



HEALTH RESOURCES and SERVICES ADMINISTRATION

FY 2013 Annual Performance Report

Department of Health
and Human Services

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INTRODUCTION

This FY 2013 Annual Performance Report (APR) presents information on the Health Resources and Services Administration's (HRSA) past and projected performance in carrying out its mission to improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs. For each major program activity, tables are provided that show key program performance measures, targets and results. The tables also show the linkage between performance measures and HRSA's strategic objectives, indicating the close alignment of performance expectations and results with HRSA's mission and priorities. HRSA, along with its partners and stakeholders, is committed to the collection, analysis and reporting of timely and accurate performance data and using these data to inform decision making.

PRIMARY HEALTH CARE

Programs included in this section are:

- Health Centers
- Free Clinics Medical Malpractice
- Hansen's Disease Activities
- Health Center Capital Development (Affordable Care Act)
- School-Based Health Centers - Construction (Affordable Care Act)

HEALTH CENTERS

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 to improve access to quality health care and services, strengthen the health workforce, build healthy communities and improve health equity. 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: providing technical assistance and training on issues such as quality improvement and risk management; enhancing health information technology; sharing best practices so that health centers learn from one another about what works in improving quality and performance; and supporting a unique model of health care delivery that emphasizes prevention, health-related enabling services, outreach, follow-up, and culturally competent services.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health services.

Measure	FY	Target	Result
<u>1.I.A.1</u> : Number of patients served by Health Centers (Output)	<i>Out-Year Target</i>	21.2 million (FY 2014)	Aug 31, 2015
	<i>2013</i>	20.9 million	Aug 31, 2014
	<i>2012</i>	20.6 million	Aug 31, 2013
	<i>2011</i>	19.7 million	Aug 31, 2012
	<i>2010</i>	20.15 million	19.5 million (Target Not Met, but Improved)
	<i>2009</i>	18.95 million	18.8 million (Target Not Met, but Improved)
	<i>2008</i>	16.75 million	17.1 million (Target Exceeded)
<u>1.I.A.2.b</u> : Percentage of grantees that provide the following services either on-site or by paid referral: Preventive Dental Care (Output)	<i>2013</i>	88%	Aug 31, 2014
	<i>2012</i>	88%	Aug 31, 2013
	<i>2011</i>	88%	Aug 31, 2012
	<i>2010</i>	88%	88% (Target Met)
	<i>2009</i>	82%	88% (Target Exceeded)
	<i>2008</i>	82%	88% (Target Exceeded)

Measure	FY	Target	Result
<u>1.I.A.2.c:</u> Percentage of grantees that provide the following services either on-site or by paid referral: Mental Health/Substance Abuse (<i>Output</i>)	2013	70%	Aug 31, 2014
	2012	70%	Aug 31, 2013
	2011	70%	Aug 31, 2012
	2010	68%	72% (Target Exceeded)
	2009	74%	70% (Target Not Met)
	2008	74%	68% (Target Not Met)
<u>1.II.B.2:</u> Rate of births less than 2500 grams (low birth weight) to prenatal Health Center patients compared to the national low birth weight rate (<i>Outcome</i>)	<i>Out-Year Target</i>	5% below national rate (FY 2014)	Apr 30, 2016
	2013	5% below national rate	Apr 30, 2015
	2012	5% below national rate	Apr 30, 2014
	2011	5% below national rate	Apr 30, 2013
	2010	5% below national rate	Apr 30, 2012
	2009	11% below national rate	7.3% 11% below the national rate (Target Met)
	2008	11% below national rate	7.6% 7.3% below the national rate (Target Not Met)
<u>1.II.B.3:</u> Percentage of adult Health Center patients with diagnosed hypertension whose blood pressure is under adequate control (less than or equal to 140/90) (<i>Outcome</i>)	<i>Out-Year Target</i>	63% (FY 2014)	Aug 31, 2015
	2013	60%	Aug 31, 2014
	2012	60%	Aug 31, 2013
	2011	60%	Aug 31, 2012
	2010	50%	63% (Target Exceeded)
	2009	43%	63% (Target Exceeded)
	2008	42.9%	62% (Target Exceeded)

Measure	FY	Target	Result
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%) <i>(Outcome)</i>	<i>Out-Year Target</i>	71% (FY 2014)	Aug 31, 2015
	2013	71%	Aug 31, 2014
	2012	71%	Aug 31, 2013
	2011	71%	Aug 31, 2012
	2010	73%	71% (Target Not Met)
	2009	N/A	71% (Target Not In Place)
	2008	N/A	73% (Baseline)
1.II.B.1: Percentage of pregnant Health Center patients beginning prenatal care in the first trimester <i>(Output)</i>	2013	64.3%	Aug 31, 2014
	2012	64.3%	Aug 31, 2013
	2011	61.3%	Aug 31, 2012
	2010	61.3%	69% (Target Exceeded)
	2009	61.6%	67.3% (Target Exceeded)
	2008	61.5%	61.3% (Target Virtually Met)
1.II.A.1: Percentage of Health Center patients who are at or below 200% of poverty <i>(Output)</i>	2013	91%	Aug 31, 2014
	2012	91%	Aug 31, 2013
	2011	91%	Aug 31, 2012
	2010	91%	93% (Target Exceeded)
	2009	86%	92.5% (Target Exceeded)
	2008	86%	91.7% (Target Exceeded)

Measure	FY	Target	Result
<u>1.II.A.2:</u> Percentage of Health Center patients who are racial/ethnic minorities <i>(Output)</i>	2013	63%	Aug 31, 2014
	2012	63%	Aug 31, 2013
	2011	63%	Aug 31, 2012
	2010	N/A ¹	62% (Target Not In Place)
	2009	N/A ¹	63% (New Baseline)
	2008	64%	D/N/A ¹
<u>1.II.A.3:</u> Percentage of Health Center patients who are uninsured <i>(Output)</i>	2013	38%	Aug 31, 2014
	2012	38%	Aug 31, 2013
	2011	38%	Aug 31, 2012
	2010	38%	38% (Target Met)
	2009	41%	38% (Target Not Met)
	2008	41%	38% (Target Not Met)
<u>1.I.A.3:</u> Percentage of health centers with at least one site recognized as a patient centered medical home <i>(Outcome)</i>	2013	25%	Nov 30, 2013
	2012	13%	Nov 30, 2012
	2011	N/A	N/A
	2010	N/A	1% (Baseline)

¹ Due to modifications in data collection, data is not available for 2007-2008. As a result, targets could not be established for 2009 and 2010.

Efficiency Measure	FY	Target	Result
1.E: Percentage increase in cost per patient served at Health Centers compared to the national rate (Efficiency)	2013	20% below national rate ²	Jan 31, 2015
	2012	20% below national rate ²	Jan 31, 2014
	2011	20% below national rate ²	Jan 31, 2013
	2010	20% below national rate ²	5% 1.1% above national rate (Target Not Met)
	2009	5.8%	2% (Target Exceeded)
	2008	5.6%	4.6% (Target Exceeded)

Measure	Data Source	Data Validation
1.I.A.1 1.E 1.II.B.2 1.II.B.3 1.II.B.4 1.II.B.1 1.II.A.1 1.II.A.3	Uniform Data System	Validated using over 1,000 edit checks, both logical and specific. These include checks for missing data and outliers and checks against history and norm.
1.I.A.2.b 1.I.A.2.c	HRSA Electronic Handbooks (EHB)	Data are edited and validated by program staff.
1.II.A.2	Uniform Data System	Data not available for FY 2008 and 2007 due to changes in how race/ethnicity data is reported in UDS.
1.I.A.3	HRSA contractors that determine PCMH recognition	Data are edited and validated by program staff.

² The target for this measure has always been to achieve a rate that is at least 20% below the National rate. In prior documents, this has been shown as a number based on projections of the National rate. (e.g., In FY 2009, the target was shown as 5.8% given projections of the National rate.) Such projections will no longer be used in showing the target. Instead the target will be stated as shown for FY 2010 and FY 2011 in this table.

FREE CLINICS MEDICAL MALPRACTICE

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. These activities support the HRSA strategic goal to strengthen the health workforce. 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 key strategy used to meet performance targets is to determine areas with few or no applications and then target these areas for outreach about the program.

Goal: Strengthen the Health Workforce

Sub-Goal: Increase the number of practicing health care providers to address shortages, and develop ongoing strategies to monitor, forecast and meet long-term health workforce needs.

Measure	FY	Target	Result
2.I.A.1: Number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage <i>(Outcome)</i>	2013	5,100	Dec 31, 2012
	2012	4,800	Dec 31, 2012
	2011	4,250	Dec 31, 2011
	2010	4,000	4,800 (Target Exceeded)
	2009	3,100	3,754 (Target Exceeded)
	2008	2,500	3,006 (Target Exceeded)
2.1: Patient visits provided by free clinics sponsoring volunteer FTCA-deemed clinicians <i>(Outcome)</i>	<i>Out-Year Target</i>	440,000 (FY 2015)	May 31, 2016
	2013	332,000	May 31, 2014
	2012	320,000	May 31, 2013
	2011	320,000	May 31, 2012
	2010	N/A	312,317 (Target Not In Place)
	2009	N/A	282,958 (Baseline)

Measure	FY	Target	Result
<u>2.I.A.2:</u> Number of free clinics operating with FTCA-deemed volunteer clinicians (Output)	<i>Out-Year Target</i>	165 (FY 2013)	Dec 31, 2013
	2013	165	Dec 31, 2013
	2012	155	Dec 31, 2012
	2011	145	Dec 31, 2011
	2010	130	132 (Target Exceeded)
	2009	105	121 (Target Exceeded)
	2008	85	93 (Target Exceeded)
<u>2.I.A.3:</u> Percent of volunteer FTCA-deemed clinicians who meet certification and privileging requirements (Output)	2013	100%	Dec 31, 2013
	2012	100%	Dec 31, 2012
	2011	100%	Dec 31, 2011
	2010	100%	100% (Target Met)
	2009	100%	100% (Target Met)
	2008	100%	100% (Target Met)
Efficiency Measure	FY	Target	Result
<u>2.E:</u> Administrative costs of the program per Federal Tort Claims Act (FTCA)-covered volunteer (Efficiency)	2013	\$155	Dec 31, 2013
	2012	\$155	Dec 31, 2012
	2011	\$155	Dec 31, 2011
	2010	\$170	\$115 (Target Exceeded)
	2009	\$190	\$154 (Target Exceeded)
	2008	\$195	\$153 (Target Exceeded)

Measure	Data Source	Data Validation
2.I.A.1 2.I.A.2 2.I.A.3 2.E	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.
2.1	Data will be provided by participating Free Clinics in a Patient Visits Data Report submitted to the program via e-mail.	Data will be validated by program staff assessing logic, outliers, history and norms.

NATIONAL HANSEN'S DISEASE PROGRAM

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. These activities support the HRSA strategic goal to improve access to quality health care and services. 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.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health services.

Measure	FY	Target	Result
3.II.A.2.: Number of private sector physicians who have received training from the NHDP <i>(Output)</i>	2013	150	Nov 30, 2013
	2012	150	Nov 30, 2012
	2011	150	Nov 30, 2011
	2010	150	220 (Target Exceeded)
	2009	50	157 (Target Exceeded)
	2008	45	146 (Target Exceeded)
3.II.A.3.: Number of patients provided Hansen's Disease outpatient care through the National Hansen's Disease Program <i>(Output)</i>	2013	3,000	Mar 31, 2014
	2012	3,000	Mar 31, 2013
	2011	3,000	Mar 31, 2012
	2010	3,000	3,117 (Target Exceeded)
	2009	3,000	2,963 (Target Virtually Met)
	2008	3,000	2,888 (Target Not Met)

Measure	FY	Target	Result
<u>3.III.A.1</u> : Develop an animal model for the full spectrum of clinical complexities of human Hansen's Disease (<i>Output</i>)	<i>Out-Year Target</i>	Produce relevant animal model for human leprosy (FY 2013)	Mar 31, 2014
	2013	Produce relevant animal model for human leprosy	Mar 31, 2014
	2012	Pursue the integration of BRM, CM, and molecular reagent breakthroughs	Mar 31, 2013
	2011	Use DNA evidence to link leprosy transmission from armadillos to humans.	Mar 31, 2012
	2010	Demonstrate defective nerve function in infected armadillos	Defective nerve function demonstrated (Target Met)
	2009	BRM 4, CM 4	BRM 4, CM 4 (Target Met)
	2008	BRM 3, CM 2,3	BRM 3, CM 2,3 (Target Met)
<u>3.II.A.1</u> : Percent increase 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) (<i>Outcome</i>)	<i>Out-Year Target</i>	50% (FY 2013)	Nov 30, 2015
	2013	50%	Nov 30, 2015
	2012	50%	Nov 30, 2014
	2011	50%	Nov 30, 2013
	2010	50%	Nov 30, 2012
	2009	50%	53% (Target Virtually Met)
	2008	50%	45% (Target Exceeded)
Efficiency Measure	FY	Target	Result
<u>3.E</u> : Maintain increases in the cost per patient served in the outpatient clinics to below the medical inflation rate (<i>Efficiency</i>)	2013	Below national medical inflation rate	Mar 31, 2014
	2012	Below national medical inflation rate	Mar 31, 2013
	2011	Below national medical inflation rate	Mar 31, 2012
	2010	Below national medical inflation rate (3.9%)	4.9 % (Target Not Met)
	2009	\$1,676	\$1,088 (Target Exceeded)
	2008	\$1,676	\$1,244 (Target Exceeded)

Measure	Data Source	Data Validation
3.E	Fiscal year budget allocations and expenditures, Ambulatory Care Program database, and NHDP records	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.III.A.1	Program research records	Validated by program staff and research presentations.
3.II.A.1	Disability/deformity data is collected from NHDP hand and foot screens (based on the World Health Organization scale) from ambulatory care clinics, NHDP outpatient clinics, and private physicians	Data are validated by staff at the Hansen's Disease Program.

**HEALTH CENTERS – CAPITAL DEVELOPMENT
(AFFORDABLE CARE ACT)**

INTRODUCTION

The Community Health Center (CHC) Fund was established under the Affordable Care Act to provide for expanded and sustained national investment in health centers funded under Section 330 of the Public Health Service Act. The Affordable Care Act CHC Fund authorized and appropriated \$1.5 billion for FYs 2011 through 2015 which is available until expended.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health services.

Measure	FY	Target	Result
39.I: Number of new/improved sites	2013	52	Nov 30, 2013
	2012	22	Nov 30, 2012
	2011	N/A	2 (Baseline)

Measure	Data Source	Data Validation
39.I:	HRSA Electronic Handbooks (EHB)	Data are edited and validated by program staff.

**SCHOOL BASED HEALTH CENTERS – CONSTRUCTION
(AFFORDABLE CARE ACT)**

INTRODUCTION

The Affordable Care Act provides funding to support expenditures for facilities (including the acquisition of improvement of land, or the acquisition, construction, expansion, replacement, or other improvement of any building or other facility), equipment, or similar expenditures, for School-Based Health Centers (SBHC).

A SBHC is often operated as a partnership between the school and a community health organization, such as a community health center, hospital, or local health department that serves as the sponsoring facility for the SBHC. In general, services provided by the SBHC are determined locally through a collaborative approach between the families and students, the community, the school district, and associated health providers. Typically, a SBHC provides a combination of primary care, mental health care, substance abuse counseling, case management, dental health, nutrition education, health education, and health promotion. An overall emphasis is placed on the services being age appropriate, with a particular focus on prevention and early intervention.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health services.

Measure	FY	Target	Result
40.I: Number of new/improved sites (Developmental)	2013	TBD	Nov 30, 2013
	2012	N/A	Nov 30, 2012 (Baseline)
	2011	N/A	N/A

Measure	Data Source	Data Validation
40.I:	HRSA Electronic Handbooks (EHB)	Data are edited and validated by program staff.

CLINICIAN RECRUITMENT AND SERVICE

Programs included in this section are:

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

NATIONAL HEALTH SERVICE CORPS

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 NHSC Scholarship Program provides financial support through scholarship payment for tuition, other reasonable education expenses, and a monthly living stipend to health professions students committed to providing primary care in underserved communities of greatest need. Awards are targeted to individuals who demonstrate characteristics that are indicative of probable success in a career in primary care in underserved communities. The Scholarship Program provides a predictable supply of clinicians who will be available for service over the next one to eight years, depending on the length of their training programs and their disciplines. Upon completion of training, NHSC scholars become salaried employees of organized systems of care in underserved communities.

