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FY 2012 Online Performance Appendix

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INTRODUCTION

The FY 2012 Online Performance Appendix is one of several documents that fulfill the Department of Health and Human Services' (HHS) performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 and Office of Management and Budget Circulars A-11 and A-136 through the HHS agencies' FY 2012 Congressional Justifications and Online Performance Appendices, the Agency Financial Report, and the HHS Summary of Performance and Financial Information. These documents are available at <http://www.hhs.gov/budget/>.

The FY 2012 Congressional Justifications and accompanying Online Performance Appendices contain the updated FY 2010 Annual Performance Report and FY 2012 Annual Performance Plan. The Agency Financial Report provides fiscal and high-level performance results. The HHS Summary of Performance and Financial Information summarizes key past and planned performance and financial information.

TRANSMITTAL LETTER

This Online Performance Appendix (OPA) is a supplement to the FY 2012 Performance Budget to the Office of Management and Budget. It includes performance measures for the agency, including measures discussed in the FY 2012 Performance Budget. The OPA indicates HRSA's 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. 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. To the best of my knowledge, the performance data reported in the OPA are complete and reliable, with no material inadequacies.

Mary K. Wakefield, Ph.D., R.N.
Administrator

PRIORITY GOAL

Primary Health Care – Field Strength of the National Health Service Corps

By the end of FY 2011, increase access to primary health care by increasing the Field Strength of the National Health Service Corps (NHSC) to 10,500 primary care providers.

NHSC Funding

(dollars in millions)

	FY 2010 Enacted	FY 2010 ARRA	FY 2011 CR	FY 2011 ARRA	FY 2012 Request
NHSC Field BA	\$40.941	\$22.500	\$41.128	\$15.000	\$24.695
NHSC Recruitment BA	\$100.479	\$90.000	\$100.797	\$60.000	\$98.782
Mandatory NHSC			\$290.000		\$295.000
Total	\$141.420	\$112.500	\$431.925	\$75.000	\$418.477

NHSC Performance

Field Strength by Fiscal Year by Funding Source

Funding Source	FY 2009 Result	FY 2010 Result	FY 2011 Target	FY 2012 Target
Base:				
Scholarship Obligors	582	523	505	389
Loan Repayers	2,597	3,201	3067	2,971
State Loan Repayment	763	581	285	-
USPHS Commissioned Corps Ready Responders	37	30	30	30
Base Field Strength (as of 9/30)	3,979	4,335	3,887	3,390
Recovery Act:				
Loan Repayers	829	3,032	3,171	1,000
State Loan Repayment	-	161	332	-
Scholar Obligors	-	2	4	30
Recovery Act Field Strength	829	3,195	3,507	1,030
Mandatory:				
Loan Repayers	-	-	2,821	5,693
State Loan Repayment	-	-	285	570
Mandatory Field Strength	-	-	3,106	6,263
Total Field Strength	4,808	7,530	10,500	10,683

Primary health care is a cornerstone to high-quality and cost-effective health care services. Yet primary care is not readily accessible to all Americans, as millions face barriers to quality primary health care. The NHSC plays a key role in the safety net for persons who would otherwise lack access to this essential level of care. It does so by aiding health professional shortage areas (HPSAs) in meeting their primary health care needs by providing recruitment and retention incentives in the form of scholarship and loan repayment support to health professionals committed to a career in primary care and service to underserved communities. HRSA tracks the program's performance by measuring the Field Strength of the NHSC on a quarterly basis.

HRSA has made significant progress in meeting NHSC Field Strength targets. The above table reflects the significant growth in recruiting qualified primary care clinicians, through the investments made by Congress through regular appropriations and the Recovery Act, from the FY 2008 Field Strength of 3,601 to a Field Strength in FY 2009 of 4,808 and a Field Strength of 7,530 in FY 2010. HRSA projects a tripling of the FY 2008 Field Strength by FY 2011 to 10,500 with the investment made in the NHSC through Recovery Act and Affordable Care Act funding. Further, HRSA projects increases in the Field Strength to continue through FY 2012, with an estimated Field Strength of 10,683, due to investments made through the Affordable Care Act. More information about HRSA's Priority Goal can be found at Performance.gov.

SUMMARY OF PERFORMANCE TARGETS AND RESULTS

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2007	143	135	94%	95	70%
2008	141	128	91%	99	77%
2009	137	101	74%	70	69%
2010	146	27	18%	22	81%
2011	151	N/A	N/A	N/A	N/A
2012	132	N/A	N/A	N/A	N/A

PERFORMANCE DETAILS (by ACTIVITY)

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

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>	29.2 million (FY 2014) ¹	Aug 31, 2015
	2012	24.4 million ¹	Aug 31, 2013
	2011	23.5 million ¹	Aug 31, 2012
	2010	20.15 million	Aug 31, 2011
	2009	18.95 million	18.8 million (Target Not Met, but Improved)
	2008	16.75 million	17.1 million (Target Exceeded)
	2007	16.1 million	16.1 million (Target Met)
<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)	2012	88%	Aug 31, 2013
	2011	88%	Aug 31, 2012
	2010	88%	Aug 31, 2011
	2009	82%	88% (Target Exceeded)
	2008	82%	88% (Target Exceeded)
	2007	82%	83% (Target Exceeded)
	<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 (Output)	2012	70%
2011		70% ²	Aug 31, 2012
2010		68%	Aug 31, 2011
2009		74%	70% (Target Not Met)
2008		74%	68% (Target Not Met)
2007		74%	80% (Target Exceeded)

¹ Target reflects impact of Affordable Care Act funding. The FY 2011 target differs from that in the FY 2011 Congressional Justification to reflect Affordable Care Act funding and current budget assumptions.

² Target differs from that in the FY 2011 Congressional Justification. Change was made to reflect most recent performance information.

Measure	FY	Target	Result
<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 (Outcome)	<i>Out-Year Target</i>	5% below national rate (FY 2014)	Apr 30, 2016
	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	Apr 30, 2011
	2008	11% below national rate	7.3% below the national rate (Target Not Met)
	2007	11% below national rate	4.9% below 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) (Outcome)	<i>Out-Year Target</i>	63% (FY 2014)	Aug 31, 2015
	2012	60%	Aug 31, 2013
	2011	60% ²	Aug 31, 2012
	2010	50%	Aug 31, 2011
	2009	43%	63% (Target Exceeded)
	2008	42.9%	62% (Target Exceeded)
	2007	42.8%	N/A ³
<u>1.II.B.4.:</u> 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%) (Outcome)	<i>Out-Year Target</i>	71% (FY 2014)	Aug 31, 2015
	2012	71%	Aug 31, 2013
	2011	71% ²	Aug 31, 2012
	2010	73%	Aug 31, 2011
	2009	N/A	71% (Target Not in Place)
	2008	N/A	73% (Baseline)

² Target differs from that in the FY 2011 Congressional Justification. Change was made to reflect most recent performance information.

³ Data not available for 1.II.B.3 for 2007 due to changes in data source for this measure. Beginning in 2008, the data source is the Uniform Data System.

Measure	FY	Target	Result
<u>1.II.B.1</u> : Percentage of pregnant Health Center patients beginning prenatal care in the first trimester (Output)	2012	64.3%	Aug 31, 2013
	2011	61.3%	Aug 31, 2012
	2010	61.3%	Aug 31, 2011
	2009	61.6%	67.3% (Target Exceeded)
	2008	61.5%	61.3% (Target Virtually Met)
	2007	61.9%	61.3% (Target Not Met)
<u>1.II.A.1</u> : Percentage of Health Center patients who are at or below 200% of poverty (Output)	2012	91%	Aug 31, 2013
	2011	91%	Aug 31, 2012
	2010	91%	Aug 31, 2011
	2009	86%	92.5% (Target Exceeded)
	2008	86%	91.7% (Target Exceeded)
	2007	86%	91.4% (Target Exceeded)
<u>1.II.A.2</u> : Percentage of Health Center patients who are racial/ethnic minorities (Output)	2012	63%	Aug 31, 2013
	2011	63%	Aug 31, 2012
	2010	N/A ⁴	Aug 31, 2011
	2009	N/A ⁴	63% (New Baseline)
	2008	64%	D/N/A ⁴
	2007	64%	D/N/A ⁴
<u>1.II.A.3</u> : Percentage of Health Center patients who are uninsured (Output)	2012	38%	Aug 31, 2013
	2011	38%	Aug 31, 2012
	2010	38%	Aug 31, 2011
	2009	41%	38% (Target Not Met)
	2008	41%	38% (Target Not Met)
	2007	41%	39% (Target Not Met)

⁴ 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.

Measure	FY	Target	Result
1.E: Percentage increase in cost per patient served at Health Centers compared to the national rate (Efficiency)	2012	20% below national rate ⁵	Jan 31, 2014
	2011	20% below national rate ⁵	Jan 31, 2013
	2010	20% below national rate ⁵	Jan 31, 2012
	2009	5.8%	2% (Target Exceeded)
	2008	5.6%	4.6% (Target Exceeded)
	2007	5.3%	4.5% (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.

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 assistance; 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

⁵ 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.

emphasizes prevention, health-related enabling services, outreach, follow-up, and culturally competent services.

The Affordable Care Act:

The Affordable Care Act authorized and appropriated \$11 billion over five years to establish a Community Health Center Fund to provide for expanded and sustained national investment in health centers under section 330 of the Public Health Service Act. \$1.5 billion will support major construction and renovation projects at community health centers nationwide. \$9.5 billion will support the establishment of new health center sites in medically underserved areas and expand preventive and primary health care services at health center sites.

DISCUSSION OF RESULTS AND TARGETS

Goal: Increase Access to Quality Health Care and Services

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

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

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

The number of patients served by Health Centers reached 16.1 million in FY 2007, 17.1 million in FY 2008. The 18.8 million patients served by Health Centers in FY 2009 are 1.7 million patients over the FY 2008 level. Health Centers are projected to serve 23.5 million patients in FY 2011 and 24.4 million patients in FY 2012. The projections for FY 2011 and FY 2012 reflect the impact of the Affordable Care Act funding.

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

Access to oral health and mental health/substance abuse (MH/SA) services is critical to ensuring overall health and well-being of Health Center populations. Lack of access to oral health care services is the primary reason for significant disparities in oral health status among vulnerable populations. MH/SA disorders, such as depression and abuse of alcohol are prevalent among underserved populations, and treatment is not accessible in many local communities.

For 2007, 83% of health center grantees reported that they provided dental care services either on-site or by paid referral. For mental health/substance abuse services, that figure was 80%. Of the grantees reporting in 2008, 88% provided preventive dental care and 68% provided mental health/substance abuse services either on-site or by paid referral. For FY 2009, health centers reported 88% for dental services, exceeding the target, and 70% for mental health/substance abuse services. The FY 2011 and FY 2012 targets are: 88% for dental services and 70% for mental health services. The FY 2011 mental health services target was reduced to reflect the most recent data reported for FY 2008 and FY 2009. In FY 2011, the Program proposes to add qualified behavioral health counselors and other addiction specialists to enhance substance abuse care in health centers. HRSA will collaborate with the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration. HRSA will train health counselors and other addiction specialists on performing Screening, Brief Intervention and Referral to Treatment (SBIRT).

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

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

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

In 2007, 7.8% of Health Center patients had low birth weight infants, a rate that was 4.9% lower than seen nationally, which did not meet the target of 11% below the national rate. In 2008, 7.6% of Health Center patients had low birth weight infants, which was 7.3% below the national rate (8.2%). The FY 2010, FY 2011, and FY 2012 targets are to achieve a rate of 5% below the national rate.

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

- Technical assistance to Health Centers on the delivery of quality health care through State Primary Care Associations.

- Outreach to patients to encourage timely entry into prenatal care, and patient education on healthy behaviors that can impact birth weight.
- Information to clinicians to help them in the identification of maternal disease and risks for complications of pregnancy or birth during the first trimester.

The Program will continue its effort to remain below the national LBW rate, while serving a higher-risk prenatal population than seen nationally.

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

Health Center patients, including low-income individuals, racial/ethnic minority groups and persons who are uninsured, are more likely to suffer from chronic diseases such as hypertension and diabetes. Clinical evidence indicates that access to appropriate care can improve the health status of patients with chronic diseases and thus reduce or eliminate disparities.

This measure focuses on quality of care and improved health outcomes for one of the most prevalent chronic conditions facing Health Center patients, hypertension. Clinical evidence indicates that controlling blood pressure (hypertension) can reduce the health risk associated with the conditions such as heart disease and stroke.

In 2008, 62% of hypertensive Health Center patients had their blood pressure under control exceeding the target of 42.9%. In 2009, the result for health centers was 63%, exceeding the target of 43%. The Program proposes to demonstrate improvements in a chronic condition that requires treatment with both lifestyle modifications, usually as the first step, and, if needed, with medications. Lifestyle factors to treat high blood pressure include weight control, exercise, healthy diet, limiting alcohol use, and other lifestyle modifications that are often challenging interventions that improve only slowly over time. The projected target is 50% for FY 2010 and 60% for FY 2011 and FY 2012.

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

This measure also focuses on quality of care and improved health outcomes for one of the most prevalent chronic conditions facing Health Center patients, diabetes.

Uncontrolled diabetes can lead to non-traumatic amputations, blindness, end-stage renal disease, and hospitalizations for diabetes-associated cardiovascular disease. These and other health problems associated with diabetes contribute to an impaired quality of life, substantial disability among people with diabetes, and increased national health care costs.

Clinical evidence indicates that controlling blood glucose through such activities as chronic care management provided in Health Centers benefits people with either type 1 or type 2 diabetes. In general, for every 1% reduction in results of HbA1c blood tests (e.g., from 8% to 7%), the risk of developing eye, kidney, and nerve disease is reduced by 40% (Centers for Disease Control and Prevention, National Diabetes Fact Sheet 2004). In 2008, the percentage of adult Health Center

patients with type 1 or 2 diabetes with their most recent HbA1c under control was 73%. In 2009, the result was 71%. The targets for FY 2011 and FY 2012 have been set to maintain the level of 71%.

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

Monitoring timely entry into prenatal care assesses both quality of care as well as Health Center outreach efforts and focuses on a process that is associated with improving birth outcomes. Identification of maternal disease and risks for complications of pregnancy or birth during the first trimester can help reduce the risk of low birth weight. Results over the past few years demonstrate improved performance as the percentage of pregnant Health Center patients that began prenatal care in the first trimester grew from 57.8% in 2000 to 61.3% in 2007, slightly less than the target of 61.9%. For 2008, the result was 61.3%, slightly below the projected target of 61.5%. For 2009, the result was 67.3%, exceeding the target of 61.6%. The Health Center Program targets the percentage of pregnant patients beginning prenatal care in the first trimester at 61.3% in FY 2010 and FY 2011 and 64.3% in FY 2012.

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

To improve the health status of the Nation's underserved communities and vulnerable populations, safety-net programs must target access to care for people of low income. According to 2007 UDS Health Center data, nearly 91.4% of patients were at or below 200% of the Federal Poverty Level. In 2008, 91.7% of patients were at or below 200% of the Federal Poverty Level, exceeding the target of 86%. In 2009, the result was 92.5% of patients, exceeding the target of 86%. The FY 2010, FY 2011 and FY 2012 target is 91%.

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

To improve the health status of the Nation's underserved communities and vulnerable populations, safety-net programs must target access to care for people of racial/ethnic minority groups. Due to modifications in data collection for this measure, FY 2009 was a new baseline year. Health centers reported that 63% of patients served were racial/ethnic minorities. The FY 2011 and FY 2012 target is 63%.

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

To improve the health status of the Nation's underserved communities and vulnerable populations, safety-net programs must also target access to care for people who are uninsured. According to UDS Health Center data, in 2007, the Health Center population served included 6.24 million uninsured individuals, which was about 39% of the client population—just slightly below the target. In 2008, 38% of the patient population was uninsured, slightly below the target of 41%. In FY 2009 the figure was 38%. The target for FY 2010, FY 2011 and FY 2012 is 38%.

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

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

In 2007, Health Center costs grew at a rate of 4.5%, which surpassed the Program goal of keeping the cost growth rate at or under 5.3%. In 2008, costs grew 4.6%, which exceeded the target growth rate compared to national health expenditures. In 2009, costs grew at a rate of 2%, which exceeded the target of keeping the cost growth rate at or under 5.8%.

The target for FY 2010, FY 2011 and FY 2012 is to keep the Program cost growth rate at or better than 20% below the actual growth rate for national health expenditures. By restraining increases in the cost per individual served at Health Centers below national per capita health care cost increases, the Health Center Program serves a volume of patients that otherwise would have required additional funding to serve, and demonstrates that it delivers its high quality services at a more cost-effective rate. Given recent performance of the Program, annual targets in growth are set at 20% below forecasted national rates. Successful restraint of the cost per individual served at Health Centers below national per capita health care cost increases may, in part, be related to the Health Centers’ strategic use of a multi- and interdisciplinary team model of care that treats the “whole patient,” with a focus on continuity of primary care and enabling services.

DISCONTINUED MEASURE

Measure	FY	Target	Result
1.I.A.2.a: Percentage of grantees that provide the following services either on-site or by paid referral: Pharmacy (Output)	2012	N/A	N/A
	2011	85%	Aug 31, 2012
	2010	85%	Aug 31, 2011
	2009	83%	85% (Target Exceeded)
	2008	83%	85% (Target Exceeded)
	2007	83%	82% (Target Not Met)

Measure	Data Source	Data Validation
1.I.A.2.a	HRSA Electronic Handbooks (EHB)	Data are edited and validated by program staff.

1.I.A.2.a Percentage of grantees that provide the following services either on-site or by paid referral:

For 2007, 82% of health center grantees reported that they provided pharmacy services either on-site or by paid referral, virtually meeting the target of 83%. Of the grantees reporting in 2008, 85% provided pharmacy services, and in 2009 that figure remained at 85%. The FY 2011 target remains at 85% for pharmacy services.

As the program advances in its future expansion activities, it is estimated that this measure will become less relevant in measuring program performance and success. Therefore, this measure is proposed for retirement in FY 2012, and the last year for which data will be reported is FY 2011.

FREE CLINICS MEDICAL MALPRACTICE

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
<u>2.I.A.1</u> : Number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage <i>(Outcome)</i>	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)
	2007	1,950	2,420 (Target Exceeded)
<u>2.1</u> : 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
	2012	350,000	May 31, 2013
	2011	320,000	May 31, 2012
	2010	N/A	May 31, 2011
	2009	N/A	282,958 (Baseline)
<u>2.I.A.2</u> : Number of free clinics operating with FTCA-deemed volunteer clinicians <i>(Output)</i>	<i>Out-Year Target</i>	165 (FY 2013)	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)
	2007	70	80 (Target Exceeded)

Measure	FY	Target	Result
2.I.A.3: Percent of volunteer FTCA-deemed clinicians who meet certification and privileging requirements (Output)	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)
	2007	100%	100% (Target Met)
Efficiency Measure	FY	Target	Result
2.E: Administrative costs of the program per Federal Tort Claims Act (FTCA)-covered volunteer (Efficiency)	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)
	2007	\$204	\$164 (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.

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 data include the locations of Free Clinics that have applied for Federal Tort Claims Act-deemed volunteer clinicians. The key strategy used to meet performance targets is to determine areas with few for no applications and then target these areas for outreach about the program.

DISCUSSION OF RESULTS AND TARGETS

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.

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

This measure examines program participation by volunteer health professionals, which continues to increase. In FY 2008, FY 2009, and FY 2010, the program exceeded its targets by deeming 3,006, 3,754, and 4,800 volunteer providers, respectively. The program aims to deem 4,800 in FY 2012.

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

This measure tracks the volume of visits performed by volunteer clinicians at free clinics that choose to sponsor these health professionals for FTCA coverage as an indicator of increased patient capacity. The program has revised its application materials to collect these data from free clinic applicants, and the result for FY 2009 is 282,958 patients. Based on this baseline data, the targets established for FY 2011 and FY 2012 are 320,000 and 350,000, respectively.

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

This measure demonstrates the extent to which free clinics are participating in the program. In FY 2005, the first year that the program began deeming providers, 38 free clinics were operating with FTCA-deemed volunteer clinicians. In FY 2008, FY 2009 and FY 2010, performance exceeded the targets, with 93, 121, and 132 clinics operating with FTCA-deemed volunteers respectively. The FY 2011 target is 145 clinics, and the FY 2012 target is 155.

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

This indicator reflects the quality of services provided by the deemed health professionals volunteering at participating free clinics as measured by the percentage meeting licensing and certification requirements. Performance continues to meet the target with 100% of FTCA-deemed clinicians meeting appropriate requirements. The FY 2011 and FY 2012 target is 100%.

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

By restraining the annual Federal administrative costs necessary to deem each provider, the program will be able to provide an increasing number of clinicians with malpractice coverage, thus building the free clinic workforce capacity nationwide and increasing access to care for the

vulnerable populations served by these clinics. In 2005, the first year that program began deeming providers, the cost per provider deemed was \$221.

The FY 2008 program cost per provider was \$153, and in FY 2009 and FY 2010 the resulting figures were \$154 and \$115, respectively. All three years show targets being surpassed, and exhibit steady efficiency. The target in FY 2011 and 2012 is \$155.

NATIONAL HANSEN'S DISEASE PROGRAM

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 (Output)	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)
	2007	40	135 (Target Exceeded)
3.II.A.3: Number of patients provided Hansen's Disease outpatient care through the National Hansen's Disease Program (Output)	2012	3,000	Mar 31, 2013
	2011	3,000	Mar 31, 2012
	2010	3,000	Mar 31, 2011
	2009	3,000	2,963 (Target Virtually Met)
	2008	3,000	2,888 (Target Not Met)
	2007	3,000	3,000 (Target Met)
3.III.A.1: Develop an animal model for the full spectrum of clinical complexities of human Hansen's Disease (Output)	<i>Out-Year Target</i>	Produce relevant animal model for human leprosy (FY 2013)	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. ¹	Mar 31, 2012
	2010	Demonstrate defective nerve function in infected armadillos	Mar 31, 2011
	2009	BRM 4, CM 4	BRM 4, CM 4 (Target Met)
	2008	BRM 3, CM 2,3	BRM 3, CM 2,3 (Target Met)
	2007	BRM 2, CM 1	BRM 2, CM 1 (Target Met)

¹ This target is different from that shown in the FY 2011 Congressional Justification due to the pace of advances made in this research endeavor.

Measure	FY	Target	Result
3.II.A.1: 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) (Outcome)	<i>Out-Year Target</i>	50% (FY 2013)	Nov 30, 2015
	2012	50%	Nov 30, 2014
	2011	50%	Nov 30, 2013
	2010	50%	Nov 30, 2012
	2009	50%	Nov 30, 2011
	2008	50%	45% (Target Exceeded)
	2007	50%	47% (Target Exceeded)
Efficiency Measure	FY	Target	Result
3.E: Maintain increases in the cost per patient served in the outpatient clinics to below the medical inflation rate (Efficiency)	2012	Below national medical inflation rate	Mar 31, 2013
	2011	Below national medical inflation rate	Mar 31, 2012
	2010	Below national medical inflation rate	Mar 31, 2011
	2009	\$1,676	\$1,088 (Target Exceeded)
	2008	\$1,676	\$1,244 (Target Exceeded)
	2007	\$1,599	\$1,277 (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.

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.

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Access to Quality Health Care and Services

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

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

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

In FY 2007, the NHDP exceeded its program performance target of 40, and trained 135 private sector physicians. In FY 2008, the figure was 146, surpassing the target of 45, due to an expansion of the training program to include an outreach Hansen's Disease (HD) awareness seminar and 3 on-line video HD clinical pathological conferences. A national promotion effort targeted at physicians whose practice may include individuals with Hansen's Disease (e.g., dermatologists) is underway, as well as training healthcare providers in targeted areas where clusters of newly diagnosed cases are appearing. In FY 2009 the program trained 157 private sector physicians, and in FY 2010, 220 private sector physicians were trained. The FY 2011 and FY 2012 target is 150.

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

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

The National Hansen's Disease Program includes a regional outpatient clinic program. The HD population in the U.S. is approximately 6,000. In FY 2007, the NHDP program met the target of caring for 3,000 HD patients through outpatient clinics in the area in which they live. In FY 2008, that figure was 2,888, and in FY 2009 the result was 2,963, virtually meeting the goal of 3,000. For FY 2010, FY 2011 and FY 2012 the target is 3,000.

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

The National Hansen's Disease Program (NHDP) seeks to prevent and manage Hansen's Disease (leprosy) through both clinical care and scientific research. As an annual and long-term measure, this indicator monitors advances in scientific knowledge related to the early diagnosis, treatment, and prevention of Hansen's Disease and the NHDP's performance in achieving breakthroughs in genomic and molecular biology. The Program is the sole provider of reagent grade viable leprosy bacilli, and continues to collaborate with researchers worldwide to further the study of and scientific advances related to the disease.

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

The annual measure specifically tracks development of six protective biological response modifiers (BRMs) and six white blood cell subtype markers (CMs) that are important in host resistance to Hansen's Disease and will ultimately permit development of the full animal model for human Hansen's Disease. In 2007, the program met its targets and developed BRM-2 and CM-1. The targets were also met in FY 2008, with the program developing BRM-3 and CM-2, 3. The Program also met its FY 2009 target and developed BRM-4 and CM-4. In FY 2010, the program expects to demonstrate defective nerve function in infected armadillos. In FY 2011, the program expects to use DNA evidence to link leprosy transmission from armadillos to humans. In FY 2012 the program expects to pursue the integration of BRM, CM and molecular reagent breakthroughs.

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

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

Through this annual and long-term measure the program will monitor its efforts to prevent an increase of the percentage of Hansen's Disease patients with grades 1 or 2 disability/deformity. Disability/deformity is measured based on the World Health Organization scale, which ranges from 0-2. Patients graded at 0 have protective sensation and no visible deformities. Patients graded at 1 have loss of protective sensation and no visible deformity. Patients graded at 2 have visible deformities secondary to muscle paralysis and loss of protective sensation. It is expected that both the program's existing case management efforts as well as its activities to train private sector physicians to recognize Hansen's Disease and initiate treatment earlier, will help prevent further increases in the level of disability/deformity among Hansen's patients. In FY 2007 and FY 2008, the results exceeded the targets at 47% and 45%, respectively. For FY 2011 and FY 2012, the target is 50%.

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

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

By restraining increases in the cost per individual served by the Ambulatory Care Program Clinics and at the National Hansen's Disease Program outpatient center below the national medical inflation rate, the Hansen's Disease Services Program can continue to serve more patients that otherwise would have required additional funding to serve in the fiscal year. In FY 2007, the cost per patient served through outpatient services was \$1,277 and was successfully below the target of \$1,599. In FY 2008, the figure of \$1,244 was better than the target of \$1,676, and in FY 2009 the figure was \$1,088, bettering the target of \$1,676. The target for FY 2010 – FY 2012 is to maintain the increase in cost per patient below the national medical inflation rate.

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

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 (Developmental)	2012	TBD	November 2012
	2011	N/A	November 2011 (Baseline)

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

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. Grant opportunities supported by the CHC Fund Capital Development program were initiated in FY 2011. These opportunities support the costs of constructing and renovating health center facilities.

The Affordable Care Act CHC Fund authorized and appropriated amount of \$1.5 billion for FYs 2011 through 2015 is available until expended. It is expected that a portion of the funding that remains available in FY 2012 will be used to support facility construction and renovation costs for health centers funded under Section 330 of the Public Health Service Act.

DISCUSSION OF TARGETS AND RESULTS

Goal: Improve Access to Quality Health Care and Services

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

39.I. Number of new/improved sites. (Developmental)

In FY 2011, the Health Center Program funded 144 Capital Development grants totaling approximately \$732 million. The Health Center Program will use the FY 2011 reports to determine appropriate targets for FY 2012 and future years.

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

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)	2012	N/A	November 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.

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.

The awarding of the first SBHC-Construction grants is expected to occur in FY 2011 with the provision of an estimated 200 grant awards. It is expected that the proposed SBHC Capital projects will support SBHCs in providing more effective, efficient, and quality health care. Applicants must also demonstrate how their proposal will lead to improvements in access to health services for children at a SBHC.

DISCUSSION OF TARGETS

Goal: Improve Access to Quality Health Care and Services

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

40.I. Number of new/improved sites. (Developmental)

In FY 2011, the Health Center Program estimates that 200 grant awards totaling \$100 million will be made to SBHCs. The timing of these awards is expected in the last quarter of FY 2011, and as a result, reports for SBHC Capital activity will not be received until FY 2012. These reports will establish baseline information that will be used to develop future targets.

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

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 through the placement and retention of NHSC clinicians. (Outcome)	<i>Out-Year Target</i>	12.0 Million ¹ (FY 2014)	Dec 31, 2014
	2012	13.1 Million ^{1,2}	Dec 31, 2012
	2011	12.18 Million ^{1,2}	Dec 31, 2011
	2010	8.56 Million ²	9.05 Million ² (Target Exceeded)
	2009	5.69 Million ²	5.94 Million ² (Target Exceeded)
	2008	3.48 Million	4.79 Million (Target Exceeded)
	2007	3.8 Million	3.88 Million (Target Exceeded)
4.1: Number of individuals served in all communities seeking NHSC assistance through NHSC placement, retention and other sources. ³ (Outcome)	<i>Out-Year Target</i>	14.1 Million ¹ (FY 2014)	Dec 31, 2014
	2010	9.04 Million ²	10.0 Million ² (Target Exceeded)
4.I.C.2: Field strength of the NHSC through scholarship and loan repayment agreements. (Outcome)	<i>Out-Year Target</i>	9,537 ¹ (FY 2014)	Dec 31, 2014
	2012	10,683 ^{1,2}	Dec 31, 2012
	2011	10,500 ^{1,2}	Dec 31, 2011
	2010	7,358 ²	7,530 ² (Target Exceeded)
	2009	4,674 ²	4,808 ^{2,4} (Target Exceeded)
	2008	3,558	3,601 (Target Exceeded)
	2007	3,706	3,820 (Target Exceeded)
4.I.C.4: Percent of NHSC clinicians retained in service to the underserved. (Outcome)	2012	76%	Dec 31, 2013
	2011	76% ⁵	Dec 31, 2012
	2010	79%	Dec 31, 2011
	2009	79%	78% (Target Not Met)
	2008	79%	76% (Target Not Met)
	2007	79%	D/N/A ⁶

¹ Reflects Affordable Care Act. FY 2011 target differs from that shown in the FY 2011 Congressional Justification.

² Reflects Recovery Act funding.

³ This long-term measure does not have annual targets. FY 2010 is the first out-year target date.

⁴ This is final audited Field Strength which differs from the 4,760 shown in the FY 2011 Congressional Justification.

⁵ This target differs from that shown in the FY 2011 Congressional Justification due to new 2010 survey results that inform target-setting.

Measure	FY	Target	Result
4.I.C.3: Number of NHSC-list vacancies filled through all sources. (Outcome)	2012	6,000 ^{1,2}	Dec 31, 2012
	2011	5,000 ^{1,2}	Dec 31, 2011
	2010	4,400 ²	4,697 ² (Target Exceeded)
	2009	3,600 ²	3,424 ² (Target Not Met)
	2008	1,776	D/N/A ⁷
	2007	1,746	1,376 (Target Not Met)
4.I.C.5: Average HPSA score of the sites receiving NHSC clinicians, as a proxy for service to communities of greatest need. (Outcome)	2012	12.0	Dec 31, 2012
	2011	12.0 ⁸	Dec 31, 2011
	2010	13.0	12.0 (Target Not Met)
	2009	13.8	13.0 (Target Not Met)
	2008	13.6	15.7 (Target Exceeded)
	2007	13.6	13.7 (Target Exceeded)
Efficiency Measure	FY	Target	Result
4.E.1: Default rate of NHSC Scholarship and Loan Repayment Program participants. (Efficiency)	2012	≤ 2.0%	Dec 31, 2012
	2011	≤ 2.0%	Dec 31, 2011
	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)
	2007	N/A	0.8% (Baseline)

Measure	Data Source	Data Validation
4.I.C.1 4.1 4.I.C.2 4.I.C.3 4.I.C.5 4.E	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

⁶ Retention data not available for FY 2007 due to incomplete data collection by contractor and contract expiration.

⁷ Data not available due to incomplete data entry and data management malfunction in BHCDANET.

⁸ Target lowered from that shown in the FY 2011 Congressional Justification due to increased placements through Affordable Care Act funding.

INTRODUCTION

The statutory purpose of the National Health Service Corps (NHSC) is to eliminate "...health manpower shortages in health professional shortage areas," (Section 331(a)(1) of the Public Health Service Act [42 USC 254d]). The performance measures gauge the NHSC's contribution to the HRSA Strategic 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.). The larger the field strength, the greater number of people served, and the pool of clinicians who fulfill the service commitment to be potentially retained increases. The increases in the NHSC field strength beginning in FY 2009 is a direct result of funding through the American Recovery and Reinvestment Act (ARRA), and will be supported into the future by the Affordable Care Act.

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 noted above.

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.

DISCUSSION OF RESULTS AND TARGETS

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.

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

The FY 2001 baseline of individuals served is 4.44 million. The NHSC has exceeded the targets of individuals served from FY 2007 through FY 2010. The projected increase in the FY 2011 target to 12.18 million reflects no change in the NHSC Recruitment Line in the FY 2011 continuing resolution, the ARRA funding and the first year of Affordable Care Act funding. The projected increase in the FY 2012 target to 13.1 million reflects the decrease in the NHSC Recruitment Line in the FY 2012 Budget Request, ARRA and the Affordable Care Act funding. The out-year target of 12.0 million takes into account the long-term decrease in NHSC field strength after clinicians funded through ARRA have fulfilled their obligated service and are no longer counted in the field strength.

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

(Baseline – 5.9 M)

The FY 2010 result of 10.0 million exceeds the target of 9.04 million by 10.6%, and reflects the increased appropriation to the NHSC Recruitment Line in the FY 2010 Budget and Recovery Act funding. FY 2010 is the first out-year target date. The out-year target of 14.1 million for FY 2014 reflects the long-term decrease in NHSC field strength after clinicians funded through ARRA have fulfilled their obligated service and are no longer counted in the field strength.

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

From FY 2007 through FY 2009 the NHSC field strength has exceeded the targets. The field strength in FY 2010 of 7,530 exceeds the target of 7,358 by slightly more than 2%, and reflects the increased appropriation to the NHSC Recruitment Line in FY 2010 Budget and Recovery Act funding. The FY 2011 target of 10,500 reflects no change in the NHSC Recruitment Line in the FY 2011 continuing resolution, the last year of ARRA, and the first year of Affordable Care Act funding. The NHSC field strength is one of the Priority Goals that the Administration will continue to track to monitor the achievement of results against performance targets in key areas. The out-year target of 9,537 takes into account the long-term decrease in NHSC field strength after clinicians funded through ARRA have fulfilled their obligated service and are no longer counted in the field strength. The FY 2012 target of 10,683 reflects the decrease in the NHSC Recruitment Line in the FY 2012 Budget Request and the second year of Affordable Care Act funding.

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

Retention of NHSC clinicians preserves access to care for the underserved beyond the period of service commitment. The NHSC measures retention at one year after fulfillment of the service commitment. In FY 2006 76% of clinicians were retained in service. Retention data was not available in FY 2007 due to incomplete data collection, the Recruitment, Training, and Support Center (RTSC) contract expiration, and a six month gap before a new contract was finalized with a new contractor. Retention data are not available for FY 2008 due to new survey form not receiving clearance. Collection of retention data is required under the new contract and mechanisms are in place to monitor performance more closely. The survey performed in 2010 showed a retention rate for FY 2009 of 76% which did not meet the target of 79%. The results of this survey will inform the survey to be done in FY 2011 to measure retention of those clinicians who will complete obligated service in FY 2010. The FY 2012 target is 76%.

