DEPARTMENT
of HEALTH
and HUMAN
SERVICES

Health Resources and
Services Administration

FY 2008 Annual Performance Report

INTRODUCTION

This FY 2008 Annual Performance Report provides information on the Health Resources and Services Administration's actual performance and progress in achieving the goals established in the FY 2008 Annual Performance Plan which was published in February 2007.

The goals and objectives contained within this document support the Department of Health and Human Services' Strategic Plan (available at http://aspe.hhs.gov/hhsplan/2007/.)

DATA QUALITY ASSURANCE STATEMENT

To the best of my knowledge, the performance data reported by the Health Resources and Services Administration (HRSA) in this 2008 Annual Performance Report are accurate, complete, and reliable.

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SUMMARY OF PERFORMANCE TARGETS AND RESULTS

FY	Total Targets	Results Reported		Targets		
		Number	%	Met	Not Met	% Met
2005	107	107	100%	79	28	74%
2006	141[*]	134	95%	88	46	66%
2007	139	104	75%	72	32	69%
2008	135	29	21%	25	4	86%
2009	118	-	-	-	-	-

[*] FY 2006 data will not be available for six (6) of these measures.

PERFORMANCE DETAILS

PRIMARY HEALTH CARE

Programs included in this section are:

- Health Centers
- Free Clinics Medical Malpractice
- Hansen’s Disease Activities

HEALTH CENTERS

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Increase the utilization of preventive health care and chronic disease management services, particularly among underserved, vulnerable, and special needs populations.								
1.II.B.2	Rate of births less than 2500 grams (low birth weight) to prenatal Health Center patients compared to the national low birth weight rate. (Baseline – 2005)	-11.0% 7.3% (HC) 8.2% (Nat.)	-7.2% 7.7% (HC) 8.3% (Nat.)[a]	-11.0%	Feb-09	-11.0%	Nov-09	-11.0%
1.II.B.3	Percentage of adult Health Center patients with diagnosed hypertension whose blood pressure is under adequate control (less than or equal to 40/90). (Baseline – 2005)	42.7%	44.4%	42.8%	DNA[b]	42.9%	Aug-09	43.0%
1.II.B.4	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%). (Baseline – 2008) **(Developmental)**						TBD Aug-09	TBD Sept-09

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Expand the capacity of the health care safety net.								
1.I.A.1	Number of patients served by Health Centers (in millions). [Baseline – 2005]	14.1	15	16.1	16.1	16.75	Aug-09	16.85
1.D.I.A.2	Total new or expanded sites.	158	122	302	337	62	61	0
Long-Term Objective: Increase the utilization of preventive health care and chronic disease management services, particularly among underserved, vulnerable, and special needs populations.								
1.II.B.1	Increase percentage of pregnant Health Center patients beginning prenatal care in the first trimester.	60.4%	61.3%	61.9%	61.3%	61.5%	Aug-09	61.6%

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Expand the availability of health care, particularly to underserved, vulnerable, and special needs populations.								
1.II.A.1	Percentage of Health Center patients who are at or below 200% of poverty. (number in millions)	91.5% 12.93	91.9% 13.81	86% 13.85	91.4% 14.67	86%	Aug-09	86%
1.II.A.2	Percentage of Health Center patients who are racial/ethnic minorities. (number in millions)	64% 9	64% 9.35	64% 9.57	DNA[c]	DNA[c]	DNA[c]	DNA[c]
1.II.A.3	Percentage of Health Center patients who are uninsured. (number in millions)	40% 5.6	40% 5.99	41% 6.6	39% 6.24	41%	Aug-09	41%
Long-Term Objective: Expand the capacity of the health care safety net.								
1.I.A.2	Percentage of grantees that provide the following services either on-site or by paid referral: a) Pharmacy	85%	83%	83%	82%	83%	Aug-09	83%
	b) Preventive Dental Care	84%	83%	82%	83%	82%	Aug-09	82%
	c) Mental Health/ Substance Abuse	77%	79%	74%	80%	74%	Aug-09	74%
Efficiency Measure								
1.E	Percentage increase in cost per patient served at Health Centers.	2.1%	4.6%	5.3%	4.5%	5.6%	Aug-09	5.8%

Notes:

[a] The National data for low birth weight (1.II.B.2) in FY 2006 is preliminary.

[b] DNA = Data not available for 1.II.B.3 due to change in data source for this measure. Previous data were collected from Health Disparity Collaboratives. In FY 2009 the data will be available from the Uniform Data System.

[c] DNA = Data not available. Due to modifications in data collection, data will not be available for 2007-2009. For FY 2008 and FY 2009 the previously published target was 64%.

INTRODUCTION

Health Centers are community-based and patient-directed organizations that serve populations lacking access to high quality, comprehensive, and cost-effective primary health care. The Health Center Program's performance measures help the Program track progress in reaching Health Resources and Services Administration's (HRSA) Strategic Plan goals of improving access to care, improving the quality of care, improving health outcomes and eliminating health disparities. The more specific HRSA objectives the Program aims to achieve include: increase the utilization of preventive health care and chronic disease management services, expand the availability of health care, and expand the capacity of the health care safety net. The Health Center Program has funded new and expanded Health Center organizations as a major strategy to reaching performance goals relating to the numbers of patients served and their demographic mix. Efforts to achieve other performance goals involve strategies that include: sharing best practices so that health centers learn from one another what works in improving quality and performance; providing technical assistance and training on issues such as quality improvement and risk management; enhancing health information technology assistance; and support of a unique model of health care delivery that emphasizes prevention, health-related enabling services, outreach, follow-up, and cultural competency services.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Increase the utilization of preventive health care and chronic disease management services, particularly among underserved, vulnerable, and special needs populations.

1.II.B.2. Rate of births less than 2500 grams (low birth weight) to prenatal Health Center patients compared to the national low birth weight rate.

Appropriate prenatal care management can have a significant effect on the incidence of low birth weight (LBW) which is the risk factor most closely associated with neonatal mortality. In turn, improvements in infant birth weight can contribute significantly to reductions in infant mortality rates. This measure reflects both on quality of care and health outcomes for Health Center women of child-bearing age, a key group served by the program.

This measure is benchmarked to the national rate to demonstrate how Health Center performance compares to performance of the Nation overall. The goal is to achieve a rate that is 11% below the national average even as Health Centers continue to serve a higher-risk prenatal population than represented nationally in terms of socio-economic status, health status and other risks factors that might predispose Health Center patients to higher risk for low birth weight and adverse birth outcomes.

In 2006, 7.7% of Health Center patients had low birth weight infants, a rate that was 7.2% lower than seen nationally (8.3%, 2006 national low birth weight rate). (See section below on “Targets Substantially Exceeded or Not Met.”) In addition, Health Center low birth weight rates have continued to follow a steady pattern at about 7%, unlike increases observed in the National rate. As indicated above, the FY 2009 target is to achieve a rate of 11% below the National rate, as previously achieved in 2005.

1.II.B.3. Percentage of adult Health Center patients with diagnosed hypertension whose blood pressure is under adequate control (less than or equal to 140/90).

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 disparities.

This measure focuses on quality of care and improved health outcomes for one of the most prevalent chronic conditions facing Health Center patients, hypertension. Clinical evidence indicates that controlling blood pressure (hypertension) can reduce the health risk associated with the conditions such as heart disease and stroke. An analysis of billing data reported in the Uniform Data System (UDS) over a five year period from 2001-2006, indicates a steady increase in the percentage of patients with a primary diagnosis of hypertension during the reporting year

(13.9% to 15.3%).

In 2004 and 2005, 42.7% of hypertensive Health Center patients had their blood pressure under control. In 2006, the figure was 44.4%, exceeding the target of 42.7%. The FY 2008 and FY 2009 targets are 42.9% and 43%, respectively. The Program proposes to demonstrate improvements in a chronic condition that requires treatment with both lifestyle modifications, usually as the first step, and, if needed, with medications. Lifestyle factors to treat high blood pressure include weight control, exercise, healthy diet, limiting alcohol use, and other lifestyle modifications that are often challenging interventions that improve only slowly over time. National data supports this as according to CDC data for 1999-2002, only 32% of adults demonstrated adequate high blood pressure control. The 2009 target is slightly below the most recent actual performance because this single data point is not enough information upon which to base a new projection, and because there will be a change in the data source for this measure as noted below.

This measure replaces a previous, related measure in which control of hypertension was self-reported via the periodic Health Center User Survey last conducted in 2002. Previously, data for this measure was reported by a subset of grantees participating in the Health Disparities Collaboratives. Future progress on the measure will be reported annually by all grantees via the UDS beginning in 2009.

1.II.B.4. Percentage of adult Health Center patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control.

This measure also focuses on quality of care and improved health outcomes for one of the most prevalent chronic conditions facing Health Center patients, diabetes. An analysis of billing data reported in the UDS over a five year period from 2001-2006, indicates a steady increase in the percentage of patients with a primary diagnosis of diabetes during the reporting year (5.6% to 7.1%).

Uncontrolled diabetes can lead to non-traumatic amputations, blindness, end-stage renal disease, and hospitalizations for diabetes-associated cardiovascular disease. These and other health problems associated with diabetes contribute to an impaired quality of life, substantial disability among people with diabetes and resulted in an estimated $92 billion in direct costs nationally in 2002.

Clinical evidence indicates that controlling blood glucose through such activities as chronic care management provided in Health Centers benefits people with either type 1 or type 2 diabetes. In general, for every 1% reduction in results of A1C blood tests (e.g., from 8.0% to 7.0%), the risk of developing eye, kidney, and nerve disease is reduced by 40%.

This measure is developmental and future progress will be monitored and reported annually by all grantees via the UDS beginning in 2009. The FY 2009 target will be established after the collection of baseline data.

Long-Term Objective: Expand the capacity of the health care safety net.

1.I.A.1. Number of patients served by Health Centers.

Monitoring the number of patients served annually by Health Centers is key to assessing the program's performance in increasing access to care for underserved and vulnerable populations. Not only do Health Center patients gain access to care, they gain access to a comprehensive health care home (also referred to as medical home). A health care home is a regular/usual, continuous, and patient-centered source of primary care, such as that offered by Health Centers. A health care home prevents sickness, manages chronic illness, and reduces the need for avoidable, costlier care such as emergency room visits and hospitalizations. This is key as an estimated 56 million Americans lack access to a health care home because they live in communities where there is an acute shortage of primary care providers. The lack of such physicians is associated with higher mortality rates and health care disparities (The National Association of Community Health Centers (NACHC) and the Robert Graham Center: 2007).

The number of patients served by Health Centers reached 15 million in 2006 and 16.1 million in 2007. The 16.1 million patients served by Health Centers in 2007 met the projected Program target and is over one million additional patients than served in 2006. Health Centers are projected to serve 16.75 million patients by the end of 2008 and reach 16.85 million patients by the end of 2009.

1.D.I.A.2. Total number of new or expanded sites.

The Health Center Program supported a total of 337 new and expanded sites in FY 2007 and 61 new and expanded sites in FY 2008. The Program has accomplished its goal of establishing 1,200 new or expanded sites since 2002, with a total of 1,297 new or expanded sites created from FY 2002 through FY 2008.

Long-Term Objective: Increase the utilization of preventive health care and chronic disease management services, particularly among underserved, vulnerable, and special needs populations.

1.II.B.1. Percentage of pregnant Health Center patients beginning prenatal care in the first trimester.

Monitoring timely entry into prenatal care assesses both quality of care as well as Health Center outreach efforts and focuses on a process that is associated with improving birth outcomes. Identification of maternal disease and risks for complications of pregnancy or birth during the first trimester can help reduce the risk of low birth weight. Results over the past few years demonstrate improved performance as the percentage of pregnant Health Center patients that began prenatal care in the first trimester grew from 57.8% in 2000 to 61.3% in 2007, slightly less than the target of 61.9%.

The Health Center program anticipates increasing the percentage of pregnant patients beginning prenatal care in the first trimester to 61.5% in 2008 and 61.6% in 2009.

Long-Term Objective: Expand the availability of health care, particularly to underserved, vulnerable, and special needs populations.

1.II.A.1. Percentage of Health Center patients who are at or below 200% of poverty.

To improve the health status of the Nation's underserved communities and vulnerable populations, safety-net programs must target access to care for people of low income. According to 2006 UDS Health Center data, nearly 92% of patients were at or below 200% of the Federal Poverty Level. In 2007, the figure was 91.4%, which exceeded the Program target of 86%. The FY 2009 target will continue to be 86%, due, in part, to factors outside the control of the Program such as fluctuations in the economy that impact poverty levels, unemployment, and insurance levels.

1.II.A.2. Percentage of Health Center patients who are racial/ethnic minorities.

To improve the health status of the nation's underserved communities and vulnerable populations, safety-net programs must target access to care for people of racial/ethnic minority groups. According to UDS Health Center data, in CY 06 the population served was 23.0% African American (AA), 36.1% Hispanic, and 4.5% Asian/Other for a rounded total of 64%, meeting the target. These percentages represent almost twice the percentage of African Americans and almost two and a half times the percentage of Hispanics reported in the overall U.S. population. It is currently estimated that the percentage of minority patients will hold steady at about two-thirds of all patients served. Due to modifications in data collection, data will not be available for 2007-2009.

1.II.A.3. Percentage of Health Center patients who are uninsured.

To improve the health status of the Nation's underserved communities and vulnerable populations, safety net programs must also target access to care for people who are uninsured. According to UDS Health Center data, in 2006 that population served included almost 6 million uninsured individuals comprising 40% of the health center patient population, which was just below the target. In 2007, the health center population served included 6.24 million uninsured individuals, which was nearly 40% of the client population - just slightly below the target. The FY 2009 Program target is 41%.

In 2007, UDS Health Center data showed that:

- One quarter of the children served by Health Centers are uninsured.
- Almost one half of adult Health Center patients are uninsured.
- About three quarters of Health Center patients are either uninsured or Medicaid recipients.

In comparison, nationally, research reveals that caseloads of private physicians in the primary care specialties include 4% uninsured and 7% Medicaid for a total of 11% (National Ambulatory Medical Care Survey: 2001), down from the 19% in the previous study (National Ambulatory Medical Care Survey: 1998). Additional reports note that:

- The percentage of physicians providing any free or reduced cost care decreased to 68.2%

in 2004-05 from 71.5% in 2000-01.
- Their overall number of charity care hours per 100 uninsured people also declined from 7.7 hours in 1996-97 to 6.3 in 2004-05, an 18% decline (Cunningham P and May J, Center for Studying Health System Change: 2006).

At the same time, the number of uninsured in the Nation has increased steadily from 38.7 million in 2000 to nearly 46 million or 15.3% of the U.S. population in 2007 (U.S. Census Bureau).

Long-Term Objective: Expand the capacity of the health care safety net.

1.I.A.2. Percentage of grantees that provide the following services either on-site or by paid referral: Pharmacy, Preventive Dental Care, and Mental Health/Substance Abuse.

Access to pharmacy, oral health, and mental health/substance abuse (MH/SA) services is critical to ensuring overall health and well-being of Health Center populations. Inadequate access to pharmacy services often leads to problems with drug interactions, inappropriate doses, and failure to adhere to prescribed therapy. Lack of access to oral health care services is the primary reason for significant disparities in oral health status among vulnerable populations. MH/SA disorders, such as depression and abuse of alcohol are prevalent among underserved populations, and treatment is not accessible in many local communities.

Of the grantees reporting in 2006, 83% provided pharmacy services, 83% provided preventive dental care, and 79% provided mental health/substance abuse services either on-site or by paid referral. For 2007, of the 1,067 grantees reporting, 82% reported that they provided pharmacy services either on-site or by paid referral, virtually meeting the target of 83%. The figures for dental care and mental health/substance abuse services were 83% and 80%, respectively. The percentage of Health Centers providing dental and MH/SA services on-site or by paid referral exceeded their respective 2007 targets. The FY 2009 targets are: 83% for pharmacy services, 82% for dental services, and 74% for mental health services.

1.E. Percentage increase in cost per patient served at Health Centers.

This efficiency measure focuses on maximizing the number of Health Center patients served per dollar. It also monitors Health Center performance in keeping cost increases below annual national health care cost increases while maintaining access to high quality services. The efficiency measure also utilizes a metric that speaks to the program as a whole. By looking at growth in total cost per patient, the full complement of services that make Health Centers a “health care home” are captured. Total cost includes all financial costs (excluding donations) for: Medical, Lab and X-Ray, Dental, Mental Health, Substance Abuse, Pharmacy, and Enabling Services (translation, transportation, case work, outreach, etc.).

In 2006, health center costs grew at a rate of 4.6%, which not only met but was under the target growth rate of 5.4%. This was 31% below the actual growth rate for national health expenditures in 2006, which was 6.7%. In 2007, health center costs grew at a rate of 4.5%, which surpassed the program goal of keeping the cost growth rate at or under 5.3%. By restraining increases in the cost per individual served at Health Centers below national per capita health care cost increases, the Health Center Program has served a volume of patients that otherwise would have required additional funding to serve and demonstrates that it delivers its high quality services at a more cost-effective rate. Given recent performance of the program, annual targets in growth are set at 20% below forecasted national rates. Successful restraint of the cost per individual served at Health Centers below national per capita health care cost increases may, in part, be related to the Health Centers' strategic use of a multi- and interdisciplinary team model of care that treats the "whole patient," with a focus on continuity of primary care and enabling services.

TARGETS SUBSTANTIALLY EXCEEDED OR NOT MET

Measure: Rate of births less than 2500 grams (low birth weight) to prenatal Health Center patients compared to the national low birth weight rate.

FY 2006 target: 11.0% below national low birth weight rate
FY 2006 result: 7.2% below national low birth weight rate

This measure is benchmarked to the national rate to demonstrate how Health Center performance compares to performance of the Nation overall. In 2005, 7.3% of Health Center patients had LBW infants, a rate that was 11% lower than seen nationally (8.2%, 2005 national LBW rate). While the incidence of LBW rates increased for the Health Center prenatal patients and prenatal patients nationally in 2006, separation between the Health Center's rate and the national rate was only 7.2% (8.3% -2006 preliminary national LBW rate).

The Program serves a prenatal care population at higher risk than that seen nationally. With the extensive expansion of health center services since 2002 through the development of new health center sites, more high risk prenatal patients who were previously underserved are being served, thus impacting the level of this rate. While the Program addresses LBW through the implementation of preventive prenatal health care in new organizations, there will be a delay before the benefit of these efforts is realized. The Program will take the following to address this issue:

- Technical assistance to health centers on the delivery of quality health care through State Primary Care Associations.
- Outreach to patients to encourage timely entry into prenatal care, and patient education on healthy behaviors that can impact birth weight.
- Information to clinicians to help them in the identification of maternal disease and risks for complications of pregnancy or birth during the first trimester.

Despite the recent slight increase in LBW, results over the past few years demonstrate that Health Center patients have continued to follow a steady LBW pattern at about 7%, unlike increases observed in the national rate (Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary data for 2006. National vital statistics reports; vol. 56, no. 7. Hyattsville, MD: National Center for Health Statistics, 2007). The Program will continue its effort to remain below the national LBW rate, while serving a higher-risk prenatal population than seen nationally.

FREE CLINICS MEDICAL MALPRACTICE

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Expand the capacity of the health care safety net								
2.I.A.1.	Number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage. (Baseline – 2005)	657	1,657	1,950	2,420	2,500	2,900	3,100
2.1*	Patient visits provided by free clinics sponsoring volunteer FTCA-deemed clinicians.* **(Developmental)**							

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Expand the capacity of the health care safety net								
2.I.A.2.	Number of free clinics operating with FTCA-deemed volunteer clinicians. (Baseline – 2005)	38	65	70	80	85	93	105
2.I.A.3.	Percent of volunteer FTCA-deemed clinicians who meet certification and privileging requirements. (Baseline – 2005)	100%	100%	100%	100%	100%	100%	100%
Efficiency Measure								
2.E	Administrative costs of the program per Federal Tort Claims Act (FTCA) -covered volunteer (Baseline – 2004)	$221	$331	$204	$164	$195	$153	$190

Note:
[*] This long-term developmental measure does not have a baseline and targets.

INTRODUCTION

The Free Clinics Program encourages health care providers to volunteer their time at free clinics by providing medical malpractice protection at sponsoring health clinics, thus expanding the health care safety net, which is a HRSA strategic objective. The Program's performance measures track progress in achieving this objective. The Program uses the data from its annual measures to track and assess program expansion. The data include the locations of Free Clinics that have applied for FTCA-deemed volunteer clinicians. The key strategy used to meet performance targets is to determine areas with few for no applications and then target these areas for outreach about the program.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Expand the capacity of the health care safety net.

2.I.A.1. Number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage.

This measure examines program participation by volunteer health professionals. In 2005, the first year that the program began covering providers, 657 providers were successfully deemed eligible for FTCA coverage. This number more than doubled in 2006, the second year of the program. In 2007 and 2008, the program exceeded its targets again by deeming 2,420 and 2,900 volunteer providers respectively. The program aims to deem 3,100 volunteer health care providers by the end of 2009.

2.1. Patient visits provided by free clinics sponsoring volunteer FTCA-deemed clinicians. (Developmental)

This developmental measure will track the volume of visits performed by volunteer clinicians at free clinics that choose to sponsor these health professionals for FTCA coverage as an indicator of increased patient capacity. The program is currently revising its application materials to collect these data from free clinic applicants and anticipates having data available in 2009.

Long-Term Objective: Expand the capacity of the health care safety net.

2.I.A.2. Number of free clinics operating with FTCA-deemed volunteer clinicians.

This measure demonstrates the extent to which free clinics are participating in the program. In 2005, the first year that the program began deeming providers, 38 free clinics were operating with FTCA-deemed volunteer clinicians. In 2007 and 2008, performance exceeded the targets, with 80 and 93 clinics operating with FTCA-deemed volunteers respectively. By 2009, the program anticipates having 105 clinics operating with FTCA-deemed volunteers.

2.I.A.3. Percent of volunteer FTCA-deemed clinicians who meet certification and privileging requirements.

This indicator reflects the quality of services provided by the deemed health professionals volunteering at participating free clinics as measured by the percentage meeting licensing and certification requirements. Performance continues to meet the target with 100 percent of FTCA-deemed clinicians meeting appropriate requirements. The FY 2009 target is 100 percent.

2.E. Administrative costs of the program per Federal Tort Claims Act (FTCA)-covered volunteer.

By restraining the annual Federal administrative costs necessary to deem each provider, the program will be able to provide an increasing number of clinicians with malpractice coverage, thus building the free clinic workforce capacity nationwide and increasing access to care for the vulnerable populations served by these clinics. In 2005, the first year that program began deeming providers, the cost per provider deemed was $221.

The 2006 target included a projected one-time increase due to new contractor costs, substantial redeeming application activities, increased technical assistance, potential claims administration and outreach assistance. The actual cost per provider deemed in FY 2006 of $331 was higher than projected. As originally estimated, the size of this increase in cost appears to be a one-time occurrence. The 2007 program cost per provider was $164, and in 2008 the resulting figure was $153. Both figures show targets being surpassed, and exhibit steady and ongoing increases in efficiency. The FY 2009 target is $190.

NATIONAL HANSEN'S DISEASE PROGRAM

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Promote effectiveness of health care outcomes								
3.II.A.1	Prevent increases in the level of Hansen's Disease related disability and deformity among patients treated and managed by the National Hansen's Disease Program (NHDP) (Percentage of patients at grades 1 and 2). (Baseline – 2002: 50%)	51%	46%	50%	Nov-09	50%	Nov-10	50%
3.III.A.1	Develop an animal model for the full spectrum of clinical complexities of human Hansen's Disease. (Baseline - 2006)		BRM 1	BRM 2 CM 1	BRM 2 CM 1	BRM 3 CM 2,3	Mar-09	BRM 4 CM 4
Notes: BRM = biological response modifiers; CM = cell markers								

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Expand the availability of health care; particularly to underserved, vulnerable, and special needs populations								
3.II.A.2.	Number of private sector physicians who have received training from the NHDP.	12	35	40	135	45	146	50
3.II.A.3.	Number of patients provided Hansen's Disease outpatient care through the National Hansen's Disease Program.	3,000	3,000	3,000	3,000	3,000	2,888	3,000
Efficiency Measure								
3.E	Maintain increases in the cost per patient served in the outpatient clinics to below the medical inflation rate.	$1,456	$1,366	$1,599	$1,277	$1,676	$1,244	$1,676

INTRODUCTION

The Hansen's Disease Program is the only dedicated provider of expert Hansen's disease treatment services in the United States, a crucial source of continuing education for providers dealing with the identification and treatment of the disease, and a major source of research on Hansen's disease. The Program's performance measures reflect the major activities of the program and are linked to the broader HRSA strategic objectives of expanding the availability of health care, particularly to underserved, vulnerable, and special needs population; and promoting the effectiveness of health care. Strategies for achieving the program's performance goals include ongoing support for ambulatory care clinics that focus on case management and patient compliance, and the identification of opportunities for training groups of private physicians in the geographic areas most impacted by the disease on the diagnosis and management of Hansen's disease.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Expand the availability of health care, particularly to underserved, vulnerable, and special needs populations.

3.II.A.1. Level of Hansen's Disease-related disability and deformity among patients treated and managed by the NHDP.

Hansen's Disease is a life-long chronic condition which left untreated and unmanaged will usually progress to severe deformity. As this deformity is generally irreversible, both the annual and long-term measure track the impact of the program's case management efforts as well as patient compliance on the prevention of further deterioration to a higher grade of disability/deformity.

Through this annual and long-term measure the program will monitor its efforts to prevent an increase of the percentage of Hansen's Disease patients with grades 1 or 2 disability/deformity. Disability/deformity is measured based on the World Health Organization scale, which ranges from 0-2. Patients graded at 0 have protective sensation and no visible deformities. Patients graded at 1 have loss of protective sensation and no visible deformity. Patients graded at 2 have visible deformities secondary to muscle paralysis and loss of protective sensation. In 2005, 51% of patients had grades 1 or 2 disability/deformity, and in 2006 that figure was 46%, bettering the target of 50%. It is expected that both the program's existing case management efforts as well as its activities to train more private sector physicians to recognize Hansen's Disease and initiate treatment earlier, will help prevent further increases in the level of disability/deformity among Hansen's patients.

Long-Term Objective: Promote effectiveness of health care services.

3.III.A.1. Develop an animal model for the full spectrum of clinical complexities of human Hansen's Disease.

The National Hansen's Disease Program (NHDP) seeks to prevent and manage Hansen's Disease (leprosy) through both clinical care and scientific research. As an annual and long-term measure, this indicator monitors advances in scientific knowledge related to the early diagnosis, treatment, and prevention of Hansen's Disease and the NHDP's performance in achieving breakthroughs in genomic and molecular biology.

The measure focuses on the development of an animal model (the armadillo) for the full spectrum of clinical complexities of human Hansen's Disease. This is the only other species besides man to naturally acquire Hansen's Disease and currently, no such model for human leprosy exists. Once the animal model is developed, potential advances in scientific knowledge related to questions associated with pathogenesis, early diagnosis, vaccine development, and transmission of Hansen's Disease can be further explored.

The annual measure specifically tracks development of six protective biological response modifiers (BRMs) and six white blood cell subtype markers (CMs) that are important in host resistance to Hansen's Disease and will ultimately permit development of the full animal model for human Hansen's Disease. In 2006, the program met its target and developed the first of the 12 reagents needed to produce a relevant animal model (armadillo). In 2007, the program met its targets and developed BRM-2 and CM-1. The targets were also met in FY 2008, with the program developing BRM-3 and CM-2, 3. The program projects the development of BRM-4 and CM-4 in FY 2009.

Long-Term Objective: Expand the availability of health care, particularly to underserved, vulnerable, and special needs populations.

3.II.A.2. Number of private sector physicians who have received training from NHDP.

Early diagnosis and treatment helps reduce Hansen's Disease-related disability and deformity. This can only be achieved if there are enough healthcare providers in the U.S. with knowledge of the disease and access to the support provided by NHDP though its function as an outpatient clinic, training education, and referral center for Hansen's Disease patients. Increasing knowledge about Hansen's Disease in the U.S. medical community should lead to earlier diagnosis and intervention, resulting in a decrease in Hansen's Disease-related disabilities.

In 2007, the NHDP exceeded its program performance target of 40, and trained 135 private sector physicians. In FY 2008, the figure was 146, surpassing the target of 45. (See section below on "Targets Substantially Exceeded or Not Met.") In FY 2009 the target is 50, reflecting the current assessment of training opportunities. A national promotion effort targeted at physicians whose practice may include individuals with Hansen's Disease (e.g., dermatologists) is underway, as well as training healthcare providers in targeted areas where clusters of newly diagnosed cases are appearing.

3.II.A.3. Number of patients provided Hansen's Disease outpatient care through the National Hansen's Disease Program.

The National Hansen's Disease Program includes a regional outpatient clinic program. The HD population in the U.S. is approximately 6,000. In FY 2007, the NHDP program met the target of caring for 3,000 HD patients though outpatient clinics in the area in which they live. In FY 2008, that figure was 2,888, slightly below the goal of 3,000. The FY 2009 target is 3,000.

3.E. Maintain increases in the cost per patient served in the outpatient clinics to below the medical inflation rate.

Hansen's Disease outpatient care supports treatment protocols for multi-drug therapy, diagnostic studies, consultant ancillary medical services, clinical laboratory analysis, hand and foot rehabilitation, leprosy surveillance, and patient transportation for indigent patients. The National Hansen's Disease Program is committed to improving overall efficiency through controlling the cost of care at all of its outpatient clinics by keeping increases in the cost per patient served at or below the national medical inflation rate.

By restraining increases in the cost per individual served by the Ambulatory Care Program Clinics and at the National Hansen's Disease Program outpatient center below the national medical inflation rate, the Hansen's Disease Services Program can continue to serve a volume of patients that otherwise would have required additional funding to serve in the fiscal year. In 2007, the cost per patient served through outpatient services was $1,277 and was successfully below the target of $1,599. In 2008, the figure of $1,244 was better than the target of $1,676. The 2009 target is $1,676.

TARGETS SUBSTANTIALLY EXCEEDED OR NOT MET

Measure: Number of private sector physicians who have received training from the NHDP.

FY 2008 target:	45
FY 2008 actual:	146

In 2008, the NHDP exceeded this performance target due to an expansion of the training program to include an outreach Hansen's Disease (HD) awareness seminar and 3 on-line video HD clinical pathological conferences.

In response to a changing dynamic in immigrant relocation in the U.S., the new outreach HD awareness training initiative is a needed expansion of our training mission. It is premature, however, to change the target for this measure.

The main topic of our outreach seminars is to bring awareness to physicians of the cardinal signs of HD and whether a HD diagnosis must be considered when treating immigrant patients from countries where HD is endemic. Increased awareness of HD by physicians should lead to earlier diagnosis of the disease with consequent easier management and fewer disabling manifestations of HD. This impact of increased training may take 10 or more years to become apparent.

CLINICIAN RECRUITMENT AND SERVICE

Programs included in this section are:

- National Health Service Corps
- Nursing Education Loan Repayment and Scholarship Programs

NATIONAL HEALTH SERVICE CORPS

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Improve the distribution of health professionals in underserved areas								
4.I.C.1	Number of individuals served through the placement and retention of NHSC clinicians. (Baseline - 2001: 4.44 M)	4.44 M	4.47 M	3.8 M	3.88 M	3.48 M	Nov-09	3.39 M
4.1*	Number of individuals served in all communities seeking NHSC assistance through NHSC placement, retention and other sources.[*] (Baseline: 5.9 M)							
4.I.C.2	Field strength of the NHSC through scholarship and loan repayment agreements.	4,602	4,109	3,706	3,820	3,559	Nov-09	3,466
4.I.C.4	Percent of NHSC clinicians retained in service to the underserved.	DNA[a]	76%	79%	DNA[b]	79%	Nov-09	79%

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Improve the distribution of health professionals in underserved areas								
4.I.C.3	Number of NHSC-list vacancies filled through all sources.	3,141	2,662	1,746	1,376	1,776	Nov-09	2,200
4.I.C.5	Average HPSA score of the sites receiving NHSC clinicians, as a proxy for service to communities of greatest need.	12.2	13.7	13.6	13.7	13.6	Nov-09	13.8
Efficiency Measure								
4.E	Maintain or decrease the average cost to the NHSC program of a patient encounter.	$4.97	$4.72	$4.19	$3.87	$4.17	Nov-09	$4.15

Notes:

[*] This long-term measure does not have annual targets.

[a] DNA = Data Not Available. Retention data was not available in FY 2004 and FY 2005 due to incomplete data collection. The program has reformatted the survey to reduce ambiguity.

[b] DNA = Data Not Available. Retention data will not be available for FY 2007 due to incomplete data collection by contractor and contract expiration.

INTRODUCTION

The statutory purpose of the National Health Service Corps (NHSC) is to eliminate "…health manpower shortages in health professional shortage areas," (Section 331(a)(1) of the Public Health Service Act [42 USC 254d]). The performance measures gauge the NHSC's contribution to the HRSA strategic goals of improving access to health care and improving the health care systems through the recruitment and retention of NHSC clinicians.

Most of these measures are dependent on the size of the Field Strength (4.I.C.2.). The larger the Field Strength, the greater number of people served, and the pool of clinicians who fulfill the service commitment to be potentially retained increases. Also, as the NHSC has been able to shift more funding to the NHSC Loan Repayment Program (LRP), the cost per patient encounter decreases. In managing performance, the NHSC uses these data to inform policy decisions regarding distribution of Recruitment Line funding between the Scholarship and Loan repayment Programs. Another strategy used by the program is to target sites that need recruitment and retention technical assistance. The NHSC constantly evaluates its options regarding distribution of funds between the programs and the size and/or duration of awards and contracts.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Improve the distribution of health professionals in underserved areas.

4.I.C.1. Number of individuals served through the placement and retention of NHSC clinicians.

The FY 2001 baseline of individuals served is 4.44 million. The FY 2006 estimate was 4.47 million, and the FY 2007 estimate of 3.88 million exceeds the target by 2 percent, and is a function of an increased number of clinicians retained out of the increased number of loan repayers recruited in previous years, as well as a larger-than-expected Field Strength. These encounters are adjusted for both type of site and by primary care, dental, and mental and behavioral health disciplines, and include patients seen by NHSC alumni in their first year post completion of the service commitment. The projected decreases through the FY 2009 target of 3.39 million reflect the decreasing number of vacancies filled by new NHSC loan repayers as the number of loan repayment amendments (extensions on existing loan repayment contracts for an additional year) is projected to increase, leading to the decline in the Field Strength described below.

4.1. Number of individuals served in all communities seeking NHSC assistance through NHSC placement, retention and other sources.

(Baseline - 5.9 M)

4.I.C.2. Field strength of the National Health Service Corps through scholarship and loan repayment agreements.

In FY 2007, NHSC Field Strength was 3,820, which is 3 percent over the target. This decrease from the FY 2005 level (4,602, the largest Field Strength in the history of the NHSC) was anticipated, due to large numbers of loan repayers have fulfilled the service commitment and are no longer counted in the Field Strength. This trend is expected to continue through FY 2009 for the reason noted in 4.I.C.1 above, at which point the number of new loan repayment contracts and amendments will achieve a balance, and the Field Strength will stabilize at the FY 2009 target of 3,466.

4.I.C.4. Percent of NHSC clinicians retained in service to the underserved.

