



# **HEALTH RESOURCES and SERVICES ADMINISTRATION**

*FY 2014 Annual Performance Report*

Department of Health  
and Human Services

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## **INTRODUCTION**

This FY 2014 Annual Performance Report (APR) presents information on the Health Resources and Services Administration's (HRSA) past and projected performance in carrying out its mission to improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs. For each major program activity, tables are provided that show key program performance measures, targets and results. The tables also show the linkage between performance measures and HRSA's strategic objectives, indicating the close alignment of performance expectations and results with HRSA's mission and priorities. HRSA, along with its partners and stakeholders, is committed to the collection, analysis and reporting of timely and accurate performance data and using these data to inform decision making.

## **PRIMARY HEALTH CARE**

Programs included in this section are:

- Health Centers
- Free Clinics Medical Malpractice
- Health Center Capital Development (Affordable Care Act)
- School-Based Health Centers - Construction (Affordable Care Act)

## HEALTH CENTERS

### INTRODUCTION

Health Centers are community-based and patient-directed organizations that serve populations lacking access to high quality, comprehensive, and cost-effective primary health care. The Health Center Program’s performance measures help the Program track progress in reaching Health Resources and Services Administration’s (HRSA) Strategic Plan goals to improve access to quality health care and services, strengthen the health workforce, build healthy communities and improve health equity. The Health Center Program has funded new and expanded Health Center organizations as a major strategy to reaching performance goals relating to the numbers of patients served and their demographic mix. Efforts to achieve other performance goals involve strategies that include: providing technical assistance and training on issues such as quality improvement and risk management; enhancing health information technology; sharing best practices so that health centers learn from one another about what works in improving quality and performance; and supporting a unique model of health care delivery that emphasizes prevention, health-related enabling services, outreach, follow-up, and culturally competent services.

**Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
<u>1.I.A.1:</u> Number of patients served by Health Centers <i>(Output)</i>	2014	22.6 million	Aug 31, 2015
	2013	22.2 million	Aug 31, 2014
	2012	20.6 million	Aug 31, 2013
	2011	19.7 million	20.2 million (Target Exceeded)
	2010	20.15 million	19.5 million (Target Not Met, but Improved)
	2009	18.95 million	18.8 million (Target Not Met, but Improved)
	2008	16.75 million	17.1 million (Target Exceeded)
<u>1.I.A.2.b:</u> Percentage of grantees that provide the following services either on-site or by paid referral:  Preventive Dental Care <i>(Output)</i>	2014	88%	Aug 31, 2015
	2013	88%	Aug 31, 2014
	2012	88%	Aug 31, 2013
	2011	88%	88% (Target Met)
	2010	88%	88% (Target Met)
	2009	82%	88% (Target Exceeded)
	2008	82%	88% (Target Exceeded)

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
<u>1.I.A.2.c:</u> Percentage of grantees that provide the following services either on-site or by paid referral:  Mental Health/Substance Abuse <i>(Output)</i>	2014	70%	Aug 31, 2015
	2013	70%	Aug 31, 2014
	2012	70%	Aug 31, 2013
	2011	70%	72% (Target Exceeded)
	2010	68%	72% (Target Exceeded)
	2009	74%	70% (Target Not Met)
	2008	74%	68% (Target Not Met)
<u>1.II.B.2:</u> Rate of births less than 2500 grams (low birth weight) to prenatal Health Center patients compared to the national low birth weight rate <i>(Outcome)</i>	2014	5% below national rate	Apr 30, 2016
	2013	5% below national rate	Apr 30, 2015
	2012	5% below national rate	Apr 30, 2014
	2011	5% below national rate	7.4% 8.6% below the national rate (Target Exceeded)
	2010	5% below national rate	7.4% 8.6% below the national rate (Target Exceeded)
	2009	11% below national rate	7.3% 11% below the national rate (Target Met)
	2008	11% below national rate	7.6% 7.3% below the national rate (Target Not Met)
<u>1.II.B.3:</u> Percentage of adult Health Center patients with diagnosed hypertension whose blood pressure is under adequate control (less than 140/90) <i>(Outcome)</i>	2014	63%	Aug 31, 2015
	2013	60%	Aug 31, 2014
	2012	60%	Aug 31, 2013
	2011	60%	63% (Target Exceeded)
	2010	50%	63% (Target Exceeded)
	2009	43%	63% (Target Exceeded)
	2008	42.9%	62% (Target Exceeded)

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
<b>1.II.B.4:</b> Percentage of adult Health Center patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9%) <i>(Outcome)</i>	2014	71%	Aug 31, 2015
	2013	71%	Aug 31, 2014
	2012	71%	Aug 31, 2013
	2011	71%	71% (Target Met)
	2010	73%	71% (Target Not Met)
	2009	N/A	71% (Target Not In Place)
	2008	N/A	73% (Baseline)
<b>1.II.B.1:</b> Percentage of pregnant Health Center patients beginning prenatal care in the first trimester <i>(Output)</i>	2014	65%	Aug 31, 2015
	2013	64%	Aug 31, 2014
	2012	64%	Aug 31, 2013
	2011	61%	70% (Target Exceeded)
	2010	61.3%	69% (Target Exceeded)
	2009	61.6%	67.3% (Target Exceeded)
	2008	61.5%	61.3% (Target Virtually Met)
<b>1.II.A.1:</b> Percentage of Health Center patients who are at or below 200% of poverty <i>(Output)</i>	2014	91%	Aug 31, 2015
	2013	91%	Aug 31, 2014
	2012	91%	Aug 31, 2013
	2011	91%	93% (Target Exceeded)
	2010	91%	93% (Target Exceeded)
	2009	86%	92.5% (Target Exceeded)
	2008	86%	91.7% (Target Exceeded)

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
<u>1.II.A.2:</u> Percentage of Health Center patients who are racial/ethnic minorities (Output)	2014	63%	Aug 31, 2015
	2013	63%	Aug 31, 2014
	2012	63%	Aug 31, 2013
	2011	63%	62% (Target Virtually Met)
	2010	N/A <sup>1</sup>	62% (Target Not In Place)
	2009	N/A <sup>1</sup>	63% (New Baseline)
	2008	64%	Data Not Available
<u>1.IA.3:</u> Percentage of health centers with at least one site recognized as a patient centered medical home (Outcome)	2014	40%	Nov 30, 2014
	2013	25%	Nov 30, 2013
	2012	13%	13% (Target Met)
	2011	N/A	N/A
	2010	N/A	1% (Baseline)
<b>Efficiency Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
<u>1.E:</u> Percentage increase in cost per patient served at Health Centers compared to the national rate (Efficiency)	2014	Below national rate	Jan 31, 2016
	2013	Below national rate	Jan 31, 2015
	2012	20% below national rate	Jan 31, 2014
	2011	20% below national rate	3.8% 2.6% below national rate of 3.9% (Target Not Met)
	2010	20% below national rate	5% 1.1% above national rate (Target Not Met)
	2009	5.8%	2% (Target Exceeded)
	2008	5.6%	4.6% (Target Exceeded)

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

## FREE CLINICS MEDICAL MALPRACTICE

### INTRODUCTION

The Free Clinics Program encourages health care providers to volunteer their time at free clinics by providing medical malpractice protection at sponsoring health clinics, thus expanding the health care safety net. These activities support the HRSA strategic goal to strengthen the health workforce. The program’s performance measures track progress in achieving this objective. The program uses the data from its annual measures to track and assess program expansion. The key strategy used to meet performance targets is to determine areas with few or no applications and then target these areas for outreach about the program.

**Goal: Strengthen the Health Workforce**

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

Measure	FY	Target	Result
2.I.A.1: Number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage <i>(Outcome)</i>	2014	7,600	Dec 31, 2014
	2013	5,100	Dec 31, 2013
	2012	4,800	7,375 (Target Exceeded)
	2011	4,250	5,400 (Target Exceeded)
	2010	4,000	4,800 (Target Exceeded)
	2009	3,100	3,754 (Target Exceeded)
	2008	2,500	3,006 (Target Exceeded)
2.1: Patient visits provided by free clinics sponsoring volunteer FTCA-deemed clinicians <i>(Outcome)</i>	2014	476,000	May 31, 2015
	2013	332,000	May 31, 2014
	2012	320,000	May 31, 2013
	2011	320,000	462,455 (Target Exceeded)
	2010	N/A	312,317 (Target Not In Place)
	2009	N/A	282,958 (Baseline)

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
<u>2.I.A.2:</u> Number of free clinics operating with FTCA-deemed volunteer clinicians ( <i>Output</i> )	2014	200	Dec 31, 2014
	2013	165	Dec 31, 2013
	2012	155	192 (Target Exceeded)
	2011	145	168 (Target Exceeded)
	2010	130	132 (Target Exceeded)
	2009	105	121 (Target Exceeded)
	2008	85	93 (Target Exceeded)
<u>2.I.A.3:</u> Percent of volunteer FTCA-deemed clinicians who meet certification and privileging requirements ( <i>Output</i> )	2014	100%	Dec 31, 2014
	2013	100%	Dec 31, 2013
	2012	100%	100% (Target Met)
	2011	100%	100% (Target Met)
	2010	100%	100% (Target Met)
	2009	100%	100% (Target Met)
	2008	100%	100% (Target Met)
<b>Efficiency Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
<u>2.E:</u> Administrative costs of the program per Federal Tort Claims Act (FTCA)-covered volunteer ( <i>Efficiency</i> )	2014	\$125	Dec 31, 2014
	2013	\$155	Dec 31, 2013
	2012	\$155	\$71 (Target Exceeded)
	2011	\$155	\$109 (Target Exceeded)
	2010	\$170	\$115 (Target Exceeded)
	2009	\$190	\$154 (Target Exceeded)
	2008	\$195	\$153 (Target Exceeded)

Measure	Data Source	Data Validation
2.I.A.1 2.I.A.2 2.I.A.3 2.E	Free Clinics Medical Malpractice Coverage Program Database stores data on providers and clinics from free clinic applications.	Data are edited and checked by program staff.
2.1	Data will be provided by participating Free Clinics in a Patient Visits Data Report submitted to the program via e-mail.	Data will be validated by program staff assessing logic, outliers, history and norms.

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

**INTRODUCTION**

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

**Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
39.I: Number of new/improved sites	2013	52	Nov 30, 2013
	2012	22	57
	2011	N/A	2 (Baseline)

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

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

**INTRODUCTION**

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

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

**Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
40.I: Number of new/improved sites	2014	165	Nov 30, 2014
	2013	65	Nov 30, 2013
	2012	N/A	15 (Baseline)
	2011	N/A	N/A

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

## **CLINICIAN RECRUITMENT AND SERVICE**

Programs included in this section are:

- National Health Service Corps
- NURSE Corps Programs

## NATIONAL HEALTH SERVICE CORPS

### INTRODUCTION

The statutory purpose of the National Health Service Corps (NHSC) is to eliminate "...health manpower shortages in health professional shortage areas," (Section 331(a)(1) of the Public Health Service Act [42 USC 254d]).

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

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

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

The performance measures gauge the NHSC's contribution to the HRSA Strategic Plan goal to strengthen the health workforce by increasing the number of health care providers through the recruitment and retention of NHSC clinicians. Most of these measures are dependent on the size of the field strength (4.I.C.2.), which measures the number of NHSC funded clinicians in service. The larger the field strength, the greater the number of people served. Further, a more robust field strength also increases the pool of clinicians who fulfill the service commitment and increases the pool of potentially retained individuals. In managing performance, the NHSC uses data to inform policy decisions regarding distribution of Recruitment Line funding between the Scholarship and Loan Repayment Programs. Another strategy used by the program is to target sites that need recruitment and retention technical assistance. The NHSC constantly evaluates its

options regarding distribution of funds between the programs and the size and/or duration of awards and contracts.

**Goal: Strengthen the Health Workforce**

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

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
4.I.C.1: Number of individuals served by NHSC clinicians. (Outcome)	<i>Out-Year Target</i>	8.15 Million (FY 2015)	Dec 31, 2015
	2014	7.99 Million	Dec 31, 2014
	2013	8.47 Million	Dec 31, 2013
	2012	9.66 Million	10.4 Million (Target Exceeded)
	2011	9.7 Million	10.5 Million (Target Exceeded)
	2010	8.56 Million	9.05 Million (Target Exceeded)
	2009	5.69 Million	5.94 Million (Target Exceeded)
	2008	3.48 Million	4.79 Million (Target Exceeded)
4.I.C.2: Field strength of the NHSC through scholarship and loan repayment agreements. (Outcome)	<i>Out-Year Target</i>	7,760 (FY 2015)	Dec 31, 2015
	2014	7,607	Dec 31, 2014
	2013	8,068	Dec 31, 2013
	2012	9,193	9,908 (Target Exceeded)
	2011	9,203	10,279 (Target Exceeded)
	2010	7,358	7,530 (Target Exceeded)
	2009	4,674	4,808 (Target Exceeded)
	2008	3,558	3,601 (Target Exceeded)

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
4.I.C.4: Percent of NHSC clinicians retained in service to the underserved for at least one year beyond the completion of their NHSC service commitment. <sup>1</sup> (Outcome)	2014	80%	Dec 31, 2015
	2013	80%	Dec 31, 2014
	2012	79%	Dec 31, 2013
	2011	79%	90% (Target Exceeded)
	2010	79%	82% (Target Exceeded)
	2009	79%	78% (Target Not Met)
	2008	79%	76% (Target Not Met)
4.1.C.6. Number of NHSC sites (Outcome)	2014	14,000	Dec 31, 2014
	2013	14,000	Dec 31, 2013
	2012	14,000	14,000 (Target Met)
	2011	11,800	14,000 (Target Exceeded)
	2010	N/A	10,273
<b>Efficiency Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
4.E.1: Default rate of NHSC Scholarship and Loan Repayment Program participants. (Efficiency)	2014	≤2.0%	Dec 31, 2014
	2013	≤ 2.0%	Dec 31, 2013
	2012	≤ 2.0%	0.47% (Target Exceeded)
	2011	≤ 2.0%	0.52% (Target Exceeded)
	2010	N/A	0.0% (Target Not in Place)
	2009	N/A	<1.0% (Target Not in Place)
	2008	N/A	0.5% (Target Not in Place)

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

<sup>1</sup> The results for this performance measure are not available until one year out because NHSC clinicians who completed their service obligation are not surveyed until one year later.

## NURSE CORPS PROGRAMS

### INTRODUCTION

The NURSE Corps Loan Repayment Program (NURSE Corps LRP), formerly known as the Nursing Education Loan Repayment Program and the NURSE Corps Scholarship Program (NURSE Corps SP), formerly known as the Nursing Scholarship Program<sup>1</sup> are authorized under Section 846 of the Public Health Service Act [42 USC 297n] to work in partnership with other HHS programs to encourage more people to consider nursing careers and motivate them to serve in areas of critical shortage. These are financial incentive programs under which individual registered nurses (RNs) and advanced practice RNs (APRNs), such as nurse practitioners (NPs), enter into a contractual agreement with the Federal government to work full-time in a health care facility with a critical shortage of nurses, also known as a critical shortage facility (CSF), in return for repayment of qualifying nursing educational loans or for a scholarship that includes payment for tuition, other reasonable education expenses, and a monthly living stipend. The performance measures gauge these programs' contribution to the HRSA Strategic Plan goal to strengthen the health workforce by increasing the number of health care providers through the recruitment and retention of nurses working in CSFs. Increasing the number of nurses at facilities with a critical shortage of nurses will be a key output. With additional funds, the program allows more individuals to enter into the nursing field and in turn address the national shortage of nurses.

