Office of Rural Health Policy
2009 Annual Report

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Health Resources and Services Administration
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ORHP Overview

The Office of Rural Health Policy (ORHP) coordinates activities related to rural health care within the U.S. Department of Health and Human Services (DHHS). Part of the Health Resources and Services Administration (HRSA), ORHP has department-wide responsibility for analyzing effects of DHHS policy on 62 million residents of rural communities. Created by Section 711 of the Social Security Act, ORHP advises the Secretary on health issues within these communities, including the effects of Medicare and Medicaid on rural citizens' access to care, the viability of rural hospitals, and the availability of physicians and other health professionals.

In FY 2009, ORHP also administered 16 grant programs designed to build health care capacity at both the local and State levels.

These grants provide funds to 50 State Offices of Rural Health (SORH) to support on-going improvements in care, and to rural hospitals through the Medicare Rural Hospital Flexibility Grant (Flex).

Through its community-based programs, ORHP encourages network development among rural health care providers and upgrades in emergency medical services, as well as places and trains people in the use of automatic external defibrillators. ORHP also oversees the Black Lung Clinics grant program and the Radiation Exposure Screening and Education grant program. While these efforts are not solely focused on rural health issues, many of the populations affected reside in rural areas.

Finally, ORHP coordinates Agency-wide enterprises: HRSA's border health initiative concentrates on improving care in the largely rural, 2,100-mile-long, boundary lands between the U.S. and Mexico. The program includes urban centers in this zone, as they face challenges similar to rural areas, such as fragile infrastructure and difficulty attracting and retaining an adequate healthcare workforce.

Authorizing Legislation

Office of Rural Health Policy
Section 711 of the Social Security Act

Black Lung
Section 427(a), Public Law 91-173 of the Federal Coal Mine Health and Safety Act of 1977 as amended by section 5(6), Public Law 92-303 of the Black Lung Benefits Act of 1972 and amended by section 9, Public Law 95-239 of the Black Lung Benefits Reform Act of 1977.

Delta Health Initiative Grant Program
Section 1820(j) of the Social Security Act 42 U.S.C. 1395

Delta States Rural Development Network Grant Program
Section 330A of the Public Health Service Act 42 U.S.C. 254c

Frontier Extended Stay Clinics Demonstration
Section 301 and 330A of the Public Health Service Act 42 U.S.C. 241 and 254c.

Medicare Rural Hospital Flexibility Grant Program
Section 1820(j) of the Social Security Act 42 U.S.C. 1395

Network Development Grant Program
Section 330A of the Public Health Service Act 42 U.S.C. 254c

Network Development Planning Grant Program
Section 330A of the Public Health Service Act 42 U.S.C. 254c

Public Access to Defibrillation Demonstration Projects
Section 313 of the Public Health Service Act 42 U.S.C. 245 as amended by section 159(c), P.L. 107-188 of the Public Heath Security and Bioterrorism Preparedness and Response Act of 2002.

Radiation Exposure, Screening and Education Program
Section 417C of the Public Health Service Act as amended by section 4, Public Law 106-245 of the Radiation Exposure Compensation Act Amendments of 2000.

Rural Access to Emergency Devices Grant Program
P.L. 106-505, Title IV – Cardiac Arrest Survival Act, Subtitle B, section 413 of the Public Health Improvement Act 42 U.S.C. 254c.

Rural Health Outreach Grant Program
Section 330A of the Public Health Service Act 42 U.S.C.

Rural Health Research Centers Program
Section 711 of the Social Security Act 42 U.S.C. 912

Small Health Care Provider Quality Improvement Grant Program
Section 330A of the Public Health Service Act 42 U.S.C. 254c

Small Rural Hospital Improvement Grant Program
Section 1820(g)(3) of the Social Security Act 42 U.S.C. as amended by section 4201(a), P.L. 105-33 of the Balanced Budget Act and section 405(f), P.L. 108-173 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

State Offices of Rural Health Grant Program
Section 338J of the Public Health Service Act 42 U.S.C. 254r as amended by section 301, P.L. 105-392.