Retention of NHSC clinicians preserves access to care for the underserved beyond the period of service commitment. The NHSC measures retention at one year after fulfillment of the service commitment. Retention data was not available in FY 2004 and 05 due to incomplete data collection, resulting in too small a sample to be considered representative. Retention data was not available in FY 2007 due to incomplete data collection, the Recruitment, Training, and Support Center (RTSC) contract expiration, and a six month gap before a new contract was finalized with a new contractor. Collection of retention data is required under the new contract and mechanisms are in place to monitor performance more closely.

4.I.C.3. Number of NHSC-list vacancies filled through all sources.

In FY 2007, 1,376 vacancies were filled, which is 21 percent below the target. This is due to a decrease in the number of vacancies filled by non-NHSC clinicians. (See section below on "Targets Substantially Exceeded or Not Met.") In 2003, the program shifted the proportion of recruitment line budget to loan repayment. As a result, an unusually large number of new loan repayment awards were made that year. The rise and fall in the target numbers from FY 2005 through FY 2009 reflect the cyclical nature of the NHSC Loan Repayment Program: as the number of loan repayment amendments (extensions on existing contracts) increases, the number of new contracts falls, resulting in fewer total vacancies filled from all sources. The target for FY 2009 is 2,200.

4.I.C.5. Average HPSA score of the sites receiving NHSC clinicians, as a proxy for service to communities of greatest need.

The HPSA score is a proxy measure for the degree of need for health professionals in an area. Scores range from 1 to 25, with 25 representing the greatest need. Increasing the average HPSA score of site vacancies filled through NHSC assistance indicates success in targeting vacancies of greatest need. The FY 2007 actual average score was 13.7, which equaled the average score of FY 2006 and exceeded the target by 3 percent. This is a function of the fact that the program did not award all qualified loan repayment applications in 2007 (as was the case in FY 2006): no loan repayment contracts were awarded to a clinician working at a facility with a HPSA score below 8, resulting in a higher average score. The FY 2009 target is 13.8 which represents the projection of a relatively stable Field Strength.

4.E. Maintain or decrease the average cost to the NHSC program of a patient encounter.

This average cost of patient encounter is the benchmark of management efficiency which the NHSC will track over time. The measure tracks how well the Program can maintain or even lower this cost regardless of changes in annual appropriations and the resulting fluctuation of the Field Strength from year to year. The estimated cost of an encounter in FY 2007 is 8 percent below the target and reflects a significant decrease from the previous year's actuals (FY 2006 and 2005). This may be due to the increased percentage of NHSC loan repayers and state loan repayers (vs. scholars) in the field strength who serve at a lower annual cost to the program than scholars. As the program continues to gather data to track this measure and gain more experience, it is believed that future targets will be estimated more accurately. The FY 2009 target is $4.15.

TARGETS SUBSTANTIALLY EXCEEDED OR NOT MET

Measure: Increase the number of NHSC-list vacancies filled through all sources.

FY 2007 Target: 1,746
FY 2007 Actual: 1,376

In FY 2007, 1,376 vacancies were filled, which is 21 percent below the target. This is due to a decrease in the number of vacancies filled by non-NHSC clinicians. Targets are based on the number of projected new loan repayment awards, the number of new scholars beginning service, and the assumption that an equal number of non-NHSC clinicians will fill NHSC-listed vacancies. This last assumption proved to be incorrect in 2007, for reasons that are not clear, as the program has no direct contact with the non-obligated clinicians who fill these positions. This could a result of the fact that the NHSC Jobs Opportunity List website was not available. The NHSC temporarily replaced the list with an Excel spreadsheet, which some may have found less user-friendly. NHSC has since replaced the list with a searchable web-based portal.

NURSING EDUCATION LOAN REPAYMENT AND SCHOLARSHIP PROGRAMS

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective : Improve the distribution of health professionals in underserved areas								
5.1*	Increase the number of individuals enrolled in professional nursing education programs.* (Baseline - 2002-2003: 240,500)							
5.I.C.1	Increase the proportion of nursing scholarship recipients working in a facility with a critical shortage of nurses within 4 months of licensure.	DNA[a]	DNA[a]	85%	DNA[a]	85%	Dec-09	85%
5.I.C.2	Increase the proportion of NELRP participants working in shortage facilities such as: Disproportionate Share Hospitals for Medicare and Medicaid, Nursing Homes, Public Health Departments (State and local) and Public Health Clinics contained in these Departments.	100%	100%	90%	97%	90%	Dec-09	90%
5.I.C.4	Reduce Federal investment per year of direct support by increasing the proportion of program participants who extend their service contracts to commit to work at a critical shortage facility for an additional year.	38%	45%	45%	45%	45%	Dec-09	45%

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Improve the distribution of health professionals in underserved areas								
5.I.C.3	Increase the percent of States in which NELRP contract recipients work.	86%	92%	93%	94%	93%	Dec-09	93%
Efficiency Measure								
5.E	Increase the proportion of NELRP participants who remain employed at a critical shortage facility for at least one year beyond the termination of their NELRP service.	DNA[a]	DNA[a]	50%	DNA[a]	50%	Dec-10	50%

Notes:
* This long-term measure does not have annual targets.
[a] DNA = Data not available. Data were not collected for FY 2005, FY 2006, and FY 2007.

INTRODUCTION

The Nurse Education Loan Repayment Program (NELRP) and the Nursing Scholarship Program (NSP) are authorized under Section 846 of the Public Health Service Act [42 USC 297n] to work in partnership with other HHS programs to encourage more people to consider nursing careers and motivate them to serve in areas of critical shortage. The performance measures gauge these programs' contribution to the HRSA strategic goals of improving access to health care and improving the health care systems through the recruitment and retention of nurses working in Critical Shortage Facilities.

A major challenge facing NELRP is ensuring placements in facilities with the greatest need. As one strategy to assure better targeting of program resources to areas and facilities of greatest need, the Program is testing a methodology for identifying Critical Shortage Facilities for nurses.

Another major challenge for the Program is the current difficulty with data collection and analysis. The Program had been using a Nursing Information System which was deactivated in anticipation of another system being brought online. This has not yet occurred. Both NSP and NELRP will participate in the new information management system of the Bureau of Clinician Recruitment and Service, which is scheduled to be operational at the end of FY 2009. The Program anticipates reporting on FY 2009 performance data in 2010.

DISCUSSION OF RESULTS AND T ARGETS

Long-Term Objective: Improve the distribution of health professionals in underserved areas.

5.1. Increase the number of individuals enrolled in professional nursing education programs.

The NSP is expected to attract more students into nursing education by providing financial support during the training years.

5.I.C.1. Increase the proportion of nursing scholarship recipients working in a facility with a critical shortage of nurses within 4 months of graduation.

In FY 2004 the proportion was 43%. Data is unavailable for this measure for FY 2005 through FY 2007 due to the lack of an information system. The program expects to report on FY 2009 data in 2010. The FY 2009 target is 85%.

5.I.C.2. Increase the proportion of NELRP participants working in shortage facilities such as: Disproportionate Share Hospitals for Medicare and Medicaid; nursing homes, public health departments (State and local) and public health clinics contained in these departments.

Data for this measure is obtained by monitoring automated data on NELRP contracts. NELRP applicants working in shortage facilities, such as Disproportionate Share Hospitals for Medicare and Medicaid; nursing homes, public health departments (State and local) and public health clinics contained in these departments are in the first preference category for awards.
These data indicate the degree to which NELRP resources are being successfully targeted to facilities experiencing the most critical shortages of nurses. All available funds for initial awards were expended to nurses working in those facility types in FY 2004 through FY 2006. The proportion in FY 2007 was 97%, exceeding the target by 8%. The target for FY 2009 is 90%, and reflects the requirement in the law (effective in 2009) that program participants may only be placed in entities that are non-profit (42 USC 297n(b)(3)), which is anticipated to disqualify some facilities such as nursing homes.

5.I.C.4. Reduce Federal investment per year of direct support by increasing the proportion of program participants who extend their service contracts and commit to work at a critical shortage facility for an additional year.

NELRP initial contracts are for two years of service. This indicator will provide a measure of the degree to which registered nurses participating in NELRP are willing to serve in a critical shortage facility for at least one additional year. The proportions in FY 2005 and FY 2006 were 38% and 45%, respectively. The target of 45% for FY 2007 was met. The target for FY 2009 is 45%, reflecting the program's expectation that third-year participation will continue at this current level.

5.I.C.3. Increase the percent of States in which NELRP contract recipients work.

Prior to FY 2002, information about this program was not widely distributed and contract recipients were limited to a small number of States. Increased funding and marketing strategies in FY 2002 resulted in broader distribution of contract awards in more States.

In FY 2007 NELRP participants were working in 94 percent of the States, which was 1 percent over the target, and 2% over the FY 2006 level. Some fluctuation from year to year is expected because awards are based on financial need and type of facility rather than the State in which the recipient plans to work. The target for FY 2009 is 93 percent.

5.E. Increase the proportion of NELRP participants who remain employed at a critical shortage facility for at least one year beyond the termination of their NELRP service.

This indicator will address the issue of retention by providing a measure of the degree to which trained nurses participating in NELRP are willing to serve in a critical shortage facility for at least one additional year beyond the termination of their NELRP service. The FY 2004 result was an estimated 90 percent. Data were not collected in FY 2005 through FY 2007 due to the lack of an information management system. The target for FY 2009 is 50 percent.

HEALTH PROFESSIONS

Programs included in this section are:

- Health Professions and Nursing Education and Training Programs
- Children's Hospitals Graduate Medical Education Payment Program
- National Practitioner Data Bank
- Healthcare Integrity and Protection Data Bank

HEALTH PROFESSIONS AND NURSING EDUCATION AND TRAINING PROGRAMS

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Promote the development of a diverse and culturally representative health care workforce								
6.I.B.1	Increase the proportion of graduates and program completers of Titles VII and VIII supported programs who are underrepresented minorities and/or from disadvantaged backgrounds. (Baseline - 2001: 42%)	57%	37%	50%[a]	Feb-09	50%[a]	Dec-09	50%[a]
6.1[b]	Increase the proportion of persons who have a specific source of ongoing care.[b] (Baseline – 2001: 88%)							
6.I.C.1	Increase the proportion of trainees in Titles VII and VIII supported programs *training* in medically underserved communities. (Baseline - 2001: 52%)	43%	54%	43%	Feb-09	43%	Dec-09	54%[b]
6.I.C.2	Increase the percentage of health professionals supported by the program who enter practice in underserved areas. (Baseline - 2001: 19%[c])	35%[d]	35%	21%	Dec-09	35%	Dec-10	35%

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Efficiency Measure								
6.E	Maintain the average cost per graduate or program completer to the program of providing pipeline and formative education and training.	$460	$460	$456	Dec-09	$456	Dec-10	$456

Notes:
These data represent academic year programmatic outputs resulting from specific fiscal year funding. Thus FY 2005 funding produced 07/01/2005 thru 06/30/2006 academic year results. (Please note: For the last several years, HRSA reported these health professions data in the fiscal year in which they were collected rather than the fiscal year for which the activities were funded. An effort is being made this year to connect funds with performance. Thus the data reported in the FY 2005- 2007 columns is different than what was reported in the FY 2009 Online Performance Appendix. The academic year captures accurate performance as the students trained during the academic year are funded with funds from one fiscal year.)

[a] Targets for FY 2007 thru FY 2009 are lower than the FY 2005 result because past performance result levels suggest that the FY 2005 result may be unusually high.

[b] This long-term measure does not have annual targets.

[c] The baseline was calculated as the average of FY 1999 through FY 2001 data and is low because reported data inadvertently contained students (such as junior and high school students) who were in early education pipeline programs (such as HCOP) who were many years away from graduating from a health professions school and could not be clinicians in 1 year.

[d] Service location data are collected on students who have been out of the HRSA program for 1 year. The results listed in 2005 and 2006 are from programs that have the ability to produce clinicians 1-year post program graduation.

INTRODUCTION

The Health Professions program performance measures and activities build upon HRSA's long-range goal to "Improve Access to Health Care" and are keyed to the following HRSA objectives:

- Promote the development of a diverse and culturally representative health care workforce
- Improve the distribution of health professions in underserved areas, including rural and border areas

Performance measure information is used by the program to highlight success in the program design and implementation and to identify areas that may require improvement. A strategy for improving performance is to identify grantees that are better meeting program goals and the best practices of such programs. These best practices may be encouraged through additional funding preferences and priorities during the grant-making process. Also, performance information is used to provide technical assistance to grantees to help them gather better data.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Promote the development of a diverse and culturally representative health care workplace.

6.I.B.1. Increase the proportion of graduates and program completers of Titles VII and VIII supported programs who are underrepresented minorities and/or from disadvantaged backgrounds.

(Baseline - 2001: 42%)

In 2006, 37 percent of graduates and program completers of Titles VII and VIII supported programs were underrepresented minorities and/or from disadvantaged backgrounds. This fell short of the FY 2006 target by 13 percentage points and was well short of the FY 2005 performance result of 57 percent. (See section below on "Targets Substantially Exceeded or Not Met.") The target for FY 2008 and FY 2009 is 50 percent which is lower than the FY 2005 result because past performance results, including the FY 2006 result level, suggest that the FY 2005 result may have been unusually high and may be difficult to achieve.

6.1. Increase the proportion of persons who have a specific source of ongoing care.

Access to a source of ongoing care does not directly reflect all of the specific activities of the Health Professions program. However, over time, HRSA expected this program to contribute to increasing the proportion of persons with a specific source of ongoing care, through its support of training health professions in all settings. The proportion has remained statistically unchanged over the past years.

6.I.C.1. Increase the proportion of trainees in Titles VII and VIII supported programs training in medically underserved communities.

The proportion of trainees in Titles VII and VIII supported programs training in medically underserved communities was 54 percent in 2006 which exceeded the target by 11 percentage points. This represents an increase over the 2005 result of 40 percent, and is comparable to the 2004 result of 53 percent. (See section below on "Targets Substantially Exceeded or Not Met.")

6.I.C.2. Increase the percentage of health professionals supported by the program who enter practice in underserved areas.

The percentage of health professionals supported by the program entering practice in underserved areas was 35 percent in 2006. The target for this measure was met. The target for FY 2008 was left level at 35 percent as a maintenance level.

6.E. Maintain the average cost per graduate or program completer to the program of providing pipeline and formative education and training.

The efficiency measure for the Health Professions program is to maintain the average cost per graduate and program completer at $456.

Per capita costs vary tremendously among these different types of programs, depending on the level of effort, and the length of the commitment required to complete them. The baseline for FY 2004 ($456) represents the average cost per graduate or program completer to Title VII and Title VIII of providing pipeline formative education and training. For FY 2005 and FY 2006, the average cost per graduate or program completer was $460. The target for this measure was $456. The number of programs in each category will change significantly in response to funding changes for Title VII and Title VIII and per capita costs will change accordingly. Changes in tuition costs will also be an important factor. The FY 2009 target is $456.

TARGETS SUBSTANTIALLY EXCEEDED OR NOT MET

Measure: Increase the proportion of graduates and program completers of Titles VII and VIII supported programs who are underrepresented minorities and/or from disadvantaged backgrounds.

FY 2006 Target: 50 percent
FY 2006 Result: 37 percent

The Program's target is ambitious because the baseline for this measure of 42 percent. This measure may be understated because grantees in some States cannot, by law, collect race/ethnicity data. A factor that may have contributed to the low FY 2006 result was the introduction of a new data collection system which collects disadvantaged status as well as ethnicity separately from racial background. The introduction of the new system may have led to underreporting by grantees of race/ethnicity and disadvantaged status of program participants. The target for FY 2008 and FY 2009 is 50 percent which is above the FY 2006 result because the program expects that as grantees become more accustomed to the enhanced data collection system more complete data will be collected.

Measure: Increase the proportion of trainees in Titles VII and VIII supported programs training in medically underserved communities.

FY 2006 Target: 43 percent
FY 2006 Result: 54 percent

The result for this measure exceeded the target by 11 percentage points. The Program removed from the calculation of performance for this measure those training programs inappropriate for the measure. That is, programs such as continuing education programs for health professionals are no longer included in the calculation. Future targets for this measure will be set to 54 percent as a maintenance level. There are natural limiting factors such as the location of health professions schools and the organizations they work with to provide training opportunities in medically underserved communities. Therefore, it would be difficult to estimate significant improvements in this area. The Program will continue to emphasize to training programs the critical importance of this measure and to strategize with the grantees on how to improve performance in this area.

CHILDREN'S HOSPITALS GRADUATE MEDICAL EDUCATION PAYMENT PROGRAM

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Improve access to health care								
7.I.A.1	Maintain the number of FTE residents in training in eligible children's teaching hospitals.	4,911[1] 192[2]	5,051[1] 192[2]	4,450[1] 378[2]	5,010[1] 333[2]	5,051[1] 192[2]	Jul-09	5,010[1] 333[2]
7.VII.C.1	Percent of hospitals with verified FTE residents counts and caps.	100%	100%	100%	100%	100%	100%	100%
Efficiency Measure								
7.E	Percent of payments made on time.	100%	100%	100%	100%	100%	100%	100%

Notes:

[1] Total trained on-site.

[2] Total trained off-site.

INTRODUCTION

The Children's Hospital's Graduate Medical Education Payment Program's (CHGME PP) performance measures and activities build upon HRSA's long-range goal to "Improve Access to Health Care" and Achieve Excellence in Management. They are keyed to the following HRSA objectives:

- Expand the capacity of the health care safety net.
- Preserve the financial integrity of HRSA's programs and activities.

This program provides payments to freestanding children's teaching hospitals to enhance their financial viability and to help them maintain graduate medical education (GME) training programs which expands the capacity of the health care safety net and improves access to health care.

Performance measure information is used by the program to assess the success of the CHGME PP in helping maintain graduate medical education programs and FTE resident counts in children's hospitals nationwide.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Expand the capacity of the health care safety net.

7.I.A.1. Maintain the number of FTE residents in training in eligible children's teaching hospitals.

In 2006 and 2007, the program exceeded its target for this program measure by 415 residents and 515 residents respectively. In 2007, the target was 4,828 residents and the actual count was 5,343. The FY 2009 target is 5,343.

7.VII.C.1. Percent of hospitals with verified FTE residents counts and caps.

In 2008 as in previous years, the program met the target of 100% of hospitals with verified FTE resident counts and caps. The target continues to be 100%.

7.E. Percent of payments made on time.

The efficiency goal for the CHGME Payment Program is to make 100 percent of DME and IME Payments to children's hospitals on time. For 2008 as in previous years, the Program made 100 percent of all payments on time. The target continues to be 100%.

NATIONAL PRACTITIONER DATA BANK

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Improve the quality of health care.								
8.III.B.1	Increase annually the use of the NPDB for licensing and credentialing decision-making, operationalized as the number of licensing and credentialing decisions which limit practitioner's ability to practice because of information contained in NPDB reports. (Baseline – 2005: 44,500 Decisions)	44,500 Decisions	46,450 Decisions	45,550 Decisions	47,200 Decisions	46,075 Decisions	Feb-09	46,600 Decisions
8.III.B.2	Increase annually the number of times information provided by NPDB is considered useful by the querying entity which received it. (Baseline - 2005: 451,400)	451,400	475,300	456,300	479,500	475,300	Feb-09	480,700

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Efficiency Measure								
8.E	Increase annually the number of queries for which NPDB and HIPDB responded within 240 minutes.	4,414,000	4,549,800	4,701,000	4,710,600	4,792,000	Feb-09	4,883,000

INTRODUCTION

The National Practitioner Data Bank (NPDB) program's performance measures and activities build upon HRSA's long-range goal to "Improve the Quality of Health Care" and are keyed to the following HRSA objective:

- Promote patient safety and improve patient protections

This program maintains a data base that identifies physicians and dentists who have malpractice judgments against them, sanctions from medical boards, or who have lost memberships in professional medical societies. This database restricts the ability of physicians and dentists with poor practice records or who have exhibited unprofessional behavior from moving State-to-State without disclosing previous damaging or incompetent performance. Potential employers will be able to make better hiring decisions that will provide for a better quality health workforce.

Performance measure information, some of which is updated monthly, is used by the program to assess the success of the Data Banks in meeting goals for querying and use of the information by queriers for decision making in individual licensing and credentialing cases. Overall the information, which is assessed annually, is used to help determine the degree to which the program is meeting the needs of the queriers. A strategy the Program uses is to regularly conduct surveys to assess the utility of its information to customers, customer satisfaction, and areas on which improvement efforts should be focused.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Promote patient safety and improve patient protections.

8.III.B.1. Increase annually the use of the NPDB for licensing and credentialing decision-making, operationalized as the number of licensing and credentialing decisions which limit practitioner's ability to practice because of information contained in NPDB reports.

In FY 2007, 47,200 licensing or credentialing decisions were impacted by information supplied by the NPDB. This was an increase over the FY 2006 actual of 46,450 and exceeded the FY 2007 target by more than 3 percent. Implementation of Section 1921of the SSA regulations will place most reports currently housed in the HIPDB into the NPDB. This is expected to substantially increase use of NPDB over what is shown in the previous table. At this time, it is uncertain when these regulations will be adopted. Future targets will be adjusted as needed after Section 1921 regulations are adopted. A target of 46,600 decisions has been set for FY 2009.

8.III.B.2. Increase annually the number of times information provided by NPDB is considered useful by the querying entity which received it.

In 479,500 cases in FY 2007, the querying entity considered the information provided by NPDB to be useful. This was an increase over the FY 2006 actual of 475,300 and exceeded the FY 2007 target by about 5 percent. The FY 2009 target is 480,700 cases.

8.E. Increase annually the number of queries for which NPDB and HIPDB responded within 240 minutes.

The length of time it takes the NPDB-HIPDB to process a query and return results to the querier has been reduced while both the number of queries and the number of reports in the system have continually increased. When the NPDB opened in 1990, it took days to process queries. The system has changed from paper documents to an internet-based system containing electronic documents. Queries are now responded to within 240 minutes. The volume of queries has increased greatly over the years, to over 4.7 million queries in FY 2007 that were responded to within 240 minutes. The FY 2009 target is 4.9 million queries.

HEALTHCARE INTEGRITY AND PROTECTION DATA BANK

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Improve the quality of health care								
8.III.B.3	Increase annually the use of the HIPDB for licensing and credentialing decision-making, operationalized as the number of licensing and credentialing decisions which limit practitioner's ability to practice because of information contained in HIPDB reports. (Baseline - 2005: 1,120 Decisions)	1,120 Decisions	1,150 Decisions	1,190 Decisions	1,300 Decisions	1,225 Decisions	Feb-09	809[a] Decisions
8.III.B.4	Increase annually the number of times information provided by HIPDB is considered useful by the querying entity which received it.	11,400	11,650	12,100	13,150	12,450	Feb-09	8,217[a]

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Efficiency Measure								
8.E	Increase annually the number of queries for which NPDB and HIPDB responded within 240 minutes.	4,414,000	4,549,800	4,701,000	4,710,600	4,792,000	Feb-09	4,883,000

Note:

[a] The FY 2009 target was developed with the assumption that the final regulations implementing Section 1921 of the SSA would go into effect in FY 2009. At this time, it appears that these regulations will not go into effect in FY 2009.

INTRODUCTION

The Healthcare Integrity and Protection Data Bank (HIPDB) program's performance measures and activities build upon HRSA's long-range goal to "Improve the Quality of Health Care" and are keyed to the following HRSA objective:

- Promote patient safety and improve patient protections

This program maintains a data base that provides critical information to State and Federal agencies, law enforcement officials, and health plans concerning adverse licensure and contract actions; health care related judgments; and criminal convictions against health care practitioners, providers and suppliers. This information is to combat fraud and abuse in health insurance and health care delivery to protect patients and provide for a better health care system.

Performance measure information, some of which is updated monthly, is used by the program to assess the success of the Data Banks in meeting goals for querying and use of the information by queriers for decision making in individual licensing and credentialing cases. Overall the information, which is assessed annually, is used to help determine the degree to which the program is meeting the needs of the queriers.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Promote patient safety and improve patient protections.

8.III.B.3. Increase annually the use of the HIPDB for licensing and credentialing decision-making, operationalized as the number of licensing and credentialing decisions which limit practitioner's ability to practice because of information contained in HIPDB reports.
(Baseline – 2005: 1,120 Decisions)

In FY 2007, 1,300 licensing or credentialing decisions were impacted by information supplied by the HIPDB. This was an increase over the FY 2006 actual of 1,150 and about 9 percent above the target. Implementation of Section 1921 regulations will place most reports currently in the HIPDB into the NPDB. This is expected to substantially decrease querying of the HIPDB. The FY 2009 target is 809 decisions. The FY 2009 target was developed with the assumption that the final regulations implementing Section 1921 of the SSA would go into effect in FY 2009. At this time, it appears that these regulations may not go into effect in FY 2009.

8.III.B.4. Increase annually the number of times information provided by HIPDB is considered useful by the querying entity which received it.

In 13,150 cases in FY 2007 the querying entity considered the information provided by HIPDB to be useful. This represents an increase over the FY 2006 actual of 11,650 and is about 8 percent above the target level. The FY 2009 target is 8,217 cases. The targets will be adjusted as needed after Section 1921 regulations are adopted.

8.E. Increase annually the number of queries for which NPDB and HIPDB responded within 240 minutes.

The length of time it takes the NPDB-HIPDB to process a query and return results to the querier has been reduced while both the number of queries and the number of reports in the system have continually increased. When the NPDB opened in 1990, it took days to process queries. The system has changed from paper documents to an internet-based system containing electronic documents. Queries are now responded to within 240 minutes. The volume of queries has increased greatly over the years, to over 4.7 million queries in FY 2007 that were responded to within 240 minutes. The FY 2009 target is 4.9 million queries.

MATERNAL AND CHILD HEALTH

Programs included in this section are:

- Maternal and Child Health Block Grant - Title V
- Traumatic Brain Injury
- Universal Newborn Hearing Screening and Early Intervention
- Emergency Medical Services for Children
- Healthy Start
- Family-to-Family Health Information Centers

MATERNAL AND CHILD HEALTH BLOCK GRANT – TITLE V

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Expand the capacity of the health care safety net.								
10.1[a]	Decrease the number of uninsured children. (Baseline - 2006: 8.7 M)		8.7 M			8 M [a]	Nov-09	
Long-Term Objective: Promote outreach efforts to reach populations most affected by health disparities								
10. IV.B.1	Decrease the ratio of the black infant mortality rate to the white infant mortality rate.	2.4 to 1	2.4 to 1 [b]	2.2 to 1	Nov-09	2.2 to 1	Nov-10	2.1 to 1
Long-Term Objective: Promote effectiveness of health care services								
10.III.A.1	Reduce the infant mortality rate. (Baseline - 2005: 6.9/1,000	6.9/1,000	6.7/1,000[b]	6.8/1,000	Nov-09	6.8/1,000	Nov-10	6.7/1,000
10. III.A.2	Reduce the incidence of low birth weight births.[c]	8.2%	8.3% [c]	8.2%	Nov-09	8.2%	Nov-10	8.2%
10.III.A.3	Increase percent of pregnant women who received prenatal care in the first trimester.	83.9%	DNA [d]	84%	Nov-09	85%	Nov-10	86%
10.2	Reduce the national rate of neonatal deaths per 1,000 live births. (Baseline - 2005: 4.6/1,000 live births)	4.6/1,000				4.5/1,000[a]	Nov-10	
10.III.A.4	Increase percent of very low-birth weight babies who are delivered at facilities for high-risk deliveries and neonates.	73.4.%	74.7%	74.5%	Nov-09	75%	Nov-10	75.5%
10.3	Increase maternal survival rate. (Baseline - 2005: 15.1 deaths/100,000 live births)	15.1/100,000				8.0/100,000[a]		

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Expand the capacity of the health care safety net.								
10.I.A.1	Increase the number of children served by Title V.	27.8 M	29 M	22 M	31.7 M	28 M	Nov-09	29 M
10.I.A.2	Increase the number of children receiving Title V services who are enrolled in and have Medicaid and SCHIP coverage.	10.1 M	11 M	9.8 M	12.8 M	11 M	Nov-09	11.5 M
Efficiency Measure								
10.E	Increase the number of children served by Title V Block Grant per $1 million in funding.	38,402	41,868	32,500	45,792	38,000	Nov-09	39,000

Notes:

[a] Long-term measure with original 2008 out-year target date.

[b] Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2008. Deaths: Preliminary Data for 2006, National Vital Statistics Reports, Vol. 56, No. 16, June 11, 2008.

[c] Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2007. Births: Preliminary Data for 2006, National Vital Statistics Reports, Vol. 56, No. 7, December 2007.

[d] Data not available. Preliminary birth data for 2006 compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (National Vital Statistics Report, Vol. 56, No. 7) do not include a description of Maternal Lifestyles and Health Characteristics, such as risk factors during pregnancy. It is anticipated that the final 2006 birth data (expected to be released in January 2009) will include these data.

INTRODUCTION

Since its inception, the Title V Maternal and Child Health (MCH) Block Grant program has provided a foundation for ensuring the health of the Nation's mothers, infants, children, adolescents, including children and adolescents with special health needs, and families. The MCH Block Grant supports a wide variety of services that address the Title V legislative requirements and the strategic goals outlined by HHS, HRSA and MCHB. Consistent with other HRSA programs, State Title V programs use their appropriated MCH Block Grant funds to address three overarching goals: 1) improving access to health care; 2) eliminating health disparities; and 3) improving the quality of health care. Progress in meeting these goals is assessed through the examination of the annual performance measure and indicator data that is reported by States. While each measure addresses a different aspect of health care delivery specific to pregnant and breastfeeding women, infants, children and adolescents, the measures collectively provide a snapshot into the health, safety and well-being of the Nation's MCH population. The Program utilizes these findings to identify emerging public health needs and critical issues relative to MCH. A strategy used in efforts to improve performance is to provide needed technical assistance to States in areas identified in their needs assessment plans and in their annual applications. Another strategy is to identify and promote promising practices that can be used by State MCH programs to improve MCH outcomes. The program also supports States in their efforts to do outreach to increase participation in Medicaid and SCHIP.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Expand the capacity of the health care safety net.

10.1. Decrease the number of uninsured children.

(Baseline – 2006: 8.7 million; Target – 2008: 8 million, 2015: 7.7 million)

Long-Term Objective: Promote outreach efforts to reach populations most affected by health disparities.

10.IV.B.1 Decrease the ratio of the black infant mortality rate to the white infant mortality rate.

While there has been progress in reducing infant mortality rates for both racial groups, the proportional discrepancy between Blacks and Whites has remained largely unchanged. Preliminary data indicate that the Black/White Infant Mortality Ratio declined slightly in FY 2006 to 2.4 to 1. The target of 2.2 to 1 was not met; however, there was continuing progress in moving towards the target. (See section on "Targets Substantially Exceeded or Not Met.") Rates for FY 2003, FY 2004, and FY 2005 were 2.43 to 1, 2.44 to 1, and 2.38 to 1 respectively. The target for FY 2009 continues to be 2.1 to 1.

Long-Term Objective: Promote effectiveness of health care services.

10.III.A.1. Reduce the infant mortality rate.

All countries of the world measure the infant mortality rate as an indicator of general health status. The U.S. has made progress in reducing this rate; however, since 2002, the rate has plateaued. Race/ethnicity, maternal age, education, smoking, and number of pregnancies are all factors that contribute to the infant mortality rate.

The overall infant mortality rate decreased slightly from 7.0 per 1,000 births in 2002 to 6.9 per 1,000 live births in 2005. Based on preliminary data, the rate declined to 6.7 per 1,000 live births in 2006. The performance goal for 2005 was met. Performance in 2006 tentatively exceeded the target of 6.8 per 1,000 live births, pending the release of the final vital statistics data. The FY 2009 target is 6.7/1,000.

10.III.A.2. Reduce the incidence of low birth weight (LBW) births.

In the past 15 years, the distribution of birthweights in the U.S. has shifted towards lower weights. The percentage of infants weighing less than 3,500 grams at birth has risen. Birthweight is an important predictor of early death and long-term disability. The lower an infant's birthweight, the greater the risk for a poor outcome.

The LBW rate (less than 2,500 grams) increased from 7.8 percent in 2002 to 8.2 % in 2005, which was the highest level reported since 1969. Preliminary data indicate that the rate further increased to 8.3 percent in 2006. The FY 2005 and FY 2006 program targets of 7.4 % were not met. (See section on "Targets Substantially Exceeded or Not Met.") The revised FY 2009 target for this measure is 8.2 %.

10.III.A.3. Increase percent of pregnant women who received prenatal care in the first trimester.

Overall, the proportion of pregnant women entering prenatal care in the first trimester has increased over the last decade (from 75.8% in 1990 to 83.9% in 2005). The percent of pregnant women who received prenatal care in the first trimester increased to 84.1 % and 84.2 % in FY 2003 and FY 2004, respectively. While the FY 2005 rate was slightly lower, the target of 84% was essentially met. Preliminary birth data for FY 2006 released by the CDC did not include data on the initiation of prenatal care, such as risk factors during pregnancy. The FY 2009 target for this measure is 86%.

Data on the timing of prenatal care are derived from the 1989 and the 2003 Revisions of the U.S. Standard Certificate of Live Birth. It is important to note that the two formats are not directly comparable, due to substantive changes in how information is reported on the timing of prenatal care in the 2003 Certificate. For 2005, data based on the 1989 Certificate (unrevised) are available for 37 States and data based on the 2003 Certificate (revised) are available for 12 States. For consistency purposes, the data presented through 2005 and the established targets through 2009 reflect the data that were reported by States using the unrevised Certificate.

Prenatal care is one of the most important interventions for ensuring the health of pregnant women and their newborn babies. High quality prenatal care begins early in the pregnancy (preferably in the first trimester), and continues throughout the pregnancy, according to accepted standards of periodicity. Accordingly, getting pregnant women into early and regular prenatal care has been a key area of emphasis for the Title V program. The program is strongly committed to achieving the Healthy People 2010 goal of getting 90% of all pregnant women into prenatal care in the first trimester.

10.2. Reduce neonatal deaths to 4.5 per 1,000 live births.
(Baseline – 1999: 4.7/1,000; Target – 2008: 4.5/1,000, 2015: 4.2/1,000)

10.III.A.4. Increase percent of very low-birth weight (VLBW) babies who are delivered at facilities for high-risk deliveries and neonates.

The Title V program plays an important role in the delivery of appropriate and effective care for high-risk pregnant women and infants. Delivering VLBW babies, who are at higher risk for mortality and morbidity than non-LBW babies, at facilities with specialized equipment and personnel capable of the highest standard of care for these babies, significantly assists in reducing their associated mortality.

The percent of VLBW babies delivered at facilities for high-risk deliveries and neonates declined from 75.2 % in FY 2002 to 71.7 % in FY 2004. Since FY 2004, there has been steady improvement in the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates, with rates at 73.4 % and 74.7 % for FY 2005 and FY 2006, respectively. Revised as part of the FY 2008 PART reassessment, the FY 2006 target of 74% was met. The revised target for FY 2009 is 75.5 %.

10.3. Increase maternal survival rate.
(Baseline – 1999: 8.3 deaths/100,000 live births; Target – 2008: 8/100,000 live births, 2015: 13.1/100,000 live births)

Long-Term Objective: Expand the capacity of the health care safety net.

10.I.A.1. Increase the number of children served by Title V.