Another measure of program performance is the number of NURSE Corps SP awards that are issued to participants pursuing a baccalaureate degree. This measure was initially developed in 2010 when the program only included undergraduate degrees in its first funding preference, resulting in a baccalaureate being the highest attainable degree in the first funding preference. In FY 2012, program shifted its focus to also include master's level Nurse Practitioners (NPs) in the first funding preference. As a result, the program is projecting that the proportion of NURSE Corps SP awardees obtaining their baccalaureate degree will be 40 percent in FY 2014. The program intends to modify the measure to account for master's level NPs.

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

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<sup>1</sup> As of FY 2013, the programs formerly known as the Nursing Education Loan Repayment Program and the Nursing Scholarship Program were rebranded to the NURSE Corps LRP and NURSE Corps SP. This change does not reflect a change in the program or its requirements, but rather an administrative name change.

**Goal: Strengthen the Health Workforce**

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

Measure	FY	Target	Result
5.1.C.4: Proportion of NURSE Corps LRP participants who extend their service contracts to commit to work at a critical shortage facility for an additional year. (Outcome)	2014	52%	Dec 31, 2014
	2013	52%	Dec 31, 2013
	2012	50%	64% (Target Exceeded)
	2011	50%	46% (Target Not Met)
	2010	50%	58% (Target Exceeded)
	2009	45%	48% (Target Exceeded)
	2008	45%	54% (Target Exceeded)
5.1.C.5: Proportion of NURSE Corps participants retained in service at a critical shortage facility for at least one year beyond the completion of their NURSE Corps commitment. <sup>2</sup> (Developmental)	2014	TBD	Dec 31, 2015
	2013	TBD <sup>3</sup>	Dec 31, 2014
	2012	N/A (Target Not in Place)	Dec 31, 2013
	2011	N/A	NELRP/NSP 82% (Baseline)
	2010	N/A	N/A
5.1.C.6: Proportion of NURSE Corps SP awardees obtaining their baccalaureate degree. <sup>4</sup> (Outcome)	2014	40%	Dec 31, 2014
	2013	40% <sup>5</sup>	Dec 31, 2013
	2012	75%	51% (Target Not Met) <sup>6</sup>
	2011	75%	74% (Target Not Met But Improved)
	2010	N/A	71% (Baseline)

<sup>2</sup> The results for this performance measure are not available until one year out because NURSE Corps LRP and SP participants who completed their service obligation are not surveyed until one year later. FY 2011 is the first reporting year for capturing retention in the NURSE Corps based on NURSE Corps Customer Satisfaction Survey data.

<sup>3</sup> Data collection for this measure was first established in FY 2012 and surveyed those participants who completed their NURSE Corps obligation in FY 2011. Since FY 2011 is the only year of available data, program will establish the FY 2013 and 2014 targets after it receives data in the second year of reporting.

<sup>4</sup> This measure was designed to track the number of NURSE Corps SP awards that were issued to nurses with degrees higher than an associate's degree. When this measure was initially developed in 2010, the program only included undergraduate degrees in its first funding preference, resulting in a baccalaureate being the highest attainable degree in the first funding preference. In FY 2012, program shifted its focus to also include master's level Nurse Practitioners (NPs) in the first funding preference.

<sup>5</sup> The NURSE Corps SP is adjusting the FY 2014 target to 40% to account for the emphasis on NPs, and the fact that these awardees will have already obtained a baccalaureate degree.

<sup>6</sup> The FY 2012 result reflects only the NURSE Corps scholars obtaining a baccalaureate degree, since NP scholars would have already obtained a baccalaureate degree. The percentage of awardees who are obtaining nursing education higher than an associate degree level is 93%, which exceeds the original intent of the performance measure.

<b>Efficiency Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
5.E.1: Default rate of NURSE Corps LRP and SP participants. (Efficiency)	2014	NURSE Corps LRP FY 2010 Cohort: 3% NURSE Corps SP FY 2005 Cohort: 15%	Dec 31, 2014
	2013	NURSE Corps LRP FY 2009 Cohort: 3% NURSE Corps SP FY 2004 Cohort: 15%	Dec 31, 2013
	2012	NURSE Corps LRP FY 2008 Cohort: 3.5% NURSE Corps SP FY 2003 Cohort: 17%	NURSE Corps LRP FY 2008 Cohort: 0.5% NURSE Corps SP 2003 Cohort: 8% (Target Exceeded)
	2011	NURSE Corps LRP FY 2007 Cohort: 3.5%	NURSE Corps LRP FY 2007 Cohort: 3.4% (Target Exceeded)
	2010	N/A	N/A

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

## **HEALTH PROFESSIONS**

Programs included in this section are:

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

## **HEALTH PROFESSIONS AND NURSING EDUCATION AND TRAINING PROGRAMS**

### **INTRODUCTION**

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

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

The Bureau of Health Professions (BHP) programs support the training and development of health professionals (particularly primary care providers) to improve the health care of our Nation's communities and vulnerable populations. Programs award grants to health professions schools and training programs across the United States to develop, expand and enhance training and to strengthen the distribution of the health care workforce. These programs serve as a catalyst to advance changes in health professions training responsive to the evolving needs of the health care system.

In addition, the BHP conducts a number of activities including the development and analysis of important health workforce studies and the maintenance of a database intended to facilitate a review of health professionals' credentials.

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

**Goal: Strengthen the Health Workforce**

**Sub-Goals:**

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

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
<b>6. I.B.1:</b> Proportion of graduates and program completers of Titles VII and VIII supported programs who are underrepresented minorities and/or from disadvantaged backgrounds. <sup>1</sup> (Outcome)	2014	46%	Dec 31, 2015
	2013	53%	Dec 31, 2014
	2012	53%	Dec 31, 2013
	2011	53%	46% (Target Not Met)
	2010	53%	58% (Target Exceeded)
	2009	50%	53% (Target Exceeded)
	2008	50%	53% (Target Exceeded)
<b>6. I.C.1:</b> Proportion of trainees in Titles VII and VIII supported programs training in medically underserved communities. <sup>1</sup> (Outcome)	2014	50%	Dec 31, 2015
	2013	44%	Dec 31, 2014
	2012	45%	Dec 31, 2013
	2011	45%	54% (Target Exceeded)
	2010	54%	52% (Target Not Met)
	2009	54%	45% (Target Not Met)
	2008	43%	45% (Target Exceeded)
<b>6. I.C.2:</b> Percentage of health professionals supported by Bureau Health Professions programs who enter practice in underserved areas <sup>1,2</sup>	2014	33%	Dec 31, 2015
	2013	43%	Dec 31, 2014
	2012	43%	Dec 31, 2013
	2011	43%	33% (Target Not Met)
	2010	43%	31% (Target Not Met) <sup>3</sup>
	2009	35%	43% (Target Exceeded)
	2008	35%	47% (Target Exceeded)

<sup>1</sup> Most recent result is for Academic Year 2011-2012 and funded in FY 2011, excluding measure 6.I.C.2.

<sup>2</sup> 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. Results are from academic year 2010-2011.

<sup>3</sup> FY 2010 actuals reported for this measure in the FY2013 Congressional Justification were misreported as 43%. Based on available performance data, the proportion of graduates and program completers entering practice in a MUC or HPSA for FY 2010 was 31%.

Measure	Data Source	Data Validation
6.I.B.1 6.I.C.2 6.I.C.1	Annual grantee data submitted through the Bureau of Health Profession's Performance Management System.	Data are entered through a web-based system that incorporates extensive validation checks. Once approved by the project officer (1st level of review), data are cleaned, validated, and analyzed by scientists within BHP's Office of Performance Measurement (2nd level of review). Inconsistencies in data reported identified throughout the 2nd level of review are flagged and sent to the project officer for follow-up and correction.

## Affordable Care Act Measures

### Goal: Strengthen the Health Workforce

#### Sub-goals:

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

ACA Measure	FY	Target	Result
6.I.C.3: Number of primary care providers who complete their education through HRSA's Bureau of Health Professions programs supported with Prevention and Public Health funding (Cumulative).	<i>Out-Year Target</i>	500 Physicians 600 PA 600 NP (FY 2015)	Dec 31, 2016
Physicians <i>Primary Care Training and Enhancement Program (Cumulative)</i>	<i>Out-Year Target</i>	500 (FY 2015)	Dec 31, 2016
	2014	332	Dec 31, 2015
	2013	166	Dec 31, 2014
	2012	N/A <sup>1</sup>	N/A
	2011	N/A <sup>4</sup>	N/A
Physician Assistants <i>Primary Care Training and Enhancement Program (Cumulative)</i>	<i>Out-Year Target</i>	600 (FY 2015)	Dec 31, 2016
	2014	420	Dec 31, 2015
	2013	280	Dec 31, 2014
	2012	140	Dec 31, 2013
	2011	N/A <sup>4</sup>	N/A
Nurse Practitioner and Nurse Midwives <i>Advanced Nursing Education Expansion Program (Cumulative)</i>	<i>Out-Year Target</i>	600 (FY 2015)	Dec 31, 2016
	2014	430	Dec 31, 2015
	2013	260	Dec 31, 2014
	2012	110	Dec 31, 2013
	2011	N/A <sup>4</sup>	N/A

<sup>1</sup> No supported trainees are eligible for completion in specified year. 1<sup>st</sup> graduating class of physicians supported through the PCTE/PCRE program will be in Academic Year 13-14. 1<sup>st</sup> graduating class of physician assistant supported through the PCTE/EPAT program will be in Academic Year 12-13. 1<sup>st</sup> graduating class of nurse practitioners and nurse midwives supported through the ANE/ANEE program will be in Academic Year 12-13.

ACA Measure	FY	Target	Result
6.I.C.4: Number of primary care providers trained through HRSA's Bureau of Health Professions programs supported with Prevention and Public Health funding (cumulative)			
Physicians <i>Primary Care Training and Enhancement Program (Cumulative)</i>	2013 <sup>2</sup>	515	Dec 31, 2014
	2012	346	Dec 31, 2013
	2011	177	168 <sup>3</sup> (Target Not Met)
Physician Assistants <i>Primary Care Training and Enhancement Program (Cumulative)</i>	2014	610	Dec 31, 2015
	2013	445	Dec 31, 2014
	2012	280 <sup>4</sup>	Dec 31, 2013
	2011	148	140 <sup>5</sup> (Target Met)
Nurse Practitioner and Nurse Midwives <i>Advanced Nursing Education Expansion Program (Cumulative)</i>	2014	600	Dec 31, 2015
	2013	430	Dec 31, 2014
	2012	260	Dec 31, 2013
	2011	110	171 <sup>6</sup> (Target Exceeded)
6.I.C.5: Number of primary care residents trained <i>Teaching Health Center Graduate Medical Education Payments (Cumulative)</i>	2014	450	
	2013	300	Dec 31, 2014
	2012	143	Dec 31, 2013
	2011	N/A	63 <sup>7</sup> (Historical Actual)
6.I.C.6: Number of Personal Care and Home Health Aides completing training program <i>Nurse Education, Practice, Quality, and Retention Program</i>	2013	1723	Dec 31, 2014
	2012	1723	Dec 31, 2013
	2011	1723	1,986 <sup>8</sup> (Target Exceeded)
6.I.C.7: Number of Primary Care Nurse Practitioner students supported <i>Advanced Nursing Education Expansion Program</i>	2014	300	Dec 31, 2015
	2013	300	Dec 31, 2014
	2012	300	Dec 31, 2013
	2011	300	368 <sup>9</sup> (Target Exceeded)

<sup>2</sup> Reflects the last starting cohort of residents funded through the PCRE grant program.

<sup>3</sup> Most recent result is for Academic Year 2011-2012.

<sup>4</sup> Cumulative. Targets in the FY 2014 Congressional Justification were misreported for FY 2012 and FY 2014. The EPAT program will support 1 cohort of physician assistants (PAs) in Academic Year 2011–2012 (FY 2011); 1 cohort of PAs in Academic Year 2012–2013 (FY 2012); 1 cohort of PAs in Academic Year 2013–2014 (FY 2013); and 1 cohort of PAs in Academic Year 2014–2015 (FY 2014). As a result, performance targets begin in FY 2011 and end in FY 2014 for this measure and have been adjusted to reflect the potential for attrition. Each cohort will graduate after 2 years of training (captured in measure 6.I.C.3.b). 1st cohort will graduate in in Academic Year 2012–2013 (FY 2012); 2nd cohort will graduate in 2013–2014 (FY 2013); 3rd cohort will graduate in Academic Year 2014–2015 (FY 2014); and the final cohort will graduate in Academic Year 2015–2016 (FY 2015).

<sup>5</sup> Most recent result is for Academic Year 2011-2012.

<sup>6</sup> Most recent result is for Academic Year 2011-2012.

<sup>7</sup> Most recent result is for Academic Year 2011-2012.

<sup>8</sup> Most recent result is for Academic Year 2011-2012.

<sup>9</sup> Most recent result is for Academic Year 2011-2012.

ACA Measure	FY	Target	Result
6.I.C.8: Number of Primary Care Patient Encounters <i>Primary Care Training and Enhancement Program</i>	2014	180,000	Dec 31, 2015
	2013	30,000	Dec 31, 2014
	2012	31,000	Dec 31, 2013
	2011	31,000	182,723 <sup>10</sup> (Target Exceeded)
6.I.C.9: Number of existing public health workers who completed continuing education sessions <i>Public Health Training Centers</i>	2014	40,445	Dec 31, 2015
	2013	84,520	Dec 31, 2014
	2012	205,645	Dec 31, 2013
	2011	205,645	161,780 <sup>11</sup> (Target Not Met)
	2010	428,264	185,266 (Target Not Met)
6.I.C.10: Percent of planning grant awardees that have established FTE health workforce baselines for primary care. <sup>12</sup> <i>State Health Care Workforce Planning Grant</i>	2013	N/A	N/A
	2012	N/A	N/A
	2011	N/A	N/A
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. <sup>13</sup> <i>State Health Care Workforce Implementation Grant</i>	2013	N/A	N/A
	2012	N/A	N/A
	2011	N/A	N/A

<sup>10</sup> Most recent result is for Academic Year 2011-2012.

<sup>11</sup> Most recent result is for Academic Year 2011-2012.

<sup>12</sup> Program no longer funded.

<sup>13</sup> Program no longer funded.

## CHILDREN'S HOSPITALS GRADUATE MEDICAL EDUCATION PAYMENT PROGRAM

### INTRODUCTION

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

The Children's Hospitals Graduate Medical Education (CHGME) Payment Program supports graduate medical education (GME) in freestanding children's teaching hospitals. CHGME helps eligible hospitals maintain GME programs to provide graduate training for physicians to provide quality care to children, and enhance their ability to care for low-income patients. It supports the training of residents and fellows and enhances the supply of primary care and pediatric medical and surgical subspecialties.

