



HEALTH RESOURCES and SERVICES ADMINISTRATION

FY 2017 Annual Performance Report

Department of Health
and Human Services

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INTRODUCTION

This FY 2017 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 information aligns with information in HRSA's *FY 2017 Justification of Estimates for Appropriation Committees*. 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 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

Objective: Increase the capacity and strength of the health care safety net.

Measure	FY	Target	Result
1.I.A.1: Number of patients served by Health Centers <i>(Output)</i>	2017	27.0 million	Aug. 31, 2018
	2016	27.0 million	Aug. 31, 2017
	2015	27.5 million	Aug. 31, 2016
	2014	24.3 million	22.9 million (Target Not Met)
	2013	22.2 million	21.7 million (Target Not Met)
	2012	20.6 million	21.1 million (Target Exceeded)
	2011	19.7 million	20.2 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 <i>(Output)</i>	2017	89%	Aug. 31, 2018
	2016	89%	Aug. 31, 2017
	2015	88%	Aug. 31, 2016
	2014	88%	89% (Target Exceeded)
	2013	88%	89% (Target Exceeded)
	2012	88%	87% (Target virtually met)
	2011	88%	88% (Target Met)

Measure	FY	Target	Result
<u>1.I.A.2.c:</u> Percentage of grantees that provide the following services either on-site or by paid referral: Mental Health/Substance Abuse (Output)	2017	75%	Aug. 31, 2018
	2016	75%	Aug. 31, 2017
	2015	70%	Aug. 31, 2016
	2014	70%	79% (Target Exceeded)
	2013	70%	74% (Target Exceeded)
	2012	70%	72% (Target Exceeded)
	2011	70%	72% (Target Exceeded)
<u>1.II.B.2:</u> Rate of births less than 2500 grams (low birth weight) to prenatal Health Center patients compared to the national low birth weight rate (Outcome)	2017	5% below national rate	Apr. 30, 2019
	2016	5% below national rate	Apr. 30, 2018
	2015	5% below national rate	Apr. 30, 2017
	2014	5% below national rate	7.3% National rate not yet available
	2013	5% below national rate	7.3% 9% below the national rate (Target Exceeded)
	2012	5% below national rate	7.1% 11% below the national rate (Target Exceeded)
	2011	5% below national rate	7.4% 8.6% below the national rate (Target Exceeded)
<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) (Outcome)	2017	63%	Aug. 31, 2018
	2016	63%	Aug. 31, 2017
	2015	63%	Aug. 31, 2016
	2014	63%	64% (Target Exceeded)
	2013	60%	64% (Target Exceeded)
	2012	60%	64% (Target Exceeded)
	2011	60%	63% (Target Exceeded)

Measure	FY	Target	Result
1.II.B.4: Percentage of adult Health Center patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9%) <i>(Outcome)</i>	2017	69%	Aug. 31, 2018
	2016	69%	Aug. 31, 2017
	2015	71%	Aug. 31, 2016
	2014	71%	69% (Target Virtually Met)
	2013	71%	69% (Target Virtually Met)
	2012	71%	70% (Target Virtually Met)
	2011	71%	71% (Target Met)
1.II.B.1: Percentage of pregnant Health Center patients beginning prenatal care in the first trimester <i>(Output)</i>	2017	68%	Aug. 31, 2018
	2016	67%	Aug. 31, 2017
	2015	66%	Aug. 31, 2016
	2014	65%	72% (Target Exceeded)
	2013	64%	72% (Target Exceeded)
	2012	64%	70% (Target Exceeded)
	2011	61%	70% (Target Exceeded)
1.II.A.1: Percentage of Health Center patients who are at or below 200% of poverty <i>(Output)</i>	2017	91%	Aug. 31, 2018
	2016	91%	Aug. 31, 2017
	2015	91%	Aug. 31, 2016
	2014	91%	92% (Target Exceeded)
	2013	91%	93% (Target Exceeded)
	2012	91%	93% (Target Exceeded)
	2011	91%	93% (Target Exceeded)

Measure	FY	Target	Result
<u>1.II.A.2</u> : Percentage of Health Center patients who are racial/ethnic minorities (<i>Output</i>)	2017	62%	Aug. 31, 2018
	2016	62%	Aug. 31, 2017
	2015	62%	Aug. 31, 2016
	2014	63%	62% (Target Virtually Met)
	2013	63%	62% (Target Virtually Met)
	2012	63%	62% (Target Virtually Met)
	2011	63%	62% (Target Virtually Met)
<u>1.I.A.3</u> : Percentage of health centers with at least one site recognized as a patient centered medical home (<i>Outcome</i>)	2017	70%	Nov. 30, 2017
	2016	65%	Nov. 30, 2016
	2015	60%	65% (Target Exceeded)
	2014	40%	58% (Target Exceeded)
	2013	25%	33% (Target Exceeded)
	2012	13%	13% (Target Met)
	2011	N/A	N/A

Efficiency Measure	FY	Target	Result
1.E: Percentage increase in cost per patient served at Health Centers compared to the national rate (Efficiency)	2017	Below national rate	Jan. 31, 2019
	2016	Below national rate	Jan. 31, 2018
	2015	Below national rate	Jan. 31, 2017
	2014	Below national rate	4.7% National rate not yet available
	2013	Below national rate	4.8% Above national rate of 4.5% (Target Not Met)
	2012	20% below national rate	3.7% Equal to national rate of 3.7% (Target Not Met)
	2011	20% below national rate	3.8% 2.6% below national rate of 3.9% (Target Not Met)

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.2	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.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

Objective: Increase the diversity and distribution of the health workforce and the ability of providers to serve underserved populations and areas.

Measure	FY	Target	Result
2.I.A.1: Number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage (Outcome)	2017	7,800	April 1, 2018
	2016	7,800	April 1, 2017
	2015	7,800	April 1, 2016
	2014	7,200	7,637 (Target Exceeded)
	2013	5,100	6,780 (Target Exceeded)
	2012	4,800	7,375 (Target Exceeded)
	2011	4,250	5,400 (Target Exceeded)
2.1: Patient visits provided by free clinics sponsoring volunteer FTCA-deemed clinicians (Outcome)	2017	500,000	Aug. 31, 2018
	2016	500,000	Aug. 31, 2017
	2015	500,000	Aug. 31, 2016
	2014	476,000	502,150 (Target Exceeded)
	2013	332,000	569,273 (Target Exceeded)
	2012	320,000	485,540 (Target Exceeded)
	2011	320,000	462,455 (Target Exceeded)

Measure	FY	Target	Result
<u>2.I.A.2:</u> Number of free clinics operating with FTCA-deemed volunteer clinicians (<i>Output</i>)	2017	240	April 1, 2018
	2016	240	April 1, 2017
	2015	240	April 1, 2016
	2014	240	232 (Target Not Met)
	2013	165	227 (Target Exceeded)
	2012	155	192 (Target Exceeded)
	2011	145	168 (Target Exceeded)
<u>2.I.A.3:</u> Percent of volunteer FTCA-deemed clinicians who meet certification and privileging requirements (<i>Output</i>)	2017	100%	April 1, 2018
	2016	100%	April 1, 2017
	2015	100%	April 1, 2016
	2014	100%	100% (Target Met)
	2013	100%	100% (Target Met)
	2012	100%	100% (Target Met)
	2011	100%	100% (Target Met)
Efficiency Measure	FY	Target	Result
<u>2.E:</u> Administrative costs of the program per Federal Tort Claims Act (FTCA)-covered volunteer (<i>Efficiency</i>)	2017	\$89	April 1, 2018
	2016	\$89	April 1, 2017
	2015	\$89	April 1, 2016
	2014	\$89	\$61 (Target Exceeded)
	2013	\$155	\$89 (Target Exceeded)
	2012	\$155	\$71 (Target Exceeded)
	2011	\$155	\$109 (Target Exceeded)

Measure	Data Source	Data Validation
2.I.A.1 2.I.A.2 2.I.A.3 2.1	HRSA Electronic Handbooks (EHB)	Data are edited and checked by program staff.
2.E	Free Clinics Medical Malpractice Coverage Program Database	Data are edited and checked by program staff.

HEALTH WORKFORCE

Programs included in this section are:

- National Health Service Corps
- NURSE Corps Programs
- 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

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 scholarships, including 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 supply of clinicians who will be available over the next one to eight years, depending on the length of their training programs. Upon completion of training, NHSC scholars become salaried employees of NHSC-approved sites in underserved communities.

The NHSC Loan Repayment Program (LRP) offers fully trained primary care clinicians the opportunity to receive assistance to pay off qualifying educational loans in exchange for service in a Health Profession Shortage Area (HPSA) of greatest need. In exchange for an initial minimum of two years of service, loan repayers receive up to \$50,000 in loan repayment assistance per year. 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.

The NHSC uses an enhanced award structure to encourage clinicians to seek placement in high-need HPSAs across the United States. Individuals who are employed in NHSC service sites with HPSA scores of 14 and higher are eligible to receive up to \$50,000 for an initial two-year contract. Individuals working in HPSAs of 13 and below are eligible for loan repayment of up to \$30,000 for a two-year contract. This policy has allowed the Corps to remain competitive with other loan repayment programs and help communities that have persistent workforce shortages. After the initial service period, NHSC loan repayers with additional eligible loans may apply for continuation awards in return for additional years of service.

The NHSC Students to Service (S2S) Loan Repayment Program, which began in FY 2012, provides loan repayment assistance of up to \$120,000 to allopathic and osteopathic medical students in their last year of school in return for selecting and completing a primary care residency and working in rural and urban HPSAs of greatest need for three years. The first cohort of these physicians will begin service in FY 2016, doubling the number of physicians available for placement in high-need areas. After the initial service period, physicians with additional eligible loans may apply for continuation awards in return for additional years of service.

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

Objective: Increase the diversity and distribution of the health workforce and the ability of providers to serve underserved populations and areas.

Measure	FY	Target	Result
4.I.C.1: Number of individuals served by NHSC clinicians (Outcome)	<i>Out-Year Target</i>	10.7 Million (FY 2017)	Dec. 31, 2017
	2017	10.7 Million	Dec. 31, 2017
	2016	9.6 Million	Dec. 31, 2016
	2015	8.9 Million	10.2 Million (Target Exceeded)
	2014	7.9 Million	9.7 Million (Target Exceeded)
	2013	7.48 Million	9.3 Million (Target Exceeded)
	2012	9.66 Million	10.4 Million (Target Exceeded)
	2011	9.7 Million	10.5 Million (Target Exceeded)
4.I.C.2: Field strength of the NHSC through scholarship and loan repayment agreements (Outcome)	<i>Out-Year Target</i>	10,155 (FY 2017)	Dec. 31, 2017
	2017	10,155	Dec. 31, 2017
	2016	9,153	Dec. 31, 2016
	2015	8,495	9,683 (Target Exceeded)
	2014	7,522	9,242 (Target Exceeded)
	2013	7,128	8,899 (Target Exceeded)
	2012	9,193	9,908 (Target Exceeded)
	2011	9,203	10,279 (Target Exceeded)

Measure	FY	Target	Result
4.I.C.4: Percent of NHSC clinicians retained in service to the underserved for at least one year beyond the completion of their NHSC service commitment. ¹ (Outcome)	2017	80%	Dec. 31, 2018
	2016	80%	Dec. 31, 2017
	2015	80%	Dec. 31, 2016
	2014	80%	87% (Target Exceeded)
	2013	80%	86% (Target Exceeded)
	2012	80%	85% (Target Exceeded)
	2011	79%	90% (Target Exceeded)
4.1.C.6: Number of NHSC sites (Outcome)	2017	14,000	Dec. 31, 2017
	2016	14,000	Dec. 31, 2016
	2015	14,000	15,979 (Target Exceeded)
	2014	14,000	15,687 (Target Exceeded)
	2013	14,000	16,047 (Target Exceeded)
	2012	14,000	14,000 (Target Met)
	2011	11,800	14,000 (Target Exceeded)
Efficiency Measure	FY	Target	Result
4.E.1: Default rate of NHSC Scholarship and Loan Repayment Program participants (Efficiency) (Baseline: FY 2007 = 0.8%)	2017	≤ 2.0%	Dec. 31, 2017
	2016	≤ 2.0%	Dec. 31, 2016
	2015	≤ 2.0%	0.7% (Target Exceeded)
	2014	≤ 2.0%	0.7% (Target Exceeded)
	2013	≤ 2.0%	0.6% (Target Exceeded)
	2012	≤ 2.0%	0.47% (Target Exceeded)
	2011	≤ 2.0%	0.52% (Target Exceeded)

¹ 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.

Measure	Data Source	Data Validation
4.I.C.1 4.I.C.2 4.E.1 4.1.C.6	BMISS - an IT system modernization program that replaces and/or retires a multitude of 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 BHW 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

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 Program¹ 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 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 or advanced practice degree to be 85 percent in FY 2017. The program has modified its measure to reflect this programmatic shift 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.

¹ 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

Objective: Increase the diversity and distribution of the health workforce and the ability of providers to serve underserved populations and areas.

Measure	FY	Target	Result
5.I.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 <i>(Outcome)</i>	2017	52%	Dec. 31, 2017
	2016	52%	Dec. 31, 2016
	2015	52%	55% (Target Exceeded)
	2014	52%	57% (Target Exceeded)
	2013	52%	70% (Target Exceeded)
	2012	50%	64% (Target Exceeded)
	2011	50%	46% (Target Not Met)
5.1.C.5: Proportion of NURSE Corps LRP/SP participants retained in service at a critical shortage facility for at least one year beyond the completion of their NURSE Corps LRP/SP commitment <i>(Developmental)</i>	2017	80%	Dec. 31, 2018
	2016	80%	Dec. 31, 2017
	2015	80%	Dec. 31, 2016
	2014	80%	90% (Target Exceeded)
	2013	80%	89% (Target Exceeded)
	2012	N/A (Target Not in Place)	83%
	2011	N/A	NELRP/NSP 82% (Baseline)
5.1.C.7: Proportion of NURSE Corps SP awardees obtaining their baccalaureate degree or advanced practice degree in nursing ² <i>(Outcome)</i>	2017	85%	Dec. 31, 2017
	2016	85%	Dec. 31, 2016
	2015	85%	88% (Target Exceeded)
	2014	85%	95% (Target Exceeded)
	2013	80%	93% (Target Exceeded)
	2012	75%	51% (Target Not Met) ³
	2011	75%	74% (Target Not Met But Improved)

² 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. This shift leads to higher targets for FY 2014 and FY 2015.

³ 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.