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

Targets are based on the number of projected new loan repayment awards, the number of new scholars beginning service, and the assumption that an equal number of non-NHSC clinicians will fill NHSC-listed vacancies. NHSC has since a searchable web-based portal which greatly facilitates the job search for scholars, potential loan repayers and other clinicians. In FY 2007, 1,376 vacancies were filled, which is 21% below the target. This is due to a decrease in the number of vacancies filled by non-NHSC clinicians for reasons that are unclear, as the NHSC has no direct contact with these non-obligated clinicians. FY 2008 data are not available due to incomplete data entry and data management malfunction in BHCDANET. In FY 2009, 3,424 vacancies were filled from all sources, falling short of the target by 5%. The rise of the target numbers after FY 2008 reflect the increased appropriations to the NHSC Recruitment Line in the FY 2009 Omnibus and Recovery Act funding. The FY 2010 result of 4,697 vacancies filled exceeded the target of 4,400 by 6.8%, in large part due to the increase in placements through ARRA funding. The FY 2011 target of 5,000 reflects no change in the NHSC Recruitment Line in FY 2011 continuing resolution, the last year of ARRA, and the first year of Affordable Care Act funding. The FY 2012 target of 6,000 reflects the decrease in the NHSC Recruitment Line in FY 2012 Budget Request and the second year of Affordable Care Act funding.

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

The Health Professional Shortage Area (HPSA) score is a proxy measure for the degree of need for health professionals in an area. Scores range from 1 to 25, with 25 representing the greatest need. Increasing the average HPSA score of site vacancies filled through NHSC assistance indicates success in targeting vacancies of greatest need. The FY 2007 actual average score was 13.7, which equaled the average score of FY 2006 and exceeded the target by 3%. This is a function of the fact that the program did not award all qualified loan repayment applications in 2007 (as was the case in FY 2006): no loan repayment contracts were awarded to a clinician working at a facility with a HPSA score below 8, resulting in a higher average score. The FY 2008 average score of 15.7 exceeded the target again because not all qualified applicants received an award resulting in a higher average score. The FY 2009 average score of 13.0 did not meet the target of 13.8, which is a function of the increased appropriation to the NHSC Recruitment Line in the 2009 Omnibus and Recovery Act funding, which will result in an increased field strength through additional loan repayers which will drive the average HPSA score down. The FY 2010 target of 13.0 reflects the increased appropriation to the NHSC Recruitment Line in FY 2010 Budget and Recovery Act funding; the results for FY 2010 of 12.0 did not meet the target, most likely due to the 70% increase in the number of placements over the FY 2009 level. The FY 2011 target of 12.0 has been lowered to reflect no change in the FY 2011 continuing resolution, the last year of ARRA funding, and the first year of Affordable Care Act funding, resulting in another large increase in the NHSC Field Strength. The FY 2012 target of 12.0 has also been lowered to reflect the decrease in the NHSC Recruitment Line in FY 2012 Budget Request and the second year of Affordable Care Act funding. In both FY 2011 and FY 2012, an increase in field strength through additional loan repayers will drive the average HPSA score down.

4.E.1. Default rate of NHSC Scholarship and Loan Repayment Program participants.

The NHSC has replaced the previous efficiency measure (see below), with a measure that tracks the default rate of NHSC program participants. The Health Resources and Services Administration has adopted the Department of Education's definition of default in an effort to standardize a government definition of the default rate; such adoption will enable the NHSC to compare the default rates of its programs with a national average.

The measure reports the cumulative number of defaulters over a 5 year period as a percentage of the total awards made in that timeframe. For example, the baseline of FY 2007 shows the total number of defaulters from 2003 to 2007 to be 49 out of a total of 6,038 awards, for a default rate of 0.8%. This rate compares very favorably with the national rate of student loan default of 6.7% in FY 2007 as reported by the Department of Education.

The purpose of this measure is to assist the NHSC in its recruitment and retention efforts in two ways. First, it enables the Program to demonstrate that it is recruiting the right clinicians; that is, those with a clear commitment to service to the underserved. Secondly, a low default rate assures the Program that its efforts to support scholars in school and in training, and the support given to both clinicians in service and the sites that employ them, are appropriate. The success of these recruitment and support efforts in keeping the default rate low ensures that Federal funds are being expended for the purpose they were appropriated: to provide access to primary care services to underserved communities and vulnerable populations to the greatest possible extent.

This measure will be reported two years after the latest award date, as the most recent reporting of defaults shows essentially no defaults occurring within the first year of the award.

Though there was no target set for FY 2009, the default rate for the NHSC Scholarship and Loan Repayment Programs was < 1.0%, and in FY 2010 the default rate was 0.0%. It is on the basis of these results that the targets for FY 2011 and FY 2012 are set at equal to or less than 2.0%.

DISCONTINUED MEASURE

Efficiency Measure	FY	Target	Result
4.E: Maintain or decrease the average cost to the NHSC program of a patient encounter. (Efficiency)	2012	N/A	N/A
	2011	N/A ¹	N/A
	2010	\$5.50	\$6.32 (Target Not Met)
	2009	\$3.50	\$5.90 (Target Not Met)
	2008	\$4.17	\$5.21 (Target Not Met)
	2007	\$4.19	\$3.87 (Target Exceeded)

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

This average cost of a patient encounter is the benchmark of management efficiency. The measure tracks how well the Program can maintain or even lower this cost. The estimated cost of an encounter in FY 2007 is eight percent below the target. This may be due to the increased percentage of NHSC loan repayers and state loan repayers (vs. scholars) in the field strength who serve at a lower annual cost to the program than scholars. The FY 2008 estimated cost of \$5.21 greatly exceeded the target of \$4.17. The FY 2009 cost estimate of \$5.90 again greatly exceeded the target of \$3.50. The FY 2010 cost estimate of \$6.32 did not meet the FY 2010 target of \$5.50. That the estimated cost per encounter has not met the targets of FY 2009 and FY 2010, and indeed the estimated cost per encounter has risen instead of fallen, demonstrates that this measure is not an effective measure of efficiency.

This measure tracks the average cost of encounters at NHSC sites. NHSC sites receive no funding from NHSC and the Program has no mechanisms to drive down costs of patient encounters. In addition, the model used to generate average cost data was based, in part, on the NHSC Uniform Data System (NHSC UDS). The NHSC UDS is no longer active, with 2007 being the last year for data collection. The mission of the NHSC is to eliminate health professions shortage areas through the recruitment and retention of clinicians to underserved areas. Measuring the clinician default rates (see above) aligns with the Program’s overall mission and provides an indicator of the Program’s success in improving access to health care in underserved areas.

¹ This differs from what was shown in the FY 2011 Congressional Justification because the measure is to be discontinued.

This measure will be retired in FY 2011. The last year for which data will be reported is FY 2010.

NURSING EDUCATION LOAN REPAYMENT AND SCHOLARSHIP PROGRAMS

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
<u>5.1</u> : Increase the number of individuals enrolled in professional nursing education programs. ¹ (Baseline – FY 2003: 240,500) (Outcome)	<i>Out-Year Target</i>	12% over baseline (FY 2014)	Dec 31, 2015
	2010	10% over baseline	Dec 31, 2011
<u>5.I.C.1</u> : Increase the proportion of nursing scholarship recipients working in a facility with a critical shortage of nurses within four months of licensure. (Outcome)	2012	85%	Dec 31, 2013
	2011	85%	Dec 31, 2012
	2010	85%	Dec 31, 2011
	2009	85%	Dec 31, 2011
	2008	85%	D/N/A ²
	2007	85%	D/N/A ²
<u>5.I.C.2</u> : Increase the proportion of NELRP participants working in shortage facilities such as: Disproportionate Share Hospitals for Medicare and Medicaid, Nursing Homes, Public Health Departments (State and local) and Public Health Clinics contained in these Departments. (Outcome)	2012	100%	Dec 31, 2013
	2011	100%	Dec 31, 2012
	2010	100%	Dec 31, 2011
	2009	100%	Dec 31, 2011
	2008	90%	100% (Target Exceeded)
	2007	90%	97% (Target Exceeded)
<u>5.I.C.4</u> : Reduce Federal investment per year of direct support by increasing the proportion of program participants who extend their service contracts to commit to work at a critical shortage facility for an additional year. (Outcome)	2012	54%	Dec 31, 2013
	2011	54%	Dec 31, 2012
	2010	54%	Dec 31, 2011
	2009	45%	Dec 31, 2011
	2008	45%	54% (Target Exceeded)
	2007	45%	45% (Target Met)
<u>5.I.C.3</u> : Increase the percent of States in which NELRP contract recipients work. (Output)	2012	93%	Dec 31, 2013
	2011	93%	Dec 31, 2012
	2010	93%	Dec 31, 2011
	2009	93%	Dec 31, 2011
	2008	93%	88% (Target Not Met)
	2007	93%	94% (Target Exceeded)

Note: While ARRA funding will increase the number of participants, it will not change the proportions targeted for these measures.

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

² Data elements were not collected for FY 2007 and FY 2008.

Efficiency Measure	FY	Target	Result
5.E: Increase the proportion of NELRP participants who remain employed at a critical shortage facility for at least one year beyond the termination of their NELRP service. (Efficiency)	2012	50%	Dec 31, 2014
	2011	50%	Dec 31, 2013
	2010	50%	Dec 31, 2012
	2009	50%	Dec 31, 2011
	2008	50%	D/N/A ²
	2007	50%	D/N/A ²

Measure	Data Source	Data Validation
5.1	American Association of Colleges of Nursing (AACN).	Validated by AACN.
5.I.C.1 5.I.C.2 5.I.C.4 5.I.C.3 5.E	Information from applications entered into Nursing Information System (NIS).	Program staff and contractors monitor the data and make corrections as needed. Information is checked with appropriate sources, including lenders.

INTRODUCTION

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

A major challenge facing NELRP is ensuring placements in facilities with the greatest need. As one strategy to assure better targeting of program resources to areas and facilities of greatest need, the Program is testing a methodology for identifying Critical Shortage Facilities for nurses. Another major challenge for the Program is the current difficulty with data collection and analysis. The Program had been using a Nursing Information System which was deactivated in anticipation of another system being brought online. This has not yet occurred. Both NSP and NELRP will participate in the new information management system of the Bureau of Clinician Recruitment and Service, which is scheduled to be operational at the end of FY 2011. The Program anticipates reporting on FY 2009 performance data in 2011. The Bureau of Clinician Recruitment and Service is beginning a process for re-evaluating the performance measures for NELRP and NSP and their possible revision to provide useful measures for management and accountability.

DISCUSSION OF RESULTS AND TARGETS

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.

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

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

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

In FY 2004 the proportion was 43%. Data elements were unavailable for this measure for FY 2006 thru FY 2008 due to the lack of an information system. The program expects to report on FY 2009 data in 2010. The FY 2009 through FY 2011 targets are 85%. Similarly, the FY 2012 target is 85%.

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

Data for this measure is obtained by monitoring automated data on NELRP contracts. NELRP applicants working in shortage facilities, such as but not limited to Disproportionate Share Hospitals for Medicare and Medicaid; nursing homes, public health departments (State and local) and public health clinics contained in these departments, are in the first preference category for awards.

These data indicate the degree to which NELRP resources are being successfully targeted to facilities experiencing the most critical shortages of nurses. All available funds for initial awards were expended to nurses working in those facility types in FY 2004 through FY 2006. The proportion in FY 2007 was 97% and 100% in FY 2008, exceeding the target by 7 and 10percentage points, respectively. The targets for FY 2009 through FY 2011 are 100%, and reflect the requirement in the law (effective in 2009) that program participants may only be placed in entities that are non-profit (42 USC 297n(b)(3)), which is anticipated to disqualify some facilities such as nursing homes. The FY 2012 target is 100%.

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

NELRP initial contracts are for two years of service. This indicator will provide a measure of the degree to which registered nurses participating in NELRP are willing to serve in a critical shortage facility for at least one additional year. The proportion in FY 2006 was 45%, and the target of 45% for FY 2007 was met. In FY 2008, the proportion was 54%, exceeding the target by 11percentage points. The target for FY 2009 is 45%; the target for FY 2010 and 2011 is 54%. The target for FY 2012 is 54%.

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

Prior to FY 2002, information about this program was not widely distributed and contract recipients were limited to a small number of States. Increased funding and marketing strategies in FY 2002 resulted in broader distribution of contract awards in more States. In FY 2007 NELRP participants were working in 94% of the States, which was 1percentage point over the target and 2percentage points over the FY 2006 level. The proportion for FY 2008 was 88% (44 states). Some fluctuation from year to year is expected because awards are based on financial need and type of facility rather than the State in which the recipient plans to work. The targets for FY 2009 through FY 2011 are 93%. For FY 2012, the target is 93%.

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

This indicator will address the issue of retention by providing a measure of the degree to which trained nurses participating in NELRP are willing to serve in a critical shortage facility for at least one additional year beyond the termination of their NELRP service. Data were not collected in FY 2006 and FY 2007 due to the lack of an information management system. The Program expects the new information management system to be operational at the end of FY 2011. At that time, data for FY 2008 will be available. The targets for FY 2009 through FY 2011 are 50%. Likewise, the target for FY 2012 is 50%.

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
- Healthcare Integrity and Protection Data Bank

HEALTH PROFESSIONS AND NURSING EDUCATION AND TRAINING PROGRAMS

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.

Sub-Goal: 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. (Outcome)	<i>Out-Year Target</i>	55% (FY 2013)	Dec 31, 2014
	2012	55%	Dec 31, 2013
	2011	53% ¹	Dec 31, 2012
	2010	53% ¹	Dec 31, 2011
	2009	50%	53% (Target Exceeded)
	2008	50%	53% (Target Exceeded)
	2007	50%	51% (Target Exceeded)
6.1: Proportion of persons who have a specific source of ongoing care. ² (Baseline – FY 2001: 88%) (Outcome)	<i>Out-Year Target</i>	92% (FY 2013)	Dec 31, 2014
6. I.C.1: Proportion of trainees in Titles VII and VIII supported programs training in medically underserved communities. (Outcome)	2012	45% ¹	Dec 31, 2013
	2011	45% ^{1,3}	Dec 31, 2012
	2010	54% ¹	Dec 31, 2011
	2009	54%	45% (Target Not Met)
	2008	43%	45% (Target Exceeded)
	2007	43%	37% (Target Not Met)
6. I.C.2: Percentage of health professionals supported by the program who enter practice in underserved areas. ⁴ (Outcome)	<i>Out-Year Target</i>	47% (FY 2013)	Dec 31, 2015
	2012	47%	Dec 31, 2014
	2011	43%	Dec 31, 2013
	2010	43%	Dec 31, 2012
	2009	35%	Dec 31, 2011
	2008	35%	47% (Target Exceeded)
	2007	21%	43% (Target Exceeded)

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

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

³ This figure differs from the FY 2011 Congressional Justification to better reflect realistic projections based on trend data.

⁴ 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.

Efficiency Measure	FY	Target	Result
6. E: Average cost per graduate or program completer to the program of providing pipeline and formative education and training. (Efficiency) (Baseline – FY 2004: \$456)	2012	\$379	Dec 31, 2014
	2011	\$379	Dec 31, 2013
	2010	\$379	Dec 31, 2012
	2009	\$456	Dec 31, 2011
	2008	\$456	Dec 31, 2010
	2007	\$456	\$379 (Target Exceeded)

Measure	Data Source	Data Validation
6.I.B.1 6.I.C.2 6.E 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.
6.1	National Health Interview Survey by Centers for Disease Control and Prevention (CDC).	Validated by CDC

INTRODUCTION

The Health Professions programs performance measures and activities build upon HRSA's Strategic goal to "Strengthen the Health Workforce" and are keyed to the following HRSA 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.
- Assure a diverse health workforce

The Health Professions programs tackle a range of current health workforce challenges through education and training in primary care, allied health, geriatrics, nursing, and other health professions. The programs increase access to health care by developing, distributing and retaining a diverse, culturally competent health workforce. 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 helps 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. In efforts to assess the future health care delivery system needs, HRSA has programs designed to encourage and track participant's intended health care career choice. A systematic, critical review of the literature on pipeline programs identified 23 studies which reported positive outcomes associated with racial/ethnic minority and disadvantaged students' participation in structured pipeline programs.

The Bureau of Health Professions is currently reviewing all of its performance measures and will be making significant revisions to better address individual program outputs and outcomes. This review is being undertaken in conjunction with the need to renew its OMB clearance of performance measures and with changes in requirements for evaluation in the Affordable Care Act. The revised measures will enable the Bureau to better address questions such as what activities grantees use the resources for, the degree to which programs increase training capacity, and the extent to which individuals trained in specific health professions (including primary care) remain in primary care and provide services to underserved populations. The revisions will also facilitate longitudinal evaluations of its programs in the future by allowing individuals who participate in programs to be followed into practice as health professionals. The long-term success of this evaluation strategy is also dependent on the development of national data on health professionals by the National Center for Health Workforce Analysis in the Bureau.

DISCUSSION OF RESULTS AND TARGETS

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.

Sub-Goal: Assure a diverse health workforce.

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.

In 2009, 53% of graduates and program completers of Titles VII and VIII supported programs were underrepresented minorities and/or from disadvantaged backgrounds. This exceeded the FY 2009 and 2008 target of 50%. Future targets are set at 55%.

Recovery Act and ACA funds will affect the total numbers for this measure in FY 2010 and FY 2011, but will not affect the proportions.

6.1. Proportion of persons who have a specific source of ongoing care.

Access to a source of ongoing care does not directly reflect all of the specific activities of the Health Professions program. However, over time, HRSA expects its programs to contribute to increasing the proportion of persons with a specific source of ongoing care, through its support of training health professions in all settings.

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

The proportion of trainees in Titles VII and VIII supported programs training in medically underserved communities was 45% in FY 2009. The FY 2009 result is consistent with results in FY 2008, but failed to meet the FY 2009 target. The program anticipates fluctuations in the performance measure results from year-to-year due to the range of program priorities the grantees may establish in any given year. The program will continue to emphasize to training programs the critical importance of this measure and strategize with the grantees on how to

improve performance in this area. The targets for FY 2011 and FY 2012 take into account fluctuations in program priorities and are set at 45%.

Recovery Act and Affordable Care Act funds will affect the total numbers for this measure in FY 2010, FY 2011, and FY 2012 but will not affect the proportions.

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

The percentage of health professionals supported by the program entering practice in underserved areas was 47% in FY 2008. This result is a 4% increase over the FY 2007 result. The programs reporting on this measure were reviewed. Several programs had been inappropriately reporting on this measure and were dropped from the calculation. As a result, the figure for FY 2007 is not comparable to past year results or the FY 2007 target. The programs that are currently counted for this measure have had a performance history consistent with the FY 2007 performance level. Targets for FY 2012 onward are set at 47% as a continuing maintenance level.

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

The efficiency measure for the Health Professions program is to maintain the average cost per graduate and program completer at \$379.

Per capita costs vary tremendously among these different types of programs, depending on the level of effort, and the length of the commitment required to complete them. The baseline for FY 2004 (\$456) represented the average cost per graduate or program completer to Title VII and Title VIII of providing pipeline formative education and training. For FY 2007 the average cost per graduate or program completer was \$379. This significantly exceeded the target of \$456 for this measure. The number of programs associated with this measure will vary significantly in response to funding changes for Title VII and Title VIII and per capita costs will change accordingly. Fluctuations in tuition costs will also be an important factor. The FY 2012 target is \$379.

Prevention and Public Health Fund Measures

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 FY 2010 Prevention and Public Health funding (cumulative).	<i>Out-Year Target</i>	500 Physicians 600 PA 600 NP (FY 2015)	Dec 31, 2016
a. Physicians <i>Primary Care Training and Enhancement Program</i>	<i>Out-Year Target</i>	500 (FY 2015)	Dec 31, 2016
	2012	N/A	N/A
	2011	N/A	N/A
b. Physician Assistants <i>Primary Care Training and Enhancement Program</i>	<i>Out-Year Target</i>	600 (FY 2015)	Dec 31, 2016
	2012	N/A	N/A
	2011	N/A	N/A
c. Nurse Practitioner <i>Advanced Nursing Education Expansion Program</i>	<i>Out-Year Target</i>	600 (FY 2015)	Dec 31, 2016
	2012	TBD	Dec 31, 2013
	2011	TBD	Dec 31, 2012
d. Nurse Midwifery <i>Advanced Nursing Education Expansion Program</i>	2012	TBD	Dec 31, 2013
	2011	TBD	Dec 31, 2012
6.I.C.4: Number of primary care providers trained through HRSA's Bureau of Health Professions programs supported with FY 2010 Prevention and Public Health funding*			
a. Physicians <i>Primary Care Training and Enhancement Program</i>	2012	178	Dec 31, 2013
	2011	177	Dec 31, 2012
b. Physician Assistants <i>Primary Care Training and Enhancement Program</i>	2012	159	Dec 31, 2013
	2011	148	Dec 31, 2012
c. Nurse Practitioner <i>Advanced Nursing Education Expansion Program</i>	2012	215	Dec 31, 2013
	2011	220	Dec 31, 2012
d. Nurse Midwifery <i>Advanced Nursing Education Expansion Program</i>	2012	65	Dec 31, 2013
	2011	55	Dec 31, 2012
6.I.C.5: Number of primary care residents trained <i>Teaching Health Center Graduate Medical Education Payments</i>	2012	50	Dec 31, 2013
	2011	50	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>	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>	2012	300	Dec 31, 2013
	2011	300	Dec 31, 2012

ACA Measure	FY	Target	Result
6.I.C.8: Number of Primary Care Patient Encounters <i>Nurse Managed Health Clinics</i>	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>	2012	389,331	Dec 31, 2013
	2011	389,331	Dec 31, 2012
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>	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>	2012	100%	Dec 31, 2013
	2011	50%	Dec 31, 2012

The programs supported with FY 2010 Prevention and Public Health funds focus on increasing the supply of, and capacity to produce high quality primary care clinicians and on enhancing the States' capacity to address healthcare workforce shortages.

6. I.C.3. Number of primary care providers who complete their education through HRSA's Bureau of Health Professions programs supported with FY 2010 Prevention and Public Health funding.

This measure is used by two programs to report on the numbers of additional physicians, physician assistants, nurse practitioners and midwives produced by these programs. The Expansion Programs are new programs that will produce the first physician graduates in academic year 2013-2014. The first physician assistants will graduate in academic year 2012-2013.

The Advanced Nursing Education Expansion Program provides stipends to primary care nurse practitioners and nurse midwives. This program anticipates a mixture of new enrollees in full-time status as well as students converting from part-time to full-time status. An advanced nursing degree can be obtained in two years. Therefore grantees may report matriculates as early as academic year 2011-2012.

6. I.C.4. Number of primary care providers trained through HRSA's Bureau of Health Professions programs supported with FY 2010 Prevention and Public Health funding.

This measure is used by two programs to quantify the number of primary care providers in training. The FY 2012 targets are 178 physician residents and 159 physician assistants in training in the Primary Care Residency Expansion Program and Expansion of Physician Assistant Training Program, respectively. The Advanced Nursing Education Expansion Program target for FY 2012 is 280 advanced nurses in training (nurse practitioners and nurse midwifery combined).

6. I.C.5. Number of primary care residents trained.

The Teaching Health Center Graduate Medical Education Payments Program provides for direct and indirect expenses for expansion of existing or establishment of new residency training programs in qualified teaching health centers. In FY 2012, the program will train approximately 50 residents.

6. I.C.6. Number of Personal Care and Home Health Aides completing training program.

State Demonstration Grants for Training Personal Care and Home Health Aides program funds States to conduct demonstration projects for purposes of developing core training competencies and certification programs for personal or home care aides. The FY 2012 target is 1,723 personal care and home health aides trained.

6. I.C.7. Number of Primary Care Nurse Practitioner students supported.

Nurse Managed Health Clinics support the development of clinical practicum sites, and the training of nurse practitioners to build the capacity of the primary care provider workforce. The FY 2012 target is 300 students supported.

6. I.C.8. Number of Primary Care Patient encounters.

Nurse Managed Health Clinics improve access to primary health care, disease prevention and health promotion in medically underserved areas (including enhancements of outreach strategies). The FY 2012 target is 31,000 patient encounters.

6. I.C.9. Number of existing public health workers retrained.

Public Health Training Centers provide education and training of the existing public health workforce and assure the future public health workforce has the knowledge, skills and abilities to address increasingly complex public health problems. The FY 2012 target is to retrain 389,331 existing public health workers in core competencies for public health.

6. I.C.10. Percent of planning grant awardees that have established FTE health workforce baselines for primary care.

The State Health Care Workforce Development Grant program contains two components, a planning and an implementation grant. Prior to a State qualifying for an implementation grant the State's healthcare workforce must be described. One means to operationalize this requirement is to describe the primary care sector. Therefore, the FY 2012 planning grant target is that 100% of States have established primary care baselines and therefore fulfilled partial requirement for the implementation grant.

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.

The State Health Care Workforce Implementation Grant requires regional partnerships to promote innovative health care workforce career pathway activities. In FY 2012 States conducting implementation will provide an update on strategies and partnerships used to reach a 10-25% increase in the primary care health workforce over a 10 year period.

CHILDREN'S HOSPITALS GRADUATE MEDICAL EDUCATION PAYMENT 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
7. I.A.1: Maintain the number of FTE residents in training in eligible children's teaching hospitals. (Output)	2012	N/A ¹	N/A
	2011	5,900 ²	Jul 31, 2012
	2010	5,600	Jul 31, 2011
	2009	5,343	5,840 (Target Exceeded)
	2008	5,243	5,631 (Target Exceeded)
	2007	4,828	5,406 (Target Exceeded)
7. VII.C.1: Percent of hospitals with verified FTE resident counts and caps. (Output)	<i>Out-Year Target</i>	N/A ¹	N/A
	2012	N/A ¹	N/A
	2011	100%	Jul 31, 2012
	2010	100%	Jul 31, 2011
	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)	2012	N/A ¹	N/A
	2011	100%	Jul 31, 2012
	2010	100%	Jul 31, 2011
	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.

¹ The target is not applicable because no funding is requested for FY2012.

² This target is different from that shown in the FY 2011 Congressional Justification to better reflect most recent performance.

INTRODUCTION

The Children's Hospital's Graduate Medical Education (CHGME) Payment Program's performance measures and activities build 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. There has been continuous yearly growth ranging from 3 to 6 percent in the number of resident full-time equivalent trainings at freestanding children's hospitals since the inception of the CHGME Payment Program, which is a greater rate of growth than the 1 to 2 percent experienced within all U.S. teaching hospitals. This expansion in the number of trainees indicates an increased emphasis on addressing the distinct health care needs of children thereby providing a greater intensity of training for pediatric and non-pediatric residency programs.

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 growth revenue for inpatient care and 41% of their growth revenue for outpatient care is from Medicaid and CHIPRA signifying that approximately half of the patients served are from low-income families.

The Affordable Care Act requires that the program make some administrative adjustments and monitor residents in non-provider settings. If the program receives funding in FY 2012 the program proposes to make changes to the measures that will better reflect program performance based on ACA requirements.

DISCUSSION OF RESULTS AND TARGETS

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.

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

Freestanding children's hospitals continue to increase the number of FTE residents at a rate of three to six percent a year due to the contribution of the CHGME funding. Since FY 2008 the CHGME Payment Program has exceeded its targets for FTE residents. In FY 2009 5,840 full time equivalent (FTE) residents were trained through the program, exceeding the target by 9%. The FY 2012 target is not applicable because funding is not requested.

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

Fiscal intermediaries (auditors) conduct yearly assessments of FTE residents' counts reported by children hospitals. CHGME has consistently met the target of 100% of hospitals with verified FTE resident counts and caps. The FY 2012 target is not applicable because funding is not requested.

7. E. Percent of payments made on time.

The efficiency goal for the CHGME Payment Program is to make 100% of direct medical education and indirect medical education payments to children's hospitals on schedule. The Program has continuously achieved the 100% goal. The FY 2012 target is not applicable because funding is not requested.

NATIONAL PRACTITIONER DATA BANK

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 for licensing and credentialing decision-making, operationalized as the number of licensing and credentialing decisions which limit practitioner's ability to practice. (Outcome)	<i>Out-Year Target</i>	54,500 Decisions (FY 2013) ¹	Feb 28, 2014
	2012	68,125 Decisions ¹	Feb 28,2013
	2011	54,500 Decisions	Feb 28,2012
	2010	53,450 Decisions	Feb 28, 2011
	2009	46,600 Decisions	51,990 Decisions (Target Exceeded)
	2008	46,075 Decisions	51,125 Decisions (Target Exceeded)
	2007	45,550 Decisions	47,200 Decisions (Target Exceeded)
8. III.B.2: Increase annually the number of times information provided by NPDB is considered useful by the querying entity which received it. (Outcome)	<i>Out-Year Target</i>	505,500 Occasions ¹ (FY 2013)	Feb 28, 2014
	2012	675,750 Occasions ¹	Feb 28,2013
	2011	530,000 Occasions	Feb 28,2012
	2010	530,000 Occasions	Feb 28, 2011
	2009	480,700 Occasions	527,750 (Target Exceeded)
	2008	475,300 Occasions	518,900 (Target Exceeded)
	2007	456,300 Occasions	479,500 (Target Exceeded)
Efficiency Measure	FY	Target	Result
8. E: Increase annually the number of queries for which NPDB and HIPDB responded within 240 minutes. (Efficiency)	2012	6,650,000 Queries ¹	Feb 28,2013
	2011	5,306,000 Queries	Feb 28,2012
	2010	5,202,000 Queries	Feb 28, 2011
	2009	4,883,000 Queries	5,085,760 (Target Exceeded)
	2008	4,792,000 Queries	5,078,400 (Target Exceeded)
	2007	4,701,000 Queries	4,710,600 (Target Exceeded)

¹The FY 2012 target reflects the NPDB-HIPDB merger. It is anticipated that a more efficient system will result in fewer duplicative queries impacting the out-year target.

Measure	Data Source	Data Validation
8.III.B.1 8.III.B.2	NPDB operations statistics, augmented by a user survey.	Financial audits, which involve confirmation of query volumes, are done continuously.
8.E	NPDB and HIPDB operations statistics.	The time required to process a query is carefully monitored by program and contractor staff because this is an explicit element of the performance-based contract.

INTRODUCTION

The National Practitioner Data Bank (NPDB) program’s performance measures and activities build upon HRSA’s strategic plan and are keyed to the following HRSA goal:

- Improve access to quality health care and services

This program 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.

With the implementation of Section 1921 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.

Performance measurement information, some of which is updated monthly, is used by the program to assess the success of the Data Banks in meeting goals for querying and use of the information by queriers for decision making in individual licensing and credentialing cases. Overall the information, which is assessed annually, is used to help determine the degree to which the program is meeting the needs of the queriers. 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. Therefore, in FY 2012 new measures will be proposed to better reflect program performance and the merger.

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve access to quality health care and services

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

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

In FY 2009, 51,990 licensing or credentialing decisions were impacted by information supplied by the NPDB. This was an increase over the FY 2008 actual of 51,125 and exceeded the FY 2009 target by more than 11%. The increase in decisions reflects a strengthening of health systems to provide better information for the delivery of quality care. The FY 2012 target is 68,125, reflecting the NPDB-HIPDB merger.

In FY 2012 the program proposes to replace this measure with a new measure that will better reflect program performance based on the merger proposed to occur in FY 2012.

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

In 527,750 cases in FY 2009, the querying entity considered the information provided by NPDB to be useful. This was an increase over the FY 2008 actual of 518,900 and exceeded the FY 2009 target by more than 9%. The future year targets are set in anticipation of increased usefulness. The FY 2012 target is 675,750, reflecting the NPDB-HIPDB merger.

In FY 2012 the program proposes to replace this measure with a new measure that will better reflect program performance based on the merger.

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

The length of time it takes the NPDB-HIPDB to process a query and return results to the querier has been reduced while both the number of queries and the number of reports in the system have continually increased. When the NPDB opened in 1990, it took days to process queries. The system has changed from paper documents to an internet-based system containing electronic documents. In FY 2009 the program responded to over 5.0 million queries. Queries are now responded to within 120 minutes. The FY 2012 target reflects the merger of the NPDB-HIPDB systems at 6,650,000 queries.

In FY 2012 the program proposes to replace this measure with a new measure that will better reflect program performance based on the merger proposed to occur in FY 2012.

HEALTHCARE INTEGRITY AND PROTECTION DATA BANK

DISCONTINUED MEASURES

Measure	FY	Target	Result
8. III.B.3: Increase annually the use of the HIPDB for licensing and credentialing decision-making, operationalized as the number of licensing and credentialing decisions which limit practitioner's ability to practice. <i>(Outcome)</i>	2012	N/A ¹	N/A
	2011	1,561 Decisions	Feb 28, 2012
	2010	1,530 Decisions	Feb 28, 2011
	2009	809 Decisions ²	1,420 Decisions (Target Exceeded)
	2008	1,225 Decisions	1,470 Decisions (Target Exceeded)
	2007	1,190 Decisions	1,300 Decisions (Target Exceeded)
8. III.B.4: Increase annually the number of times information provided by HIPDB is considered useful by the querying entity which received it. <i>(Outcome)</i>	2012	N/A ¹	N/A
	2011	18,666 Occasions	Feb 28, 2012
	2010	18,300 Occasions	Feb 28, 2011
	2009	8,217 Occasions ¹	14,390 (Target Exceeded)
	2008	12,450 Occasions	14,950 (Target Exceeded)
	2007	12,100 Occasions	13,150 (Target Exceeded)
Efficiency Measure	FY	Target	Result
8. E: Increase annually the number of queries for which NPDB and HIPDB responded within 240 minutes. <i>(Efficiency)</i>	2012	N/A ¹	N/A
	2011	5,306,000 Queries	Feb 28, 2012
	2010	5,202,000 Queries	Feb 28, 2011
	2009	4,883,000 Queries	5,085,760 (Target Exceeded)
	2008	4,792,000 Queries	5,078,400 (Target Exceeded)
	2007	4,701,000 Queries	4,710,600 (Target Exceeded)

Measure	Data Source	Data Validation
8.III.B.3 8.III.B.4	NPDB and HIPDB operations statistics, augmented by user survey.	Financial audits, which involve confirmation of query volumes, are done continuously.
8.E	NPDB and HIPDB operations and statistics	The time required to process a query is carefully monitored by program and by contractor staff, because this is an explicit element of the performance-based contract.

¹ No target was developed for FY 2012 due to the NPDB-HIPDB merger in FY 2012.

² The FY 2009 target was developed with the assumption that the final regulations implementing Section 1921 of the SSA would go into effect in FY 2009.

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

In FY 2009, 1,420 licensing or credentialing decisions were impacted by information supplied by the HIPDB. This represents a decrease from the FY 2008 actual of 1,470 and is about 75% above the FY 2009 target.

Since the HIPDB will cease operations during FY 2012, there are no outcomes and outputs goals targeted for FY 2012 and this measure will be discontinued.

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

In 14,390 cases in FY 2009 the querying entity considered the information provided by HIPDB to be useful.

Since the HIPDB will cease operations during FY 2012, there are no outcomes and outputs goals targeted for FY 2012 and this measure will be discontinued.

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

The length of time it takes the NPDB-HIPDB to process a query and return results to the querier has been reduced while both the number of queries and the number of reports in the system have continually increased. When the HIPDB opened in 1999, it took hours to process queries. The system is an internet-based system containing electronic documents that has improved in response time with new technology. In FY 2009, the program responded to over 5.0 million. Queries are now responded to within 120 minutes.