**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)	2014	6,000	July 31, 2015
	2013	5,900	July 31, 2014
	2012	5,900	July 31, 2013
	2011	5,900	6,185 <sup>14</sup> (Target Exceeded)
	2010	5,900	6,040 (Target Exceeded)
	2009	5,343	5,840 (Target Exceeded)
	2008	5,243	5,631 (Target Exceeded)
	2007	4,828	5,406 (Target Exceeded)

<sup>14</sup> Each of the children's hospitals report the number of full-time equivalent residents trained during the latest filed (completed) Medicare Cost Report period. The most recent result is for Academic Year 2011-2012 and funded in FY 2011.

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
7.VII.C.1: Percent of hospitals with verified FTE resident counts and caps. (Output)	2014	100%	July 31, 2015
	2013	100%	July 31, 2014
	2012	100%	July 31, 2013
	2011	100%	100% <sup>15</sup> (Target Met)
	2010	100%	100% (Target Met)
	2009	100%	100% (Target Met)
	2008	100%	100% (Target Met)
	2007	100%	100% (Target Met)
<b>Efficiency Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
7. E: Percent of payments made on time. (Efficiency)	2014	100%	July 31, 2015
	2013	100%	July 31, 2014
	2012	100%	July 31, 2013
	2011	100%	100% <sup>16</sup> (Target Met)
	2010	100%	100% (Target Met)
	2009	100%	100% (Target Met)
	2008	100%	100% (Target Met)
	2007	100%	100% (Target Met)

<b>Measure</b>	<b>Data Source</b>	<b>Data Validation</b>
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.

<sup>15</sup> Each of the children's hospitals report the number of full-time equivalent residents trained during the latest filed (completed) Medicare Cost Report period. The most recent result is for Academic Year 2011-2012 and funded in FY 2011

<sup>16</sup> Each of the children's hospitals report the number of full-time equivalent residents trained during the latest filed (completed) Medicare Cost Report period. The most recent result is for Academic Year 2011-2012 and funded in FY 2011

## **NATIONAL PRACTITIONER DATA BANK**

### **INTRODUCTION**

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

- Improve access to quality health care and services

The Nation must have ongoing protections for the delivery of safe health care. Therefore, health care practitioners must be monitored and restrictions must be imposed on incompetent health care practitioners ensuring they are unable to move from state to state, without discovery of previous substandard performance or unprofessional conduct.

The National Practitioner Data Bank (NPDB) serves as a flagging system intended to prompt a comprehensive review of health care practitioners' licensure activity, medical malpractice payment history and record of clinical privileges. Specifically, the NPDB maintains a database that identifies physicians, dentists and other healthcare practitioners who have malpractice judgments against them, sanctions from medical boards, or who have lost memberships in professional medical societies. This database restricts the ability of physicians, dentists and other healthcare practitioners with poor practice records or who have exhibited unprofessional behavior from moving State-to-State without disclosing previous damaging or incompetent performance. Potential employers will be able to make better hiring decisions that will provide for a better quality health workforce. The program regularly conducts surveys to assess 1) the utility of its information to customers, 2) customer satisfaction, and 3) areas on which improvement efforts should be focused.

The NPDB aims to alert users to the value of completing a thorough review of past actions of health care practitioners, providers and suppliers while encouraging professional peer review, assist in the prevention and reduction of health care fraud and abuse and promote quality health care. Used in conjunction with information from other sources, the NPDB assists in promoting quality health care, and deterring fraud and abuse in the health care delivery system.

**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.5: Increase the number of practitioners enrolled in Continuous Query. <sup>1</sup>	2014	1,149,000	Feb 28,2015
	2013	1,074,000	Feb 28, 2014
	2012	990,000	1,401,701 <sup>2</sup> (Target Exceeded)
	2011	N/A	899,149
	2010	N/A	N/A
	2009	N/A	N/A
	2008	N/A	N/A

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

<sup>1</sup> This is a new measure. Continuous Query is a subscription service for Data Bank queries that notifies them of new information on enrolled practitioners within one business day. Continuous Query is designed and developed to meet accreditation standards that require ongoing monitoring of practitioners.

<sup>2</sup> The most recent result is for FY 2012.

## **MATERNAL AND CHILD HEALTH**

Programs included in this section are:

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

## **MATERNAL AND CHILD HEALTH BLOCK GRANT – TITLE V**

### **INTRODUCTION**

Since its inception, the Title V Maternal and Child Health (MCH) Block Grant program has provided a foundation for ensuring the health of the Nation's mothers, infants, children, and adolescents, including children and adolescents with special health needs, and families. The MCH Block Grant supports a wide variety of services that address the Title V legislative requirements and the strategic goals outlined by HHS, HRSA and MCHB. State Title V programs use their appropriated MCH Block Grant funds to address three overarching HRSA goals: 1) improving access to quality health care and services, 2) improving health equity, and 3) building healthy communities. Progress in meeting these goals is assessed through the examination of the annual performance measures, Health Status Indicators, and Health Systems Capacity Indicators that are reported by States. While each measure addresses a different aspect of health care delivery specific to pregnant and breastfeeding women, infants, children and adolescents, the measures collectively provide a snapshot into the health, safety and well-being of the Nation's MCH population. The Program utilizes these findings to identify emerging public health needs and critical issues relative to MCH. In an effort to improve performance, the Program regularly provides technical support to the States around the priorities identified in their comprehensive five-year Needs Assessments and the technical assistance needs outlined in their annual grant applications. Another strategy is to identify and promote promising practices that can be used by State MCH programs to improve MCH outcomes. The Program also supports States in their efforts to do outreach to increase participation in Medicaid and CHIP.

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

**Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
10.I.A.1: Increase the number of children served by the Maternal and Child Health Block Grant. (Output)	2014	31M	Nov 30, 2015
	2013	30M	Nov 30, 2014
	2012	33M	Nov 30, 2013
	2011	31M	37.4M (Target Exceeded)
	2010	30M	34.5M (Target Exceeded)
	2009	29M	33.3M (Target Exceeded)
	2008	28M	35M (Target Exceeded)
10.I.A.2: Increase the number of children receiving Maternal and Child Health Block Grant services who are enrolled in and have Medicaid and CHIP coverage. (Output)	2014	14M	Nov 30, 2015
	2013	15M	Nov 30, 2014
	2012	14M	Nov 20, 2013
	2011	13M	14.8M (Target Exceeded)
	2010	12M	14.3M (Target Exceeded)
	2009	11.2M	15.2M (Target Exceeded)
	2008	11M	14.7M (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)	2014	2.1 to 1	Nov 30, 2016
	2013	2.1 to 1	Nov 30, 2015
	2012	2.1 to 1	Nov 30, 2014
	2011	2.1 to 1	2.2 to 1 <sup>1</sup> (Preliminary Data, Target Not Met)
	2010	2.1 to 1	2.2 to 1 <sup>2</sup> (Target Not Met)
	2009	2.1 to 1	2.4 to 1 <sup>3</sup> (Target Not Met)
	2008	2.2 to 1	2.33 to 1 <sup>4</sup> (Target Not Met)

<sup>1</sup> Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2012. Deaths: Preliminary Data for 2011, National Vital Statistics Reports, Vol. 61, No. 6, October 2012.

<sup>2</sup> Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2012. Deaths: Preliminary Data for 2011, National Vital Statistics Reports, Vol. 61, No. 6, October 2012.

<sup>3</sup> Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2011. Deaths: Final Data for 2009, National Vital Statistics Reports, Vol. 60, No. 3, December 2011.

<sup>4</sup> Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2010. Deaths: Final Data for 2008, National Vital Statistics Reports, Vol. 59, No. 10, December 2011.

**Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
<u>10.III.A.1</u> : Reduce the infant mortality rate. (Baseline – FY 2005: 6.9 per 1,000) (Outcome)	<i>Out-Year Target</i>	6 per 1,000 (FY 2015)	Nov 30, 2017
	2014	6.1 per 1,000	Nov 30, 2016
	2013	6.6 per 1,000	Nov 30, 2015
	2012	6.6 per 1,000	Nov 30, 2014
	2011	6.6 per 1,000	6.1 per 1,000 <sup>5</sup> (Preliminary Data, Target Exceeded)
	2010	6.7 per 1,000	6.2 per 1,000 <sup>6</sup> (Target Exceeded)
	2009	6.7 per 1,000	6.4 per 1,000 <sup>7</sup> (Target Exceeded)
	2008	6.8 per 1,000	6.6 per 1,000 <sup>8</sup> (Target Exceeded)
<u>10.III.A.2</u> : Reduce the incidence of low birth weight births. (Outcome)	2014	8.1%	Nov 30, 2016
	2013	8.1%	Nov 30, 2015
	2012	8.2%	Nov 20, 2014
	2011	8.2%	8.1% <sup>9</sup> (Preliminary Data, Target Exceeded)
	2010	8.2%	8.2% <sup>10</sup> (Target Met)
	2009	8.2%	8.2% <sup>11</sup> (Target Met)
	2008	8.2%	8.2% (Target Met)

<sup>5</sup> Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2012. Deaths: Preliminary Data for 2011, National Vital Statistics Reports, Vol. 61, No. 6, October 2012.

<sup>6</sup> Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2012. Deaths: Preliminary Data for 2011, National Vital Statistics Reports, Vol. 61, No. 6, October 2012.

<sup>7</sup> Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2011. Deaths: Final Data for 2009, National Vital Statistics Reports, Vol. 60, No. 3, December 2011.

<sup>8</sup> National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2010. Deaths: Final Data for 2008, National Vital Statistics Reports, Vol. 59, No. 10, December 2011.

<sup>9</sup> National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2012, Births: Preliminary Data for 2011, National Vital Statistics Reports, Vol. 61, No. 5, October 2012.

<sup>10</sup> Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2012. Births: Final Data for 2010, National Vital Statistics Reports, Vol. 61, No. 1, August 2012.

<sup>11</sup> Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2010. Births: Final Data for 2009, National Vital Statistics Reports, Vol. 60, No. 1, November 2011.

Measure	FY	Target	Result
10.III.A.3: Increase percent of pregnant women who received prenatal care in the first trimester. (New Baseline – FY 2006: 69%) <sup>7</sup> (Outcome)	2014	72%	Nov 30, 2018
	2013	71%	Nov 30, 2017
	2012	70%	Nov 30, 2016
	2011	69% <sup>12</sup>	Nov 30, 2015
	2010	86.5%	Nov 30, 2014
	2009	86%	Nov 30, 2013
	2008	85% <sup>9</sup>	71% <sup>13</sup>
10.III.A.4: Increase percent of very low-birth weight babies who are delivered at facilities for high-risk deliveries and neonates. (Outcome)	2014	76%	Nov 30, 2016
	2013	77%	Nov 30, 2015
	2012	76%	Nov 30, 2014
	2011	76%	Nov 30, 2013
	2010	76%	74.5% (Target Not Met)
	2009	75.5%	77.3% (Target Exceeded)
	2008	75%	76.1% (Target Exceeded)
10.3: Increase maternal survival rate. <sup>14</sup> (Baseline – FY 2005: 15.1 deaths per 100,000 live births) (Outcome)	Out-Year Target	13.1 per 100,000 (FY 2015)	Nov 30, 2017
	2008	8 per 100,000	Dec 30, 2013
	2007	N/A	12.7 deaths per 100,000 <sup>15</sup>

Measure	Data Source	Data Validation
10.I.A.1 10.I.A.2 10.III.A.4	The Title V Information System (TVIS) collects data on grantee performance from grantee annual reports.	TVIS allows each State to enter data on performance. TVIS provides preformatted and interactive data entry. Calculations are done automatically and the system performs immediate checks for errors. Data are validated by project officers and program staff.
10.IV.B.1 10.III.A.1 10.III.A.3 10.III.A.2 10.3	Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC).	Data validated by CDC.

<sup>12</sup> 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.

<sup>13</sup> Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention. Expanded data from the New Birth Certificate, 2008, Vol. 59, No. 7, July 2011.

<sup>14</sup> This is a long-term measure with no annual targets.

<sup>15</sup> Data for fiscal year 2007 are the most recent data available for this measure. Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention. Deaths: Final Data for 2007, Vol. 58, No. 19, May 2010.

# TRAUMATIC BRAIN INJURY PROGRAM

## INTRODUCTION

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

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

<sup>2</sup> Traumatic Brain Injury in the United States: A Report to Congress. December 1999. [http://www.cdc.gov/ncipc/pubs/tbi\\_congress/TBI\\_in\\_the\\_US.PDF](http://www.cdc.gov/ncipc/pubs/tbi_congress/TBI_in_the_US.PDF).

**Goal: Build Healthy Communities**

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

Measure	FY	Target	Result
11.V.B.4: Increase the number of State partnerships and/or collaborations with governmental and non-governmental organizations. <sup>3</sup> (Output)	2014	350	Aug 31, 2014
	2013	175	Aug 31, 2013
	2012	154	441 (Target Exceeded)
	2011	154	200 (Target Exceeded)
	2010	N/A	131 (Baseline)
11.V.B.6: Percentage of grantees that complete the 4 core components of the TBI Implementation Partnership Grant Program within the 4 year project period. <sup>4</sup> (Developmental) (Output)	2014	100%	Aug 31, 2014
	2013	100%	Aug 31, 2013
	2012	N/A	100% (Baseline)
11.V.B.8: Increase the number of individuals that receive trainings conducted by the TBI Protection and Advocacy Grant Program. <sup>5</sup> (Developmental) (Outcome)	2014	38,000	Aug 31, 2014
	2013	38,000	Aug 31, 2013
	2012	N/A	38,457 (Baseline)
11.V.B.9: Proportion of individuals with TBI and/or their families who report that a State Implementation Partnership grantee provided or helped them to better access TBI-related services. (Developmental) <sup>6</sup>	2014	TBD	N/A
	2013	N/A	N/A
	2012	N/A	N/A
11.V.B.10: Proportion of professionals participating in a HRSA grantee activity who report that they are better able to assess the needs of TBI survivors and/or their families and facilitate improved access to rehabilitative and other services.(Developmental) <sup>7</sup>	2014	TBD	N/A
	2013	N/A	N/A
	2012	N/A	N/A
11.V.B.11: Proportion of persons with TBI and/or their families who report that a HRSA TBI Protection and Advocacy grantee helped them to better access services. (Developmental) <sup>8</sup>	2014	N/A	N/A
	2013	N/A	N/A
	2012	N/A	N/A

<sup>3</sup> This new target for FY14 was based on newly established baseline data collected for FY12.

<sup>4</sup> This developmental long-term measure does not currently have targets. FY 2012 baseline data from grantees' progress reports will be available in 2013 and future year targets will be established.

<sup>5</sup> Baseline data for this developmental measure was established for FY 2012 using grantees' annual progress reports and was used to establish the new target for FY13 and FY14.