Targeted Rural Health Services Research Program
Section 711 of the Social Security Act 42 U.S.C. 912

ORHP Budget

Chart 1 – Budget Summary for Programs, FY 2008 and FY 2009 *(amounts in thousands)*

Rural Health Programs	FY 2008 Final Appropriation	FY 2009 Final Appropriation
Rural Health Outreach	48,031	53,900
Rural Health Research and Policy	8,584	9,700
Medicare Rural Hospital Flexibility	37,865	39,200
Rural and Community Access to Emergency Devices	1,461	1,751
Delta Health Initiative	24,563	26,000
State Offices of Rural Health	7,999	9,201
Denali Commission	38,597	19,642
Radiation, Screening, Exposure and Education Program	1, 884	1,952
Black Lung	5,788	7,200
CAH & SNF Federal Hospital Insurance Trust Funds	942,123	0
Total	**$ 175,713**	**168,546**

Note: Individual line items may include funding for more than one grant program. For example, the Rural Health Outreach line item includes funding for the Rural Health Care Services Outreach, Rural Network Development, Network Planning, Small Health Care Provider Quality Improvement, Frontier Extended Stay, and Delta Network grant programs. The Medicare Rural Hospital Flexibility Grant line includes funding for the Flex, Small Hospital Improvement, and Delta Health Initiative grant programs. The policy line item includes funding for the Rural Health Research Center grant program, as well as all of the Office's policy activities. Also, the Flex Line for FY 2007 includes $25 million above the base to fund the Critical Access Hospital Health Information Technology Network Grant Program.

Chart 2 – Total number of ORHP Grants and Amounts by State, FY 2009

Total number of Grants awarded: 465
Total amount Funding provided: $127,139,

State	# Grants Awarded	FY 2009 Funding
AK	9	1,845,190
AL	14	2,528,071
AR	13	2,603,413
AZ	8	1,484,999
CA	17	2,623,594
CO	8	2,009,216
CT	2	259,200
DE	3	417,200
FL	10	1,801,515
GA	12	2,428,814
HI	6	1,048,719
IA	8	2,026,853
ID	4	1,091,024
IL	10	3,409,175
IN	10	1,978,655
KS	8	2,170,017
KY	19	3,922,683

State	# Grants Awarded	FY 2009 Funding
LA	9	2,436,026
MA	4	628,418
MD	11	1,428,497
ME	12	2,339,069
MI	14	2,360,800
MN	10	3,010,817
MO	13	2,767,510
MS	8	27,632,643
MT	15	4,738,865
NC	11	2,420,030
ND	12	2,521,071
NE	11	3,014,308
NH	9	1,531,252
NJ	1	167,200
NM	9	1,778,668
NV	4	970,856
NY	11	1,739,207

State	# Grants Awarded	FY 2009 Funding
OH	12	2,797,349
OK	6	1,624,650
OR	10	1,883,766
PA	11	2,148,100
RI	1	150,000
SC	11	2,208,200
SD	10	1,828,725
TN	10	2,369,726
TX	11	3,185,014
UT	5	1,143,567
VA	12	2,275,405
VT	8	1,268,143
WA	12	3,245,577
WI	8	1,908,438
WV	7	2,595,430
WY	5	1,229,121
Puerto Rico	1	144,362

Policy Activities

Key Regulatory Review and Policy Activities

ORHP advises the Secretary on the effects of current policies and proposed statutory, regulatory, administrative, and budgetary changes on rural communities. Because many of the policy levers at the Federal level are related to the Medicare program, review and analysis of prospective changes to Medicare comprise much of the ORHP's policy work. Significant time and attention also are devoted to other policy areas, including Medicaid, the State Children's Health Insurance Program (CHIP), workforce, quality, and health information technology (HIT).

Rural Medicare Payment

During Fiscal Year 2009, the policy staff in ORHP reviewed approximately 185 drafts of Federal regulations and policies to determine how they might affect rural providers and the individuals they serve. Of these regulations, 22 included provisions ORHP staff determined had the potential to adversely affect rural providers or for which staff believed additional language should be added to provide adequate protections. ORHP often identifies issues of particular concern to rural communities during its review of the Medicare payment system regulations.

