28, 2026
Status	Target Met	Target Not Met	Target Met	Target Met	Target Not Met	Target Exceeded	In Progress	-

CDC uses several indicators to measure its ability to provide timely, useful, and high-quality data. CDC is improving access to the National Center for Health Statistics (NCHS) online data sources, including

integrating and simplifying existing points of access. Projects underway include developing a scalable data query system and a single data repository with standard and searchable metadata - with the goal of improving user experiences in accessing and using NCHS data. The number of visits to the NCHS website is nearly three times more than the average number of visitors since 2015, likely due to the increased focus on available data during the pandemic. CDC interviews Federal Power Users (key federal officials involved in health and health care policy or programs) to assess their satisfaction with CDC's Health Statistics products and services, including data quality, ease of data accessibility and use, professionalism of staff, relevance of data to major health issues, and relevance of data to user needs. 100% of federal power users rated NCHS as "good" or "excellent" in data quality – reflecting an increase from its 2022 performance.

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

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

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

HHS is strengthening governance, enterprise risk management, and strategic decision making across the Department to better pursue opportunities and address risks while creating a culture of change to support continuous improvement in program and mission delivery. The Office of the Secretary leads this objective. All divisions are responsible for implementing programs under this strategic objective.

Goal 5 Objective 1 is a milestone-based objective. Two recent efforts are contributing to this objective – an ongoing update to the HHS Enterprise Risk Management maturity assessment and the Customer Experience Agency Priority Goal.

HHS was assessed as "world-class" with a "systematic" capability. The assessment noted that HHS is among leading organizations who use Enterprise Risk Management (ERM) to "lower an organization's risk exposure and drive value through benefits like better decision-making, highly targeted business strategies, and faster responses to disruption." The independent ERM assessment was completed by the American Productivity and Quality Center (APQC) and St. John’s University Center for Excellence in Enterprise Risk Management.

During 2023, HHS continues to use ERM governance to identify and promote adoption of management best practices and lessons learned during the COVID-19 pandemic. HHS plans to incorporate derived insights into its next update of its own internal ERM organizational maturity model.

In FY 2024 and FY 2025, HHS will undertake an ambitious Agency Priority Goal focused on enhancing the customer experience capabilities across the department. HHS is committed to designing and delivering services in a manner that people of all abilities can navigate. Through the APG, HHS will identify 12 projects which will modernize and implement services that are simple to use, accessible, equitable, protective, transparent, and responsive for all people of the United States.

FY 2023 ERM Milestones

- Department-wide ERM governance was updated in FY 2023. This update incorporates lessons learned from the response to COVID-19, leading practices from government, academia, non-for profit, and private industry, and the ERM Council's most up-to-date thinking. Updated Department-wide ERM governance enables HHS and the Divisions to better pursue strategic opportunities and address risks.
- The FY 2023 HHS Risk Profile was also updated, including a thoughtful assessment of HHS's "organizational health" through a "risks and opportunities lens", and incorporating "Great Power Competition" considerations (e.g., geopolitical, supply chain, national security, and cybersecurity concerns).

FY 2024 – 2025 Milestones

- ASFR ERM will update its internal ERM organizational maturity model, to incorporate leading practices benchmarked from industry, non-profits, other governments, academia & from HHS-internal reviews of lessons learned, including response to COVID-19. ERM maturity models allow HHS and the Divisions to systematically strengthen governance, decision making, and program delivery.
- By September 30, 2025, HHS will enhance foundational CX capacity by reporting on trust and other service-level experience measures for HHS operating divisions.

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

HHS supports strategies to sustain strong financial stewardship of resources. The Department continues to strengthen the financial management environment to prevent and mitigate deficiencies. HHS is focused on upholding accountability, transparency, and financial stewardship of HHS resources to ensure program integrity, effective internal controls, and payment accuracy. The Department is also building an enhanced financial management workforce that is better able to keep pace with changing contexts.