Efficiency Measure	FY	Target	Result
5.E.1: Default rate of NURSE Corps LRP and SP participants (Efficiency)	2017	NURSE Corps LRP FY 2013 Cohort: 3% NURSE Corps SP FY 2008 Cohort: 15%	Dec. 31, 2017
	2016	NURSE Corps LRP FY 2012 Cohort: 3% NURSE Corps SP FY 2007 Cohort: 15%	Dec. 31, 2016
	2015	NURSE Corps LRP FY 2011 Cohort: 3% NURSE Corps SP FY 2006 Cohort: 15%	NURSE Corps LRP FY 2011 Cohort: 2% NURSE Corps SP FY 2006 Cohort: 7.3% (Target Exceeded)
	2014	NURSE Corps LRP FY 2010 Cohort: 3% NURS Corps SP FY 2005 Cohort: 15%	NURSE Corps LRP FY 2010 Cohort: 1.66% NURS Corps SP FY 2005 Cohort: 8.3% (Targets Exceeded)
	2013	NURSE Corps LRP FY 2009 Cohort: 3% NURSE Corps SP FY 2004 Cohort: 15%	NURSE Corps LRP FY 2009 Cohort: 0.96% NURSE Corps SP FY 2004 Cohort: 8.7% (Targets Exceeded)
	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 FY2007 Cohort: 3.5%	NURSE Corps LRP FY 2007 Cohort: 3.4% (Target Exceeded)

Measure	Data Source	Data Validation
5.I.C.4 5.1.C.7 5.E.1	BMISS - an IT system modernization program that replaces and/or retires a multitude of 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 BHW 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 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 objectives:

- Advance the competencies of the healthcare and public health workforce.
- Increase the diversity and distribution of the health workforce and the ability of providers to serve underserved populations and areas.
- Enhance focus on health workforce assessment and policy analysis.

These Bureau of Health Workforce (BHW) 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 BHW 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

Objectives:

- Advance the competencies of the healthcare and public health workforce.
- Increase the diversity and distribution of the health workforce and the ability of providers to serve underserved populations and areas.
- Enhance focus on health workforce assessment and policy analysis

Measure	FY	Target	Result
6.I.B.1: Percentage of graduates and program completers of Bureau of Health Workforce-supported health professions training programs who are underrepresented minorities and/or from disadvantaged backgrounds ¹ (Outcome)	2017	46%	Dec. 31, 2018
	2016	46%	Dec. 31, 2017
	2015	46%	Dec. 31, 2016
	2014	46% ²	60% (Target Exceeded)
	2013	53%	46% (Target Not Met)
	2012	53%	45% (Target Not Met)
	2011	53%	46% (Target Not Met)
6.I.C.1: Percentage of trainees in Bureau of Health Workforce-supported health professions training programs who receive training in medically underserved communities ¹ (Outcome)	2017	55%	Dec. 31, 2018
	2016	55%	Dec. 31, 2017
	2015	55%	Dec. 31, 2016
	2014	50%	49% (Target Not Met)
	2013	44%	66% (Target Exceeded)
	2012	45%	59% (Target Exceeded)
	2011	45%	54% (Target Exceeded)

¹ Most recent results are for Academic Year 2014-2015 and funded in FY 2014.

² The change in target is the result of improved methodology, elimination of duplicate counting and a more accurate estimate of individuals who are serving in underserved areas. HRSA is only using counts from programs that are able to accurately track individuals that are being provided direct financial support from the HRSA program.

Measure	FY	Target	Result
6.I.C.2: Percentage of individuals supported by the Bureau of Health Workforce who completed a primary care training program and are currently employed in underserved areas ^{1,3}	2017	40%	Dec. 31, 2018
	2016	34%	Dec. 31, 2017
	2015	34% ⁴	Dec. 31, 2016
	2014	33%	46% (Target Exceeded)
	2013	43%	43% (Target Met)
	2012	43%	43% (Target Met)
	2011	43%	33% (Target Not Met)
6.I.1: Percent of clinical training sites that provide interprofessional training to individuals enrolled in a primary care training program ¹	2017	19%	Dec. 31, 2018
	2016	19%	Dec. 31, 2017
	2015	19%	Dec. 31, 2016
	2014	Set Baseline	19% (Baseline)

Measure	Data Source	Data Validation
6.I.B.1 6.I.C.2 6.I.C.1 6.I.1	Annual grantee data submitted through the Bureau of Health Workforce's Performance Management Handbook.	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 BHW's National Center for Health Workforce Analysis (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.

³ Service location data are collected on students who have been out of the HRSA program for one year. The results are from programs that have the ability to produce clinicians with one year post program graduation. Results are from Academic Year 2014-2015 based on graduates from Academic Year 2013-2014.

⁴ The change in target is the result of improved methodology, elimination of duplicate counting and a more accurate estimate of individuals who are serving in underserved areas. HRSA is only using counts from programs that are able to accurately track individuals that are being provided direct financial support from the HRSA program.

Affordable Care Act Measures

Goal: Strengthen the Health Workforce

Objectives:

- Advance the competencies of the healthcare and public health workforce.
- Increase the diversity and distribution of the health workforce and the ability of providers to serve underserved populations and areas.
- Enhance focus on health workforce assessment and policy analysis

ACA Measure	FY	Target	Result
6.I.C.3: Number of primary care providers who complete their education through HRSA's Bureau of Health Workforce programs supported with Prevention and Public Health funding (Cumulative)	<i>Out-Year Target 2015</i>	500 Physicians 600 PA 600 NP	Dec. 31, 2016
Physicians <i>Primary Care Training and Enhancement Program</i> (Cumulative)	2015	500	Dec. 31, 2016
	2014	332	327 ¹ (Target Not Met)
	2013	166	156 (Target Not Met)
	2012	N/A ²	N/A
	2011	N/A	N/A
Physician Assistants <i>Primary Care Training and Enhancement Program</i> (Cumulative)	2015	600	Dec. 31, 2016
	2014	420	287 ³ (Target Not Met)
	2013	280	157 (Target Not Met)
	2012	140	37 (Target Not Met)
	2011	N/A ²	N/A
Nurse Practitioner and Nurse Midwives <i>Advanced Nursing Education Expansion Program</i> ⁴ (Cumulative)	2015	600	Dec. 31, 2016
	2014	430	542 ⁵ (Target Exceeded)
	2013	260	424 (Target Exceeded)
	2012	110	249 (Target Exceeded)
	2011	N/A	N/A

¹ Most recent results are for Academic Year 2014-2015 and funded in FY 2014.

² No supported trainees are eligible for completion in specified year. 1st graduating class of physicians supported through the PCTE/PCRE program will be in Academic Year 13-14. 1st graduating class of physician assistant supported through the PCTE/EPAT program will be in Academic Year 12-13. 1st graduating class of nurse practitioners and nurse midwives supported through the ANE/ANEE program will be in Academic Year 12-13.

³ Most recent results are for Academic Year 2014-2015 and funded in FY 2014.

⁴ Outputs are based on forward-funded grants.

⁵ Most recent results are for Academic Year 2014-2015 and funded in FY 2014.

ACA Measure	FY	Target	Result
6.I.C.4: Number of primary care providers receiving training through HRSA's Bureau of Health Workforce programs supported with Prevention and Public Health funding (cumulative)			
Physician Assistants <i>Primary Care Training and Enhancement Program (Cumulative)</i>	2014 ⁶	600	586 ^{7,8} (Target Not Met)
	2013	445	458 (Target Exceeded)
	2012	280	317 (Target Exceeded)
	2011	148	140 (Target Not Met)
Nurse Practitioners and Nurse Midwives <i>Advanced Nursing Education Expansion Program (Cumulative)</i>	2014 ⁹	600	713 ¹⁰ (Target Exceeded)
	2013	430	623 (Target Exceeded)
	2012	260	483 (Target Exceeded)
	2011	110	171 (Target Exceeded)
6.I.C.5: Number of primary care residents trained ¹¹ <i>Teaching Health Center Graduate Medical Education Payments (Cumulative)</i>	2017	760 ¹²	Dec. 31, 2018
	2016	660	Dec. 31, 2017
	2015	620	Dec. 31, 2016
	2014	402	556 ¹³ (Target Exceeded)
	2013	300	327 (Target Exceeded)
	2012	143	143 (Target Met)
	2011	N/A	63 (Historical Actual)

⁶ Reflects the last starting cohort of physician assistant students funded through the EPAT grant program.

⁷ Most recent results are for Academic Year 2014-2015 and funded in FY 2014.

⁸ Measure is cumulative and captures the training of the four cohorts of physician assistant students funded through the EPAT program with results regarding the training of each cohort applicable for FY 2011, FY 2012, FY 2013, and FY 2014

⁹ Reflects the last starting cohort of nurse practitioner and nurse midwife students funded through the ANEE grant program. Measure discontinued in FY 2015 as no further funding was provided for the ANEE program.

¹⁰ Most recent results are for Academic Year 2014-2015 and funded in FY 2014.

¹¹ Measure captures the number of full-time equivalent (FTEs) resident slots supported and not the number of individuals receiving direct financial support through the program. Awardees may use 1 FTE slot to fund two residents at 50 percent time, thus the FTE slot is not a one to one correspondence with number of individuals trained. Number of residents also does not equal the number of graduates as primary care residency programs require one year (Dental and Geriatrics), three years (Family Medicine, Internal Medicine, and Pediatrics), or four years (Ob-Gyn and Psychiatry) of training.

¹² The increase in the FY 2017 target reflects the natural scale up of new and expanding residency programs that require up to 4 years of training as each class of residents move up or graduate, a new class of residents is recruited.

¹³ Most recent results are for Academic Year 2014-2015 and funded in FY 2011.

ACA Measure	FY	Target	Result
6.I.C.7: Number of Primary Care Nurse Practitioner students supported ¹⁴ <i>Advanced Nursing Education Expansion Program</i>	2015 ¹⁵	300	Dec. 31, 2016
	2014	300	289 ¹⁶ (Target Not Met)
	2013	300	374 (Target Exceeded)
	2012	300	381 (Target Exceeded)
	2011	300	368 (Target Exceeded)
6.I.C.8: Number of Primary Care Patient Encounters <i>Primary Care Training and Enhancement Program</i>	2015 ¹⁷	180,000	Dec. 31, 2016
	2014	180,000	1,516,049 ¹⁸ (Target Exceeded)
	2013	30,000	1,164,248 (Target Exceeded)
	2012	30,000	722,298 (Target Exceeded)
	2011	30,000	182,723 (Target Exceeded)
6.I.C.9: Number of trainees participating in continuing education sessions delivered by PHTCs <i>Public Health Training Centers</i>	2017	23,000	Dec. 31, 2018
	2016	23,000	Dec. 31, 2017
	2015	23,000	Dec. 31, 2016
	2014	23,000 ¹⁹	108,216 ²⁰ (Target Exceeded)
	2013	84,520	249,933 (Target Exceeded)
	2012	205,645	207,543 (Target Exceeded)
	2011	205,645	161,780 (Target Not Met)
6.I.C.12: Number of Bureau of Health Workforce-sponsored interprofessional continuing education sessions provided on Alzheimer's disease. <i>Geriatrics Education Centers Program</i>	2017	Maintain Baseline	Dec. 31, 2018
	2016	Maintain Baseline	Dec. 31, 2017
	2015	Maintain Baseline	Dec. 31, 2016
	2014	Set Baseline	636 ²¹ (Baseline)

¹⁴ Outputs are based on forward-funded grants.

¹⁵ Reflects the last cohort of supported nurse practitioner students. This measure will be discontinued in FY 2016 as no further funding is anticipated for the ANEE program.

¹⁶ Most recent results are for Academic Year 2014-2015 and funded in FY 2014.

¹⁷ Measure will be discontinued in FY 2016.

¹⁸ Most recent results are for Academic Year 2014-2015 and funded in FY 2014.

¹⁹ Targets reduced to reflect programmatic changes and cohort effects.

²⁰ Most recent results are for Academic Year 2014-2015 and funded in FY 2014.

²¹ Most recent results are for Academic Year 2014-2015 and funded in FY 2014.

ACA Measure	FY	Target	Result
6.I.C.13: Number of trainees participating in interprofessional continuing education on Alzheimer's disease. <i>Geriatrics Education Centers Program</i>	2017	Maintain Baseline	Dec. 31, 2018
	2016	Maintain Baseline	Dec. 31, 2017
	2015	Maintain Baseline	Dec. 31, 2016
	2014	Set Baseline	51,726 ²² (Baseline)
6.I.C.14: Number of residents enrolled in preventive medicine programs that have incorporated evidence-based integrative medicine principles into the curriculum (including both practical and didactic academic course work). <i>Integrative Medicine Program</i>	2015	N/A ²³	N/A
	2014	Maintain Baseline	24 ²⁴ (Target Not Met)
	2013	Set Baseline	61 (Baseline)
	2012	--	--
6.I.C.15: Number of technical assistance consultations provided by the National Coordinating Center for Integrative Medicine (NccIM). <i>Integrative Medicine Program</i>	2015	N/A ²⁵	N/A
	2014	Maintain Baseline	1,200 ²⁶ (Target Exceeded)
	2013	Set Baseline	800 (Baseline)
	2012	--	--
6.I.C.16: Number of students receiving training via clinical Internships in Psychology or Field Placements in Social Work focused on working with high need and high demand populations. <i>Mental and Behavioral Health Education and Training Program</i>	2015	N/A ²⁷	N/A
	2014	145	214 ²⁸ (Target Exceeded)
	2013	--	--
	2012	--	--
6.I.C.17: Number of graduates entering practice with high need and high demand populations. <i>Mental and Behavioral Health Education and Training Program</i>	2015	N/A ²⁹	N/A
	2014	57	120 ³⁰ (Target Exceeded)
	2013	--	--
	2012	--	--

²² Most recent results are for Academic Year 2014-2015 and funded in FY 2014.

²³ Program was discontinued in FY 2015. HRSA will report outputs for FY 2013 and FY 2014.

²⁴ Most recent results are for Academic Year 2014-2015 and funded in FY 2014.

²⁵ Program was discontinued in FY 2015. HRSA will report outputs for FY 2013 and FY 2014.

²⁶ Most recent results are for Academic Year 2014-2015 and funded in FY 2014.

²⁷ Measures for the MBHET program will be discontinued in FY 2015, as no new funding for this program is anticipated.

²⁸ Most recent results are for Academic Year 2014-2015, which was funded in FY 2014.

²⁹ Measure discontinued in FY 2015.

³⁰ Most recent results are for Academic Year 2014-2015, which was funded in FY 2014.

ACA Measure	FY	Target	Result
6.I.2: Percent of graduates entering practice with high need and high demand populations. <i>Mental and Behavioral Health Education and Training Program</i>	2015	N/A ³¹	N/A
	2014	78%	79% ³² (Target Exceeded)
	2013	--	--
	2012	--	--
6.I.C.18: Number of instructional hours offered by PHTCs. <i>Public Health Training Centers Program</i>	2017	9,320	Dec. 31, 2018
	2016	9,320	Dec. 31, 2017
	2015	9,320	Dec. 31, 2016
	2014	9,320	8,726 ³³ (Target Not Met)
	2013	9,320	10,123 (Target Exceeded)
	2012	N/A	13,711 (Baseline)
6.I.C.19: Number of PHTC-sponsored public health students that completed field placement practicums in State, Local, and Tribal Health Departments. <i>Public Health Training Centers Program</i>	2017	150	Dec. 31, 2018
	2016	150	Dec. 31, 2017
	2015	150	Dec. 31, 2016
	2014	150	24 ³⁴ (Target Not Met)
	2013	150	278 (Target Exceeded)
	2012	N/A	277 (Baseline)

³¹ Measure discontinued in FY 2015.