Rural Health Care Quality

CAHs continued to increase their participation in reporting quality measures to the CMS Hospital Compare. For 2008 discharges, 70 percent of CAHs publicly submitted data for at least one measure. Submission rates vary by State and by CAHs organizational characteristics. By state, the percentage of participating CAHs ranged from 7.7 to 100 percent. In nine states, all CAHs were participating. CAHs were more likely to report data on pneumonia and heart failure measures than on Acute Myocardial Infarction (AMI), and surgical infection prevention measures. Participation in the program is significant since CAHs submit data on a *voluntary* basis and do not receive any payment update; unlike hospitals paid under the Medicare Inpatient Prospective Payment System (IPPS) who are required to participate in order to receive a full payment update.

In 2009 ORHP contributed funds to the HRSA Patient Safety and Clinical Pharmacy Services Collaborative (PSPC) for a second PSPC Collaborative session that began in September, 2009. Seven additional rural teams joined four rural teams who continued in the PSPC 2.0. The aim of the PSPC collaborative is to eliminate adverse drug events and improve patient outcomes. There are 109 active teams participating representing 350 organizations in 39 States and the District of Columbia and Puerto Rico.

National Advisory Committee on Rural Health and Human Services (NACRHHS)

ORHP serves as primary staff for the National Advisory Committee on Rural Health and Human Services, with assistance from the U.S. Department of Health and Human Services Administration on Aging. NACRHHS is a 21-member citizens' panel of nationally recognized rural health experts that provide recommendations on selected issues in an annual report to the Secretary.

The 2009 Report was released in July and covers the following topics:

- The Medical Home Model: Viability for Rural Communities
- Treating "At Risk" Children in Rural Areas
- Workforce and Community Development

The 2010 Report topics include:

- Health Care Provider Integration
- Home and Community Based Care for Rural Seniors
- Rural Primary Care Provider Workforce

Policy Related Projects and Partnerships

One of the unique aspects of the Office of Rural Health Policy is its entrepreneurial nature. Since its inception, ORHP has put an emphasis on working with public and private organizations to develop projects that address the long-standing problems in rural health. These "special projects" either highlight an issue, sustain development of services or resources to fill an identified need.

These projects typically focus on the interests of all rural communities, such as the need for general information and technical assistance. Others may pertain to a specific issue, such as the recruitment and retention of clinicians or the importance of economic development to health care. Still, other activities focus on particular types of health care providers and settings. In each case, however, the projects and initiatives meet an identified need in rural health care.

• **340B Drug Pricing Technical Assistance Program –** As a result of a 2003 change in the Medicare Modernization Act of 2003, approximately 350 Rural Disproportionate Share Hospitals (DSH) became eligible to participate in the 340B Drug Pricing Program. Each year ORHP provides supplemental funding to the HRSA Office of Pharmacy Affairs to assist the HRSA Pharmacy Services Support Center (PSSC) in providing technical assistance to rural DSH in securing 340B discount drug purchasing. Established in 2002, the aim of PSSC is to expand pharmacy services in eligible safety net health care providers. The Center operates under a contract between HRSA and the American Pharmacists Association (APhA). To date, it has helped almost 200 rural DSH enroll in the 340B program.

Observing that 75% of the eligible but non-participating rural DSH are in five states in the southeast, including: Alabama, Arizona, Mississippi, Kentucky, and Louisiana; plus Texas and Oklahoma, ORHP targeted these states by holding a one day free workshop to educate them on the 340B program and assist them in enrolling in the program. Over 50 people from eligible hospitals and state organizations (State Office of Rural Health and State Hospital Associations) attended. PSSC consultants were there to assist the hospitals and provided follow up contact information for further technical assistance.