The NHSC Loan Repayment Program offers fully-trained primary care clinicians the opportunity to receive assistance to pay off qualifying educational loans in exchange for service in a Health Professions Shortage Area (HPSA) of greatest need. In exchange for a minimum of two years of service, loan repayers receive up to \$60,000 in loan repayment assistance. The loan repayment program recruits clinicians as they complete training and are immediately available for service, as well as seasoned professionals seeking an opportunity to serve the Nation's most vulnerable populations. In addition, the Affordable Care Act has authorized the NHSC to increase the maximum amount that can be paid annually in the loan repayment contract, and has enabled the NHSC to offer several half-time service options. This increased flexibility will make the NHSC Loan Repayment Program more attractive to primary care clinicians, which will facilitate the program's efforts to reach the field strength targets.

The Students to Service (S2S) Loan Repayment Program was established in FY 2012 and seeks to strengthen the primary care pipeline by offering loan assistance of up to \$120,000 to medical students in their last year of training. Once they have completed an NHSC-approved primary care residency, they begin to fulfill a three-year service obligation in a high-need health professional shortage area.

The performance measures gauge the NHSC's contribution to the HRSA Strategic Plan goal to strengthen the health workforce by increasing the number of health care providers 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.), which measures the number of NHSC funded clinicians in service. The larger the field strength, the greater the number of people served. Further, a more robust field strength also increases the pool of clinicians who fulfill the service commitment and increases the pool of potentially retained individuals. In managing performance, the NHSC uses 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.

Goal: Strengthen the Health Workforce

Sub-Goal: Increase the number of practicing health care providers to address shortages, and develop ongoing strategies to monitor, forecast, and meet long-term health workforce needs.

Measure	FY	Target	Result
4.I.C.1: Number of individuals served by NHSC clinicians. (Outcome)	<i>Out-Year Target</i>	7.53 Million ¹ (FY 2015)	Dec 31, 2015
	<i>Out-Year Target</i>	6.45 Million ¹ (FY 2014)	Dec 31, 2014
	2013	7.63 Million ¹	Dec 31, 2013
	2012	9.76 Million ¹	Dec 31, 2012
	2011	9.7 Million ¹	10.5 Million (Target Exceeded)
	2010	8.56 Million	9.05 Million (Target Exceeded)
	2009	5.69 Million	5.94 Million (Target Exceeded)
	2008	3.48 Million	4.79 Million (Target Exceeded)
4.I.C.2: Field strength of the NHSC through scholarship and loan repayment agreements. (Outcome)	<i>Out-Year Target</i>	7,175 ¹ (FY 2015)	Dec 31, 2015
	<i>Out-Year Target</i>	6,143 ¹ (FY 2014)	Dec 31, 2014
	2013	7,268 ¹	Dec 31, 2013
	2012	9,298 ¹	Dec 31, 2012
	2011	9,203 ¹	10,279 (Target Exceeded)
	2010	7,358	7,530 (Target Exceeded)
	2009	4,674	4,808 (Target Exceeded)
	2008	3,558	3,601 (Target Exceeded)

¹ Targets may differ from what is reflected in the FY 2012 Congressional Justification, as targets are based on most recent NHSC FY 2012 budget and FY 2013 President's budget, February 2012.

Measure	FY	Target	Result
4.I.C.4: Percent of NHSC clinicians retained in service to the underserved for at least one year beyond the completion of their NHSC service commitment. ² (Outcome)	2013	80%	Dec 31, 2014
	2012	79%	Dec 31, 2013
	2011	79%	Dec 31, 2012
	2010	79%	82% (Target Exceeded)
	2009	79%	78% (Target Not Met)
	2008	79%	76% (Target Not Met)
4.1.C.6. Number of NHSC sites (Outcome)	2013	14,000	Dec 31, 2013
	2012	14,000	Dec 31, 2012
	2011	11,800	14,000 (Target Exceeded)
	2010	N/A	10,273
Efficiency Measure	FY	Target	Result
4.E.1: Default rate of NHSC Scholarship and Loan Repayment Program participants. (Efficiency)	2013	≤ 2.0%	Dec 31, 2013
	2012	≤ 2.0%	Dec 31, 2012
	2011	≤ 2.0%	0.52% (Target Exceeded)
	2010	N/A	0.0% (Target Not in Place)
	2009	N/A	<1.0% (Target Not in Place)
	2008	N/A	0.5% (Target Not in Place)

Measure	Data Source	Data Validation
4.I.C.1 4.I.C.2 4.E.1 4.1.C.6	BMISS - an IT system modernization program that replaces and/or retires a multitude of BCRS legacy systems (including BHCDANET) that contain information collected from individual scholarship and loan repayment applications, and recruitment and retention assistance applications and monitoring data from individual sites, thus improving information management across the BCRS enterprise	BMISS is internally managed with support from the NIH which provides: Data Management Services, Data Requests and Dissemination, Analytics, Data Governance and Quality, Project Planning and Requirements Development, Training, and Process Improvement.
4.I.C.4	Survey of NHSC clinicians who have completed their service obligation	Contractor does consistency and logic checks on survey data

² The results for this performance measure are not available until one year out because NHSC clinicians who completed their service obligation are not surveyed until one year later.

NURSING EDUCATION LOAN REPAYMENT AND SCHOLARSHIP PROGRAMS

INTRODUCTION

The Nursing 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. These are financial incentive programs under which individual registered nurses (RNs) and advanced practice RNs (APRNs), such as nurse practitioners (NPs), enter into a contractual agreement with the Federal government to work full-time in a health care facility with a critical shortage of nurses, also known as a critical shortage facility (CSF), in return for repayment of qualifying nursing educational loans or for a scholarship that includes payment for tuition, other reasonable education expenses, and a monthly living stipend. The performance measures gauge these programs' contribution to the HRSA Strategic Plan goal to strengthen the health workforce by increasing the number of health care providers through the recruitment and retention of nurses working in CSFs. Increasing the number of nurses at facilities with a critical shortage of nurses will be a key output. With additional funds, the program allows more individuals to enter into the nursing field and in turn address the national shortage of nurses.

A major challenge facing NELRP and NSP is ensuring placements in facilities with the greatest need. One strategy to assure better targeting of program resources to areas and facilities of greatest need is to refine the definition of a CSF. Beginning in FY 2012, a CSF is defined to be a health care facility located in, designated as, or serving a primary medical care or mental health Health Professional Shortage Area.

Goal: Strengthen the Health Workforce

Sub-Goal: Increase the number of practicing health care providers to address shortages, and develop ongoing strategies to monitor, forecast, and meet long-term health workforce needs.

Measure	FY	Target	Result
5.I.C.4: Proportion of NELRP participants who extend their service contracts to commit to work at a critical shortage facility for an additional year. <i>(Outcome)</i>	2013	52%	Dec 31, 2013
	2012	50%	Dec 31, 2012
	2011	50%	46% (Target Not Met)
	2010	50%	58% (Target Exceeded)
	2009	45%	48% (Target Exceeded)
	2008	45%	54% (Target Exceeded)

Measure	FY	Target	Result
5.1.C.5: Proportion of NELRP/NSP participants retained in service at a critical shortage facility for at least one year beyond the completion of their NELRP/NSP commitment. ¹ (Developmental)	2013	TBD	Dec 31, 2014
	2012	TBD	Dec 31, 2013
	2011	N/A	Dec 31, 2012 (Baseline)
	2010	N/A	N/A
5.1.C.6: Proportion of NSP awardees obtaining their baccalaureate degree. (Outcome)	2013	80%	Dec 31, 2013
	2012	75%	Dec 31, 2012
	2011	75%	74% (Target Not Met But Improved)
	2010	N/A	71% (Baseline)
Efficiency Measure	FY	Target	Result
5.E.1: Default rate of NELRP and NSP participants. (Efficiency)	2013	NELRP FY 2009 Cohort: 3% NSP FY 2004 Cohort: 15%	Dec 31, 2013
	2012	NELRP FY 2008 Cohort: 3.5% NSP FY 2003 Cohort: 17%	Dec 31, 2012
	2011	NELRP FY2007 Cohort: 3.5%	NELRP FY 2007 Cohort: 3.4% (Target Exceeded)
	2010	N/A	N/A

Measure	Data Source	Data Validation
5.I.C.4 5.1.C.6 5.E.1	BMISS - an IT system modernization program that replaces and/or retires a multitude of BCRS legacy systems (including BHCDANET and NIS) that contain information collected from individual scholarship and loan repayment applications, and recruitment and retention assistance applications and monitoring data from individual sites, thus improving information management across the BCRS enterprise	BMISS is internally managed with support from the NIH which provides: Data Management Services, Data Requests and Dissemination, Analytics, Data Governance and Quality, Project Planning and Requirements Development, Training, and Process Improvement.
5.1.C.5	Survey of NELRP/NSP clinicians who have completed their service obligation	Contractor does consistency and logic checks on survey data

¹ The results for this performance measure are not available until one year out because NELRP/NSP participants who completed their service obligation are not surveyed until one year later.

HEALTH PROFESSIONS

Programs included in this section are:

- Health Professions and Nursing Education and Training Programs
 - Affordable Care Act Prevention and Public Health Fund
- Children's Hospitals Graduate Medical Education Payment Program
- National Practitioner Data Bank

HEALTH PROFESSIONS AND NURSING EDUCATION AND TRAINING PROGRAMS

INTRODUCTION

The Health Professions programs and activities build upon HRSA's Strategic goal to "Strengthen the Health Workforce" (particularly primary care providers) and are keyed to the following HRSA sub-goals:

- Assure the health workforce is trained to provide high quality, culturally and linguistically appropriate care.
- Increase the number of practicing health care providers to address shortages, and develop ongoing strategies to monitor, forecast and meet long-term health workforce needs.
- Align the composition and distribution of health care providers to best meet the needs of individuals, families and communities.
- Assure a diverse health workforce.
- Support the development of interdisciplinary health teams to improve the efficiency and effectiveness of care.

The Bureau of Health Professions (BHP) programs support the training and development of health professionals (particularly primary care providers) to improve the health care of our Nation's communities and vulnerable populations. Programs fund education from accredited health professions schools, faith-based organizations, and hospitals targeted at all levels of learning from K-12 programs, undergraduate, and graduate education. Continuing education for professionals, curriculum expansion, workforce competencies, and faculty development assistance help to ensure the health workforce is trained to provide high quality, culturally and linguistically appropriate care. Post-professional training includes residencies, internships, traineeships, or any intermediary working experience before full employment. These programs serve as a catalyst to advance changes in health professions training responsive to the evolving needs of the health care system.

In addition, the BHP provides a number of services including identification of geographic shortage designations, the development and analysis of important health workforce studies, and the maintenance of a database intended to facilitate a review of health professionals' credentials.

The following items represent Bureau cross-cutting measures. Additional program measures are reported in the budget justification.

Goal: Strengthen the Health Workforce

Sub-Goals:

- Increase the number of practicing health care providers to address shortages, and develop ongoing strategies to monitor, forecast and meet long-term health workforce needs.
- Align the composition and distribution of health care providers to best meet the needs of individuals, families and communities.
- Assure a diverse health workforce.

Measure	FY	Target	Result
6. I.B.1: Proportion of graduates and program completers of Titles VII and VIII supported programs who are underrepresented minorities and/or from disadvantaged backgrounds. ¹ (<i>Outcome</i>)	2013	52%	Dec 31, 2014
	2012	53% ²	Dec 31, 2013
	2011	53%	Dec 31, 2012
	2010	53%	58% (Target Exceeded)
	2009	50%	53% (Target Exceeded)
	2008	50%	53% (Target Exceeded)
6. I.C.1: Proportion of trainees in Titles VII and VIII supported programs training in medically underserved communities. ¹ (<i>Outcome</i>)	2013	44%	Dec 31, 2014
	2012	45%	Dec 31, 2013
	2011	45%	Dec 31, 2012
	2010	54% ²	52% (Target Not Met)
	2009	54%	45% (Target Not Met)
	2008	43%	45% (Target Exceeded)
6. I.C.2: Percentage of health professionals supported by Bureau Health Professions programs who enter practice in underserved areas ^{1,3} (<i>HHS OPR</i>)	<i>Out-Year Target</i>	47% (FY 2013)	Dec 31, 2015
	2013	43%	Dec 31, 2014
	2012	43% ²	Dec 31, 2014
	2011	43%	Dec 31, 2013
	2010	43%	Dec 31, 2012
	2009	35%	43% (Target Exceeded)
	2008	35%	47% (Target Exceeded)

¹ Recovery Act Funds will impact total numbers, but will not change the proportions targeted for each measure.

² This figure differs from the FY 2012 Congressional Justification to better reflect realistic projections based on trend data.

³ Service location data are collected on students who have been out of the HRSA program for 1 year. The results are from programs that have ability to produce clinicians with one-year post program graduation.

Measure	Data Source	Data Validation
6.I.B.1 6.I.C.2 6.I.C.1	Annual grantee data submitted through the Bureau of Health Profession's Performance Management System.	Data are entered through a web-based system that incorporates extensive validation checks. Grantees are also required to describe methods and systems they use to collect and submit data. Those with deficient systems are required to submit a corrective action plan.

Affordable Care Act Measures

Goal: Strengthen the Health Workforce

Sub-goals:

- Assure the health workforce is trained to provide high quality, culturally and linguistically appropriate care.
- Increase the number of practicing health care providers to address shortages, and develop ongoing strategies to monitor, forecast and meet long-term health workforce needs.
- Align the composition and distribution of health care providers to best meet the needs of individuals, families and communities.
- Assure a diverse health workforce.
- Support the development of interdisciplinary health teams to improve the efficiency and effectiveness of care.

ACA Measure	FY	Target	Result
6.I.C.3: Number of primary care providers who complete their education through HRSA's Bureau of Health Professions programs supported with Prevention and Public Health funding (cumulative).	<i>Out-Year Target</i>	500 Physicians 600 PA 600 NP (FY 2015)	Dec 31, 2016
Physicians <i>Primary Care Training and Enhancement Program</i>	<i>Out-Year Target</i>	500 (FY 2015)	Dec 31, 2016
	2013	172	Dec 31, 2014
	2012	N/A ⁴	N/A
	2011	N/A ⁴	N/A
Physician Assistants <i>Primary Care Training and Enhancement Program</i>	<i>Out-Year Target</i>	600 (FY 2015)	Dec 31, 2016
	2013	280	Dec 31, 2014
	2012	140	Dec 31, 2013
	2011	N/A ⁴	N/A
Nurse Practitioner and Nurse Midwives <i>Advanced Nursing Education Expansion Program</i>	<i>Out-Year Target</i>	600 (FY 2015)	Dec 31, 2016
	2013	150	Dec 31, 2014
	2012	110	Dec 31, 2013
	2011	N/A ⁴	N/A

⁴ No supported trainees are eligible for completion in specified year.