³² Most recent results are for Academic Year 2014-2015, which was funded in FY 2014.

³³ Most recent results are for Academic Year 2014-2015 and funded in FY 2014.

³⁴ Most recent results are for Academic Year 2014-2015 and funded in FY 2014.

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

Objective: Increase the diversity and distribution of the health workforce and the ability of providers to serve underserved populations and areas.

Measure	FY	Target	Result
7. I.A.1: Maintain the number of FTE residents training in eligible children’s teaching hospitals (Output)	2017	6,300	Dec. 31, 2018
	2016	6,300	Dec. 31, 2017
	2015	6,300	Dec. 31, 2016
	2014	6,000	6,698 ¹ (Target Exceeded)
	2013	5,900	6,535 (Target Exceeded)
	2012	5,900	6,015 (Target Exceeded)
	2011	5,900	6,185 (Target Exceeded)

¹ 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 2014-2015 and funded in FY 2014.

Measure	FY	Target	Result
7.VII.C.1: Percent of hospitals with verified FTE resident counts and caps (Output)	2017	100%	Dec. 31, 2018
	2016	100%	Dec. 31, 2017
	2015	100%	Dec. 31, 2016
	2014	100%	100% ² (Target Met)
	2013	100%	100% (Target Met)
	2012	100%	100% (Target Met)
	2011	100%	100% (Target Met)
Efficiency Measure	FY	Target	Result
7.E: Percent of payments made on time (Efficiency)	2017	100%	Dec. 31, 2018
	2016	100%	Dec. 31, 2017
	2015	100%	Dec. 31, 2016
	2014	100%	100% ³ (Target Met)
	2013	100%	100% (Target Met)
	2012	100%	100% (Target Met)
	2011	100%	100% (Target Met)

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

²The most recent results are for Academic Year 2014-2015 and funded in FY 2014.

³The most recent results are for Academic Year 2014-2015 and funded in FY 2014.

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 to best ensure the safety and integrity of health care. To this end, State licensing boards, hospitals and other health care entities, and professional societies must be encouraged to identify and discipline those who engage in unprofessional behavior. The NPDB provides vital information to authorized users that impede the ability of incompetent health care practitioners to move from State to State without discovery of previous substandard performance or unprofessional conduct. Further, the Data Bank is designed to reduce health care fraud and abuse by collecting and disclosing to authorized entities information on health care-related civil judgments and criminal convictions, adverse licensure and certification actions, exclusions from health care programs, and other adjudicated actions taken against health care providers, suppliers, and practitioners.

The purpose of the National Practitioner Data Bank (NPDB) is to improve health care quality, promote patient safety, and deter fraud and abuse in the health care system by providing information about past adverse actions of practitioners, providers, or suppliers to authorized health care entities and agencies. The 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. Used in conjunction with information from other sources, the NPDB assists in promoting quality health care.

The NPDB is a web-based electronic reporting and querying system. Reports and queries can be submitted interactively on-line or via XML-based batch electronic file transfer. Credit card and Electronic Funds Transfer (EFT) transactions are securely processed using the U.S. Department of Treasury's Pay.gov service. The NPDB program supports HRSA Strategic Goal 1 (Improve access to quality health care and services), and Objective 1.2 (Improve the quality and efficacy of the healthcare safety net).

Goal: Improve Access to Quality Health Care and Services

Objective: Improve the quality and efficacy of the healthcare safety net.

Measure	FY	Target	Result
<u>8.III.B.5:</u> Increase the number of practitioners enrolled in Continuous Query (which is a subscription service for Data Bank queries that notifies them of new information on enrolled practitioners within one business day) ¹	2017	2,155,000	Feb 28, 2018
	2016	2,030,000	Feb 28, 2017
	2015	1,675,000	2,069,099 (Target Exceeded)
	2014	1,550,000	1,780,045 (Target Exceeded)
	2013	1,074,000	1,524,696 (Target Exceeded)
	2012	990,000	1,401,701 (Target Exceeded)
	2011	N/A	899,149
<u>8.III.B.7:</u> Increase annually the number of reports disclosed to health care organizations	2017	1,265,000	Feb 28, 2018
	2016	1,260,000	Feb 28, 2017
	2015	1,285,000	1,257,631 (Target Not Met)
	2014	Set Baseline	1,280,819 (Baseline)
	2013	N/A	N/A
	2012	N/A	N/A
	2011	N/A	N/A

Measure	Data Source	Data Validation
8.III.B.5 8.III.B.7	NPDB operations statistics	Program reviews and analyzes weekly and monthly statistics.

¹ Continuous Query is designed and developed to meet accreditation standards that require ongoing monitoring of practitioners.

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

The mission of the Maternal and Child Health (MCH) Block Grant Program, as authorized under Title V of the Social Security Act, is to improve the health of all mothers, children, and their families. Program funds, combined with state investments, provide the most significant funding source to help reduce health disparities, improve access to health care, and improve the quality of care for the MCH populations in 59 states and territories. The Title V program is mandated to:

- Assure access to quality care, especially for those with low-incomes or limited availability of care;
- Reduce infant mortality;
- Provide and ensure access to comprehensive prenatal and postnatal care to women (especially low-income and at risk pregnant women);
- Increase the number of children receiving health assessments and follow-up diagnostic and treatment services;
- Provide and ensure access to preventive and primary care services for low income children as well as rehabilitative services for children with special health needs;
- Implement family-centered, community-based, systems of coordinated care for children with special health care needs (CSHCN); and
- Provide toll-free hotlines and assistance in applying for services to pregnant women with infant sand children who are eligible for Title XIX (Medicaid).

Through the MCH Block Grant program, HRSA distributes funding to the states, provides oversight by requiring states to report progress annually on key MCH performance/outcome measures and indicators, and offers technical assistance to states to improve performance. Each state is responsible for determining its MCH priorities, based on a comprehensive Needs Assessment that is conducted every five years. The program emphasizes accountability while providing appropriate flexibility for each state to target its funds to address the unique needs of its MCH population. State programs use their federal MCH block grants to support the following types of activities:

- State and local capacity and health care and public health systems building,
- Public education, knowledge development, outreach and program linkage, technical assistance, provider training, evaluation,
- Support for newborn screening and genetic services, lead poison prevention and injury prevention,
- Additional support services for children with special health care needs,
- Health and safety promotion in child care settings, and
- Community capacity building to deliver such enabling services as care coordination, transportation, home visiting, and nutrition counseling.

The MCH Block Grant program also serves as the payer of last resort. In cases where no resources or services are available, states use their MCH block grant to fund direct care services, such as prenatal care, pediatric specialty care, or services for children with special health care needs. The majority of MCH Block Grant program dollars are used by states to fund services often times not covered by public or private health insurance, such as dental services, physical

and occupational therapy, and durable medical equipment (e.g., wheelchairs, walkers, and orthotics). In an era of expanding health care coverage under the Patient Protection and Affordable Care Act (ACA), State MCH Block Grant programs assure continuity of care and reduce coverage gaps created by shifts in the insurance eligibility status of individuals.

Goal: Improve Access to Quality Health Care and Services

Objective: Improve the quality and efficacy of the health care safety net

Measure	FY	Target	Result
<u>10.I.A.1:</u> The number of children served by the Maternal and Child Health Block Grant (Output)	2017	34M	Nov. 30, 2018
	2016	34M	Nov. 30, 2017
	2015	32M	Nov. 30, 2016
	2014	31M	Nov. 30, 2015
	2013	30M	34.3M (Target Exceeded)
	2012	33M	35.9M (Target Exceeded)
	2011	31M	37.4M (Target Exceeded)
<u>10.I.A.2:</u> Increase the number of children receiving Maternal and Child Health Block Grant services who are enrolled in and have Medicaid and CHIP coverage (Output)	2017	15M	Nov. 30, 2018
	2016	15M	Nov. 30, 2017
	2015	14.5M	Nov. 30, 2016
	2014	14M	Nov. 30, 2015
	2013	15M	14.9M (Target Not Met)
	2012	14M	14.2M (Target Exceeded)
	2011	13M	14.8M (Target Exceeded)

Goal: Improve Health Equity

Objective: Reduce disparities in access and quality of care, and improve health outcomes across populations and communities

Measure	FY	Target	Result
<u>10.IV.B.1:</u> Decrease the ratio of the black infant mortality rate to the white infant mortality rate (Output)	2017	2.0 to 1	Nov. 30, 2018
	2016	2.0 to 1	Nov. 30, 2017
	2015	2.1 to 1	Nov. 30, 2017
	2014	2.1 to 1	2.4 to 1 (Target Not Met)
	2013	2.1 to 1	2.2 to 1 (Target Not Met)
	2012	2.1 to 1	2.2 to 1 ¹ (Target Not Met)
	2011	2.1 to 1	2.2 to 1 ² (Preliminary Data, Target Not Met)

¹ Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC). Deaths: Final Data for 2012, National Vital Statistics Reports, Vol. 63, No. 9

² 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.

Goal: Improve Access to Quality Health Care and Services

Objective: Improve the quality and efficacy of the health care safety net

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
	2017	5.6 per 1,000	Nov. 30, 2019
	2016	5.8 per 1,000	Nov. 30, 2018
	2015	6.0 per 1,000	Nov. 30, 2017
	2014	6.1 per 1,000	5.8 per 1,000 ³ (Target Exceeded)
	2013	6.6 per 1,000	6.0 per 1,000 ⁴ (Target Exceeded)
	2012	6.6 per 1,000	6.0 per 1,000 ⁵ (Target Exceeded)
	2011	6.6 per 1,000	6.1 per 1,000 ⁶ (Preliminary Data, Target Exceeded)
<u>10.III.A.2</u> : Reduce the incidence of low birth weight births (Outcome)	2017	7.8%	Nov. 30, 2018
	2016	7.8%	Nov. 30, 2017
	2015	8.0%	Nov. 30, 2016
	2014	8.1%	8.0 (Target Exceeded)
	2013	8.1%	8.0 ⁷ (Target Exceeded)
	2012	8.2%	8.0% ⁸ (Target Exceeded)
	2011	8.2%	8.1% ⁹ (Target Exceeded)

³ Murphy SL, Kochanek KD, Xu JQ, Arias E. Mortality in the United States, 2014. NCHS data brief, no 229. Hyattsville, MD: National Center for Health Statistics. 2015. <http://www.cdc.gov/nchs/products/databriefs/db229.htm>

⁴ Xu JQ, Murphy SL, Kochanek KD, Bastian BA. Deaths: Final data for 2013. National vital statistics reports; vol 64 no 2. Hyattsville, MD: National Center for Health Statistics. 2016. See table 20 http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf

⁵ Vital Statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC). Mortality in the United States, 2012. NCHS Data Brief, No.168, October 2014.

⁶ 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.

⁷ Detailed Technical Notes prepared by the National Center for Health Statistics, Centers for Disease Control and Prevention. User Guide to the 2013 Natality Public Use File.

⁸ Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2012. Births: Final Data for 2012, National Vital Statistics Reports, Vol. 62, No. 9, December 2013.

⁹ National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2012, Births: Final Data for 2011, National Vital Statistics Reports, Vol. 62, No. 1, June 2013.

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%) ⁷ (Outcome)	2017	76%	Nov. 30, 2018
	2016	76%	Nov. 30, 2017
	2015	73%	Nov. 30, 2016
	2014	72%	76.7% (Target Exceeded)
	2013	71%	74.2% ¹⁰ (Target Exceeded)
	2012	70%	74.1% ¹¹ (Target Exceeded)
	2011	69% ¹²	73.7% (Target Exceeded) ¹³
10.III.A.4: Increase percent of very low-birth weight babies who are delivered at facilities for high-risk deliveries and neonates (Outcome)	2017	82%	Nov. 30, 2019
	2016	80%	Nov. 30, 2018
	2015	77%	Nov. 30, 2017
	2014	76%	Nov. 30, 2016
	2013	77%	80.9% (Target Exceeded)
	2012	76%	80.0% ¹⁴ (Target Exceeded)
	2011	76%	79% (Target Exceeded)
10.3: Reduce the maternal mortality rate ¹⁵ (Deaths/100,000 live births) (Outcome)	<i>Out-Year Target</i>	13.1 per 100,000 (FY 2015)	Nov. 30, 2017 ¹⁶
	2008	8 per 100,000	Dec. 30, 2015
	2007	N/A	12.7 deaths per 100,000 ¹⁷

¹⁰ Detailed Technical Notes prepared by the National Center for Health Statistics, Centers for Disease Control and Prevention. User Guide to the 2013 Natality Public Use File.

¹¹ Detailed Technical Notes prepared by the National Center for Health Statistics, Centers for Disease Control and Prevention. User Guide to the 2012 Natality Public Use File.

¹² 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.

¹³ Detailed Technical Notes prepared by the National Center for Health Statistics, Centers for Disease Control and Prevention. User Guide to the 2011 Natality Public Use File.

¹⁴ Source: Title V Information System, HRSA/MCHB (<https://mchdata.hrsa.gov/TVISReports>).

¹⁵ This is a long-term measure with no annual targets. Wording for this measure has been changed from “Increase maternal survival rate” in order to more accurately reflect data being reported..

¹⁶ Updated maternal mortality data will not be available until the revised Death Certificate is adopted by all States. Pregnancy-related mortality data are available with the most recent reporting for 2009. However, these data are not comparable to the maternal mortality data that have been previously reported as they include deaths up to one year from pregnancy termination versus the 42 day timeframe for maternal mortality. In reporting on this long-term measure, it should be noted that baseline data and current performance targets are based on the maternal mortality rate and that more current data are not available, and are not expected to be available, until the revised Death Certificate has been fully adopted by States.

¹⁷ 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.

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.

JAMES T. WALSH UNIVERSAL NEWBORN HEARING SCREENING

INTRODUCTION

The James T. Walsh Universal Newborn Hearing Screening Program (UNHS) began in FY 2000 with the purpose of assisting states to develop newborn hearing screening and early intervention programs. The program supports the Healthy People 2020 objective to increase the proportion of newborns who are screened for hearing loss no later than age one month, receive an audiologic evaluation no later than age three months, and are enrolled in appropriate intervention services no later than age six months. Additionally, programs have adopted quality improvement strategies to decrease the number of infants lost to follow-up/documentation, such as:

- Improving communications with the infant’s medical home provider and specialists;
- Scheduling rescreening and/or audiology appointments for the infant at hospital discharge;
- Streamlining the Early Intervention referral process and obtaining a consent for release of information; and
- Improving data tracking systems.

To implement the program, the Maternal and Child Health Bureau (MCHB) awards 59 competitive grants to states and territories and funds one national technical assistance center. In addition to funds to strengthen state screening efforts and reduce loss-to-follow-up/documentation, supplemental funding has been provided since FY 2009 to a total of 10 Leadership Education in Neurodevelopmental and Related Disabilities (LEND) training programs to expand and augment their pediatric audiology training efforts. In FY 2015, MCHB made awards to 59 state and territorial grantees and one national resource center.