• **Flex Monitoring Team –** The Flex Monitoring Team (FMT) is a consortium of three rural health research centers: Southern Maine University, University of Minnesota, and University of North Carolina Sheps Center, whose purpose is to monitor and evaluate the Flex Grant Program and to make recommendations for improving the program. Since its inception in 1997, an important body of knowledge has been produced about rural health care, rural hospital financial issues, network development, EMS, quality improvement, and community impact.

As the program has matured, the monitoring and evaluation process has focused less on the process of converting hospitals to critical access status and more on development of rural organized systems of care, financial performance, impact on access to and quality of care, disease management, community role, and impact on health status of rural populations served by these emerging systems. Improving clinical, financial and leadership performance of rural healthcare organizations, access to capital and progress in acquisition and use of technology will be important future areas of evaluation.

In 2009, the FMT continued to track hospital participation on CMS Hospital Compare, Health Information Technology (HIT) adoption rates in CAHs, and CAH performance improvement for 20 financial indicators. Upcoming projects include HIT "meaningful use" adoption in CAHs, Changes in Obstetrical Services in CAHs and Trends in Hospital Ownership of Skilled Nursing Facilities. The Flex Monitoring Team regularly makes presentations on their work at national conferences as well as publishes in peer reviewed journals. The FMT is also a valuable resource to ORHP regarding the Flex program and other rural hospital issues.

• **CAH Replacement Manual –** ORHP developed and has in publication a "Roadmap and Manual for CAH Replacement," containing step-by-step guidance, simple tools and successful strategies for obtaining capital and building new facilities. Some CAHs are considering replacing their facilities, many of which were built in the 1950s. These projects have proven to increase admissions and outpatient visits; as well as improving staff recruitment and clinical performance, and boosting local economies. But hospital CEOs and Boards in rural communities typically encounter serious technical hurdles. Few local lenders (public or private), architects or builders have the requisite experience with hospital projects. The manual will be available and distributed in 2010.

• **National Technical Assistance to Rural Communities –** In 2009, ORHP joined with the National Rural Health Association (NRHA) to identify and promote useful administrative and clinical practices for rural providers, advance health quality initiatives, and increase leadership and skills development training. Through teleconference and Webinar series, this initiative extends continuing education to providers in remote communities, while affording ongoing technical assistance to entities like the State Offices of Rural Health (SORHs) and State Rural Health Associations (SRHAs).

- Technical assistance was provided to the following states: Indiana, Colorado, California, Tennessee, Mississippi, Oklahoma, West Virginia, Florida, and Virginia. Activities included website redesign, fundraising, marketing, grant writing, membership recruitment, communications and strategic planning. States completed an application process for this technical assistance and funds were awarded on a first-come, first-serve basis. A record number of states applied for this assistance, however, the review committee could only approve the 9 proposals listed above based on the projects submitted.

Monthly conference calls were held to provide updated information related to technical assistance, membership, regulations and each SRHA provided an update on their activities in an effort to share information with their peers. NRHA staff members also provided onsite technical assistance to states. Specifically, strategic planning technical assistance was provided for SRHAs in Alabama, Oklahoma, Kentucky, and Oregon. NRHA also provided technical assistance for New York, Nebraska, Arizona and Minnesota. The technical assistance included strategic planning, assistance with membership issues (i.e. recruitment and retention), and role clarification of SRHAs at the national level.

• **Rapid Response to Requests for Rural Data Analysis --** In 2009, ORHP funded the Rapid Response to Requests for Rural Data Analysis to support quick turnaround requests for rural data analysis to assist with policy making. Due to the nature of rural policy analysis and formulation, policymakers often require information that is available only through specialized analysis of databases of information. In order to acquire the information from the data sets needed to identify trends, problems and progress in rural health care financing and access to care in rural areas, ORHP funds a consortium of research institutions that have access to the required data storage capacity, personnel, and computer resources to provide the information. Topics analyzed for policy makers in 2009 include the experience of rural independent pharmacies with Medicare Part D, Medicare Advantage & Part D Rural Medicare beneficiary enrollment, and rural implications of health care reform.