ACA Measure	FY	Target	Result
6.I.C.4: Number of primary care providers trained through HRSA's Bureau of Health Professions programs supported with Prevention and Public Health funding (cumulative)			
Physicians <i>Primary Care Training and Enhancement Program</i>	2013	517	Dec 31, 2014
	2012	344	Dec 31, 2013
	2011	172	Dec 31, 2012
Physician Assistants <i>Primary Care Training and Enhancement Program</i>	2013	420	Dec 31, 2014
	2012	280	Dec 31, 2013
	2011	140	Dec 31, 2012
Nurse Practitioner and Nurse Midwives <i>Advanced Nursing Education Expansion Program</i>	2013	980	Dec 31, 2014
	2012	980	Dec 31, 2013
	2011	275	Dec 31, 2012
6.I.C.5: Number of primary care residents trained <i>Teaching Health Center Graduate Medical Education Payments (Cumulative)</i>	2013	300	Dec 31, 2014
	2012	143	Dec 31, 2013
	2011	63	Dec 31, 2012
6.I.C.6: Number of Personal Care and Home Health Aides completing training program <i>State Demonstration Grants for Training Personal Care and Home Health Aides</i>	2013	1723	Dec 31, 2014
	2012	1723	Dec 31, 2013
	2011	1723	Dec 31, 2012
6.I.C.7: Number of Primary Care Nurse Practitioner students supported <i>Nurse Managed Health Clinics</i>	2013	300	Dec 31, 2014
	2012	300	Dec 31, 2013
	2011	300	Dec 31, 2012
6.I.C.8: Number of Primary Care Patient Encounters <i>Nurse Managed Health Clinics</i>	2013	30,000	Dec 31, 2014
	2012	31,000	Dec 31, 2013
	2011	31,000	Dec 31, 2012
6.I.C.9: Number of existing public health workers retrained <i>Public Health Training Centers</i>	2013	66,000	Dec 31, 2014
	2012	80,000	Dec 31, 2013
	2011	73,908	Dec 31, 2012
	2010	N/A	87,825 (Target Not In Place)
6.I.C.10: Percent of planning grant awardees that have established FTE health workforce baselines for primary care. <i>State Health Care Workforce Planning Grant</i>	2013	N/A	Dec 31, 2014
	2012	100%	Dec 31, 2013
	2011	100%	Dec 31, 2012
6.I.C.11: Number of States that disseminate their implementation plan for increasing the primary care workforce by more than 10% to key stakeholders. <i>State Health Care Workforce Implementation Grant</i>	2013	N/A	Dec 31, 2014
	2012	100%	Dec 31, 2013
	2011	50%	Dec 31, 2012

CHILDREN’S HOSPITALS GRADUATE MEDICAL EDUCATION PAYMENT PROGRAM

INTRODUCTION

The Children’s Hospital’s Graduate Medical Education (CHGME) Payment Program builds upon two of HRSA’s strategic goals 1) strengthen the health workforce, and 2) improve access to quality health care and services.

The CHGME Payment Program provides Federal GME support to freestanding children’s teaching hospitals nationwide to help hospitals maintain graduate medical education (GME) training programs and continue serving those that are financially underserved. This support allows for the training of residents and helps align the number, the composition and distribution of health care providers in the fields of general pediatrics (46%), subspecialty pediatrics (27%), and non-pediatric subspecialties (27%) to best meet the needs of children, families, and communities.

The program also improves access to health care by expanding the capacity of the health care safety net as freestanding children’s hospitals care for underserved children and families in both inpatient and outpatient settings. In their 2010 application for CHGME funds, freestanding children’s hospitals reported that that 50% of their gross revenue for inpatient care and 41% of their gross revenue for outpatient care is from Medicaid and CHIPRA signifying that approximately half of the patients served are from low-income families.

Goal: Strengthen the Health Workforce

Sub-Goal: Increase the number of practicing health care providers to address shortages, and develop ongoing strategies to monitor, forecast and meet long-term health workforce needs.

Measure	FY	Target	Result
7. I.A.1: Maintain the number of FTE residents in training in eligible children’s teaching hospitals. (Output)	2013	5,900	July 31, 2014
	2012	5,900	July 31, 2013
	2011	5,900	July 31, 2012
	2010	5,900	6,040 (Target Exceeded)
	2009	5,343	5,840 (Target Exceeded)
	2008	5,243	5,631 (Target Exceeded)
	2007	4,828	5,406 (Target Exceeded)

Measure	FY	Target	Result
7.VII.C.1: Percent of hospitals with verified FTE resident counts and caps. (Output)	2013	100%	July 31, 2014
	2012	100%	July 31, 2013
	2011	100%	Jul 31, 2012
	2010	100%	100% (Target Met)
	2009	100%	100% (Target Met)
	2008	100%	100% (Target Met)
	2007	100%	100% (Target Met)
Efficiency Measure	FY	Target	Result
7. E: Percent of payments made on time. (Efficiency)	2013	100%	July 31, 2014
	2012	100%	July 31, 2013
	2011	100%	Jul 31, 2012
	2010	100%	100% (Target Met)
	2009	100%	100% (Target Met)
	2008	100%	100% (Target Met)
	2007	100%	100% (Target Met)

Measure	Data Source	Data Validation
7.I.A.1 7.VII.C.1	Yearly reconciliation application data submitted by participating hospitals.	Resident counts are audited annually by CHGME fiscal intermediaries.
7.E	HRSA payment data.	Validated using letters of awards and vouchers generated by the program.

NATIONAL PRACTITIONER DATA BANK

INTRODUCTION

The National Practitioner Data Bank (NPDB) program builds upon HRSA's strategic plan and is keyed to the following HRSA goal:

- Improve access to quality health care and services

The National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) serve as a flagging system intended to prompt a comprehensive review of health care practitioners' licensure activity, medical malpractice payment history and record of clinical privileges. The NPDB and HIPDB aim to alert users to the value of completing a thorough review of past actions of health care practitioners, providers and suppliers. Used in conjunction with information from other sources, the NPDB and HIPDB assist in promoting quality health care, and deterring fraud and abuse in the health care delivery system.

With the implementation of Section 1921 of the Social Security Act in March 2010, a majority of the information that is currently reported to the Healthcare Integrity Protection Data Bank (HIPDB) is also available through the NPDB. With the passage of the Affordable Care Act, the HIPDB will be merged into the NPDB, thus ending the duplication of effort and cost between the Data Banks. The merger will provide a single source of information to the Data Bank and is scheduled to occur in the first part of FY 2012. The FY 2012 performance targets reflect the upcoming merger.

The NPDB maintains a database that identifies physicians, dentists and other healthcare practitioners 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, dentists and other healthcare practitioners 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. The program regularly conducts surveys to assess 1) the utility of its information to customers, 2) customer satisfaction, and 3) areas on which improvement efforts should be focused.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health services

Measure	FY	Target	Result
8.III.B.1: Increase annually the use of the NPDB and HIPDB for licensing and credentialing decision-making, operationalized as the number of licensing and credentialing decisions which limit practitioner's ability to practice. (Outcome)	2013	54,500	Feb 28, 2014
	2012	54,500	Feb 28,2013
	2011	54,500	57,227 (Target Exceeded)
	2010	54,980	56,080 (Target Exceeded)
	2009	46,600	51,990 (Target Exceeded)
	2008	46,075	51,125 (Target Exceeded)
8. III.B.5: Increase the number of practitioners enrolled in Continuous Query. ¹	2013	1,074,000	Feb 28, 2014
	2012	999,000	Feb 28,2013
	2011	N/A	899,149
	2010	N/A	N/A
	2009	N/A	N/A
	2008	N/A	N/A
8. E: Increase annually the number of queries for which NPDB and HIPDB responded within 240 minutes. (Efficiency)	2013	5,306,000	Feb 28, 2014
	2012	5,306,000	Feb 28,2013
	2011	5,306,000	5,405,184 (Target Exceeded)
	2010	5,202,000	5,311,352 (Target Exceeded)
	2009	4,883,000	5,085,760 (Target Exceeded)
	2008	4,792,000	5,078,400 (Target Exceeded)

¹ This is a new measure. Continuous Query is a subscription service for queriers that notifies the querier of new information on any of their enrolled practitioners within 24 hours of the Data Bank receipt of the information. Continuous Query is designed and developed to meet accreditation standards that require ongoing monitoring of practitioners.

Measure	Data Source	Data Validation
8.III.B.1	NPDB operations statistics, augmented by a user survey.	Financial audits, which involve confirmation of query volumes, are done continuously.
8.III.B.5	NPDB operations statistics	Program reviews and analyses weekly and monthly statistics.
8.E	NPDB and HIPDB operations statistics.	The time required to process a query is carefully monitored by program and contractor staff because this is an explicit element of the performance-based contract.

MATERNAL AND CHILD HEALTH

Programs included in this section are:

- Maternal and Child Health Block Grant - Title V
- Traumatic Brain Injury
- James T. Walsh Universal Newborn Hearing Screening
- Emergency Medical Services for Children
- Healthy Start
- Family-to-Family Health Information Centers
- Maternal, Infant and Early Childhood Visiting Program

MATERNAL AND CHILD HEALTH BLOCK GRANT – TITLE V

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, and 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. State Title V programs use their appropriated MCH Block Grant funds to address three overarching HRSA goals: 1) improving access to quality health care and services, 2) improving health equity, and 3) building healthy communities. Progress in meeting these goals is assessed through the examination of the annual performance measures, Health Status Indicators, and Health Systems Capacity Indicators that are 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. In an effort to improve performance, the Program regularly provides technical support to the States around the priorities identified in their comprehensive five-year Needs Assessments and the technical assistance needs outlined in their annual grant 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 CHIP.

The Title V Block grant program provides support to all 59 States and jurisdictions. Funds are allotted to States based on a legislated formula which provides the amount allotted to each state in 1983 and when the amount available exceeds that level, the excess is distributed based on the States proportion of children in poverty.

MATERNAL AND CHILD HEALTH BLOCK GRANT – TITLE V

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health services

Measure	FY	Target	Result
10.I.A.1: Increase the number of children served by Title V. (Output)	2013	30M	Nov 30, 2014
	2012	33M	Nov 30, 2013
	2011	31M	Nov 30, 2012
	2010	30M	34.5 (Target Exceeded)
	2009	29M	33.3M (Target Exceeded)
	2008	28M	35 M (Target Exceeded)
10.I.A.2: Increase the number of children receiving Title V services who are enrolled in and have Medicaid and CHIP coverage. (Output)	2013	15M	Nov 30, 2014
	2012	14M	Nov 20, 2013
	2011	13M	Nov 20, 2012
	2010	12M	14.3 M (Target Exceeded)
	2009	11.2M	15.2M (Target Exceeded)
	2008	11M	14.7 M (Target Exceeded)

Goal: Improve Health Equity

Sub-Goal: Reduce disparities in quality of care across populations and communities

Measure	FY	Target	Result
10.IV.B.1: Decrease the ratio of the black infant mortality rate to the white infant mortality rate. (Output)	2013	2.1 to 1	Nov 30, 2015
	2012	2.1 to 1	Nov 30, 2014
	2011	2.1 to 1	Nov 30, 2013
	2010	2.1 to 1	2.2 to 1 ¹
	2009	2.1 to 1	2.4 to 1 ² (Target Not Met) (Preliminary Data)
	2008	2.2 to 1	2.33 to 1 ³ (Target Not Met)

¹ Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2012. Deaths: Preliminary Data for 2010, National Vital Statistics Reports, Vol. 60, No. 4, January 2012.

² Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2010. Deaths: Preliminary Data for 2009, National Vital Statistics Reports, Vol. 59, No. 4, March 2011.

³ Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2010. Deaths: Final Data for 2008, National Vital Statistics Reports, Vol. 59, No. 10, December 7, 2011.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health services

Measure	FY	Target	Result
<u>10.III.A.1</u> : Reduce the infant mortality rate. (Baseline – FY 2005: 6.9 per 1,000) (Outcome)	<i>Out-Year Target</i>	6 per 1,000 (FY 2015)	Nov 30, 2017
	2013	6.6 per 1,000	Nov 30, 2015
	2012	6.6 per 1,000	Nov 30, 2014
	2011	6.6 per 1,000	Nov 30, 2013
	2010	6.7 per 1,000	6.1 per 1,000 ⁴
	2009	6.7 per 1,000	6.4 per 1,000 ⁵ (Target Exceeded) (Preliminary Data)
	2008	6.8 per 1,000	6.6 per 1,000 ⁶ (Target Exceeded)
<u>10.III.A.2</u> : Reduce the incidence of low birth weight births. (Outcome)	2013	8.1%	Nov 30, 2015
	2012	8.2%	Nov 20, 2014
	2011	8.2%	Nov 30, 2013
	2010	8.2%	8.2% ⁷
	2009	8.2%	8.2% ⁸ (Target Met)
	2008	8.2%	8.2% (Target Met)
<u>10.III.A.3</u> : Increase percent of pregnant women who received prenatal care in the first trimester. (New Baseline – FY 2006: 69%) ⁷ (Outcome)	2013	71%	Nov 30, 2016
	2012	70%	Nov 30, 2015
	2011	69% ⁹	Nov 30, 2014
	2010	86.5%	Nov 30, 2013
	2009	86%	Nov 30, 2012
	2008	85% ⁹	71% ¹⁰

⁴ Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2012. Deaths: Preliminary Data for 2010, National Vital Statistics Reports, Vol. 60, No. 4, January 2012.

⁵ Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2010. Deaths: Preliminary Data for 2009, National Vital Statistics Reports, Vol. 59, No. 4, March 2011.

⁶ National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2010. Deaths: Final Data for 2008, National Vital Statistics Reports, Vol. 59, No. 10, December 7, 2011.

⁷ Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2011. Births: Preliminary Data for 2010, National Vital Statistics Reports, Vol. 60, No. 2, November 2011.

⁸ Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2010. Births: Final Data for 2009, National Vital Statistics Reports, Vol. 60, No. 1, November 2011.

⁹ The FY 2007 - FY 2010 targets were established based on use of the 1989 unrevised Birth Certificate. Therefore, the targets and results should not be compared until FY 2011 when targets and results are both based on the Revised Birth Certificate.

¹⁰ Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention. Expanded data from the New Birth Certificate, 2008, Vol. 59, No. 7, July 2011.

Measure	FY	Target	Result
10.III.A.4: Increase percent of very low-birth weight babies who are delivered at facilities for high-risk deliveries and neonates. (Outcome)	2013	77%	Nov 30, 2015
	2012	76%	Nov 30, 2014
	2011	76%	Nov 30, 2013
	2010	76%	Nov 30, 2012
	2009	75.5%	77.3% (Target Exceeded)
	2008	75%	76.1% (Target Exceeded)
10.3: Increase maternal survival rate. ¹¹ (Baseline – FY 2005: 15.1 deaths per 100,000 live births) (Outcome)	Out-Year Target	13.1 per 100,000 (FY 2015)	Nov 30, 2017
	2008	8 per 100,000	Dec 30, 2013
	2007	N/A	12.7 deaths per 100,000 ¹²

Measure	Data Source	Data Validation
10.I.A.1 10.I.A.2 10.III.A.4	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.3 10.III.A.2 10.3	Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC).	Data validated by CDC.

¹¹ This is a long-term measure with no annual targets.

¹² Data for fiscal year 2007 are the most recent data available for this measure. Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention. Deaths: Final Data for 2007, Vol. 58, No. 19, May 2010.

TRAUMATIC BRAIN INJURY PROGRAM

INTRODUCTION

In supporting the goal of building healthy communities, the Traumatic Brain Injury (TBI) Program supports the development and implementation of statewide systems that ensure access to comprehensive and coordinated TBI services including: transitional services, rehabilitation, education and employment, and long-term community support. On average, 1.7 million Americans will sustain a TBI each year.¹ It is estimated that up to 90,000 of these individuals will experience long-term, sometimes life-long, impairments as a result of their injury.² Such statistics likely underestimate the actual incidence of TBI because surveillance only captures injuries for which medical treatment is sought. Timely, comprehensive treatment is vital not only to save lives, but also to improve the quality of life for TBI survivors. TBI can cause a range of symptoms, which may include but is not limited to memory loss, difficulty concentrating, confusion, irritability, personality changes, fatigue, and headaches. Individuals with TBI may need a variety of services and supports, including rehabilitation, counseling, academic and vocational accommodations, independent living assistance, transportation assistance, and vocational training. These services and supports are often fragmented across different State systems of care, making access difficult for families. Through the TBI Program, State and Territorial governments receive funding to help individuals with TBI and their families receive the comprehensive care and services they need to manage ongoing conditions caused by the injury. The TBI Program consists of two distinct grant programs: 1) the State Implementation Partnership Grants (competitive grant), and 2) the TBI Protection & Advocacy Grants (formula grant).

Goal: Build Healthy Communities

Sub-Goal: Lead and collaborate with others to help communities strengthen resources that improve health for the population

Measure	FY	Target	Result
11.V.B.4: Increase the number of State partnerships and/or collaborations with governmental and non-governmental organizations. (Output)	2013	175	Aug 31, 2013
	2012	154	Aug 31, 2012
	2011	154	200 (Target exceeded)
	2010	N/A	131 (Baseline)

¹ Faul M, Xu L, Wald MM, Coronado VG. *Traumatic Brain Injury in the United States: Emergency Department Visits, Hospitalizations and Deaths 2002–2006*. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2010.

