DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2012

Health Resources and Services Administration

Justification of Estimates for Appropriations Committees

MESSAGE FROM THE ADMINISTRATOR

I am pleased to present the FY 2012 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 2012 approximately 24.4 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 218,446 people infected with HIV. In July, 2010, the Obama Administration released the National HIV/AIDS Strategy (NHAS) and Implementation Plan for the United States. HRSA has an essential role to play in meeting the NHAS goals and is working across its Bureaus to fulfill the implementation plan activities. 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 2012 budget invests resources to increase the number of doctors, nurses and dentists 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 $124 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 four strategic goals, which are to:

- Improve Access to Quality Health Care and Services
- Strengthen the Health Workforce
- Build Healthy Communities
- Improve Health Equity

Our FY 2012 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 achieving health care reform.

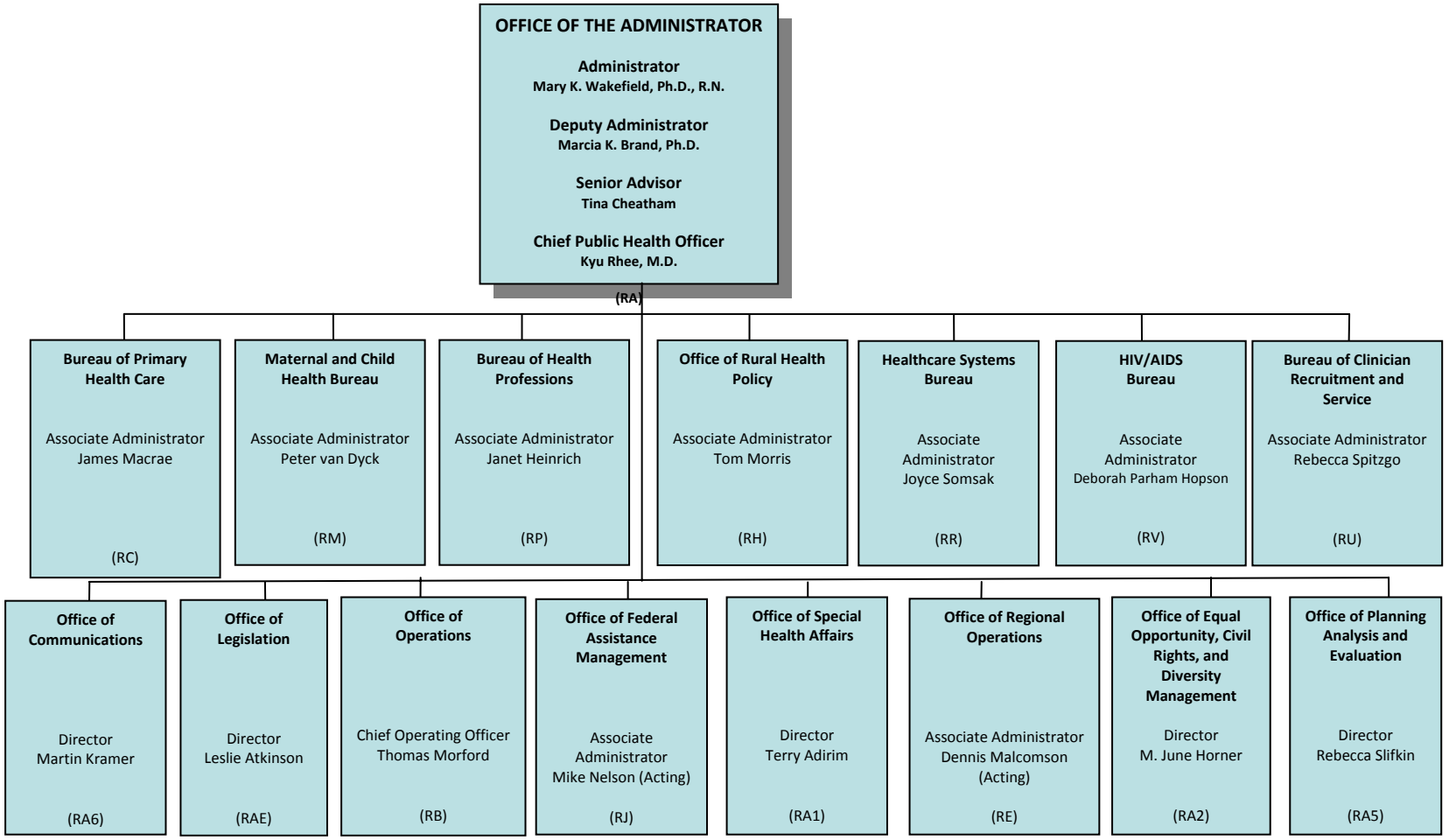
Mary K. Wakefield
Administrator

TABLE OF CONTENTS

FY 2012 Budget

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration

ORGANIZATIONAL CHART



Executive Summary

TAB

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 accessible 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. The Patient Protection and Affordable Care Act provides for a substantial expansion of components of the HRSA-supported safety net, including the Health Centers program, the National Health Service Corps, and a variety of health workforce development programs, to address these and other access problems.
Assuring a safety net for individuals and families who live outside the economic and medical mainstream remains a key HRSA role. A recent *New England Journal of Medicine* article[1] concluded that the existing safety net is simply inadequate and is continuing to deteriorate. It further noted that, while implementation of health reforms and other factors will affect the structure, function, and mission of the safety net, the underlying problems that created the need for a safety net in the first place will not be solved in the near future.

HRSA's mission as articulated in its Strategic Plan for 2010-2015 is: To improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs. HRSA supports programs and services that target, for example:

- The 50 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 providers and 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,
- The more than 100,000 Americans who are waiting for an organ transplant.

Focusing on these and other vulnerable, underserved groups, HRSA's leadership and programs promote the improvements in access, quality and equity that are essential for a healthy nation.

[1] America's Safety Net and Health Care Reform – What Lies Ahead**?** Irwin Redlener, M.D., and Roy Grant, M.A., Posted by *New England Journal of Medicine*, December 2, 2009.

OVERVIEW OF BUDGET REQUEST

The FY 2012 President's program level request of $9,034,701,000 for the Health Resources and Services Administration (HRSA) is an increase of $977,544,000 from the FY 2010 Actual level.

Program Increases:

Health Centers (+$1,132.669 million)
This request will continue to support more than 1,100 health center grantees that provide comprehensive, culturally competent, quality primary healthcare services through more than 8,000 service delivery sites. This request reflects the projected increase in FTCA program demand, given the recent expansion of the Health Center Program and the significant projected Health Center Program expansion supported by the Affordable Care Act. This funding level also includes $1.2 billion appropriated under the Affordable Care Act for health center service. As a result of the Affordable Care Act funding, the total number of patients served in FY 2012 is projected to reflect an increase of approximately 900,000.

National Health Service Corps (NHSC) (+$277.057 million)
This request includes $295 million in mandatory funding from the Affordable Care Act. This budget will support a Field Strength of 10,683. This will fund 389 scholars and 2,971 loan repayers.

Health Workforce Programs (+$71.294 million) This request includes $255 million in PHS Evaluation Funds for certain health workforce activities, $15 million from the Prevention and Public Health Fund.

National Practitioner Data Bank User Fees (+$4.508)
This reflects the estimated User Fees for the National Practitioner Data Bank.

Autism and other Developmental Disorders (+$7.102 million)
$2.6 million of the increase will support LEND interdisciplinary training programs; $2.1 million of the increase will support additional autism intervention research projects examining areas of particular interest to families as outlined in the Interagency Autism Coordinating Committee's 2010 Strategic Plan for Autism Spectrum Disorder Research; and the remainder will support State demonstration grants, resource centers, a national evaluation, and a quality improvement initiative.

Maternal, Infant and Early Childhood Visiting Program (+$250.0 million)
This level of funding will provide: $329 million for awards to 56 State grantees and associated program technical assistance; $10.5 million for 18 awards representing American Indian tribes, and $10.5 million for research, evaluation, and corrective action technical assistance for States not meeting benchmarks.

HIV/AIDS Early Intervention Part A (+$1.000 million)
The FY 2012 Request will support program activities and services for PLWH in the 24 Eligible Metropolitan Areas, 28 Transition Grant Areas, and 4 states.

HIV/AIDS Early Intervention Part B (+$82.000 million)
The increase will support program activities and includes the provision life-saving medications to persons living with HIV. The number of clients served by ADAPs is predicted to be 218,446.

HIV/AIDS Early Intervention Part C (+$5.139 million)
The increase will support the provision of comprehensive primary health care in an outpatient setting for people living with HIV disease for an additional 6,467 clients. The FY 2012 Budget Request target for the number of people receiving primary care services under Early Intervention Services programs is 247,133.

HIV/AIDS Part D (+$.166 million)
This funding level will support primary healthcare and social support services available to 90,000 women, men, transgendered persons, infants, children, youth and adults living with HIV and AIDS and their affected families at programs in 37 States, D.C., Puerto Rico and Virgin Islands. The 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 57,773.

HIV/AIDS Education and Training Centers Part F (+.074 million)
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".

HIV/AIDS Dental Services Part F (+.029 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. The FY 2012 Budget Request target for the number of persons for whom a portion of their unreimbursed oral health costs will be reimbursed is 35,474.

Cord Blood Stem Cell Bank (+$1.926 million)
This funding will support progress toward the statutory goal of building a genetically diverse inventory of at least 150,000 new units of high-quality 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 (+$3.077 million)
This funding will support progress toward the Program's ambitious performance target of 2,660,000 adult volunteers from racially/ethnically diverse minority population groups listed on the registry by September 30, 2012. These funds will also be used to support the four major Program.

340b Drug Pricing Program/Office of Pharmacy Affairs (+$3.000 million)
This funding will help to support verification of all HRSA-funded entities, ensuring accuracy and integrity of the 340B database over time.

340b Drug Pricing Program/Office of Pharmacy Affairs User Fees (+$5.000 million)
This reflects the estimates amount of user fees.

Rural Health Outreach Grants (+$1.361 million)
In FY 2012, the program will support approximately 100 outreach services grants, 12 Delta grants, 80 network development grants (which include 20 grants for the Workforce Network Development pilot program and 40 HIT grants), 59 quality improvement grants and 15 network planning grants.

State Office of Rural Health (+$.070 million)
This funding will continue to support key activities for the State Office of Rural Health Program and will support a grant award to each of the 50 states.

Program Management (+$23.756 million)
This increase supports increased rent associated with the Parklawn building.

Family Planning (+$10.524 million)
The FY 2012 request is expected to support family planning services for approximately 5,247,000 persons, with at least 90 percent of clients having incomes at or below 200 percent of the federal poverty level. These services include the provision of family planning methods, education, counseling and related preventive health services.

Decreases:

Patient Navigator (-$4.965 million)
There is no FY 2012 request for this program.

Children's Hospital GME (-$316.824 million)
There is no FY 2012 request for this program.

Maternal and Child Health Block Grant (-$6.221 million)
This level of funding will provide: $567.9 million for State Block Grant awards; $74.7 million for the SPRANS set-aside, and $11.8 million for the CISS set-aside. The request eliminates the following: $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, and $1.5 million for Doula.

Nutrition, Physical Activity, and Screening Standards (-$.255 million)
This program was funded from the Prevention and Public Health Fund in FY 2010.

State Health Access Grants (-$74.480 million)
There is no FY 2012 request for this program.

Infrastructure to expand Access to Care (-$100.000 million)
There is no FY 2012 request for this program.

Rural and Community Access to Emergency Devices (-$2.521 million)
There is no FY 2012 request for this program.

Rural Hospital Flexibility (-$14.715 million)
This funding will continue to support a range of activities focusing on CAHs. The program will award 45 grants in FY 2012. This request will also continue essential support for the three grantees funded through the Rural Veterans Health Access Program.

Delta Health (-$34.927million)
There is no FY 2012 request for this program.

Denali Project (-$10.0 million)
There is no FY 2012 request for this program.

Public Health Improvements Projects (-$337.300 million)
There is no FY 2012 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.

OVERVIEW OF PERFORMANCE

This Performance Budget documents the progress HRSA has made and expects to make in meeting the needs of uninsured and medically underserved individuals, special needs populations, and many other Americans. HRSA and its partners work to achieve the vision of "Healthy Communities, Healthy People." In pursuing that vision, HRSA's strategic goals are to: improve access to quality health care and services, strengthen the health workforce, build healthy communities, and improve health equity. The performance and expectations for HRSA programs are highlighted below as these relate to HRSA goals and HHS strategic objectives, indicating the close alignment of specific programmatic activities and performance with broader HRSA and Departmental priorities. Many of the highlighted activities also relate to the Secretary's Initiative on Transforming Health Care to help all Americans live healthier, more prosperous, and more productive lives. The examples illustrate ways HRSA helps states, communities and organizations provide essential health care and related services to meet critical needs.

Highlights of Performance Results and Targets

HRSA Goals: Improve access to quality health care and services; Improve health equity
HHS Objectives: Ensure access to quality, culturally competent care for vulnerable populations; Emphasize primary and preventive care linked with community prevention services.

HRSA programs support the direct delivery of health services and health system improvements that increase access to health care and help reduce health disparities.

- In FY 2012, the Health Centers program projects that it will serve 24.4 million patients. This is an increase of 5.6 million over the 18.8 million persons served in FY 2009.

- Through the Health Centers program, HRSA expects to provide access to care to more than 9 million uninsured individuals in FY 2012. In 2009, 7 million uninsured individuals (38% of total patients) were served by Health Centers.

- HRSA expects to serve 33 million children through the Maternal and Child Health Block Grant (Title V) in FY 2012, similar to the number served in FY 2009 (33.3 million).

- By reaching out to low-income parents to enroll their children in the Children's Health Insurance Program (CHIP) and Medicaid, HRSA improves access to critically important health care. In FY 2012, the number of children receiving Title V services that are enrolled in and have Medicaid and CHIP coverage is expected to reach 14 million. In FY 2009, the number was 15.2 million.

- In FY 2012, HRSA's Ryan White HIV Emergency Relief Grants (Part A) and HIV Care Grants to States (Part B) are projected to support, respectively, 2.63 million visits and 2.19 million visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health). Approximately 2.59 million visits and 2.11 million visits, respectively, were supported in FY 2009.

- By supporting AIDS Drug Assistance Program (ADAP) services to an anticipated 218,446 persons in FY 2012, HRSA expects to continue its contribution to reducing AIDS-related mortality through providing drug treatment regimens for low-income, underinsured and uninsured people living with HIV/AIDS. An estimated 205,446 persons were served through ADAP in FY 2009.

- The number of organ donors and the number of organs transplanted have increased substantially in recent years. In FY 2012, HRSA's Organ Transplantation program projects that 31,979 deceased donor organs will be transplanted, up from 24,116 in FY 2009.

- To increase the number of patients from racially and ethnically diverse backgrounds able to find a suitably matched unrelated adult donor for their blood stem cell transplants, HRSA's C.W. Bill Young Cell Transplantation program projects that it will have 2.66 million adult volunteer potential donors of minority race and ethnicity listed on the donor registry in FY 2012. Nearly 2.5 million were listed on the registry in FY 2010.

- In FY 2009, 375,000 persons received direct services through Rural Health Care Services Outreach, Network, and Quality Improvement Grants. The projection for FY 2012 is 390,000.

- In FY 2009, the Black Lung program supported services to more than 12,400 active and retired coal miners and others with occupation-related respiratory and pulmonary impairments. In FY 2012, an estimated 12,488 miners will be served.

<u>HRSA Goal: Strengthen the health workforce.</u>
<u>HHS Objective: Ensure that the Nation's health care workforce can meet increased demands.</u>

HRSA works to improve health care systems by assuring access to a quality health care workforce in all geographic areas and to all segments of the population through the support of training, recruitment, placement, and retention activities.

- In FY 2010, the National Health Service Corps (NHSC) had a field strength of 7,530 primary care clinicians. The NHSC projects that a field strength of 10,683 primary care clinicians will be in health professional shortage areas in FY 2012. Increasing the NHSC field strength is one of the Administration's Priority Goals.

- In FY 2008, 54% of Nursing Education Loan Repayment and Scholarship Program participants extended their service contracts and committed to work at a critical shortage facility for an additional year, up from 38% in FY 2005. The FY 2012 target is 54%.

- In FY 2010, 4,800 health care providers were deemed eligible for FTCA malpractice coverage through the Free Clinics Medical Malpractice program, which encourages providers to volunteer their time at sponsoring free clinics. The projection for this number is 4,800 in FY 2012.

HRSA Goal: Improve access to quality health care and services.
HHS Objective: Improve health care quality and patient safety.

Virtually all HRSA programs help improve health care quality, including those programs or program components that focus on improving the infrastructure of the health care system.

- In FY 2012, 95.7% of Ryan White program-funded primary care providers will have implemented a quality management program, up from 94.5 % in FY 2009.

- In FY 2012, 68,125 licensing and credentialing decisions that limit practitioners' ability to practice will be impacted by information contained in the National Practitioner Data Bank. This is a projected increase over the results of 51,990 decisions impacted in FY 2009.

- In 2012, 76% of Critical Access Hospitals (supported by the Rural Hospital Flexibility Grants program) will report at least one (quality-related) measure to Hospital Compare. This will be an increase from 70.3% in FY 2009.

HRSA Goal: Improve health equity.
HHS Objective: Accelerate the process of scientific discovery to improve patient care.

- The National Hansen's Disease Program seeks to prevent and manage Hansen's disease (leprosy) though both clinical care and scientific research. In FY 2009, the Program successfully developed additional protective biological response modifiers (BRM) and white blood cell type markers (CM) that are important in host resistance to Hansen's Disease and will ultimately permit development of the full animal model (armadillo) that will advance understanding of the disease in humans. In 2012, the Program will pursue the integration of BRM, CM and molecular reagent breakthroughs.

In the ways highlighted above and others, HRSA will continue to strengthen the Nation's healthcare safety net and improve Americans' health, health care and quality-of-life. More information on performance is provided in the companion *Online Performance Appendix*.

Performance Management

Achieving a high-level of performance in pursuing its goals is a major priority for HRSA, and is one of its Strategic Plan principles. Performance management at HRSA involves the active use

of performance data to improve its operations and those of grantees. Underpinning this is the regular collection, monitoring, analysis, and reporting of performance data. To improve this data, HRSA is assessing its programs' performance measure profiles to determine which measures may need to be retired and which added to reflect new programmatic emphases and achievement of programmatic goals. Additionally, HRSA continually works (e.g., through technical assistance) to build grantees' capacity to collect and report accurate and timely data. Further HRSA is upgrading its data systems to better manage the range and complexity of information that is needed for effective performance management. HRSA is also focusing on its programs' ability to explain, not just report, performance trends. Finally the agency is strengthening its focus on the conduct of evaluations to augment routine performance information. These steps are taken to ensure the availability of relevant, practical, timely, and useful data for decision-making and accountability.

SUMMARY OF PERFORMANCE TARGETS AND RESULTS

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

ARRA Performance Overview

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). 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.

HRSA Summary of Recovery Act Available Resources, Outlays and Performance:

($ in millions)

ARRA Implementation Plan	Total Resources Available	FY 2009/ 2010 Outlays	FY 2011 Outlays	FY 2012 Outlays
Health Centers - Services	$500.000	$363.000	$137.000	$---
Health Centers - Capital	$1,500.000	$514.000	$361.000	$360.000
Health Professions Training Program: National Health Service Corps (NHSC)	$300.000	$153.000	$108.000	$13.000
Health Professions Training Program	$200.000	$45.000	$115.000	$15.000
Total	$2,500.000	$1,075.000	$722.000	$388.000

Selected Performance Measures for Implementation Plans Listed Above:

Health Centers – Services

Performance Measure	FY 2009 Result	FY 2010 Result	FY 2011 Target	FY 2012 Target
Number of new patients served	1.01M	3.3M	2.87M	N/A
Number of new uninsured patients served	.62M	1.8M	1.34M	N/A

Data Source: ARRA Health Center Quarterly Report

Health Centers - Capital

Performance Measure	FY 2009 Result	FY 2010 Result	FY 2011 Target	FY 2012 Target
Number of Health Center sites with new space (construction)	2	42	200	405
Number of Health Center sites with improved space (alteration/repair/renovation)	16	237	600	975
Number of Health Center sites with new certified Electronic Health Record	0	22	100	245
Percent of Projects On Schedule and On Budget (construction and alteration/repair/renovation over $1M)	N/A	63.5%	80.0%	80.0%

Data Source: ARRA Health Center Quarterly Report

Health Professions Training Program: National Health Service Corps

Performance Measure	FY 2009 Result	FY 2010 Result	FY 2011 Target	FY 2012 Target
Increase in NHSC field strength (includes State Loan Repayment Program)	829	3,288	4,046	1,030

Data Source: BHCDANET; State Loan Repayment Program Report

Health Professions Training Program

Performance Measure	FY 2009 Result	FY 2010 Result	FY 2011 Target	FY 2012 Target
Nursing Education Loan Repayment Program (NELRP) - Increase in NELRP field strength	427	427	0	0
Scholarships for Disadvantaged Students (SDS) Number of scholarships awarded	9,790	10,000 (target)	0	0
Training in Primary Care	N/A	1,426 (actual)	1,603	1,603

Performance Measure	FY 2009 Result	FY 2010 Result	FY 2011 Target	FY 2012 Target
Medicine and Dentistry (TPCMD) - Number of students and residents trained				

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

FY 2012 All Purpose Table (APT)

(Dollars in Thousands)

Program	FY 2010 Actual	FY 2011 CR	FY 2012 Request
PRIMARY CARE:			
Health Centers	2,141,397	2,145,967	2,021,737
Community Health Center Fund (ACA)	-	1,000,000	1,200,000
Health Center Tort Claims	43,749	44,055	96,077
Total, Health Centers	**2,185,146**	**3,190,022**	**3,317,814**
Health Centers - Facilities Construction/NHSC	-	1,500,000	-
School-Based Health Centers - Facilities	50,000	50,000	50,000
Free Clinics Medical Malpractice	40	40	40
Hansen's Disease Center	16,075	16,109	16,075
Payment to Hawaii	1,976	1,976	1,976
Buildings and Facilities	128	129	129
Subtotal, Bureau of Primary Health Care	**2,253,365**	**4,758,276**	**3,386,034**
CLINICIAN RECRUITMENT & SERVICE:			
National Health Service Corps Field	40,941	41,128	24,695
National Health Service Corps Recruitment	100,479	100,797	98,782
National Health Service Corps (ACA)	-	290,000	295,000
Total, NHSC	**141,420**	**431,925**	**418,477**
Nurse Loan Repayment and Scholarship Program	93,864	93,864	93,864
Loan Repayment/Faculty Fellowships	1,266	1,266	1,266
Subtotal, Clinician Recruitment & Service	**236,550**	**527,055**	**513,607**
HEALTH PROFESSIONS:			
Health Professions Training for Diversity:			
Centers of Excellence	24,550	24,602	24,602
Scholarships for Disadvantaged Students	49,236	49,342	60,000
Health Careers Opportunity Program	22,086	22,133	22,133
Health Professions Training for Diversity	**95,872**	**96,077**	**106,735**
Health Care Workforce Assessment	2,826	2,832	20,000
Primary Care Training and Enhancement	38,923	39,275	139,932
Primary Care Training and Enhancement Preventon Fund	198,122		-
Subtotal, Primary Care Training and Enhancement	**237,045**	**39,275**	**139,932**
Oral Health Training Programs	32,920	32,982	49,928
GME Payments for Teaching Health Centers	-	230,000	-

Health Resources and Services Administration

Program	FY 2010 Actual	FY 2011 CR	FY 2012 Request
Interdisciplinary, Community-Based Linkages:			
Area Health Education Centers	33,274	33,345	34,833
Geriatric Programs	33,675	33,747	43,747
Allied Health and Other Disciplines	1,940	1,945	-
Mental and Behavioral Health	2,939	2,945	17,945
Subtotal, Interdisciplinary, Community-Based Linkages	**71,828**	**71,982**	**96,525**
Public Health Workforce Development:			
Public Health/Preventive Medicine;	9,647	9,668	10,068
Public Health/Preventive Medicine Prevention Fund	14,829	20,000	15,000
Subtotal, Public Health/Prevention Medicine	**24,476**	**29,668**	**25,068**
State Health Care Workforce Development Grants			51,000
State Health Care Workforce Development Grants Prevention Fund	5,750		-
Subtotal, State Health Care Workforce Development Grants	**5,750**	**-**	**51,000**
Subtotal, Public Health Workforce Development	**30,226**	**29,668**	**76,068**
Nursing Workforce Development:			
Advanced Education Nursing	64,301	64,438	104,438
Advanced Education Nursing Prevention Fund	31,431	-	-
Subtotal, Advanced Education Nursing	**95,732**	**64,438**	**104,438**
Nursing Workforce Diversity	16,073	16,107	20,000
Nurse Education, Practice and Retention	39,811	39,896	59,773
Nurse Faculty Loan Program	24,947	25,000	30,000
Comprehensive Geriatric Education	4,557	4,567	5,000
Nursing Managed Care	-	-	20,000
Nurse Managed Health Centers Prevention Fund	15,268	-	-
Subtotal Nursing Managed Care	**15,268**	**-**	**20,000**
Subtotal, Nursing Workforce Development	**196,388**	**150,008**	**239,211**
Patient Navigator Outreach & Chronic Disease Prevention	4,965	5,000	-
Children's Hospitals Graduate Medical Education Program	316,824	317,500	-
Teaching Health Centers			10,000
Subtotal, Bureau of Health Professions	**988,894**	**975,324**	**738,399**
Health Workforce Evaluation Funding	-	-	255,423
National Practitioner Data Bank (User Fees)	*19,750*	*19,750*	*28,016*
Healthcare Integrity & Protection Data Bank (User Fees)	*3,758*	*3,758*	-
Maternal and Child Health Block Grant	660,710	662,121	654,489
Autism and Other Developmental Disorders	47,898	48,000	55,000
Traumatic Brain Injury	9,918	9,939	9,918

Health Resources and Services Administration

Program	FY 2010 Actual	FY 2011 CR	FY 2012 Request
Sickle Cell Service Demonstrations	4,740	4,750	4,740
Universal Newborn Hearing	18,960	19,000	18,960
Emergency Medical Services for Children	21,454	21,500	21,454
Healthy Start	104,776	105,000	104,776
Heritable Disorders	9,992	10,013	9,992
Congenital Disabilities	499	500	499
Nutrition, Physical Activity & Screen Time Standards Prev. Fund	255	-	-
Family to Family Health Information Centers	5,000	5,000	5,000
Maternal, Infant and Early Childhood Visiting Program	100,000	250,000	350,000
Subtotal, Maternal and Child Health Bureau	**984,202**	**1,135,823**	**1,234,828**
HIV/AIDS:			
Emergency Relief - Part A	678,074	679,074	679,074
Comprehensive Care - Part B	1,276,791	1,253,791	1,358,791
AIDS Drug Assistance Program (Non-Add)	*858,000*	*835,000*	*940,000*
Early Intervention - Part C	206,383	206,823	211,522
Children, Youth, Women & Families - Part D	77,621	77,787	77,787
Education and Training Centers - Part F	34,745	34,819	34,819
Dental Services Part F	13,565	13,594	13,594
Subtotal, HIV/AIDS	**2,287,179**	**2,265,888**	**2,375,587**
SPNS Evaluation Funding	25,000	25,000	25,000
Subtotal, HIV/AIDS Bureau	**2,312,179**	**2,290,888**	**2,400,587**
HEALTHCARE SYSTEMS:			
Organ Transplantation	25,991	26,049	25,991
Cord Blood Stem Cell Bank	11,957	11,983	13,883
C.W. Bill Young Cell Transplantation Program	23,467	23,517	26,544
Poison Control Centers	29,250	29,314	29,250
340b Drug Pricing Program/Office of Pharmacy Affairs	2,220	2,220	5,220
340b Drug Pricing Program/Office of Pharmacy Affairs User Fees			*5,000*
State Health Access Grants	74,480	75,000	-
Infrastructure to Expand Access to Care	100,000	-	-
Subtotal, Healthcare Systems Bureau	**267,365**	**168,083**	**105,888**
Rural Health:			
Rural Health Policy Development	9,929	9,950	9,929
Rural Health Outreach Grants	55,905	56,025	57,266
Rural & Community Access to Emergency Devices	2,521	2,526	-
Rural Hospital Flexibility Grants	40,915	41,200	26,200
Delta Health Initiative	34,927	35,000	-
State Offices of Rural Health	10,005	10,075	10,075

Health Resources and Services Administration

Program	FY 2010 Actual	FY 2011 CR	FY 2012 Request
Denali Project	10,000	10,000	-
Radiogenic Diseases	1,948	1,952	1,948
Black Lung	7,185	7,200	7,185
Telehealth	11,575	11,600	11,575
Subtotal, Office of Rural Health Policy	**184,910**	**185,528**	**124,178**
Public Health Improvement Projects	337,300	338,002	-
Program Management	147,052	147,052	170,808
Family Planning	316,832	317,491	327,356
Healthy Weight Collaborative Prevention Fund	5,000	-	5,000
HRS Program Level	**8,057,157**	**10,867,030**	**9,034,701**
Appropriation Table Match	**7,482,994**	**7,473,522**	**6,801,262**
Less Mandatory Programs	***525,655***	***3,345,000***	***1,920,000***
Subtotal Health Reform	***255,000***	***3,325,000***	***1,900,000***
Subtotal Public Health Prevention Fund	***270,655***	***20,000***	***20,000***
Discretionary Program Level:			
HRS	**7,531,502**	**7,522,030**	**7,114,701**
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)	193,000	220,000	235,000
VICTF Direct Operations - HRSA	6,502	6,502	6,502
Subtotal, Vaccine Injury Compensation	**199,502**	**226,502**	**241,502**
Discretionary Program Level:			
HRS	**7,531,502**	**7,522,030**	**7,114,701**
HEAL Direct Operations	2,847	2,847	-
Vaccine Direct Operations	6,502	6,502	6,502
Total, HRSA Discretionary Program Level	**7,540,851**	**7,531,379**	**7,121,203**
Mandatory Programs:	525,655	3,345,000	1,920,000
Total, HRSA Program Level	**8,066,506**	**10,876,379**	**9,041,203**

Health Resources and Services Administration

Program	FY 2010 Actual	FY 2011 CR	FY 2012 Request
Less Programs Funded from Other Sources Mandatory:			
Prevention and Public Health Fund	-270,655	-20,000	-20,000
Less Programs Funded from Other Sources:			
Evaluation - Special Projects of National Significance (SPNS)	-25,000	-25,000	-25,000
Evaluation - Health Workforce	--	--	-255,423
National Practitioner Data Bank (User Fees)	-19,750	-19,750	-28,016
Healthcare Integrity and Protection Data Bank (User Fees)	-3,758	-3,758	--
340b Drug Pricing Program/Office of Pharmacy Affairs (User Fees)	--	--	-5,000
Total HRSA Discretionary Budget Authority	**7,492,343**	**7,482,871**	**6,807,764**

HEALTH RESOURCES AND SERVICES ADMISTRATION

APPROPRIATIONS LANGUAGE

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, and the Patient Protection and Affordable Care Act, $6,801,262,000, of which $26,200,000 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 for Medicare rural hospital flexibility grants, $1,000,000 shall be to carry out section 1820(g)(6) of the Social Security Act, 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 sections 340G-1(d)(1) and (d)(2), 747(c)(2), 751(j)(2), and the proportional funding amounts in paragraphs (1) through (4) of section 756(e) of the PHS Act shall not apply to funds made available in this paragraph: 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 shall be 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, That no more than $96,077,000 shall be 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, $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, $2,037,865,000 shall remain available to the Secretary of HHS through September 30, 2014, for parts A and B of title XXVI of the PHS Act, of which not less than $880,000,000 shall be for State AIDS Drug Assistance Programs under section 2616 of such Act: Provided further, That within the amounts designated in the previous proviso to carry out Parts A and B of title XXVI of the

PHS Act, $60,000,000 shall be available for allocation to State AIDS Drug Assistance Programs under section 2620 or section 311(c) 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, 2014, and shall be available to qualifying jurisdictions, within 30 days of enactment, for increasing supplemental grants for fiscal year 2012 to metropolitan and transitional areas that received grant funding in fiscal year 2011 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 2011, 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 2011, 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 in addition to amounts provided herein, (1) $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, and (2) $255,423,000 to carry out titles VII and VIII and section 340G of the PHS Act: Provided further, That notwithstanding sections 502(a)(1) and 502(b)(1) of the Social Security Act, not to exceed $74,712,263 shall be available for carrying out special projects of regional and national significance pursuant to section 501(a)(2) of such Act and $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 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, for any program operating under section 751 of the PHS Act on or before January 1, 2009, the Secretary of HHS may waive any of the requirements contained in sections 751(d)(2)(A) and 751(d)(2)(B) of such Act: 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 399BB(g) of the PHS Act, funds made available under this heading for section 399BB of the PHS Act are for carrying out the program as authorized under section 399BB(a)-(f) of such Act: Provided further, That notwithstanding section 338J(k) of the PHS Act, $10,075,000 shall be available for State Offices of Rural Health: Provided further, That the Secretary may collect a fee of 0.1 percent of each purchase of 340B drugs from entities participating in the Drug Pricing Program pursuant to section 340B of the PHS Act to pay for the operating costs of such program: Provided further, That fees pursuant to the 340B Drug Pricing Program shall be collected by manufacturers at the time of sale, and shall be credited to this account, to remain available until expended.

Language Analysis

LANGUAGE PROVISION	EXPLANATION
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, and *the Patient Protection and Affordable Care Act of 2010*, **[**$7,501,658,000**]** *$6,801,262,000* of which **[**$41,200,000**]** *$26,200,000* 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:	Citation is added to include funding from the Affordable Care Act of 2010.
Provided further, That sections 340G-1(d)(1) and (d)(2), 747(c)(2), 751(j)(2), and the proportional funding amounts in paragraphs (1) through (4) of section 756(e) of the PHS Act shall not apply to funds made available in this paragraph:	Citation is added to remove restriction on Health Workforce programs.
Provided further, That of the funds available under this heading, **[**$1,962,865,000**]***$2,037,865,000* shall remain available to the Secretary of HHS through September 30, *2014***[**2013**]**, for parts A and B of title XXVI of the PHS Act *of which not less than $880,000,000 shall be for State AIDS Drug Assistance Programs under sections 2616 of such Act*: *Provided further, That within the amounts designated in the previous provisio to carry out Parts A and B of title XXVI of the PHS Act, $60,000,000 shall be available for allocation to State AIDS Drug Assistance Programs under section 2616 or section 311(c) of the PHS Act:*	Citation is added to limit losses for prior year reductions by providing supplemental grants awards.

LANGUAGE PROVISION	EXPLANATION
Provided further, That in addition to amounts provided herein, *(1)* **[**$25,000,000**]***$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: and *(2) $255,423,000 to carry out titles VII and VIII and section 340G of the PHS Act:*	Citation is added to allow additional funding under section 241 to carry out titles VII and VII and section 340G of the PHS Act.
Provided further, That, for any program operating under section 751 of the PHS Act on or before January 1, 2009, the Secretary of HHS may waive any of the requirements contained in sections 751(d)(2)(A) and 751(d)(2)(B) of such Act:	Citation is added to allow for the continuation of Area Health Education Center grants.
Provided further, That notwithstanding section 399BB(g) of the PHS Act, funds made available under this heading for section 399BB of the PHS Act are for carrying out the program as authorized under section 399BB(a)-(f) of such Act unless otherwise authorized subsequent to enactment of this Act:	Citation is added to notwithstand the sunset provision in order to continue to make 3-year awards with the FY 2012 appropriation.
[*Provided further*, That notwithstanding subsection (d)(3)(B) of section 340A the Public Health Service Act, $5,000,000 shall be available for activities under such section:**]** *Provided further*, That notwithstanding	Citation is no longer required.
[*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.**]**	Citation is not required as funding is not requested in FY 2012.

LANGUAGE PROVISION	EXPLANATION
Provided further, The Secretary may collect a fee of 0.1 percent of each purchase of 340B drugs from entities participating in the Drug Pricing Program pursuant to section 340B of the PHS Act to pay for the operating costs of such a program: Provided further, That fees pursuant to the 340B Drug Pricing Program shall be collected by manufacturers at the time of sale, and shall be credited to this account, to remain available until expended. Note --A full-year 2011 appropriation for this account was not enacted at the time the budget was prepared; therefore, this account is operating under a continuing resolution (P.L. 111-242, as amended). The amounts included for 2011 reflect the annualized level provided by the continuing resolution.	Citation is added to establish a cost recovery fee for the 340B Drug Pricing Program.

LANGUAGE PROVISION	EXPLANATION
Provided further, The Secretary shall establish user fees of 0.1 percent of the total 340B drug purchase paid by participating 340B covered entities to pay for costs of the 340B Drug Pricing Program. Manufacturers shall collect those fees at the time of sale and transfer them into a no year account established by the Secretary to pay for administrative and operating costs of the 340B Drug Pricing Program. These funds shall be available until expended.	Citation is added to allow for the establishment of a reimbursable fee structure for the 340B program.

Amounts Available for Obligation[1]

	FY 2010 Actual	FY 2011 CR	FY 2012 Estimate
Discretionary Appropriation:			
Annual……	$7,482,294,000	$7,473,522,000	$6,801,262,000
American Recovery and Reinvestment Act……	$908,000,000	$74,000,000	
Subtotal, adjusted appropriation……	8,390,294,000	7,547,522,000	6,801,262,000
Mandatory Appropriation:			
Infrastructure to Expand Access to Care		+100,000,000	
GME Payments for Teaching Health Centers		+7,000,000	+22,000,000
Family to Family Health Information Centers…….	+5,000,000	+5,000,000	+5,000,000
Transfer from the Prevention and Public Health Fund	+271,000,000		+20,000,000
Subtotal, adjusted budget authority…….	+8,666,294,000	+7,659,522,000	+6,848,262,000
Offsetting Collections……	+48,508,000	+48,508,000	+313,439,000
Unobligated balance, start of year……..	+1,049,000	+223,000,000	+271,000,000
Unobligated balance, end of year……..	-223,000,000	-271,000,000	
Recovery of prior year obligations……	+1,000,000		
Unobligated balance, lapsing……..	-2,000,000	---	---
Total obligations……	$8,495,851,000	$7,660,030,000	$7,432,701,000

[1] Excludes the following amounts for reimbursable activities carried out by this account: FY 2010 - $65,198,000 and 19 FTE; FY 2011 - $51,970,000 and 24 FTE; FY 2012 $52,299,000 and 32 FTE .

Summary of Changes

2010 Enacted	
Total estimated budget authority	7,482,994,000
(Obligations)	(-$8,405,000,000)
2012 Estimate	6,801,262,000
(Obligations)	(-$6,801,262,000)
2010 Mandatory Enacted	525,655,000
(Obligations)	(-$375,476,000)
2012 Mandatory Estimate	1,920,000,000
(Obligations)	(-$1,946,000,000)
Net Change	**+$712,613,000**
(Obligations)	**-$33,214,000**

		Changes from Base		
	FTE 2010		FTE 2012	**Budget Authority**
Increases:				
A. Built in:	1,475		+86	
1. January 2011/2012 Military Pay Raise		$189,657,242		630,730
2. Civilian Annualization of Jan. 2010		$189,657,242		802,569
3. Military Annualization of Jan. 2010/Jan. 2011		$189,657,242		336,022
Subtotal, built-in increases				**+1,769,321**

B. Program:

	Discretionary Increases	**FY 2010**	**FY 2012**	
1	Health Center Tort Claims	43,749,000	96,077,000	+52,328,000
2	Buildings and Facilities	128,000	129,000	+1,000
3	Centers of Excellence	24,550,000	24,602,000	+52,000
4	Scholarships for Disadvantaged Students	49,236,000	52,921,000	+3,685,000
5	Health Careers Opportunity Program	22,086,000	22,133,000	+47,000
6	Primary Care Training and Enhancement	38,923,000	53,018,000	+14,095,000
7	Oral Health Training Programs	32,920,000	35,419,000	+2,499,000
8	Area Health Education Centers	33,274,000	33,345,000	+71,000
9	Geriatric Programs	33,675,000	36,907,000	+3,232,000
10	Mental and Behavioral Health	2,939,000	17,945,000	+15,006,000
11	State Health Care Workforce Development Grants	-	51,000,000	+51,000,000
12	Advanced Education Nursing	64,301,000	64,438,000	+137,000
13	Nursing Workforce Diversity	16,073,000	16,107,000	+34,000
14	Nurse Education, Practice and Retention	39,811,000	40,141,000	+330,000
15	Nursing Managed Care	-	10,000,000	+10,000,000
16	Teaching Health Centers	-	10,000,000	+10,000,000
17	Autism and Other Developmental Disorders	47,898,000	55,000,000	+7,102,000
18	Emergency Relief - Part A	678,074,000	679,074,000	+1,000,000

19	Comprehensive Care - Part B	1,276,791,000	1,358,791,000	+82,000,000
20	Early Intervention - Part C	206,383,000	211,522,000	+5,139,000
21	Children, Youth, Women & Families - Part D	77,621,000	77,787,000	+166,000
22	Education and Training Centers - Part F	34,745,000	34,819,000	+74,000
23	Dental Services Part F	13,565,000	13,594,000	+29,000
24	Cord Blood Stem Cell Bank	11,957,000	13,883,000	+1,926,000
25	C.W. Bill Young Cell Transplantation Program	23,467,000	26,544,000	+3,077,000
26	340b Drug Pricing Prog/Office of Pharmacy Affairs	2,220,000	5,220,000	+3,000,000
27	Rural Health Outreach Grants	55,905,000	57,266,000	+1,361,000
28	State Offices of Rural Health	10,005,000	10,075,000	+70,000
29	Program Management	147,052,000	170,808,000	+23,756,000
30	Family Planning	316,832,000	327,356,000	+10,524,000
	Subtotal Discretionary Program Increases			**+$301,741,000**
	Mandatory Increases			
31	Community Health Center Fund (ACA)	-	1,200,000,000	+1,200,000,000
32	National Health Service Corps (ACA)	-	295,000,000	+295,000,000
33	Public Health/Preventive Medicine Prevention Fund	14,829,000	15,000,000	+171,000
34	Maternal, Infant and Early Childhood Visiting Prog	100,000,000	350,000,000	+250,000,000
	Subtotal Mandatory Program Increases			**+$1,745,171,000**
	Subtotal Program Increases			**+$2,046,912,000**
	Decreases:			
	A. Built in:			
	1. Pay Costs	-$189,657,242		**-1,769,321,000**
	B. Program:			
	Discretionary Decreases:			
1	Health Centers	2,141,397,000	2,021,737,000	-119,660,000
2	National Health Service Corps Field	40,941,000	24,695,000	-16,246,000
3	National Health Service Corps Recruitment	100,479,000	98,782,000	-1,697,000
4	Health Care Workforce Assessment	2,826,000	-	-2,826,000
5	Allied Health and Other Disciplines	1,940,000	-	-1,940,000
6	Public Health/Preventive Medicine;	9,647,000	-	-9,647,000
7	Nurse Faculty Loan Program	24,947,000	-	-24,947,000
8	Comprehensive Geriatric Education	4,557,000	-	-4,557,000
9	Patient Navigator Prevention	4,965,000	-	-4,965,000
10	Children's Hosp Grad Medical Education Program	316,824,000	-	-316,824,000
11	Maternal and Child Health Block Grant	660,710,000	654,489,000	-6,221,000
12	State Health Access Grants	74,480,000	-	-74,480,000
13	Rural & Community Access to Emergency Devices	2,521,000		-2,521,000
14	Rural Hospital Flexibility Grants	40,915,000	26,200,000	-14,715,000
15	Delta Health Initiative	34,927,000	-	-34,927,000
16	Denali Project	10,000,000	-	-10,000,000
17	Public Health Improvement Projects	337,300,000	-	-337,300,000
	Subtotal Discretionary Program Decreases			**-$983,473,000**
	Mandatory Decreases:			
18	Primary Care Training and Enhancement Prev. Fund	198,122,000		-198,122,000
19	St Health Care Workforce Dev. Grants Prev. Fund	5,750,000		-5,750,000

20	Advanced Education Nursing Prevention Fund	31,431,000	-	-31,431,000
21	Nurse Managed Health Centers Prevention Fund	15,268,000	-	-15,268,000
22	Nutrit,Physical Activity Screen Time Stds Prev. Fund	255,000		-255,000
23	Infrastructure to Expand Access to Care	100,000,000	-	-100,000,000
	Subtotal Mandatory Program Decreases			**-$350,826,000**
	Subtotal Program Decreases			**-$1,334,299,000**
	Net Change Discretionary			**-681,732,000**
	Net Change Mandatory			**+$1,394,345,000**
	Net Change Discretionary and Mandatory			**+$712,613,000**

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

	FY 2010 Actual	FY 2011 CR	FY 2012 BP
1. Primary Care			
Health Centers	2,141,397	2,145,967	2,021,737
Community Health Center Fund (ACA)	-	1,000,000	1,200,000
Health Center Tort Claims	43,749	44,055	96,077
Total, Health Centers	**2,185,146**	**3,190,022**	**3,317,814**
Health Centers - Facilities Construction (ACA)	-	1,500,000	-
School-Based Health Centers - Facilities (ACA)	50,000	50,000	50,000
Free Clinics Medical Malpractice	40	40	40
Hansen's Disease Center	16,075	16,109	16,1075
Payment to Hawaii	1,976	1,976	1,976
Buildings and Facilities	128	129	129
Subtotal, Bureau of Primary Health Care	**2,253,365**	**4,758,276**	**3,386,034**
2. Clinician Recruitment and Service			
National Health Service Corps Field	40,941	41,128	24,695
National Health Service Corps Recruitment	100,479	100,797	98,782
National Health Service Corps (ACA)	-	290,000	295,000
Subtotal, National Health Service Corps	**141,420**	**431,925**	**418,477**
Nurse Loan Repayment and Scholarship Program	93,864	93,864	93,864
Loan Repayment/Faculty Fellowships	1,266	1,266	1,266
Subtotal, Clinician Recruitment & Service	**236,550**	**527,055**	**513,607**
3. Health Professions			
Health Professions Training for Diversity:			
Centers of Excellence	24,550	24,602	24,602
Scholarships for Disadvantaged Students	49,236	49,342	60,000
Health Careers Opportunity Program	22,086	22,133	22,133
Subtotal, Health Professions Training for Diversity	**95,872**	**96,077**	**106,735**
Health Workforce Information and Analysis	2,826	2,832	20,000
Primary Care Training and Enhancement	38,923	39,275	139,932
Primary Care Training and Enhancement Prevention Fund	198,122	-	-
Subtotal, Primary Care Training and Enhancement	**237,045**	**39,275**	**139,932**
Oral Health Training Programs	32,920	32,982	49,928
GME Payments for Teaching Health Centers (ACA)	-	230,000	-
Interdisciplinary, Community-Based Linkages:			
Area Health Education Centers	33,274	33,345	34,833
Geriatric Programs	33,675	33,747	43,747
Allied Health and Other Disciplines	1,940	1,945	-

	FY 2010 Actual	FY 2011 CR	FY 2012 BP
Mental and Behavioral Health	2,939	2,945	17,945
Subtotal, Interdisciplinary, Community-Based Linkages	**71,828**	**71,982**	**96,525**
Public Health Workforce Development:			
Public Health/Preventive Medicine;	9,647	9,668	10,068
Public Health Training Centers Prevention Fund (ACA)	14,829	20,000	15,000
Subtotal, Public Health Workforce Development	**24,476**	**29,668**	**25,068**
State Health Care Workforce Development Grants			51,000
State Health Care Workforce Development Grants Prevention Fund	5,750		
Nursing Workforce Development:			
Advanced Education Nursing	64,301	64,438	104,438
Advanced Education Nursing Prevention Fund	31,431		
Nursing Workforce Diversity	16,073	16,107	20,000
Nurse Education, Practice and Retention	39,811	39,896	59,773
Nurse Faculty Loan Program	24,947	25,000	30,000
Comprehensive Geriatric Education	4,557	4,567	5,000
Nursing Managed Care			20,000
Nurse Managed Health Centers Prevention Fund	15,268		
Subtotal, Nursing Workforce Development	**196,388**	**150,008**	**239,211**
Patient Navigator Outreach & Chronic Disease Prevention	4,965	5,000	-
Teaching Health Centers			10,000
Children's Hospitals Graduate Medical Education Program	316,824	317,500	-
Subtotal, Bureau of Health Professions	**988,894**	**975,324**	**738,399**
Health Work Force Evaluation Funding			255,423
National Practitioner Data Bank (User Fees)	(19,750)	(19,750)	(28,016)
Healthcare Integrity & Protection Data Bank (User Fees)	(3,758)	(3,758)	
4. Maternal and Child Health			
Maternal and Child Health Block Grant	660,710	662,121	654,489
Autism and Other Developmental Disorders	47,898	48,000	55,000
Traumatic Brain Injury	9,918	9,939	9,918
Sickle Cell Service Demonstrations	4,740	4,750	4,750
James T. Walsh Universal Newborn Hearing	18,960	19,000	18,860
Emergency Medical Services for Children	21,454	21,500	21,545
Healthy Start	104,776	105,000	104,776
Heritable Disorders	9,992	10,013	9,992
Congenital Disabilities	499	500	499
Nutrition, Physical Activity and Screen Time Standards Prevention Fund	255		
Family to Family Health Information Centers	5,000	5,000	5,000
Maternal, Infant and Early Childhood Visiting Program	100,000	250,000	350,000
Subtotal, Maternal and Child Health Bureau	**984,202**	**1,135,823**	**1,234,828**

	FY 2010 Actual	FY 2011 CR	FY 2012 BP
Emergency Relief - Part A	678,074	679,074	679,074
Comprehensive Care - Part B	1,276,791	1,253,791	1,358,791
AIDS Drug Assistance Program (Non-Add)	*858,000*	*835,000*	*940,000*
Early Intervention - Part C	206,383	206,823	211,522
Children, Youth, Women & Families - Part D	77,621	77,787	77,787
Education and Training Centers - Part F	34,745	34,819	34,819
Dental Services Part F	13,565	13,594	13,594
Subtotal, HIV/AIDS	**2,287,179**	**2,265,888**	**2,375,587**
SPNS Evaluation Funding	25,000	25,000	25,000
Subtotal, HIV/AIDS Bureau	**2,312,179**	**2,290,888**	**2,400,587**
6. Healthcare Systems			
Organ Transplantation	25,991	26,049	25,991
Cord Blood Stem Cell Bank	11,957	11,983	13,883
C.W. Bill Young Cell Transplantation Program	23,467	23,517	26,544
Poison Control Centers	29,250	29,314	29,250
340b Drug Pricing Program/Office of Pharmacy Affairs	2,220	2,220	5,220
340b Drug Pricing Program/Office of Pharmacy Affairs User Fees			*5,000*
State Health Access Grants	74,480	75,000	-
Infrastructure to Expand Access to Care	100,000		
Subtotal, Healthcare Systems Bureau	**267,365**	**168,083**	**105,888**
7. Rural Health			
Rural Health Policy Development	9,929	9,950	9,929
Rural Health Outreach Grants	55,905	56,025	57,266
Rural & Community Access to Emergency Devices	2,521	2,526	-
Rural Hospital Flexibility Grants	40,915	41,200	26,200
Delta Health Initiative	34,927	35,000	-
State Offices of Rural Health	10,005	10,075	10,075
Denali Project	10,000	10,000	-
Radiogenic Diseases	1,948	1,952	1,948
Black Lung	7,185	7,200	7,185
Telehealth	11,575	11,600	11,575
Subtotal, Office of Rural Health Policy	**184,910**	**185,528**	**124,178**
8. Public Health Improvement	337,300	338,002	-
9. Program Management	147,052	147,052	170,808
10. Family Planning	316,832	317,491	327,356
11. Healthy Weight Collaborative Prevention Fund	5,000	-	5,000
Total, HRS Discretionary Level	**7,482,994**	**7,473,522**	**6,801,262**
Total, HRSA Mandatory Budget Level	**525,655**	**3,345,000**	**1,920,000**
Total, Budget Authority	**8,008,649**	**10,818,522**	**8,721,262**
FTE	**1,429**	**1,160**	**1,587**

Health Resources and Services Administration
Authorizing Legislation

		FY 2010 Amount Authorized	FY 2010 Pres. Budget	FY 2012 Amount Authorized	FY 2012 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, as further amended by P.L. 111-148, Section 5601	2,602,000,000	2,141,397,000	4,990,553,440[1]	2,021,737,000
	Community Health Center Fund (ACA) P.L. 111-148, Section 10503(b)(1), as further amended by P.L. 111-152, Section			1,200,000,000	1,200,000,000
2.	Health Centers - Facilities Construction/NHSC Construction Grants P.L. 111-148, Section 4101(a		50,000,000	50,000,000[2]	50,000,000
3.	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 as further amended by Section 202 of S. 1790 as incorporated into P.L. 111-148, Section 10221	SSAN		SSAN[3]	
4.	Health Center Tort Claims: (Defense of Certain Malpractice and Negligence Suits) PHSA, Section 224, P.L. 104-73	10,000,000	43,749,000	10,000,000	96,077,000
5.	Free Clinic Medical Malpractice: PHSA, Section 224, 42 U.S.C. 233	10,000,000	40,000	10,000,000	40,000
6.	National Hansen's Disease Program: PHSA, Section 320	Indefinite	16,075,000	Indefinite	16,075,000

[1] Permanent using formula for FY 2016.
[2] Legislative authority expired September 30, 2013
[3] Legislative authority expired September 20,2019

		FY 2010 Amount Authorized	FY 2010 Pres. Budget	FY 2012 Amount Authorized	FY 2012 Pres. Budget
7.	Payment to Hawaii:				
	PHSA, Section 301	Indefinite	1,976,000	Indefinite	1,976,000
8.	Buildings and Facilities:				
	PHSA, Section 320 and 321(a)	Indefinite	128,000	Indefinite	129,000
	CLINICIAN RECRUITMENT & SERVICE:				
9.	National Health Service Corps (NHSC):				
	PHSA, Sections 331-338, as amended by the Health Care Safety Net Act of 2008, P.L. 110-355., as further amended by P.L. 111-148, Section 5207	156,235,150		535,087,442	
	NHSC Field		40,941,000		24,695,000
	NHSC Recruitment		100,479,000		98,782,000
	State Loan Repayment:				
	PHSA, Section 338I		---		
	National Health Service Corps – Fund P.L. 111-148, Section 10503(b)(2)			295,000,000	295,000,000
10.	Nursing Education Loan Repayment and Scholarship Program				
	PHSA, Section 846	Expired	93,864,000	Expired[4]	93,864,000
11.	Loan Repayments and Fellowships Regarding Faculty Positions				
	PHSA, Section 738 Nurse Faculty Loan Repayment Program – P.L. 111-148Section 5311	Expired	1,266,000	Expired[5]	1,266,000
	HEALTH PROFESSIONS:				
12.	Health Professions Training for Diversity:				
	Centers of Excellence				
	PHSA, Section 736, as amended by P.L. 111-148, Section 5401	Expired	24,550,000	50,000,000 [6]	24,602,000
13.	Scholarships for Disadvantaged Students				
	PHSA, Section 737, as amended by P.L. 111-148, Section 5402	Expired	49,236,000	SSAN[7]	60,000,000

[4] Legislative authority expired September 30, 2002
[5] Legislative authority expired September 30, 2014
[6] Legislative authority expired September 30, 2015
[7] Legislative authority expired September 30, 2014

		FY 2010 Amount Authorized	FY 2010 Pres. Budget	FY 2012 Amount Authorized	FY 2012 Pres. Budget
14.	Health Careers Opportunity Program				
	PHSA, Section 739, as amended by P.L. 111-148, Section 5402	60,000,000	22,086,000	SSAN[8]	22,133,000
15.	Health Care Workforce Assessment, PHSA, Section 761, as amended by P.L. 111-148, Section 5103		2,826,000		20,000,000
	National Center	7,500,000		7,500,000	
	Grants for Longitudinal Evaluations	SSAN		SSAN	
	State and Regional Centers	4,500,000		4,500,000	
16.	Primary Care Training and Enhancement Amends PHSA, Title VII - Section 747	125,000,000	38,923,000	SSAN	139,932,000
	Primary Care Training and Enhancement [Prevention Fund], as amended by P.L. 111-148, Section 5301		198,122,000		
17.	Oral Health Training Programs, PHSA Section 748, as amended by P.L. 111-148, Section 5303	30,000,000	32,920,000	SSAN	49,928,000
18.	Interdisciplinary, Community-Based Linkages:				
	Area Health Education Centers				
	PHSA, Section 751, as amended by P.L. 111-148, Section 5403	125,000,000	33,274,000	125,000,000	34,833,300
19.	Education and Training Related to Geriatrics				
	PHSA, Section 753, as amended by P.L. 111-148, Section 5305	Expired	33,675,000	10,000,000	43,747,000
20.	Allied Health and Other Disciplines				
	PHSA, Section 755 ,PHSA, Section 340G, as amended by P.L. 110-355	Expired	1,940,000	Expired	-
21.	Mental and Behavioral Health, PHSA Section 756, as amended by P.L. 111-148, Section 5306	35,000,000	2,939,000	35,000,000[9]	17,945,000
	P.L. 111-148, Section 5306				
22.	Dental HPSAs: Grants for Innovative Programs:	Expired		Expired	
	PHSA, Section 340G, as amended by P.L. 110-355				
	Public Health Workforce Development:				
23.	Public Health/Preventive Medicine; Dental Public Health PHSA, Sections 765. 766, 767 ,768 and 769	Expired	9,647,000	43,000,000	10,068,000
24.	Public Health/Preventive Medicine [Prevention Fund], PHSA, Section 768, as amended by P.L. 111-148, Section 10501 (m)*subset of Section 765-769 noted in #22 above		14,829,000		15,000,000

[8] Legislative authority expired September 30, 2014
[9] Legislative authority expired September 30, 2013

		FY 2010 Amount Authorized	FY 2010 Pres. Budget	FY 2012 Amount Authorized	FY 2012 Pres. Budget
	State Health Care Workforce Development Grants (Planning)	8,000,000 (Planning)	5,750,000	SSAN	
25.	State Health Care Workforce Development Grants (Implementation) [Prevention Fund], P.L. 111-148, Section 5102	150,000,000 (Implementation)		SSAN	51,000,000
26.	Nursing Workforce Development: Advanced Education Nursing PHSA, Section 811	Expired	64,301,000	Expired[10]	104,438,000
27.	Advanced Nursing Education [Prevention Fund], PHSA Section 811, as amended		31,431,000	Undefined	-
28.	Nursing Workforce Diversity PHSA, Section 821	Expired	16,073,000	Expired [11]	20,000,000
29.	Nurse Education, Practice and Retention PHSA, Section 831	Expired	39,811,000	Expired	59,733,000
30.	Nurse Faculty Loan Program PHSA, Section 846A, as amended by P.L. 107-205.	Expired	24,947,000	Expired[12]	30,000,000
31.	Comprehensive Geriatric Education PHSA, Section 855, as amended by P.L. 107-205.	Expired	4,557,000	Expired	5,000,000
32.	Nurse Managed Health Clinics [Prevention Fund], PHSA Section 330A-1, P.L. 111-148Section 5208	50,000,000	15,268,000	SSAN	20,000,000
33.	Teaching Health Centers, PHSA Section 749A, P.L. 111-148, Section 5508(a)	25,000,000		50,000,000	10,000,000
34.	Health Workforce Evaluation Funding, PHSA Section 761, P.L. 111-148, Section 5103 *subset of Section 761 already noted in #15 above				
35.	Patient Navigator Grants P.L. 109-18, Section 340A, as Amended by P.L. 111-148, Section 3510	3,500,000	4,965,000	-	-
36.	Children's Hospitals Graduate Medical Education Program: PHSA, Section 340E as amended by P.L. 109-307	330,000,000	316,824,000		-

[10] Legislative authority expired September 30, 2002
[11] Legislative authority expired September 30, 2007
[12] Legislative authority expired September 30, 2007

		FY 2010 Amount Authorized	FY 2010 Pres. Budget	FY 2012 Amount Authorized	FY 2012 Pres. Budget
37.	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	(28,016,000) (non-add)
38.	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	-
	MATERNAL & CHILD HEALTH:				
39.	Maternal and Child Health Block Grant:				
	Social Security Act, Title V	850,000,000	660,710,000	850,000,000	645,489,000
40.	Autism and Other Developmental Disorders				
	PHSA, Section 399BB	47,000,000	47,898,000	52,000,000	55,000,000
41.	Traumatic Brain Injury Program:				
	PHSA, Sections 1252 and 1253 as amended by P.L. 106-310, Title XIII, Section 1304	Expired	9,918,000	Expired	9,918,000
42.	Sickle Cell Service Demonstration Grants:				
	American Jobs Creation Act of 2004, Section 712	Expired	4,740,000	Expired	4,740,000
43.	Universal Newborn Hearing Screening:				
	PHSA, Section 399M as amended by P.L. 106-310, Title VII, Section 702	Expired	18,960,000		18,960,000
44.	Emergency Medical Services for Children:				
	PHSA, Section 1910, as amended by P.L. 111-148, Section 5603	Expired	21,454,000		21,454,000
45.	Healthy Start:				
	PHSA, Section 330H as amended by P.L. 106-310, Title XV, Section 1501 (a) - (d)	121,188,480	104,776,000		104,776,000
46.	Newborn Screening for Heritable Disorders		9,992,000		9,992,000
	PHSA, Section 1109	15,375,000			
	PHSA, Section 1111	1,025,000			
	PHSA, Section 1112	2,562,500			
47.	Congenital Disabilities PHSA, Section 399R	Indefinite	499,000		499,000
	Nutrition, Physical Activity and Screen Time Standards Prevention Fund		255,000		

		FY 2010 Amount Authorized	FY 2010 Pres. Budget	FY 2012 Amount Authorized	FY 2012 Pres. Budget
48.	Family to Family Health Information Centers : Social Security Act, Section 501 (c)(1)(A) as amended by the Deficit Reduction Act of 2005, as further amended by P.L. 111-148, Section 5507	5,000,000	5,000,000	5,000,000	5,000,000
49.	Maternal, Infant and Early Childhood Visiting Program: H.R. 3590, Section 2951 Postpartum Condition Grants PHSA, Section 512, added by P.L. 111-148, Section 2952 Amends Title V of SSA at Sec 511	SSAN	100,000,000	SSAN	350,000,000
	HIV/AIDS:				
50.	Emergency Relief - Part A: PHSA, Sections 2601-10 as amended by P.L. 109-415 as further amended by P.L 111-87	Expired	678,074,000	716,074,000	679,074,000
51.	Comprehensive Care - Part B: PHSA, Sections 2611-2631, as amended by P.L. 109-415,as further amended by	Expired	1,276,791,000	1,416,933,000	1,353,791,000
	AIDS Drug Assistance Program (Non-Add)				
52.	PHSA, Section 2616, as amended by P.L. 109-415,as further amended by	Indefinite	(858,000,000) (non-add)	Indefinite	(925,000,000) (non-add)
53.	Early Intervention - Part C: PHSA, Sections 2651-2667, as amended by P.L. 109-415 P.L. 111-87 by P.L. 111-87	Expired	206,383,000	259,198,000	212,014,000
54.	Coordinated Services and Access to Research for Women, Infants, Children and Youth - Part D: PHSA, Section 2671, as amended by P.L. 109-415, as further amended by P.L. 111-87	Expired	77,621,000	79,160,000	77,787,000
55.	Special Projects of National Significance - Part F: PHSA, Section 2691, as amended by P.L. 109-415	Expired	(25,000,000) (non-add)	(25,000,000 (non-add)	(25,000,000) (non-add)
56.	Education and Training Centers - Part F II: PHSA, Section 2692(a), as amended by P.L. 109-415 , as further amended by P.L. 111-87	Expired	34,745,000	38,257,000	34,819,000
57.	AIDS Dental Services - Part F II: PHSA, Section 2692(b), as amended by P.L. 109-415	Expired	13,565,000	14,333,000	13,594,000
	HEALTHCARE SYSTEMS				
58.	Organ Transplantation: PHSA, Sections 371 - 378, as amended by P.L. 108-216	Expired	25,991,000	Expired	25,991,000
59.	C.W. Young Cell Transplantation Program:				

		FY 2010 Amount Authorized	FY 2010 Pres. Budget	FY 2012 Amount Authorized	FY 2012 Pres. Budget
	National Cord Blood Stem Cell Bank:				
	PHSA, Section 379, as amended by the P.L. 109-129, as further amended P.L. 111-264	15,000,000	11,957,000		13,883,000
60.	C.W. Young Cell Transplantation Program:				
	Bone Marrow Donor Registry:	38,000,000	23,467,000		26,544,000
	PHSA, Section 379, as amended by the P.L. 109-129 as further amended by P.L. 111-264				
61.	Poison Control Centers:				
	PHSA, Section 1271-1273, as amended by P.L. 110-377.	28,600,000	29,250,000	27,500,000	29,250,000
	National Toll-Free Hotline	700,000		2,000,000	
	Media Campaign	800,000			
62.	340B Drug Pricing Program:	Indefinite	22,200,000	Indefinite	5,222,000
	PHSA, Section 340B, as amended by P.L. 111-8, as further amended by P.L. 111-148, as further amended by P.L. 111-152, and as further amended by P.L. 111-309				
63.	340b Drug Pricing Program/Office of Pharmacy Affairs User Fees * This is a draft legislative proposal for FY12, which would authorize $5,000,000.00 for FY12				5,000,000
64.	State Health Access				-
	P.L. 111-8	75,000,000	74,480,000		-
65.	Infrastructure to Expand Access to Care, P.L. 111-148, Section 10502	100,000,000	100,000,000	Expired	
	RURAL HEALTH:				
66.	Rural Health Policy Development:				
	Social Security Act, Section 711	Indefinite	9,929,000	Indefinite	9,929,000
67.	Rural Health Outreach Network Development and Small Health Care Provider Quality Improvement:				
	PHSA, Section 330A, as amended by P.L. 107-251.	Expired	55,905,000	Expired	57,266,000
68.	Rural Access to Emergency Devices:				
	PHSA, Section 313	Expired	2,521,000	Expired	-
69.	Rural Hospital Flexibility Grants:				
	Social Security Act, Section 1820(j) as amended by P.L. 108-173	Expired	40,915,000		26,200,000

		FY 2010 Amount Authorized	FY 2010 Pres. Budget	FY 2012 Amount Authorized	FY 2012 Pres. Budget
70.	Delta Health Initiative P.L. 110-161, Section 219	Expired	34,927,000	Expired	-
71.	State Offices of Rural Health: PHSA, Section 338J	Expired	10,005,000	Expired	10,075,000
72.	Denali Project: P.L. 105-277, Title III, Section 309, as amended by P.L. 106-113, Title VII	Expired	10,000,000	Expired	
73.	Radiogenic Diseases: PHSA, Section 417C amended by P.L. 106-245, as further amended by P.L. 109-482, Sections 103 and 104	Expired	1,948,000	Expired	1,948,000
74.	Black Lung: Federal Mine Safety and Health Act, Section 427(a)	Expired	7,185,000	Expired	7,185,000
75.	Public Health Improvement (Facilities and Other Projects) P.L. 110-161, Title II		377,300,000		-
76.	Telehealth: PHSA, Section 330I, as amended by P.L. 107-251.	Expired	11,575,000	Expired	11,575,000
	PHSA, Section 330L, as amended by P.L. 108-163	Expired		Expired	
77.	Program Management: PHSA, Section 301	Indefinite	147,052,000		170,808,000
78.	Family Planning: PHSA, Title X	Expired	316,832,000	Expired	327,356,000
79.	Healthy Weight Collaborative [Prevention Fund], P.L. 111-148. 3590, Section 4002	5,000,000	5,000,000		5,000,000
	Unfunded Authorizations:				
1.	Guarantee Level of Health Center Loans: PHSA, Section 330(d) / PHSA, Sections 1601 and 1602	SSAN	---		SSAN
2.	National Health Service Corps Recruitment: Demonstration Project: Participation of Chiropractic Doctors and Pharmacists in LRP: PHSA, Section 338L, as amended by P.L. 107-251, Section 317	Expired	---	Expired	
3.	Healthy Communities Access Program: PHSA, Section 340, as amended by P.L. 107-251.	Expired	---	Expired	

		FY 2010 Amount Authorized	FY 2010 Pres. Budget	FY 2012 Amount Authorized	FY 2012 Pres. Budget
4.	Health Professions Training for Diversity:				
	Educational Assistance for Individuals from Disadvantaged Backgrounds				
	PHSA, Section 739	Expired	---	Expired	
5.	Interdisciplinary, Community-Based Linkages:				
	Health Education and Training Centers				
	PHSA, Sections 750, 752, and 757	Expired	---	Expired	
	Quentin N. Burdick Program for Rural Interdisciplinary Training				
	PHSA, Sections 750, 754, 757	Expired	---	Expired	
6.	H. P. Workforce Information and Analysis				
	PHSA, Section 761	Expired	---	Expired	
7.	Public Health Workforce Development:				
	Health Administration Traineeships and Special Projects				
	PHSA, Section 769	Expired	---	Expired	
8.	State and Local Public Service Announcements:				
	PHSA, Section 852	Expired	---	Expired	
9.	Grants for Health Professions Education in Health Disparities and Cultural Competency:				
	PHSA, Section 741	Expired	---	Expired	
10.	Grants for Health Professions Education: (Nursing)				
11.	Epilepsy, Seizure Disorder:				
	PHSA, Section 330E(b), as amended by Sec. 801 of P.L. 106-310	Expired	---	Expired	
12.	Child Care Safety and Health Grants Programs:				
	Children's Health Act, P.L. 106-310, Section 1402	Indefinite	---	Indefinite	
13.	Early Detection and Treatment Re. Childhood Lead Poisoning:				
	PHSA, Section 317O	Expired	---	Expired	
14.	Rural EMS Training & Equipment Assistance:				
	PHSA, Section 330J amended by P.L. 107-251, the Health Care Safety Net Amendments of 2002	Expired	---	Expired	
15.	Community Access Defibrillation:				
	PHSA, Section 312 as amended by P.L. 107-188	Expired	---	Expired	
16.	Community Access Defibrillation Demonstration:				
	PHSA, Section 313 as amended by P.L. 107-188	Expired	---	Expired	
17.	Pediatric Rheumatology:				
	PHSA, Section 763	Expired	---	Expired	
18.	Grants for Children's Asthma Relief:				
	PHSA, Section 399L	Expired	---	Expired	

		FY 2010 Amount Authorized	FY 2010 Pres. Budget	FY 2012 Amount Authorized	FY 2012 Pres. Budget
19.	Prevention Research and Programs:				
	PHSA, Section 317K(b) and (c), as amended by P.L. 106-310, Section 901	Expired	---	Expired	
20.	Additional Services for At-Risk Pregnant Women and Infants:				
	PHSA, Section 330H(e), as amended by P.L. 106-310, Section 1501	Expired	---	Expired	
21.	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	
22.	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	
23.	Mental Health Services Delivered via Telehealth:				
	PHSA, Section 330K, amended by P.L. 107-251	Expired	---	Expired	
24.	Oral Health Promotion & Disease Prevention: School Based Sealant Program:				
	PHSA, Section 317M(c), as amended by P.L. 106-310, Section 1602	Expired	---	Expired	
25.	Smallpox Emergency Personnel Protection:				
	PHSA, Title II Part C, as amended by P.L. 108-20	Expired	---	Expired	
26.	Health Facilities Construction and and Other Misc. Projects:				
	P.L. 108-447, Omnibus Appropriations for FY 2009	Expired	---	Expired	
27.	Training in Primary Care Medicine and Dentistry:	Expired		Expired	
	PHSA, Section 747				
	Total, Request Level		**8,066,506,000**	**11,226,095,882**	**9,041,203,000**
	Total request level against definite authorizations	**4,257,923,630**	**3,571,683,000**	**5,912,553,440**	**3,104,968,000**

Appropriations History Table

	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[2]	4,684,232,000[1]	4,592,424,000[2]	5,550,876,000[1]
Advance		30,000,000[1]		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				

[1] Excludes $50 million mandatory appropriation for Abstenence 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.

