DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2011

Health Resources and Services Administration

Justification of Estimates for Appropriations Committees

MESSAGE FROM THE ADMINISTRATOR

I am pleased to present the Fiscal Year (FY) 2011 Congressional Justification for the Health Resources and Services Administration (HRSA). This budget targets critical healthcare needs in underserved areas.

It is estimated that in FY 2011 approximately 20.27 million patients will receive access to high quality, comprehensive and cost-effective primary health care through HRSA's Health Center program. Additional resources are also provided for the Ryan White HIV/AIDS program to enhance prevention and treatment of people impacted by HIV/AIDS. Through the AIDS Drug Assistance Program, requested resources will provide life saving medications to 149,438 people infected with HIV. The budget also requests funding for other programs that play a key role in driving down costs and expanding healthcare access for the whole family.

The FY 2011 budget invests resources to increase the number of doctors, nurses and dentists practicing in areas of the country experiencing shortages of health professionals. This will ensure that qualified clinicians will be available to serve underserved populations in the future. The budget also includes $79 million to improve both access to and quality of health care in rural areas. This will strengthen regional and local partnerships among rural health care providers, expand community-based programs and promote the modernization of the health care infrastructure in rural areas.

This budget request supports achievement of the Agency's seven strategic goals, which are to:

- Improve Access to Health Care
- Improve Health Outcomes
- Improve the Quality of Health Care
- Eliminate Health Disparities
- Improve the Public Health and Health Care Systems
- Enhance the Ability of the Health Care System to Respond to Public Health Emergencies
- Achieve Excellence in Management

Our FY 2011 budget request places a strong emphasis on investing in programs that improve access to health care in underserved areas and allows the Health Resources and Services Administration to take important steps toward healthcare reform.

Mary K. Wakefield
Administrator

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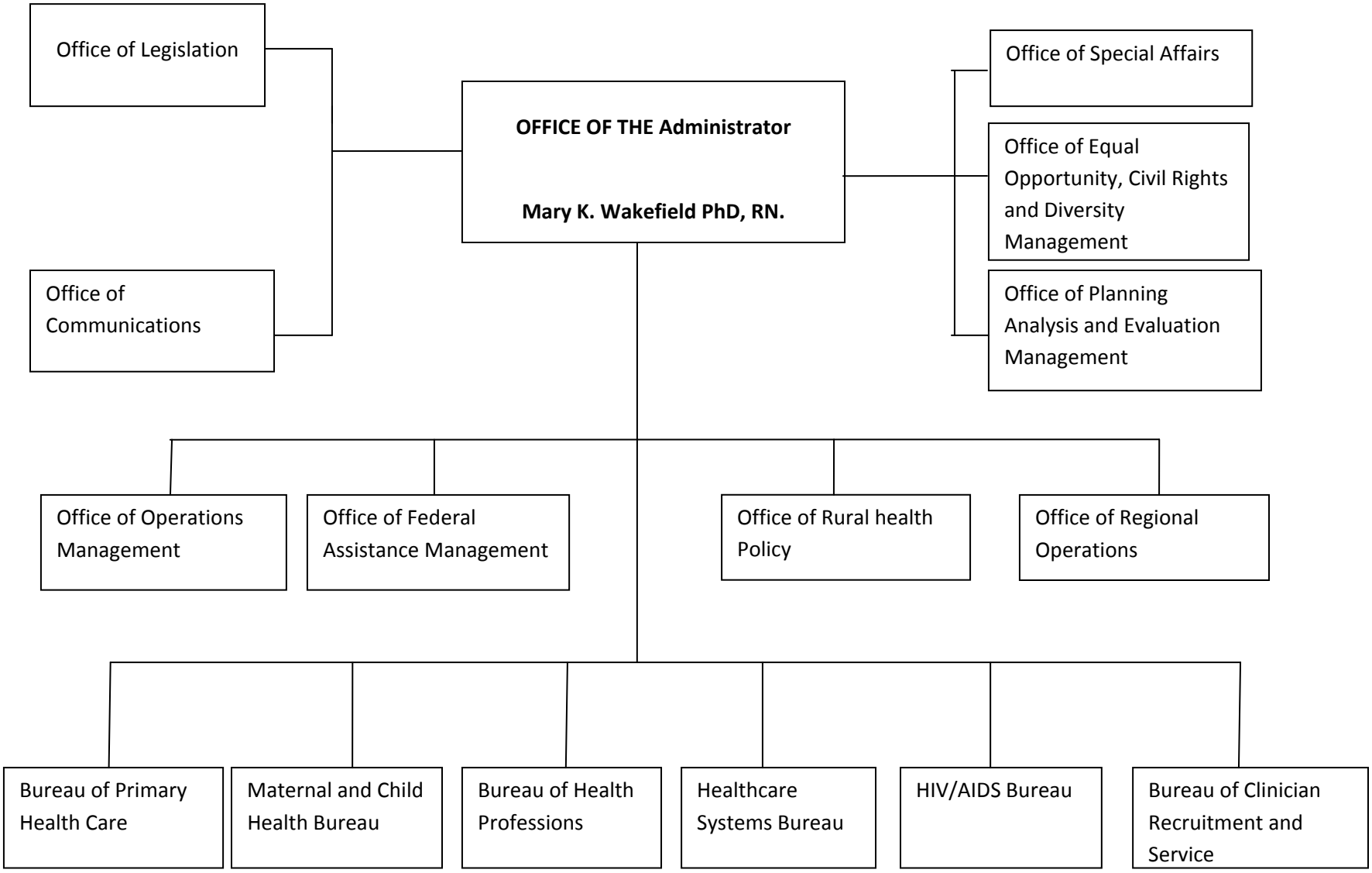

Executive Summary

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INTRODUCTION AND MISSION

The Health Resources and Services Administration (HRSA), an Agency of the U.S. Department of Health and Human Services (DHHS), is the principal Federal Agency charged with increasing access to basic health care for those who are medically underserved. Health care in the United States is among the finest in the world, but it is not available to everyone. Millions of families still face barriers to quality health care because of their income, lack of insurance, geographic isolation, or language and cultural barriers. In the report, *America's Health Care Safety Net*, the Institute of Medicine concluded that the Nation's health care safety net, while intact for the short term, is endangered over the longer term by shrinking resources (both funding and available practitioners) and expanding responsibility. The report also states that in the absence of universal insurance coverage and while paradigms are unfolding, it seems likely that the Nation will continue to rely on safety-net providers to care for it's most vulnerable and disadvantaged populations. Assuring a safety net for individuals and families who live outside the economic and medical mainstream is a key HRSA role.

HRSA's mission, as articulated in its Strategic Plan for 2005-2011, is to provide the national leadership, program resources and services needed to improve access to culturally competent, quality health care for uninsured, underserved, vulnerable, and special needs populations. HRSA programs and services target, for example:

- The 46 million Americans who lack health insurance - many of whom are racial and ethnic minorities.
- Over 50 million underserved Americans who live in rural and poor urban neighborhoods where health care services are scarce.
- African American infants who still are 2.4 times as likely as white infants to die before their first birthday.
- The more than 1 million people living with HIV/AIDS, both in and out of care, Over 94,000 Americans who are waiting for an organ transplant.

As the Nation's access agency, HRSA envisions optimal health care for all, supported by a health care system that assures access to comprehensive, culturally competent, quality care.

OVERVIEW OF BUDGET REQUEST

The FY 2011 President's Budget Request of $7,601,658,000 for the Health Resources and Services Administration is an increase of $128,136,000 from the FY 2010 Omnibus level.

Program Increases:

Health Centers (+$289.971 million)
This request includes $249 million to continue New Access Points and Services initiated under the American Recovery and Reinvestment (ARRA) Increased Demand for Services (IDS) grants, $16 million for new sites, and $25 million for substance abuse/behavioral health.

National Health Service Corps Field (NHSC) (+$4.873 million)
This increase supports the field infrastructure and provides resources for the completion of an up-to-date information management system, which will be needed to facilitate the anticipated increased management burden of the program both in the immediate future and the long-term monitoring and support of a greatly expanded Field Strength.

National Health Service Corps Recruitment (NHSC) (+$21.791 million)
This increase will fund 49 new scholars and 1,460 new loan repayers.

Health Workforce Information and Analysis (+$5.949 million)
The increase will be used to expand the following core activities that were begun in FY 2010. 1.) Establishing relationships with State organizations, health professional organizations, and health professions education organizations and developing data standards relating to health professionals (education, training, and practice); 2.) conducting specific studies as needed to meet information needs of policymakers; and 3.) establishing and expanding grant program(s) and support contracts needed to implement a standardized data collection strategy that includes a large contract for the receipt and management of data from various sources and for responding to requests for data and simple analyses. In addition, a small grant program to stimulate academic interest in conducting workforce research and policy analyses will be initiated.

Medical School Development (+$100.000 million)
This increase will fund the development of new medical schools in federally-designated Health Professional Shortage Areas (HPSAs). These funds will support approximately 20 grants. These academic health centers will provide training and research in community-oriented settings with a goal of increasing clinical training in HPSAs as well as increasing the number of new providers who go on to practice in HPSAs and other underserved areas.

Maternal and Child Health Block Grant (+$11.066 million)
This level of funding will provide: an increase of $8.46 million for a total of $567.6 million for State Block Grant awards; an increase of $1.49 million for a total of $94 million for the SPRANS set-aside, which includes $4.9 million for Oral Health, $3.8 million for Sickle Cell,

$3.7 million for Epilepsy, $0.49 million for Fetal Alcohol Syndrome, $5 million for First Time Motherhood, $1.5 million for the Doula program; and an increase of $1.49 million for a total of $11.9 million for the CISS set-aside.

Autism and other Developmental Disorders (+$7.000 million)
This increase supports the President's initiative to support children with autism spectrum disorders. The funding will expand Federal and State programs authorized in the Combating Autism Act.

Healthy Start (+$5.186 million)
The request will support 2 competing renewals for community based projects, three new grants and 102 non competing continuation grants.

HIV/AIDS Comprehensive Care Part B (+$30.0 million)
The increase will support program activities and includes the provision life-saving medications to persons living with HIV. $20 million of this increase will support AIDS Drug Assistance Program (ADAP) services. 3,389 additional clients will be served by ADAP.

HIV/AIDS Early Intervention Part C (+$5.054 million)
The FY 2011 President's Budget Request will continue to support persons receiving primary care services under the Early Intervention Services programs for 241,885, Persons Living with HIV/AIDS (PLWH) at the 353 currently funded Part C programs.

HIV/AIDS Education and Training Centers Part F (+$2.624 million)
This funding will help meet the AIDS Education and Training Center (AETC) program's performance goal of, "maintaining the proportion of racial/ethnic minority healthcare providers participating in the AETC intervention programs".

HIV/AIDS Dental Services Part F (+$1.835 million)
These funds will continue to support the reimbursement of applicant institutions, outreach to people with HIV/AIDS who need dental care, and continued efforts to improve service coordination among reimbursement recipients and other community-based health service providers. In addition, the increase will support 4 new community based dental partnership programs.

Cord Blood Stem Cell Bank (+$1.900 million)
The entire FY 2011 President's Budget Request will support more rapid progress toward the statutory goal of building a genetically diverse inventory of 150,000 new units of high-quality umbilical cord blood for transplantation and will therefore increase the number of patients in all population groups who are able to obtain life-saving transplants.

C.W. Bill Young Cell Transplantation Program (+$3.027 million)
These funds will also be used to support an infrastructure comprised of multiple contracts (Cord Blood Coordinating Center, a Bone Marrow Coordinating Center a combined contract for the Office of Patient Advocacy and Single Point of Access, and Stem Cell Therapeutic Outcomes Database). The majority of the funds will be used to support recruitment of new donors (including tissue typing costs).

340B Drug Pricing Program/Office of Pharmacy Affairs (+$3.000 million)
The funding will sustain annual verification of all covered entities ensuring accuracy and integrity of the 340B database over time and will support 508 compliance of the Pharmacy Services Support Center (PSSC)/ Office of Pharmacy Affairs (OPA) website.

Rural Health Outreach Grants (+$1.241 million)
This increase supports total program requirements.

Program Management (+$6,756 million)
This increase supports additional pay costs, increased rent associated with the Parklawn building and cost associated with relocation of personnel due to the transfer of the Health Education Assistance Loans (HEAL) program to the Department of Education.

Family Planning (+$9.865 million)
The FY 2011 request is expected to support family planning services for approximately 5,251,000 persons, with at least 90% of clients having incomes at or below 200% of the federal poverty level. These services include the provision of family planning methods, education, counseling and related preventive health services.

Program Decreases:

Delta Health (-$35.0 million)
There is no FY 2011 request for this program.

Denali Project (-$10.0 million)
There is no FY 2011 request for this program.

Public Health Improvements Projects (-$338.002 million)
There is no FY 2011 request for this program.

Investments in Information Technology (IT):
Funding for many of the HRSA Programs includes IT funding for the continued development, operations and maintenance of the HRSA Electronic Handbooks (EHBs). The EHBs is an IT Investment that supports the strategic and performance outcomes of the HRSA Programs and contributes to their success by providing a mechanism for sharing data and conducting business in a more efficient manner. The EHBs supports HRSA with program administration, grants administration and monitoring, management reporting, and performance measurement and analysis.

Health Resources and Services Administration
FY 2011 All Purpose Table (APT)
(Dollars in Thousands)

Programs	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget
PRIMARY CARE:				
Health Centers	2,145,967	2,000,000	2,145,967	2,435,938
Health Center Tort Claims	44,055	-	44,055	44,055
Total, Health Centers	**2,190,022**	**2,000,000**	**2,190,022**	**2,479,993**
Free Clinics Medical Malpractice	40	-	40	40
Hansen's Disease Center	16,109	-	16,109	16,109
Payment to Hawaii	1,976	-	1,976	1,976
Buildings and Facilities	129	-	129	129
Subtotal, Bureau of Primary Health Care	**2,208,276**	**2,000,000**	**2,208,276**	**2,498,247**
CLINICIAN RECRUITMENT & SERVICE:				
National Health Service Corps Field	39,736	60,000	41,128	46,001
National Health Service Corps Recruitment	95,230	240,000	100,797	122,588
Nurse Loan Repayment and Scholarship Program	37,128	26,997	93,864	93,864
Loan Repayment/Faculty Fellowships	1,266	1,182	1,266	1,266
Subtotal, Clinician Recruitment & Service	**173,360**	**328,179**	**237,055**	**263,719**
HEALTH PROFESSIONS:				
Health Professions Training for Diversity:				
Centers of Excellence	20,602	4,924	24,602	24,602
Scholarships for Disadvantaged Students	45,842	40,000	49,342	49,342
Health Careers Opportunity Program	19,133	2,517	22,133	22,133
Subtotal, Health Professions Training for Diversity	**85,577**	**47,441**	**96,077**	**96,077**
Health Workforce Information and Analysis	-	-	2,832	8,781
Training in Primary Care Medicine and Dentistry	48,425	47,600	54,425	54,425
Interdisciplinary, Community-Based Linkages:				
Area Health Education Centers	32,540	-	33,345	33,345
Geriatric Programs	30,997	-	33,747	33,747
Allied Health and Other Disciplines	13,890	-	22,390	22,390
Subtotal, Interdisciplinary, Community-Based Linkages	**77,427**	**-**	**89,482**	**89,482**
Public Health Workforce Development:				

Health Resources and Services Administration
FY 2011 All Purpose Table (APT)
(Dollars in Thousands)

Programs	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget
Public Health/Preventive Medicine; Dental PH Programs	9,000	10,500	10,000	10,000
Subtotal, Public Health Workforce Development	**9,000**	**10,500**	**10,000**	**10,000**
Nursing Workforce Development:				
Advanced Education Nursing	64,438	-	64,438	64,438
Nursing Workforce Diversity	16,107	2,756	16,107	16,107
Nurse Education, Practice and Retention	37,291	-	39,896	39,896
Nurse Faculty Loan Program	11,500	12,000	25,000	25,000
Comprehensive Geriatric Education	4,567	-	4,567	4,567
Subtotal, Nursing Workforce Development	**133,903**	**14,756**	**150,008**	**150,008**
Patient Navigator Outreach & Chronic Disease Prevention	4,000	-	5,000	5,000
ARRA Equipment	-	50,516	-	-
Children's Hospitals Graduate Medical Education Program	310,000	-	317,500	317,500
Medical School Development	-	-	-	100,000
Subtotal, Bureau of Health Professions	**668,332**	**170,813**	**725,324**	**831,273**
National Practitioner Data Bank (User Fees)	*19,750*	-	*19,750*	*21,000*
Healthcare Integrity & Protection Data Bank (User Fees)	*3,758*	-	*3,758*	*4,000*
MATERNAL & CHILD HEALTH:				
Maternal and Child Health Block Grant	662,121	-	662,121	673,187
Autism and Other Developmental Disorders	42,000	-	48,000	55,000
Traumatic Brain Injury	9,877	-	9,939	9,939
Sickle Cell Service Demonstrations	4,250	-	4,750	4,750
Universal Newborn Hearing	19,000	-	19,000	19,000
Emergency Medical Services for Children	20,000	-	21,500	21,500
Healthy Start	102,372	-	105,000	110,186
Heritable Disorders	10,013	-	10,013	10,013
Congenital Disabilities	1,000	-	500	500
Family to Family Health Information Centers	5,000	-	-	-
Subtotal, Maternal and Child Health Bureau	**875,633**	**-**	**880,823**	**904,075**
HIV/AIDS:				
Emergency Relief - Part A	663,082	-	679,074	679,074
Comprehensive Care - Part B	1,223,791	-	1,253,791	1,283,791

Health Resources and Services Administration
FY 2011 All Purpose Table (APT)
(Dollars in Thousands)

Programs	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget
AIDS Drug Assistance Program (Non-Add)	*815,000*	-	*835,000*	*855,000*
Early Intervention - Part C	201,877	-	206,823	211,877
Children, Youth, Women & Families - Part D	76,845	-	77,787	77,787
Education and Training Centers - Part F	34,397	-	34,819	37,443
Dental Services Part F	13,429	-	13,594	15,429
Subtotal, HIV/AIDS	**2,213,421**	**-**	**2,265,888**	**2,305,401**
SPNS Evaluation Funding	25,000	-	25,000	25,000
Subtotal, HIV/AIDS Bureau	**2,238,421**	**-**	**2,290,888**	**2,330,401**
HEALTHCARE SYSTEMS:				
Organ Transplantation	24,049	-	26,049	26,049
Cord Blood Stem Cell Bank	11,983	-	11,983	13,883
C.W. Bill Young Cell Transplantation Program	23,517	-	23,517	26,544
Poison Control Centers	28,314	-	29,314	29,314
340b Drug Pricing Program/Office of Pharmacy Affairs	1,470	-	2,220	5,220
State Health Access Grants	75,000	-	75,000	75,000
Subtotal, Healthcare Systems Bureau	**164,333**	**-**	**168,083**	**176,010**
Rural Health:				
Rural Health Policy Development	9,700	-	9,950	9,950
Rural Health Outreach Grants	53,900	-	56,025	57,266
Rural & Community Access to Emergency Devices	1,751	-	2,526	2,526
Rural Hospital Flexibility Grants	39,200	-	41,200	41,200
Delta Health Initiative	26,000	-	35,000	
State Offices of Rural Health	9,201	-	10,075	10,075
Denali Project	19,642	-	10,000	
Radiogenic Diseases	1,952	-	1,952	1,952
Black Lung	7,200	-	7,200	7,200
Telehealth	7,550	1,008	11,600	11,600
Subtotal, Office of Rural Health Policy	**176,096**	**1,008**	**185,528**	**141,769**
Public Health Improvement Projects	**310,470**	**-**	**338,002**	**-**
Program Management	**142,024**	**-**	**147,052**	**153,808**
Family Planning	**307,491**	**-**	**317,491**	**327,356**
HRS Program Level	**7,287,944**	**2,500,000**	**7,522,030**	**7,651,658**

Health Resources and Services Administration
FY 2011 All Purpose Table (APT)
(Dollars in Thousands)

Programs	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget
Appropriation Table Match	**7,234,436**	**2,500,000**	**7,473,522**	**7,601,658**
Less Mandatory Programs	***5,000***	-	-	-
Discretionary Program Level:				
HRS	**7,282,944**	**2,500,000**	**7,522,030**	**7,651,658**
Funds Appropriated to Other HRSA Accounts:				
Health Education Assistance Loans:				
Liquidating Account	1,000	-	1,000	---
HEAL Credit Reform - Direct Operations	2,847	-	2,847	---
Subtotal, Health Education Assistance Loans	**3,847**	**-**	**3,847**	**---**
Vaccine Injury Compensation:				
Vaccine Injury Compensation Trust Fund (HRSA Claims)	113,115	-	115,908	115,908
VICTF Direct Operations - HRSA	5,404	-	6,502	6,502
Subtotal, Vaccine Injury Compensation	**118,519**	**-**	**122,410**	**122,410**
Countermeasures Injury Compensation Program:				
Countermeasures Injury Compensation Program	-	-	-	2,500
Subtotal, Countermeasures Injury Compensation Program	**-**	**-**	**-**	**2,500**
Discretionary Program Level:				
HRS	**7,282,944**	**2,500,000**	**7,522,030**	**7,651,658**
HEAL Direct Operations	2,847	-	2,847	---
Vaccine Direct Operations	5,404	-	6,502	6,502
Countermeasures Injury Compensation Program	-	-	-	2,500
Total, HRSA Discretionary Program Level	**7,291,195**	**2,500,000**	**7,531,379**	**7,660,660**
Mandatory Programs:	5,000	-	-	-
Total, HRSA Program Level	**7,296,195**	**2,500,000**	**7,531,379**	**7,660,660**
Less Programs Funded from Other Sources:				

Health Resources and Services Administration
FY 2011 All Purpose Table (APT)
(Dollars in Thousands)

Programs	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget
Secretary's Transfer Authority	(25,000)	-	(25,000)	(25,000)
National Practitioner Data Bank (User Fees)	(19,750)	-	(19,750)	(21,000)
Healthcare Integrity and Protection Data Bank (User Fees)	(3,758)	-	(3,758)	(4,000)
Total HRSA Discretionary Budget Authority	**7,242,687**	**2,500,000**	**7,482,871**	**7,610,660**

HRSA Summary of Recovery Act Obligations and Performance

Under the American Recovery and Reinvestment Act of 2009 (ARRA), HRSA received $2.5 billion for a selected set of program activities:

- Health Centers – Services: $500 million
- Health Centers – Capital: $1.5 billion
- Health Professions Training: $200 million
- Health Professions Training – National Health Service Corps: $300 million

HRSA has made excellent progress in implementing program activity with these funds (www.recovery.gov). Through the first quarter of FY 2010, HRSA has obligated more than $2 billion in funds associated with ARRA program activity. Health Center Service funds have been used to support new sites and service areas, increase services at existing sites, and provide supplemental payments for spikes in uninsured populations. Health Center Capital funding has been used to support health center efforts to modernize facilities and systems, including construction, renovation and equipment purchase, and development of health information technology systems. Facility Investment Program grants were also recently awarded to support major construction and renovation projects at health centers.

Funding for the National Health Service Corps (NHSC) has led to significant efforts to increase the number of loan repayment contracts for service in underserved areas, as well as NHSC Scholarships. Under the Health Professions Training program, grants were awarded for a variety of programs, including Scholarships for Disadvantaged Students, Centers of Excellence focused on the training of minority students, Public Health Traineeships, and Nursing Workforce Diversity.

Provided below is a summary of actual and projected obligations (as of 12/2009):

($ in millions)

ARRA Implementation Plan	FY 2009	FY 2010	FY 2011	FY 2009 - 2011
Health Centers - Services	$496.894	$3.106		$500.000
Health Centers - Capital	$888.999	$611.001		$1,500.000
Health Professions Training Program: National Health Service Corps (NHSC)	$66.161	$158.839	$75.000	$300.000
Health Professions Training Program	$66.671	$133.329		$200.000
Total Obligations	$1,518.725	$906.275	$75.000	$2,500.000

Selected Performance Measures for Implementation Plans Listed Above:

Health Centers – Services

Performance Measure	FY 2009 Result	FY 2010 Target	FY 2011 Target
Number of new patients served	1.01M	2.25M	2.87M
Number of new uninsured patients served	.62M	1.1M	1.34M

Data Source: ARRA Health Center Quarterly Report

ARRA PERFORMANCE AND HIGH PRIORITY PERFORMANCE GOAL

Health Centers - Capital

Performance Measure	FY 2009 Result	FY 2010 Target	FY 2011 Target
Number of Health Center sites with new space (construction)	2	190	415
Number of Health Center sites with improved space (alteration/repair/renovation)	16	526	1,047

Data Source: ARRA Health Center Quarterly Report

Health Professions Training Program: National Health Service Corps

Performance Measure	FY 2009 Result	FY 2010 Target	FY 2011 Target
Increase in NHSC field strength (includes State Loan Repayment Program)	829	3,288	4,046

Data Source: BHCDANET; State Loan Repayment Program Report

Health Professions Training Program

Performance Measure	FY 2009 Result	FY 2010 Target	FY 2011 Target
Nursing Education Loan Repayment Program (NELRP) - Increase in NELRP field strength	427	427	0
Scholarships for Disadvantaged Students (SDS) Number of scholarships awarded	N/A	825	275
Training in Primary Care Medicine and Dentistry (TPCMD) - Number of students and residents trained	N/A	2,970	2,970

Data Source: Nursing Information System; BHPr Performance Report; BHPr Data Collection System

High Priority Performance Goal

The Department of Health and Human Services has identified a limited number of high priority performance goals that will be a particular focus over the next two years. These goals are a subset of those regularly used to monitor the achievement of results against performance targets. One of these relates to increasing the field strength of the National Health Service Corps: *By the end of FY 2011, increase access to primary health care by increasing the Field Strength of the National Health Service Corps (NHSC) to 8,561 primary care providers. This is in contrast to the FY 2008 field strength of 3,601.*

The National Health Service Corps plays a key role in the safety net for persons who would otherwise lack access to this essential level of care. The NHSC assists health professional shortage areas (HPSAs) in meeting their primary care health service needs by providing recruitment and retention incentives in the form of scholarship and loan repayment support to health professionals committed to a career in primary care and service to underserved communities.

Health Resources and Services

TAB

APPROPRIATIONS LANGUAGE

Health Resources and Services Administration

Health Resources and Services

For carrying out titles II, III, IV, VII, VIII, X, XI, XII, XIX, and XXVI of the Public Health Service Act (``PHS Act''), section 427(a) of the Federal Coal Mine Health and Safety Act, title V and sections 711, 1128E, and 1820 of the Social Security Act, the Health Care Quality Improvement Act of 1986, the Native Hawaiian Health Care Act of 1988, the Cardiac Arrest Survival Act of 2000, section 712 of the American Jobs Creation Act of 2004, and the Stem Cell Therapeutic and Research Act of 2005, **[**$7,473,522,000**]** *$7,601,658,000* of which $41,200,000 from general revenues, notwithstanding section 1820(j) of the Social Security Act, shall be available for carrying out the Medicare rural hospital flexibility grants program under such section: *Provided,* That of the funds made available under this heading [$1,000,000] *for the Medicare rural flexibility grants, $1,000,000* shall be to carry out section 1820(g)(6) of the Social Security Act[: Provided further, That amounts provided for such grants shall be] *with funds provided for such grants* available for the purchase and implementation of telehealth services, including pilots and demonstrations on the use of electronic health records to coordinate rural veterans care between rural providers and the Department of Veterans Affairs through the use of the VISTA-Electronic Health Record: *Provided* further, That of the funds made available under this heading, $129,000 shall be available until expended for facilities renovations at the Gillis W. Long Hansen's Disease Center: *Provided further*, That in addition to fees authorized by section 427(b) of the Health Care Quality Improvement Act of 1986, fees shall be collected for the full disclosure of information under the Act sufficient to recover the full costs of operating the National Practitioner Data Bank, and shall remain available until expended to carry out that Act: *Provided further*, That fees collected for the full disclosure of information under the ``Health Care Fraud and Abuse Data Collection Program'', authorized by section 1128E(d)(2) of the Social Security Act, shall be sufficient to recover the full costs of operating the program, and shall remain available until expended to carry out that Act: *Provided further*, That no more than $40,000 is available until expended for carrying out the provisions of section 224(o) of the PHS Act including associated administrative expenses and relevant evaluations: *Provided further*,

APPROPRIATIONS LANGUAGE

That no more than $44,055,000 is available until expended for carrying out the provisions of Public Law 104-73 and for expenses incurred by the Department of Health and Human Services ("HHS") pertaining to administrative claims made under such law: *Provided further*, That of the funds made available under this heading, **[**$317,491,000**]** *$327,356,000* shall be for the program under title X of the PHS Act to provide for voluntary family planning projects: *Provided further*, That amounts provided to said projects under such title shall not be expended for abortions, that all pregnancy counseling shall be nondirective, and that such amounts shall not be expended for any activity (including the publication or distribution of literature) that in any way tends to promote public support or opposition to any legislative proposal or candidate for public office: *Provided further*, That of the funds available under this heading, **[**$1,932,865,000**]** *$1,962,865,000* shall remain available to the Secretary of Health and Human Services through September 30, [2012] *2013*, for parts A and B of title XXVI of the PHS Act: *Provided further*, That within the amounts provided for part A of title XXVI of the PHS Act, $6,021,000 shall be available to the Secretary through September 30, [2012] *2013*, and shall be available to qualifying jurisdictions, within 30 days of enactment,, for increasing supplemental grants for fiscal year [2010] *2011* to metropolitan and transitional areas that received grant funding in fiscal year [2009] *2010* under subparts I and II of part A of title XXVI of the PHS Act to ensure that an area's total funding under subparts I and II of part A for fiscal year [2009] *2010*, together with the amount of this additional funding, is not less than 92.4 percent of the amount of such area's total funding under part A for fiscal year 2006: *Provided further*, That notwithstanding section 2603(c)(1) of the PHS Act, the additional funding to areas under the immediately preceding proviso, which may be used for costs incurred during fiscal year [2009] *2010*, shall be available to the area for obligation from the date of the award through the end of the grant year for the award: *Provided further*, That **[**$835,000,000**]** *$855,000,000* shall be for State AIDS Drug Assistance Programs authorized by section 2616 of the PHS Act: *Provided further*, That in addition to amounts provided herein, $25,000,000 shall be available from amounts available under section 241 of the PHS Act to carry out parts A, B, C, and D of title XXVI of the PHS Act to fund section 2691 Special Projects of National Significance: *Provided further*, That

notwithstanding section 502(a)(1) and 502(b)(1) of the Social Security Act, not to exceed [$92,551,000] *$93,999,263* is available for carrying out special projects of regional and national significance pursuant to section 501(a)(2) of such Act and [$10,400,000] *$11,810,915* shall be available for projects described in paragraphs (A) through (F) of section 501(a)(3) of such Act: [*Provided further*, That notwithstanding section 747(e)(2) of the PHS Act, not less than $29,025,000 shall be for family medicine programs, not less than $7,575,000 shall be for general dentistry programs, and not less than $7,575,000 shall be for pediatric dentistry programs including faculty loan repayments for service as a full-time faculty member in dentistry:] *Provided further,* That dentistry faculty loan repayments shall be made using the same terms and conditions as the Nursing Faculty Loan Repayment program authorized under section 738 of the PHS Act unless otherwise authorized: **[***Provided further,* That of the funds provided, $10,000,000 shall be provided to the Denali Commission as a direct lump payment pursuant to Public Law 106-113: *Provided further,* That of the funds provided, $35,000,000 shall be provided for the Delta Health Initiative as authorized in section 219 of division G of Public Law 110-161 and associated administrative expenses:**]** *Provided further*, That funds provided under section 846 and subpart 3 of part D of title III of the PHS Act may be used to make prior year adjustments to awards made under these sections: [*Provided further,* That notwithstanding section 340A(d)(3)(B) of the PHS Act, $5,000,000 shall be available for 3 year grant periods under the Patient Navigator Act:] *Provided further, That notwithstanding subsection (d) (3) (B) of section 340A of the Public Health Service Act, $5,000,000 shall be available for activities under such section.* **[***Provided further,* That of the amount appropriated in this paragraph, $338,002,000 shall be used for the projects financing the construction and renovation (including equipment) of health care and other facilities and for other health-related activities, and in the amounts, specified under the heading "Health Resources and Services" in the statement of the managers on the conference report accompanying this Act, and of which up to one percent of the amount for each project may be used for related agency administrative expenses:**]** *Provided further*, That notwithstanding section 338J(k) of the PHS Act, $10,075,000 is available for State Offices of Rural Health: *Provided further*, That of the funds provided, $15,000,000 is available

for the Small Rural Hospital Improvement Grant Program for quality improvement and adoption of health information technology: *Provided further*, That $75,000,000 is for State Health Access Grants to expand access to affordable health care coverage for the uninsured populations in such States.

LANGUAGE ANALYSIS

LANGUAGE PROVISION	EXPLANATION
Provided, That of the funds made available under this heading [$1,000,000] *for the Medicare rural flexibility grants, $1,000,000* shall be to carry out section 1820(g)(6) of the Social Security Act[: Provided further, That amounts provided for such grants shall be] *with funds provided for such grants* available for the purchase and implementation of telehealth services,	Citation is added to clarify the funding referenced is for the Medicare rural flexibility grants.
[*Provided further,* That notwithstanding section 340A(d)(3)(B) of the PHS Act, $5,000,000 shall be available for 3 year grant periods under the Patient Navigator Act:]	Citation is deleted and new provision is proposed which extends past the sunset period.
Provided further, That notwithstanding subsection (d) (3) (B) of section 340A of the Public Health Service Act, $5,000,000 shall be available for activities under such section.	Citation is added due to sunset of the program.
[*Provided further*, That notwithstanding section 747(e)(2) of the PHS Act, not less than $29,025,000 shall be for family medicine programs, not less than $7,575,000 shall be for general dentistry programs, and not less than $7,575,000 shall be for pediatric dentistry programs including faculty loan repayments for service as a full-time faculty member in dentistry:]	Citation is deleted.
[*Provided further*, That of the funds provided, $10,000,000 shall be provided to the Denali Commission as a direct lump payment pursuant to Public Law 106-113: *Provided further*, That of the funds provided, $35,000,000 shall be provided for the Delta Health Initiative as authorized in section 219 of division G of Public Law 110-161 and associated administrative expenses:**]**	Citation is not required as funding is not requested in FY 2011.
[*Provided further*, That of the amount appropriated in this paragraph, $338,002,000 shall be used for the projects financing the construction and renovation (including equipment) of health care and other facilities and for other health-related activities, and in the amounts, specified under the heading "Health Resources and Services" in the	Citation is not required as funding is not requested in FY 2011.

explanatory statement described in section 4 (in the matter preceding division A of this consolidated Act), and of which up to one percent of the amount for each project may be used for related agency administrative expenses:]	

Health Resources and Services Administration
Amounts Available for Obligation[1]

	FY 2009 Actual	FY 2010 Enacted	FY 2011 PB
Discretionary Appropriation:			
Annual	$7,234,436,000	$7,473,522,000	$7,601,658,000
American Recovery and Reinvestment Act	2,500,000,000		
Subtotal, adjusted appropriation	9,734,436,000	7,473,522,000	7,601,658,000
Mandatory Appropriation:			
Family to Family Health Information Centers	+5,000,000		
Subtotal, adjusted budget authority	+9,739,436,000	+7,473,522,000	+7,601,658,000
Offsetting Collections	+48,508,000	+48,508,000	+50,000,000
Unobligated balance, start of year	+73,000,000	+1,050,000,000	+145,000,000
Unobligated balance, end of year	-1,050,000,000	-145,000,000	-70,000,000
Recovery of prior year obligations	+21,000,000		
Unobligated balance, lapsing	-5,000,000		
Total obligations	$8,836,944,000	$8,427,030,000	$7,726,658,000

[1] Excludes the following amounts for reimbursable activities carried out by this account: FY 2009 - $46,622,000 and 45 FTE; FY 2010 - $47,000,000 and 48 FTE; FY 2011 $47,000,000 and 45 FTE.

Summary of Changes

2010 Estimate	
Total estimated budget authority	$7,473,522,000
(Obligations) (-$7,473,522,000)	
2011Estimate $7,601,658,000	
(Obligations) (-$7,601,658,000)	
2010 Mandatory Estimate	---
(Obligations) --	-
2011 Mandatory Estimate	---
(Obligations) --	-
Net Change	$128,136,000
(Obligations) (-$128,136,000)	

	2010 Current Changes FTE	Budget Authority FTE		From Base Budget Authority
Increases:				
A. Built in:				
1. January 2011 Pay Raise @ 1.4%	1,439	$187,009,000		$1,659,000
2. January 2011 Military Pay Raise @ 1.4%	1,439	$187,009,000		$ 288,000
3. Civilian Annualization of Jan. 2010 @	1,439	$187,009,000		$ 798,000
4. Military Annualization Jan. 2010 @ 3.4%	1,439	$187,009,000		$ 235,000
Subtotal, built-in increases				**+$2,980,000**
B. Program:				
1. Health Centers	20	2,145,967,000	-	+289,971,000
2. National Health Service Corps Field	127	41,128,000	-	+ 4,873,000
3. National Health Service Corps	-	100,797,000	-	+21,791,000
4. Health Workforce Information and	3	2,832,000	-	+5,949,000
5. Maternal and Child health Block Grant	-	662,121,000	-	+11,066,000
6. Medical School Development	-	-	-	+100,000,000
7. Autism and Other Developmental	5	48,000,000	-	+7,000,000
8. Healthy Start	-	105,000,000	-	+5,186,000
9. Comprehensive Care – Part B	-	1,253,791,000	-	+30,000,000
10. Early Intervention – Part C	30	206,823,000	-	+5,054,000
11. Education and Training Centers – Part F		34,819,000	-	+2,624,000
12. Dental Services - Part F	-	13,594,000	-	+1,835,000
13. Cord Blood Stem Cell Bank	4	11,983,000	-	+1,900,000
14. C.W. Bill Young Cell Transplantation	5	23,517,000	-	+3,027,000

Summary of Changes

	2010	Current Changes	From Base	
	FTE	Budget Authority	FTE	Budget Authority
15. 340b Drug Pricing Prog/Off of	-	2,220,000	-	+3,000,000
16. Rural Health Outreach Grants		56,025,000	-	+1,241,000
17. Program Management	1,084	147,052,000	14	+6,756,000
18. Family Planning	41	317,491,000	1	+9,865,000
Subtotal Program Increases			**15**	**+$511,138,000**
Decreases:				
A. Built in:				
1. Pay Costs	1,439	$187,009,000		**-$2,980,000**
B. Program:				
1. Delta Health Initiative	2	35,000,000	-2	-35,000,000
2. Denali Project	-	10,000,000	-	-10,000,000
3. Public Health Improvement (Facilities/Other Projects)	9	338,002,000	-9	-338,002,000
Subtotal Program Decreases			**-11**	**-$383,002,000**
Net Change Discretionary				**+$128,136,000**
Net Change Mandatory				

Health Resources and Services Administration
Budget Authority by Activity
(Dollars in Thousands)

	FY 2009 Enacted	FY 2010 Estimate	FY 2011 PB
1. Primary Care			
Health Centers	2,145,967	2,145,967	2,435,938
Health Center Tort Claims	44,055	44,055	44,055
Total, Health Centers	**2,190,022**	**2,190,022**	**2,479,993**
Free Clinics Medical Malpractice	40	40	40
Hansen's Disease Center	16,109	16,109	16,109
Payment to Hawaii	1,976	1,976	1,976
Buildings and Facilities	129	129	129
Subtotal, Bureau of Primary Health Care	**2,208,276**	**2,208,276**	**2,498,247**
2. Clinician Recruitment and Service			
National Health Service Corps Field	39,736	41,128	46,001
National Health Service Corps Recruitment	95,230	100,797	122,588
Subtotal, National Health Service Corps	**134,966**	**141,925**	**168,589**
Nurse Loan Repayment and Scholarship Program	37,128	93,864	93,864
Loan Repayment/Faculty Fellowships	1,266	1,266	1,266
Subtotal, Clinician Recruitment & Service	**173,360**	**237,055**	**263,719**
3. Health Professions			
Health Professions Training for Diversity:			
Centers of Excellence	20,602	24,602	24,602
Scholarships for Disadvantaged Students	45,842	49,342	49,342
Health Careers Opportunity Program	19,133	22,133	22,133
Subtotal, Health Professions Training for Diversity	**85,577**	**96,077**	**96,077**
Health Workforce Information and Analysis	-	2,832	8,781
Training in Primary Care Medicine and Dentistry	48,425	54,425	54,425
Interdisciplinary, Community-Based Linkages:			
Area Health Education Centers	32,540	33,345	33,345
Geriatric Programs	30,997	33,747	33,747
Allied Health and Other Disciplines	13,890	22,390	22,390
Subtotal, Interdisciplinary, Community-Based Linkages	**77,427**	**89,482**	**89,482**
Public Health Workforce Development:			
Public Health/Preventive Medicine; Dental PH Programs	9,000	10,000	10,000
Subtotal, Public Health Workforce Development	**9,000**	**10,000**	**10,000**
Nursing Workforce Development:			
Advanced Education Nursing	64,438	64,438	64,438
Nursing Workforce Diversity	16,107	16,107	16,107
Nurse Education, Practice and Retention	37,291	39,896	39,896

Health Resources and Services Administration
Budget Authority by Activity
(Dollars in Thousands)

	FY 2009 Enacted	FY 2010 Estimate	FY 2011 PB
Nurse Faculty Loan Program	11,500	25,000	25,000
Comprehensive Geriatric Education	4,567	4,567	4,567
Subtotal, Nursing Workforce Development	**133,903**	**150,008**	**150,008**
Patient Navigator Outreach & Chronic Disease Prevention	4,000	5,000	5,000
Children's Hospitals Graduate Medical Education Program	310,000	317,500	317,500
Medical School Development	---	---	100,000
Subtotal, Bureau of Health Professions	**668,332**	**725,324**	**831,273**
National Practitioner Data Bank (User Fees)	(19,750)	(19,750)	(21,000)
Healthcare Integrity & Protection Data Bank (User Fees)	(3,758)	(3,758)	(4,000)
4. Maternal and Child Health			
Maternal and Child Health Block Grant	662,121	662,121	673,187
Autism and Other Developmental Disorders	42,000	48,000	55,000
Traumatic Brain Injury	9,877	9,939	9,939
Sickle Cell Service Demonstrations	4,250	4,750	4,750
Universal Newborn Hearing	19,000	19,000	19,000
Emergency Medical Services for Children	20,000	21,500	21,500
Healthy Start	102,372	105,000	110,186
Newborn Screening for Heritable Disorders	10,013	10,013	10,013
Congenital Disabilities	1,000	500	500
Subtotal, Maternal and Child Health Bureau	**870,633**	**880,823**	**904,075**
5. HIV/AIDS			
Emergency Relief - Part A	663,082	679,074	679,074
Comprehensive Care - Part B	1,223,791	1,253,791	1,283,791
AIDS Drug Assistance Program (Non-Add)	*815,000*	*835,000*	*855,000*
Early Intervention - Part C	201,877	206,823	211,877
Children, Youth, Women & Families - Part D	76,845	77,787	77,787
Education and Training Centers - Part F	34,397	34,819	37,443
Dental Services Part F	13,429	13,594	15,429
Subtotal, HIV/AIDS	**2,213,421**	**2,265,888**	**2,305,401**
SPNS Evaluation Funding	25,000	25,000	25,000
Subtotal, HIV/AIDS Bureau	**2,238,421**	**2,290,888**	**2,330,401**
6. Healthcare Systems			
Organ Transplantation	24,049	26,049	26,049
Cord Blood Stem Cell Bank	11,983	11,983	13,883
C.W. Bill Young Cell Transplantation Program	23,517	23,517	26,544

Health Resources and Services Administration
Budget Authority by Activity
(Dollars in Thousands)

	FY 2009 Enacted	FY 2010 Estimate	FY 2011 PB
Poison Control Centers	28,314	29,314	29,314
340B Drug Pricing Program/Office of Pharmacy Affairs	1,470	2,220	5,220
State Health Access Grants	75,000	75,000	75,000
Subtotal, Healthcare Systems Bureau	**164,333**	**168,083**	**176,010**
7. Rural Health			
Rural Health Policy Development	9,700	9,950	9,950
Rural Health Outreach Grants	53,900	56,025	57,266
Rural & Community Access to Emergency Devices	1,751	2,526	2,526
Rural Hospital Flexibility Grants	39,200	41,200	41,200
Delta Health Initiative	26,000	35,000	---
State Offices of Rural Health	9,201	10,075	10,075
Denali Project	19,642	10,000	---
Radiogenic Diseases	1,952	1,952	1,952
Black Lung	7,200	7,200	7,200
Telehealth	7,550	11,600	11,600
Subtotal, Office of Rural Health Policy	**176,096**	**185,528**	**141,769**
8. Public Health Improvement	310,470	338,002	---
9. Program Management	142,024	147,052	153,808
10. Family Planning	307,491	317,491	327,356
Total, HRS Discretionary Level	**7,234,436**	**7,473,522**	**7,601,658**
Total, HRSA Mandatory Budget Level	**5,000**	**-**	**-**
Total, Budget Authority	**7,239,436**	**7,473,522**	**7,601,658**
FTE	**1,478**	**1,518**	**1,518**
ARRA FTE	**14**	**102**	**---**

	FY 2010 Amount Authorized	FY 2010 Omnibus	FY 2011 Amount Authorized	FY 2011 Pres. Budget
PRIMARY HEALTH CARE:				
1.Health Centers: PHSA, Section 330, as amended by the Health Care Safety Net Act of 2008, P.L. 110-355.	$2,602,000,000	$2,145,967,000	$2,940,000,000	$2,425,938,000
Native Hawaiian Health Care:				
Native Hawaiian Health Care Act of 1988 (P.L. 100-579), as amended by Section 9168 of P.L. 102-396	SSAN	---[1]	SSAN	---[1]
2.Health Center Tort Claims: (Defense of Certain Malpractice and Negligence Suits) PHSA, Section 224, P.L. 104-73	10,000,000	44,055,000	10,000,000	44,055,000
3.Free Clinic Medical Malpractice: PHSA, Section 224, 42 U.S.C. 233	10,000,000	40,000	10,000,000	40,000
4.National Hansen's Disease Program: PHSA, Section 320	Indefinite	16,109,000	Indefinite	16,109,000
5.Payment to Hawaii: PHSA, Section 301	Indefinite	1,976,000	Indefinite	1,976,000
6.Buildings and Facilities: PHSA, Section 320 and 321(a)	Indefinite	129,000	Indefinite	129,000
CLINICIAN RECRUITMENT & SERVICE:				
7.National Health Service Corps (NHSC): PHSA, Sections 331-338, as amended by the Health Care Safety Net Act of 2008, P.L. 110-355.	156,235,150		170,296,310	
NHSC Field		41,128,000		46,001,000
NHSC Recruitment		100,797,000		122,588,000
State Loan Repayment: PHSA, Section 338I		---[2]		---
8.Nursing Education Loan Repayment				

	FY 2010 Amount Authorized	FY 2010 Omnibus	FY 2011 Amount Authorized	FY 2011 Pres. Budget
and Scholarship Program PHSA, Section 846	Expired [3]	93,864,000	Expired	93,864,000
9.Loan Repayments and Fellowships Regarding Faculty Positions PHSA, Section 738	Expired [4]	1,266,000	Expired	1,266,000
HEALTH PROFESSIONS:				
10.Health Professions Training for Diversity: Centers of Excellence PHSA, Section 736	Expired[4]	24,602,000	Expired	24,602,000
Scholarships for Disadvantaged Students PHSA, Section 737	Expired	49,342,000	Expired	49,342,000
Health Careers Opportunity Program PHSA, Section 739	Expired	22,133,000	Expired	22,133,000
11.Health Workforce Information and Analysis PHSA , Sections 761, 792, and 806	Expired	2,832,000	Expired	8,781,000
12.Training in Primary Care Medicine and Dentistry: PHSA, Section 747	Expired	54,425,000	Expired	54,425,000
13.Interdisciplinary, Community-Based Linkages: Area Health Education Centers PHSA, Section 751	Expired	33,345,000	Expired	33,345,000
Education and Training Related to Geriatrics PHSA, Section 753	Expired[4]	33,747,000	Expired[4]	33,747,000
Allied Health and Other Disciplines PHSA, Section 755	Expired	3,890,000	Expired	3,890,000
PHSA, Section 340G, as amended by P.L. 110-355	25,000,000	17,500,000	25,000,000	17,500,000
Dental HPSAs: Grants for Innovative Programs: [5] PHSA, Section 340G, as amended by P.L. 110-355				
14.Public Health Workforce Development: Public Health/Preventive Medicine; Dental Public Health				

	FY 2010 Amount Authorized	FY 2010 Omnibus	FY 2011 Amount Authorized	FY 2011 Pres. Budget
PHSA, Sections 766, 767 and 768	Expired	10,000,000	Expired	10,000,000
15.Nursing Workforce Development:				
Advanced Education Nursing PHSA, Section 811	Expired	64,438,000	Expired	64,438,000
Nursing Workforce Diversity PHSA, Section 821	Expired	16,107,000	Expired	16,107,000
Nurse Education, Practice and Retention Grants PHSA, Section 831	Expired	39,896,000	Expired	39,896,000
Nurse Faculty Loan Program PHSA, Section 846A, as amended by P.L. 107-205.	Expired	25,000,000	Expired	25,000,000
Comprehensive Geriatric Education PHSA, Section 855, as amended by P.L. 107-205.	Expired	4,567,000	Expired	4,567,000
16.Patient Navigator Grants P.L. 109-18, Section 340A	3,500,000	5,000,000	Expired[15]	5,000,000
17.Children's Hospitals Graduate Medical Education Program: PHSA, Section 340E as amended by P.L. 109-307	330,000,000	317,500,000	330,000,000	317,500,000
18.National Practitioner Data Bank: (User Fees) P.L. 99-660, Section IV; Healthcare Quality Improvement Act of 1986 as amended by P.L. 100-177; P.L. 100-93, Section 5; P.L. 100-508	Indefinite	(19,750,000) (non-add)	Indefinite	(21,000,000) (non-add)
19.Health Care Fraud and Abuse Data Collection Program: (User Fees) P.L. 104-191, Social Security Act, Title XI, Section 1128E	Indefinite	(3,758,000) (non-add)	Indefinite	(4,000,000) (non-add)
<u>MATERNAL & CHILD HEALTH:</u>				
20.Maternal and Child Health Block Grant: Social Security Act, Title V	850,000,000	662,121,000	850,000,000	673,187,000
21.Autism and Other Developmental Disorders PHSA, Section 399BB	47,000,000	48,000,000	52,000,000	55,000,000
22.Traumatic Brain Injury Program:				

	FY 2010 Amount Authorized	FY 2010 Omnibus	FY 2011 Amount Authorized	FY 2011 Pres. Budget
PHSA, Sections 1252 and 1253 as amended by P.L. 106-310, Title XIII, Section 1304	Expired[6]	9,939,000	Expired	9,939,000
23.Sickle Cell Service Demonstration Grants: American Jobs Creation Act of 2004, Section 712	Expired[7]	4,750,000	Expired	4,750,000
24.Universal Newborn Hearing Screening: PHSA, Section 399M as amended by P.L. 106-310, Title VII, Section 702	Expired	19,000,000	Expired	19,000,000
25.Emergency Medical Services for Children: PHSA, Section 1910	Expired	21,500,000	Expired	21,500,000
26.Healthy Start: PHSA, Section 330H as amended by P.L. 106-310, Title XV, Section 1501 (a) - (d)	121,188,480	105,000,000	123,369,873	110,186,000
27.Newborn Screening for Heritable Disorders		10,013,000		10,013,000
PHSA, Section 1109	15,375,000		15,187,500	
PHSA, Section 1111	1,025,000		1,012,500	
PHSA, Section 1112	2,562,500		2,531,250	
28.Congenital Disabilities PHSA, Section 399R	Indefinite	500,000	Indefinite	500,000
HIV/AIDS:				
29.Emergency Relief - Part A: PHSA, Sections 2601-10 as amended by P.L. 109-415	681,975,000	679,074,000	716,074,000	679,074,000
30.Comprehensive Care - Part B: PHSA, Sections 2611-2631, as amended by P.L. 109-415	1,349,460,000	1,253,791,000	1,416,933,000	1,283,791,000
AIDS Drug Assistance Program (Non-Add) PHSA, Section 2616, as amended by P.L. 109-415	Indefinite	(835,000,000) (non-add)	Indefinite	(855,000,000) (non-add)
31.Early Intervention - Part C: PHSA, Sections 2651-2667, as amended by P.L. 109-415	246,855,000	206,823,000	259,198,000	211,877,000
32.Coordinated Services and Access to Research for Women, Infants, Children				

	FY 2010 Amount Authorized	FY 2010 Omnibus	FY 2011 Amount Authorized	FY 2011 Pres. Budget
and Youth - Part D: PHSA, Section 2671, as amended by P.L. 109-415	75,390,000	77,787,000	79,160,000	77,787,000
33.Special Projects of National Significance - Part F: PHSA, Section 2691, as amended by P.L. 109-415	(25,000,000 (non-add)	(25,000,000) (non-add)	(25,000,000) (non-add)	(25,000,000) (non-add)
34.Education and Training Centers - Part F II: PHSA, Section 2692(a), as amended by P.L. 109-415	36,535,000	34,819,000	38,257,000	37,443,000
35.AIDS Dental Services - Part F II: PHSA, Section 2692(b), as amended by P.L. 109-415	13,650,000	13,594,000	14,333,000	15,429,000
HEALTHCARE SYSTEMS				
36.Organ Transplantation: PHSA, Sections 371 - 378, as amended by P.L. 108-216	Expired	26,049,000	Expired	26,049,000
37.C.W. Young Cell Transplantation Program: National Cord Blood Stem Cell Bank: PHSA, Section 379, as amended by the P.L. 109-129	15,000,000	11,983,000	Expired[8]	13,883,000
38.C.W. Young Cell Transplantation Program: Bone Marrow Donor Registry: PHSA, Section 379, as amended by the P.L. 109-129	38,000,000	23,517,000	Expired	26,544,000
39.Poison Control Centers: PHSA, Section 1271-1273, as amended by P.L. 110-377.	28,600,000	29,314,000[9]	27,500,000	29,314,000
National Toll-Free Hotline	700,000	---[9]	2,000,000	---[9]
Media Campaign	800,000		SSAN	
40.340B Drug Pricing Program: PHSA, Section 340B, as amended by P.L. 111-8	Indefinite	2,220,000	Indefinite	5,220,000
41.State Health Access P.L. 111-8	75,000,000	75,000,000	75,000,000	75,000,000
RURAL HEALTH:				

	FY 2010 Amount Authorized	FY 2010 Omnibus	FY 2011 Amount Authorized	FY 2011 Pres. Budget
42.Rural Health Policy Development: Social Security Act, Section 711	Indefinite	9,950,000	Indefinite	9,950,000
43.Rural Health Outreach Network Development and Small Health Care Provider Quality Improvement: PHSA, Section 330A, as amended by P.L. 107-251.	Expired[10]	56,025,000	Expired	57,266,000
44.Rural Access to Emergency Devices: PHSA, Section 313	Expired	2,526,000 [11]	Expired[12]	2,526,000
45.Rural Hospital Flexibility Grants: Social Security Act, Section 1820(j) as amended by P.L. 108-173	Expired	41,200,000	Expired	41,200,000
46.Delta Health Initiative P.L. 110-161, Section 219	Expired	35,000,000	Expired	---
47.State Offices of Rural Health: PHSA, Section 338J	Expired	10,075,000	Expired	10,075,000
48.Denali Project: P.L. 105-277, Title III, Section 309, as amended by P.L. 106-113, Title VII	Expired	10,000,000	Expired	---
49.Radiogenic Diseases: PHSA, Section 417C amended by P.L. 106-245	Expired	1,952,000	Expired	1,952,000
50.Black Lung: Federal Mine Safety and Health Act, Section 427(a)	Expired	7,200,000	Expired	7,200,000
51.Public Health Improvement (Facilities and Other Projects) P.L. 110-161, Title II	---	338,002,000	---	---
52.Telehealth: PHSA, Section 330I, as amended by P.L. 107-251.	Expired	11,600,000	Expired	11,600,000
PHSA, Section 330L, as amended by P.L. 108-163	Expired		Expired	
53.Program Management: PHSA, Section 301	Indefinite	147,052,000	Indefinite	153,808,000
54.Family Planning: PHSA, Title X	Expired[13]	317,491,000	Expired	327,356,000

Unfunded Authorizations:

	FY 2010 Amount Authorized	FY 2010 Omnibus	FY 2011 Amount Authorized	FY 2011 Pres. Budget
1.Healthy Communities Access Program: PHSA, Section 340, as amended by P.L. 107-251.	Expired	---	Expired	---
2.Interdisciplinary, Community-Based Linkages: Health Education and Training Centers PHSA, Sections 750, 752, and 757	Expired[4]	---	Expired	---
Quentin N. Burdick Program for Rural Interdisciplinary Training PHSA, Sections 750, 754, 757	Expired	---	Expired	---
3.State and Local Public Service Announcements: PHSA, Section 852	Expired	---	Expired[3]	---
4.Grants for Health Professions Education in Health Disparities and Cultural Compentency: PHSA, Section 741	Expired[14]	---	Expired	---
5.Grants for Health Professions Education: (Nursing) PHSA, Section 807	Expired	---	Expired	---
6.Epilepsy, Seizure Disorder: PHSA, Section 330E(b), as amended by Sec. 801 of P.L. 106-310	Expired	---	Expired	---
7.Child Care Safety and Health Grants Programs: Children's Health Act, P.L. 106-310, Section 1402	Indefinite	---	Indefinite	---
8.Early Detection and Treatment Re. Childhood Lead Poisoning: PHSA, Section 317O	Expired	---	Expired	---
9.Rural EMS Training & Equipment Assistance: PHSA, Section 330J amended by P.L. 107-251, the Health Care Safety Net Amendments of 2002	Expired[10]	---	Expired[10]	---
10.Community Access Defibrillation: PHSA, Section 312 as amended by P.L. 107-188	Expired	---	Expired	---

	FY 2010 Amount Authorized	FY 2010 Omnibus	FY 2011 Amount Authorized	FY 2011 Pres. Budget
11.Community Access Defibrillation Demonstration: PHSA, Section 313 as amended by P.L. 107-188	Expired	---	Expired	---
12.Pediatric Rheumatology: PHSA, Section 763	Expired	---	Expired	---
13.Grants for Children's Asthma Relief: PHSA, Section 399L	Expired	---	Expired	---
14.Prevention Research and Programs: PHSA, Section 317K(b) and (c), as amended by P.L. 106-310, Section 901	Expired	---	Expired	---
15.Additional Services for At-Risk Pregnant Women and Infants: PHSA, Section 330H(e), as amended by P.L. 106-310, Section 1501	Expired	---	Expired	---
16.Identification of Intervention that Reduces the Burden and Transmission of Oral, Dental, and Craniofacial Diseases in High Risk Populations; Development of Approaches for Pediatric Oral and Craniofacial Assessment: Children's Health Act, P.L. 106-310, Section 1601	Expired	---	Expired	---
17.Training to Support Education and Training Programs for Physicians and Other Health Professionals and Reports: (Lead Poisoning) Children's Health Act, P.L. 106-310, Section 2503	Expired	---	Expired	---
18.Mental Health Services Delivered via Telehealth: PHSA, Section 330K, amended by P.L. 107-251	Expired[10]	---	Expired	---
19.Oral Health Promotion & Disease Prevention: School Based Sealant Program: PHSA, Section 317M(c), as amended by P.L. 106-310, Section 1602	Expired	---	Expired	---
20.Smallpox Emergency Personnel Protection: PHSA, Title II Part C, as amended by P.L. 108-20	Expired	---	Expired	---

	FY 2010 Amount Authorized	FY 2010 Omnibus	FY 2011 Amount Authorized	FY 2011 Pres. Budget
21.Family to Family Health Information Centers: Social Security Act, Section 501 (c)(1)(A) as amended by the Deficit Reduction Act of 2005.	Expired	---	Expired	---
Total, Request Level		$7,473,522,000		$7,501,658,000
Total request level against definite authorizations	$4,282,923,630	$3,600,108,000	$4,585,666,183	$6,189,896,000

[1] Included in Health Centers funding.
[2] Included in National Health Service Corps Recruitment funding.
[3] Legislative authority expired September 30, 2007.
[4] Legislative authority expired September 30, 2002.
[5] Included in the Allied Health and Other Disciplines funding.
[6] Legislative authority expired September 30, 2005.
[7] Legislative authority expired September 30, 2009.

[8] Legislative authority expired September 30, 2010.

[9] Included in the Poison Control Centers funding.
[10] Legislative authority expired September 30, 2006.
[11] Includes Community Access Defibrillation Demonstration Projects.
[12] Legislative authority expired September 30, 2003.
[13] Legislative authority expired September 30, 1985.
[14] Legislative authority expired September 30, 2004.
[15] Legislative authority expires September 30, 2011.

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2000				
General Fund Appropriation:				
Base	4,141,083,000[1]	4,204,395,000[1]	4,315,498,000[2]	4,584,721,000[2]
Advance				
Supplementals				5,672,000
Rescissions (Government-Wide)				-21,356,000
Rescissions (L/DHHS/E)				-5,000
Transfers (Secretary's 1%)				-902,000
Subtotal	4,141,083,000	4,204,395,000	4,315,498,000	4,568,130,000
FY 2001				
General Fund Appropriation:				
Base	4,681,337,000	4,684,232,000[1]	4,592,424,000[2]	5,550,876,000[1]
Advance		30,000,000		30,000,000[3]
Supplementals				
Rescissions (Government-Wide)				-56,000
Rescissions (L/DHHS/E)				-743,000
Transfers		20,000,000		20,000,000
Transfers (Secretary's 1%)				4,812,000
Subtotal	4,681,337,000	4,734,232,000	4,592,424,000	5,604,889,000
FY 2002				
General Fund Appropriation:				
Base	4,982,578,000	5,681,480,000	5,488,828,000	6,118,021,000
Advance			30,000,000[4]	
Supplementals				275,000,000
Rescissions				-1,905,000
Rescissions (L/DHHS/E)				-687,000
Transfers				
Subtotal	4,982,578,000	5,681,480,000	5,518,828,000	6,390,429,000
FY 2003				
General Fund Appropriation:				
Base	5,381,836,000	5,825,497,000[2]	6,075,654,000[6]	5,926,630,000[7]
Advance				
Supplementals				
Rescissions (Government-Wide)				-42,072,000
Transfers				
Subtotal	5,381,836,000	5,825,497,000	6,075,654,000	5,884,558,000

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2004				
General Fund Appropriation:				
Base	5,665,996,000[8]	6,499,987,000[2]	6,175,645,000[2]	6,805,127,000
Advance				
Supplementals				
Rescissions (L/DHHS/E)				-1,729,000
Rescissions.				-39,547,000
Secretary's Transfer Authority				-29,500,000
Subtotal	5,665,996,000	6,499,987,000	6,175,645,000	6,734,351,000
FY 2005				
General Fund Appropriation:				
Base	6,022,833,000	6,305,333,000	6,941,280,000	6,858,624,000
Advance				
Supplementals				
Rescissions (Government-Wide)				-54,862,000
Rescissions (L/DHHS/E)				-747,000
Transfers				
Subtotal	6,022,833,000	6,305,333,000	6,941,280,000	6,803,015,000
FY 2006				
General Fund Appropriation:				
Base	5,966,144,000	6,443,437,000	7,374,952,000	6,629,661,000
Advance				
Supplementals				3,989,000
Rescissions (Government-Wide)				-66,297,000
Rescission, CMS				-4,509,000
Subtotal	5,966,144,000	6,443,437,000	7,374,952,000	6,562,844,000
FY 2007				
General Fund Appropriation:				
Base	6,308,855,000	7,095,617,000	7,012,559,000	6,390,691,000
Mandatory Authority				3,000,000[9]
Advance				
Supplementals				
Rescissions				
Subtotal	6,308,855,000	7,095,617,000	7,012,559,000	6,393,691,000
FY 2008				

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
General Fund Appropriation:				
Base	5,795,805,000	7,061,709,000	6,863,679,000	6,978,099,000
Mandatory Authority				9,000,000[9]
Advance				
Supplementals				
Rescissions (L/DHHS/E)				-121,907,000
Transfers				
Subtotal	5,795,805,000	7,061,709,000	6,863,679,000	6,865,192,000
FY 2009				
General Fund Appropriation:				
Base	5,864,511,000	7,081,668,000	6,943,926,000	7,234,436,000
Mandatory Authority				5,000,000[10]
Advance				
Supplementals (P.L. 111-5)				2,500,000,000
Rescission of Unobligated Funds				
Transfers				
Subtotal.	5,864,511,000	7,081,668,000	6,943,926,000	9,739,436,000
FY 2010				
General Fund Appropriation:				
Base	7,126,700,000	7,306,817,000	7,238,799,000	7,473,522,000
Advance				
Supplementals				
Rescissions				
Transfers				
Subtotal.	7,126,700,000	7,306,817,000	7,238,799,000	7,473,522,000
FY 2011				
General Fund Appropriation:				
Base	7,601,658,000			
Advance				
Supplementals				
Rescissions				
Transfers				
Subtotal.	7,601,658,000			

[1] Excludes $50 million mandatory appropriation for Abstinence Education; includes $25.4 million appropriated outside of the L/DHHS/E.

[2]Excludes $50 million mandatory appropriation for Abstinence Education.
[3] Available for obligation in FY 2002.
[4] Available for obligation in FY 2003.
[5]Excludes $50 million mandatory appropriation for Abstinence Education, and $618,204,000 for programs financed from PHSSEF.
[6]Excludes $50 million mandatory appropriation for Abstinence Education, and $592,600,000 for programs financed from PHSSEF.
[7] Excludes $50 million mandatory appropriation for Abstinence Education, and $546,000,000 for programs financed from PHSSEF.
[8] Excludes $50 million mandatory appropriation for Abstinence Education, and $618,173,000 for programs financed from PHSSEF.
[9]Family to Family Health Information Centers and CAHs to SNFs and Assisted Living Facilities.
[10] Family to Family Health Information Centers.

Health Centers

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$2,145,967,000	$2,000,000,000	$2,145,967,000	$2,435,938,000	+$289,971,000
FTCA	$44,055,000	---	$44,055,000	$44,055,000	---
Total HC	$2,190,022,000	$2,000,000,000	$2,190,022,000	$2,479,993,000	+$289,971,000
FTE	19	---	20	20	---

Authorizing Legislation: Section 330 of the Public Health Service Act; as amended by Public Law 110-355 of the Health Care Safety Net Act of 2008; the Native Hawaiian Health Care Act of 1988; as amended by Section 9168 of the Public Law 102-396, and Section 224 of the Public Health Service Act.

FY 2011 Authorization $2,940,000,000

Allocation Method .....Competitive Grant

Program Description and Accomplishments

For more than 40 years, Health Centers have delivered comprehensive, high-quality, cost-effective primary healthcare to patients regardless of their ability to pay. During that time Health Centers have become the essential primary care provider for America's most vulnerable populations: people living in poverty, uninsured, and homeless; minorities; migrant and seasonal farmworkers; public housing residents; geographically isolated; and people with limited English proficiency. Health Centers advance the preventive and primary medical/healthcare home model of coordinated, comprehensive, and patient-centered care, coordinating a wide range of medical, dental, behavioral, and social services. Today, more than 1,100 Health Centers operate over 7,500 service delivery sites that provide care in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin. Approximately half of all Health Centers serve rural populations. In FY 2008, these community-based and patient-directed Health Centers served 17.1 million patients, providing over 67 million patient visits, at an average cost of $588 (including Federal and non-Federal sources of funding). Patient services are supported through Federal Health Center grants, Medicaid, Medicare, Children's Health Insurance Program (CHIP), other third party, self pay collections, other Federal grants, and State/local/other resources.

Health Centers serve a diverse patient population:

- People of all ages: Approximately 33 percent of patients in FY 2008 were children (age 17 and younger); about 7 percent were 65 or older.

- People without and with health insurance: Almost four in 10 patients were without health insurance in FY 2008. While the proportion of uninsured patients of all ages has held steady at nearly 40 percent, the number of uninsured patients increased from 4 million in FY 2001 to 6.5 million in FY 2008, proportionate to the growth in Federal Health Center funding.

- Special Populations: Some Health Centers also receive specific funding to focus on certain special populations including migrant and seasonal farmworkers, individuals and families experiencing homelessness, those living in public housing, and Native Hawaiians. In FY 2008 Health Centers served over 834,000 migrant and seasonal farmworkers and their families, 934,000 individuals experiencing homelessness, 156,000 residents of public housing, and over 6,500 Native Hawaiians.

- Migrant Health Centers – In FY 2008, HRSA-funded Health Centers served nearly 834,000 migrant or seasonal farmworkers and their families. It is estimated that HRSA-funded Health Center programs serve more than one quarter of all migrant and seasonal farm workers in the United States (National Agricultural Workers Survey – Department of Labor). The Migrant Health Center program provides support to Health Centers to deliver comprehensive, high quality, culturally-competent preventive and primary health services to migrant and seasonal farmworkers and their families with a particular focus on the occupational health and safety needs of this population. Principal employment for both migrant and seasonal farmworkers must be in agriculture.

- Health Care for the Homeless Program – Homelessness continues to be a pervasive problem throughout the United States, affecting rural as well as urban and suburban communities. According to a 2006 national survey, it was estimated that 1.6 million people were homeless. In FY 2008, nearly 934,000 persons experiencing homelessness were served by HRSA-funded Health Centers. In particular, the Health Care for the Homeless Program is a major source of care for homeless persons in the United States, serving patients that live on the street, in shelters, or in transitional housing. Health Care for the Homeless grantees recognize the complex needs of homeless persons and strive to provide a coordinated, comprehensive approach to healthcare including substance abuse and mental health services.

- Public Housing Primary Care Health Centers – The Public Housing Primary Care Program provides residents of public housing with increased access to comprehensive primary healthcare services through the direct provision of health promotion, disease prevention, and primary healthcare services. Services are provided on the premises of public housing developments or at other locations immediately accessible to residents. In FY 2008, HRSA-funded Health Centers served over 156,000 residents of public housing through these grants.

- Native Hawaiians – The Native Hawaiian Health Care Program, funded within the Health Center appropriation, improves the health status of Native Hawaiians by making health education, health promotion, and disease prevention services available through the support of the Native Hawaiian Healthcare Systems.

- Native Hawaiians face cultural, financial, social, and geographic barriers that prevent them from utilizing existing health services. In addition, health services are often unavailable in the community. The Native Hawaiian Healthcare Systems use a combination of outreach, referral, and linkage mechanisms to provide or arrange services. Services provided include nutrition programs, screening and control of hypertension and diabetes, immunizations, and basic primary care services.
- In FY 2008, Native Hawaiian Healthcare Systems provided medical and enabling services to more than 6,500 people.

Allocation Method: Public and non-profit private entities, including tribal, faith-based and community-based organizations are eligible to apply for funding under the Health Center Program. All Health Center grants are awarded based on a competitive process that includes an assessment of need and merit. In addition, Health Center grantees are required to compete for their existing service areas at the completion of every project period (generally every 3 to 5 years). Grant opportunities are announced nationally and applications are then reviewed by objective review committees, composed of experts who are qualified by training and experience in particular fields related to the Program.

Funding decisions are made based on committee assessments, announced funding preferences and program priorities. In addition to the Objective Review Committee (ORC) score, various statutory awarding factors are applied in the selection of Health Center grants. These include funding preferences for applications serving a sparsely populated area; consideration of the rural and urban distribution of awards (no more than 60 percent and no fewer than 40 percent of people served come from either rural or urban areas); and a requirement for continued proportionate distribution of funds to the special populations served under the Health Center Program. Health Centers demonstrate performance by

increasing access, improving quality of care and health outcomes, and promoting efficiency.

Increasing Access: Health Centers continue to serve an increasing number of the Nation's medically underserved. The number of Health Center patients served in FY 2008 was 17.1 million, exceeding the annual target. This increased access beyond the 10.3 million patients served in FY 2001 represents over a 66 percent increase within a 7-year period, and an increase of more than 300,000 uninsured patients since FY 2007. Of these 17.1 million patients served and for those for whom income status is known, approximately 92 percent were at or below 200 percent of the Federal poverty level and 38 percent were uninsured. Success in increasing the number of patients served has been due in large part to the development of new Health Centers, new satellite sites, and expanded capacity at existing clinics.

Improving Quality of Care and Health Outcomes: Health Centers continue to provide quality primary and related healthcare services, improving the health of the Nation's underserved communities and vulnerable populations. For example, by monitoring timely entry into prenatal care, the program assesses both quality of care as well as Health Center outreach efforts. Identifying maternal disease and risks for complications of pregnancy or birth during the first trimester can also help improve birth outcomes.

Results over the past few years demonstrate improved performance as the percentage of pregnant Health Center patients that began prenatal care in the first trimester grew from 57.8 percent in FY 2000 to 61.3 percent in FY 2008 virtually meeting the target of 61.5 percent and comparable to the FY 2007 rate. It should also be noted that Health Centers serve a higher risk prenatal population than seen nationally, making progress on this measure a particular accomplishment.

Appropriate prenatal care management can also have a significant effect on the incidence of low birth weight (LBW), the risk factor most closely associated with neonatal mortality. Monitoring birth weight rates is one way to measure quality of care and health outcomes for Health Center women of child-bearing age, a key group served by the Program. This measure is benchmarked to the national rate to demonstrate how Health Center performance compares to the performance of the nation overall. In FY 2007, 7.8 percent of babies born to Health Center prenatal care patients were low birth weight, a rate that is 4.9 percent lower than seen nationally (8.2% - 2007 preliminary national LBW rate).

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

diabetes via its Uniform Data System in FY 2008. That data shows that 62 percent of adult Health Center patients with diagnosed hypertension had blood pressure under adequate control (less than or equal to 140/90). Additionally, 73 percent of adult Health Center patients with type 1 or 2 diabetes had their most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9%).

Promoting Efficiency: Health Centers provide cost effective, quality primary healthcare services. The Program's efficiency measure focuses on maximizing the number of Health Center patients served per dollar as well as keeping cost increases below annual national healthcare cost increases while maintaining access to high quality services. In looking at growth in total cost per patient, the full complement of services (medical, dental, mental health, pharmacy, outreach, translation, etc.) that make Health Centers a "healthcare home" is captured. In FY 2008, costs grew by 4.6 percent, well under the target growth rate of 5.6. By continuing to keep increases in the cost per individual served at Health Centers better than 20 percent below national per capita healthcare cost increases, the Program has served more patients that otherwise would have required additional funding to serve annually, and demonstrates that it delivers its high quality services at a more cost-effective rate. Success in achieving cost-effectiveness may in part be related to Health Centers' use of a multi- and interdisciplinary team that treats the "whole patient." This, in turn, is associated with the delivery of high quality, culturally competent and comprehensive primary and healthcare services that not only increases access and reduces health disparities, but promotes more effective care for Health Center patients with chronic conditions.

The Health Center program underwent a program reassessment in FY 2007. The assessment cited that the program is effective at extending access and delivering high quality healthcare to underserved populations and that the Program has demonstrated progress in meeting long-term and short-term performance goals. It also found that collaboration with programs that share common goals has been improved since an initial assessment in FY 2002.

In addition, the Program is implementing improvements that include: 1) completion of a national survey of Health Center patients to expand and update information on program performance and impact; and 2) program-wide collection of core quality of care and health outcome performance measures, such as hypertension and diabetes-related outcomes, from all grantees.

External Evaluation: In addition to internal monitoring of Health Center performance, peer reviewed literature and major reports continue to document that Health Centers successfully increase access to care, promote quality and cost-effective care, and improve patient outcomes, especially for traditionally underserved populations.

- Rural counties with a community Health Center site had 25 percent fewer uninsured emergency department (ED) visits per 10,000 uninsured populations than those rural

counties without a Health Center site. Rural Health Center counties also had fewer ED visits for ambulatory care sensitive visits – those visits that could have been avoided through timely treatment in a primary care setting. (Rust George, et al. "Presence of a Community Health Center and Uninsured Emergency Department Visit Rates in Rural Counties." Journal of Rural Health, Winter 2009 25(1):8-16.)

- Uninsured Health Center patients were more likely than similar patients nationally to report a generalist physician visit in the past year (82 percent vs. 68 percent), have a regular source of care (96 percent vs. 60 percent), receive a mammogram in the past 2 years (69 percent vs. 49 percent), and receive counseling on exercise (68 percent vs. 48 percent) (Shi L., Stevens G.D., and Politzer R.M. Medical Care 2007; 45(3): 206-213).

- Health Centers are positively associated with "better primary care experiences" in comparison with similar patients nationally. There is also a positive association between seeking care in Health Centers and self-reported access to care for both uninsured and Medicaid patients (Shi L, Stevens GD, Journal of Ambulatory Care Management 2007;30(2): 159-170).

- Health Center uninsured patients are more likely to have a usual source of care than the uninsured nationally (98 percent vs. 75 percent) (Carlson et al. Journal of Ambulatory Care Management 24, 2001, Starfield and Shi. Pediatrics 113, 2004).

- Health Centers provide continuous and high quality primary care and reduce the use of costlier providers of care, such as emergency departments and hospitals (Proser M. Journal of Ambulatory Care Management 28(4), 2005).

- Uninsured people living within close proximity to a Health Center are less likely to have an unmet medical need (Hadley J and Cunningham P. Health Services Research 39(5): 2004).

- Health Centers have demonstrated success in chronic disease management. A high proportion of Health Center patients receive appropriate diabetes care (Maizlish et al. American Journal of Medical Quality 19(4), 2004).

- Medicaid beneficiaries receiving care from a Health Center were less likely to be hospitalized than Medicaid beneficiaries receiving care elsewhere (Falik M. et al. Medical Care 39(6), 2001).

- Health Center Medicaid patients were 11 percent less likely to be inappropriately hospitalized and 19 percent less likely to visit the emergency room inappropriately than Medicaid beneficiaries who had another provider as their usual source of care (Falik M. et al. Journal of Ambulatory Care Management 29, 2006).

- Health Centers have been found to improve patient outcomes and reduce racial and ethnic disparities in healthcare (O'Malley AS, et al. Health Affairs 24(2): 2005, Shin P, Jones K, and Rosenbaum S. George Washington University: 2003, Shi, L., J. Regan, R. Politzer, and J. Luo. International Journal of Health Services 31(3): 2001).

- Health Center low birth weight rates continue to be lower than national averages for all infants. In particular, the Health Center low birth weight for African American patients is lower than the rate observed among African Americans nationally (10.7 percent vs. 14.9 percent, respectively) (Shi et al. Health Services Research, 39:2004).

