U.S. Department of Health and Human Services

HRSA

Health Resources and Services Administration

HEALTH RESOURCES and SERVICES ADMINISTRATION

FY 2013 Annual Performance Report

Department of Health and Human Services

Contents

INTRODUCTION

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

PRIMARY HEALTH CARE

Programs included in this section are:

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

HEALTH CENTERS

INTRODUCTION

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

Goal: Improve Access to Quality Health Care and Services
Sub-Goal: Strengthen health systems to support the delivery of quality health services.

Measure	FY	Target	Result
1.I.A.1: Number of patients served by Health Centers *(Output)*	*Out-Year Target*	21.2 million (FY 2014)	Aug 31, 2015
	2013	20.9 million	Aug 31, 2014
	2012	20.6 million	Aug 31, 2013
	2011	19.7 million	Aug 31, 2012
	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)
1.I.A.2.b: Percentage of grantees that provide the following services either on-site or by paid referral: Preventive Dental Care *(Output)*	*2013*	88%	Aug 31, 2014
	2012	88%	Aug 31, 2013
	2011	88%	Aug 31, 2012
	2010	88%	88% (Target Met)
	2009	82%	88% (Target Exceeded)
	2008	82%	88% (Target Exceeded)

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

Measure	FY	Target	Result
1.II.B.4.: Percentage of adult Health Center patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9%) *(Outcome)*	*Out-Year Target*	71% (FY 2014)	Aug 31, 2015
	2013	71%	Aug 31, 2014
	2012	71%	Aug 31, 2013
	2011	71%	Aug 31, 2012
	2010	73%	71% (Target Not Met)
	2009	N/A	71% (Target Not In Place)
	2008	N/A	73% (Baseline)
1.II.B.1: Percentage of pregnant Health Center patients beginning prenatal care in the first trimester *(Output)*	*2013*	64.3%	Aug 31, 2014
	2012	64.3%	Aug 31, 2013
	2011	61.3%	Aug 31, 2012
	2010	61.3%	69% (Target Exceeded)
	2009	61.6%	67.3% (Target Exceeded)
	2008	61.5%	61.3% (Target Virtually Met)
1.II.A.1: Percentage of Health Center patients who are at or below 200% of poverty *(Output)*	*2013*	91%	Aug 31, 2014
	2012	91%	Aug 31, 2013
	2011	91%	Aug 31, 2012
	2010	91%	93% (Target Exceeded)
	2009	86%	92.5% (Target Exceeded)
	2008	86%	91.7% (Target Exceeded)

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

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

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

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

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

FREE CLINICS MEDICAL MALPRACTICE

INTRODUCTION

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

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

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

HIV CARE GRANTS TO STATES (PART B)

INTRODUCTION

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

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

Goal: Improve Access to Quality Health Care and Services
Sub-Goal: Strengthen health systems to support the delivery of quality health services.

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

Measure	Data Source	Data Validation
18.I.A.1	The Ryan White HIV/AIDS Program Services Report (RSR) is completed by all Ryan White HIV/AIDS Program Part A, B, C, and D-funded grantees and service providers.	This web-based data collection method communicates errors and warnings in the built in validation process. To ensure data quality the Program conducts data verification for all RSR submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.

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

HIV EARLY INTERVENTION SERVICES (PART C)

INTRODUCTION

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

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

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

Measure	Data Source	Data Validation
19.II.A.1	The Ryan White HIV/AIDS Program Services Report (RSR) is completed by all Ryan White HIV/AIDS Program Part A, B, C, and D-funded grantees and service providers.	This web-based data collection method communicates errors and warnings in the built in validation process. To ensure data quality the Program conducts data verification for all RSR submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.

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

INTRODUCTION

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

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

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

Measure	Data Source	Data Validation
20.II.A.1	The Ryan White HIV/AIDS Program Services Report (RSR) is completed by all Ryan White HIV/AIDS Program Part A, B, C, and D-funded grantees and service providers.	This web-based data collection method communicates errors and warnings in the built in validation process. To ensure data quality the Program conducts data verification for all RSR submissions. Reports detailing items in need of correction and instructions for submitting revised data are sent to grantees.

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

AIDS EDUCATION AND TRAINING CENTERS (PART F)

INTRODUCTION

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

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

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

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

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

DENTAL REIMBURSEMENT AND COMMUNITY PARTNERSHIP PROGRAMS
(PART F)

INTRODUCTION

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

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

Goal: Improve Access to Quality Health Care and Services
Sub-Goal: Expand the oral health services and integrate into primary care settings.