• **Rural Assistance Center –** Based at the University of North Dakota School of Medicine and Health Sciences, the ORHP-funded Rural Assistance Center (RAC) helps rural residents navigate a wide range of health policy and social services information online. RAC assists individual communities and providers in identifying potential funding streams that best meet their needs. Staff researchers also provide no-cost, customized assistance, performing database searches; referring users to qualified experts and organizations; furnishing publications; and posting a wide variety of timely information on the Internet (regulatory updates, conference announcements, bibliographies, directories, and full-text documents). The Center also acts as a repository and retrieval portal for information and research from a myriad of Federal, State, and private sources, and makes that information actionable for rural stakeholders. In 2009, RAC responded to over 910 individual requests for assistance.

The RAC Web site is the most comprehensive source of reliable information on rural health and human services on the Internet. To ensure timely and widespread distribution to often-remote communities, the Center maintains an electronic mailing list that reaches a broad audience across the breadth of rural America. The RAC site averages over 77,000 visits per month, while its electronic updates have over 13,000 combined subscribers.

• **Rural Health and Economic Development --** The health sector usually is one of the top employers in a rural economy, a role and relationship that often is not fully understood. The National Center for Rural Health Works is an ongoing program that provides technical assistance, tools and training to help States and communities substantiate the broader economic impact of the health care sector as a spur for further investment. Rural Health Works also develops profitability studies to help policymakers illustrate the economic benefits of new or expanded services in existing facilities.

During FY 2009, Rural Health Works conducted regional workshops in Wyoming and Maine; responded to more than 250 requests for technical assistance; and updated their Web site to keep current with the latest research in this area. A feasibility study was published that quantifies the costs and revenues for a rural physician practice. A new economic impact study nearing completion will quantify the costs and revenues for general surgery in rural Critical Access Hospitals. Rural Health Works completed an economic impact of Hawaiian Critical Access Hospitals on a Community, County, and State level.

Rural Health Works sends representatives to conferences nationwide to actively promote the tools and applications it has developed over the past 10 years. Rural Health Works is planning two regional training sessions in 2010 where they will hold workshops on how to conduct economic impact studies as well as how to undertake community health engagement process and health feasibility studies.

Rural Health Works joined with the National Association of Counties (NACo) in an outreach campaign to elected county officials interested in launching community engagement projects to help rural communities recognize that improving their health care systems boosts local economic growth generally. A new initiative in FY 2005, it continued through FY 2009 with on-site technical assistance to three rural counties. The partnership between the Center and NACo will evolve to include two webcasts for NACo members and continued technical assistance. For each, the project has produced a county-level report covering such topics as economic impact, community need, and a health services directory. All are posted on the NACo Web site and were featured in NACo workshops at the Western Regional and Annual Conferences, as well as in articles for NACo's publication "County News."

• **Rural Health Clinic Technical Assistance --** More than 3,000 Rural Health Clinics (RHCs) nationwide receive technical assistance funded by ORHP. As safety-net providers, these clinics are critical in maintaining access to care for underserved rural populations. RHCs face unique operational and administrative challenges however, which often require real-time technical assistance. ORHP provides this support through conference calls, as well as frequent updates through a listserv, free of charge. The RHC Web site posts written transcripts, speaker presentations, and audio transcripts of each call as a ready-reference for clinicians and administrators.

In FY 2009, the RHC technical assistance conference call series provided five calls, with topics determined by an advisory group of national experts versed in the most pressing concerns of rural providers. Discussions included: RHC billing issues; RHC clinician recruitment strategies; Medicare Administrative Contractors' (MAC) transitions; Electronic Health Record incentives; and depression & mental health screening for adolescents ("Teen Screen"). An average of 300 providers nationwide dialed in for each session, saving RHCs about $900 per conference call compared to the cost of sending staff to similar training/conferences off-site. In the aggregate, this savings amounted to over $270,000 per session, thereby substantially extending local patient care budgets. Average call participation in FY2009 increased by approximately 5% in comparison to FY2008.