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
General Fund Appropriation:				
Base	5,381,836,000	5,825,497,000[2]	6,075,654,000[5]	5,926,630,000[6]
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
FY 2004				
General Fund Appropriation:				
Base	5,665,996,000[7]	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

[5] Excludes $50 million mandatory appropriation for Abstinence Education, and $592,600,000 for programs financed from PHSSEF

[6] Excludes $50 million mandatory appropriation for Abstinence Education, and $546,000,000 for programs financed from PHSSEF

[7] Excludes $50 million mandatory appropriation for Abstinence Education, and $618,173,000 for programs financed from PHSSEF

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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[8]
Advance				
Supplementals				
Rescissions				
Subtotal	6,308,855,000	7,095,617,000	7,012,559,000	6,393,691,000
FY 2008				
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[8]
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[9]
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				9,472,000
Subtotal.	7,126,700,000	7,306,817,000	7,238,799,000	7,482,994,000

[8] Family to Family Health Information Centers and CAHs to SNFs and Assisted Living Facilities.
[9] Family to Family Health Information Centers

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
[10]FY 2011				
General Fund Appropriation:				
Base	7,473,522,000		7,491,063,000	
Advance				
Supplementals				
Rescissions				
Transfers				
Subtotal.	7,473,522,000		7,491,063,000	
FY 2012				
General Fund Appropriation:				
Base	6,801,262,000			
Advance				
Supplementals				
Rescissions				
Transfers	6,801,262,000			

[10] Continuing Resolution Level

Primary Health Care

Health Centers

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$2,141,397,000	$2,145,967,000	$2,021,737,000	-$119,660,000
ACA	---	$1,000,000,000	$1,200,000,000	+$1,200,000,000
FTCA	$43,749,000	$44,055,000	$96,077,000	+$52,328,000
Total HC	$2,185,146,000	$3,190,022,000	$3,317,814,000	+$1,132,668,000
FTE	75	76	50	-25

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, Section 224 of the Public Health Service Act; Public Law 111-148, the Affordable Care Act of 2010, Title V, Section 5601 and Title X, Section 10503. Public Law 111-152, Health Care and Education Reconciliation Act of 2010, Section 2303.

FY 2012 Authorization: $4,990,553,440
.
FY 2012 CHC Fund Authorization.....$1,200,000,000

Allocation Method: Competitive grants/cooperative agreements; Formula grants/cooperative agreements

Program Description and Accomplishments

For more than 40 years, health centers have delivered comprehensive, high-quality, cost-effective primary health care 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; 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 8,000 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 2009, these community-based and patient-directed health centers served 18.8 million patients, providing almost 74 million patient visits, at an average cost of $600 (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 2009 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 2009. 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 approximately 7.2 million in FY 2009, 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 2009 health centers served approximately 865,000 migrant and seasonal farmworkers and their families, more than 1 million individuals experiencing homelessness, 165,000 residents of public housing, and over 7,800 Native Hawaiians.

- Migrant Health Centers – In FY 2009, HRSA-funded health centers served nearly 865,000 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 2009, more than 1 million 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 2009, HRSA-funded health centers served more than 165,000 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 2009, Native Hawaiian Healthcare Systems provided medical and enabling services to more than 7,800 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. New 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). New Health Center 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 priorities 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 2009 was 18.8 million. This increased access beyond the 10.3 million patients served in FY 2001 represents over an 82 percent increase within a 8-year period, and an increase of approximately 3.2 million uninsured patients since FY 2001. Of the 18.8 million patients served and for those for whom income status is known, 92 percent were at or below 200 percent of the Federal poverty level and over 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 67.3 percent in FY 2009, exceeding the target of 61.6 percent. 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 2008, 7.6 percent of babies born to Health Center prenatal care patients were low birth weight, a rate that is 7.3 percent lower than seen nationally (8.2%).

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. In FY 2009, 63 percent of adult Health Center patients with diagnosed hypertension had blood pressure under adequate control (less than or equal to 140/90). Additionally, 71 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 health care 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. In FY 2009, costs grew by 2 percent. 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 Program is implementing improvements that include: 1) the use 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. Key program activities for risk mitigation include risk management of reviews and sites visits as well as risk management technical assistance and resources to support health centers. 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 Affordable Care Act:
The Affordable Care Act authorized and appropriated $11 billion over five years to establish a Community Health Center Fund to provide for expanded and sustained national investment in health centers under section 330 of the Public Health Service Act. $1.5 billion will support major construction and renovation projects at community health centers nationwide. $9.5 billion will support the establishment of new health center sites in medically underserved areas and expand preventive and primary health care services at health center sites. The amount appropriated to support health center services is $1 billion in FY 2011 and $1.2 billion in FY 2012. In FY 2011, approximately $732 million in Affordable Care Act funding supported awards to 144 health centers for the construction and renovation of 190 new or improved sites. Additionally, an estimated 385 new access point grants and over 1,100 expanded services grants are projected to be supported by the Affordable Care Act in FY 2011. Approximately 3.3 million additional patients are projected to be served in FY 2011 as a result of the Affordable

Care Act funding. In FY 2012, affordable Care Act funding will support base activities and additional expansion activities

Funding History

FY	Amount
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	$2,185,146,000
FY 2011	$3,190,022,000

Budget Request

The FY 2012 Request of $3,317,814,000 is an increase of $1,132,668,000 from the FY 2010 Actual level which includes the Affordable Health Care Act funding. The FY 2012 Budget Request will support the Program's achievement of its ambitious performance targets and continue to enable the provision of access to primary health care services and the improvement of the quality of care in the health care safety net.

The FY 2012 Discretionary Request also supports $96,077,000 for the FTCA program, which is an increase of $52,328,000 from the FY 2010 Actual level. This request reflects the projected increase in FTCA program demand, given the recent expansion of the Health Center Program and the significant projected Health Center Program expansion supported by the Affordable Care Act.

This funding level will continue to support more than 1,100 health center grantees that provide comprehensive, culturally competent, quality primary healthcare services through more than 8,000 service delivery sites.

The FY 2012 Discretionary 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 approximately 23.5 million patients in FY 2011, and approximately 24.4 million patients under this FY2012 Budget Request.

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 2012 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 2012 target for the Program's

hypertension measure is that 60 percent of adult patients with diagnosed hypertension will have blood pressure under adequate control. The FY 2012 target for the Program's diabetes management measure is 71 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 2012 is to keep the Program's cost per patient increase at least 20 percent below the 2012 national healthcare cost increase. 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. By restraining increases in the cost per individual served at health centers below the national per capita health care cost increases, the Health Center Program serves a volume of patients that otherwise would have required additional funding to serve, and demonstrates that it delivers its high quality services at a more cost effective rate.

The FY 2012 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 health care. 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 report with those of national quality measurement organizations, such as the Ambulatory Care Quality Alliance and the National Quality Forum. These measures are consistent with the overarching goals of Healthy People 2010, and include: immunizations; prenatal care; cancer screenings; cardiovascular disease/hypertension; and diabetes. In FY 2011, the Health Center Program will begin collecting data on four additional clinical performance measures: weight assessment and counseling for children and adolescents, adult weight screening and follow up, tobacco use assessment and counseling, and asthma treatment.

In addition to tracking these core clinical indicators, Health Center grantees 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, 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.

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 Centers for Medicaid and Medicare Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) 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 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.

IT Investments

The Program's investment in IT supports the strategic and performance outcomes of the Health Centers and contributes to its success by providing a mechanism for sharing data and conducting business in a more efficient manner. The HRSA Electronic Handbooks (EHBs) supports the Health Centers with program administration, grants administration and monitoring, management reporting, and grantee performance measurement and analysis.

The Program's investment in the Application Submission and Processing System (ASAPS) streamlines and expedites the application development & review process for areas, populations & facilities seeking to designate or update current Health Professional Shortage Areas (HPSAs) & Medically Underserved Areas/Populations (MUA/Ps).

Sources of Revenue:

	FY 2010 Enacted	**FY 2011 CR**	**FY 2012Request**
Health Centers	$2,141,4	$3,145.9	$3,221.7
Other Sources:			
Medicaid	3,500.0	5,140.0	5,260.0
Medicare	600.0	885.0	900.0
CHIPRA	245.0	360.0	365.0
Other Third	870.0	1,390.0	1,300.0
Self Pay Collections	655.0	960.0	980.0
Other Federal Grants	215.0	315.0	320.0
State/Local/Other	2,000.0	2,940.0	3,000.0
TOTAL ($ in millions)	$10,226.4	$15,020.9	$15,346.7

*Note: Health Center program amounts and revenue sources reflect the impact of Affordable Care Act funding in FY 2011 and FY 2012.

.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
1.I.A.1: Number of patients served by health centers (Output)	FY 2009: 18.8 million (Target Not Met)	20.15 million	24.4 million	+4.25 million
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 2009: 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 Health/Substance Abuse (Output)	FY 2009: 70% (Target Not Met)	68%	70%	+ 2%points
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[1]	20% below national rate	Maintain
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 2008: 7.3% 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 2009: 63% (Target Exceeded)	50%	60%	+10%points
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 2009:71 (Target Not in Place)	73%	71%	-2%points
1.II.B.1: Percentage of pregnant Health Center patients beginning prenatal care in the first trimester (Output)	FY 2009: 67.3% (Target Exceeded)	61.3%	64.3%	+3%points
1.II.A.1: Percentage of Health Center patients who are at or below 200% of poverty (number in millions) (Output	FY 2009: 92.5% (Target Exceeded)	91%	91%	Maintain
1 II.A.2: Percentage of Health Center patients who are racial/ethnic minorities (number in millions) (Output).	FY 2009: 63% (Baseline)	N/A	63%	N/A
1.II.A.3: Percentage of Health Center patients who are uninsured (Output)	FY 2009: 38% (Target Not Met)	38%	38%	Maintain

[1] The target for this measure has always been to achieve a rate that is at least 20% below the National rate. In prior documents, this had been show as a number on projection of the National rate. Such projection will no longer be used in showing the target.

Grants Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	1,133	1,287	1,287
Average Award	$1.7 million	$2.3 million	$2.3 million
Range of Awards	$200,000 – $11 mil.	$475,000 – $13 mil.	$475,000 – $13 mil.

Program Outputs

	FY 2010 Enacted	FY 2011 CR [2]	FY 2012 Request
New Access Points	---	385	---
Expanded Sites	---	1,130	---
Total New/Expanded	---	1,515	---
Total Sites	8,156	8,541	8,541
Estimated Patients Served	20.15 million	23.5 million	24.4 million

[2] FY 2011 Continuing Resolution Level - also includes ACA funding.

Community Health Center Fund – Construction

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	---	$1,500,000,000	---	---
FTE	---	12	26	+26

Authorizing Legislation: Affordable Care Act of 2010, Title X, Section 10503(c).

ACA Authorization:.....$1,500,000,000

Allocation Method:.....Competitive grants/cooperative agreement

Program Description and Accomplishments

The Construction section of the Community Health Center (CHC) Fund was established under the Affordable Care Act to provide for expanded and sustained national investment in health centers funded under Section 330 of the Public Health Service Act. Grant opportunities supported by the CHC Fund Construction program were implemented in FY 2011 Approximately, $732 million in Affordable Care Act funding supported awards to 144 health centers for the construction and renovation of 190 new or improved sites.

Budget Request

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

School Based Health Centers – Facilities

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$50,000,000	$50,000,000	$50,000,000	---
FTE	0	9	9	9

Authorizing Legislation: Affordable Care Act of 2010, Title IV, Section 4101(a)

FY 2012 Authorization: $50,000,000

Allocation Method: ..... Competitive grants

Program Description and Accomplishments

Section 4101(a) of the Affordable Care Act authorizes and appropriates funding to support grants for the establishment of school-based health centers. Funds can be used for expenditures for facilities (including the acquisition or improvement of land, or the acquisition, construction, expansion, replacement, or other improvement of any building or other facility), equipment, or similar expenditures.

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

It is expected that the proposed projects will support the SBHC in providing more effective, efficient, and quality health care. Applicants must also demonstrate how their proposal will lead to improvements in access to health services for children at a SBHC.

Funding History

FY	Amount
FY 2007	---
FY 2008	---
FY 2009	---
FY 2010	$50,000,000
FY 2011	$50,000,000

Budget Request

The Affordable Care Act authorized and appropriated amount for FY 2012 $50 million. This funding is expected to support expenditures for school based health center facilities, including equipment, the acquisition or improvement of land, or the acquisition, construction, expansion, replacement, or other improvement of a school based health center facility. This requested level is expected to fund approximately 100 SBHC awards.

Free Clinics Medical Malpractice

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$40,000	$40,000	$40,000	---
FTE	2	2	2	---

Authorizing Legislation: Section 224 of the Public Health Service Act

FY 2012 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);or 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 2010, 4,800 volunteer healthcare providers received Federal malpractice coverage through the Program, exceeding the Program target and representing an increase of more than 1,000 volunteer providers over FY 2009, and almost 1,800 providers over the FY 2008 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, in FY 2009 121 free clinics participated, and in FY 2010 132 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. In FY 2009, the Program supported 282,958 patient visits provided by free clinics sponsoring volunteer FTCA deemed clinicians.

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, in FY 2009 the cost per provider was $154, and in FY2010, the result was $115 per provider, exceeding the program performance target each year.

Through FY 2010 there have been no paid claims under the Free Clinics Medical Malpractice Program.

Funding History

FY	Amount
FY 2007	$41,000
FY 2008	$40,000
FY2009	$40,000
FY 2010	$40,000
FY 2011	$40,000

Budget Request

The FY 2012 Discretionary Request for the Free Clinics Medical Malpractice Program is $40,000. The entire FY 2012 Discretionary 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 2012 focus on maintaining the number of volunteer free clinic healthcare providers deemed eligible for FTCA malpractice coverage at 4,800 while also increasing the number of free clinics operating with FTCA-deemed volunteer clinicians to 155. 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 target of $155 administrative cost per provider in FY 2012.

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.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012+/- FY 2010
2.I.A.1: Number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage *(Outcome)*	FY 2010: 4,800 (Target Exceeded)	4,000	4,800	+800
2.1: Patient visits provided by free clinics sponsoring volunteer FTCA-deemed clinicians (Outcome)	FY 2009: 282,958 (Baseline)	N/A	350,000	N/A
2.I.A.2: Number of free clinics operating with FTCA-deemed volunteer clinicians *(Output)*	FY 2010: 132 (Target Exceeded)	130	155	+25
2.I.A.3: Percent of volunteer FTCA-deemed clinicians who meet certification and privileging requirements *(Output)*	FY 2010: 100% (Target Met)	100%	100%	Maintain
2.E: Administrative costs of the program per Federal Tort Claims Act (FTCA)-covered volunteer *(Efficiency)*	FY 2010: $115 (Target Exceeded)	$170	$155	-$15

National Hansen's Disease Program

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$16,075,000	$16,109,000	$16,075,000	---
FTE	65	69	69	+4

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

FY 2012 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 2,963 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 2010, the NHDP exceeded its program performance target of 150, and trained 220 private sector physicians, an increase over the 157 physicians trained in FY 2009, 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 patient with grades 1 or 2 disability/ deformity. In FY 2005, 51% of patients

had grades 1 or 2 disability In FY 2006 that figure was 46%, in FY 2007 that figure was 47%, and in FY 2010 the result was 45%, exceeding the target of 50% each year.

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). In FY 2009, the Program met its target and developed BRM-4 and CM-4.

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. In FY 2009, the cost per patient served through outpatient services was $1,088, bettering the target of $1,676.

Funding History

FY	Amount
FY 2007	$15,972,000
FY 2008	$15,693,000
FY 2009	$16,109,000
FY 2010	$16,075,000
FY 2011	$16,109,000

Budget Request

The FY 2012 Discretionary Request of $16,075,000 reflects the same level as the FY 2010 Actual level. The entire FY 2012 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 2012 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[1] 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 2012. The Program's FY 2011 target for its research measure is to use DNA evidence to link leprosy transmission from armadillos to humans. This target is particularly ambitious because it requires breakthroughs in genomic and molecular biology. For FY 2012, the target is to pursue the integration of BRM, CM and molecular reagent breakthroughs to explore a potential leprosy vaccine and to predict or treat nerve damage. The Program will also continue to promote efficiency by targeting in FY 2011 and FY 2012 cost per patient increases below the national medical inflation rate.

The FY 2012 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 is the sole provider of reagent grade viable leprosy bacilli, and continues to collaborate with researchers worldwide to further the study of and scientific advances related to the disease.

[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

To support the program training initiative of increasing the awareness of leprosy in the U.S. the program has facilitated outpatient management of leprosy in the U.S. by providing to private sector physicians additional laboratory, diagnostic, consultation and referral services.
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 2012 Target	FY 2012 +/- FY 2010
3.E: Maintain increases in the cost per patient served in the outpatient clinics to below the medical inflation rate *(Efficiency)*	FY 2009: $1,088 (Target Exceeded)	Below national medical inflation rate	Below national medical inflation rate	Maintain
3.II.A.2.: Number of private sector physicians who have received training from the NHDP *(Output)*	FY 2010: 220 (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 2009: 2,963 (Target Virtually Met)	3,000	3,000	Maintain
3.III.A.1Develop an animal model for the fall spectrum of clinical complexities of human Hanes's Disease.(Output)	FY 2009: BRM 4, CM 4 (Target Met)	Demonstrate defective nerve function in infected armadillos	Pursue the integration of BRM, CM and molecular reagent breakthroughs	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 2008: 45% (Target Exceeded)	50%	50%	Maintain

Program Outputs

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
NHDP Resident Population	20	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 2010 Enacted	FY 2011 CR	FY 2012 Request
Administration	1,250,000	1,250,000	1,250,000
Clinical Care	5,283,000	5,317,000	5,283,000
Regional Centers	3,390,000	3,390,000	3,390,000
Research	2,435,000	2,435,000	2,435,000
Facility Operations	2,267,000	2,267,000	2,267,000
Assisted Living Allowance	1,450,000	1,450,000	1,450,000
Total	16,075,000	16,109,000	16,075,000

National Hansen's Disease Program - Buildings and Facilities

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$128,000	$129,000	$129,000	+1,000
FTE	---	---	---	---

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

FY 2012 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 2007	$220,000
FY 2008	$157,000
FY 2009	$129,000
FY 2010	$129,000
FY 2011	$129,000

Budget Request

The FY 2012 Discretionary Request of $129,000 for the Buildings and Facilities program is an increase of $1,000 from the FY 2010 Actual level. 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.

Payment to Hawaii

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$1,976,000	$1,976,000	$1,976,000	---
FTE	---	---	---	---

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

FY 2012 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 2007	$1,996,000
FY 2008	$1,961,000
FY 2009	$1,976,000
FY 2010	$1,976,000
FY 2011	$1,976,000

Budget Request

The FY 2012 Discretionary request of $1,976,000 for the Payment to Hawaii program is the same as the FY 2010 Actual level to maintain current service levels.

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Average daily HD Kalaupapa patient load	19	19	19
Total Kalaupapa and Halemohalu patient hospital days	3,579	3,579	3,579
Total Kalaupapa homecare patient days	6,395	6,395	6,395
Total Hawaiian HD program outpatients	235	235	235
Total outpatient visits	3,740	3,740	3,740

CLINICIAN RECRUITMENT AND SERVICE

National Health Service Corps

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
NHSC Field BA	$40,941,000	$41,128,000	$24,695,000	-$16,246,000
NHSC Recruitment BA	$100,479,000	$100,797,000	$98,782,000	-$1,697,000
NHSC - Mandatory	---	$290,000,000	$295,000,000	+$295,000,000
Total NHSC	$141,420,000	$431,925,000	$418,477,000	+$277,057,000
Total FTE	121	194	174	+53
Ready Responders (non-add)	34	34	34	--

Authorizing Legislation: Sections 338A, B, and I of the Public Health Service Act, as amended by P.L. 111-148;

Section 10503(b)(2) of the Affordable Care Act (ACA), as amended by P.L. 111-148

FY 2012 Authorization……...$535,087,442
FY 2012 Authorization (ACA).....$295,000,000

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 that provide primary medical, oral, and mental and behavioral health care to approximately 11.2 million underserved people. Over its 40-year history, the NHSC has offered recruitment incentives, in the form of scholarship and loan repayment support, to more than 37,000 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 41 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 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 one to eight 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 09/30/10

Programs	**No.**
Scholarship Program clinicians	525
Loan Repayment Program clinicians	6,233
Ready Responders	30
State Loan Repayment clinicians	742
Total	**7,530**

Table 2. NHSC Field Strength by Discipline as of 09/30/10

Disciplines	**No.**
Allopathic/Osteopathic physicians	1,904
Dentists	882
Dental Hygienists	155
Nurse Practitioners	1,204
Physician Assistants	1,034
Nurse Midwives	186

Disciplines	**No.**
Mental and Behavioral Health professionals	2,165
Total	**7,530**

In FY 2010:

- The NHSC Jobs Opportunity List showed a total of 9,157 vacancies nationwide; of these, 4,705 (51 percent) were located in Health Centers.
- The NHSC Scholarship Program made 25 new awards.
- The NHSC Loan Repayment Program made 1,335 new awards – of these, 220 were made under the NHSC Half-Time Loan Repayment Pilot Project.

ARRA Funds:

- The NHSC Scholarship Program made 185 new awards in FY 2010.
- The NHSC Loan Repayment Program made 2,214 new awards in FY 2010.

In FY 2011:

- The NHSC Scholarship Program is projected to make no new awards, and will make 45 continuation contracts (formerly called amendments) for students initially funded through Base and ARRA.
- The NHSC consolidated the NHSC Half-Time Loan Repayment Pilot Project with the NHSC Loan Repayment Program which will offer both full-time and half-time contracts.
- The NHSC Loan Repayment Program is projected to make 735 new awards for full-time and half-time service, and will make 1,256 continuation contracts for clinicians initially funded through Base and ARRA.

ARRA Funds:

- The NHSC Scholarship Program is projected to make no new awards in FY 2011.
- The NHSC Loan Repayment Program is projected to make 1,000 new awards in FY 2011 for full-time and half-time service.

ACA Funds:

- The ACA provides $290,000,000 for the NHSC. These funds are projected to be distributed as follows:
- Field Line - $ 58.0 M
- Scholarships - $ 46.4 M = 230 Awards
- Loan Repayment - $ 175.6 M = 2,821 Awards for full-time and half-time service
- State LRP - $ 10.0 M = 285 Awards

These awards, in addition to awards made through the annual appropriation and remaining ARRA funds, will enable the NHSC to project an increase in its Field Strength in FY 2011 to 10,500 clinicians, who will provide primary care to approximately 11.0 million underserved people. The NHSC Field Strength is one of the Priority Goals that the administration will continue to track to monitor the achievement of results against performance targets in key areas.

In FY 2010 the NHSC placed more than 3,300 clinicians in sites with an average HPSA score of 12.0. The NHSC fell short of the target set for average HPSA score; however, this is due, in large part, to the 70 percent increase in the number of placements over the FY 2009 level (1,975 placements). (The HPSA score is a proxy for the degree of 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 History

FY	Amount
FY 2007	$125,673,000
FY 2008	$123,477,000
FY 2009	$134,966,000
FY 2009 Recovery Act	$300,000,000
FY 2010	$141,420,000
FY 2011 CR	$141,925,000
FY 2011 ACA	$290,000,000

Budget Request

The FY 2012 Discretionary Request of $123,477,000 is a reduction of $17,943,000 from the FY 2010 Actual Level. This request will fund 38 scholarship continuations, 149 new loan repayment awards and 2,093 loan repayment continuations. In addition, the Affordable Care Act has appropriated $295,000,000 for the NHSC in FY 2012, which will fund 216 new scholarships and 2,872 new loan repayment awards. The total appropriation for the NHSC in FY 2012 will be $418,477,000, which will result in an overall reduction of $13,448,000 from the FY 2011 Level and an increase of $277,057,000 from the FY 2010 level.

The Affordable Care Act raised the maximum annual award for the NHSC Loan Repayment Program from $35,000 per year to $50,000. Beginning in FY 2011, the NHSC began offering a maximum two-year award of $60,000 to new loan repayers and a maximum $40,000 for third and fourth year continuation to all current loan repayers who qualify. Also in FY 2011, the NHSC began offering to new loan repayers half-time loan repayment contracts with either a maximum four-year award of $60,000 or a minimum two-year award of $30,000. All current loan repayers who qualify will be offered half-time loan repayment continuations with a maximum of $20,000 for a one-year continuation.

The Affordable Care Act also enables the NHSC to offer half-time service to scholarship participants, which will be implemented in FY 2011. Additionally, all full-time NHSC participants will be able to fulfill the service commitment through teaching; up to 50 percent of the 40-hour week in a Teaching Health Center, and up to 20 percent in other facilities.

A programmatic decision was made in FY 2009 to increase funding of the State Loan Repayment Program (formerly 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 the number of new SLRP contracts more than makes up for the loss in the other NHSC programs. Beginning in FY 2011, SLRP will be administered by the Bureau of Clinician Recruitment and Service and will be funded through the Affordable Care Act 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 health care needs.

Funding in FY 2012 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 2012:

Budget Request

- The NHSC Scholarship Program is projected to make no new awards and will make 38 continuations to Base and ARRA-funded scholarships with the annual appropriation.
- The NHSC Loan Repayment Program is projected to make 149 new awards for full-time and half-time service and will make 2,093 continuations to Base and ARRA-funded loan repayors with the annual appropriation.
- The NHSC Field Strength is projected to be 10,683.

ACA Funds:

- The ACA provides $295,000,000 for the NHSC. These funds are projected to be distributed as follows:
- Field Line - $ 59.0 M
- Scholarships - $ 47.2 M = 216 Awards
- Loan Repayment - $ 178.8 M = 2,872 Awards for full-time and half-time service
- State LRP- $ 10.0 M = 285 Awards

These awards, in addition to awards made through annual appropriations and remaining ARRA funds, will enable the NHSC to project an increase in its Field Strength to 10,683 clinicians, who will provide primary medical, oral, and mental and behavioral health care to approximately 11.2 million underserved people.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
4.I.C.1: Number of individuals served through the placement and retention of NHSC clinicians. *(Outcome)*	FY 2010: 9.05 Million [1] (Target Exceeded)	8.56[1] Million	13.1[1,2] Million	+4.54 Million
4.1: Number of individuals served in all communities seeking NHSC assistance through NHSC placement, retention and other sources. *(Outcome)*[3]	FY 2010: 10 Million (Target Exceeded)	9.04 Million[1]	N/A	---
4.I.C.2: Field strength of the NHSC through scholarship and loan repayment agreements. *(Outcome)*	FY 2010: 7,530 [1] (Target Exceeded)	7,358[1]	10,683[1,2]	+3,325
4.I.C.4: Percentage of NHSC clinicians retained in service to the underserved. *(Outcome)*	FY 2009: 76% (Target Not Met)	76%	76%	Maintain
4.I.C.3: Number of NHSC-list vacancies filled through all sources. *(Output)*	FY 2010: 4,697[1] (Target Exceeded)	4,400	6,000[1,2]	+1,600
4.I.C.5: Average HPSA score of the sites receiving NHSC clinicians, as proxy for service to communities of greatest need. *(Output)*	FY 2010: 12.0 (Target Not Met)	13.0	12.0	Reduced
4.E.1: Default rate of NHSC Scholarship and Loan Repayment Program participants. *(Efficiency)* (Baseline: FY 2007 = 0.8%)	FY 2010: 0.0% (Target Not in Place)	< or = 2.0%	< or = 2.0%	Maintain

[1] Reflects ARRA funding.
[2] Reflects Affordable Care Act funding.
[3] This long-term measure does not have annual targets.

Loans/Scholarships Table

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Loans	$79,965,554	$97,800,000	$96,000,000
State Loans	$10,000,000	-	-
Scholarships	$8,532,238	$2,900,000	$2,700,000
ARRA Loans	$99,410,136	$56,000,000	-
ARRA State Loans	$10,000,000	-	-
ARRA Scholarships	$28,202,137	-	-
ACA Loans	-	$175,600,000	$178,800,000
ACA State Loans	-	$10,000,000	$10,000,000
ACA Scholarships	-	$46,400,000	$47,200,000

Waterfall Table

Table 3. Impact on NHSC Field Strength of FY 2012 Request Awards

Fiscal Year	2007	2008	2009	2010	2011	2012
AWARDS:						
Scholarship	118	76	88	25	-	-
Scholarship Continuation [4]	19	18	8	5	45	38
Federal Loan Repayment	899	867	949	1,335	735	149
Federal Loan Repayment Continuation [5]	648	668	705	701	1,256	2,093
State Loan Repayment	280	280	400	285	-	-
ARRA Scholarship	-	-	70	185	-	-
ARRA Federal Loan Repayment	-	-	829	2,214	1,000	-
ARRA State Loan Repayment	-	-	-	161	171	-
ACA Fund Scholarships	-	-	-	-	230	216
ACA Loans	-	-	-	-	2,821	2,872
ACA State Loan Repayment	-	-	-	-	285	285

[4] Includes ARRA-funded scholarship continuations.
[5] Includes 3rd and 4th year continuations of ARRA-funded loan repayers awarded in FY 2010 & FY 2009.

Table 4. Impact on NHSC Field Strength of FY 2012 Request

Fiscal Year	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
FIELD STRENGTH:						
Scholarship Obligors	633	598	582	523	505	389
Loan Repayers	2,535	2,451	2,597	3,201	3,067	2,971
State Loan Repayment	592	514	763	581	285	-
USPHS Commissioned Corps Ready Responders	57	37	37	30	30	30
Community Scholarship Clinicians	3	1	-	-	-	-
Base Field Strength (as of 9/30)	**3,820**	**3,601**	**3,979**	**4,335**	**3,887**	**3,390**
ARRA Loan Repayers			829	3,032	3,171	1,000
ARRA State Loan Repayment			-	161	332	-
ARRA Scholar Obligors			-	2	4	30
ARRA Field Strength	-	-	**829**	**3,195**	**3,507**	**1,030**
ACA Loan Repayment			-	-	2,821	5,693
ACA State Loan Repayment					285	570
ACA Field Strength	-	-	-	-	**3,106**	**6,263**
Total Field Strength	**3,820**	**3,601**	**4,808**	**7,530**	**10,500**	**10,683**
Placements:						
Grant	2,063	1,944	2,149	1,777	2,099	1,831
Non-Grant	1,757	1,657	1,830	2,558	1,788	1,559
ARRA Grant			448	1,310	1,894	556
ARRA Non-Grant			381	1,885	1,613	474
ACA Fund Grant	-	-	-	-	1,677	3,382
ACA Non-Grant	-	-	-	-	1,429	2,881

Waterfall Assumptions:

a. Starting FY 2011 - Funding Distribution: 20% Scholarship / 80% Loan Repayment for Affordable Care Act Fund
b. Starting FY 2011 - SLRP Funding - $10 million out of Affordable Care Act Fund.
c. Estimates 2010 and forward
d. FY 2011 & FY 2012 – Base Funding toward SP continuations and LRP new awards and continuations

Nursing Education Loan Repayment and Scholarship Programs

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$93,864,000	$93,864,000	$93,864,000	---
FTE	20	32	32	+12

Authorizing Legislation: Section 846 of the Public Health Service Act

FY 2012 Authorization ..... Expired

Allocation Method ..... Competitive 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 health care 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 health care 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 Affordable Care Act of 2010 amended the NELRP to extend loan repayment to nurse faculty, which is administered as part of NELRP. FY 2010 was the first year of the Nursing Education Loan Repayment Program for Nurse Faculty (NELRP-NF). The purpose of NELRP-NF is to assist in the recruitment and retention of nurse faculty at accredited schools of nursing by decreasing economic barriers that may be associated with pursuing a career in academic nursing.

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 health care 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 2010:

- NELRP made 1139 new loan repayment awards and 135 contract extensions.
- NSP made 458 scholarship awards and 18 continuation awards.
- The average new NELRP award was $46,905. The average NELRP continuation was $26,198.
- The average new NSP award was $57,149. The average NSP continuation was $24,152.

In FY 2011:

- NELRP expects to make 991 new loan repayment awards and 395 contract continuation.
- NSP expects to make 458 scholarship awards.

.

To contribute to program performance, NELRP will finalize the methodology for identifying Critical Shortage Facilities (CSPs) for nurses, in order to better target program resources to areas and facilities of greatest need. This new methodology is projected to be implemented in FY 2012.

Funding History

FY	**Amount**
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
FY 2011 CR	$ 93,864,000

Budget Request

The FY 2012 Discretionary Budget Request of $93,864,000 is equal to the FY 2010 Actual Level and would support 781 new loan repayment awards and 535 contract extensions, and 458 new scholarships and 30 continuations.

Between FY 2009 and FY 2010, funding for NELRP and NSP increased 253 percent to address the shortage of registered nurses. With steady-state funding from FY 2010 through 2012, the program has adjusted its human and budgetary resources to manage the large influx of students

and nurses in the program. The program continues its contracts, which 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 2012:

- NELRP expects to make 781 new loan repayment awards and 535 contract extensions.
- NSP expects to make 458 scholarship awards.

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 with a critical shortage of nurses will be a key output. With additional funds, the program allows more individuals to enter into the nursing field and in turn address the national shortage of nurses.

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.

Outputs and Outcomes Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
5.1: Increase the number of individuals enrolled in professional nursing education programs. [1] *(Outcomes)*	FY 2003 240,500 (Baseline)	N/A	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.

Loans/Scholarships Table

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Loans	$56,961,802	$62,456,119	$62,456,119
Scholarships	$26,609,074	$31,228,060	$31,228,060

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

Faculty Loan Repayment Program

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$1,266,000	$1,266,000	$1,266,000	---
FTE	---	---	---	---

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

FY 2012 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 OIG found in 2002 that institutions participating in the faculty loan repayment program frequently waive matching requirements, reducing the impact per Federal investment.

The Affordable Care Act included physician assistants as an eligible discipline for the FLRP program. In FY 2010, FLRP began accepting applications from physician assistants.

In FY 2010:

The FLRP program made 23 new loan repayment awards.

In FY 2011:

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

Funding History

FY	Amount
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
FY 2011 CR	$1,266,000

Budget Request

The FY 2012 Discretionary Request of $1,266,000 is equal to the FY 2010 Actual Level. 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 2010 Enacted	FY 2011 CR	FY 2012 Request
Loans	$1,086,195	$1,266,000	$1,266,000

HEALTH PROFESSIONS

The Bureau of Health Profession (BHPr) programs are designed to improve the health of the Nation's communities, especially vulnerable populations by supporting programs to improve the supply of physicians, nurses, dentists and other providers and to improve access to quality health care, including primary care, oral and mental health services. The Health Professions Programs award grants to health professions schools and training programs across the United States to develop, expand and enhance training and to improve the distribution of the health care workforce.

In addition, the Bureau of Health Professions provides a number of services including identification of geographic shortage designations, the development and analysis of important health workforce studies, and maintaining a list of unsafe health care practitioners.

Summary of Request

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$723,494,000	$725,324,000	$467,976,000	-$255,518,000
PHS Evaluation			$255,423,000	+255,423,000
Mandatory (ACA)	---	$230,000,000	---	---
Prevention/Public Health Fund	$265,400,000	---	$15,000,000	-$250,400,000
Total Program Level	$988,894,000	$955,324,000	$738,399,000	-250,495,000
FTE	24	52	29	+5

Authorizing Legislation: Title III, Title VII, and Title VIII of the Public Health Service Act as amended by the Affordable Care Act P.L. 111-148; The Affordable Care Act

Allocation Method .....Competitive Grants/Contracts

State of the Health Professions Workforce

Evidence shows that much of the United States health care delivery system is inefficient and costly, with inconsistent health outcomes. There are shortages in the health care workforce that are expected to worsen with the retirement of current providers, along with the increased needs of a growing and aging population. Access to health care services for rural and certain inner-city populations is an additional concern.

States are reporting health workforce deficiencies across many disciplines, especially for primary care physicians. As new models of care, new technologies and updated efficiencies are put into place as part of an evolving health care system, a well trained, strategically deployed workforce will be required to deliver services. This involves understanding and anticipating trends through data collection, analysis and dissemination, and preparation of the workforce pipeline to accommodate anticipated need.

Primary care revitalization is a key focus in the Affordable Care Act. A new emphasis on primary care is supported by ample research that the nation's over reliance on specialty care services at the expense of primary care leads to a health care system that is less efficient and more costly.[1] If the health care system is to meet a growing demand for health care, it will need to train and use an efficient mix of providers. The educational system needs to support a pipeline that efficiently deploys people with varied capabilities to work effectively in teams. No single discipline or health care provider can deliver a complete episode of health care. Ensuring the skill set and division of labor is optimally applied requires fully engaging each health care team member in collaborative models of coordinated care.

Primary Care Clinician Supply

Most leading authorities recognize there will be a shortage of primary care providers over the next decade, and depending on the models employed, there are varying estimates regarding the number and the appropriate ratio of the three professions that provide the vast majority of primary care visits: primary care physicians, nurse practitioners and physician assistants. HRSA is committed to working with states, academic institutions, professional organizations and other key stakeholders to address current and anticipated shortages of doctors, nurses, and other providers in the health professions workforce.

Although the physician shortages will affect the whole population, the most severe impact will be on the 20 percent of Americans who live in rural or inner-city locations designated as health professional shortage areas, since there are currently acute shortages and, unless trends are shifted, the shortages are likely to worsen.[2]

Enhanced funding for the National Health Service Corps will help fill vacancies in shortage areas. In addition, nurse practitioners (NP's) and physician assistants (PA's) play an important role as more NP's and PA's enter the workforce. In the recent growth of nurse-managed clinics and federally qualified community health centers, NP's and PAs have demonstrated flexibility as they practice independently or partner with physicians in both primary care and specialty areas. These shifts suggest that professionals' practice can be directed to changing workforce and population needs.

---

[1] U.S. Government Accountability Office (2008). *PRIMARY CARE PROFESSIONALS :Recent Supply Trends, Projections, and Valuation of Services*. Report #GAO-08-472T Available at: http://www.gao.gov/new.items/d08472t.pdf

[2] Health Resources and Services Administration (2009). Shortage designation: HPSA's, MUAs,& MUPs. Available at: http://bhpr.hrsa.gov/shortage/

Greater use of these providers has the potential to improve access, reduce expenditures, and change patterns of care.[3]

Within the primary care environment, direct patient care is also provided by registered nurses, pharmacists, nutritionists, social workers, and medical assistants. An adequate supply of these health professionals is needed to meet the future demand for primary care services.

Major Issues of Focus for BHPr in 2012

Given the demands on the health care system described above, the health professions workforce areas requiring the greatest attention to improve delivery of health care services include strategies that will:

1) increase capacity and distribution to improve primary care workforce supply through increased education and training opportunities;
2) develop new team-based models of care founded on interprofessional education and clinical training experiences;
3) reduce health disparities by increasing workforce diversity;
4) enhance geriatric/elder care training and expertise;
5) continue development of the National Center for Health Care Workforce Analysis to improve data collection to inform policy makers and other stakeholders on health workforce issues.

The Affordable Care Act directed BHPr to be a part of a national effort to increase the health care workforce supply and skill sets to improve access to care for a Nation with diverse and complex needs. Ensuring a diverse health care workforce requires stronger pipeline development. HRSA will strengthen the implementation of programs to encourage low income, rural, and minority students to pursue health careers. Strategies to address these priorities will lead to a re-shaping of BHPr programs to strengthen alignment and accountability.

Priority #1: Increase capacity and improve distribution to improve the primary care

Workforce supply through stronger education and training opportunities for quality and access

The FY 2012 Request initiates a sustained investment that will increase the primary care workforce by 4,000 providers over five years. The proposal to increase the number of primary care providers (including physicians, physician assistants, and nurse practitioners) was initiated in FY 2010 with funds from the Prevention and Public Health Fund. The FY 2012 Request proposes to implement new programs and to restructure and expand several existing ones to sustain the focus on increasing the number of, and improving access to primary health care providers. Strategies for increasing the number of primary care providers include:

[3] Naylor, M. (2006) Transitional Care: A Critical Dimension of the Home Healthcare Quality Agenda, Journal for Healthcare Quality National Association for Healthcare Quality Vol. 28, No. 1, pp. 20–28, 40

- strengthening Internal Medicine primary care residencies to help retain more physicians in primary care;
- funding community-based ambulatory care facilities to establish primary care residency programs;
- funding to expand clinical training capacity for physician assistants to increase enrollment capacity;
- supporting innovative curricular experiences in clinical medical education related to primary care for medical students;
- funding schools of nursing to educate additional primary care nurse practitioners by providing student stipends; and
- restructuring the Scholarships for Disadvantaged Students Program giving greater focus to primary care and underrepresented minorities.

Many BHPr programs focus on both capacity and workforce redistribution. There are other programs that will support this goal. The expansion of the Nurse Managed Health Clinics will increase the number of training sites available to train nurses and other primary care providers, and provide access to primary care for many people without health insurance. The Alternative Dental Health Demonstration Project will support States where oral health services are inadequate for underserved populations and communities. Key workforce programs that will help improve capacity and distribution are:

1) Primary Care Training and Enhancement
2) Oral Health Training Programs
3) Teaching Health Centers – Development & GME Payments
4) Nursing Workforce Development Programs
5) Mental and Behavioral Health
6) Nurse Managed Clinics
7) State Workforce Development Grants

Priority #2: Develop new team-based models of care founded on interprofessional training

In an effort to address the fragmented nature of health care services, innovative team care models are being proposed. The patient-centered medical home, the chronic care model, and shared medical appointments are approaches that require effective use of health care teams. While many agree that interprofessional team-based primary care offers the most effective model for delivering primary care, it has yet to diffuse into mainstream clinical practice. Changing care delivery, expectations for quality and safety, improved outcomes and improved patient satisfaction will require changes in educational curricula and clinical training to ensure that health professionals can work more effectively and efficiently within interprofessional teams.

Key BHPr programs have a long history of supporting interprofessional education and teamwork. For example, The Nurse Education, Practice, Quality and Retention Program supports interprofessional education. Title VII, Part D – Interdisciplinary Community-Based Linkages Programs including Area Health Education Centers and Geriatric

Education Programs, and title VII programs require interprofessional training be offered. Some of these authorities provide an existing infrastructure that is flexible while other authorities support innovative models to be developed.

The Division of Medicine and the Division of Nursing will collaborate by providing equal funding for an interprofessional training project. They will fund programs that offer primary care clinical training by both physician and nurse faculty using a team approach to care. Targeted trainees include primary care nurse practitioners and primary care residents (family medicine, general internal medicine or general pediatrics). This innovative approach will ensure that approximately 1000 primary care providers have interprofessional team training.

Other activities supporting interdisciplinary team training includes the 2010 All Advisory Meeting, building consensus across the four advisory committees, producing an interprofessional team-based competencies framework. This framework was used to leverage further conversations for the development of an initiative and collaborative that has engaged foundations, other federal agencies, and health care professional organizations to develop interprofessional team based competencies to be used in education and practice. This new collaborative is committed to educating and advancing interprofessional health care teams that are prepared to provide patient-centered care in new delivery system models that improve care coordination, quality and safety of care as well as affordability.

Priority #3: Reduce disparities in the workforce

Disparities in health and health care in the United States are persistent and well documented. Research demonstrates that health professionals who identify as racial/ethnic minorities are more likely to serve in areas of need. Increasing the diversity of health professions workforce is key to reducing health disparities due to socioeconomic, geographic, race, and ethnicity factors. A report by the IOM, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*[4] illustrates that patients of color receive a lower quality of care and are less likely to receive routine care. HRSA continues a strong focus on reducing disparities in the workforce. Increasing the training of all health professions about how to identify and address health care disparities and to increase the diversity among health professions are two key strategies being implemented. Key HRSA programs that BHPr administers to increase the diversity of the health workforce and increase health care workforce knowledge to address health disparities are:

1) Centers of Excellence
2) Scholarships for Disadvantaged Students
3) Health Careers Opportunities

[4] Institute of Medicine (2004). *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce. Available at: http://www.iom.edu/Reports/2004/In-the-Nations-Compelling-Interest-Ensuring-Diversity-in-the-Health-Care-Workforce.aspx*

4) Nursing Workforce Diversity Program
5) Area Health Education Centers (AHEC)

Priority #4: Focus on geriatric/elder care training and expertise including both professional and para-professional education

The health workforce is not sufficiently prepared to meet the growing specialized needs of an aging population. HRSA supports four programs whose primary goal is to improve access to quality health care for America's elderly by educating both students and current practitioners in the care of the geriatric patient. Sustained funding for these programs is critical to updating both students and practitioners with new knowledge that is rapidly increasing regarding this population. Geriatric programs emphasize interprofessional training as care for geriatric patients must be coordinated among a wide range of providers who address various needs. These programs address both supply and education of geriatric specialists as well as generalists.

This budget request also supports the implementation of two new programs that are focused on direct care providers, such as home aides. These programs are needed to ensure that the entire range of health care workers that provide care for the chronically ill and the nation's aging population are well-trained. While the concept of front line workers is not new, establishing core competencies and the curricula leading to their development is a critical step in strengthening the rigor of training of direct care workers. Key HRSA programs that will help BHPr increase the strength and quality of the geriatric workforce are:

1) Comprehensive Geriatric Education (for nurses)
2) Geriatric Education Centers Program
3) Geriatric Training for Physicians, Dentists, and Behavioral and Mental Health Professionals
4) Geriatric Academic Awards
5) Personal and Home Care Aide State Training (PHCAST) Program
6) Nursing Assistant and Home Health Aide (NAHAA) Program

Priority #5: Continue growth of the National Center for Health Care Workforce Analysis to improve data informing policy makers and other stakeholders on workforce issues

Assuring an adequate supply of appropriately prepared health workers in the future requires information on future workforce needs in order to guide public and private investments in health workforce education and training. This is particularly true for health professions that require significant educational commitments and require lengthy periods of education. States and localities, universities and colleges, the federal government and of course students invest enormous sums in health professions education. All require accurate information on needs and opportunities to make effective decisions. However, projecting future needs is difficult and requires good data and information. Currently, the United States lacks a cohesive comprehensive approach to assessing future workforce needs.

Health workforce planning in the United States is particularly difficult because we lack a system to collect standard data across states and professions. Historically, no structure has been in place to collect data and systematically assess future needs. The anticipating health workforce marketplace needs is challenging without better information and data.

Some of the activities the National Center coordinates and leads include:

- collaboration with States, State licensing boards, professional associations, and others to develop and promote guidelines for data collection and analysis.
- development of an interagency estimate of the supply, demand and need for primary care practitioners over the next decade;
- development of draft guidelines for a minimum data set (MDS) for health professions and technical assistance and guidance to states and professional associations on the use of the MDS; and,
- collaboration on federal inter-agency workforce data collection, data ware-housing, and data-sharing.

The National Center also works closely with the State Health Care Workforce Development grantees. Workforce decision making is a shared federal and state responsibility. The National Center will work closely with and share data and information to support effective state decision making.

Evaluation of FY 2012 Program Activities:

The Health Workforce Assessment Program is responsible for the development, maintenance, and collection of annual performance measures from BHPr grantees, as well as the conduct of longitudinal evaluations. The BHPr mission of enhancing the supply of quality trained health professionals is integral to increasing access to care for the nation's population and meeting health care needs. BHPr monitors progress towards meeting this mission through the use of a number of performance measures. Ongoing performance data collected by HRSA on its programs include: (a) the number of trainees and graduates in fields such as primary care, general and pediatric dentistry, nursing, and geriatrics, along with the number and percentage of those receiving clinical training in medically underserved areas; (b) the number and percentage of trainees who are underrepresented minority and disadvantaged students; and (c) the percentage of graduates and residents who are practicing in underserved areas 1 year following completion of their education.

Collection of this data is on-going. A few of the performance measures are included below. However, more specific data needs to be collected to better understand the effectiveness of the investments and value of the programs. The ability to show that students participating in our programs graduate and enter into, as well as, remain in practice for primary care and/or in underserved areas will be fundamental in determining long-term impact of the programs. HRSA is developing new measures to appropriately

assess performance and serve as the basis for longitudinal evaluations of program outcomes.

BHPr is building capacity to monitor the state of the health professions workforce and evaluate the Bureau's programs in achieving its mission. Given the recent expanded emphasis on BHPr programs to increase the quantity of providers, outcome-focused evaluation studies are planned to provide information on best practices and stronger data regarding program outcomes that will improve program management.

Program Accomplishments

The number of graduates and program completers of Titles VII and VIII programs who are underrepresented minorities has increased since 2007. With the increase in the number of underrepresented minorities, the percentage of underrepresented minorities and/or disadvantaged graduates remained at 53 percent for FY 2009. Trainees in Titles VII and VIII programs that train in medically underserved areas remains at 45 percent. The 54 percent target was not met due to the range of program priorities the grantees may establish in any given year. Programs which monitor students who have been out of the HRSA programs for one-year show a four percent increase in the health professions who enter practice in underserved areas. More details on program accomplishments are contained in the performance measures table below:

Funding History

FY	Amount
FY 2007	$302,081,000
FY 2008	$318,225,000
FY 2009	$354,332,000
FY 2009 Recovery Act	$170,813,000
FY 2010	$723,494,000
FY 2010 Prevention Fund	$265,400,000
FY 2011 CR	$725,324,000
FY 2011 Mandatory	$230,000,000

Budget Request

The FY 2012 Discretionary Request of $723,399,000 is a decrease of $95,000 below the FY 2010 Actual Level. The total request will provide support for the health professions programs that address key priority areas and aim to increase the quantity, quality, diversity and redistribution of the health care workforce that can meet the health care needs of the Nation.

Health Professions Programs by Funding Source

Program	FY 2012 Request	FY 2012 Funding Sources: Appropriation	Evaluation Fund	Prevention Fund	ACA
HEALTH PROFESSIONS:					
Health Professions Training for Diversity:					
Centers of Excellence	24,602	24,602			
Scholarships for Disadvantaged Students	60,000	52,921	7,079		
Health Careers Opportunity Program	22,133	22,133			
Health Professions Training for Diversity	**106,735**	**99,656**	**7,079**	**-**	**-**
Health Care Workforce Assessment	20,000		20,000		
Primary Care Training and Enhancement	139,932	53,018	86,914		
Primary Care Training and Enhancement Preventon Fund	-	-	-		
Subtotal, Primary Care Training and Enhancement	**139,932**	**53,018**	**86,914**	**-**	**-**
Oral Health Training Programs	49,928	35,419	14,509		
GME Payments for Teaching Health Centers	-	-	-		
State Grants for the Training of Personal & Home Health Aides	-	-	-		
Interdisciplinary, Community-Based Linkages:					
Area Health Education Centers	34,833	33,345	1,488		
Geriatric Programs	43,747	36,907	6,840		
Allied Health and Other Disciplines	-	-	-		
Mental and Behavioral Health	17,945	17,945	-		
Subtotal, Interdisciplinary, Community-Based Linkages	**96,525**	**88,197**	**8,328**	**-**	**-**
Public Health Workforce Development:					
Public Health/Preventive Medicine;	**10,068**	**-**	**10,068**		
Public Health/Preventive Medicine Prevention Fund	15,000	-		15,000	
Subtotal, Public Health/Prevention Medicine	**25,068**	**-**	**10,068**	**15,000**	**-**

Program	FY 2012 Request	FY 2012 Funding Sources Appropriation	Evaluation Fund	Prevention Fund	ACA
State Health Care Workforce Development Grants	51,000	51,000	-		
State Health Care Workforce Development Grants Prevention Fund	-				
Subtotal, State Health Care Workforce Development Grants	**51,000**	**51,000**	**-**	**-**	**-**
Subtotal, Public Health Workforce Development	**76,068**	**51,000**	**10,068**	**15,000**	**-**
Nursing Workforce Development:					
Advanced Education Nursing	104,438	64,438	40,000		
Advanced Education Nursing Prevention Fund	-				
Subtotal, Advanced Education Nursing	**104,438**	**64,438**	**40,000**	**-**	**-**
Nursing Workforce Diversity	20,000	16,107	3,893		
Nurse Education, Practice and Retention	59,773	40,141	19,632		
Nurse Faculty Loan Program	30,000		30,000		
Comprehensive Geriatric Education	5,000		5,000		
Nursing Managed Care	20,000	10,000	10,000		
Nurse Managed Health Centers Prevention Fund	-				
Subtotal Nursing Managed Care	**20,000**	**10,000**	**10,000**	**-**	**-**
Subtotal, Nursing Workforce Development	**239,211**	**130,686**	**108,525**	**-**	**-**
Patient Navigator Outreach & Chronic Disease Prevention	-	-	-		
Children's Hospitals Graduate Medical Education Program	-	-	-		
Teaching Health Centers	10,000	10,000			
Subtotal, Bureau of Health Professions	**738,399**	**467,976**	**255,423**	**15,000**	**-**
National Practitioner Data Bank (User Fees)	*28,016*	*28,016*	-		
Healthcare Integrity & Protection Data Bank (User Fees)	-	-	-		

Performance Measures

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
6.I.B.1: Proportion of graduates and program completers of Title VII and VIII supported programs who are underrepresented minorities and/or from disadvantaged backgrounds. [5] *(Outcome)*	FY 2009: 53% (Target Exceeded)	53%	55%	+2% points
6.I.C.1: Proportion of trainees in Title VII and VIII supported programs training in medically underserved communities. *(Outcome)*[1]	FY 2009: 45% (Target Not Met)	54%	45%	-9% points
6.I.C.2: Percentage of health professionals supported by the program who enter practice in underserved areas.[1,6] *(Outcome)*	FY 2008: 47% (Target Exceeded)	43%	47%	+4% points
6.E: Average cost per graduate or program completer to the program of providing pipeline, formative education, and training.	FY 2007: $379 (Target Exceeded)	$379	$379	Maintain

[5] Recovery Act Funds will impact total numbers, but will not change the proportions targeted for each measure.

[6] 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 with one-year post program graduation.

Need for Health Professions Diversity Programs

Increasing the number of minority health professionals is a key strategy to eliminating health disparities. The Health Resources and Services Administration (HRSA) defines health disparities as "population-specific differences in the presence of disease, health outcomes, or access to health care."[7]

In the U.S., health disparities are well documented in racial and ethnic minority populations such as African Americans, Native Americans/Alaska Natives, Asian Americans, Native Hawaiians and other Pacific Islanders, and Hispanics/Latinos. For example, the cancer incidence rate among African Americans is 10 percent higher than among Caucasians. When compared to whites, the minority populations have less access to health care, receive lower-quality health care, and experience higher rates of chronic diseases, higher mortality, and poorer health outcomes. Minority health professionals are more likely to serve in areas with a high proportion of underrepresented racial and ethnic groups and uninsured and to practice in or near designated health care shortage areas.[8]

Underrepresented minorities (URMs) comprise more than 25 percent of the U.S. population and are projected by the Census Bureau to increase to 39 percent by 2050. However, URMs account for only approximately 10 percent of the physician workforce, 7 percent of the nursing professions, 7 percent of dentistry, and 7 percent of psychology health professions[9]. The disaggregated URM data reveal further disparities. In 2008, African Americans represented 12 percent of the U.S. population, but only 3.5 percent of U.S. physicians. Similarly, Hispanics/Latinos made up 15 percent of the U.S. population, yet comprised 4.9 percent of the physicians.[10] The number of African American, Hispanic, and Native American students in dental schools remains disproportionately low compared to their numbers in the U.S. population.