Since the HIPDB will cease operations during FY 2012, there are no outcome and output goals targeted for FY 2012 and this measure will be discontinued.

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

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
10.1: Decrease the number of uninsured children. ¹ (Baseline – FY 2006: 8.7M) (Outcome)	<i>Out-Year Target</i>	7.7M (FY 2015)	Nov 30, 2017
	2008	8M	7.3M ² (Target Exceeded)
10.I.A.1: Increase the number of children served by Title V. (Output)	2012	33M	Nov 30, 2013
	2011	31M	Nov 30, 2012
	2010	30M	Nov 30, 2011
	2009	29M	33.3M (Target Exceeded)
	2008	28M	35 M (Target Exceeded)
	2007	22M	31.7M (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)	2012	14M	Nov 20, 2013
	2011	13M	Nov 20, 2012
	2010	12M	Nov 30, 2011
	2009	11.5M	15.2M (Target Exceeded)
	2008	11M	14.7 M (Target Exceeded)
	2007	9.8M	12.8M (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)	2012	2.1 to 1	Nov 30, 2014
	2011	2.1 to 1	Nov 30, 2013
	2010	2.1 to 1	Nov 30, 2012
	2009	2.1 to 1	Nov 30, 2011
	2008	2.2 to 1	2.29 to 1 ³ (Target Not Met) (Preliminary Data)
	2007	2.2 to 1	2.35 to 1 (Target Not Met)

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

² U.S. Census Bureau, Current Population Reports, P60-238, *Income, Poverty, and Health Insurance Coverage in the United States: 2009*, September 2010.

³ Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2010. Deaths: Preliminary Data for 2008, National Vital Statistics Reports, Vol. 59, No. 2, December 9, 2010.

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.III.A.1: 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
	2012	6.6 per 1,000	Nov 30, 2014
	2011	6.6 per 1,000	Nov 30, 2013
	2010	6.7 per 1,000	Nov 30, 2012
	2009	6.7 per 1,000	Nov 30, 2011
	2008	6.8 per 1,000	6.6 per 1,000 ⁴ (Target Not Met) (Preliminary Data)
	2007	6.8 per 1,000	6.8 per 1,000 (Target Met)
10.III.A.2: Reduce the incidence of low birth weight births. (Outcome)	2012	8.2%	Nov 20, 2014
	2011	8.2%	Nov 30, 2013
	2010	8.2%	Nov 30, 2012
	2009	8.2%	Nov 30, 2011
	2008	8.2%	8.2% ⁵ (Target Met)
	2007	8.2%	8.2% (Target Met)
10.III.A.3: Increase percent of pregnant women who received prenatal care in the first trimester. (New Baseline – FY 2006: 69%) ⁶ (Outcome)	2012	70%	Nov 30, 2015
	2011	69% ⁶	Nov 30, 2014
	2010	86.5%	Nov 30, 2013
	2009	86%	Nov 30, 2012
	2008	85%	Nov 30, 2011
	2007	84%	70.8% ⁷ (Target Not Applicable)
10.2: Reduce the national rate of neonatal deaths per 1,000 live births. ⁸ (Baseline – FY 2005: 4.6 per 1,000 live births) (Outcome)	<i>Out-Year Target</i>	4.2 per 1000 (FY 2015)	Nov 30, 2017
	2008	4.5 per 1000	4.3 per 1,000 ⁹ (Target Exceeded) (Preliminary Data)

⁴ National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2010. Deaths: Preliminary Data for 2008, National Vital Statistics Reports, Vol. 59, No. 2, December 9, 2010.

⁵ National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2010. Births: Final Data for 2008, National Vital Statistics Reports, Vol. 59, No. 1, December 2010.

⁶ A new FY 2006 baseline and the FY 2007 result for this measure are based on the use of 2003 Revised U.S. Standard Birth Certificate. 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.

⁷ Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2010. Births: Final Data for 2007, National Vital Statistics Reports, Vol. 58, No. 24, August 2010.

⁸ This is a long-term measure with no annual targets.

⁹ National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2010. Deaths: Preliminary Data for 2008, National Vital Statistics Reports, Vol. 59, No. 2, December 9, 2010.

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. (<i>Outcome</i>)	2012	76%	Nov 30, 2014
	2011	76%	Nov 30, 2013
	2010	76%	Nov 30, 2012
	2009	75.5%	Nov 30, 2011
	2008	75%	76.1% (Target Exceeded)
	2007	74.5%	74.8% (Target Exceeded)
10.3: Increase maternal survival rate. ¹ (Baseline – FY 2005: 15.1 deaths per 100,000 live births) (<i>Outcome</i>)	<i>Out-Year Target</i>	13.1 per 100,000 (FY 2015)	Nov 30, 2017
	2008	8 per 100,000	Nov 30, 2011
Efficiency Measure	FY	Target	Result
10.E: Increase the number of children served by the Title V Block Grant per \$1 million in funding. (<i>Efficiency</i>)	2012	45,000	Nov 30, 2013
	2011	42,000	Nov 30, 2012
	2010	40,000	Nov 30, 2011
	2009	39,000	50,267 (Target Exceeded)
	2008	38,000	52,511 (Target Exceeded)
	2007	32,500	45,792 (Target Exceeded)

Measure	Data Source	Data Validation
10.I.A.1 10.I.A.2 10.E 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 10.2 10.3	Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC).	Data are validated by CDC.
10.1	U.S. Census Bureau, Current Population Reports, P60-238, Income, Poverty, and Health Insurance Coverage in the United States: 2009, U.S. Government Printing Office, Washington, DC, 2010.	Data are validated by the U.S. Census Bureau.

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 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.

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Access to Quality Health Care and Services

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

10.1. Decrease the number of uninsured children.

Research has shown that children benefit in many ways from having health insurance. Based on a 2009 report from the Institute of Medicine, titled *America's Uninsured Crisis: Consequences for Health and Health Care*, children who acquire health insurance are more likely to have access to a usual source of care, receive well-child care and immunizations to prevent future illness and to monitor developmental milestones, and receive prescription medications, appropriate care for asthma and basic dental services. Serious childhood problems are more likely to be identified early among children with health insurance. Insured children with special health needs are more likely to have access to specialists. Insured children receive more timely diagnosis of serious health conditions and have fewer avoidable hospitalizations, improved asthma outcomes and less school absences than uninsured children.

The FY 2006 baseline of 8.7 million uninsured children in the U.S. reflects data collected through the U.S. Census Bureau's Current Population Survey (CPS) in their Annual Social and Economic Supplement (ASEC). Based on the CPS ASEC, the number of children under 18 years of age who were without health insurance in FY 2008 was 7.3 million. Increased eligibility and enrollment in public programs, such as Medicaid and the Children's Health Insurance Program, have contributed to the decrease in the number of uninsured children.

The FY 2008 target of 8 million was exceeded, and the original target for FY 2015 was also achieved. The new target established for FY 2015 is 7.3 million.

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

The number of children served by Title V is a critical measure of the degree to which the program is successful in reaching and providing services to one of its key target populations. Services for children supported under the Title V MCH Block Grant program include: the provision of direct health care, enabling services, and population-based services. While the number of children served varies within a State from year to year, the number of children served nationally by Title V increased by 12.3 million between FY 2003 and FY 2008. In FY 2008, Title V Block Grant programs served the largest number of children (35 million) since data collection began in the Title V Information System in the 1990's. The number of children served by Title V in FY 2009 (33.3 million) exceeded the target by 4.3 million; however, 1.7 million fewer children were served by the Program than in FY 2008. Recent increases have been largely due to a shift towards more population-based services, such as screening services provided to school-age children. While annual targets were increased to address increasing levels of performance, the Program recognized that maintaining continued increases in program participation would be difficult given the variability in screening services that are provided for children within the States from year to year and the relatively level funding that the MCH Block Grant has received in recent years. For FY 2012, the target is for 33 million children to be served in the Title V MCH Block Grant program.

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

Increased coverage under Medicaid and CHIP for children receiving Title V services assures greater access, availability and continuity of care for the Nation's children through the provision of a wide range of services. The number of children receiving Title V services covered by Medicaid and CHIP increased from a baseline of 5.9 million in FY 2002 to 15.2 million in FY 2009. Every year since FY 2004, the Title V program has served an increasing number of children with Medicaid and CHIP coverage. Increases have ranged from 0.1 million in FY 2003 and FY 2004 to 1.9 million in FY 2007 and FY 2008. Between FY 2008 and FY 2009, the number of children who received Title V services and had Medicaid and CHIP coverage further increased by 0.5 million. These increases reflect the efforts of State MCH programs to provide outreach to populations eligible for Medicaid and CHIP coverage. While targets have been increased in recent years to reflect a greater number of children being served by Title V with Medicaid and CHIP coverage, maintaining such increases may be difficult due to changes in eligibility requirements and program funding levels. The FY 2012 target for this measure is that 14 million children with Medicaid and CHIP coverage will be served by Title V.

Goal: Improve Health Equity

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

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

While there has been progress in reducing infant mortality rates for both racial groups, the proportional discrepancy between Blacks and Whites has remained largely unchanged. Although the targets were not met, the black to white infant mortality ratio declined slightly in FY 2007 to 2.35 to 1 and based on preliminary data, the ratio declined further in 2008 to 2.29 to 1. The target for FY 2012 is 2.1 to 1.

The Black infant mortality rate remains more than twice the White rate. Research has suggested that a higher rate of very low birth weight among Blacks may contribute to, but does not fully explain, racial differences in infant mortality rates. Additional research is needed to identify factors that contribute to the black/white infant mortality disparity and to examine potential solutions.

The Program continues to monitor the Black/White Infant Mortality Ratio and to explore promising models and effective strategies for addressing this issue. Despite the slow rate of progress, the targets of 2.1 to 1 for FY 2009 through FY 2012 reflect the Program's ongoing commitment to continued improvement in this area.

Goal: Improve Access to Quality Health Care and Services

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

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

All countries of the world measure the infant mortality rate as an indicator of general health status. Prior to 2002, there was progress in reducing the infant mortality rate, but since then the rate has plateaued. Race/ethnicity, maternal age, education, smoking, and number of pregnancies are all factors that contribute to the infant mortality rate.

The overall infant mortality rate decreased slightly from 7.0 per 1,000 live births in FY 2002 to 6.7 per 1,000 live births in FY 2006. In FY 2007, the rate increased slightly to 6.8 per 1,000 live births which met the target. Based on preliminary data, the infant mortality rate for FY 2008 decreased to 6.6 infant deaths per 1,000 births. For FY 2012, the target is 6.6 per 1,000 births. Decreasing the rate of infant mortality has been and continues to be one of the primary focuses of the Maternal and Child Health Block Grant program.

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

In the past 15 years, the distribution of birth weights in the U.S. has shifted towards lower weights. The percentage of infants weighing less than 3,500 grams at birth has risen. Low birth weight (less than 2500 grams) is associated with short-term morbidity and mortality, as well as long-term disabilities, such as cerebral palsy, autism, mental retardation, vision and hearing

impairments, and other developmental disorders. The lower an infant's birth weight, the greater the risk for a poor outcome.

The LBW rate increased from 7.8% in FY 2002 to 8.3% in FY 2006, which was the highest level reported since 1969. The LBW rate improved slightly in FY 2007 and FY 2008 to 8.2%. The FY 2012 target for this measure is 8.2%.

Historical increases in the rate of LBW are influenced by the rise in the multiple birth rate, greater use of obstetric interventions, and increases in maternal age at childbearing. While multiple births are much more likely to be born LBW than singletons, the LBW rate for infants born in single deliveries has also been on the increase. Singleton LBW increased from 6.3% in FY 2004 to 6.49% for FY 2006, and the rate has risen 10% since 1990. The LBW rate for singleton births declined slightly in FY 2007 and FY 2008 to 6.45% and 6.40%, respectively. From FY 2006 to FY 2008, LBW rates declined slightly among non-Hispanic white and non-Hispanic black infants, while levels of LBW among Hispanic births have been essentially stable.

The Program continues to monitor the rate of LBW and its causes. Reasons for the increase in LBW births between 2002 and 2006 are unclear. The Bureau continues to explore and promote evidence-based practices to reduce the incidence and better understand the causes of low birth weight through such efforts as the Secretary's Advisory Committee on Infant Mortality. The Program remains committed to improvement in this area.

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

Data on trends in prenatal care are derived from two different data sources—the 1989 unrevised U. S. Standard Birth Certificate of Live Births and the 2003 revised U. S. Standard Birth Certificate of Live Births. Data captured from the unrevised birth certificates provide less information on prenatal care, thus the revision in 2003 was meant to improve the amount of data gathered on prenatal care. Data on prenatal care obtained from these two sources are not comparable; moreover, all states have not started using the revised birth certificates. The National Center for Health Statistics is now reporting birth-related data using the revised certificate, providing a 2006 figure of 69% (new baseline) for percent of pregnant women who received prenatal care in the first trimester. For FY 2007, 70.8% of pregnant women received prenatal care in the first trimester. The FY 2007 target of 84% was set based on States that used the Unrevised Birth Certificate. It is not applicable to the reported data, which derives from States that are using the Revised Birth Certificate. For the 18 States that used the Revised Birth Certificate in 2006 and 2007, the percentage of women who received first trimester prenatal care declined slightly from 69% in FY 2006 to 67.5% in FY 2007. The FY 2011 and FY 2012 targets have been revised to 69% and 70%, respectively, to reflect this change in data source.

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

the percent of pregnant women who receive care in the first trimester. Given historical trends and the challenges to reducing the individual and system barriers to receipt of timely care, modest increases are targeted for the future.

10.2. Reduce the national rate of neonatal deaths per 1,000 live births.

In 2007, slightly more than 19,000 U. S. infants died within their first 27 days of life. . Prematurity and its complications account for approximately one-fourth of all neonatal deaths. Neonatal mortality is a reflection of the newborn's health and the treatment that is provided to the pregnant mother and her infant after birth.

The neonatal mortality rate was 4.4 per 1,000 births in FY 2007. While the difference is not statistically significant, the FY 2007 rate was slightly lower than the FY 2006 rate of 4.5 per 1,000 births. Based on preliminary data, the FY 2008 target of 4.5 per 1,000 births has been achieved with a neonatal mortality rate of 4.3 per 1,000 live births.

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

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

The percentage of VLBW babies delivered at facilities for high-risk deliveries and neonates declined from 75.2% in FY 2002 to 71.7% in FY 2004. Since FY 2004, there has been some improvement in the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates, with rates at 74.7% for FY 2006, 74.8% for FY 2007, and 76.1% for FY 2008. The FY 2008 target of 76.1% was exceeded.

The Program is partnering with State programs, CDC, and the Association of Maternal and Child Health to assess influential factors. A recent study conducted by the Cecil G. Sheps Center and supported by HRSA's Maternal and Child Health Bureau examined the trends in the rate of very low birth weight deliveries in an appropriate hospital and explored reasons that States give for change in this marker. States report that systems exist for coordinating care among multiple providers, but the extent to which regionalized perinatal care systems are regulated and prescribed varies considerably. States are examining where very low birth weight births occur and why some do not occur in facilities for high-risk deliveries. Understanding if health care systems factors have played a role in a poor outcome and identifying which factors could potentially be modified would be an important contribution to improving this indicator. Surveillance of very low birth weight births is necessary for the quality improvement initiatives that are frequently cited by States as processes by which they hope to improve neonatal health and health care. The FY 2012 target is 76%. While modest, the targeted increases for this measure represent the Program's ongoing commitment to continued improvement.

10.3. Increase maternal survival rate.

The FY 2008 target is 8 deaths per 100,000 live births. Data are expected to be available in November 2011.

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

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

Per \$1 million in funding, the number of children receiving direct, enabling and population-based services through the Title V MCH Block Grant in FY 2008 reached its highest level at 52,511 since data reporting for this measure began. Greater program efficiencies resulted in an increased number of children being served by Title V at a time when Title V Block Grant funds were decreased. While the targets have steadily increased since 2006 to reflect the higher levels of service that were provided, the difficulty in maintaining such increases was previously noted above. The 2009 service level of 50,267 exceeded the target of 39,000 by approximately 29%. However, the number of children served by the Title V Block Grant per \$1 million was lower than in 2008. The FY 2012 target for this measure is 45,000.

The increase in the number of children served per \$1 million in Title V funding shows some level of improvement in program efficiency in the use of Federal funds as well as a shift towards provision of more population-based services. Programs have also had to rely more heavily on other sources for program funding, including Medicaid and CHIP, and an increasing level of payments made by those who receive services. Performance for this measure has also been impacted by the steady increases in the number of children served annually by Title V and the reduction in Title V MCH Block Grant funding since FY 2004. The Program continues to monitor the number of children served by Title V and to explore opportunities for greater program efficiencies.

DISCONTINUED MEASURE

Measure	FY	Target	Result
10.III.A.5: Reduce maternal illness and complications due to pregnancy. ¹ (Outcome)	2009	36 per 1,000	Nov 30, 2012
	2008	37 per 1,000	Nov 30, 2011
	2007	30 per 1,000	41.8 per 1,000 (Target Not Met)
	2006	30 per 1,000	40.7 per 1,000 ² (Target Not Met)
	2005	N/A	39.2 per 1,000 (Target Not In Place)

Measure	Data Source	Data Validation
10.III.A.5	Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC)	Data validated by CDC

10.III.A.5. Reduce maternal illnesses and complications due to pregnancy.

Medical risk factors, such as diabetes and pregnancy-induced hypertension, can contribute to serious complications during pregnancy as well as maternal and infant morbidity and mortality, particularly if they are not properly identified and treated. The level of pregnancy-associated hypertension for 2005 (39.9 per 1,000 deliveries) was the highest reported since these data became available. In 2006, pregnancy-associated hypertension occurred at a rate of 39.1 per 1,000 deliveries. Since 2000, the prevalence of pregnancy-associated hypertension has increased by an average of one percent per year, compared with an average increase of nearly four percent per year throughout the 1990s. Diabetes prevalence has risen markedly since 1990, and the increase has quickened in recent years. In 2006, diabetes during pregnancy was reported at a rate of 42.3 per 1,000 deliveries, compared with 38.5 per 1,000 deliveries in 2005.

The average rate for the two most common conditions in pregnancy (i.e., diabetes and pregnancy-induced hypertension) increased from 36.8 per 1,000 deliveries in FY 2004 to 41.8 per 1,000 deliveries in FY 2007. Due to changes in the revised 2003 Certificate of Live Birth, previous years' data are not comparable. Data reported prior to FY 2004 were based on the three most common conditions in pregnancy (i.e., diabetes, pregnancy-induced hypertension and anemia.) Given the change in how data are reported for this measure, comparison of actual performance in FY 2007 with the established target of 30 per 1,000 deliveries is not appropriate. The FY 2009 target for this measure is 36 per 1,000 deliveries.

¹ Indicator: Hospitalizations per 1000 deliveries due to illness and complications resulting from pregnancy. Actual data reported for FY 2004, FY 2005 and FY 2006 are based on the average rates for the two most common illnesses in pregnancy (i.e., diabetes and pregnancy-induced hypertension). The targets for FY 2006 and 2007 were developed based on earlier data which included three conditions of pregnancy (i.e., diabetes, pregnancy-induced hypertension and anemia). These targets are not appropriate for the data as it is currently collected. This difference in data collection is due to changes in the revised 2003 Certificate of Live Birth.

² National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2009. Births: Final Data for 2006, National Vital Statistics Reports, Vol. 57, No. 7, January 2009.

This annual measure was discontinued for FY 2010 due to the lack of a national data source. The average rate for the two most common conditions in pregnancy (i.e., diabetes and pregnancy-induced hypertension) had been used as a proxy for reporting on this measure. The last year for which data will be reported is FY 2009.

TRAUMATIC BRAIN INJURY PROGRAM

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
11.1: Proportion of children with brain injury who are able to participate in community activities. ¹ (Outcome)	<i>Out-Year Target</i>	55% (FY 2011)	Aug 31, 2012
	2007	N/A	52.5% (Baseline)
11.V.B.4: Increase the number of new State partnerships and/or collaborations with governmental and non-governmental organizations. (Output)	2012	154 ²	Aug 31, 2012
	2011	154	Aug 31, 2011
	2010	N/A	131 (total) (Baseline)
11.V.B.5: Increase the number of public schools in the States/Territories that screen children for TBI on an annual basis (Developmental). ³ (Output)	2012	TBD	TBD
Efficiency Measure	FY	Target	Result
11.E: Decrease the application and reporting time burden of grantees (hours) (Efficiency)	2012	127	Nov 20, 2014
	2011	127	Nov 30, 2013
	2010	132	Nov 30, 2012
	2009	139	Nov 30, 2011
	2008	147	147 (Target Met)
	2007	154	155 (Target Not Met but Improved)

Measure	Data Source	Data Validation
11.E 11.1	Grantee annual reports.	Data confirmed by project officers.

INTRODUCTION

The Traumatic Brain Injury Program’s performance measures link to HRSA’s Strategic Plan goal to build healthy communities and also link to the sub-goal: of leading and collaborating with others to help communities strengthen resources that improve health for the population. Performance data are used to inform the Program’s strategies to provide guidance and technical assistance to grantees in efforts to improve performance. Below is a discussion of current performance measures.

¹This long term measure does not have annual targets. The next time the National Survey of Children’s Health will be fielded is in 2011.

²No increase is projected for number of partnerships between FY 2011 and FY 2012 because it is anticipated that the focus of States will be on consolidating existing partnerships.

³ The baseline for this developmental measure will be reported by August 2011 for FY 2010.

DISCUSSION OF RESULTS AND TARGETS

Goal: Build Healthy Communities

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

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

This measure focuses on the functional status and quality of life of children with TBI. Evidence suggests that children and adolescents are an important population for assessing the ability of persons with TBI to function in the community. Systems infrastructure-building for TBI programs is an integral part of enhancing and/or sustaining the functional status and quality of life for this population. The FY 2007 baseline for this measure is 52.5%. The long-term target is 55% in FY 2011.

11.V.B.4: Increase the number of new State partnerships and/or collaborations with governmental and non-governmental organizations.

An important strategy for grantees is to increase the number of new State partnerships and/or collaborations with at least one new governmental and/or non-governmental organization annually. Evidence suggests that building partnerships can increase resources and help with sustainability of resources and programs that serve the community. The baseline is 131 total partnerships. The targets for FY 2011 and FY 2012 are set at 154 total partnerships.

11.V.B.5: Increase the number of public schools in the States/Territories that screen children for TBI on an annual basis (Developmental).

An important strategy for grantees is to increase the number of public schools in the States/Territories that screen children for TBI on an annual basis. Increasing the number of public schools screening children will increase the total number of children screened for TBI. Evidence suggests that early identification in children leads to early intervention thus increasing the chances of individuals living productive lives. The baseline for this developmental measure will be reported by August 2011 for FY 2010.

11.E. Decrease the application and reporting time burden of grantees

A new on-line application and reporting system was implemented in FY 2005 and was fully operational in FY 2006. This system provides grantees with information from previous years, including budget and service data. This alleviates the necessity of grantees supplying information that was previously provided. Also, the system pre-populates figures into subsequent forms so that grantees do not have to enter the same data more than once. Reporting is also easier on the on-line system and provides program management with data that are far more reliable and valid, with a shorter lag time. The number of hours of application and reporting time burden of grantees decreased from 162 hours in 2006 to 155 hours in FY 2007. In FY 2008, the target of 147 hours was met. The FY 2012 target is 127 hours.

DISCONTINUED MEASURES

Measure	FY	Target	Result
<u>11.V.B.1:</u> Increase the number of States and Territories that have achieved a minimum TBI core capacity (including State Action Plan, Statewide Needs and Resources Assessment, designated State agency staff, and State Advisory Board). (Output)	2012	N/A ¹	N/A
	2011	21	Nov 20, 2012
	2010	51	Nov 30, 2011
	2009	51	23 (Target Not Met)
	2008	51	51 (Target Met)
	2007	51	51 (Target Met)
<u>11.V.B.2:</u> Increase the number of States/Territories that have begun to implement their TBI plan of action. (Output)	2012	N/A ¹	N/A
	2011	21	Nov 20, 2012
	2010	51	Nov 30, 2011
	2009	51	22 (Target Not Met)
	2008	51	51 (Target Met)
	2007	48	47 (Target Not Met but Improved)
<u>11.V.B.3:</u> Increase the number of States/Territories that have completed at least 50% of the objectives contained in their TBI plan of action. (Output)	2012	N/A ¹	N/A
	2011	24	Dec 31, 2012
	2010	24	Dec 31, 2011
	2009	24	18 (Target Not Met)
	2008	24	24 (Target Met)
	2007	18	24 (Target Exceeded)

Measure	Data Source	Data Validation
11.V.B.1 11.V.B.2 11.V.B.3 11.V.B.4 11.V.B.5	Grantee annual reports.	Data confirmed by project officers.

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

Coordinated, community-based and culturally competent systems that address the needs of individuals with TBI advance the goal of access to high quality care that can improve health outcomes. The number of States and Territories that have achieved minimum core capacity to serve individuals with TBI and their families is an indicator of the extent to which the U.S. is

¹ The FY 2012 target is N/A because this measure has been discontinued.

able to provide systematic, appropriate care for individuals with TBI, including veterans with TBI who return home to continue their post-acute care in the community. In FY 2005, the number of States and Territories with core capacity was 51 and this number remained constant through FY 2008. The FY 2009 target was not met due to expiration of grants resulting in a reduction in the number of grants to 23. The FY 2011 target is 21.

The measure will be discontinued in FY 2012. The last year for which data will be reported is FY 2011. The measure is being retired because the number of states achieving the desired result is at or near the maximum. New measures have been developed (11.V.B.4 and 11.V.B.5).

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

As States and Territories actually begin to put in place their Statewide Action Plan (based on their Statewide Needs and Resources Assessment) they are demonstrating their ability to correctly assess and meet the needs of individuals with TBI and their families. The number of States and Territories increased from 45 in 2006 to 47 in 2007, missing the 2007 target of 48. For FY 2008, the target of 51 was met. The FY 2009 target of 51 was not met due to a reduction in the number of grants. The FY 2011 target is 21 States/Territories. While the Program continues to encourage the remaining States/Territories to begin implementation of plans, greater emphasis is now placed on assisting States/Territories in completing more objectives contained in their plans.

This measure will be discontinued in FY 2012. The last year for which data will be reported is FY 2011. The measure is being retired because the number of states achieving the desired result is at or near the maximum. New measures have been developed (11.V.B.4 and 11.V.B.5).

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

Moving to completion of 50% of program (action plan) goals indicates steady progress towards implementation of a coordinated, community-based and culturally competent system of care for individuals with TBI and their families. The number of States and Territories that have completed at least 50% of their objectives increased from 17 in FY 2006 to 24 in FY 2007. In FY 2008 the number remained 24, meeting the target. In FY 2009 the result was 18, not meeting the target of 24 because the number of grantees decreased. In addition to the number of grantees decreasing, new grantees would not be expected to have 50% of their action plans completed in their first year of award. For FY 2011, the target was set to remain 24 due to the expiration of grants resulting in a reduction in the number of active grantees from 49 in FY 2008 to around 22 by the end of FY 2010. This anticipated reduction will result in fewer States/Territories participating in the program.

This measure will be discontinued in FY 2012. The last year for which data will be reported is FY 2011. The measure is being retired because the expiration of grants will result in the reduction of grantees by the end of FY 2010. New measures have been developed (11.V.B.4 and 11.V.B.5).

JAMES T. WALSH UNIVERSAL NEWBORN HEARING SCREENING

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>13.1:</u> Increase the percentage of children with non-syndromic hearing loss entering school with developmentally appropriate language skills. ¹ (Baseline – FY 2004: 20% estimated) (<i>Outcome</i>)	<i>Out-Year Target</i>	85% (FY 2013)	Jul 31, 2014
<u>13.2:</u> Increase the percentage of infants with hearing loss enrolled in early intervention before 6 months of age. ¹ (Baseline – FY 2004: 57%) (<i>Output</i>)	<i>Out-Year Target</i>	85% (FY 2013)	Jul 31, 2014
<u>13.III.A.1:</u> Percentage of infants suspected of having a hearing loss with a confirmed diagnosis by 3 months of age. (<i>Output</i>)	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)
	2007	62%	66% (Target Exceeded)
<u>13.III.A.2:</u> 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>)	2012	95%	Dec 31, 2013
	2011	95%	Dec 31, 2012
	2010	94%	Dec 31, 2011
	2009	N/A	N/A ²
	2008	88%	N/A ²
	2007	87%	N/A ²
<u>13.III.A.3:</u> Percentage of infants screened for hearing loss prior to hospital discharge. (<i>Output</i>)	2012	98%	Mar 31, 2015
	2011	98%	Mar 31, 2014
	2010	98%	Mar 31, 2013
	2009	98%	Mar 31, 2012
	2008	98%	97% (Target Not Met but Improved)
	2007	97%	94% (Target Not Met but Improved)

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

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.

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. (Efficiency)	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)
	2007	62%	66% (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.

INTRODUCTION

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.

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Access to Quality Health Care and Services

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

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

The FY 2013 target is 85%. Data are anticipated on July 2014.

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

The FY 2013 target is 85%.Data are anticipated on July 2014.

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

While major success has been achieved in screening infants for hearing loss before hospital discharge, those suspected of a hearing loss were receiving timely re-screening and diagnostic services only about 55% of the time, as reported for FY 2005. Many of the reasons, such as health provider information about hearing loss in infants, a dearth of audiologists capable of caring for infants, and inadequate data and tracking systems, have been identified and mechanisms to address these problems are being developed and implemented. Results for this performance measure include an increase from 50% in FY 2004 to 55% in FY 2005. The actual result for this measure was 36% in FY 2006. This decrease is likely attributable to a change in data source for this measure. Previously data were collected by the National Center for Hearing Assessment and Management (NCHAM), the national resource center for the Universal Newborn Hearing Screening and Intervention program. Annual data are now collected by the CDC which uses different definitions than NCHAM. Data from the CDC Hearing Screening and Follow-up Survey (HSFS) reflects data that states and territories have *documented*, allowing no estimates. In FY 2007, 66% of infants with a suspected hearing loss received a confirmed diagnosis by 3 months of age. In FY 2008, that percentage rose to 68%. The FY 2012 target is 70%.

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

Limited research on health outcomes for Children with Special Health Care Needs (CSHCN) indicates that those children who are in a medical home fare better than those receiving health care in settings where there is no mechanism for care coordination. States are encouraged to identify a medical home for each infant suspected of a hearing loss, and to assist the medical home in assuring appropriate and timely follow-up for those infants and their families. A variety of tools have been developed in conjunction with the American Academy of Pediatrics (AAP) to support the medical home in caring for infants with a suspected (or confirmed) hearing loss and their families. Available data for 2005 indicate that 80% of infants with a suspected or confirmed hearing loss were referred to an ongoing source of comprehensive care. In FY 2006, 94% were referred to an ongoing source of care, exceeding the target of 85%. The target is based on responses to the question: "Do you have one person you think of as child's personal doctor or nurse?" from the National Survey of Children with Special Health Care Needs. Data for FY 2007 thru FY 2009 are not available since the Children with Special Health Care Needs Survey is only fielded every four years. The FY 2012 target is 95%.

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

The number of infants receiving a physiologic screening test for hearing loss prior to discharge from the newborn nursery has increased dramatically over the past several years. In FY 2007, States reported that 94% of infants were screened. This was a decrease from 95% of infants screened in FY 2005. The decrease is a function of a change in data source. Data that were collected by the National Center for Hearing Assessment and Management (NCHAM) have been replaced by Center for Control and Prevention (CDC), whose definitions differ from NCHAM.

NCHAM no longer collects national data on these items. Additional gains are to be achieved by focusing on infants born at home or in other out-of-hospital settings, transferred infants who require neonatal intensive care, and births in small hospitals where screener experience is limited. For FY 2008, States reported that 97% of infants were screened. The FY 2012 target is 98%.

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

Increasing the percentage of infants who receive a confirmed diagnosis by 3 months of age while maintaining a consistent level of Federal funding would indicate increased program efficiency. In FY 2005, 55% of infants who failed the screening test received a confirmed diagnosis by three months of age, as compared to 50% in FY 2004. In FY 2006 the figure was 36% possibly reflecting a change in the data source. In FY 2007, 66% of infants who failed the screening test received a confirmed diagnosis by three months of age, indicating substantial improvement, while continuing to fall short of the target. In FY 2008, this number rose to 68%, exceeding the target. Annual data are now collected by the CDC which uses different definitions than NCHAM, which previously collected the data. Data from the CDC Hearing Screening and Follow-up Survey reflects data that states and territories have *documented*, allowing no estimates. Future targets have been adjusted to reflect this change in data collection. The FY 2012 target is 70%.

EMERGENCY MEDICAL SERVICES FOR CHILDREN

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%) <i>(Outcome)</i>	<i>Out-Year Target</i>	8.1% (FY 2014)	July 31, 2016
	<i>2012</i>	8.4%	July 31, 2014
	<i>2011</i>	8.5%	July 31, 2013
	<i>2010</i>	8.6%	July 31, 2012
	<i>2009</i>	8.7%	July 31, 2011
14.V.B.1: Increase the number of awardees that demonstrate the operational capacity to provide pediatric emergency care, including all core capacity elements related to: (a) on-line and off-line medical direction at the scene of an emergency for Basic Life Support (BLS) and Advanced Life Support providers, (b) essential pediatric equipment and supplies, (c) designation of pediatric specialty care hospitals, and inter-facility transfer agreements. (Baseline – FY 2005: 20) <i>(Output)</i>	<i>2012</i>	30	July 31, 2013
	<i>2011</i>	28	July 31, 2012
	<i>2010</i>	26	July 31, 2011
	<i>2009</i>	24	26 (Target Exceeded)
	<i>2008</i>	21	23 (Target Exceeded)
<i>2007</i>	28	22 (Target Not Met but Improved)	
14.V.B.2: Increase the number of awardees that have adopted requirements for pediatric emergency education for the re-certification of paramedics. <i>(Output)</i>	<i>2012</i>	39	July 31, 2013
	<i>2011</i>	37 ³	July 31, 2012
	<i>2010</i>	27	July 31, 2011
	<i>2009</i>	25	37 (Target Exceeded)
	<i>2008</i>	22	24 (Target Exceeded)
	<i>2007</i>	43	23 (Target Not Met but Improved)
14.V.B.3: Transfer rate for children with an injury severity score (ISS) of 15 or more. ⁴ (Developmental) <i>(Output)</i>	<i>2012</i>	TBD	TBD
	<i>2011</i>	N/A	N/A
	<i>2010</i>	N/A	N/A
	<i>2009</i>	N/A	TBD (Baseline)

³ Target differs from that shown in the FY 2011 Congressional Justification to reflect most recent performance.

⁴ This developmental measure does not currently have annual targets. Baseline data for FY 2009 will be available in 2011 when the 2012 target will be established.

Efficiency Measure	FY	Target	Result
14.E: Decrease the application and reporting time burden of grantees. (Efficiency)	2012	70 hours	July 31, 2013
	2011	75 hours	July 31, 2012
	2010	80 hours	July 31, 2011
	2009	85 hours	85 hours (Target Met)
	2008	90 hours	90 hours (Target Met)
	2007	90 hours	90 hours (Target Met)

Measure	Data Source	Data Validation
14.E 14.V.B.1 14.V.B.2	Grantee reports.	Data confirmed by project officers.
14.1 14.V.B.3	Grantee reports; Healthcare Cost and Utilization Project (HCUP)	Data confirmed by project officers.