² Traumatic Brain Injury in the United States: A Report to Congress. December 1999. http://www.cdc.gov/ncipc/pub-res/tbi_congress/TBI_in_the_US.PDF

Measure	FY	Target	Result
11.V.B.6: Percentage of grantees that complete the 4 core components of the TBI Implementation Partnership Grant Program within the 4 year project period. ³ (Developmental) (Output)	2013	TBD	Aug 31, 2013
	2012	N/A	Aug 31, 2012 (Establish Baseline)
11.V.B.7: Increase the number of trainings conducted by the TBI Protection and Advocacy Grant Program. ⁴ (Developmental) (Outcome)	2013	TBD	TBD
	2012	TBD	TBD
Efficiency Measure	FY	Target	Result
11.E.1: Increase the percentage of information requests from grantees and the public that are resolved with 7 calendar days. ⁵ (Developmental) (Efficiency)	2013	100%	Aug 31, 2013
	2012	100%	Aug 31, 2012
	2011	N/A	100% (Baseline)

Measure	Data Source	Data Validation
11.V.B.4 11.V.B.6 11.V.B.7 11.E.1	Grantee annual reports.	Data confirmed by project officers.

³ This developmental long-term measure does not currently have targets. FY 2012 baseline data from grantees' progress reports will be available in 2013 and future year targets will be established.

⁴ This developmental measure does not currently have targets. FY 2012 baseline data will be available in 2013 and future year targets will be established.

⁵ This developmental measure does not currently have targets. FY 2012 baseline data will be available in 2013 and future year targets will be established.

JAMES T. WALSH UNIVERSAL NEWBORN HEARING SCREENING

INTRODUCTION

The James T. Walsh Universal Newborn Hearing Screening program began in FY 2000 and supports the following Healthy People 2010 Objective: (1) physiologic testing of newborn infants prior to their hospital discharge, (2) audiologic evaluation by three months of age, and (3) entry into a program of early intervention by six months of age with linkages to a medical home and family-to-family support.

As of December 2011, there were 56 states and jurisdictions receiving HRSA grant funds to implement the program in addition to one National Resource Center.

The performance measures of the Universal Newborn Hearing Screening program link to the HRSA goal of improving access to quality health care and services. Performance measure data are 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 documentation or lost to follow-up, thereby ensuring that more children receive the care they need.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health services

Measure	FY	Target	Result
13.1: Increase the percentage of children with non-syndromic hearing loss entering school with developmentally appropriate language skills. ¹ (Baseline – FY 2004: 20% estimated) (Outcome)	<i>Out-Year Target</i>	85% (FY 2013)	Jul 31, 2014
13.2: Increase the percentage of infants with hearing loss enrolled in early intervention before 6 months of age. ¹ (Baseline – FY 2004: 57%) (Output)	<i>Out-Year Target</i>	65% (FY 2013)	Jul 31, 2014
13.III.A.1: Percentage of infants suspected of having a hearing loss with a confirmed diagnosis by 3 months of age. (Output)	2013	65%	Mar 31, 2016
	2012	70%	Mar 31, 2015
	2011	60%	Mar 31, 2014
	2010	60%	Mar 31, 2013
	2009	40%	Mar 31, 2012
	2008	63%	68% (Target Exceeded)

¹This long-term measure does not have annual targets.

Measure	FY	Target	Result
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). (<i>Output</i>)	2013	90%	Sept 1, 2015
	2012	95%	Sept 1, 2014
	2011	95%	Sept 1, 2013
	2010	94%	Sept 1, 2012
	2009	N/A	N/A ²
	2008	88%	94%
13.III.A.3: Percentage of infants screened for hearing loss prior to hospital discharge. (<i>Output</i>)	2013	98%	Mar 31, 2016
	2012	98%	Mar 31, 2015
	2011	98%	Mar 31, 2014
	2010	98%	Mar 31, 2013
	2009	98%	97% (Target Not Met)
	2008	98%	97% (Target Not Met but Improved)
Efficiency Measure	FY	Target	Result
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. (<i>Efficiency</i>)	2013	65% ⁱ	Mar 31, 2016
	2012	70%	Mar 31, 2015
	2011	60%	Mar 31, 2014
	2010	60%	Mar 31, 2013
	2009	40%	Mar 31, 2012
	2008	63%	68% (Target Exceeded)

Measure	Data Source	Data Validation
13.1 13.2 13.III.A.1 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.
13.III.A.2	Survey of Children with Special Health Care Needs by the Centers for Disease Control and Prevention (CDC).	Data validated by CDC.

² Data are not available due to the timing of the Children with Special Health Care Needs Survey which is the data source for this measure. The next survey results are not available until late summer 2011. There is no interim data source.

EMERGENCY MEDICAL SERVICES FOR CHILDREN

INTRODUCTION

The Emergency Medical Services for Children (EMSC) Program is designed to reduce child and youth mortality and morbidity resulting from severe illness or trauma. It aims to: 1) ensure that state-of-the-art emergency medical care for the ill or injured child and adolescent is available when needed, 2) ensure that pediatric services are well integrated into the existing state emergency medical services (EMS) system and backed by optimal resources, and 3) ensure that the entire spectrum of emergency services, including primary prevention of illness and injury, acute care, and rehabilitation is provided to children and adolescents at the same level as adults.

The EMSC Program was established under the Preventive Health Amendments of 1984 (PL 98-555). Additional authority exists under the Public Health Service Act, Title XIX, §1910, (42 U.S.C. 300w-9), as amended by The Patient Protection and Affordable Care Act, §5603 (P.L. 111-148). It is administered by the Health Resources and Services Administration’s (HRSA) Maternal and Child Health Bureau (MCHB). The EMSC Program is the only Federal program whose sole focus is on improving the quality of emergency care for children.

To measure the impact on improving access to quality health care and services, the program monitors performance measures that assess program objectives. The performance measures of the EMSC Program are linked to HRSA’s Strategic Plan goal of improving access to quality health care and services.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health services

Measure	FY	Target	Result
14.1: Mortality rate for children with an injury severity score (ISS) greater than 15. (Baseline – FY 2005: 9.1%) ¹ (Outcome)	<i>Out-Year Target</i>	8.1% (FY 2014)	July 31, 2016
	2013	5.91%	July 31, 2015
	2012	8.4%	July 31, 2014
	2011	5.93%	July 31, 2013
	2010	8.6%	July 31, 2012
	2009	8.7%	5.97% (Target Exceeded)

¹ The new data sources for this measure are the National Inpatient Sample (NIS), Kids Inpatient Database (KID), Nationwide Emergency Department Sample (NEDS), and the Trauma Information Exchange Program (TIEP).

Measure	FY	Target	Result
14.V.B.1a: Increase the number of awardees that demonstrate the operational capacity to provide pediatric emergency care, including all core capacity elements related to on-line and off-line medical direction at the scene of an emergency for Basic Life Support (BLS) and Advanced Life Support (ALS). (Baseline – FY 2005: 20) (Output)	2013	32	July 31, 2014
	2012	30	N/A ²
	2011	28	35
	2010	26	N/A ²
	2009	24	26 (Target Exceeded)
	2008	21	23 (Target Exceeded)
14.V.B.1b: Increase the number of awardees that demonstrate the operational capacity to provide pediatric emergency care regarding essential pediatric equipment on transport vehicles. (Output)	2013	3	July 31, 2014
	2012	2	July 31, 2013
	2011	N/A	2
	2010	N/A	N/A
	2009	N/A	3 (Baseline)
14.V.B.1c: Increase the number of awardees that demonstrate the operational capacity to provide pediatric emergency care regarding designation of pediatric specialty care hospitals, and inter-facility transfer agreements. (Output)	2013	11	July 31, 2014
	2012	10	N/A ²
	2011	N/A	9
	2010	N/A	N/A ²
	2009	N/A	5 (Baseline)
14.V.B.2: Increase the number of awardees that have adopted requirements for pediatric emergency education for the re-certification of paramedics. (Output)	2013	41	July 31, 2014
	2012	39	N/A ²
	2011	37	40
	2010	27	N/A ²
	2009	25	37 (Target Exceeded)
	2008	22	24 (Target Exceeded)

Measure	Data Source	Data Validation
14.1	National Inpatient Sample (NIS), Kids Inpatient Database (KID), Nationwide Emergency Department Sample (NEDS), and the Trauma Information Exchange Program (TIEP).	Data confirmed by project officers.
14.V.B.1a,b,c 14.V.B.2	Grantee reports.	Data confirmed by project officers.

² Data are not collected annually.

HEALTHY START

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 program began in 1991 with grants to 15 communities with infant mortality rates 1.5 to 2.5 times the national average. In 2012, 105 Healthy Start projects provided services in 39 States, the District of Columbia and Puerto Rico. The Program's activities are linked to HRSA's strategic goal of improving health equity.

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 improving health outcomes and expanding the availability and utilization of health care. Fluctuations that occur in the results alert program to potential problems within the community and emerging national trends, such as decreased first trimester entry into prenatal care potentially indicating problems with pregnant women accessing obstetrical providers. Strategies used by Healthy Start to improve performance include technical assistance, shared best practices, supporting peer mentoring, and strengthening collaborative linkages with States and other partners both public and private. The program has undertaken a learning collaborative model to enhance 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 preconception and interconceptional care.

Goal: Improve Health Equity

Sub-Goal: Reduce disparities in quality of care across populations and communities

Measure	FY	Target	Result
<u>12.1:</u> Reduce the infant mortality rate (IMR) among Healthy Start program clients. ¹ (Baseline – FY 2004: 7.65 per 1,000) (Outcome)	<i>Out-Year Target</i>	4.3 per 1,000 (FY 2013)	Oct 31, 2015

Goal: Improve Health Equity

Sub-Goal: Monitor, identify and advance evidence-based and promising practices to achieve health equity

Measure	FY	Target	Result
<u>12.III.A.1:</u> Increase annually the percentage of women participating in Healthy Start who have a prenatal care visit in the first trimester. (Outcome)	2013	75%	Oct 31, 2015
	2012	75%	Oct 31, 2014
	2011	75%	Oct 31, 2013
	2010	75%	Oct 31, 2012
	2009	75%	70.9% (Target Not Met but Improved)
	2008	75%	68.5% (Target Not Met but Improved)
<u>12.III.A.2:</u> Decrease annually the percentage of low birth weight infants born to Healthy Start program participants. (Outcome)	2013	9.6%	Oct 31, 2015
	2012	9.6%	Oct 31, 2014
	2011	9.6%	Oct 31, 2013
	2010	9.6%	Oct 31, 2012
	2009	9.6%	10.1% (Target not met but Improved)
	2008	9.7%	10.7% (Target Not Met but Improved)
<u>12.II.B.1:</u> Increase annually the number of community members (providers and consumers, residents) participating in infant mortality awareness public health information and education activities. (Output)	2013	354,000	Oct 31, 2015
	2012	376,000	Oct 31, 2014
	2011	396,000	Oct 31, 2013
	2010	395,000	Oct 31, 2012
	2009	350,000	389,460 (Target Exceeded)
	2008	340,000	369,845 (Target Exceeded)

¹This long-term measure does not have annual targets.

Efficiency Measure	FY	Target	Result
12.E: Increase the number of persons served by the Healthy Start program with a (relatively) constant level of funding. (Baseline – FY 2002: 288,800) (Efficiency)	2013	547,317 (\$188/participant)	Oct 31, 2015
	2012	532,500	Oct 31, 2014
	2011	552,500 (\$192/participant)	Oct 31, 2013
	2010	524,500	Oct 31, 2012
	2009	485,000	570,927 persons served (\$172.8/ participant) (Target Exceeded)
	2008	475,000	546,773 persons served (\$175.1/participant) (Target Exceeded)

Measure	Data Source	Data Validation
12.1 12.III.A.1 12.III.A.2 12.II.B.1 12.E	Grantee reports.	Data confirmed by project officers.

FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS

INTRODUCTION

The “Family-to-Family Health Information Centers” program was established by the Family Opportunity Act of 2005 through FY 2009 and was extended through FY 2012 by The Patient Protection and Affordable Care Act of 2010 (PPACA) (P.L. 111-148), Sec. 5507- Health Reform. Grants under the program fund state-wide, family-staffed/run centers that provide information, education, technical assistance and peer support to Children with Special Health Care Needs families and the health professionals that serve them.

The performance measures for the Family-to-Family Health Information Centers help the Program track progress in meeting the HRSA’s strategic plan goals to improve access to quality health care and services, strengthen the health workforce and to build healthy communities 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 also uses results to identify and address technical assistance needs and any changes that need to be made with respect to data collection and analysis.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Increase outreach and enrollment into quality care

Measure	FY	Target	Result
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. <i>(Output)</i>	2013	N/A	N/A
	2012	123,000	Sep 30, 2012
	2011	122,000	146,813 (Target Exceeded)
	2010	N/A ¹	121,476 (Target Not in Place)
	2009	77,082	92,395 (Target Exceeded)
	2008	70,082	75,532 (Target Exceeded)

¹ No targets were established for FY 2010 because the program was scheduled to end.

Measure	FY	Target	Result
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. (Outcome)	2013	N/A	N/A
	2012	85%	Oct 30, 2012
	2011	83%	86% (Target Exceeded)
	2010	N/A ¹	81% (Target Not in Place)
	2009	61%	65% (Target Exceeded)
	2008	N/A	59.8% (Baseline)

Measure	Data Source	Data Validation
15.III.C.1	Annual progress/continuation reports submitted by grantees & quarterly data analysis reports from the National Center for Family/Professional Partnerships.	The National Center for Family/Professional Partnerships, which follows up with grantees when data corrections are needed.
15.III.C.2	Grantees follow-up with interviews and surveys with families and then report results in progress/continuation reports and data reports to National Center for Family/Professional Partnerships.	The National Center for Family/Professional Partnerships, which follows up with grantees when data corrections are needed.

MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAM

INTRODUCTION

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program links to the HRSA goal of improving health equity. The Program was established in FY 2010 under the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) to be collaboratively implemented by HRSA and the Administration for Children and Families (ACF). The program is designed to: (1) strengthen and improve the programs and activities carried out under Title V; (2) improve coordination of services for at-risk communities; and (3) identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. There are 56 eligible entities for this program: the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

HRSA and ACF regard home visiting as one of several service strategies embedded in a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development as well as strong parent-child relationships. Both agencies envision evidence-based home visiting programs as part of a system for promoting health and well-being for pregnant women, children through age 5 and their families which includes a range of other services such as well-child health care, child care, Head Start, pre-kindergarten, special education, and the early elementary grades.

Goal: Improve Health Equity

Sub-Goal: Reduce disparities in quality of care across populations and communities

Measure	FY	Target	Result
37.I: Number of children and families receiving services through evidence-based home visiting models (Output) (Developmental)	2013	TBD	TBD
	2012	N/A	N/A
	2011	N/A	N/A
	2010	N/A	N/A
37.II: Number and percent of grantees that meet benchmark requirements for demonstrating improvements (Outcome) (Developmental)	<i>Out-Year Target</i>	TBD ²	TBD
	2013	N/A	N/A
	2012	N/A	N/A
	2011	N/A	N/A
	2010	N/A	N/A

² Data are anticipated to be available in FY 2014-2015 when States are required to report on benchmarks (i.e., after the end of the 3rd year of program operations).

Measure	Data Source	Data Validation
37.I	Annual progress/continuation reports submitted by grantees.	Data confirmed by project officers.
37.II	Annual progress/continuation reports submitted by grantees.	Data confirmed by project officers.

RYAN WHITE HIV/AIDS

Programs included in this section are:

- Ryan White HIV/AIDS Treatment Extension Act of 2009 (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 EXTENSION ACT OF 2009 (SUMMARY)

INTRODUCTION

The purpose of the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White HIV/AIDS Program) is to address the unmet care and treatment needs of persons living with HIV/AIDS (PLWH) who are uninsured or underinsured and, therefore, have limited or no resources to pay for HIV/AIDS health care and vital health-related supportive services. Ryan White HIV/AIDS Program funding pays for primary health care and treatment including referrals to specialty care and for support services that enhance access to and retention in care. The Ryan White HIV/AIDS Program fills gaps in care for PLWH not covered by other resources or payers.

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 quality health care and services by strengthening health systems to support the delivery of quality health services and by promoting innovative and cost-efficient approaches to improve health; Strengthen the health workforce by assuring the health workforce is trained to provide high quality, culturally and linguistically appropriate care; Build healthy communities by leading and collaborating with others to help communities strengthen resources that improve health for the population; and Improve health equity by reducing disparities in quality of care across populations and communities.