The UNHS has been making progress toward the Healthy People 2020 objectives. Screening for hearing loss prior to hospital discharge improved from 95 percent in 2005 to 97 percent in 2013. The percent of infants who screened positive with appropriate follow-up also improved from 33 percent in 2005 to 65 percent in 2012 and 74 percent in 2013. However, this improvement is not universal, with loss-to-follow-up and/or documentation rates ranging from 2.5 percent to 77 percent among the states and territories. Most states now have legislation mandating hearing screening for newborns, and most U.S. hospitals have implemented newborn hearing screening programs. However, few states and territories have comprehensive data reporting requirements for service providers (audiologists, clinicians, and early intervention providers), which makes accurate and timely monitoring and documentation of follow-up and intervention difficult. The current UNHS program focuses on supporting timely screening and diagnosis and addressing issues related to loss-to-follow-up/documentation so that all children with or suspected to have a hearing loss receive timely diagnostic and early intervention services, including early access to language development supports.

Goal: Improve Access to Quality Health Care and Services

Objective: Increase the capacity and strength of the health care safety net

Measure	FY	Target	Result
<u>13.1:</u> Increase the percentage of children with non-syndromic hearing loss entering school with developmentally appropriate language skills ¹ (Baseline – FY 2004: 20% estimated) (Outcome)	<i>Out-Year Target</i>	85% (FY 2013)	March 31, 2015
<u>13.2:</u> Increase the percentage of infants with hearing loss enrolled in early intervention before six months of age (Baseline – FY 2009: 68%) (Output)	2017	72%	March 31, 2018
	2016	72%	March 31, 2018
	2015	72%	March 31, 2017
	2014	70%	March 31, 2016
	2013	65%	67% (Target Exceeded)
	2012	67%	66%
	2011	67%	68% (Target Exceeded)
<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)	2017	77%	March 31, 2018
	2016	77%	March 31, 2018
	2015	77%	March 31, 2017
	2014	75%	March 31, 2016
	2013	65%	69% (Target Exceeded)
	2012	70%	70%
	2011	63%	71% (Target Exceeded)
<u>13.III.A.3:</u> Percentage of infants screened for hearing loss prior to 1 month of age (Output)	2017	98%	March 31, 2018
	2016	98%	March 31, 2018
	2015	98%	March 31, 2017
	2014	98%	March 31, 2016
	2013	98%	86% (Target Not Met)
	2012	98%	86% (Target Not Met)
	2011	98%	98% (Target Met)

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

Measure	Data Source	Data Validation
13.1 13.2 13.III.A.1 13.III.A.3	For FY 2006 and beyond, data are obtained from the CDC Hearing Screening and Follow-up Survey.	For 2006 and subsequent years, data are validated by CDC through ongoing communications with States.

EMERGENCY MEDICAL SERVICES FOR CHILDREN

INTRODUCTION

The Emergency Medical Services for Children (EMS-C) Program, established in 1984, is the only Federal program that focuses specifically on improving the pediatric components of the emergency medical services (EMS) system. The Institute of Medicine (IOM) and other national experts have stated that there are significant gaps across the country in providing quality care to children in emergencies. Pediatric emergency care begins with the 911 call through the delivery of the patient to the appropriate hospital and the return of the child to the community. The mission of the EMS-C program is to reduce child and youth mortality and morbidity resulting from severe illness or trauma.

The EMS-C Program currently funds 75 grants to support improvements to pediatric emergency care within 49 states, all territories, the Republics of the Marshall Islands and Palau, and the Federated States of Micronesia. By having a presence across the United States, the program aims to reach its goal of ensuring that all children receive optimal emergency care no matter where they are. Each of these entities works to implement the same prehospital and hospital quality performance measures, representing the largest national effort for standardized pediatric emergency care. The program provides state infrastructure support to address the ongoing variability in care due to geographical, jurisdictional and workforce issues as well as evolving best practices. To improve the quality of pediatric emergency care, the EMS-C Program continues to invest in initiatives that promote evidence-based or evidence-informed pediatric emergency care practices.

The EMS-C Program allocates funds through competitive grants and cooperative agreements to state governments and schools of medicine which are divided into five categories: infrastructure, systems of care, research, innovative best-practices, and data support. The types of grants and cooperative agreements include:

- **State Partnership grants** (states, territories and the Freely Associated States) (58 awards) provide infrastructure funding to ensure quality pediatric care in the prehospital and hospital setting as assessed by program performance measures.
- **State Partnership Regionalization of Care (SPROC) demonstration grants** (4 awards) focus on improved access to pediatric emergency care by developing model systems of care to improve pediatric emergency care capacity in rural and tribal communities.
- **Pediatric Emergency Care Applied Research Network (PECARN) grants** (6 awards) conduct meaningful and rigorous multi-institutional studies in the management of acute illness and injury in children across the continuum of emergency medicine.
- **Targeted Issues grants** (5 awards) address cross-cutting issues of pediatric emergency care.
- **EMS-C Innovation and Improvement Center (EIIC) grant** (1 award) supports the implementation of best-practices at the state and local level through quality improvement strategies.
- **EMS-C Data Center grant** (1 award) supports data collection, coordination and analysis for the state partnership performance measures and the research network.

Goal: Improve Access to Quality Health Care and Services

Objective: Improve the quality and efficacy of the health care safety net

Measure	FY	Target	Result
<u>14.1.A:</u> Percent reduction in mortality rate for children with an injury severity score (greater than 15) <i>(Outcome)</i>	2017	Annual 0.5% reduction from prior year	July 31, 2020
	2016	Annual 0.5% reduction from prior year	July 31, 2019
	2015	Annual 0.5% reduction from prior year	July 31, 2018
	2014	Annual 0.5% reduction from prior year	Jul 31, 2017
	2013	Annual 0.5% reduction from prior year	Jul 31, 2016
	2012	Annual 0.5% reduction from prior year	16.4% decrease (Target Met)
	2011	Annual 0.5% reduction from prior year	14.6% increase (Target Not Met)
<u>14.V.B.4A:</u> Number of awardees that have made significant progress in implementing a pediatric recognition system for hospitals capable of dealing with pediatric medical emergencies. <i>(Output)</i>	2017	27	July 31, 2019
	2016	27	July 31, 2018
	2015	26	July 31, 2017
	2014	26	25 (Target not Met)
	2013	16	25 (Target Exceeded)
	2012	15	25 (Target Exceeded)
<u>14.V.B.4B:</u> Number of awardees that have made significant progress in implementing a pediatric recognition system for hospitals capable of dealing with pediatric traumatic emergencies. <i>(Output)</i>	2017	44	July 31, 2019
	2016	44	July 31, 2018
	2015	44	July 31, 2017
	2014	46	43 (Target Not Met)
	2013	46	43 (Target Not Met)
	2012	45	48 (Target Exceeded)
<u>14.V.B.5:</u> Number of EMS agencies in the state/territory that have a designated individual who coordinates pediatric emergency care. <i>(Output)</i> <i>(Developmental)</i>		N/A	N/A
<u>14.V.B.6:</u> Number of EMS agencies that monitor EMS provider skill retention and performance in the use of pediatric equipment. <i>(Output)</i> <i>(Developmental)</i>		N/A	N/A

Measure	Data Source	Data Validation
14.1.A	The 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. Data was recently collected between 3/1/2013 to 2/28/2014. This data will be analyzed and reported in July 2014 by the EMSC grantees through the HRSA Electronic Handbook. Thus a change in this measure cannot be demonstrated until July 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 reviewed by project officers.
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

Healthy Start (HS) reaches out to pregnant women and new parents, provides them information and support to ensure a healthy pregnancy, and connects them with the health care and other resources they need to nurture their children. HS services begin in preconception and follow the woman and child for two years after the end of the pregnancy. HS aims to reduce disparities in access to and use of health services, to improve the quality of the local health care system, to empower women and their families, and to increase consumer and community participation in health care decisions. HS targets communities with infant mortality rates that are at least 1½ times the U.S. national average, other negative perinatal outcomes (such as low birth weight, preterm delivery, maternal morbidity and mortality), and/or high indicators of poor perinatal outcomes (such as poverty, education, access to care, and other socioeconomic factors), particularly among non-Hispanic Black and other disproportionately affected populations.

The Healthy Start program service delivery model includes the entire family in order to achieve better health outcomes. The program enrolls women and their families at various stages of pregnancy, including pre-conception, inter-conception, and post-conception. Each family enrolling in HS, regardless of the site, receives a standardized, comprehensive assessment that considers health and behavioral health, employment, housing, domestic violence risks, and more. Understanding all aspects of family needs helps provide targeted and appropriate services. Services provided include:

- Health Care Services, including prenatal, postpartum, well-baby, adolescent care, family planning, and women's health;
- Enabling Services, including case management, outreach, home visiting, adolescent pregnancy prevention, childbirth education, parenting skill-building, youth self-esteem building, transportation, translation, child care, breastfeeding and nutrition education, father support, housing assistance, job training, and prison/jail services;
- Public Health Services, including immunization and health education; and
- Provider training

Healthy Start provides community level grants to support three levels of service. The most basic, Level 1, is the Community-Based Healthy Start Program that implements the five HS approaches for the clients it serves. Level 2, the Enhanced Services Healthy Start Program, goes beyond its clients to serve as a leader in the community in achieving program objectives and measuring performance through Fetal and Infant Mortality Reviews, Perinatal Periods of Risk, and/or Maternal Morbidity and Mortality Reviews. Level 3, the Leadership and Mentoring Healthy Start Program, provides mentoring to other HS sites and coordinates, within its community, all of the organizations providing MCH services to ensure continuity and avoid duplication of efforts.

Goal: Improve Health Equity

Objective: Reduce disparities in access and quality of care, and improve health outcomes across populations and communities

Measure	FY	Target	Result
12.1: The infant mortality rate (IMR) per 1,000 live births among Healthy Start program clients ¹ (Baseline – FY 2004: 7.65 per 1,000) (Outcome)	Out-Year Target	4.3 per 1,000 (FY 2013)	5.48 per 1,000 live births (Target Not Met)

Goal: Improve Health Equity

Objective: Inform program improvement efforts by assessing the effectiveness of HRSA programs in addressing health disparities

Measure	FY	Target	Result
12.III.A.1: Increase annually the percentage of women participating in Healthy Start who have a prenatal care visit in the first trimester (Outcome)	2017	75%	Oct. 31, 2019
	2016	75%	Oct. 31, 2018
	2015	75%	Oct. 31, 2017
	2014	75%	Oct. 31, 2016
	2013	75%	76% (Target Exceeded)
	2012	75%	75% (Target Met)
	2011	75%	75% (Target Met)
12.III.A.2: Percent of singleton births weighing less than 2,500 grams (low birth weight) (Outcome)	2017	9.6%	Oct. 31, 2019
	2016	9.6%	Oct. 31, 2018
	2015	9.6%	Oct. 31, 2017
	2014	9.6%	Oct. 31, 2016
	2013	9.6%	10% (Target Not Met)
	2012	9.6%	10% (Target Not Met)
	2011	9.6%	9.8% (Target Not Met but Improved)
Efficiency Measure	FY	Target	Result
12.E: Increase the number of persons served by the Healthy Start program with a (relatively) constant level of funding (Efficiency)	2017	550,000	Oct. 31, 2019
	2016	550,000	Oct. 31, 2018
	2015	445,259	Oct. 31, 2017
	2014	466,259	Oct. 31, 2016
	2013	547,317	442,223 (Target Not Met)
	2012	532,500	419,126 (Target Not Met)
	2011	524,500	548,450 (Target exceeded)

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

Measure	Data Source	Data Validation
12.1 12.III.A.1 12.III.A.2 12.E	Grantee reports.	Data reviewed by Federal Project Officers.

FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS

INTRODUCTION

The Family-to-Family Health Information Centers (F2F HICs) Program, as reauthorized through the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (P.L. 114-10, Sec. 216), funds family-staffed and family-run centers in the 50 states and the District of Columbia. The F2F HICs provide information, education, technical assistance, and peer support to families of children (including youth) with special health care needs (CSHCN) and health professionals who serve such families. They also assist in ensuring that families and health professionals are partners in decision making at all levels of care and service delivery.

In FYs 2011-2015, the F2F HICs in the 50 states and the District of Columbia received funding to:

- Assist families of CSHCN to make informed choices about healthcare in order to promote good treatment decisions, cost effectiveness, and improved health outcomes;
- Provide information regarding the healthcare needs of and resources available for CSHCN;
- Identify successful health delivery models;
- Develop models for collaboration between families of CSHCN and health professionals, including representatives of healthcare providers, managed care organizations, healthcare purchasers, and appropriate state agencies;
- Provide training and guidance regarding the care of CSHCN;
- Conduct outreach activities to families, health professionals, schools, and other appropriate entities; and
- Enlist families of CSHCN, who have expertise in federal and state public and private healthcare systems, and health professionals to staff these efforts.

Currently, 51 F2F HICs are collecting data on the issues facing families in areas such as service needs, the financing of those services, and communicating the needs of the families of CSHCN with community and state agencies, including Medicaid, Department of Education, and Title V. In addition to serving on state-appointed task forces and committees, F2F HICs are disseminating information to families and health professionals on new legislation such as the Medicare Access and CHIP Reauthorization Act of 2015 and its impact on their respective states. They help families understand the new provisions and how they affect individual access to coverage. The F2F HICs disseminate information via fact sheets, social media, newsletters and listservs. In addition, they assist HRSA-funded federally qualified health centers (FQHCs), children's hospitals, and pediatric practices across the nation to implement medical/health homes by providing training and educational materials to families and health professionals.

Goal: Improve Access to Quality Health Care and Services

Objective: Improve the quality and efficacy of the health care safety net

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)	2017	166,000	September 30, 2017
	2016	151,000	September 30, 2016
	2015	137,000	155,950 (Target Exceeded)
	2014	124,000	178,539 (Target Exceeded)
	2013	124,000	140,151 (Target Exceeded)
	2012	123,000	147,280 (Target Exceeded)
	2011	122,000	146,813 (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)	2017	94%	September 30, 2017
	2016	92%	September 30, 2016
	2015	90%	98% (Target Exceeded)
	2014	87%	96% (Target Exceeded)
	2013	87%	91% (Target Exceeded)
	2012	85%	94% (Target Exceeded)
	2011	83%	86% (Target Exceeded)

Measure	Data Source	Data Validation
15.III.C.1	MCHB Discretionary Grants Information System, annual progress/continuation reports submitted by grantees and 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 the National Center for Family/Professional Partnerships.	The National Center for Family/Professional Partnerships, which follows up with grantees when data corrections are needed.

MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAM

INTRODUCTION

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV, The Federal Home Visiting Program) program links to the HRSA goal of improving health equity. The program was first authorized by section 2951 of the Patient Protection and Affordable Care Act of 2010 which amended Title V of the Social Security Act, section 511, to include the Maternal Infant and Early Childhood Home Visiting Program. The Federal Home Visiting Program was reauthorized under Medicare Access and Chip Reauthorization Act through September 30, 2017 with appropriations of \$400 million for each of the 2016 and 2017 fiscal years.