INTRODUCTION

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

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Access to Quality Health Care and Services

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

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

The EMSC program is designed to ensure state-of-the-art emergency medical care for ill or injured children and adolescents. It covers the entire spectrum of emergency medical care. This measure was selected as a measure of performance because the right emergency care should result in reduced mortality. The FY 2012 target is 8.4%

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

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

In FY 2007, 22 States were considered to have met the operational capacity to provide pediatric emergency care, based upon reports from individual States. This was an increase over FY 2006 but did not meet the FY 2007 target. The fact that the FY 2007 target was not met is due to a change that occurred in 2006 in the definition of what is required to meet the performance standard. The current definition and method of data collection are more rigorous than when the target was established. As a result, many States that reported meeting all components in FY 2005 did not meet the requirements for FY 2006 and FY 2007 reporting. In areas such as "essential pediatric equipment and supplies," for example, some States may be missing only one piece of equipment, but these States are now considered as not meeting the essential pediatric equipment requirement. States must completely meet all three categories of core elements in order to be considered as demonstrating the operational capacity to provide pediatric emergency care. Collection of the data is a requirement of the State Partnership grant program. In FY 2008, 23 States were considered to have met the operational capacity to provide pediatric emergency care, slightly exceeding the target of 21 and exceeding the FY 2007 actual by one. In FY 2009, 26 States were considered to have met the operational capacity to provide pediatric emergency care, exceeding the target of 24. The target for FY 2012 is 30.

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

The adoption of guidelines for pediatric emergency care training/education for pre-hospital providers is an integral component of the EMSC Program and helps to ensure the provision of appropriate pediatric emergency care across the continuum of care. In FY 2007, the number of awardees that met this goal was 23, and is expected to increase annually. This was an increase over FY 2006 but did not meet the FY 2007 target (43 states). The target was not met because the requirements for pediatric emergency education for the re-certification of paramedics were made more rigorous based on feedback from national stakeholders to add the specification that the requirement for recertification be State-mandated through statute, rules, or regulations. This change resulted in fewer states being able to meet the performance standard. However, the amount of pediatric emergency education within States did not diminish. Rather, training in some States is not yet mandated through State statutes, rules or regulations. In FY 2009, 37 awardees adopted requirements for pediatric emergency education for pre-hospital providers, exceeding the target of 25. The target for FY 2012 is 39.

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

The EMSC program seeks to improve the inter-facility transfer rate to hospitals that have the special expertise to care for critically ill or injured children. By improving the inter-facility transfer rate, it is expected that mortality rates for critically ill and injured children will improve. Baseline data for FY 2009 will be available in 2011 when the 2012 target will be established.

14.E. Decrease the application and reporting time burden of grantees by 5% per year

A new on-line application and reporting system was implemented in FY 2005 and became fully implemented in FY 2006 through Grants.gov and HRSA's Electronic Handbook. This system provides grantees with information from previous years, including budget and service data. This alleviates the grantees from having to supply information that was previously provided. Also, the system pre-populates figures into subsequent forms so that grantees do not have to enter the same data more than once. Reporting is also easier on the on-line system and provides program management with performance data that are far more reliable and valid, with a shorter lag time. In FY 2009 the number of hours was 85, meeting the target. This was down from 125 hours in FY 2006. The target for FY 2012 is 70 hours.

HEALTHY START

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
<u>12.2:</u> Reduce the neonatal mortality rate among Healthy Start program clients. ¹ (Baseline – FY 2004: 4.8 per 1,000) (Outcome)	<i>Out-Year Target</i>	2.7 per 1,000 (FY 2013)	Oct 31, 2015
<u>12.3:</u> Reduce the post-neonatal mortality rate among Healthy Start program clients. ¹ (Baseline – FY 2004: 2.82 per 1,000) (Outcome)	<i>Out-Year Target</i>	1.6 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)	2012	75%	Oct 31, 2014
	2011	75%	Oct 31, 2013
	2010	75%	Oct 31, 2012
	2009	75%	Oct 31, 2011
	2008	75%	68.5% (Target Not Met but Improved)
	2007	75%	68.2% (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)	2012	9.6%	Oct 31, 2014
	2011	9.6%	Oct 31, 2013
	2010	9.6%	Oct 31, 2012
	2009	9.6%	Oct 31, 2011
	2008	9.7%	10.7% (Target Not Met)
	2007	9.2%	10.3% (Target Not Met)

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

Measure	FY	Target	Result
12.II.B.1: Increase annually the number of community members (providers and consumers, residents) participating in infant mortality awareness public health information and education activities. (<i>Output</i>)	2012	376,000	Oct 31, 2014
	2011	396,000	Oct 31, 2013
	2010	395,000	Oct 31, 2012
	2009	350,000	Oct 31, 2011
	2008	340,000	394,239 (Target Exceeded)
	2007	337,000	391,143 (Target Exceeded)
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) (<i>Efficiency</i>)	2012	532,500	Oct 31, 2014
	2011	552,500	Oct 31, 2013
	2010	524,500	Oct 31, 2012
	2009	485,000	Oct 31, 2011
	2008	475,000	571,167 (Target Exceeded)
	2007	420,000	542,484 (Target Exceeded)

Measure	Data Source	Data Validation
12.1 12.2 12.3 12.III.A.1 12.II.B.1 12.III.A.2 12.E	Grantee reports.	Data confirmed by project officers.

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’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 interconception care.

Projects re-compete for funding every five years; at that point in time they may adjust their service areas to exclude areas that no longer need Healthy Start services because the Program has been successful and to incorporate other neighborhoods where there is a significant need for the program. Some variation in results occurs when successful neighborhoods are phased out at the end of a grant period and new high-risk neighborhoods are added.

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Health Equity

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

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

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

Results of this measure will be reported in October 2015.

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

Results of this measure will be reported in October 2015.

Goal: Improve Health Equity

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

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

Healthy Start focuses intensive outreach efforts on enrolling hard-to-reach, high-risk women in prenatal care. The percentage of women participating in Healthy Start who had a prenatal visit in the first trimester fell from 70% in FY 2004 to 68% in FY 2006 and rose slightly in FY 2008 to 68.5%, which was below the target. Healthy Start was not successful in meeting its target of 75% entry into prenatal care due to a resurgence of barriers to access to care, such as state budget crises, changes in financing of prenatal care at the State level, a shortage of obstetric providers due to professional liability litigation and malpractice coverage factors, and a growing trend among obstetric providers to delay the first prenatal health care visit until early in the second

trimester. Along with the resurgence of these factors, many projects adjusted their project areas to include new neighborhoods where there was a significant need for the program (e.g., high rates of infant mortality and other adverse perinatal health outcomes).

Healthy Start is continuing to work with individual projects on identifying the challenges in their local communities as well as sharing among projects successful strategies to improve access. A learning collaborative model program has been established to further assist projects in strengthening their project's capacity to offer primary and support healthcare services to participants. The program has also identified and synthesized evidence-based practices that contribute to improved perinatal outcomes and disseminated this information to the HS communities.

Future targets for this measure are set at 75%.

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

Healthy Start is designed to reduce adverse perinatal outcomes, such as low birthweight (LBW) and infant mortality, by helping communities identify, plan and implement a diverse range of interventions to support and improve perinatal delivery systems in project communities. Because Healthy Start participants are among those at highest risk for poor perinatal outcomes and the hardest to engage in ongoing preventive healthcare, improved health outcomes are harder to achieve than in the general population.

Low birthweight is associated with an increased risk of infant death; an infant's size at birth is also a key predictor of short and long-term health status. The percentage of low birthweight babies born to Healthy Start clients in FY 2003 was 10.5% and showed a reduction to 10.3% in FY 2006 and FY 2007. The figure increased to 10.7% in FY 2008, not meeting the target. During this period, the national LBW rate for African-Americans actually increased from 13.6% in FY 2003 to 14.0% in FY 2006; in 2007 and 2008, a slight decrease in LBW for African-Americans of 13.9% and 13.6%, respectively, was reported. The Healthy Start program will work through the learning collaborative program and other venues to improve the modifiable factors (e.g., tobacco use) associated with LBW.

The FY 2011 and FY 2012 targets of 9.6% reflect the national trend.

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

Each of the Healthy Start projects has committed to reducing disparities in perinatal health and infant mortality by transforming their communities, strengthening community based systems to enhance perinatal care and improving the health of the young women and infants in their vulnerable communities. This measure demonstrates the participation of community members in infant mortality awareness activities. In FY 2008 the number of community members estimated to participate in public health information and education activities increased to 394,239,

exceeding the target of 340,000. The FY 2008 result is up from the FY 2006 actual of 338,800 but down from the FY 2007 result of 391,143. This may be due to changes in service area as mentioned previously. The FY 2012 target is 376,000.

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

The program proposes to demonstrate its efficiency by serving more persons each year with a (relatively) constant level of funding. In FY 2008, the number of persons served by the Healthy Start program was 571,167, up from 288,800 in FY 2002 and 542,484 in FY 2007; the FY 2008 result exceeds the target of 475,000. The target for FY 2009 is 485,000 because of expected year-to-year fluctuations. The FY 2010 target is 524,500 and the FY 2011 target is 552,500. The FY 2012 target is 532,500.

FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS

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.	2012	123,000 ¹	Sep 30, 2012
	2011	122,500 ¹	Sep 30, 2011
	2010	N/A ¹	121,476 (Target Not in Place)
	2009	77,082	92,395 (Target Exceeded)
	2008	70,082	75,532 (Target Exceeded)
	2007	N/A	35,041 ² (Baseline)
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)	2012	85% ¹	Oct 30, 2012
	2011	83%	Oct 30, 2011
	2010	N/A ¹	81% (Target Not in Place)
	2009	61%	65% (Target Exceeded)
	2008	N/A	59.8% ³ (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.

INTRODUCTION

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

¹ These targets reflect Affordable Care Act funding. No targets were established for FY 2010 because the program was scheduled to end.

² Data for the 6 month period of June 1, 2007 – December 31, 2007.

³ Baseline data are for the July 2008 – May 2009 time period.

and analysis. A funding level of 5 million dollars is appropriated for the Family-To-Family-Health Information Centers program in FY 2012 through the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148), Sec. 5507 (Health Reform/addressing workforce needs).

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Increase outreach and enrollment into quality care

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.

This measure captures annual progress on the extent to which up to 51 Family-to-Family Health Information Centers provide information, education and training to families. This is an unduplicated count with one center not able to provide data. Information captured in this measure are: (1) information that is provided via direct one-on-one contact around a family health or access issue in person or by telephone to families with Children with Special Health Care Needs (CSHCN); and (2) Technical assistance pertaining to grantees' strategies to collect data and use of a uniform database provided on an ongoing basis. This technical assistance is provided via conference calls, and one-on-one assistance provided by the National Center for Family Professional Partnerships, which provides technical assistance for this group of grantees.

Based on 2008 data, it is estimated that 75,532 families were provided the two types of information noted above. This 75,532 figure represents individual families (unduplicated) that were tracked by 29 grantees and aggregated by the National Center for Family Professional Partnerships. The FY 2008 actual exceeded its target by 5,450. At that time, only 30 grantees were funded. The number of grantees increased as funding increased: in 2008-2009 there were 41 centers and in 2009-2010 there were 51 centers.

For FY 2009, the target was increased to 77,082. Actual results for one-to-one unduplicated contacts from 40 grantees for FY 2009 is 92,395, which exceeds the target. In addition, Family to Family Health Information Centers also provided 679,923 additional families training, newsletters, and listservs for a total of 772,318 families served. Throughout the year, the centers were better able to capture data through the use of a uniform database with on-going technical assistance. Funding was not expected for the program for FY 2010; therefore, no target was established. The result for FY 2010 for 50 centers that reported data is an unduplicated count of 121,476 families served. The target for FY 2012 is 123,000.

While the total number of unduplicated contacts with families increased from FY 2009 to FY 2010, the number of specific one-to-one contacts decreased. This decrease is a result of the economy driven increase in more time consuming complex calls that reduced that number of one-to-one contacts that could be fielded by the centers. In addition, there has been less non-profit/partner in-kind fiscal support for center staff time. For example, some centers have had to reduce the number of newsletters and listservs that they produce and maintain. The economy has also impacted some families' abilities to attend training sessions or to volunteer in outreach activities. In addition, 688,699 people received information via newsletters and listservs.

On-going technical assistance and data tips sheets are extremely helpful to grantees in acquiring more accurate data.

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.

This measure will capture the Centers' impact on the enhanced ability of families to better document and discuss health issues, ask questions and communicate with providers in making decisions around their children's care. It will also capture their ability to participate in systems building efforts in communities and on a State level (task forces, advisory committees, etc) after receiving services from the Centers. Together these data provide information on families' ability to better partner in decision making. Outcomes, to be obtained through follow-up telephone calls and surveys of a sample of families served by the Centers, will be tracked. A contractor was used to assist program staff, a workgroup of selected grantees and the National Center for Family Professional Partnerships in assessing grantee capacity to do the following: collect impact data; develop a technical assistance plan based upon this assessment; and develop strategies for collecting data that will be consistent across all grantees. Data collection from 40 centers was initiated after conducting a series of technical assistance calls with grantees, developing a set of OMB approved questions that all grantees would ask in follow-up with families and disseminating "tip sheets" on how to conduct follow-up with families. The percentage reported for FY 2008 is 59.8% which serves as a baseline. The actual result for 2009 is 65% of families responding that their center's assistance was useful to extremely useful in helping them be better partners in decision-making with their child's provider. Although no target was set for FY 2010, the actual result shows that 81% of families served by 50 centers said that the centers were somewhat useful, very useful or extremely useful in helping them to be better able to partner in decision making at any level. The 2012 target is 85%.

MATERNAL, INFANT, AND EARLY CHILDHOOD VISITING PROGRAM

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 (<i>Output-Developmental</i>)	2012	TBD	TBD
	2011	N/A	N/A
	2010	N/A	N/A
37.II: Number and percent of grantees that meet benchmark requirements for demonstrating improvements (<i>Outcome- Developmental</i>)	<i>Out-Year Target</i>	TBD ¹	TBD
	2012	N/A	N/A
	2011	N/A	N/A
	2010	N/A	N/A

Measure	Data Source	Data Validation
37.1	Annual progress/continuation reports submitted by grantees.	Data confirmed by project officers.
37.2	Annual progress/continuation reports submitted by grantees.	Data confirmed by project officers.

INTRODUCTION

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program links to the HRSA goal 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 the Health Resources and Services Administration (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.

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 8 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.

¹ 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).

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Health Equity

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

Grantees are required by statute to show measurable improvement for program participants in various benchmark areas at years 3 and 5 after program inception. These benchmark areas are 1) maternal and newborn health; 2) child injuries, child abuse, neglect, or maltreatment, and emergency department visits; 3) school readiness and achievement; 4) crime or domestic violence; 5) family economic self-sufficiency; and, 6) coordination and referrals for other community resources and supports. Each benchmark area includes multiple constructs. Grantees will provide information on these constructs (e.g., incidence of child injuries) and the associated measures (e.g., visits to the emergency department) selected for each benchmark area.

In addition to reporting on benchmark areas, grantees will collect individual-level demographic and service-utilization data on the participants in their program which are necessary to analyze and understand the progress children and families are making. Individual-level demographic and service-utilization data will include:

- Family's participation rate in the home visiting program (e.g., number of sessions/number of possible sessions);
- Demographic data for the participant child/children, pregnant woman, expectant father, parent(s), or primary caregiver(s) receiving home visiting services including: child's gender, age of all at each data collection point, and racial and ethnic background of all participants in the family;
- Participant child's exposure to languages other than English; and
- Family socioeconomic indicators (e.g., family income, employment status).

37.I. Number of children and families receiving services through evidence-based home visiting models. (Developmental)

This developmental measure captures the progress in reaching a larger number of families at risk for sub-optimal health and developmental trajectories with home visiting models that have proven effective in reducing risk factors (e.g., substance abuse, maternal depression) and enhancing protective factors (e.g., access to health services, parental and child exposure to reading) to improve participant outcomes.

37.II. Number and percent of grantees that meet benchmark requirements for demonstrating improvements. (Developmental)

This developmental measure captures the legislative requirements that grantees show improvement in at least four of the six benchmark areas by the end of the third year after program inception. Data collected for all constructs within each of the benchmark areas will be

reported. States must achieve improvement for at least half of the constructs to attain improvement in a given benchmark area. For each construct within individual benchmark areas (e.g. “general cognitive skills” within the School Readiness and Achievement benchmark area) grantees will specify the measure (or measures) proposed. Grantees will also propose a definition of improvement for the individual constructs (e.g. “improvement will be quantified as a decrease in the number of children identified as at risk by the Ages and Stages Questionnaire for Children’s Social-Emotional development (ASQ-SE) at over one year of program enrollment.”)

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)

Goal: Improve Health Equity

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

Measure	FY	Target	Result
<u>16.I.</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)	2012	5percentage points above CDC data	Oct. 31, 2013
	2011	5percentage points above CDC data	Oct 31, 2012
	2010	5percentage points above CDC data	Oct 31, 2011
	2009	5percentage points above CDC data	73% (CDC data not available for comparison)
	2008	5percentage points above CDC data	73% (CDC= 65.9%) (Target Exceeded)
	2007	5percentage points above CDC data	72% (CDC=64.1%) (Target Exceeded)
<u>16.I.A.2:</u> Proportion of women in Ryan White HIV/AIDS funded-programs served. (Outcome)	2012	5percentage points above CDC data	Oct. 31, 2013
	2011	5percentage points above CDC data	Oct 31, 2012
	2010	5percentage points above CDC data	Oct 31, 2011
	2009	5percentage points above CDC data	32% (CDC data not available for comparison)
	2008	5percentage points above CDC data	33% (CDC=23.2%) (Target Exceeded)
	2007	5percentage points above CDC data	33% (CDC = 23%) (Target Exceeded)
<u>16.III.A.2:</u> Proportion of new Ryan White HIV/AIDS Program HIV-infected clients who are tested for CD4 count and viral load. (Output)	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%	Aug 31, 2011
	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)
	2007	CD4 – 85.2% Viral Load – 81.3%	CD4 – 83.9% Viral Load – 81.2% (Target Not Met)

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

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>16.2</u> : 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
<u>16.II.A.1</u> : Number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs annually. (Output)	2012	218,446	Jan. 31, 2014
	2011	208,836 ³	Jan 31, 2013
	2010	149,946	Jan 31, 2012
	2009	146,486	205,446 (Target Exceeded)
	2008	158,739 ⁴	175,194 (Target Exceeded)
	2007	143,339 ⁴	163,925 (Target Exceeded)
<u>16.II.A.2</u> : Number of persons who learn their serostatus from Ryan White HIV/AIDS Programs. (Output)	2012	739,779	Feb. 28, 2014
	2011	572,397	Feb 28, 2013
	2010	572,397	Feb 28, 2012
	2009	572,397	871,696 (Target Exceeded)
	2008	572,397	739,779 (Target Exceeded)
	2007	572,397	738,181 (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)	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)
	2007	87.3%	85.1% (Target Not Met but Improved)

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.

Goal: Improve Access to Quality Health Care and Services

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

Measure	FY	Target	Result
16.3: Ryan White HIV/AIDS Program-funded HIV primary medical care providers will have implemented a quality management program and will meet two “core” standards included in the October 10, 2006 “Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents.” ⁵ (Baseline – FY 2005: 63.7%) (<i>Output</i>)	<i>Out-Year Target</i>	90% (FY 2014)	Aug 31, 2015
16.III.A.1: Percentage of Ryan White HIV/AIDS Program-funded primary medical care providers that will have implemented a quality management program. (<i>Output</i>)	2012	95.7%	Aug 31, 2013
	2011	95.7%	Aug 31, 2012
	2010	95.7%	Aug 31, 2011
	2009	95.7%	94.5% (Target Not Met but Improved)
	2008	93.2%	92.3% (Target Not Met but Improved)
	2007	90.7%	88.8% (Target Not Met but Improved)
Efficiency Measure	FY	Target	Result
16.E: Amount of savings by State ADAPs’ participation in cost-savings strategies on medications. (<i>Efficiency</i>)	2012	Sustain FY 11 results	Apr 30, 2014
	2011	Sustain FY 10 results	Apr 30, 2013
	2010	Sustain FY 09 results	Apr 30, 2012
	2009	Sustain FY 08 results	Apr 30, 2011
	2008	\$267.9 M	\$374.2 M (Target Exceeded)
	2007	\$260.6 M	\$265.2 M (Target Exceeded)

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

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.

INTRODUCTION

The Ryan White HIV/AIDS Program’s performance measures are tied to HRSA’s overall goals, which serve as the performance management framework for the Program. The measures allow the Program to track progress toward reaching these goals. Specific performance measures are linked to the following HRSA goals: Improve access to 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 aggregate above. This is followed by additional Part-specific measures.

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

The Ryan White HIV/AIDS Program uses various strategies to achieve the performance goals including targeting resources to address the unmet care and treatment needs of persons living with HIV/AIDS who are uninsured or underinsured and therefore unable to pay for HIV/AIDS health care and vital health-related support services; 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 encourage them to refer clients who test positive to Ryan White HIV/AIDS Programs for treatment.

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Health Equity

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

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

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

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

Even though new HIV infections among racial/ethnic minorities overall have been roughly stable, unlike in earlier years where racial/ethnic minorities accounted for an increasing proportion of HIV/AIDS cases. Racial/ethnic minorities continue to account for a higher proportion of cases at all stages of HIV—from new infections, to AIDS diagnosis, to death than non-racial/ethnic minorities. In addition, benefits provided by new combination drugs (anti-retrovirals/protease inhibitors/HAART) have not uniformly reduced the disparities in incidence of AIDS among racial/ethnic minorities. The proportion of racial/ethnic minorities served by the Ryan White HIV/AIDS Program was selected as a measure to demonstrate progress towards the program goal to improve access to health care among individuals infected with HIV/AIDS by increasing utilization for traditionally underserved populations.

Ryan White HIV/AIDS-funded programs serve a significantly higher proportion of racial/ethnic minorities than the target, which is five percentage points higher than the representation of racial/ethnic minorities among all AIDS cases in the Nation, as reported by CDC. In FY 2009, 73% of the Ryan White HIV/AIDS Program clients were racial/ethnic minorities. The CDC

AIDS data for comparison is not available as of this writing. In FY 2008 73% of the Ryan White HIV/AIDS Program clients were racial/ ethnic minorities, compared to 65.9% of CDC-reported AIDS cases. In FY 2007, 72% of clients served in the Ryan White HIV/AIDS – funded programs were racial/ethnic minorities, compared to 64.1% of CD4-reported AIDS cases. The Ryan White HIV/AIDS Program has historically seen a greater proportion of racial/ethnic minorities than are represented in the CDC AIDS data. The FY 2012 target for the proportion of racial/ethnic minorities served by the Ryan White HIV/AIDS Program continues to be 5percentage points above CDC data for the same period.

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

Women have been affected by HIV/AIDS since the beginning of the epidemic, the impact of HIV/AIDS on women has grown since the beginning of the epidemic. Women of color, have been especially hard hit by HIV/AIDS and they represent the majority of new HIV infections and AIDS diagnoses among women, and the majority of women living with HIV disease. For instance, women represented 8% of AIDS diagnoses in 1985, 20% in 1995, and 27% in 2000, roughly the same share as today. HIV incidence among women rose gradually until the late 1980s, but then declined in the early 1990s and has remained fairly stable since that time. Today about one in four Americans living with HIV are women. African American women are most affected. Benefits provided by combination drugs (anti-retrovirals/protease inhibitors/HAART) have not uniformly reduced the disparities in incidence of AIDS among women. The proportion of women served by the Ryan White HIV/AIDS Program was selected as a measure to demonstrate progress towards the program goal to improve access to health care among individuals infected with HIV/AIDS by increasing utilization for traditionally underserved populations.

The Ryan White HIV/AIDS-funded programs are serving a significantly higher proportion of women than the target, which is five percentage points higher than the representation of women among all AIDS cases in the Nation, as reported by CDC. In FY 2009, 32% of the Ryan White HIV/AIDS Program clients were women. CDCs AIDS data for comparison is not available as of this writing. In FY 2008, 33% of the Ryan White HIV/AIDS Program clients were women, compared to 23.2% of CDC-reported AIDS cases. The proportion of women served by the Ryan White HIV/AIDS Program in FY 2006 and FY 2007 was 33%, compared to 23% of CDC-reported AIDS cases. The Ryan White HIV/AIDS Program has historically seen a greater proportion of women than are represented in the CDC AIDS data. The FY 2012 target for the proportion of women served by the Ryan White HIV/AIDS Program is 5percentage points above CDC data for the same period.

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

The proportion of new Ryan White HIV/AIDS Program HIV-infected clients that are tested for CD4 count and viral load was selected as a measure to demonstrate progress towards the program goal to improve quality of health care for individuals infected with HIV/AIDS. CD4 cell measurement is a key test used: to assess the functioning of the immune system, guide

decisions about when to start HIV treatment, and monitor effectiveness of HIV treatment. Viral load tests measure the amount of HIV in the blood and are used along with CD4 cell counts to decide when to start HIV treatment and to monitor response to therapy. In FY 2009, the Ryan White HIV/AIDS Program provided CD4 count testing to 84.7% of new clients and viral load testing to 81.3% of these new clients. These results fell short of the target for CD4 tests by 2.5 percentage points and fell short of the target of new clients receiving viral load testing by 2.0 percentage points. In FY 2008, the Ryan White HIV/AIDS Program provided CD4 count testing to 86.4% of new clients and viral load testing to 84.4% of these new clients. In 2007, the Ryan White HIV/AIDS Program provided CD4 count testing to 83.9% of new clients and viral load testing to 81.2% of these new clients. The proportion of new clients being tested for CD4 count and viral load had improved from FY 2007 to FY 2008 but saw slight reduction in 2009. The FY 2012 target for CD4 is 88.2% and viral load is 84.3%.

Goal: Improve Access to Quality Health Care and Services

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

16.2. Deaths due to HIV infection below 3.1 per 100,000 people.

(Baseline – FY 2003: 4.7 per 100,000; Target - 2014 3.1 per 100,000)

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

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

In FY 2009, the AIDS Drug Assistance Program (ADAP) served 205,446 clients through State ADAPs, exceeding the target. In FY 2008, the AIDS Drug Assistance Program (ADAP) served 175,194 clients through State ADAPs. In FY 2007, the AIDS Drug Assistance Program (ADAP) served 163,925 clients through State ADAPs. The number of ADAP clients served through State ADAPs annually in FY 2009 was 58,960 persons above the FY 2008 annual results. These three years represents a substantial growth of 20.2% or 41,521 additional ADAP clients served from FY 2007 – FY 2009. About one in four HIV positive people in care in the U.S. receive their medications through State ADAPs. The FY 2012 target for clients served through State ADAPs is 218,446. The impact of these results are that more people, primarily low-income persons who had limited or no access to needed medications, gained access to essential medications to treat their disease and/or prevent the serious deterioration in health arising from their HIV disease. The ADAP target reflects consideration of increased medical inflation including rising health insurance premiums; many states are reporting decreases in state contributions and drug rebates; the addition of two new drug classes that include drugs requiring patients to have special laboratory testing; the new PHS guidelines concerning starting therapies earlier; and the impact of anticipated changes in the level of state contributions. The Program's ADAP Marginal Cost Analysis is used to help inform target setting.

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

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

CDC estimates that 1.039 to 1.185 million people in the United States are living with HIV/AIDS, of whom an estimated 25% are unaware of their serostatus. In FY 2009, 871,696 persons learned their serostatus from the Ryan White HIV/AIDS Program, exceeding the target by 299,299 persons. The number of persons learning their serostatus from Ryan White HIV/AIDS Programs was 739,779 in FY 2008. In FY 2007, the number of persons who learned their serostatus from Ryan White HIV/AIDS Programs was 738,181. These three years represents a growth of 133,515 persons who learn their serostatus or 15.3%. These efforts demonstrate that the Ryan White HIV/AIDS Program has made important strides in reaching people living with HIV/AIDS in the United States who do not know their serostatus. Future Program activities will have a heavier focus/emphasis on providing core medical services activities as opposed to testing. Ryan White HIV/AIDS Program dollars are used for HIV testing only when HIV testing is not otherwise available. The FY 2012 target for persons learning their serostatus from Ryan White HIV/AIDS Programs is 739,779.

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

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

Mother-to-child transmission in the U.S. has decreased dramatically, since its peak in 1992, due to the use of anti-retroviral therapy which significantly reduces the risk of transmission from the mother to her baby. The proportion of Ryan White HIV-positive pregnant women receiving anti-retroviral medication in both FY 2008 and FY 2009 was 87%. In FY 2007 the Ryan White HIV/AIDS Program provided 85.1% of HIV-pregnant women in the Ryan White Program with anti-retroviral medications. The percentage of HIV pregnant women in the Ryan White HIV/AIDS Program receiving anti-retroviral medications has grown 1.9 percentage points in the years FY 2007 – FY 2009. The FY 2012 target for the percentage of HIV-positive pregnant women in Ryan White HIV/AIDS programs receiving anti-retroviral medication is 90%.

Goal: Improve Access to Quality Health Care and Services

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

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

(Baseline – FY 2005: 63.7%; Target – 2014: 90%)

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

A major focus of the Ryan White HIV/AIDS Program is to improve the quality of care that its clients receive. Legislative requirements in both the Ryan White HIV/AIDS Extension Act of 2009 and in the Ryan White HIV/AIDS Treatment Modernization Act of 2006 direct grantees to develop, implement, and monitor clinical quality management programs to ensure that service providers adhere to established HIV clinical practices and quality improvement strategies; and that demographic, clinical, and health care utilization information is used to monitor trends in the spectrum of HIV-related illnesses and the local epidemic. The proportion of Ryan White HIV/AIDS Program-funded primary care medical providers that had implemented a quality management program by FY 2009 was 94.5%. This fell below the target by 1.2 percentage points. Additionally, the FY 2009 results represent a growth by 2.2 percentage points over the FY 2008 data which indicated that 92.3% of primary care providers had implemented a quality management program. In the baseline year of FY 2005 the Ryan White HIV/AIDS Program implemented a quality management program among 85.3% of primary medical care providers. This represents a growth of 9.2 percentage points, from FY 2005 to FY 2009, in implementing quality management programs. The FY 2012 target for the measure is 95.7%.

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

State ADAPs use a variety of strategies to contain costs which results in a more effective use of funding, enabling ADAPs to serve more people. Cost-containment measures used by ADAPs include: using drug purchasing strategies like seeking cost recovery through drug rebates and third party billing; and direct negotiation of pharmaceutical pricing. ADAPs’ savings strategies on medications resulted in a savings of \$374.2 million in FY 2008, exceeding the target by \$106.3 million. The amount of savings by State ADAPs participation in cost-saving strategies on medication in FY 2007 resulted in \$265.2 million in savings. The cost saving strategies resulted in an increase in saving of \$109 million from FY 2007 to FY 2008. In FY 2006 the ADAP cost-saving strategies resulted in \$258 million in savings. The FY 2012 target for the measure is to sustain the FY 2011 results.

HIV EMERGENCY RELIEF GRANTS (PART A)

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)	2012	2.63 M	Jan 31, 2014
	2011	2.63 M	Jan 31, 2013
	2010	2.63 M	Jan 31, 2012
	2009	2.59 M	2.59 M (Target Met)
	2008	2.47 M	2.60 M (Target Exceeded)
	2007	2.91 M	2.65 M (Target Not Met)

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.

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Access to Quality Health Care and Services

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

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

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

More than 70% of all people living with HIV/AIDS in the U.S. reside in a metropolitan area served by Part A. Part A serves an estimated 300,000 people living with HIV/AIDS each year. Seventy-five percent of Part A clients are people of color and 30% are women. In FY 2009, Part A provided 2.59 million visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health). This result is in line with the FY 2009 target. In 2008 Part A provided 2.60 million visits for health-related care. In FY 2007, 2.65 million visits were provided by 51 Part A grantees.

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

The trend demonstrates a decrease in visits from FY 2007 – FY 2009 which may be the result of fewer Part A providers and fewer clients served, and the impact of health care inflation. Additionally the range of services that are counted under health-related care includes rehabilitative services, which is not considered a core medical service. Patient outreach and follow-up are among the strategies grantees use to achieve targets.

The FY 2009 target was met, providing evidence that the Part A programs are successful in ensuring that many low-income, uninsured and underinsured people affected by HIV/AIDS had access to care and support services delivered in eligible metropolitan areas and transitional grant areas. The FY 2012 target is 2.63 million visits.

HIV CARE GRANTS TO STATES (PART B)

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>)	2012	2.19 M	Jan 31, 2014
	2011	2.19 M	Jan 31, 2013
	2010	2.19 M	Jan 31, 2012
	2009	2.14 M	2.11 M (Target Not Met But Improved)
	2008	2.14 M	2.02 M (Target Not Met)
	2007	1.56 M	2.06 M (Target Exceeded)

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.

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Access to Quality Health Care and Services

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

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

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

The Part B programs have been successful in helping to ensure that people living with HIV/AIDS can get the care and services they need to stay healthy longer. In FY 2009, the Part B program provided 2.11 million visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health), which fell short of the target by 30,000 visits. Part B programs provided 2.02 million visits in FY 2008 and 2.06 million visits in FY 2007.

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

The number of visits provided by the Part B program did not meet the FY 2009 target but has improved from FY 2007 and FY 2008. This target for visits was not met and may be the result of fewer Part B providers and fewer clients served, and the impact of health care inflation. Additionally the range of services that are counted under health-related care includes rehabilitative services, which is not considered a core medical service but rather categorized as a support service. Visit data for support services (i.e. rehabilitative services) is not collected.

Patient outreach and follow-up are among the strategies grantees use to achieve targets. The FY 2012 target is 2.19 million visits.

HIV EARLY INTERVENTION SERVICES (PART C)

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)	2012	247,361	Mar 21, 2014
	2011	241,885	Mar 31, 2013
	2010	240,666	Mar 31, 2012
	2009	236,745	Mar 31, 2011
	2008	216,591	247,133 (Target Exceeded)
	2007	158,346	236,745 (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.

DISCUSSION OF RESULTS AND TARGETS

Goal: Build Healthy Communities

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

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

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

The number of people receiving primary care services under Early Intervention Services (EIS) programs in FY 2008 was 247,133, exceeding the target by 12% and representing an increase of 4% in clients served compared to FY 2007. In FY 2007, the Part C program provided primary care services under Early Intervention Services (EIS) to 236,745 clients. In FY 2006, Part C Early Intervention Program served 225,410 clients and 216,591 clients were served in FY 2005. Over this four year period there has been a growth of 12.3% or 30,542 clients. The FY 2012 target for persons receiving primary care under Early Intervention Services programs is 247,361.

Key strategies used by grantees in continuing to exceed their performance targets include patient outreach and retention, education, continuity of care, effective treatment, linguistically and culturally appropriate services, treatment adherence support services, and addressing emotional barriers (i.e. stigma, fear, denial, shame) and structural barriers (i.e. lack of knowledge, transportation) that prevent people living with HIV from engaging in and retaining in medical care. The impact of surpassing the target is that more people gained access to ongoing medical, oral health, nutritional, psychosocial, and other treatment for HIV-positive individuals; laboratory, x-ray and other diagnostic tests; and medical case management to help patients access care and remain in treatment.

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

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)	2012	57,773	Jan 31, 2014
	2011	51,937	Jan 31, 2013
	2010	51,316	Jan 31, 2012
	2009	50,695	55,335 (Target Exceeded)
	2008	52,306	57,773 (Target Exceeded)
	2007	32,772	48,485 (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.