- Health Center patient rates of blood pressure control were better than rates in hospital affiliated clinics, the Veterans Affairs health system, or in commercial managed care populations (Hicks LS. et al. Health Affairs 25, 2006).

- *Federal Tort Claims Act (FTCA) Program*: The Health Center Program administers the FTCA program, under which employees of eligible health centers may be deemed to be federal employees qualified for malpractice coverage under the FTCA. The health center, its employees and eligible contractors are considered Federal employees immune from suit for medical malpractice claims while acting within the scope of their employment. The Federal government assumes responsibility for such claims. In FY 2008, 107 claims were paid through the FTCA program, totaling approximately $61.2 million, and in FY 2009, 107 claims were paid totaling $71.2 million.

***The American Recovery and Reinvestment Act of 2009 (Recovery Act)*:** The Recovery Act provided $2 billion for grants to Health Centers, an opportunity to serve more underserved communities, create/retain jobs, meet the significant increase in demand for primary healthcare services among the Nation's uninsured and underserved populations and address the construction, renovation, and health information technology needs of health centers.

The Recovery Act funding is separated into two distinct categories:

1. $500 million for Health Center services – new sites and service areas; increase services at existing sites; and support increases in uninsured populations.

2. $1.5 billion for Health Center facilities – construction, repair and renovation of facilities; acquisition of equipment; acquisition of health information technology (HIT) systems.

Recovery Act Services: New Access Point grants were awarded to a total of 127 community-based organizations that submitted highly-rated but unfunded applications. The new Health Centers received a total of $156 million to support operations in FY 2009 and FY 2010, providing services to an estimated 750,000 new Health Center patients and support an estimated 5,500 Health Center jobs. Increased Demand for Services (IDS) grants were awarded to 1,129 Health Center grantees nationwide. Health Centers received approximately $342 million to increase Health Center staffing (i.e., full-time equivalents), extend hours of operations and expand existing services. This funding is available for FY 2009 and FY 2010. Through these grants, Health Centers will provide services to an estimated 2,100,000 new health center patients, including 1,000,000 uninsured patients.

Recovery Act Capital Resources: Capital Improvement Program (CIP) grants totaling $851 million were awarded to upgrade over 1,500 health center sites. More than 650 health centers will use the funds to purchase new equipment or health information technology (HIT) systems, and nearly 400 health centers will adopt and expand the use of electronic health records. Additionally, Facility Investment Program (FIP) grants totaling $508.5 million were awarded to support major construction and renovation projects at 85 health centers nationwide.

Fiscal Year 2009:

The FY 2009 Health Center Program appropriation provides an increase of $125 million over the FY 2008 appropriated level. With the additional funding, the Program provided $56.1 million in base funding increases to over 1,100 existing Health Center organizations to strengthen their ability to maintain current service delivery capacity and address increases in the cost of providing primary health care services to vulnerable patient populations, including the uninsured. In addition, HRSA awarded $25.6 million to expand medical capacity at 54 existing health centers, helping an additional 230,000 individuals in 25 states receive primary health care services. The Program also awarded 180 grants totaling $21.9 million to expand oral health, behavioral health, pharmacy, and enabling services at existing health centers, and $3.8 million for 48 planning grants to support the development of future health centers in underserved areas.

Funding History

FY	Amount
FY 2006	$1,785,076,000
FY 2007	$1,988,039,000
FY 2008	$2,065,022,000
FY 2009	$2,190,022,000
FY 2009 Recovery Act	$2,000,000,000
FY 2010	$2,190,022,000

Budget Request

The FY 2011 Request of $2,479,993,000 is an increase of $289,971,000 over the FY 2010 Appropriation. The entire FY 2011 Budget Request will support the Program's achievement of its ambitious performance targets and continue its goal of increasing access and improving the quality of care in the healthcare safety net. This request includes:

- ARRA New Access Points. These funds will assure that these health centers will continue to provide comprehensive primary health care and access to oral and mental health services to 127 underserved communities across the country. These grants will allow the continued support of services to an estimated 750,000 health center patients and continue to support an estimated 5,500 health center jobs.

- Services initiated under the ARRA Increased Demand for Services (IDS) grants, including addressing increases in uninsured populations and increasing services at existing sites. IDS grants have increased health center staffing (i.e., full-time equivalents), extended hours of operations and expanded services. Through this funding, health centers will continue to provide services to an estimated 2.1 million health center patients, 1 million of which are uninsured.

- This funding level will support the development of approximately 25 new access points, increasing access to comprehensive primary health care services to an estimated 150,000 additional health center patients. The Budget proposes to coordinate with HUD, Ed, and DOJ as part of the Administration's place-based initiative on Neighborhood Revitalization.

- Additionally, this level will support an estimated 125 service expansion grants to expand the integration of behavioral health into existing primary health care systems, enhancing the availability and quality of addiction care at existing health centers. Request includes $25 million to add qualified and trained behavioral health counselors and other addiction specialists to enhance substance abuse care in

federally supported community health centers. HRSA will collaborate with the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration by utilizing agency's technical assistance expertise. HRSA will train health counselors and other addiction specialists on performing Screening, Brief Intervention and Referral to Treatment (SBIRT).

The FY 2011 Budget Request supports $44,055,000 for the FTCA program.

This funding level will also continue to support over 1,100 Health Center grantees that provide comprehensive, culturally competent, quality primary healthcare services through approximately 7,500 service delivery sites.

The FY 2011 Budget Request will support the Program's achievement of its performance targets including the performance improvement efforts within Health Centers. Funding also includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews. The Program will continue to achieve its goal of providing access to care for underserved and vulnerable populations. Health Centers are projected to serve 18.95 million patients by the end of FY 2009, approximately 20.15 million patients in FY 2010, and approximately 20.27 million patients in FY 2011.

As part of the Program's efforts to improve quality of care and health outcomes, the Health Center program has established ambitious targets for FY 2011 and beyond. For low birth weight, the Program seeks to be at least 5 percent below the national rate. This is ambitious because Health Centers continue to serve a higher risk prenatal population than represented nationally in terms of socio-economic, health status and other factors that predispose Health Center patients to greater risk for low birth weight and adverse birth outcomes. The FY 2011 target for the Program's hypertension measure is to increase the rate of adult patients with diagnosed hypertension whose blood pressure is under adequate control to 50 percent. The FY 2011 target for the Program's diabetes management measure is 73 percent of adult patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9%). These targets will be challenging to achieve because chronic conditions require treatment with lifestyle modifications, usually as the first step, and, if needed, with medication.

The Program will also continue to promote efficiency and aims to keep cost per patient increases below annual national healthcare cost increases, as provided by the Center for Medicare and Medicaid Services' National Health Expenditure Amounts and Projections. By benchmarking the Health Center efficiency to national per capita healthcare cost increases, the measure takes into account changes in the healthcare marketplace while demonstrating the Program's continued ability to deliver services at a more cost-effective rate. The target for FY 2011 is to keep the

Program's cost per patient increase at least 20 percent below the 2011 national healthcare cost increase, which is currently projected at 5.6 percent. To assist in areas of cost-effectiveness, the program offers technical assistance to grantees to review costs and revenues and develop plans to implement effective cost containment strategies.

The FY 2011 Budget Request will also support the Program's ongoing involvement in an agency-wide effort to improve quality and accountability in all HRSA-funded programs that deliver direct healthcare. One of the key steps the Health Center Program has taken in this area is to establish a core set of clinical performance measures for all Health Centers.

The Program has aligned its new required clinical performance measures that all Health Center grantees will report with those of national quality measurement organizations, such as the Ambulatory Care Quality Alliance and the National Quality Forum, and are consistent with the overarching goals of Healthy People 2010. Core measures will include: Immunizations; Prenatal care; Cancer screenings; Cardiovascular Disease/Hypertension; and Diabetes.

In addition to tracking these core clinical indicators, Health Centers will also report their health outcome measures (Low Birth Weight, Diabetes, and Hypertension) by race/ethnicity in order to demonstrate progress towards eliminating health disparities in health outcomes. To support quality improvement across all Health Centers, the Program will continue to support national and State-level technical and training programs that promote quality improvements in health center data and quality reporting, clinical and quality improvement, and implementation of innovative quality activities.

The Program continues to promote the integration of Health Information Technology (HIT) into Health Centers as part of HRSA's strategy to assure that key safety-net providers are not left behind as this technology advances. In addition to supporting funding opportunities around HIT, HRSA will continue its partnership with the Agency for Healthcare Research and Quality (AHRQ) on the HRSA HIT Community Portal designed exclusively for Health Centers, Primary Care Associations, and Primary Care Offices to access information about HIT, share best practices, and support collaborative efforts to expand access to HIT services.

Funding will also allow the Program to continue to coordinate and collaborate with related Federal, State, local, and private programs in order to further leverage and promote efforts to expand and improve Health Centers. The Program will continue to work with the AHRQ on HIT, the Centers for Disease Control and Prevention (CDC) to address Migrant Stream Farmworker issues and HIV prevention initiatives, and the National Institutes of Health (NIH) on U.S.-Mexico Border health issues, among others. In addition, the Program will continue to coordinate with the Centers for Medicare and Medicaid Services (CMS) to jointly review section 1115 Medicaid Demonstration Waivers to address any concerns for Health Centers within States.

The Program will also work closely with the Department of Justice on the Federal Tort Claims Act (FTCA) program, which provides medical malpractice liability protection to section 330 supported Health Centers. Additionally, the proposed Budget will allow coordination with programs in HUD, Ed, and DOJ as part of the Administration's place-based initiative on Neighborhood Revitalization.

Sources of Revenue

	FY 2009	FY 2010	FY 2011 President's Budget
Health Centers	$2,146.0	$2,146.0	$2,435.0
Other Sources:			
Medicaid	3,500.0	3,550.0	3,960.0
Medicare	600.0	610.0	680.0
CHIP	245.0	250.0	275.0
Other Third	870.0	880.0	980.0
Self Pay Collections	655.0	665.0	740.0
Other Federal Grants	215.0	220.0	240.0
State/Local/Other	2,000.0	2,020.0	2,265.0
TOTAL ($ in millions)	$10,231.0	$10,341.0	$11,575.0

Outcomes and Outputs Tables

Long Term Objective: Expand the capacity of the healthcare safety net.

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
1.I.A.1: Number of patients served by Health Centers (Output)	FY 2008: 17.1 million (Target Exceeded)	20.15[1] million	20.27 million	+.12
1.I.A.2.a: Percentage of grantees that provide the following services either on-site or by paid referral: (a) Pharmacy (Output)	FY 2008: 85% (Target Exceeded)	85%	85%	Maintain
1.I.A.2.b: Percentage of grantees that provide the following services either on-site or by paid referral: (b) Preventive Dental Care (Output)	FY 2008: 88% (Target Exceeded)	88%	88%	Maintain
1.I.A.2.c: Percentage of grantees that provide the following services either on-site or by paid referral: (c) Mental	FY 2008: 68% (Target Not Met)	68%	72%	Maintain

[1] Target reflects ARRA funding

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Health/Substance Abuse (Output)				
1.E: Percentage increase in cost per patient served at Health Centers compared to the national rate (Efficiency)	FY 2008: 4.6% (Target Exceeded)	20% below national rate[2]	20% below national rate	Maintain

Long Term Objective: Increase the utilization of preventive healthcare and chronic disease management services, particularly among underserved, vulnerable and special needs populations.

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
1.II.B.2: Rate of births less than 2500 grams (low birth weight) to prenatal Health Center patients compared to the national low birth weight rate (Outcome)	FY 2007: 4.9% below national rate (Target Not Met)	5% below national rate	5% below national rate	Maintain
1.II.B.3: Percentage of adult Health Center patients with diagnosed hypertension whose blood pressure is under adequate control (less than or equal to 140/90) (Outcome)	FY 2008: 62% (Target Exceeded)	50%	50%	Maintain
1.II.B.4: Percentage of adult Health Center patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9%) (Outcome)	FY 2008: 73.0% (Baseline)	73%	73%	Maintain
1.II.B.1: Percentage of pregnant Health Center patients beginning prenatal care in the first trimester (Output)	FY 2008: 61.3% (Target Not Met)	61.3%	61.3%	Maintain

[2] The target for this measure has always been to achieve a rate that is a least 20% below the National rate. In prior documents, this has been shown as a number based on projections of the national rate. Such projections will no longer be used in showing the target.

Long Term Objective: Expand the availability of healthcare, particularly to underserved, vulnerable, and special needs populations.

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
1.II.A.1: Percentage of Health Center patients who are at or below 200% of poverty (number in millions) (Output)	FY 2008: 91.7% (Target Exceeded)	91%	91%	Maintain
1.II.A.2: Percentage of Health Center patients who are racial/ethnic minorities (number in millions) (Output)	N/A	TBD[3]	TBD	N/A
1.II.A.3: Percentage of Health Center patients who are uninsured (Output)	FY 2008: 38% (Target Not Met)	38%	38%	Maintain

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 Request
Number of Awards	1,133	1,133	1,143
Average Award	$1.7 million	$1.7 million	$1.85 million
Range of Awards	$200,000 –$11mil.	$200,000 – $11mil.	$240,000 –$12.8mil.

[3] Racial/ethnic minority data will be available in late FY 2010

Program Outputs

	FY 2009	FY 2010 Appropriation	FY 2011 President's Budget Request
New Access Points	126	---	25
Expanded Sites	54	---	---
Total New/Expanded	180	---	25
Total Sites	7,892	7,892	7,917
Estimated Patients Served	18.95M	20.15M	20.27M

Free Clinics Medical Malpractice

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$40,000	---	$40,000	$40,000	---
FTE	3	---	3	3	---

Authorizing Legislation: Section 224 of the Public Health Service Act

FY 2011 Authorization $10,000,000

Allocation Method ..... Other

Program Description and Accomplishments

The Free Clinics Medical Malpractice Program encourages healthcare providers to volunteer their time at free clinics by providing medical malpractice protection at sponsoring health clinics, thus expanding the capacity of the healthcare safety net. In many communities, free clinics assist in meeting the healthcare needs of the uninsured and underserved. They provide a venue for providers to volunteer their services. Most free clinics are small organizations with annual budgets of less than $250,000.

In FY 2004, Congress provided first-time funding for payments of free clinic provider's claims under the Federal Tort Claims Act (FTCA). The appropriation established the Free Clinics Medical Malpractice judgment fund and extended FTCA coverage to medical professional volunteers in free clinics in order to expand access to healthcare services for low-income individuals in medically underserved areas.

Allocation Method: Qualifying Free Clinics submit applications to the Department of Health and Human Services to have volunteer providers that they sponsor deemed. Qualifying 'free clinics' or healthcare facilities operated by nonprofit private entities must be licensed or certified in accordance with applicable law regarding the provision of health services. They cannot:

- Accept reimbursements from any third-party payor (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program including Medicare or Medicaid).
- Impose charges on the individuals to whom the services are provided, or impose charges according to the ability of the individual involved to pay the charge.

Increasing Access: In FY 2009, 3,754 volunteer healthcare providers received Federal malpractice coverage through the Program, exceeding the Program target and representing an increase of more than 748 volunteer providers over FY 2008, and 1,334 providers over the FY 2007 level.

In FY 2005, the first year that the program began deeming providers, 38 free clinics were operating with FTCA-deemed volunteer clinicians; in FY 2006, this number increased to 65 clinics; in FY 2007, this number further increased to 80 clinics; in FY 2008, the number was 93 clinics, and in FY 2009 121 free clinics participated, exceeding the Program's annual targets each year. The Program also examines the quality of services annually by monitoring the percentage of free clinic health professionals meeting licensing and certification requirements. Performance continues to meet the target with 100 percent of FTCA-deemed clinicians meeting appropriate licensing and credentialing requirements.

Promoting Efficiency: The Free Clinics Medical Malpractice Program is committed to improving overall efficiency by controlling the Federal administrative costs necessary to deem each provider. By restraining these annual administrative costs, the Program is able to provide an increasing number of clinicians with malpractice coverage, thus building the free clinic workforce capacity nationwide and increasing access to care for the vulnerable populations served by these clinics. In FY 2005, the first year the Program deemed providers, the cost per provider was $221. The FY 2006 target included a projected one-time increase due to new contractor costs, substantial initial redeeming application activities, increased technical assistance, development of claims administration systems and outreach assistance. In FY 2007, the cost per provider was $164, well below the performance target and more than 50 percent less than FY 2006 costs. In FY 2008, the cost per provider was $153, and in FY 2009 the cost per provider was $154, exceeding the program performance target each year.

Program Assessment: The Free Clinics Medical Malpractice Program underwent a program assessment in FY 2006. The assessment cited that the Program is adequate in achieving its annual goal in the percentage of volunteer FTCA-deemed clinicians who meet certification and privileging requirements and is managing risk with procedures in place to ensure that only providers with a relatively low risk of receiving a malpractice suit receive malpractice coverage.

Through FY 2009, there have been no paid claims under the Free Clinics Medical Malpractice Program.

Funding History

FY	Amount
FY 2006	$40,000
FY 2007	$41,000
FY 2008	$40,000
FY2009	$40,000
FY 2010	$40,000

Budget Request

The FY 2011 Request for the Free Clinics Medical Malpractice Program is $40,000 to maintain current service levels. It is the same as the FY 2010 Appropriation.

The entire FY 2011 Budget Request will support the Program's achievement of its ambitious performance targets and continue its goal of increasing access and capacity in the healthcare safety net.

Targets for FY 2011 focus on increasing the number of volunteer free clinic healthcare providers deemed eligible for FTCA malpractice coverage to 4,250 while also increasing the number of free clinics operating with FTCA-deemed volunteer clinicians to 145. The focus on quality will continue to hold the Program to a target of 100 percent for FTCA-deemed clinicians meeting appropriate licensing and certification requirements. The Program will also continue to promote efficiency by restraining growth in the annual Federal administrative costs necessary to deem each provider, with a $165 administrative cost per provider target in FY 2011.

The Budget Request will also support the Program's continued coordination and collaboration with related Federal programs in order to further leverage and promote efforts to increase the capacity of the healthcare safety net. Areas of collaboration include coordination with the Health Center FTCA Program, also administered by HRSA, to share program expertise. In addition, the two programs control costs by sharing a contract to process future claims, and by providing technical support and outreach. The Program will coordinate with non-profit free clinic-related umbrella groups on issues related to program information dissemination and outreach and will continue to collaborate with the Department of Justice (DOJ) and the HHS Office of General Counsel (HHS/OGC) to assist in drafting items including deeming applications and related policies. The Program continues to work with the HHS/OGC to answer legal technical assistance issues raised by free clinics in the program and clinics interested in joining the program.

Outcome and Output Table

Long Term Objective: Expand the capacity of the healthcare safety net

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011+/- FY 2010
2.I.A.1: Number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage *(Outcome)*	FY 2009: 3,754 (Target Exceeded)	4,000	4,250	+250
2.1: Patient visits provided by free	N/A	N/A	TBD	N/A

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011+/- FY 2010
clinics sponsoring volunteer FTCA-deemed clinicians (Developmental)[1] (Outcome)				
2.I.A.2: Number of free clinics operating with FTCA-deemed volunteer clinicians *(Output)*	FY 2009: 121 (Target Exceeded)	130	145	+15
2.I.A.3: Percent of volunteer FTCA-deemed clinicians who meet certification and privileging requirements *(Output)*	FY 2009: 100% (Target Met)	100%	100%	Maintain
2.E: Administrative costs of the program per Federal Tort Claims Act (FTCA)-covered volunteer *(Efficiency)*	FY 2009: $154 (Target Exceeded)	$170	$165	-$5

1 Data for this developmental long-term measure is projected to be available in May 2010, at which time 2011 targets are projected to be established.

National Hansen's Disease Program

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$16,109,000	---	$16,109,000	$16,109,000	---
FTE	74	---	74	83	---

Authorizing Legislation: Section 320 of the Public Health Service Act.

FY 2011 Authorization ..... Indefinite

Allocation Method ..... Contract

Program Description and Accomplishments

The National Hansen's Disease Program (NHDP) has been providing care and treatment for Hansen's Disease (leprosy) and related conditions since 1921. The Program provides medical care to any patient living in the United States or Puerto Rico through direct patient care at its facilities in Louisiana, through grants to an inpatient program in Hawaii and by contracting with 11 regional outpatient clinics. Currently there are 2,888 patients cared for through the NHDP's outpatient clinics. The Program also provides training to health professionals, and conducts scientific research at the world's largest and most comprehensive laboratory dedicated to Hansen's Disease. The Program is the only dedicated provider of expert Hansen's disease treatment services in the United States and a crucial source of continuing education for providers dealing with the identification and treatment of the disease in the United States.

Increasing Quality of Care: Early diagnosis and treatment helps reduce Hansen's Disease-related disability and deformity. This can only be achieved if there are enough healthcare providers in the U.S. with knowledge of the disease and access to the support provided by the NHDP though its function as an outpatient clinic, training, education, and referral center. Increasing knowledge about Hansen's Disease in the U.S. medical community is expected to lead to earlier diagnosis and intervention, resulting in a decrease in Hansen's Disease-related disabilities. In FY 2009, the NHDP exceeded its program performance target of 50, and trained 157 private sector physicians, also an increase over the 146 physicians trained in FY 2008 and the 135 physicians trained in FY 2007.

Improving Health Outcomes: Hansen's Disease is a life-long chronic condition which left untreated and unmanaged will usually progress to severe deformity.

Through its focus on early diagnosis and treatment, the NHDP is monitoring its impact on improving health outcomes for Hansen's Disease patients through the prevention of increases in

the percentage of patients with grades 1 or 2 disability/deformity.[1] In FY 2005, 51% of patients had grades 1 or 2 disability/deformity. In FY 2006 that figure was 46%, and in FY 2007 that figure was 47%, exceeding the target of 50% in both years.

The Program is also working to improve health outcomes through advances in Hansen's Disease research. The Program is measuring its advances in scientific knowledge through breakthroughs in genomic and molecular biology. The key performance measure examines the development of six protective biological response modifiers (BRMs) and six white blood cell subtype markers (CMs) that are important in host resistance to Hansen's Disease. These markers and other progress will aid in the study of defective nerve function in infected armadillos which will ultimately permit development of a full animal model for human Hansen's Disease. In FY 2007, the program met its target and developed the second of the 12 reagents (BRM-2) needed to produce a relevant animal model, as well as the first of six white blood cell subtype markers (CM-1). In FY 2008, the Program met its target and developed the third of the 12 reagents (BRM-3) needed to produce a relevant animal model, as well as the second and third of six white blood cell subtype markers (CM-2 and CM-3).

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

By restraining increases in the cost per individual served by the Ambulatory Care Program Clinics and at the NHDP's outpatient centers below the national medical inflation rate, the Program can continue to serve more patients that otherwise would have required additional funding to serve in the fiscal year. In FY 2008, the cost per patient served through outpatient services was $1,244, more than $400 or 26% below the target of expected growth in cost per patient served.

Program Assessment: The National Hansen's Disease Program underwent a program assessment in FY 2006. The assessment cited that the Program is the only dedicated provider of expert Hansen's Disease treatment, education, and research in the U.S. and is on track to meet its long-term goals. The assessment noted that the Program lacks an independent evaluation that provides information on the overall effectiveness of the program. In response, an independent evaluation of the Program is being planned.

[1] Disability/ deformity is measured based on the World Health Organization scale, which ranges from 0-2. Patients graded at 0 have protective sensation and no visible deformities. Patients graded at 1 have loss of protective sensation and no visible deformity. Patients graded at 2 have visible deformities secondary to muscle paralysis and loss of protective sensation.

In addition, the Program is expanding its efforts to train private sector physicians in the diagnosis and treatment of Hansen's disease and is also implementing recommendations of a recent Research Advisory Panel of national and international experts regarding the NHDP's research activities.

Funding History

FY	Amount
FY 2006	$15,894,000
FY 2007	$15,972,000
FY 2008	$15,693,000
FY 2009	$16,109,000
FY 2010	$16,109,000

Budget Request

The FY 2011 Budget Request of $16,109,000 reflects no increase over the FY 2010 appropriated level. The entire FY 2011 Budget Request will support the Program's achievement of its ambitious performance targets. The Program will continue its goals in the area of increasing quality of care and improving health outcomes for Hansen's Disease patients.

A target for FY 2011 is to train 150 physicians, improving their knowledge and ability to diagnose and treat Hansen's Disease. A national promotion effort targeted at physicians whose practice may include individuals with Hansen's Disease (e.g., dermatologists) is underway, as well as targeted efforts to train healthcare providers in Hansen's Disease where clusters of newly diagnosed cases are appearing.

In the area of Hansen's Disease disability/deformity prevention, it is expected that both the program's existing case management efforts as well as its activities to train more private sector physicians to recognize Hansen's Disease and initiate treatment earlier, will help prevent further increases in the level of disability/deformity among Hansen's patients, maintaining the Grade 1 and Grade 2 levels of deformity to 50% in FY 2011. The Program's target for its research measure is to continue to develop animal model reagents, as necessary. This target is particularly ambitious because it requires breakthroughs in genomic and molecular biology where currently, no such model for human leprosy exists. The Program will also continue to promote efficiency by targeting in FY 2010 and FY 2011 cost per patient increases below the national medical inflation rate.

The FY 2011 funding will support the Program's continued coordination and collaboration with related Federal, State, local, and private programs to further leverage and promote efforts to improve quality of care, health outcomes and research related to Hansen's Disease.

Areas of collaboration include a partnership with the Food and Drug Administration (FDA) Drug Shortage Program to distribute the anti-leprosy drug clofazimine to over 500 providers nationally. At the request of the FDA, the Program has also agreed to manage an investigational new drug (IND) distribution that makes the drug available in the United States. The Program continues to collaborate with researchers worldwide to further the study of and scientific advances related to the disease.

The Program continues to share its expertise in treatment of the Hansen's Disease insensitive foot to the more prevalent insensitive diabetic foot by providing multilingual training and education on the prevention and care of the diabetic insensitive foot.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
3.E: Maintain increases in the cost per patient served in the outpatient clinics to below the medical inflation rate *(Efficiency)*	FY 2008: $1,244 (Target Exceeded)	Below national medical inflation rate	Below national medical inflation rate	Maintain

Long Term Objective: Expand the availability of healthcare, particularly to underserved, vulnerable, and special needs populations

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
3.II.A.2.: Number of private sector physicians who have received training from the NHDP *(Output)*	FY 2009: 157 (Target Exceeded)	150	150	Maintain
3.II.A.3: Number of patients provided Hansen's Disease outpatient care through the National Hansen's Disease Program *(Output)*	FY 2008: 2,888 (Target Not Met)	3,000	3,000	Maintain

Long Term Objective: Promote effectiveness of healthcare services

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
3.III.A.1: Develop an animal model for the full spectrum of clinical complexities of human Hansen's Disease *(Output)*	FY 2008: BRM 3, CM 2, 3 (Target Met)	Demonstrate defective nerve function in infected armadillos	Continue to develop animal model reagents, as necessary	N/A
3.II.A.1: Percent increases in the level of Hansen's Disease related disability and deformity among patients treated and managed by the National Hansen's Disease Program (NHDP) (Percentage of patients at grades 1 and 2) *(Outcome)*	FY 2007: 47 (Target Exceeded)	50%	50%	Maintain

Program Outputs

	FY 2009 Appropriation	**FY 2009 ARRA**	**FY 2010 Appropriation**	**FY 2011 Request**
NHDP Resident Population	25	---	20	20
NHDP Non-Residential Outpatients	180	---	180	180
Ambulatory Care Program (ACP) Clinics	11	---	11	11
ACP Clinic Patients (Outpatients)	3,000	---	3,000	3,000
ACP Clinic Patient Visits	16,000	---	16,000	16,000
NHDP Non-Residential Outpatient Visits	21,075	---	21,075	21,075

National Hansen's Disease Program by Sub – Activity

	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 Budget Level
Administration	$1,589,000	$1,589,000	$1,589,000
Clinical Care	5,867,000	6,260,000	6,260,000
Regional Centers	2,000,000	2,000,000	2,000,000
Research	2,500,000	2,500,000	2,500,000
Facility Operations	2,546,000	2,153,000	2,153,000
Assisted Living Allowance	1,607,000	1,607,000	1,607,000
Total	$16,109,000	$16,109,000	$16,109,000

Payment to Hawaii

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$1,976,000	---	$1,976,000	$1,976,000	---
FTE	---	---	---	---	---

Authorizing Legislation: Section 301 of the Public Health Service Act.

FY 2011 Authorization ..... Indefinite

Allocation Method ..... Direct Federal

Program Description and Accomplishments

Payments are made to the State of Hawaii for the medical care and treatment in its hospital and clinic facilities at Kalaupapa, Molokai and Honolulu, of persons with Hansen's Disease. Expenses above the level of the Federal funds appropriated for the support of medical care are borne by the State of Hawaii.

Funding History

FY	Amount
FY 2006	$1,995,000
FY 2007	$1,996,000
FY 2008	$1,961,000
FY 2009	$1,976,000
FY 2010	$1,976,000

Budget Request

The FY 2011 Budget Request of $1,976,000 for the Payment to Hawaii program is the same as the FY 2010 Appropriation to maintain current service levels.

Outcomes and Outputs Tables

Program Outputs	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget
Average daily HD Kalaupapa patient load	23	---	19	19
Total Kalaupapa and Halemohalu patient hospital days	4,333	---	3,579	3,579
Total Kalaupapa homecare patient days	9,068	---	6,935	6,395
Total Hawaiian HD program outpatients	235	---	235	235
Total outpatient visits	3,740	---	3,740	3,740

Buildings and Facilities

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$129,000	---	$129,000	$129,000	---
FTE	---	---	---	---	---

Authorizing Legislation: Sections 320 and 321(a) of the Public Health Service Act.

FY 2011 Authorization ..... Indefinite

Allocation Method ..... Direct Federal

Program Description and Accomplishments

This activity provides for the renovation and modernization of buildings at the Gillis W. Long Hansen's Disease Center at Carville, Louisiana to eliminate structural deficiencies under applicable laws in keeping with accepted standards of safety, comfort, human dignity, efficiency, and effectiveness. The projects are intended to assure that the facility provides a safe and functional environment for the delivery of patient care and training activities; and meets requirements to preserve the Carville historic district under the National Historic Preservation Act.

Funding History

FY	Amount
FY 2006	$220,000
FY 2007	$220,000
FY 2008	$157,000
FY 2009	$129,000
FY 2010	$129,000

Budget Request

The FY 2011 Budget Request of $129,000 for the Buildings and Facilities program is the same as the FY 2010 Appropriation to maintain current service levels. The request is required for continued renovation and repair work on patient areas, to complete minor renovation work on the Carville museum, and to continue regular renovation and repair work on clinic areas and offices.

Outcomes and Outputs

See National Hansen's Disease Program.

National Health Service Corps

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
NHSC Field BA	$39,736,000	$60,000,000	$41,128,000	$46,001,000	+$4,873,000
NHSC Recruitment BA	$95,230,000	$240,000,000	$100,797,000	$122,588,000	+$21,791,000
Total NHSC	$134,966,000	$300,000,000	$141,925,000	$168,589,000	+$26,664,000
Total FTE	131	---	127	127	---
Ready Responders	41	---	37	37	---

Authorizing Legislation: Sections 338A, B, and I of the Public Health Service Act, as amended by P.L. 110-355.

FY 2011 Authorization……$170,296,310

Allocation Method ..... Competitive Awards to Individuals

Program Description and Accomplishments

The National Health Service Corps (NHSC) assists Health Professional Shortage Areas (HPSAs) in every State, Territory, and Possession of the United States to meet their primary care, oral, and mental and behavioral health services needs. Over its 39-year history, the NHSC has offered recruitment incentives, in the form of scholarship and loan repayment support to more than 29,000 health professionals committed to service to the underserved. NHSC clinicians have expanded access to high quality health services and improved the health of underserved people.

The NHSC has, since its inception in 1972, worked closely with the Federally-funded Health Centers to help meet their clinician needs. Currently, approximately 50 percent of the NHSC clinicians serve in Health Centers around the Nation. The NHSC also places clinicians in other community-based systems of care that serve underserved populations, targeting HPSAs of greatest need.

The NHSC Scholarship Program awards scholarships to health professions students committed to a career in primary care and service in underserved communities of greatest need. Awards are targeted to individuals who demonstrate characteristics that are significantly related to a probable success in a career of service to the underserved. The Scholarship Program provides a predictable supply of clinicians who will be available over the next 1 to 8 years, depending on the length of their training programs. Upon completion of training, NHSC scholars become salaried employees of organized

systems of care in underserved communities.

The NHSC Loan Repayment Program offers fully trained primary care clinicians the opportunity to receive assistance to pay off qualifying educational loans in exchange for service in a HPSA of greatest need. This service commitment is for a minimum of two years in an underserved community. 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 combination of these two programs allows flexibility in meeting the future needs (through scholars) and the immediate needs (through loan repayers) of underserved communities in the following ways:

Table 1. NHSC Field Strength by Program as of 09/30/09

Programs	No.
Scholarship Program clinicians	576
Loan Repayment Program clinicians	3,385
Ready Responders	36
State Loan Repayment clinicians	763
Total	**4,760**[1]

Table 2. NHSC Field Strength by Discipline as of 09/30/09

Disciplines	No.
Allopathic/Osteopathic physicians	1,658
Dentists	614
Dental Hygienists	72
Nurse Practitioners	583
Physician Assistants	664
Nurse Midwives	109
Mental and Behavioral Health professionals	1060
Total	**4,760**[1]

In FY 2008:

- The NHSC had 3,601 clinicians in service to the underserved, which exceeded the target of 3,559 by three percent.

[1] Field strength number 4,760 is subject to an internal program audit, and the number may be changed slightly at the completion of the audit.

- The NHSC Scholarship Program made 76 new awards; 179 scholars were placed in service.
- The NHSC Loan Repayment Program placed 867 clinicians in service through new loan repayment contracts.

In FY 2009:

- The NHSC Jobs Opportunity List showed a total of 7,678 vacancies Nationwide; of these, 4,287 (56 percent) were located in Health Centers.
- The NHSC had 4,760 clinicians in service to the underserved, which exceeded the target of 4,674 by two percent.
- The NHSC Scholarship Program made 88 new awards; there are 532 scholars in school or in training, and 197 scholars were placed in service.
- The NHSC Scholarship Program average award was $202,506.
- The NHSC Loan Repayment Program made 949 new awards.
- The NHSC Loan Repayment average award was $38,328.

- ARRA Funds:
  - The NHSC Scholarship Program made 70 new awards in FY 2009.
  - The NHSC Loan Repayment Program made 829 new awards in FY 2009.

In FY 2010:

- The NHSC Scholarship Program is projected to make 42 new awards.
- The NHSC Loan Repayment Program is projected to make 1,099 new awards.

- ARRA Funds:
  - The NHSC Scholarship Program is projected to make 70 new awards in FY 2010.
  - The NHSC Loan Repayment Program is projected to make 1,995 new awards in FY 2010.

The NHSC had a program assessment review in 2002. This assessment found that the NHSC had a clear purpose and was designed to have a unique and significant impact; that the program ensures clinicians honor their service agreements, uses information to improve outcomes, and had shown some efficiency improvements. The review noted that efficiency could be improved with greater flexibility in allocating funds between scholarships and loan repayments.

In response to this review, the NHSC has in recent years better targeted NHSC placements in HPSAs of greatest need: in 2009 placing 1,975 NHSC clinicians in sites with an average HPSA score of 13.0, a score which did not meet the target, which is likely due to the 88 percent increase in the number of placements over the FY 2008 level (1,046 placements). (The HPSA score is a proxy for the degree of

[2] Reflects impact of ARRA Funding
[3] This long-term measure does not have annual targets. FY 2010 is the first out-year target date
[4] Does not include State Loan Repayment program (SLRP) funding

need for health professionals in an area. Scores range from 1 to 25, with 25 representing the greatest need.) The program has been as flexible as possible under the current law to allocate more funds to loan repayers to meet more of the immediate need in underserved communities, and is endeavoring to replace its legacy information system to further increase management efficiencies.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews. Funds are also used to administer the American Recovery and Reinvestment Act (ARRA).

Funding History

FY	Amount
FY 2006	$125,441,000
FY 2007	$125,673,000
FY 2008	$123,477,000
FY 2009	$134,966,000
FY 2009 Recovery Act	$300,000,000
FY 2010	$141,925,000

Budget Request

The FY 2011 President's Budget Request of $168,589,000 is an increase of $26,664,000 above the FY 2010 Appropriation. The $26,664,000 increase will result in a $4,873,000 increase in the NHSC Field Line, which will be used to increase the infrastructure support described above, including operations and maintenance of an up-to-date information management system, which will be needed to facilitate the anticipated increased management burden of the program both in the immediate future and the long-term monitoring and support of a greatly expanded Field Strength.

The Recruitment Line will increase by $21,791,000, which will fund 49 new scholars and 1,460 new loan repayers in FY 2011.

A programmatic decision that was made in FY 2009 to increase funding of the State Loan Repayment Program (administered by the Bureau of Health Professions) to $10,000,000 annually. The State Loan Repayment Program (SLRP) is a grant which offers a dollar-for-dollar match between the State and the NHSC for loan repayment contracts to clinicians to practice in a HPSA in that State. While this results in a decrease in funding for other NHSC programs, the cost-per-clinician to the NHSC is so much less in the SLRP that number of new SLRP contracts more than makes up for the loss in the other NHSC programs.

- **ARRA Funds**:

- In FY 2010 the NHSC will fund the State Loan Repayment Program with $14,200,000 in ARRA Recruitment funds.

As a significant source of highly qualified, culturally competent clinicians for the Health Center Program, as well as other safety net providers, the NHSC can build on its success in assuring access to residents of HPSAs, removing barriers to care and improving the quality of care to these underserved populations. The NHSC Program is working with many communities in partnership with State, local, and National organizations to help address their healthcare needs.

Funding in FY 2011 for the NHSC Programs will support efforts to work with Health Centers and other community-based systems of care to improve the quality of care provided and reduce the health disparities gap. As measurement of these efforts:

In FY 2011:

- The NHSC Scholarship Program is projected to make 49 new awards.
- The NHSC Loan Repayment Program is projected to make 1,460 new awards.

- ARRA:
  The NHSC Scholarship Program is projected to make 25 new awards in FY 2011.
- The NHSC Loan Repayment Program is projected to make 671 new awards in FY 2011.

- The NHSC Field Strength is projected to be 8,561 (reflecting ARRA funding and FY 2011 Request). The NHSC field strength is one of the High Priority Performance goals that the Administration will track over the next two years to monitor the achievement of results.
- The NHSC will continue the pilot demonstration project to test less-than-full-time service for Loan Repayment Program clinicians begun in 2010.
- The NHSC will continue the Provisional Qualification for the NHSC Loan Repayment Program for those in the last year of school or training to broaden the recruitment pool begun in 2010.

ARRA:

The NHSC received $300,000,000 in ARRA funding, of which $75,000,000 is authorized to be expended in FY 2011, and will be expended in the following manner:

	Field Line	Recruitment Line
FY 2011	$60,000,000	$15,000,000

Field Line funding will support expanded infrastructure including contracts, additional temporary Federal and contract staff to support a massive outreach and recruitment campaign and the resulting additional burdens of increased application processing, obligation of funding for awards, and short and long term monitoring of an NHSC Field Strength that is projected to be more than double the FY 2008 level.

BCRS Management Information Support System (BMISS) costs are split among the National Health Services Corps and the Nursing Education Loan Repayment and Scholarship Programs. BMISS is in direct response to a reorganization of several scholarship and loan repayment programs under one umbrella. With this reorganization, multiple, disconnected IT solutions continue to be used, resulting in inefficient processes and manual workarounds. BMISS will consolidate the process into one unified solution shared across the programs to increase efficiency and cost effectiveness.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
UU4.I.C.1: Number of individuals serviced through the placement and retention of NHSC clinicians. *(Outcome)*	FY 2009: 5.94 Million[2] (Target Exceeded)	8.56[2] Million	9.9[2] Million	+1.34 Million
4.1: Number of individuals served in all communities seeking NHSC assistance through NHSC placement, retention and other sources. *(Outcome)*[3]	N/A	9.04[2] Million	N/A	---
4.I.C.2: Field strength of the NHSC through scholarship and loan repayment agreements. *(Outcome)*	FY 2009: 4,760[1,2] (Target Exceeded)	7,358[2]	8,561[2]	+1,203
4.I.C.4: Percentage of NHSC clinicians retained in service to the underserved. *(Outcome)*	FY 2006: 76% (Target Not Met)	79%	79%	Maintain
4.I.C.3: Number of NHSC-list vacancies filled through all sources. *(Output)*[2]	FY 2009: 3,424[2] (Target Not Met)	4,400[2]	5,000[2]	+600
4.I.C.5: Average HPSA score of the sites receiving NHSC clinicians, as proxy for service to communities of greatest need. *(Output)*	FY 2009: 13.0 (Target Not Met)	13.0	13.0	Maintain
4.E: Maintain or decrease the average cost to the NHSC program of a patient encounter. *(Efficiency)*	FY 2009: $5.90 (Target Not Met)	$5.50	$5.45	-$0.05

Loans/Scholarships Table[4]

(whole dollars)	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget Request
Loans	$63,394,077	$77,723,630	$96,666,270
Scholarships	$19,238,109	$9,747,120	$12,851,804
ARRA Loans	$37,087,055	$99,750,000	$33,430,000
ARRA Loan Amendments			$20,300,000
ARRA Scholarships	$8,411,500	$13,851,445	$5,000,000
ARRA Scholarship Continuations			$970,000

Table 3. Impact on NHSC Field Strength of FY 2011 Budget Request Awards

Fiscal Year	2006	2007	2008	2009	2010	2011
AWARDS:						

Scholarship	97	118	76	88	42	49
Scholarship Continuation	37	19	18	8	25	25
Federal Loan Repayment	929	899	867	949	1,099	1,460
Federal Loan Repayment Amendment	558	648	668	705	651	676
State Loan Repayment	280	280	280	400	400	400
ARRA Scholarship				70	70	25
ARRA Scholarship Continuation						20
ARRA Federal Loan Repayment				829	1,995	671
ARRA Federal Loan Repayment Amendment						580
ARRA State Loan Repayment				-	800	--

Table 4. Impact on NHSC Field Strength of FY 2011 Budget Request Grants

Fiscal Year	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
FIELD STRENGTH:						
Scholarship Obligors	658	633	598	576	588	507
Loan Repayers	2,752	2,535	2,451	2,556	2,645	3,171
State Loan Repayment	622	592	514	763	800	800
ARRA Loan Repayers				829	2,824	3,246
ARRA State Loan Repayment				--	464	800
Community Scholarship Clinicians	11	3	1	--	--	--
USPHS Commissioned Corps Ready Responders	66	57	37	36	37	37
(as of 9/30)	4,109	3,820	3,601	3,931	4,070	4,515
ARRA Field Strength				829	3,288	4,046
Total Field Strength	**4,109**	**3,820**	**3,601**	**4,760**	**7,358**	**8,561**
Placements:						
Grant	2,219	2,063	1,709	2,123	2,197	2,438
Non-Grant	1890	1,757	1,892	1,808	1,873	2,077
ARRA Grant				448	1,775	2,185
ARRA Non-Grant				381	1,513	1,861

Waterfall Assumptions:
1. Starting FY 2009 - Funding Distribution: 10% Scholarship/90% Loan Repayment
2. Increase SLRP Funding to $10 million beginning FY 2009.
3. Estimates 2010 and forward

Nursing Education Loan Repayment and Scholarship Programs

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$37,128,000	$27,000,000	$93,864,000	$93,864,000	---
FTE	---	---	---	---	---

Authorizing Legislation: Section 846 of the Public Health Service Act

FY 2011 Authorization ..... Expired

Allocation Method ..... Awards to Individuals

Program Description and Accomplishments

The Nursing Education Loan Repayment Program (NELRP) is a financial incentive program under which individual registered nurses (RNs) enter into a contractual agreement with the Federal government to work full-time in a healthcare facility with a critical shortage of nurses in return for repayment of qualifying nursing educational loans. NELRP repays 60 percent of the principal and interest on nursing education loans of RNs with the greatest financial need in exchange for two years of full-time service at a healthcare facility with a critical shortage of nurses. Participants may be eligible to receive an additional 25 percent of the original loan balance for an additional year of full-time service in a critical shortage facility. A funding preference is given to RNs with the greatest financial need.

The Nurse Scholarship Program (NSP) offers scholarships to individuals attending accredited schools of nursing in exchange for a service commitment payback of at least two years in healthcare facilities with a critical shortage of nurses after graduation. The NSP award reduces the financial barrier to nursing education for all levels of professional nursing students, thus increasing the pipeline. A funding preference is given to qualified applicants who have zero expected family contribution and who are enrolled full-time in an undergraduate nursing program.

NELRP and NSP work together in an effort to address the need for nurses in Critical Shortage Facilities. The programs receive assistance in application processing and scholar and clinician support through its contracts.

As measurements of that effort:

In FY 2007:

- NELRP made 586 loan repayment contracts; and 902 loan repayers were working in Critical Shortage Facilities.
- NSP made 173 scholarship awards; and 337 scholars were working in Critical Shortage Facilities.

In FY 2008:

- NELRP made 426 loan repayment contracts.
- NSP made 178 scholarship awards.
- NELRP exceeded the goal of 90 percent of participants working in Critical Shortage Facilities,
- NELRP failed to meet the goal of having participants working in 93 percent of the States. Some fluctuation from year to year is expected because awards are based on financial need and type of facility rather than geographical distribution.

In FY 2009:

- NELRP made 392 new loan repayment contracts and 171 3rd year amendments.
- NSP made 189 new scholarship awards and 15 continuations.

- ARRA Funds:
  NELRP made 427 new awards in FY 2009 with ARRA funds.

- The average new NELRP award for ARRA and Base was $53,095. The average NELRP amendment was $19,719.

- The average new NSP award was $49,383. The average NSP continuation was $19,004.

In FY 2010:

- NELRP expects to make 740 new loan repayment awards and 115 contract extensions.
- NSP expects to make 470 scholarship awards.
- NELRP and NSP expects to meet the goal of 85 percent of participants working in Critical Shortage Facilities within four months of licensure,
- NELRP and NSP expects to meet the goal of 100 percent of participants working in Critical Shortage Facilities,

- NELRP and NSP expects to meet the goal of 45 percent of participants working in Critical Shortage Facilities one year beyond completion of the service obligation, and

- NELRP and NSP expects to meet the goal of having participants working in 93 percent of the States.

The NELRP had a program assessment review in 2002. The assessment noted that research has found healthcare quality and patient well-being appear to be impacted by the number of nurses working in the facility relative to the number of patients in their care. Additional annual performance measures were identified at that time, covering program participants' extension of their service obligations and retention in service to shortage facilities following completion of contractual obligations.

To contribute to program performance, NELRP will finalize the methodology for identifying Critical Shortage Facilities for nurses, in order to better target program resources to areas and facilities of greatest need. Both NSP and NELRP will be part of the development of an information system to replace the legacy Nursing Information System, expected to be completed in spring of 2011. Funds are also used to administer the American Recovery and Reinvestment Act (ARRA).

Funding History

FY	Amount
FY 2006	$ 31,034,000
FY 2007	$ 31,055,000
FY 2008	$ 30,512,000
FY 2009	$ 37,128,000
FY 2009 Recovery Act	$ 27,000,000
FY 2010	$ 93,864,000

Budget Request

The FY 2011 President's Budget Request of $93,864,000 is equal to the FY 2010 appropriation level. Funds in the amount of $54,936,119 will support approximately 555 new loan repayment awards and 395 contract extensions (including 256 ARRA extensions) for RNs agreeing to work in healthcare facilities with a critical shortage of nurses. The NELRP provides an economic incentive to these nurses to begin and/or continue practice in these healthcare facilities. Funds in the amount of $27,468,060 out of the total budget will be used to support 425 NSP scholarship awards.

Base appropriations will be used to support 256 ARRA contract extensions in FY 2011; therefore, NELRP program will make 185 fewer new awards in FY 2011 than in FY 2010.

From FY 2009 to FY 2010, NELRP and NSP program has increased 253 percent to address the shortage of registered nurses. With additional increases in FY 2011 appropriation, the program will require additional resources to continue to manage the large influx of students and nurses in the program. The remaining funds will be used to fund the programs' support contracts. These

contracts support the application processing center; stipend processing center; call center; monitoring center; IT system development; and maintenance of the legacy systems.

There is a shortage of nurses at health facilities in certain areas of the United States. The demand has intensified for nurses prepared in programs that emphasize leadership, patient education, case management, and care across a variety of delivery settings. National and State studies, including the HRSA's *Finding from the National Sample Survey of Registered Nurses - March 2004* demonstrate that the aging nursing workforce could reduce the supply of RNs in the future. Both the NELRP and the NSP are part of the National strategy to alleviate the immediate shortfall in the number of working nurses and to assure an adequate supply of nurses in the future.

Funding for NELRP and NSP will continue to address the critical shortage of nurses across the U.S. As a measurement of that effort:

In FY 2011:

- NELRP expects to make 555 new loan repayment awards and 395 contract extensions.
- NSP expects to make 425 scholarship awards.
- NELRP and NSP expect to meet the goal of 85 percent of participants working in Critical Shortage Facilities within four months of licensure,
- NELRP and NSP expect to meet the goal of 100 percent of participants working in Critical Shortage Facilities,
- NELRP and NSP expect to meet the goal of 54 percent of participants working in Critical Shortage Facilities one year beyond completion of the service obligation, and
- NELRP and NSP expect to meet the goal of having participants working in 93 percent of the States.

The Nurse Education Loan Repayment Program (NELRP) and the Nursing Scholarship Program (NSP) are authorized under Section 846 of the Public Health Service Act [42 USC 297n] to work in partnership with other HHS programs to encourage more people to consider nursing careers and motivate them to serve in areas of critical shortage. The performance measures gauge these programs' contribution to the HRSA strategic goals of improving access to health care and improving the health care systems through the recruitment and retention of nurses working in Critical Shortage Facilities. Increasing the number of nurses at facilities critical shortage of nurses will be a key output. With additional funds, the program allows more individuals to enter into the nursing field and in turn address the national shortage of nurses.

A major challenge facing NELRP is ensuring placements in facilities with the greatest need. As one strategy to assure better targeting of program resources to areas and facilities of greatest need, the Program is finalizing a methodology for identifying Critical Shortage Facilities for nurses.

Another major challenge for the Program is the current difficulty with data collection and analysis. The Program had been using a Nursing Information System which was deactivated in anticipation of another system being brought online. The development of the new system in the spring of 2011 will alleviate the data collection and analysis issues.

BCRS Management Information Support System (BMISS) costs are split among the National Health Services Corps and the Nursing Education Loan Repayment and Scholarship Programs. BMISS is in direct response to a reorganization of several scholarship and loan repayment programs under one umbrella. With this reorganization, multiple, disconnected IT solutions continue to be used, resulting in inefficient processes and manual workarounds. BMISS will consolidate the process into one unified solution shared across the programs to increase efficiency and cost effectiveness.

Outputs and Outcomes Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
5.1: Increase the number of individuals enrolled in professional nursing education programs. [1] *(Outcomes)*	FY 2002-2003 240,500 (Baseline)	10 % over Baseline	N/A	N/A
5.I.C.1: Increase the proportion of nursing scholarship recipients working in a facility with a critical shortage of nurses within 4 months of licensure. *(Outcomes)*	N/A	85%	85%	Maintain
5. I.C.2: Increase the proportion of NELRP participants working shortage facilities such as: Disproportionate Share Hospitals for Medicare and Medicaid, Nursing Homes, Public Health Departments (State and local) and Public Health Clinics contained in these Departments. *(Outcomes)*	FY 2008: 100% (Target Exceeded)	100%	100%	Maintain
5.I.C.4: Reduce Federal investment per year of direct support by increasing the proportion of program participants who extend their service contracts to commit to work at a critical shortage facility for an additional year. *(Outcomes)*	FY 2008: 54% (Target Exceeded)	54%	54%	Maintain
5.I.C.3: Increase the percent of States in which NELRP contract recipients work. *(Outputs)*	FY 2008: 88% (Target Not Met)	93%	93%	Maintain
5.E: Increase the proportion of NELRP participants who remain employed at a critical shortage facility for at least one year beyond the termination of their NELRP service. *(Efficiency)*	N/A	50%	50%	Maintain

Note: While ARRA funding will increase the number of participants, it is not expected to change the targets.

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

Loans/Scholarships Table

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY2011 President's Budget Request
Total Loans	$19,994,198	$26,862,400	$55,634,477	$54,936,119
Total Scholarships	$9,618,535	---	$27,812,239	$27,468,060

Faculty Loan Repayment Program/Minority Faculty Fellowship Program

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$1,266,000	$1,200,000	$1,266,000	$1,266,000	---
FTE	---	---	---	---	---

Authorizing Legislation: Sections 738 of the Public Health Service Act.

FY 2011 Authorization ..... Expired

Allocation Method ..... Competitive Awards to Individuals

Program Description and Accomplishments

The Faculty Loan Repayment Program (FLRP) is a loan repayment program for health profession graduates from disadvantaged backgrounds who serve as faculty at an eligible health professions college or university for a minimum of two years. In return, the Federal Government agrees to pay up to $20,000 of the outstanding principal and interest on the individual's health professions education loans for each year of service. The employing institution must also make payments to the faculty member equal to the principal and interest amount made by the HHS Secretary for each year in which the recipient serves as a faculty member. The Secretary may waive the institution's matching requirements if the Secretary determines it will impose an undue financial hardship. The Minority Faculty Fellowship Program is administered separately from FLRP by the Bureau of Health Professions. Most of the Health Professions' Title VII and Title VIII, PHS Act programs had a program assessment review as a unit in 2002. This program was included in that assessment. The assessment cited that the OIG found in 2002 that institutions participating in the faculty loan repayment program frequently waive matching requirements, reducing the impact per Federal investment. Funds are also used to administer the American Recovery and Reinvestment Act.

In FY 2008:

- The FLRP program made 23 new loan repayment awards, and 43 currently obligated loan repayers from disadvantaged backgrounds were teaching in health professions schools

In FY 2009:

- The FLRP program made 23 new loan repayment awards.

ARRA Funds:**:**
FLRP received $1,200,000 in ARRA funds in FY 2009, which provided 22 new awards.

In FY 2010:

- The FLRP program is expected to make 20 new loan repayment awards.

Funding History

FY	**Amount**
FY 2006	$1,288,000
FY 2007	$1,289,000
FY 2008	$1,266,000
FY 2009	$1,266,000
FY 2009 Recovery Act	$1,200,000
FY 2010	$1,266,000

Budget Request

The FY 2011 President's Budget Request of $1,266,000 is equal to the FY 2010 Appropriation. The Program expects to make about 20 new awards to health profession graduates from disadvantaged backgrounds who serve as faculty at an eligible health professions college or university.

Loans Table

(whole dollars)	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request
Total Loans	$1,167,693	$1,176,142	$1,134,300	$1,134,300

HEALTH PROFESSIONS

Summary of Request

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$354,332,000	$170,813,000	$402,824,000	$408,773,000	+$5,949,000

Authorizing Legislation: Title III, Title VII, and Title VIII of the Public Health Service Act

FY 2011 Authorization ..... Expired

Allocation Method ..... Competitive Grants/Contracts

Authorized by Title III, Title VII, and Title VIII of the Public Health Service Act, the Health Professions programs provide both policy leadership and support for health professions workforce enhancement and educational infrastructure development. BHPr programs tackle a range of current health workforce challenges. There are numerous reports of shortages of primary care physicians, nurses, public health and allied health professionals. The shortage of nurses is made worse by a critical shortage of faculty to provide training in nursing schools. The face of the Nation's health care workforce does not currently reflect the diversity of the population that it serves. A recent Institute of Medicine (IOM) study identifies the aging of the population as a significant trend that requires retooling of the health workforce to deal with geriatric issues.

In FY2009, the health professions programs represented in this summary received $170,813,000 in ARRA funding. In addition, $29,187,000 in health professions training funds are located in other HRSA Bureaus for a total of $200 million in ARRA health professions funding. The specific programs and amounts are addressed elsewhere in the budget request.

The FY 2011 President's Budget Request for Health Professions Training is $408,773,000. The Health Professions programs are comprised of the following activities:

Centers of Excellence: These grants support designated health professions schools to increase the supply and quality of underrepresented minorities in the health professions workforce. The FY 2011 President's Budget Request for the Centers of Excellence Program is $24,602,000. This is the same as the FY 2010 Appropriation.

Scholarships for Disadvantaged Students: These grants fund scholarships to financially needy students from disadvantaged backgrounds who are pursuing a health professions or nursing education in order to increase diversity in the health professions and nursing workforce. The FY 2011 President's Budget Request for the Scholarships for Disadvantaged Students Program is $49,342,000. This is the same as the FY 2010 Appropriation.

Health Careers Opportunity Program: These grants provide funding to support a variety of academic and social supports to individuals throughout the education pipeline in order to increase the number of individuals from economically and educationally disadvantaged backgrounds. Those served through this program span from students early in the education pipeline (to encourage and prepare them in the pursuit of a health professions education and entry into the health professions workforce) to those entering and graduating from health and allied health professions programs. This program provides greater access for these populations to health professions careers. The FY 2011 President's Budget Request for the Health Careers Opportunity Program is $22,133,000. This is the same as the FY 2010 Appropriation.

Health Workforce Information and Analysis Program: This program funds grants and contracts that focus on the collection of core data on the health workforce and the conduct of analytic studies examining a broad range of issues that impact the supply, demand, distribution, and education of the Nation's health workforce. The FY 2011 President's Budget Request for the Health Workforce Information and Analysis Program is $8,781,000. This is an increase of $5,979,000 above the FY 2010 Appropriation.

Training in Primary Care Medicine and Dentistry: These grants support the training of primary care physicians through pre-doctoral education, residency training, and faculty development in order to encourage development of the healthcare workforce. In addition, this program supports improvement of academic administrative units, training of physician assistants, and residency training in general or pediatric dentistry. The FY 2011 President's Budget Request for the Training in Primary Care Medicine and Dentistry Program is $54,425,000. This is the same as the FY 2010 Appropriation.

Area Health Education Centers: These grants are designed to encourage the establishment and maintenance of community based training programs in off-campus rural and underserved areas. The FY 2011 President's Budget Request for the Area Health Education Centers Program is $33,345,000. This is the same as the FY 2010 Appropriation.

Geriatric Programs: These grants provide funding for the training and education of health professionals in geriatrics and support academic career development of geriatricians. The goal is to improve access to health care for older Americans. The FY 2011 President's Budget Request for Geriatric Programs is $33,747,000. This is the same as the FY 2010 Appropriation.

Allied Health and Other Disciplines: These grants provide funding to expand and establish allied health professions programs to improve access to health care. The FY 2011 President's Budget Request for the Allied Health and Other Disciplines Program is $22,390,000. This is the same as the FY 2010 Appropriation.

Public Health, Preventive Medicine, and Dental Public Health Programs: These grants support the education and training of the public health workforce to better equip these individuals with the tools to address emerging issues and provide services to those in medically underserved areas. The FY 2011 President's Budget Request for the Public Health, Preventive Medicine, and Dental Public Health Programs is $10,000,000. This is the same as the FY 2010 Appropriation.

Advanced Nursing Education: These grants support advanced nursing education and practice, and provide traineeships for individuals pursuing advanced nursing education in order to directly address nursing workforce shortages. The FY 2011 President's Budget Request for Advanced Nursing Education is $64,438,000. This is the same as the FY 2010 Appropriation.

Nursing Workforce Diversity: These grants are designed to increase nursing education opportunities for individuals from disadvantaged backgrounds. The program aims to improve the racial and ethnic diversity of the nursing workforce to meet the increasing need for culturally sensitive and quality health care. The FY 2011 President's Budget Request for Nursing Workforce Diversity is $16,107,000. This is the same as the FY 2010 Appropriation.

Nursing Education, Practice and Retention Grants: These grants fund projects designed to strengthen capacity for nurse education and practice in three priority areas: education, practice, and retention. The FY 2011 President's Budget Request for Nursing Education, Practice and Retention Grants is $39,896,000. This is the same as the FY 2010 Appropriation.

Nurse Faculty Loan Program: These grants fund loans to assist nurses in completing their graduate education to become qualified nurse faculty. The FY 2011 President's Budget Request for the Nurse Faculty Loan Program is $25,000,000. This is the same as the FY 2010 Appropriation.

Comprehensive Geriatric Education: These grants the support training, education and development of individuals providing care to the aging population. The FY 2011 President's Budget Request for Comprehensive Geriatric Education is $4,567,000. This is the same as the FY 2010 Appropriation.

The Health Professions programs are subject to reauthorization.

The Health Professions programs were grouped together and underwent a program assessment in 2002. The assessment noted that Health Professions programs did not regularly use performance data to improve program outcomes. It noted, based on a Government Accountability Office report, that effectiveness has not been shown and impact will be difficult to measure without common grantee goals, outcome measures, and reporting.

As a result of the program assessment, Health Professions developed new annual performance measures, established baseline data, regularly collects data and reports on performance. Health Professions has subsequently developed additional measures that encourage the use of strategies most likely to increase positive program outcomes and, in FY 2008 began to collect data for those measures.

In 2008, 53 percent of graduates and program completers of VII and VIII supported programs were underrepresented minorities and/or from disadvantaged backgrounds. This slightly exceeded the FY 2008 target of 50 percent. It slightly exceeded the FY 2007 actual of 51 percent and significantly exceeded the FY 2006 actual of 37 percent.

The long term measure, to increase the proportion of persons who have a specific source of ongoing care, does not have yearly targets. Access to a source of ongoing care does not directly reflect all of the specific activities of the Health Professions program. However, over time, HRSA expected this program to contribute to increasing the proportion of persons with a specific source of ongoing care, through its support of training health professions in all settings. It has remained statistically unchanged.

The proportion of trainees in VII and VIII supported programs training in medically underserved communities was 45 percent in 2008. This slightly exceeded the FY 2008 target of 43 percent. It exceeded the FY 2007 result by six percentage points, but was well short of the FY 2006 result of 54 percent. The program expects such fluctuations in the measure will continue from year-to-year given the range of program purposes grantees may address and which purposes are prioritized in any given year. The program will continue to emphasize to training programs the critical importance of this measure and to strategize with the grantees on how to improve performance in this area.

The programs reporting on the final performance measure, percentage of health professionals supported by the program entering practice in underserved areas, were reviewed in the past year. Several programs had been inappropriately reporting on this measure and were dropped from the calculation. As a result, the percentage reported in the table, 43 percent in 2007, is not comparable to past year results or the FY 2007 target. The programs who are currently reporting on this measure have had a performance history consistent with the present performance level.

Funding History

FY	Amount
FY 2006	$262,352,000
FY 2007	$302,081,000
FY 2008	$318,225,000
FY 2009	$354,332,000
FY 2009 Recovery Act	$170,813,000
FY 2010	$402,824,000

Budget Request

The FY 2011 President's Budget Request for Health Professions is $408,773,000. This is an increase of $5,949,000 above the FY 2010 Appropriation level.

The increase in funding provides support for an increased level of data collection on the health workforce and associated analytical studies. The collection of relevant and current data will provide policymakers with the information necessary to make informed decisions regarding the health professions workforce and provision of care. The initiation of a grant program to academic institutions will increase the availability of research on health workforce issues and build capacity to conduct critical, policy-relevant studies on health workforce issues.

At this level of funding, Health Professions should achieve its FY 2011 targets: (1) 53 percent of graduates and program completers of VII- and VIII- supported programs be underrepresented minorities and/or individuals from disadvantaged backgrounds; (2) 54 percent of trainees in Titles VII- and VIII- supported programs training in medically underserved communities; and (3) 43 percent of health professionals supported by the program entering practice in underserved areas.

Long Term Objective: Promote the development of a diverse and culturally representative health care workforce

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
6.I.B.1: Increase the proportion of graduates and program completers of VII and VIII supported programs who are underrepresented minorities and/or from disadvantaged backgrounds. *(Outcome)*	FY 2008: 53% (Target Exceeded)	53%[1] 53	%[1] Main	tain
6.1: Increase the proportion of persons who have a specific source of ongoing care. [2](Outcome)	FY 2001: 88% (Baseline)	N/A	N/A	N/A
6.I.C.1: Increase the proportion of trainees in VII and VIII supported programs training in medically underserved communities. *(Outcome)*	FY 2008: 45% (Target Not Met)	54%[1] 54	%[1] Main	tain
6.I.C.2: Increase the percentage of health professionals supported by the program who enter practice in underserved areas.[3] *(Outcome)*	FY 2007: 43% (Target Met)	43%	43%	Maintain
6.E: Maintain the average cost per graduate or program completer to the program of providing pipeline and formative education and training. *(Efficiency)*	FY 2007: $379 (Target Exceeded)	$379 $	379	Maintain

[1] Recovery Act Funds will impact total numbers, but will not change the proportions targeted for each measure.
[2] This long-term measure does not have annual targets. The first reporting year is FY 2013.
[3] Service location data are collected on students who have been out of the HRSA program for 1 year. The results are from programs that have the ability to produce clinicians 1-year post program graduation.

Health Professions Training for Diversity

Centers of Excellence

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$20,602,000	$4,924,000	$24,602,000	$24,602,000	---

Authorizing Legislation: Section 736 of the Public Health Service Act.

FY 2011 Authorization .....Expired

Allocation Method .....Competitive Grant/Contract

Program Description and Accomplishments

The Centers of Excellence (COE) Program was enacted in 1988 under Section 736 of the Public Health Service Act. The COE program goal of increasing the supply and quality of underrepresented minorities (URM) in the health professions workforce is accomplished by supporting eligible schools to develop and/or maintain educational programs of excellence in health professions for URMs.

Awards are made competitively to designated health professions schools. Designated health professions schools include schools that meet the required general conditions regarding: (a) certain Historically Black Colleges and Universities; (b) Hispanic individuals; and, (c) Native American individuals. Funds are available to these different types of schools according to proportions prescribed in the statute. These schools have an enrollment that historically includes a significant number of URM students. The Centers of Excellence serve as education centers to recruit, train, and retain URM students and faculty at health professions schools.

Funding for this grant program is utilized to develop competitive applicant pools through linkages and partnerships with institutions of higher education, local school districts, and other community based entities and establish an educational pipeline for health professions careers. COEs also collaborate with other HRSA grant programs through shared resources, marketing and creative theory and clinical practice activities. They work to enhance academic performance of URM students through professional test preparation courses, mentoring programs and structured programs. The grants improve the capacity of schools to train, recruit, and retain URM faculty through provision of stipends and fellowships, and facilitation of faculty and student research on health issues affecting URM groups and the delivery of health care.

Additional activities improve information resources, clinical education, curricula and cultural competence with an emphasis on training in health care services at community based health facilities.

Schools with training and education programs in allopathic and osteopathic medicine, pharmacy, dentistry, and graduate programs in behavioral or mental health are eligible to apply for funds in the COE program.

Underrepresented minorities comprise more than 25 percent of the U.S. population; however, they account for approximately 10 percent of the physician workforce, 7 percent of the nursing professions, 7 percent of dentistry, and 7 percent of psychology health professions (George Washington University Policy Update, July 2008 and *In the Nation's Compelling Interest: Ensuring Diversity in the Health Professions,* Institute of Medicine). The disaggregated URM data reveal further disparities. In 2006, African Americans represented 12.3 percent of the U.S. population but only 3.5 percent of U.S. physicians. Similarly, Hispanics/Latinos made up 14.8 of the U.S. population, yet comprised 5.0 percent of the physicians. (Source: http://www.kaiseredu.org/tutorials/roosevelt/james.ppt, slide 2). The Census Bureau projects that underrepresented minorities will comprise 28 percent of the U. S. population by 2010 and 39 percent in 2050; yet, the annual enrollment of underrepresented minority medical students has not increased since 2000 when it reached 12 percent of all medical students (George Washington University Policy Update, July 2008).

Although all Americans are affected by problems with our healthcare delivery system, an overwhelming body of evidence demonstrates that certain populations are significantly more likely to receive lower quality healthcare than others resulting in health disparities for these populations. HRSA defines health disparities as "population-specific differences in the presence of disease, health outcomes, or access to healthcare." In the U.S., health disparities are well documented in minority populations such as African Americans, Native Americans/Alaska Natives, Asian Americans, Native Hawaiians and other Pacific Islanders, and Latinos. When compared to whites, these minority groups have less access to healthcare, receive lower-quality healthcare, and experience higher rates of chronic diseases, higher mortality, and poorer health outcomes. One of the disease-specific examples of racial and ethnic disparities in the U.S. is the cancer incidence rate among African Americans, which is 10 percent higher than among whites. In addition, adult African Americans and Latinos have approximately twice the risk as whites of developing diabetes. Minorities also have higher rates of cardiovascular disease, HIV/AIDS, and infant mortality than whites. African Americans, Hispanics, Asian Americans, Native Hawaiians and other Pacific Islanders, and American Indian/Alaska Natives are underrepresented in the health professions. It has been found that minority health professionals are more likely to serve in areas with a high proportion of underrepresented racial and ethnic groups and to practice in or near designated healthcare shortage areas. (J. Y. Reede, "A Recurring Theme: The Need for Minority Physicians," Health Affairs 22, No. 4(2003):2); H.K. Rabinowitz et al., "The Impact of Predictors on Generalist Physicians' Care of Underserved Populations, "American Journal of Public Health 90, No.8(2000): 1225-1149)

Numerous studies, for example, (Missing Persons: Minorities in the Health Professions, A Report of the Sullivan Commission on Diversity in the Healthcare Workforce, 2004 available at http: www.wkkf.org/default.aspx?tabid=94&CID=1&ItemID=10415&NID=85&LanguageID=0; "A Recurring Theme: The Need for Minority Physicians," Health Affairs 22, No. 4(2003): 91-93; The National Partnership for Action: Changing Outcomes- Achieving Health Equity, Chapter Two, DHHS, 2010:31-92) have documented that increasing the number of minority health professionals is a key strategy to eliminating health disparities. Diversity in the health workforce strengthens cultural competence throughout the healthcare system. Cultural and linguistic competencies profoundly influence how health professionals deliver quality healthcare. The COE Program affords individuals from underrepresented minority backgrounds the opportunity to be exposed to and pursue careers in the health professions as a means to increasing access to healthcare for underserved minority populations and address these health disparities. The Department of Health and Human Services has a priority of increasing diversity of the healthcare workforce in order to eliminate inequities in healthcare, ensure culturally effective healthcare, and address health disparities.

Community coalitions for diversity and Federal Advisory Committee reports have supported the need for increased numbers of underrepresented minorities in the health professions. The Council on Graduate Medical Education (COGME) (12th and 17th Reports) and the Advisory Committee on Interdisciplinary, Community-Based Linkages (4th Annual Report and 6th Annual Report) have identified recommendations consistent with needs in the field to improve racial and ethnic minorities in the health professions. These reports support the need to increase the number of underrepresented minorities in the health professions schools as well as promoting cultural and linguistic competence in the health professions.

The COE Program was appropriated a total of $4,924,000 in Recovery Act funding in FY 2009. In FY 2009, two grants awarded supported 878 URM students and 308 faculty participating in research on minority health issues. These awards are for three-year grant period. There is no Recovery Act funding for this program in FYs 2010 and 2011.

Most of the Health Profession's Title VII and Title VIII programs were grouped together and underwent a program assessment in 2002. This program was included in that assessment. (See Health Professions Summary).

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$11,872,000
FY 2007	$11,880,000
FY 2008	$12,773,000
FY 2009	$20,602,000[1]
FY 2009 Recovery Act	$ 4,924,000
FY 2010	$24,602,000

Budget Request

The FY 2011 President's Budget Request of $24,602,000 is the same as the FY 2010 Appropriation. The total request will continue support for projects that increase the supply and quality of URMs in the health professions workforce. This program provides support to entities to meet the need to strengthen the pipeline for all health professions schools, to increase the numbers of health professionals in primary care and prevention activities, to promote cultural and linguistic competence in the health professions and to increase programming to promote faculty development in diversity and cultural competence.

Outcomes and Outputs Table

Outputs	Most Recent Result[2]	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Number of projects	4	17	17	--
Number of URM students participating in research on minority health issues	234	465	465	--
Number of URM faculty	109	257	257	--

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA[3]	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	14	2	17	17
Average Award	$1,376,0130	$815,753	$1,366,778	$1,366,778
Range of Awards	$390,000 - $4,200,000	$710,418-$922,728	$400,000 - $6,200,000	$400,000 - $6,200,000

[1] Regular Appropriation Only
[2] Most Recent Results FY 2008
[3] ARRA awards were made for 3-year grant periods. Average amounts reflected are annual for comparability.

Health Professions Training for Diversity

Scholarships for Disadvantaged Students

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$45,842,000	$40,000,000	$49,342,000	$49,342,000	---

Authorizing Legislation: Section 737 of the Public Health Service Act.

FY 2011 Authorization ..... Expired

Allocation Method ..... Formula Grant

Program Description and Accomplishments

The Scholarships for Disadvantaged Students (SDS) Program was established by the Disadvantaged Minority Health Improvement Act of 1990, Section 737 of the Public Health Service Act. The purpose of the program is to increase diversity in the health professions and nursing workforce by providing grants to eligible health professions and nursing schools for use in awarding scholarships to students from disadvantaged backgrounds with financial need, many of whom are underrepresented minorities (URMs). URMs comprise more than 25 percent of the U.S. population; however, they account for approximately 10 percent of the physician workforce, 7 percent of the nursing professions, 7 percent of dentistry, and 7 percent of psychology health professions (George Washington University Policy Update, July 2008 and *In the Nation's Compelling Interest: Ensuring Diversity in the Health Professions,* Institute of Medicine). The Census Bureau projects that underrepresented minorities will comprise 28 percent of the U. S. population by 2010 and 39 percent in 2050; yet, the annual enrollment of underrepresented minority medical students has not increased since 2000 when it reached 12 percent of all medical students (George Washington University Policy Update, July 2008). The health disciplines funded by the SDS Program include allopathic medicine, osteopathic medicine, dentistry, veterinary medicine, optometry, podiatry, pharmacy, chiropractic, behavioral and mental health, public health, nursing, allied health, and physician assistants.

A school with SDS funds must develop and implement a program to recruit and retain students from disadvantaged backgrounds, including racial and ethnic minorities. In addition to recruitment and retention program activities, a school must demonstrate that the program has achieved success based on the percentage of disadvantaged students enrolled and graduated from the school. The SDS Program supports the goal of increasing diversity of the health professions workforce, increasing the diversity and supply of the primary healthcare workforce, and expanding high-quality educational opportunities to disadvantaged students. Toward these

objectives, the SDS Program has three funding priorities; enrollment of underrepresented minorities above the national average; graduates practicing in primary care; and, graduates working in medically underserved communities. The SDS supported students generally enter medically underserved communities two to three times the national average and are 62 percent URM.

All eligible applicants receive funding. Award amounts are determined by a formula and are based on data provided in the school's application. First, a base number is established which is the lesser of either (a) the number of economically disadvantaged enrolled or (b) the number of economically disadvantaged graduated multiplied by length of program. Second, the school's base number is multiplied by (1 point for eligibility plus the number of priority points received) to determine the school's weight amount. Third, the school's weight amount is divided by all schools' total weight amount to determine the percentage of the school's award. Fourth, that percentage of the SDS funds available equals Schools' potential award amount. Fifth, if the potential award amount is less than the requested amount and no greater than $650,000, the potential amount becomes the actual award amount. However, if the potential award amount exceeds the requested award amount up to $650,000, the school will be awarded the requested amount.

The SDS Program was appropriated a total of $40,000,000 in Recovery Act funding. In FY 2009, $20,000,000 was used to support 281 grants to health professions institutions to support an estimated 10,000 student scholarships. In FY 2010, the remaining $20,000,000 will support an estimated 336 grants to institutions that will provide support for an estimated additional 10,000 student scholarships. There is no FY 2011 Recovery Act funding for this program. Grants awarded under this program are yearly.

The SDS Program's investment in IT supports the strategic and performance outcomes of the program and contributes to its success. This investment will allow an old stand alone electronic system to be consolidated into HRSA's Electronic Handbook (EHB) by FY 2011. The older system which monitors and processes loan program data and evaluates financial information will be retired once the transition to the EHB is completed. This project also upgrades and develops a link between an archival document system and the EHB. In addition to the consolidation and link, this project upgrades the security standards.

Most of the Health Profession's Title VII and Title VIII programs were grouped together and underwent a program assessment in 2002. This program was included in that assessment. (See Health Professions Summary).

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$46,625,000
FY 2007	$46,657,000
FY 2008	$45,842,000
FY 2009	$45,842,000[1]
FY 2009 Recovery Act	$40,000,000
FY 2010	$49,342,000

Budget Request

The FY 2011 President's Budget Request of $49,342,000 is the same as the FY 2010 Appropriation. The total request will support an estimated 18,000 disadvantaged students. The program facilitates the training of health practitioners from disadvantaged backgrounds, including URMs, helping to increase diversity among health practitioners affecting improved access to healthcare.

The SDS Program tackles a major barrier for a disadvantaged student's access to a health professions education because of high tuition costs. The SDS Program also supports the Department of Health and Human Services' goals to diversify the health workforce to ensure culturally effective care and to help reduce health disparities. Funding for the SDS Program will help foster a strong and diversified health workforce that will champion prevention and public health activities.

There is a strong correlation between increased disadvantaged and URM representation within the health professions workforce and improved access to healthcare. Underrepresented minorities (URMs) are four times more likely to choose primary care, provide healthcare to poor, uninsured and Medicaid-insured patients and locate their practice in underserved areas (Gauntt, Jennifer, et. al. "Increasing the Number of Health Care Professionals in Medically Underserved Areas and Ensuring Diversity in the Health Care Workforce." Association of Clinicians for the Underserved, 2007).

Outcomes and Outputs Tables

Outputs	Most Recent Result[2]	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Number of disadvantaged students	16,782	18,000	18,000	--
Number of URM students	10,408	11,200	11,200	--
Percent of students who are URM	62%	62%	62%	--

[1] Regular Appropriation Only
[2] Most recent result reflects FY 2008 (AY 2008-09) report data.

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	294	281	350	400
Average Award	$155,925	$74,174	$140,977	$123,355
Range of Awards	$1,000 – $650,000	$1,000 – $650,000	$1,000 – $650,000	$1,000 – $650,000

Health Professions Training for Diversity

Health Careers Opportunity Program

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$19,133,000	$2,517,000	$22,133,000	$22,133,000	---

Authorizing Legislation: Section 739 of the Public Health Service Act.