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 the Summary table below. 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 evaluate the effectiveness of the program and activities and the resources spent on conducting them, and to assess training needs of Project Officers in order to assure better monitoring of grantee performance. 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; providing HIV-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 and encourages them to refer clients who test positive to Ryan White HIV/AIDS Programs for treatment.

Goal: Improve Health Equity

Sub-Goal: Reduce disparities in quality of care across populations and communities.

Measure	FY	Target	Result
<u>16.1</u> : Number of racial/ethnic minorities and the number of women served by Ryan White HIV/AIDS-funded programs. ¹ (Baseline – FY 2005: 12,000/195,000) (Outcome)	<i>Out-Year Target</i>	422,300/199,875 (FY 2014)	Oct 31, 2015
<u>16.I.A.1</u> : Proportion of racial/ethnic minorities in Ryan White HIV/AIDS-funded programs served. (Outcome)	2013	5percentage points above CDC data	Oct. 31, 2014
	2012	5percentage points above CDC data	Oct. 31, 2013
	2011	5percentage points above CDC data	Oct 31, 2012
	2010	5percentage points above CDC data	72% (CDC- Not Yet Available For Comparison)
	2009	71.4%	73% (CDC – 66.4%) (Target Exceeded)
	2008	5percentage points above CDC data	73% (CDC= 65.9%) (Target Exceeded)
<u>16.I.A.2</u> : Proportion of women in Ryan White HIV/AIDS funded- programs served. (Outcome)	2013	5percentage points above CDC data	Oct. 31, 2014
	2012	5percentage points above CDC data	Oct. 31, 2013
	2011	5percentage points above CDC data	Oct 31, 2012
	2010	5percentage points above CDC data	31% (CDC- Not Yet Available For Comparison)
	2009	28.3%	32% (CDC = 23.3%) (Target Exceeded)
	2008	5percentage points above CDC data	33% (CDC=23.2%) (Target Exceeded)

¹ This long-term measure does not have annual targets.

Measure	FY	Target	Result
16.III.A.2: Proportion of new Ryan White HIV/AIDS Program HIV-infected clients who are tested for CD4 count and viral load. (Output)	2013	CD4 – 88.2% Viral Load – 84.3%	Aug. 31, 2014
	2012	CD4 – 88.2% Viral Load – 84.3%	Aug. 31, 2013
	2011	CD4 - 88.2% Viral Load - 84.3%	Aug 31, 2012
	2010	CD4 - 88.2% Viral Load - 84.3%	CD4 - 84.7% Viral Load – 82.9% (Target Not Met but Improved)
	2009	CD4 - 87.2% Viral Load - 83.3%	CD4 – 84.7% Viral Load – 81.3% (Target Not Met)
	2008	CD4 - 86.2% Viral Load - 82.3%	CD4 - 86.4% Viral Load – 84.4% (Target Exceeded)

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health services.

Measure	FY	Target	Result
16.2: Reduce deaths of persons due to HIV infection. ² (Baseline – FY 2003: 4.7 per 100,000) (Outcome)	<i>Out-Year Target</i>	3.1 per 100,000 (FY 2014)	Feb 28, 2015
16.II.A.1: Number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs annually. (Output)	2013	236,230	Jan 31, 2015
	2012	217,324	Jan 31, 2014
	2011	208,836 ³	Jan 31, 2013
	2010	149,946	208,809 (Target Exceeded)
	2009	146,486	194,039 (Target Exceeded)
	2008	158,739 ⁴	175,194 (Target Exceeded)

² This long-term measure does not have annual targets.

³ This target differs from that shown in the FY 2011 Congressional justification to reflect a budget amendment.

⁴ The FY 2007 and FY 2008 targets are based on number of persons served at least one quarter of the year, rather than number of persons served annually.

Measure	FY	Target	Result
<u>16.II.A.2</u> : Number of persons who learn their serostatus from Ryan White HIV/AIDS Programs. (Output)	2013	877,525	Feb. 28, 2015
	2012	872,565	Feb. 28, 2014
	2011	583,730	Feb 28, 2013
	2010	572,397	Feb 28, 2012
	2009	572,397	871,696 (Target Exceeded)
	2008	572,397	739,779 (Target Exceeded)
<u>16.II.A.3</u> : Percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive anti-retroviral medications. (Output)	2013	90%	Feb. 28, 2015
	2012	90%	Feb. 28, 2014
	2011	90%	Feb 28, 2013
	2010	90%	Feb 28, 2012
	2009	89.3%	87% (Target Not Met)
	2008	88.3%	87% (Target Not Met but Improved)

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Promote innovative and cost-efficient approaches to improve health.

Measure	FY	Target	Result
<u>16.3</u> : 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." ⁵ (Baseline – FY 2005: 63.7%) (Output)	<i>Out-Year Target</i>	90% (FY 2014)	Aug 31, 2015
<u>16.III.A.1</u> : Percentage of Ryan White HIV/AIDS Program-funded primary medical care providers that will have implemented a quality management program. (Output)	2013	95.7%	Aug 31, 2014
	2012	95.7%	Aug 31, 2013
	2011	95.7%	Aug 31, 2012
	2010	95.7%	95.2% (Target Not Met but Improved)
	2009	95.7%	94.5% (Target Not Met but Improved)
	2008	93.2%	92.3% (Target Not Met but Improved)

⁵ This long-term measure does not have annual targets.

Efficiency Measure	FY	Target	Result
16.E: Amount of savings by State ADAPs' participation in cost-savings strategies on medications. (Efficiency)	2013	Sustain FY 2012 results	Apr 30, 2015
	2012	Sustain FY 2011 results	Apr 30, 2014
	2011	Sustain FY 2010 results	Apr 30, 2013
	2010	Sustain FY 2009 results	Apr 30, 2012
	2009	374.2 M	\$487.3 M (Target Exceeded)
	2008	\$267.9 M	\$374.2 M (Target Exceeded)

Measure	Data Source	Data Validation
16.1 16.I.A.1 16.I.A.2 16.III.A.2 16.II.A.2 16.II.A.3 16.3 16.III.A.1	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 RSR submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.
16.2	An analysis of trends in rates and distributions of deaths in the United States, focusing on deaths due to human immunodeficiency virus (HIV) disease (disease directly or indirectly attributable to HIV, including acquired immunodeficiency syndrome [AIDS]). Data are compiled from death certificates from all 50 states and the District of Columbia by the National Center for Health Statistics (NCHS). The underlying cause of each death is selected from the conditions reported by physicians, medical examiners, and coroners in the cause-of-death section of the death certificate. When more than one condition is reported, the underlying cause is determined by using a set of standardized rules promulgated as part of the International Classification of Diseases (ICD).	In coding causes of death, NCHS adheres to the World Health Organization Nomenclature Regulations specified in the most recent revision of the International Statistical Classification of Diseases and Related Health Problems (ICD). NCHS also uses the ICD international rules for selecting the underlying cause of death for primary mortality tabulation in accordance with the international rules.
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.

HIV EMERGENCY RELIEF GRANTS (PART A)

INTRODUCTION

Funds for Part A of the Ryan White HIV/AIDS Program are used to provide a continuum of care for people living with HIV disease who are primarily low income, underserved, uninsured and underinsured. Part A grants are distributed to metropolitan areas experiencing the greatest burdens of the country’s HIV/AIDS epidemic, and provide those communities with resources they need to confront the highly concentrated epidemic within the jurisdiction.

The Program prioritizes primary medical care, access to anti-retroviral therapies, and other core services as the areas of greatest need for persons with HIV disease. The grants fund systems of care to provide 13 core medical services and additional support services for individuals with HIV/AIDS in 4 Eligible Metropolitan Areas (EMAs), which are jurisdictions with 2,000 or more AIDS cases over the last five years, and 28 transitional grant areas (TGAs) (jurisdictions with at least 1,000 but fewer than 2,000 AIDS cases over the last five years). In addition, Part A funds 4 states (California, New Jersey, New York, and Puerto Rico) that have a city that was previously a TGA.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health services.

Measure	FY	Target	Result
17.I.A.1: Number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative ¹ , and home health). (Output)	2013	2.63 M	Jan 31, 2015
	2012	2.63 M	Jan 31, 2014
	2011	2.63 M	Jan 31, 2013
	2010	2.63 M	2.63 (Target Met)
	2009	2.59 M	2.59 M (Target Met)
	2008	2.47 M	2.60 M (Target Exceeded)

Measure	Data Source	Data Validation
17.I.A.1	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 RSR submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.

¹ Rehabilitative services are a support service and visit data is not collected for support services.

HIV CARE GRANTS TO STATES (PART B)

INTRODUCTION

Part B, the largest of the Ryan White HIV/AIDS programs, provides grants to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and 5 U.S. Pacific Territories or Associated Jurisdictions to provide services for people living with HIV/AIDS, including outpatient medical care, oral health care, home- and community-based services, continuation of health insurance coverage, prescription drugs, HIV care consortia, and support services.

Part B includes the AIDS Drug Assistance Program (ADAP), which supports the provision of HIV medications and related services. Seventy-five percent of Part B funds must be used to support 13 core medical services. Part B funds are distributed through base and supplemental grants, ADAP, and ADAP supplemental grants, Emerging Communities (ECs) grants, and Minority AIDS Initiative grants.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health services.

Measure	FY	Target	Result
18.I.A.1: Number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative ¹ , and home health). <i>Output</i>	2013	2.27 M	Jan 31, 2015
	2012	2.19 M	Jan 31, 2014
	2011	2.19 M	Jan 31, 2013
	2010	2.19 M	2.20 M (Target Exceeded)
	2009	2.14 M	2.11 M (Target Not Met But Improved)
	2008	2.14 M	2.02 M (Target Not Met)

Measure	Data Source	Data Validation
18.I.A.1	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 RSR submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.

¹ Rehabilitative services are a support service and visit data is not collected for support services.

HIV EARLY INTERVENTION SERVICES (PART C)

INTRODUCTION

Part C of the Ryan White HIV/AIDS Program provides direct grants to 344 community and faith-based primary health clinics and public health providers in 49 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Part C programs are the primary means for targeting HIV medical services to underserved and uninsured people living with HIV/AIDS in specific geographic communities, including rural and frontier communities. Part C programs target the most vulnerable communities, including people of color, men-who-have-sex-with-men (MSM), women, and low-income populations.

Goal: Build Healthy Communities

Sub-Goal: Lead and collaborate with others to help communities strengthen resources that improve health for the population.

Measure	FY	Target	Result
19.II.A.1: Number of people receiving primary care services under Early Intervention Services programs. (Output)	2013	265,325	Mar 31, 2015
	2012	257,053	Mar 31, 2014
	2011	255,429	Mar 31, 2013
	2010	240,666	Mar 31, 2012
	2009	236,745	255,429 (Target Exceeded)
	2008	216,591	247,133 (Target Exceeded)

Measure	Data Source	Data Validation
19.II.A.1	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 RSR submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.

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

INTRODUCTION

The Part D of the HIV/AIDS Program focuses on providing access to coordinated, family-centered primary medical care and support services for HIV-infected women, infants, children, and youth and their affected family members. It also funds support services, like case management and childcare that help clients get the care they need. Eligible organizations are public or private nonprofit entities that provide or arrange for primary care for HIV-positive women, infants, children, and youth. Part D programs include community based organizations, hospitals, and state and local governments.

Goal: Build Healthy Communities

Sub-Goal: Lead and collaborate with others to help communities strengthen resources that improve health for the population.

Measure	FY	Target	Result
20.II.A.1: Number of female clients provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission. ¹ (Output)	2013	49,802	Jan 31, 2015
	2012	53,753	Jan 31, 2014
	2011	55,355	Jan 31, 2013
	2010	51,316	53,753 (Target Exceeded)
	2009	50,695	55,335 (Target Exceeded)
	2008	52,306	57,773 (Target Exceeded)

Measure	Data Source	Data Validation
20.II.A.1	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 RSR submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.

¹ Female clients counted are age 13 and above.

AIDS EDUCATION AND TRAINING CENTERS (PART F)

INTRODUCTION

The AIDS Education and Training Centers (AHECs) – a network of 11 regional centers with more than 130 local performance sites and five national centers – offer specialized clinical education and consultation on HIV/AIDS transmission, treatment, and prevention to front-line health care providers, including physicians, nurses, physician assistants, dentists, and pharmacists.

The AETCs target training to providers who serve minority populations, the homeless, rural communities, incarcerated persons, federally qualified community and migrant health centers, and Ryan White HIV/AIDS Program sites. AETC-trained providers are more competent with regard to HIV issues and more willing to treat persons living with HIV than other primary care providers. The AETCs provide education in a variety of formats including skills building workshops, hands-on preceptorships and mini-residencies, on-site training, and technical assistance. Clinical faculty also provide timely clinical consultation in person or via the telephone or internet. Based in leading academic centers across the country, the AETCs use nationally recognized faculty and HIV researchers in the development, implementation, and evaluation of the education and training offered.

Goal: Strengthen the Health Workforce

Sub-Goal: Assure the health workforce is trained to provide high quality, culturally and linguistically appropriate care.

Measure	FY	Target	Result
21.V.B.1: Proportion of racial/ethnic minority health care providers participating in AETC training intervention programs. (Output)	2013	43%	Jun 30, 2015
	2012	43%	Jun 30, 2014
	2011	43%	Jun 30, 2013
	2010	43%	Jun 30, 2012
	2009	43%	43% (Target Met)
	2008	43%	44% (Target Exceeded)

Measure	Data Source	Data Validation
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.

DENTAL REIMBURSEMENT AND COMMUNITY PARTNERSHIP PROGRAMS (PART F)

INTRODUCTION

The HIV/AIDS Dental Reimbursement Program provides access to oral health for people living with HIV/AIDS by reimbursing dental education programs for the non-reimbursed costs they incur providing such care. By offsetting the costs of non-reimbursed HIV care in dental education institutions, the Dental Reimbursement Program improves access to oral health care for people living with HIV and trains dental, dental hygiene students, and dental residents to provide oral health care services to people living with HIV. The care provided through the program includes full range of diagnostic, preventive, and treatment services, including oral surgery, as well as oral health education and health promotion.

The Community-Based Dental Partnership Program supports collaborations between dental education programs and community-based partners to deliver oral health services in community settings while training students and residents enrolled in accredited dental education programs. Dental schools, post-doctoral dental education programs, and dental hygiene education programs accredited by the Commission of Dental Accreditation that have documented non-reimbursed costs for providing oral health care to people living with HIV are eligible to apply for reimbursement. Funds are then distributed to eligible organizations taking into account the number of people served and the cost of providing care.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Expand the oral health services and integrate into primary care settings.

Measure	FY	Target	Result
22.I.D.1: Number of persons for whom a portion/percentage of their unreimbursed oral health cost were reimbursed. (Output)	2013	33,316	Apr 30, 2014
	2012	33,316	Apr 30, 2013
	2011	34,240	Apr 30, 2012
	2010	33,508	35,659 (Target Exceeded)
	2009	33,508	35,474 (Target Exceeded)
	2008	34,394	36,193 (Target Exceeded)

Measure	Data Source	Data Validation
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.

HEALTHCARE SYSTEMS

Programs included in this section are:

- Organ Transplantation
- C.W. Bill Young Cell Transplantation Program

ORGAN TRANSPLANTATION

INTRODUCTION

The Organ Transplantation Program supports HRSA’s mission to improve access to quality healthcare and services by increasing the number of deceased donor organs transplanted and increasing the survival benefit of kidney transplantation. 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 intermediate measures, which are monitored internally, include: number of deceased organ donors, number of donors that meet cardiac-death and non-cardiac death criteria and number of organs transplanted on average from each category of deceased organ donor.

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 to sustain and improve upon the gains made in the highly effective *Breakthrough Collaboratives* supported by HRSA beginning in 2003. HRSA is working with the organ donation and transplantation community to institutionalize these gains through a ‘Community of Practice.’ 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.

Goal: Improve Access to quality health care and services

Sub-goal: Strengthen health systems to support the delivery of quality health services.