The Office of the Secretary leads this objective. All divisions are responsible for implementing programs under this strategic objective. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 5.2 Table of Related Performance Measures

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	7%	7%	6%	N/A	N/A	N/A	N/A	TBD
Result	7.56%	4.85%	3.36%	N/A	N/A	N/A	-	-
Status	Target Not Met	Target Exceeded	Target Exceeded	N/A	N/A	N/A	-	-

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

The FY 2019 foster care error rate was 4.85 percent, which exceeded the target of 7 percent. In FY 2020, ACF set an error rate target of 6.00 percent, recognizing that changes in Title IV-E Foster Care eligibility requirements made by the Family First Prevention Services Act may contribute to increased improper payments as states adjusted to changes in law affecting eligibility, particularly for children placed in child care institutions. Due to the COVID-19 pandemic, ACF made the decision to postpone IV-E reviews beginning in the Spring of 2020 until it is again safe to travel and meet onsite. Therefore, ACF has not yet conducted reviews for states subject to the updated child care institution safety check requirements. The error rate for FY 2020 was, therefore, based on updated review data for six states as well as previous years' data for other states. Encouragingly, the improper error rate decreased from 4.85 percent in FY 2019 to 3.36 percent in FY 2020 because five out of the six states that were newly reviewed had decreases in error rates. In particular, two states with large programs (and thus more impact) had substantial decreases of more than 13 percent in their state-level error rates.

Foster Care is not reporting an error rate for FY 2023 as HHS was finalizing the Title IV‐E Foster Care Eligibility Review Instrument (IV-E instrument) to reflect changes in Title IV-E eligibility requirements enacted through the Family First Prevention Services Act of 2018. In addition, HHS needed to train HHS regional staff, IV-E agencies and other stakeholders on the IV-E instrument and provide other technical assistance prior to recommencing Title IV-E reviews. HHS is planning to resume conducting onsite Title IV-E Reviews in FY 2024. In addition, once reviews resume, the reported error rate will be based only on the results of the newly completed reviews. HHS will not set a target for improvement until all states have been newly reviewed and the program reestablishes a baseline.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	$5.20	$5.20	$5.20	$5.20	$5.20	$5.20	$5.20	$5.20
Result	$5.14	$5.06	$5.51	$5.27	$4.73	Nov 30, 2024	Nov 30, 2025	Nov 30, 2026
Status	Target Not Met	Target Not Met	Target Exceeded	Target Exceeded	Target Not Met	Pending	In Progress	-

The purpose of the Child Support Services program is to provide funding to states to support state-administered programs of financial assistance and services for low-income families to promote their economic security, independence, and self-sufficiency. This performance measure calculates efficiency by comparing total IV-D dollars collected and distributed by states with total IV-D dollars expended by states for administrative purposes; this is the Child Support Performance and Incentive Act (CSPIA) cost-effectiveness ratio (CER). The formula for determining the CER is the total collections distributed, plus the collections forwarded to other states and countries for distribution, and fees retained by other states, divided by the administrative expenditures, less the non-IV-D administrative costs. In FY 2022 the national CER ratio declined to $4.73 from $5.27 when collections surged due to increased unemployment insurance benefits and economic impact payments because of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Similarly, increases in total IV-D dollars expended on program investments may decrease the CER initially, even though the investment may ultimately lead to increased program performance. Since continued fluctuations are expected, the $5.20 target is maintained through FY 2025.

ACF will continue to focus on increased efficiency of state programs through approaches such as automated systems of case management and enforcement techniques, administration simplifications, improving collaboration with families and partner organizations, and building on evidence-based innovations. The Child Support Program has continued to promote and advance key priorities that have a direct and positive impact on states, territories, and tribes and, most importantly, families. Maintaining investments in vital programs that serve to reduce poverty and improve families' economic stability are effective ways to avoid public assistance costs and save money long-term. Furthermore, the Child Support Program serves mostly families with modest incomes who are more likely to spend the child support money quickly to meet basic household needs.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	8.08%	7.90%	7.77%	N/A	9.69%[41]	5.77%	6.38%[42]	TBD
Result	8.10%	7.87%	6.78%	10.28%	5.42%	6.01%	Nov 15, 2024	Nov 15, 2025
Status	Target Not Met but Improved	Target Exceeded	Target Exceeded	Historical Actual	Target Exceeded	Target Exceeded	In Progress	-

[41] Targets are re-established as of FY 2022. FY 2019-2021 results do not reflect all states under the new eligibility methodology.
[42] CMS Improper Payment Rate targets will be established in the FY 2024 Agency Financial Report.