<sup>6</sup> This developmental measure does not currently have targets. Baseline data for 2014 will be available in 2015 and future year targets will be established in FY2016.

<sup>7</sup> This developmental measure does not currently have targets. Baseline data for 2014 will be available in 2015 and future year targets will be established in FY2016.

<sup>8</sup> This developmental measure does not currently have targets. Baseline data for 2014 will be available in 2015 and future year targets will be established in FY2016.

Measure	Data Source	Data Validation
11.V.B.4 11.V.B.6 11.V.B.8 11.V.B.9 11.V.B.10 11.V.B.11	Grantee annual reports.	Data confirmed by project officers.

## JAMES T. WALSH UNIVERSAL NEWBORN HEARING SCREENING

### INTRODUCTION

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

As of December 2012, there were 57 states and jurisdictions receiving HRSA grant funds to implement the program in addition to one National Resource Center.

The performance measures of the Universal Newborn Hearing Screening program link to the HRSA goal of improving access to quality health care and services. Performance measure data are used by the program for quality improvement. A current strategy to improve performance is to shift program emphasis to reducing the number of children who are lost to documentation or lost to follow-up, thereby ensuring that more children receive the care they need.

### **Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
<u>13.1</u> : Increase the percentage of children with non-syndromic hearing loss entering school with developmentally appropriate language skills. <sup>1</sup> (Baseline – FY 2004: 20% estimated) (Outcome)	<i>Out-Year Target</i>	85% (FY 2013)	Mar 31, 2015
<u>13.2</u> : Increase the percentage of infants with hearing loss enrolled in early intervention before 6 months of age. (Baseline – FY 2010: 67%) (Output)	2014	70%	Mar 31, 2016
	2013	65%	Mar 31, 2015
<u>13.III.A.1</u> : Percentage of infants suspected of having a hearing loss with a confirmed diagnosis by 3 months of age. (Output)	2014	75%	Mar 31, 2016
	2013	65%	Mar 31, 2015
	2012	70%	Mar 31, 2014
	2011	60%	Mar 31, 2013
	2010	63%	72% (Target Exceeded)
	2009	40%	68% (Target Exceeded)
	2008	63%	68% (Target Exceeded)

<sup>1</sup>This long-term measure does not have annual targets.

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
13.III.A.3: Percentage of infants screened for hearing loss prior to hospital discharge. (Output)	2014	98%	Mar 31, 2016
	2013	98%	Mar 31, 2015
	2012	98%	Mar 31, 2014
	2011	98%	Mar 31, 2013
	2010	98%	98% (Target Met)
	2009	98%	97% (Target Not Met)
	2008	98%	97% (Target Not Met but Improved)

<b>Measure</b>	<b>Data Source</b>	<b>Data Validation</b>
13.1 13.2 13.III.A.1 13.III.A.3	For FY 2005, data collected from grantees by Utah State University, National Technical Resource Center, based on survey of all States. For FY 2006 and beyond, data obtained from the CDC Hearing Screening and Follow-up Survey.	Through 2005, data validated against annual progress reports submitted by States. For 2006 and subsequent years, data validated by CDC through ongoing communications with States.

## EMERGENCY MEDICAL SERVICES FOR CHILDREN

### INTRODUCTION

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

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

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

**Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
<b>14.1.A:</b> Percent reduction in mortality rate for children with an injury severity score (greater than 15) <i>(Outcome)</i> From FY 2005-2009, each year there was an approximate reduction in the mortality rate of approximately 0.5%. Baseline Mortality Rate in FY 2009 was 5.72%.	2014	Annual 0.5% reduction from prior year	Jul 31, 2015
	2013	Annual 0.5% reduction from prior year	Jul 31, 2014
	2012	Annual 0.5% reduction from prior year	Jul 31, 2013
<b>14.V.B.3A:</b> Increase the number of awardees that demonstrate the operational capacity to provide pediatric emergency care based on the nationally-recommended pediatric equipment available on basic life support (BLS) ambulances. <i>(Output)</i>	2014	N/A	N/A
	2013	2	Jul 31, 2014
	2012	N/A	N/A
	2011	N/A	N/A
	2010	1	2 (Target Exceeded)
	2009	N/A	0 (Baseline)

Measure	FY	Target	Result
<u>14.V.B.3B</u> : Increase the number of awardees that demonstrate the operational capacity to provide pediatric emergency care based on nationally-recommended pediatric equipment available on advanced life support (ALS) ambulances. (Output)	2014	N/A	N/A
	2013	2	Jul 31, 2014
	2012	N/A	N/A
	2011	N/A	N/A
	2010	1	2 (Target Exceeded)
	2009	N/A	0 (Baseline)
<u>14.V.B.4A</u> : Increase the number of awardees that have made significant progress in implementing a pediatric recognition system for hospitals capable of dealing with pediatric medical emergencies.	2014	25	Jul 31, 2015
	2013	16	Jul 31, 2014
	2012	15	Jul 31, 2013
	2011	14	24 (Target Exceeded)
<u>14.V.B.4B</u> : Increase the number of awardees that have made significant progress in implementing a pediatric recognition system for hospitals capable of dealing with pediatric traumatic emergencies. (Output)	2014	49	Jul 31, 2015
	2013	46	Jul 31, 2014
	2012	45	Jul 31, 2013
	2011	45	48 (Target Exceeded)
<u>14.V.B.2A</u> : Increase the number of awardees that have adopted requirements for pediatric emergency education for the re-certification of basic life support (BLS) providers. (Outcome)	2014	44	Jul 31, 2015
	2013	42	Jul 31, 2014
	2012	41	Jul 31, 2013
	2011	41	43 (Target Exceeded)
<u>14.V.B.2B</u> : Increase the number of awardees that have adopted requirements for pediatric emergency education for the re-certification of advance life support (ALS) providers. (Outcome)	2014	46	Jul 31, 2015
	2013	42	Jul 31, 2014
	2012	41	Jul 31, 2013
	2011	41	45 (Target Exceeded)

Measure	Data Source	Data Validation
14.1.A	The new data source for this measure is Nationwide Emergency Department Sample (NEDS). Data is reported from the most currently available pediatric mortality data. To determine the average annual percent reduction to be expected, an average percent reduction was derived over a 4 year period (2005-2009). The annual percentage reduction is calculated by the difference in mortality rate from the previous year divided by the base year rate.	Source: Healthcare Cost and Utilization Project (HCUP) Agency for Healthcare Research and Quality.
14.V.B.3A, 3B	N/A is listed for non-data collection years. Data collection for these specific performance measures is resource intensive; therefore grantees collect data every 3 years. The MCH DGIS is the data source for this performance measure. The next data collection cycle will be in 2013, which will be analyzed and reported in 2014. Thus a change in this measure cannot be demonstrated until 2014. Achievement requires all BLS and ALS ambulances in the State to have 100% of equipment listed on the nationally recommended pediatric equipment list.	Data confirmed by project officers.

<b>Measure</b>	<b>Data Source</b>	<b>Data Validation</b>
14.V.B.4A	MCH Discretionary Grant Information System (DGIS) grantee reporting. Significant progress is defined as achieving an overall score of "5." A score of "5" means a pediatric medical recognition system has been established and at least one facility has been formally recognized.	Grantee reports.
14.V.B.4B	MCH DGIS grantee reporting. Significant progress is defined as achieving an overall score of "5." A score of "5" means a pediatric trauma recognition system has been established and at least one facility has been formally recognized.	Grantee reports.

## HEALTHY START

### INTRODUCTION

To reduce the factors that contribute to the Nation's high infant mortality rate, particularly among African-American and other disparate racial and ethnic groups, Healthy Start (HS) provides intensive services tailored to the needs of high risk pregnant women, infants and mothers in geographically, racially, ethnically, and linguistically diverse communities with exceptionally high rates of infant mortality. The program began in 1991 with grants to 15 communities with infant mortality rates 1.5 to 2.5 times the national average. In 2012, 105 Healthy Start projects provided services in 39 States, the District of Columbia and Puerto Rico. The Program's activities are linked to HRSA's strategic goal of improving health equity.

The Healthy Start program's capacity to achieve its ambitious performance and outcome objectives is challenged by the multiple risk factors faced by the families they serve. Each of the Healthy Start projects is committed to reducing disparities in perinatal health and infant mortality by transforming their communities, strengthening community-based systems to enhance perinatal care and improving the health of the women, infants and families. 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 new vision for, Healthy Start which reflects a holistic approach in addressing the short and long-term needs of women, infants and their families. Though the strategic planning process is ongoing, this process has revealed central elements in providing quality of care that underscore the following:

- Community-based approaches to service delivery;
- Comprehensive approaches to health care;
- Coordination of services and care;
- Systems Integration; and
- Quality Improvement and Evaluation.

Ultimately, the refocused approach to Healthy Start will result in improved outcomes for women, infants and their families.

**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. <sup>1</sup> (Baseline – FY 2009: 6.0 per 1,000) (Outcome)	<i>Out-Year Target</i>	4.3 per 1,000 (FY 2013)	Oct 31, 2015

**Goal: Improve Health Equity**

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

Measure	FY	Target	Result
	2014	75%	Oct 31, 2016
<u>12.III.A.1</u> : Increase annually the percentage of women participating in Healthy Start who have a prenatal care visit in the first trimester. (Outcome)	2013	75%	Oct 31, 2015
	2012	75%	Oct 31, 2014
	2011	75%	Oct 31, 2013
	2010	75%	74% (Target Not Met but Improved)
	2009	75%	70.9% (Target Not Met but Improved)
	2008	75%	68.5% (Target Not Met but Improved)
<u>12.III.A.2</u> : Percent of singleton births weighing less than 2,500 grams (low birth weight). (Outcome)	2014	9.6%	Oct 31, 2016
	2013	9.6%	Oct 31, 2015
	2012	9.6%	Oct 31, 2014
	2011	9.6%	Oct 31, 2013
	2010	9.6%	10% (Target Not Met but Improved)
	2009	9.6%	10.1% (Target Not Met but Improved)
	2008	9.7%	10.7% (Target Not Met but Improved)
	2014	466,259	Oct 31, 2016
<b>Efficiency Measure</b> <u>12.E</u> : Increase the number of persons served by the Healthy Start program with a (relatively) constant level of funding. (Efficiency)	2013	547,317	Oct 31, 2015
	2012	532,500	Oct 31, 2014
	2011	552,500	Oct 31, 2013
	2010	524,500	445,259 Persons Served (Target Not Met)
	2009	485,000	570,927 Persons Served (Target Exceeded)
	2008	475,000	546,773 Persons Served (Target Exceeded)

<sup>1</sup>This long-term measure does not have annual targets.

<b>Measure</b>	<b>Data Source</b>	<b>Data Validation</b>
12.1 12.III.A.1 12.III.A.2 12.E	Grantee reports.	Data confirmed by project officers.

## **FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS**

### **INTRODUCTION**

The Family-to-Family Health Information Centers program was established by the Family Opportunity Act of 2005 through FY 2009 and was extended through FY 2012 by The Patient Protection and Affordable Care Act of 2010 (ACA) (P.L. 111-148), Sec. 5507. Most recently, the program was extended through FY 2013 by the American Taxpayer Relief Act of 2012 (P.L. 112-240), Sec. 624 – at a funding level of 5 million dollars. Grants under the program fund state-wide, family-staffed/run centers that provide information, education, technical assistance and peer support to families of children with special health care needs and the health professionals that serve them. The program accomplishes its legislative intent by assisting families and professionals so that “families of children with special health care needs will partner in decision making at all levels” of health care decision making.

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

**Goal: Improve Access to Quality Health Care and Services**

Sub-Goal: Increase outreach and enrollment into quality care

Measure	FY	Target	Result
15.III.C.1: Number of families with CSHCN who have been provided information, education and/or training from Family-to-Family Health Information Centers. (Output)	2014	N/A <sup>1</sup>	N/A
	2013	124,000	Sep 30, 2013
	2012	123,000	147,280 (Target Exceeded)
	2011	122,000	146,813 (Target Exceeded)
	2010	N/A <sup>2</sup>	121,476 (Target Not in Place)
	2009	77,082	92,395 (Target Exceeded)
	2008	70,082	75,532 (Target Exceeded)
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)	2014	N/A <sup>3</sup>	N/A
	2013	87%	Sep 30, 2013
	2012	85%	94% (Target Exceeded)
	2011	83%	86% (Target Exceeded)
	2010	N/A <sup>4</sup>	81% (Target Not in Place)
	2009	61%	65% (Target Exceeded)
	2008	N/A	59.8% (Baseline)

Measure	Data Source	Data Validation
15.III.C.1	MCHB Discretionary Grants Information System, 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.

<sup>1</sup> No targets have been established for FY 2014, as the authorization for this program expires at the end of FY 2013.

<sup>2</sup> No targets were established for FY 2010 because the program was scheduled to expire.

<sup>3</sup> No targets have been established for FY 2014, as the authorization for this program expires at the end of FY 2013.

<sup>4</sup> No targets were established for FY 2010 because the program was scheduled to expire.

## MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAM

### INTRODUCTION

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

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

#### **Goal: Improve Health Equity**

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

Measure	FY	Target	Result
37.I: Number of home visits to families receiving services under the MIECHV program <sup>1</sup> (Output)	2014	565,992 <sup>2</sup>	TBD
	2013	404,280 <sup>2</sup>	TBD
	2012	N/A	161,712
	2011	N/A	N/A
	2010	N/A	N/A
37.II: Number and percent of grantees that meet benchmark area-related data requirements for demonstrating improvement. (Outcome) (Developmental)	Out-Year Target	TBD <sup>3</sup>	TBD
	2014	N/A <sup>3</sup>	N/A
	2013	N/A	N/A
	2012	N/A	N/A
	2011	N/A	N/A
	2010	N/A	N/A

<sup>1</sup> A home visit is the service provided by qualified professionals within the home to the enrolled caregiver and the index child. The number of "home visits" demonstrates the level of effort and service utilization for all enrollees and index children participating in the MIECHV program.

<sup>2</sup> Data based on internal assumptions. There is no statutory requirement that states serve a targeted number of families. Also, our estimates are based upon preliminary data from our first MIECHV reporting in DGIS on February 4, 2013. As the program evolves, we may have to adjust our target numbers to meet the realities of program implementation.

<sup>3</sup> 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 3<sup>rd</sup> year of program operations).

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

## **RYAN WHITE HIV/AIDS**

Programs included in this section are:

- Ryan White HIV/AIDS Treatment Extension Act of 2009 (Summary)
- HIV Emergency Relief Grants (Part A)
- HIV Care Grants to States (Part B)
- HIV Early Intervention Services (Part C)
- HIV Women, Infants, Children and Youth Grants (Part D)
- AIDS Education and Training Centers (Part F)
- Dental Reimbursement and Community Partnership Programs (Part F)

## **RYAN WHITE HIV/AIDS TREATMENT EXTENSION ACT OF 2009 (SUMMARY)**

### **INTRODUCTION**

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

The Ryan White HIV/AIDS Program's performance measures are tied to HRSA's overall goals, which serve as the performance management framework for the Program. The measures allow the Program to track progress toward reaching these goals. Specific performance measures are linked to the following HRSA goals: Improve access to quality health care and services by strengthening health systems to support the delivery of quality health services and by promoting innovative and cost-efficient approaches to improve health; Strengthen the health workforce by assuring the health workforce is trained to provide high quality, culturally and linguistically appropriate care; Build healthy communities by leading and collaborating with others to help communities strengthen resources that improve health for the population; and Improve health equity by reducing disparities in quality of care across populations and communities.