• **Rural Health Research Center Gateway** -- The Rural Health Research Gateway (Research Gateway) Web site was developed to speed the dissemination of information and publications of the ORHP-funded Rural Health Research Centers, including contact information for subject-area experts; summaries of research projects, both those underway and completed; full text versions of Policy Briefs, Analytic Reports, Fact Sheets, and other products of the Research Centers. In 2009, the Gateway continued a *Research Alert* feature to notify listserv members about the availability of recently released reports. The Gateway includes all projects and their related publications dating from 2006. Earlier publications are being added as resources permit.

• **Rural Hospital Performance Improvement Project (RHPI) –** ORHP provides ongoing technical assistance to historically distressed rural hospitals in the Mississippi Delta Region, as defined by the Delta Regional Authority (DRA). The program focuses on improving financial, operational, and clinical performance through remote and on-site consultative services for hospitals that otherwise would not have had the resources to afford these needed services.

In 2009, RHPI provided 41 consultations at 39 of the 171 eligible hospitals in DRA. Thirty-eight hospitals received on-site consultations, and nine received feedback assessments. Of the on-site visits, 7 were general Performance Improvement Assessments (PIA), and 25 were consultations for specified issues, with 6 leadership development trainings and two "Balanced Scorecard" review. Of the feedback

assessments, seven each were conducted for community feedback, and two were employee feedback assessments. There was 400% increase in the number of participants in the web trainings. The schedule was preset for 2009 and time changed to avoid conflict with shift changes. The results for the first year of an evaluation indicate hospitals have overall demonstrated improved post PIA financial performance. RHPI has developed performance improvement strategies at the State, regional and local (hospital) levels in conjunction with State offices of rural health (SORH) and State hospital associations.

• **Rural Policy Analysis Cooperative Agreement --** ORHP funds the Rural Policy Analysis Cooperative Agreement to support research and analysis on key policy issues affecting rural communities. In 2009, this funding supported activities with the Rural Policy Research Institute (RUPRI) Rural Health Panel; the Rural Hospital Issues Group; and the RUPRI Rural Human Services Panel. The Rural Health Panel provides science-based, objective analysis to Federal policymakers. Panel members come from a variety of academic disciplines and author documents that reflect the consensus judgment of all panelists. The Rural Hospitals Issues Group, a panel of hospital administrators and finance experts from across the country, discuss issues such as the Medicare reimbursement, Medicare Advantage, and other policy issues affecting small rural hospitals. The Rural Human Services Panel provides background, advice and presentations on rural human services issues and the intersection between health and human services to the National Advisory Commission on Rural Health and Human Services. As with the Rural Health Panel, the Rural Human Services Panel members come from a variety of human services disciplines and author documents that reflect the consensus judgment of all panelists.

• **State Partnerships --** For the fourth consecutive year, ORHP continued a cooperative agreement with the National Organization of State Offices of Rural Health (NOSORH). The purpose of the State Rural Health Coordination and Development Cooperative Agreement (SRHCD-CA) is to enhance the rural health infrastructure in each State by providing guidance and technical assistance to State Offices of Rural Health (SORHs) as well as their partners and to identify and promote best practices. The goals of the SRHCD-CA are 1) to assist in the coordination of health care delivery through the development of State level rural health leadership; and 2) to facilitate partnerships and collaboration at the national and State levels to improve the exchange of information and engage in collaborative activities for supporting rural health.

NOSORH and the National Association of Rural Health Clinics are working together on a pilot project to build the capacity of SORH to provide technical assistance to rural health clinics (RHCs). The project will identify and document best practices by SORHs when rendering technical assistance to RHCs in their states and develop resources for SORH to support the work of rural health clinics. SORHs will work with NOSORH to make recommendations, identify and document best practices, barriers to rendering technical assistance, estimated staffing and start-up costs; and identify other key elements necessary for SORHs to start offering technical assistance to RHC's including developing learning modules for SORHs.

• **Technical Assistance Services Center --** The Technical Assistance Services Center (TASC) provides expert guidance to Rural Hospital Flexibility Program (Flex Program) grantees in such areas as Medicare reimbursement policies, Federal regulations, and hospital operations. The staff of ORHP works closely with TASC to prioritize key issues and develop information resources to share with Flex grantees.