FY 2011 Authorization ..... Expired

Funding Allocation ..... Competitive Grant

Program Description and Accomplishments

The Health Careers Opportunity Program (HCOP) was established in 1972 and provides grants to eligible accredited schools and public and private non-profit health educational entities. The goal of the HCOP is to increase the number of individuals from economically and educationally disadvantaged backgrounds entering and graduating from health professions programs, providing a sufficient applicant pool of academically prepared and competitive disadvantaged students. As the disadvantaged population is comprised of a high percentage of minorities, this program increases diversity in the health professions workforce and improves access to healthcare in underserved areas. In order to enhance the students' ability to enter and graduate from health professions programs, HCOP provides interventions at the earliest educational level and continues throughout the educational pipeline.

The HCOP provides a variety of academic and social supports throughout the health professions pipeline to students interested in pursuing careers in medicine, osteopathic medicine, public health, dentistry, veterinary medicine, optometry, pharmacy, allied health, chiropractic and podiatric medicine, public and non profit private schools that offer graduate programs in behavioral and mental health professions. The program provides activities to disadvantaged students enrolled at their institutions through formal academic and research training and programming. The HCOP grantees provide counseling and mentoring services to assist students in successfully completing their education and training. The program also exposes students to community-based primary healthcare experiences with public and private nonprofit providers. In addition, HCOP provides student stipends and financial planning resources to students and parents, as well as information about healthcare careers and training.

In FY 2008, 12,318 students from disadvantaged backgrounds and under-represented minorities participated in HCOP sponsored activities including 1,118 graduates.

The HCOP Program was appropriated $2,517,000 in Recovery Act funding in FY 2009. The two grants awarded support an estimated 925 disadvantaged students. These awards are made for three-year grant periods. There is no Recovery Act funding for this program in FYs 2010 and 2011.

Most of the Health Profession's Title VII and Title VIII programs were grouped and underwent a program assessment in 2002. This program was included in that assessment. (See Health Professions Summary).

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$3,957,000
FY 2007	$3,960,000
FY 2008	$9,825,000
FY 2009	$19,133,000[1]
FY 2009 Recovery Act	$ 2,517,000
FY 2010	$22,133,000

Budget Request

The FY 2011 President's Budget Request of $22,133,000 is the same as the FY 2010 Appropriation. The total request will support the program's efforts to afford individuals from underrepresented minority and disadvantaged backgrounds the opportunity to be exposed to and pursue careers in the health professions effecting increased access to healthcare to underserved populations. This program addresses the Department of Health and Human Services' priority of increasing diversity of the healthcare workforce in order to eliminate inequities in healthcare, ensure culturally effective healthcare, and address health disparities.

[1] Regular Appropriation Only

Outcomes and Outputs Tables

Outputs	Most Recent Result [2]	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Number of disadvantaged students in structured programs:	4,217	9,530	9,530	--
Post-secondary 20	3	458	458	--
Secondary education (K-12)	137	309	309	--
Number of grants	14	33	33	--

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA [3]	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	30	2	33	33
Average Award	$612,909	$504,117	$750,000	$750,000
Range of Awards	$199,468-$1,491,276	$325,582- $509,117	$500,00 - $1,000,000	$500,000 - $1,000,000

[2] Most recent result: FY 2008

[3] ARRA awards were made for 3-year grant periods. Average amounts reflected are annual for comparability

Health Workforce Information and Analysis

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	---	---	$2,832,000	$8,781,000	+$5,949,000
FTE	---	---	3	3	---

Authorizing Legislation: Sections 761, 792, and 806 of the Public Health Service Act

FY 2011 Authorization……..……Expired

Allocation Method…….Grant/Contract

Program Description and Accomplishments

To accomplish the Bureau of Health Professions' mission of assuring access to health care and an adequate supply of health professionals to provide for our Nations health care needs, it is essential to routinely collect core data on health workforce and to conduct analytic studies examining a broad range of issues that impact the supply, demand, distribution and education of the Nation's health workforce. With the possible exception of physicians, the nation lacks a routine source of comprehensive data on any segment of the health workforce. Conducting timely studies using relevant and current data is essential to provide policymakers with the information necessary to make informed decisions regarding the health professions workforce and provision of care. For example, assessing factors affecting the current supply of particular health professionals like primary care providers is critical to insuring that there are enough primary care providers to meet the demand. Examining the effects of the availability and size of scholarships, loans, or loan repayments on career or specialty choice is another example where analytic studies would prove instrumental in developing effective programs and policies to address the Nation's health workforce needs. The purpose of this program is to address both the availability of core baseline data and the analytic studies needed to respond to health workforce questions raised by policymakers and stakeholders themselves.

The goals of the Health Workforce Information and Analysis Program are to 1) develop standards and work with a range of organizations to collect a broad range of health workforce data, 2) develop a repository of health workforce data including education, training, and practice, 3) conduct high priority studies that address issues of national significance, and 4) support the work of national, State, and local policymakers and researchers by providing timely access to current workforce data and forums for the presentation and discussion of health workforce issues.

Health policymakers and groups of experts have advocated for a strong Federal Government role in developing information and conducting objective analyses on health workforce supply,

requirements, and distribution. In order to accomplish this it is essential that core data be collected to allow for relevant analyses and policy impact assessments to be conducted.

Funding History

FY	Amount
FY 2006	$---
FY 2007	$---
FY 2008	$---
FY 2009	$---
FY 2010	$2,832,000

Budget Request

The FY 2011 President's Budget Request of $8,781,000 is an increase of $5,949,000 above the FY 2010 Appropriation. The increase will be used to expand the following core activities that were begun in FY 2010:

- establishing relationships with State organizations, health professional organizations, and health professions education organizations and developing data standards relating to health professionals (education, training, and practice);
- conducting specific studies as needed to meet information needs of policymakers; and
- establishing and expanding grant program(s) and support contracts needed to implement a standardized data collection strategy that includes a large contract for the receipt and management of data from various sources and for responding to requests for data and simple analyses.

In addition, a small grant program to stimulate academic interest in conducting workforce research and policy analyses will be initiated. The focus will be national but would allow for grantees to address regional, State, and local issues as well. This activity would re-establish a network of workforce research centers last funded in FY 2005. Having workforce policy analysis and research embedded with academic settings provides expertise that is widely available to State and local policy makers and enables the development of a cohort of trained workforce researchers who can fill positions at all levels of the system.

Training in Primary Care Medicine and Dentistry

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$48,425,000	$47,600,000	$54,425,000	$54,425,000	---

Authorizing Legislation: Section 747 of the Public Health Service Act

FY 2011 Authorization .....Expired

Allocation Method .....Competitive Grant/Contract

Program Description and Accomplishments

The Training in Primary Care Medicine and Dentistry (TPCMD) Program, authorized in 1963, is comprised of six program areas (Residency Training, Predoctoral Training, Faculty Development, Academic Administrative Units, Physician Assistant, and Residency Training in General and Pediatric Dentistry) and five disciplines: (1) Family Medicine (2) General Internal Medicine (3) General Pediatrics (4) Physician Assistant and (5) General and Pediatric Dentistry.

In 1992 the Health Professions Education Extension Amendments (Public Law 102-408) refined training in primary care to include increasing the number of primary care providers for medically underserved communities (MUCs), increasing the number of students entering family medicine, and exposing students to primary care in ambulatory settings. This act substantially shifted the focus for Title VII, Section 747 to providing for MUCs and targeting primary care providers to fill this need.

Training in Primary Care Medicine and Dentistry Programs

Discipline	FY 2009 Appropriation	FY 2009 ARRA [1]	FY 2010 Appropriation	FY 2010 ARRA	FY 2011 President's Budget
Family Medicine	$31,599,900	--	$29,025,000	$31,061,543	$29,025,000
General Internal Medicine	$1,964,431	--	$3,537,625	$1,930,964	$3,537,625
General Pediatrics	$2,117,888	--	$3,809,750	$2,081,806	$3,809,750
Discipline	**FY 2009 Appropriation**	**FY 2009 ARRA [2]**	**FY 2010 Appropriation**	**FY 2010 ARRA**	**FY 2011 President's Budget**

[1] Recovery Act funding was appropriated in FY 2009 however, the obligations will not occur until FY 2010.

[2] Recovery Act funding was appropriated in FY 2009 however, the obligations will not occur until FY 2010.

Physician Assistant	$1,732,328	--	$2,902,625	$1,702,815	$2,902,625
General and Pediatric Dentistry	$11,010,452	--	$15,150,000	$10,822,872	$15,150,000

The TPCMD Program provides grants or contracts to public or nonprofit private hospitals, schools of allopathic or osteopathic medicine, dental schools or approved residency programs in general or pediatric dentistry, physician assistants programs and other public or private nonprofit entities, including faith-based organizations and community-based organizations. The purposes of these program areas are to:

- Plan, develop, and operate, or participate in approved professional training programs in family medicine, general internal medicine, or general pediatrics; medical students, interns, residents, or practicing physicians that emphasizes training for the practice of family medicine; general internal medicine, or general pediatrics.
- Provide financial assistance (in the form of traineeships and fellowships) to medical students, interns, residents, practicing physicians, or other medical personnel, who are participants in any such program, and who plan to specialize or work in the practice of family medicine, general internal medicine, or general pediatrics.
- Train physicians who plan to teach in family medicine (including geriatrics), general internal medicine or general pediatrics training programs and to provide financial assistance.
- Plan, develop, and operate, or maintain programs for the training of physician assistants, and for the training of individuals who will teach in programs to provide such training.
- Establish, maintain, or improve academic administrative units (departments, divisions, or other units) to provide clinical instruction in family medicine, general internal medicine, or general pediatrics, and
- Plan, develop, and operate, or participate and to provide financial assistance to residents in programs of general dentistry or pediatric dentistry.

Title VII Section 747 funds are focused exclusively on education and seek to improve the structures and processes of health professions training and to produce more primary care graduates to respond to the Nation's well-established healthcare needs. As part of the review criteria, applicants must address the commitment of the institution to meet the diversity of the health professions workforce, which includes disadvantaged and minority students, residents, and faculty. For Family Medicine residents, those in HRSA Title VII-funded programs, reported higher cross-cultural preparedness (well prepared or very well prepared) to care for racial/ethnic minority patients compared with non HRSA-funded residents 76.3 percent verses 60.8 percent (Lipkin M. et al, *Academic Medicine* 83: 2008, 1074).

The graduates of TPCMD programs provide primary healthcare services to the American public in all areas of the country, including those geographic areas where primary healthcare providers are in short supply. The graduates of these programs also help to reduce disparities in the availability of healthcare services to different groups in our country.

As discussed in a recent academic journal article ("Reflections on the Impact of Title VII Funding at the University of New England College of Osteopathic Medicine"), Title VII-supported programs played a major role in establishing the infrastructure and curriculum that supported roughly 115 medical students in each year of University of New England College of Osteopathic Medicine's (UNECOM) four-year curriculum. The college institutionalized all these programs after the grants ended by self-funding and reorganization of departments and personnel. Concerning one recent cohort of 662 UNECOM graduates, who have been out of residency training for at least two years (1996-2002), 71 percent are practicing in primary care with 17 percent serving in medically underserved areas (Shannon S. Academic Medicine. 2008;83:1060-63).

In FY 2009, the TPCMD Program received an appropriation of $47,600,000 to support training for the primary care medical and dental workforce to help address the primary care workforce shortage. These appropriated funds will be obligated in FY 2010 and will be allocated across the six program areas supported by this program. It is estimated that 70 awards will be made using Recovery Act funds. There is no FY 2011 Recovery Act funding for this program. Grants awarded under this program are awarded for a three year grant period.

Most of the Health Profession's Title VII and Title VIII programs were grouped together and underwent a program assessment in 2002. This program was included in that assessment. (See Health Professions Summary.)

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbook (EHB), performance reviews, Advisory Committee on Training in Primary Care Medicine and Dentistry, and the Council on Graduate Medical Education.

Funding History

FY	Amount
FY 2006	$40,823,000
FY 2007	$48,851,000
FY 2008	$47,998,000
FY 2009	$48,425,000[3]
FY 2009 Recovery Act	$47,600,000
FY 2010	$54,425,000

Budget Request

The FY 2011 President's Budget Request of $54,425,000 is the same as the FY 2010 Appropriation. The total request will provide support for these programs which will continue to make primary healthcare services more available to the American public in all areas of the country, including those geographic areas where primary care healthcare providers are in short supply. These programs will help to reduce disparities in the availability of healthcare services to different groups in our country. The TPCMD programs will also support grantees that improve structures and processes of health professions training and produce more primary care graduates to respond to the Nation's well-established healthcare needs. The TPCMD programs

will significantly contribute to strengthening the infrastructure for training in primary care and invest in changing the trend of short supply of healthcare providers in primary care.

These grants significantly support clinical education by providing funding for the establishment or enhancement of Academic Administrative Units. An Academic Administrative Unit can be a department or division of family medicine, a division of osteopathic or allopathic general internal medicine or general pediatrics; or an osteopathic department of internal medicine or pediatrics with a primary care focus. These Units are essential for developing the infrastructure required for student and resident primary care training activities.

Continued support for these programs will: increase the number of medical students exposed to primary care training early in their medical school training to influence their choice of practice, thus increasing the number of trainees in primary care residency programs who will practice primary care; increase the number of general and pediatric dental residents training, thus increasing access to dental care; and, increase the number of physician assistants in practice to provide health care services.

Funding will support the development of new teaching methods for clinical care and curricular changes that directly improve medical students and resident's skills and knowledge in the care of vulnerable populations such as the elderly, the homeless, and victims of domestic violence. Other approaches will provide training within high need settings such as medically underserved areas, rural and urban areas, and models of care such as the medical and dental home. These

[3] Regular appropriation only

approaches will expand health professions training in order to increase services, produce a diverse workforce, improve access to health care services and improve distribution of graduates to areas that lack a sufficient health professions workforce.

Outcomes and Outputs Tables

Outputs	Most Recent Result[4]	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
No. in clinical training with healthcare service delivery organizations serving **underserved areas**				
Residents/Graduates	3,690	4,100	4,100	--
Students/Trainees	11,544 1	2,700 1	2,700	--
Faculty Trainees Residents/Graduates	187	200	200	--
No. who enter practice in underserved areas				
Residents/Graduates	805	900	900	--
Students/Trainees	674	740	740	--
Faculty Trainees	61	70	70	--
No. who provide and support primary care				
Residents/Graduates	4,765	5,200	5,200	--
Students/Trainees	24,846 2	7,300 2	7,300	--
Faculty Trainees	250	270	270	--
No. of minority/disadvantaged individuals				
Residents/Graduates	1,195	1,300	1,300	--
Students/Trainees	6,222	6,800	6,800	--
Faculty Trainees	36	40	40	--

Grant Awards Table – Family Medicine*

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA**	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	113	---	136	136
Average Award	$241,118	---	$213,235	$213,235
Range of Awards	$41,257 – $601,123	---	$41,257 – $601,123	$41,257 – $601,123

[4] Most Recent Result: FY 2008.
* One award may include funding for up to 3 disciplines.
** Recovery Act funding was appropriated in FY 2009 however, the obligations will not occur until FY 2010.

Grant Awards Table – General Internal Medicine*

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA**	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	28	---	29	29
Average Award	$141,066	---	$141,066	$141,066
Range of Awards	$17,093 –$444,992	---	$17,093 $444,992	$17,093 – $444,992

Grant Awards Table – General Pediatrics*

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA**	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	20	---	25	25
Average Award	$151,220	---	$151,220	$151,220
Range of Awards	$19,298 – $377,697	---	$19,298 – $377,697	$19,298 – $377,697

Grant Awards Table – Physician Assistant*

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA**	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	18	---	20	20
Average Award	$180,100	---	$181,901	$181,901
Range of Awards	$63,260 – $233,634	---	$63,893 - $235,970	$63,893 - $235,970

Grant Awards Table – General and Pediatric Dentistry

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA**	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	31	---	42	42
Average Award	$353,632	---	$357,168	$357,168
Range of Awards	$122,316 – $893,970	---	$123,539 - $902,910	$123,539 - $902,910

* One award may include funding for up to 3 disciplines.

** Recovery Act funding was appropriated in FY 2009 however, the obligations will not occur until FY 2010.

Interdisciplinary, Community-Based Linkages

Area Health Education Centers (AHEC)

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$32,540,000	---	$33,345,000	$33,345,000	---

Authorizing Legislation: Section 751 of the Public Health Service Act

FY 2011 Authorization.....Expired

Allocation Method.....Cooperative Agreement/Competitive Grant

Program Description and Accomplishments

The AHEC Program was initiated in 1972 with the first awards implemented via contracts in 1973, to 11 schools of medicine in 11 States for the purpose of regionalizing medical and associated health professions education in the regions of a State. Over the years, the reauthorizing legislation resulted in the following key changes: (1) the sense of the Congress to establish an AHEC Program in each State; (2) cooperative agreement awards representing a Federal, State, and local funding partnerships; (3) the establishment of contracts by grantees (e.g., medical schools) with community-based partners (Area Health Education Centers); and (4) an emphasis on primary care, underserved populations and recruitment of minority and/or disadvantaged students into health careers.

The AHEC Program enters into cooperative agreements with accredited schools of medicine and nursing to encourage the establishment and maintenance of community-based, primary care training programs in off-campus rural and underserved areas. Schools of allopathic and osteopathic medicine are eligible to apply for AHEC funding. Additionally, schools of nursing are also eligible applicants in States where there is no medical school. The purpose is (1) to educate and train students to become culturally competent primary care health professionals who will provide healthcare to underserved populations, and (2) to increase the number and variety of primary care health professionals who provide care to underserved populations in Health Professional Shortage Areas (HPSAs) and other medically underserved areas.

The Association of American Medical Colleges (2008) projected a shortage of as many as 150,000 physicians by 2025 that will impact all specialties. In addition, the American College of Physicians (2008) reported that the number of U.S. medical graduates entering residencies in family medicine and internal medicine has declined by half in the last decade. Graduates are seeking higher-paying specialties over the longer hours and lower pay of primary care. The AHEC Program addresses this shortage through a range of training activities by offering of an

educational continuum of health career recruitment through clinical education concerning underserved areas in a comprehensive health workforce strategy.

The AHEC Program addresses issues between minority populations and their representation among health professionals by working to increase the number of minority/disadvantaged students selecting health professions as a career option and exposing high school students in underserved areas to health professions careers. In FY 2008, there were 28,556 high school students who received AHEC health careers training of more than 20 hours (e.g., summer health careers programs and mentoring by health professionals). The majority of the students were from underrepresented minority populations and from economically and educationally disadvantaged populations. Approximately 242,000 underserved minority or disadvantaged students participated in health careers training presentations or academic enrichment experiences, and overall, 516,000 elementary/high school students were exposed to health careers guidance and recruitment presentations.

The AHEC Program grantees partner with community-based AHEC centers through contracts to implement health professions training directly in the community and specifically in underserved area sites. The AHEC centers connect remote health science training institutions with a continuing stream of new medical, nursing, and dental students, primary care residents, allied health and pharmacy students, and other health professions students and trainees via clinical rotations at medically underserved area sites. The AHEC training programs address access to care for underserved populations by focusing on local workforce needs to enhance the supply, recruitment, distribution and diversity of the primary care workforce and ultimately to increase the number of primary care providers who practice in HPSAs and other medically underserved communities.

In FY 2008 there were 18,096 AHEC training sites in underserved areas across the Nation. A total of 49,469 health professions students (including 20,000 medical students) participated in AHEC rotations at community sites serving medically underserved populations. Additionally, medically underserved communities were served by 17,321 on-site AHEC preceptors. Also in FY 2008, AHEC grantees reported that continuing education training was provided to a range of health professionals from underserved area sites, including Community Health Centers (HCs) and Migrant Health Centers; Rural Health Clinics; Health Departments; Governor-Designated Areas; and National Health Service Corps (NHSC) sites.

In 2008, the total number of medical students enrolled nationwide was 91,704 (76,070 enrolled in allopathic medical schools according to the American Association of Medical Colleges and 15,634 enrolled in osteopathic medical schools according to the American Association of Colleges of Osteopathic Medicine). The AHEC Program provided 20,000 medical students (21 percent of all enrolled medical students nationwide) with a clinical rotation in a primary care community-based site in a rural or underserved area, thereby exposing students to primary care delivery and to the needs of underserved populations.
In FY 2008, there were 54 AHEC programs ongoing in 46 States and the Territories of Palau. All have State/local dollars to match Federal funds. Most of the AHEC programs have matured over time and have moved from the Basic AHEC program development and implementation

phase to a mature Model AHEC Program where centers and community-based training programs are fully established in a multi-county region or an entire State.

Most of the Health Profession's Title VII and Title VIII programs were grouped together and underwent a program assessment in 2002. This program was included in that assessment. (See Health Professions Summary).

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$28,661,000
FY 2007	$28,681,000
FY 2008	$28,180,000
FY 2009	$32,540,000
FY 2010	$33,345,000

Budget Request:

The FY 2011 President's Budget Request of $33,345,000 is the same as the FY 2010 Appropriation. The total request will support 56 AHEC programs (42 Model contracting with 210 Centers, and 14 Basic contracting with 36 Centers) in 48 States and the Territories of Guam and Palau to provide community-based primary care training programs to more trainees in rural and underserved communities to increase the number of culturally competent primary care health providers who will locate in HPSAs and other medically underserved areas and will provide care to underserved people.

Outcomes and Outputs Tables

Outputs	Most Recent Result[1]	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
No. of medical students and associated health professions trained in community sites in rural/underserved areas	49,469	49,500	50,500	+1,000
No. of medical students trained in community sites in rural/underserved areas	20,000	20,000	20,500	+500
No. of associated health professions students trained in community sites in rural/underserved areas	29,469	29,500	30,000	+500
No. of training linkages with community/migrant health centers and other underserved area sites	14,736	15,000	15,500	+500
No. of local providers who received continuing education, e.g., on Cultural Competence, Women's Health, Diabetes, Hypertension, Obesity, Health Disparities and related topics.	400,000	412,000	415,000	+3,000
No. and percent of local providers receiving continuing education in medically underserved areas	126,696 21%	130,000 21%	132,000 21%	+2,000
No. of elementary/high school students receiving health career guidance and information from the AHEC Programs	515,978	516,000	520,000	+4,000
No. of high school students (grade 9-12) participating in $\geq$ 20 hours of health career training and/or academic enhancement experience	28,556	30,000	32,000	+2,000

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	55	56	56
Average Award	$591,636	$570,500	$570,500
Range of Awards	$92,940 - $1,389,783	$92,940 - $1,389,783	$92,940 - $1,389,783

[1] Most Recent Result: FY 2008

Interdisciplinary, Community-Based Linkages

Geriatric Programs

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$30,997,000	---	$33,747,000	$33,747,000	---
FTE	3	---	3	3	---

Authorizing Legislation: Section 753 of the Public Health Service Act.

FY 2011 Authorization .....Expired

Allocation Method .....Competitive Grants/Contracts

Program Description and Accomplishments

Geriatric programs include three activities: (1) Geriatric Education Centers; (2) the Geriatric Training Program for Physicians, Dentists, and Behavioral/Mental Health Professionals Program; and (3) the Geriatric Academic Career Awards Program. The goal of the three geriatric programs is to improve access to quality healthcare for America's elderly by educating health professionals in the interdisciplinary care of the geriatric patient.

By 2030, the population of adults aged 65 and older in the United States will almost double compared to the United States population. The Institute of Medicine (2008) report on "Retooling for an Aging America: Building the Healthcare Workforce" identified that a) healthcare professionals will have difficulty meeting the increased need for services for older adults, b) there are severe shortages of geriatric specialists as well as health professionals with skills in caring for older adults, and c) there is need for chronic disease management. Most healthcare practitioners do not receive content in geriatrics during their formative education. The Title VII geriatrics programs are designed to improve the interdisciplinary education and training of health professions students, faculty, and practitioners at both the generalist and specialist levels.

Geriatric Programs

Programs	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget
Geriatric Education Centers	$17,837,293	$19,597,542	$19,597,542
Geriatric Training Program for Physicians, Dentists, and Behavioral/Mental Health Professionals Program	$6,569,999	$7,330,634	$7,330,634
Geriatric Academic Career Awards Program	$6,589,708	$6,818,824	$6,818,824

Geriatric Education Centers Program (GEC)

The GEC Program was established in FY 1983. The purpose of this program is to improve the interdisciplinary education and training of health professions students, faculty, and practitioners in geriatrics. The GEC Program serves accredited schools of allopathic medicine, osteopathic medicine, chiropractic, veterinary medicine, dentistry, public health, pharmacy, optometry, allied health, podiatric medicine, nursing, and physician assistant programs. In addition, the following accredited graduate programs are served by the GEC Program: clinical psychology, clinical social work, health administration, and behavioral health and mental health practice. The GEC Program operates by awarding grants to eligible institutions for the establishment or operation of GECs.

The GEC grantees conduct a range of activities including the development and dissemination of a variety curricula related to health problems of the elderly such as polypharmacy and adverse drug reactions, cultural competence, chronic disease management, dementias and Alzheimer disease, depression, and interdisciplinary team care. In FY 2008, 48 GEC Program grantees developed and provided educational and training offerings to health professions students, faculty, and practitioners related to care of the older adult. Interdisciplinary education and training was provided to interdisciplinary teams.

The GECs provided clinical training in geriatrics to health professions students, faculty and practitioners which resulted in about 6,800,000 patient encounters across the health care continuum in FY 2008. A contract, the National Training and Coordination Collaborative (NTACC), is currently being funded to improve evaluation planning for GEC grantees. Activities include training on logic modeling, formative to summative evaluation planning, and data collection and management. Improving grantee skills in evaluation should result in better-informed actions to improve program performance as well as improved performance reporting. This multi-year contract will end in September, 2012.

Geriatric Training for Physicians, Dentists, and Behavioral and Mental Health Professionals (GTPD)

The GTPD Program was established in FY 1989. In FY 1998, behavioral and mental health professionals were added. The purpose of this program is to provide intensive one-year retraining and two-year fellowship training in geriatrics. The GTPD Program serves accredited schools of medicine, schools of osteopathic medicine, teaching hospitals and graduate medical education programs.

The GTPD Program operates by awarding grants to eligible institutions to support fellowships and other training efforts that assist physicians, dentists, and behavioral and mental health professionals who teach or plan to teach geriatric medicine, geriatric dentistry, or geriatric behavioral and mental health.

In FY 2008, 11 non-competing continuation grants were supported. Forty four physicians, dentists, and psychiatric fellows provided geriatric care to 18,000 older adults across the care continuum. Some activities addressed by grantees include developing culturally competent geriatric academicians and clinicians by emphasizing ethnogeriatrics and community service to minority and underserved elderly, provide longitudinal geriatrics primary care in ambulatory, acute care, community-based and long term care settings, apply contemporary educational and teaching skills by utilizing instructional technology, distance learning and simulated patient cases, demonstrate application of administrative skills as academic and clinical faculty, and engage in scholarly research in the field of aging.

Geriatric Academic Career Awards Program (GACA)

The GACA Program was established in FY 1998. The purpose of this program is to increase the number of junior faculty at accredited schools of allopathic and osteopathic medicine and to promote the development of their careers as academic geriatricians. The GACA Program operates by providing a financial incentive for junior faculty to pursue an academic career in geriatrics.

In FY 2008, 86 non-competing continuation awards were supported. GACA awardees provided interdisciplinary training in geriatrics to about 60,000 health professionals including physicians, physician assistants, nurses including advanced practice nurses, social workers, health educators, nutritionists, dietitians, physical therapists, occupational therapists, speech-language pathologists, respiratory therapists, psychologists, radiology technicians, hospital administrators, and nursing home administrators. Interdisciplinary training activities included, but were not limited to, cultural competence, chronic disease management, geriatric ethics, palliative care, effective interdisciplinary management of chronic diseases, dementia, delirium, mental health, and health promotion. The amount of awards is adjusted each year to reflect the increase in the Consumer Price Index. These awardees provided culturally competent quality healthcare to over

525,000 underserved and uninsured patients in acute care services, geriatric ambulatory care, long-term care, and geriatric consultation services settings.

Most of the Health Profession's Title VII and Title VIII programs were grouped together and underwent a program assessment in 2002. This program was included in that assessment. (See Health Professions Summary).

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	---
FY 2007	$31,548,000
FY 2008	$30,997,000
FY 2009	$30,997,000
FY 2010	$33,747,000

Budget Request

The FY 2011 President's Budget Request of $33,747,000 is the same as the FY 2010 Appropriation. The total request will provide support for 40 Geriatric Education Centers grants, 14 Geriatric Training for Physician, Dentists, and Behavioral and Mental Health grants, and 90 Geriatric Academic Career Awards.

Outcomes and Outputs Tables

Outputs	Most Recent Result [1]	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Number of healthcare providers receiving training in geriatrics	229,330	263,700	263,700	--
Number of GECs	48	40	40	--
Number of GTPD Fellows	44	56	56	--
Number of GACAs	86	90	90	--
Number of Patient Encounters	6,838,778	1,850,000	1,850,000	--

[1] Most Recent Result: FY 2008.

Grant Awards Table – Geriatric Education Centers Program

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	48	40	40
Average Award	$338,574	$498,938	$498,938
Range of Awards	$215,756- $432,248	$300,000- $500,000	$300,000- $500,000

Grant Awards Table – Geriatric Training for Physicians, Dentists, and Behavioral and Mental Health Professionals

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	11	14	14
Average Award	$588,836	$523,616	$523,616
Range of Awards	$501,113- $1,090,000	$500,000- $1,000,000	$500,000- $1,000,000

Grant Awards Table – Geriatric Academic Career Awards Program

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	84	90	90
Average Award	$69,426	$69,426	$71,509
Range of Awards	N/A	N/A	N/A

Interdisciplinary, Community-Based Linkages

Allied Health and Other Disciplines

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$13,890,000	---	$22,390,000	$22,390,000	---

Authorizing Legislation: Section 755 of the Public Health Service Act (Allied Health Projects, Podiatry, Chiropractic Demonstration Projects Grant Program, Grant Program to Support Graduate Psychology Education, and Graduate Geropsychology); Section 340 G of the Public Health Service Act (State Oral Health Workforce Grant Program)

FY 2011 Authorization (Chiropractic, Psychology Programs, Allied Health Projects)...Expired

FY 2011 Authorization (State Oral Health Workforce Program)……..$25,000,000 for the 5-fiscal year period beginning with fiscal year 2008

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The following programs are included under Allied Health and Other Disciplines: Graduate Psychology Education, State Oral Health Workforce, Chiropractic Demonstration Project Grants, Allied Health Projects, Graduate Geropsychology and Podiatry.

The following three components of this program have not been funded since FY 2005: Graduate Geropsychology, Allied Health Projects, and Podiatry.

Program Description and Accomplishments are listed for Graduate Psychology Education, State Oral Health Workforce, and Chiropractic Demonstration Project Grants.

Allied Health and Other Disciplines Programs

Programs	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget
Graduate Psychology Education	$1,945,000	$2,945,000	$2,945,000
State Oral Health Workforce	$10,000,000	$17,500,000	$17,500,000
Chiropractic Demonstration Project Grants	$1,945,000	$1,945,000	$1,945,000

Graduate Psychology Education Program

Graduate Psychology Education grants support post-baccalaureate education within accredited psychology training programs, in collaboration with two or more medical or behavioral health disciplines. The purpose of the program is to train psychologists in behavioral and mental health to work with individuals and families in medically underserved areas. Eligible entities include accredited health profession schools, universities, and other public or private nonprofit entities, including faith-based and community-based organizations. Since its inception in FY 2004, this program has trained from 80 to 90 graduate psychologists annually. The majority of these graduates enter practice in underserved communities. **As of September 30, 2009 there were 3,291 Mental Health HPSAs** with 80 million people living in them. It would take 5,338 practitioners to meet their need for mental health providers (a population to practitioner ratio of 10,000:1).

Oral Health Workforce Program

Grants to States to Support Oral Health Workforce Activities, funded under Section 340 G of the Public Health Service Act, provide the opportunity for States to implement a range of innovative approaches to improve access to oral health services. Eligible applicants include Governor-appointed State government entities. Since FY 2006, when the first awards were made, the program has resulted in increased proportions of Medicaid beneficiaries receiving dental care as well as increased numbers of dental professionals who are trained for and are practicing in underserved communities. It has also allowed for States to augment their planning efforts to improve oral healthcare training and service capacity, including services and facilities for children with special needs.

The Grants to States to Support Oral Health Workforce Activities is an effort to address, at the State level, some of the nation's significant dental access, training and delivery needs. Despite significant advances in dental productivity, distribution problems remain for specific geographic areas and populations. United States dental schools play an important role in improving access to care for underserved populations through the provision of direct services and exposure of students and residents to caring for the special needs of such populations. However, dental school faculty and the nation's practicing dentists are quickly nearing retirement age.

The program supports activities in States where oral health services for underserved populations are geographically dispersed and address the oral health workforce needs of underserved areas in both urban and rural locations. As of September 30, 2009, there were **4,230 dental HPSAs** with 49 million people living in them. This program directly addresses this need.

In FY 2009, HRSA funded a one-year contract to meet legislative requirements for the development of a report to Congress containing data relating to whether grants provided under this program have increased access to dental services in designated dental HPSAs. Due to the diverse nature of this program the contract also focuses on developing "standard" and "applicable" program specific measures to track the accomplishments of future grants. HRSA anticipates that the Oral Health Draft Report to Congress will be released by the end of December 2010.

To date, 59 grants have been awarded under this program to 34 States or eligible U.S. territories.

Chiropractic Demonstration Project Program

Chiropractic Demonstration Project grants support research in which chiropractors and physicians collaborate to identify and provide effective treatments for spinal and/or lower back conditions. Projects supported by this program: a) identifies and treats spinal and/or lower back conditions for patients at risk or those living with spinal and/or lower back conditions; b) is founded on collaborative efforts between chiropractors and allopathic or osteopathic physicians; c) includes a strong research protocol which results in a significant expansion of documented research, suitable for peer-reviewed health professions journals; d) includes a strategy for making direct comparisons to other forms of treatment; and, e) includes minorities and women in the study populations so that the research findings are relatable to all persons at risk for spinal and/or low back conditions.

Since its inception in FY 1994, the program has supported chiropractic training institutions in seven States and has supported dozens of chiropractors and physicians in identifying best practices in the treatment of spinal and lower back conditions. These best practices have been disseminated through the publication of articles in professional journals. This program addresses the need for cost-effective, quality care for patients with chronic diseases and demonstrates the benefit of integrative medicine in providing a comprehensive, patient-centered, team-based approach to health care delivery

Funding below includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbook (EHB), and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$ 3,957,000
FY 2007	$ 3,960,000
FY 2008	$ 8,803,000
FY 2009	$13,890,000
FY 2010	$22,390,000

Budget Request

The FY 2011 President's Budget Request of $22,390,000 is the same as the FY 2010 Appropriation. The total request will provide continued support for an estimated 18 continuation Psychology grants, approximately 45 continuing State Oral Health grants, and an estimated four chiropractic continuation grants.

Outcomes and Outputs Tables

Outputs	Most Recent Result [3]	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Graduate Psychology				
Number of Grantees	18	18	18	--
Number of Trainees	94	100	100	--
Number of Graduates	88	90	90	--
Number of Graduates entering practice in MUCs	54	65	65	--
Percent of Graduates entering practice in MUCs	61	70	70	--
Oral Health Workforce				
Number of Grantees	34	45	45	--
Chiropractic Demonstration Projects				
Number of awards	4	4	4	--
No. of chiros. involved in research projects	28	30	30	--

Grant Awards Table –Graduate Psychology

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	18	18	18
Average Award	$104,672	$160,000	$160,000
Range of Awards	$70,000-$150,529	$75,000-$190,000	$75,000-$190,000

Grant Awards Table –State Oral Health

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	30	45	45
Average Award	$330,000	$388,880	$388,880
Range of Awards	$160,000-$500,000	$160,000-$725,000	$160,000-$725,000

[3] Most Recent Result: FY 2008

Grant Awards Table –Chiropractic Demonstrations

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	4	4	4
Average Award	$453,623	$453,623	$453,623
Range of Awards	$383,375-$534,327	$383,375-$534,327	$383,375-$534,327

Public Health Workforce Development

Public Health, Preventive Medicine, and Dental Public Health Programs

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$9,000,000	$10,500,000	$10,000,000	$10,000,000	---

Authorizing Legislation: Sections 766, 767 and 768 of the Public Health Service (PHS) Act.

FY 2011 Authorization .....Expired

Funding Allocation .....Competitive Grant/Formula Grant

Program Description and Accomplishments

The current public health workforce is inadequate to meet the health needs of the United States population and worsening shortages will reach crisis proportions in the coming years (Association of Schools of Public Health, 2008). HRSA defines the public health workforce as public health workers in formal public health agencies and departments, as well as those in community based organizations providing public health services. Public health workers protect and improve the health of communities through education, promotion of healthy lifestyles, and research for disease and injury prevention. The Association of Schools of Public Health (2008) projected that by 2020 the nation will require 250,000 more public health workers. In addition, ASPH projects that almost 110,000 workers, 23 percent of the current workforce, will be eligible to retire by 2012. Over the next 12 years, schools of public health will need to train three times the current number of graduates to meet projected public health needs. Another factor compounding this problem is that approximately 85 percent of the existing public health workforce lacks formal preparation in public health. It is essential that these public health workers receive foundational training in the core public health skills and competencies as well as education and training to maintain and upgrade their skills. The Public Health Workforce Development programs provide support to help meet public health workforce needs and address public health workforce shortages.

For communities to thrive, essential public health services must be provided. There are many critical challenges facing the public health sector today. Identified areas of severe shortages in public health personnel are found in the areas of epidemiology, environmental health, toxicology, nutrition, biostatistics and maternal and child health. The extent of these shortages in the public health specialties are debated in the field. However, local health departments have the greatest difficulty recruiting public health nurses, epidemiologists and environmental health scientists (National Association of County and City Health Officials, NACCHO, 2007). Among the reasons cited by a variety of organizations are budget constraints and non-competitive

salaries, a rapidly aging workforce, high turnover rates, shortages of disciplines and poorly prepared practitioners.

The Institute of Medicine (IOM) (2004) reports that public health physicians are needed in sufficient numbers to address health promotion and disease prevention issues, chronic infectious disease management, safe food and water supplies, sanitation and environmental exposures. The results of the American Association of Medical Colleges (2008) Physician Specialty Data Report indicate that the practicing preventive medicine physician workforce is aging and has the highest percentage of individuals aged 55 or older. The IOM (2004) Report entitled Training Physicians for Public Health Careers estimates that to maintain the current level of preventive medicine physicians, 400 preventive medicine physicians would have to graduate each year. Kahn (2003) noted that in the past 30 years the preventive medicine physician workforce decreased from 2.3 percent to 0.8 percent of the total physician workforce and that only 23 percent of the local health agencies are directed by physicians. This may cause concerns about a non-physician directors' ability to adequately manage serious disease outbreaks or public medical emergencies.

Public Health, Preventive Medicine, and Dental Public Health Programs

Program	FY 2009 Appropriation	FY 2009 ARRA[1]	FY 2010 Appropriation	FY 2010 ARRA	FY 2011 President's Budget
Public Health Training Center Program	$5,868,346	---	$5,868,346	---	$5,868,346
Public Health Traineeships	$1,434,356 $	2,985,000 $	1,434,356	---	$1,434,356
Dental Public Health Residency Training Program	$332,086 $	815,000 $	332,086	---	$332,086
Preventive Medicine Residency Program	$1,365,212	---	$2,365,212 $	6,685,000	$2,365,212

Public Health Training Center Program: Section 766 of the PHS Act

The Public Health Training Centers Programs (PHTCs) was established in FY1999. This Program focuses on the technical, scientific, managerial and leadership competencies and capabilities of the current and future public health workforce with emphasis on the existing public health workforce. Eligible applicants include accredited schools of public health or other public or nonprofit private institutions accredited for the provision of graduate or specialized training in public health.

The PHTCs provide education and training offerings to public health workers in 45 States and the District of Columbia. In FY 2008, PHTC grantees developed over 1,700 educational offerings and trained over 200,000 professionals in public health. Approximately 163,000 received training through distance learning. Education and training provided by the PHTC

[1] Recovery Act funding was appropriated in FY 2009, however, funding for the Preventive Medicine Residency Program will not be obligated until FY 2010.

program are in all eight Domains of Practice and reflect the core public health competencies (68) as defined by the Council on Linkages between Academia and Public Health Practice (Public Health Foundation, 2009). These trainings are offered at varying levels of sophistication to accommodate the education and experience levels of the public health workers trained. Those trained reflect 19 public health disciplines with 45 percent working for public health departments and 55 percent delivering public health services in community based organizations. As of September, 2009, PHTCs began to include the revised competency set released by the Council on Linkages in June, 2009.

Public Health Traineeship Program, Section 767 of the PHS Act

The Public Health Traineeships Program (PHT) was established in 1956. The Public Health Traineeships (PHT) Program is a formula grant program that supports the education and training of the individuals pursuing a master's degree in public health in the fields of epidemiology, environmental health, biostatistics, toxicology, nutrition and maternal and child health.

Eligible entities for PHT grants include schools of public health, and other public or non-profit private entities, including faith-based and community-based organizations accredited by the Council on Education for Public Health, and other public or non-profit private institutions accredited by a body recognized for this purpose by the Secretary of the Department of Education. Grant funds are distributed according to the grantee institutions' policy for tuition, fees, and allowances. Traineeships provide for tuition, fees, stipends, and allowances (including travel and subsistence expenses and dependency allowances that can be used to support students that commit to serve in areas with a severe shortage of public health professionals).

In FY 2008, the Public Health Traineeships Program (PHT) supported a total of 2,350 graduate and postgraduate students. This program addresses HRSA's goal to improve public health and health care systems.

Residency Training Program in Dental Public Health, Section 768 of the PHS Act

The Residency Training Program in Dental Public Health (DPH) provides support to assist accredited dental public health programs in developing new training programs, maintaining or improving existing residency training programs, and providing financial assistance to trainees enrolled in such programs. This program emphasizes the education and training of the public health professional dental workforce in urban and rural settings, and access to oral healthcare for underserved populations including, but not limited to, the homeless, pediatrics, geriatrics, individuals with HIV/AIDS and substance abuse issues. The program achieves this by communicating and collaborating with community health centers, hospitals, public schools, nursing homes and other long term care facilities.

There are currently 129 active Board certified public health dentists (Diplomates of the Board in Dental Public Health, 2009) in the U.S., with a ratio of 0.042 per 100,000 population. The Health Resources and Services Public Health Workforce Study (2005) reported that recruitment of dentists into public health service was difficult, but those who chose to work in public health tended to stay. Most dentists employed by public health agencies were providing personal health

services, not population health. Yet oral health is one of the key areas that could benefit from a population health approach. Dental caries are preventable, yet it remains the number one disease of childhood in America. This study found that the scarce dollars that local health departments had for oral health in many instances attempted to address the problem through the provision of direct patient services. In FY 2008, five grantees trained 30 dental public health residents which is an increase of four students from 2007. Three graduates entered practice in underserved areas. Grantee progress reports indicate that the majority of the graduates are employed by State and local departments of health. However, their practices continue to be characterized by provision of direct services because of the limited resources to focus on the broader public health landscape. Ninety six percent (29) were trained for a career in primary care.

Preventive Medicine Residency Program, Section 768 of the PHS Act

The Preventive Medicine Residency Program (PMRP) was established in 1999. The purpose of the PMRP is to assist academic institutions in meeting the cost of preventive medicine residency programs which cannot be met from other sources. The Preventive Medicine Residency Program (PMRP) is authorized to (1) plan and develop new residency training programs, (2) maintain or improve existing residency programs, and (3) provide financial support to residency trainees in these programs. Public and nonprofit private accredited schools of medicine, osteopathic medicine, and public health are eligible to apply.

Preventive medicine is a unique medical specialty that combines knowledge and skills in clinical medicine with those in population health. Preventive medicine residencies teach post-graduate physicians the competencies to address population-level problems such as health care for the indigent, bioterrorism prevention and response, communicable disease control, and health care delivery. Population-based training takes place in the community at community health centers, public health departments and community research facilities.

In FY 2008, the five residency programs supported a total of 35 trainees (17 enrollees, 18 graduates). Of these, 14 were from underrepresented minority backgrounds

The Public Health Workforce Development Program was appropriated at total of $10,500,000 in Recovery Act funding in FY 2009. In FY 2009, $3,815,000 supported 30 awards through Public Health Traineeships and three awards in the Residency Training Program in Dental Public Health. In FY 2010, $6,685,000 in Recovery Act funding will support an estimated 8 preventive medicine grants supporting about 100 residents. These awards are made for a three year grant period. There is no Recovery Act funding for this program in FY 2011.

Most of the Health Profession's Title VII and Title VIII programs were grouped together and underwent a program assessment in 2002. This program was included in that assessment. (See Health Professions Summary).

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$7,915,000
FY 2007	$7,920,000
FY 2008	$8,273,000
FY 2009	$9,000,000[2]
FY 2009 Recovery Act	$10,500,000
FY 2010	$10,000,000

Budget Request

The FY 2011 President's Budget Request of $10,000,000 is the same as the FY 2010 Appropriation. The total request will support continuing education in public health to 217,000 individuals in the public health workforce, 2,500 graduate students in public health through traineeships, four dentists in the residency training program in dental public health, and about 50 physicians in preventive medicine residency programs. These programs address public health workforce shortages by increasing public health education capacity, providing traineeship support for students enrolled in graduate public health degree programs, increasing the number of preventive medicine physicians, increasing the number of dentists who specialized in public health, and promoting a diverse public health workforce to reduce racial and ethnic health disparities.

Outcomes and Outputs Tables

Outputs	Most Recent Result [3]	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Public Health Training Centers				
Number of existing public health workers retrained	200,795	217,000	217,000	--
Public Health Traineeships				
No. of students supported with traineeship funds	2,350	2,500	2,500	--
No. of graduates supported with traineeship funds	781	840	840	--
No. of URM grads supported with traineeship funds	209	230	230	--
Percent of URM graduates supported	8%	8%	8%	--
Average Traineeships	$600	$ 600	$600	--
Average Award to Institution	$57,194	$57,194	$57,194	--
Dental Public Health				
Number of residents/graduates who enter practice in underserved areas	3	4	4	--

[2] Regular Appropriation Only
[3] Most Recent Result: FY 2008

Outputs	Most Recent Result [3]	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Number of residents/graduates that provide and support public health	29	30	30	--
Number of minority/disadvantaged residents/graduates who completed training.	12	2	2	--
Number of minority/disadvantaged residents/graduates in training.	14	10	10	--
Preventive Medicine Residency Training				
Number of residents participating in residencies	35	40	40	--
Number of residents completing training	18	20	20	--
Number of URM residents completing training	9	14	14	--
Percent of URM residents completing training	50	70	70	--
Number of residents entering practice in MUCs	2	6	6	--
Percent of residents entering practice in MUCs	11	10	10	--
Average cost per resident	$55,640	$85,000	$85,000	---

Grant Awards Table – Public Health Training Center Program

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	14	14	14
Average Award	$325,000	$325,000	$325,000
Range of Awards	$250,000-$401,003	$250,000-$401,003	$250,000-$401,003

Grant Awards Table – Public Health Traineeships

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA[4]	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	30	30	30	30
Average Award	$57,194	$33,166	$57,194	$57,194
Range of Awards	$9,000-$182,096	$4,808 - $425,055	$9,000-$182,096	$9,000-$182,096

Grant Awards Table – Residency Training Program in Dental Public Health

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA[4]	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	3	3	3	3
Average Award	$94,303	$90,989	$94,303	$94,303
Range of Awards	$84,000-$100,000	$84,000-$100,000	$84,000-$100,000	$84,000-$100,000

Grant Awards Table – Preventive Medicine Residency Program

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA[5]	FY 2010 Appropriation	FY 2011 Request
Number of Awards	5	---	8	8
Average Award	$236,735	---	$236,735	$236,735
Range of Awards	$211,825-$250,000	---	$211,825-$250,000	$218,825-$250,000

[4] ARRA awards were made for 3-year grant periods. Average amounts reflected are annual for comparability

[5] Recovery Act funding was appropriated in FY 2009, however, part of the funds will not be obligated until FY 2010.

Nursing Workforce Development

Advanced Education Nursing Program

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$64,438,000	---	$64,438,000	$64,438,000	---

Authorizing Legislation: Section 811, Public Health Service Act, Title VIII, (42 U.S.C. 296j)

FY 2011 Authorization ..... Expired

Allocation Method ..... Competitive Grant/Contract

Program Description and Accomplishments

The purpose of the Advanced Education Nursing (AEN) Program is to increase the number of advanced education nurses trained to practice as primary care providers and/or nursing faculty. This program was established in 1998 to support the preparation of advanced practice nurses such as nurse practitioners, clinical nurse specialists, nurse-midwives, nurse anesthetists, nurse educators, nurse administrators, and public health nurses. The program addresses the continuing need for advanced practice nurses to work in primary care and increasingly complex healthcare systems; the increasing need for nursing faculty; and the need for nurses prepared in public health. The AEN infrastructure grants are awarded to schools of nursing with graduate programs for three-year project periods and undergo a competitive peer-reviewed application process. The Advanced Education Nursing Traineeship (AENT) and the Nurse Anesthetist Traineeship (NAT) programs as part of the AEN cluster in Section 811 and are awarded for a one-year project period.

The AEN Program also prepares faculty to teach for all levels of nursing education. The inability of schools of nursing to recruit and retain qualified nursing faculty has directly impacted the nursing supply in the U.S. The nurse faculty shortage continues to inhibit nursing schools from educating the number of nurses needed to meet the demand. According to the American Association of Colleges of Nursing (AACN), almost 50,000 qualified applicants were turned away from baccalaureate and graduate nursing programs in 2008 primarily due to insufficient number of faculty. According to a *Special Survey on Vacant Faculty Positions* released by AACN in August 2009, a total of 803 faculty vacancies were identified in a survey of 554 nursing schools with baccalaureate and/or graduate programs across the country (70.2% response rate). Besides the vacancies, schools cited the need to create an additional 279 faculty positions to accommodate student demand. The data show a national nurse faculty vacancy rate of 6.6%. Most of the vacancies (90.6%) were faculty positions requiring or preferring a doctoral degree.

The top reasons cited by schools having difficulty finding faculty were noncompetitive salaries compared to positions in the practice arena (32.2%) and a limited pool of doctorally-prepared faculty (30.3%).

In FY 2009 the AEN Program funded 53 new and 107 non-competing continuation grants for a total of 160 awards. In FY 2008, the AEN Program funded 152 grants and supported the training of 5,649 part-time and full-time advanced level nursing students. The contributions of the 1,785 graduates from these projects include increasing access to primary healthcare, providing primary, secondary and tertiary prevention, and providing direct care across the life span in a wide variety of settings such as hospitals, in the home, long term care settings, and in healthcare systems.

The Advanced Education Nursing Traineeship (AENT) and the Nurse Anesthetist Traineeship (NAT) Programs that are both under the AEN Program legislation, provide schools with funds for student financial support which is essential to increasing the graduation rate from advanced nursing education programs and nurse anesthetist programs. Due to the high number of full and part-time students relative to the funds available for traineeship programs, most students receive only partial support. As tuition and living costs increase, student support has become an essential element in increasing the rate at which a nurse can complete graduate education. Fiscal pressures on State governments and hospital cost containment measures have reduced student support at the same time tuition is increasing. The increased debt burden, combined with a static wage scale has diminished access to educational opportunities and more students are enrolled on a part-time basis.

In FY 2009, the AENT program funded 270 new grants to schools of nursing. In FY 2008, 316 grant awards provided direct financial support to 6,675 graduate nursing students producing 2,550 graduates that were prepared as advanced practice nurses. The NAT program funded 83 nurse anesthesia programs which provided direct financial support to 2,145 nurse anesthetist students producing 1,368 nurse anesthetists graduates that were prepared to enter into the workforce.

The Advanced Education Nursing Traineeship and Nurse Anesthetist Traineeship programs are both awarded by formula grants. Technical IT contract support was awarded to create an automated database system (Nurse Traineeship Database) for two nursing traineeship programs: AENT, and NAT. The new database system automates the previous manual data entry, analysis, reconciliation and award process by electronically capturing the data reported on each AENT and NAT grantee. This system has been incorporated as a part of the HRSA Electronic Handbooks (EHBs) Maintenance and Support Contract (program system integration).

Most of the Health Profession's Title VII and Title VIII programs were grouped together and underwent a program assessment in 2002. This program was included in that assessment. (See Health Professions Summary).

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Advanced Education Nursing Programs

Disciplines	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget
Advanced Education Nursing $	47,188,000	$47,188,000	$47,188,000
Advanced Education Nursing Traineeship	$16,000,000 $	16,000,000	$16,000,000
Nurse Anesthetist Traineeship	$1,250,000 $	1,250,000	$1,250,000

Funding History

FY	Amount
FY 2006	$57,021,000
FY 2007	$57,061,000
FY 2008	$61,875,000
FY 2009	$64,438,000
FY 2010	$64,438,000

Budget Request

The FY 2011 President's Budget Request of $64,438,000 is the same as the FY 2010 Appropriation. The total request will continue support for advanced education nursing traineeship grants, traineeship grants to nurse anesthesia schools, and advanced education nursing projects. The total request will provide: approximately 270 formula-driven advanced education nursing traineeship grants to graduate nursing programs; approximately 83 formula-driven traineeship grants to nurse anesthesia schools, approximately 160 advanced education nursing grants. Support for these programs will address the health care needs of the Nation by supporting the training of advanced practice nurses such as nurse practitioners which are needed to effectively address and reduce health disparities and to increase access to quality health care for all Americans.

Outcomes and Outputs Tables

Outputs	Most Recent Result [1]	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Advanced Education Nursing Program: [2]				
Number of students	5,649	5,649	5,649	--
Number of minority/disadvantaged students enrolled	906	906	906	--
% minority/disadvantaged enrollment	26%	26%	26%	--
Number of graduates	1,785	1,785	1,785	--
Traineeship Programs: [3]				
Number of students supported	9,560	9,560	9,560	--
Number of graduates Supported	4,321	4,321	4,321	--
Number of graduates practicing in underserved areas	5,649	5,649	5,649	--

Grant Awards Table

AEN Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	160	160	160
Average Award	$268,200	$268,200	$268,200
Range of Awards	$89,200-$618,000	$89,200-$618,000	$89,200-$618,000

AENT Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	270	270	270
Average Award	$48,000	$48,000	$48,000
Range of Awards	$1,800-$303,000	$1,800-$303,000	$1,800-$303,000

NAT Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget

[1] Most Recent Result: FY 2008

[2] Advanced Education Nursing Program outputs targets have been consolidated and include the Nurse Practitioner and Nurse Midwifery Programs, the Nurse Anesthetist Education Programs and Other Educational Nursing programs.

[3] Traineeship Program targets have been consolidated and include the Nurse Anesthetist Traineeship Program and the Advanced Education Nursing Traineeship program.

(whole dollars)	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	83	83	83
Average Award	21,084	21,084	$21,084
Range of Awards	$276-$56,200	$276-$56,200	$276-$56,200

Nursing Workforce Development

Nursing Workforce Diversity

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$16,107,000	2,756,000	$16,107,000	$16,107,000	---

Authorizing Legislation: Section 821 of the Public Health Service Act.

FY 2011 Authorization .....Expired

Allocation Method .....Competitive Grant/Contract

Program Description and Accomplishments

The purpose of the Nursing Workforce Diversity (NWD) Program is to increase nursing education opportunities for individuals from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among registered nurses). The NWD Program was established in 1998 and provides grants to projects that incorporate retention activities, pre-entry preparation activities, and supports student scholarships and/or stipends. The goal of the NWD Program is to improve the diversity of the nursing workforce to meet the increasing need for culturally sensitive and quality healthcare. In addition to contributing to the preparation of a racially and ethnically diverse nursing workforce, this program also contributes to the basic preparation of disadvantaged and minority nurses for leadership positions within the nursing profession and the healthcare community. The NWD grants are awarded for three-year project periods through a competitive peer-reviewed process.

Project participants impacted by this program are students from disadvantaged backgrounds in middle school, high school, or post-high school and students enrolled in pre-nursing and nursing programs. Projects are expected to demonstrate that a cohort of nursing students will graduate within the three-year project period.

In addition to contributing to the preparation of a racially and ethnically diverse healthcare workforce, this program contributes to the basic preparation of disadvantaged and minority health professionals within the healthcare community. It has been found that minority and disadvantaged health professionals are more likely to serve in areas with a high proportion of underrepresented racial and ethnic groups and to practice in or near designated healthcare shortage areas. Numerous studies have documented that increasing the number of minority health professionals is a key strategy to eliminating health disparities. Diversity in the health workforce will strengthen cultural competence throughout the healthcare system. Cultural competence profoundly influences how health professionals deliver healthcare.

Although the minority population in the U.S. accounts for 33 percent of the total population, the 2004 National Sample Survey of Registered Nurses reports that only 10.6 percent of the nursing workforce comes from racial/ethnic minority groups. An estimated 500,000 registered nurses from racial/ethnic minority groups would be needed if the nurse population were to reflect the U.S. population as a whole.

The retention activities focus on creative interventions designed to assist nursing students from disadvantaged backgrounds to continue their pursuit of a nursing education. Nursing students are engaged in programs that include activities that are creative interventions designed to academically assist, mentor, and coach them to successfully complete the nursing programs. These activities address identified educational barriers, reduce attrition rates, and improve graduation rates for NWD Program participants.

The pre-entry preparation activities focus on creative interventions designed to enhance the academic abilities and preparation of students from disadvantaged backgrounds to increase their competitiveness for entry into a professional nursing program.

The student stipends and scholarship provide direct financial assistance to project participants to enhance their ability for successful entrance and completion of a professional nursing education program. The purpose of the stipend and scholarship support is to reduce the financial barriers associated with disadvantaged students obtaining a higher level of education. The entity organization is responsible for disbursing scholarships and stipends to project participants.

In FY 2009, the NWD program funded 14 new competitive grants and 33 non-competitive continuation grants for a total of 47 new grant awards. In FY 2008, the NWD program funded 51 grant awards to eligible entities to increase nursing education opportunities for 11,638 individuals from disadvantaged backgrounds.

- 3,162 high school, pre-nursing and nursing students received financial assistance through NWD funded grant stipends and scholarships totaling over $4 million

- 998 nursing students graduated from NWD funded nursing programs. Of those graduates, 553 (55 percent) were identified as disadvantaged minorities and 415 (42 percent) were identified as disadvantaged whites. Race/ethnicity was not reported for 30 graduates.

- 6,128 middle and high school students participated in NWD mentoring projects and academic enrichment activities to increase their competitiveness for entry into nursing programs.
- 1,882 post high school and pre-nursing students and 3,628 nursing students participated in NWD funded nursing programs.

In FY 2009, three grantees were awarded Recovery Act funding which will provide support for 720 pre-nursing and nursing students receiving academic enrichment support, stipend and

scholarship assistance and coaching and mentoring services and will produce 240 graduates over a two year project period.

Most of the Health Profession's Title VII and Title VIII programs were grouped together and underwent a program assessment in 2002. This program was included in that assessment. (See Health Professions Summary).

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews

Funding History

FY	Amount
FY 2006	$16,096,000
FY 2007	$16,107,000
FY 2008	$15,826,000
FY 2009	$16,107,000[1]
FY 2009 Recovery Act	$ 2,756,000
FY 2010	$16,107,000

Budget Request

The FY 2011 President's Budget Request of $16,107,000 is the same as the FY 2010 Appropriation. The total request will support pre-entry preparation, retention and stipend/scholarships program activities. The total request will also continue support for the training of disadvantaged students to become registered nurses. Support will be provided for the training of approximately 11,600 minority and white disadvantaged students/participants become registered nurses.

The grants focus on creative interventions designed to enhance the academic abilities and preparation of students from disadvantaged backgrounds to increase their competitiveness for entry into a professional nursing program. The program and its activities must identify, motivate, recruit, and select potential candidates for a professional nursing education. In FY 2011, the NWD program will implement a requirement that grantees incorporate a structured science, math and technology centered curriculum that will enhance student performance in those areas and to gain entrance into nursing program.

[1] Regular appropriation only.

Outcomes and Outputs Tables

Outputs	Most Recent Result[2]	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Disadvantaged Students/Participants				
Number and percent of minority student/participants	8,577 (74%)	8,577 (74%)	8,577 (74%)	--
Number and percent of white disadvantaged student/participants	3,061 (26%)	3,061 (26%)	3,061 (26%)	--
Total number of minority and white disadvantaged students/participants	11,638 1	1,638	11,638	--
Level of Students/Participants				
Number of nursing program students	3,628	3,628	3,628	--
Number of post high school, college, and pre-entry nursing students	1,882	1,882	1,882	--
Number of K-12 students/participants	6,128	6,128	6,128	--
Student Financial Support				
Number of nursing students expected to receive scholarships	814	814	814	--

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA[3]	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	47	3	47	47
Average Award	$294,500	$294,500	$294,500	$294,500
Range of Awards	$134,600 - $528,000	$134,600 - $528,000	$134,600 - $528,000	$134,600 - $528,000

[2] Most recent result: FY 2008

[3] ARRA awards were made for 3-year grant periods. Average amounts reflected are annual for comparability.

Nursing Workforce Development

Nurse Education, Practice and Retention

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$37,291,000	---	$39,896,000	$39,896,000	---

Authorizing Legislation: Section 831 of the Public Health Service Act.

FY 2011 Authorization .....Expired

Allocation Method .....Competitive Grant/Contract

Program Description and Accomplishments

The purpose of the Nurse Education, Practice and Retention (NEPR) program is to strengthen capacity for basic nurse education and practice. The grant program was established in 1998 in an effort to address the critical nursing shortage. HRSA estimates that hundreds of thousands of additional nurses will be needed by 2020, as the health care system changes and the population ages. According to the Bureau of Labor Statistics (2009), employment of registered nurses is expected to grow 23 percent from 2006 to 2016, much faster than the average for all occupations. Growth will be driven by technological advances in patient care, which permits a greater number of health problems to be treated, and an increased emphasis on preventive care. In addition, the number of older people who are more likely to need nursing care is projected to grow rapidly.

The program's flexibility and broad focus allows the nursing profession to respond to State, regional and national needs. The NEPR is built on a foundation of three priority areas: education, practice, and retention. There are nine separate purposes that are clustered under these three areas. Eligible applicants must select one of the nine purposes under the three clusters. The purposes identified under the *education priority area* include: (1) expanding enrollment in baccalaureate nursing programs, (2) developing and implementing internship and residency programs, and (3) providing education in new technologies. The purposes identified under the *practice priority area* include: (1) establishing or expanding nursing practice arrangements, (2) providing care for underserved populations and other high risk groups, (3) continuing education to practice in the emerging healthcare system, and (4) developing cultural competencies for nurses. The purposes identified under the *retention priority area* include: (1) promoting advancement for nursing personnel through career ladder programs and (2) improving the retention of nurses and enhancing patient care directly related to nursing activities.

The NEPR Program addresses the nursing shortage by supporting initiatives designed to: expand the capacity of the nursing pipeline, promote career mobility for individuals in nursing, prepare more nurses at the baccalaureate level, and provide continuing education training to enhance the quality of patient care that nurses provide in a healthcare environment adapting to complex

technological changes. The NEPR Grants are awarded for three-year and five-year project periods, depending on its focus, and undergo a competitive peer-reviewed process.

In FY 2009 the NEPR Program funded 32 new competitive and 85 non-competitive continuation grants for a total of 117 grant awards. In FY 2008, the NEPR program funded 121 grant awards impacting 42,761 nursing students and registered nurses. The NEPR Program impacted 42,761 nursing students and registered nurses engaged in the 117 grant project activities. The NEPR projects support academic, service, and continuing education projects designed to strengthen the nursing workforce and improve nurse retention and quality of patient care. Amongst the FY 2009 117 NEPR grants, 14 new accelerated baccalaureate programs were launched which is another effective strategy to address the nursing shortage in a rapid manner by building the nursing workforce capacity

Most of the Health Profession's Title VII and Title VIII programs were grouped together and underwent a program assessment in 2002. This program was included in that assessment. (See Health Professions Summary).

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$37,266,000
FY 2007	$37,291,000
FY 2008	$36,640,000
FY 2009	$37,291,000
FY 2010	$39,896,000

Budget Request

The FY 2011 President's Budget Request of $39,896,000 is the same as the FY 2010 Appropriation. The total request will continue support for 4,696 baccalaureate nursing students, 92,351 primary care encounters in nurse practice arrangements, 3,407 internship and residency nurse participants, and 2,443 nurses and nursing students engaged in career ladder programs. This level of funding will also be used to support targeted initiatives focusing on faculty development, informatics, community colleges, and baccalaureate education.

Funding will specifically address enhancing the educational mix and utilization of the nursing workforce by supporting innovative approaches to shape the nursing workforce. Funding facilitates flexibility in meeting local/regional nursing needs as identified in the priorities referenced in the legislation, including enhancing career ladder programs for career advancement in nursing, expanding baccalaureate education, supporting internships and residency programs to facilitate the transition from student to graduate and retention initiatives to keep experienced nurses in the workforce.

Outcomes and Outputs Tables

Outputs	Most Recent Result [1]	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Number of Baccalaureate Projects Targeting Expanded Enrollment	20	23	23	--
Number of BSN Student Participants	4,696	4,696	4,696	--
Number of Primary Care Encounters	92,351 9	2,351	92,351	--
Number of Career Ladder (Mobility) Projects	14	20	20	--
Number of Career Ladder Participants	2,443	2,443	2,443	--
Number of Internship/Residency Projects	9	9	9	--
Number of Internship/Residency Participants	3,407	3,407	3,407	--

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	117	123	123
Average Award	$288,300	$288,300	$288,300
Range of Awards	$65,400-$584,800	$65,400-$584,800	$65,000-$584,800

[1] Most recent result: FY 2008

Nursing Workforce Development

Nurse Faculty Loan Program

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$11,500,000	$12,000,000	$25,000,000	$25,000,000	---

Authorizing Legislation: Title VIII, Section 846A of the Public Health Act, as amended by the Nurse Reinvestment Act of 2002.

FY 2011 Authorization ..... Expired

Allocation Method ..... Formula Grant

Program Description and Accomplishments

The Nurse Faculty Loan Program (NFLP), implemented in FY 2003, seeks to increase the number of qualified nursing faculty. The program supports the establishment and operation of a loan fund within participating schools of nursing to assist nurses in completing their graduate education to become qualified nurse faculty. Accredited collegiate schools of nursing are eligible to apply for funding. Eligible schools must offer an advanced education nursing degree program(s) that will prepare the graduate student to teach.

Almost 50,000 qualified applicants were turned away from baccalaureate and graduate nursing programs in 2008, according to the American Association of Colleges of Nursing (AACN). The primary barrier to accepting all qualified students at nursing colleges and universities continues to be the insufficient number of qualified nursing faculty. The NFLP serves as an incentive for nurses to select careers as nurse educators.

According to a Special Survey on Vacant Faculty Positions released by AACN in August 2009, a total of 803 faculty vacancies were identified in a survey of 554 nursing schools with baccalaureate and/or graduate programs across the country (70.2% response rate). Besides the vacancies, schools cited the need to create an additional 279 faculty positions to accommodate student demand. The data showed a national nurse faculty vacancy rate of 6.6%. Most of the vacancies (90.6%) were faculty positions requiring or preferring a doctoral degree. The top reasons cited by schools having difficulty finding faculty were noncompetitive salaries compared to positions in the practice area (32.2%) and a limited pool of doctorally-prepared faculty (30.3%).

The NFLP addresses the current shortage of nurse faculty. This shortage is expected to continue over the next 10 years as more than half of the current full-time nurse faculty members at the baccalaureate and graduate levels are likely to retire. This projection is based on the fact that the

average retirement age for nurse faculty members is 63.5 years and that 55.6 percent of the current full-time faculty members are 53 years or older. By continuing to make advanced education nursing financially accessible for more nurse faculty candidates, HHS believes that it can contribute strongly to confronting the nursing shortage.

The Health Resources and Services Administration (HRSA) makes an award and enters into an agreement with the school to establish and operate a distinct account for the NFLP loan fund (a revolving fund). The award to the school, the Federal Capital Contribution (FCC), must be deposited into the NFLP loan fund. The school is required to deposit the Institutional Capital Contribution (ICC) that is equal to no less than one-ninth of the FCC. The account may only be used to make loans to graduate nursing students who agree to meet the requirements of the NFLP.

Participating schools make NFLP loans to eligible graduate (master's and doctoral) nursing students to complete the nursing education program. Students may receive NFLP loans up to $30,000 per year for a maximum of 5 years. Following graduation from the nursing program, loan recipients may cancel up to 85 percent of the loan principal and interest in exchange for service as a full-time nursing faculty at a school of nursing.

The loan cancellation is made over a 4-year period, as follows: 20 percent of the principal and interest may be canceled for each of the first, second, and third years, totaling up to 60 percent, followed by 25 percent for the fourth year of full-time employment as a nursing faculty. The NFLP loans accrue interest at a rate of three percent per annum for loan recipients who establish employment as nurse faculty. Payment on the remaining 15 percent of the loan balance is deferred during the cancellation period.

During the latest reporting period covering academic year 2008-09, the NFLP facilitated the graduation of 223 students qualified to fill nurse faculty positions. During the same period, 194 NFLP graduates reported employment as nurse faculty. Each year has seen an increase in the number of participating schools coupled with an even greater increase in the number of graduates employed as nurse faculty. In FY 2008, 133 schools participated in the NFLP and in FY 2009, 149 schools participated. The consistent increase in school participation, supported students, and number of graduates employed as faculty demonstrate NFLP's success.

The NFLP was appropriated a total of $12,000,000 from the Recovery Act of 2009 to be disbursed over a two year period. In FY 2009, $5,350,000 was used to support 65 grants to schools of nursing that provided support for an estimated 500 loans. In FY 2010, the remaining $6,650,000 will support an estimated 91 grants to graduate nursing programs that will provide support for an estimated additional 700 loans to student. There is no FY 2011 Recovery Act appropriation for this program. Grants are awarded under this program on a yearly basis.

The Nurse Faculty Loan Program's investments in IT supports an IT system that will enable staff to monitor and evaluate institutional performance and, therefore, ensure the existence of sound cash management practices and procedures of funds administered by participating institutions. The automated data collection performance provided by this IT investment will: (1) streamlines the application submission process; (2) establishs an efficient method for capturing data required

to calculate the award; (3) serve as a data repository to facilitate program monitoring, reporting and analysis and (4) supports primary financial management tasks.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, follow-up performance reviews, maintenance and enhancements to the system, and primary financial management tasks.

Funding History

FY	Amount
FY 2006	$ 4,770,000
FY 2007	$ 4,773,000
FY 2008	$ 7,860,000
FY 2009	$11,500,000[1]
FY 2009 Recovery Act	$12,000,000
FY 2010	$25,000,000

Budget Request

The FY 2011 President's Budget Request of $25,000,000 is the same as the FY 2010 Appropriation. The total request will support approximately 177 schools receiving funds under the Nurse Faculty Loan Program.

Outcomes and Outputs Tables

Outputs	Most Recent Result [2]	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Number of Schools Receiving New Funds	99	215	215	--

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	99	65	215	215
Average Award	$116,162	$92,308	$116,162	$116,162
Range of Awards	$2,270 - $655,804	$6,495 – 451,792	N/A	N/A

[1] Regular Appropriation Only.
[2] Most Recent Result: FY 2009.

Nursing Workforce Development

Comprehensive Geriatric Education

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$4,567,000	---	$4,567,000	$4,567,000	---

Authorizing Legislation: Title VIII of the Public Health Service (PHS) Act, as amended by the Nurse Reinvestment Act, 2002, P.L. 107-205, Section 855 of the Public Health Service Act.

FY 2011 Authorization .....Expired

Allocation Method .....Competitive Grant/Contract

Program Description and Accomplishments

The Comprehensive Geriatric Education grant program (CGEP) prepares individuals to care for the aging population, the fastest growing group in today's society. The program supports grants to develop and implement, in coordination with programs under the Public Health Service Act, Title VII, Section 753, projects and initiatives to train and educate individuals providing care for the elderly. Funds are used to: (1) provide training to individuals who will provide geriatric care for the elderly, (2) develop and disseminate curricula relating to the treatment of the healthcare problems of elderly individuals, (3) train faculty members in geriatrics, or (4) provide continuing education to individuals who provide geriatric care. These grants prepare nurse aides, licensed practical nurses, registered professional nurses, nursing faculty and other individuals in the care of the elderly. The program was authorized in 2002 and implemented in 2003. Schools of nursing, healthcare facilities, programs leading to certification as a certified nursing assistant (CNA), partnerships of such a school and facility, or partnerships of such a program and facility are eligible to apply for these grants.

Over the next 25 years, the population over 65 will grow at a rate five times that of those under 65, and those over the age of 85 will be in the fastest growing segment of the population. It is estimated that by 2030 there will be approximately 70 million individuals aged 65 and older who will constitute about 20 percent of the total U.S. population. Many individuals 65 years and older are living longer, healthier lives. Currently, about 80 percent of older Americans are living with at least one chronic condition. As a result, it is important that individuals providing care for older adults be educated and trained in the area of health promotion specifically targeted to older adults as well as in the area of multiple chronic disease management and self-care management.

The Institute of Medicine (2008) reported that direct-care workers, also referred to as paraprofessionals, are the primary providers of paid hands-on care, supervision, and emotional support for older adults in the United States. While not all direct-care workers provide care to

older patients, they work primarily in settings important in the care of older adults, such as nursing homes, assisted living facilities, and home and community-based settings. According to the Bureau of Labor Statistics (BLS), 3.8 million workers were employed in health care support occupations in May 2008. Of this group, home health aides and personal and home care aides currently number 1,739,000. Projected employment for home health aides and personal and home care aides in 2018 will reach 2,575,600. This represents an almost 50 percent growth in the number of jobs available in these occupations and makes them among the fastest growing jobs in the country.

Another trend that accounts for this expected job growth, especially for personal- and home-care aides, is a shift away from institutional care to home- and community-based care. Home- and community-based care programs are increasing in response to consumer preferences and legal mandates with the hope that costs will be lower for at least some types of services. However, caring for older adults in these settings may require proportionately more direct care-level staff than institutional facilities (National Center for Health Workforce Analysis, 2004). The workforce providing non-institutional personal assistance and home health services tripled between 1989 and 2004, and Medicaid spending for these services also increased significantly during that time. Over that same time period, the workforce providing similar services in institutional settings remained relatively stable. The BLS predicts that personal- and home-care aides and home health aides will represent the second and third fastest growing occupations between 2006 and 2016. This trend will not only lead to an increase in demand for services in non-institutional settings but will also require home-based workers to deliver more skilled care to patients with more complex needs. In home- and community-based care settings, personal- and home-care aides work more independently and rely on personal skill and judgment; however, many direct-care workers do not receive the education or training they need in order to be prepared for the care of older patients with complex care needs.

Although there are a number of State and Federal requirements for the education and training of nurse aides, home health aides, and personal- and home-care aides, these requirements are minimal. Minimum training requirements for these workers are often inadequate or non-existent, and they vary across occupational categories and settings of care as well as among States. A number of other training-program characteristics vary among States as well, including the specific qualifications that instructors are expected to have, maximum student/instructor ratios, and the required program approval and oversight processes (AARP, 2006). The Institute of Medicine (2008) recommends that the minimum training for certified nursing assistants and home health aides should be raised to at least 120 hours and should include demonstration of competence in the care of older adults as a criterion for certification.

In FY 2008, 18 CGEP grantees provided education and training to 405 advanced practice nurses, 3,046 registered nurses, 517 licensed practical nurses, 1,169 certified nursing

assistants, 197 undergraduate nursing students, and 1,890 other health professionals. The CGEP grantees developed 362 educational offerings in the care of the elderly on a variety of topics including, but not limited to, delirium, dementia, depression, falls, geriatric assessment, pneumonia, swallowing difficulties, end of life care, and team communication.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$3,389,000
FY 2007	$3,392,000
FY 2008	$3,333,000
FY 2009	$4,567,000
FY 2010	$4,567,000

Budget Request

The FY 2011 President's Budget Request of $4,567,000 is the same as the FY 2010 Appropriation. The total request will support an estimated 27 projects to provide education and training on a variety of geriatric related health topics to 126 advanced practice nurses, 5,329 registered nurses, 941 licensed practical nurses, 2,153 certified nursing assistants, 950 undergraduate nursing students, and 840 other health professionals. The total request will be used to provide support for advanced practice nurses, registered nurses, licensed practical nurses, certified nursing assistants, and individuals with specialized education and training to care for the unique needs of the elderly.

Outcomes and Outputs Tables

Outputs	Most Recent Result [3]	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Number of Geriatric Projects	18	27	27	--

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	27	27	27
Average Award	$154,188	$154,007	$154,007
Range of Awards	$98,691 - $172,800	$118,443 - $172,800	$118,443 - $172,800

[3] Most Recent Result: FY 2008.

Patient Navigator Outreach and Chronic Disease Prevention

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$4,000,000	---	$5,000,000	$5,000,000	---
FTE	2	---	2	2	---

Authorizing Legislation: Patient Navigator Outreach and Chronic Disease Prevention Act of 2005, P. L. 109-18, Section 340A

FY 2011 Authorization .....Expired

Allocation Method .....Competitive Grant

Program Description and Accomplishments

The purpose of the Patient Navigator Outreach and Chronic Disease Prevention (PNDP) Program is to make grants to eligible entities for the development and operation of demonstration programs to provide patient navigator services to improve healthcare outcomes for individuals with cancer and other chronic diseases, with a specific emphasis on health disparity populations. The grants are used to recruit, train and employ patient navigators, including nurses, social workers, community health workers or anyone with first-hand knowledge of the communities they serve. The PNDP provides eligible institutions with funding to develop and implement education and training of community-based workers to improve the health of the diverse communities where they live and work.

The goal of the PNDP is to provide patient navigator services in order to reduce barriers, promote the adoption of healthy lifestyles, and prevent further disability by working directly with diverse, chronically ill patients with higher rates of cancer and other chronic diseases, morbidity, and mortality than the general population. By coordinating healthcare services, referrals for prevention, early detection, and access to community resources the patient navigators assist patients to receive prompt diagnosis and treatment resolution of abnormal findings before they become emergencies or require hospitalization. In addition to prevention activities, navigation is expected to decrease utilization of emergency room care and hospitalization, improve compliance with appropriate prescription drug use and increase appropriate healthcare and other medical visits.