Diversity in the health workforce also strengthens cultural competence throughout the health care system. Cultural and linguistic competencies profoundly influence how health professionals deliver quality health care. Community coalitions for diversity and Federal Advisory Committee reports have supported the need for increased numbers of URMs 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, 2004 and 6th Annual Report, 2006) have made recommendations to improve racial and ethnic minorities in the

[7] U.S. Department of Health and Human Services, 2006; *In the Nation's Compelling Interest: Ensuring Diversity in the Health Professions*, Institute of Medicine, 2004.
[8] Missing Persons: Minorities in the Health Professions, A Report of the Sullivan Commission on Diversity in the Healthcare Workforce, 2004; National Partnership for Action: Changing Outcomes-Achieving Health Equity, Chapter Two, DHHS, 2010:31-92
[9] George Washington University Policy. Update July 2008
[10] U.S. Department of Health and Human Services, 2006; *In the Nation's Compelling Interest: Ensuring Diversity in the Health Professions*, Institute of Medicine, 2004.

health professions. These reports support the need to increase the number of URMs in health professions schools as well as promote cultural and linguistic competence in the health professions.

Bureau of Health Professions Programs, whose main focus is on diversity, include the Centers of Excellence (COE) Program, Scholarships for Disadvantaged Students, and the Health Careers Opportunities Program. Detailed information on these three programs will follow. Additionally, diversity is a primary focus in the Nursing Workforce Diversity Program, discussed under the Nursing Workforce Development Section. This program provides disadvantaged individuals and URMs, interested in nursing or nurses interested in advancing their education, with stipends and scholarships.

Health Professions Training for Diversity

Centers of Excellence

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$24,550,000	$24,602,000	$24,602,000	+$52,000
FTE	--	--	--	--

Authorizing Legislation: Section 736 of the Public Health Service Act, as amended by the Affordable Care Act

FY 2012 Authorization $50,000,000

Allocation Method .....Competitive Grant/Contract

Program Description: The Centers of Excellence (COE) program supports activities to develop an educational pipeline to enhance academic performance of underrepresented minority (URM) students, support URM faculty development, and facilitate research on URM health issues.

Need: Please see previous section titled "Need for Health Professions Diversity Programs"

Goal: To recruit, train, and retain URM students and faculty to increase the supply and quality of URMs in the health professions workforce

Eligible Entities: Health professions schools and other public and nonprofit health or educational entities that operate programs of excellence for URM individuals and meet the required general conditions regarding: (a) COEs at certain Historically Black Colleges and Universities, (b) Hispanic COEs, (c) Native American COEs, and d) Other COEs.

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Allopathic medicine • Osteopathic medicine • Pharmacy • Dentistry • Graduate programs in behavioral or mental health • Allied Health	• Undergraduate • Graduate • Faculty development	• Create large competitive applicant pool through linkages and establish an education pipeline for health professions careers • Develop academic enhancement programs for URMs • Train, recruit and retain URM faculty • Improve information resources, clinical education and curricula relating to URMs • Facilitate opportunities for faculty and student research on URMs • Train students at community-based health centers targeting URMs • Provide stipends and fellowships

Program Accomplishments: In FY 2010, a total of 18 grants were awarded, which includes four new awardees. In Academic Year 2009-2010, 14 COE grantees provided academic enrichment training to 3,218 URM students in health professions programs and 276 URM faculty. The Affordable Care Act expanded the formula for allocation of funding by identifying how appropriations would be allocated among the different types of minority serving institution.

Funding History

FY	Amount
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	$24,550,000
FY 2011 CR	$24,602,000

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.

[1] Regular Appropriation Only

Budget Request

The FY 2012 Discretionary Request of $24,602,000 is an increase of $52,000 above the FY 2010 Actual Level. The total request will support competitive grants and will continue to provide support to the designated health professions schools to facilitate faculty and student research on health issues particularly affecting URM groups, strengthen programs to enhance the academic performance of URM students attending the school, and promote faculty development in diversity and cultural competence.

Outcomes and Outputs Table

Outputs	Most Recent Result[2]	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Number of projects	14	18	18	---
Number of URM students participating in research on minority health issues	446	573	573	---
Number of URM faculty participating in research on minority health issues	268	345	345	---

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	18	18	18
Average Award	$1,313,322	$1,313,322	$1,313,322
Range of Awards	$404,706 - $4,797,277	$404,706 - $4,797,277	$404,706 - $4,797,277

[2] Most Recent Results Academic Year 2009-2010

Health Professions Training for Diversity

Scholarships for Disadvantaged Students

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$49,236,000	$49,342,000	$52,921,000	+$3,685,000
PHS Evaluation			$7,079,000	+$7,079,000
Total Program Level	$49,236,000	$49,342,000	$60,000,000	+$10,764,000
FTE	--	--	--	--

Authorizing Legislation: Section 737 of the Public Health Service Act, as amended by the Affordable Care Act

FY 2012 Authorization ..... Unspecified

Allocation Method .....Formula Grant

Program Description: The purpose of the Scholarships for Disadvantaged Students (SDS) 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).

Need: Please see previous section titled "Need for Health Professions Diversity Programs

Goal: The SDS program has three key goals: 1) increasing enrollment and retention of URMs, 2) increasing the number of graduates practicing in primary care, and 3) increasing the number of graduates working in medically underserved communities.

Eligible Entities: All accredited health professions schools with degree programs including Allied Health, Medicine, Nursing and Behavioral and Mental Health.

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Allied Health • Behavioral and Mental Health • Chiropractic • Dentistry • Medicine • Nursing • Optometry • Osteopathic Medicine • Pharmacy • Physician Assistants • Podiatric Medicine • Public Health • Veterinary medicine	• Undergraduate • Graduate	• Provides student scholarships through educational institutions

Program Accomplishments: In 2010, 50 percent of health professions graduates who had received SDS funding entered service into medically underserved communities, five times the national average. Additionally, 54 percent of students receiving SDS support were URM.

Affordable Care Act: The Affordable Care Act expanded the formula for allocation of funding by identifying how appropriations would be allocated among the different types of minority serving institution.

Funding History

FY	Amount
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	$49,236,000
FY 2011 CR	$49,342,000

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

Budget Request

The FY 2012 Discretionary Request of $60,000,000 is an increase of $10,764,000 above the FY 2010 Actual Level. In FY 2012, HRSA will reform the program to make grant awards through a competitive process instead of using a formula to distribute grant award

[1]Regular Appropriations Only

amounts. The current formula allocation results in many students receiving small scholarship amounts relative to their tuition and other costs. This new approach will provide full scholarships to students to ensure they complete their education and enter the workforce as primary care providers. Using a competitive process will allow for a greater focus on key program priorities: 1) to increase the enrollment and retention of disadvantaged and URM students to enhance diversity within the health care workforce; 2) to augment the number of these students who become primary care providers; and 3) to raise the number of providers who go on to work in underserved areas. A competitive grant process will create a stronger incentive and accountability structure to ensure that funded programs achieve their intended goals.

Outcomes and Outputs Tables

Outputs	Most Recent Result[2]	FY 2010 Target	FY 2012 Target[3]	FY 2012 +/- FY 2010
Number of disadvantaged students	18,408	18,000	2,000	-16,000
Number of URM students	10,006	11,200	1,300	-9,900
Percent of students who are URM	54%	62%	65%	+3%

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	308	350	390
Average Award	$160,201	$140,977	$150,000
Range of Awards	$1,000 –$ 650,000	$1,000 – $650,000	$30,000-$650,000

[2] Most Recent Result: Academic Year 2009-2010

[3] Estimates will change depending on the specific program reforms that are implemented. In general, it is assumed that individual students will receive significantly higher support approximating average tuition for primary care training ($30,000) as compared to current average of approximately $2,500 per student.

Health Professions Training for Diversity

Health Careers Opportunity Program

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$22,086,000	$22,133,000	$22,133,000	+$47,000
FTE	--	--	--	--

Authorizing Legislation: Section 739 of the Public Health Service Act, as amended by the Affordable Care Act

FY 2012 Authorization ..... Unspecified

Funding Allocation .....Competitive Grant

Program Description: This program supports services for K through 12th grade, baccalaureate and post-baccalaureate students to improve the recruitment of students from disadvantaged backgrounds into the health professions.

Need: Please see previous section titled "Need for Health Professions Diversity Programs

Goal: To increase the diversity of the health care workforce

Eligible Entities: Accredited health professions schools and other public and nonprofit health or educational institutions

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Allied health • Behavioral and mental health • Chiropractic • Allopathic medicine • Optometry • Osteopathic medicine • Pharmacy • Physician assistants • Public health • Dentistry • Veterinary medicine	• Elementary school • Middle school • High school • Undergraduate • Graduate	• Recruit individuals from disadvantaged backgrounds for academic enhancement • Facilitate entrance to health profession school • Publicize information on financial aid • Provides stipends and scholarship • Provides training at community-based primary health service sites

Program Accomplishments: In Academic Year 2009-2010, there were 8,912 participants in the formative education and pre-professional training activities. In addition, 8,843 URMs participated in structured and unstructured programs.

Funding History

FY	Amount
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	$22,086,000
FY 2011 CR	$22,133,000

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.

Budget Request

The FY 2012 Discretionary Request of $22,133,000 is an increase of $47,000 above the FY 2010 Actual Level. The total request will support grant awards to afford individuals from disadvantaged backgrounds the opportunity to be exposed to and pursue careers in the health professions effecting increased access to health care to underserved populations.

Outcomes and Outputs Tables

Outputs	Most Recent Result [2]	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Number of disadvantaged students in structured programs:	5,753	6,328	6,328	--
Post-secondary	1,823	2,005	2,005	--
Secondary education	2,720	2,992	2,992	--
Number of grants	30	33	33	--

[1] Regular Appropriation Only
[2] Most recent result: Academic Year 2009-2010

Grant Awards Table
Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	33	33	33
Average Award	$640,318	$640,318	$640,318
Range of Awards	$199,271–$1,516,342	$199,271– $1,516,342	$199,271–$1,516,342

Health Care Workforce Assessment

The National Center for Health Workforce Analysis

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$2,826,000	$2,832,000	---	-$2,826,000
PHS Evaluation	---	---	$20,000,000	+$20,000,000
Total Program Level	$2,826,000	$2,832,000	$20,000,000	+$17,174,000
FTE	--	7	7	+7

Authorizing Legislation: Sections 761, 792, and 806(f) of the Public Health Service Act, as amended by the Affordable Care Act

FY 2012 Authorization ..... (see below)
National Center for Health Care Workforce Analysis $7,500,000
State and Regional Centers $4,500,000
Increase in Grants for Longitudinal Evaluations ..... Such Sums as Necessary

Allocation Method…….…… Contract

Program Description: The National Center was established to collect and analyze health workforce data and information in order to provide National and State policy makers and the private sector with information on health workforce supply, demand and needs. The National Center also evaluates workforce policies and programs as to their effectiveness in addressing workforce issues.

Need: Producing a workforce of sufficient size and skills to meet the Nation's health care needs requires better data and information than is currently available. The Nation spends billions of dollars each year on the education and training of the health workforce, yet basic data on workforce supply and demand does not exist. Effective decision making at the State and Federal level requires far better information on the current workforce and estimates of future needs.

Goal: The National Center will provide data and information to inform public policies and programs as well as private sector investments related to the health workforce. This data will provide ongoing supply and distribution trends of the U.S. health professions workforce to assure access to high quality, efficient care for the Nation.

Program Activities: In order to provide the Nation with the necessary data and information, the National Center will:

- Build National Capacity for Health Workforce Data Collection - The National Center will work with States, professional associations, and others to develop and promote guidelines for data collection and analysis.
- Develop Data Management, Data Analysis, Modeling and Projections - A comprehensive database on health professionals will be established to support analysis and decision making regarding the supply, demand and distribution of the health workforce as well as evaluation of the effectiveness of workforce programs and policies. The authorizing legislation makes clear the expectation that longitudinal evaluation include the analysis of practice patterns and reports on data from large sets of performance measures which requires that the National Center have modeling and projection capabilities.
- Build Health Workforce Research Capacity - There are significant gaps in our knowledge that limit our ability to accurately project future supply and demand. The Center will oversee and promote research that inform workforce projections. The research agenda will be developed in consultation with key stakeholders including others at Health Resources and Services Administration (HRSA), the Bureau of Health Professions (BHPr) advisory committees, such as the Council on Graduate Medical Education, additional Federal agencies and other interested parties.
- Respond to Information and Data Needs - The Center will respond to inquiries as to the current supply and future needs for health workers. The Center will translate data and findings into useful information to inform policies and programs. This will include evaluation of the performance of programs authorized in Titles VII and VIII of the Public Health Service (PHS) Act. Performance measures and guidelines for longitudinal evaluations of Title VII programs will be reviewed and adopted by the relevant BHPr's Advisory Committees as required by the Affordable Care Act's reauthorization of Title VII programs.
- Inform the Nation through Reports and Timely Dissemination - The Affordable Care Act specifically requires that the National Center develop and publish program performance measures, establish, maintain, and publicize a national internet registry, as well as collaborate and share data. Because so many key workforce investment and policy decisions are made by States and the private sector, dissemination of timely and accurate data is vital. The National Center will develop reports as well as web based systems that facilitate access to this data.

Program Accomplishments:

- The National Center for Health Workforce Analysis was established in 2010.
- Released comprehensive report on the results of the 2008 National Sample Survey of Registered Nurses (NSSRN)
- Reviewed data available within the Federal government to support health workforce analysis and developed a plan for capitalizing on national data bases

Funding History

FY	Amount
FY 2007	---
FY 2008	---
FY 2009	---
FY 2010	$2,826,000
FY 2011 CR	$2,832,000

Budget Request

The FY 2012 Discretionary Request of $20,000,000 in the PHS Evaluation Funds is an increase of $17,174,000 above the FY 2010 Actual Level. This funding will be used for the following products and outcomes:

- **Increase the use of the minimum data set** to allow for tracking of health workforce trends and comparisons across professions and States. In some cases, funding would be used to support State and professional association data collection efforts consistent with the Minimum Data Set.
- **Purchase data** from more national associations and States to build a national health professions database. This allows HRSA to track workforce supply and distribution as well as assess the outcomes of publically supported programs.
- **Increase research and analysis:** allows for an early analysis of key factors influencing future supply and demand, such as retirement patterns and the impact of changes in organization and financing.

With the expanded database and the increased understanding of the impact of factors influencing the workforce, the National Center will be in position to make more accurate projections of the supply and demand for health workers in the future and produce new projections to help identify priority needs.

Primary Care Training and Enhancement Program

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$38,923,000	$39,275,000	$53,018,000	+$14,095,000
PHS Evaluation			$86,914,000	+$86,914,000
Prevention and Public Health Fund	$198,122,000	---	---	-$198,122,000
Total Program Level	$237,045,000	$39,275,000	$139,932,000	-$97,113,000
FTE	2	7	7	+5

Authorizing Legislation: Section 747 of the Public Health Service Act, as amended by the Affordable Care Act

FY 2012 Authorization .....Such Sums as Necessary

Allocation Method .....Competitive Grant/Contract

Program Description: The purpose of this program is to support and develop primary care physician and physician assistant training programs.

Need: It has been shown, both nationally and internationally, that high quality accessible primary care improves health care outcomes and reduces costs, with improved satisfaction for both recipients and providers of the care. Recent decades have seen a decline in primary care in the United States, which many believe has contributed to poorer health outcomes, including decreased longevity and infant mortality, compared to other nations which have invested in primary care.

Although the 2010 residency match rate for primary care increased slightly, there has been a recent significant net loss of primary care training positions. While subspecialty training positions grew between 1998 and 2008, family medicine lost 46 programs (390 positions) and general internal medicine primary care positions declined by more than half. Additionally, nearly 900 general internal medicine faculty positions were lost.

Current estimates predict that fewer than 25 percent of graduating U.S. medical students will enter primary care fields, even though there is a projected need for almost half of all medical school graduates to provide critical primary care services. Physician assistants have also migrated to specialty care, leaving primary care in similar proportions as physicians.

Equally important to the supply issue is the persistent geographic mal-distribution of primary care physicians. Even as the physician supply grows, new physicians tend to

practice in areas where the supply is already high,[1] as opposed to rural and inner city areas where need is great and some health outcomes are poorer than national averages.

In a reformed health care system, care will be provided by teams which will vary depending on patient care needs, the region, the institution, and a multiplicity of other factors. New care models will utilize technologies to communicate across a variety of settings among a variety of professionals all focused on improving patient outcomes and patient satisfaction. The knowledge, attitude and skills required to deliver interprofessional team-based coordinated care have yet to be consistently delineated, defined, or incorporated into curricula and clinical practice. There is much work to do to prepare future practitioners to succeed in a modern delivery system.

Goal: The Primary Care Training Enhancemnt (PCTE) Program deploys its resources to strengthen and support the quality and quantity of primary care trainees in order to improve the quantity, quality, distribution and diversity of the workforce.

Eligible Entities: Health professions training institutions

Designated Health Professions:	**Targeted Educational Levels:**	**Program Activities:**
• **Physicians:** - Family medicine - General internal medicine - General pediatrics - Combined internal medicine and pediatrics (Med-Peds) • Physician assistants	• Residency Training • Medical school • Masters level • Faculty Development	• Primary care curricular enhancement • Community based residency training • Primary care faculty development • Physician Assistant curricular enhancement • Primary Care Academic Administrative Unit support and enhancement • Support innovations in primary care curricular development, education, and practice • Support primary care physician GME positions and Physician Assistant stipends

Program Accomplishments: To expand enrollment and produce more primary care providers, resources from the Prevention and Public Health Fund, established in the Affordable Care Act, supported two programs, the Primary Care Residency Expansion (PCRE) Program and the Expansion of Physician Assistant Training (EPAT) Program in FY 2010. Studies[2,3,4] of The Public Health Service Act, Section 747 program which supports primary care physician and physician assistant training and enhancement show a correlation between program grantees and intended workforce outcomes, including

[1] Goodman, David. *Twenty-Year Trends in Regional Variations in U.S. Physician Workforce*, Health Affairs (October 7, 2004).
[2] Academic Medicine (November, 2008) . History of the Title VII Section 747Grant Programs, 1963-2008 and their impact, Vol. 83, No.11.
[3] Meyers D, Fryer GE, Krol D, Phillips RL, Green LA, Dovey SM. Title VII funding is associated with more family physicians and more physicians serving the underserved. Am Fam Physician 2002;66:554.
[4] Rittenhouse DR, Fryer GE, Phillips RL, Miyoshi T, Nielsen C, Goodman DC, Grumbach K Impact of Title VII Training Programs on Community Health Center Staffing and the National Health Service Corp Participation, Annals of Family Medicine. 2008;(6)5: 397-405

higher percentage entrance into primary care training, and post training practice in rural areas and in community health centers.

In FY 2011, PCRE and EPAT grantees will expand their class sizes by adding 177 residents and 140 physician assistant students, respectively. This investment will result in an additional 500 primary care physicians and an additional 600 physician assistants by FY 2015.

Discipline	FY 2010 Actual	FY 2010 Prevention and Public Health Fund	FY 2011 CR	FY 2012 Request
Physician Training	$33,084,000	$165,942,000	33,384,000	118,942,000
Physician Assistant	$5,839,000	$32,180,000	$5,891,000	$20,990,000

Affordable Care Act: Previously grant support targeted specific domains, including pre-doctoral education, residency training, and faculty development. The Affordable Care Act provides opportunities for awards that encompass multiple domains. New grantees will be able to leverage resources to create programs that address a variety of phases of health professionals' development, specifically targeting and supporting students through the pipeline to become primary care providers.

Funding History

FY	Amount
FY 2007	$ 38,851,000
FY 2008	$ 37,998,000
FY 2009	$ 38,425,000
FY 2009 Recovery Act	$ 40,800,000
FY 2010	$ 38,923,000
FY 2010 Prevention Fund	$198.122.000
FY 2011 CR	$ 39,275,000

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.

Budget Request

The FY 2012 Discretionary Request of $139,932,000 is an increase of $101,009,000 above the FY 2010 Actual Level. The request will support both new and continuation awards to eligible primary care physician and physician assistant programs. The Affordable Care Act requires funded grantees be supported for five years (three years under prior statute) which represents a longer investment commitment.

This budget request supports several initiatives to strengthen primary care and support innovation in primary care delivery. Three activities proposed to begin in 2012 focus on producing primary care providers. These investments when sustained over five years will produce an additional 2,500 physicians and physician assistants. These sustained investments will also produce 100 primary care providers through Teaching Health Center Development Grants.

Physician Assistant (PA): clinical education enhancement--This program will support the enhancement of clinical training infrastructure in order to expand and improve clinical teaching capacity in approximately 65 physician assistant programs.

Medical School: at entrance into clinical medical school education pipeline--This program would focus on third and fourth year clinical experiences. Support would be provided to schools to develop innovative curricular experiences, including faculty development, communication skill improvement, mentoring, and service learning to pre-clinical and clinical medical students. Focused on family medicine clinical medical education opportunities in high quality, programs providing primary care will be expanded. One hundred grants will be awarded.

Primary Care Residency Training: at entrance into primary care residence--This program's goal is to retain internal medicine residents in primary care practice, instead of entering specialty training and increase the number of primary care providers being trained. Grantees will implement improved community education opportunities, service learning, population health, innovative clinical models, faculty development and mentoring. Approximately 80 grants will be made.

Another initiative will focus on developing interprofessional clinical teaching models in primary care. Interdisciplinary team-based primary care offers an effective model for delivering primary care. Establishing team-based primary care as the future practice norm will require inter-professional team-based clinical training. This program will fund clinical education that offers primary care clinical training provided by both physician and nurse faculty using a team approach to care. The program will focus principally on primary care nurse practitioners and primary care residents. This initiative will be supported by both the Primary Care Training Enhancement Program and the Advanced Nursing Education Program for a total of $15 million dollars to be shared by both programs.

Pre-Medical Education: Innovations in medical education and faculty development
The Budget Request also supports innovative approaches to expanding and enhancing primary care by enhancing pre-clinical medical education. Appropriated funds will be used to support a program to enhance and shorten the pre-medical training period by one year (from four years to three years). Decreasing the pre-clinical pipeline from four years to three years would be accomplished by decreasing required science courses and encouraging completion of the bachelor degree in shorter time period including advanced college credit in high school. This could reduce student debt, cited as one of the prominent reasons students may not enter primary care as a profession.

Outputs and Outcomes Tables

The following outcomes table contains both the traditional measures for PCTE awards and new measures for the PCRE and EPAT initiatives. In the past, funding has supported curricular innovations and academic infrastructure; the measures reflect these aims and include, for example, the number of students receiving training in underserved settings. As PCTE awards are restructured to provide a greater recognition of the importance of the multi-year primary care training pipeline and greater accountability for the production of primary care providers, some of these current outcome measures for PCTE will be revised and re-formulated and new measures added. However, results for these measures may not be immediately available since it takes a number of years for students in the pipeline to complete their training and begin practicing primary care.

Outputs	Most Recent Result[5]	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Number of primary care physicians and physicians assistants whose training or stipend is primarily funded by Prevention and Public Health Fund (cumulative)				
Primary Care Residency Expansion (PCRE)	--	177	532	+355
Physician Assistant Expansion (EPAT)	--	140	447	+307
Number of primary care physicians and physician assistants with some portion or aspect of their training funded by PCTE	30,253	30,255	108,720	+78,465
Percent receiving at least a portion of their clinical training in an underserved area	63%	63%	63%	Maintain
Number of physician and physician assistant graduates in 2009-2010	1,096	1,000	3,900	+2,900
Percent of physician and physician assistant graduates who practice in medically underserved areas	47%	47%	47%	Maintain
Number of graduates and program completers	7,611	7,600	27,000	+19,400
Percent of graduates and program completers who are minority and/or from disadvantaged backgrounds	27%	27%	27%	Maintain

Grant Awards Table – Physician Training Grants[6]

Size of Awards (whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	190	190	825
Average Award	$169,000	$169,000	$169,000
Range of Awards	$24,000- $450,000	$24,000-$450,000	$24,000-$450,000

Grant Awards Table – Physician Assistant

Size of Awards (whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	20	32	115
Average Award	$181,901	$182,000	$182,000
Range of Awards	$63,893 - $235,970	$63,893-$235,970	$63,893-$235,970

[5] Most recent result: Academic Year 2009-2010

[6] Some of the grants may have more than one discipline funded within a single award.

Oral Health Training Programs

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$32,920,000	$32,982,000	$35,419,000	+$2,499,000
PHS Evaluation	---	---	$14,509,000	+14,509,000
Total Program Level	$32,920,000	$32,982,000	$49,928,000	+17,008,000

Authorizing Legislation: Section 748, 340G, and 340G-1 of the Public Health Service Act

FY 2012 Authorization:……Such Sums as Necessary

Allocation Method: ……Competitive Grants/Contracts

Program Description: The Oral Health Training Programs include Training in General Dentistry, Pediatric Dentistry, Public Health Dentistry, Dental Hygiene, State Oral Health Workforce, and Alternative Dental Health Care Provider Demonstration Project programs. Each of these programs is designed to increase access to dental health services by increasing the number of oral health care providers and improving the training programs for oral health care providers.

Need: Oral health is an essential component of overall health status, and poor oral health and untreated oral diseases and conditions can have significant impacts on quality of life. Currently, about 108 million people in the U.S. have no dental insurance. Access to oral health services is a problem for many segments of the U.S. population and is typically related to geography and mal-distribution of providers, insurance status, socio-demographic characteristics, and low income levels. The U.S. has 4,230 Dental Health Professional Shortage Areas with approximately 49 million people living in them. Dental school faculty and practicing dentists are quickly nearing retirement age and will leave the workforce, yet the oral and general overall health needs of the population are growing. With the oral health care needs of this growing population increasing, production of dentists are just not keeping pace. It is estimated that by the year 2014, the number of dentists reaching retirement age will outpace the number of new dentists entering the workforce. Additional challenges to improving access to oral health services include the lack of coordination and integration of oral health, public health, and medical health care systems.

Discipline	FY 2010 Appropriation	FY 2011 CR	FY 2012 Request
Training in General Dentistry, Pediatric Dentistry and Public Health Dentistry and Dental Hygiene	$15,457,000	$15,482,000	$25,000,000
State Oral Health Workforce	$17,463,000	$17,500,000	$20,000,000
Alternative Dental Demonstration Projects	---	---	$4,928,000

Training in General, Pediatric, Public Health Dentistry and Dental Hygiene Program

Goal: To increase the number of dental students, residents, practicing dentists and dental hygienists.

Eligible Entities: Schools of dentistry, public or non-profit private hospitals, and public or non-profit private entities determined eligible by the Secretary.

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• General Dentists • Pediatric Dentists • Public Health Dentistry • Dental Hygienists	• Dental Hygiene Training Programs • Undergraduate • Graduate School (dental schools) • Pre- and Post-Doctoral • Residency Programs	• Grantees provide financial assistance to dental students, residents, practicing dentists, and dental hygiene students who are in need, who are participants in any such program, and who plan to work in the practice of general, pediatric, or public health dentistry, or dental hygiene. • Traineeships and fellowships are provided to dentists who plan to teach or are teaching in general, pediatric, or public health dentistry. • Loan repayment for faculty in the dental programs when individuals agree to serve full-time as faculty members in exchange for repayment of outstanding student loans.

Affordable Care Act: Through the Affordable Care Act, this program was recently expanded to include the training of dental students, practicing dentists, public health dentists, and dental hygienists. The Affordable Care Act expansion also provides for the funding of a dental loan repayment program, which supports full-time faculty members.

Program Accomplishments: In 2009, there were 35 active grants in the Residency Training in General and Pediatric Dentistry and in the Dental Public Health Residency programs that trained 534 residents. In 2010, the Affordable Care Act allowed for the awarding of 70 grants to fund trainees in the various oral health disciplines.

State Oral Health Workforce Grant Program

Goal: The purpose of the program is to help States develop and implement innovative programs to address the dental workforce needs of designated dental health professional shortage areas (Dental HPSAs) in a manner that is appropriate to the State's individual needs. States may receive funding to conduct 13 different activities described in the legislation for the program.

Eligible Entities: Eligible applicants include Governor-appointed, State governmental entities.

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Dentistry	• N/A	• Loan forgiveness and repayment programs for dentists • Dental recruitment and retention efforts • Grants and low-interest or no-interest loans • The establishment or expansion of dental residency programs • Expand or establish oral health services and facilities for children with special needs • Placement and support of dental trainees • Continuing dental education • Practice support through tele-dentistry • Community-based prevention services • Programs that promote children going into oral health or science professions • Faculty recruitment programs at accredited dental training institutions • The development of a State dental officer position or the augmentation of a State dental office • Other activities deemed appropriate by the Secretary

Program Accomplishments: A detailed evaluation of the programs' first two funding cycles is currently nearing completion and will be included in a Report to Congress, expected to be submitted in early 2011.

In 2008, 16 States were awarded one-year "planning" grants to assist the States with developing Strategic Oral Health Plans. The greatest priority areas identified in these 16 strategic plans were: 1) community-based prevention, 2) distribution of the oral health workforce, and 3) recruitment and retention of oral health providers.

Currently, there are a total of 34 active grants that were awarded in both the 2009 and 2010 cycles. While these grants focus on many of the activities outlined in the legislation, the more prevalent activities undertaken were projects associated with community-based prevention, placement and support of dental trainees in shortage areas, and continuing education for dental professionals. As progress reports flow in for these active grants, a more in-depth evaluation will become available in 2011.

Alternative Dental Health Care Provider Demonstration Project

Goal: To increase access to dental health services in rural and underserved communities.

Eligible Entities: Community colleges, public-private partnerships, Federally Qualified Health Centers, Indian Health Service facilities or a Tribe or Tribal organizations, State or County public health clinics, a health facility operated by an Indian Tribe or Tribal organization, or Urban Indian organizations providing dental services, and public hospital or health systems.

Designated Health Professions:	**Targeted Educational Levels:**	**Program Activities:**
• Community dental health coordinators • Supervised dental hygienists • Dental health aids • Independent dental hygienists • Advanced practice dental hygienists • Dental therapists • Primary care physicians	• Post high school • College • Post graduate	Grants will be awarded for a five-year project period to: • Establish a demonstration program to train, or to employ alternative dental health care providers

Program Accomplishments: New program in FY 2012.

Funding History

FY	**Amount**
FY 2007	$11,980,000
FY 2008	$15,000,000
FY 2009	$20,000,000
FY 2010	$32,920,000
FY 2011 CR	$32,982,000

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.

Budget Request

The FY 2012 Discretionary Request of $49,928,000 is an increase of $17,008,000 above the FY 2010 Actual Level. The request will support 41 continuation grants in the Training in General, Pediatric and Public Health Dentistry and Dental Hygiene programs and 25 new grants. The request will provide continuation funding for nine State Oral Health Workforce grants and supports approximately 25–30 new grants in this program. The increase will support the new Alternative Dental Health Care Provider Demonstration Project. Additionally, the request will enable the Department to fulfill its

statutory requirement under the program to contract with the Institutes of Medicine to conduct a study of the Alternative Dental Health Care Provider Demonstration Project.

Outcomes and Outputs Tables

Outputs	Most Recent Result[1,2]	FY 2010 Target[2]	FY 2012 Target[2]	FY 2012 +/- FY 2010[2]
Residency Training in General, Pediatric and Public Health Dentistry				
Number of residents in training	208			
Number of residents graduated	326			
Total number of residents trained	534			
Percent of minority/disadvantaged residents who completed training	32%			
Pre-doctoral, Post-doctoral, Faculty Development Training and Faculty Loan Repayment in General, Pediatric and Public Health Dentistry and Dental Hygiene				
Number of students trained		1,218	1,949	+ 731
Number of residents trained		334	534	+200
Number of faculty trained		86	138	+52
Number of faculty receiving loans		18	28	+10

Grant Awards Table – Pre-doctoral, Post-doctoral, Faculty Development Training and Faculty Loan Repayment in General, Pediatric and Public Health Dentistry and Dental Hygiene

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	42	42	67
Average Award	$357,168	$357,168	$357,168
Range of Awards	$123,539-$902,910	$123,539-$902,910	$123,539-$902,910

Grant Awards Table –State Oral Health Workforce

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	34	34	40
Average Award	$430,098	$430,098	$430,098
Range of Awards	$147,412 - $748,948	$147,412 - $748,948	$147,412 - $748,948

[1] Most Recent Result: Academic Year 2009/2010

[2] The Residency Training in General, Pediatric and Public Health Dentistry grant programs were absorbed by the new Affordable Care Act Post-doctoral Training grant programs. Therefore, there are no Targets for these programs in FY 2012.

Grant Awards Table—Alternative Dental Health Care Provider Demonstration Project

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	---	---	6
Average Award	---	---	$800,000
Range of Awards	---	---	$800,000

Teaching Health Center Graduate Medical Education Payments

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
ACA Mandatory	---	$230,000,000	---	---
FTE	--	5	5	+5

Authorizing Legislation: Section 340H of the Public Health Service Act

FY 2012 Authorization .....Such Sums as Necessary
(Not to exceed $230,000,000, for the period of fiscal years 2011 through 2015)

Allocation Method .....Formula Based Payments

Program Description: This program will provide Graduate Medical Education (GME) payments to support community-based training. Teaching Health Center (THC) GME payments will cover the costs of new resident training in community-based ambulatory primary care settings, such as health centers, and will bolster the primary care workforce.

Need: Poor health outcomes are linked to lack of reliable access to primary care. Rural and inner city areas are particularly hard hit. There is good evidence that physicians who receive training in community and underserved settings tend to practice in such environments, for example Community Health Centers (CHCs). Though CHCs are well supported by Federal funding to improve access to care, they have difficulty recruiting and retaining primary care professionals[1]. The THC program is designed to address the primary care workforce shortage by increasing residency training in community-based settings.

To address the need to expand residency training into underserved and community-based settings, the June 2010 the Medicare Payment Advisory Commission (MedPAC) report called for increasing the amount of GME time spent in nonhospital settings, changes to GME funding to meet goals such as community-based care, and increasing the diversity of the pipeline of health professionals.[2] In its 19th Report to Congress[3], the Council on Graduate Medical Education (COGME) concluded that resident physicians must be trained in environments which are more reflective of the evolving health care delivery system.

---

[1] Rosenblatt RA, Andrilla CH, Curtin T, Hart LG. Shortages of medical personnel at community health centers: Implications for planned expansion. JAMA 2006; 295:1042-9.
[2] Report to the Congress: Aligning Incentives in Medicare (June 2010). Medicare Payment Advisory Commission. (available at http://www.medpac.gov).
[3] Enhancing Flexibility in Graduate Medical Education (September 2007), COGME Nineteenth Report, (available at http://www.cogme.gov/pubs.htm).

THCs have demonstrated progress toward innovative models of patient care delivery such as the patient-centered medical home, implementation of electronic health records, population-based care management, and use of interdisciplinary team-based care. The growth of THCs has been limited due to difficulty bringing together the dual mission of training and service in health centers, administrative complexity, and a lack of financial resources.[4] Successful THCs have common elements, foremost of which is an institutional commitment to a dual mission of medical education and service to an underserved patient population, including underrepresented minority and other high risk populations.

Goal: To bolster the primary care workforce by providing THC GME payments to support the costs of new resident training in community-based ambulatory primary care settings, such as health centers, in order to improve the distribution of primary care physicians into needed areas.

Eligible Entities: Eligible entities include community-based ambulatory patient care centers that operate a primary care residency program. Specific examples of eligible entities include, but are not limited to Federally Qualified Health Centers, community mental health centers, rural health clinics, health centers operated by the Indian Health service, an Indian tribe or tribal organization, or an urban Indian organization, and an entity receiving funds under title X of the Public Health Service Act.

Designated Health Professions:	**Targeted Educational Levels:**	**Program Activities:**
• Family medicine • General dentistry • Geriatrics • Internal medicine • Internal medicine-pediatrics • Obstetrics and gynecology • Pediatrics • Psychiatry • Pediatric dentistry	• Residents Medical and Dental	• Payments for direct and indirect expenses of qualified teaching health centers. • Medical and dental residents in health centers will provide patient care services during their training in health centers.

Program Accomplishments: The first THC funding opportunity announcement was released in November 2010. Eleven THCs have been designated as eligible and will begin receiving THC GME payments in July 2011.

[4] Morris CG and Chen FM. Training Residents in Community Health Centers: Facilitators and Barriers. Annals of Family Medicine 2009; 7:488-94.

Funding History

FY	Amount
FY 2007	---
FY 2008	---
FY 2009	---
FY 2010	---
FY 2011 CR	$230,000,000

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.

Budget Request

No funds are requested for this program in FY 2012 Request. In FY 2011, the Teaching Health Center GME payment program received a $230,000,000 mandatory appropriation with funding available for five years.

The approximate annual training cost per resident is $150,000 (combined direct graduate medical education expenses and indirect medical education expenses). Residency training programs vary in length depending on specialty. This request assumes the majority of payments will be for primary care physicians who require three years of training. To support one primary care resident for three years of training would cost approximately $450,000. In FY 2012, $30,400,000 will provide support for an additional 150 residents, in addition to the 50 who will be continuing their training. Over time, the entire five-year appropriation will produce almost 1,000 primary care physicians and dentists who have had at least part of their residency training supported by the THC GME program.

Interdisciplinary, Community- Based Linkages

Area Health Education Centers (AHEC) Program

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$33,274,000	$33,345,000	$33,345,000	+$71,000
PHS Evaluation			$1,488,000	+$1,488,000
Total Program Level	$33,274,000	$33,345,000	$34,833,000	+$1,559,000
FTE	--	--	--	--

Authorizing Legislation**:** Section 751 of the Public Health Service Act as amended by the Affordable Care Act

FY 2012 Authorization.....$125,000,000

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

Program Description: The AHEC Programs and Centers play a critical national role in addressing health care workforce shortages, particularly those in primary care through an established infrastructure. The AHEC Program grantees support the recruitment and retention of physicians, students, faculty and other primary care providers in rural and medically underserved areas by providing local, community-based, interdisciplinary primary care training.

Need: In 2010, the number of enrolled students in schools of medicine totaled 97,000 and with less than a one percent increase in the medical school graduates selecting primary care residency training, the need for increased numbers of primary care providers remains critical, particularly in medically underserved areas.[1,2,3]

[1] Association of American Medical Colleges, *FACTS – (2010) Applicants, Matriculates', Graduates, and Residency Applicants*, available online at https://www.aamc.org/data/facts/ (accessed 12/20/10).

[2] American Association of Colleges of Osteopathic Medicine, *Trends in Osteopathic Medical School Applicants, Enrollment and Graduates*, available online at http://publish.aacom.org/data/Documents/2010-10_Trends-apps-enroll-grads.pdf (accessed 12/20/10)

[3] Center for Workforce Studies, (2009). *State Physician Workforce Data Book*. Washington, D.C.: Association of American Medical Colleges. available on line at https://www.aamc.org/download/47340/data/statedata2009.pdf (accessed 12/21/10)

Goal: Support primary care workforce development including improving the distribution, diversity, and quality of health care personnel by offering training in rural and other underserved areas.

Eligible Entities: Public or private non-profit accredited schools of allopathic and osteopathic medicine. Accredited schools of nursing are eligible applicants in States and Territories in which no AHEC Program is in operation.
.

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• All health professions	• All education levels are targeted to provide pipeline development including students and faculty	• Develop and operate an AHEC Program • Plan, develop, operate and evaluate AHEC Center(s) • Address health care workforce needs in the service areas coordinating with local workforce investment boards (WIBs) • Two types of awards: infrastructure development awards, and point of service maintenance and enhancement awards • Provides a national infrastructure for clinical rotations and the dissemination of continuing education of health professions content to those audiences while promoting health careers in the elementary and high school grades

Program Accomplishments: AHEC Programs are in operation in 47 States. Additionally, three States are provided AHEC services through centers established and operated by AHECs located in other States. The national AHEC programs and the national Health Career Opportunities (HCOP) programs with legislative mandates to provide elementary through high school recruitment activities have begun collaborations toward improved efficiencies. Twenty AHECs and 20 HCOPs currently collaborate to provide programming in middle and high school grades.

Affordable Care Act: The Affordable Care Act included legislative changes renaming the two existing program components to better reflect their purposes. The AHEC Infrastructure Development awards replaced Basic/Core AHEC Program awards and AHEC Point of Service Maintenance and Enhancement awards replaced Model State Supported AHEC Program awards. The legislative changes also require that the allocation of appropriations shall be no greater than 35 percent for Infrastructure Development awards and no less than 60 percent for Point of Service (POS) Maintenance and Enhancement awards.

Funding History

FY	Amount
FY 2007	$28,681,000
FY 2008	$28,180,000
FY 2009	$32,540,000
FY 2010	$33,274,000
FY 2011 CR	$33,345,000

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.

Budget Request:

The FY 2012 Discretionary Request of $34,833,000 is an increase of $1,559,000 above the FY 2010 Actual Level. The increase will allow for the expansion of three Infrastructure Development programs started in Michigan, Illinois and Puerto Rico, and a new start in one of the States without an AHEC Program. The total request will provide support for approximately 55 AHEC Programs and 240 community-based training centers.

Outcomes and Outputs Table

Outputs	Most Recent Result[4]	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
No. of medical students trained in community sites in rural/underserved areas	21,999	22,500	22,600	+100
No. of associated health professions students trained in community sites in rural/underserved areas	33,036	33,500	33,600	+100
No. of training partnerships with community/migrant health centers and other underserved area sites	11,155	12,000	12,100	+100
No. of local providers who received continuing education, e.g., on Cultural Competence, Women's Health, Diabetes, Hypertension, Obesity, Health Disparities and related topics.	365,137	365,500	366,000	+500
No. and percent of local providers receiving continuing education in medically underserved areas	55,833 15.3%	55,652 15.5%	56,730 15.5%	+1,078

[4] Most Recent Result: Academic Year 2009/2010

Outputs	Most Recent Result[4]	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
No. of elementary/high school students receiving health career guidance and information from the AHEC Programs	453,638	455,000	456,000	+1,000
No. of high school students (grade 9-12) participating in $\geq$ 20 hours of health career training and/or academic enhancement experience	25,319	26,000	26,500	+500

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	54	55	56
Average Award	$570,711	$560,335	$560,335
Range of Awards	$99, 015-$1,661,003	$100,000-$1,230,000	$100,000-$1,230,000

Interdisciplinary, Community-Based Linkages

Geriatric Programs

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$33,675,000	$33,747,000	$36,907,000	+$3,232,000
PHS Evaluation	---	---	$6,840,000	+$6,840,000
Total Program Level	$33,675,000	$33,747,000	$43,747,000	+$10,072,000
FTE	2	4	4	+2

Authorizing Legislation: Section 753 of the Public Health Service (PHS) Act as amended by the Affordable Care Act

FY 2012 Authorization:
Geriatric Education Centers……...Unspecified
Ger Training for Physicians, Dentists, Behavioral/Mental Health Professionals..... Unspecified
Geriatric Academic Career Awards……...Unspecified
Geriatric Workforce Development……....$10,800,000
Geriatric Career Incentive Awards……$10,000,000

Allocation Method .....Competitive Grants/Contracts

Program Description: Geriatric Programs improve and increase the number of geriatric specialists and increase geriatrics competencies in the generalist workforce through education and training to improve care to this often vulnerable, underserved population.

Need: The Institute of Medicine identified three shortfalls the health care system will face as the number of aging Americans (over 65) increase: 1) health care needs of older adults will be difficult to meet by the current health care workforce; 2) there will be severe shortages of geriatric specialists and other providers with geriatric skills; and 3) there will be increased demand for chronic care management skills.

Geriatric Workforce Development Programs

There are four geriatric workforce development programs designed to improve access to quality health care for America's elderly. The programs target different workforce development needs:

- The Geriatric Education Centers (GEC) Program provides institutional support for

a broad range of geriatric education and training activities through interprofessional, continuing education.

- Geriatric Training for Physicians, Dentists, and Behavioral/Mental Health Professionals Program (GTPD) focuses on institutional support for faculty development in geriatrics through geriatric fellowships.
- Geriatric Academic Career Awards Program (GACA) provides career development opportunities to junior faculty for clinical training.
- The Geriatric Career Incentive Awards Program (GCIA) provides individual support for the final two years of doctoral study for advanced practice nurses, clinical social workers, pharmacists, or students of psychology who are in geriatric doctoral programs or other advanced degrees in geriatrics or related fields through an eligible, accredited health professions school.

Geriatric Programs

Programs	FY 2010 Appropriation	FY 2011 CR	FY 2012 Request
Geriatric Education Centers	$19,919,000	$19,991,000	$19,991,000
Geriatric Training Program for Physicians, Dentists, and Behavioral/Mental Health Professionals Program	$8,518,000	$8,518,000	$8,518,000
Geriatric Academic Career Awards Program	$5,238,000	$5,238,000	$5,238,000
Geriatric Career Incentive Award	---	---	$10,000,000

Geriatric Education Centers Program (GEC)

Program Description: This program provides support to establish or operate geriatric education centers. GECs train health professional faculty, students, and practitioners in the diagnosis, treatment, prevention of disease, disability, and other health problems of the elderly. They provide services to and foster collaborative relationships among health professions educators (organizations and institutions that sponsor formal and informal educational programs and activities for faculty, students and practitioners) within defined geographic areas (States, counties, metropolitan areas or portions thereof). GECs strengthen the interdisciplinary training of health professionals to diagnose, treat and prevent disease and other health problems affecting older adults.

Goal: To provide quality interdisciplinary geriatric education and training to the health professions workforce including geriatric specialists and non-specialists.

Eligible Entities: Accredited schools of multiple health disciplines

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Allied health • Allopathic medicine • Behavioral and mental	• Undergraduate • Graduate • Post-graduate	• Support eligible entities to operate Geriatric Education Centers to provide interprofessional geriatric education and training to students, faculty and practitioners

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
health • Chiropractic • Clinical psychology • Social work • Dentistry • Health administration • Public health • Optometry • Osteopathic medicine • Podiatric medicine • Nursing • Pharmacy • Physician assistant • Veterinary medicine	• Practicing health providers • Faculty	• Curricula development • Faculty development • Continuing education • Clinical training

Program Accomplishments: In Academic Year 2009-2010, the GEC grantees provided clinical training to 54,167 health professional students and to 20,791 interdisciplinary teams in multiple settings. A contract, the National Training and Coordination Collaborative (NTACC), is currently being funded to provide technical assistance to the GECs to improve evaluation planning. Activities include training on logic modeling, formative to summative evaluation planning, and data collection and management. The GECs are developing strategies for implementing evidence based practice projects in order to demonstrate their influence on health professionals' practice improvements. The conditions included in this evaluation project comprise prevention and treatment of falls, pain (palliative care issues), diabetes, depression and delirium. This multi-year contract to build the evaluation capacity of the GECs ends in September 2012.

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

Program Description: The program supports faculty development in geriatrics through two options: a one-year retraining program for mid-career faculty and a two-year geriatric fellowship training.

Goal: To increase the supply of quality and culturally competent geriatric clinical faculty and to retrain mid-career faculty in geriatrics.

Eligible Entities: Accredited schools of medicine, schools of osteopathic medicine, teaching hospitals, and graduate medical education programs.

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Dentistry • Medicine • Counseling - Marriage & family - Professional	• Graduate • Post-graduate • Faculty	• Provide intensive one-year retraining and two-year fellowship training in geriatrics • Provide community service to minority and underserved elderly • Practice the delivery of longitudinal geriatrics primary

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Osteopathic Medicine • Psychology • Psychiatric Nursing • Psychiatry • Social Work • Substance Abuse		care in ambulatory, acute care, community-based and long term care settings, • Apply contemporary educational delivery methods to interprofessional audiences • Demonstrate application of administrative skills as academic and clinical faculty • Engage in scholarly research in the field of aging.

Program Accomplishments: In Academic Year 2009-2010, 11 non-competing continuation grants were supported. Forty-nine physicians, dentists, and psychiatric fellows provided geriatric care to 20,078 older adults across the care continuum. Geriatric physician fellows provided health care to 12, 254 older adults. Geriatric dental fellows provided health care to 4,073 older adults. Geriatric psychiatry fellows provided health care to 3,751 older adults.

Geriatric Academic Career Awards Program (GACA)

Program Description: This program provides support to build academic capacity for geriatric workforce development.

Goal: To promote the development of academic clinician educators in geriatrics

Eligible Entities: Individuals from the following disciplines: Allied health, Dentistry, Allopathic medicine, Osteopathic medicine, Nursing, Pharmacy, Psychology, and Social work

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Allied health • Allopathic medicine • Dentistry • Medicine • Nursing • Osteopathic medicine • Pharmacy • Psychology • Social work	• Faculty	• Provides training in clinical geriatrics for interdisciplinary teams of health professionals. • Provides junior faculty with release time to focus on teaching activities such as interdisciplinary curriculum development and integrating geriatrics into health professions curricula.

Program Accomplishments: In Academic Year 2009-2010, there were 84 non-competing continuation awards. GACA awardees provided interdisciplinary training in geriatrics to about 60,000 health professionals. These awardees provided culturally competent quality health care to over 525,000 underserved and uninsured patients in acute care services, geriatric ambulatory care, long-term care, and geriatric consultation services settings.

Geriatric Career Incentive Awards Program (GCIA)

Program Description: This program provides support to foster greater interest among a variety of health professionals in entering the field of geriatrics, long-term care, and chronic care management.

Goal: To increase the number of individuals who will teach or practice in the fields of geriatrics, long-term care, or chronic care management

Eligible Entities: See Designated Health Professions listed below

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Advanced practice nurses • Clinical social workers • Pharmacists • Psychologists	• Doctoral	• Provides support for doctoral or other advanced degree training in geriatrics or related fields

Program Accomplishments: This program has not yet been implemented. It is proposed for implementation in FY 2012.

Affordable Care Act: Under the Affordable Care Act, legislative changes stipulates that this program offer short-term intensive courses that focus on geriatrics, chronic care management, and long-term care that provide supplemental training for faculty in health professions schools. Additional activities may include family caregiver and direct care provider training or incorporation of best practices related to mental disorders common among older adults, medication safety issues, and management of dementia.

Funding History

FY	Amount
FY 2007	$31,548,000
FY 2008	$30,997,000
FY 2009	$30,997,000
FY 2010	$33,675,000
FY 2011 CR	$33,747,000

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.

Budget Request

The FY 2012 Discretionary Request of $43,747,000 is an increase of $10,072,000 above the FY 2010 Actual Level. The increase will be used to fund the Geriatric Incentive Career Award Program to foster greater interest among a variety of health professionals in entering the field of geriatrics, long term care, and chronic care management. An estimated 120 eligible doctoral students in the final two years of the doctoral program of study will be awarded through eligible health professions schools. The amount of the award will cover the cost of tuition, fees, stipends, and reasonable living expenses as determined by the institution. Approximately 71,000 additional health professionals are expected to participate in GEC programming; another 78 geriatric physicians, dentists, and behavioral and mental health professionals will receive geriatric fellowship training through the GTPD Program, and 68 GACA awardees will continue to promote their career development.

Outcomes and Outputs Tables

Outputs	Most Recent Result [1]	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Number of health care providers receiving training through the GEC Program in geriatrics	75,471	70,755	70,755	--
Number of GECs	48	45	45	--
Number of GTPD Fellows	49	78	78	--
Number of GACAs	84	68	68	--
Geriatric Career Incentive Awardees	--	--	120	+120

Grant Awards Table – Geriatric Education Centers Program
Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	45	45	45
Average Award	$408,232	$408,232	$408,232
Range of Awards	$216,000-$432,000	$216,000-$432,000	$216,000-$432,000

[1] Most Recent Result: Academic Year 2009-2010.

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

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	13	13	13
Average Award	$630,755	$729,621	$729,601
Range of Awards	$350,036 - $1,177,593	$418,030- $1,434,217	$418,030- $1,456,205

Grant Awards Table – Geriatric Academic Career Awards Program
Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	68	68	68
Average Award	$74,991	$74,991	$74,991
Range of Awards	N/A	N/A	N/A

Grant Awards Table – Geriatric Career Incentive Awards Program
Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	--	--	130
Average Award	---	---	$75,000
Range of Awards	---	---	N/A

Interdisciplinary Community-Based Linkages

Allied Health and Other Disciplines

Chiropractic Demonstration Projects Program

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$1,940,000	$1,945,000	---	-$1,940,000
FTE	--	1	--	--

Authorizing Legislation: Section 755(b)(3) of the Public Health Service Act

FY 2012 Authorization ..... Unspecified

Allocation Method ..... Competitive Grants

Program Description: This program funds demonstration projects to identify the most effective treatment of spinal and lower-back conditions by linking schools of chiropractic and schools of allopathic and osteopathic medicine in collaborative research projects.

Need: Significant numbers of Americans suffer from spinal and lower-back conditions, with seniors commonly reporting impaired activity due to musculoskeletal pain or stiffness, including spinal pain[1].

Goal: To support demonstration projects which identify and provide effective treatments for spinal and/or lower back conditions in which chiropractors and physicians collaborate

Eligible Entities: Accredited health professions schools, academic health centers, and public or private nonprofit accredited schools of chiropractic

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Chiropractic • Medicine	• Doctoral	• Supports collaborative projects to identify and provide effective treatment of spinal and/or lower back conditions

Program Accomplishments:

- Grantees developed a biomechanical outcome measures to assess seniors' physical function and balance and participated in the development of qualitative interview questions and interviewing techniques.

[1] Gill, TM, Desai MM, Gahbaure, EA, Holford TR, Willaims, CS. Restricted activity among community-living older persons: incidence,precipitants,and health care utilization. Annals of Internal Medicine 2001; 135:313-21.

- New clinics were established at the Saint Louis University Center for Biomedical and Health care Research and at the Veteran's Administration Hospital's Geriatric Research Education and Clinical Center (GRECC) in St. Louis.

Funding History

FY	Amount
FY 2007	$1,802,228[2]
FY 2008	$1,817,000
FY 2009	$1,945,000
FY 2010	$1,940,000
FY 2011 CR	$1,945,000

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.

Budget Request

The Chiropractic Demonstration Project Program has shown effective programmatic models over the life of the program and has been successfully implemented. No funds are requested for this program in FY 2012.

Outcomes and Outputs Tables

Outputs	Most Recent Result [3]	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Number of awards	4	4	--	-4
No. of Chiros. involved in research projects	17	17	--	-17

Grant Awards Table – Chiropractic Demonstration Projects Program

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	4	4	--
Average Award	$486,250	$521,622	---
Range of Awards	$386,686-$536,717	$368,938 - $543,741	---

[2] In prior Fiscal Years, the Chiropractic Demonstration Project was in a line that included multiple Allied Health Programs. Prior to FY 2008, appropriations were not broken out by individual programs within the line, so the FY 2008 appropriation specific to the Chiropractic Demonstration Project is unavailable.
[3] Most Recent Result: Academic Year 2009/2010

Interdisciplinary, Community-Based Linkages

Mental and Behavioral Health Education and Training

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$2,939,000	$2,945,000	$17,945,000	+15,006,000

Authorizing Legislation: Sections 755 and 756 of the Public Health Service Act

FY 2012 Authorization: $35,000,000

Allocation Method: ..... Competitive Grant/Cooperative Agreement; Contract

Program Description: The Mental and Behavioral Health Education and Training Grant and the Graduate Psychology Education Programs work to close the gap in access to mental and behavioral health care services by increasing the numbers of adequately prepared mental and behavioral health and substance abuse providers.

Need: Mental disorders rank in the top five chronic illnesses in the U.S. Over ten years, the number of people accounting for expenses from mental disorders increased from 19.3 million in 1996 to 36.2 million in 2006.[1]

Mental and Behavioral Health Education and Training Grant Program

Goal: To increase the supply of mental and behavioral health professionals and paraprofessionals

Eligible Entities: Eligible entities vary according to the statutory purpose for which the application is submitted.

[1] MEPS Statistical Brief #248, The five most costly conditions 1996 and 2006, Estimates for the U.S. Non-Institutionalized population.

Designated Health Professions:	**Targeted Educational Levels:**	**Program Activities:**
• Social work • Psychology • Child and adolescent professional • Child and adolescent paraprofessional	• Paraprofessional • Undergraduate • Graduate • Post graduate internships or residencies	• Formal and clinical interdisciplinary education and training of designated disciplines in the mental health and substance abuse workforce • Child and adolescent professional and paraprofessional program development and implementation • Social Work faculty development • Interdisciplinary graduate and post graduate psychology preparation, including internships and residencies and substance abuse prevention and treatment

Program Accomplishments: This is a new program proposed for implementation in FY 2012, therefore, no accomplishments are identified.

Graduate Psychology Education Program

Goal: To support graduate psychology education programs in behavioral and mental health practice and to train doctorally prepared psychologists to work with underserved populations

Eligible Entities: Eligible entities include accredited health profession schools, universities, and other public or private nonprofit entities

Designated Health Professions:	**Targeted Educational Levels:**	**Program Activities:**
• Psychology • Other health professions disciplines	• Graduate (doctoral)	• Support post baccalaureate education leading to a doctoral degree in clinical psychology or an equivalent interprofessional degree • Increased access and quality services to vulnerable and underserved, needy populations • Increased number of prepared

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
		psychologists with doctoral degrees • Data collection, analysis and synthesis

Program Accomplishments: During Academic Year 2009-2010, 18 grantees graduated 103 psychologists with 83 percent of graduates practicing with medically underserved populations, where workforce shortages exist and mental health services are most often needed.[2] Psychologists experience interdisciplinary training by at least 30 health professionals and medical specialists to promote integrated care to treat vulnerable populations. In 2010, 3,483 U. S. communities had mental health shortages which influenced the potential access to services for approximately 84 million people.

Funding History

FY	Amount
FY 2007	---
FY 2008	$1,851,000
FY 2009	$1,945,000
FY 2010	$2,939,000
FY 2011 CR	$2,945,000

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.

Budget Request

The FY 2012 Discretionary Request of $17,945,000 is an increase of $15,006,000 above the FY 2010 Actual Level. The increase will be used to support the new Mental and Behavioral Health Program. It is estimated that the increase would support 10 grants in graduate social work education; 17 grants in graduate psychology education for the development and implementation of interdisciplinary training of psychology graduate students; 12 grants for professional child and adolescent mental health education; and, six grants for paraprofessional child and adolescent mental health. The total request will also provide continuation of grants supported by the Graduate Psychology Education Program.

[2] U. S. Department of Health and Human Services, Health Resources and Services Administration. Mary Wakefield, Ph.D., R.N., HRSA Administrator. HRSA News Room, August 13, 2010. http://newsroom.hrsa.gov

Outcomes and Outputs Tables

Outputs	Most Recent Result [3]	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Mental and Behavioral Health Education and Training				
Number of enrollees/students in graduate programs in Social Work Number of Grantees	N/A	N/A	300	+300
Number of enrollees/students in graduate programs in Psychology	N/A	N/A	340	+340
Number of professionals in child and adolescents mental and behavioral health careers	N/A	N/A	100	+100
Number of para-professionals trained in child and adolescent mental behavioral health careers	N/A	N/A	120	+120
Number of HBCUs and other minority serving institutions	N/A	N/A	4	+4
Graduate Psychology Education				
Number of Grantees	18	19	19	--
Number of Trainees	688	726	726	--
Number of Graduates	103	108	108	--
Number of Graduates entering practice in MUCs	86	86	86	--
Percent of Graduates entering practice in MUCs	83	83	83	--

Grant Awards Table – Mental and Behavioral Health Education and Training Grant Program

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	N/A	N/A	45
Average Award	N/A	N/A	$350,000
Range of Awards	N/A	N/A	$250,000 - $350,000

[3] Most Recent Result: Academic Year 2009/2010

Grant Awards Table –Graduate Psychology

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	19	19	19
Average Award	$137,000	$137,000	$137,000
Range of Awards	$80,000 – $190,000	$80,000 – $190,000	$80,000 – $190,000

Public Health Workforce Development

Public Health and Preventive Medicine

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$9,647,000	$9,668,000	---	-$9,647,000
PHS Evaluation	---	---	$10,068,000	+$10,068,000
Prevention and Public Health Fund	$14,829,000	---	$15,000,000	+$171,000
Total Program Level	$24,476,000	$9,668,000	$25.068.000	+$592,000
FTE	--	2	2	+2

Authorizing Legislation: Sections 766, 767 and 768 of the Public Health Service (PHS) Act, as amended by the Affordable Care Act

FY 2012 Authorization……..Unspecified

Funding Allocation.....Competitive Grant

Need: Public health workers protect and improve the health of communities through education, disease prevention and health promotion, and monitoring, diagnosis, research, and provision of services to address community health problems. A shortage of experienced public health professionals equipped to address the growing burden of chronic disease in this country is predicted.[1] In addition, the Institute of Medicine's Committee on Training Physicians predicts a shortage of physicians in public health careers.[2] Public health workers need foundational training in core public health skills and competencies as well as education and training to maintain and upgrade their skills.

[1]Bodenheimer T, Chen E, Bennett HD. Confronting The Growing Burden of Chronic Disease: can the U.S. Health Care Workforce Do the Job? *Health Affairs* January 2009 vol. 28 no. 1 64-74.
[2] Institute of Medicine. Committee on Training Physicians for Public Health Careers. *Training Physicians for Public Health Careers.* The National Academies Press. 2007

Program	FY 2010 Appropriation	FY 2011 CR	FY 2012 Request
Public Health Training Center Program	$5,651,000	$5,663,000	$5,863,000
PPHF	$14,829,000	$20,000,000	$15,000,000
Public Health Traineeships	$1,510,000	$1,513,000	$1,513,000
Preventive Medicine Residency Program	$2,486,000	$2,492,000	$2,692,000

Public Health Training Center Program

Program Description: The Public Health Training Center Program (PHTC) 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. Education and training provided by the PHTC Program reflect the core public health competencies as defined by the Council on Linkages between Academia and Public Health Practice.[3] Training topics addressed by the PHTCs include environmental health, public health leadership, nutrition, management, cultural competency, and risk communication.

Goal: To support the ongoing education of the current and future public health workforce with emphasis on the existing public health workforce to ensure competent practice

Eligible Entities: Accredited schools of public health or other public or nonprofit private institutions accredited for the provision of graduate or specialized training in public health

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
Public health workforce	Graduate health professions students and public health professionals	• Provide graduate or specialized training in public health in the areas of preventive medicine, health promotion and disease prevention, or improving access to and quality of health services in medically underserved communities • Establish or strengthen field placements for students • Involve faculty and students in collaborative projects to

[3] Public Health Foundation. Council on Linkages Between Academia and Public Health Practice (COL) Core Competencies for Public Health Professionals. Available at: http://www.phf.org/resourcestools/Documents/Core_Public_Health_Competencies.pdf Accessed December 13, 2010.

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
		enhance public health services to medically underserved communities • Assess the health personnel needs of the service area and assist in the planning and development of training programs to meet such needs

Program Accomplishments: In FY 2010, 24 PHTC Program grants were supported through the Prevention and Public Health Fund. Three PHTCs were newly funded and six were supported through noncompeting continuation grants with the FY 2010 appropriation. In total, the 33 PHTCs cover 49 States plus the District of Columbia, Puerto Rico and the U.S. Associated Pacific Islands.

Public Health Traineeship Program

Program Description: The Public Health Traineeship (PHT) Program provides grants to institutions accredited for the provision of graduate or specialized training in public health through traineeships.

Goal: To support the development of the public health workforce

Eligible Entities: Schools of public health, other public or non-profit private entities accredited by the Council on Education for Public Health, and other public or non-profit private institutions

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
Public health workforce	• Masters and Doctoral Levels	• Supports graduate education in public health in the fields of epidemiology, environmental health, biostatistics, toxicology, nutrition and maternal and child health. • Provide for tuition, fees, stipends, and allowances

Program Accomplishments: During Academic Year 2009 - 2010, 30 PHT grantees provided tuition, fees, and allowances to approximately 2,500 enrollees in 21 States and Puerto Rico. In 2010, approximately 900 graduates received some form of financial support as a result of participating at a PHT supported training site.

Preventive Medicine Residency Program

Program Description: The Preventive Medicine Residency (PMR) Program supports post-graduate physician training. Preventive medicine physicians are uniquely trained in both clinical medicine and public health in order to promote, and maintain health and well-being and reduce the risks of disease, disability, and death in individuals and populations.

Goal: To increase the number of preventive medicine physicians in the public health workforce.