Measure	FY	Target	Result
23.II.A.1: Increase the annual number of deceased donor organs transplanted. (<i>Outcome</i>)	<i>Out-Year Target</i>	33,473 (FY 2013)	May 30, 2014
	2013	33,473	May 30, 2014
	2012	31,979	May 30, 2013
	2011	30,515	May 30, 2012
	2010	29,084	24,598 (Target Not Met but Improved)
	2009	27,683	24,116 (Target Not Met but Improved)
	2008	26,314	23,933 (Target Not Met)
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. (<i>Outcome</i>)	<i>Out-Year Target</i>	7,299 (FY 2013)	May 30, 2014
	2013	7,299	May 30, 2014
	2012	6,928	May 30, 2013
	2011	6,565	May 30, 2012
	2010	6,213	4,381 (Target Not Met)
	2009	5,873	4,868 (Target Not Met)
	2008	5,543	4,835 (Target Not Met)

Measure	FY	Target	Result
23.II.A.8: Increase the annual conversion rate of eligible donors.	<i>Out-Year Target</i>	75% (FY 2013)	May 30, 2014
	<i>2013</i>	75%	May 30, 2014
	<i>2012</i>	72.9%	May 30, 2013
	<i>2011</i>	70.8%	May 30, 2012
	<i>2010</i>	68.6%	71.2% (Target Exceeded)
	<i>2009</i>	66.5%	69.1% (Target Exceeded)
	<i>2008</i>	64.4%	66.5% (Target Exceeded)

Measure	Data Source	Data Validation
23.II.A.1 23.II.A.7 23.II.A.8	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 the transplant programs, organ procurement organizations and histocompatibility laboratories 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 that the number of deaths reported pre- and post-transplant are accurate.

C.W. BILL YOUNG CELL TRANSPLANTATION PROGRAM

INTRODUCTION

The Stem Cell Therapeutic and Research Act of 2010 (P.L. 111-264) reauthorized the C.W. Bill Young Cell Transplantation Program (Program). The Program activities support HRSA’s strategic goal to improve access to quality health care and services. The Program’s performance measures allow 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.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Increase outreach and enrollment into quality care

Measure	FY	Target	Result
24.II.A.2: Increase the number of adult volunteer potential donors of minority race and ethnicity. (Outcome)	2013	2.85 Million	Dec 31, 2013
	2012	2.66 Million	Dec 31, 2012
	2011	2.48 Million	2.67Million (Target Exceeded)
	2010	2.35 Million	2.46 Million (Target Exceeded)
	2009	2.06 Million	2.22 Million (Target Exceeded)
	2008	1.94 Million	2.03 Million (Target Exceeded)
24.1: Increase the number of blood stem cell transplants facilitated annually by the Program. ² (Outcome)	<i>Out-Year Target</i>	5,513 (FY 2013)	Dec 31, 2013
	2010	4,500	5,228 (Target Exceeded)
24.2: Increase the number of blood stem cell transplants facilitated annually by the Program for minority patients. ¹ (Outcome)	<i>Out-Year Target</i>	845 (FY 2013)	Dec 31, 2013
	2010	636	820 (Target Exceeded)

²This long term measure does not have annual targets.

Measure	FY	Target	Result
24.3: Increase the rate of patient survival at one year, post transplant. ¹ (Outcome)	<i>Out-Year Target</i>	69% (FY 2013)	Dec 31, 2015
	2010	69%	Dec 31, 2012
Efficiency Measure	FY	Target	Result
24.E: Decrease the unit cost of human leukocyte antigen (HLA) typing of potential donors. (Efficiency)	2013	\$49.93	Dec 31, 2013
	2012	\$50.44	Dec 31, 2012
	2011	\$52	\$52 (Target Met)
	2010	\$52	\$52 (Target Met)
	2009	\$52	\$52 (Target Met)
	2008	\$52	\$52 (Target Met)

Measure	Data Source	Data Validation
24.II.A.2	Data are captured within the National Marrow Donor Program's computerized system, containing information pertaining to registered volunteer adult donors willing to donate blood stem cells to patients in need. Monthly reports generated from the computerized system to indicate the number of registered donors (broken down by self-reported race and ethnicity).	Validated by project officers analyzing comprehensive monthly reports broken down by recruitment organization. To decrease the likelihood of data entry errors, the program contractor utilizes value protected screens and optical scanning forms.
24.1 24.2	Data are captured within the National Marrow Donor Program's computerized system, containing information pertaining to the number of transplants facilitated through the Program. The transplants are tracked and reported according to patient diagnosis, patient age, patient race, and location of transplant center.	Validated by project officers analyzing comprehensive monthly reports detailing the number of transplants facilitated through the Program.
24.3	Data are reported by the transplant centers, and maintained by the National Marrow Donor Program pertaining to the outcomes of patient transplants at different time points (date of engraftment, 100 days, 6 months, and annually thereafter).	Validated by the National Marrow Donor Program in on-site audits of transplant centers. Validated by project officer analyzing deliverables detailing patient survival rates by transplant center and by keeping abreast of latest developments in the field by reading journal articles and attending conferences.
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.

POISON CONTROL PROGRAM

INTRODUCTION

The Poison Control Program has three components: (1) maintaining a single national toll-free number (800-222-1222) to access poison center services, (2) providing grants to poison control centers (PCCs) to support their efforts to provide triage and treatment recommendations for poisonings, (3) implementing a public relations campaign to increase awareness of the toll-free number and PCCs. The Program works to ensure ready access to quality poison control services and maintain the national poison control system's infrastructure. As a result, the Program aligns with HRSA's goal to improve access to quality health care and services, and HRSA's related sub-goal to strengthen health systems to support the delivery of quality health services.

The performance measures to increase calls to the national toll-free number, the percent of national survey respondents who are aware that calls to PCCs are handled by health care professionals, and the percent of human poison exposure calls made to PCCs that were managed by PCCs outside of a health care facility are utilized for strategic planning to ensure that the program is increasing access to comprehensive quality services for the entire population.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health services

Measure	FY	Target	Result
<u>25.III.D.3:</u> Increase percent of inbound volume on the toll-free number. (Output)	2013	75%	Oct 31, 2013
	2012	75%	Oct 31, 2012
	2011	73.7%	81% (Target Exceeded)
	2010	73.7%	75.6% (Target Exceeded)
	2009	71%	73.7% (Target Exceeded)
	2008	69.3%	70% (Target Exceeded)
<u>25.III.D.4:</u> Percent of national survey respondents who are aware that calls to poison control centers are handled by health care professionals. ³ (Outcome)	<i>Out-Year Target</i>	25% (FY 2016)	February 15, 2017
	2011	N/A	February 15, 2012

³ This is a long-term measure. FY 2016 is the first year for which there is a target. The FY 2016 target is 25 percent. Interim data from FY 2011 will be available February 15, 2012.

Measure	FY	Target	Result
25.III.D.5: Percent of human poison exposure calls made to PCCs that were managed by poison centers outside of a health care facility. ⁴ (Output)	2013	71%	January 30, 2015
	2012	N/A	N/A
	2011	N/A	N/A
	2010	N/A	January 30, 2012
	2009	N/A	72% (Baseline)

Measure	Data Source	Data Validation
25.III.D.3	Telephone billing reports and the National Poison Data System operated by the American Association of Poison Control Centers.	Validated by HRSA Poison Control Staff and the American Association of Poison Control Centers.
25.III.D.4	Poison Help Campaign General Population Survey	StrategyOne, Inc. under subcontract to Edelman Public Relations, Inc.
25.III.D.5	National Poison Data System operated by the American Association of Poison Control Centers.	Validated by the American Association of Poison Control Centers.

⁴ This is an annual measure with FY 2010 as the first year for which data will be reported. FY 2010 data will be available January 30, 2012.

INFRASTRUCTURE TO EXPAND ACCESS TO CARE

INTRODUCTION

The Affordable Care Act provided funds for the Infrastructure to Expand Access to Care Program to be used for debt service on, or direct construction or renovation of, a health care facility that provides research, inpatient tertiary care, or outpatient clinical services. A construction grant was awarded in FY 2011. This measure reflects the ongoing monitoring performed by HRSA to ensure that the project is completed on schedule as proposed.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health services

Measure	FY	Target	Result
41.I: Extent to which pre-established process and time milestones/standards are met. (Outcome)	2013	Awardee complies with quarterly reporting requirements	December 15, 2013
	2012	Awardee complies with quarterly reporting requirements	December 15, 2012
	2011		2011 Accomplishments: National Environmental Policy Act and National Historic Preservation Act requirements met. The grantee entered into a Construction Management agreement within one year of the award, as required. The Bid Tabulation and Project Schedule documentation were submitted timely. The grantee submitted the Quarterly Progress Reports in a timely manner. All reporting requirements are current.

Measure	Data Source	Data Validation
41.I	Electronic Handbook (EHB) Reporting	

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
- Telehealth

RURAL HEALTH ACTIVITIES

INTRODUCTION

Established in 1987, the Office of Rural Health Policy (ORHP) serves as a focal point for rural health activities within the Department. The Office is specifically charged with serving as a policy and research resource on rural health issues as well as administering grant programs that focus on supporting and enhancing health care delivery in rural communities.

ORHP advises the Secretary and other components of the Department on rural health issues with a particular focus on working with rural hospitals and other rural health care providers to ensure access to high quality care in rural communities. The Department has maintained a significant focus on rural activities for more than 20 years. Historically, rural communities have struggled with issues related to access to care, recruitment and retention of health care providers and maintaining the economic viability of hospitals and other health care providers in isolated rural communities.

ORHP’s goals and objectives support HRSA’s Strategic Plan goal to improve access to quality health care and services and sub-goals to strengthen health systems to support the delivery of quality health services and strengthen financial soundness and viability of HRSA-funded health organizations. This is done by improving the health and wellness of rural communities as well as increasing the financial viability of small rural hospitals. Strategies include making revisions to program guidance to assure that performance expectations and goals are clear and focus the attention of grantees on performance improvement and efficiency.

This section looks broadly at four key performance measures within ORHP. More program-specific performance measures are provided later in this document.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health care services

Measure	FY	Target	Result
27.1: Reduce the proportion of rural residents of all ages with limitation of activities caused by chronic conditions. ¹ (Baseline – FY 2000: 14.67%) (Outcome)	<i>Out-Year Target</i>	13% (FY 2013)	Oct 31, 2015
	<i>2010</i>	13.9%	Oct 31, 2012

¹ This is a long-term measure with no annual targets.

Measure	FY	Target	Result
27.IV.A.3: Increase the number of people receiving direct services through Outreach Grants. (Outcome)	2013	395,000	Oct 31, 2014
	2012	390,000	Oct 31, 2013
	2011	385,000	Oct 31, 2012
	2010	380,000	383,776 (Target Exceeded)
	2009	N/A	375,000 (Baseline)
	2008	N/A	N/A

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen the financial soundness and viability of HRSA-funded health organizations

Measure	FY	Target	Result
27.2: Increase the proportion of critical access hospitals with positive operating margins. ¹ (Baseline – FY 1999: 10%) (Outcome)	<i>Out-Year Target</i>	60% (FY 2013)	Dec 31, 2015
27.V.B.1: Increase the average operating margin of critical access hospitals. (Outcome)	2013	0.5% point below FY 2012	Dec 31, 2014
	2012	0.5% point below FY 2011	Dec 31, 2013
	2011	0.5% point below FY 2010	Dec 31, 2012
	2010	0.5% point below FY 2009	-2.04% (Target Exceeded)
	2009	0.5% point below FY 2008	-3.3% (Target Not Met)
	2008	0.5% point below FY 2007	-1.9% (Target Exceeded)

Measure	Data Source	Data Validation
27.1	Centers for Disease Control and Prevention (CDC), "Health in the United States."	Data validated by CDC
27.IV.A.3	Reported by grantees through the Program's Performance Improvement Measurement System.	Validated by project officers
27.2 27.V.B.1	Medicare Cost Reports	Validated by Centers for Medicare and Medicaid Services

RURAL HEALTH POLICY DEVELOPMENT

INTRODUCTION

Rural Health Policy Development activities support a range of policy analysis, research and information dissemination. The Office is charged in its authorizing language to advise the Secretary on how Departmental policies affect rural communities and to conduct research to inform its policy analysis activities. The Office is also charged with supporting information dissemination and the operation of a clearinghouse on national rural health initiatives.

The ORHP Rural Health Research Center Grant Program is a major component of Rural Health Policy Development activities. It is designed to provide both short- and long-term policy relevant studies on rural health issues. In the past, efforts to understand and appropriately address the health needs of rural Americans were severely limited by the lack of information about the rural population and the impact of Federal policies and regulations on the rural health care infrastructure. The work of the research centers is published in policy briefs, academic journals, research papers, and other venues and is made available to policy makers at both the Federal and State levels. In addition to the research center program, the Rural Health Policy Development Activities also support two additional cooperative agreements that focus on data and trend analysis on new and ongoing policy issues. These agreements are used to support data needs across the Department.

Another major component of Rural Health Policy Development is the Office's work in staffing the National Advisory Committee on Rural Health and Human Services, which advises the Secretary on rural health and human service programs and policies and produces an annual report on critical rural issues for the Secretary.

Rural Health Policy Development also plays an important role in serving as a broker of information on rural health issues through a cooperative agreement with the Rural Assistance Center (RAC). In keeping with the statutory mandate, the office established the RAC as a clearinghouse for anyone in need of rural health policy and program information. The RAC responds individually to hundreds of inquiries each month by both phone and e-mail and disseminates information through its web site and various reports and information guides on a range of key rural health issues.

The following performance measure supports HRSA's Strategic Plan Goal IV to improve health equity through monitoring, identifying and advancing evidence-based and promising practices.

Goal: Improve Health Equity

Sub-Goal: Monitor, identify and advance evidence-based and promising practices to achieve health equity.

Measure	FY	Target	Result
28.V.A.1: Conduct and disseminate policy relevant research on rural health issues. (Outcome)	2013	35	Sep 30, 2014
	2012	30	Sep 30, 2013
	2011	30	Sep 30, 2012
	2010	30	48 (Target Exceeded)
	2009	30	30 (Target Met)
	2008	30	30 (Target Met)

Measure	Data Source	Data Validation
28.V.A.1	Annual grantee reports	Validated by project officers

RURAL HEALTH OUTREACH, NETWORK, AND QUALITY IMPROVEMENT GRANTS

INTRODUCTION

The Rural Health Care Services Outreach, Network and Quality Improvement Grants include a range of programs and services designed to improve access to and coordination of health care services in rural communities as well as focus on quality improvement. In addition, these programs support collaborative models to deliver basic health care services to the 55 million Americans living in rural areas.

The grants began as a demonstration program in 1993 and were formally authorized in 1996 through the Public Health Service Act, Section 330A (e) (42 U.S.C. 254(c)), as amended. These programs are among the few non-categorical grants within HHS that allow the grantees to determine the best way to meet local need. This flexibility in funding reflects the unique nature of health care challenges in rural communities and the need to allow communities to determine the best approach to addressing need. ORHP has begun to focus a great deal on sustainability to demonstrate the impact these programs make in rural communities and has seen a tremendous increase in the percent of programs that continue once federal funding has ended.

The Outreach Authority includes five key programs: (1) Outreach Services Grants which focus on improving access to care in rural communities through community coalitions and partnerships; (2) Rural Network Development Grants which support building regional or local partnerships to improve management of scarce health care resources; (3) Network Planning Grant Program which provides funds to bring together key parts of a rural health care delivery system so they can work in concert to establish or improve local capacity and coordination of care; (4) Small Health Care Provider Quality Improvement Grants which help small health care providers focus on specific interventions to improve health care quality in specific chronic disease since rural communities have higher rates of chronic diseases relative to urban areas; and (5) the Delta States Network Grant Program which provides network development grants to the eight states in the Mississippi Delta for network and rural health infrastructure development.

The program measures support HRSA's Strategic Plan Goal I to improve access to quality health care and services through strengthening health systems to support the delivery of quality health care services. Strategies used to improve performance include providing improved guidance and information to grantees on performance expectations and providing technical assistance to grantees.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health care services.

Measure	FY	Target	Result
<u>29.IV.A.4:</u> Percent of outreach Authority grantees that will continue to offer services after the Federal grant funding ends. (Outcome)	2013	68%	Oct 31, 2014
	2012	75%	Oct 31, 2013
	2011	75%	Oct 31, 2012
	2010	N/A	75% (Target Not in Place)
	2009	N/A	75% (baseline)
<u>29.IV.A.3:</u> Increase the number of people receiving direct services through Outreach Grants. (Outcome)	2013	395,000	Oct 31, 2014
	2012	390,000	Oct 31, 2013
	2011	385,000	Oct 31, 2012
	2010	380,000	383,776 (Target Exceeded)
	2009	N/A	375,000 (Baseline)
<u>29.IV.A.2:</u> Increase the proportion of the target population served through Outreach Authority grants. ² (Outcome)	2013	6%	Oct 31, 2014
	2012	5%	Oct 31, 2013
	2011	N/A	N/A
	2010	N/A	4.3% (Baseline)
	2009	N/A	N/A

Measure	Data Source	Data Validation
29.IV.A.2 29.IV.A.3 29.IV.A.4	Reported by grantees through the Program's Performance Improvement Measurement System.	Validated by project officers.