Administered by HRSA in partnership with the Administration for Children and Families (ACF), the Program supports voluntary, evidence-based home visiting services during pregnancy and to parents with young children up to kindergarten entry. Fifty states and six jurisdictions (the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa) and Indian Tribes, Tribal Organizations, and Urban Indian Organizations are eligible to receive funding through the Federal Home Visiting Program and have the flexibility to tailor the program to serve the specific needs of their communities. States and tribal entities are required to direct their home visiting efforts to at-risk communities.

HRSA and ACF regard home visiting as one of several service strategies embedded in a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development as well as strong parent-child relationships. By equipping parents with the skills they need to support the cognitive, socio-emotional and physical health and development of their children, the program works as part of a prenatal to kindergarten entry continuum with the other parts of the President's Early Learning Initiative.

The Home Visiting Program builds upon decades of scientific research, which shows that home visits improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness. Research shows that home visiting provides a positive return on investment to society through savings in public expenditures on things like emergency room visits, public benefits, child protective services, as well as increased tax revenues from parents' earnings.

Goal: Improve Health Equity

Objective: Advance evidence-based, evidence-informed, and innovative practices that have the potential to reduce health disparities

Measure	FY	Target	Result
37.I: Number of home visits to families receiving services under the MIECHV program ¹ (Output)	2017	912,000	Dec. 31, 2017
	2016	912,000	Dec. 31, 2016
	2015	805,000	912,119 (Target Exceeded)
	2014	450,000	746,000 ²
	2013	404,280	494,310
	2012	N/A	169,139
	2011	N/A	N/A
37.II: Number and percent of grantees that meet benchmark area-related data requirements for demonstrating improvement (Outcome)	2017	53 (98%)	Dec. 31, 2017
	2016	53 (98%)	Dec. 31, 2016
	2015	45 (80%)	52 (98%) (Baseline)
	2014	N/A ³	N/A
	2013	N/A	N/A
	2012	N/A	N/A
	2011	N/A	N/A
37.3 Number of participants served by the Home Visiting Program	2017	145,000	Dec. 31, 2017
	2016	145,000	Dec. 31, 2016
	2015	125,000	145,561 (Target Exceeded)
	2014	NA	115,545
	2013	N/A	N/A
	2012	N/A	N/A
	2011	N/A	N/A

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

¹ 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 Home Visiting program.

² Information includes data (as of September 30, 2014) for the state/territory MIECHV program. Tribal data for 2014 will be available in the first quarter of 2015.

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

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 (RWHAP) 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 RWHAP, the largest Federal program focused exclusively on domestic HIV/AIDS care, the RWHAP provides services that are intended to 1) reduce the use of more costly inpatient care; 2) increase access to care for underserved populations; and 3) improve the quality of life for PLWH. Recent studies have demonstrated that individuals with HIV on antiretroviral medications who achieve viral load suppression are less likely to transmit HIV to others, reducing the chance of other Americans becoming infected. The Ryan White HIV/AIDS Program coordinates with cities, states, and local community-based organizations to deliver a comprehensive system of HIV care, treatment and support that is critical to ensuring that individuals with HIV are linked to and retained in care, able to adhere to their medication regimens, and ultimately, remain virally suppressed. This has important implications for both individual health outcomes as well as a significant public health impact on HIV incidence.

The RWHAP'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.

Performance measure information is used by the program to identify potential policy issues, to share best practices, to provide 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 RWHAP uses various strategies to achieve the performance goals including targeting resources to address the unmet care and treatment needs of PLWH who are uninsured or underinsured; 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 RWHAP collaborates with other Federal, State and local providers who conduct HIV testing and encourages them to refer clients who test positive to RWHAP-funded programs for treatment.

Several cross-cutting long-term and annual measures have been identified to use in assessing the RWHAP’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.

Goal: Improve Health Equity

Objective: Reduce disparities in access and quality of care, and improve health outcomes across populations and communities.

Measure	FY	Target	Result
<u>16.1</u> : Number of racial/ethnic minorities and the number of women served by Ryan White HIV/AIDS-funded programs. ¹ (Long-term Outcome)	<i>Out-Year Target</i>	FY 2005 Baseline: 412,000 racial/ethnic minorities 195,000 women	Oct 31, 2016
<u>16.IA.1</u> : Proportion of persons served by the Ryan White HIV/AIDS Program who are racial/ethnic minorities. (Outcome)	2017	Within 3 percentage points of CDC data	Oct. 31, 2019
	2016	Within 3 percentage points of CDC data	Oct. 31, 2018
	2015	Within 3 percentage points of CDC data ²	Oct. 31, 2017
	2014	5 percentage points above CDC data	Oct. 31, 2016
	2013	5 percentage points above CDC data (68.2%)	72.4% (Target Not Met)
	2012	5 percentage points above CDC data (67.1%) or 72.1%	72.6% (Target Exceeded)
	2011	5 percentage points above CDC data or 71.7%	72.2% (CDC – 66.7%) (Target Exceeded)

¹ This long-term measure does not have annual targets. FY 2014 is the long-term target year. The FY 2014 target is 422/199,875. Next long-term target will be set for 2019.

² This is a new FY 2015 target “Within 3 percentage points of CDC data” and it will be reported using national HIV/AIDS prevalence data provided to HRSA by CDC rather than previous target through FY 2014 of “5 percentage points above CDC data” as reported by national AIDS prevalence data reported in CDC’s HIV Surveillance Report. HAB will report on this measure using the “5 percentage points above CDC data” as reported by national AIDS prevalence data from CDC’s HIV Surveillance Report through FY 2014. The FY 2014 data from HABs RSR will be available in October 2015 and the CDC comparison data from the HIV Surveillance Report may be available around July 2016.

Measure	FY	Target	Result
<u>16.I.A.2:</u> Proportion of persons served by the Ryan White HIV/AIDS Program who are women. (Outcome)	2017	Within 3 percentage points of CDC data	Oct. 31, 2019
	2016	Within 3 percentage points of CDC data	Oct. 31, 2018
	2015	Within 3 percentage points of CDC data ³	Oct. 31, 2017
	2014	5 percentage points above CDC data	Oct. 31, 2016
	2013	5 percentage points above CDC data (24.2%)	27.8% (Target Not Met)
	2012	5 percentage points above CDC data (24.7%) or 29.7%	29.1% (Target Not Met)
	2011	5 percentage points above CDC data (24.8%) or 29.8%	30.1% (Target Exceeded)
<u>16.III.A.3:</u> Proportion of HIV infected Ryan White HIV/AIDS Program clients that received medical care who were tested for viral load. (Outcome)	2017	84.3%	Aug. 31, 2019
	2016	84.3%	Aug. 31, 2018
	2015	84.3%	Aug. 31, 2017
	2014	84.3%	Aug. 31, 2016
	2013	84.3%	94% (Target Exceeded)

³ This is a new FY 2015 target “Within 3 percentage points of CDC data” and it will be reported using national HIV/AIDS prevalence data provided to HRSA by CDC rather than previous target through FY 2014 of “5 percentage points above CDC data” as reported by national AIDS prevalence data reported in CDC’s HIV Surveillance Report. HAB will report on this measure using the “5 percentage points above CDC data” as reported by national AIDS prevalence data from CDC’s HIV Surveillance Report through FY 2014. The FY 2014 data from HABs RSR will be available in October 2015 and the CDC comparison data from the HIV Surveillance Report may be available around July 2016.

Goal: Improve Access to Quality Health Care and Services

Objective: Increase the capacity and strength of the healthcare safety net.

Measure	FY	Target	Result
16.II.A.1: Number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs annually. <i>(Output)</i>	2017	206,305	Apr 31, 2019
	2016	212,107	Apr 31, 2018
	2015	212,107	Apr 31, 2017
	2014	211,988	Apr 31, 2016
	2013	236,230	264,955 (Target Exceeded)
	2012	217,324	244,436 (Target Exceeded)
	2011	208,836 ⁴	211,037 (Target Exceeded)
16.II.A.2: Number of persons who learn their serostatus from Ryan White HIV/AIDS Programs. <i>(Output)</i>	2017	676,003	May 28, 2019
	2016	676,003	May 28, 2018
	2015	676,003	May 28, 2017
	2014	679,531	May 28, 2016
	2013	877,525	787,663 (Target Not Met But Improved)
	2012	872,565	657,596 (Target Not Met)
	2011	583,730	679,531 (Target Exceeded)
16.II.A.3: Percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive anti-retroviral medications. <i>(Output)</i>	2017	90%	Jul 28, 2019
	2016	90%	Jul 28, 2018
	2015	90%	Jul 28, 2017
	2014	90%	Jul 28, 2016
	2013	90%	95% (Target Exceed)
	2012	90%	95.6% (Target Exceeded)
	2011	90%	92.3% (Target Exceeded)

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

Goal: Improve Access to Quality Health Care and Services

Objective: Increase the capacity and strength of the healthcare safety net.

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. <i>(Output)</i>	2017	95.7%	Aug 31, 2019
	2016	95.7%	Aug 31, 2018
	2015	95.7%	Aug 31, 2017
	2014	95.7%	Aug 31, 2016
	2013	95.7%	99.2% (Target Exceeded)
	2012	95.7%	96.8% ⁵ (Target Exceeded)
	2011	95.7%	95.7% (Target Met)
Efficiency Measure	FY	Target	Result
16.E: Amount of savings by State ADAPs' participation in cost-savings strategies on medications. <i>(Efficiency)</i>	2017	Sustain FY 2016 results	Apr 30, 2019
	2016	Sustain FY 2015 results	Apr 30, 2018
	2015	Sustain FY 2014 results	Apr 30, 2017
	2014	Sustain FY 2013 results	Apr 30, 2016
	2013	\$989.8 M	896.0M (Target Not Met)
	2012	\$616.1 M	\$989.8 M (Target Exceeded)
	2011	\$551.2 M	\$616.1 M (Target Exceeded)

⁵ The results differ from that shown in the FY 2015 CJ due to data corrections.

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.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.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.
16.II.A.1 16.E	ADAP Quarterly Report data provided by State ADAPs	Web-based data checked through a series of internal consistency/validity checks. Also HIV/AIDS program staff review submitted Quarterly reports, and provide technical assistance on data-related issues.

HIV EMERGENCY RELIEF GRANTS (PART A)

INTRODUCTION

Funds for Part A of the Ryan White HIV/AIDS Program are used to provide a continuum of care for PLWH 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. The grants fund systems of care to provide 13 core medical services and additional support services for PLWH in 24 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).

Goal: Improve Access to Quality Health Care and Services

Objective: Increase the capacity and strength of the healthcare safety net.

Measure	FY	Target	Result
17.I.A.1: Number of visits for health-related care (primary medical, oral health, mental health, substance abuse, home health, and home and community based services). <i>(Output)</i>	2017	1.91 M	May 31, 2019
	2016	1.963M	May 31, 2018
	2015	1.963 M	May 31, 2017
	2014	1.994 M	May 31, 2016
	2013	2.63 M	1.91 M (Target Not Met)
	2012	2.63 M	2.28 M (Target Not Met but Improved)
	2011	2.63 M	1.994 M (Target Not Met)

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 PLWH, including outpatient ambulatory medical care, HIV-related prescription medications, case management, oral health care, health insurance premium and cost-sharing assistance, mental health and substance abuse services, and support services.

Part B includes the AIDS Drug Assistance Program (ADAP), which supports the provision of HIV medications and related services, including health insurance premium and cost-sharing assistance. 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

Objective: Increase the capacity and strength of the healthcare safety net.

Measure	FY	Target	Result
18.I.A.1: Number of visits for health-related care (primary medical; oral health; mental health; substance abuse; home health; and home and community based services). <i>Output)</i>	2017	1.51 M	May 31, 2019
	2016	1.80 M	May 31, 2018
	2015	1.63 M	May 31, 2017
	2014	2.19 M	May 31, 2016
	2013	2.27 M	1.49 M (Target Not Met)
	2012	2.19 M	2.04 M (Target Not Met but Improved)
	2011	2.19 M	1.086 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. 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.
18.I.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 EARLY INTERVENTION SERVICES (PART C)

INTRODUCTION

Part C of the Ryan White HIV/AIDS Program provides direct grants to 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 PLWH 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. Part C programs have the cultural competency and expertise to provide care to those underserved and vulnerable populations.

Goal: Build Healthy Communities

Objective: Improve population health through the use of community partnerships and collaboration with stakeholders.

Measure	FY	Target	Result
19.II.A.2: Number of people receiving primary care services under Early Intervention Services programs. (Output)	2017	1.46 M	May 31, 2019
	2016	1.45 M	May 31, 2018
	2015	N/A	N/A
	2013	N/A	1.68 M
	2012	Baseline	1.6 M
Retired Measure⁷⁴	2017	N/A	N/A
19.II.A.1: Number of people receiving primary care services under Early Intervention Services programs. (Output)-	2016	N/A	N/A
	2015	312,807	May 31, 2017
	2014	268,877	May 31, 2016
	2013	265,325	292,653 (Target Exceeded)
	2012	257,053	288,347 (Target Exceeded)
	2011	255,429	256,347 (Target Exceeded)

⁷⁴ This measure will be retired given the Part C and Part D consolidation. HAB will report on this measure through FY 2015. The FY 2015 data will be available in in May 2017.

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

Objective: Improve population health through the use of community partnerships and collaboration with stakeholders.

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. ⁷⁵ (Output)	2017	N/A	N/A
	2016	N/A ⁷⁶	N/A
	2015	66,672	May 31, 2017
	2014	52,790	May 31, 2016
	2013	49,802	60,777 (Target Exceeded)
	2012	53,753	66,672 (Target Exceeded)
	2011	55,355	60,621 (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.

⁷⁵ Female clients counted are age 13 and above

⁷⁶ The FY 2016 Budget proposes to consolidate funds from Part D to Part C. The Part C program will emphasize care across all vulnerable populations, genders, and ages, thus assuring services to women, infants, children, and youth throughout the program. By consolidating the two programs, resources can be better targeted to points along the care continuum and populations most in need throughout the country among an increased number of grantees.

AIDS EDUCATION AND TRAINING CENTERS (PART F)

INTRODUCTION

The AIDS Education and Training Centers (AETCs) – a network of 11 regional centers with more than 100 local performance sites, three National Centers (AETC National Resource Center, AETC National Evaluation Center, AETC National HIV/AIDS Clinical Consultation Center); nine Telehealth Training Centers; three Graduate Medical Education (GME) projects; and five Nurse Practitioner/Physician Assistant (NP/PA) projects. AETCs 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 care and more willing to treat PLWH 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 provides 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

Objective: Increase the diversity and distribution of the health workforce and the ability of providers to serve underserved populations in areas.