Eligible Entities: Accredited schools of public health; osteopathic medicine; accredited public or private non-profit hospitals; State, Local or Tribal health departments or a consortium of two or more of the above entities.

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
Preventive Medicine Physicians	• Residency training	• Plan and develop new residency training programs • Maintain or improve existing residency programs • Provide financial support to residency trainees • Support planning, development operations, and/or participate in an accredited residency program • Establish, maintain or improve academic administrative units in preventive medicine and public health, or programs that improve clinical teaching in preventive medicine and public health

Program Accomplishments: During Academic Year 2009-2010, five residency programs supported a total of 39 trainees. Of these, 36 percent were from underrepresented minority backgrounds. In FY 2010, nine new awards were made to support an estimated 17 resident physicians during the 2010-2011 Academic Year.

Funding History

FY	Amount
FY 2007	$ 7,920,000
FY 2008	$ 8,273,000
FY 2009	$ 9,000,000[4]
FY 2009 Recovery Act	$10,500,000
FY 2010	$ 9,647,000
FY 2010 Prevention Fund	$14,829,000
FY 2011 CR	$ 9,668,000

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.

Budget Request

The FY 2012 Discretionary Request of $10,068,000 is an increase of $421,000 above the FY 2010 Actual Level. The total request will support continuing education in public health to individuals in the public health workforce, graduate students in public health through traineeships, and physicians in preventive medicine residency programs. These programs address public health workforce shortages by increasing public health

[4] Regular Appropriation Only

education capacity, providing traineeship support for students enrolled in graduate public health degree programs, increasing the number of preventive medicine physicians, and promoting a diverse public health workforce.

Outcomes and Outputs Tables

Outputs	Most Recent Result [5]	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Public Health Training Centers				
Number of existing public health workers retrained	181,688	428,264	389,331[6]	--
Public Health Traineeships				
No. of students supported with traineeship funds	2,479	2,500	2,666	+166
No. of graduates supported with traineeship funds	873	840	896	+56
No. of URM grads supported with traineeship funds	184	230	245	+15
Preventive Medicine Residency Training				
Number of residents participating in residencies	39	40	44	+4
Number of residents completing training	20	20	22	+2
Number of URM residents completing training	5	10	11	+1
Percent of URM residents completing training	25	50	50	--
Number of residents entering practice in MUCs	8	8	9	+1
Percent of residents entering practice in MUCs	40	40	40	--
Average cost per resident	$31,571	$162,304	$162,304	--

Grant Awards Table – Public Health Training Center Program
Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	33	8	30
Average Award	$571,247	$649,292	$647,964
Range of Awards	$371,000-$650,000	$643,875-$650,000	$643,893-$650,000

[5] Most Recent Result: Academic Year 2009-2010
[6] Target reflects reduction in number of centers.

Grant Awards Table – Public Health Traineeships

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	30	30	32
Average Award	$57,194	$57,194	$57,194
Range of Awards	$9,000-$182,096	$9,000-$182,096	$9,000-$182,096

Grant Awards Table – Preventive Medicine Residency Program

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	9	9	10
Average Award	$314,572	$525,181	$525,181
Range of Awards	$154,478-$643,328	$180,000-$782,889	$180,000-$782,889

State Health Care Workforce Development

	FY 2010 Appropriation	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	---	---	$51,000,000	+$51,000,000
Prevention and Public Health Fund	$5,750,000	---	---	-$5,750,000
Total Program Level	$5,750,000	---	$51,000,000	+$45,250,000
FTE	--	--	---	---

Authorizing Legislation: Section 5102 of the Affordable Care Act, Public Law 111-148

FY 2012 Authorization .....Such Sums as Necessary

Allocation Method .....Competitive Grants/Contracts

Program Description: The State Health Care Workforce Development Program enables State partnerships (generally the State Workforce Investment Board) to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the State and local levels, with particular emphasis on primary care.

Need: The Bureau of Labor Statistics has projected job growth in many of the health professions over the next decade. There is also the anticipated retirement of large numbers and a variety of health professionals during this same timeframe, which will result in a shortage expected to significantly impact primary care delivery (including geriatrics). Given this shifting context, States in partnership with Federal support, will need to examine current resources, policies and practices that influence the supply and demand of the health care workforce and identify strategies to remove or reduce barriers that can increase the supply and direction of workforce expansion.

Goal: Support States to engage in comprehensive health care workforce planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the State and local levels, with particular emphasis on primary care

Eligible Entities: State partnerships that meet specific statutory requirements (generally the State Workforce Investment Board).

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
NA	NA	• Awards **planning** grants to States (limited to one year and $150,000 plus 15 percent matching funds) to assess current status of the health workforce in their respective States. • Awards **implementation** grants – (limited to two years and requires 25 percent matching funds) allow States to regularly convene stakeholders at the State and regional levels to develop and implement a health care workforce development plan.

Program Accomplishments: In late FY 2010, Health Resources and Services Administration (HRSA) awarded 25 planning grants and one implementation grant using $5.6 million from the Prevention and Public Health Fund created by the Affordable Care Act.

Program Performance Measurement and Evaluation: As a new program, there are currently no performance data or evaluation results to present. Grantees in the program are expected to establish targets for when certain grant requirements will be met and report on when the requirements are actually completed. For planning grants, the outcome measure is the percent of planning grant awardees that have established primary care FTE health workforce baselines. The target for FY 2012 is 100 percent of grantees. For implementation grants, the outcome measure is percent of grantees that complete their plan for increasing the primary care workforce by more than 10 percent and disseminate it to key stakeholders. The target for FY 2012 is 100 percent of grantees.

Funding History

FY	Amount
FY 2007	---
FY 2008	---
FY 2009	---
FY 2010	---
FY 2010 Prevention Fund	$5,750,000
FY 2011 CR	---

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.

Budget Request

The FY 2012 Discretionary Request of $51,000,000 is an increase of $51,000,000 above the FY 2010 Actual Level. A competitive grant cycle would be conducted in FY 2012 and the request would be used to fund approximately 20 implementation grants and 25 planning grants.

Nursing Workforce Development

Advanced Education Nursing

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$64,301,000	$64,438,000	$64,438,000	+$137,000
Evaluation Fund			$40,00,000	+$40,000,000
Prevention and Public Health Fund	$31,431,000	---	---	-$31,431,000
Total Program Level	$95,732,000	$64,438,000	$104,438,000	+$8,706,000
FTE	2	2	2	--

Authorizing Legislation: Section 811, Public Health Service Act, Title VIII, as amended by the Affordable Care Act

FY 2012 Authorization .....Such Sums as Necessary

Allocation Method .....Competitive Grant/Contract

Program Description: The Advanced Nursing Education (ANE) Program comprises infrastructure grants to schools to build and enhance advanced nursing education programs, and two traineeship programs—the Advanced Education in Nursing Traineeship (AENT) and the Nurse Anesthesia Traineeship (NAT) Programs. In addition, the Advanced Nursing Education Expansion (ANEE) program, funded through the Affordable Care Act provides grants to schools of nursing to accelerate the production of primary care advanced practice nurses.

Need: The combined factors of an aging and growing population with an aging health care workforce are expected to result in increased demand for health care service, in particular primary care services. Advanced practice nurses are a critical part of the primary care workforce and will be needed in growing numbers to meet this increasing demand. Building this workforce will require support for advanced nursing education students, specifically those electing primary care practice disciplines, and for faculty preparation to ensure adequate training capacity.

The nurse faculty shortage continues to inhibit nursing schools from educating the number of nurses needed to meet projected demand. According to the American

Association of Colleges of Nursing[1], almost 50,000 qualified applicants were turned away from baccalaureate and graduate nursing programs in 2008 primarily due to an insufficient number of faculty. Most of the vacancies (90.6%) were faculty positions requiring or preferring a doctoral degree. Among the top reasons cited by schools having difficulty finding faculty was the limited pool of faculty prepared at the doctoral level.

Goal: To increase the number of advanced education nurses trained to practice as primary care providers and/or nursing faculty

Eligible Entities: Schools of nursing, academic health centers, and other private or public entities accredited by a national nursing accrediting agency recognized by the Secretary of the U.S. Department of Education

Designated Health Professions:	**Targeted Educational Levels:**	**Program Activities:**
• Nurse practitioners • Clinical nurse specialists • Midwives and nurse midwives • Nurse anesthetists • Nurse educators • Nurse administrators • Public health nurses	• Masters programs in nursing • Doctor of nursing	• Provides schools of nursing with infrastructure grants to build and enhance advanced nursing education programs. • Provides schools of nursing with funds to support advanced nursing education students. • Provides stipends to support primary care advanced practice nursing students.

Program Accomplishments: In FY 2009, 151 schools of nursing received grants through the ANE Program and enrolled 7,518 advanced nursing education students. The AENT and NAT Programs provided direct financial support to 8,820 advanced nursing education and nurse anesthesia students and 3,918 graduates ready to enter into the workforce. In FY 2010, 26 schools of nursing received grants under the ANEE program to support the production of over 600 primary care advanced practice nurses during their five-year fully-funded programs.

Affordable Care Act: The Affordable Care Act removed the 10 percent cap on doctoral student education for both the AENT and NAT traineeship programs allowing an increase in support to doctorally-prepared advanced practice nurses, particularly students in the new Doctor of Nursing Practice (DNP) programs which now total 120 nationwide. These DNP programs prepare expert clinicians who serve as an important pool of faculty.

[1] American Association of Colleges of Nursing. *2008–2009 enrollment and graduations in baccalaureate and graduate programs in nursing.* Washington (DC): AACN; 2009. Pub. no. 08-09-1.

Advanced Nursing Education Programs

Programs	FY 2010 Appropriation	FY 2010 Prevention and Public Health Fund	FY 2011 CR	FY 2012 Request
Advanced Nursing Education	$47,051,000	---	$47,188,000	$71,348,000
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
Advanced Nursing Education Expansion	---	$31,431,000	---	$15,840,000

Funding History

FY	Amount
FY 2007	$57,061,000
FY 2008	$61,875,000
FY 2009	$64,438,000
FY 2010	$64,301,000
FY 2010 Prevention Fund	$31,431,000
FY 2011 CR	$64,438,000

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.

Budget Request

The FY 2012 Discretionary Request of $104,438,000 is an increase of $40,137,000 above the FY 2010 Actual Level. These additional funds would support expansion of the Advanced Nursing Education Expansion Program to increase the number of primary care advanced practice nurses (APNs). Targeted investments to expand training capacity when sustained over five years will produce an additional 1,400 primary care APNs. In addition, the increased funds would be targeted to the ANE program for infrastructure grants to support the development of interprofessional primary care clinical training programs for advanced practice primary care nursing students. . These funds would support the development of interprofessional primary care clinical training programs that would annually train 250 primary care APN trainees enrolled in 2-year programs, producing 750 primary care APNs trained in interprofessional clinical training programs in 5 years with stable funding across this period. The remaining $64,301,000 in the

FY 2012 request will support students in advanced nursing education and nurse anesthesia programs, and provide support to build and enhance the capacity of advanced nursing education programs.

Outcomes and Outputs Tables

Outputs	Most Recent Result [2]	FY 2010 Target	FY 2012[3] Target	FY 2012 +/- FY 2010
Advanced Nursing Education Program: [4]				
Number of students	7,518	7,518	8,243	+725
Number of minority/disadvantaged students enrolled	1,875	1,875	1,978	+103
% minority/disadvantaged enrollment	24%	24%	24%	--
Number of graduates	1,785	1,785	1,785	--
Traineeship Programs: [5]				
Number of students supported	8,820	8,820	8,820	--
Number of graduates supported	3,918	3,918	3,918	--
Number of graduates practicing in underserved areas	5,298	5, 298	5,298	--

Grant Awards Table - ANE

Size of Awards (whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	151	151	211
Average Award	$278,298	$278,298	$337,500
Range of Awards	$79,469-$589,379	$79,469-$589,379	$312,500-$400,000

Grant Awards Table - AENT

Size of Awards (whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	351	351	351
Average Award	$45,584	$45,584	$45,584
Range of Awards	$1,994-$282,288	$1,994-$282,288	$1,994-$282,288

Grant Awards Table - NAT

Size of Awards (whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	82	82	82
Average Award	$15,262	$15,262	$15,262
Range of Awards	$1,711-$41,983	$1,711-$41,983	$1,711-$41,983

[2] Most Recent Result: Academic Year 2009-2010

[3] ANE Program outputs include the additional primary care advanced practice students training in interprofessional clinical training programs.

[4] ANE program outputs include students across all specialties.

[5] Traineeship Program targets have been consolidated and include the NAT and AENT programs.

Grant Awards Table - ANEE

Size of Awards (whole dollars)	FY 2010[6] Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	26	--	50
Average Award	$1,194,010	---	$316,800
Range of Awards	$704,000-$1,425,000	---	$316,800

[6] The award data for FY 2010 reflects full funding (5 years).

Nursing Workforce Development

Nursing Workforce Diversity

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$16,073,000	$16,107,000	$16,107,000	+$34,000
PHS Evaluation	---	---	$3,893,000	+3,893,000
Total Program Level	$16,073,000	$16,107,000	$20,000,000	+$3,927,000
FTE	--	--	--	--

Authorizing Legislation: Section 821 of the Public Health Service Act, as amended by the Affordable Care Act

FY 2012 Authorization .....Such Sums as Necessary

Allocation Method .....Competitive Grant/Contract

Program Description: 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) by providing student stipends and scholarships, stipends for diploma or associate degree nurses to enter a bridge or degree completion program, student scholarships or stipends for accelerated nursing degree programs, pre-entry preparation, advanced education preparation, and retention activities.

Need: A diverse health care workforce with diverse executive leadership and governance is necessary to help meet the needs of a diverse minority population and reduce health disparities and inequities. A U.S. Department of Health and Human Services report identifies 14 principles for minority health equity, including the recommendation for health care professional schools and the health care workforce to represent and reflect the diverse communities. [1]

The 2008 National Sample Survey of Registered Nurses reports that only 17 percent of the nursing workforce comes from racial/ethnic minority groups. While there has been a

[1] U.S. Department of Health and Human Services, Office of Minority Health, (July, 2009). *Ensuring that health care reform will meet the health care needs of minority communities and eliminate health disparities*, Available at: http://minorityhealth.hhs.gov/Assets/pdf/Checked/1/ACMH_HealthCareAccessReport.pdf

modest increase, additional efforts are needed to ensure a more diverse nursing workforce. 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.

Goal: To increase nursing education opportunities for individuals from disadvantaged backgrounds, including racial and ethnic minorities underrepresented among registered nurses to improve the diversity of the health care workforce and to improve the diversity of the nursing workforce to meet the increasing need for culturally sensitive and quality health care. The NWD program will also, for the first time, provide support for nurses pursuing advanced practice degrees, as authorized by the Affordable Care Act.

Eligible Entities: Eligible entities are accredited schools of nursing, nursing centers, academic health centers, State or local governments, and other private or public entities, including faith-based and community based organizations, and tribes and tribal organizations.

Designated Health Professions:	**Targeted Educational Levels:**	**Program Activities:**
• Registered Nurses (RNs) • Second degree students	• Pre-Entry Preparation - middle school students - high school students - high school graduates or equivalent - certified nursing assistants - licensed practical or vocational nurses • Diploma or Associate Degree RNs • College graduates with bachelors degree in another discipline • RNs who will matriculate into an accredited bridge or degree completion program within the three-year project period. • Baccalaureate Degree • Advanced nursing education	• Use financial support to assist the educational advancement of disadvantaged students to become RNs. • Prepare diploma or associate degree RNs to become baccalaureate-prepared RNs. • Prepare practicing RNs for advanced nursing.

Program Accomplishments: In FY 2009, 47 grantees provided academic enrichment support, financial assistance, and coaching and mentoring services for 5,247 pre-nursing and 3,431 nursing students and produced 705 nursing graduates.

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 2007	$16,107,000
FY 2008	$15,826,000
FY 2009	$16,107,000[2]
FY 2009 Recovery Act	$2,756,000
FY 2010	$16,073,000
FY 2011 CR	$16,107,000

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.

Budget Request

The FY 2012 Discretionary Request of $20,000,000 is an increase of $3,927,000 above the FY 2010 Actual Level. The increased funding would support the development of programs to recruit, prepare, mentor and support racial and ethnic minorities under-represented in nursing for advanced nursing education. The total request will support the education of pre-nursing and nursing students to become registered nurses and the preparation of participants for entry into a professional nursing program through pre-entry preparation, retention and stipend/scholarship program activities.

Outcomes and Outputs Tables

Outputs	Most Recent Result[3]	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Disadvantaged Students/Participants				
Number and percent of minority student/participants	6,116 (70%)	6,116 (70%)	6,566 (72%)	+450
Number and percent of white disadvantaged student/participants	2,562 (30%)	2,562 (30%)	2,562 (28%)	--
Total number of minority and white disadvantaged students/participants	8,678	8,678	9,128	+450
Level of Students/Participants				
Number of nursing program students	3,431	3,431	3,881	+450
Number of post high school, college, and pre-entry nursing students	1,925	1,925	1,925	--
Number of K-12 students/participants	3,322	3,322	3,322	--
Number of Nursing Graduates	910	910	910	--
Student Financial Support				

[2] Regular appropriation only.
[3] Most recent result: Academic Year 2009-2010

Outputs	Most Recent Result[3]	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Number of nursing students expected to receive scholarships	705	705	930	+225

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	45	45	60
Average Award	$316,000	$316,000	$316,000
Range of Awards	$134,600-$528,000	$134,600-$528,000	$134,600-$528,000

Nursing Workforce Development

Nurse Education, Practice, Quality and Retention Program

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$39,811,000	$39,896,000	$40,141,000	+$330,000
PHS Evaluation			$19,632,000	+$19,632,000
	$39,811,000	$39,896,000	$59,773,000	+$19,962,000
FTE	1	1	2	+1

Authorizing Legislation: Section 831 and Section 831 A of the Public Health Service Act, as amended by the Affordable Care Act

FY 2012 Authorization .....Such Sums as Necessary

Allocation Method .....Competitive Grant/Contract

Program Description: Nurse Education, Practice, Quality and Retention (NEPQR) Program is broad in scope and addresses the critical nursing shortage by supporting initiatives designed to expand the nursing pipeline, promote career mobility, provide continuing education and support retention.

The Nurse Education, Practice, Quality and Retention (NEPQR) Program has three major priority areas: education, practice, and retention. The Affordable Care Act modified retention priority area by requiring collaboration with an accredited school of nursing for nurse internship and residency programs and promoting career advancement for nursing personnel to become baccalaureate or advanced education nurses.

Need: A growing and aging population continues to increase the demand for nursing services. At the same time the nursing workforce is steadily aging and projected retirements from the workforce may significantly shrink the supply.

Goal: This program seeks to strengthen capacity for nurse education and practice to build current and future nursing workforce capacity.

Eligible Entities: Accredited schools of nursing, health care facilities including nurse-managed clinics and academic health centers, partnerships of a nursing school or health care facility, State or local governments, and other public or private non-profit entities.

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Registered Nurses • Certified Nursing Assistants • Home Health Aides • Licensed Practical Nurses • Licensed Vocational Nurses	• Baccalaureate education • Advanced nursing education • Diploma Degree • Associate Degree	• expand enrollment in baccalaureate nursing programs • provide education in new technologies • develop internships and residency programs • provide continuing education and training • develop cultural competencies • offer programs to promote nurse retention • increase access to primary care and clinical training sites for primary care advanced practice nurses, including inter-professional clinical training

Program Accomplishments: In FY 2010, the NEPQR Program funded 108 infrastructure grant awards which impacts associate and baccalaureate nursing students and the continuing education training for registered nurses. With these grants, 22 nurse managed health centers, four nurse internships, and five new accelerated baccalaureate programs were launched. Also in FY 2010 this program expanded beyond the scope of registered nurse training to include training grants for nursing aides and home health aides. In September 2010, the Nursing Assistant and Home Health Aide (NAHHA) Program awarded approximately $2.5 million to 10 colleges or community-based training programs for this new training initiative.

Funding History

FY	Amount
FY 2007	$37,291,000
FY 2008	$36,640,000
FY 2009	$37,291,000
FY 2010	$39,811,000
FY 2011 CR	$39,896,000

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.

Budget Request

The FY 2012 Discretionary Request of $59,773,000 is an increase of $19,962,000 above the FY 2010 Actual Level. These additional funds will support new training programs in interprofessional clinical training in primary care—focused on team-based comprehensive primary care services, including chronic disease management, preventive services, and coordinated care across settings—for primary care nurse practitioners in collaboration with other primary care providers. These additional funds would annually provide stipend support to primary care APN trainees in enrolled 2-year interprofessional primary care clinical training programs, producing approximately 1,000 primary care APNs in 5 years with stable funding across this period. The training programs will be conducted jointly with primary care medical residency programs, with advanced practice nursing students training directly with medical residents in team-based clinical practice methods. The National Committee for Quality Assurance recognizes team-based care as one of the core features of patient-centered primary care medical homes, and these new training programs will assist advanced practice nursing students in developing these competencies. Furthermore, these increased funds would support programs to expand enrollment in accelerated BSN programs that are designed to directly matriculate students in primary care advanced practice training, adding to the pipeline of the primary care workforce. The remaining request will support projects to enhance the educational mix and utilization of the nursing workforce through innovative approaches to shape the nursing workforce. Funding will support 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. The total request would continue to support the FY 2010 non-competing grant applications for the Nursing Assistant and Home Health Aide Program.

Outcomes and Outputs Tables

Outputs	Most Recent Result[1]	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Number of Expanded Baccalaureate Education Projects	20	20	40	+20
Number of BSN Student Participants	4,696	4,696	9,400	+4,704
Number of IP Primary Care Training Programs	--	--	40	+40
Number of IP Primary Care Trainees	--	--	600	+600

[1] Most Recent Result: Academic Year 2009-2010

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	108	108	188
Average Award	$288,300	$288,300	$346,400
Range of Awards	$100,000-$584,000	$100,000-$584,000	$100,000-$584,000

Nursing Workforce Development

Nurse Faculty Loan Program

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$24,947,000	$25,000,000	---	-$24,947,000
PHS Evaluation	---	---	$30,000,000	+$30,000,000
Total Program Level	$24,947,000	$25,000,000	$30,000,000	+$5,053,000
FTE	--	--	--	--

Authorizing Legislation: Title VIII, Section 846A of the Public Health Act, as amended by the Affordable Care Act

FY 2012 Authorization .....Such Sums as Necessary

Allocation Method .....Formula Grant

Program Description: The Nurse Faculty Loan Program (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.

Need: An insufficient number of qualified nursing faculty continues to be the primary barrier to accepting all qualified students at nursing colleges and universities. 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.[1]

Goal: The NFLP seeks to increase the number of qualified nursing faculty.

Eligible Entity: Accredited schools of nursing who offer advanced nursing education degree program(s) that will prepare graduate students for roles in education.

[1]American Association of Colleges of Nursing. *2008–2009 enrollment and graduations in baccalaureate and graduate programs in nursing.* Washington (DC): AACN; 2009. Pub. no. 08-09-1.

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Nursing	• Graduate (masters and doctoral)	• **Loan Fund:** - Provides funding to nursing schools for the establishment and operation of a revolving loan fund - Provide low interest rate loans to nursing students - Requires an institutional match of at least 1/9 of the Federal contribution to the loan fund • **Loan Cancellation Provision:** - Provide loan cancellation upon completion of service with 85 percent cancellation after 4 years of service

Program Accomplishments: In FY 2010, schools of nursing supported by the NFLP Program supported 1,518 students. 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.

Affordable Care Act: The NFLP was modified by the Affordable Care Act in the following ways: section 846A was amended to increase the annual loan limit to $35,500 from $30,000 and allow for annual increases in loan awards after FY 2011. Section 847(f) was added following 846A to include a funding priority that will be awarded to school of nursing student loans that support doctoral nursing students.

Funding History

FY	Amount
FY 2007	$4,773,000
FY 2008	$7,860,000
FY 2009	$11,500,000[2]
FY 2009 Recovery Act	$12,000,000
FY 2010	$24,947,000
FY 2011 CR	$25,000,000

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.

[2] Regular appropriation only

Budget Request

The FY 2012 Discretionary Request of $30,000,000 is an increase of $5,053,000 above the FY 2010 Actual Level. The increase will expand the number of grant awards made to eligible entities, which will in turn increase the number of students supported. The total request would support schools of nursing to establish and operate loan funds. The additional funds would increase the number of students receiving support for nurse faculty training. The number of schools is not anticipated to increase as many offering faculty preparation are already funded; each school has additional unmet need and therefore the number of students supported per school is expected to increase.

Outcomes and Outputs Tables

Outputs	Most Recent Result [3]	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Number of Schools Receiving Awards	99	114	114	--
Number of Students Supported	880	1,518	1,856	+338

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	114	114	114
Average Award	$205,970	$205,970	$240,300
Range of Awards	$1,000 - $1,788,817	$1,000 - $1,788,817	$1,000 - $ 2,086,953

[3] Most Recent Result: Academic Year 2009-2010

Nursing Workforce Development

Comprehensive Geriatric Education

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$4,557,000	$4,567,000	---	-$4,557,000
PHS Evaluation	---	---	$5,000,000	+$5,000,000
Total Program Level	$4,557,000	$4,567,000	$5,000,000	+$443,000

Authorizing Legislation: Section 865 of the Public Health Service (PHS) Act, as amended by the Affordable Care Act

FY 2012 Authorization .....Such Sums as Necessary

Allocation Method .....Competitive Grant/Contract

Program Description: This program provides support to train and educate individuals who provide geriatric care for the elderly.

Need: More than 65 million people, 29 percent of the U.S. population, provide care for a chronically ill, disabled or aged family member or friend during any given year and spend an average of 20 hours per week providing care for their loved one.[1] In addition, the Institute of Medicine[2] 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 U.S., primarily in nursing homes, assisted living facilities, and home and community-based settings. 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.

Goal: To provide quality geriatric education and training to individuals caring for the elderly.

---

[1] National Alliance for Caregiving in collaboration with AARP (2009). Caregiving in the United States 2009. www.caregiving.org/data/Caregiving_in_the_US_2009_full_report.pdf

[2] Institute of Medicine (2008). Retooling for an Aging America: Building the Health Care Workforce. National Academies Press, Washington, DC.

Eligible Entities: Schools of nursing, health care facilities, programs leading to certification as a certified nursing assistant, partnerships of such a school and facility, and partnerships of such a program and facility

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• All health professions • Direct service workers • Individuals	• Certificate • Diploma • Undergraduate • Graduate • Post-Graduate • Individuals with no professional education	• Provide training to individuals who will provide geriatric care for the elderly • Develop and disseminate curricula • Faculty development • Continuing education

Program Accomplishments: In Academic Year 2009-2010, 27 CGEP grantees provided education and training to 3,030 Registered Nurses/Registered Nursing Students; 260 Advanced Practice Nurses; 221 Faculty; 110 Home Health Aides; 483 Licensed Practical/Vocational Nurses & LPN students; 730 Nurse Assistants/Patient Care Associates; 810 Allied Health Professionals and 929 lay persons, guardians, activity directors. The CGEP grantees provided 459 educational course offerings in the care of the elderly on a variety of topics to 6,846 participants.

The Affordable Care Act: Amended this program to expand activities to include establishing traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing, long-term care, gero-psychiatric nursing or other nursing areas that specialize in the care of the elderly population.

Funding History

FY	Amount
FY 2007	$3,392,000
FY 2008	$3,333,000
FY 2009	$4,567,000
FY 2010	$4,557,000
FY 2011 CR	$4,567,000

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.

Budget Request

The FY 2012 Discretionary Request of $5,000,000 is an increase of $443,000 above the FY 2010 Actual Level. The increase will be used to support program development and implementation activities. The total request will support an estimated 16 projects to

provide education and training on a variety of geriatric related health topics to approximately 5,700 individuals providing geriatric care to older adults. The increase will also address program expansion activities in the form of traineeship support. Traineeship support will increase the cost of each award by $124,000. As a result, the number of awards will decrease.

Outcomes and Outputs Tables

Outputs	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Number of Geriatric Projects	27	27	16	-11

Grant Awards Table
Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	27	27	16
Average Award	$127,000	$127,000	$296,400
Range of Awards	$98,691-$172,080	$98,691-$172,080	$246-056-$320,112

Nursing Workforce Development

Nurse Managed Health Clinics

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	---	---	$10,000,000	+$10,000,000
PHS Evaluation	---	---	$10,000,000	+$10,000,000
Prevention and Public Health Fund	$15,268,000	---	---	-$15,268,000
Total Program Level	$15,268,000	---	$20,000,000	+$4,732,000
FTE	---	---	---	---

Authorizing Legislation: Affordable Care Act, Public Law 111-148

FY 2012 Authorization .....Such Sums as Necessary

Allocation Method .....Competitive Grant/Contract

Program Description: This program supports nurse managed clinics which improve access to primary care, enhance nursing practice by increasing the number of clinical teaching sites for primary care and community health nursing students, and develop electronic processes for establishing effective patient and workforce data collection systems.

Need: Nurse Managed Health Clinics (NMHC) serve as primary care access points in areas where primary care providers are in short supply. Approximately 58 percent of NMHC patients are either uninsured, Medicaid recipients, or self-pay.[1] The complexity of care of these patients presents significant financial barriers and heavily impacts the sustainability of these clinics over time. Additionally, limited clinical training sites were identified as one of the primary barriers to quality clinical training for nursing students.[2]

Goal: To provide comprehensive primary health care services, disease prevention and health promotion in medically underserved areas for vulnerable populations and to

[1] National Nursing Consortium Membership Survey 2005-2006
[2] American Association of Colleges of Nursing (2010). *Nursing Shortage Fact Sheet.* Available at http://www.aacn.nche.edu/media/factsheets/nursingshortage.htm

enhance nursing practice by increasing the number of structured clinical teaching sites for undergraduate and graduate nursing students.

Eligible Entities: Community based NHMC's, which provide primary care or wellness services to underserved or vulnerable populations, and have an association with a school, college, university, or department of nursing, federally qualified health center, or independent nonprofit health or social services agency

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Registered Nurses • Advanced Practice Nurses	• Graduate • Baccalaureate programs	• Assure the health workforce is trained to provide quality, culturally and linguistically appropriate care • Increase the number of practicing health care providers to address shortages • Provides new training and practice development sites for nurse practitioners to build the capacity of the primary care provider workforce

Program Accomplishments: In FY 2010, HRSA awarded $15,268,000 for 10 three-year infrastructure grants to community based NMHCs. These clinics expect to train 900 primary care nurse practioners during their three-year grants.

Funding History

FY	Amount
FY 2007	---
FY 2008	---
FY 2009	---
FY 2010	---
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.

Budget Request

The FY 2012 Discretionary Request of $20,000,000 is an increase of $20,000,000 above the FY 2010 Actual Level. The total request would continue the expansion of the primary care training infrastructure so that the nurse practitioners can be trained. The HRSA funded nurse managed clinics would be required to ensure that 30 percent of their training slots were available for nurse practitioners.

The NMHCs would increase access to primary care for thousands of uninsured populations in some of the most vulnerable communities. The funding of additional

NMHCs will enable schools of nursing to increase innovative clinical teaching site opportunities for advanced practice nursing students which directly expand the capacity of nursing school enrollments.

Outcomes and Outputs Tables

Outputs	Most Recent Result	FY 2010 Target[3]	FY 2012 Target	FY 2012 +/- FY 2010
Number of advanced practice nursing students supported	NA	300	1,200	+900
Number of patient encounters	NA	31,000	124,000	+93,000

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request[4]
Number of Awards	10	---	40
Average Award	$1,484,809	--	$500,000
Range of Awards	$1,400,000-$1,500,000	--	$500,000

[3] These figures represent FY 2010 grantees that were fully-funded from the Prevention and Public Health Fund for three years at the time of award.

[4] These figures represent projected grant awards for the FY 2012 budget request

Patient Navigator Outreach and Chronic Disease Prevention Program

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$4,965,000	$5,000,000	---	-$4,965,000
FTE	2	3	--	-2

Authorizing Legislation: Section 340A of the Public Health Service Act, as amended by the Affordable Care Act

FY 2012 Authorization ..... Such Sums as Necessary

Allocation Method ..... Grants/Contract

Program Description: The purpose of the Patient Navigator Outreach and Chronic Disease Prevention (Patient Navigator) Program, a demonstration grant program, is to make available grants which provide training to individuals to reduce barriers to care, promote health education, and encourage the use of primary care services to population with health disparities. By coordinating health care services and community resources, the patient navigators assist patients in receiving prompt diagnosis and treatment.

Need: Widespread failings in chronic care management are a major National concern. Many of these failings stem from systemic problems, rather than a lack of effort or intent by providers to deliver high quality care. In addition, patients with multiple chronic disease co-morbidities are often disproportionately affected, because of the complexity of their self-care regimes and medical care needs.[5] They have a higher risk of developing co-morbid conditions, complications, and acute care crises. Controlling these conditions successfully may require ongoing guidance and support beyond individual provider settings.

Goal: To evaluate approaches to developing and implementing patient navigator services to improve health care outcomes for individuals with cancer and other chronic diseases, with a specific emphasis on health disparities populations

Eligible Entities: Public and nonprofit private health centers (including Federally qualified health centers (as the term is defined in section 1861 (aa)(4) of the Social Security Act), health facilities operated by or pursuant to a contract with the Indian Health Service, hospitals, cancer centers, rural health clinics, academic health centers, or nonprofit entities that enter into partnerships or coordinates referrals with such centers, clinics, facilities, or hospitals to provide patient navigation services.

[1]Vogeli, C, et al. "Multiple Chronic Conditions: Prevalence, Health Consequences, and Implications for Quality, Care Management, and Costs." *Journal of General Internal Medicine*, 2007; 22(Suppl 3): 391-5.

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Paraprofessional	• NA	• Recruit patient navigators • Develop and operate patient navigator programs • Employ patient navigators who have direct knowledge of the communities they serve • Facilitate the involvement of community organizations • Identify and help patients overcome barriers within the health system • Conduct ongoing outreach to health disparities populations • Coordinate with relevant health insurance ombudsman programs • Evaluate outcomes of program

Program Accomplishments: Funds were first appropriated in FY 2008 for six grants with two-year project periods. The initial six grantees trained 37 navigators who provided outreach to about 20,000 patients and navigated about 6,500 patients over the two-year project period.

Funding History

FY	Amount
FY 2007	---
FY 2008	$2,948,000
FY 2009	$4,000,000
FY 2010	$4,965,000
FY 2011 CR	$5,000,000

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.

Budget Request

No funds are requested for this program in FY 2012. The Patient Navigator Program was authorized in FY 2005 as a demonstration program and has been successful in accomplishing its goal and may serve as a model for future efforts. The Report to Congress will describe patient navigator services as a promising model for chronic disease prevention and management.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	10	10	---
Average Award	$380,398	$400,000	---
Range of Awards	$372,642-$381,735	$400,000	---

Children's Hospitals Graduate Medical Education Payment Program

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$316,824,000	$317,500,000	---	-$316,824,000
FTE	15	20	---	-15

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

FY 2012 Authorization ..... Expired

Allocation Method ..... Formula Based Payment

Need: 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. These children's hospitals are considered safety net hospitals as they serve a large number of Medicaid and uninsured patients and provide charity care.

Program Description: The Children's Hospitals Graduate Medical Education (CHGME) Payment Program supports graduate medical education (GME) in freestanding children's teaching hospitals.

Goal: To help eligible hospitals maintain GME programs to provide graduate training for physicians to supply quality care to children, and enhance their ability to care for low income patients

Eligible Entities: Free standing children's teaching hospitals

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Pediatric Medicine	• Graduate Medical Education	• Monthly payments to the participating hospitals • Hospitals have established a "Resident Assessment Program" and are 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. • Submit an annual report on the status of GME in their institutions

Program Accomplishments: In FY 2009, the CHGME Payment Program supported 56 freestanding children's hospitals located in 31 States which were responsible for the training of 5,840 full time equivalent (FTE) residents on and off site.

Funding History

FY	Amount
FY 2007	$297,009,000
FY 2008	$301,646,000
FY 2009	$310,000,000
FY 2010	$316,824,000
FY 2011 CR	$317,500,000

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.

Budget Request

The FY 2012 President's Budget does not request funding for this program. The budget request focuses on competitive activities that more directly fund the expansion of the primary care workforce in community-based settings.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
7.I.A.1: Maintain the number of FTE residents in training in eligible children's teaching hospitals	FY 2009: 5,840 (Target Exceeded)	5,900[1]	N/A	--
7.VII.C.1: Percent of hospitals with verified FTE residents counts and caps	FY 2009: 100% (Target Met)	100%	N/A	--
7.E: Percent of payments made on time	FY 2009: 100% (Target Met)	100%	N/A	--

Grant Awards Table

Size of Award

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	56	56	---
Average Award	$5,422,850	$5,422,850	---
Range of Awards	$24,252-$22,938,900	$24,252-$22,938,000	---

[1] This target was updated from that shown in the FY 2011 Congressional Justification to better reflect most recent performance.

Teaching Health Centers Development Grants

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	---	---	$10,000,000	+$10,000,000
FTE	--	--	--	--

Authorizing Legislation: Affordable Care Act Section 749A

FY 2012 Authorization $50,000,000

Allocation Method ..... Competitive grant

Program Description: The Teaching Health Centers (THC) Development Grant Program provides funding to cover the costs of curriculum development, accreditation, faculty salaries, and the recruitment, training and retention of residents and faculty.

Need: Health centers are a significant source of primary care services, but face considerable workforce shortages. By 2015, it is estimated that an additional 15,000 primary care providers will be needed to care for 30 million patients in health centers. Studies have shown that graduates of residency programs where significant amounts of time are spent training in health centers are more likely to practice in these settings.

Goal: Increase the supply of primary care providers through new or expanded primary care residency programs sponsored by community based ambulatory settings.

Eligible Entities: Community-based clinics that intend to operate a primary care residency program and become eligible Teaching Health Centers.

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Primary Care Physicians • Dentists	• Graduate Medical Education	• Grants are awarded to eligible entities to provide technical assistance in the development of teaching health centers • Increase the number of eligible Teaching Health Centers that will train primary care physicians and dentists in community-based settings such as federally qualified health centers, community mental health clinics, rural health clinics, and Indian Health clinics

Program Accomplishments: New program for 2012.

Funding History

FY	Amount
FY 2007	---
FY 2008	---
FY 2009	---
FY 2010	---
FY 2011 CR	---

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

Budget Request

The FY 2012 Discretionary Request of $10,000,000 is an increase of $10,000,000 above the FY 2010 Actual Level. The total request will be used to cover the cost of establishing new Teaching Health Centers, including costs associated with: curriculum development; recruitment, training and retention of residents and faculty; accreditation by the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association (ADA), or the American Osteopathic Association (AOA); and faculty salaries during the development phase; and, technical assistance provided by an eligible entity. In addition to supporting the cost of establishing or expanding teaching health center residency programs, up to $1 million of this funding will be awarded to technical assistance organizations.

During their training, resident physicians and dentists in Teaching Health Centers will provide supervised patient care, thereby helping to address the Nation's primary care needs. These training opportunities are part of the primary care workforce pipeline. The impact of the expanded primary care residency programs will be to increase the supply of primary care physicians and dentists.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Average number of additional resident physicians trained per health center	NA	NA	6	+6
Number of new accredited Teaching Health Centers	NA	NA	18	+18
Additional Primary care physicians trained in 18 health centers	NA	NA	108	+108

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	NA	NA	18
Average Award	NA	NA	$500,000
Range of Awards	NA	NA	$250,000-$500,000

National Practitioner Data Bank

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$23,508,000	$23,508,000	$28,016,000	+$4,508,000
FTE	27	45	45	+18

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); 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; and Section 6403 of the Affordable Care Act of 2010.

FY 2012 Authorization ..... Indefinite

Allocation Method ..... User Fee Program

Program Description: The National Practitioner Data Bank (NPDB) collects certain adverse information, medical malpractice payment history, and information related to health care fraud and abuse and discloses it to health care agencies and organizations that make licensing and employment decisions.

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

Goal: To encourage professional peer review, assist in the prevention and reduction of health care fraud and abuse and promote quality health care.

Consolidation: Under the Affordable Care Act, the Healthcare Integrity and Protection Data Bank (HIPDB) will be merged into the NPDB, thus ending the duplication of effort and cost between the two Data Banks. The users that currently query both Data Banks will receive the same information with one query, thereby reducing their cost by half. The merger of the two Data Banks is scheduled to occur after the publication of final regulations in the first part of FY 2012.

Program Accomplishments: The Health Resources and Services Administration (HRSA) took important steps to strengthen the Data Banks, including:

- Implemented Section 1921 of the Social Security Act, which expanded the NPDB to include adverse licensure actions on all health care practitioners and entities.
- Expanded its technical assistance efforts to reach over 350 individuals employed by State Licensing agencies in all 50 States.

- Completed a gap analysis of reports on specific health care practitioners in the HIPDB with publicly available disciplinary actions obtained from State licensing agencies.
- Increased its efforts to improve the time to complete a review requested by practitioners to determine if the report meets the statutory requirements.

Funding History
The table below shows the user fees (revenue) collected during the last five years:

FY	Amount
FY 2007	$22,573,263
FY 2008	$24,545,442
FY 2009	$23,508,000
FY 2010	$23,508,000
FY 2011 CR	$23,508,000

Budget Request

As mandated by the Health Care Quality Improvement Act, the NPDB does not receive appropriated funds. Instead, the NPDB is financed by the collection of user fees. Annual Appropriations Act language since FY 1993 requires that user fee collections cover the full cost of NPDB operations; therefore, there is no request for appropriation for operating the NPDB.

It is anticipated that with the implementation of Section 6403 of the Affordable Care Act, the HIPDB will be terminated after the third quarter of FY 2012. Therefore, the FY 2012 user fee collections are projected to be $28,016,000. User fees are established at a level to cover all program costs to allow the Data Banks to meet short and long term program performance goals. Fees are established based on query volume that will result in adequate revenues to pay all program costs.

Since 1990, user fees have changed due to increases and decreases in query volume.
The NPDB estimate for FY 2012 is 6,650,000 queries.

Outcomes and Outputs Tables

Measure	Most Recent Result[1]	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
8.III.B.1: Increase annually the use of the NPDB and HIPDB for licensing and credentialing decision-making, operationalized as the number of licensing and credentialing decisions which limit practitioner's ability to practice.	FY 2009: 53,410 Decisions (Target Exceeded)	54,980 Decisions	68,125 Decision	+13,145
8.III.B.2: Increase annually the number of times information provided by NPDB and HIPDB is considered useful by the querying entity which received it.	FY 2009: 542,140 Occasions (Target Exceeded)	544,390 Occasions	675,750 Occasions	+131,360
8.E: Increase annually the number of queries for which NPDB and HIPDB responded within 240 minutes	FY 2009: 5,085,760 Queries (Target Exceeded)	5,202,000 Queries	6,650,000 Queries	+1,448,000

[1] The most recent results and FY 2010 targets reflect the NPDB and HIPDB programs. The FY 2012 target reflects the NPDB-HIPDB merger.

Maternal and Child Health

Maternal and Child Health Block Grant

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$660,710,000	$662,121,000	$654,489,000	-$6,221,000
FTE	14	9	9	-5

Authorizing Legislation - Title V of the Social Security Act.

FY 2012 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 health care, and improve the quality of health care. 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 health care 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 health care 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 health care needs.

Table 1. Maternal and Child Health Block Grant Activities

MCHB Activities	FY 2010 Enacted	FY 2011 CR	FY 2012 Budget Request	FY 2012+/- FY 2010
State Block Grant Awards[1]	$557,978,392	$559,170,000	$567,965,822	+$9,987,430
SPRANS	$ 92,353,771	$92,551,000	$ 74,712,263	-$17,641,508
CISS	$ 10,377,837	$10,400,000	$ 11,810,915	+$1,433,078
Total	$660,710,000	$662,121,000	$654,489,000	-$6,221,000

Additional activities that support the improved health care 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.

[1] Through the MCH Block Grant, HRSA distributes funding to the States, provides oversight by requiring States to report progress annually on key MCH performance/outcome measures and indicators, and offers technical assistance to States to improve performance. Each State is responsible for determining its MCH priorities, based on the findings of a comprehensive Needs Assessment every five years, targeting funds to address the identified priorities and reporting annually on its progress. The MCH Block Grant emphasizes accountability in ensuring that States meet the legislative and programmatic requirements while providing appropriate flexibility for each State to address the unique needs of its MCH population.

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

MCH SPRANS Set-Aside Programs	FY 2010 Enacted	FY 2011 CR	FY 2012 Budget Request	FY 2012+/- FY 2010
SPRANS	$73,107,873	$73,264,000	$74,712,263	+$1,604,390
SPRANS - Oral Health	$ 4,848,645	$ 4,859,000	---	-$4,848,645
SPRANS – Epilepsy	$ 3,700,098	$ 3,708,000	---	-$3,700,098
SPRANS - Sickle Cell	$ 3,765,957	$ 3,774,000	---	-$3,765,957
SPRANS - Fetal Alcohol	$ 484,964	$ 486,000	---	-$484,964
SPRANS – Doula	$ 1,500,795	$ 1,504,000	---	-$1,500,795
SPRANS - 1st time Motherhood	$ 4,945,439	$ 4,956,000	---	-$4,945,439
Total SPRANS	$92,353,771	$92,551,000	$74,712,263	-$17,641,508
CISS	$10,377,837	$10,400,000	$11,810,915	+$1,433,078

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 quality health care and services; 2) improving health equity; and 3) building healthy communities. 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 quality health care and services, the program has been able to exceed the targets for both the number of children served by the States under Title V (33.3 million in FY 2009) and the number of children receiving Title V services who have Medicaid and Child Health Insurance Program (CHIP) coverage. In FY 2008, the Title V MCH Block Grant Program served the largest number of children (35 million) since data collection began in the Title V Information System in the 1990's. While 1.7 million fewer children were served by Title V in FY 2009 than in FY 2008, the target of 29 million was exceeded. 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. Exceeding the targets is significant as these increases occurred in a period of severe financial constraints at the State and local levels. The 15.2 million children who received Title V services and had Medicaid and CHIP coverage in FY 2009 is a significant increase over the FY 2002 baseline of 5.9 million.

Title V programs work to improve health equity and eliminate 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 2.35:1 from FY 2002 to FY 2007. Additionally, preliminary data indicate that the ratio declined further in 2008 to 2.29:1 (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, the rate increased slightly in 2007 to 6.8 per 1,000 births (National Vital Statistics Reports). Based on preliminary data, the infant mortality rate for 2008 decreased to 6.6 infant deaths per 1,000 births (National Vital Statistics Report). An increase in the rate to 7.0 per 1000 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).

The Bureau continues to explore and promote evidence-based practices to reduce the incidence and better understand the causes of low birth weight. 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. The low birth weight rate improved slightly in 2007 and 2008 to 8.2 percent (National Vital Statistics Report). 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. The delivery of very low birth weight infants (i.e. babies born weighing less than 1500 grams) 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 and 2008, the rate increased to 74.8 percent and 76.1 percent, respectively.

The program is partnering with State programs, the Centers for Disease Control and Prevention, and the Association of Maternal and Child Health Programs to assess influential factors. A recent study conducted by the Cecil G. Sheps Center and supported by the Bureau examined the trends in the rate of very low birth weight deliveries in an appropriate hospital and explored reasons that States give for change in this marker.The extent to which regionalized perinatal care systems are regulated and prescribed varies considerably. States are examining where very low birth weight births occur and why some do not occur in facilities for high-risk deliveries. Understanding if health care systems factors have played a role in a poor outcome and identifying which factors could potentially be modified would be an important contribution to improving this indicator. Surveillance of very low birth weight births is necessary for the quality improvement initiatives that are frequently cited by States as processes by which they hope to improve neonatal health and health care.

Prenatal care is one of the most important interventions for ensuring the health of pregnant women and their infants. Data on the timing of prenatal care are derived from the 1989 and the 2003 Revisions of the U.S. Standard Certificate of Live Birth. Due to substantive changes in how information is reported on the timing of prenatal care in the 2003 Certificate, the two formats are not directly comparable. Prenatal care data based on the revised certificate show a less favorable picture of prenatal care utilization in the U.S. than do the data from the unrevised certificate. However, most of the difference can be attributed to changes in reporting rather than changes in prenatal care utilization.

The percentage of women who began care in the first trimester of pregnancy declined in both the revised and unrevised reporting areas between 2005 and 2006. Based on the 18 States for which 2006 revised prenatal care data were available (which represented 35 percent of all 2006 births), 69.0 percent of mothers reportedly began care within the first 3 months of pregnancy. For 2007, the percentage increased to 70.8, based on prenatal care data from the 22 States that used the Revised Birth Certificate (which represents 53 percent of all births). However, for the 18 States that reported Revised Birth Certificate data in both 2006 and 2007, the percentage of women who received first trimester care decreased slightly from 69 percent to 67.5 percent. While prenatal care utilization rose fairly steadily during the 1990s through 2003, the decline in 2006 followed two consecutive years (2004 and 2005) in which prenatal care levels did not improve. 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.

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 Actual level 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 also used to support 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.

The MCHB investment in IT supports the strategic and performance outcomes of the program and contributes to its success by providing a mechanism for sharing data and conducting business in a more efficient manner. The HRSA Electronic Handbooks (EHBs) supports MCHB with program administration, grants administration and monitoring, management reporting, and grantee performance measurement and analysis. The MCHB investment in IT includes funding for the continued level.

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 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[2]
FY 2009	$662,121,000[3]
FY 2010	$660,710,000
FY 2011 CR	$662,121,000

Budget Request

The FY 2012 Discretionary Request for the Maternal and Child Health Block Grant program is $654,489,000, which is $6.2 million less than the FY 2010Actual Level. This level of funding

2 Reflects moving $20 million to the Autism and Other Developmental Disorders Program.

3 Reflects moving $6.9 million to the Newborn Screening for Heritable Disorders Program.

will provide: $568.0 million for State Block Grant awards; $74.7 million for the SPRANS set-aside, and $11.8 million for the CISS set-aside. The request eliminates the following: $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, and $1.5 million for Doula.

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 2012 target for the number of children served by the Title V Block Grant is 33 million, an increase of 3.0 million over the FY 2010 target. Between 2004 and 2008, the number of children served by Title V steadily increased. There was a slight decrease between 2008 and 2009. While the cost of health care has continued to increase, funding for the MCH Block Grant has been relatively level in recent years. This factor may impact the number of children who can be served by the State Title V MCH programs in future years. MCHB will continue to monitor the number of children served to assess if the 2008 decrease represents an exception or a trend.

Similarly, the FY 2012 target of 14 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 and FY 2008 performance levels of 12.8 million and 14.7 million, respectively. 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 of 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 2012 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. Given the slow rate of progress, the FY 2012 performance target is ambitious and 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. 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 2012 Target	FY 2012 +/- FY 2010
10.1: Decrease the number of uninsured children [4] *(Outcome)*	FY 2008: 7.3M [5]	N/A	N/A	N/A
10.I.A.1: Increase the number of children served by Title V. *(Output)*	FY 2009: 33.3M (Target Exceeded)	30M	33M	+3M
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 2009: 15.2M (Target Exceeded)	12M	14M	+2M
10.E: Increase the number of children served by the Title V Block Grant per $1 million in funding *(Efficiency)*	FY 2009: 50,267 (Target Exceeded)	40,000	45,000	+5,000
10.IV.B.1: Decrease the ratio of the black infant mortality rate to the white infant mortality rate *(Output*	FY 2007: 2.4 to 1[6] (Preliminary 2008: 2.29 to 1)[7]	2.1 to 1	2.1 to 1	Maintain

[4] This is a long-term measure with no annual target.
[5] *U.S. Census Bureau, Current Populations Reports, P60-238,* Income, Poverty and Health Insurance Coverage in the U.S.*: 2009 U.S. Government Printing Office, September 2010.*
[6] National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2010. Deaths: preliminary data for 2008, National Vital Statistics Reports, Vol. 59, No. 2, December 9, 2010.

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
10.III.A.1: Reduce the infant mortality rate (Baseline – FY 2005: 6.9/1,000) *(Outcome)*	Preliminary FY 2008: 6.6 per 1,000[7] (Target Not Met)	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 2008: 8.2% [8] (Target Met)	8.2%	8.2%	Maintain
10.III.A.3: Increase percent of pregnant women who received prenatal care in the first trimester *(Outcome)*	FY 2007: 70.8% [9] (Target Not Applicable)	86.5%[9]	70%[9]	N/A[9]
10.2: Reduce the national rate of neonatal deaths per 1,000 live births *(Outcome)*	Preliminary FY [10]2008: 4.3 per 1,000 (Target Exceeded)	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 2008: 76.1%[11] (Target Exceeded)	76%	76%	Maintain
10.3: Increase maternal survival rate (deaths/100,000 live births) *(Outcome)* [4]	FY 2005: 15.1 per 100,000[8] (Baseline)	N/A	N/A	N/A

[7] *The National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2010. Births: final Data for 2008, National Vital Statistics Reports, Vol. 59, No. 1, December,2010*

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

[9] National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2010.Births: final Data for 2007, National Vital Statistics Reports, Vol. 58, No. 42,August,2010 the FY 2007 result end the FY 2012 target are based on the use of 2003Revised Birth Certificate. This cannot be compared to previous targets which are based revised Birth Certificate

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

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

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	59	59	59
Average Award	$9,366,816	$9,312,658	$9,449,525
Range of Awards	$149,214-$43,143,965	$148,351-$42,683,449	$150,532-$43,847,257

State Table

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

State	FY 2010	FY 2011 CR	FY 2012 PB
Alabama	11,698,114	11,635,768	11,804,641
Alaska	1,113,957	1,108,180	1,123,827
Arizona	7,065,379	6,997,836	7,180,786
Arkansas	7,083,516	7,045,167	7,149,041
California	43,143,965	42,683,449	43,930,821
Colorado	7,236,695	7,204,822	7,291,156
Connecticut	4,739,759	4,717,244	4,778,230
Delaware	1,964,226	1,958,092	1,974,708
District of Columbia	7,064,107	7,054,838	7,079,945
Florida	19,101,317	18,936,726	19,382,543
Georgia	16,246,359	16,150,591	16,409,994
Hawaii	2,270,185	2,259,559	2,288,340
Idaho	3,231,383	3,217,789	3,254,610
Illinois	21,649,495	21,529,746	21,854,102
Indiana	11,752,551	11,703,330	11,836,561
Iowa	6,521,209	6,500,439	6,556,697
Kansas	4,710,420	4,688,416	4,748,017
Kentucky	11,334,565	11,281,218	11,425,717
Louisiana	13,329,670	13,245,888	13,472,823
Maine	3,397,305	3,386,777	3,415,294

State	FY 2010	FY 2011 CR	FY 2012 PB
Maryland	11,940,135	11,902,951	12,003,670
Massachusetts	11,434,154	11,387,664	11,513,589
Michigan	18,839,219	18,746,719	18,997,268
Minnesota	9,060,776	9,028,882	9,115,271
Mississippi	9,715,445	9,661,337	9,807,896
Missouri	12,365,078	12,307,273	12,463,846
Montana	2,430,627	2,419,381	2,449,844
Nebraska	4,019,019	4,004,741	4,043,415
Nevada	1,785,662	1,767,374	1,816,909
New Hampshire	2,000,454	1,994,260	2,011,083
New Jersey	11,661,388	11,601,696	11,763,379
New Mexico	4,346,273	4,313,454	4,402,347
New York	40,947,507	40,707,509	41,356,575
North Carolina	16,584,224	16,502,701	16,723,519
North Dakota	1,815,867	1,810,058	1,825,792
Ohio	22,078,420	21,971,308	22,261,435
Oklahoma	7,273,407	7,228,346	7,350,399
Oregon	6,213,685	6,181,851	6,268,076
Pennsylvania	24,349,665	24,239,131	24,538,529
Rhode Island	1,766,145	1,755,357	1,784,578
South Carolina	11,388,174	11,339,092	11,472,039
South Dakota	2,254,601	2,245,699	2,269,811
Tennessee	11,673,430	11,608,590	11,785,218
Texas	34,321,224	34,009,355	34,854,094
Utah	6,006,354	5,987,545	6,038,492
Vermont	1,692,918	1,688,569	1,700,349
Virginia	12,369,389	12,314,473	12,463,220
Washington	9,002,043	8,948,867	9,092,900
West Virginia	6,423,134	6,397,949	6,466,168
Wisconsin	10,809,198	10,769,841	10,876,445
Wyoming	1,254,457	1,249,683	1,262,614
SUBTOTAL	532,476,249	529,397,531	537,736,668
American Samoa	497,378	494,502	502,292
Guam	768,173	763,732	775,762
Marshalls	232,108	230,766	234,401

State	FY 2010	FY 2011 CR	FY 2012 PB
Micronesia	525,011	521,975	530,197
Northern Marianas	469,747	467,030	474,387
Palau	149,214	148,351	150,688
Puerto Rico	16,015,570	15,922,970	16,173,790
Virgin Islands	1,508,714	1,499,991	1,523,619
SUBTOTAL	20,165,915	20,049,317	20,367,136
TOTAL Resources	552,642,164	549,446,848	558,101,804

Autism and Other Developmental Disorders

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$47,898,000	$48,000,000	$55,000,000	+$7,102,000
FTE	4	5	5	+1

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

FY 2012 Authorization .....Expired

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 to expand the LEND interdisciplinary training programs, including 4 new planning grants; expand the autism research intervention grants, and to support additional state demonstration grants, supplements to developmental-behavioral pediatrics training programs, resource centers and a national evaluation. 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. The FY 2011 anticipated budget, assuming a year-long continuing resolution, is $48,000,000. This budget will support 40 LEND interdisciplinary training programs, providing services and training to 1 additional state; 3 research networks and 15 autism intervention research projects examining areas of particular interest to families as outlined in the Interagency Autism Coordinating Committee's 2010 Strategic Plan for Autism Spectrum Disorder Research; and state13 State demonstration grants, resource centers, and a national evaluation. All activities continue to be coordinated with the Centers for Disease Control and Prevention's Learn the Signs. Act Early. public awareness campaign. LEND programs and State demonstrations jointly sponsor regional summits with CDC to coordinate early screening, diagnosis and treatment programs.

A Report to Congress with findings to date was submitted to the National Institute of Mental Health (NIMH) in December 2010. Selected findings are presented here.

The Combating Autism Act Initiative (CAAI) expansion of LEND training programs improved health professionals' ability to conduct screenings and assessments as well as treat those with ASD. This resulted in a substantive increase in the number of infants and children who were screened or evaluated in grantee-affiliated clinics between FY 2009 and FY 2010. In FY 2009, the 22 LEND programs that received CAAI funding collectively screened 12,751 infants and children and provided diagnostic evaluation services to 12,390. In FY 2010, the 39 LENDs collectively screened more than 46,000 infants and children and provided diagnostic evaluation services for more than 35,000 infants and children.

The 39 LEND and 6 Developmental-Behavioral Pediatrics (DBP) training programs that received CAAI grant funding cover 32 States and the District of Columbia, and their reach extends beyond those States because of partnerships formed and services provided across State lines. CAAI training efforts are effectively reducing barriers to screening and diagnosis by increasing professional capacity and increasing awareness about ASD among providers in the

community. With the CAAI funding, the training programs have significantly expanded their didactic, clinical, and community based training activities, including 781 continuing education training events reaching over 92,000 participants, an increase in participants of 248% from the previous year. Recruitment and support of trainees obtaining instructional and practical experience in screening, diagnostic evaluation, or evidence-based intervention services for children with ASD and other DD increased in every grant program. Short term trainees (those receiving up to 40 hours of clinical training) increased 642%, from 1,137 trainees in 2009 to 8,437 in 2010. Medium term (>40 hours and less than 300 hours of clinical and didactic training) and Long term trainees (>=300 hours of training) increased 82% (from 1,377 to 2,496) and 173% (from 510 to 1,391), respectively.

The Research Networks are actively developing evidence-based clinical practice guidelines to support clinicians in decision-making, diagnosis, management, and treatment of children with ASD. The Networks are also working on developing tools designed to assist physicians and families in managing the care of children with ASD. These tools may, for example, help to quickly assess a child's engagement level on the playground or help parents manage their children's sleep behavior. Other significant R40 research projects explore comparative outcomes of parent-mediated vs. center-based interventions for minority and underserved toddlers with ASD and evaluation of interactive tele-video technology to deliver mental health interventions to families of children with ASD who are geographically removed from specialty medical centers.

Nine States were awarded implementation grants (Alaska, Illinois, Missouri, New Mexico, New York, Rhode Island, Utah, Washington and Wisconsin). State activities have focused on building infrastructure, reducing barriers to care, raising awareness, and enhancing the training available. Select accomplishments include development of: training summits for State agencies and providers who serve youth with ASD; a model resource center for adults with ASD and their families; resource guides for families to ensure successful transition to adult services; a portable medical summary of young adult's pediatric care for adult provider; online trainings for families and providers that can be accessed at any time; regional referral systems; and private insurance and Medicaid policy changes that would make ASD services more accessible.

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 2007	---
FY 2008	$36,354,000
FY 2009	$42,000,000
FY 2010	$47,898,000
FY 2011 CR	$48,000,000

Budget Request

In FY 2012, funds will be used to continue and expand activities initiated in FY 2008 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.

The FY 2012 Discretionary Request is $55,000,000, an increase of $7.1 million from the FY 2010 Actual Level. Of the $7.1 million increase, $2.6 million will support LEND interdisciplinary training programs; $2.1 million will support additional autism intervention research projects examining areas of particular interest to families as outlined in the Interagency Autism Coordinating Committee's 2010 Strategic Plan for Autism Spectrum Disorder Research; and the remainder will support State demonstration grants, resource centers, a national evaluation, and a quality improvement initiative. All activities will continue to be coordinated with the Interagency Autism Coordinating Committee and, in particular, with the Centers for Disease Control and Prevention's Learn the Signs. Act Early. public awareness campaign.

A program evaluation will be completed in July 2011 and will assess all aspects of the program (research, training and State demonstration efforts).

Grant Awards Table
Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Grants:			
LEND	$28,323,188	$28,390,132	$30,956,283
DBP	$1,854,672	$1,854,672	$1,854,672
Research	$10,179,492	$10,300,000	$12,200,000
State Demonstration	$3,800,000	$3,700,000	$5,000,000
Resource Centers	$912,641	$912,641	$987,641
Quality Improvement			$581,806
Number of Awards	86	83	102
Average Award	$519,232	$544,065	$505,690

Traumatic Brain Injury

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$9,918,000	$9,939,000	$9,918,000	---
FTE	---	---	---	---

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

FY 2012 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: 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. For TBI, 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 the objectives contained in their TBI action plans. Since the program has reached its potential on these annual measures, new measures have been developed. The first measure is to "increase the number of new State partnerships and/or collaborations with governmental and non-governmental organizations." The FY 2010 baseline data show that there are at least 131 new partnerships. The second measure to "increase the number of public schools in the States/Territories that screen children for TBI on an annual basis" is developmental and should have baseline data for FY 2010 by August 2011.

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. There were 3 new awards made in 2010 and 1 additional award in 2011. 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 2010 Enacted	FY 2011 CR	FY 2012 Budget Request	FY 2012+/- FY 2010
State Grants for Demonstration Projects	$5,204,419	$5,204,419	$5,167,988	-$36,431
Protection and Advocacy Grants	$3,272,375	$3,272,375	$3,249,468	-$22,907

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, the Administration for Children and Families' Administration on Developmental Disabilities, 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 handbooks, and follow-up performance reviews.