Services for children supported under the Title V MCH Block Grant program include: the provision of direct health care, enabling services, population-based services, and infrastructure building activities. Since FY 2003, the number of children served by Title V has been increasing. Due to increases in screening services, the number of children served by Title V increased by 4 million between FY 2003 and FY 2004. The number of children served by Title V varies within a State from year to year. In FY 2007, the largest number of children (31.7 million) was served by Title V since data collection began in the Title V Information System in the 1990's. The number served exceeds the FY 2007 target by 9.7 million. (See section below on “Targets Substantially Exceeded or Not Met.”) The FY 2009 target for this measure is that 29 million children will be served by Title V.

10.I.A.2. Increase the number of children receiving Title V services who are enrolled in and have Medicaid and SCHIP coverage.

The number of children receiving Title V services covered by Medicaid and SCHIP increased from a baseline of 5.9 million in FY 2002 to 12.8 million in FY 2007. The number served exceeded the FY 2007 target by 3 million. (See section below on "Targets Substantially Exceeded or Not Met.") Between FY 2002 and FY 2003, the number of children served by Title V who received these services increased by 3.8 million. The Title V program has continued to serve an increasing number of children with Medicaid and SCHIP coverage since FY 2004, with annual increases ranging between 0.1 million between FY 2003 and FY 2004 and 1.8 million between FY 2006 and FY 2007. These increases reflect the efforts of State MCH programs to provide outreach to populations eligible for Medicaid and SCHIP coverage. The FY 2009 target for this measure is that 11.5 million children with Medicaid and SCHIP coverage will be served by Title V.

10.E. Increase the number of children served by the Title V Block Grant per $1 million in funding.

The Title V Block Grant program provides States with Federal funds for a wide variety of health projects to improve the lives of all women and children. These funds are spent by the States to support services for the maternal and child health populations, including children with special health care needs, at four levels – direct services, enabling services, population-based services, and infrastructure-building.

Per $1 million in funding, the number of children receiving direct, enabling and population-based services through the Title V MCH Block Grant in FY 2007 reached its highest level at 45,792 since data reporting for this measure began. This level of service exceeded the FY 2007 target of 32,500 by approximately 41 percent. (See section below on "Targets Substantially Exceeded or Not Met.") The FY 2009 target for this measure is 39,000.

TARGETS SUBSTANTIALLY EXCEEDED OR NOT MET

Measure: Decrease the ratio of the black infant mortality rate to the white infant mortality rate.

FY 2006 Target: 2.2 to 1
FY 2006 Result: 2.4 to 1 (Preliminary data)

While the U.S. has made progress in reducing the overall infant mortality rate, the significant disparity that still exists seriously impacts selected racial groups. The Black infant mortality rate is more than twice the White rate. Research has suggested that a higher rate of very low birth weight among Blacks may contribute to, but does not fully explain, racial differences in infant mortality rates. Additional research is needed to identify factors that contribute to the black/white infant mortality disparity and to examine potential solutions.

The Program continues to monitor the Black/White Infant Mortality Ratio and to explore promising models and effective strategies for addressing this issue. Despite the slow rate of progress, the Program's targets of 2.2 to 1 and 2.1 to 1 for FY 2008 and FY 2009, respectively, reflect the Program's ongoing commitment for continued improvement in this area.

Measure: Reduce the incidence of low birth weight (LBW) births.

FY 2006 Target: 7.4%
FY 2006 Result: 8.3 % (Preliminary data)

The increasing rate of LBW births is a recognized concern across the Nation. The percentage of infants born LBW has increased 17 percent since the mid-1990s and 22 percent since 1984. Recent increases are influenced by the rise in the multiple birth rate, greater use of obstetric interventions, and increases in maternal age at childbearing. While multiple births are much more likely to be born LBW than singletons, the LBW rate for infants born in single deliveries has also been on the increase. Singleton LBW rose from 6.3 to 6.4 percent for 2004-2005, and the rate has risen 7 percent since 2000. LBW levels also increased for 2004-2005 among each of the largest racial/ethnic groups (non-Hispanic White births rose from 7.2% to 7.3%; non-Hispanic Black births rose from 13.7% to 14%; and Hispanic births rose from 6.8% to 6.9%).

The Program continues to monitor the rate of LBW and its causes. The full reasons for the increasing rate of LBW births are unclear and are under investigation. Despite recent increases, the Program remains committed to improvement in this area. Given these trends, however, the Program's performance targets for FY 2008 and FY 2009 were revised to 8.2 %.

Low birth weight is associated with short-term morbidity and mortality, as well as long-term disabilities, such as cerebral palsy, autism, mental retardation, vision and hearing impairments, and other developmental disorders. The reduction of the incidence of low birth weight babies would substantially reduce the risk of, and therefore the number of, babies that die in their first year of life, or suffer from long-term disabilities.

Measure: Increase the number of children served by Title V.

FY 2007 Target:	22 million
FY 2007 Result:	31.7 million

The number of children served by Title V is a critical measure of the degree to which the program is successful in reaching and providing services to one of its key target populations. From 1997 through 1999, the number of children served by Title V increased steadily. In 2000, there was a temporary slight decrease from 23.0 million to 22.8 million. Increases in screening services contributed to a large increase in the number of children served by Title V in FY 2004. Given the variability in screening services provided for children within the States from year to year and the reductions in State MCH Block Grant allocations since FY 2004, participation data for multiple years were collected to determine if the increases in the number of children served by Title V performance could be maintained.

The Program continues to monitor the number of children served by Title V. Targets for FY 2008 and 09 were adjusted.

Measure: Increase the number of children receiving Title V services who are enrolled in and have Medicaid and SCHIP coverage.

FY 2007 Target: 9.8 million
FY 2007 Result: 12.8 million

Between FY 2002 and FY 2003, the number of children receiving Title V services who had Medicaid and SCHIP coverage increased from 5.9 million children to 9.7 million. The continuing increases in the number of children served by Title V who have Medicaid and SCHIP coverage since FY 2003 reflect the ongoing efforts of the State to do outreach to eligible populations and to increase participation in these programs.

The Program continues to monitor the number of children served by Title V who have Medicaid and SCHIP coverage. Targets for FY 2008 and 09 were adjusted to 11 million and 11.5 million, respectively.

Increased coverage under Medicaid and SCHIP for children receiving Title V services assures greater access, availability and continuity of care for the Nation's children through the provision of a wide range of services.

Measure: Increase the number of children served by the Title V Block Grant per $1 million in funding.

FY 2007 Target: 32,500
FY 2007 Result: 45,792

The number of children receiving services through the Title V MCH Block Grant funding mechanism has increased annually since FY 2003. Per $1 million of funding, the number of children who have received direct, enabling and population-based services through the Title V program has increased from 31,515 in 2004 to 45,792 in 2007. The FY 2007 performance was impacted by an increased number of children being served by the Title V program. This increase has been largely due to a greater number of screening services being provided to school-aged children in the States. Performance for this measure was further impacted by a reduction in the Title V MCH Block Grant funding since FY 2004.

The Program continues to monitor the number of children served by Title V and to explore opportunities for greater program efficiencies. Performance targets for FY 2008 and 09 were adjusted.

The increase in the number of children served per $1 million in Title V funding shows some level of improvement in program efficiency in using Federal funds as well as a shift toward more population-based services. Programs have also had to rely more heavily on other sources for program funding, including Medicaid and SCHIP, and to increasing the level of payments made by those receiving services.

TRAUMATIC BRAIN INJURY PROGRAM

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-term objective: Promote effectiveness of health care services.								
11.1[a]	Proportion of children with brain injury who are able to participate in community activities.[a] **(Developmental)**							

#	Key Outputs[b]	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Increase collaborative efforts to improve the capacity and efficiency of the public health and health care system.								
11.V.B.1	Increase the number of States and Territories that have achieved a minimum TBI core capacity (including State Action Plan, Statewide Needs and Resources Assessment, designated State agency staff, and State Advisory Board).	51	51	51	51 [c]	51	Nov-09	51
11.V.B.2	Increase the number of States/Territories that have begun to implement their TBI plan of action.	45	45	48	47	51	Nov-09	51
11.V.B.3	Increase the number of States/Territories that have completed at least 50% of the objectives contained in their TBI plan of action.	12	17	18	24	24	Nov-09	24
Efficiency Measure								
11.E	Decrease the application and reporting time burden of grantees by 5% per year for 4 years, thereby collecting more accurate and timely data.	171	162	154	155	147	147	139

Notes:

[a] This developmental long-term measure does not have annual targets.

[b] New annual measures are being developed to replace or supplement those shown in the table.

[c] This figure is not expected to increase since federal funds are now directed to implementation activities vs. the planning activities under which core capacity was developed.

INTRODUCTION

The Traumatic Brain Injury Program's performance measures link to HRSA's Strategic Plan goal to improve public health and health care systems, and to the related objective to increase collaborative efforts to improve the capacity and efficiency of these systems. Performance data are used to inform the Program's strategies to provide guidance and technical assistance to grantees in efforts to improve performance.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Increase collaborative efforts to improve the capacity and efficiency of public health and health care systems.

11.1 Proportion of children with brain injury who are able to participate in community activities. (Developmental)

This developmental measure focuses on the functional status and quality of life of children with TBI. Evidence suggests that children and adolescents are an important population for assessing the ability of persons with TBI to function in the community. Systems infrastructure-building for TBI programs is an integral part of enhancing and/or sustaining the functional status and quality of life for this population. The program has added questions to the National Survey of Child Health to obtain data for this measure.

11.V.B.1. Increase the number of States and Territories that have achieved minimum TBI core capacity.

Coordinated, community-based and culturally competent systems that address the needs of individuals with TBI advance the goal of access to high quality care that can improve health outcomes. The number of States and Territories that have achieved minimum core capacity to serve individuals with TBI and their families is an indicator of the extent to which the U.S. is able to provide systematic, appropriate care for individuals with TBI, including veterans with TBI who return home to continue their post-acute care in the community. In FY 2007, the number of States and Territories with core capacity was 51, meeting the target.

11.V.B.2. Increase the number of States and Territories that have begun to implement their TBI plan of action.

As States and Territories actually begin to put in place their Statewide Action Plan (based on their Statewide Needs and Resources Assessment) they are demonstrating their ability to correctly assess and meet the needs of individuals with TBI and their families. The number of States and Territories increased from 45 in 2006 to 47 in 2007, missing the 2007 target of 48 by 1.

11.V.B.3. Increase the number of States/Territories that have completed at least 50% of the objectives in their TBI plan of action.

Moving to completion of 50% of program (action plan) goals indicates steady progress towards implementation of a coordinated, community-based and culturally competent system of care for individuals with TBI and their families. The number of States and Territories that have completed at least 50% of their objectives increased from 17 in FY 2006 to 24 in 2007, exceeding the target of 18.

11.E. Decrease the application and reporting time burden of grantees by 5% per year for 4 years, thereby collecting more accurate and timely data.

A new on-line application and reporting system was implemented in FY 2005 and was fully operational in FY 2006. This system provides grantees with information from previous years, including budget and service data. This alleviates the grantees from having to supply information that was previously provided. Also, the system pre-populates figures into subsequent forms so that grantees do not have to enter the same data more than once. Reporting is also easier on the on-line system and provides program management with performance data that are far more reliable and valid, with a shorter lag time. The number of hours of application and reporting time burden of grantees decreased from 162 in 2006, meeting the 5 percent target reduction; but the time for reporting only decreased to 155 in 2007, reflecting a slower than expected adjustment to on-line processing.

UNIVERSAL NEWBORN HEARING SCREENING AND EARLY INTERVENTION

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective : Promote effectiveness of health care services								
13.1*	Increase the percentage of children with non-syndromic hearing loss entering school with developmentally appropriate language skills.* (Baseline - 2004: 20% estimated)							

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective : Promote effectiveness of health care services								
13.2	Increase the percentage of infants with hearing loss enrolled in early intervention before 6 months of age.* (Baseline - 2004: 57%)							
13.III.A.1	Percentage of infants suspected of having a hearing loss with a confirmed diagnosis by 3 months of age.	55%	36%[a]	62%	Jul-09	63%	Jul-10	40%
13.III.A.2	Percentage of infants with a suspected or confirmed hearing loss referred to an ongoing source of comprehensive health care (i.e. medical home).	80%	94%[b]	87%	DNA	88%	DNA	DNA
13.III.A.3	Percentage of infants screened for hearing loss prior to hospital discharge.	95%	92%[a]	97%	Jul-09	98%	Jul-10	98%
Efficiency Measure								
13.E	Increase the percentage of infants suspected of having hearing loss (based on the results of their newborn hearing screen) who receive a confirmed diagnosis by 3 months of age while maintaining a constant Federal expenditure.	55%	36%[a]	62%	Jul-09	63%	Jul-10	40%

Notes:

[*] This long-term measure does not have annual targets.

[a] The data source for measure numbers 13.III.A.1, 13.III.A.3, and 13.E has changed. Previously data were collected by the National Center for Hearing Assessment and Management (NCHAM), the national resource center for the Universal Newborn Hearing Screening and Intervention Program. Annual data are now collected by the CDC which uses different definitions than NCHAM. Data from the CDC Hearing Screening and Follow-up Survey (HSFS) reflects data that states and territories have *documented*, allowing no estimates.

[b] Source: The National Survey of Children with Special Health Care Needs 2005-2006.

DNA = Data not available. The National Survey will not be fielded again until 2010. There is no interim data source.

INTRODUCTION

The performance measures of the Universal Newborn Hearing Screening program link to the long-term objective to promote effectiveness of health care services under the overarching goal to improve the quality of health care. Performance measure data is used by the program for quality improvement. A current strategy to improve performance is to shift program emphasis to reducing the number of children who are lost to follow-up.

DISCUSSION OF RESULTS AND TARGETS

13.1. Increase the percentage of children with non-syndromic hearing loss entering school with developmentally appropriate language skills.

13.2. Increase the percentage of infants with hearing loss enrolled in early intervention before 6 months of age.

13.III.A.1. Percentage of infants suspected of having a hearing loss with a confirmed diagnosis by 3 months of age.

While major success has been achieved in screening infants for hearing loss before hospital discharge, those suspected of a hearing loss are receiving timely re-screening and diagnostic services only about 55 percent of the time, as reported for 2005. Many of the reasons, such as health provider information about hearing loss in infants, a dearth of audiologists capable of caring for infants, and inadequate data and tracking systems have been identified and mechanisms to address these problems are being developed and implemented. Trends in results for this performance measure include an increase from 50 percent in 2004 to 55 percent in 2005. The figure was 36% in 2006, missing the target of 60%. (See section on "Targets Substantially Exceeded or Not Met.")

13.III.A.2. Percentage of infants with a suspected or confirmed hearing loss referred to an ongoing source of comprehensive health care (i.e. medical home).

Limited research on health outcomes for CSHCN indicates that those children who are in a medical home fare better than those receiving health care in settings where there is no mechanism for care coordination. States are encouraged to identify a medical home for each infant suspected of a hearing loss, and to assist the medical home in assuring appropriate and timely follow-up for those infants and their families. A variety of tools have been developed in conjunction with the American Academy of Pediatrics (AAP) to support the medical home in caring for infants with a suspected (or confirmed) hearing loss and their families. Available data for 2005 indicate that 80 percent of infants with a suspected or confirmed hearing loss were referred to an ongoing source of comprehensive care. In 2006 94% were referred to an ongoing source of care. The 2006 target was 96%.

13.III.A.3. Percentage of infants screened for hearing loss prior to hospital discharge.

The number of infants receiving a physiologic screening test for hearing loss prior to discharge from the newborn nursery has increased dramatically over the past several years. In 2006, States reported that 92 percent of infants were screened. This was a decrease from 95 percent of infants screened in 2005. The decrease is a function of a change in data source. Data that were collected by the National Center for Hearing Assessment and Management (NCHAM) have been replaced by Center for Control and Prevention (CDC), whose definitions differ from NCHAM. NCHAM no longer collects national data on these items. Additional gains are to be achieved by focusing on infants born at home or in other out-of-hospital settings, transferred infants who require neonatal intensive care, and births in small hospitals where screener experience is limited.

13.E. Increase the percentage of infants suspected of having hearing loss (based on the results of their newborn hearing screen) who receive a confirmed diagnosis by 3 months of age while maintaining a constant Federal expenditure.

Increasing the percentage of infants who receive a confirmed diagnosis by 3 months of age while maintaining a consistent level of Federal funding, should that funding continue, would indicate increased program efficiency. In 2005, 55 percent of infants screened received a confirmed diagnosis by three months of age, as compared to 50 percent in 2004. In 2006, 36% of infants screened received a confirmed diagnosis by three months of age. The percentage decrease from 2005 to 2006 can be attributed to a change in data source. (See section on “Targets Substantially Exceeded or Not Met.”)

TARGETS SUBSTANTIALLY EXCEEDED OR NOT MET

Measure: Percentage of infants suspected of having a hearing loss with a confirmed diagnosis by 3 months of age.

FY 2006 Target: 60%
FY 2006 Actual: 36%

Measure: Increase the percentage of infants suspected of having hearing loss (based on the results of their newborn hearing screen) who receive a confirmed diagnosis by 3 months of age while maintaining a constant Federal expenditure.

FY 2006 Target: 60%
FY 2006 Actual: 36%

Trends in results for this performance measure included an increase from 50 percent in 2004 to 55 percent in 2005. However, FY 2006 shows an actual of 36% due to a change in the data source for these measures.

The data source for measure numbers 13.III.A.1 and 13.E has changed. Previously data were collected by the National Center for Hearing Assessment and Management (NCHAM), the national resource center for the Universal Newborn Hearing Screening and Intervention program. Annual data are now collected by the CDC which uses different definitions than NCHAM. Data from the CDC Hearing Screening and Follow-up Survey (HSFS) reflects data that states and territories have *documented*, allowing no estimates. Future targets have been adjusted to reflect this change in data collection.

While major success has been achieved in screening infants for hearing loss before hospital discharge, those suspected of a hearing loss are not always receiving timely re-screening and diagnostic services. Many of the reasons, such as health provider information about hearing loss in infants, a dearth of audiologists capable of caring for infants, and inadequate data and tracking systems have been identified and mechanisms to address these problems are being developed and implemented. Examples include a publication by the American Academy of Pediatrics (AAP) of on-line resources for health providers caring for an infant with hearing loss in their practice, and designation of funds to increase pediatric audiology content in graduate level audiology training programs.

EMERGENCY MEDICAL SERVICES FOR CHILDREN

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Promote effectiveness of health care.								
14.1[a]	Mortality rate for children with an injury severity score (ISS) greater than 15. (Baseline - 2005: 9.1%) [a]							8.7%

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target [b]	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Promote effectiveness of health care.								
14.V.B.1	Increase the number of awardees that demonstrate the operational capacity to provide pediatric emergency care, including all core capacity elements related to: (a) on-line and off-line medical direction at the scene of an emergency for Basic Life Support (BLS) and Advanced Life Support providers, (b) essential pediatric equipment and supplies, (c) designation of pediatric specialty care hospitals, and inter-facility transfer agreements. (Baseline - 2005)	20	20	28	22	21	Jul-09	24
14.V.B.2	Increase the number of awardees that have adopted requirements for pediatric emergency education for the re-certification of paramedics. (Baseline - 2005	37	21	43	23	22	Jul-09	25
14.V.B.3[b]	Transfer rate for children with an injury severity score (ISS) of 15 or more.) [b] **(Developmental)**							
Efficiency Measure								
14.E	Decrease the application and reporting time burden of grantees by 5% per year for 4 years, thereby collecting more accurate and timely data.	90 hours	125	90	90	90	Jul-09	85

Notes:

[a] This long-term measure does not have annual targets.

[b] This new developmental annual measure does not currently have annual targets.

INTRODUCTION

The performance measures of the Emergency Medical Services for Children (EMSC) Program are linked to HRSA's Strategic Plan objective of increasing collaborative efforts to improve the capacity and efficiency of the public health and health care system. These performance measures are designed to assist State EMS programs to measure progress toward achieving high quality services for children's emergencies. The measures help States to focus their resources on pediatric program components in greatest need. Tracking progress also helps the Federal program implement its strategies to target technical assistance and fiscal resources to States needing help, and to identify successful State programs which then are used as models to assist States that need to improve.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Increase collaborative efforts to improve the capacity and efficiency of the public health and health care system.

14.1 Mortality rate for children with an injury severity score (ISS) greater than 15.

The EMSC program is designed to ensure state-of-the-art emergency medical care for ill or injured children and adolescents. It covers the entire spectrum of emergency medical care. This measure was selected as a measure of performance because the right emergency care should result in reduced mortality.

14.V.B.1. Increase the number of awardees that demonstrate the operational capacity to provide pediatric emergency care, including all core capacity elements related to: (a) on-line and off-line medical direction at the scene of an emergency for Basic Life Support (BLS) and Advanced Life Support providers, (b) essential pediatric equipment and supplies, (c) designation of pediatric specialty care hospitals, and inter-facility transfer agreements.

The EMS System was originally designed to address the needs of adults. The purpose of this program is to increase awareness of the specific needs of children in emergency situations, and increase EMS capacity to address them. The number of States that demonstrate the operational capacity to provide pediatric emergency care provides a critical indicator of the degree to which the appropriate care for children has been integrated into the EMS system.

In 2007, 22 States were considered to have met the operational capacity to provide pediatric emergency care, based upon reports from individual States. This was an increase over 2006 but did not meet the 2007 target. (See section below on "Targets Substantially Exceeded or Not Met.") Collection of the data is a requirement of the State Partnership grant program.

14.V.B.2. Increase the number of awardees that have adopted requirements for pediatric emergency education for the re-certification of paramedics.

The adoption of guidelines for pediatric emergency care training/education for pre-hospital providers is an integral component of the EMSC Program and helps to ensure the provision of appropriate pediatric emergency care across the continuum of care. In 2007, the number of awardees that met this goal was 23, and is expected to increase annually. This was an increase over 2006 but did not meet the 2007 target. (See section below on "Targets Substantially Exceeded or Not Met.")

14.V.B.3. Transfer rate for children with an injury severity score (ISS) of 15 or more. (Developmental)

The EMSC program seeks to improve the inter-facility transfer rate to hospitals that have the special expertise to care for critically ill or injured children. By improving the inter-facility transfer rate, it is expected that mortality rates for critically ill and injured children will improve.

14.E. Decrease the application and reporting time burden of grantees by 5% per year for 4 years, thereby collecting more accurate and timely data.

A new on-line application and reporting system was implemented in FY 2005 and became fully implemented in FY 2006 through grants.gov and HRSA's Electronic Handbook. This system provides grantees with information from previous years, including budget and service data. This alleviates the grantees from having to supply information that was previously provided. Also, the system pre-populates figures into subsequent forms so that grantees do not have to enter the same data more than once. Reporting is also easier on the on-line system and provides program management with performance data that are far more reliable and valid, with a shorter lag time.

The previous baseline estimate of 180 hours per application in 2004 has been revised to 84 hours per application based on more complete information from grantees. In 2005 the application reporting time was 90 hours. The time burden increased because some grantees were learning to use the electronic process. The time increased again in 2006, but the increase to 125 hours was lower than the expected 171 hour increase. This is most likely due to the grantees having an additional year of experience in utilizing HRSA's Electronic Handbook.

TARGETS SUBSTANTIALLY EXCEEDED OR NOT MET

Measure: Increase the number of awardees that demonstrate the operational capacity to provide pediatric emergency care.

FY 2007 Target: 28
FY 2007 Result: 22

The fact that the target was not met is due to a change in 2006 in the definition of what is required to meet the performance standard. The current definition and method of data collection are more rigorous than when the target was established. As a result, many States that reported meeting all components in 2005 did not meet the requirement for the 2006 and 2007 reporting. In areas such as "essential pediatric equipment and supplies," for example, some States may be missing only one piece of equipment, but these States are now considered as not meeting the essential pediatric equipment requirement. States must completely meet all three categories of core elements in order to be considered as demonstrating the operational capacity to provide pediatric emergency care.

Measure: Increase the number of awardees that have adopted requirements for pediatric emergency education for the re-certification of paramedics.

FY 2007 Target: 43
FY 2007 Result: 23

The target was not met because the requirements for pediatric emergency education for the re-certification of paramedics were made more rigorous based on feedback from national stakeholders to add the specification that the requirement for recertification be state-mandated through statute, rules, or regulations. This change resulted in fewer states being able to meet the performance standard. While the number of States meeting this performance measure decreased, the amount of pediatric emergency education in the removed States did not diminish. Rather, training in these States is not yet mandated through statute, rules or regulation.

HEALTHY START

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Expand the availability of health care, particularly in underserved, vulnerable, and special needs populations.								
12.1*	Reduce the infant mortality rate (IMR) among Healthy Start program clients.* (Baseline - 2004: 7.65 per 1,000)							
12.2*	Reduce the neonatal mortality rate among Healthy Start program clients.* (Baseline - 2004: 4.8 per 1,000)							
12.3*	Reduce the post-neonatal mortality rate among Healthy Start program clients.* (Baseline - 2004: 2.82 per 1,000)							
Long-Term Objective: Promote the effectiveness of health care services								
12. III.A.1	Increase annually the percentage of women participating in Healthy Start who have a prenatal care visit in the first trimester.	66%	68%	75%	Oct-09	75%	Oct-10	75%
12.III.A.2	Decrease annually the percentage of low birth weight infants born to Healthy Start program participants.	10.8%	10.3	9.2%	Oct-09	9.7%	Oct-10	9.6%

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Promote the effectiveness of health care services								
12.II.B.1	Increase annually the number of community members (providers and consumers, residents) participating in infant mortality awareness public health information and education activities. (Baseline - 2004)	333,225	338,800	337,000	376,769	340,000	Oct-09	350,000
Efficiency Measure								
12.E	Increase the number of persons served by the Healthy Start program with a (relatively) constant level of funding. (Baseline - 2002: 288,800 ($343/participant))	503,411 ($196/ participant)	493,030 ($206/ Participant)	420,000 ($242/ participant)	Oct-09	475,000 ($228/ participant)	Oct-10	485,000 ($194 participant)

Note:
* This long-term measure does not have annual targets.

INTRODUCTION

To reduce the factors that contribute to the Nation's high infant mortality rate, particularly among African-American and other disparate racial and ethnic groups, Healthy Start (HS) provides intensive services tailored to the needs of high risk pregnant women, infants and mothers in geographically, racially, ethnically, and linguistically diverse communities with exceptionally high rates of infant mortality.

The Healthy Start program's capacity to achieve its ambitious performance and outcome objectives is challenged by the multiple risk factors faced by the families they serve.
Each of the Healthy Start projects is committed to reducing disparities in perinatal health and infant mortality by transforming their communities, strengthening community-based systems to enhance perinatal care and improving the health of the women and infants in their vulnerable communities. The performance measures chosen reflect access to care and major factors, at the individual and community level, that must be overcome in order to have positive perinatal outcomes.

The Healthy Start program's performance measures allow the program to track progress toward achieving the HRSA goals to improve health outcomes and expand the availability and utilization of health care. Fluctuations that occur in the measures alert program to potential problems within the community and emerging national trends. Strategies used by Healthy Start to improve performance are to provide technical assistance, share best practices, support peer mentoring, and strengthen collaborative linkages with States and other partners both public and private. The program has undertaken a learning collaborative to enhance its projects' ability to unify the varied systems of care in their communities and increase the capacity of local providers to incorporate emerging evidence-based guidelines on preconceptional and interconceptional care.

With projects re-competing for funding every four years, projects have adjusted their service areas from areas that no longer need Healthy Start services because they have been successful in order to incorporate other neighborhoods where there is a significant need for the program. Some variation in results occurs when successful neighborhoods are phased out at the end of a four year grant period and new high risk neighborhoods are added.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Expand the availability of health care, particularly in underserved, vulnerable, and special needs populations.

12.1. Reduce the infant mortality rate (IMR) among Healthy Start program clients.

12.2. Reduce the neonatal mortality rate among Healthy Start program clients.

12.3. Reduce the post-neonatal mortality rate among Healthy Start program clients.

Long-Term Objective: Promote the effectiveness of health care services.

12.III.A.1. Increase annually the percentage of women participating in Healthy Start who have a prenatal care visit in the first trimester.

Healthy Start focuses intensive outreach efforts on enrolling hard-to-reach, high-risk women in prenatal care. The percentage of women participating in Healthy Start who had a prenatal visit in the first trimester fell from 70 percent in 2004 to 68 percent in 2006, which was below the target. This reduction was expected due to a major resurgence in barriers to early access to prenatal care. (See section below on "Targets Substantially Exceeded or Not Met.") Because of the commitment of the Healthy Start projects to reach out to high risk women, the FY 2009 target remains at 75%. (Note: Due to a significant difference in the definition of when prenatal care begins, the Healthy Start performance measure cannot be compared to HEDIS national estimates of entry into prenatal care.)

12.III.A.2. Decrease annually the percentage of low birthweight infants born to Healthy Start program participants.

Healthy Start is designed to reduce adverse perinatal outcomes, such as low birthweight (LBW) and infant mortality, by helping communities identify, plan and implement a diverse range of interventions to support and improve perinatal delivery systems in project communities. Low birthweight is associated with an increased risk of infant death. The percentage of low birthweight babies born to Healthy Start clients in 2003 was 10.5% and showed a reduction to 10.3% in 2006. During the same period, the percentage of LBW births increased nationally, with the national LBW rate for African-Americans actually increasing from 13.6% in 2003 to 14.0 in 2006. The FY 2009 target of 9.6% has been adjusted to reflect the national trend.

12.II.B.1. Increase annually the number of community members (providers and consumers, residents) participating in infant mortality awareness public health information and education activities.

Each of the Healthy Start projects has committed to reducing disparities in perinatal health and infant mortality by transforming their communities, strengthening community based systems to enhance perinatal care and improving the health of the young women and infant in their vulnerable communities. This measure demonstrates the participation of community members in infant mortality awareness activities. In 2006 the number of community members estimated to participate in public health information and education activities increased to 376,769, up from 338,800 in 2006. The target for FY 2009 is 350,000.

12.E. Increase the number of persons served by the Healthy Start program with a (relatively) constant level of funding.

The program proposes to demonstrate its efficiency by serving more persons each year with a (relatively) constant level of funding. In 2006, the number of persons served by the Healthy Start program was 493,030, up from 288,800 in 2002 and exceeding the target. The target for FY 2009 is 485,000 because of expected year-to-year fluctuations.

TARGETS SUBSTANTIALLY EXCEEDED OR NOT MET

Measure: Increase annually the percentage of women participating in Healthy Start who have a prenatal care visit in the first trimester.

FY 2006 Target: 75%
FY 2006 Result: 68%

Healthy Start was not successful in meeting its target of 75% entry into prenatal care due to a resurgence of barriers to access to care, such as state budget crises, changes in financing of prenatal care at the State level, a shortage of obstetric providers due to professional liability litigation and malpractice coverage factors, and a growing trend among obstetric providers to delay the first prenatal health care visit until early in the second trimester. Along with the resurgence of these factors, many projects are adjusting their project areas to include new neighborhoods where there was a significant need for the program and eliminating neighborhoods where they were successful. Further, hurricanes affected projects such as those in the Mississippi Delta, New Orleans, Florida, and Texas resulting in the displacement of families served by the projects along with their providers.

Healthy Start is continuing to work with individual projects on identifying the challenges in their local communities as well as sharing among projects successful strategies to improve access. A learning collaborative has been established to further assist projects in strengthening their project. The program is also identifying and synthesizing evidence-based practices that contribute to improved perinatal outcomes that it will disseminate to the HS communities.

FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Promote access to, and appropriate use of health care information								
15.III.C.1	Number of families with CSHCN who have been provided information, education and/or training from Family-to-Family Health Information Centers. **(Developmental)**				35,041*	70,082		77,082
15.III.C.2	Proportion of families with CSHCN who received services from the Family-to-Family Health Information Centers reporting that they were better able to partner in decision making at any level. **(Developmental)**						TBD	TBD

Note:

* Data for the 6-month period, June 1, 2007 – December 31, 2007.

INTRODUCTION

The performance measures for the Family-to-Family Health Information Centers will help the program track progress in meeting the HRSA objective to promote access to and appropriate use of health care information and the Maternal and Child Health Bureau's goal to provide national leadership through a strategy of promoting family leadership in MCH service delivery, evaluation and program/policy development. Performance measure information will be used as a continuous quality improvement strategy, which is an evidence-based approach to ensure high levels of customer satisfaction and system efficiency. The Program will also use results to identify and address technical assistance needs and any changes that need to be made with respect to data collection and analysis.

DISCUSSION OF RESULTS AND TARGETS

15.III.C.1. Number of families with CSHCN who have been provided information, education and/or training from Family-to-Family Health Information Centers. (Developmental)

This developmental measure will capture annual progress on the extent to which 30 Family-to-Family Health Information Centers provide information, education and training to families and the impact of center services on the ability of families to partner with providers and policy makers. Technical assistance pertaining to data sources, strategies and use of the Family Voices Solutions Database is being provided on an ongoing basis. This technical assistance is via monthly conference calls, and one-on-one assistance with the National Center for Family Professional Partnerships which provides support for this group of grantees. Thirty centers are currently collecting data for FY 2007 which will be available by June, 2008. This data will establish a baseline from which FY 2008 and FY 2009 targets can be established. It is expected that follow-up data from this group of grantees will available beginning in 2009.
Three types of information are captured in this measure: 1) information that is provided via

direct one-on-one contact around a family health or access issue in person or by telephone to families with Children with Special Health Care Needs (CSHCN); 2) educational material that is provided to families, and 3) training to families during conference sessions, workshops and other activities.

The figure provided for 2007 is an average, based on a six month period from June 1, 2007- Dec. 31, 2007. This figure represents individual families (unduplicated) that were tracked by 30 grantees and aggregated by the TA center, National Center for Family Professional Partnerships. The 2008 target doubles that number and will include 41 grantees. The 2009 target increases by 10% by including the last 10 remaining centers to be funded.

15.III.C.2. Proportion of families with CSHCN who received services from the Family-to-Family Health Information Centers reporting that they were better able to partner in decision making at any level. (Developmental)

This measure will capture partnering in decision making, the enhanced ability of families to be better able to document and discuss health issues, ask questions and communicate with providers in making decisions around their children's care and in their preparation to be able to participate in systems building efforts in communities and on a State level (task forces, advisory committees, etc.). Outcomes, to be obtained through follow-up telephone calls and surveys of a sample of families served by the Centers, will be tracked. A contractor is being used to: assist program with a workgroup of selected grantees and the National Center for Family Professional Partnerships, in assessing grantee capacity to collect impact data; develop a technical assistance plan based upon this assessment; and develop strategies for grantees to collect this data that will be consistent across all grantees. Data collection has just begun after a series of initial technical assistance to all current grantees. The percentage will be reported for FY 2008.