DISCUSSION OF RESULTS AND TARGETS

Goal: Build Healthy Communities

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

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

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

The number of female clients served in FY 2009 in the Part D program who were provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission was 55,335. This number exceeded the FY 2009 target by 4,640 clients or 8.3%. In FY 2008, Part D served 57,773 females. In FY 2007, Part D provided 48,485 female clients with comprehensive services. The FY 2012 target for female clients served is 57,773 female clients.

¹ Female clients counted are age 13 and above.

Key strategies used by grantees in achieving targets include patient outreach and follow-up. The result of surpassing the target is that many more female clients gained access to services including primary and specialty medical care, psychosocial services, logistical support and coordination, and outreach and case management.

AIDS EDUCATION AND TRAINING CENTERS (PART F)

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)	2012	43%	Jun 30, 2014
	2011	43%	Jun 30, 2013
	2010	43%	Jun 30, 2012
	2009	43%	Jun 30, 2011
	2008	43%	44% (Target Exceeded)
	2007	43%	43% (Target Met)

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.

DISCUSSION OF RESULTS AND TARGETS

Goal: Strengthen the Health Workforce

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

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

This measure was selected to demonstrate progress towards improvements in the public health and health care system by providing the education and training in HIV care to the health care workforce serving medically underserved populations. A training intervention is defined as an interaction between a health care provider and an AETC trainer for the purposes of receiving clinical consultation or other types of training related to the provision of HIV/AIDS related health care services.

Forty-four percent of the AETC program training interventions were provided to racial/ethnic minorities in FY 2008, exceeding the target. In FY 2007, the proportion of health care providers participating in the AETC programs who were racial/ethnic minority providers was 43% and the FY 2006 result was 44%. These proportions are approximately the same as in previous years and it is not expected to increase in the future. These results are a positive indicator of the programs' ability to have sustained levels of racial/ethnic minority health care providers participating in the AETC training interventions. The FY 2012 target is 43%.

**DENTAL REIMBURSEMENT AND COMMUNITY PARTNERSHIP PROGRAMS
(PART F)**

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)	2012	33,584	Apr 30, 2013
	2011	33,580	Apr 30, 2012
	2010	33,508	Apr 30, 2011
	2009	33,508	35,474 (Target Exceeded)
	2008	34,394	36,193 (Target Exceeded)
	2007	30,600	32,819 (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.

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Access to Quality Health Care and Services

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

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

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

In FY 2009, the Dental Reimbursement Program (DRP) awards met 35.4% of the total non-reimbursed costs reported by 57 participating institutions in support of oral health care. These institutions reported providing care to 35,474 HIV-positive individuals, for whom no other funded source was available. This number exceeded the goal by 1,966 individuals or 5.9%. The Dental Reimbursement Program contributed to the payment of unreimbursed oral health care for 34,394 persons in FY 2008 and 30,600 persons in FY 2007. Between FY 2007 and FY 2009 there was a growth of 2,655 persons receiving provider reimbursement for oral health costs or

8.0%. In FY 2009, the demographic characteristics of patients for whom a portion of their unreimbursed oral health costs was reimbursed by the DRP were 35.7% women and 62.6% minorities. The FY 2012 target for number of persons being reimbursed for oral health care is 33,584.

HEALTHCARE SYSTEMS

Programs included in this section are:

- Organ Transplantation
- C.W. Bill Young Cell Transplantation Program
- Poison Control Program
- Infrastructure to Expand Access to Care

ORGAN TRANSPLANTATION

Goal: Improve Health Equity

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

Measure	FY	Target	Result
<u>23.II.A.1</u> : Increase the annual number of deceased donor organs transplanted. (<i>Outcome</i>)	<i>Out-Year Target</i>	33,473 (FY 2013)	May 30, 2014
	2012	31,979	May 30, 2013
	2011	30,515	May 30, 2012
	2010	29,084	May 30, 2011
	2009	27,683	24,116 (Target Not Met but Improved)
	2008	26,314	23,933 (Target Not Met)
	2007	27,877	24,230 (Target Not Met)
<u>23.II.A.7</u> : 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>	7,302 (FY 2013)	May 30, 2014
	2012	6,928	May 30, 2013
	2011	6,565	May 30, 2012
	2010	6,213	May 30, 2011
	2009	5,873	4,851 (Target Not Met but Improved)
	2008	5,543	4,586 (Target Not Met)
	2007	5,477	4,775 (Target Not Met)
Efficiency Measure	FY	Target	Result
<u>23.II.A.8</u> : Increase the annual conversion rate of eligible donors. (<i>Efficiency</i>)	<i>Out-Year Target</i>	75% (FY 2013)	May 30, 2014
	2012	72.9%	May 30, 2013
	2011	70.8%	May 30, 2012
	2010	68.6%	May 30, 2011
	2009	66.5%	69.1% (Target Exceeded)
	2008	64.4%	66.5% (Target Exceeded)
	2007	62.3%	67% (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.

INTRODUCTION

The Organ Transplantation Program’s performance goals of increasing the number of deceased donor organs transplanted and increasing the survival benefit of kidney transplantation supports HRSA’s mission to improve health equity.

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.

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Health Equity

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

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

(Baseline - FY 2003: 20,392)

The intent of this measure is to increase the number of deceased donor organs transplanted on an annual basis. The number of deceased donor organs transplanted in FY 2009 was 24,116; 12.9% lower than target. However, it is a slight increase (.76%) over FY 2008 result. In FY 2008 there were 23,933 deceased organs transplanted. It was a slight decrease, 1.2%, from the FY 2007

result. After a 5.2% increase in FY 2006 over the FY 2005 result, there has been a decline in the number of deceased organs transplanted through FY 2008.

The FY 2012 target is 31,979 deceased donor organs transplanted.

The number of deceased donor organs made available for transplantation is a function of the number of deceased donors and the number of organs that are made available for transplant from each deceased donor. There were 8,022 deceased donors in FY 2009, which is slight increase over the 7,989 in FY 2008. However the FY 2008 number represents a 1.3% decrease from 8,091 in FY 2007. There were 8,026 deceased donors in FY 2006.

Targets for the number of deceased donor organs transplanted were established based on the best data available in 2004 on the estimated number of eligible organ donors. The number of eligible deaths in 2002 was in excess of 12,000 and the number had decreased to just below 10,000 in 2009. This decrease is in part due to fewer severe head traumas and improved management of brain injuries, e.g., pharmaceutical and bone flap interventions, resulting in fewer patients proceeding to brain death. Another example is that first-time cardiovascular events (resulting in anoxic brain injuries that may lead to brain death) have seen a 28% reduction in the event fatality rate since 1990 as a result of improvements in emergency and acute care. HRSA also believes that the decline in the number of eligible donors can in part be attributed to an aging population, increasing rates of diseases and morbidities, such as diabetes and hypertension, and a reduction in the number of deaths that occur in hospitals.

In FY 2010, HRSA initiated a study under the OPTN contract to ascertain potential deceased donor availability for the next 5 years. This study will evaluate dynamics in the U.S. population including changes to population demographics and trends in the health of the population that influence the demand for organ transplantation and the number of deaths that could potentially result in organ donation. Analyses of such dynamics are critical to projecting donor potential and for developing appropriate strategies to maximize the number of viable donor organs made available for transplantation. Also in FY 2010, HRSA funded a national survey to ascertain public opinion about organ donation and transplantation issues.

HRSA initiated several activities in 2010 to sustain and improve upon the gains of the Breakthrough Collaboratives. The umbrella for these activities is the 'Organ Donation and Transplantation Community of Practice' (ODTCP). The major focus of ODTCP is to sustain and increase the achievements of the Collaboratives and institutionalize identified best practices. The DTCP continues the knowledge-sharing model through local and regional networks and interaction known as the Donation Service Area (DSA) Action Teams and Regional Collaboratives.

HRSA will continue to support efforts to institutionalize the organ donation gains resulting from the series of Breakthrough Collaboratives that began in 2003. One of the major activities HRSA will undertake in FY 2010 and will continue in FY 2011 is the creation and support of a technology infrastructure to disseminate information about the most effective organ donation practices to targeted audiences that are critical to increasing the number of viable deceased donor organs for transplantation.

(See discussion of measures 23.II.A.4, 23.II.A.5, 23.II.A.2, and 23.II.A.3 under discontinued measures for additional efforts undertaken to increase the number of organs transplanted.)

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

(Baseline - FY 2003: 3,871)

The intent of this measure is to increase, on an annual basis, the total number of life-years gained in the first 5 years following transplantation for deceased kidney or kidney-pancreas transplants compared to the total life-years gained if this group had remained on the waiting list. This measure is a product of the number of kidneys and kidneys-pancreases transplanted and the average expected life-years gained from each transplanted kidney. The total number of expected life-years gained in the first 5 years after transplant was 4,851 in FY 2009. This is 5.8% above the FY 2008 result of 4,586 and 1.6% above the FY 2007 result of 4,775. However, the FY 2009 result falls 17.4% short of the FY 2009 target of 5,873. The FY 2008 result was 4% lower than the FY 2007 result.

The FY 2012 target is 6,928 expected life-years gained in the first 5 years after transplant.

(See discussion of measure 23.II.A.1 for efforts undertaken to increase the expected life-years gained in the first 5 years after transplant.)

23.II.A.8. Increase the annual conversion rate of eligible donors.

(Baseline - FY 2003: 52.21%)

The donor conversion rate is the percentage of 'eligible donors' that actually become donors. An eligible donor is a deceased individual, aged 70 or younger, whose death is determined based on neurological criteria and who does not have certain diseases and/or morbidities that would excluded the individual from becoming a donor. The donor pool is a finite resource that the Program must use efficiently to reach its long-term goal of increasing the number of deceased organs transplanted. In the conversion rate, the denominator is the available deceased donor pool and the numerator is the number of deceased donors from the eligible donor pool who become actual donors. In FY 2009, the conversion rate was 69.1%, which is 3.9% above the 66.5% target and FY 2008 result. In FY 2008, the conversion rate was 66.5% which was a .75% drop over FY 2007 result. The conversion rate in FY 2007 was 67%.

The FY 2012 target is a 72.9% conversation rate.

DISCONTINUED MEASURES

Measure	FY	Target	Result
<u>23.II.A.4:</u> Increase the average number of organs transplanted per "non-cardiac death" donor each year. (<i>Outcome</i>)	<i>Out-Year Target</i>	N/A	N/A
	2012	N/A	N/A
	2011	3.64	May 30, 2012
	2010	3.58	May 30, 2011
	2009	3.56	3.16 (Target Not Met but Improved)
	2008	3.52	3.12 (Target Not Met but Improved)
	2007	3.52	3.11 (Target Not Met)
<u>23.II.A.5:</u> Increase the average number of organs transplanted per "cardiac death" donor each year. (<i>Outcome</i>)	<i>Out-Year Target</i>	N/A	N/A
	2012	N/A	N/A
	2011	2.61	May 30, 2012
	2010	2.53	May 30, 2011
	2009	2.46	1.92 (Target Not Met)
	2008	2.39	1.95 (Target Not Met but Improved)
	2007	2.42	1.92 (Target Not Met)
<u>23.II.A.6:</u> Increase the average number of expected life-years gained in the first 5 years after transplantation for deceased kidney/kidney-pancreas transplants. (<i>Outcome</i>)	<i>Out-Year Target</i>	N/A	N/A
	2012	N/A	N/A
	2011	0.43	May 30, 2012
	2010	0.427	May 30, 2011
	2009	0.424	0.42 (Target Not Met but Improved)
	2008	0.421	0.41 (Target Not Met)
	2007	0.418	0.42 (Target Exceeded)
<u>23.II.A.2:</u> Increase the annual number of "non-cardiac death" donors. (<i>Outcome</i>)	<i>Out-Year Target</i>	N/A	N/A
	2012	N/A	N/A
	2011	7,785	May 30, 2012
	2010	7,551	May 30, 2011
	2009	7,317	7,100 (Target Not Met)
	2008	7,083	7,143 (Target Exceeded)
	2007	7,253	7,298 (Target Exceeded)

23.II.A.3: Increase the annual number of "cardiac death" donors. (Outcome)	<i>Out-Year Target</i>	N/A	N/A
	2012	N/A	N/A
	2011	788	May 30, 2012
	2010	723	May 30, 2011
	2009	658	921 (Target Exceeded)
	2008	593	846 (Target Exceeded)
	2007	968	793 (Target Not Met but Improved)
Efficiency Measure	FY	Target	Result
23.E: Decrease the total OPTN operating costs per deceased organ transplanted. (Efficiency)	2012	N/A	N/A
	2011	\$1,065	May 30, 2012
	2010	\$1,075	May 30, 2011
	2009	\$1,086	\$1,153 (Target Not Met but Improved)
	2008	\$1,098	\$1,196 (Target Not Met)
	2007	\$960	\$1,096 (Target Not Met)

Measure	Data Source	Data Validation
23.II.A.4 23.II.A.5 23.II.A.6 23.II.A.2 23.II.A.3	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.
23.E	OPTN Contract budget and OPTN financial statements.	OPTN Financial Statements are independently audited in accordance with OMB A-133 Circular.

The Program is proposing to discontinue the performance measures above because these metrics are already incorporated in the Program two long-term measures. In addition, the Program believes that these annual measures, on their own, may not be easily interpretable by the non-technical audience and the public. However, the Program will continue to track these metrics internally in monitoring its strategies to reach its long-term performance measures.

The Program is proposing to replace the existing efficiency measure with the annual conversion rate of eligible donors (23.II.A.8). The existing conversion rate is based on the annual cost of operations of the Organ Procurement and Transplantation Network (OPTN) as the numerator and the annual number of deceased organs transplanted as the denominator. Because of the evolving nature of the work of the OPTN, there is not a direct correlation between the cost of operations

of the OPTN and the number of deceased organs transplanted. The operations of the OPTN include an array of activities outside of matching deceased donors to individuals on the waitlist. A significant aspect of the OPTN includes policy development and implementation. In addition, the work of OPTN involves monitoring and oversight activities of transplant centers to ensure compliance with OPTN policies. In addition, for the past five years the OPTN activities have included development of policies and monitoring for living organ transplants including paired exchange transplantation.

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

(Baseline – FY 2003: 3.20)

One element contributing to increasing the overall number of deceased donor organs transplanted is the average number of organs transplanted from each deceased donor. The intent of this measure is to increase the average number of organs procured from “non-cardiac death” donors on an annual basis. The average number of organs transplanted from each non-cardiac death donor was 3.16 in FY 2009. This represents a 1.28% increase from the FY 2008 result of 3.12 and 11.24% below FY 2009 target of 3.56. The FY 2008 result was slightly higher than FY 2007 result of 3.11.

The FY 2012 target is not applicable because the Program discontinued this measure.

HRSA continues to support activities, in collaboration with the ‘Organ Donation and Transplant Alliance’ (the Alliance) , a private, non-profit organization whose mission is to expand and accelerate the work of the Breakthrough Collaboratives supported by HRSA, to help transplant programs expand capacity to perform additional transplants.

HRSA’s activities through the ODTCP have the potential to increase the number of organs transplanted per donor. Increasing the number of organs per donor will result in thousands of additional donor organs made available for transplant. Additionally, the Program is continually working with the OPTN and the organ procurement and transplant community to improve technological infrastructures to facilitate the rapid placement of organs.

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

(Baseline - FY 2003: 2.04)

Similar to increasing the average number of organs transplanted per non-cardiac death donor (Measure II.A.4.), the intent of this short-term goal is to increase the average number of organs transplanted from cardiac death donors on an annual basis. The average number of organs transplanted for each cardiac-death donor was 1.92 in FY 2009. This is 22% below target and 1.54% below the FY 2008 result. The FY 2008 result was a 1.56% improvement over the FY 2007 result.

The FY 2012 target is not applicable because the Program discontinued this measure. As the number of donors meeting eligible donor criteria decreases, more donors with co-morbid conditions, such as chronic hypertension, are being utilized. These donors are referred to as “expanded criteria donors.” While these donors expand the total number of donors, fewer organs, on average, can be transplanted from an expanded criteria donor. This is particularly true for the kidneys which can be damaged by chronic hypertension. The findings from the FY 2010 study may provide the Program a clearer understanding of the donor potential in this area, which will be necessary for developing effective strategies.

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

(Baseline - FY 2003: 0.406)

The intent of this goal is to increase, on an annual basis, the average number of life-years gained in the first 5 years following transplantation for deceased kidney or kidney-pancreas transplants. The reported value for FY 2009 is 0.42 compared to a reported value of 0.41 in FY 2008. The FY 2009 result is 0.94% lower than the FY 2009 target of 0.424. However, the FY 2009 result is 2.4% above the FY 2008 result. The FY 2009 result is equal to the FY 2007 result.

The FY 2012 target is not applicable because the Program discontinued this measure.

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

While it is anticipated that improvements in kidney allocation policies will increase the benefit of kidney transplantation, it is also anticipated that there will be continued improvements in kidney dialysis technology. As a result, predicting the relative benefit in kidney transplantation is difficult.

23.II.A.2. Increase the annual number of “non-cardiac death” donors.

(Baseline - FY 2003: 6,187)

The greatest contributing aspect to the increase in the overall number of deceased donor organs transplanted is the number of non-cardiac-death donors. There were 7,100 non-cardiac-death donors in FY 2009, which is 2.97% lower than the FY 2009 target of 7,317. It also represents a slight decrease from 7,143 non-cardiac death donors in FY 2008. The number of non-cardiac death donors has been decreasing since FY 2006. In FY 2007, there were 7,298 non-cardiac death donors, 1% less than FY 2006 number of 7,375.

The FY 2012 target is not applicable because the Program discontinued this measure.

The FY 2006 and FY 2007 targets were based on a donor potential pool of 12,000 eligible deaths in the United States. The revised targets for FY 2008 through FY 2013 are based on a donor potential pool of 11,000 eligible deaths in the United States. However, recent data indicate that the estimated number of eligible donors is continuing to decline to under 10,000 annually. The number of eligible deaths had originally been projected to increase over time. As previously stated, the Program will fund a study in FY 2010 to ascertain the donor potential (both non-cardiac and cardiac death donors) in the United States.

23.II.A.3. Increase the annual number of “cardiac-death” donors.

(Baseline - FY 2003: 268)

Another aspect contributing to the increase in the overall number of deceased donor organs transplanted is the number of cardiac-death donors. There were 921 cardiac death donors in FY 2009, which is 40% above the FY 2009 target and 8.8% above the FY 2008 result. In FY 2008, there were 846 cardiac death donors, which was a 6.7% above the 793 cardiac death donors in FY 2007. The number of cardiac-death donors has increased 42% since FY 2006.

The FY 2012 target is not applicable because the Program discontinued this measure.

23.E. Decrease the total OPTN operating costs per deceased organ transplanted.

(Baseline - FY 2003: \$924)

The intent of this goal is to reduce the total OPTN operating costs associated with organ transplantation per deceased organ transplanted on an annual basis factoring in the effects of inflation. This measure is a quotient of the OPTN annual budget and the number of deceased organs transplanted annually. The reported value for FY 2009 is \$1,153 which is 6.2% deviation from target. However, it represents a 3.6% improvement over FY 2006 result. The reported value in FY 2008 was \$1,196, a 9.1% increase over FY 2007 result. The FY 2007 result was \$1,096. The FY 2009 OPTN operating cost was \$27,811,565, which is 7.5% lower than projected FY 2009 operating cost of \$30,056,131. The FY 2009 cost represents a 2.9% decrease over the FY 2008 operating cost of \$28,629,483. Even though the operating cost was lower than projected, the number of deceased donor organs transplanted (24,116) was 12.9% lower than FY 2009 target of 27,683.

The FY 2012 target is not applicable because the Program discontinued this measure.

C.W. BILL YOUNG CELL TRANSPLANTATION PROGRAM

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Increase outreach and enrollment into quality care

Measure	FY	Target	Result
<u>24.II.A.2:</u> Increase the number of adult volunteer potential donors of minority race and ethnicity. (<i>Outcome</i>)	2012	2.66 Million	Dec 31, 2012
	2011	2.48 Million	Dec 31, 2011
	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)
	2007	1.83 Million	1.86 Million (Target Exceeded)
<u>24.1:</u> Increase the number of blood stem cell transplants facilitated annually by the Program. ¹ (<i>Outcome</i>)	<i>Out-Year Target</i>	5,513 (FY 2013)	Dec 31, 2013
	2010	4,500	5,228 (Target Exceeded)
<u>24.2:</u> Increase the number of blood stem cell transplants facilitated annually by the Program for minority patients. ¹ (<i>Outcome</i>)	<i>Out-Year Target</i>	845 (FY 2013)	Dec 31, 2013
	2010	636	820 (Target Exceeded)
<u>24.3:</u> Increase the rate of patient survival at one year, post transplant. ¹ (<i>Outcome</i>)	<i>Out-Year Target</i>	72% (FY 2013)	Dec 31, 2015
	2010	69%	Dec 31, 2012
Efficiency Measure	FY	Target	Result
<u>24.E:</u> Decrease the unit cost of human leukocyte antigen (HLA) typing of potential donors. (<i>Efficiency</i>)	2012	\$50.44	Dec 31, 2012
	2011	\$52	Dec 31, 2011
	2010	\$52	\$52 (Target Met)
	2009	\$52	\$52 (Target Met)
	2008	\$52	\$52 (Target Met)
	2007	\$59.95	\$52 (Target Exceeded)

¹This long term measure does not have annual targets.

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.

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.

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Access to Quality Health Care and Services

Sub-Goal: Increase outreach and enrollment into quality care

24.II.A.2. Increase the number of adult volunteer potential donors of minority race and ethnicity. (Baseline - FY 2003: 1.37 million)

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

The Program has experienced significant improvement in increasing the overall size of the registry of adult volunteer donors from 6,856,150 in FY 2007 to 8,799,643 in FY 2010. The number of adult volunteer donors who self-identify as belonging to a racial/ethnic minority population group has increased from 1,856,434 in FY 2007 to 2,463,830 in FY 2010. The targets to reach racial/ethnic minority communities have been exceeded during the past three fiscal years, due to initiatives to increase community awareness and outreach in minority populations. The Program expects to continue to make progress in this area. The target established for FY 2012 is 2,660,000 adult volunteers from racially/ethnically under-represented minority population groups.

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

(Baseline - FY 2003: 2,310)

The purpose of the Program is to increase the number of unrelated blood stem cell transplants facilitated for patients in need. This long-term goal directly reflects the program's purpose. The FY 2010 result for this measure was 5,228 (exceeding the target). The FY 2013 target is 5,513.

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

(Baseline - FY 2003: 318)

Reaching this goal will further the statutory aim of ensuring that patients from racially and ethnically diverse backgrounds will have a chance of receiving an unrelated blood stem cell transplant that is comparable to that of non-Hispanic Caucasian patients. The FY 2010 result for this measure was 820 (exceeding the target). The FY 2013 target is 845.

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

(Baseline - FY 2003: 62%)

The intent of this health outcome measure is to increase the health benefit to patients receiving an unrelated blood stem cell transplant. The Program recognizes that it does not have a direct impact on patient care delivery. Nonetheless, the Program can influence survival rates in several

ways, including improving the degree of tissue-type match between patient and donor by adding adult volunteer potential donors and cord blood units and making them available through the Program, ensuring that the Program is working with highly competent transplant centers and other organizations, decreasing the time required to identify the best available donor for each patient, and engaging in research to improve transplant outcomes (e.g., by better prevention and treatment of infections and other transplant complications). The first target for this measure (69%) is set for FY 2010. The FY 2013 target is 72%.

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

(Baseline - FY 2003: \$65.00)

The cost of Human Leukocyte Antigen (HLA) typing strongly influences the number of potential volunteer donors who can be recruited to potentially donate for patients in need of blood stem cell transplantation. Reductions in the cost of typing makes increases in donor recruitment possible even without increased funding. The FY 2010 actual cost for tissue typing was \$52.00, thus meeting the target. The FY 2012 target is \$50.44.

POISON CONTROL PROGRAM

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>25.1:</u> Decrease the number of visits to the emergency room (per 1,000 live ER discharges) ¹ (<i>Outcome</i>)	<i>Out-Year Target</i>	1.54 (FY 2013)	Dec 31, 2015
	2009	1.54	Dec 31, 2011
<u>25.III.D.1:</u> Develop and ratify uniform and evidence-based guidelines for the treatment of poisoning. (Targets are cumulative.) (<i>Output</i>)	2012	17	Oct 31, 2013
	2011	17	Oct 31, 2012
	2010	20	17 ² (Target Not Met)
	2009	20	17 ² (Target Not Met)
	2008	17	17 ³ (Target Met)
	2007	18	17 (Target Not Met but Improved)
<u>25.III.D.3:</u> Increase percent of inbound volume on the toll-free number. (<i>Output</i>)	2012	75%	Oct 31, 2012
	2011	73.7%	Oct 31, 2011
	2010	73.7%	75.6% (Target Exceeded)
	2009	71%	73.7% (Target Exceeded)
	2008	69.3%	70% (Target Exceeded)
	2007	63.3%	66% (Target Exceeded)
Efficiency Measures	FY	Target	Result
<u>25. E.1:</u> Decrease application time burden. (<i>Efficiency</i>)	2012	26.5 hrs	Oct 31, 2012
	2011	26.5 hrs	Oct 31, 2011
	2010	27 hrs	25.47 hrs (Target Exceeded)
	2009	27.5 hrs	27 hrs (Target Exceeded)
	2008	29 hrs	28.9 hrs (Target Exceeded)
	2007	29 hrs	29 hrs (Target Met)

¹This is a long-term measure with FY 2009 as the first year for which data will be reported. The next year for reporting is FY 2013.

²Patient management guidelines activities were not done in FY 2009 and FY 2010; therefore the most recent result remained at 17.

³The FY 2008 actual for 25.III.D.1 remained 17 because the final extension on the cooperative agreement expired December 2007, precluding the grantee's ability to conduct extensive work required to develop a guideline.

Measure	Data Source	Data Validation
25.1	National Hospital Ambulatory Medical Care Survey	Validated by CDC.
25.III.D.1	HHS National Guideline Clearinghouse	Validated by the American Association of Poison Control Centers.
25. E.1	Online grant applications and grantee reports.	Data are regularly reviewed by project officers.
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 PSC telecom manager and American Association of Poison Control Centers.

INTRODUCTION

The Poison Control 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 by working to ensure universal access to quality poison control services. The performance measures to increase calls to the national toll-free number and develop uniform guidelines are utilized for program strategic planning to ensure that the program is increasing access to comprehensive quality services for the entire population, particularly children who are the most vulnerable to poisonings. The Program provides grants to poison control centers (PCCs) to support efforts made by PCCs to prevent and provide treatment recommendations for poisonings. In addition, strategies used by the Program include implementing a national media campaign to promote the Poison Control toll free number and developing partnerships with private and public organizations to promote poison prevention.

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Access to Quality Health Care and Services

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

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

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

Decreasing unneeded emergency room visits for poisoning or suspected poisoning will reduce unnecessary utilization of extremely costly resources, and allow those resources to be better utilized for persons in need of them. The first report for this long-term measure will be for FY 2009.

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

Having evidence-based guidelines available for use at the poison control centers will improve uniformity and standard care for acute poisoning-related incidents, thereby improving the quality of care. By FY 2007, 17 guidelines had been developed through a cooperative agreement with the American Association of Poison Control Centers. As a result, the FY 2008 target was reduced from 18 to 17 because the final extension on the cooperative agreement expired December, 2007, precluding the grantee’s ability to conduct the extensive work required to

develop a guideline. Although new goals were established to develop 3 additional guidelines in 2009, the Program did not meet the FY 2009 and FY 2010 targets as it was unable to award a contract to develop the additional guidelines. The cumulative target remains at 17 for FY 2011. All of the completed guidelines have been reproduced and distributed to the poison centers and are available on the HHS National Guideline Clearinghouse (NGC) website. The Program is focusing on updating the existing guidelines so they remain available on the NGC website and determining whether additional guidelines are warranted. Pending this assessment, the FY 2012 target remains at 17 guidelines.

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

Public Law 106-174, the Poison Control Enhancement and Awareness Act, mandated the development of a single, national toll-free number to ensure universal access to poison control services. In 2002, the Poison Control Program, in conjunction with the Centers for Disease Control and Prevention (CDC), initiated the Poison Help campaign, a national media campaign to promote the use of 1-800-222-1222. Increasing the use of the national number provides universal access and provides individuals the resource to determine the severity of the exposure and respond accordingly, which has proven to reduce the number of emergency room visits. According to the AAPCC in 2002, the baseline year, 24.6% of callers utilized the new toll-free number. From FY 2007 to FY 2010, the percent of calls to poison centers on the toll-free number exceeded the targets. The FY 2010 actual was 75.6%. The FY 2012 target is 75%.

The Program entered into a contractual agreement with Edelman, a public relations firm, to expand the Poison Help campaign. Edelman's work is expected to assist in making the general population aware of the toll-free poison hotline (1-800-222-1222), which should increase the percent of inbound volume of calls.

25.E.1. Decrease the application time burden of grantees.

In FY 2007, all grantees were required to provide application time burden information as part of their grant submission. The FY 2007 target of 29 hours was met. In FY 2008 the program met the application submission target of 29 hours with a result of 28.9 hours. Likewise, the FY 2009 target to decrease the application submission time burden to 27.5 hours was exceeded with a result of 27 hours. The FY 2010 application time burden target of 27 hours was exceeded with a result of 25.47 hours. The FY 2011 application time burden target is 26.5 hours, 0.5 hours less than the FY 2010 target. The FY 2012 target is also 26.5 hours.

DISCONTINUED MEASURES

Measure	FY	Target	Result
<u>25.III.D.2</u> : Increase the number of PCCs with 24-hour bilingual staff. ¹ (Output)	2012	N/A	N/A
	2011	5	Oct 31, 2011
	2010	5	4 (Target Not Met)
	2009	4	4 (Target Met)
	2008	4	4 (Target Met)
	2007	4	4 (Target Met)
<u>25.E.2</u> : Decrease reporting time burden. (Efficiency)	2012	N/A	N/A
	2011	17 hrs	May 31, 2012
	2010	17 hrs	May 31, 2011
	2009	18 hrs	2.71 hrs (Target Exceeded)
	2008	19 hrs	2 hrs ² (Target Exceeded)
	2007	19 hrs	20 hrs (Target Not Met)

Measure	Data Source	Data Validation
25.III.D.2 25.E.2	Online grant applications and grantee reports.	Data are regularly reviewed by project officers.

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

According to the American Association of Poison Control Centers (AAPCC), in 2004 only 1 of 62 Poison Control Centers in the U.S. had 24-hour bilingual staff. In order for the Poison Control Program to ensure universal access and serve a larger population, the original goal was to increase the number of PCCs with 24-hour bilingual staff coverage by at least 2 centers per year. In FY 2005, the Program queried all the PCCs and found that 4 provided 24-hour bilingual services. In FY 2006, there remained 4 PCCs with 24-hour bilingual staff although the target was set at 5. In September 2006, HRSA began providing translation services to all PCCs through a service called Language Line. Language Line provides translation services in 161 languages thereby providing a cost effective means for all PCCs to offer 24-hour translation services. Given the challenges with recruiting qualified bilingual health care providers and the successful implementation of Language Line, in FY 2007, the target for this measure was modified to 4. From FY 2007 – FY 2009, the target of 4 was met. In FY 2010, the target was increased to 5 because poison control centers were expanding efforts to recruit and train bilingual

¹ In September 2006, HRSA offered translational services to all PCCs through a service called Language Line. Language Line provides translational services in 161 languages.

² This information was inadequately reported by grantees. To address this issue, the Program was more specific in the FY 2009 grant application guidance about reporting FY 2008 financial status reporting in the FY 2009 application to ensure more complete and accurate reporting.

poison experts through rotational opportunities. However, the new target will not be met in FY 2010. Because the Program provides the Language Line service to all PCCs and does not require hiring of specific personnel within poison centers, the measure is proposed for retirement in FY 2012. The last year for which data will be reported is FY 2011.

25.E.2. Decrease reporting time burden. (Financial reporting)

A new on-line application and reporting system was implemented in FY 2005 and was fully implemented in FY 2006. This system was designed to simplify data collection by pre-populating forms with electronic information from previous years, including budget and service data, eliminating the need for grantees to reenter it. The system also eliminates the need for grantees to reenter the same information in different parts of the application. The target was a 5% reduction each year. In March 2005, a limited number of PCCs were queried to determine the number of hours to complete a financial report on grant activities. From this limited query an average number of hours were calculated. The result was 85 hours to complete a financial reporting document.

For 2006, all grantees were required to provide this information as part of their grant submission. Per the grant submissions, the average number of hours to complete a financial reporting document was 20 (gathered at the end of the grant cycle), far exceeding the goal to reduce reporting time burden of grantees. PCCs were queried again in FY 2007 with the resulting output of 20 hours for submission of financial documents, one hour more than the target. FY 2008 was a new grant cycle (not continuation) with a requirement to report application and financial reporting time annually. However, the submission requirements may not have been specific enough and the grantees misunderstood what year of information they were to submit with their new application. When the program gathered this information, the results (2 hours) indicated that the program substantially exceeded the financial reporting time target of 19 hours. Only three grantees submitted information for the financial reporting time and it is believed that the three grantees submitted this information related to past-due reports. Same year financial status reporting documents are not due at the same time as the application; therefore, the information to be reported needed to be clarified. For FY 2009, the program was more specific in the grant application guidance about reporting FY 2008 financial status reporting time. FY 2009 financial reporting time was 2.71 hours, exceeding the target of 18 hours. The FY 2010 reporting time burden target is 17 hours. The FY 2011 financial reporting time burden target has been maintained at 17 hours.

The lack of standardization of the definition of reporting time across grantees has led to inconsistent and unreliable data. Despite offering technical assistance to the grantees in person and over the phone and providing clarifying information about the measure in the written grant guidance, the grantees continue to inconsistently report this information. The grantees have also expressed difficulty in assembling this data, primarily due to the complexity and diversity of their organizational structures. Additionally, this information is of limited value to the PCP and to the grantees. This measure is proposed for retirement in FY 2012. The last year for which data will be reported is FY 2011.

INFRASTRUCTURE TO EXPAND ACCESS TO CARE

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)	2011	N/A	Apr 30, 2011

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

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.

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Access to Quality Health Care and Services

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

41.I. Extent to which pre-established process and time milestones/standards are met.

This measure reflects the ongoing monitoring done by HRSA to ensure that the project is completed on schedule as proposed. One specific indicator is the grantee must provide through the EHB Reporting process Quarterly Progress Reports indicating the percentage complete. The first quarterly report is due April 2011. Other specific indicators include:

Pre-start of construction:

- The grantee must certify through the Electronic Handbook (EHB) Reporting process that it has entered into a construction contract within 12 months (December 2010 – December 2011) of the issuance of the Notice of Grant Award.
- The grantee must submit through the Electronic Handbook Reporting process Bid Tabulations and a Project Schedule.

Post-start of construction:

- The grantee must provide through the EHB Reporting process a copy of the certificate of substantial completion.
- The grantee must provide through the EHB Reporting process a copy of the certificate of occupancy.