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

Performance measure information is used by the program to identify potential policy issues, to share best practices, for providing accountability for results, to evaluate the effectiveness of the program and activities and the resources spent on conducting them, and to assess training needs of Project Officers in order to assure better monitoring of grantee performance. The Ryan White HIV/AIDS Program uses various strategies to achieve the performance goals including targeting resources to address the unmet care and treatment needs of persons living with HIV/AIDS who are uninsured or underinsured and therefore unable to pay for HIV/AIDS health care and vital health-related support services; providing HIV-related support services; assuring patient adherence and compliance (e.g., through patient education and follow-up); directing outreach and prevention education and testing to populations at disproportionate risk for HIV infection; tailoring health care and related services to populations known to have delayed care-seeking behaviors (e.g. varying hours, care offered in various sites, linguistically and culturally appropriate service provision); and assuring that appropriate services are being provided in areas of greatest need, including where there are high rates of HIV infection, rural areas, and in communities with health disparities. In many instances, the Program collaborates with other Federal, State and local providers who conduct HIV testing and encourages them to refer clients who test positive to Ryan White HIV/AIDS Programs for treatment.

**Goal: Improve Health Equity**

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

Measure	FY	Target	Result
<u>16.1</u> : Number of racial/ethnic minorities and the number of women served by Ryan White HIV/AIDS-funded programs. <sup>1</sup> (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)	2014	5 percentage points above CDC data	Oct. 31, 2015
	2013	5 percentage points above CDC data	Oct. 31, 2014
	2012	5 percentage points above CDC data	Oct. 31, 2013
	2011	5 percentage points above CDC data	72.2% (CDC – Not Yet Available For Comparison)
	2010	5 percentage points above CDC data or 71.5%	72% (CDC- 66.5%) (Target Exceeded)
	2009	5 percentage points above CDC data or 71.4%	73% (CDC – 66.4%) (Target Exceeded)
	2008	5 percentage points above CDC data or 69.9%	73% (CDC= 65.9%) (Target Exceeded)
<u>16.I.A.2</u> : Proportion of women in Ryan White HIV/AIDS funded-programs served. (Outcome)	2014	5 percentage points above CDC data	Oct. 31, 2015
	2013	5 percentage points above CDC data	Oct. 31, 2014
	2012	5 percentage points above CDC data	Oct. 31, 2013
	2011	5 percentage points above CDC data	30.1% (CDC- Not Yet Available For Comparison)
	2010	5 percentage points above CDC data or 27.5%	31% (CDC- 23.5%) (Target Exceeded)
	2009	5 percentage points above CDC data or 27.3%	32% (CDC = 23.3%) (Target Exceeded)
	2008	5 percentage points above CDC data or 27.2%	33% (CDC=23.2%) (Target Exceeded)

<sup>1</sup> This long-term measure does not have annual targets.

Measure	FY	Target	Result
16.III.A.2: Proportion of new Ryan White HIV/AIDS Program HIV-infected clients who are tested for CD4 count and viral load. <sup>2</sup> (Output)	2014	CD4 – 88.2% Viral Load – 84.3%	Aug. 31, 2015
	2013	CD4 – 88.2% Viral Load – 84.3%	Aug. 31, 2014
	2012	CD4 – 88.2% Viral Load – 84.3%	Aug. 31, 2013
	2011	CD4 - 88.2% Viral Load - 84.3%	CD4 – 87.4% Viral Load – 83.6% (Target Not Met but Improved)
	2010	CD4 - 88.2% Viral Load - 84.3%	CD4 - 84.7% Viral Load – 82.9% (Target Not Met but Improved)
	2009	CD4 - 87.2% Viral Load - 83.3%	CD4 – 84.7% Viral Load – 81.3% (Target Not Met)
	2008	CD4 - 86.2% Viral Load - 82.3%	CD4 - 86.4% Viral Load – 84.4% (Target Exceeded)

**Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
16.2: Reduce deaths of persons due to HIV infection. <sup>3</sup> (Baseline – FY 2003: 4.7 per 100,000) (Outcome)	<i>Out-Year Target</i>	3.1 per 100,000 (FY 2014)	Feb 28, 2015
16.II.A.1: Number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs annually. (Output)	2014	218,942	Jan 31, 2016
	2013	236,230	Jan 31, 2015
	2012	217,324	Jan 31, 2014
	2011	208,836 <sup>4</sup>	211,037 (Target Exceeded)
	2010	149,946	208,809 (Target Exceeded)
	2009	146,486	194,039 (Target Exceeded)
	2008	158,739 <sup>5</sup>	175,194 (Target Exceeded)

<sup>2</sup> The implementation of HRSA/HAB’s new client-level data reporting system, the Ryan White Services Report (RSR), included a change in how CD4 count and viral load data are reported. These data are now collected for all HIV-positive clients who receive outpatient ambulatory medical care, rather than just new clients. The FY 2011 result is from the new data system.

<sup>3</sup> This long-term measure does not have annual targets.

<sup>4</sup> This target differs from that shown in the FY 2011 Congressional justification to reflect a budget amendment.

<sup>5</sup> The FY 2007 and FY 2008 targets are based on number of persons served at least one quarter of the year, rather than number of persons served annually.

Measure	FY	Target	Result
<u>16.II.A.2:</u> Number of persons who learn their serostatus from Ryan White HIV/AIDS Programs. (Output)	2014	879,546 <sup>6</sup>	May 28, 2016
	2013	877,525	May 28, 2015
	2012	872,565	May 28, 2014
	2011	583,730	May 28, 2013
	2010	572,397	1,200,000 (Target Exceeded)
	2009	572,397	871,696 (Target Exceeded)
	2008	572,397	739,779 (Target Exceeded)
<u>16.II.A.3:</u> Percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive anti-retroviral medications. (Output)	2014	90%	Feb. 28, 2016
	2013	90%	Feb. 28, 2015
	2012	90%	Feb. 28, 2014
	2011	90%	92.3% (Target Exceeded)
	2010	90%	87% (Target Not Met)
	2009	89.3%	87% (Target Not Met)
	2008	88.3%	87% (Target Not Met but Improved)

**Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
<u>16.3:</u> Ryan White HIV/AIDS Program-funded HIV primary medical care providers will have implemented a quality management program and will meet two “core” standards included in the October 10, 2006 “Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents.” <sup>7</sup> (Baseline – FY 2005: 63.7%) (Output)	<i>Out-Year Target</i>	90% (FY 2014)	Aug 31, 2015

<sup>6</sup> The RSR also included a change in how HIV testing is reported. Previously, Ryan White funded providers reported on all HIV testing, regardless of the source of funding for testing. Approximately 40 % of HIV testing reported was not supported with Ryan White funds. Under the new reporting requirements, only HIV testing funded by the Ryan White HIV/AIDS Program is reported. The FY2014 target reflects this change in reporting requirements.

<sup>7</sup> This long-term measure does not have annual targets.

Measure	FY	Target	Result
16.III.A.1: Percentage of Ryan White HIV/AIDS Program-funded primary medical care providers that will have implemented a quality management program. (Output)	2014	95.7%	Aug 31, 2015
	2013	95.7%	Aug 31, 2014
	2012	95.7%	Aug 31, 2013
	2011	95.7%	95.7% (Target Met)
	2010	95.7%	95.2% (Target Not Met but Improved)
	2009	95.7%	94.5% (Target Not Met but Improved)
	2008	93.2%	92.3% (Target Not Met but Improved)
Efficiency Measure	FY	Target	Result
16.E: Amount of savings by State ADAPs' participation in cost-savings strategies on medications. (Efficiency)	2014	Sustain FY 2013 results	Apr 30, 2016
	2013	Sustain FY 2012 results	Apr 30, 2015
	2012	Sustain FY 2011 results	Apr 30, 2014
	2011	Sustain FY 2010 results	Apr 30, 2013
	2010	\$487.3 M	\$551.2 M (Target Exceeded)
	2009	\$374.2 M	\$487.3 M (Target Exceeded)
	2008	\$267.9 M	\$374.2 M (Target Exceeded)

Measure	Data Source	Data Validation
16.1 16.I.A.1 16.I.A.2 16.III.A.2 16.II.A.2 16.II.A.3 16.3 16.III.A.1	The Ryan White HIV/AIDS Program Services Report (RSR) is completed by all Ryan White HIV/AIDS Program Part A, B, C, and D-funded grantees and service providers. These data were used for this measure beginning with 2011 data. The RSR is client-level data and enables HAB to unduplicate the estimated number of people who received at least one Ryan White funded service within the reporting period.	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. The web system has an array of reports available through which the grantees and their funded providers can identify data issues that need to be resolved. In addition, the Program provides technical assistance during and after the submission period to address data quality issues. The Program also conducts annual data training to help grantees collect and report high quality data.
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 Data Report (RDR) was completed by all Ryan White HIV/AIDS Program Part A, B, C, and D-funded grantees and service providers through 2010. It was retired after the 2010 reporting period given that the RSR data had been fully implemented. The RDR is aggregated data by provider.	This web-based data collection method communicates errors and warnings in the built in validation process. To ensure data quality the Program conducted data verification for all RDR submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.

Measure	Data Source	Data Validation
16.2	<p>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).</p>	<p>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.</p>
16.II.A.1 16.E	<p>ADAP Quarterly Report data provided by State ADAPs</p>	<p>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.</p>

## HIV EMERGENCY RELIEF GRANTS (PART A)

### INTRODUCTION

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

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

**Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
17.I.A.1: Number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative <sup>1</sup> , and home health). (Output)	2014	2.63 M	May 31, 2016
	2013	2.63 M	May 31, 2015
	2012	2.63 M	May 31, 2014
	2011	2.63 M	May 31, 2013
	2010	2.63 M	2.63 M (Target Met)
	2009	2.59 M	2.59 M (Target Met)
	2008	2.47 M	2.60 M (Target Exceeded)

<sup>1</sup> Rehabilitative services are a support service and visit data is not collected for support services.

Measure	Data Source	Data Validation
17.I.A.1	<p>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. These data were used for this measure beginning with 2011 data. The RSR is client-level data and enables HAB to unduplicate the estimated number of people who received at least one Ryan White funded service within the reporting period.</p>	<p>This web-based data collection method communicates errors, warnings and alerts in the built in validation process. The web system has an array of reports available through which the grantees and their funded providers can identify data issues that need to be resolved. In addition, the Program provides technical assistance during and after the submission period to address data quality issues. The Program also conducts annual data training to help grantees collect and report high quality data.</p>
17.I.A.1	<p>The Ryan White HIV/AIDS Program Data Report (RDR) was completed by all Ryan White HIV/AIDS Program Part A, B, C, and D-funded grantees and service providers through 2010. It was retired after the 2010 reporting period given that the RSR data had been fully implemented. The RDR is aggregated data by provider.</p>	<p>This web-based data collection method communicates errors and warnings in the built in validation process. To ensure data quality the Program conducted data verification for all RDR submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.</p>

## HIV CARE GRANTS TO STATES (PART B)

### INTRODUCTION

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

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

**Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
<u>18.I.A.1</u> : Number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative <sup>1</sup> , and home health). <i>Output</i> )	2014	2.19 M	May 31, 2016
	2013	2.27 M	May 31, 2015
	2012	2.19 M	May 31, 2014
	2011	2.19 M	May 31, 2013
	2010	2.19 M	2.20 M (Target Exceeded)
	2009	2.14 M	2.11 M (Target Not Met But Improved)
	2008	2.14 M	2.02 M (Target Not Met)

<sup>1</sup> Rehabilitative services are a support service and visit data is not collected for support services.

Measure	Data Source	Data Validation
18.I.A.1	<p>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. These data were used for this measure beginning with 2011 data. The RSR is client-level data and enables HAB to unduplicate the estimated number of people who received at least one Ryan White funded service within the reporting period.</p>	<p>This web-based data collection method communicates errors, warnings and alerts in the built in validation process. The web system has an array of reports available through which the grantees and their funded providers can identify data issues that need to be resolved. In addition, the Program provides technical assistance during and after the submission period to address data quality issues. The Program also conducts annual data training to help grantees collect and report high quality data.</p>
18.I.A.1	<p>The Ryan White HIV/AIDS Program Data Report (RDR) was completed by all Ryan White HIV/AIDS Program Part A, B, C, and D-funded grantees and service providers through 2010. It was retired after the 2010 reporting period given that the RSR data had been fully implemented. The RDR is aggregated data by provider.</p>	<p>This web-based data collection method communicates errors and warnings in the built in validation process. To ensure data quality the Program conducted data verification for all RDR submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.</p>

## HIV EARLY INTERVENTION SERVICES (PART C)

### INTRODUCTION

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

#### **Goal: Build Healthy Communities**

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

Measure	FY	Target	Result
19.II.A.1: Number of people receiving primary care services under Early Intervention Services programs. (Output)	2014	268,877	May 31, 2016
	2013	265,325	May 31, 2015
	2012	257,053	May 31, 2014
	2011	255,429	May 31, 2013
	2010	240,666	273,157 (Target Exceeded)
	2009	236,745	255,429 (Target Exceeded)
	2008	216,591	247,133 (Target Exceeded)

Measure	Data Source	Data Validation
19.II.A.1	The Ryan White HIV/AIDS Program Services Report (RSR) is completed by all Ryan White HIV/AIDS Program Part A, B, C, and D-funded grantees and service providers. These data were used for this measure beginning with 2011 data. The RSR is client-level data and enables HAB to unduplicate the estimated number of people who received at least one Ryan White funded service within the reporting period.	This web-based data collection method communicates errors, warnings and alerts in the built in validation process. The web system has an array of reports available through which the grantees and their funded providers can identify data issues that need to be resolved. In addition, the Program provides technical assistance during and after the submission period to address data quality issues. The Program also conducts annual data training to help grantees collect and report high quality data.
19.II.A.1	The Ryan White HIV/AIDS Program Data Report (RDR) was completed by all Ryan White HIV/AIDS Program Part A, B, C, and D-funded grantees and service providers through 2010. It was retired after the 2010 reporting period given that the RSR data had been fully implemented. The RDR is aggregated data by provider.	This web-based data collection method communicates errors and warnings in the built in validation process. To ensure data quality the Program conducted data verification for all RDR submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.