RYAN WHITE HIV/AIDS PROGRAMS

Programs included in this section are:

- Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Summary)
- HIV Emergency Relief Grants (Part A)
- HIV Care Grants to States (Part B)
- HIV Early Intervention Services (Part C)
- HIV Women, Infants, Children and Youth Grants (Part D)
- AIDS Education and Training Centers (Part F)
- Dental Reimbursement and Community Partnership Programs (Part F)

RYAN WHITE HIV/AIDS TREATMENT MODERNIZATION ACT OF 2006 (SUMMARY)

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Expand the Capacity of the Health Care Safety Net.								
16.1*	Number of racial/ethnic minorities and the number of women served by Ryan White HIV/AIDS-funded programs.[*] (Baseline – 2005)	412,000/ 195,000						
16.I.A.1	Proportion of racial/ethnic minorities in Ryan White HIV/AIDS-funded programs served.	72% (CDC = 64.1%)	72% (CDC = 63.7%)	5 percentage points above CDC data	72%[a]	5 percentage points above CDC data	Oct-09	5 percentage points above CDC data
16.I.A.2	Proportion of women in Ryan White HIV/AIDS funded-programs served.	33% (CDC = 24%)	33% (CDC = 23%)	5 percentage points above CDC data	33%[a]	5 percentage points above CDC data	Oct-09	5 percentage points above CDC data
Long-Term Objective: Expand the Availability of Health Care, Particularly to Underserved, Vulnerable, and Special Needs Populations.								
16.2*	Reduce deaths of persons due to HIV infection.[*] (Baseline - 2003: 4.7 per 100,000)							

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Expand the Availability of Health Care, Particularly to Underserved, Vulnerable, and Special Needs Populations.								
16.II.A.1.	Number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs annually.	147,187	157,988	143,339[b]	163,927	158,739	Jan-10	142,865
16.II.A.2.	Number of persons who learn their serostatus from Ryan White HIV/AIDS Programs.	572,397	641,866	572,397	Feb-09	572,397	Feb-10	572,397
16.II.A.3.	Percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive anti-retroviral medications.	85.3%	84.7%	87.3%	Feb-09	88.3%	Feb-10	89.3%
Long-Term Objective: Promote Effectiveness of Health Care Systems.								
16.3*	Ryan White HIV/AIDS Program-funded HIV primary medical care providers will have implemented a quality management program and will meet two “core” standards included in the October 10, 2006 “Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents.”[*] (Baseline - 2005)	63.7%						

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
16.III.A.1	Percentage of Ryan White HIV/AIDS Program-funded primary medical care providers that will have implemented a quality management program.	85.7%	88.6%	90.7%	88.8%	93.2%	Aug-09	95.7%
16.III.A.2	Proportion of new Ryan White HIV/AIDS Program HIV-infected clients who are tested for CD4 count and viral load.	CD4 - 83.2% Viral Load - 79.3%	CD4- 84.9% Viral Load - 82.5%	CD4- 85.2% Viral Load - 81.3%	CD4- 83.9% Viral Load – 81.2%	CD4- 86.2% Viral Load - 82.3%	Aug-09	CD4-87.2% Viral Load - 83.3%
Efficiency Measure								
16.E.	Amount of savings by State ADAPs' participation in cost-savings strategies on medications. [c]	$275M	$258 M	1 percent over FY 2006	Apr-09	1 percent over FY 2007	Apr-10	Sustain FY 2008 results

Notes:

[*] This long-term measure does not have annual targets.

[a] CDC's data for comparison is not available as of this writing.

[b] The FY 2007 target is based on number of persons served at least one quarter of the year, rather than number of persons served annually.

[c] Cost-saving strategies are defined as rebates, third party reimbursements, and direct negotiations with pharmaceutical companies.

INTRODUCTION

The Ryan White HIV/AIDS Program's performance measures are tied to HRSA's overall goals, which serve as the performance management framework for the Program. The measures allow the Program to track progress toward reaching these goals. Specific performance measures are linked to the following HRSA goals: Improve Access to Health Care by expanding the capacity of the health care safety net; Improve Health Outcomes by expanding the availability of health care, particularly to underserved, vulnerable, and special needs populations; Improve the Quality of Health Care; and Improve the Public Health and Health Care Systems.

Several cross-cutting long-term and annual measures have been identified to use in assessing the Ryan White HIV/AIDS Program's performance. Because these goals are related to the program as a whole, rather than to specific Parts, they are presented in aggregate above. This is followed by additional Part-specific measures.

Performance measure information is used by the program to identify potential policy issues, to share best practices, for providing accountability for results, to assess training needs of Project Officers in order to assure better monitoring of grantee performance, and to evaluate the effectiveness of the program and activities and the resources spent on conducting them.

The Ryan White HIV/AIDS Program uses various strategies to achieve the performance goals including targeting resources to address the unmet care and treatment needs of persons living with HIV/AIDS who are uninsured or underinsured and therefore unable to pay for HIV/AIDS health care and vital health-related support services; assuring patient adherence and compliance (e.g., through patient education and follow-up); directing outreach and prevention education and testing to populations at disproportionate risk for HIV infection; tailoring health care and related services to populations known to have delayed care seeking behaviors (e.g. varying hours, care offered in various sites, linguistically and culturally appropriate service provision); and assuring that appropriate services are being provided in areas of greatest need, including where there are high rates of HIV infection, rural areas, and in communities with health disparities. In many instances, the Program collaborates with other Federal, State and local providers who conduct HIV testing to encourage them to refer clients who test positive to Ryan White HIV/AIDS Programs for treatment.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Expand the Capacity of the Health Care Safety Net.

16.1. Number of racial/ethnic minorities and the number of women served by Ryan White HIV/AIDS-funded programs.

(Baselines - 2005: 412,000/195,000; Targets - 2014: 422,300/199,875)

16.I.A.1. Proportion of racial/ethnic minorities in Ryan White HIV/AIDS-funded programs served. (exceeding their representation in national AIDS prevalence data reported by the CDC)

Despite the reduction seen in overall AIDS mortality, annual incidence data show that the proportion of AIDS cases among racial/ethnic minorities continues to increase. In addition, benefits provided by new combination drugs (anti-retrovirals/protease inhibitors/HAART) have not uniformly reduced the disparities in incidence of AIDS among racial/ethnic minorities. The proportion of racial/ethnic minorities served by the Ryan White HIV/AIDS Program was selected as a measure demonstrating progress toward the program's goal to improve access to health care among individuals infected with HIV/AIDS by increasing utilization for traditionally underserved populations.

Ryan White HIV/AIDS-funded programs serve a significantly higher proportion of racial/ethnic minorities than the target, which is five percentage points higher than the representation of racial/ethnic minorities among all AIDS cases in the Nation, as reported by CDC. In FY 2007, 72% of clients served in the Ryan White HIV/AIDS – funded programs were racial/ethnic minorities. (The CDC AIDS data for comparison is not available as of this writing.) Seventy-two percent (72%) of clients served in Ryan White HIV/AIDS-funded programs in FY 2006 were racial/ethnic minorities, compared to the 63.7% of CDC-reported AIDS cases. The proportion of Ryan White clients who were racial/ethnic minorities in 2005 was 72%, compared to the 64.1% of CDC-reported AIDS cases. The FY 2009 target for the proportion of racial/ethnic minorities served by the Ryan White HIV/AIDS Program continues to be 5 percentage points above CDC data for the same period.

16.I.A.2. Proportion of women in Ryan White HIV/AIDS funded-programs served. (exceeding their representation in national AIDS prevalence data reported by the CDC)

Despite the reduction seen in overall AIDS mortality, annual incidence data show the proportion of AIDS cases among women continues to increase. In addition, benefits provided by combination drugs (anti-retrovirals/protease inhibitors/HAART) have not uniformly reduced the disparities in incidence of AIDS among women. The proportion of women served by the Ryan White HIV/AIDS Program was selected as measure demonstrating progress toward the program's goal to improve access to health care among individuals infected with HIV/AIDS by increasing utilization for traditionally underserved populations.

The Ryan White HIV/AIDS-funded programs are serving a significantly higher proportion of women than the target, which is five percentage points higher than the representation of women among all AIDS cases in the Nation, as reported by CDC. The proportion of women served by the Ryan White HIV/AIDS Program in 2007 was 33%. (The CDC AIDS data for comparison is not available as of this writing.) In 2006, 33% of those clients in the Ryan White HIV/AIDS Program were women, compared to 23% of CDC-reported AIDS cases. In 2005, 33% of persons served by the Ryan White HIV/AIDS Program were women, compared to 24% of CDC-reported AIDS cases. The FY 2009 target for the proportion of women served by the Ryan White HIV/AIDS Program is 5 percentage points above CDC data for the same period.

Long-Term Objective: Expand the Availability of Health Care, Particularly to Underserved, Vulnerable, and Special Needs Populations.

16.2. Deaths due to HIV infection below 3.1 per 100,000 people.
(Baseline - 2003: 4.7 per 100,000; Target - 2014 3.1 per 100,000)

16.II.A.1. Number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs annually.

The number of ADAP clients served through State ADAPs annually was selected as a measure demonstrating progress toward the program's goal to improve health outcomes among individuals with HIV/AIDS who are underserved by increasing availability and utilization of essential medications. Many clients are enrolled in ADAP only temporarily while they await acceptance into other insurance programs, like Medicaid.

In 2007, the AIDS Drug Assistance Program (ADAP) served 163,927 clients through State ADAPs. The impact of this result is that more people, primarily low-income persons who have limited or no access to needed medications, had access to essential medications to treat their disease and/or prevent the serious deterioration in health arising from their HIV disease. This can not be compared with the FY 2007 target because the actual performance is based on a revised measure using annual data and the target is based on a previous measure based on quarterly utilization. The number of ADAP clients served through State ADAPs annually in FY 2006 was 157,988. The number of ADAP clients served through State ADAPs annually in 2007 was 5,939 persons above the 2006 annual results. About one in four HIV positive people in care in the U.S. receive their medications through State ADAPs. The FY 2009 target for clients served through State ADAPs is 142,865. The ADAP target reflects consideration of increased medical inflation including rising health insurance premiums; the addition of two new drug classes that include drugs requiring patients to have special laboratory testing; the new PHS guidelines concerning starting therapies earlier; and the impact of anticipated changes in the level of state contributions. The Program's ADAP Marginal Cost Analysis is used to help inform target setting.

16.II.A.2. Number of persons who learn their serostatus from Ryan White HIV/AIDS Programs.

The number of individuals who learn their serostatus from the Ryan White HIV/AIDS Programs was selected as a measure demonstrating progress toward achieving the program's goal to improve health outcomes for individuals infected with HIV/AIDS by increasing access to services. Knowing one's HIV status helps prevent the spread of HIV. Additionally, early diagnosis and treatment can vastly improve the quality and length of life.

CDC estimates that 1.039 to 1.185 million people in the United States are living with HIV/AIDS, of whom an estimated 25 percent are unaware of their serostatus. In 2006, the number of persons who learned their serostatus from Ryan White HIV/AIDS Programs was 641,866 exceeding the target by 58,021 persons. The number of persons learning their serostatus from Ryan White HIV/AIDS Programs in 2005 was 572,397. These efforts demonstrate that the Ryan White HIV/AIDS Program has made important strides in reaching people living with HIV/AIDS in the United States who do not know their serostatus. Ryan White HIV/AIDS Program dollars are used for HIV testing only when HIV testing is not otherwise available. The FY 2009 target for persons learning their serostatus from Ryan White HIV/AIDS Programs is 572,397.

16.II.A.3. Percentage of HIV positive pregnant women in Ryan White HIV/AIDS Programs who receive Anti-Retroviral Medications.

The percentage of HIV positive pregnant women in Ryan White HIV/AIDS Programs who received anti-retroviral medications was selected as a measure demonstrating progress toward achieving the Program's goal to improve health outcomes for individuals infected with HIV/AIDS by increasing access to services to reduce perinatal transmission. Approximately 100,000 childbearing-aged women in the United States are infected with human immunodeficiency virus (HIV), and an estimated 7,000 infants are born to HIV-positive mothers each year. In the United States, the rate of perinatal transmission of HIV among mothers who do not receive antiretroviral therapy is 25%- 30%. The transmission risk can be reduced to below 8% when pregnant women receive anti-retroviral medications.

Mother-to-child transmission in the U.S. has decreased dramatically, since its peak in 1992, due to the use of anti-retroviral therapy which significantly reduces the risk of transmission from the mother to her baby. In FY 2006 the Ryan White HIV/AIDS Program provided 84.7% of HIV-positive pregnant women in the Ryan White Program with anti-retroviral medication. This result fell below the target by 1.6 percentage points. The proportion of Ryan White HIV-positive pregnant women receiving anti-retroviral medications in 2005 was 85.3%. The slight decrease in the FY 2006 performance is within the expected variation range from year to year. The FY 2009 target for the percentage of HIV-positive pregnant women in Ryan White HIV/AIDS programs receiving anti-retroviral medication is 89.3%.

Long-Term Objective: Promote Effectiveness of Health Care Systems

16.3. Ryan White HIV/AIDS Program-funded HIV primary medical care providers will have implemented a quality management program and will meet two "core" standards included in the October 10, 2006 "Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents."

(Baseline - 2005: 63.7%; Target - 2014 90%)

16.III.A.1. Percentage of Ryan White HIV/AIDS Program-funded primary medical care providers that will have implemented a quality management program.

A major focus of the Ryan White HIV/AIDS Program is to improve the quality of care that its clients receive. Legislative requirements in the Ryan White HIV/AIDS Treatment Modernization Act of 2006 direct grantees to develop, implement, and monitor clinical quality management programs to ensure that service providers adhere to established HIV clinical practices and quality improvement strategies; and that demographic, clinical, and health care utilization information is used to monitor trends in the spectrum of HIV-related illnesses and the local epidemic. The proportion of Ryan White HIV/AIDS Program-funded primary care medical providers that had implemented a quality management program by 2007 was 88.8%. This fell below the target by 1.9 percentage points. Additionally, the FY 2007 results represent a growth by 0.2 percentage point over the FY 2006 data which indicated that 88.6% of primary care providers had implemented a quality management program. The FY 2009 target for the measure is 95.7%.

16.III.A.2. Proportion of new Ryan White HIV/AIDS Program HIV-infected clients who are tested for CD4 count and viral load.

The proportion of new Ryan White HIV/AIDS Program HIV-infected clients that are tested for CD4 count and viral load was selected as a good measure demonstrating progress toward the program goals to improve quality of health care for individuals infected with HIV/AIDS. CD4 cell measurement is a key test used: to assess the functioning of the immune system, guide decisions about when to start HIV treatment, and monitor effectiveness of HIV treatment. Viral load tests measure the amount of HIV in the blood and are used along with CD4 cell counts to decide when to start HIV treatment and to monitor response to therapy. In 2007, the Ryan White HIV/AIDS Program provided CD4 count testing to 83.9% of new clients and viral load testing to 81.2% of these new clients. This fell short of the target for CD4 tests by 1.3 percentage points and fell below the target of new clients receiving viral load testing by 0.1 percentage point.
In 2006, the Ryan White HIV/AIDS Program provided CD4 count testing to 84.9% of new clients and Viral Load testing to 82.5% of these new clients. The slight decrease in the FY 2007 performance is within the expected variation range from year to year. The FY 2009 target for CD4 is 87.2% and Viral Load is 83.3%.

16.E. Amount of savings by State ADAPs participation in cost-savings strategies on medications.

State ADAPs use a variety of strategies to contain costs which results in a more effective use of funding, enabling ADAPs to serve more people. Cost-containment measures used by ADAPs include: using drug purchasing strategies like seeking cost recovery through drug rebates and third party billing; and direct negotiation of pharmaceutical pricing. ADAPs' savings strategies on medications resulted in a savings of $258 million in 2006, missing the target by $22.5 million. The amount of savings by State ADAPs participation in cost-saving strategies on medication in 2005 resulted in $275 million is savings and the result of these savings in 2004 was $143.5 million. The decline in savings from FY 2005 to FY 2006 led to the adjustment of the FY 2009 target to "sustain the FY 2008 results."

HIV EMERGENCY RELIEF GRANTS (PART A)

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long – Term Objective: Expand the Capacity of the Health Care Safety Net.								
17.I.A.1	Number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative[a], and home health).	3.18 M	2.89 M[b]	2.91 M	2.65 M	2.47 M	Jan-10	2.47 M

Notes:

[a] Beginning in 2007 this constitutes Home and Community Based Services.

[b] This FY 2006 actual performance is different than that shown in the FY 2009 Congressional Justification due to a contractor reporting error.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Expand the Capacity of the Health Care Safety Net.

17.I.A1. Number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health).

The number of visits provided for health-related services was selected as a measure demonstrating progress toward the program goal to improve access to health care and related services for individuals infected with HIV/AIDS by increasing availability of and access to care.

More than 70 percent of all people living with HIV/AIDS in the U.S. reside in a metropolitan area served by Part A. Part A serves an estimated 300,000 people living with HIV/AIDS each year. Seventy-five percent of Part A clients are people of color and 30 percent are women. In 2007 Part A provided 2.65 million visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health). This result is 260,000 below the 2007 target. In 2006, 2.89 million visits were provided by 51 Part A grantees. (See section below on "Targets Substantially Exceeded or Not Met.")

TARGETS SUBSTANTIALLY EXCEEDED OR NOT MET

Measure: Number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health).

FY 2007 Target: 2.91 million visits
FY 2007 Result: 2.65 million visits

The number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health) continued to decrease annually and the FY 2007 number of visits fell below the target by 260,000 visits. In FY 2005 there were 3.18 million health-related care visits reported and FY 2006 produced 2.89 million visits. The decrease in visits may be the result of fewer Part A providers and fewer clients served, and the impact of health care inflation.

The FY 2007 target had not been adjusted to reflect the historical trends caused by these factors. The Ryan White HIV/AIDS Program has adjusted future targets to reflect these realities. Patient outreach and follow-up are among the strategies grantees use to achieve targets.

While the target was not met, the visits provided by the Part A programs indicate that many low-income, uninsured and underinsured people affected by HIV/AIDS had access to care and support services delivered in eligible metropolitan areas and transitional grant areas.

HIV CARE GRANTS TO STATES (PART B)

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long – Term Objective: Expand the Capacity of the Health Care Safety Net.								
18.I.A.1.	Number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative[a], and home health).	2.34 M	2.12 M[b]	1.56 M	2.06 M	2.14 M	Jan-10	2.14 M

Notes:

[a] Beginning in 2007 this constitutes Home and Community Based Services.

[b] This FY 2006 actual performance is different than that shown in the FY 2009 Congressional Justification due to a contractor reporting error.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Expand the Capacity of the Health Care Safety Net.

18.I.A.1. Number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health).

The number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health) was selected as the best measure demonstrating progress toward the program's goal to increase access to health care and related services for individuals with HIV/AIDS.

The Part B programs have been successful in helping to ensure that people living with HIV/AIDS can get the care and services they need to stay healthy longer. Part B programs provided 2.06 million visits in 2007. The actual performance for FY 2007 exceeded the target by 500,000 visits. This however was a decrease from FY 2006, when 2.12 million Part B visits were provided. In FY 2005, Part B provided 2.34 million visits. The FY 2009 target of visits for health-related care is 2.14 million visits. (See section below on "Targets Substantially Exceeded or Not Met.")

TARGETS SUBSTANTIALLY EXCEEDED OR NOT MET

Measure: Number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health).

FY 2007 Target: 1.56 million visits
FY 2007 Result: 2.06 million visits

The number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health) exceeded the target by 500,000 visits in 2007. There has been a declining trend in client visits is the past years as follows. In FY 2005 there were 2.34 million health-related care visits reported and FY 2006 produced 2.12 million visits. The decrease in visits may be the result of fewer Part B providers and fewer clients served, and the impact of health care inflation.

The Ryan White HIV/AIDS Program has adjusted future targets to reflect the performance in FY 2006. Patient outreach and follow-up are among the strategies grantees use to achieve targets.

The number of visits provided by the Part B program has far exceeded the FY 2007 target, which translated to increased access to services for many more low-income, uninsured and underinsured people affected by HIV/AIDS.

HIV EARLY INTERVENTION SERVICES (PART C)

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long – Term Objective: Expand the Availability of Health Care, Particularly to Underserved, Vulnerable, and Special Needs Populations.								
19.II.A.1	Number of people receiving primary care services under Early Intervention Services programs.	216,591	225,410	158,346[a]	Mar-09	216,591[a]	Mar-09	225,410

Note:

[a] The FY 2007 and FY 2008 targets were set prior to the availability of FY 2004 and FY 2005 results.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Expand the Availability of Health Care, Particularly to Underserved, Vulnerable, and Special Needs Populations.

19.II.A.1. Number of people receiving primary care services under Early Intervention Services programs.

The number of individuals receiving primary care services through the Early Intervention Services program was selected as the best measure demonstrating progress toward achieving the program's goal to improve health outcomes for individuals infected with HIV/AIDS by increasing access to these services.

In 2006, the Part C program provided primary care services under Early Intervention Services (EIS) to 225,410 clients, exceeding the target by 42.3 percent and representing an increase of 4% in clients served compared to FY 2005. In FY 2005, Part C Early Intervention Program served 216,591 clients, exceeding the targeted goal by 37%, and representing an increase of 2% in new clients served compared to FY 2004. The 2004 results showed 212,471 persons were served by the Early Intervention Services program. The FY 2009 target for persons receiving primary care under Early Intervention Services programs is 225,410. (See section below on "Targets Substantially Exceeded or Not Met.")

TARGETS SUBSTANTIALLY EXCEEDED OR NOT MET

Measure: Number of people receiving primary care services under Early Intervention Services.

FY 2006 Target: 158,346 clients
FY 2006 Result: 225,410 clients

The FY 2006 result of 225,410 persons receiving primary care services under Early Intervention Services program is consistent with the previous trends in FY 2005 of 216,591 and FY 2004 of 212,471. The FY 2006 result exceeded the target by 67,064 and represents an increase of 4% in clients served compared to FY 2005.

Key strategies used by grantees in achieving targets include patient outreach and follow-up. The impact of surpassing the target is that more people gained access to ongoing medical, oral health, nutritional, psychosocial, and other treatment for HIV-positive individuals; laboratory, x-ray and other diagnostic tests; and medical case management to help patients access care and remain in treatment.

HIV WOMEN, INFANTS, CHILDREN AND YOUTH GRANTS (PART D)

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long – Term Objective: Expand the Availability of Health Care, Particularly to Underserved, Vulnerable, and Special Needs Populations.								
20.II.A.1	Number of female clients[a] provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission.	52,306	49,701	32,772	48,485	52,306	Jan-10	49,701

Note:

[a] Female clients counted are age 13 and above.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Expand the Availability of Health Care, Particularly to Underserved, Vulnerable, and Special Needs Populations.

20.II.A.1. Number of female clients provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission.

The number of female clients receiving comprehensive services, including appropriate services before or during pregnancy to reduce perinatal transmission, was selected as the best way to measure demonstrating progress toward the Part D program's goal to improve health outcomes for HIV-infected children, adolescents, women and families through increasing utilization of care among this traditionally underserved population.

Part D served 48,485 females with comprehensive services, including appropriate services before and during pregnancy, to reduce perinatal transmission in 2007. This number exceeds the FY 2007 target by 15,713 clients. In FY 2006, Part D provided 49,701 female clients comprehensive services and Part D served 52,306 female clients in 2005. The FY 2009 target for female clients served in Part D programs is 49,701 female clients. (See section below on "Targets Substantially Exceeded or Not Met.")

TARGETS SUBSTANTIALLY EXCEEDED OR NOT MET

Measure: Number of female clients provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission.

FY 2007 Target: 32,772 female clients
FY 2007 Result: 48,485 female clients

The FY 2007 result of 48,485 female clients provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission is consistent with the previous trends in FY 2006 of 49,701 and in FY 2005 of 52,701. The FY 2007 result was above the target although the target was set as a result of an earlier, subsequently revised, target setting method. The Ryan White HIV/AIDS Program has adjusted future targets to reflect the trends in performance. Key strategies used by grantees in achieving targets include patient outreach and follow-up. The result of surpassing the target is that many more female clients gained access to services including primary and specialty medical care, psychosocial services, logistical support and coordination, and outreach and case management.

AIDS EDUCATION AND TRAINING PROGRAMS (PART F)

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long – Term Objective: Increase Collaborative Efforts to Improve the Capacity and Efficiency of the Public Health and Health Care Systems.								
21.V.B.1	Proportion of racial/ethnic minority health care providers participating in AETC training intervention programs.	43%	44%	43%	Mar-09	43%	Mar-10	43%

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Increase Collaborative Efforts to Improve the Capacity and Efficiency of the Public Health and Health Care Systems.

21.V.B.1. Proportion of racial/ethnic minority health care providers participating in AETC training intervention programs.

To increase proportion of racial/ethnic minority health care providers participating in AETC training intervention programs was selected to demonstrate progress toward improvements in the public health and health care system by providing the education and training in HIV care to the health care workforce serving medically underserved populations. A training intervention is defined as an interaction between a health care provider and an AETC trainer for the purposes of receiving clinical consultation or other types of training related to the provision of HIV/AIDS related health care services.

Forty-four percent (44%) of the AETC program training interventions were provided to racial/ethnic minorities in 2006, meeting the target. In FY 2005, the proportion of health care providers participating in the AETC programs who were racial/ethnic minority providers was 43%. The FY 2009 target is 43%.

DENTAL REIMBURSEMENT AND COMMUNITY PARTNERSHIP PROGRAMS
(PART F)

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long – Term Objective: Promote Access to Health Insurance and Maximize Use of Available Reimbursements for Health Care Services.								
22.I.D.1.	Number of persons for whom a portion/ percentage of their unreimbursed oral health cost were reimbursed.	31,050	34,394	30,600	32,819	34,394	Apr-09	32,819

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Promote Access to Health Insurance and Maximize Use of Available Reimbursements for Health Care Services.

22.I.D.1. Number of persons for whom a portion/percentage of their unreimbursed oral health costs were reimbursed.

As the rate of HIV-related mortality slows, the number of people living with HIV who are in need of continuing and regular oral health services continues to grow. The number of persons for whom a portion of their unreimbursed oral health costs were reimbursed was selected as the best measure demonstrating progress toward the program's goal to improve access to health care for those HIV infected individuals who require oral health services but are without the financial means to afford them.

In FY 2007, the Dental Reimbursement Program (DRP) awards met 42.8% of the total non-reimbursed costs reported by 65 participating institutions in support of oral health care. These institutions reported providing care to 32,819 HIV-positive individuals, for whom no other funded source was available. This number exceeded the goal by 2,219 individuals or 7.2%. In FY 2007, the demographic characteristics of patients for whom a portion of their unreimbursed oral health costs was reimbursed by the DRP were: 33.2% women, 57.9% minority. The FY 2009 target for number of persons being reimbursed for oral health care is 32,819 persons.

HEALTHCARE SYSTEMS

Programs included in this section are:

- Organ Transplantation
- C.W. “Bill” Young Cell Transplantation Program
- Poison Control Centers

ORGAN TRANSPLANTATION

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Expand the availability of health care, particularly to underserved, vulnerable and special needs population.								
23.II.A.1	Increase the annual number of deceased donor organs transplanted. (Baseline - 2003: 20,392)	23,249	24,461	27,877	24,230	26,314	Apr-09	27,683
23.II.A.4	Increase the average number of organs transplanted per "non-cardiac death" donor each year. (Baseline - 2003: 3.20)	3.15	3.13	3.52	3.11	3.52	Apr-09	3.56
23.II.A.5	Increase the average number of organs transplanted per "cardiac death" donor each year. (Baseline - 2003: 2.04)	1.97	2.11	2.42	1.92	2.39	Apr-09	2.46
23.II.A.6	Increase the average number of expected life-years gained in the first 5 years after transplantation for deceased kidney/kidney-pancreas transplants. (Baseline - 2003: 0.406)	0.44	0.42	0.418	0.42	0.421	Apr-09	0.424
23.II.A.7	Increase the total number of expected life-years gained in the first 5 years after the transplant for all deceased kidney and kidney-pancreas transplant recipients compared to what would be expected for these patients had they remained on the waiting list. (Baseline - 2003: 3,871)	4,758	4,913	5,477	4,775	5,543	Apr-09	5,873
23.II.A.2	Increase the annual number of "non-cardiac death" donors. (Baseline - 2003: 6,187)	7,032	7,375	7,253	7,298	7,083	Apr-09	7,317
23.II.A.3	Increase the annual number of "cardiac death" donors. (Baseline - 2003: 268)	561	647	968	793	593	Apr-09	658
23.II.A.8	Increase the annual conversion rate of eligible donors. (Baseline - 2003: 52.2%)	58.90%	64.20%	62.30%	67.00%	64.40%	Apr-09	66.50%
Efficiency Measure								
23.E	Decrease the total OPTN operating costs per deceased organ transplanted. (Baseline - 2003: $924)	$986	$1,012	$960	$1,096	$1,098	Apr-09	$1,098

INTRODUCTION

The Organ Transplantation Program's performance goals of increasing the number of deceased donor organs transplanted and increasing the survival benefit of kidney transplantation supports HRSA's mission of improving access to culturally competent, quality health care. Increasing the number of deceased donor organs available for transplantation increases access to this life-saving procedure and contributes to improvements in health outcomes. Additionally, improving the policies by which donor organs are allocated improves the benefit of the transplant procedure for patients and seeks to maximize the best utilization of the scarce organ resource.

The key aggregate performance measure used by the program is the number of deceased donor organs transplanted. This measure encapsulates several intermediate measures that the Program monitors to assess its progress towards achieving its performance goals. These measures include: the total number of deceased organ donors; the percentage of donors that meet the definition of 'eligible donor' (i.e., the conversion rate), the number of donors that meet cardiac-death criteria and the number of organs that are transplanted on average from each category of deceased organ donor. The Program has established specific goals for each of these measures and continually monitors its progress towards these goals. The Program develops new and modifies existing Program initiatives, as appropriate, based on assessments of performance results. A key Program strategy to improve performance is the use of the *Breakthrough Collaborative* methodology, developed by the Institute for Healthcare Improvement, to rapidly disseminate and improve upon best organ donation practices. Collaboratives on organ donation and organ transplantation are primarily responsible for the increases in the number of organ donors and number of organs transplanted. Other strategies include support of efforts to test and replicate new approaches for increasing organ donation, promote public awareness about organ donation, and develop and improve state donor registries.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Expand the availability of health care, particularly to underserved, vulnerable and special needs population.

23.II.A.1. Increase the annual number of organs transplanted.

(Baseline - FY 2003: 20,392)

The intent of this short-term measure is to increase the number of deceased donor organs transplanted on an annual basis. The number of deceased donor organs transplanted in FY 2007 was 24,230. This is 13 percent lower than the target of 27,877. This represents a slight decrease, .94 percent, from the FY 2006 result. (See section below on "Targets Substantially Exceeded or Not Met.") The FY 2009 target is 27,683 deceased donor organs transplanted.

23.II.A.4. Increase the average number of organs transplanted per "non-cardiac death" donor each year.

(Baseline – FY 2003: 3.20)

Another aspect contributing to increasing the overall number of deceased donor organs transplanted is the average number of organs transplanted from each deceased donor. The intent of this short-term goal is to increase the average number of organs procured from “non-cardiac death” donors on an annual basis. The average number of organs transplanted from each non-cardiac death donor was 3.11 in FY 2007. This represents a slight decrease from the FY 2006 result and 11.6 percent below the FY 2007 target. The FY 2006 result was .63 percent decrease from the FY 2005 result. The FY 2005 result was a .96 percent increase from the FY 2004 result. Since FY 2003, there has been an overall decrease of 2.8 percent in this measure. (See section below on “Targets Substantially Exceeded or Not Met.”) The FY 2009 target is 3.56 organs transplanted per non-cardiac donor.

23.II.A.5. Increase the average number of organs transplanted per “cardiac death” donor each year.

(Baseline - FY 2003: 2.04)

Similar to increasing the average number of organs transplanted per non-cardiac death donor (goal II.A.4.), the intent of this short-term goal is to increase the average number of organs transplanted from “cardiac death” donors on an annual basis. The average number of organs transplanted for each cardiac-death donor was 1.92 in FY 2007. This is 20.7 percent below the FY 2007 target and a 9.0 percent decrease from the FY 2006 result. (See section below on “Targets Substantially Exceeded or Not Met.”). The FY 2009 target is 2.46 organs transplanted per cardiac donor.

23.II.A.6. Increase the average number of expected life-years gained in the first 5 years after transplantation for deceased kidney/kidney-pancreas transplants.

(Baseline - FY 2003: 0.406)

The intent of this short-term goal is to increase on an annual basis the average number of life-years gained in the first 5 years following transplantation for deceased kidney or kidney-pancreas transplants. The reported value for FY 2007 was .420. This slightly exceeds the FY 2007 goal by .48 percent and is unchanged from the FY06 actual. It also represents a 4.5 percent decrease from the FY 2005 result. As with the other annual measures, annual variations can be expected. The Program believes that the trend towards achieving the long-term goal is important. While it is anticipated that improvements in kidney allocation policies will increase the benefit of kidney transplantation, it is also anticipated that there will be continued improvements in kidney dialysis technology, so predicting the relative benefit in kidney transplantation is difficult. FY 2009 target is 0.424 life-years gained per kidney and kidney-pancreas transplant.

The OPTN is currently in the process of examining its policy for allocating deceased donor kidneys. The current allocation system places significant emphasis on time waiting for an organ as a major determinant for allocation. Based on the work that has been done to date, it is anticipated that a major component of the new policy will include using expected life years after transplantation as a major component of the new policy. This approach would evaluate the patient’s benefit derived from kidney transplantation as opposed to remaining on the waiting list and continuing to be treated with kidney dialysis. It is anticipated that the policy will also attempt to better match donor kidneys to recipients to maximize the utility of the organ.

23.II.A.7. Increase the total number of expected life-years gained in the first 5 years after the transplant for all deceased kidney and kidney-pancreas transplant recipients compared to what would be expected for these patients had they remained on the waiting list.
(Baseline - FY 2003: 3,871)

The intent of this short-term goal is to increase on an annual basis the total number of life-years gained in the first 5 years following transplantation for deceased kidney or kidney-pancreas transplants compared to the total life-years gained if this group had remained on the waiting list. This measure is a product of the number of kidneys and kidneys-pancreases transplanted and the average expected life-years gained from each transplanted kidney. The total number of expected life-years gained in the first 5 years after transplant was 4,775 in FY 2007. This is 12.8 percent less than the FY 2007 target of 5,477; it is also a 2.8 percent decrease from the FY 2006 result. The Program fell short of this target because fewer kidneys were transplanted than the number projected. In FY 2005, the total number of expected life-years gained in the first 5 years after transplant was 4,758 which as a 7.4 percent increase from the FY 2004 result of 4,427. Overall, the FY 2007 result still represents a 23.4 percent increase over the FY 2003 baseline.

23.II.A.2. Increase the annual number of “non-cardiac death” donors.
(Baseline - FY 2003: 6,187)

The greatest contributing aspect to the increase in the overall number of deceased donor organs transplanted is the number of non-cardiac-death donors. There were 7,298 non-cardiac death donors in FY 2007, which exceeded the 7,253 goal for FY 2007 by .62 percent. While the number of donors exceeded the FY 2007 target, the number represents a 1 percent decrease from the FY 2006 result.

In FY 2006, there were 7,375 non-cardiac death donors, 4.9 percent more than FY 2005 number of 7,032. The FY 2005 result was 4.0 percent more than the FY 2004 number of 6,759. The FY 2004 result represents a 9.2 percent increase from the FY 2003 baseline of 6,187 non-cardiac death donors. Overall, the FY 2007 result represents a 19.2 percent increase over FY 2003 baseline. The FY 2009 target is 7,317 non-cardiac death donors.

23.II.A.3. Increase the annual number of “cardiac-death” donors.
(Baseline - FY 2003: 268)

Another aspect contributing to the increase in the overall number of deceased donor organs transplanted is the number of cardiac-death donors. There were 793 cardiac-death donors in FY 2007, which was 22.6 percent above the 647 number of cardiac-death donors in FY 2006. While this is a substantial increase, the Program fell short of its 968 target by 18 percent. (See section below on “Targets Substantially Exceeded or Not Met.”) The FY 2009 Target is 658 cardiac-death donors.