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

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>27.1:</u> 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
	2010	13.9%	Oct 31, 2012
<u>27.IV.A.2:</u> Increase the number of people receiving direct serves through Outreach Grants. (Outcome)	2012	390,000	Oct 31, 2013
	2011	385,000	Oct 31, 2012
	2010	380,000	Oct 31, 2011
	2009	N/A	375,000 (Baseline)
	2008	N/A	N/A
	2007	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
<u>27.2:</u> 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
<u>27.V.B.1:</u> Increase the average operating margin of critical access hospitals. (Outcome)	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	Dec 31, 2011
	2009	0.5% point below FY 2008	-3.3% (Target Not Met)
	2008	0.5% point below FY 2007	-1.9% (Target Exceeded)
	2007	-8.3%	-6.7% (Target Exceeded)

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

Efficiency Measure	FY	Target	Result
27.E: Increase the return on investment of funds by the Rural Hospital Flexibility (FLEX) grant program, as measured by change in total operating margin of critical access hospitals in relation to FLEX dollars invested (<i>Efficiency</i>)	2012	30%	Oct 31, 2014
	2011	29%	Oct 31, 2013
	2010	28%	Oct 31, 2012
	2009	27%	Oct 31, 2011
	2008	26%	-383% (Target Not Met)
	2007	25%	68% (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.1	Reported by grantees through the Program's Performance Improvement Measurement System.	Validated by project officers
27.2 27.V.B.1 27.E	Medicare Cost Reports	Validated by Centers for Medicare and Medicaid Services

INTRODUCTION

The goals and measures are used to assess the Office of Rural Health Policy's (ORHP) performance. (This does not include the Black Lung, Radiation Exposure Screening, and Telehealth programs, which are presented later.)

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 through improving the health and wellness in 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 to focus the attention of grantees on performance improvement and efficiency.

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Access to Quality Health Care and Services

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

27.1. Reduce the proportion of rural residents of all ages with limitation of activities caused by chronic conditions.

(Baseline – FY 2000: 14.67%)

This long-term measure was chosen because rural residents experience greater limitation of activity caused by chronic conditions than urban residents. A reduction of activity limitation is an indicator of improvement of health status and wellness. According to the Centers for Disease Control and Prevention (CDC) the proportion of rural residents of all ages with limitation of

activities caused by chronic conditions in FY 2000 was 14.67%. By 2013, the goal is to reduce this proportion to 13%.

27.IV.A.2. Increase the number of people receiving direct services through Outreach grants.

This revised performance measure will examine the increase in the number of people receiving direct services through Outreach Grants. This new measure will focus on only direct patient care such as screenings and treatment which is clearer, easier to interpret, easier to quantify and, thus, more accurate. The baseline for this measure is 375,000 in FY 2009. The targets for FY 2011 and FY 2012 are 385,000 and 390,000, respectively.

Goal: Improve Access to Quality Health Care and Services

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

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

This long-term measure is used to monitor efforts to increase the financial viability of small rural hospitals. Medicare cost-report data for CAHs shows that progress toward this goal is being made. In FY 2009, the number of CAHs with positive operating margins had increased to 54%. As these facilities become more economically viable, they will be more likely to survive long term and therefore continue serving as a key access point for health care in rural communities.

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

An increase in the average operating margin of CAHs can contribute to these hospitals' financial viability. CAHs serve as key access points for Medicare beneficiaries in rural areas and also act as the focal point for expanded health care services in rural communities by helping to attract physicians and other health care personnel. Therefore, the focus on operating margin helps determine the long-term viability of CAHs to continue to perform that access role. A large representative sample of Medicare cost reports show that CAHs had a -14.05% average operating margin in 1999. Since that time, Congress has enacted three laws that have included provisions increasing administrative flexibility for CAHs. It is expected that these changes in the law will help address some of the financial challenges and barriers facing CAHs. Analysis of the sample representation of Medicare cost report data shows positive progress toward this goal. In FY 2005, CAHs had an average operating margin of -9.6%. In FY 2006, the average operating margin improved to -8.8%. This figure improved to -6.7% in 2007, which was better than the FY 2007 target of -8.3%. The FY 2008 result is -1.9% which exceeded its target of a 0.5 percentage point improvement from FY 2007. This improvement is mostly associated with the increase in the number of CAHs that have submitted a full year of cost report data. The FY 2009 operating margin is -3.3%, not meeting the target. This decrease from last year could be attributed to the economic downturn beginning in 2008, which impacted the number of insured patients within hospitals' patient mix. The FY 2012 target is to show a 0.5 percentage point improvement as compared to the FY 2011 operating margin.

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

This efficiency measure indicates the return on investment of funds by the Rural Hospital Flexibility grant program as measured by the change in total operating margin of critical access hospitals in relation to the investment of Flex program dollars. The measure looks at the change in total operating margin for all CAHs from one year to the next relative to the programmatic investment that is specifically focused on finance-related activities to yield a percentage that quantifies return on investment annually. The return on investment in FY 2006 was 13.4% which was below the target but still indicative of a positive return on investment for the program. The return on investment in FY 2007 was 68% which considerably exceeded the target of 25%. The return on investment for FY 2008 was -383%, a significant decline from the previous year. The return on investment may fluctuate year to year as rural hospitals experience significant variability in their patient volume and revenue, but these factors tend to balance out to some degree over time. The FY 2008 number captures the struggles hospitals faced during the economic downturn, with decreased insurance coverage of the patients in the catchment areas. In addition, there have been changes in the way some hospital systems are reporting costs for their CAHs which are impacting the CAHs return on investment percentage. Given the outside factors beyond the control of the Flex grant program and the difficulties caused by changes in hospital reporting, the Office of Rural Health Policy will be proposing alternatives to this measure. The FY 2012 target is 30%.

DISCONTINUED MEASURE

Measure	FY	Target	Result
<u>27.IV.A.1</u> : Increase the number of people served through Outreach Grants. (Outcome)	2012	N/A	N/A
	2011	980,000	Oct 31, 2012
	2010	950,000	Oct 31, 2011
	2009	930,000	2,451,969 (Target Exceeded)
	2008	635,000	828,360 (Target Exceeded)
	2007	777,000	923,003 (Target Exceeded)

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

The Outreach grant program demonstrates an effective way to provide services to rural communities in order to improve the health and wellness of people served. In FY 2008, the number of individuals served was 828,360, exceeding its target of 635,000. In FY 2009, the number of individuals served was 2,451,969, exceeding its target of 930,000. This increase was due to two reasons: 1) an increase in the number of awards made and 2) a new method that ORHP is using to collect more accurate data. Grantees currently collect the direct and indirect services they provide through the Outreach grants which can be a very large number. This new data collection method may help to explain the large increase in the number of individuals served in FY 2009 over the previous year. Accurately accounting for persons receiving indirect services, which includes such things as handing out brochures and flyers and making radio and television announcements, is very challenging to grantees. This impacts the consistency and reliability of this data, despite Program efforts in providing guidance to grantees. More important, the measure, which includes such a hodgepodge of services, is difficult to interpret and lacks sufficient meaning for grantees and for Program management.

This performance measure has been discontinued and replaced with a revised performance measure that will examine the increase the number of people receiving direct services through Outreach Grants. This new measure will focus on only direct patient care such as screenings and treatment which is clearer, easier to interpret, easier to quantify, more accurate, and more meaningful to grantees and Program management.

RURAL HEALTH POLICY DEVELOPMENT

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)	2012	30	Sep 30, 2013
	2011	30	Sep 30, 2012
	2010	30	Sep 30, 2011
	2009	30	30 (Target Met)
	2008	30	30 (Target Met)
	2007	30	30 (Target Met)

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

INTRODUCTION

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

This performance measure supports HRSA’s Strategic Plan Goal IV to improve health equity through monitoring, identifying and advancing evidence-based and promising practices by using trend data to assist in targeting program resources toward goals. The Office of Rural Health Policy is planning to develop a new performance measure for its policy activities that reflects how it serves rural residents through the use of a national clearinghouse and web portal.

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Health Equity

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

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

The program produced 30 research projects in FY 2009, meeting the target. These reports represented a full range of rural health services projects. The studies also continue to examine the sustainability of small rural hospitals, including their low volume, and assuring quality through improving patient safety and reducing medical errors. Through the policy research, ORHP expects to predict the impact of the payment reforms on rural citizens, their hospitals and communities and, most importantly, to identify options for changes to lessen any negative effects

while also identifying positive outcomes of the Medicare Modernization Act (MMA) provisions for increasing services for rural Medicare beneficiaries. Other ongoing reports inform the policy discussion on improving the health of rural citizens by ensuring access to health promotion programs, rural health clinics, and mental health care. The FY 2012 target is 30 reports.

RURAL HEALTH OUTREACH, NETWORK, AND QUALITY IMPROVEMENT GRANTS

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
29.IV.A.3: Increase the number of people receiving direct services through Outreach Grants. (Outcome)	2012	390,000	Oct 31, 2013
	2011	385,000	Oct 31, 2012
	2010	380,000	Oct 31, 2011
	2009	N/A	375,000 (Baseline)
	2008	N/A	N/A
	2007	N/A	N/A
29.IV.A.2: Increase the proportion of the target population served through Outreach Authority grants. ¹ (Outcome) (Developmental)	2012	TBD	Oct 31, 2013
	2011	N/A	N/A
	2010	N/A	Oct 31, 2011 (Baseline)
	2009	N/A	N/A

Measure	Data Source	Data Validation
29.IV.A.1 29.IV.A.2	Reported by grantees through the Program's Performance Improvement Measurement System.	Validated by project officers.

INTRODUCTION

These measures assess how well the grants administered under this authority affect rural residents. The various grant programs administered under this authority focus on a range of health issues from improving access to care to recruitment and retention of health care providers to improved coordination of services. Both measures focus on how many rural residents are served by the program. The measure supports 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. ORHP is currently reviewing this program to determine how to adapt the program to the Affordable Care Act as it is implemented. Any programmatic changes will also be followed by a reevaluation of the current performance measures, which may need to be revised.

¹ Baseline data for FY 2010 and targets for FY 2012 and FY 2013 will be available by October 2011.

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Access to Quality Health Care and Services

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

29.IV.A.3. Increase the number of people receiving direct services through Outreach grants.

This revised performance measure will examine the increase the number of people receiving direct services through Outreach Grants. This new measure will focus on only direct patient care such as screenings and treatment which is clearer, easier to interpret, easier to quantify and, thus, more accurate. The baseline for this measure is 375,000. The targets for FY 2011 and FY 2012 are 385,000 and 390,000 respectively.

29.IV.A.2. Increase the proportion of the target population served through Outreach Authority grants. (Developmental)

This new performance measure will gauge how successful grantees are at reaching their target population. The Program will have baseline information for FY 2010 and targets for FY 2012 and FY 2013 by October 2011.

DISCONTINUED MEASURE

Measure	FY	Target	Result
<u>29.IV.A.1</u> : Increase the number of people served through Outreach Grants. (Outcome)	2012	N/A	N/A
	2011	980,000	Oct 31, 2012
	2010	950,000	Oct 31, 2011
	2009	930,000	2,451,969 (Target Exceeded)
	2008	635,000	828,360 (Target Exceeded)
	2007	777,000	923,003 (Target Exceeded)

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

The Outreach grant program demonstrates an effective way to provide services to rural communities in order to improve the health and wellness of people served. In FY 2008, the number of individuals served was 828,360, exceeding its target of 635,000. In FY 2009, the number of individuals served was 2,451,969, exceeding its target of 930,000. This increase was due to two reasons: 1) an increase in the number of awards made and 2) a new method that ORHP is using to collect more accurate data. Grantees currently collect the direct and indirect services they provide through the Outreach grants which can be a very large number. This new data collection method may help to explain the large increase in the number of individuals served in FY 2009 over the previous year. Accurately accounting for persons receiving indirect services, which includes such things as handing out brochures and flyers and making radio and television announcements, is very challenging to grantees. This impacts the consistency and reliability of this data, despite Program efforts in providing guidance to grantees. More important, the measure, which includes such a hodgepodge of services, is difficult to interpret and lacks sufficient meaning for grantees and for Program management.

This performance measure has been discontinued and replaced with a revised performance measure that will examine the increase the number of people receiving direct services through Outreach Grants. This new measure will focus on only direct patient care such as screenings and treatment which is clearer, easier to interpret, easier to quantify, more accurate, and more meaningful to grantees and Program management.

RURAL HOSPITAL FLEXIBILITY GRANTS

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)	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	Dec 31, 2011
	2009	0.5% point below FY 2008	-3.3% (Target Not Met)
	2008	0.5% point below FY 2007	-1.9% (Target Exceeded)
	2007	-8.3%	-6.7% (Target Exceeded)
30.V.B.4: Increase the percent of Critical Access Hospitals reporting at least one measure to Hospital Compare. (Outcome)	2012	76%	Dec 31, 2013
	2011	74%	Dec 31, 2012
	2010	72%	Dec 31, 2011
	2009	70%	70.3% (Target Exceeded)
	2008	N/A	70% (Target Not in Place)
	2007	N/A	69% (Baseline)
30.V.B.5: Number of individuals trained in emergency medical services leadership and/or trauma courses. (Outcome)	2012	3,615	Dec 31, 2013
	2011	3,615	Dec 31, 2012
	2010	3,615	Dec 31, 2011
	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.

INTRODUCTION

These measures assess the performance of the Office's rural hospital grant programs. The various grant programs administered under this authority focus on working with the grantees to assist Critical Access Hospitals and the communities they serve. The measures focus on increasing the annual operating margin, increasing the percentage of hospitals that report on quality measures, and identifying the number of individuals trained in emergency medical services leadership and/or trauma courses. 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.

These performance measures 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.

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Access to Quality Health Care and Services

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

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

An increase in the average operating margin of CAHs can contribute to these hospitals' financial viability. CAHs serve as key access points for Medicare beneficiaries in rural areas and also act as the focal point for expanded health care services in rural communities by helping to attract physicians and other health care personnel. Therefore, the focus on operating margin helps determine the long-term viability of CAHs to continue to perform that access role. A large representative sample of Medicare cost reports show that CAHs had a -14.05% average operating margin in 1999. Since that time, Congress has enacted three laws that have included provisions increasing administrative flexibility for CAHs. It is expected that these changes in the law will help address some of the financial challenges and barriers facing CAHs. Analysis of the sample representation of Medicare cost report data shows positive progress toward this goal. In analyzing cost report data for a representative selection of CAHs, these facilities are seeing improved operating margins. In FY 2005, CAHs had an average operating margin of -9.6%. In FY 2006, the average operating margin improved to -8.8%. This figure improved to -6.7% in 2007, which was better than the FY 2007 target of -8.3%. The FY 2008 result is -1.9% which exceed its target of a 0.5 percentage point improvement from FY 2007. This improvement is mostly associated with the increased number of CAHs that have submitted a full year of cost report data. The FY 2009 operating margin is -3.3%, not meeting the target. This decrease from last year could be attributed to the economic downturn beginning in 2008, which impacted the number of insured patients within a hospitals patient mix. The FY 2012 target is to show a 0.5 percentage point improvement as compared to the FY 2011 operating margin.

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

Increasing the number of Critical Access Hospitals (CAHs) that report data on at least one measure to the Centers for Medicare and Medicaid Services' (CMS) Hospital Compare is an important activity for rural communities. Participation in Hospital Compare is voluntary for this class of hospitals. The Flex program's focus on quality improvement provides support for this activity. The data posted on the Hospital Compare Website is a key part of the Department's ongoing efforts to increase transparency in the health care system by measuring all hospitals, including CAHs, on how they perform across a variety of clinical measures. This is a new

measure for FY 2009. Until FY 2008, CMS' Quality Improvement Organizations (QIOs) provided assistance to CAHs on this reporting. The QIOs are no longer charged with that task but the funding provided through the Flex program is intended to focus on quality and performance improvement in CAHs. Therefore, the Flex program can provide assistance to support this Departmental priority. The baseline for this measure is 63.14% of CAHs reporting at least one measure to Hospital Compare in FY 2006. In FY 2007, 69% of CAHs reported data on at least one measure. The program saw a slight increase in FY 2008 and FY 2009 at 70% and 70.3%, respectively. The FY 2012 target is 76%.

30.V.B.5. Number of individuals trained in emergency medical services leadership and/or trauma courses.

This new performance measure will indicate the state impact on building capacity for the EMS system through training on EMS provision of services and on managing an EMS system. Given the level funding of the Flex grant and cyclical nature of the certification training, the Program is not targeting increases in this measure, but for maintenance of effort for these Flex activities. The baseline for FY 2008 is 3,613. In FY 2009, Flex programs trained 3,002 individuals. While this number dropped from the previous year, Flex grant dollars target to these activities declined by almost half, as dollars were shifted to other priorities. The target for FY 2012 is 3,615.

DISCONTINUED MEASURES

Measure	FY	Target	Result
30.V.B.2: Appropriate rural facilities will be assisted in converting to Critical Access Hospital (CAH) status to help stabilize their financial status. (Outcome)	2012	N/A	N/A
	2011	1,290	Dec 31, 2012
	2010	1,290	Dec 31, 2011
	2009	1,288	1,320 (Target Exceeded)
	2008	1,284	1,298 (Target Exceeded)
	2007	1,286	1,282 (Target Not Met but Improved)
30.V.B.3: Facilities and communities will be assisted in the development of networks. (Output)	2012	N/A	N/A
	2011	N/A	N/A
	2010	2,690	Dec 31, 2011
	2009	2,660	2,787 (Target Exceeded)
	2008	2,600	2,607 (Target Exceeded)
	2007	2,400	2,533 (Target Exceeded)

Measure	Data Source	Data Validation
30.V.B.2	Medicare Cost Reports	Validated by Centers for Medicare and Medicaid Services
30.V.B.3	Annual grantee reports	Validated by project officers

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

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

Conversion-related activities have been a major emphasis of the program. As the program has matured, additional emphasis has been placed on quality and performance improvement, improving existing CAH operations, and development of community-level collaborative relationships (including EMS) which strengthen rural healthcare. The program expects the potential growth in the number of conversions to slow in the coming years with the total universe of conversions expected to peak at approximately 1,300. There were 1,277 CAHs in FY 2006, exceeding the target of 1,185, and the 1,282 CAHs result in FY 2007, narrowly missing the target by 4 in FY 2007. The number of CAH conversions in FY 2008 is 1,298 which surpassed its target of 1,284. In FY 2009 the number of CAH conversions reached 1,320, surpassing the target. Since this measure has virtually reached its likely potential of around 1,300 CAHs, the

measure is proposed for retirement in FY 2012. The last year for which data will be reported is FY 2011.

Beginning FY 2012, this performance measure will be discontinued because the number of hospitals likely to convert to CAH status is nearing its ceiling. The program has introduced a new measure (30.V.B.4) to gauge CAH performance. The data for this measure (30.V.B.4) will be reported through FY 2011 as published.

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

Building relationships between CAHs and other providers is a critical component of infrastructure and systems development to sustain viable delivery capability in rural communities. Network development is promoted to reduce duplication, reduce overhead costs, improve services and improve quality of care. In FY 2006, ORHP exceeded its target of 1,250 by assisting 2,326 facilities/communities in the development of networks. In FY 2008, the program again exceeded its target of 2,600 facilities/communities by working with 2,607 entities. The FY 2009 activities exceeded the target with 2,787 communities. As the total number of CAHs reaches its expected peak at just over 1,300, the program emphasis is moving more toward quality, financial and operational improvement. The FY 2010 target is 2,690. There are no targets set for FY 2011 and FY 2012.

This performance measure has been discontinued because of the difficulty in accurately counting the broad definition of facilities, communities, and networks which are not descriptive enough to determine the impact of these grants. The data for this measure will be reported through FY 2010 as published. This measure was discontinued in FY 2011. The last year for which data will be reported is FY 2010.

STATE OFFICES OF RURAL HEALTH

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)	2012	66,269	Oct 31, 2013
	2011	65,614	Oct 31, 2012
	2010	68,990	Oct 31, 2011
	2009	N/A	64,321 (Target Not in Place)
	2008	N/A	68,307 (Baseline)
31.V.B.4: Number of clients (unduplicated) that received technical assistance directly from SORHs. ^{1,2} (Outcome)	2012	30,826	Oct 31, 2013
	2011	30,521	Oct 31, 2012
	2010	35,225	Oct 31, 2011
	2009	N/A	29,920 (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)	2012	1,053	Oct 31, 2013
	2011	1,043	Oct 31, 2012
	2010	1,033	Oct 31, 2011
	2009	N/A	Feb 28, 2011
	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)

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.

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.

INTRODUCTION

The measures are used to assess the performance of the Office's investment in the 50 State Offices of Rural Health. The program provides matching grants to each of the 50 States to support the ongoing efforts of creating a single point of contact within the State for rural health issues. The performance measures focus on key activities of the grantees which include how many communities receive technical assistance from the grantee and how many clinical placements are facilitated through SORHs for recruitment and retention of health professionals in rural areas, an important need for rural communities. The program uses an annual grantee meeting to focus attention on performance expectations and to provide a forum for grantees to share approaches used to improve performance.

These measures support HRSA's Strategic Plan goal to improve access to quality health care and services through strengthening health systems to support the delivery of quality health services.

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Access to Quality Health Care and Services

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

31.V.B.3. Number of technical assistance (TA) encounters provided directly to clients by SORHs.

This new performance measure informs the program office of the extent of the technical assistance provided by the grantees each year. The baseline for FY 2008 is 68,307. The FY 2009 TA encounters totaled 64,321, a slight decrease from the baseline year. This decline may reflect the impact of the budget crisis that many states faced which affected their ability to award contracts or hire staff. The target for FY 2012 is 66,269.

Additionally, this is the second year that the SORH grantees have submitted information on this new measure through the standardized Performance Improvement Measurement System within ORHP. As grantees now have a better understanding of the measures and have better tracking systems within their own programs, the reported numbers are better reflective of the actual TA encounters.

31.V.B.4. Number of clients (unduplicated) that received technical assistance directly from SORHs.

This new performance measure captures the number of clients served each year. This unduplicated count demonstrates the number of unique entities that work with the SORHs. The baseline for FY 2008 is 34,876. In FY 2009, the SORHs served 29,920 clients. As with the TA encounters, this decrease could be related to the budget complications many states faced. The target for FY 2012 has been revised to 30,826.

Additionally, this is the second year that the SORH grantees have submitted on this new measure through the standardized Performance Improvement Measurement System within ORHP. As grantees now have a better understanding of the measures and have better tracking systems within their own programs, the reported numbers are better reflective of the actual number of clients.

31.V.B.5. Number of clinician placements facilitated by the SORHs through their recruitment initiatives.

This new performance measure provides outcomes on how the SORH program is addressing the workforce shortage needs. This information is captured from the annual clinician placement data from the Rural Recruitment and Retention Network (3RNet) which supports rural recruitment by linking health professionals to provider sites. State Offices of Rural Health are either members of 3RNet or work with other organizations within their states who are members of the network. The baseline for FY 2008 is 1,023. The target for FY 2012 is 1,053.

DISCONTINUED MEASURES

Measure	FY	Target	Result
31.V.B.1: Increase the number of communities receiving technical assistance from a State Office of Rural Health. (Outcome)	2012	N/A	N/A
	2011	N/A	N/A
	2010	5,250	Dec 31, 2011
	2009	5,225	6,172 (Target Exceeded)
	2008	4,750	6,131 (Target Exceeded)
	2007	4,700	5,823 (Target Exceeded)
31.V.B.2: Increase the number of States that have an identified focal point for rural recruitment with a national source of applications. (Outcome)	2012	N/A	N/A
	2011	N/A	N/A
	2010	50	Dec 31, 2011
	2009	49	50 (Target Exceeded)
	2008	48	49 (Target Exceeded)
	2007	44	49 (Target Exceeded)

Measure	Data Source	Data Validation
31.V.B.1 31.V.B.2	Annual grantee reports	Validated by project officers

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

This measure is important because rural communities and providers are often isolated and have unique technical assistance needs. By providing this technical assistance, a State Office of Rural Health (SORH) is equipping rural communities with the tools and resources needed to coordinate rural health at the local level. The SORH enables a community to create localized solutions to problems which in turn strengthens the rural health delivery system one community at a time. This goal reflects one of the program's core functions. The program established a baseline of 4,120 communities in FY 2003. In FY 2006, the State Offices of Rural Health provided technical assistance to 4,699 rural communities exceeding the target of 4,450. In FY 2007, the program again exceeded its goal of 4,700 communities served by working with 5,823 communities. The number of communities that received technical assistance in FY 2008 is 6,131 which exceeded its target of 4,750. The FY 2009 target was exceeded with 6,172 communities receiving TA. The FY 2010 target is 5,250. This measure was discontinued in FY 2011. The last year for which data will be reported is FY 2010. This measure was discontinued because it does not provide an accurate representation of the technical assistance (TA) activities that are provided by SORHs. In addition, it is difficult for SORHs to consistently account for communities when many TA activities are directed to specific groups, organizations, individuals, or specific communities.

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

This measure was chosen because rural communities experience greater challenges in recruitment of health professionals. With at least 20% of the population living in rural areas and less than 11% of the nation's physicians practicing in non-metropolitan areas, the goal of fostering rural recruitment activities is a key component to many activities of the State Offices. Workforce shortages hamper attempts to address other pressing health care problems in rural America. A strategy that many State Offices use to meet this goal is to participate in a national rural recruitment program, such as the National Rural Recruitment and Retention Network (3RNET). The program established a baseline with FY 2003 data that indicated 41 States having identified a focal point for rural recruitment. This number has been steadily increased from 46 in FY 2006 to 49 in FY 2007, exceeding the target each year. The number for FY 2008 remained at 49 states, exceeding its target of 48. In FY 2009, the number reached 50, exceeding the target. The FY 2010 target is 50. This measure was discontinued in FY 2011. The last year for which data will be reported is FY 2010. This measure was discontinued because it will have reached its maximum level.

RADIATION EXPOSURE SCREENING AND EDUCATION PROGRAM

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)	2012	1,400	Nov 30, 2013
	2011	1,400	Nov 30, 2012
	2010	1,400	Nov 30, 2011
	2009	1,800	1,373 (Target Not Met)
	2008	1,700	1,270 (Target Not Met)
	2007	2,225	1,689 (Target Not Met but Improved)
Efficiency Measure	FY	Target	Result
32.E: Average cost of the program per individual screened. (Efficiency)	2012	\$1,397	Dec 31, 2013
	2011	\$923	Dec 31, 2012
	2010	\$720	Dec 31, 2011
	2009	\$760	\$1,249 (Target Not Met)
	2008	\$810	\$1,195 (Target Not Met)
	2007	\$850	\$923 (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.

INTRODUCTION

The measures focus on identifying possible patients who may have suffered radiation poisoning and providing needed services to them for screening. The measures also focus on helping to determine if eligible patients might be eligible to seek compensation through the filing of Radiation Exposure and Compensation Act claims. The annual measure focuses on increasing the number of individuals screened each year. The data from the performance measures are used

to refine the actual guidance for the grantees to focus more explicitly on the activities that directly impact the ability to identify and screen affected patients. The program is also partnering with the Department of Justice to collect data in support of long-term performance measures.

The measures support HRSA's Strategic Plan Goal I of improving access to quality health care and services through strengthening health systems to support the delivery of quality health services.

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Access to Quality Health Care and Services

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

32.1. Percent of RECA successful claimants screened at RESEP centers.

This long-term measure reflects RESEP's primary purpose to screen and educate those that might be eligible for compensation under the Radiation Exposure Compensation Act. The measure was determined by comparing the number of successful RECA claimants screened through RESEP centers (i.e., the numerator) with the total number of successful RECA claimants (i.e., the denominator). The 3-year rolling baseline for FY 2008 is 8.5% and the long-term target is 8.8% for FY 2013.

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

This long-term measure reflects the program's efforts to accurately screen and refer individuals potentially eligible for RECA claims. Findings from RESEP's screenings must be confirmed outside the screening program through definitive diagnostic tests in order for an individual to receive benefits. The measure was determined by comparing the number of successful RECA claimants screened through RESEP centers as reported to the Department of Justice (i.e., the numerator) with the total number of RECA claimants screened at RESEP centers as reported to the Department of Justice (i.e., the denominator). The baseline for FY 2008 is 70% and the long-term target is 72% for FY 2013.

32.IA.1. Total number of individuals screened per year.

This annual measure indicates the total number of individuals adversely affected by the mining, transport and processing of uranium and the testing of nuclear weapons for the Nation's weapons arsenal screened at RESEP centers. This measure defines screening as including:

1) occupational history, 2) medical history, 3) physical examination, 4) diagnostic testing (when appropriate), and 5) access to a range of comprehensive services including outreach, education, case management, referrals for treatment, and assistance in applying for RECA compensation. The population of former uranium mine workers continues to require the services of this program. To increase the number of people screened, efforts were made to identify individuals who were potentially exposed but no longer lived in the local area. The program has shown a consistent increase in users from FY 2005 to FY 2007: 1,551 (FY 2005), 1,464 (FY 2006), and

1,689 (FY 2007). This number declined in FY 2008 to 1,270 individuals screened but increased in FY 2009 to 1,373 (below the target of 1,800). The FY 2008 and FY 2009 results are somewhat lower than previous years due to the rapidly aging former uranium mine worker population in which potential patients have passed away as well as the relocation of this population from the original mining sites. The FY 2012 target is 1,400 individuals screened.

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

The efficiency measure compares the total costs of the program to the program's outcome of getting individuals screened. The average cost per individual screened is based on the fiscal year dollars spent to pay for the screenings. The costs include all education and outreach efforts as well as the costs of the screening exams. In FY 2006 the program showed an average cost of \$1,084, which did not meet the target of \$893. In FY 2007, the program showed an average cost of \$923, which did not meet the target of \$850. The average cost in FY 2008 was \$1,195 which did not reach its target of \$850. The average cost in FY 2009 was \$1,249 which did not reach its target of \$760. The average costs for FY 2006 through FY 2009 can be associated with the varying number of individuals screened each year as well as increases in various costs related to testing procedures for the detection of radiogenic disease and cancer. The FY 2012 target is \$1,397.

BLACK LUNG CLINICS

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. ¹ (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)	2012	12,836	Aug 31, 2013
	2011	12,626 ²	Aug 31, 2012
	2010	12,088	Aug 31, 2011
	2009	11,575	12,436 (Target Exceeded)
	2008	11,550	11,888 (Target Exceeded)
	2007	10,933	11,647 (Target Exceeded)
33.I.A.2: Number of medical encounters from Black Lung each year. (Baseline – FY 2005: 20,844) (Output)	2012	26,403	Aug 31, 2013
	2011	25,403	Aug 31, 2012
	2010	24,403	Aug 31, 2011
	2009	22,525	21,727 (Target Not Met)
	2008	21,269	23,403 (Target Exceeded)
	2007	21,121	22,484 (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)	2012	4,272	Aug 31, 2013
	2011	4,172	Aug 31, 2012
	2010	4,072	Aug 31, 2011
	2009	3,862	3,798 (Target Not Met)
	2008	3,630	3,972 (Target Exceeded)
	2007	3,610	3,817 (Target Exceeded)

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

² This target differs from that shown in the FY 2011 Congressional Budget Justification to align it with the most recent performance.

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

INTRODUCTION

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

The measures support HRSA’s Strategic Plan goal 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.

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Access to Quality Health Care and Services

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

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

Functional improvement will be measured using the 6 minute walk pre/post test, applying uniform standards of measurement established by the American Thoracic Society (ATS). The 6 minute walk test is one of several tests available as an objective indicator of functional improvement; measuring the distance the patient can walk during a 6 minute period. For the purposes of this measure the patient will take the test prior to starting the pulmonary rehabilitation program and again after the completion of the program. An improvement in the post-test indicates an improved functional capacity in the patient, an indication of improved quality of life. The FY 2008 baseline for this measure is 80% and the long-term target for FY 2014 is 85%.

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

A miner served is anyone with a history of coal mine employment that receives at least one medical encounter at a clinic during the year. It is often difficult to encourage miners to come into the Black Lung clinics for the initial visits. However, grantees will devote a greater emphasis on program outreach towards affected populations. In FY 2007, the program saw 11,647 miners, exceeding the target of 10,933. In FY 2008, the program served 11,888 miners, exceeding the target of 11,550. In FY 2009, the program served 12,436 miners, exceeding the target of 11,575. The FY 2012 target is 12,836.

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

To improve the quality of life of miners, it is important for clinics to provide ongoing, consistent care once the initial screening is conducted. The program expects the number of medical encounters to increase proportionate to the number of miners served. The program had 22,484 medical encounters in FY 2007, exceeding the target of 21,121 and 23,403 medical encounters in FY 2008, exceeding the target of 21,269. The program result increased to 21,727 medical encounters in FY 2009; however, it did not meet its target of 22,525. The FY 2012 target is 26,403.

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

The number of medical encounters per million dollars was 3,972 in FY 2008, exceeding the target of 3,360. In FY 2009, this number was 3,798 which is slightly below the target of 3,862. The Program offers technical assistance (TA) to grantees. The TA consultants look at specific activities and offer suggestions for cutting costs while maintaining the same level of services. The program is looking into methods for collecting data that will highlight cost efficiencies to better identify best practices and target technical assistance. The FY 2012 target is 4,272.

TELEHEALTH

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>34.II.A.1</u> : 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%). (<i>Outcome</i>)	<i>Out-Year Target</i>	21% (FY 2013)	Mar 31, 2015
	2012	20% ¹	Mar 31, 2015
	2011	42%	Mar 31, 2013
	2010	21%	Mar 31, 2012
	2009	14.5%	Mar 31, 2011
	2008	30%	41% (Target Exceeded)
	2007	21%	42% (Target Exceeded)
<u>34.I</u> : Percent of TNGP grantees that continue to offer services after the TNGP funding has ended. ² (Baseline – FY 2005: 100%) (<i>Outcome</i>)	<i>Out-Year Target</i>	95% (FY 2013)	Mar 31, 2015
<u>34.III.D.2</u> : 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. ³ (Baseline - FY 2005: 489) (<i>Outcome</i>)	2012	2,556	Mar 31, 2014
	2011	2,537	Mar 31, 2013
	2010	2,456	Mar 31, 2012
	2009	1,371	Mar 31, 2011
	2008	968	1,295 (Target Exceeded)
	2007	943	1,275 (Target Exceeded)

¹ 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.

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

³ 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. ⁴ (<i>Outcome</i>)	<i>Out-Year Target</i>	300 (FY 2013)	Mar 31, 2015
	2012	223	Mar 31, 2014
	2011	219	Mar 31, 2013
	2010	219	Mar 31, 2012
	2009	207	Mar 31, 2011
	2008	160	162 (Target Exceeded)
	2007	160	191 (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
	2012	188	Mar 31, 2014
	2011	186	Mar 31, 2013
	2010	186	Mar 31, 2012
	2009	175	Mar 31, 2011
	2008	134	158 (Target Exceeded)
	2007	125	159 (Target Exceeded)
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. ⁵ (<i>Efficiency</i>)	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 \$	Mar 31, 2011
	2008	121 per Million \$	218 per Million \$ (Target Exceeded)
	2007	116 per Million \$	173 per Million \$ (Target Exceeded)

⁴ 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.

⁵ 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.

INTRODUCTION

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

DISCUSSION OF RESULTS AND TARGETS

Goal: Improve Access to Quality Health Care and Services

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

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%).

At the end of FY 2006, HRSA began to fund a new three-year cohort of grantees under the Telehealth Network Grant Program (TNGP). When the original targets were developed, it was estimated that in this new cohort, 10% of the patients who entered a telehealth diabetes case management program would have ideal glycemic control (hemoglobin A1c at or below 7%) and, during the first year, this cohort would have achieved a 45% increase to 14.5% achieving ideal control. Among the FY 2006 cohort of patients, 34% had ideal glycemic control. In FY 2007, 42% achieved ideal glycemic control compared to a target of 21%. Finally, in FY 2008, 41% achieved ideal glycemic control. This can be attributed to an increase in the number of patients being served and monitored as the management program continues to be implemented among existing grantees. During the FY 2006 thru FY 2008 cohort, grantees exceeded the respective targets. However, during the last two fiscal years, there was a reduction in the actual result of one percentage point, due to a stabilization of patients served during the last fiscal year. In FY 2012, the new cohort of programs (FY 2012-2015) will achieve 20% of their patients under control, assuming a similar rate of growth as experienced in the former cohort.