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

### INTRODUCTION

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

#### **Goal: Build Healthy Communities**

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

Measure	FY	Target	Result
20.II.A.1: Number of female clients provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission. <sup>1</sup> (Output)	2014	52,790	May 31, 2016
	2013	49,802	May 31, 2015
	2012	53,753	May 31, 2014
	2011	55,355	May 31, 2013
	2010	51,316	53,753 (Target Exceeded)
	2009	50,695	55,335 (Target Exceeded)
	2008	52,306	57,773 (Target Exceeded)

Measure	Data Source	Data Validation
20.II.A.1	The RSR is completed by all Ryan White HIV/AIDS Program Part A, B, C, and D-funded grantees and service providers. These data were used for this measure beginning with 2011 data. The RSR is client-level data and enables HAB to unduplicate the estimated number of people who received at least one Ryan White funded service within the reporting period.	This web-based data collection method communicates errors, warnings and alerts in the built in validation process. The web system has an array of reports available through which the grantees and their funded providers can identify data issues that need to be resolved. In addition, the Program provides technical assistance during and after the submission period to address data quality issues. The Program also conducts annual data training to help grantees collect and report high quality data.
20.II.A.1	The RDR was completed by all Ryan White HIV/AIDS Program Part A, B, C, and D-funded grantees and service providers through 2010. It was retired after the 2010 reporting period given that the RSR data had been fully implemented. The RDR is aggregated data by provider.	This web-based data collection method communicates errors and warnings in the built in validation process. To ensure data quality the Program conducted data verification for all RDR submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.

<sup>1</sup> Female clients counted are age 13 and above

## AIDS EDUCATION AND TRAINING CENTERS (PART F)

### INTRODUCTION

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

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

#### **Goal: Strengthen the Health Workforce**

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

Measure	FY	Target	Result
21.V.B.1: Proportion of racial/ethnic minority health care providers participating in AETC training intervention programs. (Output)	2014	43%	Jun 30, 2016
	2013	43%	Jun 30, 2015
	2012	43%	Jun 30, 2014
	2011	43%	Jun 30, 2013
	2010	43%	42% (Target Not Met)
	2009	43%	43% (Target Met)
	2008	43%	44% (Target Exceeded)

Measure	Data Source	Data Validation
21.V.B.1	AETC Participant Information Form from training program participants.	Participant Information Forms are scanned into a Web-based system that communicates errors and inaccuracies in the built in validation process.

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

**INTRODUCTION**

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

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

**Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
22.I.D.1: Number of persons for whom a portion/percentage of their unreimbursed oral health cost were reimbursed. (Output)	2014	33,316	Apr 30, 2015
	2013	33,316	Apr 30, 2014
	2012	33,316	Apr 30, 2013
	2011	34,240	37,194 (Target Exceeded)
	2010	33,508	35,659 (Target Exceeded)
	2009	33,508	35,474 (Target Exceeded)
	2008	34,394	36,193 (Target Exceeded)

Measure	Data Source	Data Validation
22.I.D.1	Dental Reimbursement Program, Application Form.	Database Utility, a Web-based tool, is used to electronically complete and submit the Dental Reimbursement application. The Database Utility application validates the report prior to the submission to the Program. To ensure data quality, the Program also conducts data verification for all Dental Reimbursement Program Application Form submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantee.

## **HEALTHCARE SYSTEMS**

Programs included in this section are:

- Organ Transplantation
- C.W. Bill Young Cell Transplantation Program
- Poison Control Program
- National Hansen's Disease Program
- Infrastructure to Expand Access to Care

## ORGAN TRANSPLANTATION

### INTRODUCTION

The Organ Transplantation Program supports HRSA's mission to improve access to quality healthcare and services by increasing the number of deceased donor organs transplanted and increasing the survival benefit of kidney transplantation. The key aggregate performance measure used by the Program is the number of deceased donor organs transplanted. This measure encapsulates several intermediate measures that the Program monitors to assess its progress towards achieving its performance goals. These intermediate measures, which are monitored internally, include: number of deceased organ donors, number of donors that meet cardiac-death and non-cardiac death criteria and number of organs transplanted on average from each category of deceased organ donor.

The Program develops new and modifies existing Program initiatives, as appropriate, based on assessments of performance results. A key Program strategy to improve performance is to sustain and improve upon the gains made in the highly effective *Breakthrough Collaboratives* supported by HRSA beginning in 2003. HRSA is working with the organ donation and transplantation community to institutionalize these gains through a 'Community of Practice.' Other strategies include improve the organ allocation policies for efficient and effective allocation of donor organs through the OPTN, support of efforts to test and replicate new approaches for increasing organ donation, and promote public awareness about organ donation.

**Goal: Improve Access to quality health care and services**

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

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
<u>23.II.A.1:</u> Increase the annual number of deceased donor organs transplanted. ( <i>Outcome</i> )	2014	25,014	May 30, 2015
	2013	24,638	May 30, 2014
	2012	31,979	May 30, 2013
	2011	30,515	24,973 (Target Not Met)
	2010	29,084	24,598 (Target Not Met but Improved)
	2009	27,683	24,116 (Target Not Met but Improved)
	2008	26,314	23,933 (Target Not Met)
<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> )	2014	4,433	May 30, 2015
	2013	4,367	May 30, 2014
	2012	6,928	May 30, 2013
	2011	6,565	4,069 (Target Not Met)
	2010	6,213	4,381 (Target Not Met)
	2009	5,873	4,868 (Target Not Met)
	2008	5,543	4,835 (Target Not Met)
<u>23.II.A.8:</u> Increase the annual conversion rate of eligible donors.	2014	73.25%	May 30, 2014
	2013	73.00%	May 30, 2014
	2012	72.9%	May 30, 2013
	2011	70.8%	72.71% (Target Exceeded)
	2010	68.6%	71.2% (Target Exceeded)
	2009	66.5%	69.1% (Target Exceeded)
	2008	64.4%	66.5% (Target Exceeded)

Measure	Data Source	Data Validation
23.II.A.1 23.II.A.7 23.II.A.8	The Organ Procurement and Transplantation Network (OPTN) data system collects information from transplant centers, organ procurement organizations and histocompatibility laboratories on all organ transplants that involve the use of deceased donor organs.	Data entry screens include a variety of data element checks and cross checks that must be satisfied before the data are accepted by the system. The contractor for the OPTN conducts additional data quality checks and follows-up with the transplant programs, organ procurement organizations and histocompatibility laboratories to resolve discrepancies in the data. An additional level of data quality review is performed by the contractor for the Scientific Registry of Transplant Recipients (SRTR) to verify that the number of deaths reported pre- and post-transplant are accurate.

## C.W. BILL YOUNG CELL TRANSPLANTATION PROGRAM

### INTRODUCTION

The Stem Cell Therapeutic and Research Act of 2010 (P.L. 111-264) reauthorized the C.W. Bill Young Cell Transplantation Program (Program). The Program activities support HRSA’s strategic goal to improve access to quality health care and services. The Program’s performance measures allow program staff to monitor progress towards the overarching goal of increasing access to blood stem cell transplant for patients in need of these life saving therapies with a particular emphasis on eliminating racial and ethnic barriers to accessing suitable blood stem cell sources. Strategies used to ensure that performance targets are met include: incorporation of quantitative performance standards into each of the four contracts for the Program; alignment of the contractor’s strategic and operational plans with the standards; quarterly reporting and reviews by HRSA and the contractors of performance against the standards; development of a process to improve donor searches; aggressive contractor negotiations of cost reductions in subcontracts for tissue typing; and development and funding of new initiatives to increase awareness and outreach in support of recruiting minority donors.

**Goal: Improve Access to Quality Health Care and Services**

Sub-Goal: Increase outreach and enrollment into quality care

Measure	FY	Target	Result
<u>24.II.A.2:</u> Increase the number of adult volunteer potential donors of minority race and ethnicity. (Outcome)	2014	3.05 Million	Dec 31, 2014
	2013	2.85 Million	Dec 31, 2013
	2012	2.66 Million	2.88 Million (Target Exceeded)
	2011	2.48 Million	2.67Million (Target Exceeded)
	2010	2.35 Million	2.46 Million (Target Exceeded)
	2009	2.06 Million	2.22 Million (Target Exceeded)
	2008	1.94 Million	2.03 Million (Target Exceeded)
<u>24.1:</u> Increase the number of blood stem cell transplants facilitated annually by the Program. <sup>1</sup> (Outcome)	<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. <sup>1</sup> (Outcome)	<i>Out-Year Target</i>	845 (FY 2013)	Dec 31, 2013
	2010	636	820 (Target Exceeded)

<sup>1</sup>This long term measure does not have annual targets.

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
24.3: Increase the rate of patient survival at one year, post transplant. <sup>1</sup> (Outcome)	<i>Out-Year Target</i>	69% (FY 2013)	Dec 31, 2015
	2010	69%	Dec 31, 2012
<b>Efficiency Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
24.E: Decrease the unit cost of human leukocyte antigen (HLA) typing of potential donors. (Efficiency)	2014	\$40.81	Dec 31, 2014
	2013	\$40.81	Dec 31, 2013
	2012	\$50.44	\$40.81 (Target Exceeded)
	2011	\$52	\$52 (Target Met)
	2010	\$52	\$52 (Target Met)
	2009	\$52	\$52 (Target Met)
	2008	\$52	\$52 (Target Met)

<b>Measure</b>	<b>Data Source</b>	<b>Data Validation</b>
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 contracting officer representative (COR) 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 contracting officer representative (COR) 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 contracting officer representative (COR) 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 contracting officer representative (COR) monitoring the contractor's budget and vouchers submitted for payment.

## POISON CONTROL PROGRAM

### INTRODUCTION

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

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

#### **Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
<u>25.III.D.3:</u> Increase percent of inbound volume on the toll-free number. ( <i>Output</i> )	2014	75%	Oct 31, 2014
	2013	75%	Oct 31, 2013
	2012	75%	84% (Target Exceeded)
	2011	73.7%	81% (Target Exceeded)
	2010	73.7%	75.6% (Target Exceeded)
	2009	71%	73.7% (Target Exceeded)
	2008	69.3%	70% (Target Exceeded)
<u>25.III.D.4:</u> Percent of national survey respondents who are aware that calls to poison control centers are handled by health care professionals. <sup>1</sup> (FY 2006 Baseline: 19%) ( <i>Outcome</i> )	<i>Out-Year Target</i>	25% (FY 2016)	February 15, 2017
	2012	N/A	25%

<sup>1</sup> This is a long-term measure. FY 2016 is the first year for which there is a target. The FY 2016 target is 25 percent.

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
25.III.D.5: Percent of human poison exposure calls made to PCCs that were managed by poison centers outside of a health care facility. (Output)	2014	71%	January 30, 2016
	2013	71%	January 30, 2015
	2012	N/A	January 30, 2014
	2011	N/A	69.9%
	2010	N/A	71.3%
	2009	N/A	72% (Baseline)

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

## NATIONAL HANSEN'S DISEASE PROGRAM

### INTRODUCTION

The Hansen's Disease Program is the only dedicated provider of expert Hansen's disease treatment services in the United States, a crucial source of continuing education for providers dealing with the identification and treatment of the disease, and a major source of research on Hansen's disease. These activities support the HRSA strategic goal to improve access to quality health care and services. Strategies for achieving the program's performance goals include ongoing support for ambulatory care clinics that focus on case management and patient compliance, and the identification of opportunities for training groups of private physicians in the geographic areas most impacted by the disease on the diagnosis and management of Hansen's disease.

**Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
3.II.A.2.: Number of private sector physicians who have received training from the NHDP <i>(Output)</i>	2014	150	Nov 30, 2014
	2013	150	Nov 30, 2013
	2012	150	202 (Target Exceeded)
	2011	150	556 (Target Exceeded)
	2010	150	220 (Target Exceeded)
	2009	50	157 (Target Exceeded)
	2008	45	146 (Target Exceeded)
3.II.A.3.: Number of patients provided Hansen's Disease outpatient care through the National Hansen's Disease Program <i>(Output)</i>	2014	3,000	Mar 31, 2015
	2013	3,000	Mar 31, 2014
	2012	3,000	Mar 31, 2013
	2011	3,000	3,311 (Target Exceeded)
	2010	3,000	3,117 (Target Exceeded)
	2009	3,000	2,963 (Target Virtually Met)
	2008	3,000	2,888 (Target Not Met)

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
<b>3.III.A.1:</b> Develop an animal model for the full spectrum of clinical complexities of human Hansen's Disease <i>(Output)</i>	2014	Pursue relevant animal model for human leprosy	Mar 31, 2015
	2013	Pursue relevant animal model for human leprosy	Mar 31, 2014
	2012	Pursue the integration of BRM, CM, and molecular reagent breakthroughs	Mar 31, 2013
	2011	Use DNA evidence to link leprosy transmission from armadillos to humans.	Leprosy Link Demonstrated (Target Met)
	2010	Demonstrate defective nerve function in infected armadillos	Defective nerve function demonstrated (Target Met)
	2009	BRM 4, CM 4	BRM 4, CM 4 (Target Met)
	2008	BRM 3, CM 2,3	BRM 3, CM 2,3 (Target Met)
<b>3.II.A.1:</b> Percent increase in the level of Hansen's Disease related disability and deformity among patients treated and managed by the National Hansen's Disease Program (NHDP) (percentage of patients at grades 1 and 2) <i>(Outcome)</i>	2014	50%	Nov 30, 2016
	2013	50%	Nov 30, 2015
	2012	50%	Nov 30, 2014
	2011	50%	Nov 30, 2013
	2010	50%	47% (Target Exceeded)
	2009	50%	53% (Target Virtually Met)
	2008	50%	45% (Target Exceeded)
<b>Efficiency Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
<b>3.E:</b> Maintain increases in the cost per patient served in the outpatient clinics to below the medical inflation rate <i>(Efficiency)</i>	2014	Below national medical inflation rate	Mar 31, 2015
	2013	Below national medical inflation rate	Mar 31, 2014
	2012	Below national medical inflation rate	Mar 31, 2013
	2011	Below national medical inflation rate 4.1%	-7.4% (Target Met)
	2010	Below national medical inflation rate (3.9%)	4.9 % (Target Not Met)
	2009	\$1,676	\$1,088 (Target Exceeded)
	2008	\$1,676	\$1,244 (Target Exceeded)

Measure	Data Source	Data Validation
3.E	Fiscal year budget allocations and expenditures, Ambulatory Care Program database, and NHDP records	Data are validated by staff at the Hansen's Disease Program.
3.II.A.2	National Hansen's Disease Program annual training records	Data are validated by staff at the Hansen's Disease Program
3.II.A.3	National Hansen's Disease Program Registry	Data are validated by staff at the Hansen's Disease Program.
3.III.A.1	Program research records	Validated by program staff and research presentations.
3.II.A.1	Disability/deformity data is collected from NHDP hand and foot screens (based on the World Health Organization scale) from ambulatory care clinics, NHDP outpatient clinics, and private physicians	Data are validated by staff at the Hansen's Disease Program.