23.II.A.8. Increase the annual conversion rate of eligible donors.
(Baseline - FY 2003: 52.21%)

The donor conversion rate is the percentage of ‘eligible donors’ that actually become donors. An eligible donor is a deceased individual, aged 70 or younger, whose death is determined based on neurological criteria and who does not have certain diseases and/or morbidities that would excluded the individual from becoming a donor. The conversion rate is an intermediate measure that is useful in measuring progress towards the goal of increasing the number of donors and number of donor organs transplanted. In FY 2007, the conversion rate was 67 percent, 7. 5 percent or 4.7 percentage points above target. Since FY 2003, the conversion rate has increased by 28.4 percent or 14.8 percentage points from a baseline of 52.2 percent.

HRSA believes that the gains in the conversion rate are attributable to the *Organ Donation Breakthrough Collaborative* initiated in October 2003. The goal of this Collaborative is to increase the organ donor conversion rate to 75 percent in the Nation's hospitals with the greatest number of potential organ donors. In an effort to increase the number of donor organs made available for transplantation from each deceased donor, a second Collaborative, *the Organ Transplantation Breakthrough Collaborative,* was launched in the fall of 2005. The goal of this Collaborative is to increase the number of organs transplanted from each deceased donor from 3.06 to 3.75. Together, these two Collaboratives have the potential to increase the number of deceased donor organs transplanted to nearly 35,000 annually.

23.E. Decrease the total OPTN operating costs per deceased organ transplanted.
(Baseline - FY 2003: $924)

The intent of this goal is to reduce the total OPTN operating costs associated with organ transplantation per deceased organ transplanted on an annual basis factoring in the effects of inflation. The reported value for FY 2007 was $1,096 -- 8.3 percent above FY 2006 result and 14.2 percent above the $960 target. Although the actual FY 2007 OPTN operating cost of $26,545,289 was less than the $26,750,000 specified in the OPTN contract, the number of deceased donor organs transplanted (24,230) was (13.1 percent) lower than FY 2007 target of 27,877 resulting in a higher cost per deceased donor organ transplanted. (See section below on "Targets Substantially Exceeded or Not Met.") The FY 2009 target is $1,086 per deceased donor organ transplanted.

TARGETS SUBSTANTIALLY EXCEEDED OR NOT MET

Measure: Increase the annual number of organs transplanted.

FY 2007 target: 27,877 deceased donor organs transplanted
FY 2007 result: 24,230 deceased donor organs transplanted

The number of deceased donor organs made available for transplantation is a function of the number of deceased donors and the number of organs that are made available for transplant from each deceased donor. There were 8,091 deceased donors in FY 2007, which up slightly from 8,026 in FY 2006. However, this represents an overall increase of 13 percent above the record-breaking number of 7,151 in FY 2004 and 19 percent above the 2003 base year of 20,392.

Targets for the number of deceased donor organs transplanted were established based on the best data available in 2004 on the estimated number of eligible organ donors. These data indicated that the number of estimated number of eligible donors was 12,000 annually. More recent data indicate that the estimated number of eligible donors is closer to 11,000 annually, and the trend in the number of eligible donors is decreasing as opposed to increasing, as had originally been projected. While the possible causes of this decline is complex, HRSA believes that the declined in the number of eligible donors can in part be attributed to an aging population, increasing rates of diseases and morbidities, such as diabetes and hypertension, and a reduction in the number of deaths that occur in hospitals. Additionally, the number of deceased donor organs transplanted from each deceased donor is not increasing at the rate that was originally projected in part due to some of the issues related to increases in disease and morbidities in potential deceased donors. Out-year targets have been adjusted downward to reflect the projected smaller number of eligible donors. The Program will continue to aggressively utilize methods such as Breakthrough Collaboratives to rapidly increase the number of donor organs made available for transplantation. Other than Breakthrough Collaboratives, the Program is also working on other initiatives to increase the number of donors and donor organs made available for transplant. These initiatives include support to States to implement and improve State donor registries, public and professional education campaigns and supporting research and demonstration projects to test and replicate new approaches for increasing the number of donors and donor organs made available for transplantation. These initiatives are very important, but have a longer time horizon before the benefits of the investment are realized.

Measure: Increase the average number of organs transplanted per "non-cardiac death" donor.

FY 2007 target: 3.52 organs transplanted per non-cardiac death donors
FY 2007 result: 3.11 organs transplanted per non-cardiac death donors

Measure: Increase the average number of organs transplanted per "cardiac death" donor.

FY 2007 target: 2.42 organs transplanted per cardiac-death donor
FY 2007 result: 1.92 organs transplanted per cardiac-death donor

As the gap between the number of donors meeting eligible donor criteria and the maximum number of eligible donors narrows, more donors with co-morbid conditions, such as chronic hypertension, are being utilized. These donors are referred to as 'expanded criteria donors.' While these donors expand the total number of donors, fewer organs, on average, can be transplanted from an expanded criteria donor. This is particularly true for the kidneys which can be damaged by chronic hypertension.

The Program is actively working to increase the number of organs transplanted from deceased donors. One key activity that was launched in early fall of 2005 is the *Organ Transplantation Breakthrough Collaborative*, the purpose of which is to share the best practices of transplant hospitals and organ procurement organizations in maximizing the number of organs transplanted from each deceased donor.

Increasing the number of organs per donor will result in thousands of additional donor organs made available for transplant. Additionally, the Program is working with the OPTN and the organ procurement and transplant community to improve technological infrastructures to facilitate the rapid placement of organs, which will increase organ utilization, particularly for highly time-sensitive thoracic organs. A new rapid placement system was launched by the

OPTN in 2007. The Program is also conducting a thorough review of donor comorbidities to determine whether the goals for the number of organs transplanted from each donor type need further modification.

Measure: Increase the annual number of "cardiac-death" donors.

FY 2007 Target: 968 cardiac death donors
FY 2007 Result: 793 cardiac death donors

This measure was based on the anticipation that ethical, legal and other issues associated with cardiac-death donors would be resolved more rapidly than has been realized. The number of cardiac-death donors has increased 295 percent since the based period in 2003. As the number of cardiac death donors increases, it is essential that more hospitals develop policies and procedures to assure that each cases is conducted using medically and ethically appropriate procedures. In late 2005, the national Organ Procurement and Transplantation Network (OPTN) implemented a policy requiring each transplant hospital to have policies that facilitate cardiac death donation. As a result many hospitals spent 2006 and 2007 shepherding new policies through their internal approval processes which likely contributed to the slower rate of cardiac death donor rates than in previous years.

HRSA commissioned a study with the Institute of Medicine (IOM) to examine various approaches for increasing organ donation. IOM issued its report in May 2006. One of the major recommendations of the IOM was to explore the use of uncontrolled cardiac death donors as an approach for increasing the number of organs made available for transplantation. (Uncontrolled cardiac death donation refers to circumstances where donation is initially considered after death has occurred, but was not anticipated. This may occur in the emergency department, hospital wards, ICU/special care unit or pre-hospital locations.) The IOM estimates that at least 22,000 uncontrolled cardiac deaths may result in organ donation annually.

As the IOM recognized, there are numerous ethical, technical and administrative issues that must be resolved before the full potential of cardiac death donors may be realized. A major focus of the *Organ Transplantation Breakthrough Collaborative* that was launched in the fall of 2005 is to increase the number of cardiac death donors. The Program believes that the number of cardiac-death donors will continue to increase, however, at a much slower pace. Based on discussions with experts in the community, the Program has established a performance goal of achieving 10% cardiac-death donors of the total number of deceased donors by 2013. As more hospitals develop formalized cardiac death donation policies and as HRSA increases its focus on spreading effective donation practices to all hospitals, it is expected that the number of cases will reach the targets established by the Program. In FY 2007, HRSA, through the Clinical and Interventions Grant Program awarded two grants to two separate entities to further to explore the potential of uncontrolled cardiac deaths as a way to increase the pool of organs available for transplantation.

Measure: Decrease the total OPTN operating costs per deceased organ transplanted.

FY 2007 Target: $960 per deceased transplant facilitated
FY 2007 Result: $1,096 per deceased transplant facilitated

This measure is based on goal 23.II.A.2., the number of deceased organs transplanted, and the expenses associated with operating the Organ Procurement and Transplantation Network (OPTN). Even though actual operating costs were below those projected, the target number of deceased organs transplanted was not met (see the annual number of organs transplanted above for more details), therefore the OPTN operating cost per deceased donor organ transplanted was greater than anticipated.

HRSA has expanded the role of the OPTN with respect to living organ donation and transplantation. The OPTN is now responsible for establishing program criteria for transplant programs that perform transplants using living donor organs and for monitoring compliance with these criteria. This role will continue to expand as a result of the enactment of the Charlie Norwood Living Organ Donation Act (H.R. 710) that permits the paired-exchange of living donor organs. This complex system will allow multi-level pairing of donor organs from individuals who desire to donate a kidney to an intended recipient, but have an incompatible tissue type with the intended recipient. The OPTN will be the entity responsible for establishing a national system to facilitate these living donor organ exchanges. These activities are impacting the overall operating cost of the OPTN.

Under the current OPTN contract that was negotiated in late FY 2005, after the targets for this performance measure were established, HRSA authorized the OPTN to invest in improving its information technology (IT) infrastructure in FY 2006 and FY 2007. These IT improvements are supportive of the long-term strategic goal to increase the number of deceased organs transplanted and will increase the efficiency by which organs are allocated. It is expected that through technological and other OPTN system efficiencies, the Program will achieve increases in the number of organs transplanted. This will curb the rate of increase and possibly decrease the cost per organ transplanted in subsequent fiscal years.

Additionally, the OPTN expanded its oversight activities in 2006 and 2007 in response to several high-profile incidents that occurred in California that involved transplant programs that did not abide by the OPTN final rule, OPTN bylaws and policies. This expansion of oversight activities was not envisioned in FY 2004 when the performance goals were established. These activities have and will continue to increase the OPTN operating costs.

The IT improvements are supportive of the long-term strategic goal to increase the number of deceased organs transplanted and will increase the efficiency by which organs are allocated. It is expected that through technological and other OPTN system efficiencies, the Program will achieve increases in the number of organs transplanted.

The OPTN has been making greater usage of technology such as teleconferencing, Live Meeting to reduce travel costs. In addition, the OPTN is looking at ways to reduce the number of committee members without interfering with the committee's strategic goal. Fewer committee members will result in reducing travel costs.

The increasing cost of operation of the OPTN does not impact the Federal funds provided for the operations of the OPTN. HRSA, by statute, can provide no more than $2 million each fiscal year toward the operations of the OPTN. Additional funds to operate the OPTN come from registration fees charged to register patients on the organ waitlist.

C.W. BILL YOUNG CELL TRANSPLANTATION PROGRAM

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Expand the availability of health care, particularly to underserved, vulnerable, and special needs populations								
24.1[*]	Increase the number of blood stem cell transplants facilitated annually by the Program.[*] (Baseline - 2003: 2,310)							
24.2[*]	Increase the number of blood stem cell transplants facilitated annually by the Program for minority patients.[*] (Baseline - 2003: 318)							
24.3[*]	Increase the rate of patient survival at one year, post transplant.[*] (Baseline: 2003, 62%)							
24.II.A.1[**]	Increase the number of cord blood units listed for transplantation by the Program.	45,807	51,693	38,500	69,081	NA	NA	NA
24.II.A.2	Increase the number of adult volunteer potential donors of minority race and ethnicity.	1.59 M	1.70 M	1.83 M	1.86 M	1.94 M	2.03 M	2.06 M
Efficiency Measure								
24.E	Decrease the unit cost of human leukocyte antigen (HLA) typing of potential donors.	$63.65	$52.00	$59.95	$52.00	$52.00	$52.00	$52.00

Notes:

[*] Out-year targets are due in FY 2010. Annual targets have been established for FY 2010 and beyond.

[**] The FY 2008 and 2009 targets for 24.II.A.1. have been changed to NA (not applicable) as a result of the new program structure per P.L. 109-129, under which HRSA funding for cord blood collection occurs through a related program, the National Cord Blood Inventory. Appropriate measures and targets for the National Cord Blood Inventory have been developed.

INTRODUCTION

The Stem Cell Therapeutic and Research Act of 2005 (P.L. 109-129) authorized the C.W. Bill Young Cell Transplantation Program (Program) as successor to the National Bone Marrow Donor Registry. The performance measures and targets discussed below were established for the Registry (new measures and targets have not yet been established for the Program). The performance measures allow HRSA program staff to monitor progress towards the overarching goal of increasing access to blood stem cell transplant for patients in need of these life saving therapies with a particular emphasis on eliminating racial and ethnic barriers to accessing suitable blood stem cell sources. Strategies used to ensure that performance targets are met include: incorporation of quantitative performance standards into each of the four contracts for the Program; alignment of the contractor’s strategic and operational plans with the standards; quarterly reporting and reviews by HRSA and the contractors of performance against the standards; development of a process to improve donor searches; aggressive contractor negotiations of cost reductions in subcontracts for tissue typing; and development and funding of new initiatives to increase awareness and outreach in support of recruiting minority donors.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Expand the availability of health care, particularly to underserved, vulnerable, and special needs populations.

24.1. Increase the number of blood stem cell transplants facilitated annually by the Program.

(Baseline – 2003: 2,310)

The purpose of the Program is to increase the number of unrelated blood stem cell transplants facilitated for patients in need. This long-term goal directly reflects the program's purpose. The first target for this measure is set for FY 2010.

24.2. Increase the number of blood stem cell transplants facilitated annually by the Program for minority patients.

(Baseline – 2003: 318)

Reaching this goal will further the statutory aim of ensuring that patients from racially and ethnically diverse backgrounds will have a chance of receiving an unrelated blood stem cell transplant that is comparable to that of non-Hispanic Caucasian patients. The first target for this measure is set for FY 2010.

24.3. Increase the rate of patient survival at one year, post transplant.

(Baseline: 2003, 62%)

The intent of this health outcome measure is to increase the health benefit to patients receiving an unrelated blood stem cell transplant. The program recognizes that it does not have a direct impact on patient care delivery. Nonetheless, the program can influence survival rates in several ways, including improving the degree of tissue-type match between patient and donor by adding adult volunteer potential donors and cord blood units and making them available through the Program, ensuring that the Program is working with highly competent transplant centers and other organizations, decreasing the time required to identify the best available donor for each patient, and engaging in research to improve transplant outcomes (e.g., by better prevention and treatment of infections and other transplant complications). The first target for this measure is set for FY 2010.

24.II.A.1. Increase the number of cord blood units listed through the Program.

In FY 2005, the Program's registry listed 45,807 cord blood units. In FY 2006, the registry listed 51,693 units, a 12.8% increase over FY 2005. (See section below on "Targets Substantially Exceeded or Not Met.") In FY 2007, the registry listed 69,081 units, which was close to 1.8 times the target of 38,500 units. The targets established for FY 2008 - FY 2009 have now been substantially exceeded. Funding for the collection and storage of cord blood units has transitioned from the C.W. Bill Young Cell Transplantation Program to a related program, the National Cord Blood Inventory. New targets are not being proposed under this program. Separate goals have been developed for the National Cord Blood Inventory.

24.II.A.2. Increase the number of adult volunteer potential donors of minority race and ethnicity.

Reaching this goal will increase the number of patients from racially and ethnically diverse backgrounds able to find a suitably matched unrelated adult donor for their blood stem cell transplant. This will lead to more minority patients receiving unrelated donor transplants.

In FY 2005, a total of 5,907,923 adult volunteers were listed on the Program's registry, of whom 1,591,628 (or 26.9%) self-identified as belonging to a racial/ethnic minority population group. In FY 2006, a total of 6,317,827 adult volunteers were listed on the registry, of whom 1,698,616 (or 26.9%) self-identified as belonging to a racial/ethnic minority population group. In FY 2007, a total of 6,856,150 adult volunteer donors were listed on the registry of whom 1,856,434 (or 27.1%) self-identified as belonging to a racial/ethnic minority population group (exceeding the goal of 1.8 million). In FY 2008, a total of 7,294,630 adult volunteer donors were listed on the registry of whom 2,028,600 (or 27.8%) self-identified as belonging to a racial/ethnic minority population group (exceeding the goal of 1.94 million). Initiatives to increase community awareness and outreach in minority populations were implemented in FY 2006 and additional funds were committed to this effort in FY 2007 and FY 2008 to make improvements in meeting the annual targets established for the Program. The Program expects to continue achieving future targets. The target established for FY 2009 is 2,060,000 adult volunteers from racially/ethnically under-represented minority population groups.

24.E. Decrease the unit cost of Human Leukocyte Antigen (HLA) typing of potential donors.

The cost of Human Leukocyte Antigen (HLA) typing strongly influences the number of potential volunteer donors who can be recruited to potentially donate for patients in need of blood stem cell transplantation. Reductions in the cost of typing makes increases in donor recruitment possible even without increased funding. In FY 2004, the National Marrow Donor Program successfully negotiated a 2.7% reduction in cost with its contracted laboratories for Human Leukocyte Antigen (HLA) tissue typing. The cost of tissue typing decreased from $65.00 in FY 2003 to $63.65 in FY 2004. The contractor that maintains the registry did not negotiate new laboratory contracts during FY 2005. In FY 2006, the contractor negotiated an 18% cost reduction, which was expected to remain in effect over the next three years. This reduction in tissue typing cost to $52.00 far exceeds the annual target for FY 2007 of $59.95. The FY 2008 actual cost for tissue typing was $52.00. The FY 2009 target will remain at $52.00.

TARGETS SUBSTANTIALLY EXCEEDED OR NOT MET

Measure: Increase the number of cord blood units listed on the Registry.

FY 2007 Target: 38,500
FY 2007 Result: 69,081

When developed, the Program's target was ambitious given the fact that the listing of umbilical cord blood units on the Registry was a relatively new aspect of the Program. The target was exceeded in large part through increasing the number of blood banks participating in the program and making cord blood units available to patients through the program.

The targets established for FY 2007- 09 have been exceeded. Funding for the collection and storage of cord blood units has transitioned from the C.W. Bill Young Cell Transplantation Program to a related program, the National Cord Blood Inventory. New targets are not being proposed under this program. Separate goals are being developed for the National Cord Blood Inventory and HRSA will propose deleting this goal from the Program's performance measures and establishing a cord blood collection goal for new units for the National Cord Blood Inventory.

The impact of this result is that more people in need of blood stem cell transplantation, particularly minority patients, are able to find an adequate cord blood unit for transplantation through the Program.

POISON CONTROL PROGRAM

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Promote the implementation of evidence-based methodologies and best practices								
25.1	Decrease the number of visits to the emergency room. (Baseline-2002: 2.05 live ER discharges per 1,000)							1.54

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Promote the implementation of evidence-based methodologies and best practices								
25.III.D.1	Develop and ratify uniform and evidence-based guidelines for the treatment of poisoning. (targets are cumulative)	6	16	18	17	17 [a]	17 [a]	20
25.III.D.2	Increase the number of PCCs with 24-hour bilingual staff.	4	4	4	4 [b]	4 [b]	4	4 [b]
25.III.D.3	Increase percent of inbound volume on the toll-free number.	52.00%	57.50%	63.30%	66%	69.30%	68.5%	69.30%
Efficiency Measure								
25. E	Decrease application and reporting time burden. (Est. Baseline - 2005: 120 and 85 hrs)	NA	30.5 & 20 hrs.	29 & 19 hrs.	29 & 20	29 & 19	28.9 & 2 [c]	27.5 & 18

Notes:

[a] The FY 2008 actual for 24.III.D.1 remained 17 because the final extension on the cooperative agreement expired December, 2007, precluding the ability to conduct extensive work required to develop a guideline. The program conducted an evaluation of use of the developed guidelines and found that continuing the development would be beneficial to the program; therefore the program will continue development with FY 2009 funding.

[b] In September 2006, HRSA began providing translation services to all PCCs through a service called Language Line. Language Line provides translation services in 161 languages. Therefore, targets for bilingual staff have not increased.

[c] In FY 2008, only three grantees reported the amount of time to complete the financial status report with an average completion time of 2 hours. The program was gathering this information through the grant application process. The financial status reporting documents are not due at the same time therefore it is believed that the completion time reported was unclear. For FY 2009, the program will specify the year more specifically and gather FY 2009 application reporting time and FY 2008 financial status reporting time as part of the FY 2009 grant guidance application.

INTRODUCTION

The performance goals align with the Poison Control Program goal to ensure universal access to quality poison control services. The performance measures to increase calls to the national toll-free number, develop uniform guidelines and provide access to bilingual services are utilized for program strategic planning to ensure that the program is increasing access to comprehensive quality services for the entire population, particularly children who are the most vulnerable to poisonings. Strategies used by the Program include a national media campaign to promote the Poison Control toll free number, and developing partnerships with private and public organizations to promote poison prevention. The Program also provides technical assistance to

Poison Control Centers on such issues as financial planning, marketing, infrastructure development, and data analysis.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Promote the implementation of evidence-based methodologies and best practices.

25.1. Decrease the number of visits to the emergency room.

(Baseline - 2002: 2.05 live ER discharges per 1,000)

Decreasing unneeded emergency room visits for poisoning or suspected poisoning will reduce unnecessary utilization of extremely costly resources, and allow those resources to be better utilized for persons in need of them.

25.III.D.1. Develop and ratify uniform and evidence-based guidelines for the treatment of poisoning.

Having evidence-based guidelines available for use at the poison control centers will improve uniformity and standard care for acute poisoning-related incidents, thereby improving the quality of care. The baseline for FY 2004 is the cumulative total of guidelines developed and ratified, 3; one guideline covering 35 non-toxic substances and two guidelines for the treatment of toxic poisonings. The goal to develop three additional guidelines in FY 2005 was met in June 2005. Ten guidelines were completed in FY 2006 and one additional guideline in FY 2007, making the total number of guidelines developed 17. The target for FY 2007 was 18 and was not met, therefore the FY 2008 target was reduced from 18 to 17 because the final extension on the cooperative agreement expired December, 2007, precluding the ability to conduct the extensive work required to develop a guideline. The FY 2008 performance remained at 17 cumulative guidelines developed. As part of the project, an evaluation was conducted concluding that the development of additional guidelines would be beneficial to the poison control centers. Therefore the cumulative FY 2009 target is 20.

25.III.D.2. Increase the number of PCCs with 24-hour bilingual staff.

According to the American Association of Poison Control Centers (AAPCC), in 2004 only 1 of 62 Poison Control Centers in the U.S. had 24-hour bilingual staff. In order for the Poison Control Program (PCP) to ensure universal access and serve a larger population, the original goal was to increase the number of PCCs with 24-hour bilingual staff coverage by at least 2 centers per year. In FY 2005, the PCP queried all the PCCs and found that 4 provided 24-hour bilingual services. In FY 2006, there remained four PCCs with 24-hour bilingual staff, one below the FY 2006 performance goal of five. However, in September of 2006, HRSA began providing translation services to all PCCs through a service called Language Line. Language Line provides translation services in 161 languages thereby providing a cost effective means for all PCCs to offer 24-hour bilingual services. Given the challenges with recruiting qualified bi-lingual health care providers and the successful implementation of Language Line, the target for this measure has been set and will remain at four. The performance output for FY 2007 – FY 2008 remained the same as well. The program will explore an alternative to this measure in the future.

25.III.D.3. Increase percent of inbound volume on the toll-free number.

Public Law 106-174, the Poison Control Enhancement and Awareness Act, mandated the development of a single, national toll-free number to ensure universal access to poison control services. In 2002, the Poison Control Program, in conjunction with the Centers for Disease Control and Prevention (CDC), initiated a national media campaign to promote the use of 1-800-222-1222. Increasing the use of the national number provides universal access and provides individuals the resource to determine the severity of the exposure and respond accordingly, which has proven to reduce the number of emergency room visits. According to the AAPCC in 2002, the baseline year, 24.6% of callers utilized the new toll-free number. By 2004, the percentage increased to 46.8% and was up to 52% in 2005. In 2006, 57.5% of calls to poison control centers were on the toll-free number and in 2007 the percentage of calls was 66%, exceeding the 2007 target of 63.3%. The number of calls to poison centers on the toll-free number in FY 2008 was 68.5%, shy of the 69.3% goal. The FY 2009 target is 69.3%; it is expected that the percentage of usage will begin to level out.

25.E. Decrease the application and reporting time burden of grantees by 5% per year for 4 years, thereby collecting more accurate and timely data.

A new on-line application and reporting system was implemented in FY 2005 and was fully implemented in FY 2006. This system was designed to simplify data collection by prepopulating forms with electronic information from previous years, including budget and service data, eliminating the need for grantees to reenter it. The system also eliminates the need for grantees to reenter the same information in different parts of the application. Reporting is also designed to be easier on the on-line system and provides performance data that are far more reliable and valid, with a shorter lag time. The annual target is a 5% reduction from the baseline. In March 2005, a limited number of PCCs were queried to determine a baseline number of hours to complete a grant application and to determine the number of hours to complete a financial report on grant activities. From this limited query an average number of hours were calculated. The results were 120 hours for an application and 85 hours for a financial reporting document. For 2006, all grantees were required to provide this information as part of their grant submission. Per the grant submissions, the average number of hours to complete the on-line application was 30.5 and the average number of hours to complete a financial reporting document was 20 (gathered separately at the end of the grant cycle), both far exceeding the goal to reduce the application and reporting time burden of grantees. The same process occurred in FY 2007 with the resulting output of 29 hours for application submission, meeting the goal, 20 hours for submission of financial documents, one hour more than the goal. FY 2008 was a new grant cycle (and not continuation) with a requirement to report application and financial reporting time annually. However, the submission requirements may not have been specific enough and the grantees misunderstood what year of information they were to submit with their new application. When the program gathered this information (28.9 and 2 hours), the results indicated that the program met the application submission goal and substantially exceeded, by 17 hours, the financial reporting time. Only three grantees submitted information for the financial reporting time and it is believed that the three grantees submitted this information related to past-due reports. Same year financial status reporting documents are not due at the same time as the application therefore what information to report on was unclear. For FY 2009, the program will specify the year more specifically and gather FY 2009 application reporting time and FY 2008 financial status reporting time as part of the FY 2009 grant guidance application.

RURAL HEALTH

Programs included in this section are:

- Rural Health Activities
- Rural Health Policy Development
- Rural Health Outreach and Network Development Grants
- Rural Hospital Flexibility Grants
- State Offices of Rural Health
- Radiation Exposure Screening and Education Program
- Black Lung Clinics

RURAL HEALTH ACTIVITIES

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Focus resources and services on diseases and conditions with the greatest health disparities.								
27.1*	Reduce the proportion of rural residents of all ages with limitation of activities caused by chronic conditions. * (Baseline - 2000: 14.67%)							
Long-Term Objective: Focus resources and services on diseases and conditions with the greatest health disparities.								
27. IV.A.1	Increase the number of people served through Outreach Grants.	776,880	627,120	777,000	923,003	635,000	Oct-09	791,000
Long-Term Objective: Increase collaborative efforts to improve the capacity and efficiency of public health and health care systems.								
27.2*	Increase the proportion of critical access hospitals with positive operating margins.* (Baseline - 1999: 10%)							
27.V.B.1	Increase the average operating margin of critical access hospitals.	-9.6%	-8.8%	0.5% point over FY 2006	-6.7%	0.5% over FY 2007	Dec-09	0.5% over FY 2008
Efficiency Measure								
27.E	Increase the return on investment of funds by the Rural Hospital Flexibility (FLEX) grant program, as measured by change in total operating margin of critical access hospitals in relation to FLEX dollars invested.	14.8%	13.4%	25%	Oct-09	26%	Oct-10	27%

Notes:
* This is a long-term measure with no annual targets.

INTRODUCTION

The long-term and annual goals and measures discussed below have been identified to use in assessing the Office of Rural Health Policy's (ORHP) performance. Also discussed below is an efficiency measure for ORHP. (This does not include the Black Lung and Radiation Exposure Screening programs, which are presented later.) These measures assess the progress in meeting the following goals:

- Increased access to quality health care services
- Improved access to hospital care for rural residents

These goals support HRSA's Strategic Plan Goal IV of eliminating health disparities and the HHS Strategic Goal 2.1 of increasing health care service availability and accessibility. The measure focused on increasing the operating margin of Critical Access Hospitals makes the link between economic viability of these facilities and their ability to continue playing an important safety-net role in isolated rural communities. The program uses performance data to improve program design and delivery. Strategies include making revisions to program guidance to assure that performance expectations and goals are clear and to focus the attention of grantees on performance improvement and efficiency. The Program also partners with State Offices of Rural Health to provide technical assistance to grantees.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Focus resources and services on diseases and conditions with the greatest health disparities.

27.1. Reduce the proportion of rural residents of all ages with limitation of activities caused by chronic conditions.
(Baseline - 2000: 14.67%)

This long-term measure was chosen because rural residents experience greater limitation of activity caused by chronic conditions than urban residents. A reduction of activity limitation is an indicator of improvement of health status and wellness. According to the Centers for Disease Control and Prevention, (CDC), the proportion of rural residents of all ages with limitation of activities caused by chronic conditions in FY 2000 was 14.67%. By 2013, the goal is to reduce this proportion to 13%.

27.IV.A.1. Increase the number of people served through Outreach Grants.

The Outreach grant program is an effective way to provide services to rural communities to improve health and wellness. In FY 2004 the program served 655,257 individuals. In FY 2005, the program served 766,880 individuals. In FY 2006, the Outreach program served 629,120 individuals, just below the target of 675,300. In FY 2007, this program served 933,003 individuals, exceeding the target of 777,000. (See section below on “Targets Substantially Exceeded or Not Met.”) The program reduced the amount of some grant awards to make additional awards to other communities through another program, which increased the number of people served. The program also increased the amount and quality of technical assistance for potential applicants. The FY 2009 target is 791,000.

Long-Term Objective: Increase collaborative efforts to improve the capacity and efficiency of public health and health care systems.

27.2. Increase the proportion of critical access hospitals with positive operating margins.
(Baseline - 1999: 10%)

This long-term measure is used to monitor efforts to increase the financial viability of small rural hospitals. According to the Flex Tracking Project, 17% of Critical Access Hospitals (CAHs) were operating with positive operating margins in FY 99. Preliminary analysis of Medicare cost-report data for CAHs shows that progress toward this goal is being made. In FY 2002, the number of CAHs with positive operating margins had increased to 29%. As these facilities become more economically viable, they will be more likely to survive long term and therefore continue serving as a key access point for health care in rural communities.

27.V.B.1. Increase the average operating margin of critical access hospitals.

This measure is important because an increase in the average operating margin of CAHs will contribute to these hospitals' financial viability. CAHs serve as key access points for Medicare beneficiaries in rural areas and also act as the focal point for expanded health care services in rural communities by helping to attract physicians and other health care personnel. Therefore, the focus on operating margin helps determine the long-term viability of CAHs to continue to perform that access role. Medicare cost reports show that CAHs had a -14.05% average operating margin in 1999. Since that time, the Congress has enacted three laws that have included provisions increasing administrative flexibility for CAHs. It is expected that these changes in the law will help address some of the financial challenges and barriers facing CAHs. Analysis of Medicare cost report data shows positive progress toward this goal. In analyzing cost report data for a representative selection of CAHs, these facilities are seeing improved operating margins. In FY 2005, CAHs had an average operating margin of -9.6 percent. In FY 2006, the average operating margin improved to -8.8%. This figure improved to -6.7 percent in 2007, which was better than the FY 2007 target of improving the margin by 0.5% to 8.3 %.

27.E. Increase the return on investment of funds by the Rural Hospital Flexibility (FLEX) grant program, as measured by change in total operating margin of critical access hospitals in relation to FLEX dollars invested.

This efficiency measure indicates the return on investment of funds by the Rural Hospital Flexibility grant program as measured by the change in total operating margin of critical access hospitals in relation to the investment of Flex program dollars. The measure looks at the change in total operating margin for all CAHs from one year to the next relative to the programmatic investment that is specifically focused on finance-related activities to yield a percentage that quantifies return on investment annually. In FY 2004, the baseline year, the return on investment was 23.36 percent. The return on investment in FY 2005 was 14.8 percent, which is below the target of 24 percent but still indicative of a positive return on investment for the program. The reduction in overall return on investment may fluctuate year to year as rural hospitals experience significant variability in their patient volume and revenue but these factors tend to balance out to some degree over time. The return on investment in FY 2006 was 13.4 percent, which was again below the target but still indicative of a positive return.

The Office of Rural Health Policy is looking at a range of options for a new efficiency measure. New performance data will be collected. Initial data measurement and analysis will take place in FY 2008 and an assessment of the potential for a new efficiency measure will be done after this analysis takes place.

TARGETS SUBSTANTIALLY EXCEEDED OR NOT MET

Measure: Increase the number of people served through Outreach Grants.

FY 2007 Target:	777,000
FY 2007 Result:	923,000

The results for FY 2007 have improved as the program exceeded the target of 777,000 by serving 923,000. The program reduced the amount of some grant awards to make additional awards to other communities through another program, which increased the number of people served. The program also increased the amount and quality of technical assistance for potential applicants.

RURAL HEALTH POLICY DEVELOPMENT

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Utilize trend data to assist in targeting program resources toward goals.								
28.V.A.1	Conduct and disseminate policy relevant research on rural health issues.	30	30	30	30	30	Sep-09	30

INTRODUCTION

This measure assesses how productive the Office is in producing research reports that informed its policy activities. The research reports produced by the Office play a key role that inform HRSA, HHS and others about the impact of health care policy on rural communities.

This performance measure supports HRSA's Strategic Plan Goal V of improving the public health and health care systems by using trend data to assist in targeting program resources toward goals. The performance measure also supports HHS Strategic Goal 4 of supporting scientific research.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Utilize trend data to assist in targeting program resources toward goals.

28.V.A.1. Conduct and disseminate policy relevant research on rural health issues.

The program produced 30 research projects in FY 2006 and FY 2007, meeting the target. The 30 reports in FY 2007 represented a full range of rural health services projects with a particular focus on issues connected to the implementation of the provisions in the Medicare Modernization Act of 2003, most notably the potential rural implications and benefits of the new Medicare prescription drug benefit and the transition toward offering more health coverage options under Medicare Advantage. The studies also continue to examine the sustainability of small rural hospitals, including their low volume, and assuring quality through improving patient safety and reducing medical errors. Through the policy research, ORHP expects to predict the impact of the payment reforms on rural citizens, their hospitals and communities and, most importantly, to identify options for changes to lessen any negative effects while also identifying positive outcomes of the MMA provisions for increasing services for rural Medicare beneficiaries. Other ongoing reports inform the policy discussion on improving the health of rural citizens by ensuring access to health promotion programs, rural health clinics, and mental health care. The FY 2009 target is 30 reports.

RURAL HEALTH OUTREACH AND NETWORK DEVELOPMENT GRANTS

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Focus resources and services on diseases and conditions with the greatest health disparities.								
29.IV.A.1	Increase the number of people served through Outreach Grants.	682,253	627,120	777,000	923,003	635,000	Oct-09	791,000

INTRODUCTION

This measure assesses how well the grants administered under this authority affect rural residents. The various grant programs administered under this authority focus on a range of health issues from improving access to care to recruitment and retention of health care providers to improved coordination of services. The measure focuses on how many rural residents are served by the program. The measure supports HRSA's Strategic Plan Goal IV of eliminating health disparities. The performance measure also supports HHS Strategic Goal 1 of improving the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care. Providing improved guidance and information to grantees on performance expectations and technical assistance to grantees are strategies used to improve performance.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Focus resources and services on diseases and conditions with the greatest health disparities.