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

For FY 2023 reporting, CMS selected a stratified random sample of beneficiaries with a risk adjusted payment in Payment Year 2021 and reviewed medical records of the diagnoses submitted by plans for the sample beneficiaries. CMS provides interim finding reports to MAOs during the documentation submission window, detailing preliminary results as well as suggested remedies for the potential discrepancies. CMS also conducts training and provides other educational materials to ensure MAOs understand the IPM medical review requirements. At the conclusion of the IPM sample cycle, CMS provides a Final Finding Report to each participating MAO, allowing them to validate discrepancies and make data corrections as appropriate.

The Medicare Part C improper payment result for FY 2023 is 6.01 percent, or $16.55 billion. Because the FY 2023 target of 5.77 percent is within the 95% confidence internal for the FY 2023 Medicare FFS improper payment estimate, the target was exceeded. Information on the Medicare Part C improper payment methodology can be found in the FY 2023 Department of Health and Human Services (HHS) Agency Financial Report (AFR).[43]

The FY 2024 Medicare Part C improper payment rate will be reported in the FY 2024 HHS AFR published on November 15, 2024, with a target of 6.38 percent. In accordance with Office of Management and Budget guidance, CMS establishes improper payment rate targets only for the next fiscal year, and therefore, the FY 2025 target will be established in the FY 2024 HHS AFR.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	1.66%	1.65%	0.74%	1.14%	1.2%[44]	1.64%	N/A[45]	TBD
Result	1.66%	0.75%	1.15%	1.33%	1.54%	3.72%	Nov 15, 2024	Nov 15, 2025
Status	Target Met	Target Exceeded	Target Not Met	Target Not Met	Target Not Met	Target Not Met	In Progress	-

The Part D improper payment measurement (IPM) methodology estimates the payment error related to Prescription Drug Event (PDE) data, where most errors for the program exist. CMS measures inconsistencies between information reported on PDEs and supporting documentation submitted by Part D sponsors, including prescription record hardcopies (or medication orders as appropriate) and detailed

[43] In FY 2023, CMS implemented a revised sample allocation methodology which yields a more precise overall error estimate. In FYs 2021 and FY 2022, CMS implemented methodology and policy changes, and FY 2023 establishes a baseline. The FY 2023 error rate calculation follows those previously implemented policy changes. While FY 2023 and FY 2022 are comparable, they are not directly comparable to earlier reporting years.
[44] Targets are re-established as of FY 2022. FY 2019-2021 results do not reflect all states under the new eligibility methodology.
[45] CMS Improper Payment Rate targets will be established in the FY 2024 Agency Financial Report.

claims information. Based on these reviews, each PDE in the audit sample is assigned a gross drug cost error. A representative sample of beneficiaries undergoes a simulation to determine the Part D improper payment estimate. CMS provides interim finding reports to Part D plan sponsors during the documentation submission window, detailing preliminary results. CMS also conducts training and provides other educational materials to ensure Part D plan sponsors understand the IPM clinical review requirements. At the conclusion of the IPM sample cycle, CMS provides a Final Finding Report to each participating Part D plan sponsor, allowing it to validate discrepancies and make data corrections as appropriate.

The Medicare Part D improper payment result for FY 2023 is 3.72 percent, or $3.35 billion**.** This does not meet the FY 2023 target of 1.64 percent. Information on the Medicare Part D improper payment methodology can be found in the 2023 Department of Health and Human Services (HHS) Agency Financial Report (AFR). The increase from the prior year's estimate of 1.54 percent is attributed to the multiple methodological changes implemented for the FY 2023 improper payment estimate.[46]

The FY 2024 Medicare Part D improper payment rate will be reported in the FY 2024 HHS AFR published on November 15, 2024. There is no target for FY 2024 because numerous methodology changes were implemented in the FY 2023 reporting period and a baseline has not yet been established. In accordance with Office of Management and Budget guidance, CMS establishes improper payment rate targets only for the next fiscal year; therefore, the FY 2025 target will be established in the FY 2024 HHS AFR.