² Baseline data for FY 2010 and targets for FY 2012 and FY 2013 will be available by October 2011.

RURAL HOSPITAL FLEXIBILITY GRANTS

INTRODUCTION

The Rural Hospital Flexibility grants support a range of activities focusing primarily on Critical Access Hospitals (CAHs) and consist of three programs: the Medicare Hospital Flexibility Program, the Small Hospital Improvement Program, and the Flex Rural Veterans Health Access Program.

The Medicare Rural Hospital Flexibility (Flex) Grant Program targets funding to over 1,300 critical access hospitals in 45 states. The focus of the program includes providing support for CAHs for quality improvement, quality reporting, performance improvements and benchmarking within the CAH and the community through technical assistance and some direct support to hospitals. In the past 12 years, the Flex Program and CAH designation has been instrumental in strengthening the infrastructure of these small rural hospitals, as evidenced in the trend of the operating margins improving from operating margins in negative double digits to close to zero. Economic viability is important in ensuring continued access to care, but quality improvement is now just as important. Given the larger trends in health care, the Flex Program provides essential support to CAHs and help to prepare them to successfully navigate a future that will emphasize pay for performance and value based purchasing, while improving outcomes and managing growth in health care spending.

The performance measures for the Rural Hospital Flexibility Grants support HRSA’s Strategic Plan goal to improve access to quality health care and services and the sub-goal to strengthen health systems to support the delivery of quality health services. Strategies used to improve performance include providing improved guidelines on performance expectations and technical assistance to grantees, including technical assistance that states provide to hospitals around quality, financial, and operational improvement.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health care services.

Measure	FY	Target	Result
30.V.B.1: Increase the average operating margin of critical access hospitals. (Output)	2013	0.5% point below FY 2012	Dec 31, 2014
	2012	0.5% point below FY 2011	Dec 31, 2013
	2011	0.5% point below FY 2010	Dec 31, 2012
	2010	0.5% point below FY 2009	-2.04% (Target Exceeded)
	2009	0.5% point below FY 2008	-3.3% (Target Not Met)
	2008	0.5% point below FY 2007	-1.9% (Target Exceeded)

Measure	FY	Target	Result
30.V.B.4: Increase the percent of Critical Access Hospitals reporting at least one measure to Hospital Compare. (Outcome)	2013	78%	Dec 31, 2014
	2012	76%	Dec 31, 2013
	2011	74%	Dec 31, 2012
	2010	72%	72.6% (Target Exceeded)
	2009	70%	70.3% (Target Exceeded)
	2008	N/A	70% (Target Not in Place)
30.V.B.5: Number of individuals trained in emergency medical services leadership and/or trauma courses. (Outcome)	2013	3,615	Dec 31, 2014
	2012	3,615	Dec 31, 2013
	2011	3,615	Dec 31, 2012
	2010	3,615	2,996 (Target Not Met)
	2009	N/A	3,002 (Target Not in Place)
	2008	N/A	3,613 (Baseline)

Measure	Data Source	Data Validation
30.V.B.1	Medicare Cost Reports	Validated by Centers for Medicare and Medicaid Services
30.V.B.4 30.V.B.5	This information will be reported by grantees through the Program's Performance Improvement Measurement System	Validated by project officers.

STATE OFFICES OF RURAL HEALTH

INTRODUCTION

The State Offices of Rural Health (SORH) Grant Program was created in 1992 to support rural health care in each of the 50 states by providing grants to states to establish and maintain SORHs. The grantees collect and disseminate health-related information in rural areas. They also provide technical and other assistance to rural health providers, including small rural hospitals. SORHs also help communities recruit and retain health professionals. Each dollar of Federal support for the program is matched by three state dollars.

The performance measures for this program support HRSA’s Strategic Plan goal to improve access to quality health care and services through strengthening health systems to support the delivery of quality health services.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health care services.

Measure	FY	Target	Result
31.V.B.3: Number of technical assistance (TA) encounters provided directly to clients by SORHs. ¹ (Outcome)	2013	66,932	Oct 31, 2014
	2012	66,269	Oct 31, 2013
	2011	65,614	Oct 31, 2012
	2010	68,990	77,036 (Target Exceeded)
	2009	N/A	54,689 (Target Not in Place)
	2008	N/A	68,307 (Baseline)

¹ Technical Assistance (TA) Encounter: Any activity that is planned, funded, organized, administered or provided by SORH that results in the delivery of substantive information, advice, education or training directly to a client (s). TA must be provided face to face, thru teleconference / webinar technology or via in-depth telephone and e-mail interactions that result in the delivery of substantive service or subject content (problem solving, proposal feedback, regulation interpretation, grant application guidance etc.) to a client. Relatively brief / routine telephone and email responses and direct mass mailings are not considered TA for the purpose of this measure. A client usually requests TA or receives an invitation from SORH to participate in scheduled / formal TA activities such as workshops, conferences, seminars, meeting or training sessions. A TA encounter provided to the same client (on different occasion) shall still be counted as an individual encounter. The language - provided directly in both measures was inserted to emphasize that only TA provided (by staff or contractors) or funded by SORH can be counted. This was to ensure that TA provided by affiliated offices or organizations is not counted by the SORH as having been provided by them.

Measure	FY	Target	Result
31.V.B.4: Number of clients (unduplicated) that received technical assistance directly from SORHs. ^{1,2} (Outcome)	2013	31,134	Oct 31, 2014
	2012	30,826	Oct 31, 2013
	2011	30,521	Oct 31, 2012
	2010	35,225	22,731 (Target Not Met)
	2009	N/A	27,259 (Target Not in Place)
	2008	N/A	34,876 (Baseline)
31.V.B.5: Number of clinician placements facilitated by the SORHs through their recruitment initiatives. (Outcome)	2013	1,260	Feb 28, 2015
	2012	1,053	Feb 28, 2014
	2011	1,043	Feb 28, 2013
	2010	1,033	Feb 28, 2012
	2009	N/A	1,256 (Target Not in Place)
	2008	N/A	1,023 (Baseline)

Measure	Data Source	Data Validation
31.V.B.3 31.V.B.4	This information is reported by grantees through the Program's Performance Improvement Measurement System.	Validated by project officers
31.V.B.5	This information is captured from the annual clinician placement data from the Rural Recruitment and Retention Network (3RNet).	Validated by Rural Recruitment and Retention Network (3RNet)

² Client (unduplicated): Any individual, group or organization that received TA as defined above at least once during the reporting period. Examples include but are not limited to: providers / technicians, hospitals, clinics, networks, agencies, associations, organizations, academic institutions, government officials, communities, partners and other stakeholders. Affiliated individuals (i.e., members of an association or organization) would normally be considered a single client. Example - SORH addressing State Rural Health Association about grant opportunities. Non-affiliated individuals (i.e. hospital administrators or nurses) would normally be considered as multiple clients. Example – hospital staff attending a SORH sponsored workshop on quality and performance improvement. A client may only be counted once regardless of how many times the client receives TA during the reporting period.

RADIATION EXPOSURE SCREENING AND EDUCATION PROGRAM

INTRODUCTION

The Radiation Exposure Screening and Education Program (RESEP), which began in 2002, provides grants to States, local governments, and appropriate health care organizations to support programs for cancer screening for individuals adversely affected by the mining, transport and processing of uranium and the testing of nuclear weapons for the Nation’s weapons arsenal. The RESEP grantees also help clients with appropriate medical referrals, engage in public information development and dissemination, and facilitate claims documentation to aid individuals who may wish to apply for support under the Radiation Exposure Compensation Act. The Program has adopted steps to ensure that grantees comply with uniform screening guidelines. In addition, the program has undertaken new outreach strategies to identify where this patient population has relocated and to make them aware of available screening sites.

The Program performance measures support HRSA’s Strategic Plan Goal I of improving access to quality health care and services through strengthening health systems to support the delivery of quality health services. The Program partners with the Department of Justice to collect data in support of some of these measures. 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.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health care services.

Measure	FY	Target	Result
32.1: Percent of RECA successful claimants screened at RESEP centers. (Outcome)	<i>Out-Year Target</i>	8.8% (FY 2013)	Nov 30, 2014
	2008	N/A	8.5% (Baseline)
32.2: Percent of patients screened at RESEP clinics who file RECA claims that receive RECA benefits. (Outcome)	<i>Out-Year Target</i>	72% (FY 2013)	Nov 30, 2014
	2008	N/A	70% (Baseline)
32.I.A.1: Total number of individuals screened per year. (Output)	2013	1,450	Nov 30, 2014
	2012	1,400	Nov 30, 2013
	2011	1,400	Nov 30, 2012
	2010	1,400	1,371 (Target Not Met)
	2009	1,800	1,373 (Target Not Met)
	2008	1,700	1,270 (Target Not Met)

Efficiency Measure	FY	Target	Result
32.E: Average cost of the program per individual screened. (Efficiency)	2013	\$1,397	Dec 31, 2014
	2012	\$1,397	Dec 31, 2013
	2011	\$923	Dec 31, 2012
	2010	\$720	\$1,251 (Target Not Met)
	2009	\$760	\$1,249 (Target Not Met)
	2008	\$810	\$1,195 (Target Not Met)

Measure	Data Source	Data Validation
32.1 32.2	Department of Justice (DOJ)	Validated by DOJ.
32.I.A.1 32.E	Annual grantee data reports	Verified by project officers.

BLACK LUNG CLINICS

INTRODUCTION

The Black Lung Clinics program was established in 1980 and provides funds through grants to public and private entities, including faith-based and community-based organizations, for the purpose of establishing and operating clinics that provide for the outreach and education, diagnosis, treatment, rehabilitation, and benefits counseling of active and retired coal miners and others with occupation-related respiratory and pulmonary impairments.

Many miners suffering from Black Lung 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. As persons with respiratory and pulmonary disease age, their disease severity progresses and their need for health care services increases along with the cost of those services. The Program annually examines performance data 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 to improve access to quality health care and services by strengthening health systems to support the delivery of quality health services to care and expanding the capacity of the health care safety net.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health care services.

Measure	FY	Target	Result
33.1: Percent of miners that show functional improvement following completion of a pulmonary rehabilitation program. ³ (Outcome)	<i>Out-Year Target</i>	85% (FY 2014)	August 31, 2015
	2008	N/A	80% (Baseline)
33.I.A.1: Number of miners served each year. (Baseline – FY 2005: 10,790) (Output)	2013	12,688	Aug 31, 2014
	2012	12,836	Aug 31, 2013
	2011	12,626 ⁴	Aug 31, 2012
	2010	12,088	10,554 (Target Not Met)
	2009	11,575	12,436 (Target Exceeded)
	2008	11,550	11,888 (Target Exceeded)

³ This long-term outcome measure does not have annual targets.

⁴ This target differs from that shown in the FY 2011 Congressional Budget Justification to align it with the most recent performance.

Measure	FY	Target	Result
33.I.A.2: Number of medical encounters from Black Lung each year. (Baseline – FY 2005: 20,844) (Output)	2013	27,403	Aug 31, 2014
	2012	26,403	Aug 31, 2013
	2011	25,403	Aug 31, 2012
	2010	24,403	23,109 (Target Not Met)
	2009	22,525	21,727 (Target Not Met)
	2008	21,269	23,403 (Target Exceeded)
Efficiency Measure	FY	Target	Result
33.E: Increase the number of medical encounters per \$1 million in federal funding. (Baseline – FY 2005: 3,503) (Efficiency)	2013	4,372	Aug 31, 2014
	2012	4,272	Aug 31, 2013
	2011	4,172	Aug 31, 2012
	2010	4,072	3,687 (Target Not Met)
	2009	3,862	3,798 (Target Not Met)
	2008	3,630	3,972 (Target Exceeded)

Measure	Data Source	Data Validation
33.1 33.I.A.1 33.I.A.2 33.E	Annual Grantee Report	Verified by project officers.

TELEHEALTH

INTRODUCTION

The Office for the Advancement of Telehealth (OAT) administers three grant programs that support telehealth technologies: Telehealth Network Grant Program (TNGP), Telehealth Resource Center Grant Program (TRCGP), and Licensure Portability Grant Program (LCGP). The Telehealth Programs strengthen partnerships among rural health care providers, recruit and retain rural health care professionals, and modernize the health care infrastructure in rural areas.

The Telehealth Network Grant Program (TNGP) funds projects that demonstrate the use of telehealth networks to improve healthcare services for medically underserved populations in urban, rural, and frontier communities. More specifically, the networks can be used to: (a) expand access to, coordinate, and improve the quality of health care services, (b) improve and expand the training of health care providers, and/or (c) expand and improve the quality of health information available to health care providers, patients, and their families. The primary objective of the TNGP is to help communities build the human, technical, and financial capacity to develop sustainable telehealth programs and networks. Within the TNGP Program, is the provision to support Telehomecare projects that focus on demonstrating how telehealth networks can improve healthcare through provision of clinical care and remote monitoring of patients in their place of residence using telehealth technologies. These projects provide a mechanism to evaluate the cost-effectiveness of telehomecare services and may include, but are not limited to, case management by physicians, hospitals, medical clinics, home health agencies, or other health care providers who supervise the care of patients in their homes.

The TNGP tracks progress in achieving its objectives to improve access to quality health care services, particularly to rural and other underserved populations, and to implement 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.

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health care services.

Measure	FY	Target	Result
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%). (Outcome)	<i>Out-Year Target</i>	21% (FY 2013)	Mar 31, 2015
	2013	21% ¹	Mar 31, 2015
	2012	20% ⁵	Mar 31, 2014
	2011	42%	Mar 31, 2013
	2010	21%	Mar 31, 2012
	2009	14.5%	44% (Target Exceeded)
	2008	30%	41% (Target Exceeded)
34.1: Percent of TNGP grantees that continue to offer services after the TNGP funding has ended. ⁶ (Baseline – FY 2005: 100%) (Outcome)	<i>Out-Year Target</i>	95% (FY 2013)	Mar 31, 2015
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. ⁷ (Baseline - FY 2005: 489) (Outcome)	2013	2,565	Mar 31, 2015
	2012	2,556	Mar 31, 2014
	2011	2,537	Mar 31, 2013
	2010	2,456	Mar 31, 2012
	2009	1,371	2,350 (Target Exceeded)
	2008	968	1,295 (Target Exceeded)

⁵ FY 2012 represents a new cohort of patients. It is estimated that in the new cohort 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 100% increase to 20% achieving ideal control.

⁶ This long-term measure does not have annual targets.

⁷ The targets for this measure are cumulative, building on the 489 sites and services achieved through the 2003-2006 cohort.

This cycle began again in FY 2009 with a new cohort, building on the 1295 sites and services achieved through 2003-2009 cohort. Please note that the targets were exceeded for FY 2008. The 2011 and 2012 targets have been increased, given the most recent data (2008) and the significant increase in congressional funding of the TNGP program in 2010. Although we have exceeded our targets to date, current 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.

Measure	FY	Target	Result
34.III.D.1: Increase the number of communities that have access to pediatric and adolescent mental health services where access did not exist in the community prior to the TNGP grant. ⁸ (<i>Outcome</i>)	<i>Out-Year Target</i>	300 (FY 2013)	Mar 31, 2015
	2013	239	Mar 31, 2015
	2012	223	Mar 31, 2014
	2011	219	Mar 31, 2013
	2010	219	Mar 31, 2012
	2009	207	323 (Target Exceeded)
	2008	160	162 (Target Exceeded)
34.III.D.1.1: Increase the number of communities that have access to adult mental health services where access did not exist in the community prior to the TNGP grant. ⁴ (<i>Outcome</i>)	<i>Out-Year Target</i>	195 (FY 2013)	Mar 31, 2015
	2013	202	Mar 31, 2015
	2012	188	Mar 31, 2014
	2011	186	Mar 31, 2013
	2010	186	Mar 31, 2012
	2009	175	322 (Target Exceeded)
	2008	134	158 (Target Exceeded)
Efficiency Measure	FY	Target	Result
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. ⁹ (<i>Efficiency</i>)	2013	203 per Million \$	Mar 31, 2015
	2012	202 per Million \$	Mar 31, 2014
	2011	199 per Million \$	Mar 31, 2013
	2010	186 per Million \$	Mar 31, 2012
	2009	106 per Million \$	250 per Million \$ (Target Exceeded)
	2008	121 per Million \$	218 per Million \$ (Target Exceeded)

⁸ 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. However, with each new cohort, the distribution of these services is uncertain. Therefore, the targets for FY2012 may need to be revised if there is evidence of a significant increase in grantees that are providing mental health services.