29.IV.A.1. Increase the number of people served through Outreach grants.

The Outreach grant program is an effective way to provide services to rural communities to improve health and wellness. In FY 2004 the program served 655,257 individuals. In FY 2005, the program served 766,880 individuals. In FY 2006, the Outreach program served 629,120 individuals, just below the target of 675,300. In FY 2007, this program served 933,003 individuals, exceeding the target of 777,000. (See section below on "Targets Substantially Exceeded or Not Met.") The program reduced the amount of some grant awards to make additional awards to other communities through another program, which increased the number of people served. The program also increased the amount and quality of technical assistance for potential applicants. The FY 2009 target is 791,000.

TARGETS SUBSTANTIALLY EXCEEDED OR NOT MET

Measure: Increase the number of people served through Outreach Grants.

FY 2007 Target:	777,000
FY 2007 Result:	923,000

The results for FY 2007 have improved as the program exceeded the target of 777,000 by serving 923,000. The results for FY 2007 have improved as the program exceeded the target of 777,000 by serving 923,000. The program reduced the amount of some grant awards to make additional awards to other communities through another program, which increased the number of people served. The program also increased the amount and quality of technical assistance for potential applicants.

RURAL HOSPITAL FLEXIBILITY GRANTS

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Increase the collaborative efforts to improve the capacity and efficiency of public health and health care systems								
30.V.B.1	Increase the average operating margin of critical access hospitals.	-9.6%	-8.8%	0.5 % point over FY 2006	-6.7%	0.5 % point over FY 2007	Dec-09	0.5 % point over FY 2008
30.V.B.2	Appropriate rural facilities will be assisted in converting to Critical Access Hospital (CAH) status to help stabilize their financial status. [a]	1,100	1,277	1,286	1,282	1,284	Dec-09	1,288
30.V.B.3	Facilities and communities will be assisted in the development of networks.	1,209	2,326	2,400	2,533	2,600	Dec-09	2,660
30.V.B.4	Increase the percent of Critical Access Hospitals reporting at least one measure to Hospital Compare. [a]		63.14% (baseline)		69%			70%

Notes:

[a] The number of hospitals likely to convert to CAH status is nearing its maximum. The program has introduced a new measure to gauge CAH performance. The new measure, 30.V.B.4, will have its first target in 2009, subject to funding.

INTRODUCTION

These measures assess the performance of the Office's rural hospital grant programs. The various grant programs administered under this authority focus on working with the grantees to assist Critical Access Hospitals and the communities they serve. The measures focus on increasing the annual operating margin, assisting hospitals in the conversion to CAH status and the formation of networks of care involving CAHs. Providing improved guidance and information to grantees on performance expectations and technical assistance to grantees are strategies used to improve performance.

These performance measures supports HRSA's Strategic Plan Goal V of improving the public health and health care systems by increasing collaborative efforts to improve the capacity and efficiency of public health and health care systems. The performance measure also supports HHS Strategic Goal 1 of improving the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Increase the collaborative efforts to improve the capacity and efficiency of public health and health care systems.

30.V.B.1. Increase the average operating margin of critical access hospitals.

This measure is important because an increase in the average operating margin of CAHs will contribute to these hospitals' financial viability. CAHs serve as key access points for Medicare beneficiaries in rural areas and also act as the focal point for expanded health care services in rural communities by helping to attract physicians and other health care personnel. Therefore, the focus on operating margin helps determine the long-term viability of CAHs to continue to perform that access role. Medicare cost reports show that CAHs had a -14.05% average operating margin in 1999. Since that time, the Congress has enacted three laws that have included provisions increasing administrative flexibility for CAHs. It is expected that these changes in the law will help address some of the financial challenges and barriers facing CAHs. Analysis of Medicare cost report data shows positive progress toward this goal. In analyzing cost report data for a representative selection of CAHs, these facilities are seeing improved operating margins. In FY 2005, CAHs had an average operating margin of -9.6 percent. In FY 2006, the average operating margin improved to -8.8%. This figure improved to -6.7 percent in 2007, which was better than the FY 2007 target of improving the margin by 0.5% to 8.3 %.

30.V.B.2. Appropriate rural facilities will be assisted in converting to Critical Access Hospital (CAH) status to help stabilize their financial status.

Conversion of appropriate rural facilities to CAH status will help sustain the rural health care infrastructure to provide access to high quality care for rural Medicare beneficiaries. This is a core component of the Flex program. Meeting statutory requirements for certification and Conditions of Participation for CAHs enables the facility to be reimbursed on the basis of reasonable cost. This demonstrably improves financial performance of these most vulnerable facilities, thereby sustaining access.

Conversion-related activities have been a major emphasis of the program. As the program has matured, additional emphasis has been placed on quality and performance improvement, improving existing CAH operations, and development of community-level collaborative relationships (including EMS) which strengthen rural healthcare. The program expects the potential growth in the number of conversions to slow in the coming years with the total universe of conversions expected to peak at approximately 1,300. There were 1,277 CAHs in FY 2006 and 1,282 in FY 2007, exceeding the target in FY 2006 and narrowly missing the target by 4 in FY 2007.

30.V.B.3. Facilities and communities will be assisted in the development of networks.

Building relationships between CAHs and other providers is a critical component of infrastructure and systems development to sustain viable delivery capability in rural communities. Network development is promoted to reduce duplication, reduce overhead costs, improve services and improve quality of care. In FY 2006, ORHP exceeded its target of 1,250 by assisting 2,326 facilities/communities in the development of networks. In FY 2007, the program exceeded its target of 2,400 facilities/communities by working with 2,553 entities. As the total number of CAHs reaches its expected peak at just over 1,200, the program emphasis is moving more toward network development activities. As a result, the number of facilities and communities assisted in network development is increasing and future targets reflect that.

30.V.B.4. Increase the percent of Critical Access Hospitals reporting at least one measure to Hospital Compare.

Increasing the number of Critical Access Hospitals (CAHs) that report data on at least one measure to the Centers for Medicare and Medicaid Services' (CMS) Hospital Compare is an important activity for rural communities. Participation in Hospital Compare is voluntary for this class of hospitals. The Flex program's focus on quality improvement provides support for this activity. The data posted on the Hospital Compare Website is a key part of the Department's ongoing efforts to increase transparency in the health care system by measuring all hospitals, including CAHs, on how they perform across a variety of clinical measures. This is a new measure for FY 2009. Until FY 2008, CMS' Quality Improvement Organizations (QIOs) provided assistance to CAHs on this reporting. The QIOs are no longer charged with that task but the funding provided through the Flex program is intended to focus on quality improvement and performance improvement in CAHs. Therefore, the Flex program can provide assistance to support this Departmental priority. The baseline for this measure is 63.14% percent of CAHs reporting at least one measure to Hospital Compare in FY 2006. In FY 2007, 69% of CAHs reported data on at least one measure. The program expects this measure to see moderate improvement but not at the same level as shown from the baseline year to 2006. This is due mainly to the change in work by the QIOs, who played a key role in supporting this activity in 2006 but will not do so in subsequent years. The FY 2009 target is 70%.

STATE OFFICES OF RURAL HEALTH

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Increase collaborative efforts to improve the capacity and efficiency of the public health and health care systems.								
31.V.B.1	Increase the number of communities receiving technical assistance from a State Office of Rural Health.	4,655	4,699	4,700	5,823	4,750	Oct-09	4,775
31.V.B.2	Increase the number of States that have an identified focal point for rural recruitment with a national source of applications.	45	46	44	49	48	Oct-09	49

INTRODUCTION

The measures are used to assess the performance of the Office's investment in the 50 State Offices of Rural Health. The program provides matching grants to each of the 50 States to support the ongoing efforts of creating a single point of contact within the State for rural health issues. The performance measures focus on two key activities of the grantees. The first looks at how many communities receive technical assistance from the grantee. The second looks at how many States have identified a focal point for the recruitment and retention of health professionals in rural areas which has long been an important need for rural communities. The program uses an annual grantee meeting to focus attention on performance expectations and to provide a forum for grantees to share approaches used to improve performance.

These measures support HRSA's Strategic Plan Goal V of improving the public health and health care systems by increasing the collaborative efforts to improve the capacity and efficiency of the public health and health care systems. The measures also support HHS Strategic Goal 1 of improving the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Increase collaborative efforts to improve the capacity and efficiency of the public health and health care systems.

31.V.B.1. Increase the number of communities receiving technical assistance from a State Office of Rural Health.

This measure is important because rural communities and providers are often isolated and have unique technical assistance needs. By providing this technical assistance, a State Office of Rural Health (SORH) is equipping rural communities with the tools and resources needed to coordinate rural health at the local level. The SORH enables a community to create localized solutions to problems which in turn strengthens the rural health delivery system one community at a time. This goal reflects one of the program's core functions. The program established a baseline of 4,120 communities in FY 2003. In FY 2006, the State Offices of Rural Health provided technical assistance to 4,699 rural communities exceeding the target of 4,450. In FY 2007, the program again exceeded its goal of 4,700 communities served by working with 5,823 communities. The FY 2009 target for the number of communities receiving technical assistance is 4,775.

31.V.B.2. Increase the number of States that have an identified focal point for rural recruitment with a national source of applicants.

This measure was chosen because rural communities experience greater challenges in recruitment of health professionals. With at least 20 percent of the population living in rural areas and less than 11 percent of the nation's physicians practicing in non-metropolitan areas, the goal of fostering rural recruitment activities is a key component to many activities of the State Offices. Workforce shortages hamper attempts to address other pressing health care problems in rural America. A strategy that many State Offices use to meet this goal is to participate in a national rural recruitment program, such as the National Rural Recruitment and Retention Network (3RNET). The program established a baseline with FY 2003 data that indicated 41 States having identified a focal point for rural recruitment. The number increased to 46 in FY 2006, exceeding the target and to 49 in FY 2007, also exceeding the target. The FY 2009 target is 49, reflecting the likely upper limit of this measure.

RADIATION EXPOSURE SCREENING AND EDUCATION PROGRAM

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Expand the capacity of the health care safety net								
32.1[*]	Percent of RECA successful claimants screened at RESEP centers. [*] **(Developmental)**							
32.2[*]	Percent of patients screened at RESEP clinics who actually receive RECA benefits. [*] **(Developmental)**							

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Expand the capacity of the health care safety net								
32.I.A.1	Total number of individuals screened per year.	1,551	1,464	2,225	1,689	1,700	Nov-09	1,800
32.I.A.2	Total number of telephone inquiries to RESEP clinics based on expanded nationwide outreach efforts. [*] **(Developmental)**							
32.E	Average cost of the program per individual screened.	$1,046	$1,084	$850	$923	$810	Nov-09	$760

Note:
[*] These developmental measures do not have established targets.

INTRODUCTION

The measures focus on identifying possible patients who may have suffered radiation poisoning and providing needed services to them for screening. The measures also focus on helping to determine if eligible patients might be eligible to seek compensation through the filing of Radiation Exposure and Compensation Act claims. The annual measure focuses on increasing the number of individuals screened each year. The data from the performance measures are used to refine the actual guidance for the grantees to focus more explicitly on the activities that directly impact the ability to identify and screen affected patients. A key strategy to improve performance is to increase RESEP national outreach to spread the word about the program. The program is also partnering with the Department of Justice to collect data in support of long-term performance measures.

The measures support HRSA's Strategic Plan Goal I of improving access to care and expanding the capacity of the health care safety net The measures also support HHS Strategic Goal 1 of improving the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Expand the capacity of the health care safety net.

32.1. Percent of RECA successful claimants screened at RESEP centers. (Developmental)

This long-term measure reflects RESEP's primary purpose to screen and educate those that might be eligible for compensation under the Radiation Exposure Compensation Act. The measure will be determined by comparing the number of successful RECA claimants screened through RESEP centers (i.e. the numerator) with the total number of successful RECA claimants (i.e. the denominator). This is a developmental measure since there is not sufficient data currently to set a baseline and target. The program is working with the Department of Justice to obtain necessary data.

32.2. Percent of patients screened at RESEP clinics who actually receive RECA benefits. (Developmental)

This long-term measure reflects the program's efforts to accurately screen and refer individuals potentially eligible for RECA claims. Findings from RESEP's screenings must be confirmed outside the screening program through definitive diagnostic tests in order for an individual to receive benefits. The measure will be determined by comparing the number of successful RECA claimants screened through RESEP centers as reported to the Department of Justice (i.e. the numerator) with the total number of RECA claimants screened at RESEP centers as reported to the Department of Justice (i.e. the denominator). This is a developmental measure since there is not sufficient data currently to set a baseline and target. The program is working with the Department of Justice to obtain necessary data.

32.I.A.1. Total number of individuals screened per year.

This annual measure indicates the total number of individuals screened at RESEP centers. This measure defines screening as including: 1) occupational history, 2) medical history, 3) physical examination, 4) diagnostic testing (when appropriate), and 5) access to a range of comprehensive services including outreach, education, case management, referrals for treatment, and assistance in applying for RECA compensation. The baseline for this measure is 1,859 individuals screened in FY 2004. The number of individuals screened in FY 2005 is 1,551, below the FY 2005 target of 2,045. In FY 2006, the number of individuals screened is 1,464, below the FY 2006 target of 2,147. In FY 2008, the program screened 1,689 individuals, below the target of 2,225. (See section below on “Targets Substantially Exceeded or Not Met.”) The FY 2009 target is 1,800 individuals screened.

32.I.A.2. Total number of telephone inquiries to RESEP clinics based on expanded nationwide outreach efforts. (Developmental)

The second annual measure expands the program’s local outreach activities to a nationwide approach attempting to identify individuals potentially exposed, who no longer reside in the local area. Though some RESEP grantees currently collect information from each inquiry to determine where the person heard about the RESEP program, there is no program-wide data collection system yet. Thus, this measure is developmental as the program seeks to implement a streamlined process for data collection.

32.E. Average cost of the program per individual screened

The efficiency measure compares the total costs of the program to the program's outcome of getting individuals screened. The average cost per individual screened is based on the fiscal year dollars spent to pay for the screenings. The costs include all education and outreach efforts as well as the costs of the screening exams. The baseline is $1,062 for FY 2004. In FY 2005 the program showed an average cost of $1,046. In FY 2006 the program showed an average cost of $1,084 which was above the target of $893. (See section below on "Targets Substantially Exceeded or Not Met.") In FY 2007, the program showed an average cost of $923, which did not meet the target of $850. The FY 2009 target is $760.

TARGETS SUBSTANTIALLY EXCEEDED OR NOT MET

Measure: Total number of miners screened.

FY 2007 Target: 2,225
FY 2007 Result: 1,689

Measure: Average cost of the program per individual screened.

FY 2007 Target: $850
FY 2007 Result: $923

The program has not met its target for its annual goals in FY 2006 or FY 2007 of increasing the total number of individuals screened or for its related efficiency measure of reducing the average cost per individual screened. The lower number of individuals screened is driven primarily by changes in the target population. The number of uranium miners served by the program has decreased. In some cases, the population of former uranium mine workers is aging rapidly and a cohort of potential patients has died. In other cases, the population of former uranium mine workers has diffused away from the original mine sites. This, in turn, affected the efficiency measure since there were higher per unit costs. The program is devising new outreach strategies to identify where this patient population has relocated and to make them aware of available screening sites.

BLACK LUNG CLINICS

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Expand the capacity of the health care safety net								
33.1[*]	Percent of miners that show functional improvement following completion of a pulmonary rehabilitation program.[*] **(Developmental)**							

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Expand the capacity of the health care safety net								
33.I.A.1	Number of miners served each year.	10,790	11,444	10,933	11,647	11,550	Aug-09	11,700
33.I.A.2	Number of medical encounters from Black Lung each year.	20,844	19,165	21,121	22,484	21,269	Aug-09	22,525
Efficiency Measure								
33.E	Number of medical encounters per $1 million in federal funding.	3,503[a]	3,255[a]	3,610	3,817	3,630	Aug-09	3,862

Notes:

[*] This long-term developmental measure does not have annual targets and the long-term target is still to be developed.

[a] These numbers differ from those previously published to correct for calculation errors.

INTRODUCTION

The measures for the Black Lung Program assess how well the program meets the needs of miners suffering from Black Lung disease. Many miners suffering from this disease live in isolated rural areas or economically challenged communities in which access to health care services is difficult and in which expertise among the existing clinicians on black lung disease is limited. The measures focus both on long-term and short-term goals. The long-term goal assesses improved pulmonary function for coal miners. The short-term goal assesses increasing services to victims of black lung disease. Performance data is used to examine how to refine program guidance annually to focus grantees on ways to improve services and increase efficiency. Two other strategies used to improve performance include developing a mechanism to collect data on the location of miners to better target resources, and enhancing outreach efforts.

The measures support HRSA’s Strategic Plan Goal I of improving access to care and expanding the capacity of the health care safety net The performance measure also supports HHS Strategic Goal 1 of improving the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Expand the capacity of the health care safety net.

33.1. Percent of miners that show functional improvement following completion of a pulmonary rehabilitation program. (Developmental)

Functional improvement will be measured using the 6 minute walk pre/post test, applying uniform standards of measurement established by the American Thoracic Society (ATS). The 6 minute walk test is one of several tests available as an objective indicator of functional improvement; measuring the distance the patient can walk during a 6 minute period. For the purposes of this measure the patient will take the test prior to starting the pulmonary rehabilitation program and again after the completion of the program. An improvement in the post-test indicates an improved functional capacity in the patient, an indication of improved quality of life.

33.I.A.1. Number of miners served each year.

A miner served is anyone with a history of coal mine employment that receives at least one medical encounter at a clinic during the year. It is often difficult to encourage miners to come into the Black Lung clinics for the initial visits. However, grantees will devote a greater emphasis on program outreach towards affected populations. The baseline for this measure is 10,790 for 2005. In FY 2006, the program saw 11,444 miners, exceeding the target of 10,862. In FY 2007, the program served 11,647 miners, exceeding the target of 10,933. The FY 2009 target is 11,700.

33.I.A.2. Number of medical encounters from Black Lung each year.

To improve the quality of life of miners, it is important for clinics to provide ongoing, consistent care once the initial screening is conducted. The program expects the number of medical encounters to increase proportionate to the number of miners served. The baseline for this measure is 20,844 for 2005. The program totaled 19,165 medical encounters in FY 2006, missing its target of 20,983. The drop in encounters is attributed to increased costs per encounter due to rising medical costs. The program had 22,484 medical encounters in FY 2007, exceeding the target of 21,121. The FY 2009 target is 22,525.

33.E. Number of medical encounters per $1 million in federal funding.

The number of medical encounters per million dollars increased from 2,600 in FY 2004 to 3,503 in FY 2005. In FY 2006 the number of encounters per million dollars was 3,255, falling short of the target. In FY 2007, the number of medical encounters increased to 3,817, exceeding the target of 3,618. The Program offers technical assistance to grantees. The technical assistance consultants look at specific activities and offer suggestions for cutting costs while maintaining the same level of services. The program is looking into methods for collecting data that will highlight cost efficiencies to better identify best practices and target technical assistance. The FY 2009 target is 3,862.

TELEHEALTH

The program included in this section is:

- Telehealth

TELEHEALTH

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Expand the availability of health care, particularly to underserved, vulnerable, and special needs populations.								
34.II.A.1	Increase the proportion of diabetic patients enrolled in a telehealth diabetes case management program with ideal glycemic control (defined as hemoglobin A1c at or below 7%). (Est. Baseline - 2006: 10%) [a]	N/A	34%	21%	Mar-09	30%	Mar-10	14.5%
34.1*	The percent of TNGP grantees that continue to offer services after the TNGP funding has ended.* (Baseline - 2005)	100%						
Long-Term Objective: Promote the implementation of evidence-based methodologies and best practices.								
34.III.D.2	Expand the number of telehealth services (e.g., dermatology, cardiology) and the number of sites where services are available as a result of the TNGP program. [b]	489	1145	943	1,275	968[b]	Mar-10	1,371
34.III.D.1	Increase the number of communities that have access to pediatric and adolescent, and adult mental health services where access did not exist in the community prior to the TNGP grant. (Baseline - 2003: 79 Peds/51 Adults) [c]	101 Peds/ 72 Adults	190 Peds/ 125 Adults	160 Peds/ 125 Adults	Mar-09	160 Peds/ 134 Adults	Mar-10	207 Peds/ 175 Adults
Efficiency Measure								
34.E	Expand the number of services and/or sites that provide access to health care as a result of the TNGP program per Federal program dollars expended. (Baseline - 2003: 105/million) [d]	125 per Million $	168 per Million $	116 per Million $	Mar-09	121 per Million $	Mar-10	106 per Million $

Notes:

[a] It is estimated that in the new cohort (2006) 10 % of the patients enter in telehealth diabetes case management program with ideal glycemic control (hemoglobin A1C at or below 7%) and, during the first year, this cohort will achieve a 45% increase to 14.5 percent achieving ideal control. With funding in FY 2007, this cohort of programs will achieve 21% of their patients under control and those in the cohort funded in FY 2008 will have 30% of their patients under ideal glycemic control. In 2009, the process begins again with a new cohort of patients entering with 10% having ideal glycemic control, increasing to 14.5% in the first year of the new cohort.

[b] These targets are cumulative building on the 489 Sites and Services achieved through the 2003-2006 cohort. This cycle will begin again in FY 2009 with the new cohort - annual targets were established based on the 2006-2009 cohort experience. Current targets are ambitious in that grantees continue to face significant barriers to deploying telemedicine and with each new set of grantees, the program funds grantees who add more difficult services, as grantees explore the boundaries of providing these services, e.g., innovative use of telehealth for physical therapy, stroke assessment and post-treatment rehabilitation, teledentistry, etc. Please note in FY 2006, we exceeded the targets for FY 2007 and FY 2008, but current reporting rules do not permit adjusting these targets.

[c] Please note: Because this is a demonstration program, every three years each cohort of TNGP grantees "graduates" from its three-year grant while a new cohort of grantees commences a new three-year cycle of grant-supported telehealth activities. The data are calculated as a cumulative number.

[d] This measure provides the number of sites and services made available to people who otherwise would not have access to them per million dollars of program funds spent. Every three years, a new cohort of grantee commences a new three-year cycle of grant supported activities, gradually expanding sites and services per dollar invested. With each cohort, there a start-up period where services are being put in place but are not yet implemented. Over the three years of the grant, efficiency increases as grantees implement sites and services.

* This long-term measure does not have annual targets.

INTRODUCTION

The Telehealth Network Grant Program's (TNGP) performance measures allow the Program to track progress in achieving its objectives of improving access to quality health care services, particularly to rural and other underserved populations, and promoting the implementation of evidence-based technologies and best practices. Strategies used that support efforts to meet performance targets include sharing best practices, offering technical assistance to grantees, and encouraging grantees to offer specific types of services to address their communities' needs.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Expand the availability of health care, particularly to underserved, vulnerable, and special needs populations.

34.II.A.I. Increase the proportion of diabetic patients enrolled in a telehealth diabetes case management program with ideal glycemic control (defined as hemoglobin A1c at or below 7%).

At the end of FY 2006, HRSA began to fund a new three-year cohort of grantees under the Telehealth Network Grant Program (TNGP). The data indicate that, among this FY 2006 cohort of patients, 34% had ideal glycemic control. When the original targets were developed, it was estimated that in this new cohort 10 % of the patients who entered a telehealth diabetes case management program would have ideal glycemic control (hemoglobin A1c at or below 7%) and, during the first year, this cohort would have achieved a 45% increase to 14.5 percent achieving ideal control. It was estimated that this cohort funded in FY 2007 would achieve 21% of their patients under control (data available in March 2009) and those funded in FY 2008 would have 30% of their patients under ideal glycemic control. These targets were exceeded in the first year of this cohort. (See section below on "Targets Substantially Exceeded or Not Met.") In FY 2009, the process begins again with a new cohort of patients entering with 10% having ideal glycemic control, increasing to 14.5% in the first year of the new cohort.

34.1. Percent of Telehealth Network Grant Program (TNGP) grantees that continue to offer services after the TNGP funding has ended.

(Baseline – 2005: 100%; Target – 2012: 95%)

Sustainability of grant-funded programs resulting in increased access to health care for more Americans is a key objective of this program. History suggests that 100% of grantees continue to provide some level of telehealth services. It is reasonable to set a target of 95%, allowing for unforeseen events associated with a more heterogeneous program and changes in the healthcare environment over a period of six years. The Program does not anticipate significant challenges to achieving this target.

Long-Term Objective: Promote the implementation of evidence-based methodologies and best practices.

34.III.D.2. Expand the number of telehealth services (e.g., dermatology, cardiology) and the number of sites where services are available as a result of the TNGP program.

The first cohort of grantees in this program was funded in FY 2003 and the second funded in FY 2006. As grantees mature, learn best practices from other grantees, and learn of new needs in the communities they serve, grantees may make additional telehealth services and service locations available. It is anticipated that the program will experience a slightly reduced rate of growth in the future, after adjustment for carrying over existing sites that continue into the second cohort, that began in FY 2006. As of August of 2007, this cohort of TNGP grantees provided a total number of 96 clinical services, across 690 sites in underserved rural communities for a total of 786 sites and services. When added to the baseline of 489 services, the TNGP supported 1,275 sites and services in these communities since FY 2005. This result exceeds the FY 2007 target by 332 sites and services. The targets for the second cohort of grantees reflect a slight reduction from the first cohort because beginning in FY 2006, the program requires that grantees put greater emphasis on evaluating services rather than on expanding the number of sites where services are provided in accordance with Congressional directives. The targets are cumulative, building on the 489 sites and services made available in the first cohort (2003-2005) through TNGP funding, and are calculated by adding the number of projected services offered by each grantee to the number of sites operated by the grantee's networks in each year to the baseline (i.e., 489). FY 2009 begins a new cohort of grantees, and the target of 1,371 services and sites assumes a similar rate of growth as experienced in past cohorts. Achieving this target will be dependent on the FY 2009 level of funding and whether past trends of gradual growth continue into the future. Of particular note is the challenge of clinical and payer acceptance, which is influenced by the development of solid models of best practices. HRSA's Telehealth programs strive to glean solid models of best practices from the grants that then can support enhanced clinician and payer acceptance of Telehealth services.

34.III.D.1. Increase the number of communities that have access to pediatric and adolescent, and adult mental health services where access did not exist in the community prior to the TNGP grant.

(Baseline – 2003: 79 Peds / 51 Adults)

The cumulative targets and data include the first 3-year cohort whose funding began in FY 2003, and whose project period ended in August 2006; the second 3-year cohort whose funding began in FY 2006 and whose project period will end in September 2009; and the FY 2009 target for the first year of the third cohort.

With funds awarded in FY 2003, 79 communities had access to pediatric and adolescent mental health services and 51 communities had access to adult mental health services as a result of the TNGP grant. With funds awarded in FY 2004, 99 communities had access to pediatric and adolescent mental health services and 62 communities had access to adult mental health services. With funds awarded in FY 2005, 101 communities had access to pediatric and adolescent mental health services and 72 communities had access to adult mental health services. Finally, with funds awarded in FY 2006, 190 communities had access to pediatric and adolescent mental health services and 125 communities had actually gained access to adult mental health services as a result of the TNGP grant, demonstrating the continued significant impact of the program on expanding access. When the original targets were developed, it was estimated that grants funded in FY 2007 would expand access to pediatric and adolescent mental health services to 160 communities and 125 communities would have gained access to adult mental health services as a result of the TNGP grants (data available in March 2009). In FY 2008, the target was increased to 134 communities for adult mental health services. Although these targets were exceeded in the first year (FY 2006) of this cohort, data for the second year have not been received, and the Program is concerned that these first year results may be anomalous. Thus, the Program is not prepared to readjust these figures until the March 2009 results are readily available. The FY 2009 cumulative targets of 207 and 175 communities gaining access to pediatric and adult mental health services, respectively, through telehealth networks are based on prior experience. In addition, the FY 2009 target reflects the beginning of a new cohort of grantees.

These targets take into account the environmental challenges experienced by grantees even when grant funds are available. For example, difficulty in obtaining services due to the shortage in the supply of mental health specialists and continued low reimbursement for these services. In the second cohort, 16 programs were funded, but three of the sixteen are required to focus on providing and evaluating tele-home care services in accordance with Congressional directives. Moreover, fewer programs are offering pediatric/mental health services in the second cohort compared to the first (6 programs vs. 10 programs), and the targets reflect this fact. The number of programs offering these services is difficult to predict as the legislation authorizing the TNGP grants provides grantees with wide discretion as to what they propose to provide, based on community need. Nevertheless, the Program will continue to encourage applicants in the guidance to propose these services and provide continuing technical assistance to those that do provide services.

34.E. Expand the number of services and/or sites that provide access to health care as a result of the TNGP program per federal program dollar expended.

(Baseline – 2003: 105/million)

One measure of the Telehealth Network Grant Program's (TNGP) efficiency is the number of sites + services that provide access to health care as a result of the TNGP grant per $1 million Federal program dollars. The Telehealth program's efficiency measure captures the fundamental underlying mission of the program: namely to expand access to services in underserved communities at an affordable cost. This is a consistent indicator that can be tracked over time. For example, with funds awarded in FY 2003, grantees were able to achieve an efficiency of 105 sites + services per million dollars appropriated ($3.9 million). With FY 2004 funding, the efficiency factor increased to 119 per million and to 125 per million with FY 2005 funds. In FY 2006, a new set of programs was awarded telehealth grants, with slightly more funding ($4.55 million). When the original targets were developed, we anticipated having fewer sites as a result of the program requiring that grantees put greater emphasis on evaluating services rather than on expanding the number of sites where services are provided. However, with FY 2006 funding, the efficiency factor increased to 168 per million, as a result of the three additional Tele-homecare grantees, which provide care in the homes, resulting in significantly more sites. This has resulted in a higher efficiency factor for FY 2006 than anticipated when the targets for FY 2006, 07, and 08 were established. The original FY 2009 target is also low compared to the FY 2006 actuals, assuming a similar pattern to that experienced in earlier cohorts. That is, a decrease in sites and services offered in the first year of a new cohort and an emphasis on evaluation of the quality and cost of services rather than a simple increase in the sites and services provided. It is anticipated that the efficiency will rise each year within the new cohort, similar to prior years, as new sites and services are implemented. Although all of these targets were exceeded in the first year (FY 2006) of this cohort, data for the second year have not been received, and the Program is concerned that these first year results may be anomalous. Thus, the Program is not prepared to readjust these figures until the March 2009 results are readily available.

TARGETS SUBSTANTIALLY EXCEEDED OR NOT MET

Measure: Increase the proportion of diabetic patients enrolled in a telehealth diabetes case management program with ideal glycemic control (defined as hemoglobin A1c at or below 7%)

FY 2006 Target: 14%
FY 2006 Result: 34%

Although the target was exceeded in the first year of this cohort of grants (34% under ideal glycemic control compared to target of 14.5% in FY 2006), data for the second year have not been received, and the Program is concerned that this first year result may be anomalous. Thus, the Program is not prepared to adjust the target figures until the March 2009 results are available.

HEALTH EDUCATION AND ASSISTANCE LOANS (HEAL)

The program included in this section is:

- Health Education and Assistance Loans (HEAL)

HEALTH EDUCATION ASSISTANCE LOANS

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Achieve Excellence in Management								
9.VII.C.1	Conduct an orderly phase-out of the outstanding loan portfolio, resulting in a reduction in the Federal liability associated with the HEAL program (balance in the portfolio, dollars in $000's).	$1,709	$1,375	$1,090	$1,131	$997	$980	$866

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Efficiency Measure								
9.E	Improve claims processing efficiency through implementation of an online processing system (HOPS). (Avg. number of days to process claim)	9 days	8 days	8 days	8 days	8 days	11 days	8 days

INTRODUCTION

The Health Education Assistance Loans (HEAL) program's performance measures and activities build upon HRSA's long-range goal to "Achieve Excellence in Management" and are keyed to the following HRSA Objective:

- Preserve the financial integrity of HRSA's programs and activities.

Performance measure information is used by the program to assess the success of HEAL in meeting goals of conducting an orderly phase-out of HEAL's outstanding loan portfolio and thus reducing Federal liability associated with the HEAL program. Strategies used to improve performance include providing borrowers who have not yet fully repaid their loans with appropriate assistance to facilitate the repayment of their loans, working with lenders and loan holders to minimize defaults, and aggressively pursuing HEAL defaulters.

DISCUSSION OF RESULTS AND TARGETS

9.VII.C.1. Conduct an orderly phase-out of the outstanding loan portfolio, resulting in a reduction in the Federal liability associated with the HEAL program.

The HEAL program is currently phasing out an outstanding loan portfolio of approximately $980 million as of September 30, 2008. The program has historically met or exceeded its targets for phasing out the outstanding loan portfolio, through initiatives to help borrowers manage their indebtedness, and through partnerships with lenders and loan holders. In FY 2007, the projection of $1.090 billion was not able to be met due to the historical downward trend of HEAL loans that refinanced out of the program and borrowers that paid-in-full turned out to be lower than anticipated. In FY 2008, the target was met and slightly exceeded by $17 million in loans. This was primarily due to the target being adjusted for the historical trend. The FY 2009 target is $886 million. However, target projections are difficult to determine when the economy and banking industry are in flux with direct results to students refinancing and paying off loans.

9.E. Improve claims processing efficiency through implementation of an online processing system (HOPS).

The efficiency measure for the HEAL program is to improve claims processing efficiency through the implementation of an online processing system. In FY 2004 and FY 2005, the processing time was 10 days and 9 days, respectively. Processing time was reduced to 8 days in FY 2006, which was lower than the target. The target of 8 days was met in FY 2007 but, in FY 2008, the target of 8 days was not met. It took 11 days on average to process claims, because there were management changes and other reduction in staff that resulted in the workload of claims specialists to increase. It is believed that the FY 2008 result was an anomaly, thus the FY 2009 target remains 8 days.

NATIONAL VACCINE INJURY COMPENSATION PROGRAM

Programs included in this section are:

- National Vaccine Injury Compensation Program

NATIONAL VACCINE INJURY COMPENSATION PROGRAM

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long - Term Objective: II. IMPROVE HEALTH OUTCOMES **A. Expand the availability of health care resources to underserved, vulnerable, and special needs populations.**								
26.II.A.1	Percentage of cases in which judgment awarding compensation is rejected and an election to pursue a civil action is filed.	0%	0%	0%	0%	0%	0%	0%
26.II.A.2	Average claim processing time.	894 days	834 days	1,231 days	1,337 days	1,433 [a] days	1,280 days	1,300 [b] days
26.II.A.3	Percentage of cases where the deadline for the Rule 4(b) report is met once the case has been deemed complete**.**	83.7%	82.4%	83%	89.3%	86%	94.7%	86%
26.II.A.4	Decrease the average time settlements are approved from the date of receipt of the DOJ settlement proposal.	18 days	11 days	10 days	9.6 days	10 days	5.8 days	10 days
26.II.A.5	Decrease the average time that lump sum only awards are paid from the receipt of all required documentation to make a payment.	11 days	3 days	5 days	3.9 days	5 days	1.5 days	5 days

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Efficiency Measure								
26.E.	Percentage of cases in which case settlements are completed within 15 weeks.	95%	97.9%	92%	96.4%	92%	100%	92%

Notes:

[a] The targets for 26.II.A.2. are increasing because some claims have been stayed (i.e., the Court has stopped the adjudication process at the request of the petitioner) for several years and when they are finally resolved, they will significantly increase processing times.