The HRSA program supports the range of chronic diseases, including cancer. Chronic illness is severe and costly. Kung (2008) reported that seven of the ten leading causes of death in 2005 were from chronic diseases. Patients with chronic illness, especially multiple chronic illnesses, are also known to be major users of emergency rooms, hospitalizations, prescription drugs, and doctor visits. Patients with more than one chronic illness are often elderly and at risk for developing acute complications requiring acute and complex care services (Institute of Medicine,

2008). Data from the Robert Wood Johnson Foundation show that nearly all of the Medicare and 83 percent of the Medicaid spending is for services provided to individuals with chronic illnesses (sources: http://www.rwjf.org/reports/npreports/betterlives.htm and http://www.fightchronicdisease.org/pdfs/2009_PFCDAlmanac.pdf).

Chronic illness costs the United States more than $1 trillion per year and it is estimated to increase to about $6 trillion by 2050 (source: DeVol, Ross, Armen Bedroussian, Anita Charuworn, Anusuya Chatterjee, In Kyu Kim, Soojung Kim, and Kevin Klowden . An Unhealthy America: The economic burden of chronic disease. The Milken Institute. October 2007.) More than half of Americans are diagnosed with chronic illness such as cancer, diabetes, hypertension, and obesity. All of these chronic diseases may be influenced by lifestyle changes and prevention activities. Chronic diseases are often particularly devastating in populations experiencing health care disparities. Prevention, particularly with health disparity populations, is a Presidential priorty. Prevention of complications and disability is the anticipated outcome of patient navigation services.

Patient Navigator Outreach and Disease Prevention Program was authorized in FY 2005 and funds were first appropriated in FY 2008 for 6 grants with 2-year project periods. Two additional grants were awarded in FY 2009 with 1-year project periods. The authorizing statute requires all grant periods to end September 30, 2010; however, the Consolidated Appropriations Act, 2010 provides for grants with 3-year grant periods.

A contract supporting the mandated Congressional report was awarded in 2008 to collect descriptive data relevant to project outcomes. By FY 2010, grantees will report on common measures such as the number of patient navigators recruited, assigned, trained, and employed, as well as information on program activities and the target populations served along with selected patient outcomes. In addition, each grantee will describe site specific outcomes and other information to inform future Federal patient navigation programming.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	**Amount**
FY 2006	---
FY 2007	---
FY 2008	$2,948,000
FY 2009	$4,000,000
FY 2010	$5,000,000

Budget Request

The FY 2011 President's Budget Request of $5,000,000 is the same as the FY 2010 Appropriation. The total request will continue to support nine grants and one evaluation contract to describe the outcomes of patient navigation for patients with chronic illness, particularly from health disparity populations. The President's Budget proposes to continue the FY2010 appropriations language allowing for three-year grant periods.

Outcomes and Outputs Tables

Measure	Most Recent Result [1]	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Number of Grants	8	9	9	---

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	8	9	9
Average Award	$383,533	$383, 353	$383,353
Range of Awards	$156,643 - $500,000	$156,643 - $500,000	$156,643 - $500,000

[1] Most Recent Result: FY 2009.

Children's Hospitals Graduate Medical Education Payment Program

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$310,000,000	---	$317,500,000	$317,500,000	---
FTE	9	---	9	9	---

Authorizing Legislation: Section 340E of the Public Health Service Act; Public Law 109-307

FY 2011 Authorization $330,000,000

Allocation Method ..... Formula Based Payment

Program Description and Accomplishments

The Children's Hospitals Graduate Medical Education (CHGME) Payment Program supports graduate medical education (GME) in freestanding children's teaching hospitals. Payments are made to these hospitals to help them maintain GME programs train future physicians to provide quality care to children, and enhance their ability to care for low income patients. Teaching hospitals including children's hospitals may receive some additional support for GME from sources other than Medicare and HRSA, such as Medicaid or Title VII programs**.** However, children's hospitals receive little to no funding from the primary source of Federal GME funding, Medicare, because they treat few to no Medicare patients. The projected Medicare disbursement for GME for 2011 is more than $8 billion. As such, the CHGME Payment Program was designed to address the disparity in Federal support for GME between freestanding children's hospitals and other teaching hospitals supported by Medicare.

There are approximately 60 children's hospitals nationwide that are considered freestanding and are potentially eligible for this program. In FY 2008, the CHGME Payment Program supported 57 freestanding children's hospitals located in 31 States which were responsible for the training of more than 5,600 medical residents on and off site. About 48 percent of these residents are training in pediatrics, about 24 percent in pediatric subspecialties and about 27 percent are non-pediatric residents rotating through these hospitals. Among this last group are, for example, future family physicians that will care for adults and children, future radiologists, and future pathologists who need to be exposed to medical knowledge specific to children.

These children's hospitals are considered safety net hospitals as they serve a large number of Medicaid and uninsured patients and provide charity care. Over 50 percent of the inpatient hospitals revenue and over 40 percent of the hospitals outpatient revenue is attributed to Medicaid, SCHIP and charity care. Supporting the training of residents and

fellows in these hospitals serve a dual purpose: 1) the exposure of residents to children who are financially underserved increases their experience in caring for poor and disadvantaged children after they are fully licensed, and 2) residents and fellows provide hospitals the labor capacity needed to continue to serve as a safety net hospital while protecting their financial viability.

The current Federal support for GME at these freestanding hospitals is still estimated to be lower than that provided by Medicare for GME in other teaching hospitals. The Medicare estimated average per-resident amount is over $108,600. Based on the proposed level of funding, the estimated average per-resident amount for children's hospitals is $75,100 or less than 75 percent of the estimated Medicare outlay per-resident for other hospitals. Each year has shown an increase in number of residents being trained by children's hospitals.

HRSA makes monthly payments to these hospitals and has established a "Resident Assessment Program" that requires each participating hospitals to be audited during the period of October through March of each fiscal year as required by Public Law 109-307. The audits focus only on the number of resident FTEs being claimed for GME support.

HRSA has established a data system that computes CHGME interim and final payments and help determine if any recoupment and redistribution of funds is necessary. This data system supports the strategic and performance outcomes and contributes to the program's success. Children's Hospitals, HRSA staff, and fiscal intermediaries, utilize a web based application to apply for funds, process and review applications, and document results of the audits. This system helps (1) reduce the error rates and the burden associated with applying and reviewing applications, and (2) significantly reduce the need for paper, faxes and other modes of communication. Once all CHGME applications are approved, application data is downloaded into a system that computes the payments and enables the determination of initial and final GME payments. The computational system was structured to determine payments using "a formula based zero sum gain model" that is subject to fixed appropriated funds.

In order to increase the Department and HRSA oversight of the program, this functionality will be integrated with the Electronic Handbook Book (EHB), HRSA's centralized system for grants management.

A program assessment of the CHGME was conducted in 2003 which noted that the program makes timely payments to eligible hospitals. The program assessment required several actions regarding this program which have since been carried out: (1) reducing the number of payments from bi-weekly to monthly payments, (2) assessing the feasibility of carrying out additional audits, and (3) auditing 100 percent of hospitals as to their reported FTE resident counts. The program has carried out all activities required and is achieving its long-term goal of 100 percent of hospitals with a verified count of the number of medical residents as it is an integral part of the administration of this program. Public law 109-307 amended the initial authorization to require monthly payments rather than the required bi-weekly payments.

Furthermore, as part of the program's reauthorization, Congress mandated that freestanding children's hospitals submit an annual report to describe the status of GME in their institutions and that the Secretary transmit a report to Congress in 2011 including recommendations regarding the CHGME Payment Program. Data are required to be collected on: (1) the types of training programs that the hospital provided for residents; (2) the number of training positions for residents, the number of such positions recruited to fill, and the number of positions filled; (3) the types of training that the hospital provided for residents related to the healthcare needs of different populations; (4) changes in residency training including changes in curricula, training experiences, and types of training programs, and benefits that have resulted from such changes; and (5) the numbers of residents (disaggregated by specialty and subspecialty) who completed training in the academic year and care for children within the borders of the service area of the hospital or within the borders of the State in which the hospital is located. All children's hospitals complied with this legislative mandate and provided annual reports for the 2006-2007, and 2007-2008 academic years and data are being compiled and analyzed. Data has been compiled for both years and preliminary analysis is being conducted for the 2006-2007 academic year.

Funding History

FY	Amount
FY 2006	$296,795,000
FY 2007	$297,009,000
FY 2008	$301,646,000
FY 2009	$310,000,000
FY 2010	$317,500,000

Budget Request

The FY 2011 President's Budget Request of $317,500,000 is the same as the FY 2010 Appropriation. The total request will be used to support an estimated 60 freestanding children's hospitals providing support for an estimated 5,600 FTE residents in training in eligible children's teaching hospitals. The FY 2011 funding request will support meeting the target of 100 percent verification of hospitals with verified FTE resident counts and caps.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2010 +/- FY 2011
7.I.A.1: Maintain the number of FTE residents in training in eligible children's teaching hospitals	FY 2008: 5,631 (Target Exceeded)	5,600	5,600	--
7.VII.C.1: Percent of hospitals with verified FTE residents counts and caps	FY 2008: 100% (Target Met)	100%	100%	--
7.E: Percent of payments made on time	FY 2008: 100% (Target Met)	100%	100%	--

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	56	56	56
Average Award	$5,288,821	$5,4228,50	$5,422,850
Range of Awards	$23,707 - $22,423,168	$24,252 - $22,938,900	$24,252-22,938,900

Medical School Development

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	---	---	---	$100,000,000	+$100,000,000
FTE	---	---	---	---	---

Authorizing Legislation:

FY 2011 Authorization .....TBD

Allocation Method .....Competitive Grant

Program Description and Accomplishments

The purpose of the Medical School Development Program is to fund the development of new medical schools in federally-designated Health Professional Shortage Areas (HPSAs). This includes the acquisition and building of medical school campuses, the purchase of equipment, curriculum and faculty development, and general operations related to the development and establishment of the medical schools. Grants will be awarded to nonprofit organizations or institutions of higher education that demonstrate substantial funding from other public and/or private sources. The new medical schools will have a community focus, and provide students with clinical training experiences within HPSAs.

Approximately 62 million Americans, 20 percent of the population, live in HPSAs. These individuals lack access to an on-going source of health care due to the limited number of primary care providers where they live. An estimated additional 16,800 primary care providers would be needed to address these shortages.

Access to health care is one of the key reasons for health disparities, particularly among minority populations. Individuals who lack access to regular health care do not get important preventive services such as important medical screenings. According to the National Healthcare Disparities Report, 2003 http://www.ahrq.gov/qual/nhdr03/fullreport/exec.htm) minorities are more likely to be diagnosed with late-stage breast cancer and colorectal cancer compared with whites. Patients of lower socioeconomic position are less likely to receive recommended diabetic services and more likely to be hospitalized for diabetes and its complications. Studies have also shown that individuals who train in underserved areas are more likely to practice in them when they complete their training.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$---
FY 2007	$---
FY 2008	$---
FY 2009	$---
FY 2010	$---

Budget Request

The FY 2011 President's Budget Amendment of $100,000,000 represents the initial year of funding for this program. These funds will support grants to non-profit organizations and institutes of higher education. These new medical schools will provide training in community-oriented settings within HPSAs with the goal of increasing the number of medical students who later on to practice in HPSAs and other underserved areas.

National Practitioner Data Bank

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	($19,750,000)	---	($19,750,000)	($21,000,000)	(+$1,250,000)
FTE	21	---	21	21	---

Authorizing Legislation: Section IV, P.L. 99-660; Healthcare Quality Improvement Act of 1986, as amended by P.L. 100-177; Section 5, Medicare and Medicaid Patient Protection Act of 1987 (P.L. 100-93), and Omnibus Budget Reconciliation Act of 1990 (P.L. 100-508).

FY 2011
Authorization……Indefinite

Allocation Method……..……User Fee Program

Program Description and Accomplishments

The Healthcare Quality Improvement Act of 1986 (HCQIA) Title IV of Public Law 99-660 was enacted to enhance the quality of healthcare, encourage greater efforts in professional peer review and restrict the ability of incompetent healthcare practitioners to move from State to State without discovery of previous substandard performance or unprofessional conduct. Title IV led to the creation of the National Practitioner Data Bank (NPDB) to collect and disclose certain information related to the professional competence and conduct of physicians, dentists, and other healthcare practitioners.

The NPDB is primarily an alert or flagging system whose principal purpose is to facilitate peer review. As a nationwide flagging system, it provides another resource to assist State licensing boards, hospitals and other healthcare entities in conducting independent investigations of the qualifications of the healthcare practitioners that they seek to license, hire, contract, or to whom they wish to grant clinical privileges. The NPDB was designed for the receipt, storage, and dissemination of the following types of information: (1) paid medical malpractice judgments and settlements against all licensed healthcare practitioners; (2) boards of medical examiners adverse actions against State licensure; (3) hospital and other healthcare entities adverse actions against clinical privileges (medical staff membership); and (4) professional societies adverse action against membership. Consequently, insurance companies as well as any payer of a medical malpractice claim for the benefit of any licensed healthcare practitioner, State licensure authorities for physicians and dentists, and professional societies are required to report their adverse actions to the NPDB.

Early in Calendar Year 2010, HHS will issue regulations to implement Section 1921 of the Social Security Act, broadening the scope of the National Practitioner Data Bank. With this addition, the NPDB will cover not only doctors and dentists, as the law is written now, but all licensed healthcare practitioners, including among others nurses, pharmacists and respiratory therapists. As a result of this implementation, practitioners who demonstrate professional incompetence or misconduct will be reported to the NPDB and this information could be used in hiring, licensing, and privileging decisions by healthcare entities. This expansion will provide hospitals with the capability to verify all allied health practitioners' backgrounds before employing them.

The appropriations legislation for FY 1993 and all subsequent years requires that user fee collections cover the full cost of NPDB operations; therefore, there is no appropriation for operating the NPDB.

As part of the Data Banks' continual efforts to maximize advancements in information technology and to protect the public, in May 2007, the Data Banks introduced and executed the Proactive Disclosure Service Prototype (PDS). The PDS technology builds on current NPDB- Healthcare Integrity and Protection Data Bank (HIPDB) technology by providing the PDS' subscribers with continuous querying of their enrolled practitioners. With this service, eligible entities that choose to enroll their practitioners with the Data Banks will be notified of new reported actions that names any of their enrolled practitioners within 24-hours of the Data Banks' receipt. This service is offered in addition to, and not as a replacement of, the current Data Bank's traditional querying service.

Over 18 months after its initial implementation, PDS has successfully completed a full monitoring cycle, including the opportunity for entities to renew their PDS enrollments for another 1-year period. Because of PDS' success, HRSA has decided that the PDS is considered to be a permanent service. There was a 97 percent renewal rate for the service. The service runs smoothly and entities participating in the program have expressed enthusiasm with the service. This initiative has continued to keep the Data Banks on the forefront of information technology by providing customers a choice in services.

Now that the PDS has been online for approximately two years, the Data Banks are conducting an analysis of the PDS and traditional querying pricing methodology and user behavior. This analysis will inform the Data Banks on whether or not the current pricing structure is accurate.

As a means for the Government to track enhancements, maintenance, and implementation of the NPDB-HIPDB and manage costs and schedule, the Data Banks continue to successfully employ an Earned Value Management System (EVMS) that is applied throughout the full contract life-cycle. Thus EVMS enables the Data Banks to track how the project is proceeding in terms of its budget and schedule and to alert management of any shortfalls and potential problems.

In FY 2009, the NPDB underwent several technology and operating enhancements to improve system availability, performance, and security. These enhancements included:

- Two NPDB-HIPDB User Review Panel and Policy Education Forums were conducted to continue helping entities increase their knowledge of the Data Banks and enhance the Data Banks' relationships with licensing boards.

- Over 24 presentations were given to licensing boards, credentialers and practitioner groups in order to increase timely reporting and/or to develop a better understanding of the Data Banks.

- In an effort to become less paper-oriented, the Data Banks Newsletter began to implement electronic distribution to users who have an e-mail address stored in the Data Banks.

- Work continues on the complete re-design of the Data Banks Informational Website, as well as the addition of a web site monitoring application.

- Additional support is being provided to perform data integrity tasks to improve the Data Banks quality.

- A requirements analysis study was initiated to determine the optimal solutions to meet National Information Security and Technology (NIST) authentication guidelines.

- Letters were sent to over 3,200 hospitals that have never reported to the NPDB. The letters reminded the hospitals of NPDB reporting requirements and requested information about their reporting practices. The resulting information received from the hospitals is being analyzed.

Under a HRSA awarded contract, the Gallup Organization is conducting a national sample survey of NPDB-HIPDB reporters and queriers to determine how the Data Banks could be improved, how the Data Banks' and the information is used. Data collection was conducted in FY 2008 and FY 2009, and analysis of the collected data has begun. The full survey results are expected in FY 2010.

In FY 2009, 51,990 licensing or credentialing decisions were impacted by information supplied by the NPDB. This exceeded the target by more than 11 percent. In 527,750 cases the querying entity considered the information provided by NPDB to be useful. This exceeded the target by more than 9 percent.

The length of time it takes the NPDB-HIPDB to process a query and return results to the querier has been reduced while both the number of queries and the number of reports in the system have continually increased. When the NPDB opened in 1990, it took days to process queries. The system has changed from paper documents to an internet-based

system containing electronic documents. Queries are now responded to within 120 minutes. The volume of NPDB-HIPDB queries has increased greatly over the years, to over five million queries in FY 2009.

The NPDB, together with the HIPDB, was assessed in 2006. The review noted that overall the program achieves its goals and is managed well. In addition the program's purpose is clear and is designed to have a unique and significant impact on the quality of healthcare in this country. By providing a single source of information regarding all malpractice payments, clinical privileges, health plan action or professional society membership information, the Data Banks can assist entities in making critical staffing decisions regarding healthcare professionals. It ensures that entities submitting inquiries to the Data Banks are served promptly and uses performance information to improve both operations and customer service.

The 2006 review also noted that the program has some limitation on its ability to maximize its efficiency and effectiveness. According to the law, the Data Banks have some restrictions on organizations that are able to make inquiries about healthcare practitioners.

The NPDB-HIPDB Program, a major HHS/HRSA IT investment, has consistently strived to maximize the latest available applications (i.e., COTS or developed) and technologies in order to make the Data Banks more customer-friendly, useful, and more efficient. As a result, the value of the Data Banks, as a tool, continues to meet its strategic and performance goals by improving the quality of healthcare and reducing healthcare fraud. Each generation of the NPDB-HIPDB system–from paper-based main frame processing in the early 1990s, through a client server architecture in the mid 1990s, to a modern Internet web-based architecture that came on-line in 1999–has been designed and developed to meet this program's specific mission, goals, outcomes, and business processes. Use of information technology has increased the Data Banks' response time and accuracy, eliminated and/or minimized paper forms and other labor intensive activities, automatically notified entities of reports naming any of their registered practitioners, and provided real-time reports on enrolled practitioners. In addition, with the improved information technology the average time for the electronic report processing (with notification back to the user) has continued to be reduced. The percentage of available time of an accessible and functioning website has remained continually high.

As mandated by the HCQIA, the NPDB does not receive appropriated funds. Instead, the NPDB is financed by the collection of user fees. The table below shows the user fees (revenue) collected during the last five years:

FY	Amount
FY 2006	$16,631,786
FY 2007	$18,748,073
FY 2008	$20,100,291
FY 2009	$19,750,000
FY 2010	$19,750,000

Budget Request

Because of the statutory mandate to operate on collected user fees, there is no FY 2011 President's Budget Request for the NPDB. The NPDB user fee collections are projected to be $21,000,000. User fees are established at a level to cover all program costs to allow the NPDB to meet short and long term program performance goals. Fees are established based on query volume that will result in adequate, but not excessive, revenues to pay all program costs.

Since 1990, user fees have changed due to increases and decreases in query volume. In FY 2009, the NPDB received 4,044,638 queries. The level of querying activity is expected to increase slightly through FY 2010. The NPDB-HIPDB estimate for FY 2011 is 5,306,000 queries.

For FY 2011, the NPDB estimates that 54,500 licensing or credentialing decisions being impacted by information supplied by NPDB and 540,600 cases in which information provided by NPDB will be considered useful by the querying entity.

Legislation in the Health Reform Bill proposes to eliminate all duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank. This piece of legislation would require the HHS Secretary to maintain a national health care fraud and abuse data collection program for reporting certain adverse actions taken against health care providers, suppliers, and practitioners, and submit information on the actions to the National Practitioner Data Bank (NPDB). The Secretary would also be required to establish a process to terminate the Healthcare Integrity and Protection Databank (HIPDB) and ensure that the information formerly collected in the HIPDB is transferred to the NPDB.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
8.III.B.1: Increase annually the use of the NPDB for licensing and credentialing decision-making, operationalized as the number of licensing and credentialing decisions which limit practitioner's ability to practice because of information contained in NPDB reports. (Baseline – 2005: 44,500 Decisions)	FY 2009: 51,990 Decisions (Target Exceeded)	53,450 Decisions	54,500	+1,050
8.III.B.2: Increase annually the number of times information provided by NPDB is considered useful by the querying entity which received it. (Baseline 2005 – 451,400)	FY 2009: 527,750 (Target Exceeded)	530,000	540,600	+10,600
8.E: Increase annually the number of queries for which NPDB and HIPDB responded within 240 minutes	FY 2009: 5,085,760 (Target Exceeded)	5,202,000	5,306,000	+104,000

Healthcare Integrity and Protection Data Bank

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	($3,758,000)	---	($3,758,000)	($4,000,000)	(+242,000)
FTE	5	---	5	5	---

Authorizing Legislation: Title II, Subtitle C of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104-191), establishes Section 1128E of the Social Security Act.

FY 2011 Authorization……Indefinite

Allocation Method……..……User Fee Program

Program Description and Accomplishments

Title II, Subtitle C of the HIPAA establishes Section 1128E of the *Social Security Act*. The purpose of Section 1128E is to prevent or reduce fraud and abuse and improve quality in healthcare. Section 1128E directs the Secretary of Health and Human Services (HHS), acting through the Office of Inspector General (OIG), to establish a program to collect, maintain and report final adverse actions taken against healthcare practitioners, providers and suppliers. This information is collected from and made available to Federal and State government agencies and health plans. The Healthcare Integrity and Protection Data Bank (HIPDB) was designed to collect, maintain, and distribute this information and opened for reporting on November 22, 1999 and for queries on March 6, 2000.

Through an agreement with the OIG, HRSA is responsible for the development and operation of the HIPDB. Final policy decision-making remains with the OIG. The HRSA received allocations from the Health Care Fraud and Abuse Control (HCFAC) account for the development of the HIPDB system, which is modeled after the National Practitioner Data Bank (NPDB). There is no appropriation for the HIPDB.

The HIPDB provides critical information to State and Federal agencies, law enforcement officials, and health plans concerning adverse licensure and contract actions; healthcare related civil judgments; and, criminal convictions against healthcare practitioners, providers and suppliers. This information helps prevent practitioners, providers and suppliers from moving from State-to-State without disclosure of prior acts. In addition, it helps law enforcement officials in the battle against healthcare fraud and abuse.

From March 2000 through FY 2009, the HIPDB processed 9,252,486 queries from health plans, State and Federal agencies. Of these, health plans submitted 73 percent. Also of these, 1,688 queries were provided to the Centers for Medicare and Medicaid Services and the Department of Veteran Affairs as well as other Federal agencies such as HHS' OIG.

The length of time it takes the NPDB-HIPDB to process a query and return results to the querier has been reduced while both the number of queries and the number of reports in the system have continually increased. When the HIPDB opened in 1999, it took days to process queries. The system has changed from paper documents to an internet-based system containing electronic documents. Queries are now responded to within 120 minutes. The volume of NPDB-HIPDB queries has increased greatly over the years, to over 5.0 million queries in FY 2009.

The intent of the HIPDB is to provide health care entities with another tool to measure health care providers' professional practices. These statistics clearly demonstrate that the HIPDB is achieving its intent. In FY 2009, 1,420 licensing or credentialing decisions were impacted by information supplied by the HIPDB. In 14,390 cases, the querying entity considered the information provided by HIPDB to be useful.

The HIPDB, together with the NPDB, was assessed in 2006. The review noted that overall the program achieves its goals and is managed well. In addition the program's purpose is clear and is designed to have a unique and significant impact on the quality of healthcare in this country. By providing a single source of information regarding all malpractice payments, clinical privileges, health plan action or professional society membership information, the Data Banks can assist entities in making critical staffing decisions regarding healthcare professionals. It ensures that entities submitting queries to the Data Banks are served promptly and use performance information to improve both operations and customer service.

The 2006 review also noted that the program has some limitations on its ability to maximize its efficiency and effectiveness. According to the law, the Data Banks have some restrictions on organizations that are able to make queries about healthcare practitioners.

Early in Calendar Year 2010, HRSA will issue regulations that incorporates requirements of Section 1921 of the Social Security Act into the NPDB in 2010. Public Law 100-93 amends Section 1921 to require that each State have in effect a system of reporting disciplinary licensure actions taken against all licensed health care practitioners and entities. It also requires States to report any negative action or finding that a peer review organization, private accreditation entity, or a State has concluded against a health care practitioner or entity. Section 1921 directs the Secretary to provide for maximum appropriate coordination in the implementation of these reporting requirements with those of the Health Care Quality Improvement Act of 1986 (Title IV, Public Law 99-660). Therefore, this final rule makes this critical information available to hospitals on a national basis from a single source.

With the Section 1921 implementation, a majority of the information that is currently reported to the HIPDB will be reported to the NPDB. This will create substantial duplication of information

for release between the NPDB and the HIPDB. Reportable actions such as all adverse licensure actions as well as health care related civil judgments and criminal convictions of health care practitioners, providers, and suppliers will exist in both Data Banks. Consequently, legislation is currently being considered to merge these two programs into one program—the NPDB.

Funding History

HIPDB user fees are established to conform exactly to NPDB user fees on a cost per query basis. The table below shows the HIPDB user fees collected (revenue) during the last five years:

FY	Amount
FY 2006	$4,000,000
FY 2007	$3,825,190
FY 2008	$4,445,151
FY 2009	$3,758,000
FY 2010	$3,758,000

Budget Request

There is no FY 2011 President's Budget Request for the HIPDB. The HIPDB user fee collections are projected to be $4,000,000. Although fees are established based on query volume to result in adequate, but not excessive, revenues to pay all program costs, HIPDB fees at the same level may not provide enough revenue to pay all allocated HIPDB costs. This is because the HIPDB report-to-query ratio is much higher and because Federal agencies do not pay HIPDB query fees, as provided by law.

As a result of the previously mentioned Section 1921 implementation, approximately 92 percent of data currently maintained in the HIPDB will also be available in the NPDB. Given that many of the health plans, which, to date, submit 73 percent of all HIPDB queries and 52 percent of NPDB queries, will no longer have a need to query the HIPDB since they can get the same information from the NPDB at half the cost ($4.75 versus $9.50). Implementation of Section 1921 equates to the HIPDB losing a significant amount of revenue starting in the 2nd & 3rd quarters of FY 2010. Therefore, user fee collections for FY 2011 could be severally impacted.

To possibly address this issue the Health Reform Bill has provisions to eliminate all duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank by requiring State licensing authorities, peer review organizations, or private accreditation entities to report any negative action or finding against a health care practitioner or health care entity to the NPDB. In addition, a process will be established to terminate the Healthcare Integrity and Protection Databank (HIPDB) and ensure that the information formerly collected in the HIPDB is transferred to the NPDB.

HRSA will continue to strive to meet HIPDB performance goals through outreach and education to State licensing boards, health plans, and law enforcement. In addition the program will

continue to try and maintain an HIPDB reserve that is equal to one-half of HIPDB's annual operating cost.

For FY 2011, the HIPDB has set targets of 1,561 licensing or credentialing decisions being impacted by information supplied by HIPDB and 18,666 cases in which information provided by HIPDB will be considered useful by the querying entity.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
8.III.B: Increase annually the use of the HIPDB for licensing and credentialing decision-making, operationalized as the number of licensing and credentialing decisions which limit practitioner's ability to practice because of information contained in NPDB reports. (Baseline – 2005: 1,120 Decisions)	FY 2009: 1,420 Decisions (Target Exceeded)	1,530 Decisions	1,561	+31
8.III.B.4: Increase annually the number of times information provided by HIPDB is considered useful by the querying entity which received it. (Baseline 2005 – 11,400)	FY 2009: 14,390 (Target Exceeded)	18,300	18,666	+366
8.E: Increase annually the number of queries for which NPDB and HIPDB responded within 240 minutes.	FY 2009: 5,085,760 (Target Exceeded)	5,202,000	5,306,000	+104,000

Maternal and Child Health Block Grant

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$662,121,000	---	$662,121,000	$673,187,000	+$11,066,000
FTE	---	---	---	---	---

Authorizing Legislation - Title V of the Social Security Act.

FY 2011 Authorization $850,000,000

Allocation Methods:

- Direct federal/intramural
- Contract
- Formula grant/co-operative agreement
- Competitive grant/co-operative agreement

Program Description and Accomplishments

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. These legislated responsibilities reduce health disparities, improve access to healthcare, and improve the quality of healthcare. Specifically the program seeks to: (1) assure access to quality care, especially for those with low-incomes or limited availability of care; (2) reduce infant mortality; (3) provide and ensure access to comprehensive prenatal and postnatal care to women (especially low-income and at risk pregnant women); (4) increase the number of children receiving health assessments and follow-up diagnostic and treatment services; (5) provide and ensure access to preventive and child care services as well as rehabilitative services for certain children; (6) implement family-centered, community-based, systems of coordinated care for children with special healthcare needs (CSHCN); and (7) provide toll-free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Title XIX (Medicaid).

Section 502 of the Social Security Act states that of the amounts appropriated, up to $600,000,000, 85% is for allocation to the States, and 15 % is for Special Projects of Regional and National Significance (SPRANS) activities. Any amount appropriated in excess of $600,000,000 is distributed as follows: 12.75% is for Community Integrated Service Systems (CISS) activities; of the remaining amount, 85% is for allocation to the States, and 15% is for SPRANS activities.

The MCH Block Grant is at its core a public health program that reaches across economic lines to improve the health of all mothers and children. Created as a partnership with

State MCH programs and with broad State discretion, State Title V programs use appropriated formula grant funds for: capacity and systems building, public information and education, knowledge development, outreach and program linkage, technical assistance, provider training, evaluation, support for newborn screening and genetic services, lead poisoning and injury prevention, additional support services for children with special healthcare needs, and promotion of health and safety in child care settings.

Special efforts are made to build community capacity to deliver such enabling services as care coordination, transportation, home visiting, and nutrition counseling. Where no services are available, States also use Title V to provide categorical direct care such as prenatal care or services for children with special healthcare needs.

Additional activities that support the improved healthcare of mothers and children are SPRANS and CISS. SPRANS funds support projects (through grants, contracts, and other mechanisms) in research, training, genetic services and newborn screening and follow-up, sickle cell disease, hemophilia, and maternal and child health improvement. SPRANS projects must:

- Support national needs and priorities or emerging issues
- Have regional or national significance
- Demonstrate ways to improve State systems of care for mothers and children.

CISS projects (through grants, contracts, and other mechanisms) seek to increase the capacity for service delivery at the local level and to foster formation of comprehensive, integrated, community level service systems for mothers and children using six specified strategies:

- Provide maternal and infant home health visiting, health education, and related support services for pregnant women and infants up to one year old.
- Increase participation of obstetricians and pediatricians under Titles V and XIX.
- Integrate MCH service delivery systems.
- Operate MCH centers under the direction of not-for-profit hospitals.
- Increase MCH projects in rural areas.
- Provide outpatient and community-based services for children with special healthcare needs.

Table 1. Maternal and Child Health Block Grant SPRANS Set-Aside Grants

MCH Set-Aside Programs	FY 2009 Enacted	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 Request
SPRANS	$73,556,000	---	$73,264,000	$74,712,263
SPRANS - Oral Health	$4,859,000	---	$4,859,000	$4,859,000
SPRANS -Epilepsy	$3,416,000	---	$3,708,000	$3,708,000
SPRANS - Sickle Cell	$3,774,000	---	$3,774,000	$3,774,000
SPRANS - Fetal Alcohol	$486,000	---	$486,000	$486,000
SPRANS - Doula	$1,504,000	---	$1,504,000	$1,504,000
SPRANS – 1st time	$4,956,000	---	$4,956,000	$4,956,000

MCH Set-Aside Programs	FY 2009 Enacted	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 Request
Motherhood				
Total SPRANS	$92,551,000	---	$92,551,000	$93,999,263
CISS	$10,400,000	---	$10,400,000	$11,810,915

The Title V Block grant program provides support to all 59 States and jurisdictions. Consistent with other HRSA programs, the MCH Block grant addresses three overarching goals:
1) improving access to healthcare; 2) eliminating health disparities; and 3) improving the quality of healthcare. Funds are allotted to States based on a legislated formula which provides the amount allotted to each state in 1983, and when the amount available exceeds that level, the excess is distributed based on the States proportion of children in poverty.

In working to improve access to healthcare, the program has been able to increase both the number of children served by the States under Title V (to 35 million in FY 2008) and the number of children receiving Title V services who have Medicaid and Child Health Insurance Program (CHIP) coverage. Increased coverage under Medicaid and CHIP for children receiving Title V services better assures access, availability, and continuity of care to a wide range of preventive and acute care services. These increases are significant as they occurred in a period of severe financial constraints at the State and local levels. The 14.7 million children who received Title V services and had Medicaid and CHIP coverage in 2008 is a significant increase over the FY 2002 baseline of 5.9 million.

Title V programs work towards the elimination of health disparities in health outcomes through the removal of economic, social, and cultural barriers to receiving comprehensive, timely, and appropriate healthcare. The ratio of the black infant mortality rate to the white infant mortality rate decreased from 2.48:1 to 2.39:1 from FY 2002 to FY 2006 (National Vital Statistics Reports). Preliminary data for FY 2007 indicate that the ratio further declined to 2.26:1 (National Vital Statistics Reports).

The Title V program plays an important role in the delivery of appropriate and effective care for high-risk pregnant women and infants. Efforts to reduce the overall infant mortality rate continue, with the rate having decreased from 9.2 per 1,000 live births in 1990 to 6.7 per 1,000 live births in 2006. However, preliminary data indicate that the rate increased slightly in 2007 to 6.8 per 1,000 births (National Vital Statistics Reports). An increase in the rate to 7.0 in 2002 reversed, temporarily, a long-term downward trend. Since 2002, the rate has remained essentially unchanged, with a range of between 6.7 per 1,000 live births and 6.9 per 1,000 live births. An analysis of the 2002 increase concluded that factors contributing to the increase included the higher risk profile of multiple births and an increase in the number of very small infants (less than 750 grams).

Nationally the number of low birth weight infants (less than 2500 grams) has been steadily increasing. From 2002 to 2006, the rate of low birth weight infants increased from a baseline of 7.8 percent to 8.3 percent. Preliminary data indicate that the rate

improved slightly in 2007 to 8.2 percent. Increases in the number of low birth weight infants have been influenced by: 1) the rise in the multiple birth rate; 2) greater use of obstetric interventions; 3) increases in maternal age at childbearing; and 4) increased infertility therapies. Delivering very low birth weight infants at facilities with specialized equipment and personnel significantly contributes to reducing the risk of mortality. The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates increased in 2006 to 74.7 percent, following a decline from 75.2 percent to 71.7 percent between 2002 and 2004. In 2007, the rate increased slightly to 74.8 percent. While the MCH Block Grant program has worked with States to implement perinatal regionalization strategies and protocols for the transfer of high-risk women to level III facilities, the performance described above and analyses reported by CDC indicate that these systems may be eroding as healthcare networks and financing systems change. In addition, CDC reports that there is considerable variation in State definitions and criteria relative to neonatal levels of care.

Prenatal care is one of the most important interventions for ensuring the health of pregnant women and their infants. Overall, the proportion of pregnant women entering prenatal care in the first trimester increased from 75.8 percent in 1990 to 83.9 percent in 2005. While there has been progress in the timely initiation of prenatal care for all population groups, the rate of increase has been slow in recent years. Between 2004 and 2006, the percent of women entering prenatal care in the first trimester declined slightly from 84.2 to 83.2 percent. Given the increasing prevalence of diabetes, obesity and pregnancy-induced hypertension during pregnancy, there is a need for such risk factors to be monitored and for timely and appropriate prenatal care to be provided.

The Maternal and Child Health Bureau (MCHB) has worked with the State MCH programs to build a data capacity that supports the performance elements in the Title V MCH Block Grant. Efforts have centered on the development of client-based data systems that more accurately capture the direct, enabling and population-based services provided, as required. Previously reported data on the number of children served by Title V and the number of children served who have Medicaid and CHIP coverage were often based on the direct services provided. In addition, increases in the number of children served by Title V who have Medicaid and CHIP coverage reflect the ongoing efforts of the States to do outreach to eligible populations and to increase participation in these programs. MCHB regularly provides technical support to the States around the priorities identified in their comprehensive five-year needs assessments and the areas of needed technical assistance outlined in their annual applications. In the FY 2010 MCH Block Grant applications, frequently identified areas of needed technical assistance were health disparities, which included disparities in the Black and White Infant Mortality Rates, and healthy perinatal and birth outcomes.

A program reassessment of the Title V MCH Block Grant in 2008 determined that the program has had a positive impact, with strong and effective collaborations established between Federal, State, local and private-sector entities concerned with MCH. While the program has shown improvements in the scope and quality of evaluations conducted since 2002, there is a continuing need to determine what actions are required to improve

the percent of low birth weight births. To address these concerns, MCHB developed an Improvement Plan which includes the following objectives: 1) develop a program performance measure targeting the ratio of racial and ethnic disparities in low birth weight infants; 2) promote evidence-based practices to reduce the incidence (and better understand the causes) of low birth weight; and 3) conduct a technical review and evaluation of the States' Title V MCH priority needs, State performance measures and promising practices.

In FY 2004, the Title V Block Grant program initiated a customer satisfaction survey utilizing the American Customer Satisfaction Index (a standardized methodology used by both public and private sectors). Recipients of the Title V Block grantees' services were surveyed. As a result, the program received a score of 91 out of a possible 100, the second highest score ever recorded for a government program.

The FY 2010 appropriation included appropriations language which provided SPRANS set aside funds for Oral Health ($4.9 million); Sickle Cell ($3.8 million); Epilepsy ($3.7 million); Fetal Alcohol ($0.49 million); Doula ($1.5 million); and First Time Motherhood ($5.0 million).

Funds are included to conduct a survey using the State and Local Area Integrated Telephone Survey (SLAITS) mechanism, which utilizes the sampling frame of the ongoing CDC-Sponsored Immunization Survey (CSIS). SLAITS provides the capacity to field surveys on a wide range of health and welfare related topics using the CSIS screening sample. The survey provides representative, reliable and previously unavailable information on: 1) special healthcare needs among children in 50 States and the District of Columbia; and 2) the competency of the service system in meeting the needs of these children and their families.

Funding also includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2001	$709,151,000
FY 2002	$731,259,000
FY 2003	$730,710,000
FY 2004	$729,817,000
FY 2005	$723,928,000
FY 2006	$692,521,000
FY 2007	$693,000,000
FY 2008	$666,155,000[1]
FY 2009	$662,121,000[2]
FY 2010	$662,121,000

[1] Reflects moving $20 million to the Autism and Other Developmental Disorders Program.
[2] Reflects moving $6.9 million to the Newborn Screening for Heritable Disorders Program.

Budget Request

The FY 2011 Budget Request for the Maternal and Child Health Block Grant program is $673,187,000, an increase of $11.066 million over the FY 2010 Appropriation. This level of funding will provide: an increase of $8.2 million for a total of $567.4 million for State Block Grant awards (of which $5.7 million is for technical assistance, contracts and other cross cutting items); an increase of $1.4 million for a total of $94 million for the SPRANS set-aside, which includes $4.9 million for Oral Health, $3.8 million for Sickle Cell, $3.7 million for Epilepsy, $0.49 million for Fetal Alcohol Syndrome, $5 million for First Time Motherhood, $1.5 million for Doula; and an increase of $1.4 million for a total of $11.8 million for the CISS set-aside.

Title V is the only Federal program that focuses solely on improving the health of all mothers, adolescents and children, whether insured or not, through a broad array of public health and community-based programs that are designed and carried out through well-established Federal/State partnerships. The budgeted funds will help State Title V programs support capacity and infrastructure building, population-based and enabling services, as well as direct healthcare services where no services are available. In these latter roles, Title V programs serve as a safety net for uninsured and underinsured children, including CSHCN. Title V continues to play a valuable, complementary role to CHIP and Medicaid programs.

The FY 2011 target for the number of children served by the Title V Block Grant is 31 million, an increase of 1.0 million over the FY 2010 target. Since 2004, the number of children served by Title V has steadily increased. Further gains in the number of clients served by Title V may be modest, given that States are better able to report the number of children who receive a Title V service and the level funding that MCH Block Grant has received in recent years. The MCHB will continue to work with States to further enhance their data capacity for tracking and reporting the number of clients served through direct, enabling and population-based services.

Similarly, the FY 2011 target of 13 million for the number of children receiving Title V services who are enrolled in and have Medicaid and CHIP coverage was increased based on the FY 2007 performance level of 12.8 million. Steady increases have occurred since 2003 due to a change in reporting methods by several large States which previously did not report many recipients because of reliance on the use of reimbursement data. The impact of Medicaid and CHIP expansions in 2009 and the potential for shifts in children served from Title V to Title XIX and Title XXI programs is not yet known. Additional years data are needed to determine if continuing increases in the number of children receiving MCH Block Grant services who are also enrolled in Medicaid and/or CHIP can be maintained. The MCHB will monitor the impact of State Medicaid and CHIP expansions on the number of children served by Title V and review future years' targets based on the findings.

The FY 2011 target for the rate of infant mortality is 6.6 per 1,000 births. Infant mortality continues to be an extremely complex problem with many medical, social and economic determinants, including race/ethnicity, maternal age, education, smoking and economic status. Despite a slow rate of progress, the increased performance target reflects the program's ongoing commitment for continued progress in this area.

The MCHB will continue to monitor emerging issues and areas of needed technical assistance in providing technical support to the States. In addition, the MCHB will continue to explore promising models and effective strategies that promote improved maternal and child health outcomes.

SPRANS and CISS funds will support innovative projects in the areas of: applied MCH research; MCH Leadership training in areas such as pediatric pulmonary centers, pediatric dentistry, nursing, nutrition, schools of public health, adolescent health; expansion of genetics services capacity; hemophilia treatment centers; and a variety of MCH Improvement Projects (MCHIP) including, adolescent health; SIDS; "Bright Futures" guidelines for practitioners; medical homes; early childhood comprehensive care systems; and oral health disease prevention and early treatment interventions. Appropriations language is provided to continue funding at the FY 2010 level for Oral Health, Epilepsy, Sickle Cell, Fetal Alcohol Syndrome, Doula, and First Time Motherhood. SPRANS and CISS both complement and help ensure the success of State Title V, Medicaid, and CHIP programs, building community capacity to create family-centered, integrated systems of care for mothers and children, including children with special healthcare needs.

In addition, Title V funds the only statutorily required genetic services program. This program funds initiatives to facilitate the early identification of children with genetic conditions and works to increase public and professional knowledge of how genetic risk factors affect health in order to create more responsive systems of care. The newborn screening and genetics public health infrastructure activities are to help support State newborn screening and genetics programs, integrate newborn and genetic screening programs with other community services and medical homes, and strengthen existing newborn and genetic screening and service programs. The programs also are established to aid State MCH officials, health care providers, public health professionals and families, and individuals respond to new scientific findings and technologies in the fields of genetic medicine and newborn screening. Special emphasis is being given to the financial, ethical, legal, and social implications of these issues and technologies for maternal and child health populations.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
10.1: Decrease the number of uninsured children [3] *(Outcome)*	FY 2006: 8.7M	N/A	N/A	N/A
10.I.A.1: Increase the number of children served by Title V. *(Output)*	FY 2008: 35 M (Target Exceeded)	30M	31M	+1M
10.I.A.2: Increase the number of children receiving Title V services who are enrolled in and have Medicaid and CHIP coverage *(Output)*	FY 2008: 14.7M (Target Exceeded)	12M	13M	+1M
10.E: Increase the number of children served by the Title V Block Grant per $1 million in funding *(Efficiency)*	FY 2008: 52,511 (Target Exceeded)	40,000	42,000	+2,000

Long Term Objective: Promote outreach efforts to reach populations most affected by health disparities

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
10.IV.B.1: Decrease the ratio of the black infant mortality rate to the white infant mortality rate *(Output)*	FY 2007: 2.3 to 1 (Preliminary Data)[4]	2.1 to 1	2.1 to 1	Maintain

Long Term Objective: Promote effectiveness of healthcare services.

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
10.III.A.1: Reduce the infant mortality rate (Baseline - 2005: 6.9/1,000) *(Outcome)*	FY 2007: 6.8 to 1,000 [4] (Preliminary Data)	6.7 per 1,000	6.6 per 1,000	-0.1 per 1,000
10.III.A.2: Reduce the incidence of low birth weight births *(Outcome)*	FY 2007: 8.2% [5] (Preliminary Data)	8.2%	8.2%	Maintain

[3] This is a long-term measure with no annual target.

[4] Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2009. Deaths: Preliminary Data for 2007, National Vital Statistics Reports, Vol. 58, No. 1, August, 2009.

[5] Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2009. Births: Preliminary Data for 2007, National Vital Statistics Reports, Vol. 57, No. 12, March, 2009.

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
10.III.A.3: Increase percent of pregnant women who received prenatal care in the first trimester *(Outcome)*	FY 2006: 83.2% [6] (Target Not Met)	86.5%	86.5%	Maintain
10.2: Reduce the national rate of neonatal deaths per 1,000 live births (Baseline 2005: 4.6/1,000 live births) *(Outcome)* [3]	FY 2005: 4.6 to 1000 (Target Not In Place)	N/A	N/A	N/A
10.III.A.4: Increase percent of very low-birth weight babies who are delivered at facilities for high-risk deliveries and neonates *(Outcome)*	FY 2007: 74.8% [7] (Target Exceeded)	76%	76%	Maintain
10.3: Increase maternal survival rate (Baseline-2005: 15.1 deaths/100,000 live births) *(Outcome)* 3	FY 2005: 15.1 to 100,000 (Target Not In Place)	N/A	N/A	N/A

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	59	---	59	59
Average Award	$9,386,967	---	$9,386,967	$9,386,967
Range of Awards	$149,535 – $43,315, 317	---	$149,535 – $43,315, 317	$149,535 – $43,315, 317

[6] Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2009. Births: Final Data for 2006, National Vital Statistics Reports, Vol. 57, No. 7, January 2009. Prenatal care data based on the 1989 and 2003 Standard Certificates of Live Birth are reported separately and are not comparable. For consistency with previous years' data, the reported prenatal care data are based on States using the unrevised (1989) certificate.

[7] Title V Information System, HRSA/MCHB, https://perfdata.hrsa.gov/MCHB/TVISReports/default.aspx.

State Table

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant

STATE/TERRITORY	FY 2009 Enacted	FY 2010 Estimate	FY 2011	Difference +/- 2010
Alabama	11,721,312	11,721,312	11,874,907	+153,595
Alaska	1,116,106	1,116,106	1,130,338	+14,232
Arizona	7,090,511	7,090,511	7,256,909	+166,398
Arkansas	7,097,785	7,097,785	7,192,262	+94,477
California	43,315,317	43,315,317	44,449,841	+1,134,524
Colorado	7,248,555	7,248,555	7,327,079	+78,524
Connecticut	4,748,137	4,748,137	4,803,606	+55,469
Delaware	1,966,509	1,966,509	1,981,621	+15,112
District of Columbia	7,067,556	7,067,556	7,090,392	+22,836
Florida	19,162,559	19,162,559	19,568,043	+405,484
Georgia	16,281,994	16,281,994	16,517,929	+235,935
Hawaii	2,274,139	2,274,139	2,300,316	+26,177
Idaho	3,236,441	3,236,441	3,269,931	+33,490
Illinois	21,694,052	21,694,052	21,989,064	+295,012
Indiana	11,770,865	11,770,865	11,892,124	+121,259
Iowa	6,528,937	6,528,937	6,580,105	+51,168
Kansas	4,718,608	4,718,608	4,772,817	+54,209
Kentucky	11,354,415	11,354,415	11,485,841	+131,426
Louisiana	13,360,844	13,360,844	13,567,248	+206,404
Maine	3,401,222	3,401,222	3,427,160	+25,938
Maryland	11,953,971	11,953,971	12,045,578	+91,607
Massachusetts	11,451,452	11,451,452	11,565,985	+114,533
Michigan	18,873,637	18,873,637	19,101,520	+227,883
Minnesota	9,072,643	9,072,643	9,151,217	+78,574
Mississippi	9,735,578	9,735,578	9,868,878	+133,300

STATE/TERRITORY	FY 2009 Enacted	FY 2010 Estimate	FY 2011	Difference +/- 2010
Missouri	12,386,586	12,386,586	12,528,995	+142,409
Montana	2,434,812	2,434,812	2,462,519	+27,707
Nebraska	4,024,332	4,024,332	4,059,506	+35,174
Nevada	1,792,466	1,792,466	1,837,520	+45,054
New Hampshire	2,002,759	2,002,759	2,018,020	+15,261
New Jersey	11,683,598	11,683,598	11,830,654	+147,056
New Mexico	4,358,484	4,358,484	4,439,335	+80,851
New York	41,036,806	41,036,806	41,628,062	+591,256
North Carolina	16,614,558	16,614,558	16,815,399	+200,841
North Dakota	1,818,028	1,818,028	1,832,338	+14,310
Ohio	22,118,275	22,118,275	22,382,154	+263,879
Oklahoma	7,290,174	7,290,174	7,401,185	+111,011
Oregon	6,225,530	6,225,530	6,303,954	+78,424
Pennsylvania	24,390,794	24,390,794	24,663,106	+272,312
Rhode Island	1,770,159	1,770,159	1,796,737	+26,578
South Carolina	11,406,437	11,406,437	11,527,357	+120,920
South Dakota	2,257,913	2,257,913	2,279,844	+21,931
Tennessee	11,697,556	11,697,556	11,857,295	+159,739
Texas	34,437,266	34,437,266	35,205,583	+768,317
Utah	6,013,353	6,013,353	6,059,690	+46,337
Vermont	1,694,536	1,694,536	1,705,251	+10,715
Virginia	12,389,822	12,389,822	12,525,113	+135,291
Washington	9,021,828	9,021,828	9,152,831	+131,003
West Virginia	6,432,506	6,432,506	6,494,553	+62,047
Wisconsin	10,823,842	10,823,842	10,920,801	+96,959
Wyoming	1,256,233	1,256,233	1,267,994	+11,761
Subtotal	**533,621,798**	**533,621,798**	**541,206,507**	**+7,584,709**
Indian Tribes				
Migrant Program				
American Samoa	498,448	498,448	505,533	+7,085
Guam	769,826	769,826	780,768	+10,942
Marshall Islands	232,608	232,608	235,914	+3,306

STATE/TERRITORY	FY 2009 Enacted	FY 2010 Estimate	FY 2011	Difference +/- 2010
Micronesia	526,140	526,140	533,619	+7,479
Northern Mariana Islands	470,757	470,757	477,448	+6,691
Palau	149,535	149,535	151,660	+2,125
Puerto Rico	16,050,025	16,050,025	16,278,155	+228,130
Virgin Islands	1,511,960	1,511,960	1,533,450	+21,490
Subtotal	**20,209,299**	**20,209,299**	**20,496,547**	**+287,248**
TOTAL RESOURCES	**$553,831,097**	**$553,831,097**	**$561,703,054**	**+$7,871,957**

Autism and Other Developmental Disorders

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$42,000,000	---	$48,000,000	$55,000,000	+$7,000,000
FTE	3	---	5	5	---

Authorizing Legislation - Section 399BB of the Public Health Service Act.

FY 2011 Authorization $52,000,000

Allocation Methods:

- Direct federal/intramural
- Contract
- Competitive grant/co-operative agreement
- Other

Program Description and Accomplishments

The Combating Autism Act of 2006 authorized a program for early detection, education and intervention activities on autism and other developmental disorders. This program supports activities to:

- provide information and education on autism spectrum disorders and other developmental disabilities to increase public awareness;
- promote research into the development and validation of reliable screening tools and interventions for autism spectrum disorders and other developmental disabilities and disseminate information;
- promote early screening of individuals at higher risk for autism spectrum disorders and other developmental disabilities as early as practicable, given evidence-based screening techniques and interventions;
- increase the number of individuals who are able to confirm or rule out a diagnosis of autism spectrum disorders and other developmental disabilities; and
- increase the number of individuals able to provide evidence-based interventions for individuals diagnosed with autism spectrum disorders or other developmental disabilities.

In FY 2008 Congress appropriated $36,354,000 for this program of which approximately $20 million was moved from the Maternal and Child Health Block Grant training programs for Leadership Education in Neurodevelopmental and Related Disabilities (LEND) and Developmental Behavioral Pediatrics. Funds were used to expand these interdisciplinary training programs as well as support: autism intervention research network grants to study the effectiveness of interventions for autism and related developmental disabilities; demonstration grants to develop models of systems of services for children with autism and other developmental disabilities; grant(s) to disseminate current and accurate information to families

and consumers on early identification, diagnosis and access to services; grants to disseminate screening intervention, and guideline information; and other technical assistance and evaluation. In FY 2009, Congress appropriated an additional $6,000,000 to expand the LEND program, support autism intervention research grants to study evidence-based practices for interventions to improve the health and well-being of children and adolescents with autism spectrum disorders (ASD) and other developmental disabilities, support grants that analyze secondary data, expand demonstration grants to develop models of systems of services for children with ASD and other developmental disabilities, expand grants to resource centers to disseminate ASD information to families and consumers and to disseminate screening intervention and guideline information, and support for other technical assistance and evaluation activities. In FY 2010, Congress appropriated an additional $6,000,000 of which $2,200,000 will expand the LEND interdisciplinary training programs, $2,200,000 will expand the autism research intervention grants, and the remainder will support additional state demonstration grants, supplements to developmental-behavioral pediatrics training programs, resource centers and a national evaluation. All activities are coordinated with the Centers for Disease Control and Prevention's Learn the Signs Act Early programs. LEND programs and State demonstrations jointly sponsor regional summits with CDC to coordinate early screening, diagnosis and treatment programs. Developmental-behavioral pediatrics training programs have developed nine case studies on autism spectrum disorders and will disseminate to pediatric residency training programs and practicing primary care providers to improve screening, diagnosis and treatment of autism spectrum disorders.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	---
FY 2007	---
FY 2008	$36,354,000
FY 2009	$42,000,000
FY 2010	$48,000,000

Budget Request

The FY 2011 President's Budget for the Autism and Other Developmental Disorders program is $55,000,000, an increase of $7,000,000 from the FY 2010 Appropriation.

In FY 2011, funds will be used to continue and expand activities initiated in FY 2008 and continued and expanded in FY 2009 and FY 2010 to:

- provide information, education and coordination;
- promote research into evidence based practice for interventions and the development of reliable screening tools;

- promote the development, dissemination and implementation of guidelines;
- promote early screening and intervention;
- train providers to diagnose and provide care for individuals with autism spectrum disorder and other developmental disorders;
- Develop innovative strategies to integrate and enhance existing investments, including translating research findings to training settings and into practice;
- Initiate quality improvement efforts, particularly around guidelines dissemination; and
- Promote lifecourse considerations, from developmental screening in early childhood to transition to adulthood issues.

A program evaluation is underway (to be completed in July 2011) and will assess all aspects of the program (research, training and state demonstration efforts). Findings from the program evaluation will inform the Report to Congress.

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget
Grants:				
LEND	39		42	45
DBP	10		10	10
Research	9		17	26
State Demonstration	9		13	19
Resource Centers	2		2	2
Quality Improvement	---		---	---
Number of Awards	69	---	84	103
Average Award	$570,000	---	$834,937	$834,937
Range of Awards	$93,533 – $3,997,824	---	$100,000 – $3,999,342	$100,000 – $4,000,000

Traumatic Brain Injury

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$9,877,000	---	$9,939,000	$9,939,000	---
FTE	---	---	---	---	---

Authorizing Legislation - Sections 1252 and 1253 of the Public Health Service Act.

FY 2011 Authorization .....Such Sums as Necessary

Allocation Method:

- Formula grant
- Competitive grant

Program Description and Accomplishments

The Traumatic Brain Injury (TBI) Grant Program funds the development and implementation of statewide systems that ensures access to comprehensive and coordinated TBI services including: pre-hospital care, emergency department care, hospital care, transitional services, rehabilitation, education and employment, and long-term community support.

TBI core capacity includes: a statewide action plan, statewide needs assessments, a designated State agency staff, and a State advisory board for TBI systems development to improve services to individuals with TBI and their families. In treatment of traumatic brain injury, rapid, organized treatment is vital not only to saving lives, but also in improving the quality of life for TBI survivors. By FY 2005, 51 States and territories had achieved a minimum TBI core capacity, meeting the target established for FY 2007 and thereafter. By 2008, 51 States and territories had begun to implement their TBI plans of action, up from 45 in 2006. Further, by 2008, 24 States and territories had completed at least 50% of their objectives contained in their TBI action plans. Since the program has reached its potential on these annual measures, new measures have been proposed.

Since the program's inception in 1996, it has evolved from being a demonstration program to a full implementation program with the grants developing from planning grants to full implementation partnership grants. The current authorization for the program is more prescriptive in terms of both sustainable systems change in states and in how grant funds ought to be used to accomplish this over-arching goal. For 2009, the guidance for new awards was changed to reflect an increased emphasis on those special populations with high rates of TBI that have not necessarily received adequate attention in the past, including veterans, children and youth, incarcerated juveniles, those with substance abuse problems, as well as Native Americans and African Americans. The amount of each award was raised to $250,000 per state, and 16 new awards were made in FY 2009. Most of the states funded have made remarkable progress in

developing and linking accessible TBI services and supports, as well as educating consumers, families and professionals about the needs of individuals with TBI.

Section 1253 of the Public Health Service Act recognizes that State Protection and Advocacy (P&A) systems are critical to achieving the goals and objectives of the TBI program. In FY 2003, grants were awarded to all 57 State P&A systems to evaluate State TBI P&A capacity and to develop plans to ensure P&A services, e.g., individual and family advocacy, self-advocacy training, specific self-advocacy assistance, information and referral services, and legal representation. These formula grants continue to be awarded.

The TBI program also provides for a National Technical Assistance Center. A new four year contract was awarded for this purpose in FY 2009.

Programs	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget
State Grants for Demonstration Projects	$6,445,000	---	$6,486,000	$6,486,000
Protection and Advocacy Grants	$3,432,000	---	$3,453,000	$3,453,000

The TBI Act is a partnership of the Health Resources and Services Administration (HRSA), Centers for Disease Control (CDC), and National Institutes of Health (NIH). Collaboration also occurred with the Department of Education's Office of Special Education and Rehabilitation Services, the Department of Veterans Affairs, and the Administration for Children and Families' Administration on Developmental Disabilities, and the Department of Defense, as well as the Substance Abuse and Mental Health Administration.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$8,904,000
FY 2007	$8,910,000
FY 2008	$8,754,000
FY 2009	$9,877,000
FY 2010	$9,939,000

Budget Request

The FY 2011 President's Budget for the Traumatic Brain Injury program is $9,939,000, the same as the FY 2010 Appropriation.

Starting in FY 2009, as grants were competed for new awards the amount of the grant award was increased to $250,000, which resulted in awards to 16 States. This competition required larger grant awards to allow the states to create a statewide system of care that can work with all the state-level agencies (Education, Vocational Rehabilitation, Social Services, Mental Health and Substance Abuse, the State Corrections System, Housing, and Transportation) that play a role in the overall state plan that ensures a comprehensive and sustainable system of care for individuals with TBI and their families. The FY 2011 request will continue these activities. By FY 2011, 51 States and territories will have begun implementing their TBI action plans and 24 will have completed 50% of the objectives in their action plans. New annual performance measures for the TBI program have been proposed.

TBI Protection and Advocacy grants will continue to receive a total of $3.3 million in FY 2011, the same as FY 2010 Appropriation.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
11.E: Decrease the application and reporting time burden of grantees (hours). *(Efficiency)*	FY 2008: 147 (Target Met)	132	127	-5

Long Term Objective: Promote effectiveness of healthcare services

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
11.1: Proportion of children with brain injury who are able to participate in community activities [1] *(Outcome)*	FY 2007: 52.5% (Baseline)	N/A	55%	N/A

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

Long Term Objective: Increase collaborative efforts to improve the capacity and efficiency of the public health and healthcare system.

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
11.V.B.1: Increase the number of States and Territories that have achieved a minimum TBI core capacity (including State Action Plan, Statewide Needs and Resources Assessment, designated State agency staff, and State Advisory Board). *(Output)*	FY 2008: 51 (Target Met) [2]	51	51	Maintain
11.V.B.2: Increase the number of States/Territories that have begun to implement their TBI plan of action. *(Output)*	FY 2008: 51 (Target Met)[3]	51	51	Maintain
11.V.B.3: Increase the number of States/Territories that have completed at least 50% of the objectives contained in their TBI plan of action. *(Output)*	FY 2008: 24 (Target Met)	24	24	Maintain

Note: New annual and efficiency measures are under development by the program.

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	82 (25 State and 57 P&A's)	---	79 (22 State and 57 P&A's)	79 (22 State and 57 P&A's)
Average Award	$203,493/ $57,431	---	$232,359/ $57,431	$232,359/ $57,431
Range of Awards	$250,000 - $20,000	---	$250,000 - $20,000	$250,000 - $20,000

[2] This figure is not expected to increase since federal funds are now directed to implementation activities vs. the planning activities under which core capacity was developed. A new replacement annual measure has ben proposed.
[3] This measure has reached its capacity. A new replacement measure has been proposed.

Sickle Cell Services Demonstration Program

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$4,250,000	---	$4,750,000	$4,750,000	---
FTE	2	---	2	2	---

Authorizing Legislation - Section 712(c) of the American Jobs Creation Act of 2004.

FY 2011 Authorization .....Expired

Allocation Method

- Competitive grant/co-operative agreement
- Contract

Program Description and Accomplishments

The Sickle Cell Service Demonstration Program was created in FY 2005 to develop systemic mechanisms for the prevention and treatment of Sickle Cell Disease, including the coordination of service delivery for individuals with Sickle Cell Disease. The program has been able to realize the expansion of service outreach through the development of infrastructure including, identification and establishment of genetic counseling, testing and other education opportunities for families and communities; provision of educational training sessions and engagement opportunities for health care providers; and generation of data that will demonstrate the effectiveness of the emerging practice models of the projects. The four year plan for the Sickle Cell Service Demonstration Program that charts the course of the program by outlining objectives and priority areas has been developed. The priorities include:

- Technical assistance/information exchange
- Materials review and development
- Collection, coordination, and distribution of Sickle Cell Service Demonstration Program data, best practices, and findings
- developing and sustaining partnerships
- reporting and dissemination of results

Activities funded under this authority have addressed HRSA strategic goals 1, 2, 3, 4 and 5. In particular this program has addressed the elimination of health disparities for individuals with Sickle Cell Disease. The program will continue to address the priorities described above in the four year plan. The program will facilitate the delivery of education, health promotion, patient and family support, state of the art treatment, and continuous, coordinated care to individuals with Sickle Cell Disease. In addition, the protocols and educational materials will facilitate the establishment of a uniform and quality approach to the care and treatment of individuals with Sickle Cell Disease.

In 2008 the Sickle Cell Demonstration Program received OMB clearance to begin data collection for an evaluation of the program. Tools include an Individual Utilization Data Form plus a patient questionnaire seeking specific data elements, indicators, measures and performance targets. Data is being collected prospectively 1) at baseline when the patients and caregivers are enrolled into the Network and 2) at 12 months every year after for as long as the subject remains a client of the Network. The study will recruit patients into the project on a rolling basis such that new patients will be added continuously to the study over the life of the project. In 2009 Grantees began enrolling clients and collecting baseline data. During 2010 follow-up data will be collected and analyzed.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$2,177,000
FY 2007	$2,180,000
FY 2008	$2,653,000
FY 2009	$4,250,000
FY 2010	$4,750,000

Budget Request

The FY 2011 President's Budget for the Sickle Cell Treatment Demonstration Program is $4,750,000, the same as the FY 2010 Appropriation. The funding will allow (1) continued funding of seven geographically distributed demonstration projects for enhanced access to comprehensive, coordinated, culturally effective, and family centered high quality services for individuals with sickle cell disease, (2) program expansion to fund to additional regional networks and (3) expansion of the data collection capacity and analysis to more fully achieve the evidence to evaluate the network activities and outcomes.

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	7	---	7	7
Average Award	$380,000	---	$380,000	$380,000
Range of Awards	$370,000 - $390,000	---	$370,000 - $390,000	$370,000 - $390,000

James T. Walsh Universal Newborn Hearing Screening

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$19,000,000	---	$19,000,000	$19,000,000	---
FTE	4	---	4	4	---

Authorizing Legislation - Section 399M of the Public Health Service Act.

FY 2011 Authorization ..... Expired

Allocation Method ..... Competitive grant/co-operative agreement

Program Description and Accomplishments

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

In FY 2008, the Maternal and Child Health Bureau awarded competitive grants to states to implement the program, and to one national technical assistance center. Collaboration with the Centers for Disease Control (CDC) and National Institutes of Health (NIH) National Institute on Deafness and Other Communication Disorders (NIDCD) is ongoing to coordinate programs at the national and state level. For FY 2009, additional supplemental funds were directed toward reducing loss-to-follow-up by implementing strategies to assure that infants identified through screening receive timely diagnosis and early intervention, and that parents are connected to ongoing family-to-family support. Forty two states competed successfully for these funds.

The Universal Newborn Hearing Screening program has been successful in increasing the percentage of newborns screened for hearing loss prior to hospital discharge. In 2005, 95% of newborns were screened for hearing loss prior to hospital discharge, exceeding the target of 94% according to data collected by the National Center for Hearing Assessment and Management (NCHAM). In FY 2006, the Centers for Disease Control (CDC) and Prevention's National Center for Birth Defects and Developmental Disabilities (NCBDDD) began collecting State data for the first time on newborn hearing screening services. For FY 2006, data from the 43 States and one territory responding to the survey indicated the number of infants screened was 92%. For FY 2007, data from the 48 States and two territories responding to the survey indicated the number of infants screened 94%. Although most of the States now have laws mandating hearing screening for newborns, few have comprehensive reporting provisions. Hospitals report screening in nearly all US hospitals, but service providers (audiologists, PCPs and Early Intervention providers) in the continuum of services do not routinely report in many places.

In FY 2005, the newborn hearing screening and intervention program underwent a program assessment. The assessment revealed the program had achieved a remarkable increase, since the program began in 2000, in the number of infants screened for hearing loss prior to discharge from the newborn nursery. However, the number of infants for whom follow-up services could not be documented remained high. An independent evaluation of the program was completed in 2006. The evaluation produced results similar to the program assessment. Findings were used to implement a quality improvement initiative. This initiative focuses on implementation of recommendations for programmatic changes which have proven to be effective in reducing loss to follow up. These strategies have been incorporated into subsequent grant guidances.

Program funding includes staffing, costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$ 9,794,000
FY 2007	$ 9,804,000
FY 2008	$11,790,000
FY 2009	$19,000,000
FY 2010	$19,000,000

Budget Request

The FY 2011 President's Budget for the James T. Walsh Universal Newborn Hearing Screening program is $19,000,000, the same as the FY 2010 Appropriation.

FY 2011 funding will continue 58 awards to assist the program in achieving the FY 2011 target of screening 98% of infants prior to hospital discharge.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
13.1: Increase the percentage of children with non-syndromic hearing loss entering school with developmentally appropriate language skills [1] *(Outcome)*	FY 2004: 20% (Baseline)	N/A	N/A	N/A
13.2: Increase the percentage of infants with hearing loss enrolled in early intervention before 6 months of age [1] *(Output)*	FY 2004: 57% (Baseline)	N/A	N/A	N/A
13.III.A.1: Percentage of infants suspected of having a hearing loss with a confirmed diagnosis by 3 months of age *(Output)*	FY 2007: 66%[2] (Target Exceeded)	60%	60%	Maintain
13.III.A.2: Percentage of infants with a suspected or confirmed hearing loss referred to an ongoing source of comprehensive healthcare (i.e. medical home) *(Output)*	FY 2006: 94% (Target Exceeded)	94%	95%	+1% pt.
13.III.A.3: Percentage of infants screened for hearing loss prior to hospital discharge *(Output)*	FY 2007: 94%[2] (Target Not Met)	98%	98%	Maintain
13.E: Increase the percentage of infants suspected of having hearing loss (based on the results of their newborn hearing screen) who receive a confirmed diagnosis by 3 months of age while maintaining a constant Federal expenditure *(Efficiency)*	FY 2007: 66%[2] (Target Exceeded)	60%	60%	Maintain

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	58	---	58	58
Average Award	$225,000	---	$225,000	$225,000
Range of Awards	$150,000 - $300,000	---	$150,000 - $300,000	$150,000 - $300,000

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

[2]The data source for measure numbers 13.III.A.1, 13.III.A.3, and 13.E has changed beginning for FY 2006 data. Previously data were collected by the National Center for Hearing Assessment and Management (NCHAM), the national resource center for the Universal Newborn Hearing Screening and Intervention Program. Annual data are now collected by the CDC which uses different definitions than NCHAM. Data from the CDC Hearing Screening and Follow-up Survey (HSFS) reflects data that states and territories have documented, allowing no estimates.

Emergency Medical Services for Children

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$20,000,000	---	$21,500,000	$21,500,000	---
FTE	---	---	---	---	---

Authorizing Legislation - Section 1910 of the Public Health Service Act.

FY 2011 Authorization ..... Expired

Allocation Method ..... Competitive grant/co-operative agreement

Program Description and Accomplishments

The Emergency Medical Services for Children (EMSC) Program began in 1984 and was designed to ensure state-of-the-art emergency medical care for ill or injured children and adolescents. It covers the entire spectrum of emergency medical care. The EMSC program provides grants to States to improve existing Emergency Medical Services (EMS) systems and to schools of medicine to develop and evaluate improved procedures and protocols for treating children.

In FY 2010, the EMSC Program will award 56 State Partnership Grants which focused on ensuring operational capacity to provide pediatric emergency care through: (1) building capacity for pediatric components of statewide EMS data collection efforts; (2) adopting requirements for pediatric emergency education for the recertification of paramedics; (3) establishing permanence of EMSC in the State/Territory EMS system and; (4) incorporating pediatric EMS issues into preparedness for mass casualty disasters and terrorism. Each State's progress in achieving these outcomes is being tracked using EMSC Program performance measures. The EMSC Program supports the National EMSC Data Analysis Resource Center in order to help State EMS Offices and medical schools develop their own capabilities to collect, analyze, and utilize EMS and other healthcare data to improve the quality of care in State EMS systems.

The EMSC Program also will fund 19 Targeted Issues grants to States and medical schools. These grants were demonstration projects that focused on a wide array of emerging and critical topics including: improving emergency department management of children with head trauma, seizures, and diabetic ketoacidosis; increasing patient safety; improving pre-hospital pain management in children; developing a system to effectively reunite children separated from their parents/guardians during a disaster; enhancing coordination between EMS and primary care for injured adolescents including alcohol problems and post-traumatic stress disorder; improving the quality of prehospital care of pediatric patients through more accurate assessment by paramedic providers; and studying the impact of family presence on the timeliness and effectiveness of care during pediatric trauma evaluation/resuscitation.

The EMSC Program also funded the Network Development Demonstration Project (NDDP) in order to conduct meaningful and rigorous multi-institutional studies in the management of acute illness and injury in children across the continuum of emergency medicine. The NDDP consists of 5 cooperative agreements that collectively form the Pediatric Emergency Care Applied Research Network. The EMSC Program collaborated with the Department of Transportation's National Highway Traffic Safety Administration since its inception and is a partner in the implementation of the National EMS Information System. The EMSC Program collaborated with the Indian Health Service (IHS) in order to ensure the availability of pediatric specific training initiatives tailored to the needs of tribal EMS and IHS medical facility professionals.

The program supports the development of improved emergency procedures and protocols for children. In FY 2007, 22 State EMS systems demonstrated the operational capacity to provide pediatric emergency care, and 23 States had adopted requirements for pediatric emergency education for the re-certification of paramedics. In FY 2008, these numbers improved to 23 States and 24 States, respectively. The program is also focused on decreasing the mortality rate for children with significant injury (an injury severity score (ISS) of greater than 15). An additional objective is to determine the transfer rate of children with an ISS of 15 or more from one hospital to another hospital that provides a higher lever of care (e.g. Level 1 trauma center) in order to further assess the impact of transfer rate on mortality.

The EMSC program had a program assessment in 2004. Since that time, the program has developed a long-term health outcome measure and annual measures that have been approved by OMB. The Institute of Medicine (IOM) completed a study of the Nation's emergency care system entitled "The Future of Emergency Care in the U.S. Health System" in 2006. The study included an examination of the unique challenges associated with the provision of emergency services to children and adolescents (http://www.iom.edu/emergencycare). The study noted that "the program has broadly advanced the state of pediatric emergency care nationwide."

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$19,786,000
FY 2007	$19,800,000
FY 2008	$19,454,000
FY 2009	$20,000,000
FY 2010	$21,500,000

Budget Request

The FY 2011 President's Budget for the Emergency Medical Services for Children program is $21,500,000, the same as the FY 2010 Appropriation. This request will assist the program in achieving its FY 2011 target of 28 awardees that demonstrate the operational capacity to provide pediatric emergency care and a target of 29 awardees that have adopted requirements for pediatric emergency education for the re-certification of paramedics.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
14.E: Decrease the application and reporting time burden of grantees (hours). *(Efficiency)*	FY 2008: 90 (Target Met)	80	75	-5

Long Term Objective: Promote effectiveness of healthcare

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
14.1: Mortality rate for children with an injury severity score (ISS) greater than 15 *(Outcome)*	FY 2005: 9.1% (Baseline)	8.6%	8.5%	-0.1
14.V.B.1: Increase the number of awardees that demonstrate the operational capacity to provide pediatric emergency care, including all core capacity elements related to: (a) on-line and off-line medical direction at the scene of an emergency for Basic Life Support (BLS) and Advanced Life Support providers, (b) essential pediatric equipment and supplies, (c) designation of pediatric specialty care hospitals, and inter-facility transfer agreements. *(Output)*	FY 2008: 23 (Target Exceeded)	26	28	+2
14.V.B.2: Increase the number of awardees that have adopted requirements for pediatric emergency education for the re-certification of paramedics. *(Output)*	FY 2008: 24 (Target Exceeded)	27	29	+2
14.V.B.3: Transfer rate for children with an injury severity score (ISS) of 15 or more. (Developmental) *(Output)* [1]	N/A	N/A	N/A	NA

[1]This developmental measure does not currently have annual targets. Baseline data for FY 2009 will be available in 2011.

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	74	---	79	79
Average Award	$240,000	---	$240,000	$240,000
Range of Awards	$115,000 - $2,000,000	---	$130,000 -$2,000,000	$130,000-$2,000,000

Healthy Start

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$102,372,000	---	$105,000,000	$110,186,000	+$5,186,000
FTE	---	---	---	---	---

Authorizing Legislation - Section 330H of the Public Health Service Act.

FY 2011 Authorization ..... $123,369,873 [1]

Allocation Method ..... Competitive grant/co-operative agreement

Program Description and Accomplishments

The Children's Health Act of 2000 (P. L. 106-310) amended the Public Health Service Act to provide "such sums as necessary" for continuation and expansion of a distinct Healthy Start program of grants that use community-designed and evidence-supported strategies aimed at reducing infant mortality and improving perinatal outcomes in project areas with high annual rates of infant mortality.

In the United States each year, approximately four million women become pregnant. Preliminary 2007 data indicate a 1 percent increase in births, the highest number of births ever registered in the United States. (National Center for Health Statistics (NCHS), Births: Preliminary data for 2007. National vital statistics reports (NVSR), vol. 57 no. 12, March, 2009). While most women have a safe pregnancy and deliver a healthy infant, that is not the experience for all women. Major and persistent racial and ethnic disparities exist in the proportion of pregnancy-related maternal death, in preterm birth, and in infant mortality. For example, results from an analysis of preterm-related causes of death indicated that 36.5 percent of infant deaths in 2005 were due to preterm-related causes. The preterm-related infant mortality rate for non-Hispanic black mothers was 3.4 times higher, and the rate for Puerto Rican mothers was 87 percent higher than for non-Hispanic white mothers (NCHS, Infant mortality statistics from the 2005 period linked birth/infant death data set, NVSR, vol. 57 no. 2, revised July, 2008). Despite considerable research efforts to understand and prevent these adverse outcomes, the factors that make some pregnancies more vulnerable than others have not been clearly defined. Emerging research indicates that environmental, biological and behavioral stressors occurring over the life span of the mother from her earliest life experiences until she delivers her own child may account for a significant portion of the disparities. Moreover, it may take specific

[1] The Healthy Start authorization is $120,000,000 for FY 2008 and for each of fiscal years 2009 through 2013, the amount authorized for the preceding fiscal year increased by the percentage increase in the Consumer Price Index for all urban consumers for such year. The CPIU estimates included in the FY 2010 President's Budget is -0.6 for FY 2009, 1.6 for FY 2010, and 1.8 for FY 2011.

interventions consistently provided to several generations before the factors responsible for the disparities in adverse birth outcomes have been overcome.

The interconceptional period (the time between the end of a woman's pregnancy to the beginning of her next pregnancy) is a critical time to modify risk factors, particularly those such as tobacco use, that are causally associated with infant mortality. Interconceptional healthcare may improve complications from a recent pregnancy and/or prevent the development of a new health problem (obesity, diabetes, depression, and hypertension) in both the woman and her children. Additionally, interconceptional healthcare provides a valuable opportunity to reduce or eliminate risks before one or more future pregnancies to ensure healthier (full term) infants and mothers.

To reduce the factors that contribute to the Nation's high infant mortality rate, particularly among African-American and other minority groups, Healthy Start (HS) provides intensive services tailored to the needs of high risk pregnant women, infants and mothers in geographically, racially, ethnically, and linguistically diverse low income communities with exceptionally high rates of infant mortality.