Funding History

FY	Amount
FY 2007	$8,910,000
FY 2008	$8,754,000
FY 2009	$9,877,000
FY 2010	$9,918,000
FY 2011 CR	$9,939,000

Budget Request

The FY 2012 Discretionary Request for the Traumatic Brain Injury program is $9,918,000, the same as the FY 2010 Actual Level. 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 number of State partnerships has an FY 2010 baseline of 131 and the target for FY 2012 is 154. TBI Protection and Advocacy grants will continue to receive a total of $3.3 million in FY 2012, approximately the same as FY 2010 Actual.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
11.1: Proportion of children with brain injury who are able to participate in community activities *(Outcome)*[1]	FY 2007: 52.5% (Baseline)	N/A[1]	N/A	N/A
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)	51	N\A[2]	N/A
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)	51	N/A[2]	N/A
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	N/A[2]	N/A
11.V.B.4: Increase the number of new State partnerships and/or collaborations with governmental and non-governmental organizations.	FY 2010: 131 (Baseline)	N/A	154	N/A
11.V.B.5: Increase the number of public schools in the States/Territories that screen children for TBI on an annual basis (developmental)	Baseline by August 2011	TBD	TBD	N/A
11.E: Decrease the application and reporting time burden of grantees (hours). *(Efficiency)*	FY 2008: 147 (Target Met)	132	127	-5

[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.
[2] The FY 2012 target is N/A because this measure has been discontinued

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	79(States & P&As)	80(States and P&As)	78(States and P&As)
Average Award	$250,000/$50,000	$250,000/$50,000	$250,000/$50,000
Range of Awards	$100,000-$250,000/$20,000-$50,000	$100,000-$250,000/$20,000-$50,000	$100,000-$250,000/$20,000-$50,000

Sickle Cell Services Demonstration Program

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$4,740,000	$4,750,000	$4,740,000	---
FTE	2	2	2	---

Authorizing Legislation - Section 712(c) of the American Jobs Creation Act of 2004.

FY 2012 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 (SCD). Investments in SCD service delivery, safety net access points, and the preparation of primary care clinicians have been created to serve this underserved population. Over the past seven years this 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 individuals, families and communities; provision of educational training sessions; and engagement opportunities for health care providers. During the two years of data collection, some successes have been realized by the demonstration program as it relates to emerging practice models of care and the benefits of co-management and care plans. Over the past four years the Sickle Cell Service Demonstration Program has been involved in the following activities to meet objectives and address priority areas of the program:

- Technical assistance/information exchange
- Developing and sustaining partnerships
- Materials review and development
- Collection, coordination, and distribution of Sickle Cell Service Demonstration Program data, best practices, and findings

Of particular note, this program is addressing the elimination of health disparities for individuals with Sickle Cell Disease. The program has received continual funding allowing the continuation of addressing activities and priorities described above. This funding has also provided for an increase in the number of grantees for a current total of nine. Funding includes costs associated with awards to grantee networks, a contract, HRSA staff salaries and grant related activities including grant reviews, processing of grants through the Grants Administration Tracking and

Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

In 2008, the Sickle Cell Demonstration Program received a two year OMB clearance to begin data collection for evaluation of the program. Renewal of clearance from OMB currently is in process for continued data collection. This data will be collected under the National Coordinating Center (NCC) [contract with National Initiative for Children's Health Care Quality (NICHQ)]. To date, over 400 individuals reflecting services across the lifespan have participated in the program. In early 2010, follow-up data analysis provided findings which were incorporated into a report to Congress. In addition, evaluation of the demonstration network development and provider capacity occurred through the assessment of health care provider's co-management and coordination.

Funded grantee networks will be supported by the NCC. HRSA's multi-layered approach to the program utilizes the HRSA funded hemoglobinopathies (for sickle cell disease and thalassemia) programs along with NICHQ, in partnership with the Sickle Cell Disease Association of America (SCDAA), the Federally Qualified Health Centers (FQHC's), the HRSA funded Rural Health Centers (RHC's), Ryan White Clinics (RWC), the National Health Services Corps (NHSC) and the HRSA Regional offices. Efforts involve surveillance and analysis of hemoglobinopathy data; Quality Improvement (QI) Learning Collaborative sessions and targeted technical assistance; evaluation of treatment and management guidelines; translation, dissemination and education; and practice innovation. HRSA is collaborating with the National Institutes of Health (NIH) and the Centers for Disease Control (CDC) to ensure data elements can be used across programs as well as address Healthy People 2020 objectives.

Funding History

FY	Amount
FY 2007	$2,180,000
FY 2008	$2,653,000
FY 2009	$4,250,000
FY 2010	$4,740,000
FY 2011 CR	$4,750,000

Budget Request

The FY 2012 Discretionary Request for the Sickle Cell Service Demonstration Program is $4,740,000, the same as the FY 2010 Actual Level. Funding will allow: (1) continued funding of nine 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) expansion and upgrade of data collection efforts, capacity and analysis to more fully achieve the evidence to evaluate the network activities and outcomes; and (3) expertise in informatics for data elements, interoperability and messaging capabilities in order to ensure that the data elements can be used across programs.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	9	9	9
Average Award	$390,000	$390,000	$390,000
Range of Awards	$380,000-$400,000	$380,000-$400,000	$380,000-$400,000

James T. Walsh Universal Newborn Hearing Screening

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$18,960,000	$19,000,000	$18,960,000	---
FTE	3	4	4	+1

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

FY 2012 Authorization ..... Such Sums as Necessary

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 and Prevention (CDC) and National Institutes of Health's (NIH) National Institute on Deafness and Other Communication Disorders (NIDCD) is ongoing to coordinate programs at the national and state levels. For FY 2009 and 2010, 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. In 2011, 49 currently funded States will competitively apply to be continued.

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 and Prevention's (CDC) National Center for Birth Defects and Developmental Disabilities (NCBDDD) began collecting State data for the first time on newborn hearing screening services. For FY 2008, data from the 50 States, two territories and the District of Columbia responding to the survey indicated the number of infants screened was 97%. 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, save military birthing hospitals. Service providers

(audiologists, PCPs and Early Intervention providers) in the continuum of services do not routinely report in many places.

An independent evaluation of the program was completed in 2006. 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 handbooks, and follow-up performance reviews.

Funding History

FY	Amount
FY 2007	$ 9,804,000
FY 2008	$11,790,000
FY 2009	$19,000,000
FY 2010	$18,960,000
FY 2011 CR	$19,000,000

Budget Request

The FY 2012 Discretionary Request for the James T. Walsh Universal Newborn Hearing Screening program is $18,960,000 is the same as the FY 2010 Actual Level.
FY 2012 funding will continue 58 awards to assist the program in achieving the FY 2012 target of screening 98% of infants prior to hospital discharge.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- 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

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

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
13.III.A.1: Percentage of infants suspected of having a hearing loss with a confirmed diagnosis by 3 months of age *(Output)*	FY 2008: 68%[2] (Target Exceeded)	60%	70%	+10% point
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% point
13.III.A.3: Percentage of infants screened for hearing loss prior to hospital discharge *(Output)*	FY 2008: 97% (Target Not Met but Improved)	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 2008: 68%[2] (Target Exceeded)	60%	70%	+10% point

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	57	59	59
Average Award	$250,000	$250,000	$250,000
Range of Awards	$150,000-300,000	$150,000-300,000	$150,000-300,000

[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 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$21,454,000	$21,500,000	$21,454,000	---
FTE	---	3	4	+4

Authorizing Legislation - Section 1910 of the Public Health Service Act.

FY 2012 Authorization 27,562,500

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 2011, the EMSC Program will award 55 State Partnership Grants which focus 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 supports the EMSC National Resource Center to help improve the pediatric emergency care infrastructure throughout the United States and its territories through technical assistance and targeted information to State governments, academic medical centers, health care professionals, and the public at large.

The EMSC Program also funds 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 6 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 2010, the number of State EMS systems that demonstrated the operational capacity to provide pediatric emergency care improved to 26 States, and the number of States that have adopted requirement for pediatric emergency education for the recertification of paramedics improved to 37 States. 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 level of care (e.g. Level 1 trauma center) in order to further assess the impact of transfer rate on mortality.

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. 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 handbooks, and follow-up performance reviews.

Funding History

FY	Amount
FY 2007	$19,800,000
FY 2008	$19,454,000
FY 2009	$20,000,000
FY 2010	$21,454,000
FY 2011 CR	$21,500,000

Budget Request

The FY 2012 Discretionary Request for the Emergency Medical Services for Children program is $21,454,000, the same as the FY 2010 Actual Level. This request will assist the program in achieving its FY 2012 target of 30 awardees that demonstrate the operational capacity to provide pediatric emergency care and a target of 39 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 2012 Target	FY 2012 +/- FY 2010
14.E: Decrease the application and reporting time burden of grantees (hours). *(Efficiency)*	FY 2009: 85 (Target Met)	80	70	-10
14.1: Mortality rate for children with an injury severity score (ISS) greater than 15 *(Outcome)*	FY 2005: 9.1% (Baseline)	8.6%	8.4%	-0.2% point
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 2009: 26 (Target Exceeded	26	30	+4
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 2009: 37 (Target Exceeded)	27	39	+12
14.V.B.3: Transfer rate for children with an injury severity score (ISS) of 15 or more Developmental) *(Output)*	N/A	N/A	N/A	N/A

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	75	74	75
Average Award	$260,000	$258,000	$259,000
Range of Awards	$130,000 - $2,404,999	$130,000 - $1,860,000	$130,000 - $1,900,000

Healthy Start

	FY 2010 Appropriation	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$104,776,000	$105,000,000	$104,776,000	---
FTE	4	4	4	---

Authorizing Legislation - Section 330H of the Public Health Service Act.

FY 2012 Authorization .....$126,216,695[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, more than four million women become pregnant. This resulted in 4.25 million live births in 2008, a 2 percent decrease from 2007. In 2007 there were 4.3 million live births, a 1 percent increase in births from 2006 and the highest number of births ever registered in the United States. (Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Mathews Osterman MJK. Births: Final data for 2008. National vital statistics reports; vol 59 no 1. Hyattsville, MD: National Center for Health Statistics. 2010.). 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

[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 2011 Mid-Session Review is -0.3 for FY 2009, 1.9 for FY 2010, 1.5 for FY 2011, and 2.0 for FY 2012

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 interventions consistently provided to several generations before the factors responsible for the disparities in adverse birth outcomes have been overcome.

The interconception 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. Interconception 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, interconception healthcare provides a valuable opportunity to reduce or eliminate risks before one or more future pregnancies to ensure healthier (full term) infants and mothers.

Today, through a lifespan approach and a focus on the interconception health of women, Healthy Start aims to reduce disparities in access to and utilization of health services, improve the quality of the local health care system, empower women and their families, and increase consumer and community voices and participation in health care decisions. Through grants to communities with exceptionally high rates of infant mortality, the Healthy Start program continues to focus on the contributing factors which research shows are associated with poor perinatal outcomes, particularly among African-American and other disproportionately affected populations. In these geographically, racially, ethnically, and linguistically diverse low income communities, Healthy Start provides intensive services tailored to the needs of high risk pregnant women, infants and mothers.

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, Healthy Start 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.

At the system level, every Healthy Start 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. Healthy Start 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 tobacco 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. Through 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 highest risk for 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 per 1000 in 1998 to 9.17 per 1000 live births in 2006. In contrast, the Tulsa County rate was 10.58 per 1000 live births during the same timeframe.

There are achievements linked to the Healthy Start program in other communities as well, most significantly, a decrease in the number of infant deaths of Healthy Start participants. In fact, fourteen Healthy Start communities report no infant deaths among program participants for the past three years (2006-2008): Maricopa County, AZ; Englewood, County; Hawaii County, HA; Des Moines, IA; Chicago, IL; Pembroke, NC; Manhattan, NY; Portland, OR; Philadelphia, PA; San Antonio, TX. An additional eight communities reported no infant deaths over the last two years: (2007-2008).): Blytheville, AR; Mariposa, AZ; Boynton Beach, FL; Louisville, KY; Missouri Bootheel, MO; Tougaloo, MS; Deming, NM; Bellaire, 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 in 2005 and no infant deaths in 2008. 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. When Genesee County Healthy Start began their project in 2001, their three-year infant mortality rate was 23.7; for 2007-2009 their infant mortality rate for program participants was 4.0.

Overall, Healthy Start is successful in reducing infant mortality in the Nation's highest risk populations for adverse outcomes (African-Americans, American Indians/Native Americans). In

contrast to the overall national infant mortality rate of 6.7 in 2006, the infant mortality rate for Healthy Start participants was 5.7. In 2007, the national infant mortality rate rose slightly to 6.75 (Xu JQ, Kochanek KD, Murphy SL, Tejada-Vera B. Deaths: Final data for 2007. National vital statistics reports; vol 58 no 19. Hyattsville, MD:
National Center for Health Statistics. 2010.), while the infant mortality rate for Healthy Start participants dropped to 5.1.

Low birth weight (LBW), a major contributor to infant mortality, has been dramatically reduced among Healthy Start participants. In 2007, the most recent year for which data are available, the national LBW rate was 8.2%, the highest level recorded since the early 1970s (Martin JA, Hamilton BE, Sutton PD, et al. Births: Final data for 2007. National vital statistics reports; vol 58 no 24. Hyattsville, MD: National Center for Health Statistics. 2010.). 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 2007, in contrast to the upward trend in the nation, Healthy Start projects had reduced LBW to an average rate of 10.3%; in 2008, the LBW rate for Healthy Start projects increased slightly to 10.7 percent. (see Outcomes and Outputs Table). The 2007 Healthy Start LBW rate was particularly significant because the 2007 national LBW rate for African-Americans had risen to 13.9 percent (Martin, Hamilton, Sutton et al, 2010, ibid) . Healthy Start 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 Healthy Start 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%. *Kalamazoo Healthy Baby Healthy Start* has reduced the racial disparity in prematurity to the point that black participants have pregnancies that are as healthy, (i.e., full term and normal weight) as their white neighbors.

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 (EPNC entry) to 68.2% and in 2008, EPNC climbed to 68.5 percent (see Outcomes and Outputs Table). The *Luna County Healthy Start,* located along the New Mexico-Mexico border, increased the percentage of clients entering care during the first trimester from 69% in 2004 to 85.4% (2009). 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%. In the same year, 77.4% of the *Richmond Virginia Healthy Start* participants entered prenatal

care in the first trimester compared to 30.8% in 2005. *Indianapolis Healthy Start* increased the percentage of clients entering prenatal care in the first trimester from 64% in 2005 to 80% in 2009.The *Laurens County Heart of Georgia Healthy Start Initiative* increased first trimester entry from 21.6% in 2003 to 91.5% in 2009.

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 a 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.

To improve quality, the Healthy Start program is also identifying and synthesizing evidence-based practices that contribute to improved perinatal outcomes and it will disseminate this information to Healthy Start 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 Healthy Start 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 programmatic support and performance reviews.

Funding History

FY	Amount
FY 2007	$101,518,000
FY 2008	$ 99,744,000
FY 2009	$102,372,000
FY 2010	$104,776,000
FY 2011 CR	$105,000,000

Budget Request

The FY 2012 Discretionary Request for the Healthy Start program is $104,776,000 is the same as the FY 2010 Actual Level.

The current project periods for eight Healthy Start projects will end in FY 2012. The request will provide support for 8 competing renewals for community based projects and 96 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 infants 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, 8 to 10 webcasts, site visits and sharing of best practices among projects. Additionally, the program will complete the third year of 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.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
12.1: Reduce the infant mortality rate (IMR) among Healthy Start program clients. *(Outcome)*[2]	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. *(Outcome)* [2]	FY 2004: 4.8 per 1,000 persons (Baseline)	N/A	N/A	N/A
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

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- 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 2008: 68.5% (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 2008: 10.7% (Target Not Met)	9.6%	9.6%	Maintain

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

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
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 2008: 369,845 (Target Exceeded)	395,000	376,000	-19,000
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 2008: 546,773 (Target Exceeded) ($182/participant)	524,500 (est. $190/ participant	532,500 (est. $197/ participant	+8,000

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	104	104	104
Average Award	$750,000	$750,000	$750,000
Range of Awards	$255,000-$2,350,000	$255,000-$2,350,000	$255,000-$2,350,000

Heritable Disorders Program

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$9,992,000	$10,013,000	$9,992,000	--
FTE	3	3	3	---

Authorizing Legislation - Sections 1109, 1110, 1111, and 1112 of the Public Health Service Act.

FY 2012 Authorization: 1109……$15,562,500
FY 2012 Authorization: 1110……..…$5,187,500
FY 2012 Authorization: 1111……..…$1,037,500
FY 2012 Authorization: 1112……..…$2,593,750

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. This budget request relates to sections 1109, 1110, 1111, and 1112.

- 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 Collaboratives 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, U.S. Territories, and the District of Columbia.

  In the 2nd grant cycle, 3 of the 7 Collaboratives received awards for 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.

  A national evaluation report of the accomplishments of the Regional Collaboratives on four primary program outcome measures, covering December 1, 2008 to November 30, 2009 showed an overall increase in activities from the previous year as follows:

  1) 67 percent of States/Territories had collaborations facilitated by their Regional Collaborative between primary care providers and specialty (including genetic) providers to improve care coordination for people with heritable disorders. This was an increase from the 48 percent of States/Territories reported to have these collaborations during the first year of the evaluation.
  2) 98 percent of States/Territories had systems in place to assure entry of newborns that are diagnosed with condition(s) mandated by their State-sponsored newborn blood spot screening programs into clinical management systems. In the first year of the evaluation, 93 percent of the States/Territories had such tracking systems.
  3) 13 percent of States/Territories had systems in place to track receipt of clinical services and/or health outcomes for all children diagnosed with any of the conditions mandated by their State-sponsored newborn blood spot screening program and/or with hearing loss through their State-sponsored newborn hearing screening programs. In last year's evaluation report, 15 percent of the States/Territories reported having these systems in place. However, this apparent decrease actually reflects a clarification on the different ways in which the regions are to report data.
  4) 96 percent of States/Territories had newborn screening programs that disseminated just-in-time/point-of-care information on specific heritable

disorders to primary care providers. This was an increase from the 88 percent of States/Territories that disseminated such information during the first year of the evaluation.

- Section 1110: Evaluating the Effectiveness of Newborn and Child Screening Programs

- Early and Continuous Screening through the Medical Home

- This initiative began in 2010; one grantee was awarded $500,000 per year for 4 years. The grant activities for the Early and Continuous Screening in the Medical Home initiative focus on improving screening and surveillance practices within the medical home for all children and adolescents. At its completion the initiative's products are: 1) promote greater understanding among key stakeholders of the need for and benefits of early and continuous screening for conditions, including congenital and heritable disorders, sensory impairments, developmental delay, autism, mental health disorders, sexually transmitted infections and psychosocial problems; and 2) promote healthcare professionals' use of evidence-based screening guidelines such as Bright Futures and validated screening tools in their practices.

- Effective Follow-up in Newborn Screening Initiative

This initiative began in 2009; four grantees were awarded $400,000 each for 3 years. Projects 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. Projects include methods to capture and analyze clinical and related variables to determine health outcomes; these outcomes provide an assessment of the impact of the newborn screening system specifically related to follow-up efforts. Grantees are also encouraged to use standard electronic messages, documents, and codes as specified in the HRSA/National Library of Medicine (NLM) newborn screening results messaging guidance and the Newborn Screening Coding and Terminology Guide.

Requirements include: Strengthen newborn screening follow-up activities using real-time HIE; establish minimum health information technology language and terminology standards and related policies and procedures for use by the newborn screening programs; and coordinate State or regional surveillance activities.

- Section 1111: The Advisory Committee on Heritable Disorders in Newborns and Children

In adherence with the Act, the Committee will continue to: 1) make 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) develop a model decision-matrix for newborn screening expansion; and 3) consider 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, nine nominated conditions have been sent to the Committee for addition to the Committee's Recommended Uniform Screening Panel (RUSP): five nominated conditions have undergone external evidence reviews; one nominated condition is currently being evaluated by the external evidence review workgroup; and three nominated conditions were deemed by the Committee as not ready for review by the Committee's external evidence review workgroup. Of the five nominated conditions that have undergone external evidence review, two have been recommended by the Committee for addition to the RUSP (Severe Combined Immunodeficiency (SCID) and Critical Cyanotic Congenital Heart Disease).

On May 21, 2010, the Secretary adopted the Committee's recommendations to adopt the Committee's Recommended Uniform Screening Panel (screen for the identified 30 core conditions; report on the identified 26 secondary conditions) as a national standard for newborn screening programs and to facilitate the adoption of the Committee's Recommended Uniform Screening Panel by all State newborn screening programs. This included the adoption of SCID as a core condition to the RUSP. The Secretary is currently reviewing the Committee's recommendation to add Critical Cyanotic Congenital Heart Disease to the RUSP.

- Section 1112: The Clearinghouse of Newborn Screening Information

- The Clearinghouse for Newborn Screening Information

The Clearinghouse is a central repository of current educational and family support and services information, materials, resources and research, 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 it also links with the public site of the National Newborn Screening Information Systems which maintains current data on quality indicators of newborn screening performance.

- National Newborn Screening and Genetics Resource Center

This program serves as a technical assistance program for the various state newborn screening systems. It provides technical assistance (broadly - including telephone/internet/written inquiries and on-site program reviews); resource development; education and training; policy initiatives; surveillance; evidence-based data collection; evaluation; and collaborative efforts with various stakeholders, including Federal and non-Federal partners.

- Section 1114: The Interagency Coordinating Committee (ICC) on Newborn and Child Screening

This is expected to be established in 2011. 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 and a reduction in funding would delay implementation of the ICC.

Funding History

FY	**Amount**
FY 2007	---
FY 2008	---
FY 2009	$10,013,000
FY 2010	$9,992,000
FY 2011 CR	$10,013,000

Budget Request

The FY 2012 Discretionary Request for the Heritable Disorders program is $9,992,000. This is the same as the FY 2010 Actual Level and will allow for continued programmatic support as outlined below.

Section 1109: Improved Newborn and Child Screening For Heritable Disorders

Regional Genetic and Newborn Screening Services Collaboratives
The Regional Collaborative Program is ending the 2nd grant cycle, 2007-2012. With stable funding the Regional Collaboratives will continue to provide the services and projects outlined to complete their 2nd grant cycle. With continued funding, a 3rd grant cycle will be implemented in FY 2012. As health care reform matures, as its capacity to personalize health care is realized, the integration of genetic medicine, as its capacity to personalize health care is realized, into the health care delivery system is essential.

Section 1110: Evaluating the Effectiveness of Newborn and Child Screening Programs

1. Early and Continuous Screening through the Medical Home

FY 2012 is Year 3 of 5 of the program. Continued stable funding will allow for continued integration of screening in the Medical Home model with outcomes being a complete review of the methodology employed and measurement of impact.

2. Effective Follow-up in Newborn Screening Initiative

   Continued funding will allow for a second grant cycle. This will provide for continued integration of activities that move towards an electronic system of communication. Funding states to develop and troubleshoot a system to assure and facilitate appropriate and coordinated sample collection, laboratory testing, diagnosis, timely treatment, tracking of outcomes and ultimately, referral to a medical home for care coordination.

3. Genetic Services Learning Collaborative

   With the completion of the previously funded Priority Activities in the Regional Collaborative and with continued funding for the Heritable Disorders Program, the funds dedicated to those endeavors are targeted at development of a Genetic Services Learning Collaborative. The collaborative will have members from each of the Genetic Regional Collaboratives and a coordinating center. The project will provide a gap analysis of the state service infrastructure for people with heritable disorders. Based on that analysis, the members will develop a framework to close the gaps. This will be undertaken in collaboration with the federally qualified Community Health Centers and primary care practices in the regions. Model programs will be developed, evaluated and disseminated where possible.

Section 1111: The Advisory Committee on Heritable Disorders in Newborns and Children

In adherence with the Act, the Committee will continue to: 1) make 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) develop a model decision-matrix for newborn screening expansion; and 3) consider ways to ensure that all States attain the capacity to screen for the recommended conditions. The Act also requires the Committee to address other legislative requirements toward facilitating the harmonization of newborn screening standards and quality measures for newborn screening programs. For example, at this time there is no consensus on diagnostic criteria, so calculations of incidence and prevalence of disorders are inaccurate. There are no established criteria for acceptable screening rates, or for that matter, an ability to calculate how many infants are unscreened each year. The development of quality measures requires a process for input from multiple stakeholder groups, which requires expertise,

staff time and logistics. The Committee management capacity would not be able to fully address the legislative requirements with a reduction in budget.

Section 1112: The Clearinghouse of Newborn Screening Information

In 2012, the following four activities will be funded to fully implement the legislative requirements:

1. State Newborn Screening Resource Center

   Previously funded as the National Newborn Screening and Genetics Resource Center, this program has evolved to be a technical assistance program for the various state newborn screening systems. With stable funding, a new grant cycle will begin and will continue to provide a vital resource for technical assistance and programmatic support for the State public health programs, particularly as new conditions for newborn screening are considered and implemented throughout the United States.

- National Newborn Screening Information System

  This information system previously has been embedded in the National Newborn Screening and Genetics Resource Center. In FY 2012 it will be a separate entity from other programs, interfacing at multiple levels with various other HRSA funded programs, including but not limited to the Clearinghouse for Newborn Screening Information as required by the authorizing legislation. This system is being re-designed in order to meet needs of automatic downloads from States, interoperability with electronic medical records and messaging capabilities for the State newborn screening programs. The new design will have multiple tiers of access for State and patient privacy but still allow for aggregate data on the newborn screening system across the United States.

2. Quality Enhancement Program

   This program provides a mechanism for newborn screening system certification and a method for Continuous Quality Enhancement (CQE). Funding will be from the quality measures previously in the Clearinghouse and in the National Newborn Screening Resource Center presuming stable funding into FY 2012.

3. The Clearinghouse for Newborn Screening Information

- The Clearinghouse is in year 3 of 5 for FY 2012. Continued stable funding will allow for the Clearinghouse to continue to be a central repository of current educational and family support and services information, materials, resources and research, 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) link with the public site of the National Newborn Screening Information Systems which maintains current data on quality indicators of newborn screening performance.

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 data for programs to collect and 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 and a reduction in funding would delay implementation of the ICC.

Grant Awards Table

Size of Awards

(whole dollars)	**FY 2010 Enacted**	**FY 2011 CR**	**FY 2012 Request**
Number of Awards	13	13	13
Average Award	$500,000	$500,000	$500,000
Range of Awards	$400,000-$800,000	$400,000-$800,000	$400,000-$800,000

Congenital Conditions

	FY 2010 Appropriation	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$499,000	$500,000	$499,000	---
FTE	1	1	---	-1

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

FY 2012 President's Budget……..…….$500,000

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, evidence 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. Key components of this program are, 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.

MCHB cooperative agreement number U35MC16451, funded in response to the PPDCAA continued activities during FY 2010, included the development of patient and family educational materials on congenital disorders, meetings of lay and professional representatives about best outcomes for families of children diagnosed with congenital disorders and established workgroups consisting of national support groups and experts on the three disorders named in the legislation (spina bifida, Down syndrome and dwarfism). The U.S. Government Accountability Office (GAO) published the report *Children with Down Syndrome: Families Are More Likely to Receive Resources at Time of Diagnosis Than in Early Childhood* (GAO-11-57) in response to the legislative requirement in the PPDCAA. MCHB, in response to the HRSA Administrator's delegation of authority for the PPDCAA legislation, contributed comments on drafts of the GAO report.

Funding History

FY	Amount
FY 2007	---
FY 2008	---
FY 2009	$1,000,000
FY 2010	$499,000
FY 2011 CR	$500,000

Budget Request

The FY 2012 Discretionary Budget Request for the Congenital Conditions Program is $499,000, the same as the FY 2010 Actual Level. This funding will be used for continued support of the 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.

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	1	1	1
Average Award	$300,000	$300,000	$300,000
Range of Awards	$300,000	$300,000	$300,000

Nutrition, Physical Activity and Screen Time Standards

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$255,000	$	$	-$255,000
FTE				---

FY 2012 Authorization…….. Expired

Allocation Method .....Supplement to a Grant

Program Description and Accomplishments

In FY 2010 The Health Resources and Services Administration will be issuing non-competitive supplemental funding under the Maternal Child and Health Bureau's National Resource Center for Health and Safety in Early Care and Education program (NRC). The NRC will use these funds to support key national campaigns for early development of healthy lifestyle habits (e.g., HHS Healthy Weight Initiative) by defining core *Caring for Our Children (CFOC)* standards for evidenced-based or best practices in nutrition (including food safety), physical activity, and screen time in child care.NRC will assess the status of obesity prevention indicators in states' child care licensing regulations, with the outcome of a report summarizing the baseline status of states' efforts by, January 31, 2010. The NRC will also develop seven products based upon the *CFOC* standards for nutrition, physical activity and screen time recommendations for child care.

Funding History

FY	Amount
FY 2007	---
FY 2008	---
FY 2009	---
FY 2010	$255,000
FY 2011	---

Budget Request

No funds are requested in FY 2012 for this grant supplement, the same as the FY 2011 President's Budget request.

Outcomes and Output Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
---	---	---	---	---

Family-To-Family Health Information Centers

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Appropriation	FY 2012+/- FY 2010
BA	$5,000,000	$5,000,000	$5,000,000	---
FTE	---	1	2	+2

Authorizing Legislation - Section 501(c)(1)(A) of the Social Security Act.

FY 2012 Authorization $5,000,000

Allocation Method ..... Competitive grant/co-operative agreement

Program Description and Accomplishments

The Family-to-Family Health Information Centers (F2F HICs) support 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 2010-2012 will continue to support 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, 51 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. Centers will have to be able to disseminate new information as a result of ACA. Such information will be about additional options for healthcare financing, new options for long-term supports and services such as Medicaid home and community based services and potential access to state-based health insurance Exchanges.

Program continues working with grantees, in collaboration with the National Center for Family/Professional Partnerships (NCFPP), 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/discussion sessions occurred at a topical meeting held in 2009 with follow- up conference calls. Regional T.A. meetings with the NCPPP were held in 2010 in leau of a national meeting. Another topical meeting is scheduled for Feb. 2011 with follow-up calls as necessary.

In FY 2008, 75,532 families with CSHCN were provided information, education and/or training from Family-to-Family Health Information Centers. In FY 2009 more than 92,000 families were provided information. These exceeded the targets set for those years. The actual numbers for FY 2010 will be available Sept. 30 2010. No targets were set due to the fact that program funding was to end. In addition, for FY2009, 65% of families responded that their center's assistance was useful to extremely useful in helping them be better partners in decision-making with their child's provider), exceeding the target.

More accurate data has been submitted on new OMB approved performance measures that is enabling MCHB to better evaluate progress. With ongoing technical assistance on data collection from MCHB and the National Center for Family Professional Partnerships, for FY 2010, 50 centers reported an unduplicated count of 121,476 families served. In FY 2010, 81% of families served by 50 centers said that the centers were somewhat useful, very useful or extremely useful in helping them to be better able to partner in decision making at any level.

Funding also is obligated for 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, and an FTE.

Funding History

FY	Amount
FY 2007	$3,000,000
FY 2008	$4,000,000
FY 2009	$5,000,000
FY 2010 Health Reform	$5,000,000
FY 2011 Health Reform	$5,000,000

Budget Request

In FY 2012, $5 million is requested for the Family-To-Family Health Information Centers program, the same as the FY 2010 Actual Level. Funding is through the Affordable Care Act (P.L. 111-148) Sec. 5507, which expanded the program from FY 2010 through FY 2012. The Affordable Care Act will enable 51 centers in all States and the District of Columbia to continue serving CSHCN and their families and their providers, and to provide an FTE to work closely with them.

Targets for the upcoming fiscal years are: 1) For FY 2011, to provide information to 122,000 families with CSHCN, and for 83% of families with CSHCN served reporting that they are better able to partner in decision making; and 2) For FY 2012, to provide information to 123,000 families with CSHCN, and for 85% of families with CSHCN served reporting that they are better able to partner in decision making.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- 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 2010: 121,476 (Target not in place)	N/A	123,000	N/A
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)*	FY 2010: 80% (Target not in place)	N/A	85%	N/A

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 Enacted	FY 2012 Request
Number of Awards	50	51	51
Average Award	$95,700	$95,700	$95,700
Range of Awards	$90,000-95,700	$90,000-95,700	$90,000-95,700

Maternal, Infant, and Early Childhood Home Visiting Program

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Appropriation	FY 2012+/- FY 2010
BA	$100,000,000	$250,000,000	$350,000,000	+$250,000,000
FTE	4	23	28	+24

Authorizing Legislation - Section 511 of the Social Security Act.

FY 2012 Authorization $350,000,000

Allocation Method: ..... Direct federal/intramural,Contract,Formula grant/co-operative agreement
Competitive grant/co-operative agreement, Other

Program Description and Accomplishments

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, established in FY 2010, is a collaboration between the Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF). The MIECHV Program is designed: (1) to strengthen and improve the programs and activities carried out under Title V; (2) to improve coordination of services for at-risk communities; and (3) to identify and provide evidence-based home visiting programs to improve outcomes for families who reside in at-risk communities. At-risk communities will be identified through a statewide assessment of needs and of existing resources to meet those needs. HRSA and ACF intend that the home visiting program will result in a coordinated system of early childhood home visiting in every State that has the capacity and commitment to provide infrastructure and supports to assure high-quality, evidence-based practice.

There are 56 eligible entities for this program: the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa. While most of the program funds are allocated to the State home visiting grants, 3% is set aside for grants available to Indian Tribes, Tribal organizations and Urban Indian organizations and 3% is set aside for Research, Evaluation and Technical Assistance to poorly performing State grants and contracts.

The program enables eligible entities to utilize what is known about effective home visiting services to provide evidence-based programs to promote: improvements in maternal and prenatal health, infant health, and child health and development; increased school readiness; reductions in the incidence of child maltreatment; improved parenting related to child development outcomes; improved family socio-economic status; greater coordination of referrals to community resources and supports; and reductions in crime and domestic violence.

This program requires participating States to utilize evidence-based home visiting models and provides an exciting opportunity for States and the federal government to work together to deploy proven programs and build upon the existing evidence base. The program allows for continued experimentation with new models and evaluation of both new and existing approaches so that, over time, policy makers and practitioners will have more refined information about the approaches that work best, how different approaches work for different kinds of target populations or targeted outcomes, and the relative costs and benefits of different models.

The target areas for this program, to be identified by a needs assessment, are communities with concentrations of premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health; poverty; crime; domestic violence; high rates of high-school drop-outs; substance abuse; unemployment; or child maltreatment.

Grants to States are available to be administered by the lead State agency designated by the Governor to act on behalf of the State. American Indian grants can be awarded to an Indian Tribe, Tribal Organization or Urban Indian Organization as defined in section 4 of the Indian Health Care Improvement Act.

In FY 2010, 56 State grants and 13 American Indian grants were awarded.

Funding History

FY	Amount
FY 2007	---
FY 2008	---
FY 2009	---
FY 2010	---
FY 2010 Health Reform	$100,000,000
FY 2011 Health Reform	$250,000,000

Budget Request

The FY 2012 Appropriation for the Maternal, Infant, and Early Childhood Home Visiting Program is $350,000,000, an increase of $250,000,000 above the FY 2010 Actual Level. This level of funding will provide: $329 million for awards to 56 State grantees and associated program technical assistance; $10.5 million for 18 awards representing American Indian tribes, and $10.5 million for research, evaluation, and corrective action technical assistance for States not meeting benchmarks.

Outcomes and Outputs

The following are developmental measures for this program:

1. 37.1: Number of children and families receiving services through evidence-based home visiting models.
2. 37.1: Number and percent of grantees that meet benchmark requirements for demonstrating improvements.

Grant Awards Tables

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 Enacted	FY 2012 Request
Number of Awards	69	74	74
Average Award	$1,461,051	$2,554,945	$3,620,878
Range of Awards	$100,000 - $8,982,701	$215,000 -$24,533,069	$300,000 - $36,025,825

HIV/AIDS

Ryan White HIV/AIDS Overview

	FY 2010 Appropriation	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$2,287,179,000	$2,265,888,000	$2,375,587,000	+$88,408,000
ADAP (non add)	858,000,000	835,000,000	940,000,000	+82,000,000
MAI (non add)	146,055,000	153,358,000	161,026,000	+14,971,000
SPNS	25,000,000	25,000,000	25,000,000	--
Total Funding	$2,312,179,000	$2,290,888,000	$2,400,587,000	+$88,408,000
FTE	72	50	50	-22

**The amounts include funding for Special Projects of National Significance (SPNS) funded from Department PHS Act evaluation set-asides in FY 2011 President's Budget and proposed for FY 2012.*

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 2012 Authorization……..…...$2,650,151,000

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, have limited or no resources to pay for HIV/AIDS health care and vital health-related supportive services. Ryan White HIV/AIDS Program funding pays for primary health care and treatment including referrals to specialty care and for support services that enhance access to and retention in care. The Ryan White HIV/AIDS Program fills gaps in care for PLWH not covered by other resources or payers. The 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 thereby decreasing mortality, 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's HIV/AIDS Bureau.

In July 2010, the Obama Administration released the first comprehensive *National HIV/AIDS Strategy for the United States*. The NHAS was the result of unprecedented public input, including 14 HIV/AIDS community discussions held across the country, as well as an online suggestions process, various expert meetings and other inputs. Senior officials at HRSA were involved in a Federal interagency working group that reviewed recommendations from the public and worked with the Office of National AIDS Policy to develop the NHAS.

The Strategy focuses on three overarching goals: reducing the number of new HIV infections, increasing access to care for people living with HIV, and reducing HIV-related health disparities.

Reaching these goals will require broad support across federal, state, local, and tribal governments, business, faith-based communities, philanthropy, the scientific and medical communities, educational institutions, people living with HIV, and others. The HIV/AIDS Bureau and the Ryan White HIV/AIDS Program has an essential role to play in meeting these NHAS goals, both because of its critical role in filling in gaps in the health system, but also the unique capacity, experience, and expertise of the Ryan White HIV/AIDS Program to meet the diverse and challenging health care and related needs of people living with HIV/AIDS.

The second goal of the NHAS, to increase access to care and improve health outcomes for people living with HIV, has two goals directly related to the mission of the HIV/AIDS Bureau: to increase the proportion of newly diagnosed patients linked to care within three months of their HIV diagnosis from 65% to 85% and to increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care from 73% to 80%. HAB will work closely with their grantees and partners over the coming years to meet these goals.

The Ryan White HIV/AIDS Program demonstrates a comprehensive and aggressive approach in how government has targeted dollars toward the development of a highly effective service delivery system. By funding and partnering with community, faith based, and not-for-profit organizations and with local and State governments, 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 and treatment needs. The distinct components of the Ryan White HIV/AIDS Program serve very specific purposes. The FY 2012 Discretionary Budget Request of $2.40 billion for the Ryan White HIV/AIDS Program includes:

- Part A -- $679.1 million, which provides grants for 24 eligible metropolitan areas (EMAs) and 28 transitional grant areas (TGAs) disproportionately affected by HIV/AIDS. In addition, 4 states (New York, New Jersey, California, and Puerto Rico)

that previously had a TGA receive Part A grants to fund a variety of medical and support services;

- Part B -- $1,358.8 million, which provides grants to 59 States and Territories to improve the quality, availability, and organization of HIV/AIDS health care and support services; this includes $940 million to provide access to FDA approved, HIV-related medications through the AIDS Drug Assistance Program (ADAP). The 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;
- Part C -- $211.5 million, which provides grants directly to 349 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;
- Part D -- $77.8 million, which provides grants to 82 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. In addition, the Part D Program supports 17 adolescent-specific programs.
- Part F – $34.8 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 5 National Centers;
- $13.6 million for 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 clinicians to provide increased access to oral health care 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. Examples of SPNS initiatives include expanding the capacity of grantees to: 1) utilize standard electronic client information data systems to report client level data; 2) take a more systems level/public health approach to test people who do not know their status and link them to care; 3) develop innovative models to reach women of color and link them to and retain them in care; and 4) expand access to HCV treatment through the development of models to integrate HCV care into HIV primary care.

Ryan White Minority AIDS Initiative (MAI): Within the total amount included for the Ryan White HIV/AIDS Program, the Budget Requests $161.0 million 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 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 of health care professionals in order to expand the number of them with HIV treatment expertise who are then better able to provide 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 the AIDS Drug Assistance Program.

Minority AIDS Initiative (MAI) Funding

(whole dollars)	FY 2010 Actual	FY 2011 CR	FY 2012 Budget Request
Part A	$46,738,000	$49,075,000	$51,528,000
Part B	8,763,000	9,202,000	9,662,000
Part C	61,343,000	64,410,000	67,631,000
Part D	20,448,000	21,470,000	22,543,000
Part F – AETC	8,763,000	9,201,000	9,662,000
Part F – Dental	---	---	---
Total MAI Funding	$146,055,000	$153,358,000	$161,026,000

Program Evaluations

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 1) client-level health outcomes (the MAI client-level health outcomes indicators include: improve and stabilize client CD4 counts and reduce client viral load counts); 2) rates of kept appointments and retention in care; and 3) the proportion of health care providers trained in the clinical management of HIV/AIDS who serve primarily uninsured and underinsured minority populations.

Program Performance: The HIV/AIDS Bureau continues to demonstrate outstanding performance in improving access to health care, improving health outcomes, improving quality of health care, and promoting efficiency. The Ryan White HIV/AIDS Program uses various strategies to achieve its performance goals including: 1) targeting resources to high-risk areas; 2) ensuring availability, access to and excellence of critical HIV-related care and support services and optimizing health outcomes for people living with HIV; 3) working to assure patient adherence; 4) directing outreach and prevention education and testing to populations at disproportionate risk for HIV infection; 5) 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 6) collaborating with other programs and providers for referrals to Ryan White HIV/AIDS Program service providers.

Improving Access to Health Care: The Ryan White HIV/AIDS Program works to improve access to health care 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 2007 was 72%, compared to the 64.1% of CDC-reported AIDS cases. In 2008, 73% of the Ryan White HIV/AIDS Program clients were racial/ethnic minorities compared to 65.9% of CDC-reported AIDS cases. In FY 2009, 73% of the Ryan White HIV/AIDS Program clients were racial/ethnic minorities. The CDC AIDS data for comparison are not available as of this writing.

In 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 among women in 2007 and 2008. In FY 2009, 32% of the Ryan White HIV/AIDS Program clients were women. The CDC AIDS data for comparison are not available as of this writing.

Improving Health Outcomes: In FY 2009, the AIDS Drug Assistance Program (ADAP) served 205,446 clients through State ADAPs, exceeding the target. In FY 2008, the AIDS Drug Assistance Program (ADAP) served 175,194 clients through State ADAPs. The number of ADAP clients served through State ADAPs annually in 2009 was 30,252 persons above the 2008 annual results. In 2007, the ADAP served 163,925 clients through State ADAPs. FY 2007 results cannot 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 previous measure utilizing quarterly Program data. FY 2007 – FY 2009 represent a substantial growth in the persons served in the State ADAP programs of 20.2% or 41,521 additional ADAP clients served in these three years. 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. In FY 2009, 871,696 persons learned their serostatus from the Ryan White HIV/AIDS Program, exceeding the target by 299,299 persons. The number of persons learning their serostatus from the Ryan White HIV/AIDS Program was 739,779 in FY 2008. In 2007, the number of persons who learned their serostatus from Ryan White HIV/AIDS Programs was 738,181. These three years represent a growth of 135,515 persons who learned their serostatus or 15.3%. 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 both 2008 and 2009 was 87%. In FY 2007, the Ryan White HIV/AIDS Program provided 85.1% of HIV-positive pregnant women in the Program with anti-retroviral medications. The percentage of HIV- positive pregnant women in the Ryan White HIV/AIDS Program receiving anti-retroviral medication has grown 1.9 percentage points in the years FY 2007 – FY 2009.

Improving the Quality of Health Care: 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 health care 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%. In 2008, 92.3% of Ryan White HIV/AIDS Program-funded primary medical care providers had implemented a quality management program. Improvements continued in 2009 with 94.5% of medical care providers implementing a quality management program.

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 2007 was: CD4 – 83.9% and Viral Load – 81.2%; and in 2008 was CD-86.4% and Viral Load-84.4%. In 2009, the Ryan White HIV/AIDS Program provided CD4 count testing to 84.7% of new clients and viral load testing to 81.3% of these new clients. These 2009 results fell short of the target for CD4 tests by 2.5 percentage points and fell short of the target for viral load tests by 2.0 percentage points.

Promoting Efficiency: State ADAPs use a variety of strategies to contain costs which results in a more effective use of funding, and enables 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, direct negotiation of pharmaceutical pricing, reducing ADAP formularies, capping enrollment, and lowering financial eligibility. ADAPs' savings strategies on medications resulted in a savings of $265.2 million in 2007. In 2008, the ADAP program had cost-savings on medications of $374.2 million, exceeding the target by $106.3 million.

Funding History

FY	Amount[1]
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	$2,312,179,000
FY 2011	$2,290,888,000

Budget Request

The FY 2012 Discretionary Budget Request for the Ryan White HIV/AIDS Programs of $2,400,587,000 is $88,408,000 above the FY 2010 Actual Level.

As previously mentioned, the National HIV/AIDS Strategy (NHAS) has three primary goals: 1) reducing the number of people who become infected with HIV; 2) increasing access to care and optimizing health outcomes for people living with HIV; and 3) reducing HIV-related health disparities.

The NHAS states that more must be done to ensure that news prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of getting people with HIV into care early after infection to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to reduce HIV infection in high-risk communities and reduce stigma and discrimination against people living with HIV.

In FY 2012, the Program will continue its central goals of providing access to care for uninsured and 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 some PLWH are unaware of the availability of Ryan White HIV/AIDS Program services. To the extent possible, the Program targets resources to address these challenges.

[1] Includes SPNS

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 to minority populations. The MAI funds will support primary health care and related services; outreach and education to improve minority access to HIV/AIDS treatment medications; and targeted, multidisciplinary education and training programs for health care providers treating minority PLWH.

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. Although new HIV infections have remained fairly stable among blacks, from 2005–2008 estimated HIV diagnoses increased approximately 12%. At some point in their lifetimes, 1 in 16 black men will be diagnosed with HIV infection, as will 1 in 30 black women. With regard to women, data from the 2009 CDC Surveillance Report show that together, black and Hispanic women represent 25% of all U.S. women. However, women in these 2 groups accounted for 81% of the estimated total of AIDS diagnoses for women. The FY 2012 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 2012, the Program will aim to reach the following performance targets. The number of clients served by ADAPs given the FY 2012 Discretionary Budget Request is predicted to be 218,446 clients. The ADAP target reflects adjustment for our current performance and increased resources, in addition to medical inflation, rising health insurance premiums, reported decreases in state contributions and decreases in drug rebates, and increased costs of laboratory testing associated with antiretroviral use (e.g. resistance, tropism and Human Leukocyte Antigen (HLA) testing for patients). The FY 2012 Discretionary Budget Request target for persons who learn their serostatus from Ryan White HIV/AIDS programs is 739,779. The budget will also support the Program's ongoing efforts to improve the quality of health care for PLWH. The FY 2012 Discretionary Budget Request 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 2012 Discretionary Budget Request targets for new HIV infected clients who are tested for CD4 and for viral load are 88.2% and 84.3%, respectively.

In FY 2012, the Ryan White HIV/AIDS Program will continue to coordinate and collaborate with related Federal, State, and 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 Office of the Assistant Secretary for Health (OASH), 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 National Institutes of Health (NIH), Agency for Healthcare Research and Quality (AHRQ), the Department of Housing and Urban Development (HUD), the Department of Veterans Affairs (VA), and the Department of Justice (DOJ) as well as other HRSA-funded programs.

The Ryan White HIV/AIDS Program uses 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 Ryan White HIV Program grantees and providers. It contains modules for tracking demographic, service, clinical information and quality measures. CAREWare directly supports DHHS strategic goals to promote up-to-date and interoperable health information technology. It is a software tool that allows funded agencies to rigorously monitor the quality of care that they provide.

The Ryan White HIV/AIDS Program's investment in IT supports the strategic and performance outcomes of the program and contributes to its success by providing a mechanism for sharing data and conducting business in a more efficient manner. The HRSA Electronic Handbooks (EHBs) supports the Ryan White HIV/AIDS Program with program administration, grants administration and monitoring, management reporting, and grantee performance measurement and analysis. The Ryan White HIV/AIDS Program's investment in IT includes funding for the continued level.

Outcomes and Output Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- 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 2009: 73% (CDC data not 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 2009: 32% (CDC data not 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 2009: CD4 – 84.7%Viral Load – 81.3% (Target Not Met)	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 2009: 205,446 (Target Exceeded)	149,946	218,446	+68,500
16.II.A.2: Number of persons who learn their serostatus from Ryan White HIV/AIDS Programs. *(Output)*	FY 2009: 871,696 (Target Exceeded)	572,397	739,779	167,382

[2] These are long-term measures without annual targets. Long-term targets for FY 2014 are as follows: measure 16.1 = 422,300/199,875; measure 16.2=3.1 per 100,000; measure 16.3 = 90%.

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
16.II.A.3: Percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive anti-retroviral medications. *(Output)*	FY 2009: 87 % (Target Not Met)	90 %	90 %	Maintain

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
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".[3]	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 2009: 94.5% (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 2008: $374.2M (Target Exceeded)	Sustain FY 09 results	Sustain FY11 results	Sustain

[3] These are long-term measures without annual targets. Long-term targets for FY 2014 are as follows: measure 16.1 = 422,300/199,875; measure 16.2=3.1 per 100,000; measure 16.3 = 90%.

Emergency Relief Grants – Part A

	FY 2010 Appropriation	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$678,074,000	$679,074,000	$679,074,000	+$1,000,000
MAI (non add)	46,738,000	49,075,000	51,528,000	+$4,790,000
SPNS	7,588,000	7,588,000	7,588,000	--
Total Funding	$685,662,000	$686,662,000	$686,662,000	+$1,000,000
FTE	14	7	7	-7

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 2012 Authorization…….……$751,877,000

Allocation Method ..... Competitive and Formula Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

Part A funds are used to provide a continuum of care for people living with HIV disease who are primarily low income, underserved, uninsured and underinsured. Part A grants are distributed to metropolitan areas experiencing the greatest burdens of the country's HIV/AIDS epidemic, and provide those communities with resources they need to confront the highly concentrated epidemic within the jurisdiction. The Part A grantees in New York, Los Angeles, Washington, D.C., Chicago, Atlanta, Miami, Philadelphia, Houston, San Francisco, Baltimore, Dallas, and San Juan will also play a vital role in implementation of the National HIV/AIDS Strategy through the mobilization of the Ryan White resources in the "Twelve Cities Initiative." This initiative is a key part of the DHHS strategy to better coordinate HIV prevention, care, and treatment across DHHS, state, and local partners.

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. The grants fund systems of care to provide 13 core medical services and 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 28 transitional grant areas (TGAs) (jurisdictions with between 1,000 and 2,000 living AIDS cases over the last five years). In addition, Part A funds 4 states (California, New Jersey, New York and Puerto Rico) that have a city that was previously a TGA. Two-thirds of the funds available for EMAs and TGAs 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, as Minority AIDS Initiative grants and as grants to the 4 specific states. 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 2007, Part A provided 2.65 million visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health) and 2.60 million visits were provided in 2008. In FY 2009, Part A provided 2.59 million visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health). This result is in line with the FY 2009 target.

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 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	$678,074,000
FY 2011	$679,074,000

Budget Request

The FY 2012 Discretionary Budget Request of $679,074,000 is $1,000,000 more than the FY 2010 Actual Level and will support program activities and services for PLWH in the 24 Eligible Metropolitan Areas, 28 Transition Grant Areas, and 4 states.

The FY 2012 Discretionary Budget Request 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 2012 targets for the Ryan

[1] Excludes comparable amounts for SPNS.

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.)

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- 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 2009: 2.59 M (Target Met)	2.63 M	2.63 M	Maintain

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Actual	FY 2011 CR	FY 2012 Budget Request
Number of Awards	112	112	112
Average Award	$5,826,355	$5,826,355	$5,826,355
Range of Awards	$234,300-$93,013,940	$234,300-$93,013,940	$234,300-$93,013,940

Part A – FY 2010 Formula & Supplemental Grants

Table 1. Eligible Metropolitan Areas

EMAs	Formula[3]	Supplemental	MAI	Total
Atlanta, GA	$13,372,699	$5,291,533	$1,672,622	$20,336,854
Baltimore, MD	13,876,932	5,970,606	1,947,181	21,794,719
Boston, MA	9,212,901	4,121,667	813,845	14,148,413
Chicago, IL	17,548,172	7,463,039	2,059,034	27,070,245
Dallas, TX	9,944,346	4,251,693	916,078	15,112,117
Detroit, MI	5,781,850	2,162,005	696,283	8,640,138
Ft. Lauderdale, FL	10,117,916	4,205,637	1,071,700	15,395,253
Houston, TX	13,003,056	5,519,546	1,525,669	20,048,271
Los Angeles, CA	25,477,748	11,426,473	2,773,712	39,677,933
Miami, FL	16,183,910	7,205,104	2,310,335	25,699,349

[2] Rehabilitative services are a support service and visit data is not collected for support services.
[3] EMAs Hold Harmless Amount is included in their Formula Award; TGAs are not eligible for Hold Harmless

EMAs	Formula[3]	Supplemental	MAI	Total
Nassau-Suffolk, NY	4,455,844	1,481,244	377,426	6,314,514
New Haven, ,CT	5,117,731	1,679,626	429,864	7,227,221
New Orleans, LA	4,925,025	2,090,256	542,352	7,557,633
New York, NY	84,574,079	28,074,666	8,439,861	121,088,606
Newark, NJ	9,477,245	3,744,226	1,195,077	14,416,548
Orlando, FL	5,950,279	2,519,900	619,000	9,089,179
Philadelphia, PA	15,640,053	6,753,174	1,906,161	24,299,388
Phoenix, AZ	5,659,065	2,336,195	377,320	8,372,580
San Diego, CA	7,694,291	3,317,988	570,262	11,582,541
San Francisco, CA	15,406,181	9,898,965	704,423	26,009,569
San Juan, PR	11,218,774	2,761,246	1,215,481	15,195,501
Tampa-St. Petersburg, FL	6,454,492	2,416,571	532,414	9,403,477
Washington, DC-MD-VA-WV	19,702,375	8,993,990	2,756,163	31,452,528
West Palm Beach, FL	6,499,851	2,038,891	619,106	9,157,848
Total	**$337,294,815**	**$135,724,241**	**$36,071,369**	**$509,090,425**

Table 2. Transitional Grant Areas[4]

TGAs	Formula	Supplemental	MAI	Total
Austin, TX	$2,958,396	$1,160,317	$230,262	$4,348,975
Baton Rouge, LA	2,712,380	1,026,427	344,230	4,083,037
Bergen-Passaic, NJ	2,846,759	1,125,083	301,941	4,273,783
Caguas, PR	902,749	483,041	138,495	1,524,285
Charlotte-Gastonia, NC-SC	3,744,684	1,246,530	427,433	5,418,647
Cleveland, OH	3,012,147	1,182,260	294,118	4,488,525
Denver, CO	5,699,719	1,951,217	293,906	7,944,842
Dutchess County, NY	890,344	352,410	104,559	1,347,313
Ft. Worth, TX	2,722,028	1,100,270	227,090	4,049,388
Hartford, CT	2,644,158	1,347,396	272,445	4,263,999
Indianapolis, IN	2,687,572	1,029,392	191,462	3,908,426
Jacksonville, FL	3,768,114	1,410,490	402,482	5,581,086
Jersey City, NJ	3,340,858	1,405,847	393,919	5,140,624

[4] Note: In FY 2012, Caguas, PR; Dutchess County, NY; Middlesex, NJ; and Santa Rosa, CA will not receive TGA grants. Rather, Part A funds will be awarded to PR, NY, NJ, and CA to maintain services in these areas.

TGAs	Formula	Supplemental	MAI	Total
Kansas City, MO	3,062,454	1,199,676	213,663	4,475,793
Las Vegas, NV	3,947,285	1,406,452	286,611	5,640,348
Memphis, TN	4,473,085	1,750,657	574,703	6,798,445
Middlesex-Somerset-Hunterdon, NJ	1,901,284	699,486	189,982	2,790,752
Minneapolis-St. Paul, MN	3,712,983	1,441,492	262,507	5,416,982
Nashville, TN	3,111,381	1,254,120	246,226	4,611,727
Norfolk, VA	4,145,062	1,632,042	478,919	6,256,023
Oakland, CA	4,180,831	2,055,341	471,201	6,707,373
Orange County, CA	3,733,235	1,579,339	322,134	5,634,708
Ponce, PR	1,405,807	669,197	215,672	2,290,676
Portland, OR	2,454,178	1,058,036	87,326	3,599,540
Riverside-San Bernardino, CA	4,926,360	2,131,939	370,766	7,429,065
Sacramento, CA	1,693,173	829,807	120,100	2,643,080
St. Louis, MO	4,247,052	1,612,166	373,937	6,233,155
San Antonio, TX	3,037,645	1,218,053	325,200	4,580,898
San Jose, CA	1,826,054	854,020	179,410	2,859,484
Santa Rosa, CA	806,373	333,816	28,862	1,169,051
Seattle, WA	4,868,640	1,952,097	232,905	7,053,642
Vineland-Millville-Bridgeton, NJ	587,131	234,300	76,225	897,656
Subtotal	**$96,049,921**	**$38,732,716**	**$8,678,691**	**$143,461,328**
Total EMAs/TGAs	**$433,344,736**	**$174,456,957**	**$44,750,060**	**$652,551,753**

HIV Care Grants to States – Part B

	FY 2010 Appropriation	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$1,276,791,000	$1,253,791,000	$1,358,791,000	+$82,000,000
ADAP (non add)	858,000,000	835,000,000	940,000,000	+82,000,000
MAI (non add)	8,763,000	9,202,000	9,662,000	+899,000
SPNS	14,077,000	14,077,000	14,077,000	--
Total Funding	$1,290,868,000	$1,267,868,000	$1,372,868,000	+$82,000,000
FTE	25	7	7	-18

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 2012 Authorization……$1,487,780,000

Allocation Method ..... Competitive and Formula Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

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

Over the past two years, the convergence of several factors has resulted in significant budget challenges for the Part B program. These include the economic downturn, a national HIV testing initiative that has brought more people infected with HIV into care, federal recommendations for earlier treatment of HIV, and continued improvements in HIV care and treatment that has prolonged survival, increasing HIV prevalence. Part B grants provide critical resources for States and territories to meet these increased demands and provide life-saving HIV/AIDS care, treatment, and support for people living with HIV/AIDS without access to health care.

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 FY 2011 and FY 2012 hold harmless, the amount is 100%. The 2010 Hold Harmless amount was 95%. 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 and less than 5% unobligated prior year funds. 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 the ADAPs. The 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 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.

Due to the combination of factors mentioned above, including the economic downturn which results in less state discretionary spending on ADAP and more people losing their jobs and thus needing assistance for the first time, increased testing, changes in treatment recommendations, and improved survival, a number of States have started or significantly increased waiting lists for people to enroll in their ADAP programs and implemented other cost-containment mechanisms such as restricting the income eligibility for their programs. DHHS took several actions to address the ADAP crisis:

- In FY 2010, DHHS used emergency authority to redistribute and transfer $25 million from other DHHS resources to provide direct assistance to help State ADAP programs eliminate their waiting lists and the need for cost containment measures.

- In August of 2010, the FY 2011 Budget was amended to request an additional $30 million to create a new supplemental grant program to provide direct assistance to State ADAP programs with waiting lists and other cost containment measures.

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 2.06 million visits in 2007. In FY 2008, Part B provided 2.02 million visits for health-related care. In FY 2009, the Part B program provided 2.11 million visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health), which fell short of the FY 2009 target by 30,000 visits. However, the 2.11 million visits in FY 2009 was an increase of 90,000 visits over the number of visits in FY 2008. Not meeting the FY 2009 target was likely the result of fewer Part B providers, fewer clients served, and the impact of health care inflation. ADAP served 163,925

clients in 2007 and 175,194 clients in 2008. In FY 2009, 205,446 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.

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 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)
FY 2010	$1,276,791,000	($858,000,000)
FY 2011	$1,253,791,000	($835,000,000)

Budget Request

Given the states' continuing fiscal challenges and shortfalls in meeting the growing HIV epidemic in their jurisdictions, this Budget Request reflects a strong commitment to partnering with States to respond to the HIV epidemic.

The FY 2012 Discretionary Budget Request includes $1,358,791,000 for Ryan White HIV/AIDS Part B Program to support the provision life-saving medications and health care services to persons living with HIV in all fifty States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam and five Pacific jurisdictions.

Currently, ADAP waiting lists have increased to over 5,000 people in 10 states, with many other states curtailing their programs to avoid waiting lists. The budget maintains and bolsters the Federal commitment to supporting States and their ADAP programs. The Budget includes $940,000,000 for AIDS drug assistance programs, an increase of $80,000,000 above the FY 2010 Actual Level to provide access to life saving HIV related medications for approximately 13,000 additional patients. Within this total, the Budget includes $60 million for

[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.

the new supplemental competitive grant program to provide direct assistance to distressed state ADAP program with ADAP waiting lists or other cost containment measures.

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 2012. The FY 2012 Discretionary Budget Request target for the number of visits for health related care (primary, medical, dental, mental health, substance abuse, rehabilitative and home health) is 2.19 million visits. The 2012 Budget Request will maintain the Part B visits provided for health-related care in FY 2010. Part B funding will also contribute to achieving the FY 2012 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.)