To meet the FY 2025 and future targets, CMS reviews strategies and actions annually to ensure corrective actions address the root causes of the improper payments and increase the likelihood that programs meet targets, reduce improper payment estimates, or perform other activities to strengthen program integrity. If targets are not met, CMS develops new strategies, adjusts staffing and other resources, or revises targets. Because actions vary and are implemented on a concurrent or continuous basis, it can be difficult to establish key milestones and target completion dates for individual activities. Despite these challenges, CMS evaluates the impact of mitigation strategies and corrective actions to refine program integrity activities.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	9.40%	8.00%	7.15%	6.17%	6.16%	7.36%	7.28%[47]	TBD
Result	8.12%	7.25%	6.27%	6.26%	7.46%	7.38%	Nov 15, 2024	Nov 15, 2025
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met but Improved	Target Not Met	Target Met	In Progress	-

[46] CMS methodology changes included: adjusting the methodology to recognize payment errors resulting from the use of incorrect benefit parameters, using a more appropriate sampling unit, and applying more accurate parameter assumptions when benefit parameters are missing or incomplete. Due to the methodology changes introduced in FY 2023, the rates for FY 2022 and FY 2023 are not comparable.
[47] CMS Improper Payment Rate targets will be established in the FY 2024 Agency Financial Report.

The Medicare Fee-for-Service (FFS) improper payment rate is calculated by the Comprehensive Error Rate Testing (CERT) program and reported in the Department of Health and Human Services (HHS) Agency Financial Report (AFR) on an annual basis. The CERT program selects a statistically valid stratified random sample of Medicare FFS claims from a population of claims submitted for payment. CMS performs a complex medical review on the sample of Medicare FFS claims to determine if the claims were properly paid under Medicare coverage, coding, and billing rules. The CMS improper payment measurement programs support our programs' sustainability for future generations by serving as a responsible steward of public funds.

The Medicare FFS improper payment estimate for Fiscal Year (FY) 2023 is 7.38 percent, or $31.23 billion. Because the FY 2023 target of 7.36 percent is within the 95% confidence internal for the FY 2023 Medicare FFS improper payment estimate, the target was met. Information on the Medicare FFS improper payment methodology can be found in the FY 2023 HHS AFR.

CMS has developed corrective actions for specific service areas with high improper payment estimates, including SNF, hospital outpatient, hospice, and IRF. CMS believes targeted corrective actions will prevent and reduce improper payments in these areas. Many of CMS' corrective actions center around prior authorization, medical review, and targeted probe and education efforts. CMS also uses automation, billing reviews, and the fraud prevention system to address improper payments. Detailed information on these corrective actions can be found in Section 7.1 of the FY 2023 HHS AFR.

The FY 2024 Medicare FFS improper payment rate will be reported in the FY 2024 HHS AFR published on November 15, 2024, with a target of 7.28 percent. In accordance with Office of Management and Budget guidance, CMS establishes improper payment rate targets only for the next fiscal year, and therefore the FY 2025 target will be established in the FY 2024 HHS AFR. To meet the FY 2024 and future targets, CMS reviews strategies and actions annually to ensure corrective actions address the root causes of the improper payments and increase the likelihood that programs meet targets, reduce improper payment estimates, or perform other activities to strengthen program integrity. If targets are not met, CMS develops new strategies, adjusts staffing and other resources, or revises targets. Because actions vary and are implemented on a concurrent or continuous basis, it can be difficult to establish key milestones and target completion dates for individual activities. Despite these challenges, CMS evaluates the impact of mitigation strategies and corrective actions to refine program integrity activities.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	7.93%	N/A	N/A	N/A	18.94%	12.68%	7.34%[48]	TBD
Result	9.79%	14.90%	21.36%	21.69%	15.62%	8.58%	Nov 15, 2024	Nov 15, 2025
Status	Target Not Met but Improved	Historical Actual	Historical Actual	Historical Actual	Target Exceeded	Target Exceeded	In Progress	-

[48] CMS Improper Payment Rate targets will be established in the FY 2024 Agency Financial Report.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	8.2%	N/A	N/A	N/A	27.88%	21.04%	10.28%[49]	TBD
Result	8.57%	15.83%	27%	31.84%	26.75%	12.81%	Nov 15, 2024	Nov 15, 2025
Status	Target Not Met but Improved	Historical Actual	Historical Actual	Historical Actual	Target Exceeded	Target Exceeded	In Progress	-

The Payment Error Rate Measurement (PERM) program measures improper payments for the FFS, managed care, and eligibility components of both Medicaid (MIP9.1) and CHIP (MIP9.2). CMS measures improper payments in 17 states each year to calculate a rolling, three-year national improper payment rate for both Medicaid and CHIP.