Through the implementation of innovative community-driven interventions, HS works with individual communities to build upon their resources (outreach, health education, case management, utilization of prenatal/postnatal care) to improve the quality of and access to healthcare for women and infants at both service and system levels. At the service level, beginning with direct outreach by community health workers to women at high risk, HS projects ensure that the mothers and infants have ongoing sources of primary and preventive healthcare and that their basic needs (housing, psychosocial, nutritional and educational support and job skill building) are met. Following assessments and screening for perinatal depression and other risk factors, case managers provide linkages with appropriate services and health education for risk reduction and prevention. Mothers and infants are linked to a medical home and followed, at a minimum, from entry into prenatal care through two years after delivery (interconceptional). At the system level, every HS project has developed a consortium composed of neighborhood residents, perinatal care clients or consumers, medical and social service providers, as well as faith-based and business community representatives. Together these key stakeholders and change agents address the system barriers in their community, such as fragmentation in service delivery, lack of culturally appropriate health and social services, and barriers to accessing care. HS projects are required to have strong collaborative linkages with State programs including Title V MCH Block Grant, Medicaid, State Child Health Insurance Program, and with local perinatal systems such as those in community health centers. The close connection between these services can assist in reducing significant risk factors such as smoking and alcohol use, while promoting behaviors that can lead to healthy outcomes for women and their families. These positive relationships and effects, beginning during the perinatal period, continue to be monitored for both mother and baby for two years post-delivery to ensure that they remain linked to ongoing sources of primary care.

Communities in the 38 States, the District of Columbia, and Puerto Rico that are served by Healthy Start have large minority populations with high rates of unemployment, poverty and major crime. Parents at highest risk typically have less than a high school education, are low income and have limited access to safe housing. Medical providers are limited, and often can only be reached after long commutes on crowded public transportation. Tulsa Healthy Start

(THS) in Tulsa, OK typifies one of Healthy Start's urban projects, with deep historic social and economic disparities in comparison to the City of Tulsa as a whole and the U.S. Though its commitment to providing accessible family-centered, high-quality pre- and postnatal care that is unique to their community needs, Tulsa Healthy Start serves pregnant women who are at most risk of poor birth outcomes. Of the 8,260 Tulsa Healthy Start clients that were case managed from September 1998 to August 31, 2007, 11.5% were found to use illicit drugs, 9.9% were found to drink alcoholic beverages, 12.9% were in domestic violence situations, and 13.7% were found to have depression. Depression was a co-factor with domestic violence in 478 cases, illicit drug use in 328 cases, and drinking alcoholic beverages in 350. Despite the high-risk level of THS clients, infant outcomes continue to improve. THS client infant mortality rate (IMR) has decreased over time from 14.2/1000 in 1998 to 9.17 in 2006. In contrast, the Tulsa County rate is 10.58 per 1000 live births.

There are achievements linked to the HS program in other communities as well. Most significantly, a decrease in the number of infant deaths of Healthy Start participants. In fact, twenty two Healthy Start communities report no infant deaths among program participants for the past two years (2006-2007): Blytheville, AR; Los Angeles, CA; Fresno, CA; Englewood, CO; Washington D.C.; Hawaii County, HA; Des Moines, IA; Chicago, IL; Witchita, KS; Manhattan, NY; Lafayette, LA; Flint, MI; St. Louis, MO; Columbus, OH; Portland, OR; Philadelphia, PA; Westchester, PA; Springfield, PA; Bellaire, TX; San Antonio, TX. Among African Americans in 2007, the infant mortality rate for the program participants in *Saginaw County's Great Beginnings Healthy Start* was only 5.8 per 1,000 live births. The infant mortality rate for the *Jacksonville* Healthy Start, a program that focuses on high risk interconceptional women, was reported at 15.6 per 1,000 live births in 2001, 14.0 per 1000 live births for in 2005 and no infant deaths in 2006. The infant mortality rate for the northern Wisconsin tribes served by the *Great Lakes Intertribal Councils Honoring Our Children Project* for 2002 to 2004 was 10.5; in contrast the infant mortality rate was only 3.3 among program participants for 2005 to 2007.

Low birthweight (LBW), a major contributor to infant mortality, has been dramatically reduced. In 2007, the national LBW rate was 8.2%, the highest level recorded since the early 1970s (National Center for Health Statistics, Births: Preliminary Final Data for 2007, vol. 57 no. 12, March, 2009). In 1998, the National LBW was 7.6% and 65% of all infant deaths were attributed to LBW (Source: NVSS, NCHS, 2000). At the same time, the LBW rate in the Healthy Start projects averaged 12.1%. By 2006, in contrast to the upward trend in the nation, HS projects had reduced LBW to an average rate of 10.3%. In FY 2007 the figure was also 10.3% (see Outcomes and Outputs Table). This was particularly significant because the national LBW rate for African-Americans was 13.8% (NCHS, Births: Final Data for 2004, September 29, 2006). HS communities demonstrating remarkable successes in reducing low birth weight include: *Baltimore Healthy Start,* where the very low birth weight (VLBW) rate is 2.0% (17 of 852) among HS enrolled participants (99% African-American) with singleton births, compared to a 3.7% citywide African-American VLBW rate. The percent of African-American babies born VLBW in Baltimore is now approaching that of white babies citywide VLBW (1.5%). In the *St. Petersburg Healthy Start Federal Project,* black infants were 3.2 times more likely to be born VLBW than whites (2002-2004). Among program participants, the VLBW for 2007 was 2.2%.

Another risk factor for infant mortality is late entry into prenatal care. In 2004, the mortality rate for infants of mothers who began prenatal care after the first trimester of pregnancy or not at all was 8.35 per 1,000. This rate was 37 percent higher than the rate for infants of mothers who began care in the first trimester (NVSS, NCHS, 2007). While nationally, 82.8% of pregnant women received prenatal care in the first trimester in 1998, first trimester entry into prenatal care for Healthy Start projects was only 41.8% in 1998. By 2007, the projects had increased first trimester entry into prenatal care to 68.2% (see Outcomes and Outputs Table). In 2007 the *Luna County Healthy Start,* located along the Texas-Mexico border, percentage of clients entering care during the first trimester increased from 69% in 2004 to 83% (2007). In that same year 77.4% of the *Richmond Virginia* Healthy Start participants entered prenatal care in the first trimester compared to 30.8% in 2005. Since the *Michigan Inter-Tribal Council's (MITC)* Healthy Start Project began, the rate of first trimester prenatal care among American Indian Project Participants has increased; fully closing the racial disparity gap that existed prior to Healthy Start project implementation. In 1996, the rate of first trimester care for MITC Healthy Start participants was 74 % compared to the state rate of 82%. By 2007, the rate of first trimester care for MITC Healthy Start participants was 91% compared to a state rate of 83.4%. The *Laurens County Heart of Georgia Healthy Start Initiative* increased first trimester entry from 21.6% in 2003 to 89.9% in 2007.

Focusing on systems development and coordination improves maternal and infant outcomes. Decreasing the inter pregnancy interval increases a woman's chances of having a better birth outcome with a subsequent pregnancy. *Healthy Start, Chester, PA,* identified the lack of health insurance as a significant barrier to utilizing care resulting in delayed initiation of prenatal care and pediatric care. This financial barrier to care is compounded by the extremely limited healthcare services for the under/uninsured in the project area. Prenatal and pediatric care is provided by private practice groups. Many of these groups are reluctant to see uninsured women and children. During the most recent project period (FY 2001 - 2005), 74% of the pregnant women enrolled in Healthy Start had no health insurance at the time of enrollment. Healthy Start staff completed Medicaid or SCHIP applications on all uninsured Healthy Start participants. 969 (98%) of 991 Medicaid/SCHIP applications submitted by Healthy Start were approved for Medicaid or SCHIP coverage. By reducing a significant barrier to utilizing appropriate healthcare, Healthy Start projects have made important strides in helping at-risk mothers have healthy babies and families.

A program assessment in 2006 found that the Healthy Start program resources are effectively targeted, and that independent evaluations are conducted. The Healthy Start program has taken steps, including providing training for grantees to assure the quality of grantee-reported data. The program is also identifying and synthesizing evidence-based practices that contribute to improved perinatal outcomes that it will disseminate to HS communities.

To improve quality, the program is also identifying and synthesizing evidence-based practices that contribute to improved perinatal outcomes that it will disseminate to HS communities. The program has launched a 27 month quality learning community initiative to translate the Select Panel on Preconception evidenced–based practices related into reality in the Healthy Start projects. The HS program has also undertaken several steps, including providing training for grantees to assure the quality of grantee-reported data reported on MCHB Discretionary Grant Information website. Funding includes costs associated with grant reviews, processing of grants

through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$101,447,000
FY 2007	$101,518,000
FY 2008	$ 99,744,000
FY 2009	$102,372,000
FY 2010	$105,186,000

Budget Request

The FY 2011 President's Budget for the Healthy Start program is $110,186,000, an increase of $5,186,000 over the FY 2010 Appropriation.

Two Healthy Start projects will end in FY 2011. The request will support 2 competing renewals for community based projects, three new grants and 102 non competing continuation grants. Each of the Healthy Start projects has committed to reducing disparities in perinatal health and infant mortality by transforming their communities, strengthening community-based systems to enhance perinatal care and improving the health of the young women and infant in their vulnerable communities. To assist projects, the Healthy Start program will provide support for peer mentoring, technical assistance, the Healthy Start Leadership Training Institute, eight to ten webcasts, site visits and sharing of best practices among projects. Additionally the program is in the third year of a learning collaborative to enhance the projects' ability to unify the varied systems of care in their community and increase the capacity of local providers to incorporate emerging evidence-based health guidelines on preconception and interconception care. The FY 2011 target for percent of low birth weight births among HS women is 9.6%, reflecting experience in the field and the upward national trend.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
12.1: Reduce the infant mortality rate (IMR) among Healthy Start program clients. [2] *(Outcome)*	FY 2004: 7.65 per 1,000 persons (Baseline)	N/A	N/A	N/A
12.2: Reduce the neonatal mortality rate among Healthy Start program clients. [2] *(Outcome)*	FY 2004: 4.8 per 1,000 persons (Baseline)	N/A	N/A	N/A

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

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
12.3: Reduce the post-neonatal mortality rate among Healthy Start program clients. *(Outcome)* [2]	FY 2004: 2.82 per 1,000 persons (Baseline)	N/A	N/A	N/A

Long Term Objective: Promote the effectiveness of healthcare services

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
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)*	FY 2007: 68.2% (Target Not Met but Improved)	75%	75%	Maintain
12.III.A.2: Decrease annually the percentage of low birth weight infants born to Healthy Start program participants. *(Outcome)*	FY 2007: 10.3% (Target Not Met)	9.6%	9.6%	Maintain
12.II.B.1: Increase annually the number of community members (providers and consumers, residents) participating in infant mortality awareness public health information and education activities. *(Output)*	FY 2007: 391,143 (Target Exceeded)	TBD	TBD	Maintain
12.E: Increase the number of persons served by the Healthy Start program with a (relatively) constant level of funding.(Baseline - 2002: 288,800 ($343/participant)) *(Efficiency)*	FY 2007: 542,484 (Target Exceeded) ($189/participant)	524,500 ($195/ particiapant	552,500 ($192/ particiapant	-$3.00/ participant

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	102	---	104	107
Average Award	$750,000	---	$750,000	$750,000
Range of Awards	$255,000 – $2,350,00	---	$255,000 – $2,350,000	$255,000 - $2,350,000

Family-To-Family Health Information Centers

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$5,000,000	---	---	---	---
FTE	---	---	---	---	---

Authorizing Legislation - Section 501(c)(1)(A) of the Social Security Act.

FY 2010 Authorization ..... Expired

Allocation Method ..... Competitive grant/co-operative agreement

Program Description and Accomplishments

The Family-to-Family Health Information Centers supports grants to family-run organizations to ensure families have access to adequate information about healthcare, community resources and supports in order to make informed decisions around their children's healthcare.

The program for FY 2009 supported centers in 50 states and the District of Columbia to: (1) assist families of children with special healthcare needs (CSHCN) make informed choices about healthcare in order to promote good treatment decisions, cost effectiveness and improved health outcomes; (2) provide information regarding the healthcare needs of and resources available for CSHCN; (3) identify successful health delivery models; (4) develop with representatives of healthcare providers, managed care organization, healthcare purchasers, and appropriate State agencies, a model for collaboration between families of CSHCN and health professionals; (5) provide training and guidance regarding the care of CSHCN; (6) conduct outreach activities to families, health professionals, schools and other appropriate entities; and (7) be staffed by such families who have expertise in Federal and State public and private healthcare systems and by health providers.

Currently, 41 centers are collecting data on the issues facing families regarding services and financing of those services while working with Medicaid, Education, Title V and other agencies to inform them of families' needs. Information about healthcare financing and community resources remain the most frequently reported type of assistance provided.

Program continues working with grantees, in collaboration with the National Center for Family/Professional Partnerships, on monthly technical assistance calls to enhance program content and data collection, including impact data. A series of calls with other national centers to provide expertise on the six directives by Congress has been completed. In addition, program has completed an effort with a grantee evaluation workgroup and a contractor on assessing grantee data collection capacity in order to implement any recommendations to ensure more accurate data collection.

All centers are now reporting numbers served and impact data (using the protocol referenced above) through their continuation reports and quarterly reports to the National Center for Family/Professional Partnerships. Data technical assistance one-pagers have been disseminated and additional training and discussion sessions will occur at a topical meeting May, 2009 and on follow up conference calls.

In FY 2008, 75,532 families with CSHCN were provided information, education and/or training from Family-to-Family Health Information Centers. In FY 2007 more than 92,000 families were provided information. This exceeded the target.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	---
FY 2007	$3,000,000
FY 2008	$4,000,000
FY 2009	$5,000,000
FY 2010	---

Budget Request

No funds are requested for the Family-To-Family Health Information Centers program in FY 2011, the same as the FY 2010 Appropriation. The authorization for the Family-To-Family Health Information Centers program expired in FY 2009.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
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 *(Outcome)*	FY 2009: 92,395 (Target Exceeded)	N/A	N/A	N/A

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
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)* [1]	FY 2008: 59.8% (Baseline)	N/A	N/A	N/A

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	51	---	N/A	N/A
Average Award	$95,700	---	N/A	N/A
Range of Awards	$95,700 – $100,000	---	N/A	N/A

[1] This developmental measure does not have annual targets.

Heritable Disorders Program

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$10,013,000	---	$10,013,000	$10,013,000	---
FTE	1	---	3	3	---

Authorizing Legislation - Sections 1109, 1110, 1111, and 1112 of the Public Health Service Act.

FY 2011 Authorization: 1109……$15,375,000
FY 2011 Authorization: 1110……..…$5,125,000
FY 2011 Authorization: 1111……..…$1,025,000
FY 2011 Authorization: 1112……..…$2,562,500

Allocation Methods:

- Direct federal/intramural
- Contract
- Competitive grant/co-operative agreement
- Other

Program Description and Accomplishments

The programs and activities under this Act are established to improve the ability of States to provide newborn and child screening for heritable disorders and affect the lives of all of the nation's infants and children. Newborn and child screening occur at intervals across the life span of every child. Newborn screening universally provides early identification and follow-up for treatment of infants affected by certain genetic, metabolic, hormonal and/or functional conditions. It is expected that newborn and child screening will expand as the capacity to screen for genetic and congenital conditions expands.

Legislation Background for the Heritable Disorders Program

Public Health Service Act (Act), 42 U.S.C. 300b, "Screening for Heritable Disorders," as amended in the Newborn Screening Saves Lives Act of 2008. There are 8 sections of the Act: Sections 1109 -1116. MCHB has been delegated authority for implementing Sections 1109, 1111, and 1112 and has requested authority to implement Sections 1110 and 1114 (utilizing a co-chair structure with CDC).

1. **Section 1109: Improved Newborn and Child Screening for Heritable Disorders**
   Regional Genetic and Newborn Screening Services Collaboratives

Seven Regional Genetic and Newborn Screening Service Collaboratives and a National Coordinating Center were established in 2004 to support the Heritable Disorders Program. These Cooperative Agreements take a regional, collaborative approach to address the maldistribution of genetic resources and services and the problems families and primary health care providers have in accessing and utilizing those services. Special emphasis is given to underserved populations and those families and providers in rural areas. The Collaboratives comprise all States, Territories, and the District of Columbia. For grant activities, refer to website: http://www.nccrcg.org.

1. **Section 1110: Evaluating the Effectiveness of Newborn and Child Screening Programs**

- *Screening for Heritable Disorders in Children: Efficacy from a Family/Consumer Perspective* Four cooperative agreements were funded in 2007 to address the current knowledge gap in this area and propose models of practices that will promote positive family adaptation and interaction within the newborn screening system. Topics of studies included: (1) measurement of parental behavior after receiving false positive screening results; (2) assessment of potential "harm" on children and their families with notification of false positive screening results; (3) assessment of the impact of carrier identification, particularly on diverse populations and what information may be desired by families; (4) determination of the information that would be necessary for parental decision making about screening for conditions that may not have a medically proven treatment; and (5) determination of changes in parental attitudes and responses with increased education and knowledge about newborn screening.
- *Effective Newborn Screening Follow-up*
  Begun in 2009, this initiative's activities focus on the use of electronic health information exchange (HIE) to improve the newborn screening system, with attention to both short and long-term follow up, per the guidance offered in the Statement of the Advisory Committee on Heritable Disorders in Newborns and Children (Committee) on Long-term Follow-up after diagnosis resulting from newborn screening (located: http://www.hrsa.gov/heritabledisorderscommittee/reports/longtermfollowupafternewborn.htm).

  Achieving the goal of long-term follow-up requires effective and timely communication and information sharing among patients/families, clinicians, laboratorians, public health agencies, researchers, and relevant community support services. Working partnerships among the stakeholders will facilitate meaningful electronic HIE for attaining effective follow-up of children and youths with conditions identified by newborn screening, including the evaluation of benefits accrued by the individual throughout his or her life. The benefits of HIE including improved timeliness of reporting, reduction of data entry errors, and

long-term savings to laboratories and public health programs, have been demonstrated on a small scale.

2. Section 1111: *The Advisory Committee on Heritable Disorders in Newborns and Children*

In adherence with the Act, the Committee will continue: 1) making recommendations to enhance, expand or improve the ability of the Secretary to reduce the mortality or morbidity in newborns and children from heritable disorders; 2) developing a model decision-matrix for newborn screening expansion; and 3) considering ways to ensure that all States attain the capacity to screen for the recommended conditions. In February 2008, the Committee finalized its nomination and evidence review process for candidate conditions to be considered for addition to the recommended uniform screening panel. Thus far, 9 nominated conditions have been sent to the Committee for addition to the Committee's recommended uniform newborn screening panel: three nominated conditions have undergone external evidence reviews; two nominated conditions currently are being evaluated by the Committee for an external evidence review; and four nominated conditions were deemed by the Committee as not ready for review by the Committee's external evidence review workgroup. Thus far, the Committee has not put forth recommendations to add any conditions to their Recommended Screening Panel.

3. Section 1112: The Clearinghouse

The Clearinghouse for Newborn Screening Information
The Clearinghouse will be central repository of current educational and family support and services information, materials, resources, research, and data on newborn screening for the following purposes: 1) increase awareness, knowledge, and understanding of newborn screening by parents and family members of newborns, health professionals, industry representatives, and the public; 2) increase expectant individuals and families' awareness, knowledge, and understanding of newborn disease and screening services; and 3) maintain current data on quality indicators of newborn screening performance.

Funding History

FY	Amount
FY 2006	---
FY 2007	---
FY 2008	---
FY 2009	$10,013,000
FY 2010	$10,013,000

Budget Request

The FY 2011 President's Budget for the Heritable Disorders program is $10,013,000, the same as the FY 2010 Appropriation.

1. <u>Section 1109: Improved Newborn and Child Screening for Heritable Disorders</u>

-
  - Regional Genetic and Newborn Screening Services Collaboratives

The Regional Collaborative grant activity is in its 2nd grant cycle, 2007-2012. During the 1st funding cycle, 2004-2007, each Collaborative received base infrastructure and activity funding of $500,000. In the 2nd cycle, 3 of the 7 Collaboratives received an additional $250,000 in awards for each of two Additional Priority Activities: 1) Laboratory Quality Assurance Activity for specific newborn screening public health laboratory quality-improvement projects such as enhancing newborn screening analytical laboratory test performance across the region; and 2) Collaborative Follow-up Activity using health information technology and information exchange activities including the creation and use of regional and national information systems designed to monitor health outcomes of infants and children identified with heritable disorders in newborn screening programs, evaluate newborn screening program performance, and evaluate treatment protocols. Accomplishments include the mapping of the requirements of a state newborn screening system into a framework, a registry of heritable conditions to improve management and treatment outcomes with a platform for future research, and the development of interstate Charter Agreements for data sharing. An evaluation plan and four performance measures have been developed for these programs. The first year of data has been compiled and reported. These measures include amount of collaboration facilitated by the regional programs, integration of systems to track infants and newborns diagnosed through newborn screening, systems for tracking receipt of clinical services after diagnosis through newborn screening, and dissemination of information on disorders to primary care providers in a "just-in-time" capacity.

The funding for the Regional Collaboratives remains the same for the next fiscal year. With stable funding the program will continue to provide the services and projects outlined above. As health care reform matures, the integration of genetic medicine, as its capacity to personalize health care is realized, into the health care delivery system is essential. The Laboratory Quality Assurance Activity has become international in participation; the Collaborative Follow-up Activity has been developed into the ***<u>Effective Newborn Screening Follow-up</u>*** initiative ***(see below).***

2. Section 1110: Evaluating the Effectiveness of Newborn and Child Screening Programs

- *Screening for Heritable Disorders in Children: Efficacy from a Family/Consumer Perspective*

  These projects end May 31, 2010. Preliminary analysis of data indicates that women need and want more information about NBS: 39% of recent mothers indicated they were either not given any or enough information about NBS, and 63% of prospective mothers indicated they had not heard of NBS. Majority of respondents preferred learning about NBS earlier in pregnancy. These projects also pooled their literature reviews to enable a systematic review of the depiction of attitudes, beliefs, and perceptions held by parents about newborn screening. Various psychosocial aspects such as anxiety and depression and beliefs including decision making and action taking were examined.

2. *Effective Newborn Screening Follow-up*

   Three cooperative agreements were funded in FY 2009 to enhance State newborn screening program follow-up utilizing HIE. An additional cooperative agreement was funded in FY 2010. Addressing the unmet needs for capacity building on both the sending and receiving sides of HIE through implementation of interoperable health information systems allows these benefits to be realized nation-wide and at all levels of the public health and health care system allowing for earlier detection of potential outbreaks, more rapid intervention, and more complete and timely information.

   Maintaining the same level of funding as in FY 2010 of $1,600,000 will provide for the continuation of the grant programs activities toward implementing standards based interoperable electronic newborn screening reports and exchanging newborn screening (including hearing) data with hospitals; medical homes/community based practices and subspecialists. The *Effective Newborn Screening Follow-up* initiative is laying the foundation for an interoperable system exchanging data relating to children, developing interoperable registries and clinical data repositories, developing a secure system for data exchange and promotes electronic health information technology in state health departments. The project also aligns to the ***Nationwide Health Information Network*** (***NHIN***) goals of developing a standards based bidirectional transfer of public health and medical information and improving coordination of care. This will be accomplished when providers have access to the integrated health record, thus ensuring appropriate information is available at the time and place of care, and providing timely access to this information for consumers (public health, clinical care, and patients/parents) securely via the internet. Since the system will be built using interoperability standards, it also supports regional efforts to exchange information between states.

3. Section 1111: *The Advisory Committee on Heritable Disorders in Newborns and Children*

In adherence with the Act, the Committee will continue: 1) making recommendations to enhance, expand or improve the ability of the Secretary to reduce the mortality or morbidity in newborns and children from heritable disorders; 2) developing a model decision-matrix for newborn screening expansion; and 3) considering ways to ensure that all States attain the capacity to screen for the recommended conditions.

***4.* Section 1112: Clearinghouse**

The Clearinghouse for Newborn Screening Information
The Clearinghouse for Newborn Screening Information (Clearinghouse) will contain evidence-based and scientifically sound materials and resources available from existing government and non-profit newborn screening and related websites. New content will also be developed to prepare and support patients, families and providers during the newborn screening process. With sustained funding in FY 2011, we will be able to conduct quarterly reviews and updates as indicted in the legislation to ensure that information housed on the Clearinghouse is accurate and reliable. In addition, sustained funding in FY 2011 will support implementation of interactive discussion forums, collection and/or analysis of current data on quality indicators which measure how well the newborn screening system is performing, and other indicators of quality –outputs also part of the Newborn Screening Saves Lives Act legislation. FY 2011 activities are necessary evaluative activities that follow the formative development of the Clearinghouse website completed and in progress between FY 2009 and FY 2010. Interactive forums planned in FY 2011 will help to gauge the use and utility of materials available on the Clearinghouse website.

New content developed for the Clearinghouse will address cultural competency and health literacy . State of the art communication and social networking methods are an integral part of the Clearinghouse communication and dissemination strategy with the goal of reaching a variety of populations using popular Internet social networking websites and other web-based communication methods. As the Department continues its efforts toward improved health care for the nation, especially persons with limited or no health care services access, quality Internet-based health education and communication techniques as well as Health Information Technology (HIT) and Health Information Exchange (HIE) like those that are part of the Clearinghouse, will be an essential component of improving health care for the nation. Sustained funding in FY 2011 for the Clearinghouse will contribute to departmental and HRSA specific goals, by facilitating data collection and analysis, allowing adoption and use of innovative resources and multi-modalities to enhance access to and raise awareness, knowledge and understanding about newborn screening.

3. Section 1114: The Interagency Coordinating Committee (ICC) on Newborn and Child Screening

Upon establishment, the ICC will undertake relevant activities including: 1) assessing existing newborn and child screening data, in order to make recommendations for programs to collect, analyze,; 2) making data available on the heritable disorders recommended by the

Committee under section 1111, including data on the incidence and prevalence of, as well as poor health outcomes resulting from such disorders; and 3) making recommendations for the establishment of regional centers for the conduct of applied epidemiological research on effective interventions to promote the prevention of poor health outcomes resulting from such disorders, as well as providing information and education to the public on such effective interventions. The ICC would also serve to coordinate collaborative efforts for newborn and child screening among all agencies in HHS and serve to identify policy issues requiring attention by federal agencies. The Act specifies that the ICC be composed of the Administrator of HRSA, the Director of CDC, the Director of AHRQ, and the Director of NIH. Delegation for authority to implement this ICC is pending. Funding would be needed to implement many of the ICC activities.

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	15	---	16	16
Average Award	$400,000	---	$650,000	$650,000
Range of Awards	$250,000 - $600,000	---	$500,000 - $1,000,000	$500,000 - $1,000,000

Congenital Conditions

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$1,000,000	---	$500,000	$500,000	---
FTE	---	---	---	1	---

Authorizing Legislation - Section 399R of the Public Health Service Act.

FY 2010 President's Budget ..... Indefinite

Allocation Methods:

- Competitive grant/co-operative agreement
- Other

Program Description and Accomplishments

The Congenital Conditions Program, established in September 2009, is a funding activity that responds to the 2008 Prenatally and Postnatally Diagnosed Conditions Awareness Act (PPDCA). The program provides information and support services to women and their families who have received a diagnosis for Down Syndrome, Spina Bifida, Dwarfism and other prenatally or postnatally diagnosed conditions. This program aims to increase patient referrals to providers of key support services for women; improve available data by incorporating up-to-date, evidenced based information into existing state programs for congenital anomalies and prenatally or postnatally diagnosed conditions, and ensure that patients receive information about the accuracy of the diagnostic tests for the conditions. Program activities rely on partnerships among family support groups, health professionals, State and Federal health agencies.
Components of this program, including the expansion and further development of national and local peer-support programs; development of evidence-based practice guidelines; and increased linkages to existing and new information and service resources are critical components of the needed information system and would be significantly affected by the proposed reduction.

Multiple stakeholders have committed support to this program. This stakeholders group met on November 19 representing the interest of persons and families affected by conditions named in the PPDCA.

The U.S. Government Accountability Office (GAO) is using this program to respond to the legislative requirement in the PPDCA that the GAO submit a report to Congress concerning the effectiveness of current healthcare and family support programs serving as resources for families of children with disabilities. Representatives from the GAO participated at the November 19 Stakeholders Meeting.

Funding also includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	---
FY 2007	---
FY 2008	---
FY 2009	$1,000,000
FY 2010	$500,000

Budget Request

The FY 2011 President's budget for the Congenital Conditions Program is $500,000, which is the same as the FY 2010 Appropriation. This funding will be used to support one cooperative agreement to provide information and support services to families receiving a diagnosis of down syndrome, spina bifida, dwarfism, or other prenatally or postnatally congenital diagnosed conditions. Funding also includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Program Level Funding ($ in millions)	$1.000	$0.500	$0.500	---

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	1	---	1	1
Average Award	$820,000	---	$320,000	$320,000
Range of Awards	$820,000	---	$320,000	$320,000

Ryan White HIV/AIDS Treatment Extension Act of 2009

Summary of Request

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$2,213,421,000	---	$2,265,888,000	$2,305,401,000	+$39,513,000
ADAP (non add)	$815,000,000	---	$835,000,000	$855,000,000	+$20,000,000
MAI (non add)	$139,100,000	---	$146,055,000	$153,358,000	+$7,303,000
SPNS	$25,000,000	---	$25,000,000	$25,000,000	---
Total Funding	$2,238,421,000	---	$2,290,888,000	$2,330,401,000	+$39,513,000
FTE	27	---	30	30	---

**The amounts include funding for Special Projects of National Significance (SPNS) funded from Department PHS Act evaluation set-asides in FY 2010 President's Budget and proposed for FY 2011.*

Authorizing Legislation: The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Title XXVI of the Public Health Service Act) was enacted on October 30, 2009.

FY 2011 Authorization……...$2,523,955,000

Allocation Method .....Competitive and Formula Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

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, are unable to pay for HIV/AIDS healthcare and vital health-related supportive services. Ryan White HIV/AIDS Program funding pays for core primary health care and support services that enhance access to and retention in care and fills gaps in care not covered by other resources or payers. The Program serves more than half a million low-income people with HIV/AIDS in the U.S. each year. Thirty-three percent of those served by the Ryan White HIV/AIDS Program are uninsured and an additional 56 percent are underinsured. Ryan White HIV/AIDS Program services are intended to increase access to care for underserved populations, reduce the use of more costly emergency services and inpatient care, and improve the quality of life for PLWH and for those affected by the HIV/AIDS epidemic.

The Ryan White Comprehensive AIDS Resources Emergency Act was first enacted in August 1990. It was amended and reauthorized for five years in May 1996 and for an additional five

years in October 2000. The Program was reauthorized again in December 2006 for three years as the Ryan White HIV/AIDS Treatment Modernization Act of 2006 and for another four years in October 2009 as the Ryan White HIV/AIDS Treatment Extension Act of 2009. The Ryan White HIV/AIDS Program is administered by the HRSA HIV/AIDS Bureau.

The Ryan White HIV/AIDS Program demonstrates a comprehensive and aggressive approach in how government has targeted dollars toward the development of an effective service delivery system. By funding and partnering with community and faith based, not-for-profit, local and State programs, the Ryan White HIV/AIDS Program provides primary medical care and support services, health care provider training, and technical assistance to help funded programs address current and emerging HIV care needs. The distinct components of the Ryan White HIV/AIDS Program serve very specific purposes. The FY 2011 President's Budget Request of $2.30 billion for the Ryan White HIV/AIDS Program includes:

- For Part A -- $679.1 million, which will provide grants for 24 eligible metropolitan areas (EMAs) and 32 transitional grant areas (TGAs) disproportionately affected by HIV/AIDS to fund a variety of medical and support services;
- For Part B -- $1,283.8 billion, which will provide grants to 59 States and Territories to improve the quality, availability, and organization of HIV/AIDS healthcare and support services; this includes $855 million to provide access to FDA approved, HIV-related medications through the AIDS Drug Assistance Program (ADAP) serves primarily low-income PLWH who have limited or no access to needed medication, and is the nation's prescription drug safety net for PLWH.;
- For Part C -- $211.9 million, which will provide 353 grants directly to service providers (i.e. Federally-qualified health centers, family planning clinics, rural health clinics, Indian Health Service facilities; community-based organizations, and nonprofit faith-based organizations) to support outpatient HIV early intervention services and ambulatory care.
- For Part D -- $77.8 million, which will provide 80 grants to community based and non-profit private and public organizations to support family-centered, comprehensive care to HIV-infected women, infants, children and youth and support to their affected family members; this includes 17 Adolescent Program grants.
- For Part F –
    - $37.4 million for AIDS Education and Training Center (AETC) grants to organizations to support education and training of health care providers through 11 Regional Centers, 130 Local Performance Sites and 4 National Centers;
    - $15.4 million the HIV/AIDS Dental Reimbursement Program, a program that provides reimbursement to dental schools, hospitals with postdoctoral dental education programs, and colleges with dental hygiene programs for uncompensated costs incurred in providing oral health treatment to patients with HIV disease; and for 20 Community-Based Dental Partnership Grants to provide support to dental providers for increased access to oral healthcare services for HIV-positive individuals while providing education and clinical training for dental care providers, especially those located in community-based settings; and

- $25 million for Special Projects of National Significance (SPNS) funded from the Department PHS Act evaluation set-aside.

Ryan White Minority AIDS Initiative (MAI): Within the total amount included for the Ryan White HIV/AIDS Program, the Budget Requests $153.4 million be used to address the disproportionate impact of HIV/AIDS on communities of color. Ryan White MAI dollars focus specifically on the elimination of racial and ethnic disparities in the delivery of comprehensive, culturally and linguistically appropriate HIV/AIDS care and treatment in the United States. To achieve this objective, the Ryan White HIV/AIDS Program uses MAI funds to conduct the following activities:

Provide capacity-building grants and services grants to health care providers who have a history of providing culturally and linguistically appropriate care and services to racial and ethnic minorities;

Increase the training capacity of centers to expand the number of healthcare professionals with treatment expertise and knowledge about the most appropriate standards of HIV disease-treatments and medical care for racial and ethnic minority adults, adolescents, and children with HIV disease; and

Support education and outreach services to increase the number of eligible racial and ethnic minorities who have access to treatment through the program .

Minority AIDS Initiative (MAI) Funding

(whole dollars)	FY 2009	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President'sBudget Request
Part A	$ 47,100,000	---	$ 46,738,000	$49,075,000
Part B	$ 7,500,000	---	$ 8,763,000	9,202,000
Part C	$ 57,400,000	---	$ 61,343,000	64,410,000
Part D	$ 18,600,000	---	$ 20,448,000	21,470,000
Part F – AETC	$ 8,500,000	---	$ 8,763,000	9,201,000
Part F – Dental	---	---	---	---
Total MAI Funding	$ 139,100,000	---	$ 146,055,000	$153,358,000

The Ryan White HIV/AIDS Program has developed outcome measures and other indicators that allow for ongoing monitoring of the MAI program's effectiveness. These indicators include client-level health outcomes (the MAI client-level health outcomes indicators include: improve and stabilize client CD4 counts and reduce client viral load counts), rates of kept appointments and retention in care, and the proportion of healthcare providers trained in the clinical management of HIV/AIDS who serve primarily uninsured and underinsured minority populations.

Program Performance: The HIV/AIDS Bureau has continued to demonstrate outstanding performance by improving access to healthcare, improving health outcomes, improving quality

of healthcare, and promoting efficiency. The Ryan White HIV/AIDS Program uses various strategies to achieve its performance goals, including targeting resources to high-risk areas, working to assure patient adherence, directing outreach and prevention education and testing to populations at disproportionate risk for HIV infection, tailoring services to populations known to have delayed care-seeking behaviors (e.g., by varying hours, offering care in various sites, offering linguistically and culturally appropriate services), and collaborating with other programs and providers for referrals to Ryan White HIV/AIDS Program service providers.

Improving Access to Healthcare: The Ryan White HIV/AIDS Program works to improve access to healthcare by addressing the disparities in access, treatment, and care for populations disproportionately impacted by HIV/AIDS including racial/ethnic minorities and women. The Ryan White HIV/AIDS Program provides HIV/AIDS care and treatment services to a significantly higher proportion of racial/ethnic minorities and women than their representation among AIDS cases as reported by CDC. The proportion of Ryan White clients who were racial/ethnic minorities in 2006 was 72%, compared to the 63.7% of CDC-reported AIDS cases. In 2007, 72% of the Ryan White HIV/AIDS Program clients were racial/ethnic minorities in comparison to 64.1% reported in CDC's AIDS data. In 2008, 73% of the Ryan White HIV/AIDS Program clients were racial/ethnic minorities. CDC AIDS data for comparison are not available at this time.

In 2006, 2007, and 2008, 33% of persons served by the Ryan White HIV/AIDS Program were women. This compares to 23% of CDC reported AIDS cases in both 2006 and 2007. The CDC AIDS data for the 2008 comparison are not available at this time.

Improving Health Outcomes: In FY 2008, the AIDS Drug Assistance Program (ADAP) served 175,194 clients through State ADAPs, exceeding the target. In 2007, the ADAP served 163,925 clients through State ADAPs. This can not be compared with the FY 2007 target because the actual performance is based on the revised measure using annual data and the target is based on the former measure utilizing quarterly Program data. The number of ADAP clients served through State ADAPs annually in 2008 was 11,269 persons above the 2007 (163,925) annual results. About one in four HIV positive people in care in the U.S. receive their medications through State ADAPs.

CDC estimates that 1.039 to 1.185 million people in the United States are living with HIV/AIDS, of whom an estimated 21 percent are unaware of their serostatus. The number of persons learning their serostatus from the Ryan White HIV/AIDS Program was 739,779 in FY 2008, exceeding the target by 167,382. In 2007, the number of persons who learned their serostatus from Ryan White HIV/AIDS Programs was 738,181 exceeding the target by 165,784 persons. The number of persons learning their serostatus from Ryan White HIV/AIDS Programs in 2006 was 641,866. These efforts demonstrate that the Ryan White HIV/AIDS Program has made important strides in testing people in the United States who do not know their serostatus.

Mother-to-child transmission in the U.S. has decreased dramatically since its peak in 1992 due to the use of anti-retroviral therapy which significantly reduces the risk of HIV transmission from the mother to her baby. The proportion of Ryan White HIV-positive pregnant women receiving anti-retroviral medications in 2008 was 87%, compared to 85.1% in 2007. In FY 2006, the Ryan

White HIV/AIDS Program provided 84.7% of HIV-pregnant women in the Program with anti-retroviral medications.

Improving the Quality of Healthcare: A major focus of the Ryan White HIV/AIDS Program is to improve the quality of care that its clients receive. The Ryan White HIV/AIDS Treatment Modernization Act of 2006 directed grantees to develop, implement, and monitor clinical quality management programs to ensure that service providers adhere to established HIV clinical practices and quality improvement strategies; and that demographic, clinical, and healthcare utilization information is used to monitor trends in the spectrum of HIV-related illnesses and the local epidemic. This legislative requirement continues in the Ryan White HIV/AIDS Extension Act of 2009. The proportion of new Ryan White HIV/AIDS Program-funded primary care medical providers that implemented a quality management program by 2007 was 88.8%. By 2008, 92.3% of Ryan White HIV/AIDS Program-funded primary medical care providers had implemented a quality management program, falling short of the target by 0.9 percentage points.

CD4 cell measurement is a key test used to assess the functioning of the immune system, guide decisions about when to start HIV treatment, and monitor effectiveness of HIV treatment. Viral load tests measure the amount of HIV in the blood and are used along with CD4 cell counts to decide when to start HIV treatment and to monitor response to therapy. The proportion of new Ryan White HIV/AIDS Program clients who were tested for CD4 and viral load in 2006 was: CD4 – 84.9% and Viral Load – 82.5% and in 2007 was: CD4 – 83.9% and Viral Load – 81.2%. The proportions grew in 2008 when the Ryan White HIV/AIDS Program provided CD4 count testing to 86.4% of new clients and viral load testing to 84.4% of these new clients. This exceeded of the target for CD4 tests by 0.2 percentage points and exceeded the target for viral load tests by 2.1 percentage points.

Promoting Efficiency: State ADAPs use a variety of strategies to contain costs which results in a more effective use of funding, enabling ADAPs to serve more people. Cost-containment measures used by ADAPs include: using drug purchasing strategies like seeking cost recovery through drug rebates and third party billing; and direct negotiation of pharmaceutical pricing. ADAPs' savings strategies on medications resulted in a savings of $275 million in 2005 and $258 million in 2006. In 2007, the ADAP program had cost-savings on medications of $265.2 million, exceeding the target by $4.6 million.

Program Assessment: The Ryan White HIV/AIDS Program underwent a program assessment in 2007. The assessment cited that the program has had a positive impact, has strong and effective collaborations with similar programs, and has demonstrated improved management and oversight of the use of Federal funds. As a result of the program assessment, the Program has undertaken actions that include: 1) implementing the 2006 reauthorization of the Ryan White HIV/AIDS Program and assuring that new provisions are being fulfilled appropriately, and 2) working toward client-level data reporting by the Ryan White HIV/AIDS Program beginning in 2009 to obtain accurate counts of those served with Ryan White HIV/AIDS Program funds.

Funding History

FY	Amount[1]
FY 2001	$1,832,609,000
FY 2002	$1,927,239,000
FY 2003	$2,017,966,000
FY 2004	$2,044,861,000
FY 2005	$2,073,296,000
FY 2006	$2,061,275,000
FY 2007	$2,137,795,000
FY 2008	$2,166,792,000
FY 2009	$2,238,421,000
FY 2010	$2,290,888,000

Budget Request

The FY 2011 President's Budget Request for the Ryan White HIV/AIDS Program is $2,330,390,401 and is an increase of $39,513,000 above the FY 2010 Appropriation. This increase will provide additional services to support over 2,300 providers that help half a million individuals living with HIV/AIDS obtain access to life-sustaining care and supportive services.

The Minority AIDS Initiative (MAI) budget will continue the Ryan White HIV/AIDS Program's efforts to reduce HIV/AIDS-related health disparities in communities of color, strengthen organizational capacity, and expand HIV-related services in minority communities. The MAI funds will support primary healthcare and related services; outreach and education to improve minority access to HIV/AIDS treatment medications; and targeted, multidisciplinary education and training programs for healthcare providers treating minority PLWH.

In FY 2011, the Program will continue its central goal of providing access to care for underserved populations, and improving the quality of life for those infected with HIV or affected by the epidemic. Some ongoing challenges faced in meeting performance targets include the following: many persons are unaware of their serostatus; persons who know they are infected are reluctant to seek HIV/AIDS care; medical and prescription drug costs are rising; and persons may be unaware of the availability of Ryan White HIV/AIDS Program services. To the extent possible, the Program targets resources to address these challenges.

The Program will continue to appropriately target men who have sex with men, racial/ethnic minorities and women because these groups are disproportionately impacted by HIV/AIDS. For African Americans, HIV/AIDS is a leading cause of death. With regard to women, data from the 2005 census show that together, black and Hispanic women represent 24% of all U.S. women. However, women in these 2 groups accounted for 82% of the estimated total of AIDS diagnoses

[1] Includes SPNS

for women. The FY 2011 targets for the proportion of racial/ethnic minorities and women served in Ryan White HIV/AIDS –funded programs are 5 percentage points above CDC reported national AIDS prevalence data.

In FY 2011, the Program will aim to reach the following additional performance targets. The number of clients served by ADAPs is predicted to be 153,335 clients, an increase of 3,389 individuals above FY2010. The ADAP target reflects medical inflation including rising health insurance premiums, reported decreases in state contributions and decreases in drug rebates; and increased costs of laboratory testing associated with antiretroviral use, including resistance, tropism and Human Leukocyte Antigen (HLA) testing for patients. The FY 2011 target for persons who learn their serostatus from Ryan White HIV/AIDS programs is 572,397. The FY 2011 target for the percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive anti-retroviral medication is 90%.

The budget will also support the Program's ongoing efforts to improve the quality of healthcare for PLWH. The FY 2011 target for the percentage of Ryan White HIV/AIDS Program-funded primary care providers that will have implemented a quality management program is 95.7%. The FY 2011 targets for new HIV infected clients who are tested for CD4 and for viral load are 88.2% and 84.3%, respectively.

In FY 2011, the Ryan White HIV/AIDS Program will continue to coordinate and collaborate with related Federal, State, local entities as well as national AIDS organizations in order to further leverage and promote efforts to address the unmet care and treatment needs of persons living with HIV/AIDS who are uninsured or underinsured. The Program's work in collaboration with others has been a key to its success. Federal partners include the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare and Medicaid Service, (CMS), Indian Health Service (IHS), the Department of Housing and Urban Development (HUD), the National Institutes of Health (NIH), Agency for Healthcare Research and Quality (AHRQ),the Department of Veterans Affairs (VA), and the Department of Justice (DOJ).

The Ryan White HIV/AIDS Program use its CAREWare IT investment to support its programs strategic and performance outcomes. CAREWare is free, client level software for managing, monitoring and reporting on HIV care and treatment for CARE Act grantees and providers; it contains modules for tracking demographic, service, and clinical information. CAREWare directly supports HHS strategic goals to promote up-to-date, interoperable health information technology and a software tool that allows funded agencies to rigorously monitor the quality of care that they provide.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
16.1: Number of racial/ethnic minorities and the number of women served by Ryan White HIV/AIDS-funded programs.[2] *(Outcome)*	FY 2005: 412,000/ 195,000 (Baseline)	N/A	N/A	N/A
16.I.A.1: Proportion of racial/ethnic minorities in Ryan White HIV/AIDS-funded programs served. *(Outcome)*	FY 2008: 73% (CDC= Not Yet Available For Comparison)	5 percentage points above CDC data	5 percentage points above CDC data	Maintain
16.I.A.2: Proportion of women in Ryan White HIV/AIDS funded-programs served. *(Outcome)*	FY 2008: 33% (CDC = Not Yet Available For Comparison)	5 percentage points above CDC data	5 percentage points above CDC data	Maintain
16.III.A.2: Proportion of new Ryan White HIV/AIDS Program HIV-infected clients who are tested for CD4 count and viral load. *(Output)*	FY 2008: CD4 – 86.4%Viral Load – 84.4% (Target Exceeded)	CD4 – 88.2% and Viral Load - 84.3%	CD4 - 88.2% and Viral Load - 84.3%	Maintain
16.2: Reduce deaths of persons due to HIV infection.[2] *(Outcome)*	FY 2003: 4.7 per 100,000 (Baseline)	N/A	N/A	N/A
16.II.A.1: Number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs annually. (Output)	FY 2008: 175,194 (Target Exceeded)	149,946	153,335	+3,389
16.II.A.2: Number of persons who learn their serostatus from Ryan White HIV/AIDS Programs. *(Output)*	FY 2008: 739,779 (Target Exceeded)	572,397	572,397	Maintain
16.II.A.3: Percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive anti-retroviral medications. *(Output)*	FY 2008: 87 % (Target Not Met but Improved)	90 %	90 %	Maintain
16.3: Ryan White HIV/AIDS Program-funded HIV primary medical care providers will have implemented a quality management program and will meet two "core" standards included in the October 10, 2006 "Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents". *(Output)*	FY 2005: 63.7 % (Baseline)	N/A	N/A	N/A
16.III.A.1: Percentage of Ryan White HIV/AIDS Program-funded primary medical care providers that will have implemented a quality management program. *(Output)*	FY 2008: 92.3 % (Target Not Met but Improved)	95.7 %	95.7 %	Maintain
16.E: Amount of savings by State ADAPs' participation in cost-savings strategies on medications. *(Efficiency)*	FY 2007: $265.2 M (Target Exceeded)	Sustain FY 09 results	Sustain FY 10 results	Sustain

[2] These are long-term measure s without annual targets. Long-term targets for FY2014 are as follows: 16.1 = 422,300/199,875; 16.2=3.1 per 100,000; 16.3 = 90%.

Ryan White HIV/AIDS Program, Part A Emergency Relief Grants

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	663,082,000	---	679,074,000	679,074,000	---
MAI (non add)	47,100,000	---	46,738,000	49,075,000	+2,337,000
SPNS	7,588,000	---	7,588,000	7,588,000	---
Total Funding	670,670,000	---	686,662,000	686,662,000	---

Authorizing Legislation: The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Title XXVI of the Public Health Service Act) was enacted on October 30, 2009.

FY 2011 Authorization…….……$716,074,000

Allocation Method ..... Competitive and Formula Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

Part A of the Ryan White HIV/AIDS Program prioritizes primary medical care, access to anti-retroviral therapies, and other core services as the areas of greatest need for persons with HIV disease. Part A funds may be used to provide a continuum of care for people living with HIV disease who are primarily low income, underserved, uninsured and underinsured. The grants fund systems of care to provide 13 core medical services and other additional support services for individuals with HIV/AIDS in 24 Eligible Metropolitan Areas (EMAs), which are jurisdictions with over 2,000 living AIDS cases over the last five years, and 32 transitional grant areas (TGAs) (jurisdictions with between 1,000 and 2,000 living AIDS cases over the last five years). Two-thirds of the funds available are awarded according to a formula based on the number of living cases of HIV/AIDS in the EMAs and TGAs. The statute also includes a hold harmless provision which limits a potential loss in EMA's formula award to a specific percentage of the amount of the award in the previous year. The remaining funds are awarded as discretionary supplemental grants based on the demonstration of additional need by the EMAs and TGAs and as Minority AIDS Initiative grants. The MAI grant awards are determined based on the number of minorities living with HIV and AIDS in a jurisdiction.

More than 70 percent of all people living with HIV/AIDS in the U.S. reside in metropolitan areas served by Part A. Part A serves an estimated 300,000 people living with HIV/AIDS each year. Seventy-five percent of Part A clients are people of color and 30 percent are women. In 2005, Part A provided 3.18 million visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health) and 2.89 million visits were provided in 2006. In FY 2007, 2.65 million visits were provided by 56 Part A grantees. In FY 2008, Part A

provided 2.60 million visits for health related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health). This result was 130,000 above the FY 2008 target, but was below the FY 2006 and FY 2007 results. The decrease in visits may be a result of the rising cost of care due to complexity as the population ages coupled with healthcare inflation.

Program Assessment: Part A was included in the combined program assessment conducted in 2007 for the Ryan White HIV/AIDS Program. See Summary for more details.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, technical assistance, and follow-up performance reviews.

Funding History

FY	Amount[1]
FY 2001	$604,169,000
FY 2002	$619,381,000
FY 2003	$618,693,000
FY 2004	$615,023,000
FY 2005	$610,094,000
FY 2006	$603,576,000
FY 2007	$603,993,000
FY 2008	$627,149,000
FY 2009	$663,082,000
FY 2010	$679,074,000

Budget Request

The FY 2011President's Budget Request for the Ryan White HIV/AIDS Part A Program is $679,074,000 and equals the FY 2010 Appropriation. The FY 2011 budget supports program activities and services for PLWH in the 24 Eligible Metropolitan Areas and 32 Transition Grant Areas.

The FY 2011 target for the number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health) is 2.63 million visits. Part A funding will also contribute to achieving the FY 2011 targets for the Ryan White HIV/AIDS Program's over-arching performance measures, including proportion of racial/ethnic minorities and women served, persons tested for CD4 count and viral load, and providers implementing a quality management program. (See Summary for targets and for strategies and challenges.)

[1] Excludes comparable amounts for SPNS.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
17.I.A.1: Number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative[2], and home health). (Output)	FY 2008: 2.60 M (Target Exceeded)	2.63 M	2.63 M	Maintain

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Omnibus	FY 2009 ARRA	FY 2010 Appropriation	FY 2011President's Budget Request
Number of Awards	56	---	56	56
Average Award	11,840,750	---	12,126,321	12,126,321
Range of Awards	$849,680 to $111,682,073	---	$920,000 to $111,825,000	$920,000 to $111,825,000

Part A – FY 2009 Formula & Supplemental Grants

Table 1. Eligible Metropolitan Areas

EMAs	Formula[3]	Supplemental	MAI	Total
Atlanta, GA	$ 12,224,515	$ 5,001,200	$1,366,301	$ 18,592,016
Baltimore, MD	13,826,195	6,684,049	2,259,133	22,769,377
Boston, MA	9,091,554	3,359,633	845,424	13,296,611
Chicago, IL	17,524,988	7,924,815	1,938,755	27,388,558
Dallas, TX	9,654,841	3,980,731	864,951	14,500,523
Detroit, MI	5,649,097	2,470,410	686,595	8,806,102
Ft. Lauderdale, FL	9,444,694	4,618,155	1,126,643	15,189,492
Houston, TX	12,781,667	5,769,956	1,668,287	20,219,910
Los Angeles, CA	24,264,522	11,645,920	2,829,687	38,740,129
Miami, FL	16,015,311	7,625,037	2,537,378	26,177,726
Nassau-Suffolk, NY	4,091,917	2,488,880	367,849	6,948,646
New Haven, ,CT	4,604,295	2,486,468	374,153	7,464,916
New Orleans, LA	4,944,359	2,204,315	542,609	7,691,283
New York, NY	74,871,159	27,258,256	9,552,658	111,682,073
Newark, NJ	9,090,344	3,872,688	1,294,597	14,257,629
Orlando, FL	5,503,874	2,101,271	633,168	8,238,313

[2] Beginning in 2007 this constitutes Home and Community Based Services.
[3] EMAs Hold Harmless Amount is included in their Formula Award, and TGAs are not eligible for Hold Harmless

EMAs Formul	a[3]	Supplemen tal	MAI	Total
Philadelphia, PA	14,921,528	6,764,746	1,962,331	23,648,605
Phoenix, AZ	5,367,535	2,306,095	227,940	7,901,570
San Diego, CA	7,463,078	3,359,450	605,277	11,427,805
San Francisco, CA	14,672,553	11,598,327	764,443	27,035,323
San Juan, PR	9,415,738	3,049,098	853,542	13,318,378
Tampa-St. Petersburg, FL	6,330,428	2,730,424	558,209	9,619,061
Washington, DC	18,764,167	8,325,477	2,212,565	29,302,209
West Palm Beach, FL	5,769,721	2,238,403	566,510	8,574,634
Total	**$ 316,288,080**	**$139,863,804**	**$36,639,005**	**$ 492,790,889**

Table 2. Transitional Grant Areas

TGAs	Formula	Supplemental[4]	MAI	Total
Austin, TX	$ 2,831,277	$ 1,247,462	$255,151	$ 4,333,890
Baton Rouge, LA	2,600,647	1,039,963	267,271	3,907,881
Bergen-Passaic, NJ	2,803,574	1,385,432	293,903	4,482,909
Caguas, PR	861,573	735,589	136,904	1,734,066
Charlotte-Gastonia, NC-SC	3,480,226	1,477,321	406,274	5,363,821
Cleveland, OH	2,893,609	1,241,449	318,451	4,453,509
Denver, CO	5,508,106	2,245,671	289,304	8,043,081
Dutchess County, NY	869,191	433,002	115,310	1,417,503
Ft. Worth, TX	2,714,230	1,191,841	224,163	4,130,234
Hartford, CT	2,527,926	1,999,455	284,433	4,811,814
Indianapolis, IN	2,642,201	1,073,468	203,686	3,919,355
Jacksonville, FL	3,559,181	1,567,483	412,019	5,538,683
Jersey City, NJ	3,250,981	1,462,716	434,312	5,148,009
Kansas City, MO	3,007,885	1,361,258	208,714	4,577,857
Las Vegas, NV	3,969,189	1,527,085	257,354	5,753,628
Memphis, TN	4,230,986	1,726,365	599,772	6,557,123
Middlesex-Somerset-Hunterdon, NJ	1,838,114	548,741	170,620	2,557,475
Minneapolis-St. Paul, MN	3,557,795	1,529,213	298,416	5,385,424
Nashville, TN	2,944,168	1,262,143	217,794	4,424,105
Norfolk, VA	3,935,253	1,615,710	398,008	5,948,971
Oakland, CA	3,981,744	1,851,265	433,298	6,266,307
Orange County, CA	3,555,462	1,636,583	342,231	5,534,276

[4] Supplemental Priority Amount is included in TGA's Supplemental Awards.

TGAs Formul	a	Supplemental[4]	MAI	Total
Ponce, PR	1,383,780	678,753	173,194	2,235,727
Portland, OR	2,337,312	1,166,579	91,025	3,594,916
Riverside-San Bernardino, CA	4,691,771	2,461,422	290,114	7,443,307
Sacramento, CA	1,612,546	954,843	114,073	2,681,462
St. Louis, MO	4,152,724	1,438,729	413,715	6,005,168
San Antonio, TX	2,963,560	1,241,394	294,274	4,499,228
San Jose, CA	1,739,099	733,048	162,795	2,634,942
Santa Rosa, CA	767,974	349,983	50,000	1,167,957
Seattle, WA	4,857,081	2,104,199	265,369	7,226,649
Vineland-Millville-Bridgeton, NJ	579,000	202,046	68,634	849,680
Subtotal	**$ 92,648,165**	**$ 41,490,211**	**8,490,581**	**$ 142,628,957**
Total EMAs/TGAs	**$ 408,936,245**	**$ 181,354,015**	**$ 45,129,586**	**$ 635,419,846**

Note – EMAs are eligible for priority funding.

Ryan White HIV/AIDS Program, Part B HIV Care Grants to States

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	1,223,791,000	---	1,253,791,000	1,283,791,000	+30,000,000
ADAP (non add)	*815,000,000*	---	*835,000,000*	*855,000,000*	*+20,000,000*
MAI (non add)	*7,500,000*	---	*8,763,000*	*9,202,000*	*+439,000*
SPNS	14,077,000	---	14,077,000	14,077,000	---
Total Funding	1,237,868,000	---	1,267,868,000	1,297,868,000	+30,000,000

Authorizing Legislation: The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Title XXVI of the Public Health Service Act) was enacted on October 30, 2009.

FY 2011 Authorization……$1,416,933,000

Allocation Method ..... Competitive and Formula Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

Part B of the Ryan White HIV/AIDS Program provides grants to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam and 5 Pacific jurisdictions to provide services for people living with HIV/AIDS, including outpatient medical care, oral healthcare, home- and community-based services, continuation of health insurance coverage, prescription drugs, HIV care consortia, and support services. Part B includes the AIDS Drug Assistance Program (ADAP), which supports the provision of HIV medications and related services. Seventy-five percent of Part B funds must be used to support 13 core medical services. Part B funds are distributed through base and supplemental grants, ADAP and ADAP supplemental grants, Emerging Communities (ECs) grants, and Minority AIDS Initiative grants**.** Additionally**,** the statute includes a hold harmless provision which limits a potential loss in State's award to a specific percentage of the amount of the award in the previous year. In the case of FY 2008 and 2009, the amount was 100%. The base awards are distributed by a formula based on a state or territory's living HIV/AIDS cases weighted for cases outside of Part A-funded jurisdictions. Supplemental awards are available to states with demonstrated need. Emerging communities are metropolitan areas that do not qualify as EMAs or TGAs but have 500-999 cumulative reported AIDS cases over the last five years and apply for supplemental funding through a grant application.

Congress designates a portion of the Part B award to support ADAP. The AIDS Drug Assistance Programs (ADAPs) provide FDA-approved, prescription medications for people with HIV/AIDS who have limited or no prescription drug coverage. The majority of ADAP funds are also distributed by a formula based on living HIV/AIDS cases, although 5% of the funds are set aside for states with severe need. ADAP funds also may be used to purchase health insurance for eligible clients or to pay for services that enhance access, adherence, and monitoring of drug treatments. Individual ADAPs operate in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, Commonwealth of the Northern Mariana Islands, and the Republic of the Marshall Islands.

The Part B programs have been successful in helping to ensure that people living with HIV/AIDS can get the care and services they need to stay healthy longer. The number of visits for health-related services demonstrates the effectiveness of the Part B program in delivering primary care and related services for individuals infected with HIV by increasing the availability and accessibility of care. Part B programs provided 2.34 million visits in 2005, 2.12 million visits in 2006, and 2.06 million visits in FY 2007. In FY 2008, Part B provided 2.02 million visits for health-related care, which fell short of the target by 120,000 visits. This was a decrease from FY 2006 to FY 2008. The decrease is most likely a result of 2 factors: 1) the decline in Program resources available for funding service provision, which resulted in fewer providers and fewer clients served; and 2) the impact of healthcare inflation. ADAP served 157,988 clients in 2006. In FY 2007, 163,925 clients were served through State ADAPs, exceeding the target. Sixty-five percent of those served by ADAPS are people of color. Nationally, more than 78 percent of ADAP clients have incomes at or below 200 percent of the federal poverty level.

Program Assessment: Part B was included in the combined program assessment conducted in 2007 for the Ryan White HIV/AIDS Program. See Summary for more details.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, technical assistance and follow-up performance reviews.

Funding History

FY	Amount[1]	ADAP-Non-Add
FY 2001	$910,969,000	($589,000,000)
FY 2002	$977,240,000	($639,000,000)
FY 2003	$1,053,393,000	($714,326,000)
FY 2004	$1,085,900,000	($748,872,000)
FY 2005	$1,121,836,000	($787,521,000)
FY 2006	$1,119,744,000	($789,005,000)
FY 2007	$1,195,500,000	($789,546,000)
FY 2008	$1,195,248,000	($794,376,000)[2]
FY 2009	$1,223,791,000	($815,000,000)[3]
FY 2010	$1,253,791,000	($835,000,000)

Budget Request

The FY 2011 President's Budget Request for the Ryan White HIV/AIDS Part B Program is $1,283,791,000 which is a $30,000,000 increase over the FY 2010 Appropriation. The budget supports program activities and includes the provision life-saving medications to persons living with HIV and base formula HIV grants for the provision of services in the fifty States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam and five Pacific jurisdictions.

The FY 2011 ADAP Budget Request of $855,000,000 is an increase of $20,000,000 above the FY 2010 Appropriation. The FY 2011 target for clients served by ADAP is 153,335 providing services to an additional 3,389 individuals above FY 2010. HRSA has developed a model for estimating the marginal cost of serving ADAP clients. The model takes into account many of the factors affecting purchasing power, such as increases in cost of HIV/AIDS drugs; the legislative requirement that all State ADAPs maintain a minimum drug formulary, including new drug classes; and the impact of Medicare Part D, rebates, and insurance coverage. The marginal cost model informs the Program's projected target for number of ADAP clients in 2011. Part B funding will also contribute to achieving the FY 2011 targets for the Ryan White Program's over-arching performance measures, including proportion of racial/ethnic minorities and women served, persons tested for CD4 count and viral load, and providers implementing a quality management program. (See Summary for targets and for strategies and challenges.)

[1] Excludes comparable amounts for SPNS.
[2] FY 2008 actual expenditure was $813,858,028 due to the hold harmless provision. For FY 2008, the statute requires that the grant not be less than 100% of the FY 2007 total grant.
[3] FY 2009 actual expenditure was $820,900,839 due to the Part B statutory required hold harmless provision. For FY 2009, the statute required that the grant not be less than 100% of the FY 2007 total grant.

Outcomes and Outputs Table

Measure	Most Recent Result	FY2010 Target	FY2011 Target	FY 2011 +/- FY 2010
18.I.A.1: Number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative,[4] and home health). *(Output)*	FY 2008: 2.02 M (Target Not Met)	2.19 M	2.19 M	Maintain

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Omnibus	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 Request
Number of Awards	59		59	59
Average Award	$20,742,220		$21,250,695	$21,759,169
Range of Awards	$27,489 to $167,972,494		$60,000 to $180,000,000	$60,250 to $180,250,000

FY 2009 Total Table

FY 2009 Estimate[5, 6, 7, 8]	FY 2009 ARRA	FY 2010 President's Budget [5, 7, 8, 9]	FY 2011 Estimate [5, 7, 8, 9]	Difference +/- 2011
$1,223,791,000		$1,253,791,000	$1,283,791,000	+$30,000,000

[4] Beginning in 2007 this constitutes Home and Community Based Services.
[5] Total includes AIDS Drug Assistance Program (ADAP) and Base Formula awards, and Competitive ADAP Supplemental and Minority AIDS Initiative (MAI) award amounts.
[6] Fiscal Year 2009 grant amounts pending MAI grant amounts award calculations in August 2009.
[7] Total State Grants include or would include amounts for AIDS Drug Assistance Programs as follows:
FY 2009 $815,000,000 (excludes 5% setaside for severe need supplemental)
FY 2010 $835,000,000 (excludes 5% setaside for severe need supplemental)
FY 2011 $855,000,000 (excludes 5% setaside for severe need supplemental)
[8] Includes amount for technical assistance to Ryan White Program grantees and program evaluation.
[9] Fiscal Year 2010 grant amounts pending award calculations in March 2010. Fiscal Year 2011 grant amounts pending award calculations in March 2011.

FY 2009 State Table

State/Territory	FY 2009 Base	FY 2009 ADAP Total	Emerging Communities	FY 2009 MAI	Grand Total
Alabama	8,110,043	10,961,499	288,236	114,884	19,474,662
Alaska	500,000	686,621	-		1,186,621
American Samoa [10]	31,280	2,803	-		34,083
Arizona [10]	3,681,064	11,624,545	-		15,305,609
Arkansas [10]	3,244,608	4,174,689	-		7,419,297
California	33,993,169	94,104,451	165,802	976,189	129,239,611
Colorado [10]	2,733,770	9,612,191	-	38,229	12,384,190
Connecticut	3,410,512	11,550,284	-	96,326	15,057,122
Delaware [10]	2,387,325	2,664,690	220,343	4,722	5,277,080
District of Columbia	4,411,353	14,429,241	-	225,860	19,066,454
F. States Micronesia [10]	31,475	7,475	-		38,950
Florida	32,193,826	83,621,697	453,660	1,115,994	117,385,177
Georgia	11,208,160	31,475,700	177,070	350,541	43,211,471
Guam [10]	147,025	91,084	-		238,109
Hawaii	1,239,296	2,427,295	-		3,666,591
Idaho [10]	491,748	741,062	-		1,232,810
Illinois	9,126,346	29,009,556	-	79,825	38,215,727
Indiana	3,720,591	9,078,290	-		12,798,881
Iowa	1,237,264	1,720,997	-		2,958,261
Kansas	1,190,196	2,456,542	-		3,646,738
Kentucky	3,532,873	4,562,107	212,295		8,307,275
Louisiana	6,266,733	17,993,874	-	148,176	24,408,783
Maine [10]	755,069	866,121	-	2,545	1,623,735
Marshall Islands [10]	22,002	2,968	-		24,970
Maryland	8,613,844	27,869,094	-	338,171	36,821,109
Massachusetts	5,023,954	14,865,398	-		19,889,352
Michigan	5,126,913	12,219,172	-	152,429	17,498,514
Minnesota	1,917,992	5,444,759	-	30,218	7,392,969
Mississippi	6,409,650	7,610,703	285,111		14,305,464
Missouri	3,926,854	10,102,752	-	74,859	14,104,465
Montana	500,000	361,090	-		861,090
N. Marianas [10]	39,681	5,606	-		45,287

State/Territory	FY 2009 Base	FY 2009 ADAP Total	Emerging Communities	FY 2009 MAI	Grand Total
Nebraska [10]	883,389	1,626,559	-		2,509,948
Nevada	2,258,756	6,224,050	-		8,482,806
New Hampshire	503,035	999,945	-		1,502,980
New Jersey	12,301,766	33,279,285	-	414,054	45,995,105
New Mexico	1,822,033	2,243,691	-		4,065,724
New York	41,134,549	126,168,109	669,836	1,530,253	169,502,747
North Carolina	10,835,858	23,920,644	247,519		35,004,021
North Dakota	200,000	150,440	-		350,440
Ohio [10]	6,593,531	13,805,298	624,290	65,920	21,089,039
Oklahoma	3,808,981	5,101,885	208,033		9,118,899
Oregon	1,679,202	5,204,101	-		6,883,303
Pennsylvania [10]	11,959,136	16,341,059	260,965		28,561,160
Puerto Rico	10,023,481	24,008,337	-	163,411	34,195,229
Republic Of Palau [10]	43,567	-	-		43,567
Rhode Island	1,175,163	2,102,115	203,015		3,480,293
South Carolina	11,815,712	15,922,450	366,070	179,768	28,284,000
South Dakota	500,000	329,844	-		829,844
Tennessee	5,646,681	12,945,202	-	139,592	18,731,475
Texas	21,882,767	67,359,999	-	654,796	89,897,562
Utah	1,707,728	2,492,188	-		4,199,916
Vermont	500,000	413,006	-		913,006
Virgin Islands	191,799	517,680	-	,	709,479
Virginia	7,539,635	20,737,520	371,467	218,086	28,866,708
Washington	3,726,130	9,487,916	-	39,015	13,253,061
West Virginia	1,082,833	1,374,271	-		2,457,104
Wisconsin	3,830,426	5,222,988	246,288	43,299	9,343,001
Wyoming	500,000	193,421	-	-	693,421
Total	**329,370,774**	**820,516,359**	**5,000,000**	**7,197,162**	**1,162,084,295**

Ryan White HIV/AIDS Program, Part C Early Intervention Services

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	201,877,000	---	206,823,000	211,877,000	+5,054,000
SPNS	2,433,000	---	2,433,000	2,433,000	---
Total Funding	204,320,000	---	209,266,000	214,320,000	+5,054,000
FTE	27	---	30	30	---

Authorizing Legislation: The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Title XXVI of the Public Health Service Act) was enacted on October 30, 2009.

FY 2011 Authorization……..$259,198,000

Allocation Method ..... Competitive Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

Part C of the Ryan White HIV/AIDS Program provides direct grants to 353 community and faith based primary health clinics and public health providers in 49 states, Puerto Rico, the District of Columbia, and the US Virgin Islands. Part C programs are the primary means for targeting HIV medical services to underserved and uninsured people living with HIV/AIDS in the nation's rural and frontier communities. Part C programs target the most vulnerable communities, including people of color, women, and low-income populations. Seventy-nine percent of those served are people of color and 30 percent are female. In addition, Part C providers are central to the nation's HIV testing initiatives, providing HIV counseling and testing to more than 634,996 people each year.

The 2005 results showed 216,591 clients were served by the Early Intervention Services program, in 2006 225,410 clients were served, and 236,745 clients were provided Early Intervention Services in 2007. The number of persons receiving primary care services under Early Intervention Services programs, in FY 2008 was 247,133, exceeding the target by 12% and representing an increase of 4% in clients served compared to FY 2007.

Program Assessment: Part C was included in the combined program assessment conducted in 2007 for the Ryan White HIV/AIDS Program. See Summary for more details.

Funding includes costs associated with 30 FTEs, grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, technical assistance and follow-up performance reviews.

Funding History

FY	Amount[1]
FY 2001	$185,879,000
FY 2002	$185,879,000
FY 2003	$198,374,000
FY 2004	$197,170,000
FY 2005	$195,578,000
FY 2006	$193,488,000
FY 2007	$193,721,000
FY 2008	$198,754,000
FY 2009	$201,877,000
FY 2010	$206,823,000

Budget Request

The FY 2011 President's Budget Request for the Ryan White HIV/AIDS Part C Program of $211,877,000 is an increase of $5,054,000 above the FY 2010 Appropriation. The FY 2011 President's Budget Request will continue to support persons receiving primary care services under the Early Intervention Services programs for 241,885 PLWH at the 353 currently funded Part C programs.

The FY 2011 target for the number of people receiving primary care services under Early Intervention Services programs is 241,885. Part C funding will also contribute to achieving the FY 2011 targets for the Ryan White HIV/AIDS Program's over-arching performance measures including, proportion of racial/ethnic minorities and women served, persons learning of their serostatus from Ryan White programs, persons tested for CD4 count and viral load, and providers implementing a quality management program. (See Summary for targets and for strategies and challenges.)

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
19.II.A.1: Number of people receiving primary care services under Early Intervention Services programs. *(Output)*	FY 2008: 247,133 (Target Exceeded)	240,666	241,885	+1,219

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Omnibus	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget Request
Number of Awards	353		353	353
Average Award	$571,890		$585,900	$600,218
Range of Awards	$15,000 to $1,200,000		$15,000 to $1,200,000	$15,000 to $1,200,000

Ryan White HIV/AIDS Program, Part D Women, Infants, Children and Youth

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	76,845,000	---	77,787,000	77,787,000	---
SPNS	902,000	---	902,000	902,000	---
Total Funding	77,747,000	---	78,689,000	78,689,000	---

Authorizing Legislation: The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Title XXVI of the Public Health Service Act) was enacted on October 30, 2009.

FY 2011 Authorization……$79,160,000

Allocation Method ..... Competitive Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

The Part D program focuses on providing coordinated family-centered access to primary medical care and support services for HIV-infected women, infants, children, and youth (WICY). It also funds support services, like case management and childcare that help clients get the care they need. Currently, there are 80 WICY and 17 adolescent Part D programs in 33 states, the District of Columbia, Puerto Rico, and the Virgin Islands.

Eligible organizations are public or private nonprofit entities that provide or arrange for primary care for HIV-positive women, infants, children, and youth. Organizations include State and local governments, and Indian Tribes or tribal organizations.

The number of female clients served in FY 2008 in the Part D Program who were provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission was 57,773. The number exceeded the FY 2008 target by 5,467 clients or 9.4%. In 2007, Part D provided services to 81,462 total clients, 71 percent of whom were HIV infected. Of the clients with known race/ethnicity, the majority (86 percent) were members of racial/ethnic minority groups. Seventy percent of all clients served were females.

Part D served 52,306 female clients in 2005 and 49,701 female clients in 2006. In FY 2007, Part D provided 48,485 females with comprehensive services, including appropriate services before and during pregnancy, to reduce perinatal transmission.

Program Assessment: Part D was included in the combined program assessment conducted in 2007 for the Ryan White HIV/AIDS Program. See Summary for more details.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, technical assistance and follow-up performance reviews.

Funding History

FY	Amount[1]
FY 2001	$64,995,000
FY 2002	$70,964,000
FY 2003	$73,551,000
FY 2004	$73,108,000
FY 2005	$72,519,000
FY 2006	$71,744,000
FY 2007	$71,794,000
FY 2008	$73,690,000
FY 2009	$76,845,000
FY 2010	$77,787,000

Budget Request

The FY 2011 President's Budget Request for the Ryan White HIV/AIDS Part D Program is $77,787,000 to maintain current service levels. The FY 2011 President's Budget Request equals the FY 2010 Appropriation. The funding will help to sustain primary healthcare and social support services available to over 91,000 women, infants, children and youth living with HIV and AIDS and their affected families at programs in 34 States, D.C., Puerto Rico and Virgin Islands.

The FY 2011 target for the number of female clients provided comprehensive services through Part D including appropriate services before or during pregnancy to reduce perinatal transmission is 51,937. Part D funding will also contribute to achieving the FY 2011 targets for the Ryan White Program's over-arching performance measures including, proportion of racial/ethnic minorities and women served, HIV-positive women who receive anti-retroviral medications, persons tested for CD4 count and viral load, and providers implementing a quality management program. (See Summary for targets and for strategies and challenges.)

[1] Excludes comparable amounts for SPNS.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
20.II.A.1: Number of female clients[2] provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission. (Output)	FY 2008: 57,773 (Target Exceeded)	51,316	51,937	+621

Grant Awards Table

Size of Award

(whole dollars)	FY 2009 Omnibus	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 Request
Number of Awards	90		97	97
Average Award	$462,961		$468,000	$468,000
Range of Awards	$9,444 to $2,344,396		$9,444 to $2,364,000	$9,444 to $2,364,000

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

Ryan White HIV/AIDS Program, Part F: AIDS Education and Training Programs

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	34,397,000	---	34,819,000	37,443,000	+2,624,000
SPNS	---	---	---	---	---
Total Funding	34,397,000	---	34,819,000	37,443,000	+2,624,000

Authorizing Legislation: The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Title XXVI of the Public Health Service Act) was enacted on October 30, 2009.

FY 2011 Authorization……..….$38,257,000

Allocation Method ..... Competitive Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

The AETCs—a network of 11 regional centers with more than 130 local performance sites and four national centers—offer specialized clinical education and consultation on HIV/AIDS transmission, treatment, and prevention to front-line healthcare providers, including physicians, nurses, physician assistants, dentists and pharmacists. The clinical management of HIV/AIDS, particularly the use of highly-active antiretroviral therapy (HAART) is the central focus of training. The AETCs target training to providers who serve minority populations, the homeless, rural communities, incarcerated persons, federally qualified community and migrant health centers, and Ryan White HIV/AIDS Program sites. AETC-trained providers are more competent with regard to HIV issues and more willing to treat persons living with HIV than other primary care providers. The AETCs provide education in a variety of formats including skills building workshops, hands-on preceptor ships 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.

During the period July 1, 2007 and June 30, 2008, AETCs conducted 18,472 training sessions with a total of 150,695 trainees.

Forty-three percent of the AETC program training interventions were provided to racial/ethnic minorities in 2005. In FY 2006, the proportion of racial/ethnic minority healthcare providers among persons participating in the AETC training interventions programs was 44%. The 2007 results show the AETC program training interventions comprised 43% racial/ethnic minorities which met the target. Additional examination of the AETC data shows that 64.9% of healthcare

providers participating in the AETC training programs in 2007 primarily served racial/ethnic minority patients.

Program Assessment: The AETC program was included in the combined program assessment conducted in 2007 for the Ryan White HIV/AIDS Program. See Summary for more details.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, technical assistance and follow-up performance reviews.

Funding History

FY	Amount
FY 2001	$31,598,000
FY 2002	$35,282,000
FY 2003	$35,550,000
FY 2004	$35,335,000
FY 2005	$35,051,000
FY 2006	$34,646,000
FY 2007	$34,701,000
FY 2008	$34,094,000
FY 2009	$34,397,000
FY 2010	$34,819,000

Budget Request

The FY 2011 President's Budget Request for the Ryan White HIV/AIDS AETC Program is $37,443,000. It represents a $2,624,000 increase compared to the FY 2010 Appropriation. The AETCs are an important part of the Ryan White HIV/AIDS Program and play a vital role in ensuring the highest quality of care among providers. HRSA will continue to prioritize for the AETCs interactive training that demonstrates effectiveness to change provider behavior. This funding will help meet the program's performance goal to, "Maintain the proportion of racial/ethnic minority healthcare providers participating in the AETC intervention programs". The FY 2011 target for the proportion of racial/ethnic minority healthcare providers participating in AETC training interventions is set at 43%.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
21.V.B.1: Proportion of racial/ethnic minority healthcare providers participating in AETC training intervention programs. *(Output)*	FY 2007: 43 % (Target Met)	43 %	43 %	Maintain

Grant Awards Table

Size of Awards

(whole dollars)	**FY 2009 Omnibus**	**FY 2009 ARRA**	**FY 2010 Appropriation**	**FY 2011 President's Budget**
Number of Awards	15		16	16
Average Award	$2,488,821		$2,176,188	$2,340,188
Range of Awards	$800,647 to $5,229,437		$800,647 to $5,229,437	$800,647 to $5,229,437

Ryan White HIV/AIDS Program, Part F: Dental Reimbursement Program

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	13,429,000	---	13,594,000	15,429,000	+1,835,000
SPNS	----	---	---	---	---
Total Funding	13,429,000	---	13,594,000	15,429,000	+1,835,000

Authorizing Legislation: The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Title XXVI of the Public Health Service Act) was enacted on October 30, 2009.