Measure	FY	Target	Result
21.V.B.1: Proportion of AETC training intervention participants that are racial/ethnic minorities. (Output)	2017	43%	Nov 30, 2019
	2016	43%	Jan 30, 2019
	2015	43%	Jan 30, 2018
	2014	43%	Jan 30, 2017
	2013	43%	45.3% (Target Exceeded)
	2012	43%	44.5% (Target Exceeded)
	2011	43%	43.4% (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 (DRP) provides access to oral health for PLWH 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 DRP improves access to oral health care for PLWH and provides training to 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 PLWH 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

Objective: Increase the capacity and strength of the healthcare safety net.

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)	2017	39,138	Apr 30, 2018
	2016	39,810	Apr 30, 2017
	2015	39,810	Apr 30, 2016
	2014	33,316	39,138 (Target Exceeded)
	2013	33,316	41,464 (Target Exceeded)
	2012	33,316	39,810 (Target Exceeded)
	2011	34,240	37,194 (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

ORGAN TRANSPLANTATION

INTRODUCTION

The Organ Transplantation Program (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.

Goal: Improve Access to quality health care and services

Objective: Increase the capacity and strength of the healthcare safety net.

Measure	FY	Target	Result
<u>23.II.A.1:</u> Increase the annual number of deceased donor organs transplanted <i>(Outcome)</i>	2017	26,202	May 30, 2018
	2016	25,796	May 30, 2017
	2015	25,400	May 30, 2016
	2014	25,014	26,046 (Target Exceeded)
	2013	24,638	25,435 (Target Exceeded)
	2012	31,979	24,557 (Target Not Met)
	2011	30,515	24,973 (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>	2017	4,644	Aug. 30, 2018
	2016	4,572	Aug. 30, 2017
	2015	4,502	Aug. 30, 2016
	2014	4,433	3,466 (Target Not Met)
	2013	4,367	3,518 (Target Not Met)
	2012	6,928	3,709 (Target Not Met)
	2011	6,565	4,069 (Target Not Met)

Measure	FY	Target	Result
<u>23.II.A.8</u> : Increase the annual conversion rate of eligible donors	2017	74.00%	May 30, 2018
	2016	73.75%	May 30, 2017
	2015	73.5%	May 30, 2016
	2014	73.25%	72.60% (Target Not Met)
	2013	73.00%	71.0% (Target Not Met)
	2012	72.9%	72.6% (Target Not Met)
	2011	70.8%	72.71% (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 (OPOs) 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 Reauthorization 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 transplantation for patients in need of these lifesaving 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 contractors' strategic and operational plans with the Program's standards; quarterly reporting and reviews by HRSA of the contractors' performance against the standards; development of a process to improve donor searches; progressive contractor negotiations of cost reductions in subcontracts for laboratory 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

Objective: Increase the capacity and strength of the healthcare safety net.

Measure	FY	Target	Result
<u>24.II.A.2:</u> Increase the number of adult volunteer potential donors of blood stem cells from minority races and ethnic groups (<i>Outcome</i>)	2017	3.74 Million	Dec. 31, 2017
	2016	3.49 Million	Dec. 31, 2016
	2015	3.26 Million	3.35 Million (Target Exceeded)
	2014	3.18 Million	3.25 Million (Target Exceeded)
	2013	2.85 Million	3.05 Million (Target Exceeded)
	2012	2.66 Million	2.88 Million (Target Exceeded)
	2011	2.48 Million	2.67Million (Target Exceeded)
<u>24.1:</u> Increase the number of blood stem cell transplants facilitated annually by the Program ⁷⁷ (<i>Outcome</i>)	<i>Out-Year Target</i>	6,960 (FY 2017)	Dec. 31, 2017
	2013	5,513	6,283 (Target Exceeded)
<u>24.2:</u> Increase the number of blood stem cell transplants facilitated annually by the Program for minority patients ⁷⁸ (<i>Outcome</i>)	<i>Out-Year Target</i>	1,150 (FY 2017)	Dec. 31, 2017
	2013	845	992 (Target Exceeded)
<u>24.3:</u> Increase the rate of patient survival at one year, post-transplant ⁷⁹ (<i>Outcome</i>)	<i>Out-Year Target</i>	69% (FY 2017)	Dec. 31, 2019
	2013	69%	71% (Target Exceeded)
<u>24.4:</u> Increase the number of blood stem cell transplants facilitated by the Program for domestic patients ⁸⁰	<i>Out-Year Target</i>	4,763 (FY 2017)	Dec. 31, 2017
	2013 (<i>Baseline</i>)	N/A	3,918
<u>24.E:</u> Decrease the unit cost of human leukocyte antigen (HLA) typing of potential donors (<i>Efficiency</i>)	2017	\$58.00	Dec. 31, 2017
	2016	\$58.00	Dec. 31, 2016
	2015	\$58.00	\$58.00 (Target Met)
	2014	\$40.81	\$40.81 (Target Met)
	2013	\$40.81	\$40.81 (Target Met)
	2012	\$50.44	\$40.81 (Target Exceeded)
	2011	\$52	\$52 (Target Met)

⁷⁷ This is a long-term measure. After FY 2013, the next year for which a long-term target is set is FY 2017. The FY 2017 target is 6,960.

⁷⁸ This is a long-term measure. After FY 2013, the next year for which long-term target is set is FY 2017. The FY 2017 target is 1,150.

⁷⁹ This is a long-term measure. After FY 2013, the next year for which long-term targets are set is FY 2017. The FY 2017 target remains at 69%.

⁸⁰ This is a new long-term measure. The first year for which long-term targets are set is FY 2017. The 2017 target is 5,135.

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 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 Medical College of Wisconsin's Center for International Blood and Marrow Transplant Research (CIBMTR) pertaining to the outcomes of patient transplants at different time points (date of engraftment, 100 days, 6 months, and annually thereafter).	Validated by the Medical College of Wisconsin's Center for International Blood and Marrow Transplant Research (CIBMTR) and National Marrow Donor Program through computerized and 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 objective 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

Objective: Improve the quality and efficacy of the healthcare safety net.

Measure	FY	Target	Result
25.III.D.3: Increase percent of inbound volume on the toll-free number. (Output)	2017	83%	Oct. 31, 2017
	2016	83%	Oct. 31, 2016
	2015	83%	84.8% (Target Exceeded)
	2014	75%	83.7% (Target Exceeded)
	2013	73.7%	85.6% (Target Exceeded)
	2012	73.7%	83.7% (Target Exceeded)
	2011	73.7%	81% (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. ⁸¹ (FY 2006 Baseline: 19%) (Outcome)	<i>Out-Year Target</i>	25% (FY 2016)	Feb. 15, 2017
	2012	N/A	25%

⁸¹ 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.

Measure	FY	Target	Result
<u>25.III.D.5</u> : Percent of human poison exposure calls made to PCCs that were managed by poison centers outside of a health care facility. (Output)	2017	71%	Jan. 30, 2019
	2016	71%	Jan. 30, 2018
	2015	71%	Jan. 30, 2017
	2014	71%	68.1%
	2013	71%	71.8%
	2012	N/A	69.2%
	2011	N/A	69.9%

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.

NATIONAL HANSEN’S DISEASE PROGRAM

INTRODUCTION

The National Hansen’s Disease Program is the only dedicated provider of Hansen’s disease treatment services in the United States and serves as a source of training and education for health professionals to improve early detection. The Program also conducts scientific research dedicated to prevention and treatment of 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 support for 16 regional outpatient clinics that focus on case management and patient compliance and 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

Objective: Improve the quality and efficacy of the healthcare safety net.

Measure	FY	Target	Result
3.II.A.2.: Number of healthcare providers who have received training from NHDP <i>(Output)</i>	2017	550	Nov. 30, 2017
	2016	550	Nov. 30, 2016
	2015	150	448 Target was not in place
	2014	150	358 (Target Exceeded)
	2013	150	259 (Target Exceeded)
	2012	150	202 (Target Exceeded)
	2011	150	556 (Target Exceeded)
3.II.A.1: Percent increase in the level of Hansen’s Disease related disability and deformity among patients treated and managed by the National Hansen’s Disease Program (NHDP) (percentage of patients at grades 1 and 2) <i>(Outcome)</i>	2017	50%	Nov. 30, 2019
	2016	50%	Nov. 30, 2018
	2015	50%	Nov. 30, 2017
	2014	50%	Nov. 30, 2016
	2013	50%	25% (Target Exceeded)
	2012	50%	36% (Target Exceeded)
	2011	50%	40% (Target Exceeded)

Efficiency Measure	FY	Target	Result
3.E: Maintain increases in the cost per patient served in the outpatient clinics to below the medical inflation rate (Efficiency)	2017	Below national medical inflation rate	March 31, 2018
	2016	Below national medical inflation rate	March 31, 2017
	2015	Below national medical inflation rate	March 31, 2016
	2014	Below national medical inflation rate 3.84%	-3.5% (Target Met)
	2013	Below national medical inflation rate 4.5%	-7.9% (Target Met)
	2012	Below national medical inflation rate 3.4%	-4.0% (Target Met)
	2011	Below national medical inflation rate (4.1%)	-7.4 % (Target Not Met)

Measure	Data Source	Data Validation
3.E	Fiscal year budget allocations and expenditures, Ambulatory Care Program database, and NHDP records. National Medical Inflation Rate obtained from Centers for Medicare & Medicaid Services.	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.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.

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 Federal Office of Rural Health Policy (FORHP) serves as a focal point for rural health activities within the Department of Health and Human Services (HHS). The Office is specifically charged with advising on rural policy issues, conducting and overseeing policy-relevant research on rural health issues, and administering grant programs that focus on supporting and enhancing health care delivery in rural communities.

FORHP is charged in Section 711 of the Social Security Act with advising the Secretary on the effects of current policies and proposed statutory, regulatory, administrative, and budgetary changes in the programs established under titles XVIII and XIX (Medicare and Medicaid) on the financial viability of small rural hospitals, the ability of rural areas (and rural hospitals in particular) to attract and retain physicians and other health professionals, and access to (and the quality of) health care in rural areas.

The Office is also charged with overseeing compliance with the requirements of section 1102(b) of the Social Security Act to assess the impact of key regulations affecting a substantial number of small rural hospitals. In addition, FORHP maintains a clearinghouse for collecting and disseminating information on rural health care issues, promising approaches to improving and enhancing health care delivery in rural communities and maintaining research findings relating to rural health care.

While located within HRSA, FORHP is statutorily charged with coordinating the activities within the Department that relate to rural health care and providing information to the Secretary and others in the Department with respect to the activities, of other Federal departments and agencies, that relate to rural health care. In addition to its policy role, FORHP also administers a range of grant programs focusing on capacity building and enhancing health care delivery at the community and state levels as well as programs aimed at leveraging the use of health information technology and telehealth to enhance access to and the quality of health care services in rural and underserved areas.

FORHP's goals and objectives support HRSA's Strategic Plan Goal 1 to improve access to quality health care and services and objectives to increase the capacity and strength of the healthcare safety net and improve the quality and efficacy of the healthcare safety net.. 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, goals, and outcomes are clear and focus the attention of grantees on performance improvement and efficiency.

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

Goal: Improve Access to Quality Health Care and Services

Objectives: Increase the capacity and strength of the healthcare safety net.
 Improve the quality and efficacy of the healthcare safety net.

Measure	FY	Target	Result
27.1: Reduce the proportion of rural residents of all ages with limitation of activities caused by chronic conditions. ¹ (Baseline – FY 2000: 14.67%) (Outcome)	<i>Out-Year Target</i>	13% (FY 2013)	Oct. 31, 2016
	2010	13.9%	14.2% (Target Not Met)
27.IV.A.3: Increase the number of people receiving direct services through FORHP Outreach Grants. (Outcome)	2017	415,000	Oct. 31, 2018
	2016	410,000	Oct. 31, 2017
	2015	405,000	Oct. 31, 2016
	2014	400,000	820,176 (Target exceeded)
	2013	395,000	703,070 (Target Exceeded)
	2012	390,000	747,952 (Target Exceeded)
	2011	385,000	615,849 (Target Exceeded)

Goal: Improve Access to Quality Health Care and Services

Objective: Increase the capacity and strength of the healthcare safety net.

Measure	FY	Target	Result
27.2: Increase the proportion of critical access hospitals with positive operating margins. ² (Baseline – FY 1999: 10%) (Outcome)	<i>Out-Year Target</i>	60% (FY 2013)	54.9%

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	Medicare Cost Reports	Validated by Centers for Medicare and Medicaid Services

¹ 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.

² This is a long-term measure with FY 2013 as a long-term target date.

RURAL HEALTH POLICY DEVELOPMENT

INTRODUCTION

Rural Health Policy Development activities support a range of policy analysis, research, information dissemination and technical assistance. The Federal Office of Rural Health Policy (FORHP) 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. FORHP is also charged with supporting information dissemination and the operation of a clearinghouse on national rural health initiatives.

The FORHP Rural Health Research Center Grant Program is a major component of Rural Health Policy Development activities. Eight Centers are currently funded, including a new Center with an area of concentration on rural telehealth and telemedicine policy. The Research Center Program 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 (disseminated through a website supported by ORHP), 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 support two 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 activities also play an important role in serving as a broker of information on rural health issues through a cooperative agreement with the Rural Health Information Hub (RHIfhub, formerly the Rural Assistance Center). In keeping with the statutory mandate, FORHP established the RHIfhub as a clearinghouse for anyone in need of rural health policy and program information. The RHIfhub 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

Objective: Inform program improvement efforts by assessing the effectiveness of HRSA programs in addressing health disparities.

Measure	FY	Target	Result
28.V.A.1: Conduct and disseminate policy relevant research on rural health issues. (Outcome)	2017	35	Sep. 30, 2018
	2016	35	Sep. 30, 2017
	2015	35	Sep. 30, 2016
	2014	35	57 (Target Exceeded)
	2013	35	46 (Target Exceeded)
	2012	30	46 (Target Exceeded)
	2011	30	57 (Target Exceeded)
	2010	30	48 (Target Exceeded)
	2009	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 are a key part of the Federal Office of Rural Health Policy (FORHP)'s investments in improving rural community health. The purpose of the grants is to improve access to care, coordination of care, integration of services and to focus on quality improvement. All of the grants support collaborative models to deliver basic health care services to rural areas and are uniquely designed to meet rural needs. The grant funding allows rural communities to compete for funding against other rural communities rather than having to also compete against larger metropolitan communities with greater resources. The Outreach authority programs are among the only non-categorical grants within HHS and that allows 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. Each of the programs focus on making the initial investment in a rural area with the expectation that the community will continue to provide the services at the conclusion of the grant funding.

The Outreach authority includes a range of programs designed to improve access to and coordination of health care services in rural communities. Five of these programs are part of the President's Rural Health Care Initiative" to strengthen the regional and local partnerships among rural health care providers, improve recruitment and retention of health care professionals in rural areas, and provide direct health care services. Grantees are required to demonstrate the impact of their program through outcome-focused measures. Grantees submit baseline data that is tracked throughout the project period, and implement a program that has been adapted from a promising practice or evidence-based model. The programs support innovative models that offer rural communities the tools and resources to enhance health care services and ease in the transition to health care models focusing on improved quality and value.