Many ADAPs are in crisis as the result of State fiscal crises leading to drops in State discretionary funding for ADAP, the increasing number of people enrolling in ADAP due to the economic downturn and the increased HIV testing, patients continue to live with HIV for longer periods, fewer patients developing Medicaid-eligible disabilities, and changes in the DHHS Antiretroviral Treatment Guidelines recommending treating patients earlier. Currently, ADAP waiting lists have increased to nearly 5,000 people in 9 states, and many other states have curtailed programs to avoid waiting lists.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
18.I.A.1: Number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, [3]and home health). *(Output)*	FY 2009: 2.11M (Target Not Met but Improved)	2.19 M	2.19 M	Maintain

FY 2010 Total Table

FY 2010 Actual	FY 2011 CR	FY 2012 Budget Request	FY 2012+/- FY 2010
$1,276,791,000	$1,253,791,000	$1,353,840,000	+$77,049,000

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

Grant Awards Table – Size of Award

(whole dollars)	FY 2010 Actual	FY 2011 CR	FY 2012 Budget Request
Number of Awards	130 [4]	100	100
Average Award	$9,453,658	$11,889,700	$12,777,542
Range of Awards	$3,512 to $161,447,660	$3,512 to $161,447,660	$3,512 to $161,447,660

FY 2010 STATE TABLE

State/ Territory	Base	Base Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
Alabama	$8,050,988	$233,065	$10,966,525	$291,634	$113,087	$19,655,299
Alaska	500,000	11,889	717,360	-	-	1,229,249
American Samoa	50,000	-	2,663	-	-	52,663
Arizona	4,038,207	288,200	12,561,368	-	-	16,887,775
Arkansas	3,574,096	-	5,015,754	-	36,566	8,626,416
California	34,684,816	2,659,865	101,232,811	174,872	935,530	139,687,894
Colorado	3,655,590	242,981	9,953,123	-	56,654	13,908,348
Connecticut	3,500,189	270,982	10,972,770	-	111,583	14,855,524
Delaware	2,356,600	-	2,289,869	212,680	35,854	4,895,003
District of Columbia	4,540,467	365,413	14,964,194	-	209,964	20,080,038
F. States Micronesia	50,000	-	8,186	-	-	58,186
Florida	31,750,741	2,275,136	92,168,431	467,407	1,028,988	127,690,703
Georgia	12,067,420	711,303	34,478,154	176,406	-	47,433,283
Guam	200,000	-	86,530	-	-	286,530
Hawaii	1,301,261	50,033	2,509,815	-	14,959	3,876,068
Idaho	572,542	16,526	1,081,022	-	-	1,670,090
Illinois	9,582,663	743,929	34,065,199	-	349,359	44,741,150
Indiana	3,534,561	205,164	8,681,396	-	-	12,421,121
Iowa	1,258,207	37,181	2,378,775	-	-	3,674,163
Kansas	1,157,844	60,182	2,439,308	-	-	3,657,334
Kentucky	3,508,359	94,887	6,546,932	209,792	28,018	10,387,988
Louisiana	6,146,153	403,580	18,749,261	-	191,142	25,490,136
Maine	760,311	-	898,597	-	-	1,658,908
Marshall Islands	50,000	-	2,820	-	-	52,820
Maryland	9,044,536	-	29,262,549	-	451,824	38,758,909

[4] Includes 30 ADAP Relief Awards

State/ Territory	Base	Base Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
Massachusetts	5,275,152	-	15,013,298	-	143,258	20,431,708
Michigan	5,082,352	311,919	12,433,924	-	139,981	17,968,176
Minnesota	1,918,199	125,838	5,548,017	-	44,386	7,636,440
Mississippi	6,219,673	-	7,533,479	272,324	100,629	14,126,105
Missouri	3,809,187	261,850	10,375,045	-	85,543	14,531,625
Montana	500,000	7,095	505,782	-	-	1,012,877
N. Marianas	50,000	-	7,276	-	-	57,276
Nebraska	1,182,792	-	1,611,121	-	10,463	2,804,376
Nevada	2,189,758	144,931	6,101,000	-	48,296	8,483,985
New Hampshire	500,000	-	1,002,281	-	-	1,502,281
New Jersey	11,686,678	705,518	32,258,048	-	412,725	45,062,969
New Mexico	1,819,976	42,325	2,150,993	-	-	4,013,294
New York	39,414,059	2,977,598	119,859,704	654,191	1,519,706	164,425,258
North Carolina	11,245,753	392,261	26,472,130	259,059	271,050	38,640,253
North Dakota	200,000	3,512	223,758	-	-	427,270
Ohio	7,866,073	372,577	16,304,363	638,580	130,214	25,311,807
Oklahoma	3,618,532	-	4,919,318	203,386	-	8,741,236
Oregon	1,725,556	110,210	5,372,354	-	15,877	7,223,997
Pennsylvania	12,372,951	-	30,028,414	261,045	350,262	43,012,672
Puerto Rico	9,522,307	434,317	24,123,215	-	293,243	34,373,082
Republic of Palau	50,000	-	-	-	-	50,000
Rhode Island	1,233,921	47,379	2,286,237	205,551	21,101	3,794,189
South Carolina	11,224,926	302,439	16,517,826	351,909	171,118	28,568,218
South Dakota	500,000	6,746	378,178	-	-	884,924
Tennessee	5,364,347	350,209	15,781,399	-	141,912	21,637,867
Texas	21,625,309	1,386,821	66,057,009	-	640,007	89,709,146
Utah	1,709,161	50,547	3,052,913	-	-	4,812,621
Vermont	500,000	-	392,356	-	843	893,199
Virgin Islands	500,000	11,867	730,213	-	8,168	1,250,248
Virginia	7,539,290	447,658	21,131,215	377,444	216,137	29,711,744
Washington	3,610,260	211,501	9,516,983	-	49,515	13,388,259
West Virginia	1,061,758	-	1,579,674	-	-	2,641,432
Wisconsin	3,726,374	112,181	5,203,906	243,720	40,381	9,326,562
Wyoming	500,000	3,948	280,854	-	-	784,802
Total	**$331,279,895**	**$17,491,563**	**$866,785,695**	**$5,000,000**	**$8,418,343**	**$1,228,975,496**

Early Intervention Services – Part C

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$206,383,000	$206,823,000	$211,522,000	+$5,139,000
MAI (non add)	61,343,000	64,410,000	67,631,000	+6,288,000
SPNS	2,433,000	2,433,000	2,433,000	--
Total Funding	$208,816,000	$209,256,000	$213,955,000	+$5,139,000
FTE	29	30	30	+1

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 2012 Authorization……..…..$272,158,000

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 349 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, men-who-have-sex-with men (MSM), women, and low-income populations. The Part C program has the cultural competency and expertise to provide care to these underserved and vulnerable populations. Seventy-nine percent of those served by Part C clinics are people of color and 30 percent are female. 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. Additionally, the Part C grantees in New York, Los Angeles, Washington, D.C., Chicago, Atlanta, Miami, Philadelphia, Houston, San Francisco, Baltimore, Dallas, and San Juan will also play an important role in implementation of the National HIV/AIDS Strategy through continued provision of HIV testing, care and treatment to those infected with HIV in the "Twelve Cities Initiative." This initiative is a key part of the DHHS strategy to better coordinate HIV prevention, care, and treatment across DHHS, state, and local partners.

The 2007 results showed 236,745 clients were served by the Early Intervention Services program. 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.

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 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	$206,383,000
FY 2011	$206,823,000

Budget Request

The FY 2012 Discretionary Budget Request for the Ryan White HIV/AIDS Part C Program of $211,522,000 is $5,139,000 above the FY 2010 Actual Level. The increase will support the provision of comprehensive primary health care in an outpatient setting for people living with HIV disease for an additional 6,695 clients. The FY 2012 Discretionary Budget Request will continue to support persons receiving primary care services under the Early Intervention Services programs for about 247,361 PLWH at the 349 currently funded Part C programs.

The FY 2012 Discretionary Budget Request target for the number of people receiving primary care services under Early Intervention Services programs is 247,361. Part C funding will also contribute to achieving the FY 2012 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.)

[1] Excludes comparable amounts for SPNS.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- 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	247,361	+6,695

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Actual	FY 2011 CR	FY 2012 Budget Request
Number of Awards	349	349	349
Average Award	$591,355	$607,097	$607,490
Range of Awards	$15,000-$1,200,000	$15,000-$1,200,000	$15,000-$1,200,000

Women, Infants, Children and Youth – Part D

	FY 2010 Actual	FY 2011 CR	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$77,621,000	$77,787,000	$77,787,000	+$166,000
MAI (non add)	20,448,000	21,470,000	22,543,000	+$2,095,000
SPNS	902,000	902,000	902,000	--
Total Funding	$78,523,000	$78,689,000	$78,689,000	+$166,000
FTE	3	4	4	+1

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 2012 Authorization……$83,117,000

Allocation Method ..... Competitive Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

The Part D program focuses on providing access to coordinated, family-centered primary medical care and support services for HIV-infected women, infants, children, and youth (WICY) and their affected family members. It also funds support services, like case management and childcare that help clients get the care they need. Currently, there are 82 WICY and 17 adolescent Part D programs in 40 states, the District of Columbia, Puerto Rico, and the Virgin Islands. The Part D grantees in New York, Los Angeles, Washington, D.C., Chicago, Atlanta, Miami, Philadelphia, Houston, San Francisco, Baltimore, Dallas, and San Juan will also play a role in implementation of the National HIV/AIDS Strategy through continued provision of care, treatment, and support services for women and children living with HIV/AIDS in the "Twelve Cities Initiative." This initiative is a key part of the DHHS strategy to better coordinate HIV prevention, care, and treatment across DHHS, state, and local partners.

Eligible organizations are public or private nonprofit entities that provide or arrange for primary care for HIV-positive women, infants, children, and youth. Part D programs include community based organizations, hospitals, State and local governments.

In FY 2009, the Part D program provided comprehensive services, including treatment before and during pregnancy to reduce perinatal transmission, to 55,335 female clients. The number exceeded the FY 2009 target by 4,640 clients or 8.3%. In FY 2008, 57,773 females received such services. In FY 2007, Part D programs provided services 48,485 female clients. The results for the FY 2007 and FY 2008 also exceeded the targets. The total number of clients served in Part D in FY 2009 was 89,965. This number includes 4,766 infants (ages 0-2 years), 10,849 children (ages 2 – 12 years), 19,662 youth (ages 13 -24 years), and 54,688 persons ages

25 years and older. Of the 89,965 persons served in Part D in FY 2009, 70% were female and 29% were males, and about 1% were transgendered or unknown/unreported. Seventy-one percent of all Part D clients served were HIV infected, with the remainder largely affected family members. Of the clients with known race and ethnicity, the majority (86%) were members of racial or ethnic minority groups.

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 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	$77,621,000
FY 2011	$77,787,000

Budget Request

The FY 2012 Discretionary Budget Request for the Ryan White HIV/AIDS Part D Program of $77,787,000 is $166,000 above the FY 2010 Actual Level and will support primary health care and social support services available to 90,000 women, men, transgendered persons, infants, children, youth and adults living with HIV and AIDS and their affected families at programs in 37 States, D.C., Puerto Rico and Virgin Islands.

The FY 2012 Discretionary Budget Request 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 57,773. Part D funding will also contribute to achieving the FY 2012 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 2012 Target	FY 2012 +/- 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 2009: 55,335 (Target Exceeded)	51,316	57,773	+6,457

Grant Awards Table

Size of Award

(whole dollars)	FY 2010 Actual	FY 2011 CR	FY 2012 Budget Request
Number of Awards	98	98	98
Average Award	$792,051	$793,745	$793,745
Range of Awards	$9,444 to $2,344,396	$9,444 to $2,344,396	$9,444 to $2,344,396

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

AIDS Education and Training Programs – Part F

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$34,745,000	$34,819,000	$34,819,000	+$74,000
MAI (non add)	8,763,000	9,201,000	9,662,000	+899,000
Total Funding	$34,745,000	$34,819,000	$34,819,000	+$74,000
FTE	1	2	2	+1

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 2012 Authorization…….….$40,170,000

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 five national centers—offer specialized clinical education and consultation on HIV/AIDS transmission, treatment, and prevention to front-line health care providers, including physicians, nurses, physician assistants, dentists and pharmacists.

AETCs provide a critical area of support for the National HIV/AIDS Strategy (NHAS) by increasing access to quality HIV/AIDS care through the provision of clinical HIV/AIDS training for providers who serve the most vulnerable and hard to reach populations. The clinical management of HIV/AIDS, particularly the use of highly-active antiretroviral therapy (HAART) is the central focus of training. This is increasingly important as the HIV epidemic expands in the United States with improved testing rates and prolonged survival. In addition, the number of trained HIV care professions is projected to decease as many of those who have worked in the epidemic since its inception reach retirement age .Training an expanded cadre of culturally competent, high quality providers will be vital to meet the NHAS goals of expanding access to quality HIV/AIDS care and treatment.

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 2007. The 2008 results show the AETC program training interventions comprised 44% racial/ethnic minorities which exceeded the target. Additional examination of the AETC data show that 56% of health care providers participating in the AETC training programs in 2008 primarily served racial/ethnic minority patients.

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 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	$34,745,000
FY 2011	$34,819,000

Budget Request

The FY 2012 Discretionary Budget Request for the Ryan White HIV/AIDS AETC Program is $34,819,000 and is $74,000 above the FY 2010 Actual Level and will support targeted, multidisciplinary education and training programs for health care providers treating people living with HIV/AIDS. 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 health care providers participating in the AETC intervention programs".

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
21.V.B.1: Proportion of racial/ethnic minority health care providers participating in AETC training intervention programs. *(Output)*	FY 2008: 44 % (Target Exceeded)	43 %	43 %	Maintain

Grant Awards Table

Size of Awards

(whole dollars)	**FY 2010 Actual**	**FY 2011 CR**	**FY 2012 Budget Request**
Number of Awards	16	16	16
Average Award	$2,171,563	$2,340,187	$2,340,187
Range of Awards	$800,647-$5,229,437	$800,647-$5,229,437	$800,647-$5,229,437

Dental Reimbursement Program – Part F

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$13,565,000	$13,594,000	$13,594,000	+$29,000
FTE	--	--	--	--

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 2012 Authorization……..…..$15,049,000

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The HIV/AIDS Dental Reimbursement Program provides access to oral health care for people living with HIV/AIDS by reimbursing dental education programs for the non-reimbursed costs they incur providing such care. By offsetting the costs of non-reimbursed HIV care in dental education institutions, the Dental Reimbursement Program improves access to oral health care for people living with HIV and trains dental and dental hygiene students and dental residents to provide oral health care 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 health care to people living with HIV are eligible to apply for reimbursement. Funds are then distributed to eligible organizations taking into account the number of people served and the cost of providing care.

Dental Reimbursement Program

Programs	FY 2010 Actual	FY 2011 CR	FY 2012 Budget Request
Dental Reimbursement Program	$9,046,000	$9,046,000	$9,046,000
Community-Based Dental Partnership Program	$4,519,000	$4,548,000	$4,548,000

In FY 2009, the Dental Reimbursement Program awards met 35.4% of the total non-reimbursed costs reported by 57 participating institutions in support of oral health care. These institutions reported providing care to 35,474 HIV-positive individuals, for whom no other funded source was available. This number exceeded the goal by 1,966 individuals or 5.9%. This represents a 1.9% decrease from FY 2008 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 2009, the demographic characteristics of patients who were cared for by institutions participating in the DRP were: 35.7% women, 62.6% 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 23.2% of AIDS cases in 2008 were among women and 65.9% of AIDS cases were among racial/ethnic minorities.

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 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	$13,565,000
FY 2011	$13,594,000

Budget Request

The FY 2012 Discretionary Budget Request for the Ryan White HIV/AIDS Dental Service Program of $13,594,000 is $29,000 above the FY 2010 Actual Level and will support oral health care for people with HIV. This program 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. The FY 2012 Discretionary Budget Request target for the number of persons for whom a portion of their unreimbursed oral health costs will be reimbursed is 33,584.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
22.I.D.1: Number of persons for whom a portion/ percentage of their unreimbursed oral health costs were reimbursed. *(Output)*	FY 2009: 35,474 (Target Exceeded)	33,508	33,584	+76

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Actual	FY 2011 CR	FY 2012 Budget Request
Number of Awards	81	81	81
Average Award	$190,000	$190,000	$190,000
Range of Awards	$411 to $826,000	$411 to $826,000	$411 to $826,000

HEALTHCARE SYSTEMS

Organ Transplantation

	FY 2010 Actual	FY 2011 CR	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$25,991,000	$26,049,000	$25,991,000	----
FTE	---	---	---	---

Authorizing Legislation - Sections 371 - 378 of the Public Health Service Act, (P.L. 98-507 and P.L. 108-216), as amended.

FY 2012 Authorization ..... Expired

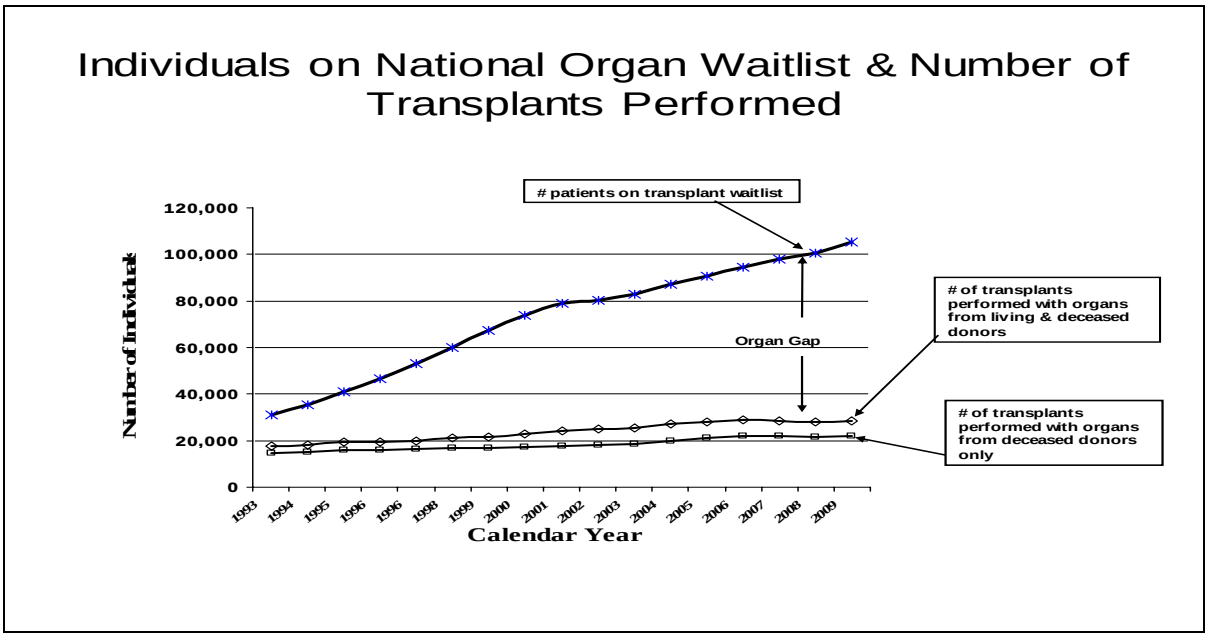
Allocation Method ..... Contracts, Competitive Grants and Cooperative Agreements

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 deceased donor organs made available for transplantation and to ensure the safety of living organ donation.

Ideally, an organ that provides optimal benefit would be available for every transplant candidate at the most appropriate time. Unfortunately, the demand for organ transplantation greatly exceeds the available supply of organs (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 2009, there were 105,526 patients listed on the waiting list. Tragically, 6,543 individuals died in 2009 (approximately 18 per day) while waiting for a donor organ.

Figure 1. Individuals on National Organ Waitlist & Number of Transplants Performed



In 2004, the Program established measurable goals for maximizing the number of deceased donor organs made available for transplantation and improving patient outcomes. These Program goals are summarized by two overarching measures: (1) increase the number of deceased donor organs transplanted to 33,473 by 2013 (64 percent above the 2003 baseline of 20,392); and (2) increase the expected life-years gained for kidney transplant recipients to 7,302 by FY 2013 compared to what would be expected for these recipients had they remained on the waiting list (additional 3,431 years, 89 percent above the 2003 baseline of 3,871).

The first long-term goal of increasing the number of deceased donor organs transplanted is based on converting the number of 'eligible deaths' into actual donors (donor conversion rate). 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. In FY 2009, 24,116 deceased donor organs were transplanted, 13 percent below the target of 27,683 for 2009, but an 18 percent increase above the 2003 baseline level of 20,392.

The number of deceased donor organs made available for transplantation is primarily dependent on the number of eligible donors. Since these data were first reported by the OPTN in 2002, the number of eligible donors has decreased due at least in part to improved prevention and treatment efforts. The number of eligible deaths in 2002 was in excess of 12,000 and the number had decreased to just below 10,000 in 2009. Fewer severe head traumas and improved management of brain injuries have resulted in fewer patients proceeding to brain death. Another example is that first-time cardiovascular events (resulting in anoxic brain injuries that may lead to brain death) have seen a 28 percent reduction in the event fatality rate since 1990 as a result of

improvements in emergency and acute care. Hospital deaths have also been declining, which is congruent with the trend of decreasing number of eligible deaths.

A major component of efforts to increase organ donation in the last decade was a series of Breakthrough Collaboratives that began in late 2003 to rapidly increase the number of deceased donors and number of donor organs made available for transplant through the sharing of best practices. 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 52 percent in 2003 to 75 percent by FY 2013. While the number of eligible deaths has been decreasing, the donor conversion rate has increased steadily from 52 percent in 2003 to 69.1 percent in 2009. Since this first Collaborative, the focus has changed over time to include efforts to improve: 1) the number of organs made available; 2) the capacity of organ procurement organizations (OPOs) and transplant centers to effectively manage more organ donors and perform more organ transplants; and 3) efforts to expand the use of other types of organ donors such as cardiac-death donors and expanded criteria donors.

HRSA initiated several activities in FY 2010 to sustain and improve upon the gains of the Breakthrough Collaboratives. The umbrella for these activities is the 'Organ Donation and Transplantation Community of Practice' (Community of Practice). The major focus of the Community of Practice is to sustain and increase the achievements of the Collaboratives and institutionalize identified best practices. The Community of Practice continues the "all teach, all learn" knowledge-sharing model through local and regional networks and interaction known as the Donation Service Area (DSA) Action Teams and Regional Collaboratives. The 58 DSAs are the areas served by each OPO. The Action Team consists of representatives of the OPO, donor hospitals, transplant centers, and in some cases, other partners in the donation process (e.g., eye and tissue banks, state hospital association members, donor registry professionals). Successful strategies at the DSA level are shared at the regional level – there are 11 regions designated by the OPTN in the United States. These local (DSA) and regional efforts culminate in the National Learning Congress (NLC), HRSA's major event educating and recognizing organizations that have met national goals in increasing organ and tissue donation: 75 percent conversion rate, 3.75 organs transplanted per donor, and 10 percent of donors being donated after cardiac death. Through the NLC, best practices identified and refined through DSA action and regional strategies are shared nationally. Attendees include professionals from OPOs, hospitals, transplant centers, eye and tissue banks, hospital associations, donor designation entities, and others. In addition, several topic-specific sharing and educational experiences are convened during the year.

Additionally, HRSA is seeking and sustaining partnerships with key organizations that touch the donation and transplantation processes, including entities with capabilities in professional development, healthcare, and public education. In FY 2011, HRSA initiated an education program to leverage web-based technological capabilities to better meet the educational needs of the community. HRSA has implemented programs to improve enrollment in donor registries, to educate healthcare professionals about honoring donor designation, and to increase support of potential donor families, all of which have an impact on conversion rate. Other programs share best practices in the medical management of organ donors to increase the number of organs that

can be recovered from each donor. Maximizing donor potential is especially critical because more donors are being accepted under extended medical, age, and recovery criteria. In July 2010, HRSA provided additional funding through the OPTN contract to conduct a scientifically rigorous study employing demographic and epidemiological methods to better define deceased donor potential in the United States. This FY 2010 funded study will serve as a basis for refining strategic approaches to maximize deceased donor potential and for modifying Program performance goals.

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 life-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 gained for each kidney transplant recipient) and the total number of expected life-years gained 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 2009, the Program fell short of its average number of life-years gained per transplant target (0.42 average, actual vs. 0.424 average, target) and its total expected life-years gained (4,851 years, actual vs. 5,873 years, target). However, both the average and total expected-life-years gained in FY 2009 improved over the FY 2008 results. In FY 2008, the average number of life-years gained per-transplant was 0.41 and the total expected life-years gained was 4,586 years.

An important component of the total expected life-years gained is the number of kidney transplants performed. The main reason the performance goal was not met is because fewer than the projected number of deceased kidney transplants were performed in FY 2009. Increasing the marginal improvement gained by each kidney transplant may also be improved by revising how kidneys are allocated. Over the past several years, the OPTN has made incremental improvements to the kidney allocation policy. Even with these improvements, the current policy still places great emphasis on the amount of time individuals wait for an organ transplant as opposed to the differential clinical benefit which may be afforded for each individual waiting for a transplant. 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.

Funding History

FY	Amount
FY 2007	$23,049,000
FY 2008	$22,646,000
FY 2009	$24,049,000
FY 2010	$25,991,000
FY 2011 CR	$26,049,000

Budget Request

The FY 2012 Discretionary Budget Request for the Organ Transplantation Program is $25,991,000. This request is equal to the FY 2010 Actual Level. 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. The EHB supports the Organ Transplantation Program with program administration, grants administration and monitoring, management reporting, and grantee performance measurement and analysis. The funding also includes IT investment costs to support the strategic and performance outcomes of the Program and contributes to its success by providing a mechanism for sharing data and conducting business in a more efficient manner.

The FY 2012 Request will maintain current service levels and continue support for the Organ Transplantation Program in achieving its FY 2012 performance targets:

Transplant 31,979 deceased donor organs; and achieve 6,928 expected life-years gained for the five-year post-transplant period for kidney and kidney/pancreas transplants performed.

The following activities will be supported with the requested funding:

Contract to Operate the OPTN ($2.56 million) — The OPTN is the critical nexus between individuals needing 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. HRSA utilizes a competitive contracting process to award the contract to operate the OPTN. The OPTN contract is a cost-share, cost-reimbursement contract. The costs of operation of the OPTN are funded with revenues generated by fees collected by the OPTN to register patients on the national donor waiting list and with appropriated funds. The Stephanie Tubbs Jones Organ Transplantation Authorization Act of 2008 (P.L. 110-426) authorizes appropriated funds up to $7 million annually for the operation of the OPTN. In FY 2012, HRSA will award a new competitive contract to continue the operation of the OPTN. The projected

cost of operating the OPTN in FY 2012 is approximately $35.9 million. This amount includes IT support for the OPTN system.

Contract to Operate the SRTR ($4.1 million) — 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. Additionally, the SRTR provides analytic support to HHS, 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 on the Internet, organ transplant program risk-adjusted patient and graft outcomes and risk-adjusted organ procurement organization performance, including comparison of the actual vs. expected number of donors and donor organs retrieved. HRSA has chosen to use a competitive contracting process in lieu of a grant to provide greater oversight and control over this critical function. A new contract was awarded in September 2010 to the Chronic Disease Research Group of the Minneapolis Medical Research Foundation using a competitive contracting process. The funding for the SRTR includes IT support for the SRTR system.

Efforts to Sustain and Improve on Gains Resulting from Breakthrough Collaboratives ($3.5 million) — HRSA will continue to support efforts to institutionalize the organ donation gains resulting from the Breakthrough Collaboratives that began in 2003. The Collaborative model of promoting rapid change through a series of frequent and intense sharing and learning experiences was effective. Because of factors such as cost and level of intensity required collaborating cannot be sustained indefinitely. Thus, it became necessary to evolve. The Collaborative effort continues through the Community of Practice, the focus of which is to sustain and increase the achievements of the Collaboratives and institutionalize identified best practices. The Community of Practice continues the "all teach, all learn" knowledge-sharing model through local and regional networks and interaction known as the Donation Service Area (DSA) Action Teams and Regional Collaboratives. The 58 DSAs are the areas served by each OPO. The Action Team consists of representatives of the OPO, donor hospitals, transplant centers, and in some cases, other partners in the donation process (e.g., eye and tissue banks, state hospital association members, donor registry professionals). HRSA will continue to leverage technology, including Internet-based webinars, to communicate this information in a cost effective manner. The Community of Practice is supported by logistics and technical assistance contracts to provide for meeting and consultant support.

Grants to Support Projects to Increase Organ Donation ($7.58 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.

Cooperative Agreement to Provide Support for Reimbursement of Travel and Subsistence Expenses toward Living Organ Donation ($2.0 million) — The existing cooperative agreement 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. The cooperative agreement was renewed through a competitive process in FY 2010 for an additional four years. 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 739 living donor transplants from October 2007 through November 2010. As of the end of November 2010, an additional 196 prospective living donors have been approved for reimbursement pending the organ donation procedures.

Activities to Support Public and Professional Education ($3.551 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 communication 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.

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.

Efforts to Evaluate Long-term Impact of Living Organ Donation ($2.5 million) — In FY 2011, HRSA either through grants/cooperative agreements, interagency agreements or contracts, with assistance from other HHS agencies and external organizations, will continue the work initiated by the National Institutes of Health (NIH) to evaluate the impact of living organ donation on donor health and psycho/social issues through the Renal and Lung Living Donors Evaluation Study (RELIVE). This work will continue in FY 2012. HRSA has provided financial and technical support to two NIH-initiated and -administered studies: (1) RELIVE, and (2) Adult-to-

Adult Living Donor Liver Transplantation Study (A2ALL). The RELIVE study examines short- and long-term outcomes of living kidney and lung donors at six transplant centers. The RELIVE study was initiated in FY 2006 and is operated by the National Institute of Allergy and Infectious Diseases (NIAID). HRSA has contributed $1.2 million to this Project since its inception including $205,000 in FY 2010, the last year of funding for this Project. The A2ALL Study focuses on long-term outcomes of living adult liver donors and recipients at nine transplant centers. The A2ALL study was initiated in FY 2002 and is operated by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). HRSA has contributed $1.625 million during the period of FY 2002 through FY 2009. NIDDK awarded new cooperative agreements in FY 2010 to continue this study for an additional five years. HRSA has not contributed to the new A2ALL cooperative agreement.

Outcomes and Outputs

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
23.II.A.1: Increase the annual number of deceased donor organs transplanted *(Outcome)*	FY 2009: 24,116 (Target Not Met but Improved)	29,084	31,979	+2,895
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 2009: 4,851 (Target Not Met but Improved)	6,213	6,928	+715
23.II.A.8: Increase the annual conversion rate of eligible donors. *(Efficiency)*	FY 2009: 69.1% (Target Exceeded)	68.6%	72.9%	+4.3
Program Level Funding ($ in millions)	N/A	$25.991	$26.049	+0.058

Grant Awards Table

Size of Awards

(whole dollars)	**FY 2010 Actual**	**FY 2011 CR**	**FY 2012 Request**
Number of Awards	26	35	30
Average Award	$317,101	$488,841	$510,471
Range of Awards	$57,563-$1,718,236	$10,000-$3,000,000	$150,000-$3,000,000

National Cord Blood Inventory

	FY 2010 Actual	FY 2011 CR	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$11,957,000	$11,983,000	$13,883,000	+$1,926,000
FTE	1	4	4	+3

Authorizing Legislation - Section 379 of the Public Health Service Act, as amended and Public Law 111-264.

FY 2012 Authorization $23,000,000

Allocation Method .....Contract

Program Description and Accomplishments

The National Cord Blood Inventory (NCBI) Program, established through legislation renewed on October 8, 2010, is charged with building a genetically and ethnically diverse inventory of at least 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 potentially 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 for which 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 tissue-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 racial and ethnic minorities, especially African-Americans, racial and ethnic minorities are less likely to find a suitably matched adult marrow

donor on the Registry of the C.W. Bill Young Cell Transplantation Program. 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. Minority patients, especially African-American patients, are especially likely to benefit from additional cord blood units. For these reasons, HRSA policy for the NCBI continues to emphasize increasing the number of cord blood units collected from minority donors. In the earlier years, the majority of cord blood transplants were performed for pediatric recipients because of the smaller number of stem cells present in cord blood relative to adult marrow. However, the introduction of multiple cord blood unit transplants, and NCBI-led increases in the cord blood inventory including units with larger cell counts, have increased the availability of cord blood for adult recipients. During FY 2009 and FY 2010 the number of adult recipients has surpassed the number of pediatric patients receiving cord blood transplants.

Requests for proposals have been announced annually since the inception of the Program to add additional cord blood banks to the NCBI Program for the collection of additional cord blood units. These proposals have been reviewed by technical review committees composed of individuals qualified by training and experience in fields related to blood stem cell transplantation and cord blood banking. Funding decisions are made based on assessments of technical merit, overall quality, ability to collect from diverse populations, geographic dispersion of offerors, evaluation of past performance including progress toward achieving self-sufficiency of collections and banking operations, and evaluation of proposed costs. When exercising option years beyond the original one-year base period of the contracts, current performance including progress toward self-sustainability and compliance with contract terms are 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 five more banks were added in FY 2008 through FY 2010. Currently, 13 banks hold NCBI contracts. HRSA awarded six contracts (five were new contracts to current NCBI banks) near the end of FY2010. As of September 30, 2010 34,744 NCBI cord blood units were available through the Program. An additional 15,212 units will be collected with funds awarded through FY 2010. A total of 49,956 units of cord blood will be put into the NCBI with all funds awarded through FY 2010. We estimate that approximately 7,700 additional units will be banked with funds awarded in FY 2011, assuming an average price to HRSA of $1,500 and the final appropriation at the CR level.

During the first year of collections for the NCBI (FY 2007), four cord blood units from this then very small inventory were released for transplantation, with an additional 104 units released for transplantation during FY 2008. During FY 2009 458 units were released for transplantation and an additional 530 of units were released in FY 2010, with many units currently under evaluation for use by patients in need of transplant. This represents a use rate approximately twice that of non-NCBI units, showing that transplant physicians have been preferentially selecting NCBI units. The benefit of large volume units, such as those collected with HRSA funds, is

demonstrated by the fact that all of the NCBI units released for transplantation have 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 2010, over 60 percent 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 one half of the growth in transplants over the life of the NCBI Program, and 22 percent of all transplants facilitated through the C.W. Bill Young Cell Transplantation Program during FY 2010. Multiple-unit transplants continue to rise, from 29 percent of all cord blood transplants during FY 2009 to nearly 35 percent in FY 2010.

For minority patients, cord blood has been especially critical in increasing access to transplantation, with 42 percent of the transplants for minority patients facilitated through the C.W. Bill Young Cell Transplantation Program in FY 2010 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 adequately matched adult donors; thus cord blood was their only chance for life-saving transplants.

Moreover, NCBI banks have provided to researchers more than 12,000 non-NCBI units, for a wide variety of pre-clinical and clinical research.

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
FY 2010	34,744

Funding History

FY	Amount
FY 2007	$3,963,000
FY 2008	$8,843,000
FY 2009	$11,983,000
FY 2010	$11,957,000
FY 2011 CR	$11,983,000

Budget Request

The FY 2012 Discretionary Budget Request for the National Cord Blood Inventory is $13,883,000 which is an increase of $1,926,000 above the FY 2010 Actual Level. This funding will support progress toward the statutory goal of building a genetically diverse inventory of at least 150,000 new units of high-quality cord blood for transplantation and will, therefore, increase the number of patients in all population groups who are able to obtain life-saving transplants. More units in the inventory also will improve patient survival after transplant because a larger inventory with higher cell counts will allow better tissue matches between patient and cord blood unit and higher cell doses, both of which strongly affect transplant outcomes. We estimate that this request will support the collection and banking of approximately 8,900 additional cord blood units, assuming an average price to HRSA of $1,500.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- 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 2010: 58,535 (Target Exceeded)	50,000	62,500	+12,500
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 2010: 34,744 (Target Exceeded)	26,000	46,800	+20,800
Increase the number of sites where NCBI participating banks collect cord blood units	FY 2010: 107 (Target Exceeded)	90	118	+28
Increase the annual number of NCBI cord blood units released for transplant	FY 2010: 530 (Target Exceeded)	140	650	+510
Program Level Funding ($ in millions)	N/A	$11.957	$13.883	+$1.926

Contracts Awards Table

Size of Contracts

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Contracts	10	10	10
Average Contract	$1,150,030	$1,152,531	$1,335,274
Range of Contracts	$173,497-$2,706,853	$57,287-$2,700,000	$200,000-$3,000,000

C.W. Bill Young Cell Transplantation Program

	FY 2010 Actual	FY 2011 CR	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$23,467,000	$23,517,000	$26,544,000	+$3,077,000
FTE	5	5	5	---

Authorizing Legislation - Section 379 of the Public Health Service Act as amended, and P. L. 111-264.

FY 2012 Authorization $30,000,000

Allocation Method .....Contract

Program Description and Accomplishments

The primary goal of the C.W. Bill Young Cell Transplantation 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 data on transplant outcomes. 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 tissue-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.

Per authorizing legislation renewed on October 8, 2010 (The Stem Cell Therapeutic and Research Reauthorization Act of 2010, P.L. 111-264), 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 data on transplant outcomes now including all allogeneic transplants, and other therapeutic uses of blood stem cells. The Program is operated through four major contracts that require close coordination. The authorizing legislation also requires 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 more complex C.W. Bill Young Cell Transplantation Program structure; (2) developed initiatives to meet and/or exceed established long-term and short-term goals; (3) established a methodology for comparing one-year patient survival rates over time and established baselines and targets for this performance measure; (4) updated and implemented a comprehensive plan to increase transplants; (5) begun 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 matters related to the Program.

In FY 2006, the Health Resources and Services Administration (HRSA) awarded four contracts for: (1) a Cord Blood Coordinating Center 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) a Bone Marrow Coordinating Center 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) 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 and obtain a suitable 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; and (4) a Stem Cell Therapeutic Outcomes Database 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.

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 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 contractor performance and compliance with contract terms. HRSA awarded an option year for each of the four contracts in FY 2008, FY 2009 and again in FY 2010, based on satisfactory performance.

Performance measures, which are monitored quarterly, indicate that the Program is on or ahead of schedule to meet its three long-term goals which concern: (1) increasing the number of blood stem cell transplants facilitated; (2) increasing the number of transplants facilitated for minority patients; and (3) increasing patient survival at one-year post-transplant. The Program continues to serve a diverse patient population, with cord blood transplants playing a very important role for minority patients. Notably, survival at one year after unrelated donor transplants, for standard risk patients, has been improving steadily and now is essentially the same as for sibling donor transplants. The Program's long term goals are supported by two annual measures: (1)

the increase in the number of adult volunteer potential donors of minority race and ethnicity on the Registry and (2) the decrease of the unit cost for human leukocyte antigen (HLA) tissue typing needed to match patients and donors.

As of the end of FY 2010, a total of 8,799,643 adult volunteer donors were listed on the registry of whom 2,463,830 (or 28 percent) self-identified as belonging to a racial/ethnic minority population group, exceeding the goal of 2.35 million. The target established for FY 2012 is 2,660,000 adult volunteers from racially/ethnically under-represented minority population groups.

The purpose of the Program is to increase the number of unrelated blood stem cell transplants facilitated for patients in need. This long-term goal directly reflects the Program's purpose. The FY 2010 result for this measure was 5,228 (exceeding the target of 4,500).
Increasing the number of blood stem cell transplants facilitated for patients from racially and ethnically diverse backgrounds furthers the statutory aim of ensuring comparable access for this potentially life-saving therapy that is comparable to that of non-Hispanic Caucasian patients.

The FY 2010 result for this measure was 820 (exceeding the target of 636). 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 make increases in donor recruitment possible for a given level of funding. The FY 2010 actual cost for tissue typing was $52.00, down from $65.86 in FY 2003, thus meeting the target. The price for FY 2011 will remain at $52.00 and the target for FY 2012 is $50.44.

Funding History

FY	Amount
FY 2007	$25,168,000
FY 2008	$23,517,000
FY 2009	$23,517,000
FY 2010	$23,467,000
FY 2011 CR	$23,517,000

Budget Request

The FY 2012 Discretionary Budget Request for the C.W. Bill Young Cell Transplantation Program is $26,544,000 which is an increase of $3,077,000 above the FY 2010 Actual Level. This funding will support progress toward the Program's ambitious performance target of 2,660,000 adult volunteers from racially/ethnically diverse minority population groups listed on the registry by September 30, 2012. These funds will also be used to support the four major Program 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 to increase the number of transplants for recipients suitably matched to biologically unrelated donors of bone marrow and cord blood. Additionally the Program will continue efforts to collect comprehensive outcomes data on related-donor transplants as well as 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 collect data on emerging therapies using cells derived from bone marrow and umbilical cord blood.

FY 2012 funding will also allow the Program to continue critical planning to respond to a radiation or chemical 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.

The Authorization for the Program (P.L. 111-264) expires September 30, 2015.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
24.II.A.2: Increase the number of adult volunteer potential donors of minority race and ethnicity. *(Outcome)*	FY 2010: 2.46 Million (Target Exceeded)	2.35 Million	2.66 Million	+.31 Million
24.1: Increase the number of blood stem cell transplants facilitated annually by the Program.[1] *(Outcome)*	FY 2010: 5,228 (Target Exceeded)	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 2010: 820 (Target Exceeded)	636	N/A	N/A
24.3: Increase the rate of patient survival at one year, post transplant. [1] *(Outcome)*	FY 2010 data will be available on 12/31/2012 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 2010: $52.00 (Target Met)	$52	$50.44	-$1.56
FY 2010 Program Level Funding ($ in millions)	N/A	$23.467	$26.544	+$3.077

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

Contracts Awards Table **Size of Contracts**

(whole dollars)	**FY 2010 Enacted**	**FY 2011 CR**	**FY 2012 Request**
Number of Contracts	8	6	6
Average Contracts	$2,695,620	$3,601,818	$4,065,428
Range of Contracts	$7.500 - $15,671,402	$15,000 - $15,700,000	$15,000 - $17,500,000

Poison Control Program

	FY 2010 Actual	FY 2011 CR	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$29,250,000	$29,314,000	$29,250,000	----
FTE	4	3	4	---

Authorizing Legislation - Section 1271-1274 of the Public Health Service Act, as amended by P.L. 110-377.

FY 2012 Authorization .....National Toll Free Number - $700,000
FY 2012 Authorization .....Nationwide Media Campaign - $800,000
FY 2012 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 57[1] PCCs; (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 accreditation.

The Poison Control Program (PCP) awards two categories of funds to PCCs across the Nation: (1) the Support and Enhancement Grant Program assists PCCs in preventing and providing treatment recommendations for poisoning, and for maintaining or attaining accreditation thereby enhancing the quality of poison control services available to the public, and (2) the Incentive Cooperative Agreement Program encourages and supports 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 PCCs 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.

[1] In FY 2010 and the beginning of FY 2011, there were 60 PCCs. As of January 1, 2011, the State of New York closed 3 of their 5 centers. As a result, there are now 57 PCCs providing service to the Nation.

PCCs are our Nation's primary defense against injury and death from poisonings. Annually, approximately 2.4 million poisonings are reported and approximately 4.2 million poisoning-related calls are made to the Nation's PCCs. Centers 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 to 44 and 45 to 54 age groups for the first time in 2005. In 2006, poisoning remained the leading cause of death among these groups. Ninety-six (96) percent of unintentional poisoning deaths were caused by drugs. Opioid pain medications were involved in more than half of these deaths.

According to 2009 data from the American Association of Poison Control Centers (AAPCC), 90 percent of all poisoning exposures occurred in people's homes. Over half of the calls to PCCs involved possible poisonings of children age five and under. In 2009, 72 percent or more of the general public who called a PCC got the help they needed over the phone with guidance from trained healthcare professionals (nurses, pharmacists and certified specialists in poison information), avoiding 1.8 million 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 PCC costs $43 and saves $290 in medical costs. At $43 a call, each $1 spent on PCC services saves almost $7 in medical spending. A working group of PCCs convened in 2007-2008 estimated that the cost savings resulting from direct federal financial support of poison centers in 2005, dollars would result in costs savings of $525 million dollars.

In addition to providing the public and health care providers with treatment advice on poisonings, one of the most important functions of the PCCs is the collection of poison exposure and surveillance data. Many Federal agencies, including CDC, Environmental Protection Agency, and Food and Drug Administration, rely on these data for early identification of outbreaks and public health surveillance. For example, data from the PCCs were used to track exposures related to the 2010 Deepwater Horizon oil spill and the 2009-2010 H1N1 outbreak.

One of the PCP's 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 (17) 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. The Program evaluated the utility of guidelines during 2008 and no new guidelines were developed during 2008, 2009, or 2010. All of the guidelines have been reproduced and distributed to the PCCs and are available on the HHS National Guideline Clearinghouse website. A competitive contract will be awarded in FY 2011 to update a segment of the existing guidelines by the end of FY 2012 and develop a plan for updating the remaining guidelines. The PCP will also determine whether any additional guidelines are warranted.

Another 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 PCCs were received on the national toll-free number. In FY 2008, 70 percent of the total calls to PCCs were received on the national toll-free number, exceeding the goal of 69.3 percent. In FY 2009, 73.7 percent of the total calls to PCCs were received on the national toll-free number, exceeding the goal of 71 percent. In FY 2010, 75.6 percent of the total calls to PCCs were received on the national toll-free number, exceeding the goal of 73.7 percent.

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. The PWg includes epidemiologists, toxicologists, prevention specialists, state-based injury experts, poison educators, academics, government officials, and survivors of opioid narcotic abuse. From 2006 to 2009, the PCP supported the group's conference calls, in-person meetings and activities including 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 Health Resources and Services Administration (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 PCC services and the toll free number.

Funding History

FY	Amount
FY 2007	$23,000,000
FY 2008	$26,528,000
FY 2009	$28,314,000
FY 2010	$29,250,000
FY 2011 CR	$29,314,000

Budget Request

The FY 2012 Discretionary Budget Request of $29,250,000 is equal to the FY 2010 Actual Level. The additional $64,000 in funding for this Program will be used to support PCCs' efforts to prevent poisonings and provide treatment recommendations. PCC grantees have implemented many strategies to accomplish the purpose of providing treatment recommendations, complying with accreditation requirements and implementing outreach activities to increase access to their centers. Through 2009, HRSA funding has represented, on average, approximately 19 percent of total financing for PCC operations. Ninety-five (95) percent of PCCs are now accredited, up from 78 percent in 2001. Many centers have implemented strategic planning initiatives and business plans, and increased access to services through outreach and education programs. In FY 2012, the Program proposes to continue to support initiatives that focus on preventing poisonings, providing treatment recommendations, complying with operational requirements needed to attain or sustain accreditation 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 PCC services, promote and maintain the national toll-free number and language line services for non-English speaking callers, and update patient management guidelines.

The FY 2012 Budget Request will support the following:

Support and Enhancement Grant Program and Incentive Cooperative Agreement Program ($27.577 million): Grant funds will be used to continue supporting PCCs efforts to prevent poisonings, provide treatment recommendations and comply with operational requirements needed to attain or sustain accreditation. Incentive cooperative agreements 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 PCCs 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 the general public, health care providers including pharmacists, and 340B participants. The FY 2012 target is to increase the percent of all calls routed to the PCCs using the toll-free number to 75 percent.

Patient Management Guidelines ($173,000): Funding will be used to continue to update the existing uniform and evidence-based guidelines for the treatment of poisonings

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
25.1: Decrease the number of visits to the emergency room, (per 1,000 live ER discharges).[2] *(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 2010: 17[3] (Target Not Met)	20	17	-3

[2] This is a long term measure with no annual target.
[3] Patient management guidelines activities were not done in 2010; therefore the most recent result remained at 17.

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
25.III.D.3: Increase percent of inbound volume on the toll-free number. *(Output)*	FY 2010: 75.6% (Target Exceeded)	73.7%	75%	+1.3% points
25. E.1: Decrease application time burden. *(Efficiency)*	FY 2010: 25.47 hrs (Target Exceeded)	27 hrs	26.5 hrs	-.5 hrs
Program Level Funding ($ in millions)	N/A	$29.250	$29.250	---

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	55*	54**	54***
Average Awards	$467,318	$467,318	$501,400
Range of Awards	$79,537-$3,089,013	$79,537-$3,089,013	$79,537-$3,314,102
Number of Cooperative Agreements	10	10	10
Average of Cooperative Agreements	$100,000	$100,000	$100,000
Range of Contracts	$24,500-$756,750	$24,500-$800,000	$24,500-$825,000

* In FY 2010, there were 60 PCCs across the Nation. Fifty-five (55) awards were made under the Support and Enhancement Grant Program, representing 58 of the 60 centers. For grant purposes, HRSA counts the California Poison System as a single entity, but it encompasses four California poison centers.

** In FY 2011, there were 57 PCCs across the Nation. Fifty-four (54) awards were made under the Support and Enhancement Grant Program, representing all of the 57 centers. For grant purposes, HRSA counts the California Poison System as a single entity, but it encompasses four California poison centers.

***In FY 2012, there are 57 PCCs across the Nation. Fifty-four (54) awards will be made under the Support and Enhancement Grant Program, representing all of the 57 centers. For grant purposes, HRSA counts the California Poison System as a single entity, but it encompasses four California poison centers.

Office of Pharmacy Affairs/340B Drug Pricing Program

	FY 2010 Actual	FY 2011 CR	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$2,220,000	$2,220,000	$5,220,000	+$3,000,000
FTE	---	---	---	---

Authorizing Legislation - Section 340B of the Public Health Service Act as amended by the Affordable Care Act (P.L. 111-148), as further amended by the Health Care and Education Reconciliation Act (P.L. 111-152).

FY 2012 Authorization ..... Indefinite

Allocation Method ..... Contract

Program Description and Accomplishments

The 340B Drug Pricing 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 health care providers are eligible to purchase outpatient drugs at 340B prices: all HRSA-assisted Federally Qualified Health Centers; 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; children's hospitals; Federally Qualified Health Center Look-A-Likes; Free-Standing Cancer Centers; Critical Access Hospitals; Rural Referral Centers; and Sole Community Hospitals.

The 340B Program requires drug manufacturers to give covered entities a discount that is at least 23.1 percent below Average Manufacturer Price (AMP) for brand name drugs; 13 percent below AMP for generic drugs; and 17.1 percent below AMP for clotting factor and pediatric drugs. From FY 2010 through FY 2011, covered entities will save an estimated $3 billion on their $6 billion outpatient drug expenditures by participating in the 340B Program. The total savings in FY 2012 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) is responsible for the negotiation of pharmaceutical prices below the 340B ceiling price as well as contracting for wholesale distribution of pharmaceuticals to covered entities. The Program is free and

voluntary. The PVP contract was re-competed and awarded in 2009 to Apexus, a non-profit organization. As of May 2010, the PVP had over 3,600 drugs under contract with an estimated average savings of 15 percent below the 340B ceiling price. In addition, the PVP has contracts for other value-added pharmacy products and services such as vaccines, diabetic supplies, pharmacy software, and outpatient pharmacy automation. Historically, the PVP contracts provided over $30 million in additional savings for covered entities enabling them to further expand their pharmacy programs and address growing patient needs during difficult economic times. Apexus has established "shareback" payments of $5 million to participating covered entities. These funds allow the covered entities to purchase more medications at a reduced cost for their patients. 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.

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. The PSSC contract was modified to accommodate the Office of Inspector General (OIG) recommendations that HRSA provide 340B Program education and training activities for covered entities. The PSSC assists the 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. The technical assistance is critical in assisting the newly eligible safety-net providers to fully utilize the 340B Drug Pricing Program. It also is important to maximize their savings through the use of all available tools, including multiple contract pharmacies since April 2010 and integrating leading patient safety practices to avoid serious adverse events.

HRSA has prepared a report, as requested in the 2007 and 2008 Senate Appropriations Committee Reports that identifies valuable lessons learned 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.

Program Growth

In FY 2010, 14,400 covered entities sites are expected to have registered in the 340B Program. The 340B Program is expected to continue experiencing a 3 percent growth per year. The number of contract pharmacies registered in the 340B Program serving covered entities has increased to over 3,000 and continues to grow since the final publication of guidance in March 2010.

Funding History

FY	Amount
FY 2007	---
FY 2008	---
FY 2009	$1,470,000
FY 2010	$2,220,000
FY 2011 CR	$2,220,000

Budget Request

The FY 2012 Discretionary Budget Request for the Office of Pharmacy Affairs/340B Program is $5,220,000 which is an increase of $3,000,000 above the FY 2010 Actual Level. This funding will help to support verification of all HRSA-funded entities, ensuring accuracy and integrity of the 340B database over time.

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 $1,470,000 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 in FY 2012 is necessary to continue these major improvements in the 340B Program operations and to resolve identified deficiencies of the current level of operations. The areas of focus include:

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 2012 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.

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, a sustained and systematic approach is needed to maintain this accuracy and integrity. HRSA will continue to require the verification of eligibility of entity types in FY 2012. In FY 2012, phased

implementation of a systematic verification system will begin to allow annual online verification of all records in the 340B database. 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.

Program Regulations and Guidance - In FY 2012, HRSA will continue to support the implementation of program regulations and guidance to provide oversight to maintain the integrity of the 340B Program.

Patient Safety and Clinical Pharmacy Services Collaborative (PSPC) - HRSA responded to the Senate Appropriations Committee's encouragement to establish a collaborative to identify and implement leading practices to 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 HRSA are external stakeholders including FDA's Office of Women's Health. FDA's interest was to reach underserved populations with medication safety and effectiveness information using specially trained health care professionals across the nation. Other partners include CMS, AHRQ, IHS, and more than 50 national organizations. The first PSPC cohort used a "collaborative care model" with 68 teams representing more than 200 safety net providers in 37 states to identify and disseminate best practices to other safety net providers. In the second cohort, more than 110 teams generated 54 percent improvement in health outcomes and a 49 percent decrease in adverse drug event rates. The fall of 2010 through 2011 marked the beginning of the third year of the Collaborative that continues and spreads throughout organizations nationwide. In this third cohort, there are 128 community-based, inter-professional teams comprised of 300+ organizations in 43 states. Schools and Colleges of Pharmacy have also adopted this model to increase their integration with safety-net partners to improve patient safety and patient health outcomes.

HRSA-Supported Performance Outcomes

The primary products are the 340B online public access database, required by legislation, for use by stakeholders of 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 Website was included in FY 2010 Planning. Implementation will continue in FY 2012. 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 2012 Target	FY 2012 +/- FY 2010
Covered Entity Sites Served	FY 2009: 14,076	14,400	15,244	+844
TA Consultations	FY 2009: 3,408	1,000	4,885	+3,885
Program Level Funding ($ in millions)	N/A	$2.220	$5.220	+$3.000

Office of Pharmacy Affairs/340B Drug Pricing Program User Fees

	FY 2010 Actual	FY 2011 CR	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	---	---	$5,000,000	+$5,000,000
FTE	---	---	5	+5

Authorizing Legislation - Section 340B of the Public Health Service Act as amended by the Affordable Care Act (P.L. 111-148), as further amended by the Health Care and Education Reconciliation Act (P.L. 111-152).

FY 2012 Authorization ..... Indefinite

Allocation Method ..... Contract

Program Description and Accomplishments

The 340B Drug Pricing Program (340B Program) is authorized by Section 340B of the Public Health Service Act (PHSA), and substantially reduces the cost of covered out-patient drugs to certain federally-supported entities and safety net hospitals. The 340B Program results in large cost savings for its participants and enables them "to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." H.R. Rep. No. 102-384(II), at 12 (1992). Section 340B was amended by sections 7101 and 7102 of the Affordable Care Act (PPACA) which significantly expanded eligibility and increased HRSA's oversight responsibilities and authorities. A sustainable funding source is needed to ensure the integrity of the Program under the demands of existing growth and the changing marketplace.

Newly eligible entities for the 340B Program are estimated to add 5,000 new sites to the Program. These new entities include: children's hospitals (previously eligible under the Social Security Act), free standing cancer hospitals, critical access hospitals, sole community hospital, and rural referral centers. HRSA began enrolling these new covered entities beginning August 2, 2010. As of October 1, 2010, 337 hospitals out of approximately 1,500 eligible hospitals have enrolled in the Program.

HRSA has increased oversight responsibilities over 340B Program which will improve Program integrity, while adding a new level of complexity to program administration. The new authorities include pricing oversight, civil monetary penalties for manufacturers and covered entities, administrative dispute resolution process, and annual recertifications of all participants in the 340B Program.

HRSA requires significant additional ongoing funding sources to be able to administer the new authorities and responsibilities. Funds are also needed to address longstanding recommendations by the OIG to make major improvements in program integrity. Implementation of the cost recovery fee would address current information deficiencies as well as provide significant resources needed to address both long standing problems and expanded authority while reducing the government expenditure of taxpayer dollars.

The 340B cost recovery fee mechanism will permit a cost recovery fee initially set at 0.1 percent of the total 340B drug purchase paid by participating covered entities. These funds shall be available until expended. The fee will be collected from the covered entities by the manufacturers who will then deposit the cost recovery fee into a no year account established by the Secretary for use by the Secretary and designees in paying the total costs of the 340B Drug Pricing Program. HRSA's recovery fee model is based on the model utilized by the Veteran's Administration (VA) for its administration of the VA pharmaceutical discount program, which shares some aspects of the 340B Program. The VA pharmaceutical discount program operates with similar cost recovery fees commonly known as industrial funding fees.

The implementation of the cost recovery system will include the reporting of sales under the 340B Program and establishment of the cost recovery fee as a percent of the drug purchases under the Program paid to the manufacturer. The collected fee is in addition to the cost to purchase the drug at the 340B price. This fee will be paid by the entity and remitted by the manufacturer to the Secretary for use in administering operations of the 340B Program including integrity provisions and access to covered drugs and services for 340B eligible entities. The 340B entities receive a significant benefit and the cost recovery fee is designed to ensure the cost of administering the Program is paid for with a small fraction of the received benefit. Without the cost recovery fee, the funding necessary to administer this Program comes exclusively from the taxpayers. The cost recovery fee will create a sustainable funding source to meet the demands of the existing growth of the Program, the changing marketplace, and the new statutory program requirements.

Program Growth

In FY 2011, approximately 1,000 newly eligible covered entity sites are expected to register in the 340B Program. While the 340B Program is expected to continue experiencing a 3 to 4 percent growth per year for existing categories of eligible entities, the covered entities that are newly eligible are expected to increase at an accelerated rate of at least 10 percent for the first two to three years. The number of contract pharmacies registered in the 340B Program serving covered entities has increased to over 3,000 and is expected to continue growing at an accelerated rate for the newly eligible covered entities.

Funding History

FY	Amount
FY 2007	---
FY 2008	---
FY 2009	---
FY 2010	---
FY 2011 CR	---

Budget Request

The FY 2012 Discretionary Budget Request of $5,000,000 for the Office of Pharmacy Affairs/340B Drug Pricing Program User Fee is $5,000,000 above the FY 2010 Actual Level. The 340B cost recovery fee will begin putting a cost recovery system in place and establish the necessary requirements for manufacturers and covered entities to efficiently implement this cost recovery system that will provide operations, oversight and integrity for the 340B Drug Pricing Program. The implementation of the cost recovery fee will support the natural growth of the 340B Program and fund new authority, responsibility, and oversight. The cost recovery fee will initially be set at 0.1 percent. During this first year of implementation for the cost recovery fee mechanism, an appropriation would still be necessary for the expanded functions until the regulations are published and funds are collected in sufficient manner to operate the Program.

Due to funding limitations, HRSA has not been able to fully implement the program integrity recommendations of the OIG or statutory requirements. Historically, the Program was supported with HRSA program management funds. Full implementation of the Program is resource dependent and is delayed due to insufficient resources. The lack of resources is partly due to the 340B Program's continuous adjustments to evolving Program needs including: normal Program growth of 3 to 4 percent a year on over 14,800 listed health care delivery sites; publishing guidelines and implementing various Program changes such as the addition of Children's Hospitals (added by the Deficit Reduction Act of 2005) and permitting multiple contract pharmacy arrangements. Full implementation of the cost recovery fee would address current information deficiencies as well as provide significant resources needed to address both long standing problems and expanded authority while reducing the government expenditure of taxpayer dollars.

Implementing the cost recovery fee will ensure a reliable and continuous funding source for HRSA to fully administer the 340B Program and will allow HRSA to better monitor compliance among both manufacturers and covered entities. The cost recovery fee will result in efficiency and fairness for the 340B Program overall. Having manufacturers collect the fees from covered entities as part of the payment process for covered drugs is the most efficient approach to ensure the accuracy and timeliness of the fee collection. In anticipation of expected further growth of the Program and additional responsibilities relating to increased eligibility and maintaining integrity and compliance, this funding mechanism will ensure the Program continues to operate successfully and effectively.

HRSA is required to develop and implement a system to verify accuracy of the 340B ceiling price in the marketplace. HRSA needs to develop and publish defined standards and methodology for the calculation of ceiling prices as well as put in place a new transparent system to calculate the official federal 340B ceiling price and make it available to the covered entities through the secured internet website that protects privileged pricing data. HRSA also needs to perform oversight activities such as spot checks of sales transactions by covered entities, selective auditing of manufacturers and wholesalers, inquire into the cause of any pricing discrepancies and take necessary corrective actions. The corrective actions include making sure the manufacturers issue timely refunds for routine retroactive adjustments and for exceptional circumstances such as erroneous or intentional overcharges. In addition, all covered entities are required to be recertified and their information must be updated on an annual basis or sooner to ensure the integrity of the system and information in the HRSA's database is accurate. These are all activities important to the integrity of the Program and it has not been possible to carry out them out due to insufficient resources.

Specifically, the activities that will be supported by this budget request include:

Cost Recovery System – The development and implementation of a comprehensive system to calculate fees and collect the appropriate amounts from manufacturers. The establishment of a cost recovery system for the 340B Program will help assure overall program integrity through systematic monitoring of compliance in accordance with 340B requirements and guidelines, by both covered entities and drug manufacturers. This can be achieved by updating the agreement between the Secretary and participating manufacturers with the following requirements: (1) to establish a cost recovery fee from participating 340B covered entities to pay for the total operating cost of the 340B Drug Pricing Program; (2) to give the Secretary discretion to require manufacturers to collect the fee at the time of sale of a covered outpatient drug to a 340B covered entity and remit that fee to the Secretary; (3) the fee initially will be 0.1 percent of the total 340B drug purchase paid by participating 340B covered entities to a manufacturer solely for drugs purchased by covered entities for 340B Drugs; (4) to incorporate the requirement that manufacturers report their calculated ceiling price with a supplemental report of the total amount obtained by the manufacturer for each covered outpatient drug sold to a covered entity (exclusive of non-discriminatory bona-fide service or administrative fees) and any additional information determined by Secretary necessary to administer the 340B Program; and (5) manufacturers would deposit the cost recovery fee into a no year account established by the Secretary for use by the Secretary and designees in paying the total costs of the 340B Drug Pricing Program. HRSA will need to issue regulatory and sub-regulatory guidance to manufacturers and covered entities to fully implement this provision. In addition to amending section 340B to authorize collection of fees from participating entities, it is imperative to add language to the legislation that gives the Secretary the authority to request participating manufacturers to sign a new Pharmaceutical Pricing Agreement that complies with the current law, or otherwise find them no longer in compliance with the requirements of 340B(a)(1).

Office of Pharmacy Affairs Information Systems (OPAIS) - Manufacturer's are required to report their 340B ceiling prices directly to HHS, HRSA must develop a system of verifying ceiling price calculations, post 340B ceiling prices to a secure website, utilize spot checks of

sales, and develop a system of refunds where appropriate. HRSA is also required to establish a single, universal, and standardized identification system by which each covered entity site can be identified by manufacturers, distributors, and covered entities for purposes of facilitating ordering, purchasing, and delivery of covered drugs, including the processing of charge-backs for such drugs. In addition, HRSA is required to make system improvements and add procedures to enable and require covered entities to regularly update the information via the internet website. The system will verify the accuracy of information regarding covered entities that are listed on the website.

Compliance and Oversight - Compliance issues are addressed primarily when they emerge as complaints from manufacturers, covered entities, or non-governmental interest groups. HRSA currently has no systematic method of monitoring manufacturer or covered entity compliance with the 340B law and HRSA's published guidelines. OIG reports on October 18, 2005, titled "Deficiencies in the Oversight of the 340B Drug Pricing Program (OEI-05-02-00072)"; and on July 14, 2006, titled "Review of 340B Prices (OEI-05-02-00073)"have outlined recommendations for Program oversight and compliance. Among five recommendations to correct non-compliance among manufacturers, the OIG urged HRSA to institute oversight mechanisms to validate its 340B price calculations and the prices charged by manufacturers to participating entities. HRSA has not been able to fully implement these recommendations due to limited resources.

Technical Assistance - The newly eligible covered entity types to the 340B Program require technical assistance and access to the patient safety clinical pharmacy collaborative (PSPC) to improve operational performance and patient outcomes. The technical assistance includes the interpretation of applicable laws and statues; the dissemination of information about the newly established cost recovery fee system; and guidance on system implementation for manufacturers. The technical assistance provided will also include recommendations to establishing affordable, high quality; comprehensive pharmacy services by the eligible entities using 340B purchased drugs. They also receive training and framework for peer to peer opportunities with other 340B safety-net providers for understanding 340B clinical and policy priorities to ensure compliance with law and guidelines. The technical assistance also includes support for implementing best pharmaceutical practices in the 340B Program to improve patient outcomes by measuring outcomes, reducing medication errors, and assisting in eliminating health disparities. These technical services are crucial to ensure participants are utilizing the 340B Program for maximum benefit. In addition, covered entities' access to PSPC will provide partnership opportunities to collaborate on leading clinical pharmacy practices to improve patient care quality and avoid adverse events.

Administrative Dispute Resolution Process - HRSA is authorized to establish and implement an administrative process for the resolution of claims by covered entities that they have been overcharged for drugs purchased and claims by manufacturers of violations, including appropriate procedures for the provision of remedies and enforcement of such process through mechanisms and sanctions. HRSA will designate or establish a decision-making official or decision-making body within the Department of Health and Human Services to be responsible for reviewing and resolving claims by covered entities that they have been overcharged prices for covered drugs and claims by manufacturers that violations have occurred. HRSA will establish

deadlines and procedures as may be necessary to ensure that claims shall be resolved fairly, efficiently, and expeditiously. The administrative resolution of claims under the regulations promulgated shall be a final agency decision and shall be binding, unless invalidated by an order of a court.