TASC supported the 45 participating State Flex Programs in 2009 as they: converted prospective payment hospitals to Critical Access Hospital (CAH) status; integrated emergency medical services into rural medical delivery systems; build rural hospital networks to exchange information, provide economies of scale, obtain collective volume, and increase cost efficiency; and helped to improve quality and overall organizational performance. TASC provided technical assistance to these 45 State Flex Programs, their 1,302 CAHs, and related partners and networks. TASC facilitated the collection and dissemination of rural-relevant information; gathered and evaluated materials; maintained relationships with national rural health organizations and experts; and conducted conferences and educational sessions. In FY2009, TASC's areas of concentration included performance improvement and health information technology, including the support for the National Rural Health Information Technology Coalition. TASC conducted eleven state site visits in FY2009, provided four conference presentations, facilitated numerous conference calls and face-to-face meetings for states and their partners, and produced two technical assistance manuals.

• **Targeted Rural Health Care Outreach Services for Vermiculite Asbestos-Related Diseases Program** —The Environmental Protection Agency (EPA) has identified Lincoln County, Montana, as a

"public health emergency" based on the residents in this rural community that have been adversely affected by the asbestos released from the vermiculite mines. Asbestos-related diseases in which Lincoln County residents have been diagnosed include asbestosis, lung cancer, colorectal cancer, and others. As a result, HRSA issued a single source award to Lincoln County Health Department on August 1, 2009 in response to the urgent public health problem in Lincoln County. The total award amount for this organization is $6M with a two year project period- $4M from HRSA to support the provision of health related services and $2M from CDC to support screening related costs. Screening and other health related services for this program began in November 2009.

• **Workforce –** In conjunction with the Bureau of Health Professions, the Bureau of Clinician Recruitment and Services, and the Bureau of Primary Health Care, the Office of Rural Health Policy held a national meeting on August 10-12, 2009 in Washington, DC focusing on the challenges rural and urban underserved communities face in attracting and retaining an adequate number of primary care providers. This meeting brought together about 500 researchers, clinicians, policy makers, national associations, and community leaders to addresses primary care workforce challenges. At the meeting participants engaged in a broader discussion on how to move forward and assist rural and urban underserved communities attract needed health care providers. Specific attention was given to the current primary care workforce challenges and successful models of primary care training and practice as well as how to identify promising future strategies. At the meeting participants were asked to provide feedback and comments on what HRSA should be doing now and in the future to address primary care workforce shortages. An email address was also set up for participants to use after the meeting and was checked daily for submission until September 30, 2009. In total, HRSA received 250 comments from participants. These recommendations are currently under review by the HRSA Administrator.

Rural Recruitment and Retention:
The National Rural Recruitment and Retention Network (3RNet) consists of 51 State-based, not-for-profit organizations that encourage and assist physicians and other health professionals in locating practices in underserved rural communities. Members include State Offices of Rural Health, Primary Care, associations, Area Health Education Centers, and other not-for-profit entities.

During FY 2008, 3RNet members placed 1,023 medical professionals, including 218 family practice physicians, 87 internal medicine physicians, 55 pediatricians, 105 dentists, 121 nurse practitioners, and 99 physician assistants. 3RNet also maintained a toll-free phone line to assist providers interested in serving rural America, saving rural communities substantial recruitment costs. A conservative estimate of physician placement fees is about $28,000 (many are in excess of $30,000), and members placed 515 physicians in FY2008. While taking into account that some 3RNet members have small posting or placement fees to support their recruitment programs, communities saved an estimated $13,420,000 in recruitment fees that can be used for patient care services in those communities. In 2008, 740 designated underserved areas (HPSA or MUA communities) received placements, compared to 2007, (524), 2006 (627), 2005 (568) and 2004 (541)

The National Resource Center has performed an independent evaluation of 3RNet since 2004. While placements are important, the best measure of 3RNet is the number applications. Health care facilities themselves do not have control over placements since candidates make that decision.