The national Medicaid and CHIP improper payment results for FY 2023 is 8.58 percent, or $50.33 billion, with national Medicaid component rates of 6.90 percent for Medicaid FFS, 0.00 percent for Medicaid managed care, and 5.95 percent for the Medicaid eligibility component. The national CHIP improper payment result for FY 2023 is 12.81 percent, or $2.14 billion, with national CHIP component rates of 7.09 percent for CHIP FFS, 0.59 percent for CHIP managed care, and 10.86 percent for the CHIP eligibility component. These improper payment rates exceeded the FY 2023 targets of 12.68 percent and 21.04 percent, respectively. Information on the Medicaid and CHIP improper payment methodology can be found in 2023 Department of Health and Human Resources (HHS) Agency Financial Report (AFR).[50]

CMS has developed corrective actions the agency will implement to prevent and reduce improper payments in Medicaid and CHIP. CMS collaborates with states to establish an effective state-specific corrective action plan process, offering enhanced technical assistance and guidance. In addition, CMS conducts eligibility determination audits in high-risk states, provides training and support to state Medicaid program integrity officials through the Medicaid Integrity Institute, and provides resources and guidance to support states' provider enrollment processes. Detailed information on these corrective actions can be found in Sections 7.4 and 7.5 of the Payment Integrity Report of the FY 2023 HHS AFR.

The FY 2024 Medicaid and CHIP improper payment rate will be reported in the FY 2024 HHS AFR published on November 15, 2024, with a target of 7.34 percent for Medicaid and 10.28 percent for CHIP. In accordance with Office of Management and Budget guidance, CMS establishes improper payment targets only for the next fiscal year, and therefore, the FY 2025 target will be established in the FY 2024 HHS AFR.

[49] CMS Improper Payment Rate targets will be established in the FY 2024 Agency Financial Report.

[50] In FY 2023, CMS implemented a revised sample allocation methodology which yields a more precise overall error estimate. In FYs 2021 and FY 2022, CMS implemented methodology and policy changes, and FY 2023 establishes a baseline. The FY 2023 error rate calculation follows those previously implemented policy changes. While FY 2023 and FY 2022 are comparable, they are not directly comparable to earlier reporting years.

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

HHS supports strategies to uphold effective and innovative human capital resource management. HHS is focused on building and sustaining a strong workforce through improved recruitment, hiring, and retention efforts. The Department is leveraging training and professional development opportunities to develop and manage a high-performing workforce while providing leaders and managers with the insight and tools to effectively carry out change management, organizational learning, and succession planning.

The Office of the Secretary leads this objective. All divisions are responsible for implementing programs under this strategic objective. In consultation with OMB, HHS has determined that performance toward this objective a focus area for improvement. In 2022, HHS retained its second-place position in Best Places to Work in the Federal Government® Rankings. The Department remains committed to continuing to improve the work experience, opportunities for growth, and employee engagement as key factors for navigating a dynamic shift to a post-pandemic landscape. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 5.3 Table of Related Performance Measures

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

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

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	-	-	-	-	80%	80.5%	81%	81.5%
Result	-	-	-	-	79.5%	80%	Dec 31, 2024	Dec 31, 2025
Status	-	-	-	-	Target Not Met	Target Not Met	In Progress	-

One of the five key drivers of employee engagement, Intrinsic Work Experience, considers employees' feelings of motivation and competency related to their role in the workplace, such as sense of accomplishment and their perception of their skill usage. Compared to other very large and large federal

agencies, HHS continues to excel in this area, and in FY 2023 initiated an employee engagement initiative to further improve employee motivation[51].