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

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

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

The first cohort of grantees in this program was funded in FY 2003. A second was funded in FY 2006 and in FY 2009, a third cohort of grantees were awarded. As grantees mature, learn best practices from other grantees, and learn of new needs in the communities they serve, grantees may make additional telehealth services and service locations available. Beginning in FY 2006, the program required that grantees place a greater emphasis on evaluating services in lieu of expanding the number of sites where services are provided in accordance with Congressional directives. The targets are cumulative, building on the sites and services made available in the first cohort (2003-2005) through TNGP funding, and are calculated by adding the number of projected services offered by each grantee to the number of sites operated by the grantee's networks in each year to the baseline. It is anticipated that the program will experience a slightly reduced rate of growth in the future, after adjustment for carrying over existing sites that continue into the second cohort, which began in FY 2006. In FY 2008, this cohort of TNGP grantees provided a total number of 95 clinical services, across 711 sites in underserved rural communities for a total of 806 sites and services. When added to the baseline of 489 services, the TNGP supported 1,295 sites and services in these communities since FY 2005. This result exceeded the FY 2008 target by 327 sites and services. The cycle began again in September 2009 with a new cohort for which annual targets are established based on the 2006-2008 cohort experience. For FY 2012, the target is 2,556, assuming a similar rate of growth as experienced in the current cohort. Although the Program has exceeded the 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 they explore the boundaries of providing these services, e.g., innovative use of telehealth for physical therapy, stroke assessment, post-treatment rehabilitation, and teledentistry.

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.

AND

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.

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

With funds awarded in FY 2003, 79 communities had access to pediatric/adolescent and 51 adult mental health services as a result of the TNGP grant. With funds awarded in FY 2004, 99 communities had access to pediatric/adolescent mental health services and 62 communities had access to adult mental health services. Lastly, funds awarded in FY 2005, 101 communities had access to pediatric/adolescent mental health services and 72 communities had access to adult mental health services. The increase continues with funds awarded in the second cohort. In FY 2006, 190 communities had access to pediatric/adolescent and 125 communities had access to adult mental health services, as a result of the TNGP grant. The increase continued with funds awarded in FY 2007, where 191 and 159 communities had access to pediatric/adolescent and adult mental health services, respectively. However, in FY 2008, the number of communities that had access to pediatric/adolescent and adult mental health services decreased to 162 and 158, respectively, although targets were exceeded. This variation between FY 2007 and FY 2008 shows a slight decrease due to the TNGP grant being used to provide other critical services in FY 2008, based on the community needs of the grantees. For FY 2012, these targets are a 223 and 188 communities gaining access to pediatric/adolescent and adult mental health services, respectively, through telehealth networks.

These targets take into account the environmental challenges experienced by grantees even when grant funds are available. For example, difficulty in obtaining services due to the shortage in the supply of mental health specialists and continued low reimbursement for these services. In the third cohort, 17 programs were funded, but six of the seventeen are required to focus on providing and evaluating tele-home care services in accordance with Congressional directives. Moreover, fewer programs are offering pediatric/adolescent mental health services in the third cohort compared to the first and second. The number of programs offering these services is difficult to predict as the legislation authorizing the TNGP grants provides grantees with wide discretion as to what they propose to provide, based on community need. Nevertheless, the Program will continue to encourage applicants in the guidance to propose these services and provide continuing technical assistance to those that do provide services.

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

One measure of the Telehealth Network Grant Program's (TNGP) efficiency is the number of sites and services that provide access to health care as a result of the TNGP grant per \$1 million Federal program dollars. The Telehealth program's efficiency measure captures the fundamental underlying mission of the program: namely to expand access to services in underserved communities at an affordable cost. This is a consistent indicator that can be tracked over time. When the original targets were developed, we anticipated having fewer sites as a result of the program requiring that grantees put greater emphasis on evaluating services rather than on expanding the number of sites where services are provided. However, with FY 2006 funding, the efficiency factor increased to 168 per million, as a result of the three additional Tele-

homecare grantees, which provide care in the homes, resulting in significantly more sites. This has resulted in a higher efficiency factor for FY 2006 than anticipated when the targets for FY 2006, FY 2007, and FY 2008 were established. In FY 2007, the efficiency factor exceeded the target of 116 per million with a result of 173 per million. The target was exceeded again in FY 2008, with an efficiency factor result of 218 per million. The actual data for FY 2006, FY 2007 and FY 2008 is a result of grantees adding more sites to their network in an effort to increase the access to care within their respective communities as the cohort matures. Grantees exceeded the respective targets for each of those years. For FY 2012, the target is 202 sites and services per million dollars. It is anticipated that the efficiency will rise each year, similar to prior years, as new sites and services are implemented by the maturing cohort.

HEALTH EDUCATION AND ASSISTANCE LOANS (HEAL)

The program included in this section is:

- Health Education and Assistance Loans (HEAL)

HEALTH EDUCATION ASSISTANCE LOANS

DISCONTINUED MEASURES

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). <i>(Outcome)</i>	2012	N/A	N/A
	2011	\$682	Dec 31, 2011
	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>	2012	N/A	N/A
	2011	8 days	Dec 31, 2011
	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.

The Health Education Assistance Loans (HEAL) program's performance measures and activities build upon HRSA's Strategic Goal to "Improve Access to Quality Access to Quality Care and Services" and is keyed to the following HRSA sub-goal:

- Strengthen the financial soundness and viability of HRSA-funded health organizations.

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.

Since the program is proposed for moving to the Department of Education, there is no FY 2012 target.

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

The HEAL program is currently phasing out an outstanding loan portfolio of approximately \$730 million as of September 30, 2010. Except for in FY 2007, the program has historically met or exceeded its targets for phasing out the outstanding loan portfolio through initiatives to help borrowers manage their indebtedness, and through partnerships with lenders and loan holders. In FY 2007, the projection of \$1.090 billion was not able to be met due to the historical downward trend of HEAL loans that refinanced out of the program and borrowers that paid-in-full turned out to be lower than anticipated. In FY 2008, the target was met and was slightly exceeded by \$17 million in loans. This was primarily due to the target being adjusted for the historical trend. The FY 2009 target of \$866 million was exceeded. From October 1, 2008 through September 30, 2009, the portfolio size decreased by \$127 million (from \$980 million to \$853 million). The FY 2010 target of \$765 million was also exceeded. From October 1, 2009 through September 30, 2010, the portfolio size decreased by \$123 million (from \$853 million to \$730 million). This measure is proposed for retirement in FY 2012 because of a proposal to transfer the program to the Department of Education. FY 2011 is the last year for which data will be reported.

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

The efficiency measure for the HEAL program is to improve claims processing efficiency through the implementation of an online processing system. In FY 2004 and FY 2005, the processing time was 10 days and 9 days, respectively. Processing time was reduced to 8 days in FY 2006, which was lower than the target? The target of 8 days was met in FY 2007 but, in FY 2008, the target of 8 days was not met. It took 11 days on average to process claims, because there were management changes and reductions in staff that caused the claims specialists' workloads to increase. It is believed that the FY 2008 result was an anomaly. In FY 2009 as well as 2010, the goal of 8 days was exceeded. In FY 2009, the goal was exceeded due to streamlined processing methods, and in FY 2010, it was due to an increased proportion of death and bankruptcy claims which are faster to process. This measure is proposed for retirement in FY 2012 because of a proposal to transfer the program to the Department of Education. FY 2011 is the last year for which data will be reported.

NATIONAL VACCINE INJURY COMPENSATION PROGRAM

The program included in this section is:

- National Vaccine Injury Compensation

NATIONAL VACCINE INJURY COMPENSATION PROGRAM

Goal: Build Healthy Communities

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

Measure	FY	Target	Result
<u>26.II.A.1:</u> Percentage of cases in which judgment awarding compensation is rejected and an election to pursue a civil action is filed. (Outcome)	<i>Out-Year Target</i>	0% (FY 2013)	Oct 31, 2014
	2012	0%	Oct 31, 2012
	2011	0%	Oct 31, 2011
	2010	0%	April 30, 2011
	2009	0%	0% (Target Met)
	2008	0%	0% (Target Met)
	2007	0%	0% (Target Met)
<u>26.II.A.2:</u> Average claim processing time. (Outcome)	<i>Out-Year Target</i>	1,300 days (FY 2013)	Oct 31, 2014
	2012	1,300 days	Oct 31, 2012
	2011	1,300 days	Oct 31, 2011
	2010	1,300 days	1,202 days (Target Exceeded)
	2009	1,300 days ¹	1,269 days (Target Exceeded)
	2008	1,433 days ²	1,280 days (Target Exceeded)
	2007	1,213 days	1,337 days (Target Not Met)
<u>26.II.A.3:</u> Percentage of cases where the deadline for the Rule 4(b) report is met once the case has been deemed complete. (Outcome)	2012	86%	Oct 31, 2012
	2011	86%	Oct 31, 2011
	2010	86%	April 30, 2011
	2009	86%	94% (Target Exceeded)
	2008	86%	94.7% (Target Exceeded)
	2007	83%	89.3% (Target Exceeded)

¹As the autism claims represent a unique category of VICP cases and are being processed under different Court proceedings and procedures, these claims have been excluded, beginning for 2009, from the calculations determining case processing times.

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

Measure	FY	Target	Result
26.II.A.4: Decrease the average time settlements are approved from the date of receipt of the DOJ settlement proposal. (<i>Outcome</i>)	2012	10 days	Oct 31, 2012
	2011	10 days	Oct 31, 2011
	2010	8 days	8.7 days (Target Not Met)
	2009	10 days	7.5 days (Target Exceeded)
	2008	10 days	5.8 days (Target Exceeded)
	2007	10 days	9.6 days (Target Exceeded)
26.II.A.5: Decrease the average time that lump sum only awards are paid from the receipt of all required documentation to make a payment. (<i>Outcome</i>)	2012	5 days	Oct 31, 2012
	2011	5 days	Oct 31, 2011
	2010	3 days	2.4 days (Target Exceeded)
	2009	5 days	2.5 days (Target Exceeded)
	2008	5 days	1.5 days (Target Exceeded)
	2007	5 days	3.9 days (Target Exceeded)
Efficiency Measure	FY	Target	Result
26.E: Percentage of cases in which case settlements are completed within 15 weeks. (<i>Efficiency</i>)	2012	92%	Oct 31, 2012
	2011	92%	Oct 31, 2011
	2010	92%	April 30, 2011
	2009	92%	100% (Target Exceeded)
	2008	92%	100% (Target Exceeded)
	2007	92%	96.4% (Target Exceeded)

Measure	Data Source	Data Validation
26.II.A.1 26.II.A.2 26.II.A.3 26.II.A.4 26.II.A.5 26.E	VICP internal data system and DOJ Office of Management Information system.	Validated by program staff through internal consistency checks.

INTRODUCTION

The purpose of the National Vaccine Injury Compensation Program (VICP) is to equitably and expeditiously compensate individuals, or families of individuals, who have been injured by childhood vaccines, and to serve as a viable alternative to the traditional tort system. This Program's performance measures focus on the timely adjudication of vaccine injury claims and monetary awards, and the extent that the VICP serves as a alternative to the traditional tort system by ensuring that no compensated claimant rejects an award, and elects to file lawsuits in

the traditional tort system (i.e., pursue civil action). A strategy used to reduce claims processing time is to increase the use of electronic file sharing among agencies, expert witnesses, and other parties.

DISCUSSION OF RESULTS AND TARGETS

Goal: Build Healthy Communities

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

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

While a purpose of the VICP is to fairly compensate individuals who have been injured by vaccines, the Act provides that petitioners may choose to reject an award from the VICP and sue in a traditional civil forum. It is the goal of the VICP to ensure that this option is rarely, if ever, utilized by those individuals with a legitimate claim for compensation for a vaccine-related injury. This measure tracks the number of individuals who pursue civil litigation following a determination that they are eligible for compensation. From FY 2007 – FY 2009, the VICP met its target of 0% for the percentage of eligible claimants who opted to reject awards. The FY 2012 target is 0%.

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

This measures the average length of time from the date the claim is filed until payment is authorized for compensable claims, and the date of filing to judgment for dismissed claims. This goal encompasses total claim processing time by all program participants, including the Department of Justice (DOJ), HRSA, petitioners and the U.S. Court of Federal Claims (the Court). In FY 2007, the VICP did not meet its target of 1,213 days for this measure due to petitioner and Court-driven delays in adjudicating claims. For this period, the performance outcome was 1,337 days. The VICP exceeded its FY 2008 target of 1,433 days with an FY 2008 actual of 1,280 days. The VICP exceeded its FY 2009 target of 1,300 days with an FY 2009 actual of 1,269 days. The VICP again exceeded its FY 2010 target of 1,300 days with an FY 2010 actual of 1,202 days. The VICP average time to process claims has been less than its targets and has improved over time. The FY 2012 target is 1,300 days.

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

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

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

Since FY 2006, the VICP has exceeded its targets for the percentage of cases where the deadline for the Rule 4(b) report is met once the case has been deemed complete. In FY 2007, the Rule 4(b) report deadline was met for 89.3% of the cases that are deemed complete which exceeded the FY 2007 target of 83%. The performance outcome for FY 2008 was 94.7% which exceeded the FY 2008 target of 86%. The performance outcome for FY 2009 was 94%, again exceeding the target. The program was able to exceed the target because it had sufficient funds to run the medical expert program which supported the filing of an expert report along with the Rule 4(b) report when required. The FY 2012 target is 86%.

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

The purpose of this measure is to track the average time that settlement payments are approved and to ensure that petitioners are satisfied with the processing of their claims, thus, preventing award rejections. Quickly and efficiently processing settlements is a top priority for the VICP. In FY 2007, the VICP was successful in reducing the average time to approve settlements and to pay lump sum only awards. The average time that settlements were approved from the date of receipt of the DOJ settlement proposal was 9.6 days, which was less than the target of 10 days and less than the FY 2006 actual of 11 days. In FY 2008 the target for this measure was exceeded, with a FY 2008 actual result of 5.8 days. The FY 2009 target for this measure was 10 days, which was exceeded by a FY 2009 actual result of 7.5 days. As a result of exceeding targets over the past three fiscal years, the Program thought that they could decrease the target. Unfortunately, the FY 2010 target for this measure was 8 days, which was not met with a FY 2010 actual result of 8.7 days. During FY 2010, the VICP received more than double the average number of claims and negotiated settlements over the last three fiscal years. The VICP is unable to reduce the targeted average time below 10 days because of factors inherent in the approval system, such as the necessary legal review and opinion by the HHS Office of General Counsel (OGC). This includes OGC reviewing the DOJ settlement proposal and preparing a legal opinion to the VICP, which often requires consultation with DOJ attorneys to clarify or amend elements in the settlement proposal. OGC attorneys are aware of their role in meeting

this measure. Performance outcome data are reported to OGC as well as HRSA and the Healthcare Systems Bureau (HSB) management, on a regular basis, to ensure continued monitoring of the process. The FY 2012 target is 10 days.

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

The purpose of this annual measure is to track the average time that lump sum awards with the required documentation to issue payments are made and to ensure that petitioners are satisfied. In FY 2005, the average time was 11 days. In FY 2006 DOJ implemented a policy to process payments only after the petitioner had submitted proof of guardianship. Additionally, this measure now accounts for time required to collect tax identification number information and other necessary payment data. The FY 2006 data is only available from May through September as the VICP database was modified in May 2006 to capture data for this revised measure. The average for FY 2006 is 3 days for the period of May through September. In FY 2007, the average time to pay a lump sum only award from the receipt of all required documentation to make a payment was 3.9 days, which was less than the target of 5 days. The FY 2008 result was 1.5 days, which was less than the target of 5 days. The FY 2009 result was 2.5 days, which exceeded the target of 5 days. The FY 2010 result was 2.4 days, which exceeded the target of 3 days. This outcome is the result of shifting priorities within the Program to ensure compliance with the target, altering the process for the collection of the required tax identification number (TIN), and having a senior staff member dedicated exclusively to discharging compensation awards and processing settlement proposals. Since the number of cases settled via negotiation has more than doubled, the FY 2012 target is 5 days.

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

The purpose of this measure is to track the percentage of cases in which settlements are processed from the date of the tentative agreement between the parties and the settlement proposal is submitted to the petitioner for his or her concurrence. Quickly and efficiently processing settlements is a top priority for the VICP and are completed within 15 weeks. In FY 2004, the percentage of cases was 80%, which is the baseline for this measure. In FY 2007, the percentage of cases in which settlements are processed within 15 weeks was 96.4%. In FY 2008, this percentage was 100%, surpassing the target of 92%. In FY 2009, this percentage was 100%, surpassing the target of 92%. In FY 2010, this percentage was 100%, again surpassing the target of 92%. The target for FY 2012 will remain at 92% due to the complex nature of case settlements.

HEALTHY WEIGHT PROGRAM

The program included in this section is:

- Healthy Weight Collaborative Prevention Fund

HEALTHY WEIGHT COLLABORATIVE PREVENTION FUND

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 (Developmental)	2012	TBD ¹	TBD
	2011	TBD ¹	TBD
38.II: Number of clinical and community-based interventions disseminated (Developmental)	2012	TBD ¹	TBD
	2011	TBD ¹	TBD

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

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 from which community teams will choose are being defined and selected currently by the Prevention Center for Healthy Weight.

DISCUSSION OF RESULTS AND TARGETS

Goal: Build Healthy Communities

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

38.I. Number of collaborative teams recruited. (Developmental)

This developmental measure focuses on the number of collaborative teams recruited under the Healthy Weight Collaborative. Teams in the Healthy Weight Collaborative can include health departments, community-based organizations, and HRSA and DHHS grantees, especially safety net providers, and other stakeholders in the HRSA and DHHS Program network. The baseline and targets for this measure are yet to be determined. FY 2011 and FY 2012 targets will be established when the full nature and scope of the program are finalized.

¹ This new program is under development. Targets will be established when the full nature and scope of the program are finalized.

**38.II. Number of clinical and community-based interventions disseminated.
(Developmental)**

This developmental measure examines the number of clinical and community-based interventions disseminated by the Healthy Weight Collaborative. This dissemination will transfer knowledge, skills, and practical approaches to quality management to prevent and treat overweight and obesity for children and families to build capacity at the regional, state, local, or community level. The baseline and targets for this measure are yet to be determined. FY 2011 and FY 2012 targets will be established when the full nature and scope of the program are finalized.

PROGRAM MANAGEMENT

The program included in this section is:

- Program Management

PROGRAM MANAGEMENT

Measure	FY	Target	Result
<p><u>35.VII.B.1:</u> Ensure Critical Infrastructure Protection</p> <p>Security Awareness Training (Output)</p>	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.	Dec 31, 2011
	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)
	2007	Full participation in Security Awareness Training by 100% of HRSA Staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation of Executive Awareness Training by 100% of HRSA executive staff.	100% completion rate for HRSA Executives and those staff identified to have significant security responsibilities. 99.9% completion rate for Security Awareness training of HRSA staff. (Target Met)

Measure	FY	Target	Result
35.VII.B.2: Ensure Critical Infrastructure Protection. Security Authorization to Operate <i>(Output)</i>	2012	100% of HRSA information systems have been Certified and Accredited and granted Authority to Operate. (ATO).	Nov 30, 2012
	2011	100% of HRSA information systems have been Certified and Accredited and granted Authority to Operate. (ATO).	Nov 30, 2011
	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
35.VII.B.3: Capital Planning and Investment Control <i>(Output)</i>	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.	Nov 30, 2011
	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

Measure	FY	Target	Result
<p><u>35.VII.A.1:</u> Strategic Management of Human Capital Initiative:</p> <p>As part of a management review, HRSA will implement a Delaying Management and Streamlining Organizational Plan. (Output)</p>	2012	Continue implementing staffing patterns initiated for health care reform.	Nov 30, 2012
	2011	Implement staffing patterns to support Affordable Care Act	Nov 30, 2011
	2010	Continue with implementation of streamlining efforts.	Delayed Management Structure by creating two new Offices and transferring functions from the following 4 offices (policy, center of quality, health information technology, minority health and health disparities) into the Office of Planning, Analysis and Evaluation and the Office of Special Health Affairs. Further restructuring was accomplished to realign core policy, oversight and coordination functions in OA and to ensure that the bureaus were operating programs and engaging in the grant making process.
	2009	Continue with implementation of streamlining efforts	Created an Office of Operations, headed by a Chief Operating Officer, which includes budget, financial policy and controls, contracts, information technology, and other management functions. (Target Met)
	2008	Continue with implementation of streamlining efforts	Implemented a restructuring of the Office of Financial Management and the Office of Management (Target Met)
	2007	Continue with implementation of streamlining efforts.	Established the Bureau of Clinician Recruitment and Service. (Target Met)
<p><u>35.VII.A.2:</u> Strategic Management of Human Capital Initiative:</p> <p>Implement the HRSA Scholars Program. (Output)</p>	2012	N/A	N/A
	2011	N/A	N/A
	2010	20	0 (Target Not Met)
	2009	N/A	N/A
	2008	30	50 (Target Exceeded)
	2007	55	62 (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.1	HRSA Office of the Administrator	Validated by administrative staff.
35.VII.A.2	Rockville Human Resources (HR) Center	Validated by HR staff

INTRODUCTION

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

DISCUSSION OF TARGETS AND RESULTS

35.VII.B.1. Ensure Critical Infrastructure Protection: Security Awareness Training

In addition to security education and outreach efforts, HRSA will expand its security awareness training program for Agency employees, and other program staff with unique information security responsibilities. In FY 2007, HRSA successfully reported a 100% completion rate for HRSA Executives and those staff identified to have significant security responsibilities and a 99.9% completion rate for Security Awareness training of HRSA staff. In FY 2008, FY 2009, and 2010 HRSA had a 100% completion rate in all areas of Security Awareness and Training. The FY 2012 target is that HRSA will have continued full participation in Security Awareness Training by 100% of HRSA Staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities, and participation of Executive Awareness Training by 100% of HRSA executive staff.

35.VII.B.2. Ensure Critical Infrastructure Protection: Security Authorization to Operate

This measure focuses on having all HRSA information systems certified and authorized to operate in accordance with Federal Laws and agency directives. In FY 2010, 100% of HRSA information systems were Certified and granted Authority to Operate. (ATO). FY 2012 target: 100% of HRSA systems will be certified and issued Authority to Operate in accordance with a memorandum signed by the HRSA Designated Authorizing Official.

35.VII.B.3. Capital Planning and Investment Control

This measure focuses on all major investments. In FY10, HRSA had 100% of major IT investments with acceptable business cases. The FY 2012 target is that 100% of major investments will receive an IT Dashboard Overall Rating of “Green”, which indicates an acceptable cost, schedule and Agency CIO Rating and 100% of major Investment Managers will be in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM).

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

HRSA has focused on efforts to consolidate and re-deploy staff to more effectively support and accomplish the mission and goals of the Department and HRSA. Each year HRSA has announced reorganizations in the Federal Register and has implemented them. They have included the restructuring of Offices and Bureaus.

During FY 2008, a restructuring of the Office of Financial Management (with the hiring of a new Chief Financial Officer) and the Office of Management was accomplished. In FY 2009 HRSA’s reorganization efforts included the creation of an Office of Operations, headed by a Chief Operating Officer, which covers budget, financial policy and controls (the Chief Financial Officer), contracts, information technology (the Chief Information Officer), and other management functions.

In FY 2010 as part of delayering, the functions of four offices (policy, center for quality, health information technology, minority health and health disparities) were transferred into two newly created Offices – Planning, Analysis and Evaluation and Special Health Affairs. In addition, a contractor (LMI) conducted an Employee Satisfaction survey and a Products and Services survey providing information related to workload distribution.

FY 2011 HRSA management will develop staffing patterns to support the Affordable Care Act and address results of the FY 2010 workload distribution survey for products and services. The FY 2012 target is to continue implementing staffing patterns to support health care reform.

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

The HRSA Scholars program was implemented in 2001 to increase career development opportunities and develop a new approach to hiring staff--experienced professionals and young graduates. Over the course of the Scholars program more than 350 scholars were brought on board and the Program served as a model for the HHS Emerging Leaders Program. The Scholars program has ended and this measure will be discontinued.

FAMILY PLANNING

Programs included in this section are:

- Family Planning

FAMILY PLANNING

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
<u>36.II.A.1:</u> Increase the total number of unduplicated clients served in Title X clinics by 5% over five years. (<i>Outcome</i>)	<i>Out-Year Target</i>	5,243,000 (FY 2014)	Oct 31, 2015
	2012	5,247,000	Oct 31, 2013
	2011	5,251,000	Oct 31, 2012
	2010	5,223,000	Oct 31, 2011
	2009	4,980,000	5,186,267 (Target Exceeded)
	2008	5,000,000	5,051,505 (Target Exceeded)
	2007	5,162,000	4,987,238 (Target Not Met)
<u>36.II.A.2:</u> 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. (<i>Outcome</i>)	<i>Out-Year Target</i>	90% (FY 2014)	Oct 31, 2015
	2012	90%	Oct 31, 2013
	2011	90%	Oct 31, 2012
	2010	90%	Oct 31, 2011
	2009	90%	91% (Target Exceeded)
	2008	90%	91% (Target Exceeded)
	2007	90%	91% (Target Exceeded)
<u>36.II.A.3:</u> Increase the number of unintended pregnancies averted by providing Title X family planning services, with priority for services to low-income individuals. (<i>Outcome</i>)	<i>Out-Year Target</i>	1,007,000 (FY 2014)	Oct 31, 2015
	2012	1,008,000	Oct 31, 2013
	2011	1,014,000	Oct 31, 2012
	2010	1,024,000	Oct 31, 2011
	2009	977,000	993,614 (Target Exceeded)
	2008	981,000	975,436 ¹ (Target Not Met but Improved)
	2007	1,012,655	968,868 (Target Not Met)

¹ 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
36.II.B.1: Reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15-24. (Outcome)	<i>Out-Year Target</i>	1,573,000 (FY 2014)	Oct 31, 2015
	2012	1,574,000	Oct 31, 2013
	2011	1,575,000	Oct 31, 2012
	2010	1,413,000	Oct 31, 2011
	2009	1,348,000	1,407,691 (Target Exceeded)
	2008	1,352,000	1,408,886 (Target Exceeded)
	2007	1,398,000	1,361,901 (Target Not Met but Improved)

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

Measure	FY	Target	Result
36.II.C.1: Increase the number of unduplicated female clients who receive a Pap test. (Outcome)	<i>Out-Year Target</i>	1,609,000 (FY 2014)	Oct 31, 2015
	2012	1,757,000	Oct 31, 2013
	2011	1,866,000	Oct 31, 2012
	2010	2,478,000	Oct 31, 2011
	2009	2,363,000	2,035,017 (Target Not Met)
	2008	2,372,000	2,088,218 (Target Not Met)
	2007	2,450,000	2,272,571 (Target Not Met)
36.II.C.2: Reduce invasive cervical cancer among women attending Title X family planning clinics by providing Pap tests. (Outcome)	<i>Out-Year Target</i>	531 (FY 2014)	Oct 31, 2015
	2012	580	Oct 31, 2013
	2011	616	Oct 31, 2012
	2010	835	Oct 31, 2011
	2009	797	672 (Target Not Met)
	2008	800	689 (Target Not Met)
	2007	809	798 (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
	2012	\$280.66	Oct 31, 2013
	2011	\$269.55	Oct 31, 2012
	2010	\$258.87	Oct 31, 2011
	2009	\$243.59	\$237.42 (Target Exceeded)
	2008	\$233.86	\$239.83 (Target Not Met)
	2007	\$224.52	\$229.32 (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.	

INTRODUCTION

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 quality assurance, staffing patterns, clinic efficiency 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 a decrease in the cost per client by controlling cost and 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 the IOM to form a Standing Committee to assist the Title X Program in developing a comprehensive strategic plan and conducting additional studies related to strengthening the infrastructure and long-term goals of the Title X family planning program.

DISCUSSION OF RESULTS AND TARGETS

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

(Indicator: Total number of unduplicated clients attending Title X family planning centers.)

In 2009, 5.186 million unduplicated clients were served at 4,515 Title X-funded clinics. This represents an increase of approximately 2.7% over the number of clients served in 2008. Of these, 93% were women and 7% were men. The increase may be a reflection of better cost control measures implemented at the grantee and clinic level as evidenced by a moderate increase in the cost per client rate over FY 2007. With the FY 2012 budget forecast, the Title X Program is projecting a slight decrease from 2011, as well as in 2014, in the number of clients that will receive services, due to a projection of level funding in the face of rising costs of services. Efficiency and quality improvement strategies will continue to be emphasized in an effort to minimize the decrease in the number of clients. The FY 2012 target is 5,247,000 unduplicated clients. The 2014 out-year target is less than the 2012 target. Increasing pharmaceutical and related medical personnel and supply costs, based on the consumer price index for medical care, (and despite implementing strategies to increase efficiency and lower costs), will contribute significantly to the likelihood of lower outputs in FY 2014 than in FY 2012.

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.

(Indicator: The proportion of clients with incomes at or below 200% of the Federal poverty level.)

Title X Family Planning centers play a key role in providing family planning and related preventive health services to individuals who can least afford such services, primarily low-income persons, many of whom have no insurance or lack insurance coverage for family planning and related preventive health care services. The Title X program provides family planning education and services to all persons who desire them and ensures access by giving priority to low-income persons. The Program consistently maintains the proportion of clients who are at or below 200% of the Federal poverty level at 90% of the total unduplicated number of family planning clients. Historically, based on the total number of unduplicated clients, 90% had family incomes at or below 200% of the Federal poverty level and in 2009, the proportion was 91%. The FY 2012 target is 90%. The 2014 out-year target is less than the 2012 target. Increasing pharmaceutical and related medical personnel and supply costs, based on the consumer price index for medical care, (and despite implementing strategies to increase efficiency and lower costs), will contribute significantly to the likelihood of lower outputs in FY 2014 than in FY 2012.

36.II.A.3. Increase the total number of unintended pregnancies averted by providing Title X Family Planning Services, with priority for services to low-income individuals.

(Indicator: Total number of unduplicated female clients served in Title X clinics multiplied by a factor of 20.65%; prior to the 2005 data the factor was 23.3%)

Each year, publicly-subsidized family planning services assist women in avoiding an estimated 1.3 million unintended pregnancies. Title X is a major provider of publicly funded family planning services and offers a broad range of contraceptive methods and services, which enables women and men to plan pregnancies and space births, important elements in ensuring positive birth outcomes and a healthy start for children and families. In FY 2009, 993,614 unintended pregnancies were averted through the provision of family planning and related preventive health services in Title X clinics. The FY 2009 figure is a 1.9% increase or approximately 18,000 more unintended pregnancies averted than in FY 2008. The FY 2009 target was exceeded by over 16,000 or 1.7% unintended pregnancies averted. This increase is primarily due to the overall increase in female clients in FY 2009. The FY 2012 target is 1,008,000 unintended pregnancies averted (target assumption: 93% of total family planning clients being female).

The FY 2008 result has been modified from what was reported in the FY 2011 Congressional Justification. Due to an error in calculation, the correct result is 975,436 unintended pregnancies averted (FY 2011 CJ amount indicated 991,273). The revised amount was 5,564 (0.57%) below the target. Though the target was not met, the number of unintended pregnancies averted increased 6,568 from FY 2007. This positive result was due to an overall increase in the number of female clients served in Title X clinics. The 2014 out-year target is less than the 2012 target. Increasing pharmaceutical and related medical personnel and supply costs, based on the consumer price index for medical care, (and despite implementing strategies to increase

efficiency and lower costs), will contribute significantly to the likelihood of lower outputs in FY 2014 than in FY 2012.

36.II.B.1. Reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15-24.

(Indicator: The number of female clients ages 15-24 who received a Chlamydia test.)

The Title X Program, through the provision of family planning and related preventive health services, has an impact on preventing infertility in women and ensuring their health, well-being and ability to have a healthy pregnancy. Because untreated Chlamydia infection can lead to pelvic inflammatory disease (PID) and ultimately infertility, preventive screening and testing in symptomatic clients can detect infection that would otherwise go untreated. As a result, Title X is focused on reducing infection and subsequent cases of infertility.

In FY 2009, 1,407,691 screenings for Chlamydia were conducted, significantly exceeding the target. Though the total number of clients increased from the previous year, the number of 15 – 24 year old females actually declined just under 1%, thus accounting for the slight decrease in performance from the FY2008 level. Despite this, the data indicate a higher proportion of females from within the target population were screened in FY 2009 and continued to increase each year since the measure was introduced in FY 05 (from 50% to 55%). Overall, the proportion of all female clients screened has also increased over the same time. The FY 2012 target is 1,574,000.

In addition to collecting data on the number of Chlamydia screenings performed, using Chlamydia prevalence data collected by the CDC Division of STD Prevention under the Infertility Prevention Program (IPP), the theoretical number of infertility cases prevented can be calculated. IPP data collected over several years illustrates a 5.9% positivity rate for Chlamydia in family planning clinics. If left untreated, an estimated 10 - 40% of those cases would be expected to lead to pelvic inflammatory disease (PID). Of those, an estimated 20% would become infertile due to the untreated infection. As a result, in FY 2009 Title X prevented at least 1,690 cases of infertility. Based on the FY 2012 target for Chlamydia screening, at least 1,850 cases of infertility will be prevented. The 2014 out-year target is less than the 2012 target. Increasing pharmaceutical and related medical personnel and supply costs, based on the consumer price index for medical care, (and despite implementing strategies to increase efficiency and lower costs), will contribute significantly to the likelihood of lower outputs in FY 2014 than in FY 2012.

36.II.C.1. Increase the number of unduplicated female clients who receive a Pap test.

(Indicator: Number of unduplicated female clients who receive a Pap test.)

Title X funded agencies are required to perform Pap tests in accordance with nationally recognized standards of care, to document these results in the client's record and to have a system to track or monitor follow-up care for abnormal results. The frequency of Pap testing varies based on individual circumstances, but current recommendations stipulate screening every one to three years beginning at age 21. Beginning in 2005, data were collected on the number of unduplicated clients receiving a Pap test in order to better understand and monitor the scope of

cervical cancer screening in Title X projects. In FY 2009, 2,035,217 unduplicated women received a Pap test, approximately 2.5% less than the previous year.

Based on epidemiological data, in 2003 and most recently in 2009, changes in the recommendations from nationally recognized organized organizations that establish standards of care for cervical cancer screening (e.g., ACOG, USPSTF) were made, resulting in Pap testing being initiated later in life, and being conducted less frequently. As a result, following these national recommendations will result in fewer overall Pap tests being performed. This is illustrated by the proportion of women who received a Pap test in a Title X family planning center decreasing from 52% in 2005 to 42% in 2009. Based on these updated recommendations and the trend evidenced in Title X family planning centers, the target for unduplicated number of women receiving a Pap test in FY 2012 is 1,757,000. The 2014 out-year target is less than the 2012 target. Increasing pharmaceutical and related medical personnel and supply costs, based on the consumer price index for medical care, (and despite implementing strategies to increase efficiency and lower costs), will contribute significantly to the likelihood of lower outputs in FY 2014 than in FY 2012. In addition, changes in nationally recognized standards of care have delayed the first and increased intervals for the screening of cervical cancer (Pap smears) had a significant impact on the lower targets.