Civil Monetary Penalties - HRSA has new authority to impose sanctions in the form of civil monetary penalties for manufacturers and covered entities. HRSA will have the authority to impose up to $5,000 of penalty to manufacturers for each instance of overcharging a covered entity knowingly and intentionally. In addition, HRSA will have the authority to require covered entities to pay monetary penalties to manufacturers in the form of compounded interest for knowing and intentional violations of diversion and/or removing and disqualifying the covered entity from the 340B Program for a designated period of time as penalty when violations are found to be systematic and egregious. These new authorities, responsibilities, and oversight are significant and will require sustainable funding resources to implement.

Outcomes and Outputs Tables

The Program measures are under development.

State Health Access Program

	FY 2010 Actual	FY 2011 CR	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$74,480,000	$75,000,000	---	-$74,480,000
FTE	4	2	---	-4

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

FY 2012 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; and 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. In 2010, the 13 grantees received non-competing continuation awards. These grants have a five-year project period.

The 13 SHAP grantees are all working towards decreasing the number of uninsured in their states. Populations being covered include children, parents, low-income childless adults, part-time, seasonal workers, young adults and pre-Medicaid population. Coverage expansions are being accomplished through various types of programs including three-share, premium assistance, health insurance exchanges, and new benefit packages.

Projects are varied across the State grants. Examples of projects include:

- Offering 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 are covered in various forms including premium assistance, subsidies, and three-share models.

- Programs that combine coverage in a standard benefit package with prevention and wellness programs.

- Operating three-share models or reinsurance pools, and designing insurance exchanges to assist low-income/small-business employees in obtaining coverage.

- Linking eligible participants with medical homes in their community, ensuring basic primary care and some specialty services.

Funding History

FY	Amount
FY 2007	---
FY 2008	---
FY 2009	$75,000,000
FY 2010	$74,480,000
FY 2011 CR	$75,000,000

Budget Request

There are no funds requested in FY 2012 for the State Health Access Program which is a decrease of $74,480,000 below the FY 2010 Actual Level. It is anticipated that programs authorized under the Affordable Care Act will be sufficient to cover the populations currently being covered by SHAP.

Outcomes and Outputs Table

SHAP grants were funded for the first time in September 2009. In September 2010, the states reported first year enrollment figures totaling 96,886. Anticipated figures for year two, increase enrollment in health care coverage programs to122,644.

Grant Awards Tables

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	13	13	---
Average Award	$5,000,000	$5,000,000	---
Range of Awards	$2,000,000 – 8,000,000	$2,000,000 – 8,000,000	---

Infrastructure to Expand Access to Care

	FY 2010 Actual	FY 2011 CR	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$100,000,000	---	---	-$100,000,000
FTE	---	---	---	---

Authorizing Legislation: Affordable Care Act as Amended by Health Care Education Affordability Reconciliation Act of 2010 – P.L. 111-148.

FY 2012 Authorization $0

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The grant, awarded on December 29, 2010 under the Infrastructure to Expand Access to Care Program, will be used for construction and renovation of a health care facility that provides research, inpatient tertiary care, or outpatient clinical services. The facility is affiliated with an academic health center at a public research university in the United States that contains the State's sole public academic medical and dental school.

Funding History

FY	Amount
FY 2007	---
FY 2008	---
FY 2009	---
FY 2010	$100,000,000
FY 2011 CR	---

Budget Request

The grant was awarded in FY 2011 and will require up to five years of monitoring to ensure that the project is completed on schedule as proposed. FY 2012 will be the second year of monitoring the project. No funds are expected to be appropriated in FY 2012. The FY 2012 request is a decrease of $100,000,000 below the FY 2010 Actual Level.

Program Output Table

At this time, there are no outcomes to report.

The performance indicators for this grant are descriptive measures, reflecting the ongoing monitoring conducted by HRSA to ensure that the project is completed on schedule, as proposed. One specific indicator is the grantee must provide, through the EHB Reporting process, Quarterly Progress Reports indicating the percentage complete. The first quarterly report is due April 2011. Other specific indicators include:

Pre-start of construction

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

Post-start of construction

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

Grant Awards Tables

Size of Awards

(whole dollars)	**FY 2010 Enacted**	**FY 2011 CR**	**FY 2012 Request**	**FY 2012+/- FY 2010**
Number of Awards	1	---	---	---
Average Award	$100,000,000	---	---	-$100,000,000
Range of Awards	$100,000,000	---	---	-$100,000,000

Office of Rural Health Policy

Summary of the Request

	FY 2010 Actual	FY 2011 CR	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$184,910,000	$185,528,000	$124,178,000	-$60,732,000

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

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

There are nearly 50 million people living in rural America who face ongoing challenges in accessing health care.[1] Rural residents have higher rates of age-adjusted mortality, disability, and chronic disease than their urban counterparts.[2] 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.[3],[4] Of the 2,052 rural counties in the U.S., 1,582 (77 percent) are primary care health professional shortage areas (HPSAs).[5]

The ORHP programs (excluding the Radiation Exposure Screening, Black Lung, and Telehealth programs) have two annual performance measures representing rural health activities as reflected in the Rural Health Services Outreach Grant Program and Rural Hospital Flexibility Grant Programs. The Rural Health Care Services Outreach Program served 2,451,969 individuals in

[1] Population and Percent Distribution by Core Based Statistical Area (CBSA) Status for the United States, Regions, and Divisions, and for Puerto Rico: 2000 and 2009 (CBSA-EST2009-11)
[2] 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.
[3] Doescher, M., Fordyce, M., Skillman S., WWAMI Rural Health Research Center Presentation: The Aging of the Rural Generalist Workforce. February 2009.
[4] Area Resource File (ARF). 2008. US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Rockville, MD.
[5] WWAMI Rural Health Research Center. Aging of the rural generalist workforce. Seattle, WA: WWAMI Rural Health Research Center, University of Washington; July, 2009

FY 2009, which exceeded the target of 828,360. 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 -3.3 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 almost each year since the benchmark of -14.05 percent operating margin was set based on 1999 data.

Improving Rural Health Initiative

The Improving Rural Health Initiative encompasses all of the HRSA programs that support rural communities. From the total amount requested for the Office of Rural Health activities, the Office has set aside approximately $79 million from three of its program lines to continue the President's initiative to improve rural health. Specifically, $57,266,000 from Rural Health Care Services Outreach; $10,005,000 from the State Offices of Rural Health; and, $11,575,000 from Telehealth.

The goal for of the 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:

- Strengthening rural health care infrastructure;
- Improving the recruitment and retention of health care providers in rural areas;
- Building an evidence base for programs that improve rural community health;
- Providing direct health care services; and
- Improving the coordination of rural health activities within HRSA, the Department of Health and Human Services, and across the Federal Government.

This initiative has a spotlight on four programs within the Office of Rural Health that support these five activities. The four programs that make up the core of this initiative are:

Rural Health Care Services Outreach, Network, and Quality Improvement

The Rural Health Outreach authority includes a range of programs designed to improve access to care, coordination of care, integration of services and to focus on quality improvement for rural communities. These programs are among the only non-categorical grants within HHS, which allows the grantees to determine the best way to meet local need. This flexibility in funding reflects the unique nature of health care challenges in rural communities and the need to allow communities to determine the best approach to addressing local health concerns. The broad non categorical nature of the programs also allows funding to be focused on key emerging needs. For example, in the first full year of the Improving Rural Health Care Initiative, ORHP was able to focus funding on two key areas of need through funding of Network Development grants. The first focused on health care workforce development in 2010 while the second focused on the adoption of health information technology in 2011. These programs help to improve access to and the quality of health care in rural areas by supporting two of the initiative's five components: *strengthening rural health care infrastructure, providing direct health care*

service, and *improving the recruitment and retention of health care providers in rural areas.*

State Offices of Rural Health Grants

This program provides funding to the State Office of Rural Health located in each state to provide technical and other assistance, information dissemination 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.

Rural Training Track Technical Assistance Grant-New Program for Rural Physician Training Grants

This pilot program provides technical assistance to new and established Rural Training Track (RTT) residency programs. The technical assistance is provided to help RTT programs across the Nation promote the training of physicians in rural areas, increase the number of physician residents that match to their open rural training slots and work with additional rural communities that have an interest in creating new Rural Training Tracks to help attract physicians to rural communities. 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 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 with specialists and other experts not available locally. These grants support the initiative by *strengthening rural health care infrastructure.*

Coordinating Programs for a Targeted Investment

All of the programs listed above support the initiative. ORHP will use the existing funds 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. The 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 successful models, lessons learned and common challenges faced by rural grantees. These best practices will be disseminated across the Nation as models that can be replicated.

Finally, as part of the initiative, ORHP will work to increase coordination with other agencies that fund programs that benefit rural communities within HRSA, DHHS, 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. In 2010, ORHP began working collaboratively with the Department of Agriculture on a variety of issues ranging from defining frontier communities to coordinating telehealth and broadband access. ORHP also will expand its work with the Department of Veteran Affairs in 2011 while also reaching out to work collaboratively with the Departments of Labor and Transportation.

Funding History

FY	Amount
FY 2007	$160,071,000
FY 2008	$179,772,000
FY 2009	$176,096,000
FY 2009 Recovery Act	$ 1,008,000
FY 2010	$184,910,000
FY 2011 CR	$185,528,000

Budget Request

The FY 2012 Discretionary Request for the Office of Rural Health Policy of $124,178,000 which is a reduction of $60,732,000 from the FY 2010 Actual Level. In addition to the program activities previously mentioned, the FY 2012 Budget Request also includes funding for the following rural health activities:

- $9,929,000 for Rural Health Policy Development, which is equal to the FY 2010 Actual 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.
- $26,200,000 for Rural Hospital Flexibility Grants, which is a reduction of $14,715,000 below the FY 2010 Actual Level, which represents funding for the Small Hospital Improvement Program. The request provides level funding for the Rural Hospital Flexibility Program, which provides grants that assist Critical Access Hospitals. The request also includes $1,000,000 for Flex Rural Veterans Health Access Program Grants (RVHAP), which is equal to the FY 2010 Actual Level. The RVHAP grants increase access to needed services for veterans living in rural areas.
- $1,948,000 for Radiation Exposure Screening and Education Program (RESEP), which is equal to the FY 2010 Actual request 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.

- $7,185,000 for Black Lung Clinics, which is equal to the FY 2010 Actual 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.

The request includes no funding for the Rural and Community Access to Emergency Devices, for the Denali Commission and for the Delta Health Initiative.

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 ORHP and other programs in HRSA and HHS address many of these needs.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
27.1: Reduce the proportion of rural residents of all ages with limitation of activities caused by chronic conditions. [6] (Outcome)	FY 2000: 14.67% (Baseline)	13.9%	N/A	N/A
29.IV.A.3. Increase the number of people receiving direct services through Outreach grants. (Outcome) (Developmental	FY 2009: 375,000 (Baseline)	380,000	390,000	+10,000
27.2: Increase the proportion of critical access hospitals with positive operating margins. [7] *(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 2009: -3.3% (Target Not Met)	0.5% point below FY 2009	0.5% point below FY 2011	Maintain
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 2008: -383% (Target Not Met)	28%	30%	+2% Points
Program Level Funding ($ in millions)	N/A	$184.910	$124.108	-$60.802

[6] The long-term established for this measure is 13% by FY 2013
[7] The long-term target established for this measure is 60% by FY 2013.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	302	401	400
Average Award	$178,000	$175,000	$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 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	36	40	40
Average Award	$262,195	$262,195	$262,195
Range of Awards	$250,000-$325,000	$250,000-$325,000	$250,000-$325,000

Rural Health Policy Development

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$9,929,000	$9,950,000	$9,929,000	---
FTE	---	---	---	---

Authorizing Legislation - Section 301 of the Public Health Service Act, Section 711 of the Social Security Act.

FY 2012 Authorization ..... Indefinite

Allocation Method .....Competitive Grant

Program Description and Accomplishments

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

The ORHP Rural Health Research Center Grant Program is a major component of Rural Health Policy Development activities. It is 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. 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. 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 addition to the research center grants, the Rural Health Policy Development Activities also support two additional cooperative agreements that focus on data and trend analysis on new and ongoing policy issues. These agreements are used to support data needs across the Department.

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

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

In FY 2010, the program produced 30 research reports, meeting the target.

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

Funding History

FY	Amount
FY 2007	$8,737,000
FY 2008	$8,584,000
FY 2009	$9,700,000
FY 2010	$9,929,000
FY 2011 CR	$9,950,000

Budget Request

The FY 2012 Discretionary Request is $9,929,000 which is equal to the FY 2010 Actual Level. Funding will support activities such as the rural health research center grant program as well as general technical assistance and information dissemination related to these issues. This program will support the production of 30 reports in FY 2012 as well as manuals and other resources focusing on identifying best practices in rural communities.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
28.V.A.1: Conduct and disseminate policy relevant research on rural health issues. (Outcome)	FY 2009: 30 (Target Met)	30	30	Maintain
Program Level Funding ($ in millions)	N/A	$9.929	$9.929	---

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	12	12	12
Average Award	$750,000	$750,000	$750,000
Range of Awards	$150,000-$200,000	$150,000-$200,000	$150,000-$200,000

Rural Healthcare Services Outreach, Network and Quality Improvement Grants

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$55,905,000	$56,025,000	$57,266,000	+$1,361,000
FTE	1	1	1	---

Authorizing Legislation - Section 330A of the Public Health Service Act, as amended by P.L. 107-251.

FY 2012 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 (ORHP). 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 Outreach authority includes a range of programs designed to improve access to and coordination of health care services in rural communities. Four of these programs are part of HRSA's "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 program supports a wide range of services, including primary medical and dental care, mental health treatment, and health promotion and health education services. The program will award approximately 111 continuation grants in FY 2011 and up to 100 new awards in FY 2012.

These programs are among the only non-categorical grants within HHS and that allows the grantees to determine the best way to meet local need. This flexibility in funding reflects the unique nature of health care challenges in rural communities and the need to allow communities to determine the best approach to addressing need. Each of the programs focus on making the initial investment in a rural area with the expectation that the community will continue to provide the services at the conclusion of the grant funding.

The Rural Healthcare Services Outreach program legislation includes five key programs:

- Outreach Services Grants, which focus on improving access to care in rural communities through the work of community coalitions and partnerships. These grants often focus on

disease prevention and health promotion but can also support expansion of services such as primary care, mental and behavioral health as well as oral health care services. This program is part of the 'Providing direct health care services' and 'Building an evidence base for programs that improve rural community health.'

- 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 20 new awards in FY 2011 and 20 continuation awards in FY 2012. In addition, the program supports two new grant programs. The Workforce Network Development pilot program assists in the development of rural health networks that focus on activities relating to the recruitment and retention of primary and allied health care providers in rural communities. The program made 20 awards in FY 2010 and plans to make 20 continuation awards in rural communities. The program made 20 awards in FY 2010 and plans to make 20 continuation awards in FY 2011. The second program is the rural Health Information Technology (HIT) pilot program which supports the widespread adoption and use of electronic health records in coordination with the ongoing HHS activities related to the Health Information Technology for Economic and Clinical Health (HITECH) Act. The program plans to make 40 new awards in FY 2011 and 40 continuation awards in FY 2012.

- Network Planning Grants Program, which began in 2004, provides funds to bring together key parts of a rural health care delivery system so they can work in concert to establish or improve local capacity and coordination of care. In addition, the program supports joint purchasing, bench-marking, and recruitment and retention efforts. 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 15 new grants in FY 2011 and FY 2012**.**

- 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 since rural communities have higher rates of chronic diseases relative to urban areas. Specifically, the program focuses on addressing obesity, cardiovascular disease and diabetes given that rural residents tend to have higher rates of these diseases than their urban counterparts. 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 award 59 continuation awards in FY 2011 and FY 2012.

- The 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. In addition, the program supports chronic disease management, oral health services, and recruitment and retention efforts. Unlike the

programs mentioned above, this program is more geographically targeted given the health care disparities across this eight-state region. The program will award 12 continuation grants in FY 2011 and FY 2012.

In FY 2009, the Rural Health Services Outreach Program served 2,451,969 individuals, which exceeded the target of 828,360. 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 in the amount and quality of technical assistance for potential applicants. In addition, ORHP has developed a new electronic method to collect data that is more reliable and accurate. ORHP is currently reviewing this program to determine how to adapt activities to the Affordable Care Act as it is implemented. Any programmatic changes will also be followed by a reevaluation of the current performance measures, which may need to be revised.

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 2007	$38,885,000
FY 2008	$48,031,000
FY 2009	$53,900,000
FY 2010	$55,905,000
FY 2011 CR	$56,025,000

Budget Request

The FY 2012 Discretionary Request is $57,266,000 which is an increase of $1,361,000 to the FY 2010 Actual 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 Health Initiative to help existing rural networks improve the coordination of health services in rural communities and strengthen the rural healthcare systems as a whole. In FY 2012, a revised performance measure will examine the increase the number of people receiving direct services through Outreach Grants. This new measure will focus only on direct patient care such as screenings and treatment which is clearer, easier to interpret, easier to quantify and, thus, more accurate. The baseline for this measure is 375,000. The targets for FY 2011 and FY 2012 are 385,000 and 390,000 respectively. In FY 2012, the program will support approximately 100 outreach services grants, 12 Delta grants, 80 network development grants (which include 20 grants for the Workforce Network Development pilot program and 40 HIT grants), 59 quality improvement grants and 15 network planning grants.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
29.IV.A.3. Increase the number of people receiving direct services through Outreach grants. (Outcome) (Developmental	FY 2009: 375,000 (Baseline)	380,000	390,000	+10,000
29.IV.A.2: Increase the proportion of the target population served through Outreach Authority grants. [1] (Outcome) (Developmental)	TBD	TBD	TBD	---
Program Level Funding ($ in millions)	N/A	$55.905	$57.266	+$1.361

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	283	293	270
Average Award	$178,000	$175,000	$175,000
Range of Awards	$75,000-$350,000	$75,000-$350,000	$75,000-$350,000

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

Rural Access to Emergency Devices

	FY 2010 Actual	FY 2011 CR	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$2,521,000	$2,526,000	---	-$2,521,000
FTE	1	2	---	-1

Authorizing Legislation - Section 313 of the Public Health Service Act. And Section 413 of Public Law 106-505

FY 2012 Authorization – Rural Access to Emergency Devices…….……..Expired
FY 2012 Authorization – Public Access Defibrillation Demonstration……...……Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Rural Access to Emergency Devices (RAED) Grant 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 awarded 19 grants in FY 2010 and expects to award as many as 18 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 approximately 17 new grants in FY 2011.

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

Funding History

FY	Amount
FY 2007	$1,485,000
FY 2008	$1,461,000
FY 2009	$1,751,000
FY 2010	$2,521,000
FY 2011 CR	$2,526,000

Budget Request

There is no request in FY 2012 for Rural Access to Emergency Devices program and the Public Access Defibrillation Demonstration Project. This is a decrease of $2,521,000 from the FY 2010 Actual Level. The discontinuation of funding for this program reflects a reprioritization of these funds to other activities within the Office of Rural Health Policy. Activities related to access to emergency medical devices and training in FY 2012 may be addressed through other funding sources available to grantees, such as the Rural Outreach and Rural Network Development programs. Rural residents could use both of these program authorities to support projects that include the purchase of AEDs and training in their use. In FY 2010, the total number of AEDs that were placed in rural communities was 800 which was an increase from 572 in FY 2008. Since the RAED Program was authorized in FY 2002, approximately $32,000,000 has been invested in rural communities to purchase, place and train providers to use AEDs.

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	19	18	---
Average Award	$150,000	$150,000	---
Range of Awards	$3300-$180,000	$3300-$180,000	---

Rural Hospital Flexibility Grants

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$40,915,000	$41,200,000	$26,200,000	-$14,715,000
FTE	---	---	---	---

Authorizing Legislation - Section 1820(j), Title XVIII of the Social Security Act.

FY 2012 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 (ORHP) and support a range of activities focusing primarily on Critical Access Hospitals (CAHs). There are two grant programs administered under this authority. 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 Medicare Rural Hospital Flexibility (Flex) Grant Program targets funding to over 1,300 critical access hospitals in 45 states. The re-authorization of the Flex Program in 2008 took into account that most conversions of hospitals to critical access hospital status have taken place. The new focus of the program includes providing support for CAHs for quality improvement, quality reporting, performance improvements and benchmarking. This program is part of the Improving the Quality of Health Care Services in Rural Areas' component of the Improve Rural Health Initiative. The Flex Program targets performance improvement and quality improvement activities within the CAH and the community through technical assistance and some direct support to hospitals.

In the past 12 years, the Flex Program and CAH designation has been instrumental in strengthening the infrastructure of these small rural hospitals, as evidenced in the trend of the operating margins improving from operating margins in negative double digits to close to zero. Economic viability is important in ensuring continued access to care, but quality improvement is now just as important. CAHs are not required to report to the Centers for Medicare and Medicaid Hospital Compare quality measures, but are encouraged to do so. The Flex Program includes a benchmarking and quality improvement project this grant cycle, expanding on the existing efforts to increase the percent of CAHs reporting on at least one measure to Hospital Compare, and making quality improvements around the measures reported.

The second program is the Flex Rural Veterans Health Access Program which began in 2010. This program provides grants to three states with high percentage of veterans compared to the total population (Alaska, Montana and Virginia) and focuses 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. This includes the provision for 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 support up to three continuation grants in FY 2011 and FY 2012.

Given the larger trends in health care, the Flex Program provides essential support to CAHs and help to prepare them to successfully navigate a future that will emphasize pay for performance and value based purchasing, while improving outcomes and managing growth in health care spending.

Programs	**FY 2010 Enacted**	**FY 2011 CR**	**FY 2012 Request**
Rural Hospital Flexibility (Flex) Grant Program	$25,157,500	$25,200,000	$25,200,000
Small Hospital Improvement Program (SHIP)	$14,757,500	$15,000,000	---
Flex Rural Veterans Health Access Program	$1,000,000	$1,000,000	$1,000,000

The Flex performance measures reflect efforts to increase the financial viability of 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 -3.3 percent -- a considerable improvement from the original baseline margin of -14.05 and though slightly lower than the 2008 performance of -1.9 percent. Measures for the Flex Veterans Health Access Program are under development.

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

Funding History

FY	Amount
FY 2007	$63,538,000
FY 2008	$37,865,000
FY 2009	$39,200,000
FY 2010	$40,915,000
FY 2011 CR	$41,200,000

Budget Request

The FY 2012 Discretionary Request is $26,200,000 which is a reduction of $14,715,000 from the FY 2010 Actual Level**.** The reduction would result in discontinuation of new grants in FY 2012 for the Small Hospital Improvement Program (SHIP). The enhancements in the Affordable Care Act for rural hospitals focus heavily on enhancing payment for rural hospitals paid under the Medicare Inpatient Prospective Payment system for inpatient and outpatient services. This lessens the need for the SHIP grants. In addition, 1,300 of the approximately 1,600 hospitals eligible for funding through the SHIP are CAHs and have access to the funding from the Flex Program. The budget request focuses on supporting CAHs by maintaining essential support for the Flex program and its focus on working with CAHs to improve quality. The FY 2012 target for the average operating margin of CAHs is 0.5 percentage point below the FY 2011 result. This funding will continue to support a range of activities focusing on CAHs. The activities supported through this funding will encourage hospitals to report quality data to Hospital Compare and to invest grant dollars in Emergency Medical Services (EMS) training and trauma system development. The program will award 45 grants in FY 2012. The FY 2012 request will also continue essential support for the three grantees funded through the Rural Veterans Health Access Program.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
30.V.B.1: Increase the average operating margin of critical access hospitals. (Output)	FY 2009: -3.3% (Target Not Met)	0.5% point below FY 2009	0.5% point below FY 2011	Maintain
30.V.B.4: Increase the percent of Critical Access Hospitals reporting at least one measure to Hospital Compare. (Outcome)	FY 2009: 70.3% (Target Exceeded)	72%	76%	+4% points
30.V.B.5: Number of individuals trained in emergency medical services leadership and/or trauma courses. (Outcome)	FY 2009: 3,002 (Baseline)	3,615	3,615	Maintain
Program Level Funding ($ in millions)	N/A	$40.915	$26.2	-$14.715

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards[1]	49	49	48
Average Award	$490,000	$490,000	$490,000
Range of Awards	$256,000-$640,000	$256,000-$640,000	$256,000-$640,000

[1] For the Number of Awards, program corrected the number of awards. In FY 2010, 45 states received Flex and SHIP awards, one additional state received a SHIP award, and three states received a Rural Veterans Access Program award. In FY 2012, SHIP is not funded and therefore, the additional state will not receive a SHIP award.

Delta Health Initiative

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$34,927,000	$35,000,000	---	-$34,927,000
FTE	4	3	---	-4

Authorizing Legislation - Section 219 of Public Law 110-161.

FY 2012 Authorization .....Expired

Allocation Method .....Competitive Grant

Program Description and Accomplishments

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 funded up to 24 individual projects across the region. 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 Health Resources and Services Administration's (HRSA) electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2007	---
FY 2008	$24,563,000
FY 2009	$26,000,000
FY 2010	$34,927,000
FY 2011 CR	$35,000,000

Budget Request

There is no request in FY 2012 for Delta Health Initiative. This is a decrease of $34,927,000 from the FY 2010 Actual Level. Since its initial funding in FY 2006, many projects continue to date as a result of its initial "seed" money. The needs in this region can best be met by other existing programs, such as the Health Center Program and the National Health Service Corps which can address the health system delivery of the Delta.

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	1	1	---
Average Award	$33,765,059	$35,000,000	---
Range of Awards	$33,765,059	$35,000,000	---

State Offices of Rural Health

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$10,005,000	$10,075,000	$10,075,000	+70,000
FTE	---	---	---	---

Authorizing Legislation - Section 338J of the Public Health Service Act.

FY 2012 Authorization ..... Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The State Offices of Rural Health (SORH) Grant Program is a key component of the Office of Rural Health Policy (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 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 and falls under the Improve the Recruitment and Retention of Health Care Providers in Rural Areas component of the Initiative.

The SORH Program initially began with two performance measures that examined the number of communities receiving technical assistance from SORHs as well as the recruitment of health professionals to rural communities. The number of communities receiving technical assistance from SORHS grew from 4,120 in 2003 to 6,172 in 2009. Beginning in FY 2011, this performance measure will be discontinued because it does not provide an accurate representation of the technical assistance activities that are provided by SORHs. The other measure examining recruitment of health professionals grew from 41 states in 2003 to 50 states in 2009. The FY 2010 target is 50. This measure will be discontinued in FY 2011 because it will have reached its maximum level.

As a result, ORHP has established three new performance measures to capture the activities of the program. Two of the three new measures were developed to collect 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 from SORHs. The FY 2008 baseline for the number of technical assistance encounters provided

directly to clients is 68,307, and the FY 2009 number was 64,321. This decline could be due to the normalizing of data collection within the states for this new measure or because of the economic downturn and the difficulty states had with their budget, or a combination of the two factors. The FY 2008 baseline for the number of clients that receive technical assistance directly is 34,876 and the FY 2009 results were 29,920, with similar reasons for decline. The third 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 Health Resources and Services Administration's (HRSA) electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2007	$8,141,000
FY 2008	$7,999,000
FY 2009	$9,201,000
FY 2010	$10,005,000
FY 2011 CR	$10,075,000

Budget Request

FY 2012 Discretionary Request is $10,075,000; which is an increase of $70,000 to the FY 2010 Actual 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 HRSA's Improve Rural Health Initiative to provide technical and other assistance to rural health providers and help rural communities recruit and retain healthcare professionals. The FY 2012 targets have been established for the three new SORH measures. The FY 2012 target for the number of technical assistance encounters provided directly to clients is 66,269. The FY 2012 target for the number of clients that received technical assistance directly from SORHs is 30,826. The FY 2012 target for the number of clinician placements facilitated by the SORHs is 1,053.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
31.V.B.3: Number of technical assistance (TA) encounters provided directly to clients by SORHs. (Outcome)	FY 2009: 64,321 (Baseline)	68,990	66,269	-2,721
31.V.B.4: Number of clients (unduplicated) that received technical assistance directly from SORHs. (Outcome)	FY 2009: 29,920 (Baseline)	35,225	30,826	-4,399
31.V.B.5: Number of clinician placements facilitated by the SORHs through their recruitment initiatives. (Outcome)	FY 2008: 1,023 (Baseline)	1,033	1,053	+20
Program Level Funding ($ in millions)	N/A	$10.005	$10.005	---

Grant Awards Table
Size of Award

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	50	50	50
Average Award	$178,000	$178,000	$178,000
Range of Awards	$160,000-$180,000	$160,000-$180,000	$160,000-$180,000

Denali Commission

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$10,000,000	$10,000,000	---	-$10,000,000
FTE	---	---	---	---

Authorizing Legislation - Section 309 of Public Law 105-277, as amended by P.L. 106-113.

FY 2012 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 Health Resources and Services Administration (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 2007	$39,283,000
FY 2008	$38,597,000
FY 2009	$19,642,000
FY 2010	$10,000,000
FY 2011 CR	$10,000,000

Budget Request

There is no request in FY 2012 for Denali Commission, this is a decrease of $10,000,000 from the Actual Level. Earmarks are not supported in the FY 2012 President's Budget. The Denali Commission has already received more than $300 million in funding since FY 2000 for construction in Alaska and this investment has helped meet the most critical needs. Additional

funds in the Recovery Act provided for health center construction and capital investments within other parts of the Government which have also helped address the need.

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	1	1	---
Average Award	$10,000,000	$10,000,000	---
Range of Awards	$10,000,000	$10,000,000	---

Radiation Exposure Screening and Education Program

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$1,948,000	$1,952,000	$1,948,000	---
FTE	1	1	1	---

Authorizing Legislation - Section 417C of the Public Health Service Act, as amended by P.L. 106-245.

FY 2012 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 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 and demonstrated an increase in users between FY 2008 (1,270) and FY 2009 (1,373). These results are somewhat lower than previous years due to the rapidly aging former uranium mine worker population in which potential patients have passed away as well as the relocation of this population from the original mining sites. The program partners with the Department of Justice to collect data in support of these measures and has adopted steps to ensure that grantees comply with uniform screening guidelines In addition; the program has undertaken new outreach strategies to identify where this patient population has relocated and to make them aware of available screening sites.

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

Funding History

FY	Amount
FY 2007	$1,919,000
FY 2008	$1,884,000
FY 2009	$1,952,000
FY 2010	$1,948,000
FY 2011 CR	$1,952,000

Budget Request

FY 2012 Discretionary Request is $1,948,000 which is equal to the FY 2010 Actual Level**.** 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 2012 and the target for the number of individuals screened is 1,400.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- 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 2009: 1,373 (Target Not Met)	1,400	1,400	Maintain
32.E: Average cost of the program per individual screened *(Efficiency)*	FY 2009: $1,249 (Target Not Met)	$720	$1,397	+677
Program Level Funding ($ in millions)	N/A	$1.948	$1.948	----

[1] The target for long term outcome measure 32.1 is 8.8 (FY 2013); the target for long term outcome measure 32.2 is 72% (FY 2013).

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	7	7	7
Average Award	$235,827	$235,827	$235,827
Range of Awards	$180,000-$279,000	$180,000-$279,000	$180,000-$279,000

Black Lung

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$7,185,000	$7,200,000	$7,185,000	---
FTE	---	---	---	---

Authorizing Legislation - Federal Mine, Health, and Safety Act of 1977, Section 427(a).

FY 2012 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 2009, the program supported services to 12,436 miners. This is an increase over the target of 11,575 miners served as well as the 11,888 miners served in FY 2008. The program also provided 21,727 medical encounters in FY 2009, which slightly missed its target of 22,525.

To target resources and further enhance outreach, the Office of Rural Health Policy (ORHP) conducted an independent evaluation of the program which resulted in the establishment of baselines and targets for its new long-term performance measure, and collection of data on the location of miners.

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

Funding History

FY	Amount
FY 2007	$5,891,000
FY 2008	$5,788,000
FY 2009	$7,200,000
FY 2010	$7,185,000
FY 2011 CR	$7,200,000

Budget Request

The FY 2012 Discretionary Request is $7,185,000 which is equal to the FY 2010 Actual Level. This funding will continue to support key activities for Black Lung Program. The program expects to fund 15 continuation awards in FY 2012 and meet the target of 12,836 miners served. In addition, the program expects to reach the target of 26,403 medical encounters in FY 2012.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- 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 2009: 12,436 (Target Exceeded)	12,088	12,836	+748
33.I.A.2: Number of medical encounters from Black Lung each year. (Output)	FY 2009: 21,727 (Target Not Met)	24,403	26,403	+2,000
33.E: Increase the number of medical encounters per $1 million in federal funding. *(*Efficiency *)*	FY 2009: 3,798 (Target Not Met)	4,072	4,272	+200
Program Level Funding ($ in millions)	N/A	$7.185	$7.185	----

Grant Awards Table

Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	15	15	15
Average Award	$381,562	$381,562	$381,562
Range of Awards	$116,742-$697,740	$116,742-$697,740	$116,742-$697,740

[1] The target for this measure long-term is 85% (FY 2014).

Telehealth

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$11,575,000	$11,600,000	$11,575,000	---
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 2012 Authorization ..... Expired

Allocation Method ..... Competitive Grants/Cooperative Agreements and Contracts

Program Description and Accomplishments

The Office for the Advancement of Telehealth (OAT) administers three grant programs that support telehealth technologies

- Telehealth Network Grant Program (TNGP), which includes funding for pilot projects to examine the cost impact and value-added from tele-home care and tele-monitoring services (Telehealth Networks-Telehomecare). The TNGP also supports activities such as chronic disease management and distance learning.
- Telehealth Resource Center Grant Program (TRCGP), which provides technical assistance to communities wishing to establish telehealth services.
- Licensure Portability Grant Program (LPGP), which assists states to improve clinical licensure coordination across state lines.

At the end of FY 2010, a total of 26 grants were awarded for telehealth networks and telehomecare networks, nine Telehealth Resource Grant Program grants were awarded, and one grant to improve licensure coordination among states. A Telehealth Technology Assessment Center was also funded under an interagency agreement with the Indian Health Service to assist the resource centers in providing technical assistance in the selection and evaluation of telehealth technologies.

The OAT Programs are 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 health care providers, recruit and retain rural health care professionals, and modernize the health care infrastructure in rural areas.

Under the current authorization of the TNGP, the authority allows HRSA to fund both urban and rural sites. In FY 2010, HRSA supported networks in urban underserved communities that are experiencing severe shortages of health care professionals.

In January 2010, OAT was relocated to HRSA's Office of Rural Health Policy and continues 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 2010 Enacted	FY 2010 Recovery Act	FY 2011 CR	FY 2012 Request
Telehealth Network Grant Program	$6,250,000	---	$6,250,000	$6,250,000
Licensure Portability Grant Program	$350,000	$1,000,000	$350,000	$350,000
Telehealth Resource Center Grant Program	$4,150,000	---	$4,150,000	$4,150,000
Contracts	$500,000	---	$500,000	$500,000
Interagency Agreements	$325,000	---	$350,000	$325,000

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

Funding History

FY	Amount
FY 2007	$6,819,000
FY 2008	$6,700,000
FY 2009	$7,550,000
FY 2009 Recovery Act	$1,000,000
FY 2010	$11,575,000
FY 2011 CR	$11,600,000

Budget Request

The FY 2012 Discretionary Request is $11,575,000 which is equal to FY 2010 Actual Level**.** The funds will support: (1) TNGP grantees (26 grants, including grants to specifically examine the cost-effectiveness of tele-homecare and tele-monitoring services); (2) TRCGP grantees (up to 13 grants); and (3) The Licensure Portability Grant Program (one grant), as well as associated technical assistance and evaluation activities. Funds will also be allocated to support an

Interagency Agreement with the Indian Health Service to continue to support the Telehealth Technology Assessment Center.

The FY 2012 Budget Request includes the same performance targets as established for FY 2011 with a few exceptions. The FY 2012 target for glycemic control (34.II.A.1) has been decreased because a new cohort of patients will begin. It is estimated that in the new cohort 10 percent of the patients enter in telehealth diabetes case management program with ideal glycemic control (hemoglobin A1c at or below seven percent), and, during the first year, this cohort will achieve a 100 percent increase to 20 percent achieving ideal control. The FY 2011 and the FY 2012 targets for sites and services (34.III.D.2) have been adjusted given the most recent data (2008) and the significant increase in congressional funding of the TNGP (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 2014 when these programs would be in their third and final year of the cohort.

Outputs and Outcomes Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- 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%). (*Outcomes*)	FY 2008: 41% (Target Exceeded)	21%	20%[137]	-1%
34.1: The percent of TNGP grantees that continue to offer services after the TNGP funding has ended. *(Outcome)*	FY 2005: 100% (Target Not In Place)	N/A	N/A	N/A
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. (*Outcomes)*	FY 2008: 1,295 (Target Exceeded)	2,456	2,556	+100
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. *(Outcomes)*	FY 2008: 162 (Target Exceeded)	219	223	+4
34.III.D.1.1: Increase the number of communities that have access to adult mental health services	FY 2008: 158 (Target Exceeded)	186	188	+2

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

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
where access did not exist in the *(Outcomes)*				
34.E:Expand the number of services and/ or sites provide access to health care as a result of the TNGP program per Federal program dollars expended (efficiency)	FY 2008: 218 per Million $ (Target Exceeded)	186 per Million $	202 Per Million $	+16 Per Million $
Program Level Funding ($ in millions)	N/A	$11.575	$11.575	---

Grants Awards Table
Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	36	40	40
Average Award	$262,195	$262,195	$262,195
Range of Awards	$250,000-$325,000	$250,000-$325,000	$250,000-$325,000

Program Management

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	147,052,000	$147,052,000	$170,808,000	+$23,756,000
FTE	942	942	942	---

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

FY 2012 Authorization ..... Indefinite

Allocation Method .....Other

Program Description and Accomplishments

HRSA's Program Management activity operates programs budgeted in FY 2012 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:

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 continuously improve and secure the Information Technology infrastructure includes improving

the perimeter protection through implementation of additional security tools that provide HRSA with a state of the art Intrusion Detection System, while simultaneously reducing physical servers as part of ongoing virtualization and consolidation initiative. The Agency has continued to mature the processes for the initiation, execution, management and oversight of IT Investments through the continued implementation of the HRSA Enterprise Architecture and Capital Planning and Investment Control (CPIC) processes and the more recent implementation of an Enterprise Performance Life Cycle (EPLC) Framework. Funding for Program Management includes IT funding for the continued development, operations and maintenance of enterprise functionality 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.

Program Name	IT Investment Title[138]	UPI	FY 2010	FY 2011	FY 2012
Program Management	HRSA - HRSA Enterprise Web	009-15-01-06-02-1001-00	$1.302M	$1.031M	$1.373M
	HRSA - OC Information Center (HRSA IC)	009-15-01-06-02-1400-00	$0.301M	$0.418M	$0.393M
	HRSA - OFAM Application Review Module	009-15-01-06-02-1050-00	$0.208M	$0.208M	$0.208M
	HRSA - OIT Knowledge Delivery	009-15-01-02-02-1211-00	$0.195M	$0.195M	$0.195M
	HRSA - OIT Agency IT Hardware Refreshment	009-15-02-00-02-1070-00	$0.800M	$0.615M	$0.460M
	HRSA - OIT Capital Planning and Investment Control (CPIC)	009-15-03-00-02-1010-00	$0.392M	$0.407M	$0.422M
	HRSA - OIT COOP (Continuity of Operations)	009-15-01-06-02-0801-00	$0.240M	$0.383M	$0.340M
	HRSA - OIT Core Business Support System	009-15-01-06-02-1080-00	$1.912M	$1.974M	$2.035M
	HRSA - OIT Data Analysis and Reporting	009-15-01-02-02-1212-00	$0.117M	$0.112M	$0.112M
	HRSA - OIT Database Administration Support	009-15-01-06-02-1002-00	$0.421M	$0.389M	$0.396M
	HRSA - OIT Education and Outreach	009-15-01-06-02-1213-00	$0.098M	$0.098M	$0.098M
	HRSA - OIT Electronic	~~009-15-01-06-01-~~	~~$7.470M~~	~~$6.206M~~	~~$6.944M~~

[138] For HRSA's major IT investment, please go to the following link: http://itdashboard.gov/

Program Name	IT Investment Title[138]	UPI	FY 2010	FY 2011	FY 2012
	Handbooks	1060-00			
	HRSA - OIT Enterprise Architecture (EA)	009-15-03-00-02-1000-00	$0.153M	$0.158M	$0.163M
	HRSA - OIT Federal Information Systems Security Program	009-15-02-00-02-1380-00	$1.417M	$1.563M	$1.567M
	HRSA - OIT Geospatial Data Warehouse	009-15-01-06-02-1350-00	$2.925M	$3.573M	$3.537M
	HRSA - OIT Information Management	009-15-01-06-02-1214-00	$0.270M	$0.172M	$0.172M
	HRSA - OIT Infrastructure Services/NIH Infrastructure Service	009-15-02-00-02-1090-00	$2.620M	$3.269M	$3.359M
	HRSA - OIT Project Management Office (PMO)	009-15-01-06-02-1380-00	$1.065M	$0.320M	$0.175M
	HRSA - OIT SharePoint Platform Development	009-15-01-06-02-1340-00	$0.333M	$1.631M	$1.984M
	HRSA - OIT Software License Management	009-15-02-00-02-2000-00	$1.712M	$1.763M	$1.816M
	HRSA - OIT Technical Assistance Support	009-15-01-02-02-1210-00	$0.239M	$0.302M	$0.302M
	HRSA - OO - Full-Time Equivalent Management Tracking System (FEMTS)	009-15-01-01-02-1003-00	$0.120M	$0.140M	$0.140M
	HRSA - OO - Integrated Resources Management System (IRMS)	009-15-01-06-02-1440-00	$0.217M	$0.130M	$0.130M

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 2012 Request.

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 2007	$146,283,000
FY 2008	$141,087,000
FY 2009	$142,024,000
FY 2010	$147,052,000
FY 2011	$ 153,808,000

Budget Request

The FY 2012 Discretionary Request is $ $170,808,000, which is an increase of $23,756,000 from the FY 2010 Actual level. The total request will support funding for salaries, benefits and Parklawn expenses. The increase in funding reflects an increase in rent at Parklwan building along with creating additional workstations for new staff. Lack of additional funding will have a major impact for HRSA to accomplish its mission.

HRSA is committed to improving the quality of output at a lower cost and improving the speed of government operations. As a part of the SAVE award initiative, HRSA has launched different programs to maximize energy efficacy and reduce travel costs and support of Telehealth participation. HRSA is working towards its goal to reduce the IT network infrastructure and data center footprint by twenty percent. In addition, HRSA is reducing travel costs and supporting telework participation by increasing the agency- wide utilization of web collaboration tools by twenty- five percent, which will lead to greater business productivity.

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
35.VII.B.3: Capital Planning and Investment Control (Output)	FY 2010: 100% of major IT investments with acceptable business cases. (Target Met)	100% of major IT investments with acceptable business cases.	1) 100% of major investments will receive an IT Dashboard Overall Rating of "Green", which indicates an acceptable cost, schedule and Agency CIO Rating; 2) 100% of major Investment Managers will be in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM).	--

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
35.VII.B.1.: Ensure Critical Infrastructure Protection: Security Awareness Training *(Output)*	FY 2010: 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)*	FY 2010: 100% of HRSA information systems have been Certified and Accredited and granted Authority to Operate (ATO). (Target Met)	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

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- 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 2010: Delayered Management Structure by creating two new Offices and transferring functions from the following 4 offices (policy, center of quality, health information technology, minority health and health disparities) into the Office of Planning, Analysis and Evaluation and the Office of Special Health Affairs. Further restructuring was accomplished to realign core policy, oversight and coordination functions in OA and to ensure that the bureaus were operating programs and engaging in the grant making process.. (Target Met)	Continue with implementation of streamlining efforts.	Continue implementing staffing patters initiative for health care reform.	--
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 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$316,832,000	$317,491,000	$327,356,000	+10,524,000
FTE	35	35	35	---

Authorizing Legislation: Title X of the Public Health Service Act
FY 2012 Authorization ..... Indefinite
Allocation Method ..... Competitive Grant, Contract, Direct

Program Description and Accomplishments

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

The public health value of family planning services is well documented. Cited by the Centers for Disease Control and Prevention (CDC) in 1999 as one of the greatest public health achievements of the 20th century, family planning services have been used by millions of individuals in the United State and around the world (CDC, 1999). In this spirit, the Title X Family Planning program is committed to the delivery of high-quality family planning and reproductive health services to all women and men who want them. Guided by nationally recognized standards of care, all Title X family planning centers provide contraceptive options, education and related preventive health services to their clients.

President Obama echoed this support on 22 January 2009, calling for stronger efforts to "prevent unintended pregnancies …and support women and families in the choices they make." The Title X program has greatly contributed to decreasing unintended pregnancy among teens and young adults. Historically, of the more than 5 million individuals served each year in Title X clinics, approximately 1.13 million are adolescents and more than 2.6 million are under 25 years of age [2009 Family Planning Annual Report (FPAR)]. By providing comprehensive family planning and related reproductive and preventive health services (such as STD and HIV prevention education and screening), unintended pregnancy, infertility and related morbidity have been reduced for these populations.

Shortly after President Obama's pronouncement, the HHS Office of Family Planning (Title X program) completed a two-year independent evaluation by the Institute of Medicine (IOM) in May 2009. The IOM committee found the Title X program to be extremely resilient and valuable, especially in providing family planning services to its priority population, individuals from low-income families. In addition, the IOM offered several recommendations supporting

the Secretary's Strategic Initiative - to accelerate the process of scientific discovery through the use of evidence-based practices, and Interagency Collaborations to reduce teen and unintended pregnancy. Some of the IOM recommendations include:

- Reassert family planning as a core value in public health practice;
- Increase program funding so statutory responsibilities can be met;
- Improve the continuity of products provided to clients of Title X clinics (increase range of highly effective contraceptives available at Title X clinics); and
- Develop and implement a multi-year strategic planning process.

As a result of the IOM findings, the Program has begun to address a number of recommendations that emerged. Currently the Program has a contract with the IOM to form a Standing Committee that will assist the Title X Program in developing a comprehensive strategic plan and conducting additional studies related to strengthening the infrastructure and long-term goals of the Title X family planning program.

The Title X program is able to fulfill its mission by awarding grant funds to public and private not-for-profit organizations to support the provision of family planning clinical services and information. Services are provided through 90 service delivery grants that support a nationwide network of more than 4,500 community-based clinics which provide services to more than 5,000,000 persons annually. Grantees include State and local health departments, hospitals, community health centers, Planned Parenthoods, and other private nonprofit agencies, and there is at least one Title X services grantee in every state and U.S. Territory. Title X Family Planning program regulations require that projects provide a broad range of effective and acceptable family planning methods and related preventive health services. At least 90 percent of Title X program funds are used to provide clinical services, and findings from a Guttmacher Institute study found that for more than half of clients, publicly funded family planning clinics such as Title X clinics, are reported to be their "usual" or only continuing source of health care and/or health education. Historically, at least 90 percent of the clients served each year have family incomes at or below 200 percent of the Federal poverty level

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 and three national training programs; (2) information dissemination and community-based education and outreach activities; and (3) data collection and research to improve the delivery of family planning services.

In 2009, the most recent year for which complete data are available, the Program accomplished the following: Served 5,186,267 clients (2.7% increase), averting approximately 994,000 unintended pregnancies, and preventing at least 672 cases of invasive cervical cancer through the services provided by Title X funded centers. In addition, 1.41 million screenings for Chlamydia infection were performed in 15 – 24 year old females. Targets were exceeded for the number of unintended pregnancies averted, which continue to increase annually, and the number of screenings for Chlamydia infection in females ages 15 – 24. 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. Based on epidemiological data, in 2003 and most

recently in 2009, changes in recommendations were issued by nationally recognized organizations that establish standards of care for cervical cancer screening (e.g., ACOG, ACS, USPSTF), resulting in cervical cancer screening being initiated later in life, and performed less frequently. As a result, fewer overall screening tests for cervical cancer are being performed in Title X clinics. This is illustrated by data showing the proportion of women who received a cervical cancer screening in Title X family planning centers decreased from 52 percent in 2005 to 42 percent in 2009.

Despite the rise in medical care costs, the family planning program has historically been able to maintain the average cost per Title X client below the medical rate of inflation (except FY 2007). In 2009, the program's cost per client was actually less than in 2008. Since FY 2007, the Program focused its national training priority on, "improving clinic efficiency in an effort to address increasing cost of health care without sacrificing quality." This included a concerted training effort and the development of region-specific plans to address clinic efficiency, quality assurance/continuous quality improvement, appropriate staffing patterns, 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 his or her appointment, reducing other costs, and creating more efficient administrative procedures, more clients can receive services. In FY 2010, the Program began assessing and evaluating these efforts and the impact on Title X family planning service delivery. Though the final analyses of the evaluations have not been completed, it appears these targeted training strategies have contributed to some extent to a decrease in the cost per client via controlling cost and increasing clinic efficiency.

Funding History

FY	Amount
FY 2007	$283,146,000
FY 2008	$299,981,000
FY 2009	$307,491,000
FY 2010	$316,832,000
FY 2011	$317,491,000 (Continuing Resolution)

Budget Request

The FY 2012 Discretionary Request is $327,356,000, $9,865,000 more than the FY 2010 Actual level. 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 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 centers.

The FY 2012 request is expected to support family planning services for approximately 5,247,000 persons, with at least 90 percent of clients having incomes at or below 200 percent 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 1,850 cases of infertility through Chlamydia screening of 1,574,000 females ages 15 - 24, reducing invasive cervical cancer through Pap tests and a goal of preventing 1,008,000 unintended pregnancies in 2012. Although the program will continue to emphasize efficiency, the targets for FY 2012 are ambitious and assume that other sources of clinic revenue will remain at historical proportions of the total Title X revenue.

At least 90 percent of funding will continue to be used for clinical family planning services. Funding will continue for Chlamydia screening 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 working with a Standing Committee, via a contract with the Institute of Medicine, to advise the Program on a range of scientific, workforce, health services and education issues relevant to the family planning program. Specifically, the Standing Committee will address the following topics: strategic planning for advancing the Title X program, workforce planning, improving data collection on program performance, and improving communication and transparency within the Title X program, all recommendations offered as part of the IOM independent evaluation. In addition, the committee will examine the role of family planning/reproductive health (including the Title X program) in health care reform. Family planning centers will be encouraged and trained to provide a broad range of contraceptives, with a focus on expanding the availability of long-acting reversible methods, and will also be encouraged to transition to use of electronic health records and electronic practice management systems.

The program will continue to seek ways to increase efficiencies 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 elevated cost of highly effective contraceptive and diagnostic methods and the increasing costs for medical providers as well as the added expenses of electronic systems are significant challenges to maintaining the level of services to clients or to serving additional clients. 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.

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 2012 Target	FY 2012 +/-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 2009: 5,186,267 (Target Exceeded)	5,223,000	5,247,000	+24,000
36.II.A.2: Maintain the proportion of clients served who are	FY 2009: 91% (Target Exceeded)	90%	90%	Maintain

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/-FY 2010
at or below 200% of the Federal poverty level at 90% of total unduplicated family planning users. *(Outcome)*				
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 2009: 993,614 (Target Exceeded)	1,024,000	1,008,000	-16,000

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 2012 Target	FY 2012 +/-FY 2010
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 2009: 1,407,691 (Target Exceeded)	1,413,000	1,574,000	+161,000

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 2012 Target	FY 2012 +/-FY 2010
36.II.C.1: Increase the number of unduplicated female clients who receive a Pap test. *(Outcome)*	FY 2009: 2,035,017 (Target Not Met)	2,478,000	1,757,000	-721,000
36.II.C.2: Reduce invasive cervical cancer among women attending Title X family planning clinics by providing Pap tests. *(Outcome)*	FY 2009: 672 (Target Not Met)	835	580	-255

Efficiency Measure:

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/-FY 2011
36.E: Maintain the actual cost per Title X client below the medical care inflation rate. *(Efficiency)*	FY 2009: $237.42 (Target Exceeded)	$258.87	$280.66	+21.79

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/-FY 2011
Program Level Funding ($ in millions)	N/A	$317.491	$327.356	+9.865

Grant Awards Tables - Size of Awards

(whole dollars)	FY 2010 Enacted	FY 2012 President's Budget Request
Number of Awards	90	90
Average Award	$3,175,000	$3,274,000
Range of Awards	$180,000-$22,511,000	$186,000-$23,210,000

Public Health Improvements (Facilities and Other Projects)

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	337,300,000	$338,002,000		-337,300,000
FTE	7	---	---	-7

Authorizing Legislation: Title II of Public Law 111-8

FY 2012 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 is 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. The Federal interest in properties over $500,000 continues in perpetuity or such time that property use changes or is disposed of with appropriate compensation to the Government. 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 2007	---
FY 2008	$304,475,000
FY 2009	$310,470,000
FY 2010	$338,002,000
FY 2011 CR	$338,002,000

Budget Request

The FY 2012 Discretionary Request does not include funds for Public Health Improvements. The Public Health Improvement program has received over $2.6 billion in funding since FY 2001 for facility construction and renovation, equipment acquisition, and other public health improvement projects.

Healthy Weight Collaborative

	FY 2010 Actual	FY 2011 CR	FY 2012 Budget Request	FY 2012+/- FY 2010
BA	$5,000,000	----	$5,000,000	---
FTE	---		---	---

Authorizing Legislation – Section 4002 of the Affordable Care Act
(P.L. 111-148)

FY 2012 Authorization $1,000,000,000

- Allocation Methods Competitive cooperative agreement

Program Description and Accomplishments

The Healthy Weight Collaborative is authorized under Title V, Section 501(a)(2) Social Security Act (42 U.S.C. 701) and Section 4002 of the Affordable Care Act (P.L. 111-148) to transfer knowledge, skills, and practical approaches to quality management for the prevention and treatment of overweight and obesity for children and families. One award for this cooperative agreement was made on September 24, 2010 for an 18 month budget and project period. Eligible entities included any public or private nonprofit entity, including state and local government agencies, institutions of higher education, and an Indian tribe or tribal organization (as those terms are defined at 25 USC 450(b)).

The Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA), Office of Planning, Analysis and Evaluation (OPAE) announced the awardee for the cooperative agreement (Prevention Center for Healthy Weight (PC)) to the National Initiative for Children's Healthcare Quality (NICHQ, www.nichq.org). The Prevention Center will plan, implement and manage a nation-wide Healthy Weight Collaborative as well as recruit and support at least 50 community teams participating in the Healthy Weight Collaborative (HWC). The mission of the HWC is to discover, develop, and disseminate evidence-based and promising community-based and clinical interventions to prevent and treat obesity for children and families. The cooperative agreement awardee will do the following:

- Plan, implement, and manage the HWC;
- Provide technical assistance to HWC teams to improve approaches to prevent and treat overweight and obesity in their respective communities;
- Improve quality of care to prevent and treat overweight and obesity through understanding of quality improvement concepts, tools, and techniques;
- Support teams participating in the HWC; and
- Demonstrate a commitment to long-term sustainability of the project after the Federal period of support.

Budget allocation and requests

- $5,000,000 allocated from the Prevention and Public Health Fund in FY 2010
- $5,000,000 planned in FY 2011 for continuing and expanding the program

Activities to be completed and objectives to be attained

The awardee will engage grantees from HRSA and DHHS in at least 50 communities in a variety of activities that will build capacity at the regional, state, local, or community level to transfer knowledge, skills, and practical approaches to quality management to prevent and treat overweight and obesity for children and families. The target audience for this program is children and their families, and teams in the HWC must include a safety net setting (such as a community health center; a state, county or local health department; any community-based organizations. These entities should include HRSA and DHHS grantees especially safety net providers and other stakeholders in the HRSA and DHHS Program network. The first six months of the project are considered planning with a 12 month implementation phase. Typically, collaboratives have fewer teams in the first year with significant increases in the number of teams in subsequent years.

Purpose and Use of the Prevention and Public Health Fund

The purpose of the Public Health and Prevention fund is to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs. The Fund is to be used for prevention, wellness, and public health activities including prevention research and health screenings, such as the Community Transformation grant program, the Education and Outreach Campaign for Preventive Benefits, and immunization programs. The Healthy Weight Collaborative's mission is to discover, develop, and disseminate both evidence-based and promising clinical and community-based interventions to prevent and treat obesity. These interventions may reduce health care costs by improving quality in public health and clinical settings around the treatment and prevention of overweight and obesity.

This activity is not implementing a provision of the Affordable Care Act, but is funded through the Prevention and Public Health Fund.

Funding History

FY	Amount
FY 2007	---
FY 2008	---
FY 2009	---
FY 2010	$5,000,000
FY 2011	--

Budget Request

In FY 2012 the Healthy Weight Collaborative is requesting $5,000,000. This is equal to the FY 2010 Actual level. One cooperative agreement was funded, and it is anticipated that funding will remain at $5,000,000 for each year. In the first year there will likely be fewer teams and more funding dedicated to infrastructure since this is a new program. After the first funding cycle, we anticipate there will be much interest and the same amount of funding will be required to support the growth predicted in community teams. The awardee will conduct the following work:

- Plan, manage and implement the Healthy Weight Collaborative
- Recruit and manage faculty and leadership to provide technical assistance to collaborative teams
- Build and maintain a web portal that includes a warehouse of technical assistance modules, a site to upload and share data and reports
- Plan and manage virtual and in-person meetings for staff, partners and collaborative teams
- Recruit teams (50 at a minimum)
- Develop and package change concepts or interventions to be conducted through the collaborative
- Provide outreach and dissemination of models and teams
- Continuous engagement and management of public-private partners
- Provide technical assistance to teams based on the set of change concepts and packaged interventions
- Support collaborative teams

Outcomes and Output Tables

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Number of collaborative teams recruited (Developmental)	N/A	TBD[139]	TBD[1]	TBD[1]
Number of clinical and community-based interventions disseminated (Developmental)	N/A	TBD[1]	TBD[1]	TBD[1]

Data Source: Prevention Center for Healthy Weight

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

Supplementary Tables

TAB

Budget Authority by Object Class

(Dollars in thousands)

	FY2010 Actual	FY 2012 Request	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	117,829	114,261	-3,569
Other than full-time permanent (11.3)	4,708	4,493	-215
Other personnel compensation (11.5)	4,628	4,315	-314
Military personnel (11.7)	18,181	18,450	+ 269
Special personnel services payments (11.8)	291	247	-44
Subtotal personnel compenstion	**+$145,638**	**+$141,766**	**-$3,872**
Civilian benefits (12.1)	31,704	31,122	-582
Military benefits (12.2)	9,800	9,223	-577
Benefits to former personnel (13.1)	1,973	1,983	+ 10
Total Pay Costs	**$189,115**	**$184,094**	**-$5,021**
Travel and transportation of persons (21.0)	3,723	3,067	-656
Transportation of things (22.0)	401	292	-109
Rental payments to GSA (23.1)	12,970	46,298	+ 33,327
Rental payments to Others (23.2)	1,945	1,867	-78
Communication, utilities, and misc.charges (23.3)	677	671	-5
Printing and reproduction (24.0)	1,089	1,039	-50
Other Contractual Services: 25.0	1	1	-
Advisory and assistance services (25.1)	37,868	40,769	+ 2,902
Other services (25.2)	125,520	110,421	-15,099
Purchase of goods and services from government accounts (25.3)	224,683	188,004	-36,679
Operation and maintenance of facilities (25.4)	2,618	2,491	-127
Research and Development Contracts (25.5)	90	90	-
Medical care (25.6)	3,606	3,621	+ 15
Operation and maintenance of equipment (25.7)	6,239	5,424	-815
Subsistence and support of persons (25.8)	42	42	-
Discounts and Interest (25.9)	31	29	-2
Supplies and materials (26.0)	1,334	944	-391
Subtotal Other Contractual Services	**$402,031**	**$ 351,836**	**$-50,196**
Equipment (31.0)	5,158	3,684	-1,474
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	6,827,711	6,117,915	-709,796
Insurance Claims and Indemnities (42.0)	38,174	90,499	+ 52,325
Total Non-Pay Costs	**+$7,293,879**	**+$6,617,168**	**-$676,711**
Total Budget Authority by Object Class	**+$7,482,994**	**+$6,801,262**	**-$681,732**

Salaries and Expenses

(Dollars in thousands)

Personnel compensation:	**FY2010 Actual**	**FY 2012 Request**	**Increase or Decrease**
Full-time permanent (11.1)	117,829	114,261	-3,569
Other than full-time permanent (11.3)	4,708	4,493	-215
Other personnel compensation (11.5)	4,628	4,315	-314
Military personnel (11.7)	18,181	18,450	+269
Special personnel services payments (11.8)	291	247	-44
Subtotal personnel compenstion	**$145,638**	**$141,766**	**-$3,872**
Civilian benefits (12.1)	31,704	31,122	-582
Military benefits (12.2)	9,800	9,223	-577
Benefits to former personnel (13.1)	1,973	1,983	+10
Total Pay Costs	**$189,115**	**$184,094**	**-$5,021**
Travel and transportation of persons (21.0)	3,723	3,067	-656
Transportation of things (22.0)	401	292	-109
Rental payments to Others (23.2)	1,945	1,867	-78
Communication, utilities, and misc. charges (23.3)	677	671	-5
Printing and reproduction (24.0)	1,089	1,039	-50
Contractual Services:			
Other Contractual Services: 25.0	1	1	---
Advisory and assistance services (25.1)	37,868	40,769	+2,902
Other services (25.2)	125,520	110,421	-15,099
Purchase of goods and services from government accounts (25.3)	224,683	188,004	-36,679
Operation and maintenance of facilities (25.4)	2,618	2,491	-127
Medical care (25.6)	3,606	3,621	+15
Operation and maintenance of equipment (25.7)	6,239	5,424	-815
Subsistence and support of persons (25.8)	42	42	---
Discounts and Interest (25.9)	31	29	-2
Supplies and materials (26.0)	1,334	944	-391
Subtotal Other Contractual Services	**$ 401,941**	**$ 351,746**	**-$50,196**
Total Non-Pay Costs	**$ 409,775**	**$ 358,681**	**-$51,094**
Total Budget Authority by Object Class	**$ 598,890**	**$ 542,776**	**-$56,115**

Health Resources and Services Administration
Detail of Full Time Equivalents (FTE)

PROGRAMS	2010 Actual Civilian	2010 Actual Military	2010 Actual Total	2011 Est. Civilian	2011 Est. Military	2011 Est. Total	2012 Est. Civilian	2012 Est. Military	2012 Est. Total
Bureau of Primary Health Care:									
Direct:									
Health Centers/Tort	70	5	75	70	6	76	43	7	50
Free Clinics Medical Malpractice	2	0	2	2	0	2	2	0	2
Community Health Center Fund	0	0	0	45	0	45	91	0	91
HC- Facilities Construction/NHSC	0	0	0	12	0	12	26	0	26
School-based Health Centers-Facilities	0	0	0	9	0	9	9	0	9
Hansen's Disease Center	57	8	65	61	8	69	59	10	69
Reimbursable:									
Hansen's Disease Center	3	-	3	3	-	3	3	-	3
Total:	132	14	145	202	14	216	233	17	250
Bureau of Health Professions:									
Direct:									
Health Workforce Information Analysis	-	-	-	7	-	7	7	-	7
Training in Primary Care Med/Dentistry	2	-	2	7	-	7	7	-	7
Children's Hospitals Medical Education	13	2	15	18	2	20	-	-	-
Nurse, Education, Practice	1	-	1	1	-	1	2	-	2
Advanced Education Nursing Program	2	-	2	2	-	2	2	-	2
Geriatrics Program.	2	-	2	4	-	4	4	-	4
Patient Navigator Outreach	1	1	2	2	1	3	-	-	-
GME Payments for Teaching Hlth Centers	-	-	-	5	-	5	5	-	5
State Grants for Personal Home Hlth Aids	-	-	-	2	-	2	2	-	2
Public Health/Preventive Medicine	-	-	-	2	-	2	2	-	2
Allied Health				1		1	-	-	0
HEAL.	14	-	14	14	-	14	-	-	0
Reimbursable:									
National Practitioner Data Bank	20	2	22	38	2	40	43	2	45
Hlthcare Integrity & Protection Data Bank	5	0	5	5	-	5	0	-	0
Total:	60	5	65	108	5	113	74	2	76
Bureau of Clinician Recruitment & Service:									
Direct:									
National Health Service Corps	78	7	85	103	7	110	76	14	90
NHSC Ready Responders	-	30	30	3	31	34	3	31	34
NHSC Recruitment	2	-	2	-	-	-	-	-	-
National Health Service Corps (ACA)				47	3	50	36	14	50

PROGRAMS	2010 Actual Civilian	2010 Actual Military	2010 Actual Total	2011 Est. Civilian	2011 Est. Military	2011 Est. Total	2012 Est. Civilian	2012 Est. Military	2012 Est. Total
Total:	80	37	117	153	41	194	115	59	174
Nurse Loan Repayment & Scholarships.	18	2	20	30	2	32	30	2	32
Maternal and Child Health Bureau:									
Direct:									
Autism/Other Developmental Disorders	3	1	4	4	1	5	3	2	5
Heritable Disorder Newborn Screening	3	-	3	3	-	3	3	-	3
Congenital Disabilites	1	-	1	1	-	1	-	-	-
Universal Newborn Screening	3	-	3	4	-	4	4	-	4
Block Grant	14	-	14	9	-	9	9	-	9
Healthy Start	4	-	4	4	-	4	4	-	4
Family to Family Health Info Centers	-	-	-	1	-	1	2	-	2
Maternal/Infant/Early Childhood Visitation	3	1	4	22	1	23	27	1	28
Emergency Medical Services for Children...	-	-	-	3		3	4	-	4
Sickle Cell Program	2	-	2	2	-	2	2	-	2
Total:	33	2	35	53	2	55	58	3	61
HIV/AIDS Bureau:									
Direct:									
Ryan White Part A	14	-	15	6	1	7	6	1	7
Ryan White Part B	26	-	28	5	2	7	5	2	7
Ryan White Part C	25	4	29	26	4	30	25	5	30
Ryan White Part D	3	-	3	4	-	4	4	-	4
Ryan White Part F	1	-	1	2	-	2	2	-	2
Reimbursable:									
OGAC Global AIDS	12	3	15	17	3	20	20	3	23
Total.	80	7	87	60	10	70	62	11	73
Healthcare Systems Bureau:									
Direct:									
Health Care Facilities & Other Projects.	7	-	7	-	-	-	-	-	-
C.W.Bill Young Cell Transplantation Prog	5	-	5	5	-	5	5	-	5
Cord Blood Stem Cell Registry	1	-	1	4	-	4	4	-	4
Poison Control Centers	4	-	4	3	-	3	4	-	4
State Health Access Grants	4	-	4	2	-	2	-	-	-
Reimbursable:									
Covered Countermeasures Compensation	3	1	4	4	1	5	7	1	8
Vaccine	19	1	20	22	1	23	22	1	23
340B Drug Pricing User Fees	-	-	-	-	-	-	5	-	5
DHHS/ACYF	1	-	1	1	-	1	1	-	1
Total:	44	2	46	41	2	43	48	2	50
Office of Rural Health Policy:									

PROGRAMS	2010 Actual Civilian	2010 Actual Military	2010 Actual Total	2011 Est. Civilian	2011 Est. Military	2011 Est. Total	2012 Est. Civilian	2012 Est. Military	2012 Est. Total
Direct:									
Rural Access to Emergency Devices	1	-	1	2	-	2	-	-	-
Outreach	1	-	1	1	-	1	1	-	1
Radiogenic Diseases	1	-	1	1	-	1	1	-	1
Delta Health Initiative	3	1	4	2	1	3	-	-	-
Total:	6	1	7	6	1	7	2	-	2
Family Planning (Direct)	26	9	35	26	9	35	24	11	35
Program Management (Direct)	827	115	942	827	115	942	827	115	942
OPDIV FTE Total	**1,306**	**193**	**1,499**	**1,506**	**201**	**1,707**	**1,473**	**222**	**1,695**
Recovery Act FTE (non add)	96	7	103	36	7	43	0	-	0
Total:	1,402	208	1,602	1,542	208	1,750	1,473	222	1,695

Average GS Grade	
2007	12.6
2008	12.6
2009	12.6
2010	12.6
2011	12.6

Programs Proposed for Elimination

The following list shows the programs proposed for elimination or consolidation in the FY 2012 Budget Request. Termination of these programs frees up approximately $782.8 million (discretionary) and $100.03 million (mandatory) 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
Discretionary	
Allied Health and Other Disciplines	1.9
Patient Navigator Outreach & Chronic Disease Prevention	4.9
Children's Hospitals Graduate Medical Education Program	316.8
State Health Access Grants	74.5
Rural & Community Access to Emergency Devices	2.5
Delta Health Initiative	34.9
Denali Project	10.0
Public Health Improvement Projects	337.3
Total Discretionary	**782.8**
Mandatory	
Nutrition, Physical Activity and Screen Time Standards Prevention Fund	.03
Infrastructure to Expand Access to Care	100.0
Total Mandatory	**100.03**

Program Descriptions

Discretionary

Allied Health and Other Disciplines (-$1.9 million)

The Chiropractic Demonstration Project Program has shown effective programmatic models over the life of the program and has been successfully implemented.