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	-	-	-	-	68%	68.5%	69%	69.5%
Result	-	-	-	-	71.9%	84%	Dec 31, 2024	Dec. 31, 2025
Status	-	-	-	-	Target Exceeded	Target Exceeded	In Progress	-

Employee Satisfaction with Opportunities for Professional Development and Growth reflects the employees' perceptions of the opportunities they have to improve their skills in their organization and if their talents are used well in the workplace. The HHS Learning Management System (LMS), used across the Department, manages the administration, documentation, tracking, and reporting of training programs, classroom and online events, e-learning programs, and training content.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	72.5%	73%	75%	73%	77%	77.5%	78%	78.5%
Result	72.8%	73.5%	76.5%	77.4%	77.9%	78%	Dec 31, 2024	Dec 31, 2024
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	In Progress	-

Employee engagement is foundational to achieving the level of active strategic management needed for building and sustaining the 21st century workforce. The OPM Federal Employee Viewpoint Survey (FEVS) measures employee engagement because it drives performance. Engaged employees look at the whole of the organization and understand their purpose within the agency's mission. This understanding leads to better decision-making. In FY 2023, HHS initiated an Employee Engagement Initiative, aimed at strengthening the connections HHS employees feel to their work and to the organization.

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

HHS supports strategies to ensure the security of HHS facilities, technology, data, and information, while advancing environment-friendly practices. HHS is focused on shifting the culture of data use across the enterprise to maximize the power of data. The Department is leveraging modernization as a gateway to

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

strengthened cybersecurity and enhanced risk management. HHS also captures and applies lessons learned from real-world experiences to strengthen operational resilience.

The Office of the Secretary leads this objective. All divisions are responsible for implementing programs under this strategic objective. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 5.4 Table of Related Performance Measures

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	Set Baseline	96.5	97%	100%	100%	100%	100%	100%
Result	96%	95%	98%	99%	99%	99%	Dec 31, 2024	Dec. 31, 2025
Status	Baseline	Target Not Met	Target Exceeded	Target Not Met but Improved	Target Not Met	Target Not Met	In Progress	-

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

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

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	-	-	-	-	95%	95%	95%	95%
Result	-	-	-	-	96%	95%	Dec 31, 2024	Dec 31, 2025
Status	-	-	-	-	Target Exceeded	Target Met	In Progress	-

Phishing is a fraudulent attempt to obtain sensitive information (e.g., usernames and passwords) to access a system or network. Phishing attacks remain one of the main threat vectors targeting HHS and the healthcare industry. HHS trains and educates its personnel to reduce the likelihood of staff mistaking phishing email attempts for legitimate communications through a combination or training, education, and tools.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	-	-	-	-	2%	2%	2%	2%
Result	-	-	-	-	8.7%	-16.7%	Jan 31, 2025	Jan 31, 2026
Status	-	-	-	-	Target Exceeded	Target Not Met	In Progress	-

*This table represents the percent reduction of GHG emissions.

HHS uses the DOE Federal Energy Management Program greenhouse gas emissions (GHG) emissions report to identify high emission categories and targets specific actions to address the identified high emission areas. HHS is currently focused on Scope 1 and 2 GHG emissions generated by energy use in building and laboratory operations. HHS also continues to promote green commuting habits for employees to reduce GHG emissions. HHS transportation guidance and programs emphasize public transportation, car and van pools, and teleworking via transit subsidies, enhanced access to public transportation, and employee outreach. In FY 2022, R22 refrigerant was recovered from 2 chillers at the Bethesda Campus Centrally Utility Plant (CUP) due to condenser tube failures, which led to decreased emissions. In FY 2023, the chillers were repaired and refilled, adding additional fugitive gases back into HHS emission measurements. Additionally, that there was also an update to eGrid emissions factors which attributed to a 4% increase in electricity emissions.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	-	-	-	-	44%	46%	48%	50%
Result	-	-	-	-	72.6%	66.2%	Jan 31, 2025	Jan 31, 2026
Status	-	-	-	-	Target Exceeded	Target Exceeded	In Progress	-

*This table represents the actual diversion rate of HHS-owned facilities municipal solid waste.

HHS continues to prevent and reduce waste and pollution by diverting waste to landfills and eliminating single use plastic by promoting closed loop recycling processes.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	-	-	-	-	2%	2%	2%	2%
Result	-	-	-	-	-0.6%	4.97%	Jan 31, 2025	Jan 31, 2025
Status	-	-	-	-	Target Not Met	Target Exceeded	In Progress	-

*This table represents percent reduction of energy intensity from the prior year.