Sustainability continues to be a priority for the community-based programs. Each year, different programs within the Outreach authority closes out and, therefore, sustainability is assessed on those respective programs. While there is some variability in sustainability rates from one cohort of grantees to another, it is expected that the vast majority of projects will continue after Federal funding. The most recent cohort of community-based grantees that completed Federal funding is the Rural Health Care Services Outreach grant program. The FY 2014 results showed that 100 percent of the grantees continued to sustain either all or some of their programs exceeding the target of 60 percent

In addition to sustaining programs beyond the initial Federal investment, FORHP's community-based grants also have an economic benefit. Grantees use the RHI Hub's Economic Impact Analysis tool to assess the economic impact of the Federal investment. The tool translates project impacts into community-wide effects such as the number of jobs created, new spending and the impact of new and expanded services. A recent analysis of 20 Rural Health Network Workforce Development grants that completed the program in August 2013, showed that for every HRSA dollar invested, approximately \$1.63 in additional revenue was generated in the community for a total of \$19.4 million in new local economic activity derived from the original \$11.9 million HRSA investment over the 3-year period

In FY 2015, FORHP funded three pilot programs in further support of the Improving Rural Health Care Initiative. These three programs focus on allied health training, care coordination and benefits counseling. The Rural Allied Health Program, developed as a result of the Job-Driven Training Initiative, focuses on the recruitment and retention of allied health professionals. FORHP made 10 awards. The Rural Health Care Coordination Network Partnership Program, developed as a result of the White House Rural Council Public-Private Partnership, focuses on the delivery of coordinated care, and made 8 awards. The Rural Outreach Benefits Counseling Program, which focuses on outreach, education and enrollment efforts for the uninsured and newly insured, made 10 awards.

The program measures support HRSA Strategic Plan Goal 1 to improve access to quality healthcare and 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

Objectives: Increase the capacity and strength of the healthcare safety net.
 Improve the quality and efficacy of the healthcare safety net

Measure	FY	Target	Result
<u>29.IV.A.3:</u> Increase the number of people receiving direct services through FORHP Outreach Grants. ¹ (Outcome)	2017	415,000	Oct. 31, 2018
	2016	410,000	Oct. 31, 2017
	2015	405,000	Oct. 31, 2016
	2014	400,000	820,176 (Target Exceeded)
	2013	395,000	703,070 (Target Exceeded)
	2012	390,000	747,952 (Target Exceeded)
	2011	385,000	615,849 (Target Exceeded)
<u>29.IV.A.4:</u> Percent of Outreach Authority grantees that will continue to offer services after the Federal grant funding ends. ² (Outcome)	2017	75%	Oct. 31, 2018
	2016	70%	Oct. 31, 2017
	2015	65%	Oct. 31, 2016
	2014	60%	100% (Target exceeded)
	2013	60%	100% (Target Exceeded)
	2012	75%	96% (Target Exceeded)
	2011	75%	98% (Target Exceeded)
	2010		75% (Target Not in Place)
	2009		75% (Baseline)

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

¹ A new cohort of ORHP Outreach grants is awarded a 3-year project period. During the 1st year of the project period, the number of people receiving direct services through the ORHP Outreach grants tends to be lower due to program start up. The numbers generally increase throughout the project period as outreach efforts are implemented.

² The programs under the Outreach program authority have varying 3-year project periods. When sustainability data is captured at the end of a program project period, the result varies based on the program that closes out that particular project period.

RURAL HOSPITAL FLEXIBILITY GRANTS

INTRODUCTION

The Rural Hospital Flexibility activities are a component of the Federal Office of Rural Health Policy (FORHP) and support a range of activities focusing primarily on Critical Access Hospitals (CAHs). There are three grant programs administered under this authority:

- The Medicare Hospital Flexibility Program
- The Small Hospital Improvement Program
- The Flex Rural Veterans Health Access Program

The purpose of the Medicare Rural Hospital Flexibility Grant (Flex) Program is to assist states in working with Critical Access Hospitals (CAHs) on quality reporting and improvement and performance improvement activities as well as helping eligible rural hospitals convert to as CAHs status and enhancing emergency medical services related to CAHs. The ultimate goal of the program is to help CAHs maintain high-quality and economically viable facilities to ensure that residents in rural communities, and particularly Medicare beneficiaries, have access to high quality health care services. States use Flex resources to address identified needs for CAHs within the state and to achieve improved and measurable outcomes in each selected program area. The Flex funding supports a partnership between the states and FORHP to work with the more than 1,300 critical access hospitals in 45 states. The FY 2015 project period guidance reflects the continued push towards funding activities that can provide clear outcomes and demonstrated improvements.

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 Objective 1.1 Increase the capacity and strength of the healthcare safety net; and Objective 1.2 Improve the quality and efficacy of the healthcare safety net.

Goal: Improve Access to Quality Health Care and Services

Objective: Increase the capacity and strength of the healthcare safety net.

Measure	FY	Target	Result
30.V.B.4: Increase the percent of Critical Access Hospitals reporting at least one measure to Hospital Compare. (Outcome)	2017	94%	March 31, 2019
	2016	93%	March 31, 2018
	2015	90%	March 31, 2017
	2014	85%	March 31, 2016
	2013	78%	88.2% (Target Exceeded)
	2012	76%	87.3% (Target Exceeded)
	2011	74%	79.7% (Target Exceeded)
30.V.B.5: Number of individuals trained in emergency medical services leadership and/or trauma courses. (Outcome)	2017	2,995	March 31, 2019
	2016	2,995	March 31, 2018
	2015	2,995	March 31, 2017
	2014	2,995	March 31, 2016
	2013	2,995	3,396 (Target Exceeded)
	2012	3,615	5,099 (Target Exceeded)
	2011	3,615	2,368 (Target Not Met)
30.V.B.6: Increase the percent of Critical Access Hospitals participating in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.	2017	74%	March 31, 2019
	2016	72%	March 31, 2018
	2015	70%	March 31, 2017
	2014	60%	March 31, 2016
	2013	50%	59% (Target Exceeded)
	2012	N/A	49% (Target Not in Place)
	2011	N/A	41.3% (Target Not in Place)

Measure	Data Source	Data Validation
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 HEALTH¹

INTRODUCTION

This grant program provides funding to establish and maintain a State Office of Rural Health (SORH) within each state. The primary purpose of a SORH is to assist in strengthening the State’s rural health care delivery system. SORHs serve as focal point and clearinghouse for the collection and dissemination of information on rural health issues, research findings, innovative approaches and best-practices pertaining to the delivery of health care in rural areas. As the State’s rural institutional framework, SORHs help link rural communities with State and Federal resources in order to help develop long-term solutions to rural health problems. SORHs help form collaborative partnerships and relationships to better coordinate rural health activities, maximize limited resources and avoid duplication of effort and activities. In addition, SORHs identify Federal, State, and nongovernmental programs and funding opportunities, and provide technical assistance to public and nonprofit private entities regarding participation in such rural health programs². Finally, this program supports improving the recruitment and retention of health care providers in rural areas component of the initiative.

Each dollar of Federal support for the program is matched by three State dollars. The SORH Program is part of the “Improving Rural Health Initiative” to strengthen the regional and local partnerships among rural health care providers and improve recruitment and retention of health care professionals in rural areas and falls under the ‘Improve the Recruitment and Retention of Health Care Providers’ in Rural Areas component of the Initiative.

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

Objective: Increase the capacity and strength of the healthcare safety net

Measure	FY	Target	Result
31.V.B.3: Number of technical assistance (TA) encounters provided directly to clients by SORHs. (Outcome)	2017	82,549	Dec. 31, 2018
	2016	68,960	Dec. 31, 2017
	2015	68,277	Dec. 31, 2016
	2014	67,601	76,035 (Target Exceeded)
	2013	66,932	82,549 (Target Exceeded)
	2012	66,269	85,600 (Target Exceeded)
	2011	65,614	86,140 (Target Exceeded)

¹ For both the technical assistance encounters and number of clients, the decline this year is in part due to several states strengthening their data collection methodology to ensure it was in line with the instructions and not duplicating technical assistance encounters. FORHP will be providing additional support and guidance to states around instructions and measures and will move this measure to more of a maintenance-of-effort indicator.

Measure	FY	Target	Result
31.V.B.4: Number of clients (unduplicated) that received technical assistance directly from SORHs. (Outcome)	2017	26,574	Dec. 31, 2018
	2016	22,858	Dec. 31, 2017
	2015	22,632	Dec. 31, 2016
	2014	22,408	22,057 (Target Not Met)
	2013	31,134	26,574 (Target Not Met)
	2012	30,826	28,496 (Target Not Met)
	2011	30,521	25,541 (Target Not Met)
31.V.B.5: Number of clinician placements facilitated by the SORHs through their recruitment initiatives. (Outcome)	2017	1,260	June 30, 2018
	2016	1,260	June 30, 2017
	2015	1,260	June 30, 2017
	2014	1,260	June 30, 2016
	2013	1,260	1,718 (Target Exceeded)
	2012	1,053	1,619 (Target Exceeded)
	2011	1,043	1,767 (Target Exceeded)

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)

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 performance measures support HRSA’s Strategic Plan Goal I of improving access to quality health care and 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

Objectives: Increase the capacity and strength of the healthcare safety net.
 Improve the quality and efficacy of the healthcare safety net

Measure	FY	Target	Result
32.1: Percent of RECA successful claimants screened at RESEP centers. ¹ (Outcome)	Out-Year Target	8.8% (FY 2013)	15.23% (Target Exceeded)
	2008	N/A	8.5% (Baseline)
32.2: Percent of patients screened at RESEP clinics who file RECA claims that receive RECA benefits. ² (Outcome)	Out-Year Target	72% (FY 2013)	84.72% (Target Exceeded)
32.I.A.1: Total number of individuals screened per year. (Output)	2017	1,200	Nov. 30, 2018
	2016	1,200	Nov. 30, 2017
	2015	1,366	Nov. 30, 2016
	2014	1,400	1,205 (Target not met)
	2013	1,450	1,576 (Target Exceeded)
	2012	1,400	1,567 (Target Exceeded)
	2011	1,400	1,371 (Target Not Met)
	2010	1,400	1,371 (Target Not Met)
	2009	1,800	1,373 (Target Not Met)

¹ This is a long-term measure with FY 2013 as a long-term target date.

² This is a long-term measure with FY 2013 as a long-term target date.

Efficiency Measure	FY	Target	Result
32.E: Average cost of the program per individual screened. (Efficiency)	2017	\$1,300	Dec. 31, 2018
	2016	\$1,300	Dec. 31, 2017
	2015	\$1,093	Dec. 31, 2016
	2014	\$1,251	1,308 (Target Not Met)
	2013	\$1,397	\$1,002 (Target Exceeded)
	2012	\$1,397	\$956 (Target Met)
	2011	\$923	\$1,093 (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 (BLCP) was established in 1980 and provides grants to public and private entities, including community-based organizations, for the purpose of establishing and operating clinics that provide for outreach, education, diagnosis, treatment, and rehabilitation of active, inactive, disabled, and retired coal miner.

As persons with respiratory and pulmonary disease age, their disease severity progresses and their need for health care services increase along with the cost of those services. To assist in the longer term need faced by those miners with severe disability as a result of black lung disease, grantees can also assist coal miners and their families in preparing the detailed information needed to apply for the Federal Black Lung benefits from the Department of Labor (DOL).

According to a 2011 report developed by the National Institute for Occupational Safety and Health, the prevalence of coal worker's pneumoconiosis (CWP) is rising nationally. The overall CWP prevalence among coal miners declined from 11.2 percent in 1970 to 2.0 percent in 1999, however, since 2000, the prevalence of CWP has increased to 3.3%. This data led to HRSA implementing a new approach for the FY 2014 grant cycle to ensure that program funding levels and resources were effectively coordinated with other Federal efforts and addressed the growing needs of the target population. HRSA also funded a Black Lung Center of Excellence (BLCE) through a cooperative agreement to ensure more consistency across programs. While some grantees and applicants are clinically focused, others are more geared towards outreach, education, and counseling. The BLCE will bring more scientific rigor and consistency to the BLCP by providing technical assistance to individual grantees and helping expand the medical and public health knowledge base around black lung disease.

Goal: Improve Access to Quality Health Care and Services

Objectives: Increase the capacity and strength of the healthcare safety net
 Improve the quality and efficacy of the healthcare safety net

Measure	FY	Target	Result
33.I.A.1: Number of miners served each year. (Baseline – FY 2005: 10,790) (Output)	2017	13,800	Aug. 31, 2018
	2016	12,836	Aug. 31, 2017
	2015	13,000	Aug. 31, 2016
	2014	12,840	11,843 (Target not met)
	2013	12,688	13,643 (Target Exceeded)
	2012	12,836	12,586 (Target Not Met)
	2011	12,288	12,840 (Target Exceeded)
33.I.A.2: Number of medical encounters from Black Lung each year. (Baseline – FY 2005: 20,844) (Output)	2017	20,000	Aug. 31, 2018
	2016	19,880	Aug. 31, 2017
	2015	16,500	Aug 31, 2016
	2014	18,129	16,958 (Target not met)
	2013	27,403	19,346 (Target Not Met)
	2012	26,403	19,880 (Target Not Met)
	2011	25,403	18,129 (Target Not Met)
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)	2017	NA	NA
	2016	9,550	Aug. 31, 2017
	2015	9,550	Aug 31, 2016
	2014	10,374	7,664 (Target not met)
	2013	4,372	10,131 (Target Exceeded)
	2012	4,272	8,514 (Target Exceeded)
	2011	4,172	10,374 (Target Exceeded)

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

TELEHEALTH

INTRODUCTION

The Federal Office of Rural Health Policy funds telehealth programs through the Office for the Advancement of Telehealth (OAT). These 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 grant programs administered by OAT are the following:

- Telehealth Network Grant Program (TNGP), which funds projects that demonstrate the use of telehealth networks to improve healthcare services for medically underserved populations in rural and frontier communities. 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.
- Evidence-Based Telehealth Network Grant Program (EB TNGP), which funds projects that support implementation and evaluation of broad Telehealth networks to deliver Emergency Department consultation services via Telehealth to rural and community providers without emergency care specialists.
- Rural Child Poverty Telehealth Network Grant Program (RCP TNGP), which funds projects to demonstrate how telehealth networks can expand access to, coordinate and improve the quality of health care services for children living in impoverished rural areas, and in particular how such networks can be enhanced through the integration of social and human service organizations.
- Telehealth Resource Center Grant Program (TRC), which provides technical assistance to HRSA grantees and rural communities to establish or enhance and expand telehealth services.
- Licensure Portability Grant Program (LPGP), which provides support for State professional licensing boards to carry out programs under which licensing boards cooperate to develop and implement State policies that reduce statutory and regulatory barriers to telemedicine.

The TNGP tracks progress in achieving its objectives to improve access to quality health care services to rural and frontier 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

Objective: Improve the capacity and strength of the healthcare safety net.