FY 2011 Authorization……..…..$14,333,000

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The HIV/AIDS Dental Reimbursement Program provides access to oral healthcare for people living with HIV/AIDS by reimbursing dental education programs for the nonreimbursed costs they incur providing such care. By offsetting the costs of non-reimbursed HIV care in dental education institutions, the Dental Reimbursement Program improves access to oral healthcare for people living with HIV and trains dental and dental hygiene students and dental residents to provide oral healthcare services to people living with HIV. The care provided through the program includes a 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 educations programs. Dental schools, post-doctoral dental education programs, and dental hygiene education programs accredited by the Commission on Dental Accreditation that have documented non-reimbursed costs for providing oral healthcare to people living with HIV are eligible to apply for reimbursement. Funds are then distributed to eligible organizations taking into account the number of people served and the cost of providing care.

Dental Reimbursement Program

Programs	FY 2009 Enacted	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget
Dental Reimbursement Program	$9,046,000	---	$9,046,000	$9,046,000
Community-Based Dental Partnership Program	$4,383,000	---	$4,548,000	$6,383,000

In FY 2008, the Dental Reimbursement Program awards met 34.6% of the total non-reimbursed costs reported by 64 participating institutions in support of oral healthcare. These institutions reported providing care to 36,193 HIV-positive individuals, for whom no other funded source was available. This number exceeded the goal by 1,799 individuals or 5.2%. This represents a 10.3% increase from FY 2007 for persons whom a portion/percentage of their unreimbursed oral health costs was reimbursed. The Community Dental Partnership Program funded 12 partnership grants to collaborate and coordinate between the dental education programs and the community-based partners in the delivery of oral health services. Community-Based Dental Partnership grants are intended for a period of up to three years. In FY 2008, the demographic characteristics of patients who were cared for by institutions participating in the DRP were: 34% women, 59.1% minority. Therefore, the DRP served a higher proportion of women than the representation of women among all AIDS cases in the nation, as reported by CDC. CDC reports 23% of AIDS cases in 2007 were among women and 64.1% of AIDS cases were among racial/ethnic minorities.

Program Assessment: The Dental Reimbursement Program was included in the combined program assessment conducted in 2007 for the Ryan White HIV/AIDS Program. See Summary of Request for more details.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, technical assistance and follow-up performance reviews.

Funding History

FY	Amount
FY 2001	$9,999,000
FY 2002	$13,493,000
FY 2003	$13,405,000
FY 2004	$13,325,000
FY 2005	$13,218,000
FY 2006	$13,077,000
FY 2007	$13,086,000
FY 2008	$12,857,000
FY 2009	$13,429,000
FY 2010	$13,594,000

Budget Request

The FY 2011 President's Budget Request for the Ryan White HIV/AIDS Dental Service Programs is $15,429,000. It represents an increase of $1,835,000 compared to the FY 2010 Appropriation. These funds will continue to support the reimbursement of applicant institutions, outreach to people with HIV/AIDS who need dental care, and continued efforts to improve service coordination among reimbursement recipients and other community-based health service providers. In addition, the increase will support 4 new community based dental partnership programs. The FY 2011 target for the number of persons for whom a portion of their unreimbursed oral health costs will be reimbursed is 33,508.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
22.I.D.1: Number of persons for whom a portion/ percentage of their unreimbursed oral health cost were reimbursed. *(Output)*	FY 2008: 36,193 (Target Exceeded)	33,508	33,508	Maintain

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Omnibus	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Budget
Number of Awards	77		81	85
Average Award	$174,000		$167,827	$190,000
Range of Awards	$411 to $826,000		$411 to $826,000	$411 to $826,000

Organ Transplantation

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$24,049,000	---	$26,049,000	$26,049,000	---
FTE	---	---	---	---	---

Authorizing Legislation - Sections 371 - 378 of the Public Health Service Act, (P.L. 98-507 and P.L. 108-216), as amended.

FY 2011 Authorization ..... Expired

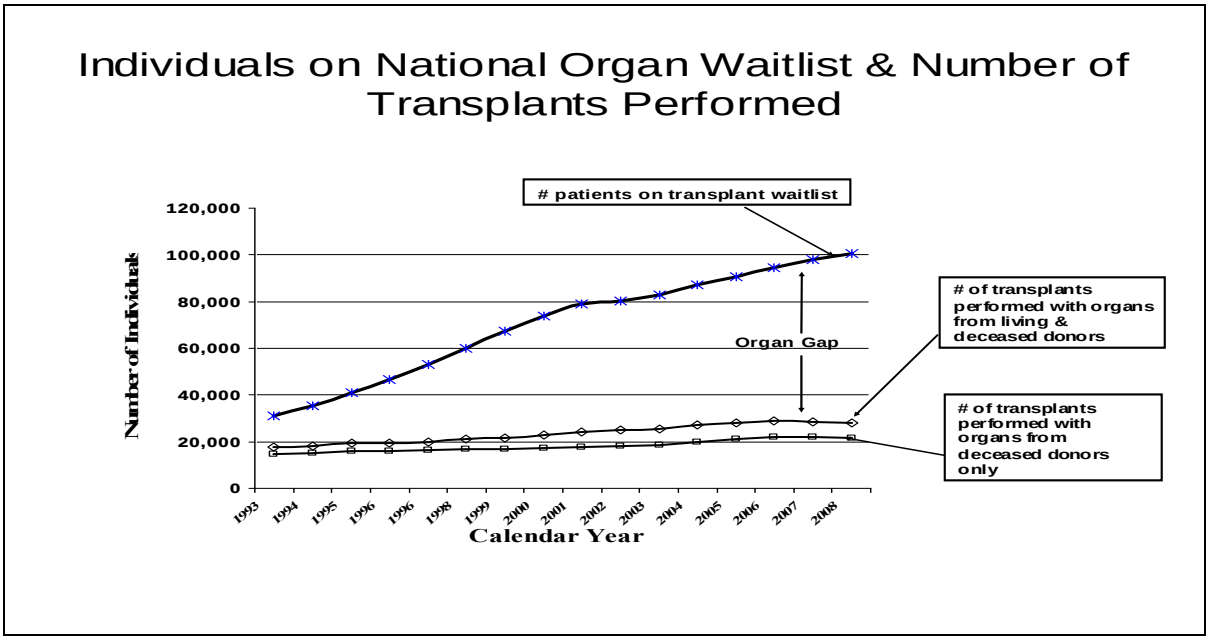
Allocation Method ..... Contracts, Competitive Grants and Cooperative Agreements

Program Description and Accomplishments

The National Organ Transplant Act of 1984 (NOTA), as amended, provides the authorities for the Program. The primary purpose of the Program is to extend and enhance the lives of individuals with end-stage organ failure for whom an organ transplant is the most appropriate therapeutic treatment. The Program works towards achieving this goal by providing for a national system, the Organ Procurement and Transplantation Network (OPTN), to allocate and distribute donor organs to individuals waiting for an organ transplant. The allocation of organs is guided by organ allocation policies developed by the OPTN with analytic support provided by the Scientific Registry of Transplant Recipients (SRTR). In addition to the efficient and effective allocation of donor organs through the OPTN, the Program also supports efforts to increase the supply of donor organs made available for transplantation.

Ideally, an organ would be available for every transplant candidate at the time the procedure would provide maximum benefit to the patient. Unfortunately, the demand for organ transplantation greatly exceeds the available supply of organs from deceased and living donors combined (see Figure 1). This trend is anticipated to continue, unless there is a major breakthrough in transplantation technology that will obviate the need for donor organs or the incidence of end-stage organ failure in the U.S. dramatically declines. At the end of 2008, there were 100,775 patients listed on the waiting list. Tragically, 6,453 individuals died, approximately 18 per day, in 2008, while waiting for a donor organ.

Figure 1. Individuals on National Organ Waitlist & Number of Transplants Performed



In an effort to develop more clearly-defined and targeted strategies to increase the number of deceased donor organs available for transplantation, the Program first identified the number of deaths that occur annually that could result in organ donation. Criteria were established to define an 'eligible donor'. An 'eligible donor' is defined as any heart-beating individual meeting the criteria for neurological death, age 70 years or under, who has not been diagnosed with exclusionary medical conditions published by the OPTN. The OPTN started collecting eligible donor data from organ procurement organizations in 2002. In 2004, after one year of data collection, the number of eligible donors was reported to be 12,000. This number, along with an estimate of the number of donors based on cessation of circulatory function (commonly referred to as cardiac-death donors), which was estimated to be 10 percent of the number of deceased donors annually, served as the basis for estimating donor potential and the performance goal for increasing the number of deceased donor organs transplanted.

Recent data indicate that the estimated number of eligible donors continues to decline. As of the end of 2008, there were 9,860 eligible donors. While the possible causes of this decline are complex, HRSA believes that the decline in the number of eligible donors can in part be attributed to an aging population, increasing rates of diseases and morbidities, such as diabetes and hypertension, and a reduction in the number of deaths that occur in hospitals. In FY 2010, HRSA will fund a study through a competitive contracting process to ascertain potential deceased donor availability for the next 5 years. In FY 2011, HRSA will fund a follow-up study to assist the Program in working with the organ donation and transplant community to develop strategies for maximizing the number of deceased donor organs made available for transplantation.

The Program established measurable goals for maximizing the number of deceased donor organs made available for transplantation and for maximizing patient outcomes. These Program goals are summarized by two overarching measures: (1) increase the number of deceased donor organs transplanted; and (2) increase the total expected life-years gained for kidney transplant recipients in the first five years after the transplant compared to what would be expected for these recipients had they remained on the waiting list.

The long-term goal is to increase the number of deceased organs transplanted to 33,473 by FY 2013. This goal is based on converting an increasing percentage of the estimated annual number of deaths that meet 'eligible donor' criteria to actual donors and increasing percentage of cardiac death donors to 10 percent of total donors by FY 2013. In FY 2008, 23,933 deceased donor organs were transplanted, 9 percent below target of 26,314 deceased donor organs transplanted. It represents a 1 percent decrease from FY 2007. After reaching a record level of 24,461 deceased organs transplanted, the number of deceased organs transplanted has decreased slightly each of the past two years. The FY 2008 number still represents a 17.4 percent increase above the FY 2003 baseline. The decrease in the number of eligible donors is the major factor in the target not being met. While the number of eligible donors has been declining, the conversion of eligible donors to actual donors has remained relatively constant. In contrast, in FY 2003, the year prior to when the performance target for the number of deceased donor organs transplanted was established the conversion rate was 52 percent.

The improvements since 2003 in the number of deceased donor organs transplanted can be largely attributed to the highly successful series of Breakthrough Collaboratives. The Breakthrough Collaboratives apply a proven methodology, established by the Institute for Healthcare Improvement (IHI), to successfully generate and sustain improvements in healthcare systems. The initial Collaborative, *the Organ Donation Breakthrough Collaborative*, was initiated in September of 2003 and established a goal of increasing the organ donation conversion rate from 50 percent to 75 percent by FY 2013. A conversion rate is the number of organ donors meeting eligible donor criteria divided by the number of deaths that meet eligible donor criteria. HRSA partnered with the Nation's 58 OPOs and donor hospitals having the highest number of eligible donors to test and implement changes to achieve this goal. As a result of this effective collaboration, the conversion rate for FY 2008 was 66.5 percent. Since the initiation of *the Organ Breakthrough Collaborative* in FY 2003, the conversation rate has increased by 33 percent. HRSA is continuing to work with the organ donation and transplant community to develop an infrastructure to sustain and improve on the increases in the number of deceased donor organs transplanted. This infrastructure will consist of an education component that will provide the organ donation community continual learning about donation best practices.

The Program is also making progress towards achieving its second long-term goal of increasing the total expected life-years gained for kidney transplant recipients in the first five years after transplant. The goal is to increase the total lifetime benefit achieved by all transplant recipients to 7,302 years by FY 2013. This target represents the expected additional life years gained five-years-post-transplant for all individuals receiving a kidney transplant in FY 2013.

As with the first long-term goal of increasing the number of deceased donor organs transplanted, the life-years gained goal has annual targets representing incremental marginal gain (i.e., the

average number of life-years gain per each kidney transplant recipient) and the total number of expected life-years gain for all individuals receiving a kidney transplant in a given year. Therefore, achieving the long-term goal is dependent on the marginal improvement gained via each transplant performed, as well as by increasing the total number of kidney transplants performed. In FY 2008, the Program fell short of its average number of life-years gain per-transplant target (0.41 average, actual vs. 0.421 average, target) and its total expected life-years gained target (4,586 years, actual vs. 5,543 years, target). In FY 2007, the Program met its average number of life years gained per-transplant target (0.420 average, actual vs. 0.418 average, target), but fell short of its target for total expected life-years gained (4,775 years, actual vs. 5,477 years, target).

An important component of the total expected life-years gained is the actual number of kidney transplants performed. The reason the Program fell short of its total expected life-years gained was that the actual number of kidney transplants performed was less than projected. While it is anticipated that improvements in kidney allocation policies will increase the benefit of kidney transplantation, it is also anticipated that there will be continued improvements in kidney dialysis technology, so predicting the relative benefit in kidney transplantation is difficult.

Increasing the marginal improvement gained by each kidney transplant also can be positively influenced by revising how kidneys are allocated. Over the past several years, the OPTN has made incremental improvements to the kidney allocation policy; but the current policy places great emphasis on the amount of time individuals wait for an organ transplant. As a way to increase the survival benefit of kidney transplantation, the OPTN is currently working on a new kidney policy that will place less emphasis on time on the waiting list and more emphasis on medical determinants that will seek to maximize benefit to the patient and maximize the use of deceased donor kidneys. Depending on the final construct of this allocation policy, which must balance many issues in addition to survival benefit, it is anticipated that this new policy will improve the expected five-year survival benefit post transplant.

The FY 2004 program assessment of the Organ Transplantation Program indicated that the Program has a clear purpose, is operated well, and meets an important need. The assessment showed that the Program was having difficulty in achieving substantial progress towards its long-term goal of increasing the number of deceased donor organs transplanted.

Some of the strategies to address this issue include the following actions:

- Fund a study to ascertain potential deceased donor availability for the next 5 years to better project donor potential in the United States and to develop appropriate strategies to maximize the number of viable donor organs made available for transplantation.

- Continue to support efforts to institutionalize the organ donation gains resulting from the series of Breakthrough Collaborative that began in 2003 by creating and supporting of a technology infrastructure to disseminate information about the most effective organ donation practices to targeted audiences that are critical to increasing the number of viable deceased donor organs for transplantation.

- Continue to work with the OPTN to examine its policy for allocating deceased donor kidneys.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook (EHB), and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$23,049,000
FY 2007	$23,049,000
FY 2008	$22,646,000
FY 2009	$24,049,000
FY 2010	$26,049,000

Budget Request

The FY 2011 President's Budget Request for the Organ Transplantation Program is $26,049,000. It is equal to the FY 2010 Appropriation. This will maintain current service levels and continue support for the Organ Transplantation Program. The Program will continue to support efforts to disseminate learning and implementation about organ donation best practices in FY 2011 to make progress towards achieving a national organ donation conversion rate of 75 percent and transplanting an average of 3.75 organs from each deceased donor by FY 2013. To assist in providing sufficient transplant capacity to effectively utilize the additional number of deceased donor organs, the Program will continue to work with organ procurement organizations (OPOs) and transplant programs in FY 2011 to increase the capacity to transplant 33,473 deceased donor organs annually by FY 2013. The performance goals for the two major program measures for FY 2011 are:

- Transplant 30,515 deceased donor organs; and
- achieve 6,565 expected life-years gained for the five-year period post-transplant for kidney and kidney/pancreas transplants performed in FY 2011.

The following activities will be supported with the requested funding:

1. Contract to Operate the OPTN ($2.5 million) — The OPTN is the critical nexus between individuals in need of an organ transplant and donor organs made available from deceased donors. Organ allocation policies developed by the OPTN prioritize the allocation of deceased donor organs to individuals waiting for an organ. The policies are under continual review and refinement to achieve the best outcomes for patients. Given the critical shortage of organs, these policies strive to achieve the maximum benefit for the recipient as well as make the best use of donor organs. A competitive contracting

process to operate the OPTN is held approximately every five years. The United Network for Organ Sharing (UNOS) has been the only contractor. The projected cost of operating the OPTN in FY 2011 is approximately $32.5 million. The OPTN contract is a cost-share contract. The costs of operation of the OPTN are paid with revenues generated by fees collected by the OPTN to register patients on the national donor waiting list and Federal dollars. Until the enactment of the Stephanie Tubbs Jones Organ Transplantation Authorization Act of 2008 (P.L. 110-426), NOTA limited the amount of direct Federal support to the OPTN to no more than $2 million annually. This Act authorizes Federal support to up to $7 million annually to ensure the continuing operation of the OPTN for this critical service that many Americans are depending on for life saving organ transplants. This amount includes the IT support for the OPTN systems.

2. Contract to Operate the SRTR ($3.9 million) — NOTA provides that the SRTR may be operated under contract or grant. HRSA has chosen to use a competitive contracting process because the work of the SRTR is essential to HRSA's oversight responsibilities of the Nation's transplant system and a contract provides greater control over this critical function. The initial contract was awarded to the UNOS in 1987 which operated the SRTR until 2000, when it was awarded to the Arbor Research Collaborative for Health (formerly known as the University Renal Research and Education Association). A new contract will be awarded via a competitive contracting process in September 2010. FY 2011 funds will be used to fund the continuing activities of the SRTR under the new contract. The major purpose of the SRTR is to provide analytic support to the OPTN in the development and evaluation of organ allocation and other OPTN policies. The SRTR will provide major support to the OPTN in the development of kidney and liver allocation policies. Analytic support will also include specific analyses outlined in the FY 2010 Conference Report language concerning broader sharing of livers. Additionally, the SRTR provides analytic support to the Department, including the Advisory Committee on Organ Transplantation. In an effort to make information about the performance of the OPTN more widely available to the public, the SRTR publishes data about OPO and transplant program performance and outcomes. This amount includes the IT support for the SRTR systems.

3. Efforts to Sustain and Improve on Gains Resulting from Breakthrough Collaboratives ($4.0 million) — HRSA will continue to support efforts to institutionalize the organ donation gains resulting from the Breakthrough Collaboratives that began in 2003. A major component of this strategy is the cooperative working relationship HRSA has established with the Organ Donation and Transplantation Alliance (Alliance). The Alliance is a private, non-profit organization whose mission is to expand and accelerate the work of the Breakthrough Collaboratives supported by HRSA. The Alliance Board is comprised of key organizations that are directly involved with or influence organ donation and transplantation in the U.S. HRSA is collaborating with Alliance to develop and refine strategies and activities to make more viable deceased donor organs available for transplantation. One of the major activities HRSA will undertake in 2010 and will continue in 2011 is the creation and support of an infrastructure that will leverage available technologies to disseminate learning about the most effective organ donation practices to targeted audiences that are directly involved in, or are critical to increasing

the number of viable deceased donor organs for transplantation.

4. Grants to Support Projects to Increase Organ Donation ($7.2 million) — HRSA awards competitive, peer-reviewed grants to public and nonprofit private entities to: test and replicate new approaches for increasing organ donation, promote public awareness about organ donation, and support development and improvements of state donor registries.

    - *Social and Behavioral Interventions to Increase Solid Organ Donation* grants implement and evaluate social and behavioral strategies to increase family and/or individual consent for donation.
    - *Clinical Interventions to Increase Organ Procurement* grants focus on clinical activities that begin after consent is determined or given at time of death and extend until transplantation. These donor-management-related activities influence whether a potential donor actually progresses to become a donor and the number and quality of organs that may be procured for transplantation.
    - *Public Education Efforts to Increase Organ and Tissue Donation* grants fund the implementation of public education strategies to increase organ and tissue donation as evidenced by increased enrollment in State donor registries or by other means where a State registry is unavailable.

5. Cooperative Agreement to Provide Support for Reimbursement of Travel and Subsistence Expenses toward Living Organ Donation ($2.0 million) — The existing cooperative agreement, which is funded through FY 2009, was awarded to the Regents of the University of Michigan (Michigan) in FY 2006. Michigan, in collaboration with the American Society of Transplant Surgeons, established the National Living Donor Assistance Center to operate the Program whose goal is to provide support for individuals by paying for travel and subsistence expenses associated with living organ donation. A new cooperative agreement will be awarded competitively in FY 2010. While the Program does not promote living organ donation and has no performance goals for increasing the number of living organ donors, this activity helps increase access to transplantation, particularly for individuals of lesser financial means. The Program has facilitated 411 living donor transplants for the time period October 2007 to November 2009. An additional 368 prospective living donors have been approved for reimbursement pending the organ donation procedures.

6. Activities to Support Public and Professional Education ($3.749 million) — The Program, independently and in collaboration with the organ donation and transplant community and other stakeholders, supports a variety of public and professional education and outreach efforts designed to increase organ donation. Included in this category are projects designed to educate various segments of the population using communications options appropriate to the message and audience including: public service announcements broadcast via electronic media, printed materials, documentaries, educational programs for the classrooms, national organ donation events, and Web sites. HRSA will continue to support innovative strategies for outreach efforts to encourage public commitment to organ donation. The Program supports education initiatives and other activities in collaboration with the OPTN and with major medical and professional

organizations that are influential in organ and tissue donation. These activities are designed to increase the number of organ donors and number of deceased donor organs made available for transplantation. In FY 2010, the Program will issue a contract to conduct a national survey to ascertain public opinion about organ donation and transplantation issues. Information obtained from this survey is helpful in refining public education outreach efforts. The surveys are conducted about every 5 years. The last survey was conducted by the Gallup Organization in 2005.

7. Advisory Committee on Organ Transplantation and Interagency Activities to Support Donation and Transplantation ($0.2 million) — The OPTN final rule (42 CFR § 121.12) authorizes the creation of an Advisory Committee on Organ Transplantation (ACOT) to provide recommendations to the Secretary on issues related to organ donation and transplantation. The Program supports the activities of the ACOT including the logistics for periodic meetings and analytic requirements. The Program also supports projects in collaboration with other agencies within the Department related to organ donation and transplantation, including issues related to long-term donor and recipient outcomes related to living organ donation and organ and tissue safety.

8. Study to Define Organ Donor Potential in the United States ($.5 million) — In FY 2010, HRSA will fund a study, through a competitive contracting process, to conduct a study to characterize factors that will influence deceased organ donor potential over the next decade and to better ascertain the reasons for the decline in the number of eligible donors. This study will evaluate such factors as projected changes to population demographics and disease trends that will impact both the need for organ transplantation and the number of viable organ donors. Such dynamics are critical to projecting donor potential and for developing appropriate strategies to maximize this donor potential.

   In FY 2011, HRSA will fund a follow-up study to assist the Program in working with the organ donation and transplant community to develop strategies for maximizing the number of deceased donor organs made available for transplantation. This follow-up study will also make use of the findings from the FY 2010 national survey to ascertain public opinion about organ donation and transplantation issues.

9. Establish a National Living Organ Donor Resources Center ($2.0 million)—In FY 2011, HRSA either through grant(s) or contract(s), with input from the transplant community, will begin the process of establishing a National Living Organ Donor Resources Center. This Resource Center will make available through the Web and other media objective information about the risks and benefits associated with living organ donation. The Center will also collect and disseminate information about short-term and long-term risks associated with living donation. This information may be collected by a living donor registry or research studies or both.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
23.II.A.1: Increase the annual number of deceased donor organs transplanted *(Outcome)*	FY 2008: 23,933 (Target Not Met)	29,084	30,515	+1,431
23.II.A.4: Increase the average number of organs transplanted per "non-cardiac death" donor each year. *(Outcome)*	FY 2008: 3.12 (Target Not Met but Improved)	3.58	3.64	+0.06
23.II.A.5: Increase the average number of organs transplanted per "cardiac death" donor each year. *(Outcome)*	FY 2008: 1.95 (Target Not Met but Improved)	2.53	2.61	+0.08
23.II.A.6: Increase the average number of expected life-years gained in the first 5 years after transplantation for deceased kidney/kidney-pancreas transplants. *(Outcome)*	FY 2008: 0.41 (Target Not Met)	0.427	0.43	+0.003
23.II.A.7: Increase the total number of expected life-years gained in the first 5 years after the transplant for all deceased kidney and kidney-pancreas transplant recipients compared to what would be expected for these patients had they remained on the waiting list *(Outcome)*	FY 2008: 4,586 (Target Not Met)	6,213	6,565	+352
23.II.A.2: Increase the annual number of "non-cardiac death" donors. *(Outcome)*	FY 2008: 7,143 (Target Exceeded)	7,551	7,785	+234
23.II.A.3: Increase the annual number of "cardiac death" donors. *(Outcome)*	FY 2008: 846 (Target Exceeded)	723	788	+65
23.II.A.8: Increase the annual conversion rate of eligible donors. *(Outcome)*	FY 2008: 66.5% (Target Exceeded)	68.6%	70.8%	+2.2
23.E: Decrease the total OPTN operating costs per deceased organ transplanted. *(Efficiency)*	FY 2008: $1,196 (Target Not Met)	$1,075	$1,065	-10

Grant Awards Table
Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 President's Request
Number of Awards	28	---	25	23
Average Award	$270,139	---	$351,537	$313,043
Range of Awards	$22,543-$520,565	---	$57,763-$2,000,000	$183,048-$2,000,000

National Cord Blood Inventory

	FY 2009 Appropriation	FY 2009 Recover Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$11,983,000	---	$11,983,000	$13,883,000	+$1,900,000
FTE	2	---	4	4	---

Authorizing Legislation - Section 379 of the Public Health Service Act, as amended by the Public Law 109-129.

FY 2011 Authorization .....Expired

Allocation Method .....Contract

Program Description and Accomplishments

The National Cord Blood Inventory (NCBI) program, established through legislation signed in December 2005, is charged with building a genetically and ethnically diverse inventory of 150,000 new units of high-quality umbilical cord blood for transplantation. These cord blood units, as well as other units in the inventories of participating cord blood banks, are made available to physicians and patients for blood stem cell transplants through the C.W. Bill Young Cell Transplantation Program (the Program), which is authorized by the same law. Cord blood banks participating in the NCBI program also make cord blood units available for preclinical and clinical research focusing on cord blood stem cell biology and the use of cord blood stem cells for human transplantation and cellular therapies. A small portion of FY 2007 – 2009 funds were also used to initiate a small Related Cord Blood Donor Demonstration Project. The NCBI provides funds through competitive contracts for the collection and storage of qualified cord blood units by a network of cord blood banks in the United States.

Blood stem cell transplantation is curative therapy for many individuals with leukemia and other life-threatening blood and genetic disorders. Each year nearly 18,000 people in the U.S. are diagnosed with life-threatening illnesses where blood stem cell transplantation from a matched donor is their best treatment option. Often, the first choice donor is a sibling, but only 30 percent of people have a fully matched brother or sister. For the other 70 percent, or approximately 12,600 people, a search for a matched unrelated adult donor or a matched umbilical cord blood unit must be performed.

The tissue types of blood stem cell donors must be closely matched with those of their recipients in order for the transplant to be successful. Since tissue types are inherited, patients are more likely to find a closely matched donor within their own racial and ethnic group. However, due to the high rate of diversity in the tissue types of minorities, especially African-Americans, minorities are less likely to find a suitably matched adult marrow donor on the Registry of the

C.W. Bill Young Cell Transplantation Program. To date, the majority of cord blood transplants have been performed on pediatric recipients because of the smaller number of stem cells present in cord blood relative to adult marrow. Increasingly, particularly with the introduction of multiple cord blood unit transplants, these units are also being used for adult recipients. Because it can be used with a less perfect match in tissue type between donor and recipient than is the case for adult marrow donors, umbilical cord blood offers a chance of survival for patients who lack a suitably tissue-matched relative and who cannot find an adequately matched unrelated adult donor through the Program or through international adult donor registries. Minority patients, especially African-American patients, are especially likely to benefit from additional cord blood units. For these reasons, the NCBI continues to emphasize increasing the number of cord blood units collected from minority donors.

Requests for proposals have been announced annually since inception of the program to add additional cord blood banks to NCBI Program. These proposals have been reviewed by technical review committees composed of individuals qualified by training and experience in particular fields related to blood stem cell transplantation and cord blood banking. Funding decisions are made based on committee assessments of technical merit, overall quality, ability to collect from diverse populations, geographic dispersion of offerors, evaluation of past performance, and evaluation of proposed costs. When exercising option years beyond the original one-year base period of the contracts, current performance and compliance with contract terms is carefully considered. Additionally, HRSA continues to place particular emphasis on the demonstrated ability of offerors to collect and bank significant numbers of cord blood units from African-American donors.

HRSA awarded six contracts to the first cohort of umbilical cord blood banks to collect for the National Cord Blood Inventory in November 2006. Two additional banks were added in September 2007 and one additional bank was added in September 2008. Three new banks were awarded contracts during FY 2009. Approximately 10,200 additional cord blood units will be added to the NCBI inventory with FY 2009 funds awarded to new and continuing contracts with NCBI banks. A cumulative total of approximately 40,000 units of cord blood will be put into the NCBI with all funds awarded during the period FY 2007 through FY 2009.

Generally, the likelihood that a cord blood unit at a given bank will be identified for match is dependent on the size of the inventory of units at that bank—the greater the number of units, the higher the likelihood of a unit being requested for a patient. Despite this statistical likelihood, during the first year of collections for the NCBI (FY 2007), four cord blood units from this small inventory were released for transplantation with an additional 104 units being released for transplantation during FY 2008. During FY 2009 408 units were released for transplantation. This represents a considerably higher use rate than that of non-NCBI units. In addition, many other units are currently under evaluation for use by patients in need of transplant. The benefit of large volume units, such as those collected with HRSA funds, is demonstrated by the fact that all of the cord blood units released for transplantation have total nucleated cell counts well above the levels generally available prior to implementation of the NCBI program. Many recipients of these cord blood units, especially those patients whose ancestry is not from northwest Europe, had no well matched adult donor.

The diverse units comprising the NCBI will serve an increasing number of patients from populations that have difficulty obtaining cells from a well-matched adult donor. Of the cord blood units collected with funds awarded through FY 2009, the majority will be from racial and ethnic minorities.

The potential of cord blood to sharply increase access to transplants is being realized in several ways. First, cord blood has accounted for about half of the growth in transplants over the last few years, and approximately 22 percent of all transplants facilitated through the C.W. Bill Young Cell Transplantation Program during FY 2009 utilized cord blood units, up from 21% in FY 2008. Approximately 29 percent of the cord blood transplants facilitated through the Program in FY 2009 utilized more than one cord blood unit.

For minority patients, cord blood has been especially critical in increasing access to transplantation for underrepresented populations, with nearly 42 percent of the minority transplants facilitated through the C.W. Bill Young Cell Transplantation Program in FY 2009 utilizing umbilical cord blood, up from 34 percent in FY 2008. Regional studies in areas with diverse patient populations (e.g., New York City and Houston) have shown that the majority of adult patients receiving cord blood transplants lacked an adequate adult donor; thus cord blood was their only chance for transplant.

Table 1. Cord Blood Collection

FY	Cumulative Units Made Available
FY 2005	---
FY 2006	---
FY 2007	2,017
FY 2008	11,870
FY 2009	22,920

Funding History

FY	Amount
FY 2006	$9,957,000
FY 2007	$3,963,000
FY 2008	$8,843,000
FY 2009	$11,983,000
FY 2010	$11,983,000

Budget Request

The FY 2011 President's Budget Request for the National Cord Blood Inventory is $13,883,000. This request is an increase of $1,900,000 above the FY 2010 Appropriation. The entire FY 2011 President's Budget Request will support more rapid progress toward the statutory goal of building a genetically diverse inventory of 150,000 new units of high-quality umbilical cord blood for transplantation and will therefore increase the number of patients in all population groups who are able to obtain life-saving transplants. It is estimated that this request will support the collection and banking of approximately 9,100 additional cord blood units.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Increase the cumulative number of minority cord blood units available through the C.W. Bill Young Cell Transplantation Program (NCBI & non-NCBI)	FY 2009: 46,434 (Target Exceeded)	50,000	60,000	+10,000
Increase the size of the National Cord Blood Inventory (cumulative # of units banked and available through the C.W. Bill Young Cell Transplantation Program)	FY 2009: 22,920 (Target Exceeded)	26,000	36,800	+10800
Increase the number of sites where NCBI participating banks collect cord blood units	FY 2009: 142 (Target Exceeded)	90	98	+8
Increase the annual number of NCBI cord blood units released for transplant	FY 2009: 408 (Target Exceeded)	140	300	+160

Contracts Awards Table

Size of Contracts

(whole dollars)	FY 2009 Appropriation	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 Presidents' Budget
Number of Contracts	11	---	10	10
Average Contracts	$1,021,117	---	$1,109,999	$1,368,300
Range of Contracts	$160,717 – $3,046,500	---	$200,000 –$2,500,000	$100,000 – $2,500,000

C.W. Bill Young Cell Transplantation Program

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$23,517,000	---	$23,517,000	$26,544,000	+$3,027,000
FTE	5	---	5	5	---

Authorizing Legislation - Section 379 of the Public Health Service Act, as amended and P. L. 109-129.

FY 2011 Authorization .....Expired

Allocation Method .....Contract

Program Description and Accomplishments

The primary goal of the C.W. Bill Young Cell Transplantation Program (Program) is to increase the number of transplants for recipients suitably matched to biologically unrelated donors of bone marrow and cord blood. The Program works towards this goal by: providing a national system for recruiting potential bone marrow donors; tissue typing potential donors; coordinating the procurement of bone marrow and umbilical cord blood units for transplantation; offering patient and donor advocacy services; providing for public and professional education; and collecting, analyzing, and reporting on transplant outcomes data. Blood stem cell transplantation is curative therapy for many individuals with leukemia and other life-threatening blood and genetic disorders. Each year nearly 18,000 people in the U.S. are diagnosed with life-threatening illnesses where blood stem cell transplantation from a matched donor is their best treatment option. Often, the first choice donor is a sibling, but only 30 percent of people have a fully matched brother or sister. For the other 70 percent, or approximately 13,000 people, a search for a matched unrelated adult donor or a matched umbilical cord blood unit must be performed.

Per authorizing legislation signed on December 20, 2005 (The Stem Cell Therapeutic and Research Act of 2005, P.L. 109-129), the C.W. Bill Young Cell Transplantation Program is the successor to the National Bone Marrow Donor Registry. While the scope of activities required of the Program is similar to that of the Registry, the Program has expanded responsibility of collecting, analyzing, and reporting on outcomes data for all allogeneic transplants and on other therapeutic uses of blood stem cells. In addition, unlike the Registry, which was administered under a single contract, the Program is made up of four contracts that require close coordination. Also, P.L. 109-129 required the establishment of an Advisory Council at the Department level to provide recommendations to the Secretary on activities related to the Program.

Since passage of the Stem Cell Therapeutic and Research Act of 2005, the Program has: (1) ensured a seamless transition from the Registry structure to the newly authorized and more complex C.W. Bill Young Cell Transplantation Program structure; (2) developed initiatives to

meet and/or exceed established goals; (3) established a methodology for determining one-year patient survival rates and established baselines and targets for this performance measure; (4) updated and implemented a comprehensive plan to increase transplants; (5) began collecting comprehensive transplant outcomes data through the Stem Cell Therapeutic Outcomes Database; and (6) established an Advisory Council for Blood Stem Cell Transplantation which provides recommendations to the Secretary on activities related to the Program.

In FY 2006, the Health Resources and Services Administration (HRSA) awarded four contracts for: (1) Cord Blood Coordinating Center which is responsible for facilitating transplants with blood stem cells from cord blood units and providing expectant mothers with information on options regarding the use of umbilical cord blood (i.e., public donation, private storage, research and discard; (2) Bone Marrow Coordinating Center which is responsible for recruiting adult potential donors of blood stem cells, especially from underrepresented ethnic and racial minority populations and for facilitating transplants with blood stem cell from adult donors; (3) Stem Cell Therapeutic Outcomes Database which is responsible for continuing and extending the collection of outcomes data on unrelated donor blood stem cell transplants using cells from adult donors and cord blood, developing and implementing data collection for related donor blood stem cell transplants, and developing and implementing an approach to collect data on emerging therapeutic uses of blood stem cells from a donor; and (4) a combined Office of Patient Advocacy and Single Point of Access which provides a single point of access for physicians, healthcare providers and patients to search for a blood stem cell product from an adult donor or cord blood unit, assist patients in need of a blood stem cell transplant from diagnosis to survivorship, and identify the gaps in services and offer programs to help meet the needs of patients.

Contracts for all components of the Program were awarded through a competitive contracting process that emphasized technical merit. Contract opportunities were announced nationally and proposals were then reviewed by objective review committees, composed of individuals who are qualified by training and experience in particular fields related to the Program. Funding decisions were made based on committee assessments of technical merit, evaluation of past performance, and evaluation of proposed costs. When exercising option years beyond the original two-year base period of the contracts, HRSA considered current performance and compliance with contract terms. HRSA awarded a one-year option for each of the four contracts in FY 2009 based on satisfactory performance.

Performance measures, which are monitored quarterly, indicate that the Program is making progress toward meeting its three long-term goals: (1) increasing the number of blood stem cell transplants facilitated; (2) increasing the number of transplants facilitated for minority patients; and (3) increasing the rate of survival at one-year, post-transplant. The Program's long term goals are supported by annual measures: (1) increase the number of adult volunteer potential donors of minority race and ethnicity on the Registry and (2) decrease the cost for human leukocyte antigen (HLA) tissue typing needed to match patients and donors. The Program continues to serve a diverse patient population.

- In FY 2006, a total of 6,317,827 adult volunteers were listed on the registry, of whom 1,698,616 (or 26.9%) self-identified as belonging to a racial/ethnic minority population group. In FY 2007, a total of 6,856,150 adult volunteer donors were listed on the registry of whom 1,856,434 (or 27.1%) self-identified as belonging to a racial/ethnic minority population group (exceeding the goal of 1.83 million). In FY 2008, a total of 7,294,630 adult volunteer donors were listed on the registry of whom 2,028,600 (or 28%) self-identified as belonging to a racial/ethnic minority population group, exceeding the goal of 1.94 million. In FY 2009, a total of 7,985,545 adult volunteer donors were listed on the registry of whom 2,221,135 (or 28%) self-identified as belonging to a racial/ethnic minority population group, exceeding the goal of 2.06 million. The Program has experienced significant improvement in increasing the size of the registry of adult volunteer donors over the past four years. Over the past three years, targets were exceeded because initiatives to increase community awareness and outreach in minority populations were implemented in FY 2006 and additional funds were committed to this effort in FY 2007 through FY 2009. The Program expects to continue to make progress in this area. The target established for FY 2011 is 2,480,000 adult volunteers from racially/ethnically under-represented minority population groups.

- The cost of Human Leukocyte Antigen (HLA) typing strongly influences the number of potential volunteer donors who can be recruited to potentially donate for patients in need of blood stem cell transplantation. Reductions in the cost of typing makes increases in donor recruitment possible even without increased funding. In FY 2004, the National Marrow Donor Program successfully negotiated a 2.7% reduction in cost with its contracted laboratories for Human Leukocyte Antigen (HLA) tissue typing. The cost of tissue typing decreased from $65.00 in FY 2003 to $63.65 in FY 2004. The contractor that maintains the registry did not negotiate new laboratory contracts during FY 2005. In FY 2006, the contractor negotiated an 18% cost reduction, which was expected to remain in effect over the next three years. The FY 2009 actual cost for tissue typing was $52.00, thus meeting the target. The FY 2010 and FY 2011 targets will remain at $52.00.

A comprehensive program assessment of the National Bone Marrow Donor Registry (Registry), predecessor to the C. W. Bill Young Cell Transplantation Program, was conducted in 2004. The review found that HRSA program staff provided effective oversight over the program and that staff appropriately were heavily engaged in all aspects of Registry operations, particularly committee work (which is where program policies are initially discussed). It also found that performance standards already were in place within the contract for the major Registry activities. During the review, aggressive long-term goals and annual measures to increase the number of transplants facilitated and improve patient survival were established.

Since the comprehensive assessment, the Program has: (1) ensured a seamless transition from the Registry structure to the newly authorized and more complex C.W. Bill Young Cell

Transplantation Program structure; (2) established a methodology for determining one-year patient survival rates and established baselines and targets for this performance measure; (3) updated and implemented a comprehensive plan to increase transplants; (4) began collecting comprehensive transplant outcomes data through the Stem Cell Therapeutic Outcomes Database; and (5) established an Advisory Council for Blood Stem Cell Transplantation which provides recommendations to the Secretary on activities related to the Program.

Funding History

FY	Amount
FY 2006	$25,145,000
FY 2007	$25,168,000
FY 2008	$23,517,000
FY 2009	$23,517,000
FY 2010	$23,517,000

Budget Request

The FY 2011 President's Budget Request for the C.W. Bill Young Cell Transplantation Program is $26,544,000. This request is an increase of $3,027,000 above the FY 2010 Appropriation. The FY 2011 President's Budget Request will support achieving the Program's ambitious performance target of having 2,480,000 adult volunteers from racially/ethnically diverse minority population groups listed on the registry. These funds will also be used to support an infrastructure comprised of multiple contracts (Cord Blood Coordinating Center, a Bone Marrow Coordinating Center a combined contract for the Office of Patient Advocacy and Single Point of Access, and Stem Cell Therapeutic Outcomes Database). The majority of the funds will be used to support recruitment of new donors (including tissue typing costs). The Program will continue its central goal of increasing the number of transplants for recipients suitably matched to biologically unrelated donors of bone marrow and cord blood. Additionally, through the Stem Cell Therapeutic Outcomes Database, the Program will continue efforts to collect comprehensive outcomes data on related-donor and unrelated-donor transplants, assess quality of life for transplant recipients, work with foreign transplant centers to obtain data on U.S. stem cell products provided to them for transplant, and new initiatives to collect data on emerging therapies using cells derived from bone marrow and umbilical cord blood.

Funding will also allow the Program to continue critical planning activities to prepare to respond to a radiation or chemical (mustard agent) emergency that would leave some casualties with temporary or permanent marrow failure, and to facilitate emergency transplants for those casualties who would not otherwise recover marrow function.

Authorization for P.L. 109-129 expires September 30, 2010.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2010 +/- FY 2011
24.II.A.2: Increase the number of adult volunteer potential donors of minority race and ethnicity. *(Outcome)*	FY 2009: 2.22 Million (Target Exceeded)	2.35 Million	2.48 Million	+.13
24.1: Increase the number of blood stem cell transplants facilitated annually by the Program.[1] *(Outcome)*	FY 2003: 2,310 (Baseline)	4,500	N/A	N/A
24.2: Increase the number of blood stem cell transplants facilitated annually by the Program for minority patients. [1] *(Outcome)*	FY 2003: 318 (Baseline)	636	N/A	N/A
24.3: Increase the rate of patient survival at one year, post transplant. [1] *(Outcome)*	FY 2003: 62% (Baseline)	69%	N/A	N/A
24.E: Decrease the unit cost of human leukocyte antigen (HLA) typing of potential donors. *(Efficiency)*	FY 2009: $52 (Target Met)	$52	$52	Maintain

[1] This long-term measure does not have annual targets. The first long-term target was set for FY 2010.

Poison Control Program

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$28,314,000	---	$29,314,000	$29,314,000	---
FTE	3	---	3	3	---

Authorizing Legislation - Section 1271-1274 of the Public Health Service Act, as amended by P.L. 110-377.

FY 2011 Authorization .....National Toll Free Number - $700,000
FY 2011 Authorization .....Nationwide Media Campaign - $800,000
FY 2011 Authorization .....Poison Control Center Grant Program - $28,600,000

Allocation Method .....Grants, Contracts, and Cooperative Agreements

Program Description and Accomplishments

The Poison Control Center Enhancement and Awareness Act (P.L. 106-174) was enacted in February 2000 to provide a source of supplemental support to Poison Control Centers (PCCs) and was amended and reauthorized in December 2003 (P.L. 108-194) and again in October 2008 (P.L. 110-377). The purpose of the Act is to (1) maintain a national toll free poison hotline (1-800-222-1222) to access the nation's 60 poison control centers; (2) implement and expand upon a national media campaign to educate the public and healthcare providers about the national toll-free hotline, poison prevention and the availability of poison control resources in local communities; and (3) support efforts made by PCCs to prevent, provide treatment recommendations for poisonings, and comply with operational requirements needed to attain and/or sustain certification.

The Poison Center Support and Enhancement Grant Programs and comprises approximately 94 percent of the total PCC budget: (1) Support and Enhancement Grant Program to assist poison centers in preventing and providing treatment recommendations for poisoning, and for maintaining or attaining certification thereby enhancing the quality of poison control services available to the public, and (2) Incentive Grant Program to encourage and support development and implementation of leading practices, innovations, and/or improvements that enhance or improve the quality and accessibility of poison education, prevention and treatment programs and services, including the capacity to answer high volume calls. Other sources of revenue for the Poison Control Centers vary from state to state and include direct state contributions, revenues from private insurers, support from telephone surcharge and license plates, and funding from various organizations. Fifty-three (53) of the 55 poison control centers are now certified, making 98 percent of poison control centers certified. This is up from 78 percent in 2001.

PCCs are our Nation's primary defense against injury and death from poisonings. Approximately 2.6 million poisonings are reported annually and approximately 4.2 million poisoning-related calls are known to all of the PCCs across the country. Center for Disease Control and Prevention (CDC) data show that poisoning displaced motor vehicle traffic fatalities as the leading cause of unintentional injury death in the 35-44 and 45-54 age groups for the first time in 2005. Ninety-five percent of unintentional poisoning is attributed to drug poisoning, most of it related to the misuse and abuse of prescription medication by adults.

According to 2007 data from the American Association of Poison Control Centers (AAPCC), 93 percent of all poisoning exposures occurred in people's homes. Over half of poisonings occur among children younger than age five. In 2009, 90 percent or more of the general public who called a local poison center got the help they needed over the phone with guidance from trained healthcare professionals (nurses, pharmacists and certified specialists in poison information), avoiding unnecessary visits to healthcare facilities. Ready access to poison control services has been proven to reduce severity of illness, death, and healthcare costs. The average call to a poison center costs $43 and saves $290 in medical costs. At $43 a call, each $1 spent on poison center services saves almost $7 in medical spending.

One of the Poison Control Program performance measures relates to the development and ratification of uniform and evidence-based guidelines for the treatment of poisonings. From 2002-07, the program supported the development of uniform, evidence-based guidelines to assist PCCs in managing patient's care out-of-the hospital. Seventeen uniform guidelines were developed, with one focusing on the treatment of 35 non-toxic substances and 16 for the treatment of toxic substances. While 17 was one less than the 2007 goal of 18, the program considers this a success because of the extensive work required to develop such guidelines. We evaluated the utility of guidelines during 2008. No new ones were developed during 2008. All of the guidelines have been reproduced and distributed to the poison centers and are available on the HHS National Guideline Clearinghouse website. An evaluation on the usefulness of the guidelines concluded that the development of additional guidelines would enhance the poison centers ability to provide quality and consistent treatment recommendations. A 3-year competitive contract is in progress to develop three additional guidelines and update an existing four guidelines per year.

A second performance measure for the program is to increase the number of PCCs with 24-hour bilingual staff. In FY 2009, the number of PCCs with bilingual staff remained unchanged at four. This result has not changed since FY 2005; however, the target for FY 2010 has increased to five because PCCs actively recruit and train poison center experts through their rotational fellowships with pharmacy schools. The program does not require hiring of specific personnel within poison centers; however, the program has implemented key activities in support of addressing bilingual needs. In FY 2005, the program hosted a diversity forum to examine increasing the accessibility of poison control center services to diverse populations and to develop recommendations for improving these services and for increasing the availability of bilingual resources. This report was distributed to all of the PCCs. In addition, since September 2006, HRSA has provided translation services under contract to all PCCs through a service called Language Line. Language Line provides translation services in 161 languages thereby providing a cost effective means for all PCCs to offer 24-hour bilingual services. Over half of all

PCCs currently use the service supported by HRSA, with Spanish being the most requested language (88 percent) and French being second. The remaining PCCS who do not use the translation service that HRSA offers have continued to utilize translation services offered through their host institutions.

A third performance measure for the program is to increase the percent of inbound volume on the toll-free number. The program has exceeded its goal each year since the baseline year in FY 2003. In FY 2007, 66 percent of the total calls to poison control centers were received on the national toll-free number. In FY 2008, 70 percent of the total calls to poison control centers were received on the national toll-free number, exceeding the goal of 69.3 percent. In FY 2009, 73.7% of the total calls to poison control centers were received on the national toll-free number, exceeding the goal of 71 percent.

The Poison Control Program (PCP) underwent a program assessment in 2004 that concluded the program made progress toward stabilizing poison control centers and toward its long-term goal of reducing emergency room visits due to poisoning. In an effort to support the financial stabilization of poison centers, the program established a technical assistance contract (from 2003 to 2008) to assist grantees with strategic plan development, resource development, and financial planning services. In April 2007, HRSA hosted a Financial Stability Workgroup made up of PCC leaders, to discuss options for achieving financial stability. In March 2008, a final report of workgroup outcomes and action plans was completed and distributed to all grantees and is being used as a strategic planning tool. In October 2008, new legislation for the program omitted financial stability as a goal of the grant program while reauthorizing the nationwide media campaign to promote poison centers, maintain the national toll-free number, and implement a grant program to provide treatment recommendations for poisonings and compliance with center certification requirements.

The program continues to work toward its long term goal of reducing emergency room visits due to poisoning. To that end, in September 2008, the program convened the Poison Workgroup (PWg), a group of professionals committed to reversing the alarming increase in fatalities due to prescription pain medication abuse and overdose. Formed in 2006, the PWg includes epidemiologists, toxicologists, prevention specialists, state-based injury experts, poison educators, academics, government officials, and survivors of opioid narcotic abuse. The PCP supports the group's conference calls, in-person meetings and future activities to include: a national forum for policy makers, an information clearinghouse about prescription pain pill fatalities, a feasibility analysis of poison death review, development of fact sheets, and targeted outreach to prescribers. In addition to the PWg, the program continues to seek partnerships with other HRSA programs and initiatives, including the Patient Safety and Clinical Pharmacy Services Collaborative, private entities and other Federal agencies to reduce emergency room visits due to poisoning via promotion of poison center services and the toll free number.

Funding History

FY	Amount
FY 2006	$23,052,000
FY 2007	$23,000,000
FY 2008	$26,528,000
FY 2009	$28,314,000
FY 2010	$29,314,000

Budget Request

The FY 2011 President's Budget Request for the Poison Control Center Program is $29,314,000, the same as the FY 2010 Appropriation. Poison Control Center grantees have implemented many strategies to accomplish the purpose of providing treatment recommendations, complying with certifications requirements and implementing outreach activities to increase access to their centers. Through 2008, HRSA funding has represented, on average, approximately 19 percent of total financing for PCC operations. Ninety-eight percent of poison control centers are now certified, up from 78 percent in 2001. Many centers have implemented strategic planning initiatives, business plans, and increased access to services through outreach and education programs. In FY 2011, the program proposes to continue support initiatives that focus on preventing poisonings, providing treatment recommendations, complying with operational requirements needed to attain or sustain certification and developing and implementing leading practices that enhance the quality and accessibility of poison education, prevention and treatment programs and services. HRSA will also use funding to promote poison center services, promote and maintain the national toll-free number and language line services for non-English speaking callers, and develop patient management guidelines. The following activities will be supported with the requested funding:

Support and Enhancement Grant Program ($27.564 million):
Grant funds will be used to continue supporting poison control centers efforts to prevent poisonings, provide treatment recommendations and comply with operational requirements needed to attain or sustain certification. Incentive grants will also be offered for the purpose of developing and implementing leading practices that enhance the quality and accessibility of poison education, prevention and treatment programs and services.

This request also includes costs associated with processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbooks (EHBs), and follow-up performance reviews.

National Toll-Free Hotline Services and Promotion of Number and Services ($1.5 million):
Ensuring access to poison control centers through the national toll-free hotline is a critical public health service that improves the quality of healthcare. The program will fund and manage the toll-free number. Funding will also be used to support Language Line services for non-English speaking callers.

As legislatively mandated, the program will also continue to fund the nationwide media campaign to educate the public and health care providers about poison prevention, poison control resources, and the national toll-free number. To that end, the program will also provide technical expertise in the development of the media campaign and will continue to raise awareness about poison prevention and the availability of the toll-free number among pharmacists, pharmacy groups and 340B participants. The FY 2011 target is to increase the percent of all calls routed to the PCCs using the toll-free number to 73.7 percent.

Patient Management Guidelines ($.25 million): Funding will be used to continue the development of uniform and evidence-based guidelines for the treatment of poisonings to include 23 guidelines for FY 2011.

Outcomes and Outputs Tables

Long Term Objective: Promote the implementation of evidence-based methodologies and best practices

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
25.1: Decrease the number of visits to the emergency room, (per 1,000 live ER discharges) [1] *(Outcome)*	FY 2002: 2.1 (Baseline)	N/A	N/A	N/A
25.III.D.1: Develop and ratify uniform and evidence-based guidelines for the treatment of poisoning. (targets are cumulative) *(Output)*	FY 2009: 17[2] (Target not Met)	20	23	+3
25.III.D.2: Increase the number of PCCs with 24-hour bilingual staff. *(Output)*	FY 2009: 4 (Target Met)	5	5	Maintain
25.III.D.3: Increase percent of inbound volume on the toll-free number. *(Output)*	FY 2009: 73.7% (Target Exceeded)	73.7%	73.7%	Maintain
25. E.1: Decrease application time burden. *(Efficiency)*	FY 2009: 27 hrs (Target Exceeded)	27 hrs	26.5 hrs	-0.5
25.E.2: Decrease reporting time burden. *(Efficiency)*	FY 2008: 2 hrs (Target Exceeded)[3]	17 hrs	17 hrs	Maintain

[1] This is a long-term measure with FY 2009 as the first year for which data will be reported. The next year for reporting is 2013.
[2] Patient Management Guideline activities were not done in 2009; therefore the most recent result remained at 17.
[3] This information was inadequately reported by grantees. To address this issue, the program was more specific in the FY 2009 grant application guidance about reporting FY 2009 application reporting time and FY 2008 financial statue reporting time in the FY 2009 application to ensure more complete and accurate reporting.

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request
Number of Awards	56	---	55	55
Average Award	$402,500	---	$408,500	$408,500
Range of Awards	$50,000-$2,803,178	---	$60,000-$2,953,704	$60,000-$2,953,704

Office of Pharmacy Affairs/340B Drug Pricing Program

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$1,470,000	---	$2,220,000	$5,220,000	+$3,000,000
FTE	---	---	---	---	---

Authorizing Legislation - Section 340(b) of the Public Health Service Act, as amended by P.L. 111-8.

FY 2011 Authorization ..... Indefinite

Allocation Method ..... Contract

Program Description and Accomplishments

The mission of the Office of Pharmacy Affairs (OPA) is to promote access to clinically and cost effective pharmacy services for over 14,000 safety net healthcare delivery sites participating in the 340B Drug Pricing Program (340B Program). The 340B Program requires drug manufacturers to provide discounts or rebates to a specified set of HHS-assisted programs and hospitals that meet the criteria in the Public Health Service Act and the Social Security Act for serving a disproportionate share of low income patients. The following clinics and hospitals are eligible to purchase outpatient drugs at 340B prices: all HRSA-assisted Federally Qualified Health Centers (FQHCs); Black Lung Clinics; Ryan White HIV/AIDS programs including AIDS Drug Assistance Programs; Comprehensive Hemophilia Treatment Centers; Indian Health Service tribal organizations and Urban Indian programs; Centers for Disease Control and Prevention- assisted sexually transmitted disease (STD) and tuberculosis (TB) clinics; Native Hawaiian Centers; Title X Family Planning Clinics; certain disproportionate share hospitals; certain Children's Hospitals; and Federally Qualified Health Center Look-Alikes.

The 340B Program requires drug manufacturers to give covered entities a discount that is at least 15.1 percent below AMP for brand name drugs and 11 percent below AMP for generic drugs. During FY 2010, covered entities will save approximately $2.5 billion on their estimated $5 billion outpatient drug expenditures by participating in the 340B Program. The total savings in FY 2011 are expected to increase as participation in the 340B Program increases. Drug purchases under the 340B Program represent approximately 2 percent of all U.S. drug purchases.

The Prime Vendor Program (PVP) established under Section 340B (a) (8) provides drug distribution and price negotiation services for entities participating in the 340B Program. As of May 2009, the PVP had over 3,400 drugs under contract with an estimated average savings of 15-20 percent below the 340B ceiling price. In addition, the PVP has contracts for other value-added products and services such as diabetes test strips, vaccines, apothecary supplies, diabetes

monitors and specialized pharmacy software. In 2009, PVP contracts provided an estimated $25 million in additional savings for covered entities below the statutory ceiling price plus additional savings on other value added products and services that afford covered entities the ability to better meet the needs of their patients. Since November 2008 Apexus, a non-profit organization, has operated the Prime Vendor Program which has resulted in approximately $2 million in "shareback" payments annually to participating covered entities. A new five year Prime Vendor agreement was competed and awarded in 2009. The 340B Prime Vendor continues to build on the value that this public/private business arrangement brings to covered entities and the government. Current PVP trends are expected to continue, and savings are expected to increase substantially in subsequent years. As of 01/01/2010, 5,878 covered entity organizations (not sites) participated in the Prime Vendor Program.

The Pharmacy Services Support Center (PSSC) was established in FY 2002 under a HRSA contract with the American Pharmacists Association to provide guidance and technical assistance to 340B covered entities and to provide support services to the OPA. The current five year PSSC contract was awarded in FY 2007. The PSSC contract was modified to accommodate the Office of Inspector General (OIG) recommendation that OPA provide broad-based 340B Program education and training activities for covered entities, manufacturers, wholesalers, and other interested stakeholders. In FY 2008 PSSC began working with safety net providers to maximize BPHC Health Center Pharmacy Expansion Grant awards by assisting with the development of sustainable and effective pharmacy programs. PSSC continues to work with covered entities through the Patient Safety and Clinical Pharmacy Services Collaborative (PSPC) and the PVP to improve medication management, drug utilization, and patient safety, and to contain healthcare costs for their patients. An increase in the number of FQHCs and other eligible entities over the past several years continues to generate increased demand for technical assistance from the PSSC.

HRSA has prepared a report, as requested in the 2007 Senate Appropriations Committee Report, that identifies valuable lessons learned from HRSA's clinical pharmacy demonstration projects with recommendations for extending the services in which medications play an integral role in patient care. The Committee requested that HRSA submit a report that includes these recommendations and "options for financing clinical pharmacy services in HRSA-supported programs, cost of such financing and opportunities for maintaining and building upon the relationships with colleges and schools of pharmacy."

Consistent with this plan, HRSA established the PSPC to identify and implement "best practices" of clinical pharmacy services that improve patient care quality and avoid adverse events by establishing the pharmacist as an integral part of a patient-centered, inter-professional health care team. Over 200 organizations in 37 states were involved in the first PSPC cohort. The second PSPC cohort begins in FY 2010. This cohort will include over 100 teams that represent over 300 organizations and 47 states.

Program Growth

Over 14,200 covered entities have registered in the 340B Program. This represents an annual growth of approximately 3 percent. The 340B Program is expected to continue experiencing a 3 percent growth per year. The number of contract pharmacies in the program serving 340B entities will increase to over 2,400.

Funding History

FY	Amount
FY 2006	---
FY 2007	---
FY 2008	---
FY 2009	$1,470,000
FY 2010	$2,220,000

Budget Request

The FY 2011 President's Budget Request for the Office of Pharmacy Affairs/340B Program is $5,220,000. This is an increase of $3,000,000 above the FY 2010 Appropriation. The funding will sustain annual verification of all covered entities ensuring accuracy and integrity of the 340B database over time and will support 508 compliance of the PSSC/OPA website. From the inception of the 340B Program in 1992, the entire cost of administering the Program, including the development of guidelines and the provision of technical assistance to eligible grantees, has been borne by HRSA program management funds until FY 2009 when a line item of $1.47 million was established. The line item was expanded to $2,220,000 in FY 2010 because of the need to make major improvements in program operations as identified by audits and evaluations conducted by the OIG. Continued and enhanced funding to $5,220,000 in FY 2011 is necessary to continue these major improvements in the 340B Program operations and to resolve identified deficiencies which cannot be addressed within the resources available for normal administrative operations.

Several OIG reports, including "Review of 340B Prices" (OEI-05-02-00073, July 2006), documented the problems that will be addressed through a combination of HRSA staff and contracts administered by HRSA. HRSA's actions will be confined to the limits of the confidentiality requirements surrounding the information used to calculate 340B ceiling prices. HRSA continues to improve on the OIG's recommendations to train manufacturers, wholesalers and other external stakeholders, along with broad-based 340B Program training for HRSA's project officers and regional personnel in FY 2011 by updating and improving 340B Program education and training modules.

1. Non-compliance with the 340B pricing requirements - 340B Program pricing errors are caused by a variety of problems including: incorrect package size data, omissions in data

needed to compute 340B ceiling prices, and mistakes in 340B prices offered by drug manufacturers and/or wholesalers. As a first step in correcting these problems, HRSA negotiated an intra-agency agreement with CMS, permitting HRSA to compute the 340B ceiling prices using data that manufacturers' supplied to CMS. Funds from the FY 2011 appropriation request will continue to support publication of policies regarding the computation of 340B ceiling prices; implement a systematic quarterly comparison of 340B ceiling prices with the selling prices offered by manufacturers and drug wholesalers, and follow-up efforts to resolve problems wherever they arise in the data supply chain.

2. Audits and civil monetary penalties for 340B Program violations - In addition, per OIG recommendations, HRSA will assess the need for additional authority and resources to perform audits and to impose fines and civil monetary penalties for violations of Section 340B of the Public Health Service Act. If necessary, the funds would also support audits undertaken by OIG-approved public accounting firms. HRSA currently must rely on the OIG for all referrals of fraud, waste and abuse issues.

3. Errors and omissions in HRSA's covered entity database - HRSA's staff and its contractors have continued to take a number of steps to improve the integrity and reliability of the database of covered entities. This includes purging duplicate and obsolete entity records and adding updated entity information. While there have been great advances in improving the integrity and accuracy of the 340B database in response to deficiencies identified by the OIG, there needs to be a sustained and systematic approach to maintaining accuracy and integrity of the 340B database. As required by law, annual verification of STD, TB and select Ryan White covered entities has been done since the inception of the program. Annual verification of family planning entities was initiated in FY 2008, but was discontinued due to funding constraints. Verifications will be resumed with the additional budget funding. HRSA will also begin designing and testing of a phased systematic verification system that will allow annual online verification of all records in the 340B database. HRSA ultimately seeks to achieve annual verification of all covered entities records to ensure the integrity of the 340B database of covered entities. HRSA considers the integrity of the 340B database to be a crucial responsibility that requires ongoing maintenance and development in order to effectively administer the 340B Program and meet the obligations of the Secretary and the law.

4. Program Guidance Clarification - In FY 2007 HRSA published three notices for public comments in the Federal Register. The notices included proposed guidance to clarify the definition of patient, to increase the utilization of contract pharmacies services, and to address the addition of certain children's hospitals under section 6004 of the DRA. In
5. FY 2010 HRSA anticipates publishing additional notices for public comments in the Federal Register. Additional guidance needed to manage new initiatives will be issued in FY 2011.

6. Patient Safety and Clinical Pharmacy Services Collaborative (PSPC) - HRSA responded to the Committee's encouragement to establish a collaborative to identify and implement

leading practices which may improve patient care quality and avoid adverse events by establishing the pharmacist as an integral part of a patient-centered, inter-professional health care team. Collaborating with OPA are HRSA's Center for Quality, Office of Health Information Technology, other programs and external stakeholders including FDA's Office of Women's Health. The purpose of this FDA relationship was to reach underserved populations with medication safety and effectiveness information using specially trained health care professionals across the Nation. The PSPC used a "collaborative care model" with 68 teams that represented more than 200 safety net providers in 37 states to identify and disseminate best practices to other safety-net providers. A second PSPC cohort will continue through 2010 and will include over 100 teams composed of over 300 organizations from 47 states.

Information Technology (IT) Program Descriptions

HRSA has contracted for the design and development of a new database to manage information on covered entities, contract pharmacies, and manufacturers. This system is in production and is being further developed to address the needs of stakeholders and improve the integrity of data entered. Concurrently, HRSA has contracted to develop a secure database module to accurately compute 340B ceiling prices. Continued work on HRSA's system prototype enables independent calculation of 340B ceiling prices and development of capabilities to validate and crosscheck the ceiling prices provided by manufacturers. This IT investment also includes maintenance of the existing system, emergency contingency plans and security requirements

HRSA supported performance outcomes:
The primary products are the 340B online public access database, required by legislation, to be used by any parties using the 340B Program, and the pricing module to be used to validate manufacturers' calculation of the 340B ceiling price. This investment allows OPA to improve its ability to respond to customer needs and improve 340B Program integrity. This project supports element 1.1 – to ensure accountability for business results by making sure stakeholders have accurate 340B program data on which to base their sales projections or other business decisions.

Section 508 compliance of the PSSC/OPA Web-site will be included in FY 2011 Planning. The purpose of this project is to make the PSSC Web-content 508 compliant and to establish a ".gov" domain. This project supports element 1.1 to strategically manage information technology to support the fair, consistent, transparent and efficient administration of the 340B Program.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Covered Entity Served	13,600	14,400	14,800	400
TA Consultations	800	1,000	1,200	200

State Health Access Program

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$75,00,000	---	$75,000,000	$75,000,000	---
FTE	1	---	2	2	---

Authorizing Legislation: Section 301 of the Public Health Service Act.

FY 2011 Authorization……..……Such Sums as Necessary

Allocation Method……..Competitive Grants

Program Description and Accomplishments

The State Health Access Program (SHAP), established in 2009, supports grants to States to implement a program design that will expand access to affordable health care coverage for the uninsured populations in that State. States are required to demonstrate that they have achieved the key State and local statutory or regulatory changes required to implement the new program within 12 months from the grant start date. The type of activities supported include, but are not limited to: "three share" community coverage (employer, State or local government, and the individual); reinsurance plans that subsidize a certain share of carrier losses within a certain risk corridor; subsidized high risk insurance pools; health insurance premium assistance; creation of a state insurance "connector" authority to develop new, less expensive, portable benefit packages for small employers and part-time seasonal workers; development of state-wide or automated enrolment systems for public assistance programs; health savings accounts; and innovative strategies to insure low-income childless adults.

Two types of grants are funded: target grants of $2-$4 million annually per State for those States that choose to target particular populations such as uninsured children, small business employees, or uninsured seniors; or comprehensive grants of $7-$10 million annually per State for those States planning extensive coverage initiatives. States are required to match 20 percent of the Federal grant through non-Federal sources and demonstrate their ability to sustain the program without Federal funding after the end of the five-year grant period. Waiver of the matching requirement is possible if financial hardship is demonstrated. Grants were awarded in 2009 to 13 states to support the expansion of health care coverage for their uninsured populations. These grants have a five year project period.

The 13 SHAP grantees are all working towards decreasing the number of uninsured on their states. Populations to be covered include children, parents, low-income childless adults, part-time, seasonal workers, young adults and pre-Medicaid population. Coverage expansion will be

accomplished through various types of programs including three-share, premium assistance, health insurance exchanges, and new benefit packages.

States such as Colorado, New York, and Wisconsin are working on developing benefit packages that target the working, childless adults who cannot afford or do not have access to employer-sponsored coverage. The costs of these benefit packages will be covered in various forms including premium assistance, subsidies, and three-share models.

Minnesota and Virginia are working towards programs that combine coverage in a standard benefit package with prevention and wellness programs.

Oregon, Texas, and Washington State are looking at implementing three-share models, reinsurance pools, and insurance exchanges to assist their low-income/small-business employees with obtaining coverage.

Nevada, North Carolina, and West Virginia will link their eligible participants with medical homes in their community, ensuring basic primary care and some specialty services. Maine will also be performing a small demonstration on medical homes during their five-year grant period.

Funding includes costs associated with grant reviews, processing of grants through HRSA's electronic handbook, follow-up performance reviews, and other administrative costs.

Funding History

FY	Amount
FY 2006	$---
FY 2007	$---
FY 2008	$---
FY 2009	$75,000,000
FY 2010	$75,000,000

Budget Request

The FY 2011 Request of $75,000,000 is the same as the FY 2010 Appropriation and will support awards to existing grantee States. In addition, funds will be used to provide technical assistance to grantees.

In 2008, 45.7 million people in the United States did not have health insurance. This is roughly one out of every five non-elderly Americans. Of these, 71 percent or 27.8 million worked during the year – 75.3 percent working full-time and 24.7 percent working part-time. Nationally, 7.3 million children are uninsured. There is considerable public and private support for examining and implementing new models for providing access to affordable health coverage.

Funding in FY 2011 will allow previous grantees to continue their efforts to implement expanded health care coverage. It is projected that all FY 2011 funding will be used on continuation grants. All grantees will be required to make their activities consistent with any enacted health care reform legislation.

Program Output Table

SHAP grants were funded for the first time in September 2009. At this time, there are no outcomes to report.

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request
Number of Awards	13	---	13	13
Average Award	$5,000,000	---	$6,000,000	$6,000,000
Range of Awards	$912,658 - $10,000,000	---	$3,000,000 - $10,000,000	$3,000,000 - $10,000,000

Office of Rural Health Policy

Summary of the Request

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$176,096,000	$1,008,000	$185,528,000	$141,769,000	$43,759,000
FTE	5	---	6	4	-2

The purpose of the Office of Rural Health Policy (ORHP) is to serve as a focal point for rural health activities within the Department. The Office meets that charge by serving as a policy and research resource on rural health issues. In addition, the Office administers several grant programs that focus on supporting and enhancing health care delivery in rural communities. Created in 1987, ORHP advises the Secretary and other components of the Department on rural health issues with a particular focus on working with rural hospitals and other rural health care providers to ensure access to high quality care in rural communities. The Department has maintained a significant focus on rural activities for more than 20 years. Historically, rural communities have struggled with issues related to access to care, recruitment and retention of health care providers and maintaining the economic viability of hospitals and other health care providers in isolated rural communities.

There are nearly 50 million people living in 2,052 rural counties throughout America who face ongoing challenges in accessing health care. Rural residents have higher rates of age-adjusted mortality, disability, and chronic disease than their urban counterparts.[1] Rural areas also continue to suffer from a shortage of diverse providers for their communities' health care needs and face workforce shortages at a greater rate than their urban counterparts.[2,3] Of the 2,052 rural counties in the U.S., 1,582 (77%) are primary care health professional shortage areas (HPSAs).[4]

Improve Rural Health Initiative

Within the total amount requested for Rural Health activities, the Budget includes $79 million to continue the President's initiative to improve rural health. The goal for of this initiative is to improve the access to and quality of health care in rural areas.

To achieve this goal, the initiative focuses on five activities:

[1] Economic Research Service (August 2009). Health Status and Health Care Access of Farm and Rural Populations. Economic Information Bulletin Number 57. Washington, D.C. U.S. Department of Agriculture.

[2] Doescher, M., Fordyce, M., Skillman S., WWAMI Rural Health Research Center Presentation: The Aging of the Rural Generalist Workforce. February 2009.

[3] Area Resource File (ARF). 2008. US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Rockville, MD.

[4] WWAMI Rural Health Research Center. Aging of the rural generalist workforce. Seattle, WA: WWAMI Rural Health Research Center, University of Washington; July, 2009

1. Strengthening rural health care infrastructure;
2. Improving the recruitment and retention of health care providers in rural areas
3. Building an evidence base for programs that improve rural community health;
4. Providing direct health care services;
5. Improving the coordination of rural health activities within HRSA, the Department of Health and Human Services, and across the Federal government

The three programs within the Office of Rural Health directly that support these five activities and make up this initiative are:

Rural Health Care Services Outreach, Network, and Quality Improvement

These programs help existing rural networks improve the coordination of health services in rural communities and strengthen rural healthcare infrastructures. These programs help to improve access to and the quality of health care in rural areas by supporting two of the initiative's six components: *strengthening rural health care infrastructure* and *providing direct health care services*.

State Offices of Rural Health Grants

This program provides technical and other assistance to rural health providers and helps rural communities recruit and retain healthcare professionals. This program also supports the *improving the recruitment and retention of health care providers in rural areas* component of the initiative.

Telehealth grants

This program expands the use of telecommunications technologies within rural areas that can link rural health providers with specialists in urban areas, thereby increasing access to and the quality of healthcare provided to rural populations. Telehealth technology also offers important opportunities to improve the coordination of care in rural communities by linking rural health care providers. These grants support the initiative by helping to *strengthen rural health care infrastructure* and directly increasing access to and the quality of health care in rural areas.

The initiative will use the existing funding levels of these programs while using new investments to conduct program evaluations and build an evidence base for new ways to improve health care in rural communities. Evaluations will focus on measuring:

1. Program impact on the health status of rural residents with chronic conditions such as diabetes, cardiovascular disease, and obesity.
2. The return on investment for rural grantees and communities; and
3. The economic impact of the Federal investment in rural communities.

The initiative will also identify lessons learned and common challenges faced by rural grantees. These best practices, lessons learned, and common challenges-will be disseminated across the nation as models that can be replicated.

In support of this initiative the Office of Rural Health (ORHP) will work to increase coordination with other agencies that fund programs that benefit rural communities within HRSA, HHS, and across the Federal government. This will include increasing rural participation in health professional training and service programs in Title VII and VIII of the Public Health Service Act as well as the National Health Service Corps. ORHP will also seek out new collaborations and increase coordination with the Departments of Agriculture, Labor, Transportation, and Veterans Affairs.

Evaluations

The ORHP programs (excluding the Radiation Exposure Screening and Black Lung programs) have two annual performance measures established during a 2003 program assessment. The Rural Health Care Services Outreach program served 828,360 individuals in FY 2008, which exceeded the target of 635,000. This is a substantial improvement from FY 2006 in which 627,120 individuals were served. The Rural Hospital Flexibility Grant program has helped improve operating margins for Critical Access Hospitals (CAHs) with these facilities reporting a -1.9 percent operating margin in 2008, an improvement from FY 2006 when CAHs had an average operating margin of -8.8 percent. This reflects a continued improvement trend as the targets have been exceeded each year since the benchmark of -14.05 percent operating margin was set based on 1999 data.

The ORHP programs went through a single entity program assessment under the title of 'Rural Health Activities' in 2003. The assessment cited that some of its programs may be duplicative of other programs within HHS and that one of the primary challenges for the programs comes from flaws in the program's various program authorizations, which are fragmented. As a result, ORHP has developed new health and quality-related annual performance measures and will continue its development of additional measures to further demonstrate program accomplishments.

Funding History

FY	Amount
FY 2006	$191,799,000
FY 2007	$166,890,000
FY 2008	$186,472,000
FY 2009	$176,096,000
FY 2009 Recovery Act	$ 1,008,000
FY 2010	$185,528,000

Budget Request

The FY 2011 President's Budget Request for the Office of Rural Health is $141,769,000 a decrease of $43,759,000 from the FY 2010 Appropriation level. Within this amount, the three programs that make up the 'improve rural health initiative' are together funded at $79 million, $1 million above the level of funding they received in FY 2010. This includes $57,266,000 for Rural Health Care Services Outreach grants, $10,075,000 for State Offices of Rural Health, and $11,600,000 for Telehealth grants.

The Budget Request also includes funding for the following rural health activities:

- $9,950,000 for Rural Health Policy Development, which is equal to the FY 2010 Appropriation level. Funding will support activities such as the rural health research center grant program as well as policy analysis and information dissemination activities on a range of rural health issues.
- $41,200,000 for Rural Hospital Flexibility Grants, which is equal to the FY 2010 Appropriation level. The Rural Hospital Flexibility Grants have supported grants that assist small rural hospitals including Critical Access Hospitals.
- $2,526,000 for Rural and Community Access to Emergency Devices which is equal to the FY 2010 Appropriation level. The Rural Access to Emergency Devices and Public Access to Defibrillation Demonstration Grants provides funds to communities for the purchase of automatic external defibrillators and the training of first responders in their use.
- $1,952,000 for Radiation Exposure Screening and Education Program (RESEP), which is equal to the FY 2010 Appropriation level. The purpose of this program is to provide grants to States, local governments, and appropriate healthcare organizations to support programs for individual 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.
- $7,200,000 for Black Lung Clinics, which is equal to the FY 2010 Appropriation level. The purpose of this program is to commit funds through project grants for establishing clinics that provide for the outreach and education, diagnosis, treatment, rehabilitation, and benefits counseling of active and retired coal miners and other with occupation-related respiratory and pulmonary impairments.
- $11,600,000 for Telehealth, which is equal to the FY 2010 Appropriation level. The purpose of this program is to provide important tools for addressing shortages of personnel and services in both urban underserved and rural communities with the use of electronic information and telecommunications technologies to support clinical healthcare, patient and professional health-related education, public health, and health administration.

The Budget includes no funding for the Denali Commission, a decrease of $10,000,000 from the FY 2010 Appropriation level, or the Delta Health Initiative, a decrease of $35,000,000 from the FY 2010 Appropriation level.

The Denali Commission, an Agency of the Department of Commerce, supports the planning, designing and construction of health care facilities in Alaska. Delta Health Initiative grants are distributed to the Delta region of the State of Mississippi to increase rural training of health care professionals, expand the use of electronic health records, and construct healthcare facilities. The Office of Rural Health Policy and other programs in HRSA address many of these needs.

Outcomes and Outputs Tables

Long-Term Objective: Focus resources and services on diseases and conditions with the greatest health disparities.

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
27.1: Reduce the proportion of rural residents of all ages with limitation of activities caused by chronic conditions. [1] (Outcome)	FY 2000: 14.67% (Baseline)	13.9%	N/A	N/A
27.IV.A.1: Increase the number of people served through Outreach Grants (Outcome)	FY 2008: 828,360 (Target Exceeded)	950,000	980,000	+30,000

Long Term Objective: Increase collaborative efforts to improve the capacity and efficiency of public health and health care systems.

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
27.2: Increase the proportion of critical access hospitals with positive operating margins. [2] *(Outcome)*	FY 1999: 10% (Baseline)	N/A	N/A	N/A
27.V.B.1: Increase the average operating margin of critical access hospitals *(Outcome)*	FY 2008: -1.9% (Target Exceeded)	0.5% point below FY 2009	0.5% point below FY 2010	-0.5% point
27.E: Increase the return on investment of funds by the Rural Hospital Flexibility (FLEX) grant program, as measured by change in total operating margin of critical access hospitals in relation to FLEX dollars invested *(Efficiency)*	FY 2007: 68% (TargetExceeded)	28%	29%	+1

[1] This is a long-term measure with no annual targets. Long-term targets established for this measure are: 13.9% by 2010 and 13.0% by FY 2013.