⁹ 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 with a new three-year cycle of grant supported activities, gradually expanding sites and services per dollar invested. With each new cohort, there is a start-up period where services are being put in place but are not yet implemented.

Measure	Data Source	Data Validation
34.II.A.1 34.III.D.2 34.III.D.1 34.III.D.1.1 34.E	Annual grantee profiles, Quarterly technical progress reports from grantees	Program staff validate data through reviews of grantee submissions, discussions with grantees, and site visits when applicable.
34.1	Grantee survey	Validated by program staff.

HEALTH EDUCATION AND ASSISTANCE LOANS (HEAL)

The program included in this section is:

- Health Education and Assistance Loans (HEAL)

HEALTH EDUCATION AND ASSISTANCE LOANS

INTRODUCTION

The Health Education Assistance Loan (HEAL) Program guaranteed \$4 billion in loans made by private lenders to 157,000 students of diverse socio-economic backgrounds to pay for their health professions education. Authority to make new loans expired September 30, 1998 and refinancing ended September 30, 2004. The HEAL Program is currently phasing out an outstanding loan portfolio of approximately \$609 million as of September 30, 2011. The functions, assets, and liabilities relating to this program are proposed be transferred to the Department of Education by the end of FY 2013.

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 included 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.

Goal: Strengthen the Health Workforce

Sub-goal: Assure a diverse health workforce

Measure	FY	Target	Result
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 millions). (Outcome)	2013	\$527	Dec 31, 2013
	2012	\$567	Dec 31, 2012
	2011	\$682	\$609 (Target Exceeded)
	2010	\$765	\$730 (Target Exceeded)
	2009	\$866	\$853 (Target Exceeded)
	2008	\$997	\$980 (Target Exceeded)
	2007	\$1,090	\$1,131 (Target Not Met but Improved)

Efficiency Measure	FY	Target	Result
9.E: Improve claims processing efficiency through implementation of an online processing system (HOPS). (Avg. number of days to process claims) (<i>Efficiency</i>)	2013	8 days	Dec 31, 2013
	2012	8 days	Dec 31, 2012
	2011	8 days	5 days (Target Exceeded)
	2010	8 days	2 days (Target Exceeded)
	2009	8 days	6 days (Target Exceeded)
	2008	8 days	11 days (Target Not Met)
	2007	8 days	8 days (Target Met)

Measure	Data Source	Data Validation
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.

HEALTHY WEIGHT PROGRAM

The program included in this section is:

- Healthy Weight Collaborative Prevention Fund

HEALTHY WEIGHT COLLABORATIVE PREVENTION FUND

INTRODUCTION

The Healthy Weight Collaborative’s mission is to discover, develop, and disseminate both evidence-based and promising clinical and community-based interventions to prevent and treat obesity. The Collaborative transfers knowledge, skills, and practical approaches to quality management. The Prevention Center for Healthy Weight will recruit, support, and provide technical assistance to community teams participating in the Healthy Weight Collaborative. These teams will be asked to implement and evaluate interventions at the community level. The specific interventions and evaluation strategies are defined by the Prevention Center for Healthy Weight.

Goal: Build Healthy Communities

Sub-Goal: Strengthen the focus on illness prevention and health promotion across populations and communities.

Measure	FY	Target	Result
38.I: Number of collaborative teams recruited	2013	NA ¹	NA ¹
	2012	50 ²	50 ²
	2011	10	10 (Target Met)
38.II: Number of clinical and community-based interventions disseminated	2013	NA	NA
	2012	NA ³	Oct. 1, 2012
	2011	NA ³	6

Measure	Data Source	Data Validation
38.I 38.II	Prevention Center for Healthy Weight	Validated by Project Officer using consistency checks and other methods

¹ Not applicable as the program ends in 2013.

² This is a cumulative number.

³ Predetermined targets are not appropriate for this measure as the number of interventions disseminated are determined through a process involving expert faculty.

PROGRAM MANAGEMENT

The program included in this section is:

- Program Management

PROGRAM MANAGEMENT

INTRODUCTION

These performance measures link to HRSA’s Strategic Plan principle to strengthen the organizational infrastructure, and excel as a high performing organization.

Measure	FY	Target	Result
35.VII.B.1: Ensure Critical Infrastructure Protection Security Awareness Training <i>(Output)</i>	2013	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 in Executive Awareness training by 100% of HRSA executive staff.	Dec 31, 2013
	2012	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 in Executive Awareness training by 100% of HRSA executive staff.	Dec 31, 2012
	2011	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 in Executive Awareness training by 100% of HRSA executive staff.	100% completion rate in all areas of Security Awareness and Training. (Target Met)
	2010	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 in Executive Awareness training by 100% of HRSA executive staff.	100% completion rate in all areas of Security Awareness and Training. (Target Met)
	2009	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. (Target Met)

	2008	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. (Target Met)
<u>35.VII.B.2:</u> Ensure Critical Infrastructure Protection. Security Authorization to Operate <i>(Output)</i>	2013	100% of HRSA information systems will be assessed and authorized to operate. (ATO)	Nov 30, 2013
	2012	All HRSA new systems will be assessed and authorized to operate prior to going into production. All existing systems that are due for reauthorization will be reassessed and reauthorized to operate.	Nov 30, 2012
	2011	100% of HRSA information systems have been Certified and Accredited and granted Authority to Operate. (ATO)	100% of HRSA's information systems have been Certified & Accredited and granted Authority to Operate. (ATO) (Target Met)
	2010	100% of HRSA information systems have been Certified and Accredited and granted Authority to Operate. (ATO)	100% of HRSA's information systems have been Certified & Accredited and granted Authority to Operate. (ATO) (Target Met)
	2009	N/A	N/A
<u>35.VII.B.3:</u> Capital Planning and Investment Control <i>(Output)</i>	2013	1) 100% of major investments will receive an IT Dashboard Overall Rating of "Green", which indicates an acceptable cost, schedule and Agency CIO Rating; 2) 100% of major Investment Managers will be in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM).	Nov 30, 2013
	2012	1) 100% of major investments will receive an IT Dashboard Overall Rating of "Green", which indicates an acceptable cost, schedule and Agency CIO Rating; 2) 100% of major Investment Managers will be in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM).	Nov 30, 2012

	2011	1)100% of major/tactical IT investments with acceptable business cases, 2) 0% of major/tactical investments on the Management Watch List (MWL)/High Variance List, 3) 50% of all DME projects from major/tactical investments executed in alignment with EPLC, 4) All IT Project managers are trained in EPLC framework and the use of the selected PPM tool.	1)100% of major/tactical IT investments with acceptable business cases, 2) 0% of major/tactical investments on the Management Watch List (MWL)/High Variance List, 3) 50% of all DME projects from major/tactical investments executed in alignment with EPLC, 4) All IT Project managers are trained in EPLC framework and the use of the selected PPM tool. (Target Met)
	2010	100% of major IT investments with acceptable business cases.	100% of major IT investments with acceptable business cases. (Target Met)
	2009	N/A	N/A
35.VII.A.3: Strengthen Program Integrity (PI) Activities	2013	1) Maintain regional PI staffing at one per region. 2) Implement Phase 2 of the online PI toolkit through the addition of program specific guidance, information, and reference tools.	Dec 30, 2013
	2012	1) Add 4 PI staff to result in one per region 2) Implement Phase 1 of the online PI toolkit through the addition of program specific guidance, information, and reference tools.	Dec 30, 2012
	2011	N/A	1) Six additional PI staff added to regions and three added to HQ to increase auditing/site visit capability. 2) HRSA PI Workgroup initiated development of online PI toolkit to provide standardized PI information and reference tools. (Target Not In Place)
	2010	20	0 (Target Not Met)
	2009	N/A	N/A
	2008	30	50 (Target Exceeded)

Measure	Data Source	Data Validation
35.VII.B.1	Chief Information System Security Officer, Federal Information Security Management Audit (FISMA) Reports which include Office of Inspector General (OIG) audit results, training logs, HHS ProSight Tool.	A database is maintained that is validated through FISMA reporting and the HHS Sport tool.
35.VII.B.2	Chief Information System Security Officer, FISMA Reports which include OIG audit results, training logs, HHS ProSight Tool	Authority to Operate (ATO) Letters have been issued by the CIO for all systems that are Certified and Accredited. This is validated through the HHS ProSight tool.
35.VII.B.3	ProSight Portfolio Management Tool is the system of record for Business Case information for HRSA information.	The CPIC office verifies the status of business case measures in the Portfolio Management Tool (ProSight)
35.VII.A.3		

FAMILY PLANNING

Programs included in this section are:

- Family Planning

FAMILY PLANNING

INTRODUCTION

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

The Program currently has five performance measures that focus on increasing access and serving individuals and families from underserved, vulnerable and low-income populations. Three measures gauge the extent to which the Program expands the availability of healthcare to the public and two measure the extent to which preventive healthcare and chronic disease management services are utilized. Each of the performance measures and the efficiency measure guide Program strategies, establish directions for technical assistance, and direct revisions to program policies. This enables the Program to better address program performance and facilitates 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 affects the number of clients that clinics are able to serve. The Program addresses this issue primarily using the strategy of employing focused training efforts. This includes providing targeted funding for a national training priority that addresses clinic efficiency, quality assurance, staffing pattern strategies and other areas related to improved clinic management, cost reduction and resource allocation. In FY 2010, national training priority funding was focused on assessing and evaluating these efforts and the impact on Title X family planning service delivery. The ultimate outcome of these strategies is to increase the number of unduplicated clients and to attain or exceed each of the targets identified for all of the performance measures. Though the final analyses of the evaluations have not been completed, it appears that these targeted training strategies have contributed to maintaining the number of clients and decreasing the cost per client by increasing clinic efficiency.

In addition, the Program is continuing to implement recommendations that emerged from the independent evaluation completed by the Institute of Medicine (IOM) in August 2009. Currently the Program has a contract with IOM for a Standing Committee to assist the Title X Program in developing a strategic plan and conducting additional studies related to strengthening the infrastructure and long-term goals of the Title X family planning program.

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

Measure	FY	Target	Result
36.II.A.1: Increase the total number of unduplicated clients served in Title X clinics by 5% over five years. (Outcome)	<i>Out-Year Target</i>	5,016,000 (FY 2014)	Oct 31, 2015
	2013	4,996,600	Oct 31, 2014
	2012	4,969,600	Oct 31, 2013
	2011	5,049,000	Oct 31, 2012
	2010	5,223,000	5,224,862 (Target Exceeded)
	2009	4,980,000	5,186,267 (Target Exceeded)
	2008	5,000,000	5,051,505 (Target Exceeded)
Measure	FY	Target	Result
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. (Outcome)	<i>Out-Year Target</i>	90% (FY 2014)	Oct 31, 2015
	2013	90%	Oct 31, 2014
	2012	90%	Oct 31, 2013
	2011	90%	Oct 31, 2012
	2010	90%	90% (Target Met)
	2009	90%	91% (Target Exceeded)
	2008	90%	91% (Target Exceeded)
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. (Outcome)	<i>Out-Year Target</i>	965,000 (FY 2014)	Oct 31, 2015
	2013	961,300	Oct 31, 2014
	2012	949,300	Oct 31, 2013
	2011	969,700	Oct 31, 2012
	2010	1,024,000	995,861 (Target Not Met but Improved)
	2009	977,000	993,614 (Target Exceeded)
	2008	981,000	975,436 ⁴ (Target Not Met but Improved)

⁴ This result differs from that reported in the FY 2011 Congressional Justification (991,273) because of the correction of a calculation error.

Long Term Objective: Reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15 – 24.

Measure	FY	Target	Result
<u>36.II.B.1:</u> Reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15-24. (Outcome)	<i>Out-Year Target</i>	1,345,000 (FY 2014)	Oct 31, 2015
	2013	1,396,300	Oct 31, 2014
	2012	1,340,300	Oct 31, 2013
	2011	1,324,000	Oct 31, 2012
	2010	1,413,000	1,417,219 (Target Exceeded)
	2009	1,348,000	1,407,691 (Target Exceeded)
	2008	1,352,000	1,408,886 (Target Exceeded)

Long Term Objective: Reduce invasive cervical cancer among women attending Title X family planning clinics by providing Pap tests.

Measure	FY	Target	Result
<u>36.II.C.1:</u> Increase the number of unduplicated female clients who receive a Pap test. (Outcome)	<i>Out-Year Target</i>	1,577,000 (FY 2014)	Oct 31, 2015
	2013	1,571,400	Oct 31, 2014
	2012	1,654,900	Oct 31, 2013
	2011	1,866,000	Oct 31, 2012
	2010	2,478,000	1,727,251 (Target Not Met)
	2009	2,363,000	2,035,017 (Target Not Met)
	2008	2,372,000	2,088,218 (Target Not Met)
<u>36.II.C.2:</u> Reduce invasive cervical cancer among women attending Title X family planning clinics by providing Pap tests. (Outcome)	<i>Out-Year Target</i>	521 (FY 2014)	Oct 31, 2015
	2013	519	Oct 31, 2014
	2012	546	Oct 31, 2013
	2011	616	Oct 31, 2012
	2010	835	570 (Target Not Met)
	2009	797	672 (Target Not Met)
	2008	800	689 (Target Not Met)

Efficiency Measure	FY	Target	Result
36.E: Maintain the actual cost per Title X client below the medical care inflation rate. (Efficiency)	<i>Out-Year Target</i>	\$304.28 (FY 2014)	Oct 31, 2015
	2013	\$292.23	Oct 31, 2014
	2012	\$280.66	Oct 31, 2013
	2011	\$269.55	Oct 31, 2012
	2010	\$258.87	\$247.63 (Target Exceeded)
	2009	\$243.59	\$237.42 (Target Exceeded)
	2008	\$233.86	\$239.83 (Target Not Met)

Measure	Data Source	Data Validation
36.II.A.1 36.II.A.2 36.II.A.3	Family Planning Annual Report (FPAR). The FPAR consists of 14 tables in which grantees report data on user demographic characteristics, user social and economic characteristics, primary contraceptive use, utilization of family planning and related health services, utilization of health personnel, and the composition of project revenues. For these specific measures, FPAR table 1: "Unduplicated Number of Family Users by Age and Gender" and Table 4: "Unduplicated Number of Family Planning Users by Income Level" are the data source tables.	The responsibility for the collection and tabulation of annual service data from Title X grantees rests with the Office of Population Affairs (OPA), which is responsible for the administration of the program. Reports are submitted annually on a calendar year basis (January 1 - December 31) to the regional offices. Grantee reports are tabulated and an annual report is prepared summarizing the regional and national data. The annual report describes the methodology used both in collection and tabulation of grantee reports, as well as the definitions provided by OPA to the grantees for use in completing data requests. Also included in the report are lengthy notes that provide detailed information regarding any discrepancies between the OPA requested data and what individual grantees were able to provide. Data inconsistencies are first identified by the Regional Office and then submitted back to the grantee for correction. Additionally, discrepancies found by the contractor compiling the FPAR data are submitted to the Office of Family Planning (OFP) FPAR data coordinator who works with the Regional Offices to make corrections. All data inconsistencies and resolutions are noted in an appendix to the report. These are included for two reasons: (1) to explain how adjustments were made to the data, and how discrepancies affect the analysis, and (2) to identify the problems grantees have in collecting and reporting data, with the goal of improving the process.
36.II.B.1	For this measure, FPAR Table 11: "Unduplicated number of Users Tested for Chlamydia by Age and Gender" is the data source.	
36.II.C.1 36.II.C.2	For this measure, FPAR Table 9: "Cervical Cancer Screening Activities" is the data source.	
36.E	For this measure FPAR Table 14: "Revenue Report" is the data source.	