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)	2017	25%	Mar 31, 2019
	2016	20%	Mar 31, 2018
	2015	30%	Mar 31, 2017
	2014	30%	Mar 31, 2016
	2013	21%	32% (Target Exceeded)
	2012	20%	23% (Target Exceeded)
	2011	42%	45% (Target Exceeded)
	2010	21%	32% (Target Exceeded)
34.I: Percent of TNGP grantees that continue to offer services after the TNGP funding has ended. ¹ (Baseline – FY 2005: 100%) (Outcome)	<i>Out-Year Target</i>	95% (FY 2013)	100%
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. ² (Baseline - FY 2005: 489) (Outcome)	2017	2,725	Mar 31, 2019
	2016	2,700	Mar 31, 2018
	2015	2,675	Mar 31, 2017
	2014	2,579	Mar 31, 2016
	2013	2,565	2,924 (Target Exceeded)
	2012	2,556	3,187 (Target Exceeded)
	2011	2,537	2,601 (Target Exceeded)
	2010	2,456	2,951 (Target Exceeded)

¹ This is a long-term measure with FY 2013 as a long-term target date.

² 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 FY 2015 may need to be revised if there is evidence of a significant increase in grantees that are providing mental health services.

Measure	FY	Target	Result
<u>34.III.D.1</u> : 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. (<i>Outcome</i>)	2017	330	Mar 31, 2019
	2016	325	Mar 31, 2018
	2015	320	Mar 31, 2017
	2014	239	Mar 31, 2016
	2013	239	377 (Target Exceeded)
	2012	223	473 (Target Exceeded)
	2011	219	310 (Target Exceeded)
	2010	219	321 (Target Exceeded)
<u>34.III.D.1.1</u> : 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. (<i>Outcome</i>)	2017	320	Mar 31, 2019
	2016	320	Mar 31, 2018
	2015	315	Mar 31, 2017
	2014	204	Mar 31, 2016
	2013	202	422 (Target Exceeded)
	2012	188	518 (Target Exceeded)
	2011	186	304 (Target Exceeded)
	2010	186	320 (Target Exceeded)
Efficiency Measure	FY	Target	Result
<u>34.E</u> : 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. ³ (<i>Efficiency</i>)	2017	106 per Million \$	March 31, 2019
	2016	106 per Million \$	March 31, 2018
	2015	105 per Million \$	Mar 31, 2017
	2014	203 per Million \$	Mar 31, 2016
	2013	203 per Million \$	65 (Target Not Met)
	2012	202 per Million \$	103 per Million \$ (Target Not Met)
	2011	199 per Million \$	201 per Million \$ (Target Exceeded)
	2010	186 per Million \$	255 per Million \$ (Target Exceeded)

³ 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. New cohorts were funded in both FY 2012 and FY 2013. With each new cohort, there is a start-up period where sites and services are being put in place but are not yet implemented. In addition, 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, and others.

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.

NATIONAL VACCINE INJURY COMPENSATION PROGRAM

The program included in this section is:

- National Vaccine Injury Compensation

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, who have been injured by vaccines recommended by the Centers for Disease Control and Prevention (CDC) for routine administration to children and on which Congress has imposed an excise tax, 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. To the extent that the VICP serves as an alternative to the traditional tort system, a Program goal that no compensated claimant would reject an award, and would elect to file a lawsuit in the traditional tort system (i.e., pursue civil action) was established. 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: Strengthen HRSA Program Management and Operations

Objective: Improve efficiency and effectiveness of operations.

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. <i>(Outcome)</i>	2017	0%	Oct. 31, 2017
	2016	0%	Oct. 31, 2016
	2015	0%	0% (Target Met)
	2014	0%	0% (Target Met)
	2013	0%	0% (Target Met)
	2012	0%	0% (Target Met)
	2011	0%	0% (Target Met)
<u>26.II.A.4:</u> Average time settlements are approved from the date of receipt of the DOJ settlement proposal. <i>(Outcome)</i>	2017	10 days	Oct. 31, 2017
	2016	10 days	Oct. 31, 2016
	2015	10 days	4.9 days (Target Exceeded)
	2014	10 days	4.7 days (Target Exceeded)
	2013	10 days	7.2 days (Target Exceeded)
	2012	10 days	6.6 Days (Target Exceeded)
	2011	10 days	9.4 days (Target Exceeded)
<u>26.II.A.5:</u> Average time that lump sum only awards are paid from the receipt of all required documentation to make a payment. <i>(Outcome)</i>	2017	7 days	Oct. 31, 2017
	2016	7 days	Oct. 31, 2016
	2015	8 days	2.2 Days (Target Exceeded)
	2014	8 days	1.5 Days (Target Exceeded)
	2013	8 days	7.8 days (Target Exceeded)
	2012	8 days	3.6 days (Target Exceeded)
	2011	5 days	4.9 days (Target Exceeded)
<u>26.II.A.6:</u> Percentage of cases in which court-ordered annuities are funded within the carrier's established underwriting deadline. <i>(Outcome)</i>	2017	98%	Oct. 31, 2017
	2016	98%	Oct. 31, 2016

Measure	FY	Target	Result
26.II.A.7: Percentage of medical reports that are completed within 90 days of receipt of complete medical records. (Developmental; Baseline Data Available 10/31/2016)	2017	TBD	Oct. 31, 2017
	2016	N/A	New Measure Implemented in FY 2016

Measure	Data Source	Data Validation
26.II.A.1 26.II.A.4 26.II.A.5 26.II.A.6 26.II.A.7	VICP internal data system and DOJ Office of Management Information system.	Validated by program staff through internal consistency checks.

PROGRAM MANAGEMENT

The program included in this section is:

- Program Management

PROGRAM MANAGEMENT

Goal: Strengthen HRSA Program Management and Operations.

Objectives: Improve efficiency and effectiveness of operations.

Enhance program oversight and integrity

Measure	FY	Target	Result
<u>35.VII.B.1:</u> Ensure Critical Infrastructure Protection Security Awareness Training <i>(Output)</i>	2017	Full participation in Security and Privacy Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security and privacy responsibilities, and participation in Executive Awareness training by 100% of HRSA executive staff	Dec. 31, 2017
	2016	Full participation in Security and Privacy Awareness training by 100% of HRSA staff. Specialized role-based training for 100% of HRSA staff identified to have significant security and privacy responsibilities.	Dec. 31, 2016
	2015	Full participation in Security and Privacy Awareness training by 100% of HRSA staff. Specialized role-based training for 100% of HRSA staff identified to have significant security and privacy responsibilities.	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 (Target Met)
	2014	Full participation in Security and Privacy Awareness training by 100% of HRSA staff. Specialized role-based training for 100% of HRSA staff identified to have significant security and privacy responsibilities.	Full participation in Security and Privacy Awareness training by 100% of HRSA staff, specialized role-based training for 100% of HRSA staff identified to have significant security responsibilities and participation in Executive Awareness training by 100% of HRSA executive staff. (Target Met)
	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.	100% completion rate in all areas of Security Awareness and Training. (Target Met)

	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)
<u>35.VII.B.2:</u> Ensure Critical Infrastructure Protection. Security Authorization to Operate (Output)	2017	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. 31, 2017
	2016	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. 31, 2016
	2015	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.	100% of HRSA information systems have been certified and authorized to operate. (ATO) (Target Met)

	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.	100% of HRSA information systems have been certified and authorized to operate. (ATO) (Target Met)
	2013	100% of HRSA information systems will be assessed and authorized to operate. (ATO)	100% of HRSA information systems has been assessed and authorized to operate. (ATO) (Target Met)
	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)
<u>35.VII.B.2a:</u> Ensure Critical Infrastructure Protection: Security HSPD-12 Privilege and Non-Privilege	2017	Privacy - 95% of HRSA staff (federal and contractor) accessing the HRSA network with Privileged accounts must use PIV cards or other 2-factor authentication.	Dec. 31, 2017
	2016	Privacy - 95% of HRSA staff (federal and contractor) accessing the HRSA network with Privileged accounts must use PIV cards or other 2-factor authentication.	Dec. 31, 2016
<u>35.VII.B.2b:</u> Ensure Critical Infrastructure Protection: Security Cyber Sprint	2017	Cyber Sprint - Remediation of critical findings from cyber hygiene scanning within 30 Days	Dec. 31, 2017
	2016	Cyber Sprint - Remediation of critical findings from cyber hygiene scanning within 30 Days	Dec. 31, 2016
<u>35.VII.B.2c:</u> Ensure Critical Infrastructure Protection: Security Privacy Impact Assessment (PIA) Or Privacy Threshold Assessment (PTA)	2017	Identify 85% of systems that require a PIA or a Privacy Threshold Assessment (PTA)	Dec. 31, 2017
	2016	Identify 85% of systems that require a PIA or a Privacy Threshold Assessment (PTA)	Dec. 31, 2016

Measure	FY	Target	Result
35.VII.B.2d: Ensure Critical Infrastructure Protection: Security Phishing	2017	5 Phishing Campaigns completed	Dec. 31, 2017
	2016	5 Phishing Campaigns completed	Dec. 31, 2016
35.VII.B.3: Capital Planning and Investment Control (Output)	2017	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).	Dec. 31, 2017
	2016	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).	Dec. 31, 2016
	2015	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).	1) 100% of major investments received an IT Dashboard Overall Rating of “Green”, which indicates an acceptable cost, schedule and Agency CIO Rating (Target Met); 2) 50% of Major Investment Managers was in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM) due to transitioning personnel. (Target Not Met)
	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).	FY 2014: 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)

	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).	FY 2013: 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)
	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)
<u>35.VII.B.4:</u> Enterprise Architecture	2017	Enterprise Architecture: 90% of IT investments reported to OMB with mapping to at least one HHS segment and domain.	Dec. 31, 2017
	2016	Enterprise Architecture: 90% of IT investments reported to OMB with mapping to at least one HHS segment and domain.	Dec. 31, 2016

Measure	FY	Target	Result
35.VII.A.3: Strengthen Program Integrity (PI) Activities	2017	1) Maintain FY 2016 PI staffing level 2) Implement HHS Enterprise Risk Management effort at HRSA	Dec. 31, 2017
	2016	1) Maintain FY 2015 PI staffing level 2) Operate and maintain PI toolkit and consider further expansion as needed.	Dec. 31, 2016
	2015	1) Increase staffing to 22 analysts. 2) Operate and maintain PI toolkit and consider further expansion as needed.	Dec. 31, 2015
	2014	1) Reach staffing of 20 PI regional analysts 2) Operate and maintain PI toolkit and consider further expansion as needed.	1) Reached staffing of 17 PI analysts (regions and HQ) to increase auditing/site visit capability. 2) HRSA PI Workgroup began to fully deploy two sections of the online PI toolkit. (Target Met)
	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	1) Reached staffing of 17 PI analysts (regions and HQ) to increase auditing/site visit capability. 2) HRSA PI Workgroup implemented and fully deployed two sections of the online PI toolkit. (Target Met)
	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 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)

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 six 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 three measures assess the quality of health care serviced delivered and 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.

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

Measure	FY	Target	Result
<u>36.II.A.1:</u> Total number of unduplicated clients served in Title X service sites. <i>(Outcome)Revised Measure</i>	2017	4,259,000	Oct 31, 2018
	2016	4,672,000	Oct 31, 2017
	2015	4,307,000	Oct 31, 2016
	2014	4,461,000	4,129,283 (Target not met)
	2013	4,996,600	4,557,824 (Target not met)
	2012	4,969,600	4,763,797 (Target not met)
	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)
<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>	2017	90%	Oct 31, 2018
	2016	90%	Oct 31, 2017
	2015	90%	Oct 31, 2016
	2014	90%	91.8% (Target met)
	2013	90%	90% (Target met)
	2012	90%	90% (Target met)
	2011	90%	89% (Target not met)
	2010	90%	90% (Target Met)
	2009	90%	91% (Target Exceeded)

Measure	FY	Target	Result
<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>	2017	977,400	Oct 31, 2018
	2016	1,080,000	Oct 31, 2017
	2015	823,000	Oct 31, 2016
	2014	858,000	941,156 (Target Met)
	2013	961,300	1,046,147 (Target Met)
	2012	949,300	910,779 (Target Not Met)
	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)
<u>36.II.A.4:</u> Increase the proportion of female clients, using a method of contraception, indicating the use of: A: Long Acting Reversible Contraceptive (LARC) as their primary method of contraception. and B: Highly or moderately effective methods of contraception as their primary method of contraception. <i>(Outcome) New</i>	2017	A: 11.0% B: 80.0%	Oct 31, 2018
	2016	A: 9.9% B: 79.0%	Oct 31, 2017
	2015	A: 9.7% B: 77.1%	Oct 31, 2016
	2014	A: N/A B: N/A	A: 13.2 % B: 74.3%
	2013	A: N/A B: N/A	A: 11.2 % B: 72.9%
	2012	A: N/A B: N/A	
	2011	A: N/A B: N/A	A: 8.8% Baseline B: 70.1% Baseline

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)	2017	1,032,500	Oct 31, 2018
	2016	1,195,000	Oct 31, 2017
	2015	1,155,500	Oct 31, 2016
	2014	1,196,600	996,379 (Target Not Met)
	2013	1,396,300	1,164,140 (Target Not Met)
	2012	1,340,300	1,247,525 (Target Not Met)
	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)
36.II.C.3: Increase the proportion of females ages 15 – 24 attending Title X family planning clinics screened for Chlamydia infection. (Outcome)	2017	64.4%	Oct 31, 2018
	2016	64.4%	Oct 31, 2017
	2015	63%	Oct 31, 2016
	2011	57.8%	Baseline

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

Measure	FY	Target	Result
<u>36.II.C.1:</u> Increase the number of unduplicated female clients who receive a Pap test. (Outcome) <i>Retired</i>	2017	Retire	Oct 31, 2018
	2016	Retire	Oct 31, 2017
	2015	Retire	Oct 31, 2016
	2014	1,215,000	785,540 (Target Not Met)
	2013	1,571,400	988,114 (Target Not Met)
	2012	1,654,900	1,237,328 (Target Not Met)
	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)
<u>36.II.C.2:</u> Reduce invasive cervical cancer among women attending Title X family planning clinics by providing Pap tests. (Outcome) <i>Retired</i>	2017	Retire	
	2016	Retire	
	2015	Retire	
	2014	449	259 (Target Not Met)
	2013	519	326 (Target Not Met)
	2012	546	408 (Target Not Met)
	2011	616	477 (Target Not Met)
	2010	835	570 (Target Not Met)
	2009	797	672 (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)	2017	\$328.21	Oct 31, 2018
	2016	\$301.14	Oct 31, 2017
	2015	\$291.94	Oct 31, 2016
	2014	\$283.85	\$301.24 (Target Not Met)
	2013	\$292.23	\$281.87 (Target Exceeded)
	2012	\$280.66	\$264.54 (Target Exceeded)
	2011	\$269.55	\$256.20 (Target Exceeded)
	2010	\$258.87	\$247.63 (Target Exceeded)
	2009	\$243.59	\$237.42 (Target Exceeded)

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