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

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request
Number of Awards	280	---	301	400
Average Award	$178,000	---	$178,000	$175,000
Range of Awards	$75,000 - $530,000	---	$75,000 - $530,000	$75,000 - $530,000

Grant Awards Table - Telehealth

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY2011 President's Budget Request
Number of Awards	23	2	39	39
Average Award	$294,461	$500,000	$262,195	$262,195
Range of Awards	$225,000-$487,950	$450,000-$550,000	$250,000-$325,000	$250,000-$325,000

Rural Health Policy Development

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$9,700,000	---	$9,950,000	$9,950,000	---
FTE	---	---	---	---	---

Authorizing Legislation - Section 301 of the Public Health Service Act, Section 711 of the Social Security Act.

FY 2011 Authorization .....Indefinite

Allocation Method .....Competitive Grant

Program Description and Accomplishments

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

The ORHP Rural Health Research Center Grant program is a major component of the Rural Health Policy Development activities. It is the only Federal research program specifically designed to provide both short- and long-term policy relevant studies on rural health issues. Grants are awarded to six Research Centers annually. The work of the Centers is published in policy briefs, academic journals, research papers, and other venues and is made available to policy makers at both the Federal and State levels. In 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 healthcare infrastructure. In addition to the research center grants, the Rural Health Policy Development Activities also support up to three single new research awards each year on select policy-relevant topics and the administration of two additional cooperative agreements that focus on data and trend analysis on new and ongoing policy issues. These agreements are used to support data needs across the Department.

Another major component of the 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 key rural issues for the Secretary. The Rural Health Policy activities also play a key role in serving as a key broker of information on rural health issues through a cooperative agreement with the Rural Assistance Center (RAC). The RAC responds individually to hundreds of inquiries each month by both phone and e-mail and disseminates information through its web site and various reports and information guides on a range of key rural health issues.

In FY 2008, the program produced 30 research reports, meeting the target. This program was also covered in a program assessment of HRSA's Rural Health Activities in 2003. Please refer to the earlier reference regarding the program assessment in the Office of Rural Health Policy Summary.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$8,731,000
FY 2007	$8,737,000
FY 2008	$8,584,000
FY 2009	$9,700,000
FY 2010	$9,950,000

Budget Request

The FY 2011 President's Budget Request for Rural Health Policy is $9,950,000 which is equal to the FY 2010 Appropriation level. Funding will support activities such as the rural health research center grant program as well as policy analysis and information dissemination activities on a range of rural health issues. This program will support the production of 30 reports in FY 2011.

Outcomes and Outputs Tables

Long-Term Objective: Utilize trend data to assist in targeting program resources toward goals.

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
28.V.A.1: Conduct and disseminate policy relevant research on rural health issues. (Outcome)	FY 2008: 30 (Target Met)	30	30	---

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request
Number of Awards	12	---	12	12
Average Award	$750,000	---	$750,000	$750,000
Range of Awards	$150,000 - $1,000,000	---	$150,000 - $1,000,000	$150,000 - $1,000,000

Rural Healthcare Services Outreach, Network and Quality Improvement Grants

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$53,900,000	---	$56,025,000	$57,266,000	+$1,241,000
FTE	---	---	---	---	---

Authorizing Legislation - Section 330A of the Public Health Service Act, as amended by P.L. 107-251.

FY 2011 Authorization .....Expired

Allocation Method .....Competitive Grants

Program Description and Accomplishments

The Rural Healthcare Services Outreach, Network and Quality Improvement Grants are a subcomponent of the Office of Rural Health Policy. The purpose of the grants is to improve access to care, coordination of care, integration of services and to focus on quality improvement. The grants began as a demonstration program in 1993 and were formally authorized in 1996. There are multiple grant programs administered under this authority. All of the grants support collaborative models to deliver basic healthcare services to the 55 million Americans living in rural areas.

The Rural Healthcare Services Outreach grant program is part of the "Improve Rural Health 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. It focuses on supporting community efforts to increase access to primary healthcare services for rural Americans. The program supports a wide range of services, including primary medical and dental care, mental health treatment, and health promotion and health education services. This program is part of the 'Provide Direct Health Care Services' component of the "Improve Rural Health" Initiative. The program awarded 111 new grants and 27 continuation grants in FY 2009. Program expects to award as many as 50 new grants and 111 continuation grants in FY 2010 and 160 continuation grants in FY 2011.

The Rural Healthcare Services Outreach program legislation includes four additional programs:

Rural Network Development grants which support building regional or local partnerships among local hospitals, physician groups, long-term care facilities and public health agencies to improve management of scarce healthcare resources. This program is part of the 'Strengthening Rural

Health Care Infrastructure' component of the "Improve Rural Health initiative". The program expects to award as many as 55 grants in FY 2011.

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Delta States Network Grant Program, which began in 2001 and provides network development grants to the eight States in the Mississippi Delta for network and rural health infrastructure development. The program will award 12 continuation grants in FY 2011.

Network Planning grants, which began in 2004, brings together key parts of a rural health care delivery system so they can work together to establish or improve local capacity and coordination of care. This program is part of the 'Strengthening Rural Health Care Infrastructure' component of the "Improve Rural Health" Initiative. The program will award as many as 20 new grants in FY 2011**.**

Small Healthcare Provider Quality Improvement Grants which began in 2006. These grants help small healthcare providers focus on specific interventions to improve healthcare quality in specific chronic disease areas. This program is part of the 'Improving the Quality of Health Care Services in Rural Areas' component of the "Improve Rural Health" Initiative. The program expects to awards as many as 60 new grants in FY 2010 and 60 continuation awards in FY 2011.

In FY 2008, the Outreach program served 828,360 individuals, which exceeded the target of 635,000. This is a considerable improvement from 2006 in which 627,120 individuals were served. This difference is due to adjustments made to the awards process (which led to increased awards) as well as an increase the amount and quality of technical assistance for potential applicants. That number is expected to steadily increase as the funding level for this program increased by approximately $2 million in FY 2010 over the FY 2009 Appropriation and $1.3 million in the FY 2011 President's Budget.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$38,858,000
FY 2007	$38,885,000
FY 2008	$48,031,000
FY 2009	$53,900,000
FY 2010	$56,025,000

Budget Request

The FY 2011 President's Budget Request for Rural Healthcare Services Outreach, Network and Quality Improvement Grants is $57,266,000 which is an increase of $1,241,000 above the FY 2010 Appropriation level. This funding will continue to support key activities for Rural Healthcare Services Outreach, Network and Quality Improvement Grants programs. It is part of the "Improve Rural Healthcare" Initiative to help existing rural networks improve the coordination of health services in rural communities and strengthen the rural healthcare systems as a whole. The performance target for FY 2011 is for the program to serve 980,000 individuals. In FY 2011, the program will support approximately 160 Outreach Services grants, 12 Delta Network Development grants, 55 Network Development grants, 60 quality improvement grants and 20 Network Planning grants.

Outcomes and Outputs Tables

Long Term Objective: Focus resources and services on diseases and conditions with the greatest health disparities.

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
29.IV.A.1: Increase the number of people served through Outreach Grants. (Outcome)	FY 2008: 828,360 (Target Exceeded)	950,000	980,000	+30,000

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request
Number of Awards	274	---	284	307
Average Award	$178,000	---	$178,000	$175,000
Range of Awards	$75,000 - $530,000	---	$75,000 - $530,000	$75,000 - $530,000

Rural Access to Emergency Devices

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$1,751,000	---	$2,526,000	$2,526,000	---
FTE	2	---	2	2	---

Authorizing Legislation - Section 313 of the Public Health Service Act. And Section 413 of Public Law 106-505

FY 2011 Authorization – Rural Access to Emergency Devices…….……..Expired
FY 2011 Authorization – Public Access Defibrillation Demonstration……...……Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Rural Access to Emergency Devices (RAED) Grant program is a key component of the Office of Rural Health Policy. The RAED program began in 2002 and provides funds to community partnerships which then purchase and distribute automatic external defibrillators (AEDs) to be placed in rural communities. The grants also provide training in the use of AEDs by emergency first responders. For the first four years of this program, large grants were given to States through a competitive process and the States then worked with their rural communities to identify where to place the AEDs and how to conduct training in their use. In FY 2006, the program was restructured and began making direct grants to community partnerships. The program will award four continuation grants in FY 2010 and expects to award as many as 5 grants in FY 2011.

In FY 2004, additional funding was allocated for the Public Access to Defibrillation Demonstration Projects (PADDP). The purpose of this program is to support grants to political subdivision of States, federally recognized Native American Tribes, or Tribal Organizations to develop and implement innovative, comprehensive, community-based public access defibrillation demonstration projects. The intent of the grant program is to support projects that will increase public access to emergency medical devices and services. The program will award five continuation grants in FY 2010 and FY 2011.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$1,484,000
FY 2007	$1,485,000
FY 2008	$1,461,000
FY 2009	$1,751,000
FY 2010	$2,526,000

Budget Request

The FY 2011 President's Budget Request for Rural Access to Emergency Devices is $2,526,000 which is equal to the FY 2010 Appropriation level. This funding will continue to maintain current service levels and support key activities for the Rural Access to Emergency Devices program and the Public Access Defibrillation Demonstration Project.

In FY 2011, the RAED program expects to award up to five grants and the PADDP program expects to award up to five grants. That investment should support the placement of more than 750 AEDs in communities and training for 2,000 individuals.

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request
Number of Awards	9	---	9	9
Average Award	$150,000	---	$150,000	$150,000
Range of Awards	$50,000-$180,000	---	$50,000- $180,000	$50,000-$180,000

Rural Hospital Flexibility Grants

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$39,200,000	---	$41,200,000	$41,200,000	---
FTE	---	---	---	---	---

Authorizing Legislation - Section 1820(j), Title XVIII of the Social Security Act.

FY 2011 Authorization .....Expired

Allocation Method .....Competitive Grants

Program Description and Accomplishments

The Rural Hospital Flexibility activities are a component of the Office of Rural Health Policy and support a range of activities focusing on small rural hospitals including Critical Access Hospitals. There are three grant programs administered under this authority, both of which assist small rural hospitals. These grant programs are also a part the "Improve Rural Health" 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.

The first program is the Rural Hospital Flexibility (Flex) grant program, which began in 1999. This program provides grants to States to support small rural and critical access hospitals (CAHs). The purpose of the program is to provide support to 1,300 CAHs by focusing on a range of performance and quality improvement activities including public reporting of quality data and a broad spectrum of clinical and financial benchmarking activities. The 45 grants awarded through the program also support States to encourage CAHs to work with rural emergency medical service providers to promote coordination and integration of pre-hospital care. This program is part of the 'Improving the Quality of Health Care Services in Rural Areas' component of the "Improve Rural Health" Initiative. The program will award 45 grants in 2011.

The second program is the Small Hospital Improvement Program (SHIP), which began in 2002. This program provides grants of about $8,000 to more than 1,600 eligible hospitals (hospitals with 50 beds or less located in a rural area). The purpose of the program is to assist small rural hospitals in quality and performance improvement. The 46 grants awarded through this program provide support to these rural hospitals to focus on improving billing systems, complying with privacy and security requirements and quality data submission. This program is part of the

'Improving the Quality of Health Care Services in Rural Areas' component of the "Improve Rural Health" Initiative.

The third program is the Mental Health Services and other Health Services to Veterans and Other Residents of Rural Areas Program which will begin in 2010. This program provides grants to States that focus on increasing the delivery of mental health services or other health care services deemed necessary to meet the needs of veterans of Operation Iraqi Freedom and Operation Enduring Freedom living in rural areas, including for the provision of crisis intervention services and the detection of posttraumatic stress disorder, traumatic brain injury, and other signature injuries of veterans of Operation Iraqi Freedom and Operation Enduring Freedom, and for referral of such veterans to medical facilities operated by the Department of Veterans Affairs, and for the delivery of such services to other residents of such rural areas. This program will award up to 3 grants in FY 2011.

Programs	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request
Rural Hospital Flexibility (Flex) Grant Program	$24,200,000	---	$25,200,000	$25,200,000
Small Hospital Improvement Program (SHIP)	$15,000,000	---	$15,000,000	$15,000,000
Mental Health Services and Other Health Services to Veterans and Other Residents of Rural Areas Program	---	---	$1,000,000	$1,000,000

The Flex performance measures reflect efforts to increase the financial viability of Critical Access Hospitals (CAHs) so they can continue to provide needed access to inpatient, outpatient and emergency care for isolated rural communities. The program uses CAH financial operating margin data as a measure of financial viability. In FY 1997, when this designation first became available, CAHs had an average operating margin of -28 percent. The most recent period for which Medicare cost report data is available shows that in FY 2008, CAHs had an average operating margin of -1.9 percent, which is an considerable improvement from the original baseline margin of -14.05 and better than the 2007 performance of -6.7.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$63,494,000
FY 2007	$63,538,000
FY 2008	$37,865,000
FY 2009	$39,200,000
FY 2010	$41,200,000

Budget Request

The FY 2011 President's Budget Request for Rural Hospital Flexibility Grants is $41,200,000 which is equal to FY 2010 Appropriation level. The FY 2011 target for the average operating margin of CAHs is 0.5 percent point below the FY 2010 result. This funding will continue to support a range of activities focusing on small rural hospitals including Critical Access Hospitals. The activities supported through this funding will encourage hospitals to report quality data to Hospital Compare and to invest grant dollars in EMS training and trauma system development.

Outcomes and Outputs Tables

Long-Term Objective: Increase the collaborative efforts to improve the capacity and efficiency of public health and healthcare systems.

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
30.V.B.1: Increase the average operating margin of critical access hospitals. (Output)	FY 2008: -1.9% (Target Exceeded)	0.5% point below FY 2009	0.5% point below FY 2010	-0.5% point
30.V.B.2: Appropriate rural facilities will be assisted in converting to Critical Access Hospital (CAH) status to help stabilize their financial status. [1] (Outcome)	FY 2008: 1,298 (Target Exceeded)	1,290	1,290	Maintain
30.V.B.3: Facilities and communities will be assisted in the development of networks. (Outcome)	FY 2008: 2,607 (Target Exceeded)	2,690	N/A[2]	N/A
30.V.B.4: Increase the percent of Critical Access Hospitals reporting at least one measure to Hospital Compare. (Outcome)	FY 2007: 69% (Target Not In Place)	72%	74%	+2
30.V.B.5: Number of individuals trained in emergency medical services leadership and/or trauma courses. (Outcome)	FY 2008: 3,613 (Baseline)	3615	3615	Maintain

[1] The number of hospitals likely to convert to CAH status is nearing its maximum and this measure is being phased out. The Program has introduced a new measure (30.V.B.4) to gauge CAH performance.
[2] This measure will be discontinued in FY 2011.

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request
Number of Awards	45	---	45	45
Average Award	$483,000	---	$490,000	$490,000
Range of Awards	$256,000 - $640,000	---	$256,000 - $640,000	$256,000-$640,000

Delta Health Initiative

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$26,000,000	---	$35,000,000	---	-$35,000,000
FTE	2	---	2	---	-2

Authorizing Legislation - Section 219 of Public Law 110-161.

FY 2011 Authorization .....Expired

Allocation Method .....Competitive Grant

Program Description and Accomplishments

1. The Delta Health Initiative (DHI) is a subcomponent of the Office of Rural Health Policy (ORHP). The purpose of this grant is to meet healthcare needs in the rural Delta region of the State of Mississippi with an emphasis on improving access to rural healthcare services, increased rural training of healthcare professionals, and implementation of electronic health records and the construction of healthcare facilities. The program awarded a single grant in FY 2009 that funds up to 24 individual projects across the region annually. Three of these projects entailed the construction of public health facilities. This program is listed as a Congressionally-directed earmark in http://earmarks.omb.gov.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$25,000,000
FY 2007	---
FY 2008	$24,563,000
FY 2009	$26,000,000
FY 2010	$35,000,000

Budget Request

FY 2011 President's Budget does not request funding for the Delta Heath Initiative. This is a decrease of $35,000,000 from the FY 2010 Appropriation level. Since its initial funding in FY 2006, many projects continue to date as a result of its initial "seed" money. There is no further request as the needs of this region have been largely met through prior investments. The needs in this region can best be met by other existing programs, such as the Health Center program which can address the health system delivery problems of the Delta.

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 Recovery Act	FY 20010 Appropriation	FY 2011 President's Budget Request
Number of Awards	1	---	1	---
Average Award	$24,543,000	---	$35,000,000	---
Range of Awards	$24,543,000	---	$35,000,000	---

State Offices of Rural Health

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$9,201,000	---	$10,075,000	$10,075,000	---
FTE	---	---	---	---	---

Authorizing Legislation - Section 338J of the Public Health Service Act.

FY 2011 Authorization .....Expired

Allocation Method .....Competitive Grants

Program Description and Accomplishments

The State Office of Rural Health Grant (SORH) program is a key component of ORHP. The SORH program was created in 1992 to support rural healthcare in each of the 50 States by providing grants to States to establish and maintain SORHs. The grantees collect and disseminate health-related information in rural areas. They also provide technical and other assistance to rural health providers, including small rural hospitals. SORHs also help communities recruit and retain health professionals. Each dollar of Federal support for the program is matched by three State dollars. The SORH program is part of the "Improve Rural Healthcare" 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 and falls under the 'Improve the Recruitment and Retention of Health Care Providers in Rural Areas" component of the Initiative.

The SORH program currently has five performance measures. One measures the number of communities receiving technical assistance from State Offices of Rural Health. These Offices play a critical role as an information resource and focal point for rural health activities within their States. In the baseline year of FY 2003, the grantees worked with 4,120 communities. That increased to 6,131 rural communities in FY 2008. Beginning in FY 2011, this performance measure will be discontinued because it does not provide an accurate representation of the technical assistance (TA) activities that are provided by SORHs. In addition, it is difficult for SORHs to consistently account for communities when many TA activities are directed to specific groups, organizations, individuals, or specific communities. Two new measures were developed to capture technical assistance activities and focus on the number of technical assistance encounters provided directly to clients by SORHs as well as the number of clients that receive technical assistance directly to SORHs. The FY 2008 baseline for the number of technical assistance encounters provided directly to clients is 68,307 and the FY 2008 baseline for the

number of clients that receive technical assistance directly is 34,876. Another measure focuses on recruitment of health professionals for rural communities, which is one of the key activities across the 50 State Offices of Rural Health. In the baseline year of FY 2003, 41 of 50 grantees identified a focal point for the recruitment and retention of healthcare professionals in rural areas. In FY 2008, the target was exceeded with 49 out of 50 State Offices identifying a recruitment and retention focal point. The FY 2010 target is 50. As a result, this measure will be discontinued in FY 2011 because it will have reached its maximum level. The final measure will help to capture the number of clinician placements facilitated by the SORHs through recruitment initiatives. The FY 2008 baseline for this measure is 1,023.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$8,135,000
FY 2007	$8,141,000
FY 2008	$7,999,000
FY 2009	$9,201,000
FY 2010	$10,075,000

Budget Request

FY 2011 President's Budget Request for State Offices of Rural Health is $10,075,000 which is equal to the FY 2010 Appropriation level. This funding will continue to support key activities for the State Offices of Rural Health program and will support a grant award to each of the 50 States. It is part of the "Improve Rural Healthcare" Initiative to provide technical and other assistance to rural health providers and help rural communities recruit and retain healthcare professionals. The FY 2011 targets have been established for the three new SORH measures. The FY 2011 target for the number of technical assistance encounters provided directly to clients is 69,680. The FY 2011 target for the number of clients that received technical assistance directly from SORHs is 35,577. The FY 2011 target for the number of clinician placements facilitated by the SORHs is 1,043.

Outcomes and Outputs Tables

Long-Term Objective: Increase collaborative efforts to improve the capacity and efficiency of the public health and healthcare systems.

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
31.V.B.1: Increase the number of communities receiving technical assistance from a State Office of Rural Health. (Outcome)	FY 2008: 6,131 (Target Exceeded)	5,250	N/A	N/A
31.V.B.2: Increase the number of States that have an identified focal point for rural recruitment with a national source of applications. (Outcome)	FY 2008: 49 (Target Exceeded)	50	N/A	N/A
31.V.B.3: Number of technical assistance (TA) encounters provided directly to clients by SORHs. (Outcome)	FY 2008: 68,307 (Baseline)	68,990	69,680	+690
31.V.B.4: Number of clients (unduplicated) that received technical assistance directly from SORHs. (Outcome)	FY 2008: 34,876 (Baseline)	35,225	35,577	+352
31.V.B.5: Number of clinician placements facilitated by the SORHs through their recruitment initiatives. (Outcome)	FY 2008: 1,023 (Baseline)	1,033	1,043	+10

This measure will be discontinued in FY 2011.

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request
Number of Awards	50	---	50	50
Average Award	$160,000	---	$160,000	$160,000
Range of Awards	$150,000 - $165,000	---	$150,000 - $165,000	$150,000 - $165,000

Denali Commission

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$19,642,000	---	$10,000,000	----	-$10,000,000
FTE	---	---	---	---	---

Authorizing Legislation - Section 309 of Public Law 105-277, as amended by P.L. 106-113.

FY 2011 Authorization ..... Expired

Allocation Method ..... Interagency Agreement

Program Description and Accomplishments

The Denali Commission, an Agency of the Department of Commerce, which began in 2001, is modeled on the Appalachian Regional Commission and directed by Federal and State (Alaska) co-chairs. Its core mission is economic development in rural Alaska. The $19,642,000 appropriated to HRSA for the Commission in FY 2009 was combined with other resources for planning, designing and constructing primary healthcare facilities in the State. Resources are also used to assist other facilities, such as hospitals and facilities that provide mental health services. The program makes a single annual award to the Commission, which then supports up to 35 individual projects each year. This program is listed as a Congressionally-directed earmark in http://earmarks.omb.gov.

Funding History

FY	Amount
FY 2006	$39,283,000
FY 2007	$39,283,000
FY 2008	$38,597,000
FY 2009	$19,642,000
FY 2010	$10,000,000

Budget Request

FY 2011 President's Budget does not request funding for the Denali Commission. This is a decrease of $10,000,000 from the FY 2010 Appropriation level. The Denali Commission has already received more than $300 million in funding since 2000 for construction in Alaska.

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request
Number of Awards	1	---	1	---
Average Award	$19,642,000	---	$10,000,000	---
Range of Awards	$19,642,000	---	$10,000,000	---

Radiation Exposure Screening and Education Program

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$1,952,000	---	$1,952,000	$1,952,000	---
FTE	1	---	2	2	---

Authorizing Legislation - Section 417C of the Public Health Service Act, as amended by P.L. 106-245.

FY 2011 Authorization .....Expired

Allocation Method .....Competitive Grants

Program Description and Accomplishments

The Radiation Exposure Screening and Education Program (RESEP), which began in 2002, provides grants to States, local governments, and appropriate healthcare organizations to support programs for individual 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 measures the total number of individuals screened at RESEP centers each year. Though the program has been unable to reach its projected targets due to potential patient deaths or relocation; it has demonstrated a consistent increase in users between FY 2005 and FY 2007: 1,551 (FY 2005), 1,464 (FY 2006), and 1,689 (FY 2007).The number of individuals screened in FY 2008 was 1,270 (slightly below the target of 1,700). The target was not met but improvements were demonstrated overall. The reduction was driven primarily by changes in one target population. The number of uranium miners served by the program decreased. In some cases, in which the population of former uranium mine workers is aging rapidly, a cohort of potential patients has died. In other cases, the population of former uranium mine workers has diffused away from the original mine sites. Given these demographic changes, the program has revised its targets accordingly. In addition, the program has undertaken new outreach strategies to identify where this patient population has relocated and to make them aware of available screening sites.

The RESEP program had a program assessment in 2006. The assessment cited that the program does not impose specific and uniform guidelines regarding screening and that there is no

evidence that the program reaches the maximum number of beneficiaries of the beneficiaries who are at the greatest risk. As a result, the program is partnering with the Department of Justice to collect data in support of newly developed long-term performance measures. The program has also adopted steps to ensure that grantees comply with uniform screening guidelines. In addition, the program has undertaken a national outreach campaign to identify potential beneficiaries for the program's services.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$1,916,000
FY 2007	$1,919,000
FY 2008	$1,884,000
FY 2009	$1,952,000
FY 2010	$1,952,000

Budget Request

FY 2011 President's Budget Request for The Radiation Exposure Screening and Education Program is $1,952,000 which is equal to the FY 2010 Appropriation. This funding will continue to support key activities for Radiation Exposure Screening and Education Program. The program will continue to support seven grantees in FY 2011 and the target for the number of individuals screened is 1,400.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
32.1: Percent of RECA successful claimants screened at RESEP centers.) [1] (Outcome)	FY 2008: 8.5% (3-year rolling baseline)	N/A	N/A	N/A
32.2: Percent of patients screened at RESEP clinics who file RECA claims that receive RECA benefits. [1] (Outcome)	FY 2008: 70% (Baseline)	N/A	N/A	N/A
32.I.A.1: Total number of individuals screened per year. (Output)	FY 2008: 1,270 (Target Not Met)	1,400	1,400	Maintain
32.I.A.2: Total number of telephone inquiries to RESEP clinics based on expanded nationwide outreach efforts.(Developmental) [2] (Output)	N/A	N/A	N/A	N/A
32.E: Average cost of the program per individual screened *(Efficiency)*	FY 2008: $1,195 (Target Not Met)	$720	$923	---

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request
Number of Awards	7	---	7	7
Average Award	$216,847	---	$235,827	$237,256
Range of Awards	$180,000 - $279,000	---	$180,000 - $279,000	$180,000 - $279,000

[1] The baselines and targets have been established for long-term measures 32.1 and 32.2. The target for outcome measure 32.1 is 8.8 (FY 2014); the target for outcome measure 32.2 is 72% (FY 2014).
[2] This developmental measure does not have established targets. Program proposes to discontinue this measure based on data limitations.

Black Lung

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$7,200,000	---	$7,200,000	$7,200,000	---
FTE	---	---	---	---	---

Authorizing Legislation - Federal Mine, Health, and Safety Act of 1977, Section 427(a).

FY 2011 Authorization .....Expired

Allocation Method .....Competitive Grants

Program Description and Accomplishments

The Black Lung program was established in 1980 and provides funds through project grants to public and private entities, including faith-based and community-based organizations, for the purpose of establishing and operating clinics that provide for the outreach and education, diagnosis, treatment, rehabilitation, and benefits counseling of active and retired coal miners and others with occupation-related respiratory and pulmonary impairments. Other patients include steel mill workers, agricultural workers, and others with occupationally-related respiratory and pulmonary disease. As persons with respiratory and pulmonary disease age, their disease severity progresses and their need for healthcare services increases along with the cost of those services.

In FY 2008, the program supported services to 11,888 miners. This is an increase over the target of 11,550 miners served as well as the 11,647 miners served in FY 2007. The program also provided 23,403 medical encounters in FY 2008, which exceeded the target of 21,269. In FY 2007, the program provided 22,484 medical encounters.

The Black Lung Program completed a program assessment in 2006. The assessment noted that the program lacked evaluations and performance data to assess the program's effectiveness and that the program lacked mechanisms to effectively target resources. As a result, the program is examining the feasibility of conducting an independent evaluation of the program, establishing baselines and targets for its new long-term performance measure, and collecting data on the location of miners to better target resources and further enhance outreach.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$5,887,000
FY 2007	$5,891,000
FY 2008	$5,788,000
FY 2009	$7,200,000
FY 2010	$7,200,000

Budget Request

The FY 2011 President's Budget Request for Black Lung is $7,200,000 which is equal to the FY 2011 Appropriation level. This funding will continue to support key activities for Black Lung program. The program expects to fund 15 grantees in FY 2011 and expects to meet the target of 12,288 miners served. In addition, the program expects to reach the target of 25,403 medical encounters in FY 2011.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
33.1: Percent of miners that show functional improvement following completion of a pulmonary rehabilitation program.[1] (Outcome)	FY 2008: 80% (Baseline)	N/A	N/A	N/A
33.I.A.1: Number of miners served each year. (Output)	FY 2008: 11,888 (Target Exceeded)	**12,088**	**12,288**	+200
33.I.A.2: Number of medical encounters from Black Lung each year. (Output)	FY 2008: 23,403 (Target Exceeded)	**24,403**	**25,403**	+1000
33.E: Increase the number of medical encounters per $1 million in federal funding. *(Output)*	FY 2008: 3,972 (Target Exceeded)	**4,072**	**4,172**	+100

[1] The baseline and target has been established for long-term measure 33.1. The target for this measure is 85% (2014).

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 Recovery Act	FY 20010 Appropriation	FY 2011 President's Budget Request
Number of Awards	15	---	15	15
Average Award	$376,562	---	$381,562	$381,562
Range of Awards	$116,742 -$697,740	---	$116,742 - $697,740	$116,742 - $697,740

Telehealth

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/ FY 2010
BA	$7,550,000	$1,008,000	$11,600,000	$11,600,000	---
FTE	---	---	---	---	---

Authorizing Legislation: Section 330I of the Public Health Service Act; as amended by Public Law 107-251, and 330L of the Public Health Service Act; as amended by Public Law 108-163.

FY 2011 Authorization ..... Expired

Allocation Method ..... Competitive Grants/Cooperative Agreements and Contracts

Program Description and Accomplishments

As this nation moves to expand access to health care services, addressing the shortages of personnel and services in both urban underserved and rural communities is critical if such reform is to succeed. HRSA's Telehealth programs provide important tools for addressing these shortages. Telehealth is the use of electronic information and telecommunications technologies to support clinical healthcare, patient and professional health-related education, public health, and health administration. Telemedicine, a subset of telehealth technologies, is defined as the use of telecommunications and information technologies to provide or support long-distance clinical care. Telemedicine and other Telehealth technologies are not products or ends in themselves, but the means to provide services at a distance and to overcome geographic, economic, and other social barriers to obtaining health care services. These technologies provide a mechanism to share scarce resources by bringing expertise and information to people, wherever and whenever it is appropriate to do so. Information may be in various forms -- audio, video, data, or text. In the end, the use of these technologies is often transformative, altering the way we provide services into a more efficient and effective system.

These programs are also an integral component of the "Improve Rural Healthcare" Initiative to expand the use of telecommunications technologies that increase the access to and quality of healthcare provided to rural populations. The Telehealth programs strengthen partnerships among rural healthcare providers, recruit and retain rural healthcare professionals, and modernize the healthcare infrastructure in rural areas.

Moreover, these programs are increasingly important in this nation's strategy to address, not only the maldistribution of health care personnel that has resulted in long-standing rural health care personnel shortages, but the nationwide shortage of health professionals that is seriously affecting the provision of health services in urban as well as rural communities. Nationwide, if current trends continue, without considering the impact of health reform, the shortage of primary care physicians alone will reach 40,000 in little more than 10 years, according to the American

Academy of Family Physicians. Medical schools are only graduating about half the needed number of primary care doctors. But shortages are not limited to primary care physicians alone. Overall, the shortage of doctors may grow to 124,400 by 2025, according to a study by the Association of Medical Colleges.

In FY 2006, Congress expanded HRSA's Telehealth programs beyond its Telehealth Network Grant Program (TNGP), which provides grants to healthcare networks to develop and evaluate the use of Telehealth technologies for improving access to underserved communities. The new funding allowed HRSA to add grants for: (a) pilot projects examining the cost impact and value added of tele-home care and tele-monitoring services (Telehealth Networks-Telehomecare); (b) telehealth resource centers (TRCs) to improve technical assistance to communities wishing to establish telehealth services (Telehealth Resource Center Grant Program --TRCGP); and (c) demonstrations to provide incentives for licensure coordination among states (Licensure Portability Grant Program -- LPGP). At the end of FY 2009, 22 new three-year grants were awarded as follows: 17 grants for telehealth networks and telehomecare networks, 4 Telehealth Resource Center grants, and one grant to improve licensure coordination among states. In addition, the grant to the existing National Telehealth Resource Center for Telehealth Legal and Regulatory Issues was extended one year to provide continuation of service while the role of that center is re-evaluated. Thus, a total of 23 grantees were supported under these programs in 2009. All grants were awarded to non-profit organizations, consistent with the statute. A Telehealth Technology Assessment Center was also to be created under an interagency agreement with the Indian Health Service to assist the regional resource centers in providing technical assistance in the selection and evaluation of telehealth technologies. The FY 2009 budget also supported one new contract to assess the use of Telehealth technologies for treating stroke and traumatic brain injury in the United States, the barriers to deployment of these services, and the successes achieved to date.

Under the American Reinvestment and Recovery Act (ARRA), funds were made available to expand activities to promote licensure coordination across states, allowing support of two additional two-year licensure portability grants to be made in FY 2010. The FY 2010 Appropriation will support continuation of the 22 new grants awarded in 2009. The 2010 Appropriation also will fund: 1) a revitalized national Legal and Regulatory TRC; 2) two new TRCs to provide evaluation and technical assistance in the establishment of cost-effective Telehomecare services; 3) six new regional TRCs to serve parts of the nation not currently covered by existing centers; and 4) eight new TNGPs to focus on expanding and evaluating Telehealth services in both urban and rural communities. Thus in FY 2010, a total of 41grants will be funded to support 25 Telehealth Networks, 13 Telehealth Resource Centers, and 3 Licensure Portability projects (1 existing grant funded under the Appropriation and 2 new grants funded under ARRA). In addition, the interagency agreement with the Indian Health Service will be continued to support the Telehealth Technology Assessment Center, and contracts will be awarded to expand performance evaluation and technical assistance activities associated with these programs.

On January 5, 2010, HRSA announced as part of their organizational change that the Office for the Advancement of Telehealth is now within the Office of Rural Health Policy and will

continue to serve as the operational focal point for coordinating and advancing the use of telehealth technologies across all of HRSA's programs.

Table 1. Actual Grant Dollars to be awarded for grants

Programs	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request
Telehealth Network Grant Program	$4,245,802	-----	$6,250,000	$6,250,000
Licensure Portability Grant Program	$350,000	$1,008,000	$350,000	$350,000
Telehealth Resource Center Grant Program	$2,176,800	----	$4,150,000	$4,150,000
Contracts	$507,398	----	$500,000	$500,000
Interagency Agreements	$270,000	----	$350,000	$350,000

The Office for the Advancement of Telehealth (OAT) received a program assessment in 2006. The Program was cited for its success in expanding access to services in underserved rural communities. OAT developed annual performance measures and is tracking performance against benchmarks. In several instances, grantees exceeded the benchmarks, but there is much variation in the data and until a full set of data is available (March 2010) for the first three years of this effort (FY 2006-FY 2008), the targets prior to 2010 will not be revised. Some of the targets for 2010 have been revised, consistent with the significant increase in the Appropriation.

As of FY 2007, this cohort of TNGP grantees provided a total number of 96 clinical services, across 690 sites in underserved rural communities for a total of 786 sites and services. When added to the baseline of 489, TNGP grantees supported 1,275 sites and services in these communities since FY 2005, exceeding the target for that year. In FY 2007, 191 communities had access to pediatric services and 159 communities had access to adult mental health services for which they otherwise would not have had access in the absence of the TNGP grants.

The Program began in FY 2006 to collect data on a long-term measure to assess the program's impact on clinical outcomes in diabetic patients served by the grantees of the TNGP program, targeting control of hemoglobin A1C levels in patients. In FY 2006, 34 percent achieved ideal glycemic control, while in FY 2007, 42 percent were able to achieve ideal glycemic control compared to a target of 21 percent. Data for FY 2008 will be available in March 2010.

To evaluate the performance of its tele-homecare/monitoring grantees, OAT has developed common metrics and data analysis strategies, based on data routinely collected through the OASIS system, which is a nationally recognized standardized data collection system of performance measures. The performance measures focus on the impact of these grants on the cost and effectiveness of the services provided. Common metrics and the analysis plan have been agreed upon. Data are being collected and aggregated from all programs, with a report of the findings from the 2006-2008 cohort of home care grantees available in FY 2010. Common metrics will continue to be collected on new home care grants awarded in FY 2009.

HRSA also has been tracking performance of its Licensure Portability Grant Program (LPGP) grantees. In FY 2006, the Federation of State Medical Boards (FSMB) was awarded a three-year grant to reduce the legal and administrative barriers to states sharing licensure information. In its first year, FSMB established pilot projects in two regions of the country to develop and maintain a centralized interactive data management system. FSMB also compiled state profiles of the technical capabilities to electronically share licensure data for each of the 14 states in the pilot regions, and conducted a policy analysis of each to determine legislative and regulatory barriers to sharing data. A comprehensive policy review of the nine states that have specific telemedicine licenses/registration programs also has been completed.

In FY 2008, the FSMB expanded the focus of its activities, adopting two major objectives: (1) to increase the number of states adopting a common licensure application (a key step in reducing the barriers to licensure portability); and (2) to increase the number of states that participate in mutual recognition of each others licenses. Results from these activities will be available in January 2010.

The National Council of State Boards of Nursing (NCSBN) was also awarded an LPGP grant to identify and implement enhancements to its current program for cross-state recognition of licenses for nurses - the Nurse Licensure Compact (NLC) - and to support states that are in the process of or considering adoption of the NLC. In the first year, NCSBN developed a cost analysis tool as a reference for States to address misconceptions regarding the cost of adopting the NLC. To date, 23 states have implemented a NLC. The NCSBN focused the third year of its grant on a detailed evaluation of the existing NLC and assessing areas for streamlining the compact to facilitate the adoption of it by more states. The final report from this grant will be made available in January 2010.

In FY 2006, six grants were awarded under the Telehealth Resource Center (TRC) grant program. During the first three years of this program, the TRC's provided individualized technical assistance to groups developing Telehealth services, created five detailed toolkits and specialized training materials, and facilitated technical assistance through regional webinars and teleconferences in the 24 states that they cover, including US-Affiliated Pacific Islands. Standard performance measures are under development to evaluate the performance of the TRC grantees beginning in the third quarter of FY 2010.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2006	$6,814,000
FY 2007	$6,819,000
FY 2008	$6,700,000
FY 2009	$7,550,000
FY 2009 Recovery Act	$1,008,000
FY 2010	$11,600,000

Budget Request

The FY 2011 President's Budget Request for Telehealth is $11,600,000, which is equal to the FY 2010 Appropriation level. All programs significantly expanded in FY 2010. The FY 2011 funding will provide continuation of the existing programs at the FY 2010 level. More specifically, the funds will support: (1) The Telehealth Network Grant Program (25 grants, including grants to specifically examine the cost-effectiveness of telehomecare and tele-monitoring services) – $6,250,000; (2) The Telehealth Resource Center Grant Program (13 grants) – $4,150,000; and (3) The Licensure Portability Grant Program (1grant) – $350,000, as well as associated technical assistance and evaluation activities. In addition, two licensure portability grants supported by ARRA in 2010 will be in continued into their second year project period, although no new funds will be allocated to them, as the second year of these grants was pre-funded by the 2010 awards. The remainder of FY 2011 appropriated funds ($850,000) will support continuation of the Interagency Agreement with IHS to continue to support the Telehealth Technology Assessment Center, expansion of the performance measurement system to new grantees, development of a refined economic model to evaluate the costs and benefits of Telehealth services on the impact (both in terms of costs and benefits) based on ongoing data that can be collected from grantees, and for other purposes to fulfill the objectives of the telehealth grant programs, including specialized technical assistance to grantees that is unavailable from the resource centers.

The FY 2011 President's Budget Request will continue support of grants funded in FY 2010, including funding of one national center devoted to assisting the regional centers and Telehealth programs on legal issues related to Telehealth, as well as two centers devoted to providing technical assistance and evaluating telehomecare programs. It also will continue funding to ensure that all 10 regions of the nation have at least one resource center, consistent with the statutory requirement to ensure reasonable geographic distribution of the centers funded. These centers are expected to continue to play a critical role in ensuring that the investments made in expanding telehealth technologies are made wisely. They are expected to be pivotal in helping the existing and new telehealth networks funded by HRSA and others to build on the successes of previous programs and avoid the pitfalls experienced by those programs. This funding will further allow HRSA to evaluate the effectiveness of providing technical assistance and outreach services through these the regional centers. In FY 2010, HRSA will pilot test new measures for the Telehealth Resources Centers. In FY 2011, the measures will be implemented.

The TNGP will continue to focus on addressing the broad needs of underserved communities for specialized services to meet the needs of our most vulnerable populations, the elderly and children. Emphasis will be placed on stabilizing the financial underpinnings of the networks funded and evaluating their impacts on the communities served. Beginning in FY 2010, HRSA will be able to fund some urban as well as rural Telehealth sites. This expansion will allow HRSA to begin to support networks in urban underserved communities that are experiencing severe shortages of health care professionals. Moreover, the FY 2010 funding will provide opportunities for mixed "urban" and rural networks, which often include borderline rural communities that are classified as urban by HRSA's strict definitions of rural, but are nevertheless rural in character. The FY 2011 President's Budget proposes continued funding of the networks, allowing them to mature and providing HRSA with continued opportunities to evaluate and garner lessons learned from these networks.

HRSA's evaluation activities will focus on the economic impact of its network programs, particularly the implications for third party payment. Telehealth technologies are increasingly seen as one piece of the puzzle for addressing the challenges of access to health care services under health care reform in the face of daunting shortages of health care personnel, especially in underserved communities. Yet, these technologies will not be sustainable under the current formulas for financially supporting them. As health care costs rise, government and other third party payers are wary of expanding financial support for any new program or technology, without having significant information supporting that the benefits outweigh the costs of doing so, or at least sufficient information to show that the programs or technologies are "budget neutral." HRSA has historically played a crucial role in providing data from its grantees that have assisted in this discussion. Working with CMS and the Office of the National Coordinator, HRSA plans to continue this tradition with robust analyses of the impact of its programs, based on hard data from ongoing programs.

Finally, the FY 2011 Budget Request includes the same performance targets as established for 2010, with a few exceptions. The FY 2011 target for glycemic control (34.II.A.1) has been increased, because the original 2010 target was too low, given recent data. The FY 2010 and the FY 2011 targets for sites and services (34.III.D.2) have been adjusted because the 2010 targets were too low, given the most recent data (2007) and the significant increase in congressional funding of the TNGP program (See Outputs and Outcomes Tables). The targets for expansion of access for pediatric and adult mental health services (34.III.D.1and 34.III.D.1.1) have not been adjusted because it is unclear whether the number of grantees that will offer these services will increase significantly. Moreover, should the number increase dramatically, the impact of that increase on access would not be felt until FY 2012 or FY 2013, when these programs would be more fully implemented.

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Outputs and Outcomes Tables

Long Term Objective: Expand the availability of healthcare, particularly to underserved, vulnerable, and special needs populations.

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
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)* [1]	FY 2007: 42% (Target Exceeded)	21%	42%	+21
34.1: The percent of TNGP grantees that continue to offer services after the TNGP funding has ended.[2] *(Outcome)*	FY 2005: 100% (Target Not In Place)	N/A	N/A	N/A

Long Term Objective: Promote the implementation of evidence-based methodologies and best practices.

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
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.[3] *(Outcome)*	FY 2007: 1,275 (Target Exceeded)	2,456	2,537	+81
34.III.D.1: Increase the number of communities that have access to pediatric and adolescent mental health services where access did not exist in the community prior to the TNGP grant. [4] *(Outcome)*	FY 2007: 191 (Target Exceeded)	219	219	Maintain

[1] It was estimated that in the new cohort (2006) 10% of the patients enter in telehealth diabetes case management program with ideal glycemic control (hemoglobin A1C at or below 7%) and, during the first year, this cohort would achieve 45% increase to 14.5% achieving ideal control. With funding in FY 2008, this cohort of programs is expected to have 30% of their patients under ideal glycemic control. In 2009, the process begins again with a new cohort of patients entering with 10% having ideal glycemic control, increasing to 14.5% in the first year of the new cohort. In both FY 2006 and FY 2007, grantees exceeded the respective targets, but there is much variation in the data and until a full set of data is available for the first three years of this effort (March 2010), the targets will not be revised.

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

[3] These targets are cumulative, building on the 489 sites and services achieved through the 2003-2006 cohorts. This cycle will begin again in FY 2009 with a new cohort- annual targets are established based on the 2006-2009 cohort experience. Please note in FY 2006, we exceeded the targets for FY 2007 and FY 2008, but current reporting rules do not permit adjusting targets prior to 2010. The 2010 and 2011 targets have been increased because the 2010 targets were too low for the sites and services measure, given the most recent data (2007) and the significant increase in congressional funding of the TNGP program in 2010. Although we have exceeded our targets to date, current grantees continue to face significant barriers to deploying telemedicine and with each new set of grantees, the program funds grantees who add more difficult services, as grantees explore the boundaries of providing these services, e.g., innovative use of telehealth for physical therapy, stroke assessment, and post-treatment rehabilitation, teledentistry, etc.

[4] Please note: Because this is a demonstration program, every three years each cohort of TNGP grantees "graduates" from its three-year grant while a new cohort of grantees commences a new three-year cycle of grant-supported

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
34.III.D.1.1: Increase the number of communities that have access to adult mental health services where access did not exist in the community prior to the TNGP grant.[4] *(Outcome)*	FY 2007: 159 (Target Exceeded)	186	186	Maintain
34.E: Expand the number of services and/or sites that provide access to health care as a result of the TNGP program per Federal program dollars expended. [5]*(Efficiency)*	FY 2007: 173 per Million $ (Target Exceeded)	186 per Million $	199 per Million $	11 per million

Grant Awards Table

Size of Awards

(whole dollars)	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY2011 President's Budget Request
Number of Awards	23	2	39	39
Average Award	$294,461	$500,000	$262,195	$262,195
Range of Awards	$225,000-$487,950	$450,000-$550,000	$250,000-$325,000	$250,000-$325,000

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 FY2011 may need to be revised if there is evidence of a significant increase in grantees that are providing mental health services.

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

Program Management

	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$142,024,000	$147,052,000	$153,808,000	+$6,756,000
FTE	1,072[1]	1,186[2]	1,098	+14

Authorizing Legislation: Section 301 of the Public Health Service Act.

FY 2011 Authorization ..... Indefinite

Allocation Method .....Other

Program Description and Accomplishments

HRSA's Program Management activity operates programs budgeted in FY 2011 at more than $7 billion. HRSA's mission is to provide the National leadership, resources and services necessary to improve and expand access to quality healthcare for all Americans. To achieve its mission, HRSA requires qualified staff to operate at maximum efficiency. Program Management activity is the primary means of support for FTEs and overhead expenses such as rent, utilities and miscellaneous charges.

Program Management personnel plan, coordinate, and direct technical assistance and program guidance to clients of all of HRSA's key programs, including:

- Health Centers and other Primary Care programs;
- Nursing programs;
- Maternal and Child Health programs;
- Ryan White AIDS programs
- Healthcare Systems programs;
- Rural Health programs; and
- Telehealth.

In addition, Program Management supports agency oversight of a broad variety of program operations funded from other sources, which include:

[1] In FY 2009 14 FTE are attributed to ARRA activities.
[2] In FY 2010 102 FTE are attributed to ARRA activities.

- National Practitioner Data Bank;
- Health Education Assistance Loan Program; and
- Vaccine Injury Compensation Program.

Significant progress has been made in a range of Program Management activities. The effort to improve the Information Technology infrastructure has involved major efforts at perimeter protection, risk assessment and security awareness training, the costs of which have expanded substantially. The Agency has moved forward with its plans for strategic management of human capital. Substantial progress has been made in terms of de-layering and streamlining. Grants management activities have been standardized and consolidated across the Agency through the Office of Federal Assistance Management. This office plans, awards, and manages HRSA's portfolio of grants and cooperative agreements. It provides leadership, direction and coordination to all phases of grants policy, administration and independent review with oversight for all HRSA activities to ensure that resources are properly used and protected.

HRSA has also continued to carry out the HRSA Scholars program, bringing on more than 300 Scholars over the life of the seven-year plan to attract a new generation of committed health program professionals. These indicators of Program Management performance, as well as the performance carried out under the specific program components reported earlier, support the FY 2011 Planning Level.

HRSA is responsible for oversight of over $1 billion worth of Federal interest with respect to construction and equipment funding resulting from previously appropriated earmarks. This function is funded out of program management.

Funding History

FY	Amount
FY 2006	$144,421,000
FY 2007	$146,283,000
FY 2008	$141,087,000
FY 2009	$142,024,000
FY 2010	$147,052,000

Budget Request

The FY 2011 request is $153,808,000 to maintain current service levels. This funding level supports salaries and benefits for Program Management. It is an increase of $6,756,000 above the FY 2010 Omnibus Level. This increase supports pay and additional Rent costs associated with the Parklawn building. In addition, the request includes costs associated with the relocation of personnel due to the transfer of the HEAL program to the Department of Education.

Outcomes and Outputs Table

Long Term Objective: Strategically manage information technology to support programs.

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
35.VII.B.1.: Ensure Critical Infrastructure Protection: Security Awareness Training *(Output)*	FY 2009: 100% completion rate in all areas of Security Awareness and Training. (Target Met)	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.	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.	Maintain
35.VII.B.2: Ensure Critical Infrastructure Protection: Security Authorization to Operate *(Output)*	N/A	100% of HRSA information systems have been Certified and Accredited and granted Authority to Operate. (ATO).	100% of HRSA information systems have been Certified and Accredited and granted Authority to Operate. (ATO).	Maintain
35.VII.B.3: Capital Planning and Investment Control (Output)	N/A[1]	100% of major IT investments with acceptable business cases.	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.	--

Long Term Objective: Foster and lead a high-quality, well trained workforce

[1] Results for this measure are expected in November 2010.

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
35.VII.A.1: Strategic Management of Human Capital Initiative: As part of a management review, HRSA will implement a Delayering Management and Streamlining Organizational Plan. *(Output)*	FY 2009: Created an Office of Operations, headed by a Chief Operating Officer, which includes budget, financial policy and controls, contracts, information technology, and other management functions. (Target Met)	Continue with implementation of streamlining efforts.	Continue with implementation of streamlining efforts.	Maintain
35.VII.A.2: Strategic Management of Human Capital Initiative: Implement the HRSA Scholars Program. *(Output)*	FY 2008: 50 (Target Exceeded)	20	N/A	N/A

Family Planning

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/ - FY 2010
BA	$307,491	---	$317,491	$327,356	+9,865
FTE	41	---	41	42	+1

Authorizing Legislation: Title X of the Public Health Service Act

FY 2009 Authorization ..... Expired

Allocation Method ..... Competitive Grant

Program Description and Accomplishments

The Title X Family Planning program was enacted in 1970 as Title X of the Public Health Service Act. Title X is the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. 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.

Title X service funds are allocated to the ten Public Health Service (PHS) Regional Offices which manage the competitive review process, make grant awards and monitor program performance. Services are provided through 88 service delivery grants that support a nationwide network of more than 4,500 clinics that provide services to approximately 5,000,000 persons annually. Historically, at least 90% of the clients served each year have family incomes at or below 200% of the Federal poverty level. Family planning service grants are made to public and private not-for-profit organizations to support the provision of family planning clinical services and information.

Services are delivered through a network of community-based clinics that include State and local health departments, hospitals, university health centers, independent clinics, and public and private nonprofit agencies. Nearly 75% of U.S. counties have at least one provider of contraceptive services funded by the Title X family planning program. Ninety percent of the program funds are used to provide clinical services. For many clients, Title X clinics are reported to be their "usual" or only continuing source of health care and/or health education.

The family planning program provides a broad range of effective and acceptable family planning methods and related preventive health services. The Title X program also supports three key functions aimed at assisting clinics in responding to clients' needs: (1) training for family planning clinic personnel through ten regional general training programs, one national clinical

training program, one national training center, and one national training program aimed at enhancing services for males in Title X projects; (2) information dissemination and community-based education and outreach activities; and (3) data collection and research to improve the delivery of family planning services.

The Title X Family Planning program addresses HHS Strategic Goal 1, "Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long term care," and Strategic Goal 2, "Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness."

In 2008, the most recent year for which complete data are available, the Program accomplished the following: approximately 991,000 unintended pregnancies were averted; 1.41 million screenings for Chlamydia infection were performed in 15 – 24 year old females; and at least 689 cases of invasive cervical cancer were prevented through the services provided by the Title X Program. Targets were exceeded for the number of unintended pregnancies averted and number of screenings for Chlamydia infection in females ages 15 – 24. The number of unintended pregnancies averted increased from the previous year and also exceeded the target figure by over 1% or 10,000 unintended pregnancies averted. The number of cases of invasive cervical prevented each year is calculated based on the unduplicated number of female clients who received a Pap test during the year. Due to current evidence, changes in the recommendations from nationally recognized organized organizations that establish standards of care for cervical cancer screening (e.g., ACOG, USPSTF) were made in 2003 and most recently in 2009, resulting in Pap testing being initiated later in life, and less frequently. Following these national recommendations results in fewer overall Pap tests being performed. This is illustrated by the fact that the proportion of women who received a Pap test in a Title X family planning center decreased from 52% percent in 2005 to 44% in 2008.

Despite the rise in medical care costs, the family planning program had been able to maintain the average cost per Title X client below the medical rate of inflation, up until FY 2007, when there was a decrease in the overall number of clients served. In 2008, despite falling short of meeting the target for cost per client by 2.5 %, the program's cost per client increased at a lesser rate than that of the consumer price index for medical care services which increased 3.7% for 2008. To address the increasing medical care costs, and the resulting decrease in clients served, the program's main strategy in FY 2008 was to increase clinic efficiency through a concentrated training effort. Each of the ten Regional Training Centers (RTCs) received targeted funding beginning in 2007 to address the National Training Priority area: "providing training to Title X providers on improving clinic efficiency in an effort to address increasing costs of health care without sacrificing quality." This concerted training effort and the development of region-specific plans to address clinic efficiency, quality assurance/continuous quality improvement, appropriate staffing patterns and purchasing strategies, and other cost saving measures were all aimed at more effectively addressing client needs and mitigating the effects of medical cost increases. By reducing the amount of time it takes a client to complete their appointment, combined with reducing other costs and creating more efficient administrative procedures, a greater number of clients can receive services. The program continues to emphasize the need for clinic efficiency and RTCs are continuing to conduct outcome evaluation on the success of strategies they used.

The Family Planning Program underwent a program assessment in the Spring of 2005. The assessment noted that the Program's overall purpose, design and management are strong, and that clients who use Title X clinics are more likely to receive a broad range of contraceptive services and preventive gynecologic care, including STD care, than women receiving care from private doctors or HMOs. As a result of the assessment, the Program developed performance targets and goals for all of its main program activities and contracted for a broad-based, independent evaluation of sufficient quality and scope which examined the overall impact of the program. Since the initial program assessment, the Program has met or exceeded its efficiency targets for all but two years. In addition, the Family Planning Program recently concluded the independent evaluation of the program by the National Academies of Science's Institute of Medicine. The evaluation included several recommendations for the Title X program, including the recommendation that family planning be recognized and supported as a core value in public health practice and that HHS reassert and commit to the original goals of the Title X program, i.e., helping individuals and families plan for pregnancy, if they desire, as well as avoid unintended pregnancy. In addition, Recommendation 4-1 from the report indicates the need to, "[I]ncrease program funding so statutory responsibilities can be met."

Funding History

FY	Amount
FY 2006	$282,907,000
FY 2007	$283,146,000
FY 2008	$299,981,000
FY 2009	$307,491,000
FY 2010	$317,491,000

Budget Request

The FY 2011 Budget Request is $327,356,000, an increase of $10,000,000 (3.1 percent) above the FY 2010 President's Budget. The Budget Request provides funding for family planning methods and related preventive health services, as well as related training, information and education, and research to improve family planning service delivery. Family planning service projects, along with these supportive activities, enable the program to achieve the overall goal of providing family planning and related preventive health services to the communities served by Title X family planning clinics.

At least 90 percent of the $10 million increase in funding will be dedicated to implementing the recommendations of the IOM, specifically supporting the infrastructure that is currently needed to meet the demand for care, including the ability to recruit and retain qualified staff, and to better meet the needs for family planning services among low-income individuals, through addressing the increasing cost of providing family planning services to low-income individuals, including uninsured and under-insured.

Funding will continue to be used for Chlamydia testing in an effort to decrease infertility related to untreated Chlamydia infection, decreasing morbidity through screening for undiagnosed cervical tissue abnormalities (ultimately reducing the number of cases of invasive cervical cancer), and reducing the number of unintended pregnancies through family planning and related preventive health services The request includes plans to continue with development and implementation of a multi-year strategic plan, examining additional data elements for the Title X program, and assessing the training and work force needs of providers, all of which will aim to expand health care access and better equip family planning centers to meet the needs of their communities. In addition, as funds allow, family planning centers will be encouraged to seek ways to incorporate the move to electronic health records into clinical services.

The program will continue to seek ways to increase efficiencies in order to maximize the level of services despite the increasing costs of pharmaceuticals, providers, and screening and diagnostic technologies with the goal of maintaining the actual cost per client below the medical care inflation rate. The continued increase to the already high cost of highly effective contraceptive and diagnostic methods and the increasing costs for medical providers remain as significant challenges to serving more clients each year. The program will continue to seek ways to increase competition for family planning service funds, targeting areas that currently lack access to family planning services.

The FY 2011 request is expected to support family planning services for approximately 5,251,000 persons, with at least 90% of clients having incomes at or below 200% of the federal poverty level. These services include the provision of family planning methods, education, counseling and related preventive health services. The performance of the program is reflected in the outcome measures developed during its performance assessment. These outcomes include preventing at least 1,660 cases of infertility through Chlamydia screening of 1,422,000 females ages 15 - 24, reducing invasive cervical cancer through Pap tests and a goal of preventing 1,030,000 unintended pregnancies in 2011. Although the program will continue to emphasize efficiency, the targets for FY 2011 are ambitious and assume that other sources of clinic revenue will remain at historical proportions of the total Title X revenue. Based on current challenges with State budgets, this assumption may need to be revisited.

Outputs and Outcomes Tables

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	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
36.II.A.1: Increase the total number of unduplicated clients served in Title X clinics by 5% over five years. *(Outcome)*	FY 2008: 5,051,505 (Target Exceeded)	5,223,000	5,251,000	+ 28,000
36.II.A.2: Maintain the proportion of clients served who are at or below 200% of the Federal poverty level at 90% of total unduplicated family planning users. *(Outcome)*	FY 2008: 91% (Target Exceeded)	90%	90%	Maintain
36.II.A.3: Increase the number of unintended pregnancies averted by providing Title X family planning services, with priority for services to low-income individuals. *(Outcome)*	FY 2008: 991,273 (Target Exceeded)	1,024,000	1,030,000	+ 6,000

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	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY2010
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)*	FY 2008: 1,408,886 (Target Exceeded)	1,413,000	1,422,000	+ 9,000

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

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
36.II.C.1: Increase the number of unduplicated female clients who receive a Pap test. *(Outcome)*	2,088,218 (Target Not Met)	2,478,000	1,895,000	- 583,000
36.II.C.2: Reduce invasive cervical cancer among women attending Title X family planning clinics by providing Pap tests. *(Outcome)*	FY 2008: 689 (Target Not Met)	835	626	**-209**

Efficiency Measure:

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
36.E: Maintain the actual cost per Title X client below the medical care inflation rate. *(Efficiency)*	FY 2008: $239.83 (Target Not Met)	$258.87	$269.55	+10.68

Grant Awards Tables

Size of Awards

(whole dollars)	FY 2009 Omnibus	FY 2009 ARRA	FY 2010 Appropriation	FY 2011 Request
Number of Awards	88	---	88	88
Average Award	$3,218,000	---	$3,323,000	$3,349,000
Range of Awards	$172,000 - $21,501,000	---	$180,000 - $22,511,000	$185,600 - $23,209,000

Public Health Improvements (Facilities and Other Projects)

	FY 2009 Appropriation	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	$310,470,000	$338,002,000	---	-$338,002,000
FTE	9	9	---	-9

Authorizing Legislation: Title II of Public Law 111-8

FY 2011 Authorization ..... Expired

Allocation Method ..... Non-Competitive Grants

Program Description and Accomplishments

The Omnibus Appropriation for FY 2010 appropriated unrequested funds for non-competitive grant awards to be used for facility construction and renovation, equipment acquisition, development and improvements of electronic medical information systems, patient care services, and provider training. Congressional direction of these funds in report language circumvents merit-based competitive allocation processes. A full list of these earmarks in available at http://www.earmarks.omb.gov.

Over the past 10 years HRSA has awarded over 4,000 earmarks. Ongoing oversight controls remain in effect as these projects are monitored long after funds are awarded. In some cases, oversight is perpetual. Recipients of HRSA grants are required to submit progress reports and financial reports to HRSA, as directed. Even after the awarding of an earmark, HRSA staff performs site visits on projects receiving the largest grant amounts.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2005	$482,729,000
FY 2006	---
FY 2007	---
FY 2008	$304,475,000
FY 2009	$310,470,000
FY 2010	$338,002,000

Budget Request

The FY 2011 Request does not include funds for Public Health Improvements.

Supplementary Tables

TAB

Health Resources and Services Administration
Budget Authority by Object

	FY 2010 Omnibus	FY 2011 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$118,685,000	$121,411,000	+$2,726,000
Other than full-time permanent (11.3)	3,716,000	3,774,000	+58,000
Other personnel compensation (11.5)	3,407,000	3,431,000	+24,000
Military personnel (11.7)	17,907,000	18,183,000	+276,000
Special personnel services payments (11.8)	59,000	60,000	+1,000
Subtotal Personnel Compensation	**143,774,000**	**146,859,000**	**+3,085,000**
Civilian benefits (12.1)	31,237,000	32,162,000	+925,000
Military benefits (12.2)	9,576,000	9,718,000	+142,000
Benefits to former personnel (13.1)	2,422,000	2,460,000	+ 38,000
Total Pay Costs	**187,009,000**	**191,199,000**	**+4,190,000**
Travel and transportation of persons (21.0)	2,677,000	2,675,000	-2,000
Transportation of things (22.0)	225,000	225,000	-
Rental payments to GSA (23.1)	11,915,000	17,200,000	+ 5,285,000
Rental payments to Others (23.2)	1,615,000	1,614,000	- 1,000
Communication, utilities, and misc. charges(23.3)	1,491,000	991,000	-500,000
Printing and reproduction (24.0)	357,000	357,000	-
Other Contractual Services:			
Advisory and assistance services (25.1)	38,763,000	41,777,000	+3,014,000
Other services (25.2)	157,191,000	148,581,000	-8,610,000
Purchase of goods and services from government accounts (25.3)	229,598,000	235,870,000	+6,272,000
Operation and maintenance of facilities (25.4)	972,000	1,025,000	+ 53,000
Research and Development Contracts (25.5)	123,000	113,000	-10,000
Medical care (25.6)	3,060,000	3,060,000	-
Operation and maintenance of equipment (25.7)	8,184,000	9,893,000	+1,709,000
Subsistence and support of persons (25.8)	208,000	208,000	-
Discounts and Interest (25.9)	8,000	8,000	-
Supplies and materials (26.0)	1,431,000	1,425,000	-6,000
Subtotal Other Contractual Services	**439,538,000**	**441,960,000**	**+2,422,000**
Equipment (31.0)	2,789,000	2,789,000	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	6,784,497,000	6,901,260,000	+116,763,000
Insurance Claims and Indemnities (42.0)	41,409,000	41,388,000	-21,000
Total Non-Pay Costs	**7,286,513,000**	**7,410,459,000**	**+123,946,000**
Total Budget Authority by Object Class	**$7,473,522,000**	**$7,601,658,000**	**+$128,136,000**

Health Resources and Services Administration
Salaries and Expenses

	FY 2010 Omnibus	FY 2011 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$118,685,000	$121,411,000	+$2,726,000
Other than full-time permanent (11.3)	3,716,000	3,774,000	+58,000
Other personnel compensation (11.5)	3,407,000	3,431,000	+24,000
Military personnel (11.7)	17,907,000	18,183,000	+276,000
Special personnel services payments (11.8)	59,000	60,000	+1,000
Subtotal Personnel Compensation	**143,774,000**	**146,859,000**	**+3,085,000**
Civilian benefits (12.1)	31,237,000	32,162,000	+925,000
Military benefits (12.2)	9,576,000	9,718,000	+142,000
Benefits to former personnel (13.1)	2,422,000	2,460,000	+ 38,000
Total Pay Costs	**187,009,000**	**191,199,000**	**+4,190,000**
Travel and transportation of persons (21.0)	2,677,000	2,675,000	-2,000
Transportation of things (22.0)	225,000	225,000	-
Rental payments to Others (23.2)	1,615,000	1,614,000	- 1,000
Communication, utilities, and misc. charges(23.3)	1,491,000	991,000	-500,000
Printing and reproduction (24.0)	357,000	357,000	-
Other Contractual Services:			
Advisory and assistance services (25.1)	38,763,000	41,777,000	+3,014,000
Other services (25.2)	157,191,000	148,581,000	-8,610,000
Purchase of goods and services from government accounts (25.3)	96,152,000	87,210,000	-8,942,000
Operation and maintenance of facilities (25.4)	972,000	1,025,000	+ 53,000
Medical care (25.6)	3,060,000	3,060,000	-
Operation and maintenance of equipment (25.7)	8,184,000	9,893,000	+1,709,000
Subsistence and support of persons (25.8)	208,000	208,000	-
Discounts and Interest (25.9)	8,000	8,000	-
Supplies and materials (26.0)	1,431,000	1,425,000	-6,000
Subtotal Other Contractual Services	**305,969,000**	**293,187,000**	**-12,782,000**
Total Non-Pay Costs	**312,334,000**	**299,049,000**	**-13,285,,000**
Total Budget Authority by Object Class	**$499,343,000**	**$490,248,000**	**-$9,095,000**

Health Resources and Services Administration
Detail of Full Time Equivalents (FTE)

PROGRAMS	2009 Actual Civilian	2009 Actual Military	2009 Actual Total	2010 Est. Civilian	2010 Est. Military	2010 Est. Total	2011 Est. Civilian	2011 Est. Military	2011 Est. Total
Bureau of Primary Health Care:									
Direct:									
Health Centers/Tort	19	-	19	20	-	20	20	-	20
Free Clinics Medical Malpractice	2	1	3	2	1	3	2	1	3
Hansen's Disease Center	64	10	74	62	12	74	71	12	83
Reimbursable:									
Hansen's Disease Center	3	-	3	3	-	3	3	-	3
Total:	88	11	99	87	13	100	96	13	109
Bureau of Health Professions:									
Direct:									
Health Workforce Information Analysis	-	-	-	3	-	3	3	-	3
Children's Hospitals Medical Education	9	-	9	9	-	9	9	-	9
Geriatrics Program	3	-	3	3	-	3	3	-	3
Patient Navigator Outreach	1	1	2	1	1	2	1	1	2
HEAL	14	-	14	14	-	14	14	-	14
Reimbursable:									
National Practitioner Data Bank	19	2	21	19	2	21	19	2	21
Healthcare Integrity & Protection Data Bank	5	-	5	5	-	5	5	-	5
Total:	51	3	54	54	3	57	54	3	57
Bureau of Clinician Recruitment & Service:									
Direct:									
National Health Service Corps	83	7	90	80	10	90	80	10	90
NHSC Ready Responders	-	41	41	-	37	37	-	37	37
Total:	83	48	131	80	47	127	80	47	127
Maternal and Child Health Bureau:									
Direct:									
Autism and Other Developmental Disorders	2	1	3	4	1	5	4	1	5
Universal Newborn Screening	4	-	4	4	-	4	4	-	4
Newborn Screening for Heritable Disorders	1	-	1	3	-	3	3	-	3
Congenital Diabilities	-	-	-	-	-	-	1	-	1
Sickle Cell Program	2	-	2	2	-	2	2	-	2
Total:	9	1	10	13	1	14	14	1	15

Health Resources and Services Administration
Detail of Full Time Equivalents (FTE)

PROGRAMS	2009 Actual Civilian	2009 Actual Military	2009 Actual Total	2010 Est. Civilian	2010 Est. Military	2010 Est. Total	2011 Est. Civilian	2011 Est. Military	2011 Est. Total
HIV/AIDS Bureau:									
Direct:									
Ryan White Part C (Title III)	22	5	27	25	5	30	25	5	30
Reimbursable:									
OGAC Global AIDS	10	4	14	10	4	14	10	4	14
Total:	32	9	41	35	9	44	35	9	44
Healthcare Systems Bureau:									
Direct:									
Health Care Facilities & Other Projects	9	-	6	8	-	8	-	-	-
C.W.Bill Young Cell Transplantation Prog.	5	-	5	5	-	5	5	-	5
Cord Blood Stem Cell Registry	2	-	3	4	-	4	4	-	4
Poison Control Centers	3	-	3	3	-	3	3	-	3
State Health Access Grants	1	-	-	2	-	2	2	-	2
Covered Countermeasures Compensation Program	-	-	-	-	-	-	3	-	3
Reimbursable:									
Vaccine	15	2	17	15	2	17	15	2	17
DHHS/ACYF	1	1	2	1	1	2	1	1	2
Covered Countermeasures Compensation Program	-	-	-	3	-	3	-	-	-
Total:	36	3	39	42	3	45	33	3	36
Office of Rural Health Policy:									
Direct:									
Rural Access to Emergency Devices	2	-	2	2	-	2	2	-	2
Radiogenic Diseases	1	-	1	2	-	2	2	-	2
Delta Health Initiative	1	1	2	1	1	2	-	-	-
Total:	4	1	5	5	1	6	4	-	4
Family Planning (Direct)	31	10	41	31	10	41	32	10	42
Program Management (Direct)	960	112	1,072	1,075	111	1,186	973	111	1,084
OPDIV FTE Total.	**1,294**	**198**	**1,492**	**1,422**	**198**	**1,620**	**1,321**	**197**	**1,518**
Recovery Act (non add)	13	1	14	102	-	102	-	-	-

Health Resources and Services Administration
Detail of Full Time Equivalents (FTE)

From FY 2010 to FY 2011 there is a net increase of 102 FTEs. The majority of the decrease is attributed to Recovery Act activities and to one-time Public Health improvement projects.

FY	Average GS Grade
2006	12.3
2007	12.6
2008	12.6
2009	12.6
2010	12.6

Health Resources and Services Administration

Programs Proposed for Elimination

The following list shows the programs proposed for elimination or consolidation in the FY 2011 Budget Request. Termination of these three programs frees up approximately $383.0 million based on the FY 2010 levels for priority health programs that have demonstrated a record of success or that hold significant promise for increasing accountability and improving health outcomes. Following the program(s) is a brief summary and the rationale for its elimination.

Program	FY 2010 Dollars in Millions
Delta Health Initiative	$ 35.0
Denali Project	$ 10.0
Public Health Improvement (Facilities and Other Projects)	$338.0
Total	$383.0

Program (FY 2010 BA in millions)

Program Descriptions

Delta Health Initiative (-$35.0 million)

There is no FY 2011 request for this program. The needs in this region have largely been met through prior investment. Since its initial funding in FY 2006, many projects continue to date as a result of this initial "seed" money.

Denali Project (-$10.0 million)

There is no FY 2011 request for this program. The needs in this region have largely been met through prior investment. The Denali Commission has already received more than $300 million in funding since 2000 for the construction in Alaska.

Public Health Improvement (Facilities and Other Projects) (-$338.0 million)

There is no FY 2011 request for these programs.

Provide information on the programs that were initially funded through appropriations and that continue to be discussed during bill development: Health Professions Student Loan (HPSL) Program, the Nursing Student Loan (NSL) Program, Loans for Disadvantaged Students (LDS), Primary Care Loans (PCL), and the CHC construction loan program. Information that is provided should include: remaining balances, the number of students or institutions served, how the programs work, and other relevant information. Work directly with your Office of Budget analyst to determine other appropriate information and placement within the CJ."

Response: The information below reflects Academic Year 2008-2009 data reported in the Annual Operating Report dated 12/30/2009.

	Number of Programs*	Number of Borrowers	Account Balance
HPSL	153	32,633	$352,840,554
PCL**	132	5,219	259,115,263
LDS	177	7,099	97,900,457
NSL *	390	42,659	161,406,555
Total	852	87,610	$871,262,829

These programs are financed through revolving accounts (Federal Capital Contribution) and do not receive annual appropriations. Through these revolving fund accounts, the HPSL, PCL, LDS, and NSL programs award funds to institutions that in turn provide loans to individual students. As borrowers pay back loans the program's revolving account gets replenished, and the collected funds are then used to give out new loans in the following academic year. If the program's revolving account has excess funds that will not be used to provide new loans, these excess funds are returned to HRSA. Funds returned to HRSA are then awarded to programs that are in need of additional funds. Therefore, the funding awarded each year fluctuates and is dependent upon the amount of loans repaid into the revolving account. The HPSL, PCL, LDS, and NSL programs aim to expand high-quality educational opportunities to those students, including racial and ethnic minorities and disadvantaged students, who otherwise could not afford a health professions education.

New Awards in Academic Year 2008-2009 were as follows:

	Number of New Loans	Amount of New Funds Awarded
HPSL	10,550	$44,018,143
PCL*	420	29,608,373
LDS	1,832	15,473,798
NSL*	14,451	27,150,331
Total	27,253	$116,250,645

* Programs refer to the number of disciplines (e.g., allopathic medicine, nursing, etc.) that maintained a revolving fund account.

** Data is estimated for the PCL and NSL programs. Final analysis of data for these two programs will be available in March 2010.

Significant Items

TAB

HEALTH RESOURCES AND SERVICES ADMINISTRATION

SIGNIFICANT ITEMS IN HOUSE AND SENATE APPROPRIATIONS COMMITTEE REPORTS

The following section represents FY 2010 Congressional requirements for reports and significant items derived from House Report 111-220 and Senate Report 111-66

FY 2010 House Appropriations Committee Report Language (House Report 111-220)

Item 1

Community Health Centers - The Committee supports continued efforts to expand the CHC program into those areas of the country with high need and no current access to a health center. Further, the Committee urges HRSA to make funding available to increase capacity at existing centers, and for service expansion awards to increase access to mental health services, dental services, and pharmacy services, as well as outreach to special populations. (Page 46)

Action Taken or To Be Taken

HRSA recognizes the importance of providing funds to expand health centers in areas without access to primary healthcare services, to increase health centers' medical capacity and to expand behavioral, dental, pharmacy and enabling services. In 2009, HRSA awarded 126 New Access Point awards to open new health center sites in communities that lacked a health center and 180 service expansion grants."

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Item 2

Committee Health Centers - The Committee recognizes that the provision of preventive and primary care to patients served in off-site, institutional and/or residential locations and sites is important to address the needs of medically underserved communities, whose patients have diverse and complicated health care needs and encounter many obstacles in accessing services. To facilitate appropriate and timely access to care, the Committee encourages HRSA to approve the health centers' proposed scope of project changes necessary to meet the comprehensive needs of medically underserved populations who may require services provided in off-site, institutional and/or residential locations and sites. (Page 46)

Action Taken or To Be Taken

HRSA will continue to give full, fair and timely consideration to scope of project change requests from Health Centers, including those that address the provision of primary health care services to underserved populations in residential, institutional and off-site locations.

Item 3

National Health Service Corp (NHSC): Field Placements - The Committee recognizes that the NHSC is an essential tool for recruitment and retention of primary care health professionals at community, migrant, homeless, and public housing health centers, especially given recent efforts to expand the health centers program. The Committee encourages HRSA to work to increase the proportion of NHSC personnel being assigned to health centers. (Page 48)

Action Taken or To Be Taken

For more than three decades the NHSC has worked in partnership with health centers to serve the underserved. In FY 2008 (latest data available) 47.7 percent of NHSC clinicians were working in health centers, and of the more than 8,000 vacancies on the NHSC Jobs Opportunity List fully 56 percent of these are health center positions. Additionally, in order to accommodate the greatly increased opportunity of loan repayment through ARRA funding of the NHSC, the program has expanded the number of vacancies a site may post on the NHSC website.

Item 4

***Health Careers Opportunity Program*.** -The Committee provides $22,133,000 for the Health Careers Opportunity Program (HCOP), which is $3,000,000 above the fiscal year 2009 funding level and the same as the Budget Request**.** The program provides grants to eligible schools and health education entities with the goal of increasing the number of disadvantaged students entering health and allied health professions programs. These funds will support 34 HCOP grantees to operate programs that will prepare 3,000 disadvantaged students at the earliest levels of the educational pipeline for careers in health and allied health professions. The Committee urges HRSA to give priority consideration to awarding grants to those institutions with an historic mission of training minorities in the health professions. (Page 49/50)

Action Taken or To Be Taken

One of the goals of the HCOP is to increase the number of individuals from economically and educationally disadvantaged backgrounds entering and graduating from health and allied health professions programs. In FY 2009, 16 new HCOP grantees were awarded and 14 HCOP grantees were non-competing continuation grants for year two of the funding cycle. Three Historically Black Colleges and Universities are funded through the HCOP. Applications competing for Federal funds receive an objective and independent review performed by a committee of experts qualified by training and experience in particular fields or disciplines related to the program being reviewed. The committee provides expert advice on the merits of each application to program officials responsible for final selections for award. Awards are made in descending rank order based upon merit. A competition to award new HCOP grantees is planned for FY 2010.

Item 5

Nursing Workforce - In addition, the Committee urges HRSA to expand its outreach program to community colleges and to bring DOL and the Department of Education into the effort. In its grant-making, the Committee encourages HRSA to increase its focus on associate degree programs that culminate in an RN degree as a way to accelerate the production of RNs. In the awarding of nurse education, practice and retention grants, HRSA should establish as a high priority those proposals that create career ladders leading to an RN degree, as well as those that address equipment needs of nursing programs. (Page 53)

Action Taken or To Be Taken

In FY 2009, HRSA met with the DOL and DOE representatives to discuss outreach strategies for increasing the nursing capacity at community colleges. HRSA has established and implemented a strategic plan to increase the number of community colleges applying and receiving grants

under the Title VIII nursing programs. HRSA's strategic plan included meeting with DOE representatives working with community colleges and the Council for Resource Development (funding resource organizations of the American Association of Community Colleges); Implementing grant writing sessions specifically targeting community college; conducted 1:1 phone and face-to-face consultations with 30 community colleges; and conducted technical assistance at two professional organization conferences with nurse educators and grant writer participants in FY 2009 (National Organization for Associate Degree Nursing and the Annual Council for Resource Development Educational Conference).

Upon implementing the community strategic plan, the applications that Nursing Workforce Diversity (NWD) and Nurse Education, Practice and Retention (NEPR) programs received from community colleges increased by 48 percent. Current data reflects that community colleges experienced a higher approval rate for the two grant programs in FY 2009 than prior year. The approval rate of the community college applications increased from 20 percent to 50 percent after the program staff increased targeted technical assistance and outreach efforts specifically for community college nurse educators and grant writers.