The Program acknowledges this measure's current wording is to increase the number of unduplicated female client's who receive a Pap test, though the targets are decreasing each of the out years. Due to the changes in recommended screening for cervical cancer, as detailed above, continuing to increase the number of females receiving a Pap test based on the current number and proportion already conducted would result in a divergence from these recommendations. As a result, the Program will be recommending retiring this measure and proposing a more appropriate measure to assess the ability of the Program to maintain high quality service delivery while complying with nationally recognized standards of care. The proposed first publication for the new measure will be the FY 2013 Department Justification.

36.II.C.2. Reduce invasive cervical cancer among women attending Title X family planning clinics by providing Pap tests.

(Indicator: The projected cases of invasive cervical cancer avoided based on the number of unduplicated female users in Title X who received a Pap test.)

Based on Title X clinics providing Pap tests for their female clients and using accepted estimates of the number of cases of invasive cervical cancer that would result if screening did not occur (33 cases per 100,000 women screened annually and 96 cases per 100,000 women screened every three years). Since FY 2005, the Program has collected data via FPAR on the unduplicated number of women receiving Pap tests in Title X projects. Using this figure, the range of invasive cancer cases prevented by Pap testing in Title X clinics can be calculated. In FY 2009, at least 672 cases of invasive cervical cancer were prevented as a result of the number of women who received a Pap test at a Title X clinic. This result is lower than the previous year as well as the target, 2.46% and 18.6% respectively. Since this measure is dependent on the number of Pap tests performed, the revised recommendations for screening women has a significant effect on these data. Though the aggregate number of annual Pap tests will likely decrease due to the conformance with these revised recommendations, it is probable that as more women begin to be

screened every three years, a greater number of invasive cervical cancer cases will be averted each year based on screening timelines, i.e. 96 cases per 100,000 women screened every three years. Based on new data, recommendations and trends within the Title X program, adjustments in out-year targets have been made. The FY 2012 target is 580 cases of invasive cervical cancer prevented. The 2014 out-year target is less than the 2012 target. Increasing pharmaceutical and related medical personnel and supply costs, based on the consumer price index for medical care, (and despite implementing strategies to increase efficiency and lower costs), will contribute significantly to the likelihood of lower outputs in FY 2014 than in FY 2012.

36.E. Maintain the actual cost per Title X family planning client below the medical care inflation rate.

(Indicator: The actual cost per client is derived by dividing the total revenue by the total number of individuals served, and then factoring in the annual medical care Consumer Price Index (CPI).)

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

In FY 2009 the actual cost per client was \$237.42, 2.5% less than the targeted projection. In addition, the actual cost per client decreased 1% from FY 2008. Moreover, Program revenue increased 1.6% from FY 2008, while the CPI for medical care rose 3.1% over the same period. An evaluation of the Title X training priority addressing clinic efficiency is currently being implemented. Though the findings of this assessment are not due until FY 2011, it is believed that a combination of more efficient clinical and administrative practices and an increase in demand for family planning and reproductive health services at Title X clinics are the major contributors to this decrease. The FY 2012 target for cost per client is \$280.66.

SUPPORT FOR HHS STRATEGIC PLAN

HRSA’s performance budget details the resources needed to achieve HRSA’s long-term goals and sub-goals which are defined in HRSA’s Strategic Plan. Achievement of these goals is essential to realizing HRSA’s mission which is “To improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs.” HRSA’s work toward accomplishing its goals is consistent with the strategic goals and objectives of the Department of Health and Human Services (HHS). HRSA’s FY 2012 budget request places strong emphasis on investing in programs that particularly support the HHS objective to ensure access to quality, culturally competent care for vulnerable populations, and ensure the Nation’s health care workforce can meet increased demands. The table below shows the general alignment of HRSA’s strategic goals with HHS Strategic Plan goals and objectives.

HHS STRATEGIC GOALS AND OBJECTIVES	HRSA Goal I. Improve Access to Quality Health Care and Services	HRSA Goal II. Strengthen the Health Workforce	HRSA Goal III. Build Healthy Communities	HRSA Goal IV. Improve Health Equity
1 Transform Health Care				
1.A: Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured				
1.B: Improve health care quality and patient safety	X			X
1.C: Emphasize primary and preventive care linked with community prevention services	X		X	X
1.D: Reduce the growth of health care costs while promoting high-value, effective care				
1.E: Ensure access to quality, culturally competent care for vulnerable populations	X	X	X	X
1.F: Promote the adoption of health information technology	X			X
2 Advance Scientific Knowledge and Innovation				
2.A: Accelerate the process of scientific discovery to improve patient care			X	
2.B: Foster innovation at HHS to create shared solutions			X	
2.C: Invest in the regulatory sciences to improve food and medical product safety				
2.D: Increase our understanding of what works in public health and human service practice	X		X	

HHS STRATEGIC GOALS AND OBJECTIVES	HRSA Goal I. Improve Access to Quality Health Care and Services	HRSA Goal II. Strengthen the Health Workforce	HRSA Goal III. Build Healthy Communities	HRSA Goal IV. Improve Health Equity
3 Advance the Health, Safety and Well-Being of Our People				
3.A: Ensure the safety, well-being, and healthy development of children and youth	X	X	X	X
3.B: Promote economic and social well-being for individuals, families, and communities				
3.C: Improve the accessibility and quality of supportive services for people with disabilities and older adults				
3.D: Promote prevention and wellness	X		X	X
3.E: Reduce the occurrence of infectious diseases				
3.F: Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies				
4 Increase Efficiency, Transparency and Accountability of HHS Programs				
4.A: Ensure program integrity and responsible stewardship of resources	X			
4.B: Fight fraud and work to eliminate improper payments	X			
4.C: Use HHS data to improve the health and well-being of the American people	X			
4.D: Improve HHS environmental, energy, and economic performance to promote sustainability				
5 Strengthen the Nation's Health and Human Services Infrastructure and Workforce Advance scientific and biomedical research and development related to health and human services.				
5.A: Invest in the HHS Workforce to help meet America's health and human service needs today and tomorrow				
5.B: Ensure that the Nation's health care workforce can meet increased demands	X	X	X	X
5.C: Enhance the ability of the public health workforce to improve public health at home and abroad	X		X	

HHS STRATEGIC GOALS AND OBJECTIVES	HRSA Goal I. Improve Access to Quality Health Care and Services	HRSA Goal II. Strengthen the Health Workforce	HRSA Goal III. Build Healthy Communities	HRSA Goal IV. Improve Health Equity
5.D: Strengthen the Nation’s human services workforce				
5.E: Improve national, state, and local, and tribal surveillance and epidemiology capacity				

**SUMMARY OF FULL COST
(Budgetary Resources in Millions)**

HHS STRATEGIC GOALS AND OBJECTIVES	FY 2010	FY 2011	FY 2012
1 Transform Health Care	\$ 5,062.669	\$ 7,446.258	\$ 5,677.362
1.A: Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured			
1.B: Improve health care quality and patient safety	410.920	409.696	412.510
1.C: Emphasize primary and preventive care linked with community prevention services	447.738	448.760	435.218
1.D: Reduce the growth of health care costs while promoting high-value, effective care			
1.E: Ensure access to quality, culturally competent care for vulnerable populations	4,096.162	6,482.943	4,718.730
1.F: Promote the adoption of health information technology	107.849	104.859	110.904
2 Advance Scientific Knowledge and Innovation	35.889	35.796	37.108
2.A: Accelerate the process of scientific discovery to improve patient care	2.435	2.435	2.435
2.B: Foster innovation at HHS to create shared solutions	23.282	23.167	24.651
2.C: Invest in the regulatory sciences to improve food and medical product safety			
2.D: Increase our understanding of what works in public health and human service practice	10.172	10.194	10.022
3 Advance the Health, Safety and Well-Being of Our People	1,644.075	1,796.848	1,914.215
3.A: Ensure the safety, well-being, and healthy development of children and youth	1,085.263	1,237.131	1,339.038
3.B: Promote economic and social well-being for individuals, families, and communities			
3.C: Improve the accessibility and quality of supportive services for people with disabilities and older adults			
3.D: Promote prevention and wellness	558.812	559.717	575.177
3.E: Reduce the occurrence of infectious diseases			
3.F: Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies			
4 Increase Efficiency, Transparency and Accountability of HHS Programs	6.520	6.426	24.276
4.A: Ensure program integrity and responsible stewardship of resources	2.900	2.819	2.981
4.B: Fight fraud and work to eliminate improper payments	0.725	0.705	0.745
4.C: Use HHS data to improve the health and well-being of the American people	2.895	2.902	20.550
4.D: Improve HHS environmental, energy, and economic performance to promote sustainability			
5 Strengthen the Nation's Health and Human Services Infrastructure and Workforce	1,308.004	1,581.702	1,381.740
Advance scientific and biomedical research and development related to health and human services.			
5.A: Invest in the HHS Workforce to help meet America's health and human service needs today and tomorrow			
5.B: Ensure that the Nation's health care workforce can meet increased demands	1,277.542	1,551.797	1,305.672
5.C: Enhance the ability of the public health workforce to improve public health at home and abroad	30.462	29.905	76.068
5.D: Strengthen the Nation's human services workforce			
5.E: Improve national, state, and local, and tribal surveillance and epidemiology capacity			
Total Program Level	\$ 8,057.157	\$ 10,867.030	\$ 9,034.701

Full Cost Estimation Methodology

The full cost of HRSA's programmatic activities by HHS strategic objectives was estimated as follows. First the full cost by program area was estimated by adding HRSA-level program management cost to the specific program funding levels from the All Purpose Table (APT) (except in cases where the APT program line includes program management cost). The HRSA-level program management cost was allocated, where appropriate, based on the proportion of total program level cost represented by each program. Next, knowledge of the specific purposes of the programs, information on specific budgetary allocations, and professional judgments about the full cost of achieving performance goals were used to inform decisions on the distribution of full cost by strategic objectives.

EVALUATIONS COMPLETED IN FY 2010

RYAN WHITE

Implementation of Core Medical Services Requirement in the Ryan White Program (OEI-07—8-00240) Published October 2009.

<http://oig.hhs.gov/oei/reports/oei-07-08-00240.pdf>

Purpose: 1) To determine the extent to which Ryan White grantees expended grant funds on core medical services, as required. 2) To describe effects of the core medical services requirement on grantee operations. 3) To assess the Health Resources and Services Administration's (HRSA) guidance on and project officers' oversight of the core medical services requirement.

Methods included: 1) grantee interviews, 2) grantee expenditure and allocation information, 3) project officer interviews, and a 4) review of HRSA guidance.

Findings: 1) Almost all grantees complied with the core medical services requirement; grantee expenditures for core medical services changed little from 2006 to 2007. 2) The core medical services requirement affected support services and administrative processes for some grantees. 3) HRSA guidance was helpful, but project officer turnover created program management difficulties.

Recommendations: HAB will offer intensified training regarding the complex requirements mandated by the Act, impending reauthorization of the Act, and the influx of new project officers, it will be intensifying training in the coming weeks.

MATERNAL AND CHILD HEALTH

Second Year National Evaluation of Regional Genetics and Newborn Screening Service Collaboratives

Study Purpose: The purpose of this study was to provide short-term evaluation data on the progress of the seven MCHB-funded Regional Genetics and Newborn Screening Services Collaboratives in achieving program goals. The Regional Collaboratives work to improve access to newborn screening and genetic services especially for medically underserved populations.

Methods: An external evaluator analyzed data collected by the seven Regional Collaboratives. Evaluation data sources included interviews and service database reviews. Program results were measured against short-term performance measures which were established by a national program evaluation workgroup.

Findings: Some of the results of the study were as follows:

- 1) 67% of states/territories had collaborations facilitated by their Regional Collaborative between primary care providers and specialty (including genetic) providers to improve care coordination for people with heritable disorders. This was an increase from the 48%

of states/territories reported to have these collaborations during the first year of the evaluation.

- 2) 98% of states/territories had systems in place to track entry into clinical management for newborns who are diagnosed with condition(s) mandated by their State-sponsored newborn blood spot screening programs. In the first year of the evaluation, 93% of the states/territories had such systems.
- 3) 96% of states/territories had newborn screening programs that disseminated just-in-time/point-of-care information on specific heritable disorders to primary care providers. This was an increase from the 88% of states/territories that disseminated such information during the first year of the evaluation.

Recommendations: None

Report Available from: Jill Shuger, HRSA Bureau of Maternal and Child Health

Evaluation of Project Access: A Program for Improving Care for Children and Youth with Epilepsy

Study Purpose: The purpose of the study was to identify the successes and challenges encountered by grantees in the implementation of Project Access and based on the study findings, offer recommendations for programmatic improvement. Project Access was funded to improve care for children and youth with epilepsy by developing and enhancing coordinated and comprehensive service systems to meet the needs of children and youth with this disease. Project Access involved two independent components: (1) state demonstration grants to develop and implement a strategic plan to improve epilepsy service systems, and (2) the establishment of a National Center for Project Access (NCPA) to provide technical assistance to community grantees and promote Project Access nationwide through social marketing and public outreach.

Methods: The evaluation was conducted by an external evaluator. The Evaluator reviewed grantee and NCPA documentation and conducted three rounds of interviews with project directors and/or project managers. The Evaluator also interviewed grantees' community partners including providers and parents involved in Project Access.

Findings: The study found that grantees conducted a range of activities with the common goal of improving the accessibility, coordination, and quality of epilepsy services for children and youth. Each grantee began the project by conducting a community-wide needs assessment. Grantees then engaged providers, school personnel, parents, youth, Title V representatives, and other stakeholders in developing and implementing interventions and educational campaigns.

Recommendations: The Evaluator recommended that MCHB position Project Access within the larger framework of services for children and youth with special health care needs to create buy-in among community partners and increase the potential for sustainability; develop clear plans for sustainability early in the project, and provide opportunities for parents and youth to guide the development, implementation, and evaluation of Project Access in each community.

Contact to Obtain Report: Diana Denboba, HRSA Bureau of Maternal and Child Health

MCHB Resource Center Customer Satisfaction Survey

Study Purpose: To determine areas of future quality improvements, MCHB evaluated the customer satisfaction of end-users of its Resource Centers in order to: (1) obtain information about the overall services provided by Resource Centers in the past 12 months, and (2) determine general information about the population served by the Resource Centers. MCHB funds 38 Resource Centers located across the country. These Resource Centers provide for national dissemination of information on particular topics in a variety of formats serving both the general public and audiences of special interest to MCHB. Resource Centers may provide technical assistance as well.

Methods: MCHB utilized the services of the CFI Group, an external evaluator, who conducted an online customer satisfaction survey of users of the 38 Resource Centers using the American Customer Satisfaction Index (ACSI). The ACSI is a uniform, cross-industry measure of satisfaction with goods and services available to U.S. consumers used in both the private and public sectors. Resource Center staff provided a survey link to their past year end-users via e-mail, through the Resource Center listservs, and by posting survey links on the Resource Center websites. 3,159 survey responses were received out of which 2,421 valid survey responses were completed (738 respondents were screened out because they had not used a Resource Center in the past 12 months).

Findings: The survey results showed that the ACSI score for MCHB Resource Centers was very strong at 84. This ACSI score was higher than the latest Federal Government ACSI of 69 and the private sector ACSI score of 76 in the third quarter of 2009. The survey showed that the most common method for accessing the resource centers was through their websites. The survey showed that Training Materials, Resource Center Contact, and Technical Assistance were considered strengths among Resource Center users. The survey showed that the likelihood to visit the Resource Center again in the future and the likelihood to recommend the Resource Center to someone else were very high among the end-users of MCHB Resource Centers.

Recommendation: The evaluator recommended that MCHB consider conducting a usability study to determine what improvements would be most effective for the resource center websites.

Contact to Obtain Report: Lisa Wright-Solomon, HRSA Bureau of Maternal and Child Health

Evaluation of State Implementation Grants for Integrated Community Systems for Children with Special Health Needs

Study Purpose: In May 2005, the MCHB Division of Services for Children with Special Health Needs (DSCSHN) developed a new grant program called *State Implementation Grants for Integrated Community Systems for Children with Special Health Needs*. The purpose of the program was for State Title V Programs and other State partners to focus on improving the system and address core programmatic outcomes to improve services for children with special health needs. In 2008, 12 States were awarded grants to: (1) develop and implement a statewide

plan to achieve a community-based system of services for CYSHN using evidence-based and best practice models; (2) integrate the plan into the Title V Block Grant and other public and private programs serving CYSHN and their families; (3) define a comprehensive evaluation plan using national, state, and community data; (4) demonstrate capacity to gather and report on outcomes related to CYSHN; and (5) demonstrate the capacity to sustain the project beyond federal funding. MCHB contracted with an external evaluator to conduct a process evaluation assessing grantees' implementation of the program and identifying lessons learned from their experiences implementing the program.

Methods: The Evaluator conducted telephone discussion groups with the 12 grantees and then reviewed and analyzed reports submitted by 10 out of the 12 states to identify strategies for systems integration; implementation successes; challenges and outcomes; and evaluation and monitoring activities.

Findings: The study found that overall the States who received the grants made significant improvements in the five program core outcome areas evaluated. The study found that the States learned three core lessons from implementing the program: need for prior understanding of capacity before undertaking initiatives, planning for sustainability, and using data for quality improvement.

Recommendations: None

Contact to Obtain Report: Diana Denboba, HRSA Bureau of Maternal and Child Health

HEALTH PROFESSIONS

Linking National Administrative Databases to Track Medical and Dental School Matriculation for HCOP AND COE Participants

<http://bhpr.hrsa.gov/healthworkforce/reports/EvalHealthCareerCollegeEnrichmentProgApril2009.pdf>

Programs: Centers of Excellence Programs (COE) and Health Careers Opportunity Program (HCOP)

Description: This study examined the feasibility of using student-level data collected as part of Disadvantaged Assistance Tracking and Outcome Report (DATOR) collected by HCOP and COE programs. The data was matched to centralized, national medical and dental databases [(Association of American Medical Colleges (AAMC) and American Dental Education Association (ADEA)] to identify which participating students went on to successfully matriculate into medical or dental school. In addition to exploring the feasibility of matching these administrative databases, this study also sought to quantify the actual outcomes for students participating in the HCOP and COE programs in terms of the number of these students entering medical and dental schools in the United States.

Key Questions:

- Is it feasible to link students across DATOR, AAMC, and ADEA databases to longitudinally identify program participants who subsequently matriculate into medical or dental schools?
- Are HCOP and COE programs successful in matriculating minority students?

Results:

HCOP and COE programs are achieving a reasonable “yield” in terms of the proportion of participants successfully matriculating into medical and dental schools. Among the pool of HCOP and COE students who participated in these programs while in college in 2006 or 2007 and were reported in the DATOR system as having a career interest in medicine, nearly 30% had matriculated into medical school by 2008. Many of these students had not yet completed college by 2008, so this is a very respectable yield of medical school matriculants among the minority and disadvantaged college students participating in these pipeline programs.

Evaluation of College Enrichment Programs at Four California Community Colleges

<http://bhpr.hrsa.gov/healthworkforce/reports/EvalHealthCareerCollegeEnrichmentProgApril2009.pdf>

Program: Health Careers Opportunity Program (HCOP) (Focus: Quality)

Description: The evaluation used four California State University (CSU) campuses, two campuses had active HCOP awards at the time that the study was performed, and the other two had formerly received HCOP awards and continued to have some enrichment activities in operation (HCOP-like) . The purpose of the study was to determine whether formal enrollment in an HCOP or HCOP-like program was prospectively associated with better academic performance, as measured by college grade point average, among minority and disadvantaged students compared with the academic performance of counterparts who were not enrolled in enrichment programs. A secondary purpose was to determine whether minority and disadvantaged students formally enrolled in an HCOP or HCOP-like enrichment program were more likely to participate in specific enrichment activities than their counterparts who are not enrolled in enrichment programs. Self-administered questionnaires and interviews were used.

Key Question:

Did the enrichment program intervention make a difference (e.g., better GPA), relative to what would have otherwise occurred in the absence of the intervention?

Results:

- Participation in an HCOP or HCOP-like enrichment program at these colleges is associated with achievement of a significantly higher GPA than would have been expected based on students’ baseline characteristics and performance on standardized college admission tests.
- Students enrolled in enrichment programs at the colleges studied are significantly more likely than students not enrolled in these programs to actively participate in a wide range of enrichment activities.

HEALTH CENTERS

GAO Studies

School-Based Health Centers: Available Information on Federal Funding

<http://www.gao.gov/products/GAO-11-18R>

Purpose :

The Health Care Safety Net Act of 2008 required that GAO study the economic costs and benefits of SBHCs. However, GAO informed cognizant committee staff that data on economic costs and benefits were unavailable. In this report, GAO describes (1) what is known about federal grant funds received by SBHCs, and (2) what is known about Medicaid reimbursements received by SBHCs.

Methods:

To describe what is known about federal grant funds received by SBHCs, GAO analyzed data from NASBHC's survey of SBHCs for the 2007-2008 school year, including data identifying the demographics of SBHC patients, services provided by SBHCs, types of organizations that sponsor SBHCs, and sources of federal grant funding for SBHCs. NASBHC conducted the survey from October 2008 through October 2009. Of the 1,909 SBHCs in its database to which it made the survey available, 1,224 SBHCs (64%) responded. GAO based its analyses on the 1,224 SBHCs that responded to the survey, while NASBHC based its analyses on the 1,096 SBHCs that indicated that primary care services was one of the service types they provided. As a result, certain percentages in this report differ from those reported by NASBHC. GAO could not examine data on the amounts of federal grant funds that SBHCs received because NASBHC did not ask SBHCs for this information. GAO interviewed HHS officials from the offices that administer the three grant programs that have been key sources of federal funds: the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care, which administers the Health Center Program, the program that provides Section 330 grant funds to certain federally qualified health centers (FQHC); the Office of Population Affairs, which administers the Title X Family Planning program; and HRSA's MCH Bureau, which administers the MCH Services Title V Block Grant program. GAO reviewed documentation for the three programs that are the key sources of federal grant funds that SBHCs use, such as information about program grantees collected by the administering agency. GAO also reviewed legislation related to funding for SBHCs and peer-reviewed and other articles related to SBHCs. In addition, GAO contacted other federal agencies that administer programs for school-aged children to determine whether SBHCs were involved in any of their programs. The other federal agencies are HHS's Substance Abuse and Mental Health Services Administration, Centers for Disease Control and Prevention, and Administration for Children and Families' Office of Community Services; and the Department of Education's Office of Safe and Drug- Free Schools.

In addition, GAO interviewed individuals knowledgeable about SBHCs, including NASBHC officials and individuals identified by NASBHC as having extensive experience in managing or sponsoring SBHCs. To describe what is known about Medicaid reimbursements received by SBHCs, GAO analyzed data from NASBHC's survey, including types of insurance that SBHCs billed. However, NASBHC did not ask SBHCs to report on reimbursements they received. GAO also interviewed officials from HHS's Centers for Medicare & Medicaid Services (CMS), which administers Medicaid at the federal level, and individuals knowledgeable about SBHCs, including NASBHC officials and individuals identified by NASBHC as having extensive experience in managing or sponsoring SBHCs. GAO assessed the reliability of NASBHC's survey data by interviewing knowledgeable NASBHC officials, reviewing related documentation, and performing data reliability checks such as examining the data for missing values. After taking these steps, GAO determined that the data GAO used were sufficiently reliable for its purposes. The findings in this report are not generalizable to all SBHCs.

Findings:

Over 40% of the SBHCs that responded to NASBHC's survey (538 of the 1,224) reported receiving funds from at least one federal grant source. The most common source was HHS's Health Center Program. Of the 538 SBHC survey respondents that reported receiving federal grant funds, 255 said they received funds from the Health Center Program, 138 said they received funds from HHS's Title X Family Planning program, and 86 said they received funds from HHS's MCH Services Title V Block Grant program. The amount of federal funding that SBHCs receive is not known, however, because SBHCs generally receive the funds from a sponsoring organization that is the federal grantee, and the federal agencies that administer the programs generally collect information at the grantee level and not at the SBHC level. Although SBHCs may bill Medicaid for services provided, the amounts of Medicaid reimbursements that SBHCs receive overall and that specific SBHCs receive are unknown. According to a CMS official, CMS collects or maintains claims data on the basis of certain categories described in Title XIX of the Social Security Act, including clinic services and FQHC services, and because SBHC services is not one of these categories, CMS claims data cannot be used to determine the amount of reimbursements received for services provided in SBHCs. Although CMS's claims data cannot be used to identify SBHC Medicaid reimbursements, some information on SBHCs' billing of Medicaid is available from NASBHC's survey. According to the survey, 72% of all SBHC respondents reported billing Medicaid. According to NASBHC officials and some individuals involved with managing or sponsoring SBHCs, some SBHCs may not bill Medicaid for services because infrastructure costs and personnel expenses associated with implementing and maintaining a Medicaid billing system could exceed the reimbursements the SBHC would receive and many services SBHCs provide are not covered by Medicaid.

Recommendations:

None

Hurricane Katrina: CMS and HRSA Assistance to Sustain Primary Care Gains in the Greater New Orleans Area

<http://www.gao.gov/products/GAO-10-773R>

Purpose:

Given the federal investment in providing and sustaining health care in the greater New Orleans area, Congress asked GAO to describe what steps CMS and the Health Resources and Services Administration (HRSA), the latter, an HHS agency responsible for improving access to health care services for vulnerable populations, have taken to help the Primary Care Access and Stabilization Grant (PCASG) sustain the primary care gains made in the greater New Orleans area. In this report, GAO describes the assistance CMS and HRSA have offered to the PCASG-funded organizations to help them sustain the primary care gains made.

Methods:

In this report, GAO describes the assistance CMS and HRSA have offered to the Primary Care Access and Stabilization Grant (PCASG)-funded organizations to help them sustain the primary care gains made. To address this objective, GAO interviewed CMS and HRSA officials and reviewed related documentation to learn about what assistance, if any, they have offered to the PCASG-funded organizations that may help sustain the provision of primary care in the greater New Orleans area. During these interviews, GAO asked the officials about their roles with the PCASG, any assistance provided to the PCASG-funded organizations, and any concerns they had regarding the sustainability of the PCASG-funded providers. GAO also interviewed an official from the Louisiana Primary Care Association (LPCA)--a nonprofit organization that partners with HRSA to support safety-net providers in Louisiana-- regarding any training, technical, or other assistance provided to PCASG-funded providers. Finally, GAO interviewed officials from Louisiana Department of Health and Hospitals (LDHH), Louisiana Public Health Institute (LPHI), and 10 PCASG-funded providers to obtain their perspectives on the assistance offered by CMS and HRSA, as well as the sustainability of primary care gains made as a result of the PCASG. GAO invited officials from all 25 PCASG-funded providers to participate in a joint interview. The participating officials represented PCASG-funded providers that varied in size and amount of PCASG funding received.

Findings:

In summary, during the 3 years since the PCASG grant was awarded, CMS and HRSA have offered five types of assistance to the PCASG-funded organizations to help them sustain the primary care gains made-- funding, training, information sharing, technical assistance, and workforce support. For example, HRSA provided about \$27.6 million in grant funding to five PCASG-funded providers and both CMS and HRSA have identified potential future funding that may be available for some PCASG-funded providers. Additionally, CMS and HRSA provided

technical assistance to PCASG-funded providers to improve their ability to bill for services and improve their clinic operations. Despite the various types of assistance offered, concerns remain about whether the primary care gains made will be sustainable after the PCASG funding ends.

Recommendations:

None

Medicare Payments to Federally Qualified Health Centers

<http://www.gao.gov/products/GAO-10-576R>

Purpose:

The Medicare Improvements for Patients and Providers Act of 2008 required GAO to examine the payment structure that Medicare used to pay Federally Qualified Health Centers (FQHCs) for services provided to Medicare beneficiaries and to take into consideration the prospective payment methodology used by Medicaid to make payments to FQHCs. This correspondence examines the relationship between Medicare payments and the costs submitted by FQHCs for services provided to Medicare beneficiaries and provides information on how CMS established the Medicare FQHC payment structure. In this correspondence GAO also describes the preventive services added to or expanded within Medicare since the upper payment methodology was implemented in 1992 and the key features of the Medicaid PPS.

Methods:

To determine the extent to which Medicare payments to FQHCs have covered the costs of services furnished to Medicare beneficiaries, GAO obtained Medicare FQHC cost report data for FQHCs in 44 states, 2 territories, and the District of Columbia from the Medicare fiscal intermediary (FI) responsible for collecting FQHC cost reports from most states in 2007. GAO obtained the most recent final cost reports submitted in calendar year 2007, reviewed by the Medicare FI, and settled in coordination with the FQHCs. FQHCs identify themselves as either rural or urban on the submitted cost reports and may submit a consolidated cost report if they have multiple clinic locations. For simplicity, GAO counted each cost report as one FQHC with its population status as rural, urban, or mixed for FQHCs submitting consolidated cost reports with both urban and rural clinics. GAO included in its analysis cost reports for FQHCs reporting at least 200 Medicare visits, for a total of 922 FQHCs. GAO analyzed the costs per visit reported by FQHCs, determined the amount of FQHCs' Medicare costs if the upper payment limits had not been applied, and compared the results to FQHCs' Medicare costs with payment limits applied. GAO examined the difference in FQHCs' Medicare costs when using FQHCs' actual number of visits and when using the minimum number of visits required by the productivity guidelines. CMS officials told GAO that the agency generally does not audit FQHC cost reports.

To determine the reliability of the FQHC cost reports for its purposes, GAO therefore interviewed the Medicare FI about the policies and procedures for collecting and processing FQHC cost reports and reviewed documentation detailing the FI's Medicare FQHC cost report review procedures and electronic cost report data checks. GAO examined the reliability of the 2007 Medicare FQHC cost report data used in this report by performing appropriate electronic data checks and checks for obvious errors, such as missing values and values outside of expected ranges. GAO determined that the FQHC cost report data were sufficiently reliable for purposes of its analysis. GAO also interviewed officials from CMS and from 3 FQHCs about Medicare payments to FQHCs.

Findings:

Based on GAO analysis of Medicare cost reports submitted by FQHCs in 2007, Medicare payments to most FQHCs were less than FQHCs' submitted costs of services. About 72% of FQHCs had costs per visit that exceeded the upper payment limits. However, FQHCs varied greatly in their costs per visit, with FQHCs with the highest costs per visit having relatively fewer Medicare visits than FQHCs with the lowest costs per visit. The application of productivity guidelines reduced Medicare payments to 7% of FQHCs, which did not meet the minimum number of visits required by the productivity guidelines and had costs per visit that did not exceed the upper payment limits. Overall, application of the upper payment limits and productivity guidelines reduced FQHCs' submitted costs of services by about \$72.8 million from about \$504 million to about \$431 million--about 14%--in 2007. Since Medicare pays 80% of the FQHCs' costs (beneficiary coinsurance is 20%), the application of these limits reduced Medicare FQHC payments by \$58.2 million.

Recommendations:

None

OIG Reports

Health Resources and Services Administration's Bureau of Primary Health Care Facility Investment Program (FIP) Grants — Internal Control Review of the Process for Awarding American Recovery and Reinvestment Act Funds (A-03-09-00364)

<http://oig.hhs.gov/oas/reports/region3/30900364.asp>

Purpose:

OIG's objective was to assess the internal controls HRSA has in place over the FIP grant-award process used by BPHC to award Recovery Act funds to determine whether the controls have been suitably designed.

Methods:

The internal control environment represents the collective effect of a number of elements in establishing, enhancing, or mitigating the effectiveness of specific policies and procedures. To gain an understanding of BPHC's control environment, OIG:

- reviewed relevant Federal laws and regulations, including Recovery Act guidance issued by the OMB, that BPHC must follow for awarding grants;
- reviewed HRSA's organizational structure, including segregation of functional responsibilities, policy statements, operating manuals, and personnel policies;
- reviewed the HRSA Federal Managers' Financial Integrity Act report;
- reviewed the HRSA Grants Management Cycle Memorandum for fiscal year ending September 30, 2008;
- reviewed the BPHC spending and implementation plans for FIP grants;
- interviewed HRSA and BPHC management as well as operations, administrative and other personnel responsible for developing, assuring adherence to, and applying internal controls; and
- reviewed the grant award process for grants funded with Recovery Act funds.

Findings:

The internal controls over the grant-award process used to award BPHC's Recovery Act funds as described by HRSA management are suitably designed to provide reasonable assurance that the specified internal control objectives would be achieved if the described internal controls were complied with satisfactorily and applied as designed.

Recommendations:

None

Health Resources and Services Administration's Bureau of Primary Health Care Capital Improvement Program (CIP) Grants — Internal Control Review of the Process for Awarding American Recovery and Reinvestment Act Funds (A-03-09-00365)

<http://www.oig.hhs.gov/oas/reports/region3/30900365.asp>

Purpose:

OIG's objective was to assess the internal controls HRSA has in place over the CIP grant-award process used by BPHC to award Recovery Act funds to determine whether the controls have been suitably designed.

Methods:

The internal control environment represents the collective effect of a number of elements in establishing, enhancing, or mitigating the effectiveness of specific policies and procedures. To gain an understanding of BPHC's control environment, OIG:

- reviewed relevant Federal laws and regulations, including Recovery Act guidance issued by the OMB that BPHC must follow for awarding grants;
- reviewed HRSA's organizational structure, including segregation of functional responsibilities and its policy statements, operating manuals, and personnel policies;
- reviewed the HRSA Federal Managers' Financial Integrity Act report;
- reviewed the HRSA Grants Management Cycle Memorandum for fiscal year (FY) ended September 30, 2008;
- reviewed BPHC's spending and implementation plans for CIP formula grants;
- interviewed HRSA and BPHC management, as well as operations, administrative, and other personnel responsible for developing, assuring adherence to, and applying internal controls; and
- reviewed the grant-award process for formula grants funded with Recovery Act funds.

Findings:

The internal controls over the grant-award process used to award BPHC's Recovery Act funds, as described by HRSA management, are suitably designed to provide reasonable assurance that the specified internal control objectives would be achieved if the described internal controls were complied with satisfactorily and applied as designed.

Recommendations:

None

Health Resources and Services Administration's Bureau of Primary Health Care New Access Points Grants — Internal Control Review of the Process for Awarding American Recovery and Reinvestment Act Funds (A-03-09-00360)

<http://www.oig.hhs.gov/oas/reports/region3/30900360.asp>

Purpose:

OIG's objective was to assess the internal controls HRSA has in place over the NAP grant-award process used by BPHC to award Recovery Act funds to determine whether the controls have been suitably designed.

Methods:

The internal control environment represents the collective effect of a number of elements in establishing, enhancing, or mitigating the effectiveness of specific policies and procedures. To gain an understanding of BPHC's control environment, OIG:

- reviewed relevant Federal laws and regulations, including Recovery Act guidance issued by OMB, that BPHC must follow for awarding grants;
- reviewed HRSA's organizational structure, including segregation of functional responsibilities, policy statements, operating manuals, and personnel policies;
- reviewed the HRSA Federal Managers' Financial Integrity Act report;
- reviewed the HRSA Grants Management Cycle Memorandum for FY ended September 30, 2008;
- reviewed BPHC's spending and implementation plans for NAP grants;
- interviewed HRSA and BPHC management, as well as operations, administrative, and other personnel responsible for developing, assuring adherence to, and applying internal controls; and
- reviewed the grant-award process for two grants funded with Recovery Act funds.

Findings:

The internal controls over the grant-award process used to award BPHC's Recovery Act funds, as described by HRSA management, are suitably designed to provide reasonable assurance that the specified internal control objectives would be achieved if the described internal controls were complied with satisfactorily and applied as designed.

Recommendations:

None