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

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

HEALTHCARE SYSTEMS

Programs included in this section are:

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

ORGAN TRANSPLANTATION

INTRODUCTION

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

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

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

Measure	FY	Target	Result
23.II.A.1: Increase the annual number of deceased donor organs transplanted. *(Outcome)*	*Out-Year Target*	33,473 (FY 2013)	May 30, 2014
	2013	33,473	May 30, 2014
	2012	31,979	May 30, 2013
	2011	30,515	May 30, 2012
	2010	29,084	24,598 (Target Not Met but Improved)
	2009	27,683	24,116 (Target Not Met but Improved)
	2008	26,314	23,933 (Target Not Met)
23.II.A.7: Increase the total number of expected life-years gained in the first 5 years after the transplant for all deceased kidney and kidney-pancreas transplant recipients compared to what would be expected for these patients had they remained on the waiting list. *(Outcome)*	*Out-Year Target*	7,299 (FY 2013)	May 30, 2014
	2013	7,299	May 30, 2014
	2012	6,928	May 30, 2013
	2011	6,565	May 30, 2012
	2010	6,213	4,381 (Target Not Met)
	2009	5,873	4,868 (Target Not Met)
	2008	5,543	4,835 (Target Not Met)

Measure	FY	Target	Result
23.II.A.8: Increase the annual conversion rate of eligible donors.	*Out-Year Target*	75% (FY 2013)	May 30, 2014
	2013	75%	May 30, 2014
	2012	72.9%	May 30, 2013
	2011	70.8%	May 30, 2012
	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
24.II.A.2: Increase the number of adult volunteer potential donors of minority race and ethnicity. *(Outcome)*	*2013*	2.85 Million	Dec 31, 2013
	2012	2.66 Million	Dec 31, 2012
	2011	2.48 Million	2.67Million (Target Exceeded)
	2010	2.35 Million	2.46 Million (Target Exceeded)
	2009	2.06 Million	2.22 Million (Target Exceeded)
	2008	1.94 Million	2.03 Million (Target Exceeded)
24.1: Increase the number of blood stem cell transplants facilitated annually by the Program. [2] *(Outcome)*	*Out-Year Target*	5,513 (FY 2013)	Dec 31, 2013
	2010	4,500	5,228 (Target Exceeded)
24.2: Increase the number of blood stem cell transplants facilitated annually by the Program for minority patients. [1] *(Outcome)*	*Out-Year Target*	845 (FY 2013)	Dec 31, 2013
	2010	636	820 (Target Exceeded)

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

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

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

POISON CONTROL PROGRAM

INTRODUCTION

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

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

Goal: Improve Access to Quality Health Care and Services
Sub-Goal: Strengthen health systems to support the delivery of quality health services

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

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

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

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

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

INFRASTRUCTURE TO EXPAND ACCESS TO CARE

INTRODUCTION

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

Goal: Improve Access to Quality Health Care and Services
Sub-Goal: Strengthen health systems to support the delivery of quality health services

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

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

RURAL HEALTH

Programs included in this section are:

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

RURAL HEALTH ACTIVITIES

INTRODUCTION

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

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

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

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

Goal: Improve Access to Quality Health Care and Services
Sub-Goal: Strengthen health systems to support the delivery of quality health care services

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

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

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

Goal: Improve Access to Quality Health Care and Services

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

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

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

RURAL HEALTH POLICY DEVELOPMENT

INTRODUCTION

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

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

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

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

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

Goal: Improve Health Equity

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

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

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

RURAL HEALTH OUTREACH, NETWORK, AND QUALITY IMPROVEMENT GRANTS

INTRODUCTION

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

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

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

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

Goal: Improve Access to Quality Health Care and Services
Sub-Goal: Strengthen health systems to support the delivery of quality health care services.

Measure	FY	Target	Result
29.1V.A.4: Percent of outreach Authority grantees that will continue to offer services after the Federal grant funding ends. *(Outcome)*	2013	68%	Oct 31, 2014
	2012	75%	Oct 31, 2013
	2011	75%	Oct 31, 2012
	2010	N/A	75% (Target Not in Place)
	2009	N/A	75% (baseline)
29.IV.A.3: Increase the number of people receiving direct services through Outreach Grants. *(Outcome)*	2013	395,000	Oct 31, 2014
	2012	390,000	Oct 31, 2013
	2011	385,000	Oct 31, 2012
	2010	380,000	383,776 (Target Exceeded)
	2009	N/A	375,000 (Baseline)
29.IV.A.2: Increase the proportion of the target population served through Outreach Authority grants. [2] *(Outcome)*	2013	6%	Oct 31, 2014
	2012	5%	Oct 31, 2013
	2011	N/A	N/A
	2010	N/A	4.3% (Baseline)
	2009	N/A	N/A

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

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

RURAL HOSPITAL FLEXIBILITY GRANTS

INTRODUCTION

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

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

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

Goal: Improve Access to Quality Health Care and Services
Sub-Goal: Strengthen health systems to support the delivery of quality health care services.