[b] As the autism claims represent a unique category of VICP cases and are being processed under different Court proceedings and procedures, these claims have been excluded, beginning for 2009, from the calculations determining case processing times. See discussion below.

INTRODUCTION

The purpose of the National Vaccine Injury Compensation Program (VICP) is to equitably and expeditiously compensate individuals, or families of individuals, who have been injured by childhood vaccines, and to serve as a viable alternative to the traditional tort system. This Program=s performance measures focus on the timely adjudication of vaccine injury claims and monetary awards, and the extent that the VICP serves as a alternative to the traditional tort system by ensuring that no compensated claimant rejects an award, and elects to file lawsuits in the traditional tort system (i.e., pursue civil action). A strategy used to reduce claims processing time is to increase the use of electronic file sharing among agencies, expert witnesses, and other parties.

DISCUSSION OF RESULTS AND TARGETS

Long-Term Objective: Expand availability of health care resources to underserved, vulnerable, and special needs populations.

26.II.A.1. Percentage of cases in which judgment awarding compensation is rejected and an election to pursue a civil action is filed.

While a purpose of the VICP is to fairly compensate individuals who have been injured by vaccines, the Act provides that petitioners may choose to reject an award from the VICP and sue in a traditional civil forum. It is the goal of the VICP to ensure that this option is rarely, if ever, utilized by those individuals with a legitimate claim for compensation for a vaccine-related injury. This measure tracks the number of individuals who pursue civil litigation following a determination that they are eligible for compensation. From FY 2005 – FY 2008, the VICP met its target of 0% for the percentage of eligible claimants who opted to reject awards. The FY 2009 target is 0%.

26.II.A.2. Average claim processing time.

This measures the average length of time from the date the claim is filed until payment is authorized for compensable claims, and the date of filing to judgment for dismissed claims. This goal encompasses total claim processing time by all program participants, including the Department of Justice, HRSA, petitioners and the U.S. Court of Federal Claims. Since FY 2005, the VICP average time to process claims has been less than its targets. In FY 2005, the average time was 894 days, which was less than the target for FY 2005 of 990 days. The average time was reduced to 834 days in FY 2006, less than the target for FY 2006 of 1,005 days. In FY 2007, the VICP did not meet its target of 1,213 days for this measure due to petitioner and Court-driven delays in adjudicating claims. For this period, the performance outcome was 1,337 days. The VICP met its FY 2008 target of 1,433 days with an FY 2008 actual of 1,280 days. The FY 2009 target is 1,300 days.

The target excludes autism claims. Using adjudication timelines for autism claims filed as part of the Omnibus Autism Proceeding (OAP) results in an inaccurate picture of VICP processing times. In contrast to non-OAP claims, which are generally not put on hold by order of a special master for any significant period, most autism claims filed as part of the OAP are essentially on hold. By order of the special masters, almost all have been on hold for years pending the resolution of the causation issues in test cases; and unlike most non-OAP cases, only a small number of claims have been required to submit the medical records and other documents required by statute. Therefore, adjudication timelines for non-OAP claims provide a more accurate picture of the VICP adjudication process.

26.II.A.3. Percentage of cases where the deadline for the Rule 4(b) report is met once the case has been deemed complete.

This annual measure tracks how efficient the VICP is at filing Rule 4(b) reports for cases that have been filed with adequate medical documentation. The filing of these reports is the first step in the process of adjudicating cases. A Rule 4(b) report is similar to the government's "answer" in a traditional civil lawsuit. Its purpose is to explain the government's position as to why an award should or should not be compensated, provides a medical analysis of petitioner's claims, and assert any applicable legal arguments. Before a Rule 4 (b) report can be completed, a VICP physician conducts a medical analysis of the case if adequate medical documentation has been filed. Also, the Department of Justice conducts a legal analysis of the case to determine if it meets the requirements of the National Childhood Vaccine Injury Act of 1986, as amended. The medical and legal analysis are combined and become the Rule 4(b). This supports the VICP's first long-term goal by helping to ensure that fair compensation is offered to claimants, and it supports the second long-term goal by moving cases toward disposition on a timely basis.

Since FY 2005, the VICP has exceeded its targets for the percentage of cases where the deadline for the Rule 4(b) report is met once the case has been deemed complete. In FY 2005, the Rule 4(b) report deadline was met for 83.7% of the cases that are deemed complete which exceeded the FY 2005 target of 78%. In FY 2006, the Rule 4(b) report deadline was met for 82.4% of the cases that are deemed complete which exceeded the FY 2006 target of 80%. In FY 2007, the Rule 4(b) report deadline was met for 89.3 percent of the cases that were deemed complete which exceeded the target of 83 percent. The performance outcome for FY 2008 was 94.7%, again exceeding the target. The FY 2009 target is 86%.

26.II.A.4. Decrease the average time settlements are approved from the date of receipt of the DOJ settlement proposal.

The purpose of this measure is to track the average time that settlement payments are approved and to ensure that petitioners are satisfied with the processing of their claims, thus, preventing award rejections. Quickly and efficiently processing settlements is a top priority for the VICP. The VICP is unable to reduce the targeted average time below 10 days because of factors inherent in the approval system, such as the necessary legal review and opinion by the HHS Office of General Counsel. In FY 2005, the average time increased to 18 days due to staff changes, but was reduced to 11 days in FY 2006. In FY 2007, the VICP was successful in reducing the average time to approve settlements and to pay lump sum only awards. The average time that settlements were approved from the date of receipt of the DOJ settlement proposal was 9.6 days, which was less than the target of 10 days.

The FY 2008 target for this measure was 10 days, with a FY 2008 actual result of 5.8 days. The process includes the HHS Office of the General Counsel (OGC) reviewing the Department of Justice (DOJ) settlement proposal and preparing a legal opinion to the VICP. This OGC review and opinion often requires consultation with DOJ attorneys to clarify or amend elements in the settlement proposal. Additionally, the OGC no longer has an attorney exclusively working on VICP correspondence and issues. OGC attorneys currently serve a number of HHS clients, thus priorities and time commitments can shift, and cause reasonable delays. Because of these variables, the FY 2009 target will remain 10 days.

26.II.A.5. Decrease the average time that lump sum only awards are paid from the receipt of all required documentation to make a payment.

The purpose of this annual measure is to track the average time that lump sum awards with the required documentation to issue payments are made and to ensure that petitioners are satisfied.

In FY 2005, the average time rose to 11 days. This measure previously read “Decrease the average time that lump sum only awards are paid from the date of the DOJ clearance letter to make a payment” to now read “Decrease the average time that lump sum only awards are paid from the receipt of all required documentation to make a payment.” This change was necessary to account for a DOJ-driven policy implemented in FY 2006 to process payments only after the petitioner had submitted proof of guardianship. Additionally, this measure change accounts for time required to collect tax identification number information and other necessary payment data. The FY 2006 data is only available from May through September as the VICP database was modified in May 2006 to capture data for this revised measure. The average for FY 2006 is 3 days for the period of May through September. In FY 2007, the average time to pay a lump sum only award from the receipt of all required documentation to make a payment was 3.9 days, which was less than the target of 5 days. The FY 2008 result was 1.5 days, which was less than the target of 5 days. Since the number of cases settled via negotiation have more than doubled in FY 2008, which will become payable in FY 2009, the target of 5 days will remain in effect for FY 2009.

26.E. Percentage of cases in which case settlements are completed within 15 weeks.

The purpose of this measure is to track the percentage of cases in which settlements are processed within 15 weeks from the date of the tentative agreement between the parties and the settlement proposal is submitted to the petitioner for his or her concurrence. Quickly and efficiently processing settlements is a top priority for the VICP. In FY 2004, the percentage of cases was 80%, which is the baseline for this measure. In FY 2005, the percentage of cases rose to 95% which surpassed the FY 2005 target of 85%. In FY 2006, the percentage was 97.9%, which exceeded the target of 90%. In FY 2007, the percentage of cases in which settlements are processed within 15 weeks was 96.4%. In FY 2008 this percentage was 100%, surpassing the target of 92%. The target for FY 2009 will remain at 92% due to the complex nature of case settlements.

PROGRAM MANAGEMENT

The program included in this section is:

- Program Management

PROGRAM MANAGEMENT

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Strategically manage information technology to support programs.								
35.VII.B.1	Information Technology Management: Ensure Critical Infrastructure Protection. A. Perimeter Protection	Implemented an updated security program plan that incorporated a comprehensive suite of security services and included improved incident response, security monitoring and risk management capabilities.	Monitoring/ auditing was redesigned to incorporate an additional monitoring and incident detection tool (Securify) which complies with HHS EA needs. In addition, there is now 24/7 monitoring supported by an agreement with the NIH.	Implement a self-defending network strategy that includes Internet filtering, redundant firewalls, intrusion prevention and detection devices, and Virtual Private Network (VPN) devices.	Improved overall security posture and compliance levels through implementation of customized and streamlined policies on various IPS/IDS devices and installation of ISS Proventia Enterprise Vulnerability Scanner, ISS Real Secure Server Sensors, and Arcsight for event correlation.	Extend security monitoring/ network auditing/ incident detection capabilities to include dedicated monitors on individual, high-risk servers and devices.	ISS Realsecure Server Sensors were installed on all public facing servers and some servers on the internal network. Realsecure Server Sensors and Proventia IPS/IDS have been configured for Intrusion Protection (active blocking) mode and are stopping suspect traffic which has further improved the overall security posture of HRSA. A Sourcefire appliance was also deployed to analyze all Internet traffic, increasing HRSA's visibility of potential vulnerabilities and attacks.	Implement and operate a cyber protection and incident handling center to conduct real-time assessment of current network vulnerabilities and remediation of network perimeters.

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
35.VII.B.1	Information Technology Management: Ensure Critical Infrastructure Protection. B. Risk Assessment	Performed annual self-assessments, privacy impact assessments, security reviews, and ensured security plans were in place for all nine (9) mission critical/essential systems (one system removed from list).	Completed 100% of planned C&A activities for FY 2006, including the testing of contingency plans and system testing and evaluation (ST&E) for all HRSA FISMA systems.	Complete re-certification for four (4) major applications and general support systems, perform annual security reviews for three (3) HRSA major applications, and determine security requirements for 100% of all new IT investments.	Completed four (4) full Certification and Accreditations and performed annual security reviews on fourteen (14) other HRSA systems.	Complete annual security reviews for ten (10) HRSA major applications, and determine security requirements for 100% of all new IT investments	Completed full Certification and Accreditations of 7 systems, and performed security reviews of 10 other systems.	Complete Certification and Accreditation for 10 HRSA systems, including the re-certification of previously certified and accredited systems that is required every three years.
35.VII.B.1	Information Technology Management: Ensure Critical Infrastructure Protection. C. Security Awareness Training	Developed and implemented updated awareness module and trained 96% of HRSA staff. Based on existing requirements, 100% of staff assigned specific security duties were trained and a new awareness and training program plan was developed to address newly defined requirements.	100% of HRSA staff completed the web-based Security Awareness training module; 100% of FISMA system ISSO's completed HRSA training.	Full participation in Security Awareness Training by 100% of HRSA Staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation of Executive Awareness Training by 100% of HRSA executive staff.	100% completion rate for HRSA Executives and those staff identified to have significant security responsibilities. 99.9% completion rate for Security Awareness training of HRSA staff.	Full participation in Security Awareness Training by 100% of HRSA Staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation of Executive Awareness Training by 100% of HRSA executive staff.	100% completion rate in all areas of Security Awareness and Training.	Full participation in Security Awareness Training by 100% of HRSA Staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities, and participation of Executive Awareness Training by 100% of HRSA executive staff.

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
35.VII.B.1	Information Technology Management: Ensure Critical Infrastructure Protection. D. Security Authorization to Operate	---	---	---	---	---	---	This is a new performance measure with its first target set for 2010. The measure focuses on having all HRSA systems certified and accredited and granted an Authority to Operate.
35.VII.B.2	Information Technology Management: Capital Planning and Investment Control	---	---	---	---	---	---	This is a new performance measure with its first target set for 2010. The measure will focus on having acceptable business cases, as defined by OMB.

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Strategically manage information technology to support programs.								
35.VII.A.1	Strategic Management of Human Capital Initiative: As part of a management review; HRSA will implement a Delayering Management and Streamlining Organizational Plan.	Developed proposal to consolidate health information technology activities.	Established Office of Health Information Technology (12/05).	Continue with implementation of streamlining efforts.	Established the Bureau of Clinician Recruitment and Service.	Continue with implementation of streamlining efforts	Implemented a restructuring of the Office of Financial Management and the Office of Management.	Continue with implementation of streamlining efforts.
35.VII.A.2	Strategic Management of Human Capital Initiative: Implement the HRSA Scholars Program.	18	51	55	62	30	50	NA

Note:
NA = Not applicable.

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These performance measures link to HRSA's Strategic Plan goal to achieve excellence in management and to the specific objectives to strategically manage information technology to support programs, and foster and lead a high-quality, well-trained workforce.

DISCUSSION OF TARGETS AND RESULTS

35.VII.B.1. Information Technology Management: Ensure Critical Infrastructure Protection.

HRSA continues to administer a diligent Critical Infrastructure Protection (CIP) program that includes, among other efforts, a strong emphasis on perimeter protection, incident response, risk assessment, and security awareness training. Legislation such as the Federal Information Security Management Act (FISMA) imposes significant computer security requirements including periodic assessments of security risks to information systems and data supporting its critical operations.

HRSA will monitor the performance of the CIP and Information Systems Security Program through the following measures:

A. **Perimeter Protection:** HRSA will protect the perimeter and network boundaries by implementing the appropriate network intrusion infrastructure to detect and mitigate improper network violations. In FY 2006, monitoring/auditing was redesigned to incorporate an additional monitoring and incident detection tool (Securify) which complies with HHS EA needs. In addition, there is now 24/7 monitoring supported by an agreement with the NIH. In FY 2007, HRSA Improved overall security posture and compliance levels through implementation of customized and streamlined policies on various IPS/IDS devices and installation of ISS Proventia Enterprise Vulnerability Scanner, ISS Real Secure Server Sensors, and Arcsight for event correlation. In FY08, ISS Realsecure Server Sensors were installed on all public facing servers and some servers on the internal network. Realsecure Server Sensors and Proventia IPS/IDS have been configured for Intrusion Protection (active blocking) mode and are stopping suspect traffic which has further improved the overall security posture of HRSA. A Sourcefire appliance was also deployed to analyze all Internet traffic, increasing HRSA's visibility of potential vulnerabilities and attacks. FY 2009 Goal: HRSA will implement and operate a cyber protection and incident handling center to conduct real-time assessment of current network vulnerabilities and remediation of network perimeters. The center is currently operating in a test mode and includes security tools such as SecureFusion, NET IQ and is staffed during duty hours by HRSA contract and Federal employees.

B. **Risk Assessment:** As defined by OMB Circular A-130 and integral to the IT security program, HRSA will broaden risk assessment efforts for Agency information systems and networks. During FY 2006, HRSA completed annual self-assessments, privacy impact assessments, security reviews, and security plans for all Agency FISMA mission critical/essential systems. During FY 2007, completed four (4) full Certification and Accreditations and performed annual security reviews on fourteen (14) other HRSA systems. In FY 2008, HRSA completed 7 full Certification and Accreditations and performed security reviews of 10 other systems. FY 2009 Goal: complete Certification and Accreditation (C&A) for 10 HRSA systems. This will include re-certification of previously certified and accredited systems that is required every three years.

C. **Security Awareness Training:** In addition to security education and outreach efforts, HRSA will expand the security awareness training program for Agency employees, and other program staff with unique information security responsibilities. In FY 2007, HRSA successfully reported a 100% completion rate for HRSA Executives and those staff identified to have significant security responsibilities and a 99.9% completion rate for Security Awareness training of HRSA staff. In FY 2008, HRSA had a 100% completion rate in all areas of Security Awareness and Training. FY 2009 Goal: HRSA will have continued full participation in Security Awareness Training by 100% of HRSA Staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities, and participation of Executive Awareness Training by 100% of HRSA executive staff.

D. **Security Authorization to Operate:** This is a new performance measure with its first target set for 2010. The measure focuses on having all HRSA systems certified and accredited and granted an Authority to Operate. Currently Authority to Operate are provided to systems that complete the Certification and Accreditation process. In FY08, 7 full Authority to Operate were signed by the Designated Approval Authority who is the HRSA Chief Information Officer. The goal for FY 2010 will be for 10 Authority to Operate approvals.

35.VII.B.2. Capital Planning and Investment Control

This is a new performance measure with its first target set for 2010. The measure focuses on having all IT investments with acceptable business cases. In FY 2008, HRSA submitted two major business cases (i.e. OMB Budget Exhibit 300) as part of the President’s Budget request. One of these IT investments was initially placed on the OMB Management Watch List for issues related to the Performance-based management system and Acquisition management, but by early-summer OMB approved the investment’s Corrective Action Plan and removed the investment from the Watch List. The goal for FY 2010 will be for all HRSA major business cases to be acceptable and excluded from the OMB Management Watch List.

35.VII.A.1. Strategic Management of Human Capital Initiative: As part of a management review, HRSA will implement a Delayering Management and Streamlining Organizational Plan.

HRSA continues to focus its efforts to consolidate and re-deploy staff to more effectively support the President’s Management Agenda and accomplish the mission and goals of the Department and HRSA. By the end of December 2001, HRSA had accomplished the following: 1) Created a Citizen-Centered Agency; 2) Realigned Health Professions Programs into one Bureau and created a mission centered Primary Care Bureau; 3) Streamlined the Office of the Administrator; 4) Consolidated Information Technology (IT) functions; and 5) Consolidated Legislative and Public Affairs staff within HRSA, with appropriate reporting relationships to OS.

During FY 2002 and FY 2003, HRSA accomplished the following restructuring efforts:

1) Completed the restructuring of its financial management functions. These functions were formerly performed by the Office of Management and Program Support and HRSA's four Bureaus. They have all been consolidated; and 2) Completed a reorganization plan that was announced in the Federal Register on January 7, 2003, which restructured the grants function within HRSA. During FY 2004, a substantial Agency restructuring package was published in the Federal Register on September 21, 2004. This eliminated a variety of levels, created an Office of Federal Assistance Management which consolidated the grants activity within HRSA, and realigned administrative and financial management activities in the Office of Administration and Financial Management. During FY 2006, HRSA created an Office of Health Information Technology, which was formally established with a Federal Register notice. During FY 2007, HRSA consolidated a variety of Health Professions loan repayment and obligated scholarship programs into a Bureau of Clinician Recruitment and Services. (April 18, 2007 Federal Register). During FY 2008, a restructuring of the Office of Financial Management (with the hiring of a new Chief Financial Officer) and the Office of Management was accomplished.

35.VII.A.2. Strategic Management of Human Capital Initiative: Implement the HRSA Scholars Program

To assist in accomplishing the President's Strategic Management of Human Capital Initiative, HRSA has developed the HRSA Scholars Program. This program will increase career development opportunities and develop a new approach to hiring staff-experienced professionals and young graduates. It has components for workforce planning, outreach and recruitment, hiring, recruiting incentives, training, developing and mentoring, and evaluation. This approach focuses on bringing in honor students at the GS-5, 7 and 9 levels.

During FY 2001, the HRSA Scholars Program was developed and implemented. Forty-eight Scholars were hired. In FY 2002 and FY 2003 the numbers of scholars were 53 and 43, respectively.

For FY 2004, 41 HRSA Scholars were brought on board. In FY 2005, an additional 18 scholars were brought on board. This initiative was originally a five-year initiative (FY 2001- FY 2005), but an additional class was added. The FY 2006 target was set at a level of 50 Scholars. Fifty-one (51) scholars were brought on board in FY 2006. In FY 2007, 53 scholars were added. In FY 2008, 50 scholars were added, exceeding the target of 30. There is no target for FY 2009.

The HRSA Scholars Program served as a model for the HHS Emerging Leaders Program. Additionally, HRSA is a full participant in the HHS Emerging Leaders Program. Of the first class of 65, HRSA took 5 positions. This represents about 7.7% of the total HHS class, although HRSA represents only 3.2% of the HHS workforce.

FAMILY PLANNING

Programs included in this section are:

- Family Planning

FAMILY PLANNING

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target*
Long-Term Objective: By 2008, increase to 1,164,965 the number of unintended pregnancies averted by providing Title X family planning services, with priority for services to low-income individuals.								
36.II.A.1	Increase the total number of unduplicated clients served in Title X clinics by 5% over five years.	5,002,961	4,992,498	5,162,000	4,987,238	5,000,000	Aug-09	4,980,000
36.II.A.2	Maintain the proportion of clients served who are at or below 200% of the Federal poverty level at 90% of total unduplicated family planning users.	90%	90%	90%	91%	90%	Aug-09	90%
36.II.A.3	Increase the number of unintended pregnancies averted by providing Title X family planning services, with priority for services to low-income individuals.	978,845	975,080	1,012,655	968,868	981,000	Aug-09	977,000
Long-Term Objective: By 2010, reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15 – 24.								
36.II.B.1	Reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15-24.	1,349,884	1,353,319	1,398,000	1,361,901	1,352,000	Aug-09	1,348,000
Long-Term Objective: By 2010, reduce invasive cervical cancer among women attending Title X family planning clinics by providing Pap tests.								
36.II.C.1	Increase the number of unduplicated female clients who receive a Pap test.	2,447,498	2,324,488	2,450,000	2,272,571	2,372,000	Aug-09	2,363,000
36.II.C.2	Reduce invasive cervical cancer among women attending Title X family planning clinics by providing Pap tests.	808	799	809	798	800	Aug-09	797

Note:

* Targets for FY 2009 have been lowered from the FY 2009 CJ. This adjustment was due to a recalculation based on the overall increase in medical costs reflected in the Consumer Price Index (CPI) for medical care costs.

#	Key Outputs	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Efficiency Measure								
36.E	Maintain the actual cost per Title X client below the medical care inflation rate.	$200.81	$215.56	$224.52	$229.32	$233.86	Aug-09	$243.59

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The Program currently has five performance measures that focus on increasing access and serving individuals and families from underserved, vulnerable and low-income populations, three gauging the extent to which the Program expands the availability of healthcare to the public and two measuring the limit to which preventive health care and chronic disease management services are utilized. Each of the performance measures and the efficiency measure, guide the Program's strategy, establish direction for technical assistance and direct revisions in program policies. This enables the Program to better address program performance and facilitate methods to increase efficiency in the delivery of preventive healthcare services. The Program's major challenge to meeting its targets and maintaining a high-level of service delivery is the continued increase in medical care prices, which ultimately results in a decrease in clients served. The Program's main strategy to address this issue continues to be employing the use of focused training efforts, directing training funding and identifying National Training Priorities to address quality assurance, staffing patterns, procurement strategies and other areas related to improved clinic management, cost reduction and resource allocation.

DISCUSSION OF RESULTS AND TARGETS

36.II.A.1. Increase the total number of unduplicated clients served in Title X clinics by 5% over five years. (Indicator: Total number of unduplicated clients served.)

In 2007, the most recent year for which Program data are available, 4.987 million unduplicated clients were served at 4,542 Title X clinics. This represents a decrease of slightly less than a quarter percent in the number of clients served in 2007 over the number served in 2006. Of these, 94 percent were women and 6 percent were men. The small decrease (0.31%) in overall users between 2005 and 2007 suggests a continuing leveling off trend in client numbers. The decrease is also a reflection of the continued increase in the cost of medical supplies and cost for services, including the rising cost of contraceptive supplies. The FY 2009 target is 4,980,000 unduplicated clients.

36.II.A.2. Maintain the proportion of clients served who are at or below 200 percent of the Federal poverty level at 90% of total unduplicated family planning users.
(Indicator: The proportion of clients with incomes at or below 200 percent of the Federal poverty level.)

Title X Family Planning clinics play a key role in providing family planning and related preventive health services to individuals who can least afford such services - low-income persons, many of whom have no insurance or lack insurance coverage for family planning and related preventive health care services. The Title X program provides family planning education and services to all persons who desire them and assures access by giving priority to low-income persons. The Program consistently maintains the proportion of clients who are at or below 200% of the Federal poverty level at 90% of the total unduplicated number of family planning clients. Historically, based on the total number of unduplicated clients, 90 percent had incomes at or below 200 percent of the Federal poverty level and in 2007, the proportion was 91%. The FY 2009 target is 90%.

36.II.A.3. Increase the total number of unintended pregnancies averted by providing Title X Family Planning Services, with priority for services to low-income individuals.
(Indicator: Total number of unduplicated female clients served in Title X clinics multiplied by a factor of 20.65%; prior to the 2005 data the factor was 23.3%)

Each year, publicly-subsidized family planning services assist women in avoiding an estimated 1.3 million unintended pregnancies. Title X is a major provider of publicly funded family planning services and offers a broad range of contraceptive methods and services, which enables men and women to plan pregnancies and space births, important elements in ensuring positive birth outcomes and a healthy start for children and families. In FY 2007, 968,868 unintended pregnancies were averted through the provision of family planning and related preventive health services in Title X clinics. The FY 2007 figure is less than the FY 2006 actual and the FY 2007 target largely due to the change in the multiplier used to determine this figure as well as a small decrease in female users. The initial FY 2005, 06 and 07 targets were established using the original multiplier which was higher than the current multiplier. (See section below on "Targets Substantially Exceeded or Not Met.") The FY 2009 target is 977,000 unintended pregnancies averted, which is based on 95 percent of the target being composed of females.

36.II.B.1. Reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15-24.
(Indicator: The number of female clients ages 15-24 who received a Chlamydia test.)

Title X, through the provision of family planning and related preventive health services, has an impact in preventing infertility in women and ensuring their health, well-being and ability to have a healthy pregnancy. Based on Chlamydia prevalence data collected by the CDC Division of STD Prevention under the Infertility Prevention Program (IPP), the theoretical number of infertility cases prevented can be calculated. IPP data collected over several years illustrates that there is a 5.9 percent positivity rate for Chlamydia in family planning clinics. If left untreated, an estimated 10 - 40 percent of those cases would be expected to lead to pelvic inflammatory disease (PID). Of those, an estimated 20 percent would become infertile due to the untreated infection. This calculation results in an estimated number of cases of infertility.

In FY 2005, the baseline as well as future targets were established regarding the number of females ages 15 - 24 years screened for Chlamydia. In FY 2007, 1,361,901 screenings for Chlamydia were conducted. While the number of screenings in FY 2007 was more than in FY 2005 and FY 2006, the target for FY 2007 was not met. The decrease in the number of female clients is the primary reason for this occurrence. The FY 2009 target is 1,348,000.

36.II.C.1. Increase the number of unduplicated female clients who receive a Pap test.
(Indicator: Number of unduplicated female clients who receive a Pap test.)

Title X funded agencies are required to perform Pap tests according to nationally recognized standards of care, to document these results in the client's record and to have a system to track or monitor follow-up care for abnormal results. The frequency of Pap testing varies based on individual circumstances, but current recommendations stipulate screening every one to three years. Beginning in 2005, data were collected on the number of unduplicated clients receiving a Pap test in order to better understand and monitor the scope of cervical cancer screening in Title

X projects. In FY 2007, 2,272,571 unduplicated women received a Pap test, about 2.2% lower than the previous year. The decrease in the number of female clients as well as less frequent screening in accordance with current medical standards are the primary reasons for this occurrence. The target for FY 2009 is 2,363,000.

36.II.C.2. Reduce invasive cervical cancer among women attending Title X family planning clinics by providing Pap tests.
(Indicator: The projected cases of invasive cervical cancer avoided based on the number of unduplicated female users in Title X who received a Pap test.)

Based on Title X clinics providing Pap tests for their female clients and using accepted estimates of the number of cases of invasive cervical cancer that would result if screening did not occur (33 cases per 100,000 women screened annually and 96 cases per 100,000 women screened every three years), the number of invasive cervical cancer cases prevented can be calculated. In FY 2005, the FPAR began collecting data on the unduplicated number of women receiving Pap test in Title X projects. Using this figure, the range of invasive cancer cases prevented by Pap testing in Title X clinics can be calculated. In FY 2007, at least 798 cases of invasive cervical cancer were prevented as a result of the number of women who received a Pap test at a Title X clinic, approximately the same number of cases prevented in FY 2006, and slightly below the target. The FY 2009 target is 797.

36.E. Maintain the actual cost per Title X family planning client below the medical care inflation rate.
(Indicator: The actual cost per client is derived by dividing the total revenue by the total number of individuals served, and then factoring in the annual medical care Consumer Price Index (CPI).)

It is vital that family planning clinics maximize the number of patients served. Tracking the average cost per client, and factoring the medical care price index, is an appropriate process to assess efficiency. The program is able to measure and set targets for the average cost per client using the FPAR data and comparing the annual rate of growth of actual expenditures to the baseline amount forecasted using the CPI for medical care prices.

In 2007 the actual cost per client was $229.32, $4.80 (2.1%) more than the targeted projection. The Program has consistently met or come under the annual target for this measure and historically has kept its increase in total cost per client below that of the CPI for medical care costs. The significant increases in the cost of pharmaceuticals and clinical service provision are the likely sources of this increase in program costs in general and over the target figure. The FY 2009 target is $243.59.

TARGETS SUBSTANTIALLY EXCEEDED OR NOT MET

Measure: Increase the number of unintended pregnancies averted by providing Title X family planning services, with priority for services to low-income individuals.

FY 2007 target:	1,012,655
FY 2007 result:	968,868

The performance result was substantially lower than the target for FY 2007. This outcome was primarily due to the change in the multiplier used to determine the number of unintended pregnancies averted through the Title X Family Planning Program. The initial targets were developed using the original multiplier, approximately 11% higher than the current figure, thus establishing an inflated target figure. In addition, the decrease in the unduplicated number of female clients seen contributed to the target not being met, but to a much lesser degree. The out-year targets have been adjusted downward to reflect the change in multiplier and the forecast in unduplicated clients. The explanation is unchanged from last year when this target was also not met.

The crisis of unintended pregnancy continues to exist, despite advances in preventive health care practice and medical advances. The Program's mission to continue to provide education and preventive health care services, especially to the underserved, vulnerable, low-income and others who are disproportionately affected, is essential given the continued decline in preventive health indicators and widening of health-related disparities. The performance measure is an effective indicator of the Program's effectiveness and reflects a positive health outcome for the mission of and the preventive health services performed by the Program.

LINK TO HHS STRATEGIC PLAN

HRSA's goals and objectives build upon and are supportive of the strategic goals and objectives of the Department of Health and Human Services and achievement of the HRSA goals and objectives is crucial to the achievement of several Departmental goals and objectives. The link between HRSA's strategic goals and the strategic goals and objectives of the Department is indicated below.

HHS STRATEGIC GOALS AND OBJECTIVES	**HRSA STRATEGIC GOALS**						
	Improve Access to Health Care	Improve Health Outcomes	Improve the Quality of Health Care	Eliminate Health Disparities	Improve the Public Health and Health Care Systems	Enhance the Ability of the Health Care System to Respond to Public Health Emergencies	Achieve Excellence in Management
1: **Health Care** Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long term care.							
1.2 Increase health care service availability and accessibility.	X	X		X	X		
1.3 Improve health care quality, safety and cost/value.			X				
1.4 Recruit, develop, and retain a competent health care workforce.	X	X		X	X		
2: **Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness** Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.							
2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery.	X	X	X	X	X		
2.4 Prepare for and respond to natural and man-made disasters.						X	
4: **Scientific Research and Development** Advance scientific and biomedical research and development related to health and human services.							
4.3 Conduct and oversee applied research to improve health and well being.	X	X		X			

Note: The HHS strategic goals and objectives that are not shown do not relate directly to HRSA's strategic goals.

EVALUATIONS COMPLETED IN FY 2008

Health Centers Program

Many Underserved Areas Lack a Health Center Site, and the Health Center Program Needs More Oversight (GAO-08-723)

The Government Accountability Office (GAO) examined (1) to what extent medically underserved areas (MUA) lacked health center sites in 2006 and 2007 and (2) HRSA's oversight of training and TA cooperative agreement recipients' assistance to grant applicants and its provision of written feedback provided to unsuccessful applicants. To do this, GAO analyzed HRSA data, grant applications, and the written feedback provided to unsuccessful grant applicants and interviewed HRSA officials. GAO found that grant awards for new health center sites in 2007 reduced the overall percentage of MUAs lacking a health center site from 47% in 2006 to 43% in 2007. GAO also found that HRSA's oversight of training and TA cooperative agreements is limited in key respects and does not always provide clear feedback to unsuccessful grant applicants. The limitations include lack of standardized performance measures and lack of comprehensive on-site reviews. Further more than a third of the written feedback HRSA sent to unsuccessful Health Center Program grant applicants in fiscal years 2005 and 2007 contained unclear statements. The GAO recommended that HRSA undertake the following: collect data on the types of services provided at each health center site, develop and implement standardized performance measures for training and TA cooperative recipients, reevaluate its policy of requiring comprehensive on-site reviews of training and TA cooperative agreement recipients every 3-5 years, ensure that the discussion of an applicant's strengths and weaknesses in all summary statements is clear.

Health Professions Training Program

Impact of Title VII Training Programs on Community Health Center Staffing and National Health Service Corps Participation. Annals of Family Medicine, Vol. 6, No.5, September/October 2008.

The study examined the association between physician's attendance in training programs funded by Health Resources and Services Administration (HRSA) Title VII Section 747 Primary Care Training Grants and two outcome variables: work in a Community Health Center (CHC) and participation in the National health Service Corps Loan Repayment Program (NHSC LRP). The study linked the 2004 American Medical Association Physician Masterfile to HRSA Title VII grants files, Medicare claims data, and data from the NHSC. The study conducted retrospective analyses to compare the proportions of physicians working in CHCs among physicians who either had or had not attended Title VII-supported medical schools or residency programs and to determine the association between having attended Title VII-funded residency programs and subsequent NYSC LRP participation. The study found that 3 percent of physicians who had attended Title VII-funded medical schools worked in CHCs in 2001-2003, compared with 1.9% of physicians who attended medical schools without Title VII funding (P<.001). The study found a similar association between Title VII funding during residency and subsequent work in CHCs. These associations remained significant (P<.001) in logistic regression models controlling for NHSC participation, public vs. private medical school, residency completion date, and physician sex. A strong association was also found between attending Title VII-funded residency programs and participation in the NHSC LRP, controlling for year completed training, physician sex, and private vs. public medical school. The study concluded that continued federal support of Title VII training grant programs is consistent with federal efforts to increase participation in NHSC and improve access to quality health care for underserved population through expanded CHC capacity.

Maternal and Child Health Block Grant

Meeting State MCH Needs: A Summary of State Priorities and Performance Measures, January 31, 2008, Prepared by the Cecil G. Sheps Center

As part of their collaborative relationship with HRSA's Maternal and Child Health Bureau, State and jurisdictional Maternal and Child Health grantees (also referred to as States or State block grantees) participate in extensive planning and evaluation processes. Beginning with a comprehensive needs assessment conducted every five years, States evaluate the needs of their MCH population, assess State resources, identify priority needs, and specify how they will measure success in meeting these needs. The Child Health Program of the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, under contract with HRSA's Maternal and Child Bureau, reviewed changes in State and jurisdictional priority needs and how performance relative to these needs is measured. A final report was prepared for MCHB to provide a broad overview of the areas identified by States as important for their constituents, to anticipate to some degree what priorities might arise in the next 5-year State planning cycle, and to determine what data States are using and what data they may need. The report is divided into three sections that correspond to the three aspects of the 2005 Needs Assessment and priority setting process that were examined: 1) comparison of priority needs identified in 2005 with those identified in 2000, 2) other needs identified by States in the 2005 Needs Assessment process, and 3) review of State performance measures and how they link to State priority needs.