The NEPR program is a broad authority consisting of three major priority areas with nine associated purposes. Career ladder and new technology: equipment grants are currently amongst the most submitted and highest priority grants funded out of the nine purposes. HRSA will continue to place high priority for career ladder and new technology (equipment) grants to community colleges. In FY 2009, HRSA funded career ladder (14) and new technology: equipment (22) grants.

Item 6

Nursing Workforce - The Committee directs HRSA and DOL to jointly establish a strategic plan for the use of fiscal year 2010 resources and to extend that plan to future years to address emerging needs in the health care sector, particularly in the event of large-scale health care reform. This plan should be drafted by a DOL-HRSA interagency taskforce, to be established by October 1, 2009, with the strategic plan due to the Committees on Appropriation of the House of Representatives and the Senate by April 1, 2010. The taskforce also should include participants from the Departments of Education and Veterans Affairs. The Committee intends for the taskforce to continue to meet regularly after the completion of the strategic plan to guide the two agencies' efforts to maximize the impact of their separate programs.

Action Taken or To Be Taken

In FY 2009, HRSA met with DOL on several occasions to discuss and identify collaborative opportunities to advance and improve targeted health care sector strategies by leveraging each other's resources, expertise and the development of policies and programs. Staff representatives from both agencies and from Department of Education and Veterans Affairs were identified for inclusion on the inter-agency taskforce. Members of the taskforce are drafting the strategic plan for approval by the full group.

Item 7

Advanced Education Nursing - The Committee provides $64,438,000 for Advanced Education Nursing, which is the same as the fiscal year 2009 funding level and the Budget Request. The

program provides grant support to eligible entities to meet the costs of: (1) projects that support the enhancement of advanced nursing education and practice; and (2) traineeships for individuals in advanced nursing education programs. The program prepares registered nurses as nurse faculty, nurse practitioners, clinical nurse specialists, nurse midwives, nurse anesthetists, nurse administrators, public health nurses, and other nurse specialists for advanced practice roles. In fiscal year 2010, almost 3,700 students and 9,500 trainees will be supported. Within the allocation, the Committee encourages HRSA to allocate funding at least at the fiscal year 2007 level for nurse anesthetist education. (Page 53)

Action Taken or To Be Taken

In FY 2010, approximately 9,100 students are expected to benefit from graduate programs funded through advanced education nursing grants. About 10,400 trainees will be supported through traineeship grants to the schools.

The HRSA will continue to support this effort. In FY 2010, it is estimated that $1,250,000 will be used to provide grants to an estimated 85 nurse anesthesia programs which will provide direct support to approximately 2,200 nurse anesthetist students. It is anticipated that the traineeship programs will produce 1,300 nurse anesthetist graduates that are prepared to enter the workforce. This level of funding and support is consistent with the FY 2007 level for nurse anesthesia education.

Item 8

Nursing Facility Loan Program - Compounding the problem is the fact that a wave of nurse faculty retirements is projected for the next ten years that will only worsen the crisis. The Committee urges HRSA to continue efforts to address the nurse faculty shortage and strengthen the pipeline of nurses entering graduate nursing programs.
(Page 55)

Action Taken or To Be Taken

The HRSA will continue efforts to address the nurse faculty shortage and strengthening the pipeline by continuing support for the Nurse Faculty Loan Program (NFLP) and the Advanced Education Nursing (AEN) Program. The NFLP supports the establishment and operation of a loan fund within participating schools of nursing to assist nurses in completing their graduate education to become qualified nurse faculty. In FY 2009, the NFLP supported 149 institutions with an estimated 1,600 students receiving loans to support their education to become faculty. This includes 500 students supported by American Recovery and Reinvestment Act funding. Grantees report that the NFLP has facilitated the graduation of 764 students qualified to fill nurse faculty positions. Each year has seen an increase in the number of participating schools. Participating schools continue to request an increased level of funding which reflects the true demand among the student population.

The AEN Program provides grants to schools for projects that prepare advanced education nurses through the enhancement of advanced nursing education and practice and through traineeships for graduate students. In FY 2009, the AEN Program provided support to 160 graduate programs. Graduates from all 160 of the master's and doctoral programs are prepared to be academic and clinical faculty in schools of nursing for all levels of nursing

students. These projects also prepare preceptors who guide the student's application of science to the evidence-based care of individuals, families, and communities. Twenty-one of the projects in FY 2009 focused specifically on innovative teaching and learning content to prepare nurse educators.

Item 9

Vision Screening - The Committee recognizes that vision disorders are the leading cause of impaired health in childhood and is concerned that one in four school-aged children has a vision problem significant enough to affect learning. Many serious ocular conditions in children are treatable if diagnosed at an early stage. The Committee understands that HRSA requires States to report on a set of core performance measures and that these performance measures, when successfully addressed, can lead to better health outcomes. The Committee urges HRSA to develop and report on the Nationwide implementation of a State Title V core performance measure related to vision screening. (Page 57)

Action Taken or To Be Taken

The Health Resources and Services Administration (HRSA) recognizes the importance of vision screening and is strongly supportive of efforts at the local, State, and National level to improve vision screening in children. In spite of the importance of vision screening, an important area of consideration in determining the potential for a proposed measure to become a National Performance Measure (NPM) is the existence of a National data source by which States can report State-specific data and rates. When considering whether to include a NPM related to vision screening, a significant obstacle has been the lack of a National data source for measuring vision screening activities. In the absence of a National data source, States have limited capacity to collect and accurately report in this area. Another consideration is that a National consensus about the adequacy of current methods for preschool vision screening has not been reached.
In an attempt to move this important issue forward HRSA's Maternal and Child Health Bureau (MCHB) has supported a number of activities. First in 2008, MCHB convened a group of experts to discuss issues pertaining to the establishment a sustainable vision screening program which entailed current challenges and what key stakeholders would be necessary to bring about vision screening initiatives and guidelines in each State. Based on input from this group and other experts in the field, in 2009 the MCHB awarded the National Society for the Prevention of Blindness a 3 year $300,000 cooperative agreement to develop a Universal Vision Screening for Young Children Coordinating Center (UVSYCCC) to support the public health role in assuring a continuum of eye care for young children within the healthcare delivery system. The UVSYCCC will address the screening and follow-up component of that continuum by: (1) providing National leadership in the development of the Statewide vision screening and intervention component of programs for all children four years of age, prior to school entry, (2) developing and implementing a plan for assisting States to coordinate existing vision screening activities within the State, and (3) working closely with Georgia, Illinois, Massachusetts, North Carolina and Ohio to develop and implement a uniform Statewide strategy for universal vision screening by age 4; determine a mechanism for uniform data collection and reporting; and establishing a State Title V performance measure for vision screening.

Item 10

Traumatic Brain Injury - The Committee urges HRSA to better align the administrative requirements including for reporting, monitoring and the application process of the TBI protection and advocacy program with the administrative requirements of the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program operated by the Substance Abuse and Mental Health Services Administration. The Committee also encourages HRSA to provide technical assistance through a granted with established legal expertise to provide assistance to protection and advocacy systems on legal matters. Such assistance could address the complex legal matters that arise in the protection and advocacy program. (Page 58)

Action Taken or To Be Taken

HRSA has enacted significant changes to the reporting, monitoring and application process in FY 2009, and these new procedures align well with the administrative requirement of the PAIMI Program. HRSA has also entered into a contract to provide technical assistance around TBI, and the new contractor has subcontracted with the well-known and experienced National Disability Rights Network (NDRN) to provide technical assistance specific to the needs of the Protection and Advocacy for Traumatic Brain Injury grantees. The agencies that have Protection and Advocacy Programs (HHS (SAMHSA, HRSA, ADD/ACF), Department of Education, and the Social Security Administration) collaborate on the Inter-agency Council to ensure alignment of administrative requirements.

Item 11

Healthy Start - The National Fetal Infant Mortality Review (NFIMR) program an important component of many Healthy Start programs, provides evidence-based interventions crucial to improving infant health in high risk communities. The Committee believes HRSA should continue to use Healthy Start funds to support the NFIMR program and that all Healthy Start Programs should be encouraged to implement NFIMR. (Page 59)

Action Taken or To Be Taken

HRSA's Maternal and Child Health Bureau (MCHB) will continue to support the National Fetal and Infant Mortality Review project by offering an open competition in 2010. The first budget period will be for one year, July 1, 2010 to June 30, 2011 in the amount of $300,000. Project periods for this cooperative agreement will be for five years, starting July 1, 2010 and concluding on June 30, 2015.

Item 12

Emergency Assistance - The Committee provides funds within the Part A program to prevent substantial funding losses in both eligible metropolitan areas and transitional grant areas. Changes in the reauthorization significantly altered the method for allocating Part A funds, and additional funds are required to create a stop loss against unanticipated cuts that threaten to disrupt access to needed medical care and support services for people living with HIV and AIDS. The Committee includes bill language to cap maximum fiscal year 2009 losses at 92.4 percent of the fiscal year 2006 level for eligible metropolitan areas and transitional grant areas. When allocating fiscal year 2010 supplement funds under Part A of the Ryan White CARE Act, the

Committee urges HRSA to provide additional increases to jurisdictions that have experienced cuts in their total awards relative to the amount awarded in fiscal year 2006. (Page 60)

Action Taken or To Be Taken
As a result of language in the newly reauthorized Ryan White law, calculations for hold harmless and priority funding will be calculated differently than it was in FY 2009. The impact of changes in the calculation of hold harmless and priority funding for Part A programs is dependent on several factors and is unknown at this time. However, HRSA believes that the new calculations may not result in providing funds in sufficient amounts to address loss in grant funds when one compares FY 2006 with FY 2009 grant awards. The inclusion of the Committee language for the FY 2010 budget is consistent with language that was added in both 2008 and 2009.

Item 13
Rural Outreach Grants - The Committee provides $56,600,000 for Rural Outreach Grants, which is $2,700,000 above the fiscal year 2009 funding level and $1,150,000 above the Budget Request. In fiscal year 2010, the program is expected to award 245 grants to deliver and improve rural health care services to 950,000 rural residents.
(Page 63)

Action Taken or To Be Taken
In FY 2009, HRSA had the opportunity to make additional Outreach awards to total 111 grantees. These grantees will continue in FY 2010 to provide services and increase the number of people served. Since grantees may implement their project into multiple counties, they are able to reach a wider population for services such as training, education, health screenings and health fairs.

Item 14
Healthcare-related Facilities and Other Program*s* - The Committee includes $179,330,000 for construction and renovation (including equipment) of health care and other facilities and other health-related activities. Th**e** Budget Request does not include funding for this purpose. HRSA should use no more than one percent of the funds allocated for projects for agency administrative expenses. (Page 64)

Action Taken or To Be Taken
HRSA will fully cooperate to award Congressionally-mandated projects during the Fiscal year.

Item 15
Program Management - The Committee urges HRSA to withdraw the proposed guidance for the 340B drug program, "Regarding Section 602 of the Veterans Health Care Act of 1992 Definition of Patient" issued on January 12, 2007 and directs that any subsequent changes to the 340B Patient Definition be issued in proposed form with stakeholders having an opportunity to provide comments. The Committee is concerned that the January 12, 2007 guidelines may dramatically change the degree to which safety net health facilities are able to participate in the program. The Committee also requests that HRSA consider a patient definition permitting safety net health facilities eligible for grant funding under the Public Health Security and Bioterrorism

Preparedness and Response Act of 2002 to use 340B pricing to purchase drugs needed to enhance preparedness for and response to bioterrorism or other public health emergencies. If HRSA chooses not to follow this request, the Committee expects a written explanation before the agency publishes final guidance. (Page 74)

Action Taken or To Be Taken

HRSA is currently assessing options for proceeding on the patient definition guidance. Under the current definition of patient (and under any formulation being considered) 340B covered entities are able to purchase 340B discounted drugs for their own patients using whatever funds are legally available for that purpose, including funds that may potentially be available through the Public Health Security and Bioterrorism Preparedness and Response Act of 2002.

FY 2009 Senate Appropriations Committee Report Language
(Senate Report 111-66)

Item 16

Child Maltreatment — Parent training is a promising strategy for preventing child maltreatment that should be tested in primary care and other settings. The Committee encourages HRSA to collaborate with the Administration for Children and Families to ensure that community health centers are eligible grantees for any parent training grants or initiatives. (Page 39)

Action Taken or To Be Taken

HRSA will continue to pursue collaborations with other agencies, including the Administration for Children and Families, to ensure that community health centers are positioned to be eligible for early childhood grants or initiatives, including those addressing parent training.

Item 17

FTCA Coverage Guidance — The Committee is pleased that HRSA is drafting a policy manual for providers on the FTCA program. The Committee encourages HRSA to survey centers to determine the extent to which centers are purchasing private malpractice insurance to fill a perceived gap for contract employees and nonhealth center patients in nonhealth center settings where reciprocal coverage between the health center and other providers is customary. To the extent that this coverage is unnecessary, the Committee expects HRSA to work with health centers to understand the FTCA coverage and adjust their supplemental coverage accordingly. (Page 39)

Action Taken or To Be Taken

HRSA will continue to work with health center grantees so that they may determine the extent to which private malpractice insurance is necessary.

Item 18

Mental Health — Among the most prevalent health problems at Federally qualified health centers are mental disorders and chronic illnesses. The Committee encourages HRSA to ensure that health centers are aware that psychologists are eligible to participate in the National Health Service Corps, which places health professionals in underserved areas including health centers. (Page 39)

Action Taken or To Be Taken

HRSA will continue to make health centers aware of the eligibility requirements for the National Health Service Corps, including those requirements pertaining to psychologists.

Item 19

Scope of Project Changes — The Committee expects that the Secretary will continue to approve community health centers' proposed scope of project changes when necessary to ensure access to needed specialty services or to meet the comprehensive needs of special populations who may require care in other types of healthcare settings. (Page 39)

Action Taken or To Be Taken
HRSA will continue to give full, fair and timely consideration to scope of project change requests from Health Centers, including those that address access to specialty services and those that address the provision of primary health care services to underserved populations in residential, institutional and off-site locations.

Item 20
Technical Assistance — The Committee strongly supports investments in health information technology at community health centers, including the rapid adoption of electronic health record. The Committee urges HRSA to coordinate with the Office of National Coordinator for Health IT to ensure that community health centers are fully integrated into community systems of care. The Committee feels strongly that technical assistance will be crucial to centers making this investment and encourages HRSA to provide additional technical assistance as new IT systems are implemented with Recovery Act investments. (Page 39)

Action Taken or To Be Taken
HRSA will continue to ensure that its HIT grants and policies are consistent with the guidance released by the Office of National Coordinator for Health IT, and that health centers are fully integrated into community systems of care. HRSA also recognizes the importance of technical assistance in supporting new health center HIT systems, and will continue to provide appropriate technical assistance as systems are implemented with Recovery Act funding.

Item 21
Workforce Recruitment — The Committee recognizes that the National Health Service Corps is an essential tool for recruitment and retention of primary care health professionals at Community, Migrant, Homeless, and Public Housing Health Centers, especially given the recent expansion of the Health Centers program. Given the dramatically increased investment made in the National Health Service Corps in the Recovery Act, the committee urges HRSA to work with health centers to qualify for additional NHSC slots to take maximum advantage of the opportunity. (Page 39/40)

Action Taken or To Be Taken
The NHSC has historically had a strong partnership with health centers. HRSA will continue to support and facilitate increased participation of health centers in the National Health Service Corps. For more than three decades the NHSC has worked in partnership with health centers to serve the underserved. In FY 2008 (latest data available) 47.7 percent of NHSC clinicians were working in health centers, and of the more than 8,000 vacancies on the NHSC Jobs Opportunity List fully 56 percent of these are health center positions. Additionally, in order to accommodate the greatly increased opportunity of loan repayment through ARRA funding of the NHSC, the program has expanded the number of vacancies a site may post on the NHSC website.

Item 22
Native Hawaiian Health Care — The Committee again includes the legal citation in the bill for the Native Hawaiian Health Care Program. The Committee has included sufficient funding so that healthcare activities funded under the Native Hawaiian Health Care Program can be

supported under the broader community health centers line. The Committee expects that not less than last year's level be provided for these activities in fiscal year 2010. (Page 40)

Action Taken or To Be Taken
HRSA expects to provide not less than the FY 2009 funding level for the Native Hawaiian program in FY 2010.

Item 23
Training in Primary Care Medicine and Dentistry — Pediatric dentistry residency programs provide both treatments for underprivileged children and training opportunities to address the National shortage of pediatric dentists. The Committee has included bill language allowing funds to be used for faculty loan repayment. The Committee encourages HRSA to communicate clearly to applicants that grant funds can be utilized for faculty development and curriculum enhancement, as well as program creation or expansion. (Page 42)

Action Taken or To Be Taken
The Training in Primary Care Medicine and Dentistry guidance indicates that the purpose of the dental residency is to "meet the costs of planning, developing, or operating programs and to provide financial assistance to residents in such programs such as general dentistry or pediatric dentistry in dental schools, approved residency programs in the general or pediatric practice of dentistry, approved advanced education programs in the general or pediatric practice of dentistry, or approved residency programs in pediatric dentistry." As part of developing and operating a dental program, a grantee could include faculty development. The HRSA currently funds faculty development activities for grantees that develop curriculum activities in their program. Programs sometimes train their faculty prior to implementing a curriculum. In terms of curriculum enhancement a number of grantees develop new or enhanced curriculum routinely.

Item 24
"Emergency Physicians — The Committee is concerned with the state of our Nation's emergency medical system and the shortage of emergency physicians. With increased fragmentation and overcrowding at emergency departments Nationwide, this shortage will have a dire effect on patient safety. To better understand the impact of this shortage on patient care, the Committee encourages HRSA to examine current and future supply, demand, need and requirements for residency trained, board certified emergency physicians." (Page 42)

Action Taken or To Be Taken
The HRSA is in the process of updating its supply and requirements models for physicians. Emergency room physicians are included in the model as one of the specialties. When the updating is completed late this fiscal year, we will have information on the current and projected supply and requirements.

Item 25
Dental Hygiene Practitioner Programs — The Committee continues to note the documented severe dental access crisis in rural and other underserved areas. The Kaiser Commission on Medicaid and the Uninsured notes that ''the supply of dentists, especially pediatric dentists, is inadequate.'' In addition to the increased investment in dental health training made by the Committee in this and previous appropriation bills, the Committee is supportive of efforts by

States to develop licensure and universities to develop curriculum for an advanced dental hygiene practitioner. The Committee urges the Secretary to develop a plan to evaluate the effectiveness of master's level advanced dental hygiene practitioner programs. (Page 42/43)

Action Taken or To Be Taken
While the Grants to States to Support Oral Health Workforce Activities program can support the development of a master's level training curriculum for dental hygiene through the 13th activity, ("any other activities determined to be appropriate by the Secretary"), it is unlikely that a State would come in for such an objective since the primary profession focus for this program is dentistry.

Few of the grantees have addressed training issues focusing on dental hygienists. A few have created a rotation for dental hygienists to expose them to underserved populations. None of the 59 grantees have requested funding for curriculum development for a master's level training program related to dental hygiene.

Item 26
Geriatric Education — The Committee encourages the Department to collaborate with institutions of higher learning for the development of a dual Doctor of Pharmacy/Nurse Practitioner degree to address the growing need for specialty trained providers in the area of gerontological health. (Page 43)

Action Taken or To Be Taken
The Titles VII and VIII do not support formal academic dual discipline degree programs under the current legislative authorities. In carrying out this initiative, HRSA will convene a discussion group to examine characteristics of a dual doctor of Pharmacy/Nurse Practitioner degree, identify elements that promote excellence, and to discuss the range of approaches to this type of program.

In FY 2009, HRSA supported the start up Nurse Practitioner/Doctor of Nursing Practice/Doctorate in Pharmacy program administered by the University of Hawaii through a Congressionally Mandated Initiative. This is the only cross-cutting program of this kind in the Nation.

Item 27
Public Health, Preventive Medicine, and Dental Public Health Programs — The Committee provides $10,000,000 for these programs. The fiscal year 2009 comparable level was $19,500,000, including $10,500,000 in American Recovery and Reinvestment Act funding. The Budget Request for fiscal year 2010 included $9,000,000 for this program. The Committee intends that the increase over the level in the fiscal year 2009 omnibus appropriations act (Public Law 111–8) be used to expand fellowships and training in the area of preventive medicine. The Committee urges HRSA to prioritize programs that seek to incorporate integrative medicine into residency training. (Page 44)

Action Taken or To Be Taken

Katz and Ali (2009) in their report entitled "Preventive Medicine, Integrative Medicine and the Health of the Public" recommended that "exposure to integrative practice should be routine in medical education (page 32)." The American College of Preventive Medicine (ACPM) identifies National education standards for accreditation. The ACPM does not require preventive medicine residency programs to include content on integrative medicine.

Residency training programs in dental public health must be accredited by the American Dental Association Commission on Dental Accreditation and the Council of Education for Public Health. Neither of these accrediting bodies requires content in integrative medicine.

Item 28

Postpartum Depression — Postpartum depression [PPD] is one of the most common and frequently undiagnosed conditions associated with childbirth. While postpartum depression is a widespread problem, there is not sufficient research on the causes and possible treatments for women suffering from this disorder. The Committee encourages HRSA to prioritize the issue of PPD by raising awareness, expanding research, and establishing grants for the operation and coordination of cost-effective services to afflicted women and their families. (Page 46)

Action Taken or To Be Taken

MCHB has developed a 22-page consumer-oriented booklet on perinatal depression titled **Depression During and After Pregnancy: A Resource for Women, Their Partners, Family and Friends.** Topics include: what is Perinatal Depression, including baby blues, and its causes, types and symptoms of depression, how would a pregnant/parenting women or their family/friends recognize someone with it, how would it affect the family and the baby, and, most important, where to go for help. The booklet is available in English and in Spanish via the HRSA Information Center and is also on HRSA's website for public downloading. To date almost a million booklets the have been disseminated Nationally.

Also in 2009, MCHB completed a series of publications under Bright Futures for Women's Health and Wellness (BFWHW). One of the series included a consumer and provider guide to women's emotional wellness across the lifespan. A second series, entitled ***Taking Care of Mom: Nurturing Self as Well as Baby*** released a consumer booklet, provider guide (pocket card) and a community poster in 2009; the purpose of this series is to raise awareness and health promotion knowledge about maternal wellness and adaptation during the prenatal and ongoing postpartum period. The maternal wellness booklet and poster are available in English and Spanish via the HRSA Information Center.

Collaboration continues with professional organizations in disseminating up to date information on PPD and with NIMH and other researchers on perinatal depression itself and effective intervention strategies. All 102 Healthy Start grantees include screening and referral for PPD as part of their core services. Resources for new grants for the operation and coordination of cost-effective services to afflicted women and their families have not been provided in the current appropriations.

Item 29

Maternal and Child Health Block Grant — The Committee recognizes that 1 in 4 school-aged children have a vision problem significant enough to affect learning. The Committee understands that the MCHB requires States to report on a set of core performance measures and that these performance measures, when successfully addressed, can lead to better health outcomes. The Committee recommends that the MCHB develop and report on the Nationwide implementation of a State title V core performance measure related to vision screening. (Page 46)

Action Taken or To Be Taken

The Health Resources and Services Administration (HRSA) recognizes the importance of vision screening and is strongly supportive of efforts at the local, State, and National level to improve vision screening in children. In spite of the importance of vision screening, an important area of consideration in determining the potential for a proposed measure to become a National Performance Measure (NPM) is the existence of a National data source by which States can report State-specific data and rates. When considering whether to include a NPM related to vision screening, a significant obstacle has been the lack of a National data source for measuring vision screening activities. In the absence of a National data source, States have limited capacity to collect and accurately report in this area. Another consideration is that a National consensus about the adequacy of current methods for preschool vision screening has not been reached.

In an attempt to move this important issue forward HRSA's Maternal and Child Health Bureau (MCHB) has supported a number of activities. First in 2008, MCHB convened a group of experts to discuss issues pertaining to the establishment a sustainable vision screening program which entailed current challenges and what key stakeholders would be necessary to bring about vision screening initiatives and guidelines in each State. Based on input from this group and other experts in the field, in 2009 the MCHB awarded the National Society for the Prevention of Blindness a 3 year $300,000 cooperative agreement to develop a Universal Vision Screening for Young Children Coordinating Center (UVSYCCC) to support the public health role in assuring a continuum of eye care for young children within the healthcare delivery system. The UVSYCCC will address the screening and follow-up component of that continuum by: (1) providing National leadership in the development of the Statewide vision screening and intervention component of programs for all children four years of age, prior to school entry, (2) developing and implementing a plan for assisting States to coordinate existing vision screening activities within the State, and (3) working closely with Georgia, Illinois, Massachusetts, North Carolina and Ohio to develop and implement a uniform Statewide strategy for universal vision screening by age 4; determine a mechanism for uniform data collection and reporting; and establishing a State Title V performance measure for vision screening.

Item 30

Traumatic Brain Injury Program — The Committee is concerned by the high percentage of traumatic brain injury funds being used for technical assistance for the State grant portion of the program. The Committee encourages HRSA to re-evaluate the proportion of funds being committed to technical assistance and to ensure that protection and advocacy programs receive the same quality technical assistance as the State grant program. (Page 47/48)

Action Taken or To Be Taken
In FY 2009, HRSA entered into a new technical assistance contract that is less expensive and more efficient than the previous contract. Indeed, this new technical assistance contract uses less than one-half the staff of the prior contract, while not sacrificing either quality or quantity of services. Although the TBI Program authorization does not require HRSA to provide any technical assistance to its TBI Protection and Advocacy grantees until their appropriation is at $6 million, we have always provided and continue to provide high quality technical assistance to these grantees.

Item 31
Healthy Start — The Committee provides $105,372,000 for the healthy start infant mortality initiative. The fiscal year 2009 comparable level was $102,372,000 and the same as the Budget Request**.** The healthy start initiative was developed to respond to persistently high rates of infant mortality in this Nation. The initiative was expanded in fiscal year 1994 by a special projects program, which supported an additional seven urban and rural communities to implement infant mortality reduction strategies and interventions. The Children's Health Act of 2000 fully authorized this initiative as an independent program. The Committee urges HRSA to give preference to current and former grantees with expiring or recently expired project periods. (Page 49)

Action Taken or To Be Taken
The $105, 372,000 for the Healthy Start program is an increase of $3,000,000 above the FY 2008 level. These additional funds will allow HRSA to fund two or more new communities. In addition to the new communities HRSA will continue to fund
13 Healthy Start Projects that end in 2010 as competing continuations, and 89 non-competing continuations.

Item 32
"Universal Newborn Hearing Screening and Early Intervention — The Committee provides $19,000,000 for universal newborn hearing screening and early intervention activities, the same as the fiscal year 2009 comparable level and the Budget Request for fiscal year 2010 for this program. The Committee expects HRSA to coordinate projects funded with this appropriation with projects related to early hearing detection and intervention by the National Center on Birth Defects and Developmental Disabilities, the National Institute on Deafness and Other Communication Disorders, the National Institute on Disability and Rehabilitation Research, and the Office of Special Education and Rehabilitative Services." (Page 49)

Action Taken or To Be Taken
HRSA has enjoyed close collaborative relationships with other Federal agencies which have a role in the newborn hearing screening and intervention program since its inception in 2000. In 2009, the CDC commissioned a report detailing those relationships. The report is available at the National Center for Birth Defects and Developmental Disabilities.

Item 33

AIDS Education and Training Centers — The Committee provides $34,397,000 for the AIDS education and training centers [AETC's]. The FY 2009 comparable level was $34,397,000 and the Budget Request for fiscal year 2010 included $38,397,000. AIDS education and training centers train healthcare practitioners, faculty, and students who care for AIDS patients outside of the traditional health professions education venues, and support curriculum development on diagnosis and treatment of HIV infection for health professions schools and training organizations. The Committee encourages AETCs to continue to prioritize interactive training that demonstrates effectiveness in changing clinician behavior. Funding may be used for existing regional and National centers to conduct clinical training and support workforce development to help meet the program's performance goal to maintain the proportion of racial/ethnic minority healthcare providers participating in the AETC intervention programs. The Committee recognizes the growing shortage of primary care health professionals trained in HIV care and treatment in the country. (Page 51)

Action Taken or To Be Taken

Level funding will provide the resources necessary to maintain a National AIDS Education and Training Centers (AETC) program comprised of regional and National centers. HRSA is concerned about the reference to "students" as this is not included in the authority granted under Section 2692 (42 U.S.C. §300ff-111) of the Public Health Service Act, as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009. Interactive and longitudinal training and support will continue as an activity as that has been demonstrated to influence changes in clinical practice. The program continues to achieve its performance goal of training racial/ethnic health care providers. But HRSA is concerned by the reference to funding to "support workforce development". While an increase in the capacity and capability of health care providers is a potential outcome of clinical training, the Committee's funding amount does not include the $4.0 million in the Administration's **Budget Request** that would have supported the intensive clinical longitudinal support that was specifically intended to contribute to workforce development.

Item 34

Office of Pharmacy Affairs — The Committee encourages HRSA to review carefully the proposed guidance for the 340B drug program, ''Regarding Section 602 of the Veterans Health Care Act of 1992 Definition of Patient'' published by the previous administration on January 12, 2007. The Committee is aware that safety net facilities will be dramatically affected by the administration's efforts to reform the health system and any changes to the drug program should be reviewed in light of the system that emerges from the health reform debate. (Page 53)

Action Taken or To Be Taken

HRSA is currently assessing options for proceeding on the patient definition guidance.

Item 35

State Health Access Grants — The Committee provides $75,000,000 for State Health Access Grants, the same as the fiscal year 2009 comparable level and the Budget Request for fiscal year 2010. This program gives grants to States to create plans and develop programs to expand access to healthcare coverage. The Committee encourages HRSA to work with States to ensure that State plans are not in conflict with any changes to the larger health system that may emerge from the current health reform debate. (Page 53)

Action Taken or To Be Taken

HRSA is adding a statement to the FY 2010 grant guidances indicating that State plans proposed are not to be in conflict with any National health reform enacted. In the interim, HRSA and its technical assistance contractor will be continuously briefing the States on the status of health reform and assisting them individually and collectively to be able to move forward rapidly when reform is enacted.

Item 36

Rural Hospital Flexibility Grants — The Committee is aware that the Department of Veterans Affairs (VA), through its Rural Health Initiative, is committed to better serving veterans residing in remote and rural areas. This initiative gives the Secretary of the VA resources and latitude to collaborate with other Federal or community providers, including rural hospitals serving a large number of veterans. The Committee is strongly supportive of this collaboration and understands that one of the largest barriers to this effort is the lack of electronic medical records that are interoperable with the VISTA system. .... the Committee has included $2,000,000 for grants authorized under section 1820(g)(6) of the Social Security Act to provide telehealth equipment and to develop electronic health records that are compatible with the VISTA system. The Committee encourages HRSA to coordinate with the VA to ensure that this equipment furthers the goal of treating the illnesses and disabilities of our Nation's veterans. The Committee is particularly concerned with ensuring that veterans receive appropriate mental healthcare. (Page 54)

Action Taken or To Be Taken

Through this funding, HRSA will make grants to up to four States to test out innovative approaches to improving access to health care services for rural veterans. In carrying out these activities, HRSA's Office of Rural Health Policy will coordinate closely with the HRSA Office for the Advancement of Telehealth as well as the Office of Rural Health at the Veteran's Administration. The emphasis of the grants will be to identify innovative approaches of using telemedicine and health information technology to reach out to Veterans in rural States where Veterans make up a high percentage of the total population.

Item 37

Native and Rural Alaskan Healthcare — The Committee provides $10,000,000 for the Denali Commission. The fiscal year 2009 comparable level was $19,642,000 and the Budget Request for fiscal year 2010 did not include funding for this program. These funds support the construction and renovation of health clinics, hospitals and social service facilities in rural Alaska, as authorized by Public Law 106–113, to help remote communities in Alaska develop critically needed health and social service infrastructure for which no other funding sources are available, thereby providing health and social services to Alaskans in remote rural communities as they are in other communities throughout the country. The Committee expects the Denali Commission to allocate funds to a mix of rural hospital, clinic, long-term care and social service facilities, rather than focusing exclusively on clinic funding. (Page 55)

Action Taken or To Be Taken

Through this funding, HRSA and the Denali Commission will give particular attention to ensuring that 2009 funding is used for a diversity of projects. The Denali Commission has a well-established planning process in place that identifies hospitals, clinics and social service facilities that are best positioned to submit a project proposal that is construction ready. HRSA will monitor the 2009 expenditures to ensure the appropriate mix of approved facilities.

Item 38

Family Planning — Title X grants support primary healthcare services at clinics Nationwide. About 85 percent of family planning clients are women at or below 150 percent of poverty level. Title X of the Public Health Service Act, which established the family planning program, authorizes the provision of a broad range of acceptable and effective family planning methods and preventive health services to individuals, regardless of age or marital status. This includes FDA-approved methods of contraception. The Committee urges HRSA to use the increased funds to augment the awards for existing grantees to offset the rising cost of providing healthcare services. In addition, the Committee encourages HRSA to increase funding to the regional training centers. (Page 55/56)

Action Taken or to be Taken

The FY 2011 Budget Request provides funds for family planning methods, including FDA-approved methods of contraception, and related preventive health services, as well as related training. At least 90 percent of the funding will be provided to Title X service grantees for clinical services including funds to address the increasing cost of providing family planning services. The Budget Request includes plans to strengthen the infrastructure of the program to meet the growing needs of the population through the provision of care, staff training and contraceptive options. As part of this effort, the program will develop a multi-year strategic plan, which will among other things, assess the training and work force needs of Title X providers and the funding requirements for the regional training centers.

Item 39

Title X Funds — The Committee remains concerned that programs receiving title X funds ought to have access to these resources as quickly as possible. The Committee again instructs the Department to distribute to the regional offices all of the funds available for family planning services no later than 60 days following enactment of this bill. The Committee intends that the regional offices should retain the authority for the review, award and administration of family planning funds, in the same manner and timeframe as in fiscal year 2006. The Committee intends that at least 90 percent of funds appropriated for title X activities be for clinical services authorized under section 1001 of the act. The Committee further expects the Office of Family Planning to spend any remaining year-end funds in section 1001 activities. (Page 56)

Action Taken or to be Taken

The PHS Regional Offices will receive their funding distribution for Title X family planning services within 60 days following enactment of this bill. At least 90 percent of the funds appropriated for Title X activities will be distributed to service grantees for clinical services authorized under section 1001 of the Act. Additionally, any year-end funds will support section 1001 activities.

Item 40

Substance Use and Mental Disorders of Persons with HIV —According to the Nationally representative HIV Cost and Services Utilization Study, almost half of persons with HIV/AIDS screened positive for illicit drug use or a mental disorder, including depression and anxiety disorder. Unfortunately, health care providers fail to notice mental disorder and substance use problems in almost half of patients with HIV/AIDS, and mental health and substance use screening is not common practice in primary care settings. Several diagnostic mental health and substance use screening tools are currently available for use by non-mental health staff. The Committee encourages SAMHSA to collaborate with HRSA to train health care providers to screen HIV/AIDS patients for mental health and substance use problems. (Page 129)

Action Taken or To Be Taken

The AETC Program has a history of working with SAMHSA to support training of AETC trainers using previously developed curricula on ethics, neuropsychiatry and mental health and substance use. Funds were provided, via an IAA in FY 2005, to provide grant supplements to the AETCs to use these curricula in regional training of HIV/AIDS service and treatment providers on HIV/AIDS related mental health, in an effort to improve clinical care to patients with mental health/substance abuse/HIV co-morbidity. These resources and efforts continue as part of the training portfolio today.

Additionally, several AETCs have gained expertise and provide training in a variety of medical care settings in Screening, Brief Intervention, Referral to Treatment (SBIRT) which focuses on implementing a system within community and medical settings to screen for and identify individuals with or at-risk for substance use-related problems. HRSA expects the AETCs to incorporate and offer clinical training on buprenorphine use in primary medical care based on recent findings for our Ryan White Special Projects of National Significance Program. These existing and new emerging issues are routinely considered in the Federal Training Center Collaborative, which represents 6 National training programs across four Federal Agencies/Offices and strives to coordinate training efforts on topics and populations of mutual interest in the field of HIV and STIs. Via this highly effective, formal mechanism for coordination and collaboration among Federal Training Centers, HRSA will work with SAMHSA this year to reassess training of providers in screening of HIV infected patients for mental health and substance abuse problems.

Item 41

Lesbian, Gay, Bisexual, and Transgender Health — The Committee notes that healthcare disparities affecting lesbian, gay, bisexual, and transgender [LGBT] persons have been recognized by various Federal agencies, including SAMHSA, HRSA, and NIH. The Committee encourages the Department to establish and fund an office focusing on LGBT health in order to strategically track and address health disparities experienced by LGBT individuals. (Page 159)

Action Taken or To Be Taken

At present, there are no programs specifically targeting LGBT populations in HRSA, though our focus is more broadly targeting access to health care services for underserved and vulnerable populations including minorities and others with increased disease burden and disparities in

health outcomes. In order to conduct and coordinate activities throughout the Agency focusing on LGBT health, we would solicit information from across HRSA Bureaus and Office programs as well as from HRSA administrative offices to learn what is currently done to target LGBT populations, what data is currently available regarding LGBT health outcomes and what is known about LGBT access to grant programs and funding. A cross-agency effort would include identifying opportunities to expand awareness about LGBT challenges and developing collaborative efforts to address disparities in access and/or health outcomes.

- In addition to an initial inventory of current information as noted above, other possible collaborative efforts could include: incorporating language about LGBT populations into HRSA documents and guidance;
- incorporating LGBT populations (re: data granularity) into dialogue for HRSA program reports;
- expanding HRSA Evaluation and research focus to ensure LGBT
- populations are captured in data and planning stages; and
- incorporating LGBT populations in health literacy and health communications materials and initiatives

Special Requirements

TAB

HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

OPDIV Allocation Statement:

The **HRSA** will use **$922,754** of its **FY 2011** budget to support Department-wide enterprise information technology and government-wide E-Government initiatives. Operating Divisions help to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process, and the government-wide E-Government initiatives. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Of the amount specified above, **$85,078.13** is allocated to developmental government-wide E-Government initiatives for **FY 2011**. This amount supports these government-wide E-Government initiatives as follows:

FY 2011 Developmental E-Gov Initiatives*	
Line of Business – Geospatial One-Stop	$719.60
Line of Business - Human Resources	$3,161.02
Line of Business - Grants Management	$16,134.35
Line of Business - Financial	$18,063.16
Line of Business - Budget Formulation and Execution	$12,000.00
Disaster Assistance Improvement Plan	$35,000.00
FY 2011 Developmental E-Gov Initiatives Total	**$85,078.13**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Prospective benefits from these initiatives are:

Lines of Business-Human Resources Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital. HHS has been selected as a Center of Excellence and will be leveraging its HR investments to provide services to other Federal agencies.

Lines of Business-Grants Management: Supports end-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and, post-award closeout actions. The Administration for Children and Families (ACF), is a GMLOB consortia lead, which has allowed ACF to take on customers external to HHS. These additional agency users have allowed HHS to reduce overhead costs for internal HHS users. Additionally,
NIH is an internally HHS-designated Center of Excellence. This effort has allowed HHS agencies using the NIH system to reduce grants management costs. Both efforts have allowed

HHS to achieve economies of scale and efficiencies, as well as streamlining and standardization of grants processes, thus reducing overall HHS costs for grants management systems and processes.

Lines of Business –Financial Management: Supports efficient and improved business performance while ensuring integrity in accountability, financial controls and mission effectiveness by enhancing process improvements; achieving cost savings; standardizing business processes and data models; promoting seamless data exchanges between Federal agencies; and, strengthening internal controls.

Lines of Business-Budget Formulation and Execution: Allows sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

Disaster Assistance Improvement Plan (DAIP): The DAIP, managed by Department of Homeland Security, assists agencies with active disaster assistance programs such as HHS to reduce the burden on other federal agencies which routinely provide logistical help and other critical management or organizational support during disasters.

In addition, **$668,855.49** is allocated to ongoing government-wide E-Government initiatives for **FY 2011**. This amount supports these government-wide E-Government initiatives as follows:

FY 2011 Ongoing E-Gov Initiatives*	
E-Rule Making	$7,244.91
Grants.Gov	$520,310.99
Integrated Acquisition Environment	$79,159.76
GovBenefits	$62,169.83
FY 2011 Ongoing E-Gov Initiatives Total	**$668,855.49**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assesse

Health Education Assistance Loans

TAB

Health Resources and Services Administration
Health Education Assistance Loans

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APPROPRIATIONS LANGUAGE

[Such sums as may be necessary to carry out the purpose of the program, as authorized by title VII of the PublicHealth Service Act ("PHS Act"). For administrative expenses to carry out the guaranteed loan program, including section 709 of the PHS Act, $2,847,000.]

(a) IN GENERAL.—The Health Education Assistance Loan (HEAL) program under title VII, part A, subpart I of the Public Health Service Act (42 U.S.C. 292-292p), and the authority to administer such program, including servicing, collecting, and enforcing any loans that were made under such program that remain outstanding, shall be permanently transferred from the Secretary of Health and Human Services to the Secretary of Education. (b) TRANSFER OF FUNCTIONS, ASSETS, AND LIABILITIES.—The functions, assets, and liabilities of the Secretary of Health and Human Services relating to such program shall be transferred to the Secretary of Education. (c) USE OF AUTHORITIES UNDER HIGHER EDUCATION ACT OF 1965.—In servicing, collecting, and enforcing the loans described in subsection (a) , the Secretary of Education shall have available any and all authorities available to such Secretary in servicing, collecting, or enforcing a loan made, insured, or guaranteed under part B of title IV of the Higher Education Act of 1965. (d) CONFORMING AMENDMENTS.—Effective as of the date on which the transfer of the HEAL program under subsection (a) takes effect, section 719 of the Public Health Service Act (42 U.S.C. 292o) is amended by adding at the end the following new paragraph: "(6) The term 'Secretary' means the Secretary of Education."

Language Analysis

LANGUAGE PROVISION	EXPLANATION
[Such sums as may be necessary to carry out the purpose of the program, as authorized by title VII of the PublicHealth Service Act ("PHS Act"). For administrative expenses to carry out the guaranteed loan program, including section 709 of the PHS Act, $2,847,000.]	• Citation is not required as program is being transferred to the Department of Education.
(a) IN GENERAL.—The Health Education Assistance Loan (HEAL) program under title VII, part A, subpart I of the Public Health Service Act (42 U.S.C. 292-292p), and the authority to administer such program, including servicing, collecting, and enforcing any loans that were made under such program that remain outstanding, shall be permanently transferred from the Secretary of Health and Human Services to the Secretary of Education. (b) TRANSFER OF FUNCTIONS, ASSETS, AND LIABILITIES.—The functions, assets, and liabilities of the Secretary of Health and Human Services relating to such program shall be transferred to the Secretary of Education. (c) USE OF AUTHORITIES UNDER HIGHER EDUCATION ACT OF 1965.—In servicing, collecting, and enforcing the loans described in subsection (a) , the Secretary of Education shall have available any and all authorities available to such Secretary in servicing, collecting, or enforcing a loan made, insured, or guaranteed under part B of title IV of the Higher Education Act of 1965. (d) CONFORMING AMENDMENTS.—Effective as of the date on which the transfer of the HEAL program under subsection (a) takes effect, section 719 of the Public Health Service Act (42 U.S.C. 292o) is amended by adding at the end the following new paragraph: "(6)	Citation is added to explain the transfer of the program to the Department of Education.

LANGUAGE PROVISION	EXPLANATION
The term 'Secretary' means the Secretary of Education.".	

Health Resources and Services Administration
Health Education Assistance Loans

Amounts Available for Obligation

Program and Financing Accounts

	FY 2009 Actual	FY 2010 Est.	FY 2011 PB
Balance, start of year	$90,808,000	$61,053,000	---
Appropriation	2,847,000	2,847,000	---
Collections:			
Upward Re-estimate		---	---
Downward Re-estimate	-27,956,000	-9,882,000	---
Interest	3,477,000	2,507,000	---
Repayments/Recoveries	5,781,000	3,566,000	---
Total collections	-18,698,000	-3,809,000	---
Total available	74,957,000	60,091,000	---
Claims:			
Death and disability	-1,955,000	-1,314,000	---
Defaults	-9,102,000	-11,092,000	---
Total claims	-11,057,000	-12,406,000	---
Administrative Expenses	-2,847,000	-2,847,000	---
Ending balance	$61,053,000	$44,838,000	---

Health Resources and Services Administration
Health Education Assistance Loans

Amounts Available for Obligation

Liquidating Account *(SLIA)*

	FY 2009 Actual	FY 2010 Est.	FY 2011 PB
Balance, start of year		---	---
Appropriation	$1,000,000	$1,000,000	---
Collections:			
Repayments/Recoveries	10,460,000	10,000,000	---
Total available	11,460,000	11,000,000	---
Total claims	-3,056,000	-2,100,000	---
Sweep-up to Treasury	$8,404,000	$8,900,000	---

Health Resources and Services Administration
Health Education Assistance Loans

Summary of Changes

Discretionary Appropriation:

Increase:	**FTE**	**BA**
2010 HEALProgram Account	14	$2,847,000
2011 HEAL Program Account	---	---
Total Change	-14	-$2,847,000

Budget Authority by Activity

(Dollars in thousands)

	FY 2009 Appropriation	**FY 2010 Omnibus**	**FY 2011 PB**
Liquidating Account SLIA	$1,000,000	$1,000,000	---
HEAL Program Account: Administrative Expenses	$2,847,000	$2,847,000	---

Budget Authority by Object

Liquidating Account *(SLIA)*

Object Class (42.0)	**FY 2010 Omnibus**	**FY 2011 Estimate**	**Increase Or Decrease**
Investments and loans	$1,000,000	---	-$1,000,000

Budget Authority by Object

Program Account

	FY 2010 Omnibus	FY 2011 Estimate	Increase Or Decrease
Full-time equivalent employment [1]	14	---	-
Average GS Grade	13.6	---	-
Average GS Salary	$101,500	---	-$101,500

	FY 2010 Omnibus	FY 2011 Estimate	Increase Or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$1,019,000	---	-$1,019,000
Other than full-time perm (11.3)	102,000	---	-102,000
Other personnel comp (11.5)	24,000	---	-24,000
Subtotal Personnel Compensation	**1,145,000**	**---**	**-1,145,000**
Civilian benefits (12.1)	213,000	---	-213,000
Benefits for Former Personnel(13.1)	6,000	---	-6,000
Total Pay Costs	**1,364,000**	**---**	**- 1,364,000**
Transportation of things (22.0)	-	-	-
Rental payments to GSA (23.1)	130,000	---	-130,000
Printing (24.0)	3,000	---	-3,000
Other Contractual Services:			
Other services (25.2)	469,000	---	-469,000
Purchase of goods and services from other Government accounts (25.3)	868,000	---	868,000
Operation and Maintenance of Equipment (25.7)	11,000	---	-11,000
Subtotal Other Contractual Services	**1,348,000**	**---**	**1,348,000**
Equipment (31.0)	2,000	---	-2,000
Total Non-Pay Cost	**1,483,000**	**---**	**-1,483,000**
Total Budget Authority by Object Class	**$2,847,000**	**---**	**-$2,847,000**

[1] Includes 7 FTEs for the Office of HEAL Default Reduction.

Salaries and Expenses

Program Account

	FY 2010 Omnibus	FY 2011 Estimate	Increase Or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$1,019,000	---	--$1,019,000
Other than full-time perm (11.3)	102,000	---	-102,000
Other personnel comp (11.5)	24,000	---	-24,000
Total personnel comp (11.9)	1,145,000	---	-1,145,000
Personnel benefits (12.1)	213,000	---	- 213,000
Benefits for Former Personnel(13.1)	6,000	---	-6,000
Subtotal Pay Costs.	1,364,000	---	-1,364,000
Transportation of things (22.0)	---	---	---
Printing (24.0)	3,000	---	-3,000
Other Contractual Services:			
Other services (25.2)	469,000	---	-469,000
Purchase of goods and services from			
Other Government accounts (25.3)	868,000	---	-868,000
Operation and Maintenance of Equipment (25.7)	11,000	---	-11,000
Subtotal Other Contractual Services	1,348,000	---	-1,348,000
Subtotal Non-Pay Cost	1,351,000	---	-1,351,000
Total Salaries and Expenses	**2,715,000**	**---**	**-2,715,000**

Authorizing Legislation

Health Resources and Services Administration
Health Education Assistance Loans

	FY 2010 Amount Authorized	FY 2010 Omnibus	FY 2011 Amount Authorized	FY 2011 Pres. Budget
Health Education Assistance Loans and Student Loan Insurance Account:				
Appropriation:				
Liquidating Account (SLIA):				
PHS Act, Sec. 710	---[2]	1,000,000	---[2]	---
Program Account:				
PHS Act, Secs. 709, 720	SSAN [3]	2,847,000	---	---
Borrowing authority (SLIA):				
PHS Act, Sec 710(b)	---[4]	---	---[4]	---

[2] Sec 710(a)(2) states, "Except as provided in subparagraph (B), all amounts received by the Secretary as premium charges for insurance and as receipts, earnings, or proceeds derived from any claim or other assets acquired by the Secretary in connection with his operations under this subpart, and any other moneys, property, or assets derived by the Secretary from the operations of the Secretary in connection with this section, shall be deposited in the Account."
[3] Such Sums as Necessary
[4] Sec 710(b) states, "If at any time, the moneys in the Account are insufficient to make payments in connection with the collection or default of any loan insured by the Secretary under this subpart, the Secretary of the Treasury may lend the Account such amounts as may be necessary to make the payments involved, subject to the Federal Credit Reform Act of 1990."

APPROPRIATION HISTORY

SLIA Liquidating Account

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2001	10,000,000	10,000,000	10,000,000	10,000,000
2002	10,000,000	10,000,000	10,000,000	10,000,000
2003	7,000,000	7,000,000	7,000,000	7,000,000
2004	4,000,000	4,000,000	4,000,000	4,000,000
2005	4,000,000	4,000,000	4,000,000	4,000,000
2006	4,000,000	4,000,000	4,000,000	4,000,000
2007	4,000,000	1,000,000	1,000,000	1,000,000
2008	1,000,000	1,000,000	1,000,000	1,000,000
2009	1,000,000	1,000,000	1,000,000	1,000,000
2010	1,000,000	1,000,000	1,000,000	1,000,000
2011	---			

APPROPRIATION HISTORY

HEAL Program Account

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
Rescission				-1,000
2001	3,679,000	3,679,000	3,679,000	3,679,000
Rescission				-7,000
2002	3,792,000	3,792,000	3,792,000	3,792,000
Rescission				-1,000
2003	3,914,000	3,914,000	3,914,000	3,914,000
Rescission				-25,000
2004	3,389,000	3,389,000	3,389,000	3,389,000
Rescission				-36,000
2005	3,270,000	3,270,000	3,270,000	3,270,000
Rescission				-26,000
2006	2,916,000	2,916,000	2,916,000	2,916,000
Rescission				-31,000
2007	2,887,000	2,887,000	2,887,000	2,898,000
2008	2,906,000	2,906,000	2,906,000	2,847,000
2009	2,847,000	2,847,000	2,847,000	2,847,000
2010	2,847,000	2,847,000	2,847,000	2,847,000
2011	---			

General Statement

Health Education Assistance Loans (HEAL)

To assist in training students in various health fields, the HEAL program was authorized to provide insured loans for students enrolled in schools of allopathic and osteopathic medicine, dentistry, veterinary medicine, optometry, podiatry, public health, pharmacy, chiropractic, and graduate programs in health administration, clinical psychology and allied health.

Eligible student borrowers obtain loans, to be used for tuition and other reasonable educational and living expenses, from participating commercial lenders, educational institutions, State agencies, insurance companies and pension funds. The repayment of principal and interest is guaranteed by the Federal Government if the borrower becomes permanently disabled, dies, or defaults on the repayments.

Student Loan Insurance Account (SLIA)

The SLIA provides repayments to the lenders on defaulted HEAL loans, and for claims due to the death or disability of student borrowers. Deposits to the fund are derived from insurance premiums charged to the borrowers when the loans are made, repayments of defaulted claims, and if necessary, from borrowing authority and/or appropriations.

Health Education Assistance Loans

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
Liquidating Account	$1,000,000	---	$1,000,000	---	-$1,000,000
Administrative Expenses	2,847,000	---	2,847,000	---	-2,847,0000
Total	$3,847,000	---	$3,847,000	---	-$3,847,000
FTE	14	--	14	---	-14

Authorizing legislation: Sections 701-720 of the Public Health Service Act

FY 2011 Authorization ..... Expired

FY 2011 Authorization - Liquidating Account..... Such Sums as Necessary

Allocation Method .....Other

Program Description and Accomplishments

The Health Education Assistance Loan (HEAL) Program was established in 1977 via Sections 701-720 of the Public Health Service Act. Between 1978 and 1998 the HEAL Program insured loans made by participating lenders to eligible graduate students in schools of allopathic medicine, osteopathic medicine, dentistry, veterinary medicine, optometry, podiatry, public health, pharmacy, health administration, clinical psychology and chiropractic medicine. The program has provided $4.0 billion to help 157,000 students of diverse socio-economic backgrounds pay for their health professions education. Authority to make new HEAL loans expired September 30, 1998, and refinancing ended September 30, 2004.

As the original and refinanced HEAL loan term can extend at least 25 to 33 years, administrative funds are required to properly service active accounts, project future claims, and to carry out default reduction activities which can save taxpayers millions of dollars. Timely payment of claims will avoid excess interest payments to lenders and aid in recovery of overdue accounts.

The HEAL Program maintains, and updates quarterly, a list of defaulted HEAL borrowers on the internet (http://www.defaulteddocs.dhhs.gov). These borrowers who have defaulted on the repayment of their HEAL loans are excluded, as practitioners, from participating in Medicare/Medicaid. The program makes available additional information with respect to these borrowers to relevant Federal and State agencies and legislators, school associations, professional and specialty associations, State licensing boards, hospitals with which such borrowers may be associated, and other relevant organizations. Millions of dollars have been received from defaulters as a result of the activities associated with publicizing their names.

The HEAL Program continues to maintain oversight for an outstanding loan portfolio, some of which may not be fully repaid until 2037.

The HEAL staff have continued to maintain essential operational activities associated with a loan guarantee program of this magnitude, such as the processing of lender claims and borrower requests for forbearance and disability. Default reduction activities have also continued, including providing technical assistance to States regarding licensing sanctions and maintaining and updating the web site of HEAL defaulters (those on web site may not participate in Medicare payment). This site includes approximately 1,044 health professionals who owe the Federal Government approximately $133 million on their defaulted HEAL loans as of November 2009. In FY 2009, the default rate for the HEAL Program decreased from 2.8 to 2.7 percent.

The HEAL Online Processing System (HOPS) is a unique web based system with an Oracle database that tracks current payment status on outstanding HEAL loans. This is the only system that enables the HEAL program to project the government's potential liability for future claim payments. The purpose of the investment is three fold: first, to ensure the integrity in the system; second to monitor adherence of loan holders and loan servicers to mandated legislative, regulatory or policy requirements; and third to pay only loan claims that should be paid and in the proper amounts. There is no alternative automated system to HOPS.

The HEAL Program's long term objective is to achieve excellence in management, as monitored through two performance measures:

- Conduct an orderly phase-out of the outstanding loan portfolio, resulting in a reduction in the Federal liability associated with the HEAL Program.

  The HEAL Program is currently phasing out an outstanding loan portfolio of approximately $853 million as of September 30, 2009. The program has historically met or exceeded its targets for phasing out the outstanding loan portfolio, through initiatives to help borrowers manage their indebtedness, and through partnerships with lenders and loan holders. In FY 2009, the target was met and slightly exceeded by $13 million in loans. The FY 2010 target is $765 million, and the FY 2011 target is more conservative ($715 million), because projections are difficult to determine when the economy and banking industry are in flux having a direct impact on students refinancing and paying off loans.

- Improve claims processing efficiency through implementation of the HEAL Online Processing System (HOPS).

  The efficiency measure for the HEAL program is to improve claims processing efficiency through the implementation of an online processing system. The target of 8 days processing time was met in FY 2007 but, in FY 2008, the target of 8 days was not met. It took 11 days on average to process claims, because there were management changes and other reductions in staff that caused the claims specialists' workload to increase. It is believed that the FY 2008 result was an anomaly. In

FY 2009 the target of eight days was met and exceeded by two days, due to hiring of additional staff. The targets for FY 2010 – FY 2011 will remain eight days since staff will be occupied throughout the next year implementing system enhancements.

Funding History

FY	Amount	Liquidating Account
2006	$2,885,000	$4,000,000
2007	$2,898,000	$1,000,000
2008	$2,847,000	$1,000,000
2009	$2,847,000	$1,000,000
2010	$2,847,000	$1,000,000

Budget Request

The FY 2011 Request does not include funds for the Health Education Assistance Loan Program. The functions, assets, and liabilities relating to this program will be transferred to the Department of Education. Transferring this activity will take advantage of the Department of Educations' greater experience and expertise in administering educational loan programs. In addition, this transfer will yield efficiencies that will save the Federal government over $1 million in FY 2011.

Outcomes and Outputs Tables

Long Term Objective: Achieve Excellence in Management

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
9.VII.C.1: Conduct an orderly phase-out of the outstanding loan portfolio, resulting in a reduction in the Federal liability associated with the HEAL program (balance in the portfolio, dollars in $000's). *(Outcome)*	FY 2009: $853 (Target Exceeded)	$765	N/A	---
9.E: Improve claims processing efficiency through implementation of an online processing system (HOPS). (Avg. number of days to process claims) *(Efficiency)*	FY 2009: 6 days (Target Exceeded)	8 days	N/A	---

Vaccine Injury Compensation Program

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Health Resources and Services Administration
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Vaccine Injury Compensation Program

APPROPRIATION LANGUAGE

For payments from the Vaccine Injury Compensation Program Trust Fund ("Trust Fund"), such sums as may be necessary for claims associated with vaccine-related injury or death with respect to vaccines administered after September 30, 1988, pursuant to subtitle 2 of title XXI of the Public Health Service Act, to remain available until expended: *Provided,* That for necessary administrative expenses, not to exceed $6,502,000 shall be available from the Trust Fund to the Secretary of Health and Human Services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration
Vaccine Injury Compensation Program

Amounts Available for Obligation

	FY 2009 Actual	FY 2010 Estimate	FY 2011 Pres. Budget
Unobligated Balance, Start of Year	$2,674,000	$2,893,000	$3,150,000
Receipts	235,000	295,000	241,000
Interest Income	89,000	93,000	97,000
Total, Receipts/Collections	$324,000	$388,000	$338,000
Total Balance/Net Collections	$2,998,000	$3,281,000	$3,488,000
Claims Appropriation (Obligation)	90,000,000	111,000,000	123,000,000
Total Admin.DOJ/Claims Ct/HRSA	17,000,000	20,000,000	20,000,000
Total New Obligations	$107,000,000	$131,000,000	$143,000,000
Unobligated Balance, End of Year	$2,893,000	$3,150,000	$3,345,000

Budget Authority by Activity

	FY 2009 Appropriation	FY 2010 Omnibus	FY 2011 Pres. Budget
Trust Fund Obligations: Post-10/1/88 claims	$90,000,000	$115,908,000	$115,908,000
Administrative Expenses: HRSA Direct Operations	$5,404,000	$6,502,000	$6,502,000
Total Obligations	$95,404,000	$122,410,000	$122,410,000

Budget Authority by Object

	FY 2010 Omnibus	FY 2011 Pres. Budget	Increase or Decrease
Insurance claims and indemnities	$115,908,000	$115,908,000	_
Other Services (25.2)	$6,502,000	$6,502,000	_
Total	$122,410,000	$122,410,000	_

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration
Vaccine Injury Compensation Program

Salaries and Expenses

	FY 2010 Omnibus	FY 2011 Pres. Budget	Increase or Decrease
Other Services (25.2)	$6,502,000	$6,502,000	_

Authorizing Legislation

	FY 2010 Amount Authorized	FY 2010 Omnibus	FY 2011 Amount Authorized	FY 2011 Pres. Budget
(a) PHS Act, Title XXI, Subtitle 2, Parts A and D:				
Pre-FY 1989 Claims	110,000,000	---	110,000,000	---
Post-FY 1989 Claims	Indefinite	115,908,000	Indefinite	115,908,000
(b) Sec. 6601 (r)d ORBA of 1989 (P.L. 101-239):				
HRSA Operations	Indefinite	6,502,000	Indefinite	6,502,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration
Vaccine Injury Compensation Program

Appropriation History Table

(Pre-1988 Claims Appropriation)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1996	110,000,000	110,000,000	110,000,000	110,000,000
1997	110,000,000	110,000,000	110,000,000	110,000,000
1998	---	---	---	---
1999	---	---	100,000,000	100,000,000
2000	---	---	---	---
2001	---	---	---	---
2002	---	---	---	---
2003	---	---	---	---
2004	---	---	---	---
2005	---	---	---	---
2006	---	---	---	---
2007	---	---	---	---
2008	---	---	---	---
2009	---	---	---	---
2010	---	---	---	---

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration
Vaccine Injury Compensation Program

National Vaccine Injury Compensation Program

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
Claims BA	$90,000,000	---	$115,908,000	$115,908,000	---
Admin BA	$5,404,000	---	$6,502,000	$6,502,000	---
Total BA	$95,404,000	---	$122,410,000	$122,410,000	---
FTE	17	---	17	17	---

Authorizing Legislation – Title XXI, Subtitle 2, Parts A and D, of the Public Health Service Act as amended, and related legislation.

FY 2011 Authorization ..... Such Sums as Necessary

Allocation Method .....Other

Program Description and Accomplishments

The National Childhood Vaccine Injury Act of 1986 (the Act) established the National Vaccine Injury Compensation Program (VICP) to equitably and expeditiously compensate individuals, or families of individuals, who have been injured by childhood vaccines, and to serve as a viable alternative to the traditional tort system. The Health Resources and Services Administration (HRSA) administers the VICP in conjunction with the Department of Justice (DOJ) and the U.S. Court of Federal Claims (Court). HRSA has been delegated the authority to administer Parts A and D of Subtitle 2. Consistent with this delegation, HRSA:

receives petitions for compensation served on the Secretary of HHS (the Secretary);

- arranges for medical review of each petition and supporting documentation by physicians with special expertise in pediatrics and adult medicine, and develops recommendations to the Court regarding the eligibility of petitioners for compensation;
- publishes notices in the Federal Register of each petition received;
- promulgates regulations to modify the Vaccine Injury Table;
- provides administrative support to the Advisory Commission on Childhood Vaccines(ACCV), composed of nine voting members, including health professionals, attorneys, and parents of children who have suffered a vaccine-related injury or death, and specified HHS agency heads (or their designees);
- informs the public of the availability of the Program; and

- processes award payments to petitioners, and attorneys for judgments entered by the Court; and informs the public of the availability of the VICP.

As of November 2009, over 2,300 families and individuals have been awarded compensation totaling over $1.9 billion. FY 2007 through FY 2009 resulted in the largest discharged outlays since VICP's inception, with over $270 million in compensation awards to more than 350 families and individuals.

A program assessment of the VICP was conducted in 2005. The assessment found that the VICP serves as a favorable alternative to the traditional tort system. The VICP had data to reflect its progress in achieving most of its long-term and annual performance measures. The assessment suggested that an independent, comprehensive evaluation of the VICP be conducted on a regular basis. During the review, the Program developed a new set of performance measures that support the purpose of the VICP. Since the assessment the Program has initiated a multi-phase comprehensive evaluation.

The VICP performance is focused on the timely adjudication of vaccine injury claims and monetary awards. From FY 2005-2009, the target for the percentage of eligible claimants who were awarded compensation, but opted to reject awards and elect to pursue civil action has been zero percent, and the VICP has met its target each of these fiscal years. The VICP average time to process claims has been less than its target for FY 2006, FY 2008 and FY 2009. However, in FY 2007 the VICP did not meet its target of 1,213 days for this measure due to petitioner and Court-driven delays in adjudicating claims. For this period, the performance outcome was 1,337 days. The target for this measure has been increased since the Court, at the request of the petitioner, stopped the adjudication process for several years resulting in a significant increase in processing time. The VICP has exceeded its targets for the percentage of cases where the deadline for the Rule 4(b) report is met once the case has been deemed complete. In FY 2008, the Rule 4(b) report deadline was met for 94.7 percent of the cases that were deemed complete which exceeded the target of 86 percent. Quickly and efficiently processing settlements is a top priority for the VICP. In FY 2008, the percentage of cases in which settlements are processed within 15 weeks was 100 percent which surpassed the target of 92 percent.

In 2009, the VICP was successful in reducing the average time to approve settlements and to pay lump sum only awards. The average time that settlements were approved from the date of receipt of the DOJ settlement proposal was 7.5 days, which was less than the target of 10 days. The average time to pay a lump sump only award from the receipt of all required documentation to make a payment was 2.5 days, which was less than the target of 5 days.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration
Vaccine Injury Compensation Program

Funding History

VICP Awards

FY	Amount
FY 2006	$54,243,624
FY 2007	$98,081,069
FY 2008	$119,000,000
FY 2009	$90,000,000
FY 2010	$115,908,000

Budget Request

The FY 2011 President's Budget Request of $122,410,000 is the same as the FY 2010 Appropriation. This includes $6,502,000 for the expert witness program and other administrative expenses. The request will fund the following:

VICP Awards - The VICP awards payments to individuals or families of individuals, who have thought to have been injured, or have died, as the result of receiving a vaccine(s) recommended by the Centers for Disease Control and Prevention for routine administration to children. In FY 2011, HRSA estimates that $115,908,000 will be paid out of the Vaccine Injury Compensation Trust Fund (Trust Fund) for payment of awards due to vaccine-related injuries or deaths. These funding levels are necessary to account for potential outlays resulting from the backlog of thousands of autism claims that are now being ordered by the Court for jurisdictional, medical staff and medical expert reviews, and the addition of four additional vaccines since 2004 --the hepatitis A, influenza, meningococcal and the human papillomavirus vaccines--for coverage under the VICP. The medical review workload is increasing each year as a result of new vaccine claims, particularly for influenza vaccines which alone make up more than a third of all vaccines administered annually.

This funding level will ensure adequate funds are available to pay awards allowing the VICP to continue to meet its zero percent target for the percentage of eligible claimants who opt to reject awards and elect to pursue civil action. Furthermore, this level will enable the VICP to meet or exceed its target of three days for the average time to pay lump sum only awards from the receipt of all required documentation to make a payment and 8 days for the average time that settlements are approved from the date of receipt of the DOJ settlement proposal. In preparing a legal opinion for VICP management, Office of General Counsel must often consult with the DOJ attorney to clarify or amend elements in the settlement proposal leading to delays in the process.

Administrative Expenses - HRSA anticipates using $6,502,000 from the Trust Fund for administrative expenses to cover costs borne by HHS that are associated with the internal medical review of claims, external medical review of claims by outside consultants (including,

where warranted, expert testimony to the Court), professional and administrative support to the ACCV, meeting specific administrative requirements of the Act, processing award payments, maintaining necessary records, and informing the public of the availability of the VICP.

Beginning in 2001, parents began filing petitions under the VICP alleging autism (or autism spectrum disorder) from either measles-mumps-rubella (MMR) vaccine or thimerosal-containing vaccines, or from both. In 2002, the Chief Special Master of the Court created the Omnibus Autism Proceeding (OAP) to adjudicate the thousands of claims that were expected. As of June 1, 2009, over 5,500 cases have been filed, and over 5,100 pending cases are being divided among the three presiding special masters. Some Petitioners have withdrawn, as is their statutory right, and may be pursuing claims against vaccine manufacturers in civil court, and some petitions have been dismissed because they were filed after the statute of limitations had expired.

Until the first autism hearing in June 2007, the Court did not require medical reviews of autism claims because it permitted them to be filed without medical records. After the first autism hearing, the Court began ordering newly filed claims to include medical records, and began requiring medical reviews by HRSA, as is standard in non-autism claims. Similar to the 4,250 "pre-1988" claims filed at the beginning of the VICP which required 13 years to completely review and adjudicate, thousands of pending autism claims pose an enormous workload challenge and burden on existing resources. In January 2008, the Court began ordering jurisdictional reviews in the pending claims at a rate of 200 per month. DOJ has taken the lead in determining if the onset of autism symptoms is within the Act's statute of limitations. However, claims of unclear onset are being ordered for a Division of Vaccine Injury Compensation (DVIC) medical officer evaluation, and a large number require medical expert evaluation, with a probable hearing before a special master. This is an additional expense for the medical expert program. As of late FY 2009, the Court began assigning autism claims for medical review and submission of Rule 4 reports. Claims must be reviewed within 90 days of assignment by the Court.

On February 12, 2009, the U.S. Court of Federal Claims issued opinions in three test cases in favor of Respondent (HHS) for Theory 1 (MMR vaccine and thimerosal-containing vaccines), ruling that the MMR, whether administered alone or in conjunction with thimerosal-containing vaccines, is not a causal factor in the development of autism or autism spectrum disorders. These decisions are the result of the 2007 hearings on general causation and the three test cases. Final decisions on general causation and three test cases for Theory 2 (thimerosal-containing vaccines only) are not expected until early 2010. All three test cases were appealed by petitioners to a judge of the US Court of Federal Claims, and all three were decided in favor of the respondent (HHS). Further appeals are expected to the U.S. Court of Appeals for the Federal Circuit. Only decisions by the Federal Circuit, and if appealed further, the Supreme Court, are binding on other VICP cases. The appeals process from the special masters' decisions to a final decision by the Federal Circuit is expected to take from 2-3 years. Regardless of the final outcome of the OAP, HRSA expects medical reviews will be necessary in a majority of the claims for procedural reasons.

This funding will also provide DVIC the opportunity to better publicize the VICP. DVIC will be exhibiting at medical and legal conferences in FY 2011. In the past, exhibiting at conferences has proven beneficial to the VICP in increasing knowledge of the availability of the VICP. Further, interactions with medical and legal professionals are helpful in identifying information gaps that can lead to improved communication materials. In the past, DVIC has been criticized for not adequately promoting public awareness of the VICP. With this funding, DVIC will have the opportunity to develop a comprehensive national outreach campaign in an effort to better inform the public and health professionals about the VICP.

Outcomes and Outputs Tables

Long Term Objective: Expand availability of healthcare resources to underserved, vulnerable, and special needs populations.

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
26.II.A.1: Percentage of cases in which judgment awarding compensation is rejected and an election to pursue a civil action is filed. *(Outcome)*	FY 2008: 0% (Target Met)	0%	0%	Maintain
26.II.A.2: Average claim processing time. *(Outcome)*	FY 2009: 1,269 days (Target Exceeded)	1,300 days	1,300 days	Maintain
26.II.A.3: Percentage of cases where the deadline for the Rule 4(b) report is met once the case has been deemed complete. *(Outcome)*	FY 2008: 94.7% [1] (Target Exceeded)	86%	86%	Maintain
26.II.A.4: Decrease the average time settlements are approved from the date of receipt of the DOJ settlement proposal. *(Outcome)*	FY 2009: 7.5 days (Target Exceeded)	8 days	8 days	Maintain
26.II.A.5: Decrease the average time that lump sum only awards are paid from the receipt of all required documentation to make a payment. (In days) *(Outcome)*	FY 2009: 2.5 days (Target Exceeded)	3 days	3 days	Maintain
26.E: Percentage of cases in which case settlements are completed within 15 weeks. *(Efficiency)*	FY 2008: 100% [1] (Target Exceeded)	92%	92%	Maintain

Preparedness Countermeasures Injury Compensation Program

TAB

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FY 2011 Budget **Page**

APPROPRIATION LANGUAGE

Health Resources and Services Administration

Covered Countermeasure Process Fund

For carrying out section 319F-4 of the Public Health Service Act (42 U.S.C. 247d-6e), $2,500,000, to remain available until expended: Provided, That amounts appropriated to this account shall also be available for related administrative expenses and costs under the Smallpox Emergency Personal Protection Act of 2003, P.L. 108-20.

Amounts Available for Obligation

	FY 2009 Actual	FY 2010 Estimate	FY 2011 Pres. Budget
Unobligated Balance, Start of Year	---	---	$2,500,000
Receipts	---	---	---
Interest Income	---	---	---
Total, Receipts/Collections	---	---	---
Total Balance/Net Collections	---	---	---
Preparedness Countermeasures Injury Compensation	---	---	2,500,000
Total New Obligations	---	---	$2,500,000
Unobligated Balance, End of Year	---	---	$---

Budget Authority by Activity

	FY 2009 Appropriation	FY 2010 Omnibus	FY 2011 Pres. Budget
Preparedness Countermeasures Injury Compensation	---	---	$2,500,000
Total	---	---	$2,500,000

Budget Authority by Object

	FY 2010 Omnibus	FY 2011 Pres. Budget	Increase or Decrease
Personnel Compensation & Benefits (10.0)	---	$400,000	+$400,000
Rent (23.1A)	---	75,000	+75,000
Other Services (25.2)	---	2,025,000	+2,025,000
Total	---	$2,500,000	+$2,500,000

Salaries and Expenses

	FY 2010 Omnibus	FY 2011 Pres. Budget	Increase or Decrease
Personnel Compensation & Benefits (10.0)	---	$400,000	+$400,000
Rent (23.1A)	---	75,000	+75,000
Other Services (25.2)	---	2,025,000	+2,025,000
Total	---	$2,500,000	+$2,500,000

Authorizing Legislation

	FY 2010 Amount Authorized	FY 2010 Omnibus	FY 2011 Amount Authorized	FY 2011 Pres. Budget
PHS Act, Section 319F-4	---	---	SSAN [1]	$2,500,000

Appropriation History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2008	---	---	---	---
2009	---	---	---	---
2010	---	---	---	---

[1] Such Sums as Necessary

Countermeasures Injury Compensation Program

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 President's Budget Request	FY 2011 +/- FY 2010
BA	---	---	---*	$2,500,000	+$2,500,000
FTE	---	---	---	3	+3

* Funds in the amount of $1,954,994.86 were transferred from the Secretary's Public Health and Social Services Emergency Funds to HRSA in support of the Preparedness Countermeasures Injury Compensation Program pursuant to the Emergency Supplemental Appropriations Act, FY 2009 (P.L. 111-32).

Authorizing Legislation - Section 319F-4 of the Public Health Service Act.

FY 2011 Authorization ..... Such Sums as Necessary

Allocation Method .....Other

Program Description and Accomplishments

The "Defense Appropriations Act" (P.L. 109-148), Public Readiness and Emergency Preparedness Act (PREP Act), enacted in December 2005, establishes broad liability protection and limited compensation in the event of designated public health emergencies. The PREP Act authorizes the Secretary of the Department of Health and Human Services (Secretary) to issue declarations that provide immunity from tort liability (except for willful misconduct) for claims of loss caused, arising out of, relating to, or resulting from administration or use of countermeasures to diseases, threats, and conditions determined by the Secretary to constitute a present, or credible risk of a future public health emergency to entities and individuals involved in the development, manufacture, testing, distribution, administration, and use of such countermeasures. A PREP Act declaration is specifically for the purpose of providing immunity from tort liability, and is different from, and not dependent on, other emergency declarations. The PREP Act also authorizes a covered countermeasure process fund in the United States Treasury to provide compensation for injuries directly caused by administration or use of a countermeasure covered by the Secretary's declaration. Furthermore, the declaration specifies the period during which liability protections are in effect, the population of individuals protected, and the geographic areas for which the protections are in effect.

The Secretary has issued the following PREP Act declarations thus far:

- H5N1 Pandemic Influenza Vaccine (Federal Register Notice, February 1, 2007);
- Amendment to H5N1 Pandemic Influenza Vaccine to add H7 and H9 subtypes (Federal Register Notice, November 30, 2007);
- Amendment to Pandemic Influenza Vaccine to add H2 and H6 subtypes (Federal

Register Notice, October 17, 2008);
    - Anthrax Countermeasures (Federal Register Notice, October 6, 2008);
    - Botulism Countermeasures (Federal Register Notice, October 17, 2008);
    - Pandemic Antiviral Countermeasures (Federal Register Notice, October 17, 2008);
    - Smallpox Countermeasures (Federal Register Notice, October 17, 2008);
    - Acute Radiation Syndrome Countermeasures (Federal Register Notice, October 17, 2008);
    - Pandemic influenza diagnostics, personal respiratory protection devices and respiratory support devices (mechanical respirators) (Federal Register Notice, December 22, 2008);
- Amendment to Pandemic Antiviral Countermeasures to add H1N1 virus under Category of Disease (Federal Register Notice, June 19, 2009);
- Amendment to H5N1, H2, H6, and H9 pandemic influenza vaccines to add 2009 H1N1 vaccines (Federal Register Notice, June 25, 2009);
- **Amendment to** June 25, 2009 Pandemic Influenza Vaccines Notice (*Federal Register Notice*, October 5, 2009); and
- **Addition of the Pandemic Antiviral Peramivir as a Covered Countermeasures** (*Federal Register* Notice, October 2, 2009).

In addition to liability protections, the PREP Act establishes the Covered Countermeasures Process Fund to provide benefits to individuals seriously injured by countermeasures covered under declarations issued by the Secretary. The Secretary delegated to Health Resources and Services Administration (HRSA) the authority to administer the program on November 8, 2006. According to the PREP Act, the Countermeasures Injury Compensation Program (CICP) will follow the laws and regulations of the Smallpox Vaccine Injury Compensation Program to a large degree.

Funding History

FY	Amount
FY 2006	---
FY 2007	---
FY 2008	---
FY 2009	---
FY 2010	---

Budget Request

The FY 2011 President's Budget Request of $2,500,000 is an increase of $2,500,000 over the FY 2010 Appropriation. The CICP is in the process of finalizing the administrative regulations governing the Program. Until these regulations are published, individuals requesting benefits from the CICP may file Letters of Intent to meet the one year statute of limitations (i.e., one year from the date that the covered countermeasure was administered or used to the filing date). As of December 9, 2009, 24 letters of intent have been submitted under the PREP Act. It is

anticipated that claims will be paid out of separate emergency appropriations and the cost for claims payment is not included in these figures. HRSA has developed an estimate of administrative costs needed for developing the procedures to implement the CICP ($2,500,000 for FY 2011). Given that a broad variety of products have been designated as covered countermeasures under the PREP Act, a range of expertise may be drawn upon to devise the new countermeasure injury tables (setting forth known adverse events and time periods) and evaluate potential claims of injuries that were incurred by a covered countermeasure. The Program will require multiple contracts such as life care planners, medical experts, database enhancement, information technology, and outreach. Because the Program is the payer of last resort, significant administrative resources will be needed to determine the extent of health and disability insurance coverage for each compensable claim.