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

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

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

STATE OFFICES OF RURAL HEALTH

INTRODUCTION

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

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

Goal: Improve Access to Quality Health Care and Services
Sub-Goal: Strengthen health systems to support the delivery of quality health care services.

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

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

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

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

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

RADIATION EXPOSURE SCREENING AND EDUCATION PROGRAM

INTRODUCTION

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

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

Goal: Improve Access to Quality Health Care and Services
Sub-Goal: Strengthen health systems to support the delivery of quality health care services.

Measure	FY	Target	Result
32.1: Percent of RECA successful claimants screened at RESEP centers. *(Outcome)*	*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)*	*2013*	1,450	Nov 30, 2014
	2012	1,400	Nov 30, 2013
	2011	1,400	Nov 30, 2012
	2010	1,400	1,371 (Target Not Met)
	2009	1,800	1,373 (Target Not Met)
	2008	1,700	1,270 (Target Not Met)

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

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

BLACK LUNG CLINICS

INTRODUCTION

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

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

Goal: Improve Access to Quality Health Care and Services
Sub-Goal: Strengthen health systems to support the delivery of quality health care services.

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

[3] This long-term outcome measure does not have annual targets.
[4] This target differs from that shown in the FY 2011 Congressional Budget Justification to align it with the most recent performance.

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

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

TELEHEALTH

INTRODUCTION

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

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

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

Goal: Improve Access to Quality Health Care and Services
Sub-Goal: Strengthen health systems to support the delivery of quality health care services.

Measure	FY	Target	Result
34.II.A.1: Increase the proportion of diabetic patients enrolled in a telehealth diabetes case management program with ideal glycemic control (defined as hemoglobin A1c at or below 7%). *(Outcome)*	*Out-Year Target*	21% (FY 2013)	Mar 31, 2015
	2013	21%[1]	Mar 31, 2015
	2012	20%[5]	Mar 31, 2014
	2011	42%	Mar 31, 2013
	2010	21%	Mar 31, 2012
	2009	14.5%	44% (Target Exceeded)
	2008	30%	41% (Target Exceeded)
34.1: Percent of TNGP grantees that continue to offer services after the TNGP funding has ended. [6] (Baseline – FY 2005: 100%) *(Outcome)*	*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. [7] (Baseline - FY 2005: 489) *(Outcome)*	*2013*	2,565	Mar 31, 2015
	2012	2,556	Mar 31, 2014
	2011	2,537	Mar 31, 2013
	2010	2,456	Mar 31, 2012
	2009	1,371	2,350 (Target Exceeded)
	2008	968	1,295 (Target Exceeded)

[5] FY 2012 represents a new cohort of patients. It is estimated that in the new cohort 10% of the patients enter in telehealth diabetes case management program with ideal glycemic control (hemoglobin A1c at or below 7%) and, during the first year, this cohort will achieve a 100% increase to 20% achieving ideal control.

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

[7] The targets for this measure are cumulative, building on the 489 sites and services achieved through the 2003-2006 cohort.
This cycle began again in FY 2009 with a new cohort, building on the 1295 sites and services achieved through 2003-2009 cohort.
Please note that the targets were exceeded for FY 2008. The 2011 and 2012 targets have been increased, given the most recent data (2008) and the significant increase in congressional funding of the TNGP program in 2010. Although we have exceeded our targets to date, current grantees continue to face significant barriers to deploying telemedicine and with each new set of grantees, the program funds grantees who add more difficult services, as grantees explore the boundaries of providing these services, e.g., innovative use of telehealth for physical therapy, stroke assessment, and post-treatment rehabilitation, teledentistry, etc.

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

[8] Please note: Because this is a demonstration program, every three years each cohort of TNGP grantees "graduates" from its three-year grant while a new cohort of grantees commences a new three-year cycle of grant-supported Telehealth activities. The data are calculated as a cumulative number. However, with each new cohort, the distribution of these services is uncertain. Therefore, the targets for FY2012 may need to be revised if there is evidence of a significant increase in grantees that are providing mental health services.

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

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

HEALTH EDUCATION AND ASSISTANCE LOANS (HEAL)

The program included in this section is:

- Health Education and Assistance Loans (HEAL)

HEALTH EDUCATION AND ASSISTANCE LOANS

INTRODUCTION

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

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

Goal: Strengthen the Health Workforce
Sub-goal: Assure a diverse health workforce

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

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

Measure	Data Source	Data Validation
9.VII.C.1	Quarterly Lender Reports of Loans; Outstanding entered into Program's Online Processing System (HOPS)	Program conducts routine validation checks of the data received with information in HOPS database on a quarterly basis.
9.E	Online Processing System (HOPS)	Reports reviewed by program staff.