## INFRASTRUCTURE TO EXPAND ACCESS TO CARE

### INTRODUCTION

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

**Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
<b>41.I:</b> Extent to which pre-established process and time milestones/standards are met. <i>(Outcome)</i>	2014	Awardee complies with quarterly reporting requirements and grant closeout requirements	August 31, 2014
	2013	Awardee complies with quarterly reporting requirements	December 15, 2013
	2012	Awardee complies with quarterly reporting requirements	2012 Accomplishments: The grantee submitted a change of scope (COS) to include additional interior build-out; the documentation was submitted in a timely manner. The COS was approved. The grantee submitted the Quarterly Progress Reports in a timely manner. All reporting requirements are current.
	2011		2011 Accomplishments: National Environmental Policy Act and National Historic Preservation Act requirements met. The grantee entered into a Construction Management agreement within one year of the award, as required. The Bid Tabulation and Project Schedule documentation were submitted timely. The grantee submitted the Quarterly Progress Reports in a timely manner. All reporting requirements are current.

Measure	Data Source	Data Validation
41.I	Electronic Handbook (EHB) Reporting	Validated by the Project Officer.

## **RURAL HEALTH**

Programs included in this section are:

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

## **RURAL HEALTH ACTIVITIES**

### **INTRODUCTION**

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

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

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

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

**Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
27.1: Reduce the proportion of rural residents of all ages with limitation of activities caused by chronic conditions. <sup>1</sup> (Baseline – FY 2000: 14.67%) (Outcome)	<i>Out-Year Target</i>	13% (FY 2013)	Oct 31, 2015
	2010	13.9%	14.2% (Target Exceeded)
27.IV.A.3: Increase the number of people receiving direct services through Outreach Grants. (Outcome)	2014	400,000	Oct 31, 2015
	2013	395,000	Oct 31, 2014
	2012	390,000	Oct 31, 2013
	2011	385,000	615,849 (Target Exceeded)
	2010	380,000	383,776 (Target Exceeded)
	2009	N/A	375,000 (Baseline)
	2008	N/A	N/A

**Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
27.2: Increase the proportion of critical access hospitals with positive operating margins. <sup>1</sup> (Baseline – FY 1999: 10%) (Outcome)	<i>Out-Year Target</i>	60% (FY 2013)	Dec 31, 2015

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

<sup>1</sup> This is a long-term measure with FY 2013 as a long-term target date. FY 2010 was an earlier target date to be reported in FY 2012.

## **RURAL HEALTH POLICY DEVELOPMENT**

### **INTRODUCTION**

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

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

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

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

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

**Goal: Improve Health Equity**

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

Measure	FY	Target	Result
28.V.A.1: Conduct and disseminate policy relevant research on rural health issues. (Outcome)	2014	35	Sep 30, 2015
	2013	35	Sep 30, 2014
	2012	30	Sep 30, 2013
	2011	30	57 (Target Exceeded)
	2010	30	48 (Target Exceeded)
	2009	30	30 (Target Met)
	2008	30	30 (Target Met)

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

## **RURAL HEALTH OUTREACH, NETWORK, AND QUALITY IMPROVEMENT GRANTS**

### **INTRODUCTION**

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

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

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

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

**Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
<u>29.IV.A.4:</u> Percent of outreach Authority grantees that will continue to offer services after the Federal grant funding ends. (Outcome)	2014	60%	Oct. 31, 2015
	2013	60%	Oct 31, 2014
	2012	75%	Oct 31, 2013
	2011	75%	98% (Target Exceeded)
	2010	N/A	75% (Target Not in Place)
	2009	N/A	75% (baseline)
<u>29.IV.A.3:</u> Increase the number of people receiving direct services through Outreach Grants. (Outcome)	2014	400,000	Oct. 31, 2015
	2013	395,000	Oct 31, 2014
	2012	390,000	Oct 31, 2013
	2011	385,000	615,849 (Target Exceeded)
	2010	380,000	383,776 (Target Exceeded)
	2009	N/A	375,000 (Baseline)
<u>29.IV.A.2:</u> Increase the proportion of the target population served through Outreach Authority grants. <sup>1</sup> (Outcome)	2014	6%	Oct. 31, 2015
	2013	6%	Oct 31, 2014
	2012	5%	Oct 31, 2013
	2011	N/A	7.0% (Target Not in Place)
	2010	N/A	4.3% (Baseline)
	2009	N/A	N/A

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

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

## **RURAL HOSPITAL FLEXIBILITY GRANTS**

### **INTRODUCTION**

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

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

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

**Goal: Improve Access to Quality Health Care and Services**

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

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
<u>30.V.B.4</u> : Increase the percent of Critical Access Hospitals reporting at least one measure to Hospital Compare. <i>(Outcome)</i>	2014	85%	March 31, 2016
	2013	78%	March 31, 2015
	2012	76%	March 31, 2014
	2011	74%	March 31, 2013
	2010	72%	72.6% (Target Exceeded)
	2009	70%	70.3% (Target Exceeded)
	2008	N/A	70% (Target Not in Place)
<u>30.V.B.5</u> : Number of individuals trained in emergency medical services leadership and/or trauma courses. <i>(Outcome)</i>	2014	2,995	March 31, 2016
	2013	2,995	March 31, 2015
	2012	3,615	March 31, 2014
	2011	3,615	March 31, 2013
	2010	3,615	2,996 (Target Not Met)
	2009	N/A	3,002 (Target Not in Place)
	2008	N/A	3,613 (Baseline)
<u>30.V.B.6</u> : Increase the percent of Critical Access Hospitals participating in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey	2014	60%	March 31, 2016
	2013	50%	March 31, 2015
	2012	N/A	March 31, 2014
	2011	N/A	March 31, 2013
	2010	N/A	38% (Baseline)

<b>Measure</b>	<b>Data Source</b>	<b>Data Validation</b>
30.V.B.4 30.V.B.5 30.V.B.6	This information will be reported by grantees through the Program's Performance Improvement Measurement System	Validated by project officers.

## STATE OFFICES OF RURAL HEALTH

### INTRODUCTION

The State Offices of Rural Health (SORH) Grant Program was created in 1992 to support rural health care in each of the 50 states by providing grants to states to establish and maintain SORHs. The grantees collect and disseminate health-related information in rural areas. They also provide technical and other assistance to rural health providers, including small rural hospitals. SORHs also help communities recruit and retain health professionals. Each dollar of Federal support for the program is matched by three state dollars. The SORHs have been instrumental in helping rural constituents to meet the challenges through sharing information and providing technical assistance around the changing environment that rural health providers face, both with the passage of meaningful use requirements under the American Recovery and Reinvestment Act and the Affordable Care Act.

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

**Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
31.V.B.3: Number of technical assistance (TA) encounters provided directly to clients by SORHs. <sup>1</sup> (Outcome)	2014	67,601	Dec 31, 2015
	2013	66,932	Dec 31, 2014
	2012	66,269	Dec 31, 2013
	2011	65,614	86,140 (Target Exceeded)
	2010	68,990	77,036 (Target Exceeded)
	2009	N/A	54,689 (Target Not in Place)
	2008	N/A	68,307 (Baseline)

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

Measure	FY	Target	Result
31.V.B.4: Number of clients (unduplicated) that received technical assistance directly from SORHs. <sup>2</sup> (Outcome)	2014	22,408	Dec 31, 2015
	2013	31,134	Dec 31, 2014
	2012	30,826	Dec 31, 2013
	2011	30,521	25,541 (Target Not Met)
	2010	35,225	22,731 (Target Not Met)
	2009	N/A	27,259 (Target Not in Place)
	2008	N/A	34,876 (Baseline)
31.V.B.5: Number of clinician placements facilitated by the SORHs through their recruitment initiatives. (Outcome)	2014	1,260	June 30, 2016
	2013	1,260	June 30, 2015
	2012	1,053	June 30, 2014
	2011	1,043	June 30, 2013
	2010	1,033	1,544 (Target Exceeded)
	2009	N/A	1,256 (Target Not in Place)
	2008	N/A	1,023 (Baseline)

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

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

## RADIATION EXPOSURE SCREENING AND EDUCATION PROGRAM

### INTRODUCTION

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

The Program performance measures support HRSA’s Strategic Plan Goal I of improving access to quality health care and services through strengthening health systems to support the delivery of quality health services. The Program partners with the Department of Justice to collect data in support of some of these measures. The data from the performance measures are used to refine the actual guidance for the grantees to focus more explicitly on the activities that directly impact the ability to identify and screen affected patients.

**Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
32.1: Percent of RECA successful claimants screened at RESEP centers. (Outcome)	Out-Year Target	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)	Out-Year Target	72% (FY 2013)	Nov 30, 2014
	2008	N/A	70% (Baseline)
32.I.A.1: Total number of individuals screened per year. (Output)	2014	1,400	Nov. 30, 2015
	2013	1,450	Nov 30, 2014
	2012	1,400	Nov 30, 2013
	2011	1,400	1,371 (Target Not Met)
	2010	1,400	1,371 (Target Not Met)
	2009	1,800	1,373 (Target Not Met)
	2008	1,700	1,270 (Target Not Met)

<b>Efficiency Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
32.E: Average cost of the program per individual screened. (Efficiency)	2014	\$1,251	Dec. 31,2015
	2013	\$1,397	Dec 31, 2014
	2012	\$1,397	Dec 31, 2013
	2011	\$923	\$1,093 (Target Not Met)
	2010	\$720	\$1,251 (Target Not Met)
	2009	\$760	\$1,249 (Target Not Met)
	2008	\$810	\$1,195 (Target Not Met)

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

## BLACK LUNG CLINICS

### INTRODUCTION

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

Many miners suffering from Black Lung disease live in isolated rural areas or economically challenged communities in which access to health care services is difficult and in which expertise among the existing clinicians on black lung disease is limited. As persons with respiratory and pulmonary disease age, their disease severity progresses and their need for health care services increases along with the cost of those services. The Program annually examines performance data to focus grantees on ways to improve services and increase efficiency. Two other strategies used to improve performance include developing a mechanism to collect data on the location of miners to better target resources, and enhancing outreach efforts. The measures support HRSA’s Strategic Plan goal to improve access to quality health care and services by strengthening health systems to support the delivery of quality health services to care and expanding the capacity of the health care safety net.

#### **Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
33.1: Percent of miners that show functional improvement following completion of a pulmonary rehabilitation program. <sup>1</sup> ( <i>Outcome</i> )	<i>Out-Year Target</i>	85% (FY 2014)	August 31, 2015
	2008	N/A	80% (Baseline)
33.IA.1: Number of miners served each year. (Baseline – FY 2005: 10,790) ( <i>Output</i> )	2014	12,840	Aug. 31, 2015
	2013	12,688	Aug 31, 2014
	2012	12,836	Aug 31, 2013
	2011	12,288	12,840 (Target Exceeded)
	2010	12,088	10,554 (Target Not Met)
	2009	11,575	12,436 (Target Exceeded)
	2008	11,550	11,888 (Target Exceeded)

<sup>1</sup> This long-term outcome measure does not have annual targets.

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
33.I.A.2: Number of medical encounters from Black Lung each year. (Baseline – FY 2005: 20,844) (Output)	2014	18,129	Aug. 31. 2015
	2013	27,403	Aug 31, 2014
	2012	26,403	Aug 31, 2013
	2011	25,403	18,129 (Target Not Met)
	2010	24,403	23,109 (Target Not Met)
	2009	22,525	21,727 (Target Not Met)
	2008	21,269	23,403 (Target Exceeded)
<b>Efficiency Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
33.E: Increase the number of medical encounters per \$1 million in federal funding. (Baseline – FY 2005: 3,503) (Efficiency)	2014	10,374	Aug. 31, 2015
	2013	4,372	Aug 31, 2014
	2012	4,272	Aug 31, 2013
	2011	4,172	10,374 (Target Exceeded)
	2010	4,072	3,687 (Target Not Met)
	2009	3,862	3,798 (Target Not Met)
	2008	3,630	3,972 (Target Exceeded)

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

# TELEHEALTH

## INTRODUCTION

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

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

The TNGP tracks progress in achieving its objectives to improve access to quality health care services, particularly to rural and other underserved populations, and to implement evidence-based technologies and best practices. Strategies used that support efforts to meet performance targets include sharing best practices, offering technical assistance to grantees, and encouraging grantees to offer specific types of services to address their communities' needs.

**Goal: Improve Access to Quality Health Care and Services**

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

Measure	FY	Target	Result
34.II.A.1: Increase the proportion of diabetic patients enrolled in a telehealth diabetes case management program with ideal glycemic control (defined as hemoglobin A1c at or below 7%). (Outcome)	2014	30%	Mar 31, 2016
	2013	21% <sup>1</sup>	Mar 31, 2015
	2012	20% <sup>1</sup>	Mar 31, 2014
	2011	42%	Mar 31, 2013
	2010	21%	32% (Target Exceeded)
	2009	14.5%	44% (Target Exceeded)
	2008	30%	41% (Target Exceeded)
34.1: Percent of TNGP grantees that continue to offer services after the TNGP funding has ended. <sup>2</sup> (Baseline – FY 2005: 100%) (Outcome)	Out-Year Target	95% (FY 2013)	Mar 31, 2015
34.III.D.2: Expand the number of telehealth services (e.g., dermatology, cardiology) and the number of sites where services are available as a result of the TNGP program. <sup>3</sup> (Baseline - FY 2005: 489) (Outcome)	2014	2,579	Mar 31, 2016
	2013	2,565	Mar 31, 2015
	2012	2,556	Mar 31, 2014
	2011	2,537	Mar 31, 2013
	2010	2,456	2,951 (Target Exceeded)
	2009	1,371	2,350 (Target Exceeded)
	2008	968	1,295 (Target Exceeded)

<sup>1</sup> 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.

<sup>2</sup> This long-term measure does not have annual targets.

<sup>3</sup> 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.

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
<b>34.III.D.1:</b> 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. <sup>4</sup> <i>(Outcome)</i>	2014	239	Mar 31, 2016
	2013	239	Mar 31, 2015
	2012	223	Mar 31, 2014
	2011	219	Mar 31, 2013
	2010	219	321 (Target Exceeded)
	2009	207	323 (Target Exceeded)
	2008	160	162 (Target Exceeded)
<b>34.III.D.1.1:</b> 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. <sup>4</sup> <i>(Outcome)</i>	2014	204	Mar 31, 2016
	2013	202	Mar 31, 2015
	2012	188	Mar 31, 2014
	2011	186	Mar 31, 2013
	2010	186	320 (Target Exceeded)
	2009	175	322 (Target Exceeded)
	2008	134	158 (Target Exceeded)
<b>Efficiency Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
<b>34.E:</b> 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. <sup>5</sup> <i>(Efficiency)</i>	2014	203 per Million \$	Mar 31, 2016
	2013	203 per Million \$	Mar 31, 2015
	2012	202 per Million \$	Mar 31, 2014
	2011	199 per Million \$	Mar 31, 2013
	2010	186 per Million \$	255 per Million \$ (Target Exceeded)
	2009	106 per Million \$	250 per Million \$ (Target Exceeded)
	2008	121 per Million \$	218 per Million \$ (Target Exceeded)

<sup>4</sup> 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.

<sup>5</sup> This measure provides the number of sites and services made available to people who otherwise would not have access to them per million dollars of program funds spent. Every three years a new cohort of grantee commences with a new three-year cycle of grant supported activities, gradually expanding sites and services per dollar invested. With each new cohort, there is a start-up period where services are being put in place but are not yet implemented.