Based on the findings of the 5-year Needs Assessment, each State is required to specify at least seven but no more than ten priority needs for their population. Under the comparison of priority needs section, a key finding is the significant increase in State priorities to address specific health and health care issues, such as obesity and overweight. In the section addressing the other needs identified by States in the needs assessment process but not included in the listed priority needs, the report identified as a key finding two main categories of needs- those that are relatively new (ex. health insurance) and those that are longstanding (ex. oral health). Each State MCH agency is required to develop seven to ten State Performance Measures to address their identified priority needs to the extent that they have not been addressed by the 18 National Performance Measures. For the third area of review, the report concludes that the State performance measures, in the most general sense, reflect the priority needs identified by States.

State Maternal and Child Health Early Childhood Comprehensive Systems Grant Program (ECCS) - Two Year Evaluation Final Report, February 2008, Prepared by The Lewin Group.
This report is the second in a series of two reports as part of a two-year national evaluation of MCHB's ECCS grant program. The purpose of the evaluation is two-fold: 1) to assess the progress and effectiveness of the ECCS initiative in meeting its goal of fostering early childhood

systems development at the state-level and 2) to assess the quality, effectiveness, and timeliness of the technical assistance provided to the grantees. Three primary data sources were used for this assessment: 1) document review of grantee applications and progress reports, 2) a minimum data set survey, and 3) telephone monitoring calls.

Findings of the report include the usefulness of identifying an ECCS champion to support the project. States have found that a high-level champion, often a politically connected person like a governor's wife, can create a good deal of visibility and political support. Other findings include the crucial role of the ECCS project as a facilitator among systems building partners to provide support in such activities as convening meetings and focusing the efforts of partners. The report also states that ECCS projects need to be flexible in their approach to be able to react to changing conditions and mentions the importance of setting realistic goals that can be accomplished. The importance of frequent communication among partners and of parental participation was also referenced.

The report contains one recommendation regarding the ECCS project as a whole- that the individual strategies used by the grantees be studied more in-depth to discern the reasons why some strategies were more successful than others. The report notes several recommendations provided by the grantees regarding the provision of technical assistance (TA) including the need for a list to be provided to grantees of currently available TA services, the process of requesting TA should be clearly explained to grantees, and the TA resources available to grantees should include an orientation composed of trainings and/or other materials for new ECCS directors.

The Assessment of the Title V Block Grant Program's and the Discretionary Grants Programs' Performance Measures, May 2008, Prepared by Mathematica Policy Research

Mathematica Policy Research, Inc was awarded a contract to evaluate the utility and comprehensiveness of the National Performance Measures (NPM) used by the Maternal and Child Health Bureau (MCHB) in monitoring its supported programs. NPM have become a vital method of monitoring program accomplishments in MCHB, and this evidence is used in the budgeting and resource allocation process. Therefore, the evaluation of these measures will enable MCHB to continue to address current and emerging issues related to Maternal and Child Health (MCH) and to have objectives that are responsive to the leadership, technical assistance and training needs of MCHB grantees. In addition, this information will better inform not only resource allocation but policy and management decisions relative to MCHB programs.

"The Assessment of the Title V Block Grant Program's and the Discretionary Grants Programs' Performance Measures" consisted of two phases. In Phase 1, specific goals and objectives were developed in addition to the initial evaluation design, methodology, construction of instruments, and techniques of data analysis. This phase also included a detailed review of the relevant literature concerning performance measures and their use. In Phase 2, the design of the evaluation was refined based on the results of the literature review carried out in Phase 1.
The final design included a plan for data collection, analysis and reporting. The plan entailed the examination of all MCHB-sponsored programs to identify data sources reported for each measure, data compatibility and recommendations for future reporting.

Upon completion of the evaluation, Mathematica produced the following four reports:

- Analysis of the review notes about Data Sources for Title V Block Grant Performance Measures in the Title V Information System (TVIS);
- Analysis of the review notes on data sources, definitions, sub-elements and instructions for selected Discretionary Grant Performance Measures in the Discretionary Grant Information System (DGIS);
- Analysis of Form #13 (family participation) in the TVIS and the Discretionary Grant Performance Measure #6 and #7 (family participation) in DGIS, and comparison of reported data and notes from both the TVIS and DGIS forms; and
- Analysis of the review notes on data sources for NPM #14 in the TVIS, concerning overweight and obesity (Percentage of children, ages 2 to 5 years, receiving Women, Infants, and Children (WIC) services with a Body Mass Index (BMI) at or above the 85th percentile).

The findings and recommendations from these reports provided the Bureau with valuable insight and methods to improve the effectiveness of the MCH Block Grant and Discretionary Programs in areas such as data reporting, suggested data sources and systematic data collection.

Ryan White HIV AIDS Program

Review of the Puerto Rico Health Department's Compliance with the Ryan White CARE Act Payer-of-Last-Resort Requirement (OIG Audit A-02-02000)

For grant years 2002-2004, OIG (Audit A-02-06-02000) estimated that Puerto Rico claimed $24.3 million in unallowable Federal funds under Title II of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990. These claims did not comply with the payer-of-last-resort requirement that Title II funds not be used to pay for HIV/AIDS drugs or services that are eligible for coverage by other Federal, State, or private health insurance. Of the 100 prescriptions that were sampled in the Audit, 57 prescriptions were incorrectly claimed for patients who had other Federal, State, or private health insurance that would have covered the HIV/AIDS drugs. The 57 prescriptions included 50 prescriptions for patients covered by Medicaid and seven prescriptions for patients covered by four private health insurance plans. Based on the sample results, OIG estimated that the Health Department claimed unallowable Federal funding totaling $24,340,789. This overpayment occurred because the Health Department had not developed procedures to bill HIV/AIDS drugs to the insurance plans with primary payment responsibility. The OIG recommended that Puerto Rico refund $24.3 million and develop procedures to bill HIV/AIDS drugs to the Federal, State, or private health insurance plans with primary payment responsibility.

DATA SOURCES AND VALIDATION

Measure Unique Identifier	Data Source	Data Validation
Health Centers		
1.I.A.1, 1.I.A.2, 1.II.A.1, 2.II.A.2, 1.II.A.3, 1.II.B.1, 1.II.B.2, 1.E	Uniform Data System	Validated using over 1,000 edit checks, both logical and specific. These include checks for missing data and outliers and checks against history and norms.
1.II.B.3	Health Disparities Collaboratives database (Beginning in FY 2009, data will be collected through the Uniform Data System)	Reported by grantees participating in the Collaborative; checked as needed by data coordinator.
Free Clinics Medical Malpractice		
2.1.A.1, 2.I.A.2, 2.I.A.3	Free Clinics Medical Malpractice Coverage Program Database stores data on providers and clinics from free clinic applications	Data are edited and checked by program staff.
Hansen's Disease Activities		
3.II.A.1	Disability/deformity data is collected from NHDP hand and foot screens (based on the World Health Organization scale) collected from Ambulatory care clinics, NHDFP outpatient clinics and private physicians	Data are validated by staff at the Hansen's Disease Program.
3.II.A.2	National Hansen's Disease Program annual training records	Data are validated by staff at the Hansen's Disease Program
3.II.A.3	National Hansen's Disease Program Registry	Data are validated by staff at the Hansen's Disease Program
3.E	Fiscal year budget allocations and expenditures; Ambulatory Care Program database and National Hansen's Disease Program Records	Data are validated by staff at the Hansen's Disease Program
National Health Service Corps		
4.I.C.1, 4.I.C.2, 4.1.C.3, 4.I.C.5, 4.E	BHCDANET—A mainframe database containing information collected from individual scholarship and loan repayment applications, and recruitment and retention assistance applications and monitoring data from individual sites	BHCDANET is internally managed, and has the capability for display and correction of information on a continuous, as needed, basis.
4.I.C.4	Survey of NHSC clinicians who have completed their service obligation	Contractor does consistency and logic checks on survey data
Nursing Education Loan Repayment Program		
5.I.C.1, 5.I.C.2, 5.I.C.3, 5.I.C.4, 5.E	Information from applications entered into Nursing Information System (NIS).	Program staff and contractors monitor the data and make corrections as needed. Information is checked with appropriate sources, including lenders.
Health Professions		
6.I.B.1, 6.1.C.1, 6.1.C.2, 6.E	Annual grantee data submitted through the Comprehensive Performance Management System/Uniform Progress Report System (CPMS/UPR).	Data are entered through a web-based system that incorporates extensive validation checks. Grantees are also required to describe methods and systems they used to collect and submit data. Those with deficient systems are required to submit a corrective action plan.

Measure Unique Identifier	Data Source	Data Validation
Children's Hospitals Graduate Medical Education Payment Program		
7.I.A.1, 7.VII.C.1, 7.VII.C.2	Yearly reconciliation application data submitted by participating hospitals	Resident counts are audited annually by CHGME fiscal intermediaries. Other data are extracted from CMS Medicare Cost Reports audited by Medicare Fiscal Intermediaries.
7.E	HRSA payment data	Validated using letters of awards and vouchers generated by CHGME PP.
National Practitioner and Health Care Integrity Data Banks		
8.III.B.1, 8.III.B.2, 8.III.B.3, 8.III.B.4	NPDB and HIPDB operations statistics, augmented by a user survey.	Financial audits, which involve confirmation of query volumes, are done continuously.
8.E	NPDB and HIPDB operations statistics	The time required to process a query is carefully monitored by program and by contractor staff, because this is an explicit element of the performance-based contract.
Maternal and Child Health Block Grant		
10.I.A.1, 10.I.A.2, 10.III.A.4, 10.E	The Title V Information System (TVIS) collects data on grantee performance from grantee annual reports.	TVIS allows each State to enter data on performance. TVIS provides preformatted and interactive data entry. Calculations are done automatically and the system performs immediate checks for errors. Data are validated by project officers and program staff.
10.IV.B.1, 10.III.A.1, 10.III.A.2, 10.III.A.3	Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC)	Data are validated by CDC.
Traumatic Brain Injury		
11.V.B.1, 11.V.B.2, 11.V.B.3, 11.E	Grantee annual reports	Data confirmed by project officers
Universal Newborn Hearing Screening		
13.III.A.1, 13.III.A.2, 13.III.A.3, 13.E	For FY 2005, data collected from grantees by Utah State University, National Technical Resource Center, based on survey of all States. For FY 2006 and beyond, data obtained from the CDC Hearing Screening and Follow-up Survey.	Through 2005, data validated against annual progress reports submitted by States. For 2006 and subsequent years, data validated by CDC through ongoing communications with States.
Emergency Medical Services for Children		
14.V.B.1, 14.V.B.2, 14.E	Grantee reports	Data confirmed by project officers
Healthy Start		
12.III.A.1, 12.III.A2, 12.II.B.1, 12.E	Grantee reports	Data confirmed by project officers
Ryan White HIV/AIDS Programs		
16.I.A.1, 16.I.A.2, 16.II.A.2, 16.II.A.3, 16.III.A.1, 16.III.A.2, 18.I.A.1, 19, II.A.1, 20.II.A.1,	The Ryan White CARE Act Data Report (CADR) [now called The Ryan White HIV/AIDS Program Annual Data Report (RDR) and beginning January 2009 it will be called The Ryan White HIV/AIDS Program Services Report (RSR)] is completed by all Ryan White HIV/AIDS Program Part A, B, C, and D-funded grantees and service providers	This web-based data collection method communicates errors and warnings in the built in validation process. To ensure data quality the Program conducts data verification for all CADR submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.

Measure Unique Identifier	Data Source	Data Validation
16.II.A.1, 16.E	ADAP Quarterly Report data provided by State ADAPs	Web-based data checked through a series of internal consistency/validity checks. Also HIV/AIDS program staff review submitted Quarterly reports, and provide technical assistance on data-related issues.
21.V.B.1	AETC Participant Information Form from training program participants	Participant Information Forms are scanned into a Web-based system that communicates errors and inaccuracies in the built in validation process.
22.I.D.1	Dental Reimbursement Program, Application Form	Database Utility, a Web-based tool, is used to electronically complete and submit the Dental Reimbursement application. The Database Utility application validates the report prior to the submission to the Program. To ensure data quality, the Program also conducts data verification for all Dental Reimbursement Program Application Form submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantee.
Organ Transplantation		
23.II.A.1, 23.II.A.2, 23.II.A.3, 22.II.A.4, 23.II.A.5, 23.II.A.6, 23.II.A.7,	The Organ Procurement and Transplantation Network (OPTN) data system collects information from transplant centers, organ procurement organizations and histocompatibility laboratories on all organ transplants that involve the use of deceased donor organs.	Data entry screens include a variety of data element checks and cross checks that must be satisfied before the data are accepted by the system. The contractor for the OPTN conducts additional data quality checks and follows-up with relevant entities to resolve discrepancies in the data. An additional level of data quality review is performed by the contractor for the Scientific Registry of Transplant Recipients (SRTR) to verify the that number of deaths reported pre- and post-transplant are accurate.
23.E	OPTN contract budget and OPTN financial statements	OPTN financial statements are independently audited in accordance with OMB A-133 Circular.
C.W. “Bill” Young Cell Transplantation Program		
24.II.A.1, 24.II.A.2,	Data are captured within the Search, Tracking and Registry (STAR) system, which is a computerized system, containing information pertaining to unrelated volunteers willing to donate blood stem cells and patients in need of blood stem cell transplants. Monthly reports generated from the STAR system are used to collect information on donors and cord blood units.	Validated by project officers analyzing comprehensive monthly reports. An additional level of data quality review is performed by the program contractor utilizing value protected screens to decrease the likelihood of data entry errors and conducting site visits to validate data and review patient records.
24.E	Data are derived from the contractor and copies of contracts with human leukocyte antigen typing laboratories.	Validated through Project Officer monitoring the contractor’s budget and vouchers submitted for payment.

Measure Unique Identifier	Data Source	Data Validation
Poison Control Centers		
25.III.D.1, 25.III.D.2, 25.III.D.3, 25.E	On-line grant applications and grantee reports	Data are regularly reviewed by project officers.
Rural Health		
27.IV.A.1, 28.V.A.1, 29.IV.A.1, 30.V.B.3, 31.V.B.1, 31.V.B.2	Annual grantee reports	Validated by project officers.
27.V.B.1, 27.E, 30.V.B.!, 30.V.B.2,	Medicare Cost Reports	Validated by Centers for Medicare and Medicaid Services
Radiation Exposure Screening and Education		
32.I.A.1, 32.I.A.2, 32.E	Annual grantee data reports	Verified by project officers
Black Lung Clinics		
33.I.A.1, 33.I.A.2, 33.E	Grantee reports	Reviewed by program staff
Telehealth		
34.III.D.1, 34.III.D.2, 34.II.A.1, 34.E	Annual grantee profiles, 6-month progress reports from grantees	Program staff validate data through reviews of grantee submissions, discussions with grantees, and site visits when applicable.
Health Education Assistance Loans		
9.VII.C.1	Quarterly Lender Reports of Loans Outstanding entered into program's Online Processing System (HOPS)	Program conducts routine validation checks of the data received with information in HOPS database on a quarterly basis
9.E	Online Processing System (HOPS)	Reports reviewed by program staff
Vaccine Injury Compensation Program		
26.II.A.1, 26.II.A.2, 26.II.A.3, 26.II.A.4, 26.II.A.5, 26.E	VICP internal data system and DOJ Office of Management Information system.	Validated by program staff through internal consistency checks.
Program Management		
35.VII.B.1	Chief Information System Security Officer, FISMA Reports which includes OIG audit results, training logs	Chief Information Security Officer examines alternative sources to confirm and validate the annual security performance metrics.
Family Planning		
36.II.A.1, 36.II.A.2, 36.II.A.3, 36.II.B.1, 36.II.C.1, 36.II.C.2, 36.E	Family Planning Annual Report (FPAR), consisting of 14 tables in which grantees report data.	Data are checked for inconsistencies and returned to grantees for correction. Data found by the contractor compiling the data submits these to the data coordinator who works with the regional offices to make corrections.

MEASURES WITH SLIGHT DEVIATIONS BETWEEN TARGETS AND RESULTS

The performance target for the following measures was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.	
Health Centers	1.II.B.3, 1.II.B.4, 1.I.A.1, 1.D.1.A.2, 1.II.B.1, 1.II.A.1, 1.II.A.2, 1.II.A.3, 1.I.A.2, 1.E
Free Clinics Medical Malpractice	2.I.A.1, 2.I.A.2, 2.I.A.3, 2.E
Hansen's Disease Activities	3.II.A.1, 3.III.A.1, 3.II.A.3, 3.E
National Health Service Corps	4.I.C.1, 4.I.C.2, 4.I.C.4, 4.I.C.5, 4.E
Nursing Education Loan Repayment Program	5.I.C.1, 5.I.C.2, 5.I.C.4, 5.I.C.3, 5.E
Health Professions	6.I.C.1, 6.1.C.2, 6E
CHGME	7.I.A.1, 7.VII.C.1, 7.E
National Practitioner Data Bank	8.III.B.1, 8.III.B.2, 8.E
Healthcare Integrity and Protect. Data Bank	8.III.B.3, 8.III.B.4, 8.E
Maternal and Child Health Block Grant	10.III.A.1, 10.III.A.3, 10.III.A.4
Traumatic Brain Injury	11.V.B.1, 11.V.B.2, 11.V.B.3, 11.E
Universal Newborn Hearing Screening	13.III.A.2, 13.III.A.3
Emergency Medical Services for Children	14.E
Healthy Start	12.III.A.2, 12.II.B.1, 12.E
Ryan White HIV/AIDS Program (overall)	16.I.A.1, 16.I.A.2, 16.II.A.1, 16.II.A.2, 16.II.A.3, 16.III.A.1, 16.III.A.2, 16E
Ryan White HIV/AIDS-AETC	21.V.B.1
Ryan White HIV/AIDS-Dental Reimbursement	22.I.D.1
Organ Transplantation	23.II.A.6, 23.II.A.7, 23.II.A.2
C.W. Bill Young Cell Transplantation	24.II.A.2, 24.E
Poison Control Centers	25.III.D.1, 25.III.D.2, 25.III.D.3, 25.E
Rural Health Activities	27.V.B.1, 27.E
Rural Health Policy Development	28.V.A.1
Rural Hospital Flexibility Grants	30.V.B.1, 30.V.B.2, 30.V.B.3
State Offices of Rural Health	31.V.B.1, 31.V.B.2
Black Lung Clinics	33.I.A.1, 33.I.A.2, 33.E
Telehealth	34.III.D.2, 34.III.D.1, 34.E
HEAL	9.VII.C.1, 9.E
National Vaccine Injury Compensation	26.II.A.1, 26.II.A.2, 26.II.A.3, 26.II.A.4, 26.E
Program Management	35.VII.B.1, 35.VII.A.1, 35.VII.A.2
Family Planning	36.II.A.1, 36.II.A.2, 36.II.B.1, 36.II.C.1, 36.II.C.2, 36.E

DISCONTINUED MEASURES

Health Centers Program

Maternal and Child Health Block Grant

Ryan White HIV/AIDS Program

HEALTH CENTERS PROGRAM

DISCONTINUED MEASURES

Discontinued Measure

I. IMPROVE ACCESS TO HEALTH CARE
A. Expand the capacity of the health care safety net

Long-Term Goal: By 2007, establish an additional 1,200 new or expanded sites.
(Baseline - 2002: 0)
(Target - 2007: 1200)

Measure	FY	Target	Result
1.D.I.A.2. Increase the infrastructure of the Health Center Program to support an increase in utilization via: a) New Starts	2009	NA	
	2008	NA	
	2007	91	
	2006	53	
	2005	43	
	2004	31	
	2003	40	
b) New Satellite Sites	2009	NA	
	2008	NA	
	2007	91	
	2006	35	
	2005	47	
	2004	30	
	2003	60	
Total New Sites	2009	NA	NA
	2008	NA	NA
	2007	182	202
	2006	88	86
	2005	90	94
	2004	61	63
	2003	100	100
Total Sites	2009	NA	NA
	2008	NA	NA
	2007	4,013	6,990
	2006	3,833	3,831
	2005	3,741	3,745
	2004	3,649	3,651
	2003	3,588	3,588

Measure	FY	Target	Result
c) Expanded Sites	2009	NA	NA
	2008	NA	NA
	2007	120	135
	2006	33	36
	2005	63	64
	2004	63	66
	2003	80	88
d) Total New or Expanded Sites **(Outcome)**	2009	40[*]	Dec-09
	2008	62	61
	2007	302	337
	2006	121	122
	2005	153	158
	2004	124	129
	2003	180	188

Data Source: The Bureau of Health Care Delivery and Assistance Network (BHCDANET) maintains data on all sites that are included in the Health Center grantee's approved scope of project. HRSA Electronic Handbooks (EHBs), a HRSA-wide web based grants management portal, also compiles and maintains Notice of Grant Awards which are issued when new and expanded site funding is awarded to Health Centers.

Data Validation: BHCDANET is an agency mainframe system with hard code editing checks built into the operating platform of the mainframe system.

Cross Reference: HHS Strategic Objective 1.2

Notes: [*] Assumes FY 2009 Presidents Budget funding level. This measure was deleted during the FY07 OMB PART reassessment.

1.D.I.A.2. Increase the infrastructure of the Health Center Program to support an increase in utilization.

As a result of FY 2008 activities, the Health Center Program created 61 new or expanded sites, only one short of the target. This measure was deleted during the FY 2007 OMB PART reassessment.

Discontinued Measure			
II. IMPROVE HEALTH OUTCOMES **A. Expand the availability of health care, particularly to underserved, vulnerable and special needs populations.**			
Long-Term Goal: Increase percent of the Nation's poor below 200% of poverty level served by the Health Center Program.* (Baseline - 2002: 11%) (Original Target: 2006, 16%)			
Measure	**FY**	**Target**	**Result**
1.D.II.A.1. Continue to assure access to preventive and primary care for low income individuals (% of Nation's poor served) **(Outcome)**	2009	NA	NA
	2008	NA	NA
	2007	14%	16.1%
	2006	16%	15.2%
	2005	14%	14.2%
	2004	14%	13.2%
	2003	13%	12.4%
Data Source: The Uniform Data System (UDS) collects data on patients and services provided. National Data: Annual Social and Economic Supplement (ASEC) to the Current Population Survey (CPS), U.S. Census Bureau.			
Data Validation: UDS data are validated using over 1,000 edit checks, both logical and specific. These include checks for missing data and outliers and checks against history and norms.			
Cross Reference: HHS Strategic Objective 1.2			
Notes: This measure was deleted during the FY 2007 PART reassessment.			

Long-Term Goal

Increase percent of the Nation's poor below 200% of poverty level served by the Health Center Program.
(Baseline - 2002: 11%)
(Original Target: 2006, 16%)

1.D.II.A.1. Continue to assure access to preventive and primary care for low income individuals.
(Indicator: Percent of Nation's poor served by Health Centers)

In FY 2007, Health Centers served 16.1% of the Nation's poor, exceeding the target of 14%. This measure was deleted during the FY 2007 OMB PART reassessment.

Discontinued Measure			
II. IMPROVE HEALTH OUTCOMES **B. Increase the utilization of preventive health care and chronic disease management services, particularly among underserved, vulnerable, and special needs populations.**			
Long-Term Goal: Reduce low birth weight rates in Health Centers.[*] (Baseline - 2002: 6.9%) (Original Target - 2006: 6.53%)			
Measure	**FY**	**Target**	**Result**
1.D.II.B.1. Decrease percent of births to health center prenatal care patients below 2500 grams (LBW). **(Outcome)**	2009	NA	NA
	2008	NA	NA
	2007	7.05%	7.8%
	2006	7.05%	7.7%
	2005	7.05%	7.3%
	2004	7.05%	7.01%
	2003	6.89%	7.05%
Data Source: The Uniform Data System (UDS) collects data on patients and services provided.			
Data Validation: UDS data are validated using over 1,000 edit checks, both logical and specific. These include checks for missing data and outliers and checks against history and norms.			
Cross Reference: HHS Strategic Objectives 1.2, 1.3; HP 2010 (16)			
Notes: [*]This measure was deleted during the FY 2007 PART reassessment and was replaced by a similar measure.			

1.D.II.B.1. Decrease the percent of births to Health Center patients below 2500 grams (LBW).

Appropriate prenatal care management can have a significant effect on the incidence of low birth weight (LBW). LBW is the risk factor most closely associated with neonatal mortality; thus improvements in infant birth weight can contribute significantly to reductions in infant mortality rates. In addition, young mothers, particularly under age 15, and African American mothers are more likely to have LBW infants. These risk factors are reported at a higher rate among Health Center mothers, predisposing Health Center births to higher risk for low birth weight and adverse birth outcomes.

According to UDS Health Center data for CY 2007, 7.8% of infants born to mothers who sought their prenatal care at Health Centers were born with LBW. This rate is above the FY 2007 target of 7.05, but is still lower than the 2006 national rate of 8.3%, despite the fact that Health Center mothers and infants are at greater risk of adverse birth outcomes. The Health Center rate continues to follow a steady pattern of under 8%, unlike the increases observed in the national rate (Source: Martin JA, Hamilton BE, Sutton PD, et al. National Center for Health Statistics: 2006). This measure was replaced with a similar measure that is benchmarked to national low birth weight rates, during the FY 2007 OMB PART reassessment.

Discontinued Measure

II. IMPROVE HEALTH OUTCOMES
B. Increase the utilization of preventive health care and chronic disease management services, particularly among underserved, vulnerable and special needs populations.

Measure	FY	Target	Result
1.D.II.B.2. Increase percent of adult diabetic patients with at least one testing of glycohemoglobin annually **(Outcome)**	2009	NA	NA
	2008	NA	NA
	2007	71%	D/N/A
	2006	71%	84.7% 363,474
	2005	71%	73.8% 258,000*
	2004	75%	72.5% 193,000*
	2003		70.9% 124,000*
	2002		74.8% 47,600*

Data Source: Diabetes data are from the Health Disparities Collaboratives (HDC) Database.

Data Validation: HDC database is maintained by a coordinator that collects health center participant patient data.

Notes: NA = Not Applicable D/N/A = Data not available.
*Size of the diabetes patient registry in given year.

1.D.II.B.2. Increase percent of adult diabetic patients with at least one testing of glycohemoglobin annually.

Health Center patients, including low-income individuals of 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 disparities. Managing the glycohemoglobin levels of individuals with diabetes and the blood pressures of individuals with hypertension can have a pronounced effect on their morbidity and mortality.

Based on information from the Health Disparities Collaboratives Program's diabetes registry, performance in 2002 through 2006 was 74.8%, 70.9%, 72.5%, 73.8% and 84.7%, respectively. The FY 2007 Health Center target was maintained at 71% of patients with at least one testing of glycohemoglobin annually, well above the HP 2010 goal of 50%. Data is not available for this measure, due to its replacement during the FY07 OMB PART reassessment and to related modifications in Program data collection methods.

Data will no longer be reported for this measure, as beginning in 2009, BPHC will be collecting a core set of clinical quality and outcome measures, including measures that focus on the outcome of appropriate management of chronic conditions including diabetes. These new measures will be aligned with those of national quality measurement organizations such as the Ambulatory Care Quality Alliance and the National Quality Forum and will be reported on annually by all grantees through the Uniform Data System.

Discontinued Measure			
Efficiency Measures	**FY**	**Target**	**Result**
1.D.E.1. Sustain the average cost per individual served at health centers[*] (Approved by OMB)	2009	NA	NA
	2008	NA	NA
	2007	$583	$562
	2006	$556	$538
	2005	$529	$515
	2004	$503	$504
	2003	$465	$479
1.D.E.2. Annual number of encounters per medical provider**.**	2009	NA	NA
	2008	NA	NA
	2007	3,475	3,446
	2006	3,475	3,470
	2005	3,475	3,510
	2004	3,475	3,501
	2003	3,475	3,521
Data Source: The Uniform Data System (UDS) collects data on patients and services provided.			
Data Validation: UDS data are validated using over 1,000 edit checks, both logical and specific. These include checks for missing data and outliers and checks against history and norms.			
Cross Reference: No cross reference.			
Notes: [*]This measure was deleted during the FY 2007 PART reassessment and has been replaced with a similar measure.			

1.D.E.1. Sustain the average cost per individual served at Health Centers.
(Indicator: Total cost divided by total patients)

It is essential that Health Centers maximize the number of patients served per dollar, and tracking their costs is an appropriate process to assure efficiency. Performance once again exceeded the target in 2007 with an annual average cost per patient of $562, $21 better than the target. This measure was replaced with a similar measure that is benchmarked to national cost increases during the FY 2007 OMB PART reassessment process.

1.D.E.2. Annual number of encounters per medical worker.
(Indicator: Total number of encounters to physicians, nurse practitioners, physician assistants, and certified nurse midwives divided by their respective FTEs)

It is important that Health Centers maximize the number of patients served and assess the number of encounters per medical provider to track their productivity. In 2007, Health Centers saw 3,446 encounters per medical provider. This was slightly less than the target of 3,475. This measure was deleted during the FY 2007 PART reassessment process as new measures were defined.

MATERNAL AND CHILD HEALTH BLOCK GRANT – TITLE V

DISCONTINUED MEASURE

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
10. III.A.5	Reduce maternal illness and complications due to pregnancy[a]	36.8/1000	39.2/1000	30.0/1000 [a]	Nov-08[**]	30.0/1000 [a]	Nov-09	37.0/1000[a]	36.0/1000[a]	NA

Notes:

[a] Indicator: Hospitalizations per 1000 deliveries due to illness and complications resulting from pregnancy. Actual data reported for FY 2004 and 2005 are based on the average rates for the two most common illnesses in pregnancy (i.e., diabetes and pregnancy-induced hypertension). The targets for FY 2006 and 2007 were developed based on earlier data which included three conditions of pregnancy (i.e., diabetes, pregnancy-induced hypertension and anemia). These targets are not appropriate for the data as it is currently collected. This difference in data collection is due to changes in the revised 2003 Certificate of Live Birth.

[**] Final Birth Data for 2006 have not yet been released. Preliminary birth data for 2006 compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (National Vital Statistics Report, Vol. 56, No. 7) do not include a description of Maternal Lifestyles and Health Characteristics, such as risk factors during pregnancy.

NA = Not applicable.

10.III.A.5. Reduce maternal illnesses and complications due to pregnancy.

Medical risk factors, such as diabetes and pregnancy-induced hypertension, can contribute to serious complications during pregnancy as well as maternal and infant morbidity and mortality, particularly if they are not properly identified and treated. The level of pregnancy-associated hypertension for 2005 (39.9/1,000 births) is the highest reported since these data became available. Diabetes prevalence rose by more than two-thirds between 1990 and 2005 (from 21.3/1,000 births to 38.5/1,000 births.)

The average rate for the two most common conditions in pregnancy (i.e., diabetes and pregnancy-induced hypertension) increased from 36.8 per 1,000 deliveries in FY 2004 to 39.2 per 1,000 deliveries in FY 2005. Due to changes in the revised 2003 Certificate of Live Birth, previous years' data are not comparable. Data reported prior to FY 2004 were based on the three most common conditions in pregnancy (i.e., diabetes, pregnancy-induced hypertension and anemia). Given the change in how data are reported for this measure, comparisons of actual performance in FY 2005 with the established target of 30% are not appropriate. The FY 2009 target for this measure is 36 per 1,000 deliveries.

This annual measure was discontinued as part of the 2008 Performance Assessment Rating Tool (PART) review due to the lack of a comparable data source. The measure was originally established during the 2002 PART review. Given the lack of a national data source, the average rate for the two most common conditions in pregnancy (i.e., diabetes and pregnancy-induced hypertension) had been used as a proxy for reporting on this measure. In the 2008 PART review, this measure was replaced by the following measure: "The percent of pregnant women who receive prenatal care in the first trimester." The measure was selected because it more directly reflects the impact of the MCH Block Grant in addressing maternal risk factors.

RYAN WHITE HIV/AIDS PROGRAM

DISCONTINUED MEASURES

Long-Term Goal: By 2010, increase the national proportion of people living with HIV receiving primary medical care and treatment to 50 percent (includes all persons who know and those who do not know their serostatus).
(Baseline - 2000: 33%)

Discontinued Measure	FY	Target	Result
16.D.I.A.1. Increase by 2 percent every second year the number of persons provided services through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act program. **(Outcome)**	2009	NA	NA
	2008	NA	NA
	2007	NA	NA
	2006	2% increase over FY 2004 or 594,068	529,000
	2005	NA	NA
	2004	582,420	531,000
	2003		NA
	2002		571,000 (baseline)

16.D.I.A.1. Increase by 2 percent every second year the number of persons provided services through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act program.

The number of persons provided services through the Ryan White HIV/AIDS Program was selected as a measure of the program goal to improve access to health care for individuals infected with HIV/AIDS by increasing availability of and access to care and services.

In FY 2006, an estimated 529,000 persons received Ryan White HIV/AIDS Program services, a decrease of 10.9% from the estimated 594,068 people served in 2004. HIV care continues to become more complex as new drug therapies are introduced and the number of patients on advanced salvage therapies increases. The decrease in clients served may represent other decreases in funding and increases in cost across the health care system as the numbers represent all HIV infected clients served by our grantees, including those covered by entitlement programs and private insurers.

This measure was discontinued during the FY 2007 PART reassessment.

HIV Emergency Relief Grants (Part A)

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long – Term Objective: Promote Effectiveness of Health Care Services									
17.III.A.1.	Proportion of women that receive PAP screening.	35.8%	38%	Baseline plus 1.5%	40.8%	Baseline plus 1.5%	38.1%	Baseline plus 1.5%	Baseline plus 1.5%
17.III.A.2.	Proportion of clients that receive TB skin tests.	28%	54%	1.5% over FY 2005	52.5%	Sustain FY 2006	51.5%	Sustain FY 2007	Sustain FY 2008

17.III.A.1. Proportion of women that receive PAP screening.

Cervical Intraepithelial Neoplasia (CIN) refers to cellular changes in the cervix, thought to be precursors of cervical cancer that can be detected with PAP screening. Researchers conclude that HIV+ women are three times as likely as HIV negative women to have CIN. Women with HIV are more likely to develop cervical cancer than other women. The possibility increases to 30 times as likely if a woman has HIV and HPV, the human papilloma virus.

In FY 2007, the Part A program provided 38.1% of women served with PAP screening. This fell short of the target of 47.4 by 9.3 percentage points.

While this information will no longer be reported in the performance reporting submissions, the data will continue to be collected by the program.

17.III.A.2. Increase the proportion of clients that receive TB skin tests.

Latent TB is much more likely to become active TB in someone with HIV. TB is an AIDS-defining condition. The CDC recommends HIV-infected persons get tested for TB, with a TB Skin Test (TST). There are a number of instances where annual TB testing for HIV-infected individuals is not supported. For instance, 10-15% of HIV-infected individuals who already have TB are not receiving annual TB skin tests. Additionally, persons who have documented false positive TB skin test results and those that have a current skin rash that interferes with reading the test results are not given annual TB skin tests.

In FY 2007, the Part A program provided 51.5% of clients with TB skin tests. This fell short of the target by 1 percentage points. Patient outreach and follow-up are among the strategies grantees use to achieve targets.

While this information will no longer be reported in the performance reporting submissions, the data will continue to be collected by the program.