HEALTHY WEIGHT PROGRAM

The program included in this section is:

- Healthy Weight Collaborative Prevention Fund

HEALTHY WEIGHT COLLABORATIVE PREVENTION FUND

INTRODUCTION

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

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

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

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

[1] Not applicable as the program ends in 2013.
[2] This is a cumulative number.
[3] Predetermined targets are not appropriate for this measure as the number of interventions disseminated are determined through a process involving expert faculty.

PROGRAM MANAGEMENT

The program included in this section is:

- Program Management

PROGRAM MANAGEMENT

INTRODUCTION

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

Measure	FY	Target	Result
35.VII.B.1: Ensure Critical Infrastructure Protection Security Awareness Training *(Output)*	2013	Full participation in Security Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation in Executive Awareness training by 100% of HRSA executive staff.	Dec 31, 2013
	2012	Full participation in Security Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation in Executive Awareness training by 100% of HRSA executive staff.	Dec 31, 2012
	2011	Full participation in Security Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation in Executive Awareness training by 100% of HRSA executive staff.	100% completion rate in all areas of Security Awareness and Training. (Target Met)
	2010	Full participation in Security Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation in Executive Awareness training by 100% of HRSA executive staff.	100% completion rate in all areas of Security Awareness and Training. (Target Met)
	2009	Full participation in Security Awareness Training by 100% of HRSA Staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation of Executive Awareness Training by 100% of HRSA executive staff.	100% completion rate in all areas of Security Awareness and Training. (Target Met)

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

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

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

FAMILY PLANNING

Programs included in this section are:

- Family Planning

FAMILY PLANNING

INTRODUCTION

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

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

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

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

Measure	FY	Target	Result
36.II.A.1: Increase the total number of unduplicated clients served in Title X clinics by 5% over five years. *(Outcome)*	*Out-Year Target*	5,016,000 (FY 2014)	Oct 31, 2015
	2013	4,996,600	Oct 31, 2014
	2012	4,969,600	Oct 31, 2013
	2011	5,049,000	Oct 31, 2012
	2010	5,223,000	5,224,862 (Target Exceeded)
	2009	4,980,000	5,186,267 (Target Exceeded)
	2008	5,000,000	5,051,505 (Target Exceeded)
Measure	**FY**	**Target**	**Result**
36.II.A.2: Maintain the proportion of clients served who are at or below 200% of the Federal poverty level at 90% of total unduplicated family planning users. *(Outcome)*	*Out-Year Target*	90% (FY 2014)	Oct 31, 2015
	2013	90%	Oct 31, 2014
	2012	90%	Oct 31, 2013
	2011	90%	Oct 31, 2012
	2010	90%	90% (Target Met)
	2009	90%	91% (Target Exceeded)
	2008	90%	91% (Target Exceeded)
36.II.A.3: Increase the number of unintended pregnancies averted by providing Title X family planning services, with priority for services to low-income individuals. *(Outcome)*	*Out-Year Target*	965,000 (FY 2014)	Oct 31, 2015
	2013	961,300	Oct 31, 2014
	2012	949,300	Oct 31, 2013
	2011	969,700	Oct 31, 2012
	2010	1,024,000	995,861 (Target Not Met but Improved)
	2009	977,000	993,614 (Target Exceeded)
	2008	981,000	975,436[4] (Target Not Met but Improved)

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

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

Measure	FY	Target	Result
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)*	*Out-Year Target*	1,345,000 (FY 2014)	Oct 31, 2015
	2013	1,396,300	Oct 31, 2014
	2012	1,340,300	Oct 31, 2013
	2011	1,324,000	Oct 31, 2012
	2010	1,413,000	1,417,219 (Target Exceeded)
	2009	1,348,000	1,407,691 (Target Exceeded)
	2008	1,352,000	1,408,886 (Target Exceeded)

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

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

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

Measure	Data Source	Data Validation
36.II.A.1 36.II.A.2 36.II.A.3 36.II.B.1 36.II.C.1 36.II.C.2 36.E	Family Planning Annual Report (FPAR). The FPAR consists of 14 tables in which grantees report data on user demographic characteristics, user social and economic characteristics, primary contraceptive use, utilization of family planning and related health services, utilization of health personnel, and the composition of project revenues. For these specific measures, FPAR table 1: "Unduplicated Number of Family Users by Age and Gender" and Table 4: "Unduplicated Number of Family Planning Users by Income Level" are the data source tables. For this measure, FPAR Table 11: "Unduplicated number of Users Tested for Chlamydia by Age and Gender" is the data source. For this measure, FPAR Table 9: "Cervical Cancer Screening Activities" is the data source. For this measure FPAR Table 14: "Revenue Report" is the data source.	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.