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

## **HEALTH EDUCATION AND ASSISTANCE LOANS (HEAL)**

The program included in this section is:

- Health Education and Assistance Loans (HEAL)

## HEALTH EDUCATION AND ASSISTANCE LOANS

### INTRODUCTION

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

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

#### **Goal: Strengthen the Health Workforce**

Sub-goal: Assure a diverse health workforce

Measure	FY	Target	Result
9.VII.C.1: Conduct an orderly phase-out of the outstanding loan portfolio, resulting in a reduction in the Federal liability associated with the HEAL program (balance in the portfolio, dollars in millions). <i>(Outcome)</i>	2014	\$489	Dec 31, 2015
	2013	\$527	Dec 31, 2014
	2012	\$567	Dec 31, 2013
	2011	\$682	\$609 (Target Exceeded)
	2010	\$765	\$730 (Target Exceeded)
	2009	\$866	\$853 (Target Exceeded)
	2008	\$997	\$980 (Target Exceeded)
	2007	\$1,090	\$1,131 (Target Not Met but Improved)

<b>Efficiency Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
9.E: Improve claims processing efficiency through implementation of an online processing system (HOPS). (Avg. number of days to process claims) ( <i>Efficiency</i> )	2014	7 days	Dec 31, 2015
	2013	8 days	Dec 31, 2014
	2012	8 days	Dec 31, 2013
	2011	8 days	5 days (Target Exceeded)
	2010	8 days	2 days (Target Exceeded)
	2009	8 days	6 days (Target Exceeded)
	2008	8 days	11 days (Target Not Met)
	2007	8 days	8 days (Target Met)

<b>Measure</b>	<b>Data Source</b>	<b>Data Validation</b>
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.

## **NATIONAL VACCINE INJURY COMPENSATION PROGRAM**

The program included in this section is:

- National Vaccine Injury Compensation Program (NVICP)

## **NATIONAL VACCINE INJURY COMPENSATION PROGRAM**

### **INTRODUCTION**

The purpose of the National Vaccine Injury Compensation Program (VICP) is to equitably and expeditiously compensate individuals, or families of individuals, found to be 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 an alternative to the traditional tort system by ensuring that no compensated claimant rejects an award and elects to file a lawsuit to pursue civil litigation. A strategy used to reduce claims processing time is to increase the use of electronic file sharing among agencies, expert witnesses, and other parties.

**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)	2014	0%	Oct 31, 2014
	2013	0%	Oct 31, 2013
	2012	0%	0% (Target Met)
	2011	0%	0% (Target Met)
	2010	0%	0% (Target Met)
	2009	0%	0% (Target Met)
	2008	0%	0% (Target Met)
<u>26.II.A.2:</u> Average claim processing time. (Outcome)	2014	1,300 days	Oct 31, 2014
	2013	1,300 days	Oct 31, 2013
	2012	1,300 days	1,309 days (Target not met)
	2011	1,300 days	993 days (Target Exceeded)
	2010	1,300 days	1,202 days (Target Exceeded)
	2009	1,300 days <sup>1</sup>	1,269 days (Target Exceeded)
	2008	1,433 days <sup>2</sup>	1,280 days (Target Exceeded)
<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)	2014	86%	Oct 31, 2014
	2013	86%	Oct 31, 2013
	2012	86%	94.7% (Target Exceeded)
	2011	86%	95.7% (Target Exceeded)
	2010	86%	95.7% (Target Exceeded)
	2009	86%	94% (Target Exceeded)
	2008	86%	94.7% (Target Exceeded)

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

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

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. (Outcome)	2014	10 days	Oct 31, 2014
	2013	10 days	Oct 31, 2013
	2012	10 days	6.6 days (Target Exceeded)
	2011	10 days	9.4 days (Target Met)
	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)
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. (Outcome)	2014	8 days	Oct 31, 2014
	2013	8 days	Oct 31, 2013
	2012	8 days	3.6 days (Target Exceeded)
	2011	8 days	4.9 days (Target Exceeded)
	2010	5 days	2.4 days (Target Exceeded)
	2009	5 days	2.5 days (Target Exceeded)
	2008	5 days	1.5 days (Target Exceeded)
Efficiency Measure	FY	Target	Result
26.E: Percentage of cases in which case settlements are completed within 15 weeks. (Efficiency)	Out-Year Target	92%	Oct 31, 2014
	2013	92%	Oct 31, 2013
	2012	92%	100% (Target Exceeded)
	2011	92%	100% (Target Exceeded)
	2010	92%	100% (Target Exceeded)
	2009	92%	100% (Target Exceeded)
	2008	92%	100% (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.

## **HEALTHY WEIGHT PROGRAM**

The program included in this section is:

- Healthy Weight Collaborative Prevention Fund

## HEALTHY WEIGHT COLLABORATIVE PREVENTION FUND

### INTRODUCTION

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

**Goal: Build Healthy Communities**

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

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

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

<sup>1</sup> Not applicable as the program ends in 2013.

<sup>2</sup> This is a cumulative number.

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

## **PROGRAM MANAGEMENT**

The program included in this section is:

- Program Management

## PROGRAM MANAGEMENT

### INTRODUCTION

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

Measure	FY	Target	Result
<b>35.VII.B.1:</b> Ensure Critical Infrastructure Protection  Security Awareness Training <i>(Output)</i>	2014	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, 2014
	2013	Full participation in Security Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation in Executive Awareness training by 100% of HRSA executive staff.	Dec 31, 2013
	2012	Full participation in Security Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation in Executive Awareness training by 100% of HRSA executive staff.	100% completion rate in all areas of Security Awareness and Training. (Target Met)
	2011	Full participation in Security Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation in Executive Awareness training by 100% of HRSA executive staff.	100% completion rate in all areas of Security Awareness and Training. (Target Met)
	2010	Full participation in Security Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation in Executive Awareness training by 100% of HRSA executive staff.	100% completion rate in all areas of Security Awareness and Training. (Target Met)

	2009	Full participation in Security Awareness Training by 100% of HRSA Staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation of Executive Awareness Training by 100% of HRSA executive staff.	100% completion rate in all areas of Security Awareness and Training. (Target Met)
	2008	Full participation in Security Awareness Training by 100% of HRSA Staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation of Executive Awareness Training by 100% of HRSA executive staff.	100% completion rate in all areas of Security Awareness and Training. (Target Met)
<u>35.VII.B.2:</u> Ensure Critical Infrastructure Protection.  Security Authorization to Operate (Output)	2014	100% of HRSA information systems will be assessed and authorized to operate (ATO). In addition, all systems will go through continuous monitoring to ensure that critical patches are applied, security controls are implemented and working as intended, and risks are managed and mitigated in a timely manner.	Dec 30, 2014
	2013	100% of HRSA information systems will be assessed and authorized to operate. (ATO)	Nov 30, 2013
	2012	All HRSA new systems will be assessed and authorized to operate prior to going into production. All existing systems that are due for re-authorization will be assessed and reauthorized to operate.	100% of HRSA's information systems have been Certified & Accredited and granted Authority to Operate. (ATO) (Target Met)
	2011	100% of HRSA information systems have been Certified and Accredited and granted Authority to Operate. (ATO)	100% of HRSA's information systems have been Certified & Accredited and granted Authority to Operate. (ATO) (Target Met)
	2010	100% of HRSA information systems have been Certified and Accredited and granted Authority to Operate. (ATO)	100% of HRSA's information systems have been Certified & Accredited and granted Authority to Operate. (ATO) (Target Met)
	2009	N/A	N/A

Measure	FY	Target	Result
<b>35.VII.B.3:</b> Capital Planning and Investment Control <i>(Output)</i>	2014	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, 2014
	2013	1) 100% of major investments will receive an IT Dashboard Overall Rating of “Green”, which indicates an acceptable cost, schedule and Agency CIO Rating; 2) 100% of major Investment Managers will be in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM).	Nov 30, 2013
	2012	1) 100% of major investments will receive an IT Dashboard Overall Rating of “Green”, which indicates an acceptable cost, schedule and Agency CIO Rating; 2) 100% of major Investment Managers will be in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM).	FY 2012: 1) 100% of major investments received an IT Dashboard Overall Rating of “Green”, which indicates an acceptable cost, schedule and Agency CIO Rating; 2) 100% of major Investment Managers are in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM). (Target Met)
	2011	1)100% of major/tactical IT investments with acceptable business cases, 2) 0% of major/tactical investments on the Management Watch List (MWL)/High Variance List, 3) 50% of all DME projects from major/tactical investments executed in alignment with EPLC, 4) All IT Project managers are trained in EPLC framework and the use of the selected PPM tool.	1)100% of major/tactical IT investments with acceptable business cases, 2) 0% of major/tactical investments on the Management Watch List (MWL)/High Variance List, 3) 50% of all DME projects from major/tactical investments executed in alignment with EPLC, 4) All IT Project managers are trained in EPLC framework and the use of the selected PPM tool. (Target Met)
	2010	100% of major IT investments with acceptable business cases.	100% of major IT investments with acceptable business cases. (Target Met)
	2009	N/A	N/A

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
<b>35.VII.A.3:</b> Strengthen Program Integrity (PI) Activities	2014	1) Reach staffing of 20 PI regional analysts 2) Complete the final phase (phase 3) of the online PI toolkit through additional sections of program-specific guidance, information, and reference tools.	Dec. 30, 2014
	2013	1) Maintain regional PI staffing at one per region 2) Implement Phase 2 of the online PI toolkit through the addition of program specific guidance, information, and reference tools	Dec 30, 2013
	2012	1) Add 4 PI staff to result in one per region 2) Implement Phase 1 of the online PI toolkit through the addition of program specific guidance, information, and reference tools	1) Reached staffing of eleven (11) PI analysts in the regions and three (3) PI analysts at HQ to increase auditing/site visit capability. 2) HRSA PI Workgroup continued development of the online PI toolkit to provide standardized PI information and reference tools, including the implementation of phase 1. (Target Met)
	2011	N/A	1) Six additional PI staff added to regions and three added to HQ to increase auditing/site visit capability. 2) HRSA PI Workgroup initiated development of online PI toolkit to provide standardized PI information and reference tools. (Target Not In Place)
	2010	20	0 (Target Not Met)
	2009	N/A	N/A
	2008	30	50 (Target Exceeded)

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

## **FAMILY PLANNING**

Programs included in this section are:

- Family Planning

## **FAMILY PLANNING**

### **INTRODUCTION**

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

The Program currently has five performance measures that focus on increasing access and serving individuals and families from underserved, vulnerable and low-income populations. Three measures gauge the extent to which the Program expands the availability of healthcare to the public and two measure the extent to which preventive healthcare and chronic disease management services are utilized. Each of the performance measures and the efficiency measure guide Program strategies, establish directions for technical assistance, and direct revisions to program policies. This enables the Program to better address program performance and facilitates methods to increase efficiency in the delivery of preventive healthcare services. The Program's major challenge to meeting its targets and maintaining a high-level of service delivery is the continued increase in medical care prices, which ultimately affects the number of clients that clinics are able to serve. The Program addresses this issue primarily using the strategy of employing focused training efforts. This includes providing targeted funding for a national training priority that addresses clinic efficiency, quality assurance, staffing pattern strategies and other areas related to improved clinic management, cost reduction and resource allocation. In FY 2010, the program began assessing and evaluating these efforts and the impact on Title X family planning service delivery. The final analyses of the evaluations are in the process of being completed, but it appears that these targeted training strategies have contributed to some extent to a decrease in the cost per client via controlling cost and increasing clinic efficiency.

The Program is continuing to implement recommendations that emerged from the independent evaluation completed by the Institute of Medicine (IOM) in August 2009. In addition, the program aims to have new Title X Family Planning Services Guidelines during CY 2013. These new guidelines will reflect a foundation of empirical evidence and information supporting clinical practice that is expected to improve the provision of family planning and reproductive health services regardless of the service setting.

**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.

<b>Measure</b>	<b>FY</b>	<b>Target</b>	<b>Result</b>
<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> )	2014	5,045,000	Oct 31, 2015
	2013	4,996,600	Oct 31, 2014
	2012	4,969,600	Oct 31, 2013
	2011	5,049,000	5,021,711 (Target Not Met)
	2010	5,223,000	5,224,862 (Target Exceeded)
	2009	4,980,000	5,186,267 (Target Exceeded)
	2008	5,000,000	5,051,505 (Target Exceeded)
<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> )	2014	90%	Oct 31, 2015
	2013	90%	Oct 31, 2014
	2012	90%	Oct 31, 2013
	2011	90%	Oct 31, 2012
	2010	90%	89% (Target Not Met)
	2009	90%	91% (Target Exceeded)
	2008	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> )	2014	970,600	Oct 31, 2015
	2013	961,300	Oct 31, 2014
	2012	949,300	Oct 31, 2013
	2011	969,700	964,121 (Target Not Met)
	2010	1,024,000	995,861 (Target Not Met but Improved)
	2009	977,000	993,614 (Target Exceeded)
	2008	981,000	975,436 <sup>1</sup> (Target Not Met but Improved)

<sup>1</sup> 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)	2014	1,353,000	Oct 31, 2015
	2013	1,396,300	Oct 31, 2014
	2012	1,340,300	Oct 31, 2013
	2011	1,324,000	1,333,149 (Target Exceeded)
	2010	1,413,000	1,417,219 (Target Exceeded)
	2009	1,348,000	1,407,691 (Target Exceeded)
	2008	1,352,000	1,408,886 (Target Exceeded)

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

Measure	FY	Target	Result
36.II.C.1: Increase the number of unduplicated female clients who receive a Pap test. (Outcome)	2014	1,528,000	Oct 31, 2015
	2013	1,571,400	Oct 31, 2014
	2012	1,654,900	Oct 31, 2013
	2011	1,866,000	1,444,418 (Target Not Met)
	2010	2,478,000	1,727,251 (Target Not Met)
	2009	2,363,000	2,035,017 (Target Not Met)
	2008	2,372,000	2,088,218 (Target Not Met)
36.II.C.2: Reduce invasive cervical cancer among women attending Title X family planning clinics by providing Pap tests. (Outcome)	2014	504	Oct 31, 2015
	2013	519	Oct 31, 2014
	2012	546	Oct 31, 2013
	2011	616	477 (Target Not Met)
	2010	835	570 (Target Not Met)
	2009	797	672 (Target Not Met)
	2008	800	689 (Target Not Met)

Efficiency Measure	FY	Target	Result
36.E: Maintain the actual cost per Title X client below the medical care inflation rate. (Efficiency)	2014	\$283.85	Oct 31, 2015
	2013	\$292.23	Oct 31, 2014
	2012	\$280.66	Oct 31, 2013
	2011	\$269.55	\$256.20 (Target Exceeded)
	2010	\$258.87	\$247.63 (Target Exceeded)
	2009	\$243.59	\$237.42 (Target Exceeded)
	2008	\$233.86	\$239.83 (Target Not Met)

Measure	Data Source	Data Validation
36.II.A.1 36.II.A.2 36.II.A.3	<p>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.</p> <p>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.</p>	<p>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.</p>
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.	