HHS is improving facility energy efficiency through dedicated energy reduction projects, renovations and upgrade projects, and new construction. Facility evaluations identify projects that can be bundled into performance contracts or with scheduled upgrades and renovations. HHS also encourages employee energy efficiency awareness via outreach that informs the HHS workforce on ways to improve facility energy efficiency.

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

-	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Target	-	-	-	-	2%	2%	2%	2%
Result	-	-	-	-	-11.4%	22.4%	Jan 31, 2025	Jan 31, 2025
Status	-	-	-	-	Target Not Met	Target Exceeded	In Progress	-

*This table represents percent reduction of water intensity from the prior year.

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

Major Management Priorities

The HHS OIG has identified the top management and performance challenges for 2023. HHS management is committed to working toward resolving these challenges. The performance measures in this document track such challenges safeguarding public health, ensuring the financial integrity of HHS programs, delivering value, quality and improved outcomes in Medicare and Medicaid, protecting the health and safety of HHS beneficiaries, harnessing data to improve the health and well-being of individuals, and improving collaboration to better serve our Nation. In addition, HHS employs a robust program integrity process. For further information about these challenges, please read the HHS 2023 Top Management and Performance Challenges.

Cross-Agency Collaborations

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

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

Lower-Priority Program Activities

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

Evidence Building Efforts

OMB Circular A-11, Section 210.11 requires the Annual Performance Reports to describe evaluations or other relevant evidence activities, and how a portfolio of evidence is used to inform decision-making. Evaluation and analysis provide essential evidence for HHS to understand how its programs work, for whom, and under what circumstances. In addition to performance measurement, HHS builds evidence through evaluation, foundational fact finding and policy analysis in order to inform decisions in the budget, legislative, regulatory, strategic planning, program, and policy arenas. Given the breadth of work supported by HHS, the Department conducts many evaluations each year that range widely in scope, scale, design, and methodology. In accordance with the HHS Evaluation Policy, these evaluations are published on Agency websites and selected significant evaluations are featured in the HHS Annual Evaluation Plans.

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

Evaluation at HHS: Across HHS, evaluation comes in many forms and focuses on "systematic analysis of a program, policy, organization, or component of these to assess effectiveness and efficiency". HHS uses both classic and innovative methods to achieve the Evidence Act's goal of improving the infrastructure needed to produce and use evidence for policy development, and to better obtain and make use of existing data. The HHS evaluations presented in this report include formative studies focused on program design and implementation and summative designs focused on measuring program results. When taken together these evaluations work to address the priority evaluation questions set out in HHS' Evidence Building Plan by either building upon other evidence-building activities or laying the foundation for evidence-building activities.

Disseminating Evidence: HHS disseminates findings from a variety of evaluations and analyses to the public on HHS agency websites, such as those operated by ACF's Office of Planning, Research, and Evaluation, and CMS's Innovation Center. HHS coordinates its evaluation community by regularly convening the HHS Evidence and Evaluation Council, which builds capacity by sharing best practices and promising new approaches across the department. In addition to building evidence through a broad range of rigorous empirical studies, analysis, and evaluations, HHS supports multiple clearinghouses that catalog, review, and disseminate evidence related to programs. Examples include the ACF Research and Evaluation Clearinghouses on Self-Sufficiency, Pathways to Work, Home Visiting, and Child Care and Early Education; the AHRQ United States Preventive Services Task Force; the CDC Community Guide; the FDA Real World Evidence framework, the IHS Best and Promising Practices Resources, and the SAMHSA Evidence-Based Practices Resource Center.

Building Evidence-Building Capacity: In addition to assessing Evidence-Building capacity every four years in conjunction with the development of the HHS Strategic Plan, HHS conducts annual capacity assessment updates. These updates are part of the Department's multi-year approach for addressing the primary capacity building needs identified through the initial FY2023-2026 HHS Capacity Assessment. The reports provide information regarding HHS' capacity improvements, ongoing capacity building activities, promising practices, opportunities for growth, and resources needed to support current and future capacity building efforts.