Patient Navigator Outreach & Chronic Disease Prevention (-$4.9 million)

The Patient Navigator Program was authorized in FY 2005 as a demonstration program and has been successful in accomplishing its goal and may serve as a model for future efforts. The Report to Congress will describe that patient navigator services are a promising model for chronic disease prevention and management.

Children's Hospitals Graduate Medical Education Program (-$316.8 million)

The budget request focuses on activities that more directly fund the expansion of primary care workforce.

State Health Access Grants (-$74.5 million)

It is anticipated that programs authorized under the Affordable Care Act will be sufficient to cover the types of activities currently being undertaken by SHAP.

Rural & Community Access to Emergency Devices (-$2,5 million)

Activities related to access to emergency medical devices and training in FY 2012 may be addressed through other funding sources available to grantees, such as the Rural Outreach and Rural Network Development programs

Delta Health Initiative (-$34.9 million)

The needs in this region can best be met by other existing programs, such as the Health Center Program and the National Health Service Corps which can address the health system delivery of the Delta.

Denali Project (-$10.0 million)

The Denali Commission has already received more than $300 million in funding since FY 2000 for construction in Alaska and this investment has helped meet the most critical needs. Additional funds in the Recovery Act provided for health center construction and capital investments within other parts of the Government which have also helped address the need.

Public Health Improvement Projects (-$337.3million)

The Public Health Improvement program has received over $2.6 billion in funding since FY 2001 for facility construction and renovation, equipment acquisition, and other public health improvement projects.

Mandatory

Nutrition, Physical Activity and Screen Time Standards Prevention Fund: (-$.03 million)

No funding has been provided from the Prevention and Public Health Fund for this program

Infrastructure to Expand Access to Care (-$100.0 million)

The grant was awarded in FY 2011 and will require up to five years of monitoring to ensure that the project is completed on schedule as proposed. FY 2012 will be the second year of monitoring the project. No funds are expected to be appropriated in FY 2012.

Health Professions Loan Programs

HRSA is responsible for the administration of the following revolving loan programs: Health Professions Student Loan (HPSL) Program, the Nursing Student Loan (NSL) Program, Loans for Disadvantaged Students (LDS), and the Primary Care Loans (PCL).

These programs were initially financed through appropriations to the revolving loan funds. Appropriations ceased in 1984.

These programs are currently 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 make 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.

The information below reflects preliminary data for Academic Year 2009-2010 and was derived from the Fall 2010 Annual Operating Report.

	Number of Programs[140]	Number of Borrowers	Account Balance
HPSL	154	33,309	$362,160,100
PCL	132	4,493	253,049,300
LDS	177	7,208	111,847,000
NSL	384	43,406	165,315,300
Total	847	88,416	$892,371,700

New Awards in Academic Year 2009-2010 were as follows:

	Number of New Loans	Amount of New Funds Awarded
HPSL	7,267	$42,653,000
PCL	417	23,436,900
LDS	1,490	19,109,100
NSL	11,081	26,754,400
Total	20,255	$111,953,400

[140] Programs refer to the number of disciplines (e.g., allopathic medicine, nursing, etc.) that maintained a revolving fund account.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Drug Budget

Resource Summary

Amounts in Millions	**2010**	**2011**	**2012**
Bureau of Primary Health Care (BPHC)			
Health Centers (discretionary)	$ 15.7	$ 15.7	$ 14.7
Health Centers (mandatory)		$ 8.1	$ 9.7
Total	**$ 15.7**	**$ 23.8**	**$ 24.4**

Source: Estimates based on 2007, 2008, and 2009 HRSA Health Centers Grant reported information into the Uniform Data System (UDS) to report on their patient services, revenues and expenditures.

METHODOLOGY

The Uniform Data System (UDS) tracks a variety of information, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues. UDS data are collected from grantees and reported at the grantee, State, and national levels. The UDS reporting provides a reasonable basis for estimating the share of the Primary Health Care Grants used for substance abuse treatment. According to the data from the 2009 Financial Report, HRSA-funded Health Centers expended a total of $94,991,120 on substance abuse services. This total represents 0.81 percent of the total value of services provided in that year from all funding sources ($11,612,308,044). To calculate the total drug control estimate, the 0.81 percent is applied to the $1,940,175,687 in HRSA grants in FY 2009, resulting in approximately $15.7 million in FY 2009 for Federal support of substance abuse treatment at these Centers. The FY 2010 through FY 2012 estimates utilizing this methodology are reflected above.

Note: The Health Centers (mandatory) estimate is comprised of mandatory funding appropriated in the Affordable Care Act.

BUDGET SUMMARY

The total drug control budget for the Health Resources and Services Administration for FY 2012 is $24.4 million, an increase of $0.6 million over the FY 2011 level.

Bureau of Primary Health Care
Total FY 2012: $24.4 million
(Reflects $0.6 million increase from FY 2011)

Health Centers (discretionary)
FY 2012: $14.7 million
(Reflects $1.0 million decrease from FY 2011)

Health Centers (mandatory)
FY 2012: $9.7 million
(Reflects $1.6 million increase from FY 2011)

The Health Center program supports more than 1,100 grantees and provides comprehensive primary health care services to more than 20 million patients. These services include substance abuse treatment.

Significant Items

TAB

HEALTH RESOURCES AND SERVICES ADMINISTRATION

SIGNIFICANT ITEMS IN HOUSE AND SENATE APPROPRIATIONS COMMITTEE REPORTS

The following section represents FY 2011 Congressional requirements for reports and significant items derived from Senate Report 111-243

FY 2011 Senate Appropriations Committee Report Language (Senate Report 111-243)

Item 1

Community Health Centers.--The Committee supports the proposal in the President's budget to continue providing funds to health centers to care for the 3 million patients added through the American Recovery and Reinvestment Act [ARRA]. Within the fiscal year 2011 program level, the Committee directs HRSA to continue the Increased Demand for Services funding and continue to support the new access points established through ARRA. (Page 43)

Action Taken or To Be Taken

HRSA plans to continue funding for the Health Center Increased Demand for Services and New Access Points established under ARRA.

Item 2

Community Health Centers.-The Committee strongly supports the expansion of primary care services in school settings. Within the funds available for new access points and expanded medical capacity, the Committee directs HRSA to give priority to applications that include school-based care. The Committee further encourages HRSA to provide technical assistance to community health centers on how they can form partnerships with school districts and Local health departments that currently operate school-based health centers within the service area of the community health center. (Page 43)

Action Taken or To Be Taken

In the most recent Health Center New Access Point and Expanded Services application guidances, HRSA highlighted the opportunity to establish or expand school-based health centers. HRSA will also continue to provide technical assistance to health centers on forming strategic partnerships that strengthen the ability to address the primary health care needs in their communities, including those with school districts and Local health departments.

Item 3

Community Health Centers.-The Committee urges HRSA to make funding available to increase capacity at existing centers, and for service expansion awards to expand access to behavioral health services, oral health services, and pharmacy services provided by community health centers. The Committee expects HRSA to implement any new expansion initiative using the existing, and statutorily-required, proportionality for urban and rural communities, as well as migrant, homeless and public housing health centers. (Page 43)

Action Taken or To Be Taken
HRSA has announced the availability of $270 to $335 million under the Expanded Services (ES) initiative to increase access to preventive and primary health care, including dental health, behavioral health, pharmacy, vision, and/or enabling services, at existing health center sites. HRSA will continue to follow the statutory proportionality requirements for rural/urban communities and special populations.

Item 4
Child Maltreatment Prevention.-The Committee continues to believe that parent training is a promising strategy for preventing child maltreatment that should be tested in primary care settings such as community health centers. The Committee urges HRSA to ensure that community health centers are actively engaged in the new home visitation initiative funded in the Patient Protection and Affordable Care Act. (Page 43)

Action Taken or To Be Taken
Promoting positive family interaction and reducing child maltreatment are important components of the program benchmarks and participant outcomes listed under the Home Visiting section of the ACA. The core components of the program focus on implementing evidence-based home visiting service models which are responsive to the specifically identified needs of at-risk communities selected by the State. Such models may or may not be intimately linked with primary care settings such as community health centers, but clearly all home visiting programs must have some significant involvement with primary care since so many of the program benchmarks and participant outcomes are impacted by delivery of good primary care. Moreover, the Home Visiting program benchmarks specifically require that programs demonstrate improvement in coordination and referrals for other community resources and supports. As part of its ongoing technical assistance responsibilities, HRSA will assure that all selected at-risk communities are aware of resources such as community health centers and will encourage strong, appropriate interaction so that the community can develop a comprehensive, high-quality early childhood system that promotes maternal, infant and early childhood health, safety, and development and strong parent-child relationships.

Health centers are actively engaged in health education activities and HRSA has highlighted the opportunity for health centers to be involved in new home visitation program

Item 5
Substance Abuse Coordination.-The Committee is aware of the initiative in the President's budget to expand behavioral and mental health services in community health centers. Insofar as those services include substance abuse treatment, the Committee encourages HRSA to issue guidance to community health centers on collaboration with State substance abuse agencies to ensure the promotion of State standards of care, coordination of referrals and further services. (Page 43)

Action Taken or To Be Taken
A funding opportunity announcement for the expansion of substance abuse treatment services would include appropriate guidance for health centers on collaboration with State agencies to ensure that appropriate standards of care are promoted and that referrals are coordinated.

Item 6

Native Hawaiian Health Care.-The Committee encourages HRSA to support efforts to expose our Nation's youth to potential careers in the health professions; for example, in nursing, pharmacy, and public health. It is especially important that youth in rural America and from a range of ethnic groups, including Native Hawaiians, have access to early career counseling and "hands on" experiences.
(Page 44)

Action Taken or To Be Taken

HRSA has four programs that aim to encourage youth to enter health professions.
The Centers of Excellence Program provides support to enhance the academic performance of underrepresented minorities, including Native Hawaiians. A grantee at the University of Hawaii provides academic and peer support through MCAT preparatory courses, learning assessments, application assistance and interview skills. In addition, they have coordinated activities focused on the recruitment of Native Hawaiian students into the health professions.

The Health Careers Opportunity Program targets disadvantaged communities of all races and ethnicities. Grantees are encouraged to reach out to the Native Hawaiian and Other Pacific Islander youths when appropriate, to encourage career awareness in the health professions along the educational pipeline.

The Nursing Workforce Diversity Program provides opportunities for individuals from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among registered nurses) through student scholarships or stipends, pre-entry preparation, and retention activities. A grantee at the University of Hawaii is working with community colleges in Hawaii to improve nursing school graduation rates and pass rates on the registered nurse licensure examination for Hawaiians, Pacific Islanders and other disadvantaged students in the rural counties in the Hawaiian isles.

The Area Health Education Centers (AHEC) Program provides support for interdisciplinary community-based primary care training. The John A. Burns School of Medicine operates the AHEC Program in Hawaii with the goal of improving the health status of its residents by providing health careers awareness training to youth, recruiting students from rural and underserved areas, providing them with health professions training, and working to return them to their communities by identifying placements and ensuring opportunities for ongoing continuing education that will facilitate their retention in these areas of tremendous need.

We will continue to work with these grantees to strengthen their efforts and also provide technical assistance to applicants who aim to encourage young people to enter the health professions.

HRSA will continue to support activities that provide opportunities to encourage our Nation’s youth to participate in health profession careers.

Item 7

Native Hawaiian Health Care. -The Committee encourages HRSA to work collaboratively with appropriate Federally qualified community health centers to develop screening, prevention and treatment initiatives addressing the extraordinarily high incidence of kidney disease among Filipino citizens. (Page 44)

Action Taken or To Be Taken

HRSA will continue to support the Native Hawaiian health care program to encourage collaboration with the Local health centers so that appropriate outreach and referral systems are utilized to address the specific needs of the Native Hawaiian population, including kidney disease.

Item 8

National Health Service Corps. -The Committee continues to recognize that the NHSC is an essential tool for recruitment and retention of primary care health professionals in Health Professional Shortage Areas nationwide. The Committee applauds efforts by HRSA to enhance access to the NHSC by reducing application documentation requirements, allowing for pre-qualification of applicants, instituting rolling deadlines, and planning a part-time service demonstration. The Committee encourages HRSA to continue with these and other improvements, as well as collaboration with the Health Centers program in order to maximize the investment in the NHSC. (Page 45)

Action Taken or To Be Taken

The NHSC has continued to improve the efficiency of its application processes for the Loan Repayment and Scholarship programs by releasing an online application for both programs, which include the ability to upload essential documents to reduce lag time in application processing. The NHSC has also expanded the part-time service demonstration to be a permanent option, which was afforded to the program in the Affordable Care Act (ACA). The FY 2011 Loan Repayment Program (LRP) Application and Program Guidance (APG) – released on November 22 – included the ability for applicants to select among three service options: 2-year full-time for up to $60,000; 4-year half-time for up to $60,000; or 2-year half-time for up to $30,000. Further, the

FY 2011 APG will now allow LRP participants to convert to half-time if they are no longer able to fulfill a full-time commitment. Lastly, the LRP APG increased program flexibility by allowing service credit for time spent teaching in a clinical setting, as provided for in the ACA. The ACA also enables NHSC Scholarship Program participants to fulfill the service commitment in a half-time status, as well as receiving credit for teaching. Additional efforts are under way to identify novel approaches for encouraging clinicians to enter into primary care earlier in their careers, which would create a larger pool from which to draw eligible applicants, and helping to direct clinicians to particularly high-need health professional shortage areas.

More broadly, HRSA is working to rebrand the NHSC to drive increased interest in its programs. HRSA has also developed communication strategies to engage clinicians directly and provide enhanced customer service to support those in the field, encouraging them to continue serving beyond their initial contract.

The NHSC is also implementing a Site Partnership Initiative to increase the number of, and enhance cooperation with, NHSC-eligible service sites, especially Community Health Centers. The Bureau of Clinician Recruitment and Service, which administers the NHSC, has engaged with the State Primary Care Offices and Primary Care Associations, Indian Health Service, Substance Abuse and Mental Health Services Administration and the National Association of Community Health Centers to increase participation of these sites in the NHSC. Collaboration is underway with the Bureau of Primary Health Care to increase the efficiency of site approvals and visits.

Item 9

National Health Service Corps.-The Committee is aware that psychologists are among the occupations eligible to participate in the NHSC if they agree to practice in underserved areas, and the Committee encourages HRSA to ensure that mental health professionals are aware of this opportunity. (Page 45)

Action Taken or To Be Taken

Broadly, the National Health Service Corps continues to increase awareness amongst all eligible behavioral health disciplines about the opportunities for loan repayment. NHSC entered new markets for recruitment efforts by launching a Facebook page, beginning a Twitter account, and utilizing a YouTube channel. Finally, the NHSC refreshed its Web site, resulting in a 200 percent increase in visits to the site from FY 2009 to FY 2010. A more comprehensive redesign of the NHSC Web site is planned for FY 2011.

With regard to interest in the NHSC by health service psychologists, HRSA has worked to increase participation in the NHSC program by these and other mental and behavioral providers. For example, HRSA representatives have exhibited at the professional conferences attended by behavioral health professionals such as: the American Psychology Association (APA), the Association of Black Psychologists (ABP), the American Psychiatric Nurses Association (APNA), Council on Social Work Education (CSWE), American Counseling Association (ACA), the National Council for Community Behavioral Health Care, and the National Association of Social Workers (NASW). The NHSC distributes information to professional publications and encouraging coverage of the NHSC loan repayment application cycle and program. These publications include: American Psychologist, Behavioral Therapist, Clinical Psychiatry News, Counseling Psychologist, gradPSYCH, Monitor on Psychology, and the NASW News. Presence at these conferences and other outreach to health professions schools that train psychologists have resulted in both an increase in applications from and awards given to health service psychologists. In addition, HRSA/NHSC staff and the Substance Abuse and Mental Health Services Administration (SAMHSA) have established a Working Group on Medical and Behavioral Health. The Working Group ensures that NHSC program requirements meet with practice standards for mental and behavioral healthcare and provides an additional network for distribution of NHSC information.

In FY 2010, 311 new awards were made to psychologists, compared with 77 awards in FY 2007; 111 in FY 2008; and 224 in FY 2009. Mental and behavioral health providers now represent 29 percent of the final FY 2010 NHSC Field Strength, up from 17 percent in 2004.

Item 10

National Health Service Corps.-The Committee is aware that specialty care is increasingly rare in communities that have been declared a public health emergency and may be critically needed to respond to injuries or illnesses sustained in the emergency. The Committee notes that HRSA has the authority to consider requests by Local entities for alternative provider types with special considerations. Therefore, the Committee encourages HRSA to provide technical assistance to communities experiencing public health emergencies to ensure that they can utilize all available options to respond to needs resulting from the disaster. (Page 46)

Action Taken or To Be Taken

HRSA is undergoing an analysis of the disciplines supported by the NHSC and has recently conducted a survey of its sites to determine the relative demand for additional disciplines. This survey is currently being analyzed and HRSA plans to announce any additional disciplines through program guidance.

Further, HRSA has launched a Site Partnership Initiative to better coordinate with NHSC sites and communities, provide technical assistance to recruit and retain NHSC clinicians and collaborate to increase participation in NHSC programs. HRSA will explore methods to use the Site Partnership Initiative to aid communities affected by public health disasters.

Finally, HRSA administers the Ready Responder Program. Ready Responders are United States Public Health Service Commissioned Corps officers who are highly trained to respond in the event of a declared emergency. These primary care clinicians have been deployed across the United States in order to respond to public health emergencies.

Item 11

Health Professions.-The Committee urges HRSA to maximize the capacity of health professions education programs to be inter-professional in nature in order that healthcare professionals educated through these programs graduate competent to provide patient-centered, team-based care. (Page 46)

Action Taken or To Be Taken

Expanding interprofessional education is a priority for HRSA. Some HRSA programs have explicit authority to support interprofessional education and teamwork. For example, the Nurse Education, Practice, Quality and Retention Program supports interdisciplinary education and the Area Health Education Center and Geriatric Education Programs have a long history of requiring that grantees offer interprofessional team-based training.

Other activities supporting interdisciplinary team training include two joint meetings of the four advisory committees that focus on health workforce issues. These two meetings produced a letter to Congress with recommendations regarding interprofessional education needs and development of interprofessional team-based competencies framework. This framework was used to leverage further conversations for the creation of an initiative and collaborative that has engaged foundations, other federal agencies, and health care professional organizations to develop interprofessional team based competencies to be used in education and practice. This

new collaborative is committed to educating and advancing interprofessional health care teams that are prepared to provide patient-centered care in new delivery system models that improve care coordination, quality and safety of care as well as affordability.

In addition, HRSA plans to support an interprofessional training project in FY 2012. This project will support programs that offer primary care clinical training by both physician and nurse faculty using a team approach to care. Targeted trainees include primary care nurse practitioners and primary care residents.

Item 12

***Health Professions*.** - In addition, the Committee is aware of research findings that suggest a neurological basis for women's experience of greater pain sensitivity which may account for the greater degree to which women seek help for chronic pain. Therefore, the Committee encourages HRSA to undertake a health professional education effort regarding these conditions. Such an effort should include the development of continuing medical education courses and other curricula to reduce gender-based barriers to effective care. (Page 46)

Action Taken or To Be Taken

Several Geriatric Education Centers Program grantees focus a component of their training grant activities on developing strategies for implementing evidence-based practice projects on the prevention and treatment of pain to improve team-based health professionals practice outcomes. While HRSA does not typically dictate that its grantees provide continuing education courses in specific topic areas, we will share the research findings with our grantees.

Item 13

Primary Care Training and Enhancement.-This program supports the expansion of training in internal medicine, family medicine, pediatrics and physician assistance. Funds may be used for developing training programs or providing direct financial assistance to students and residents. The Committee has included bill language specifying that no less than 15 percent of funds must be used to train physician assistants. The Committee urges HRSA to prioritize training physician assistants due to the ability of programs to rapidly expand to graduate high numbers of clinicians to fill the growing need for primary care. (Page 46)

Action Taken or To Be Taken

Fifteen percent of funds allocated to the Primary Care Training and Enhancement program will support physician assistant training. This support targets training, program infrastructure and includes program, curricular, and faculty development.

Item 14

Primary Care Training and Enhancement.-The Committee notes the findings of the recent "Annals in Internal Medicine" study ranking medical schools based on the communities where their graduates worked and whether those doctors practiced primary care. The Committee urges HRSA to prioritize applications from schools with a proven record of educating primary care physicians who go on to serve in shortage areas. (Page 47)

Action Taken or To Be Taken
In accordance with Section 791(a) of the Public Health Service Act, applicants receive a funding preference for the following:

> Having a high rate for placing graduates/program completers in practice settings, and having the principal focus of serving residents of medically underserved communities; or
>
> During the 2-year period preceding the fiscal year for which an award is sought, having achieved a significant increase in the rate of placing graduates/program completers in such settings.

Eligible applicants who qualify for this funding preference are moved to the top of the rank order list as long as the application is at or above the twentieth percentile of all applicants.

Item 15
***Training in Oral Health Care*.-**The Committee strongly supports the continued development of the faculty loan repayment program and expects HRSA to allocate no less than last year's level to this newly authorized activity. The Committee encourages HRSA to prioritize applications from schools with a proven track record of graduating dentists who go on to practice in underserved areas. (Page 47)

Action Taken or To Be Taken
HRSA will comply with this request. One of the funding priorities included in Section 748 of the Public Health Service Act which authorizes this program specifically States:

> "Qualified applicants that have a high rate for placing graduates in practice settings that serve underserved areas or health disparity populations, or who achieve a significant increase in the rate of placing graduates in such settings."

This language is included in the grant guidance to assure that those eligible will receive this priority as part of the grant application evaluation process. Once funded, grantees will report back to program assure compliance.

Item 16
***Allied Health and Other Disciplines*.-**The Committee has included bill language providing $8,672,000 for mental and behavioral health training grants authorized in section 756 of the Public Health Service Act. The Committee urges HRSA to allocate no less than last year's level for graduate psychology education. (Page 48)

Action Taken or To Be Taken
HRSA is complying with this request.

Item 17
Allied Health and Other Disciplines.-The Committee supports efforts by HRSA that would help integrate health service psychology trainees at Federally Qualified Health Centers to provide

behavioral and mental health services to underserved populations. In addition, the Committee encourages HRSA to focus on supporting programs with demonstrated, scientifically based potential to improve the outcome of mental and behavioral healthcare services. These programs should include academic institutions with a demonstrated commitment for improving health outcomes, as documented by science-based accreditation processes. (Page 48/49)

Action Taken or To Be Taken

HRSA will encourage current Graduate Psychology Education Program grantees to explore opportunities to utilize Federally Qualified Health Centers (FQHCs) as training sites to provide behavioral and mental health services to underserved populations. The new Mental and Behavioral Health Education and Training Program will include training in FQHCs and evidence based practice requirements as components of the application process.

Item 18

Health Professions Workforce Information and Analysis.-The allied health professions, like nurses and primary care physicians, face serious workforce shortages due to student recruitment, shortages of faculty and clinical sites. The Committee encourages HRSA to include allied health professions in any comprehensive workforce study of the health professions. (Page 49)

Action Taken or To Be Taken

HRSA shares the concern with potential shortages of allied health professions and will include these professions in the work of the new National Center for Health Workforce Analysis. This includes compiling of data and analysis of trends on the supply and demand for allied health professionals. Furthermore, HRSA has funded the Institute of Medicine to conduct a workshop on the allied health workforce which will be conducted in May 2011. The workshop will help identify strategies to assure an adequate supply and distribution of allied health professions.

Item 19

Health Professions Workforce Information and Analysis.-The Committee is aware that hospice and palliative medicine [HPM] improves quality, controls cost and enhances patient/family satisfaction for the rapidly expanding population of patients with serious or life-threatening illness. Therefore, the Committee encourages HRSA to study workforce trends, training capacity and need for HPM physicians, physician assistants and nurse practitioners in our Nation's academic medical centers, hospice organizations and palliative care programs. (Page 49)

Action Taken or To Be Taken

HRSA recognizes the importance of assuring access to quality hospice and palliative care. The new National Center for Health Workforce Analysis will collect and analyze data on trends in the supply and demand for physicians, nurse practitioners, PAs and other health personnel; at this time we do not have the resources to conduct a special study of those providing HPM services. However, we could work with and assist the HPM community in exploring how data on health personnel working in HPM services might be collected and analyzed.

Item 20
Nursing Workforce Development Programs. - Within the allocation for advanced education nursing, the Committee encourages HRSA to allocate funding for nurse anesthetist education at no less than last year's level. (Page 50)

Action Taken or To Be Taken
HRSA is complying with this request.

Item 21
Nursing Workforce Development Programs. - The increase provided for nurse education, practice and quality is intended to make grants for career ladder programs, authorized in the Affordable Care Act. (Page 50)

Action Taken or To Be Taken
The Affordable Care Act expanded the Nurse Education, Practice, Quality, and Retention Program to provide grants for career ladder programs to promote career advancement for nursing personnel—licensed practical nurses, licensed vocational nurses, certified nurse assistants, home health aides, diploma degree or associate degree nurses—to become baccalaureate or advanced education nurses. This expanded program opportunity has been included and specifically noted in the FY 2011 Funding Opportunity Announcement.

Item 22
Nursing Workforce Development Programs. - In all programs, the Committee encourages HRSA to prioritize grant applications from institutions with a proven track record for graduates practicing in underserved areas. (Page 50)

Action Taken or To Be Taken
Nursing Workforce Development Programs give a funding preference to projects that will substantially benefit rural or underserved populations. In addition, special consideration is given to traineeship programs supported under the Advanced Nursing Education Program that agree to support advanced education nurses who will practice in Health Professional Shortage Areas.

Item 23
Nursing Workforce Development Programs. - The Committee also encourages HRSA to support schools of nursing in the development and implementation of both traditional and telehealth outreach programs in rural underserved communities. (Page 50)

Action Taken or To Be Taken
The Nurse Education, Practice, Quality and Retention (NEPQR) Program provides grant support for academic, service, and continuing education projects designed to enhance nursing education, improve the quality of patient care, increase nurse retention, and strengthen the nursing workforce. One of the education purposes solicits projects that incorporate innovative approaches in the use of new technologies to enhance nursing education, including distance learning methodologies. In addition, the Funding Opportunity Announcement for the NEPQR

Program includes a funding preference for applicants with projects that will substantially benefit rural and underserved populations.

Item 24

Vision Screening.-The Committee is pleased that the Maternal and Child Health Bureau has created the National Universal Vision Screening for Young Children Coordinating Center. The center's mission is to develop the public health infrastructure to promote and ensure a continuum of eye care for young children within the healthcare delivery system. The Committee supports the mission and goals of this new center and looks forward to hearing about its progress. (Page 51)

Action Taken or To Be Taken

The Maternal and Child Health Bureau continues to recognize the importance of universal vision screening. Prevent Blindness America was awarded a $300,000 cooperative agreement for 3 years as the newly titled, "*National Center for Children's Vision and Eye Care"*, currently in its 2nd year. The Center is designed to support the development of a public health infrastructure to promote and ensure a comprehensive, multi-tiered continuum of eye health and vision care for young children within the healthcare delivery system. The Center has concentrated its efforts on achieving the following three core elements: to provide national leadership in the development of the Statewide vision screening and intervention components of programs for all children four years of age, prior to school entry; to develop and implement a plan to assist States in coordinating existing vision screening activities; to work in collaboration with five States (Georgia, Illinois, Massachusetts, North Carolina and Ohio) to develop and implement a uniform Statewide strategy for universal vision screening by age four. The National Center has been able to both mobilize a community of committed individuals with deep knowledge of the existing challenges as well as gather critical information on the current trends and opportunities in vision and eye health. At the National level, project staff has collected current and historical best practices and studies relating to vision screening and young children, designed the infrastructure and leadership of the Expert Panel, established the core elements of a communications infrastructure, and engaged in the development of web-based communications. At the State level, the leadership in pilot States has been able to mobilize their community partners quickly to establish Statewide coalitions and networks with diverse representation. Lastly, the National Expert Panel, established during the first year of the project, will provide suggestions towards the establishment of a Title V performance measure for vision screening, create mechanisms for uniform data collection and reporting, and prepare guidelines for vision screening standards.

Item 25

Congenital Disabilities Program. - The Committee is pleased with the materials created in this program and encourages HRSA to distribute the materials through the Maternal Child Health Bureau's programs. The purpose of the program is to provide information and support services to families receiving a positive test diagnosis for down syndrome, spina bifida, dwarfism, or other prenatally and postnatally diagnosed conditions. Grants may be made to States, territories, localities, and nongovernmental organizations with expertise in prenatally and postnatally diagnosed conditions. (Page 53/54)

Action Taken or To Be Taken
The program continued activities including the development of patient and family educational materials on congenital disorders, meetings of lay and professional representatives about best outcomes for families of children diagnosed with congenital disorders, and established workgroups consisting of national support groups and experts on the three disorders named in the legislation (spina bifida, Down syndrome and dwarfism).

Item 26
Healthy Start. - The Committee intends these funds to fully provide for continuations of previously awarded grants. The Committee is aware that the Patient Protection and Affordable Care Act [PPACA] includes $250,000,000 in fiscal year 2011 for home visitation programs to improve maternal and child birth outcomes, and that Healthy Start grantees are eligible to apply for this funding. In awarding the PPACA funds, the Committee encourages HRSA to give full and fair consideration to grantees currently and formerly funded in Healthy Start and in the home visitation initiative under the Administration for Children and Families. (Page 54)

Action Taken or To Be Taken
Fiscal year 2011 Healthy Start funds will support two competing renewal border health Healthy Start grants and 102 non-competing continuation grants. Eight Healthy Start projects will end in FY 2012 (two border health and six non-border health). The request will support eight competing renewals for community based projects and 96 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 infants in their vulnerable communities.

With respect to the PPACA home visitation initiative, only States and jurisdictions, themselves, are eligible entities, not specific programs. No final determination has yet been made regarding the home visiting models eligible for implementation by the eligible entities.

Item 27
Universal Newborn Hearing Screening and Early Intervention. - 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 54)

Action Taken or To Be Taken
Collaboration with the Centers for Disease Control (CDC), the National Institutes of Health (NIH) National Institute on Deafness and Other Communication Disorders (NIDCD) and the Office of Special Education and Rehabilitative Services (OSERS) is ongoing to coordinate programs at the National and State levels.

Item 28

Comprehensive Care Programs. - The Committee urges HRSA to work with States, the Centers for Medicare and Medicaid Services, and the Office of Personnel Management to maximize this resource mechanism. The Committee directs HRSA to report in the fiscal year 2012 budget submission on the number of individuals and the amount of funds being used from ADAP and each portion of the Ryan White Care Act to support premiums. (Page 56)

Action Taken or To Be Taken

HRSA worked with CMS/OCIIO to assure that ADAP funds may be used to pay premiums for the Federal Pre-Existing Condition Insurance Plan Program. ADAP funds are already used to pay premiums in State PCIPs. Parts A, B, C, and D are the portions of the Ryan White HIV/AIDS program that allow payment of premiums for health insurance or plans. HRSA will provide information on the amount of funds being used from ADAP to support premiums and the number of individuals who received such support.

Item 29

Comprehensive Care Programs. - In addition, the Committee requests that HRSA include in the fiscal year 2012 submission the average cost to ADAP of each drug included in the ADAP formulary and the cost of that prescription drug to ADAP over the previous 3 fiscal years. (Page 56)

Action Taken or To Be Taken

There is no one ADAP formulary. Rather, each State has created an ADAP formulary that may change throughout the year based on fiscal realities within the State and service utilization. HRSA will provide any available cost data in the FY 2012 budget submission.

Item 30

Office of Pharmacy Affairs. - The Committee strongly supports a definition of patient that protects the 340B drug program's integrity while ensuring the Nation's healthcare safety net is not weakened. The Committee expects HRSA to provide guidance to 340B-covered entities based upon current law. The Committee also requests that HRSA and CMS convene a working group to ensure that all phases of the 340B drug discount program are administered without redundancy or contradiction by the two agencies of jurisdiction. (Page 58)

Action Taken or To Be Taken

HRSA is currently working to provide guidance on the definition of patient that reaffirms the 340B drug pricing program’s integrity based upon current law and balanced with the needs of the Nation’s healthcare safety net providers to meet the demands of the changing marketplace. HRSA will engage CMS to develop a working group that will help both agencies coordinate efforts in the administration of the respective programs.

Item 31

Rural Hospital Flexibility Grants. - The Committee remains strongly supportive of the collaboration between the Department of Veterans Affairs and rural hospitals to provide locally based care, 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. For that reason, the Committee

has again included bill language identifying $1,000,000 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 Department of Veterans Affairs 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 59)

Action Taken or To Be Taken

HRSA has shared information about the Flex Rural Veterans Health access program with the Department of Veterans Affairs (VA). In 2010, HRSA awarded grants to Montana, Alaska and Virginia, three States with high percentage of veterans compared to the total population. The grants 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. HRSA has held several meetings with the VA Office of Rural Health to brief them about this program and those meetings will continue in 2011. Staff from the VA were consulted in preparing the initial guidance for this program and reviewed the guidance before it was issued to the public. Each grantee is working with their VISN and VA health centers in the service area to ensure the accessibility of needed services for rural veterans as well as the coordination of care for veterans that are enrolled in the VA system. While specific strategies vary, grantees are using some combination of networks, telehealth and electronic health records to increase accessibility of services and coordination of care for rural veterans.

Item 32

Rural and Community Access to Emergency Devices. - The Committee encourages the placement of additional automated external defibrillators [AEDs] in rural areas. Only an estimated 8 percent of victims who suffer a sudden cardiac arrest outside of a hospital survive. Immediate cardiopulmonary resuscitation and early intervention, using an AED, can more than double a patient's chance of survival. Communities with comprehensive AED programs, including training of anticipated rescuers, have achieved survival rates of nearly 40 percent. (Page 60)

Action Taken or To Be Taken

The Rural Access to Emergency Devices (RAED) program allows for the purchase, placement and training of AEDs. Since the start of the program, the RAED program has seen an increase in the number AEDs placed in rural communities. In FY 2010, the total number of AEDs that were placed in rural communities was 800 which was an increase from 572 in FY 2008. In FY 2011, HRSA plans to make 18 new RAED awards.

Item 33

Family Planning. - 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 the Department to provide a portion of the increase provided for family planning to be used to provide technical assistance to grantees to be prepared for healthcare reform, including the expansion of Medicaid, technology upgrades and participating as essential community providers. (Page 61/62)

Action Taken or To Be Taken

The majority of any increase in the Title X appropriation will be used to assist grantees with addressing the rising costs of providing healthcare services, primarily related to clinical provider salaries, purchasing contraceptives and other pharmaceuticals, lab and diagnostic tests, and other related preventive health services and supplies. In addition, the integration of electronic health record systems and practice management systems is critical to maintaining the viability of Title X-funded clinics in the changing health care landscape, and a portion of the increase will be used to help offset related costs.

An FY 2011 Title X Program Priority is to identify specific strategies for addressing the provisions of health care reform (Affordable Care Act), and for adapting delivery of family planning and reproductive health services to a changing health care environment, and assisting clients with navigating the changing health care system. The Office will support appropriate training and technical assistance for Title X providers on specific aspects of health care reform, and will provide up-to-date information on the role of Title X providers as essential community providers. In addition, to assist with addressing a range of issues as they relate to strengthening the infrastructure of the Title X Family Planning program and its role in health care reform, the Office of Family Planning (OFP) has initiated a contract with the Institute of Medicine (IOM) for a Standing Committee. Also, OFP has begun a series of webinars designed to inform grantees about a range of topics to prepare them for health care reform, including Health Information Technology (HIT), and other advances in technology as they relate to healthcare reform, quality improvement and improved health outcomes.

Item 34

Family Planning. - The Committee is aware of a 2009 Institute of Medicine [10M] report which found that the title X family planning program provides critically needed health services to individuals with the most difficulty accessing family planning care. The Committee supports the Office of Family Planning's efforts to review and update the title X program guidance and administrative directives in response to the 10M report. The Committee encourages the Office of Family Planning to consider additional ways to strengthen the program's infrastructure and service delivery needs. (Page 62)

Action Taken or To Be Taken

The Office of Family Planning (OFP) continues to implement recommendations that emerged from the independent evaluation completed by the Institute of Medicine (IOM) in August 2009. Currently the Program is contracting with the IOM to form a Standing Committee that will advise OFP on a range of scientific, workforce, health services and education issues relevant to family planning. Specifically, the Standing Committee will address the following topics: strategic planning for advancing the Title X program, workforce planning, improving data collection on program performance, and improving communication and transparency within the Title X program, all recommendations offered as part of the IOM independent evaluation. In addition, the committee will examine the role of family planning/reproductive health (including the Title X program) in health care reform. The Standing Committee process allows for the flexibility of being able to commission related studies and/or workshops, conducted by an ad hoc committee. All of these efforts will assist the office with strategically strengthening the program’s infrastructure, ultimately resulting in better addressing the service delivery needs for

millions of clients in need of primary preventive family planning health care services. The contract period for the IOM Standing Committee is expected to run from September 2010 – September 2012.

Item 35
Healthcare-related Facilities and Activities. - The Committee expects HRSA to use no more than 1 percent of the funds allocated for projects for agency administrative expenses. (Page 62)

Action Taken or To Be Taken
HRSA will fully cooperate to award Congressionally-mandated projects during the Fiscal year.

Health Education Assistance Loans Tab

Health Education Assistance Loans

Table of Contents

FY 2012 Budget

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) INTERDEPARTMENTAL COORDINATION OF TRANSFER.—The Secretary of Health and Human Services and the Secretary of Education shall carry out the transfer of the HEAL program described in subsection (a), including the transfer of the functions, assets, and liabilities specified in subsection (b), in the manner that they determine is most appropriate; and (d) 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. (e) 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) INTERDEPARTMENTAL COORDINATION OF TRANSFER.—The Secretary of Health and Human Services and the Secretary of Education shall carry out the transfer of the HEAL program described in subsection (a), including the transfer of the functions, assets, and liabilities specified in subsection (b), in the manner that they determine is most appropriate; and (d) 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. (e) CONFORMING AMENDMENTS.—Effective as of the date on which the transfer of the	Citation is added to explain the transfer of the program to the Department of Education.

LANGUAGE PROVISION	EXPLANATION
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.".	

Amounts Available for Obligation
Program and Financing Accounts

	FY 2010 Actual	FY 2011 Est.	[1]FY 2012 PB
Balance, start of year	$61,480,000	$48,565,000	-
Appropriation	2,847,000	2,847,000	-
Total Appropriation	2,847,000	2,847,000	-
Collections:			
Upward Re-estimate		26,492,000	-
Downward Re-estimate	-9,881,000		
Interest	2,748,000	2,826,000	
Repayments/Recoveries	5,569,000	3,511,000	
Total collections	-1,564,000	32,829,000	-
Borrowing Authority, Mandatory	784,000		
Total available	63,547,000	84,241,000	-
Claims:			
Death and disability	-981,000	-4,581,000	
Defaults	-11,124,000	-11,358,000	
Total claims	-12,105,000	-15,939,000	-
Principle Payments on Borrowing	-30,000		
Administrative BA	-2,847,000	-2,847,000	
Ending balance	$48,565,000	$65,455,000	

[1] Unobligated Balance Transferred to Other Accounts (91-4300) $65,455,000

Amounts Available for Obligation
Liquidating Account

	FY 2010 Actual	FY 2011 Est.	FY 2012 PB
Balance, start of year	---	---	---
Appropriation	$1,000,000	$1,000,000	-
Collections:			
Repayments/Recoveries	9,020,000	10,000,000	-
Total available	10,020,000	11,000,000	-
Total claims	-2,880,000	-3,000,000	-
Sweep-up to Treasury	$7,140,000	$8,000,000	-

Summary of Changes

Discretionary Appropriation:		
Increase:	**FTE**	**BA**
2010 HEALProgram Account	14	$2,847,000
2012 HEAL Program Account	-	-
Total Change	-14	-$2,847,000

Budget Authority by Activity

(Dollars in thousands)

	FY 2010 Actual	**FY 2011 CR**	**FY 2012 Request**
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

Object Class (42.0)	**FY 2010 Actual**	**FY 2012 Estimate**	**Increase or Decrease**
Investments and loans	$1,000,000	---	-$1,000,000

Budget Authority by Object
Program Account

	FY 2010 Actual	FY 2012 Request	Decrease
Full-time equivalent employment 1/	14	-	-
Average GS Grade	13.6	-	-
Average GS Salary	$103,800	-	-$103,800

1/ Includes 7 FTEs for the Office of HEAL Default Reduction.

Personnel compensation:	FY 2010 Actual	FY 2012 Request	Decrease
Full-time permanent (11.1)	$ 1,286,000		-1,286,000
Other than full-time perm (11.3)	76,000		-76,000
Other personnel comp (11.5).	35,000		-35,000
Total personnel comp (11.9)	**$ 1,397,000**	-	**-$1,397,000**
Personnel benefits (12.1)	308,000		-308,000
Benefits for Former Personnel(13.1)	-		-
Subtotal Pay Costs.	**$ 1,705,000**	-	**-$1,705,000**
Travel and transportation of Persons (21.0)	1,000		-1,000
Transportation of things (22.0)	1,000		-1,000
Rental payments to GSA (23.1)	34,000		-34,000
Printing (24.0)	-		-
Other Contractual Services:			
Other services (25.2)	21,000		-21,000
Purchase of goods and services from other Government accounts (25.3)	675,000		-675,000
Operation and Maintenance of Equipment (25.7)	395,000		-395,000
Discounts and Interest (25.9)	6,000		-6,000
Supplies and Materials (26.0)	9,000		-9,000
Subtotal Other Contractual Services	**$1,142,000**		**-$1,142,000**
Equipment (31.0)			-
Total Budget Authority by Object Class.	**$2,847,000**	-	**-$2,847,000**

Salaries and Expenses

Personnel compensation:	FY 2010 Actual	FY 2012 Request	Increase or Decrease
Full-time permanent (11.1)	$ 1,286,000.00		-1,286,000
Other than full-time perm (11.3)	76,000		-76,000
Other personnel comp (11.5).	35,000		-35,000
Total personnel comp (11.9)	**$1,397,000**	**-**	**-$1,397,000**
Personnel benefits (12.1)	308,000		-308,000
Benefits for Former Personnel(13.1)	-		-
Subtotal Pay Costs.	**$1,705,000**	**-**	**-$1,705,000**
			-
Travel and transportation of persons (21.0)	1,000		-1,000
Transportation of things (22.0)	1,000		-1,000
Printing (24.0)	-		-
			-
Other Contractual Services:			-
Other services (25.2)	21,000		-21,000
Purchase of goods and services from			-
other Government accounts (25.3)	675,000		-675,000
Operation and Maintenance of Equipment (25.7)	395,000		-395,000
Discounts and Interest (25.9)	6,000		-6,000
Supplies and Materials (26.0)	9,000		-9,000
Subtotal Other Contractual Services	891,000	-	-891,000
			-
Subtotal Non-Pay Cost	**$1,108,000**	**-**	**-$1,108,000**
			-
Total Salaries and Expenses	**$2,813,000**	**-**	**-$2,813,000**

Authorizing Legislation

	FY 2010 Amount Authorized	FY 2010 Actual	FY 2012 Amount Authorized	FY 2012 PB
Health Education Assistance Loans and Student Loan Insurance Account:				
Appropriation:				
Liquidating Account (SLIA):				
PHS Act, Sec. 710	---[1]	1,000,000	---[1]	---
Program Account:				
PHS Act, Secs. 709, 720	SSAN [2]	2,847,000	---	---
Borrowing authority (SLIA):				
PHS Act, Sec 710(b)	---[3]	---	---[3]	---

[1] 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."

[2] Such Sums as Necessary

[3] 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
HEAL Program Account

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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	2,847,000			2,847,000
2012	---			

* Continuing Resolution

APPROPRIATION HISTORY
SLIA Liquidating Account

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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	1,000,000			1,000,000
2012	----			

*Continuing Resolution

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[145]

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
Liquidating Account	$1,000,000	$1,000,000	---	-$1,000,000
HEAL Credit Reform-Direct Operations	$2,847,000	$2,847,000	---	-$2,847,000
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: The Health Education Assistance Loan (HEAL) Program insures loans made by participating lenders to eligible graduate students.

Need: The HEAL Program continues to maintain oversight for an outstanding loan portfolio valued at $730 million.

Goal: Maintain oversight for an outstanding loan portfolio, some of which may not be fully repaid until 2037.

Eligible Entity: Designated health professions students. The program stopped awarding loans in 1999.

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Allopathic Medicine • Osteopathic Medicine • Dentistry • Veterinary Medicine Optometry • Podiatry • Public Health • Pharmacy • Health Administration • Clinical Psychology • Chiropractic Medicine	• Graduate	• Monitor loan payback and pursue defaulters • Maintain and publish list of defaulted borrowers • Process lender claims and borrower requests for forbearance and disability and default reduction activities • Provide technical assistance to States regarding licensing sanctions

[145] The FY 2012 President's Budget transfers the functions, assets and liabilities to the Department of Education.

Program Accomplishments: Between 1978 and 1998 the program provided $4 billion in loans to help 157,000 students of diverse socio-economic backgrounds pay for their health professions education. Approximately $7.2 billion of HEAL loans were refinanced. Authority to make new loans expired September 30, 1998 and refinancing ended September 30, 2004. The HEAL Program continues to maintain oversight for an outstanding loan portfolio, some of which may not be fully repaid until 2037.

The HEAL Program maintains, and updates quarterly, a list of defaulted HEAL borrowers on the internet. This site includes approximately 1000 health professionals who owe the Federal Government approximately $123 million on their defaulted HEAL loans as of November 2010. Millions of dollars have been received from defaulters as a result of the activities associated with publicizing their names.

The HEAL Program is currently phasing out an outstanding loan portfolio of approximately $730 million as of September 30, 2010. The Program is scheduled to move to the Department of Education in FY 2011.

Funding History

FY	Amount	Liquidating Account
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
2011	$2,847,000 CR	$1,000,000

Budget Request

There is no FY 2012 Discretionary Request for this program. The functions, assets, and liabilities relating to this program will be transferred to the Department of Education The Department of Education's large infrastructure allows for greater efficiencies due to economies of scale in administering educational loan programs.

Outcomes and Outputs Tables
Discontinued Measures

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- 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 2010: $730(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 2010: 2 days (Target Exceeded)	8 days	N/A	---

Vaccine Injury Compensation Program

TAB

Table of Contents

FY 2012 Budget Page

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 Appropriations Act, 2010.)

Amounts Available for Obligation

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Pres. Budget
Unobligated Balance, Start of Year	$1,000,000	$70,906,900	$129,906,900
Receipts	218,000,000	228,000,000	237,000,000
Interest Income	64,000,000	71,000,000	97,000,000
Total, Receipts/Collections	$282,000,000	$299,000,000	$334,000,000
Total Balance/Net Collections	**$283,000,000**	**$369,906,900**	**$463,906,900**
Claims Appropriation (Obligation)	$193,906,900	220,000,000	235,000,000
Admin/HRSA	7,000,000	7,000,000	7,000,000
Total Admin.DOJ/Claims Ct	13,000,000	13,000,000	13,000,000
Total New Obligations	$213,906,900	$240,000,000	$255,000,000
Unobligated Balance, End of Year	$70,906,900	$129,906,900	$208,906,900

Budget Authority by Activity

	FY 2010 Appropriation	FY 2011 Continuing Resolution	FY 2012 Pres. Budget
Trust Fund Obligations: Post-10/1/88 claims	$193,906,900	$220,000,000	$235,000,000
Administrative Expenses: HRSA Direct Operations	$6,502,000	$6,502,000	$6,502,000
Total Obligations	$199,502,000	$226,502,000	$241,502,000

Budget Authority by Object

	FY 2010 Appropriation	FY 2012 Pres. Budget	Increase or Decrease
Insurance claims and indemnities	$193,906,900	$235,000,000	$42,000,000
Other Services (25.2)	$6,502,000	$6,502,000	_
Total	$199,502,000	$241,502,000	$42,000,000

	FY 2010 Omnibus	FY 2012 Pres. Budget	Increase or Decrease
Other Services (25.2)	$6,502,000	$6,502,000	_

Authorizing Legislation

	FY 2011 Amount Authorized	FY 2011 Continuing Resolution	FY 2012 Amount Authorized	FY 2012 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	$220,000,000	Indefinite	$235,000,000
(b) Sec. 6601 (r)d ORBA of 1989 (P.L. 101-239):				
HRSA Operations	Indefinite	6,502,000	Indefinite	6,502,000

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	---	---	---	---
2011	----	----	---	----
2012	---	---	---	---

Vaccine Injury Compensation Program

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012+/- FY 2010
Claims BA	$193,906,900	$220,000,000	$235,000,000	+$41,093,100
Admin BA	$6,502,000	$6,502,000	$6,502,000	---
Total BA	$200,408,900	$226,502,000	$241,502,000	+$41,093,100
FTE	20	23	23	+3

Authorizing Legislation – Title XXI, Subtitle 2, Parts A and D, of the Public Health Service Act as amended, and related legislation.

FY 2012 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;
--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 December 2010, over 2,500 families and individuals have been awarded compensation totaling over $2 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. Over 400 claims were filed in FY 2010 (versus an average of 161 non-autism claims filed annually over the preceding five years) and over 170 families and individuals have been awarded compensation totaling over $180 million, which is approximately $80 million more than previous years. Through the first three months of FY 2011, over 90 claims have been filed and over 20 families and individuals have been awarded compensation totaling over $40 million.

In spring 2011, the Institute of Medicine (IOM) will release its third consensus report on the epidemiological, clinical, and biological evidence surrounding adverse events associated with vaccines covered by the VICP. The vaccines are varicella zoster, influenza, hepatitis B, human papillomavirus, measles-mumps-rubella, hepatitis A, meningococcal, and tetanus-containing vaccines such as diphtheria and tetanus toxoids and-acellular pertussis vaccines. Two previous IOM reports published in 1991 and 1994 led to the Secretary adding injuries/conditions to the Vaccine Injury Table. The Table provides petitioners with a presumption of vaccine causation (and entitlement to compensation), if certain legal requirements are met. Since the last set of IOM report-related Table modifications in 1997, nine vaccines have been added to VICP, but there has been no independent examination of the adverse events associated with the use of these vaccines. As mandated under the Act, the Secretary must consult with the ACCV and seek public comment before any modifications to the Table are made.

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. In FY 2007, the VICP did not meet its target of 1,213 days for the average time to process claims due to petitioner and Court-driven delays in adjudicating claims. For this period, the performance outcome was 1,337 days. However, the VICP average time to process claims was less than its target for FY 2006, FY 2008, FY 2009, and FY 2010. The FY 2012 target is 1,300 days. The VICP has consistently 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 2009, the Rule 4(b) report deadline was met for 94 percent of the cases that were deemed complete which is slightly less than in FY 2008. Quickly and efficiently processing settlements is a top priority for the VICP. In FY 2009, the percentage of cases in which settlements were processed within 15 weeks was 100 percent which surpassed the target of 92 percent. The FY 2012 Rule 4(b) target is 86 percent.

In FY 2009, the VICP was successful in reducing the average time to approve settlements and to pay lump sum only awards. The FY 2009 target for the former was 10 days, which was exceeded with a FY 2009 actual result of 7.5 days. As a result of exceeding this target measure over the past three fiscal years, the Program thought that they could decrease the target. Unfortunately, the FY 2010 target was 8 days, which was not met with a FY 2010 actual result of 8.7 days. During FY 2010, the VICP received more than double the average number of claims and negotiated settlements over the last three fiscal years and this level of claims is expected to be maintained through FY 2012. The VICP is unable to reduce the targeted average below 10

days because of the need for HHS Office of General Counsel (OGC) to review the DOJ settlement proposal and prepare a legal opinion to the VICP. Consultation with DOJ attorneys to clarify or amend elements in the settlement proposal is often required. Performance outcome data are reported to OGC, HRSA, and the Healthcare Systems Bureau management, on a regular basis. The FY 2012 target is 10 days.

Funding History

VICP Awards

FY	Amount
FY 2007	$98,081,069
FY 2008	$90,402,646
FY 2009	$89,706,702
FY 2010	$193,906,900
FY 2011 CR	$220,000,000

Budget Request

The FY 2012 Budget Request of $241,502,000 is an increase of $41,093,100 above the FY 2010 Actual Level. This includes $6,502,000 for the expert witness program and other administrative expenses.

The FY 2012 Budget 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 (CDC) for routine administration to children. In FY 2012, HRSA estimates that $235,000,000 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 processing of claims ordered by the Court that require medical reviews of increasing numbers of non-autism claims filed annually, medical reviews for jurisdictional purposes for certain autism claims, and compensation for injuries and attorneys' fees and costs. The significant increase in non-autism claims is primarily the result of the addition of the influenza vaccine to the VICP, which accounts for more than 50 percent of claims filed 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 ten days for the average time that settlements are approved from the date of the DOJ settlement proposal.

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 to adjudicate the thousands of claims that were expected. As of December 2010, over 5,600 cases have been filed, and over 4,800 pending cases are pending. Some Petitioners have withdrawn, as is the Petitioners' 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.

Omnibus hearings on entitlement to compensation for two theories of causation were held in 2007 and 2008. Three test cases were utilized for each theory and three special masters issued opinions on general causation, and causation in one of the three test cases for each theory. Theory 1 hearings looked at whether MMR vaccine, administered alone or in conjunction with thimerosal-containing vaccines, can cause autism or autism spectrum disorders, while the Theory 2 hearings determined whether thimerosol-containing vaccines can cause autism or autism spectrum disorders. Decisions in the six test cases in favor of respondent were handed down by the U.S. Court of Federal Claims in 2009 and 2010. Appeals of the Theory 1 test cases were decided in favor of respondent, first by judges of the U.S. Court of Federal Claims, and then by three-judge panels of the U.S. Court of Appeals for the Federal Circuit. Petitioners chose not to appeal the Theory 2 test case decisions.

Until the first autism hearing in 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. However, with the test case proceedings concluded and the significant drop-off in autism claim filings, Court-ordered medical reviews have essentially stopped. In January 2008, the Court also began ordering jurisdictional reviews in 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. In some cases, HRSA medical review has also been necessary.

Although test case proceedings have ended, the disposition of thousands of autism claims pending remains uncertain. In 2010, the Court began issuing orders to determine which petitioners want to pursue other theories of causation. Such claims will be tried on an individual basis and will require HRSA medical reviews and may require the use of medical experts for hearings. This will be an additional expense for the medical expert program. Efforts are also underway by the Court to resolve the fees and costs issues in those claims that have been dismissed, which eventually could number in the thousands. How many of these claims will require procedural and medical review to determine if they were timely filed is also uncertain.

This funding will also provide HRSA the opportunity to better publicize the VICP. HRSA will be exhibiting at medical and legal conferences in FY 2012. 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 addition, HRSA has been criticized for not adequately promoting public awareness of the VICP. With this funding, HRSA 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

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- 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 2009: 0% (Target Met)	0%	0%	Maintain
26.II.A.2: Average claim processing time. *(Outcome)*	FY 2010: 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 2009: 94% (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 2010: 8.7 days (Target Not Met)	8 days	10 days	+2
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 2010: 2.4 days (Target Exceeded)	3 days	5 days	+2
26.E: Percentage of cases in which case settlements are completed within 15 weeks. *(Efficiency)*	FY 2009: 100% (Target Exceeded)	92%	92%	Maintain
Program Level Funding ($ in millions)	N/A	$193.907	$235.000	+$41.093

Preparedness Countermeasures Injury Compensation Program

TAB

Countermeasures Injury Compensation Program

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 both broad liability protection and also compensation for serious injuries caused by covered countermeasures designated for actual or potential public health emergencies from a pandemic or security threat. 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 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 compensation for serious injuries, and is different from, and not dependent on, other emergency declarations. Furthermore, the declaration specifies the period during which liability protections and compensation are in effect, the population of individuals protected, and the geographic areas for which the protections are in effect. The Countermeasures Injury Compensation Program (CICP) administers and manages the compensation provisions of the PREP Act.

As of January 2011, the Secretary has published declarations with respect to the following pandemic influenza countermeasures: (1) pandemic influenza vaccines (including, but not limited to the 2009 pandemic H1N1 influenza vaccine); (2) pandemic antiviral countermeasures (including Tamiflu®, Relenza® and peramivir); and (3) pandemic influenza diagnostics, personal respiratory devices (such as N 95 filter face masks), and respiratory support devices (such as mechanical ventilators). In addition, the Secretary has published declarations with respect to the following security countermeasures: (1) anthrax countermeasures; (2) botulism countermeasures; (3) smallpox countermeasures; and (4) acute radiation syndrome countermeasures.

The PREP Act establishes the provision of benefits to individuals seriously injured by countermeasures covered under declarations issued by the Secretary.
The Secretary delegated to Health Resources and Services Administration the authority to administer the Program on November 8, 2006. The CICP Program began operations in FY 2009. It hired staff, developed and published the administrative regulations, began development of the regulations for the Influenza A Countermeasure Injury Tables for each of the covered countermeasures, and implemented essential database and outreach contracts.

The CICP Program also provided information sessions for the vaccine community and other Departments, including the Department of Defense and the Veterans Administration. In addition, the Program provided information to the public through the inclusion of Program information in Vaccine Information Statements given to most individuals who receive covered

vaccinations and the inclusion of language about the Program in the letter the Food and Drug Administration sends to people who report an adverse event after a vaccination. In FY 2009, the Program developed and posted a website and updates it regularly to disseminate accurate, up-to-date information on the CICP Program.

Eligible individuals may be compensated for reasonable out-of-pocket medical expenses and lost employment income at the time of the injury. Death benefits may be paid to certain survivors of covered countermeasures recipients who have died as a direct result of the covered countermeasure injury

In the October 15, 2010 Federal Register, the administrative regulations governing the Program were published. As of February 7th, 2011, about 430 filings requesting benefits have been submitted to the CICP from individuals who received the pandemic 2009 H1N1vaccine, antiviral drugs to treat and prevent pandemic influenza, respiratory assistance devices to treat pandemic influenza, anthrax vaccine, and smallpox vaccine.

P.L. 111-32 provided permissible authority to transfer funds appropriated in that Act from the Public Health and Social Services Emergency (PHSSEF) Fund to HRSA's Countermeasure Injury Compensation Fund ("the fund authorized by section 319F-4 of the Public Health Service Act", or Fund"). In FY 2011, $3.5 million is being transferred to the Fund for administrative costs. In FY 2012, PHSSEF will transfer sufficient funds for administrative and compensation costs, currently estimated at $5 million. While almost all pending claims are related to pandemic influenza countermeasures, the PHSSEF transfer authority provided allows these funds to be used for any authorized cost of the Funds, including those related to non-influenza countermeasures.