- 2004: 3,520 postings, 10,602 applicants and 753 placements
- 2005: 4,299 postings, 11,914 applications and 715 placements
- 2006: 7,125 postings, 12,632 applications and 734 placements
- 2007: 5,700 postings, 15,382 applications and 681 placements
- 2008: 5,894 postings, 16,513 applications and 1,023 placements

Grant Programs

Research and Policy Grant Programs

In FY 2009, ORHP administered three grant programs within the Policy Research Team. The grant programs are: 1) the Frontier Extended Stay Clinic Demonstration program; 2) the Rural Health Research Centers; and 3) the Targeted Rural Health Research grant program. There were 11 grants awarded in these 3 programs with a total budget of almost $7 million. In addition to the above grants, Policy Research team members manage numerous cooperative agreements and contracts that support research and analysis of key policy issues affecting rural communities. These activities work to educate and inform rural decision makers and policy leaders at the local, State, and Federal level.

Policy Research Team Members:

Carrie Cochran, Team Lead

Heather Dimeris	Tom Morris
Nancy Egbert	Erica Molliver
Michelle Goodman	Joan Van Nostrand

Truman Fellows: Laura Merritt, Kai Smith

Frontier Extended Stay Clinic Program (FESC)

AUTHORIZING LEGISLATION: Title III, Section 330A of the Public Health Services Act, 42 U.S.C. 254c.

At a Glance

Grants Awarded:
- **2007:** 1 continuing award
- **2008:** 1 continuing award
- **2009:** 1 continuing award

Amount Awarded: Up to $1.5 million per year, per grantee
- **2007:** $1.5 million
- **2008:** $1.5 million
- **2009:** $1.5 million

Project Period: 4 years

Next Competitive Grant Application:
- **None**

PROGRAM OVERVIEW:
The purpose of the Frontier Extended Stay Clinic cooperative agreement demonstration program is to examine the effectiveness of a new type of provider in providing health care services in certain remote clinic sites. The FESC is designed to address the needs of patients who are unable to be transferred to an acute care facility because of adverse weather conditions, or who need monitoring and observation for a limited period of time.

FY 2009 program activities include, but are not limited to:
- Implementation and testing of FESC protocols;
- Evaluation of program and financial activities;
- Provision of technical assistance to CMS FESC Demonstration Project and participating organizations;
- Developing or continuing Health Information Technology (HIT) and quality initiatives; and
- Exploring the FESC model in the lower 48 states, including the relationship with Critical Access Hospitals.

In remote, frontier areas of the country, weather and distance can prevent patients who experience severe injury or illness from obtaining immediate transport to an acute care hospital. For residents in some of those communities, providers offer observation services traditionally associated with acute care inpatient hospitals until the patient can be transferred or is no longer in need of transport. However, extended stay services are not currently reimbursed by Medicare, Medicaid, or other third-party payers.

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) authorized CMS to conduct a demonstration program in which FESCs would be treated as Medicare providers. In a separate recognition of the extended care services provided by some frontier clinics, an additional demonstration program to be administered by ORHP was established by the Consolidated Appropriations Act of 2004.

KEY PROGRAM ACCOMPLISHMENTS:
In 2009, ORHP continued the work started in 2004 by providing funding to the Alaska FESC Consortium for the participation of five clinic sites in frontier Alaska and Washington. Preliminary results of the 3rd year of data collection indicate that the 5 clinics recorded 1,226 FESC encounters greater than or equal to four hours and 1,634 encounters less than four hours. The mean length of these encounters was 8.8 hours. Monitoring and observation accounted for 64% of the project's overall encounters. The most frequent diagnoses for FESC encounters were cardiovascular, gastrointestinal, and injury. Over the three data years, 25.7% of total FESC encounters (315 of 1,226) were eligible for Medicare reimbursement.

Rural Health Research Centers Program

AUTHORIZING LEGISLATION: Section 711 of the Social Security Act

PROGRAM OVERVIEW:
The ORHP funded Rural Health Research Centers conduct and disseminate policy-relevant research on the problems that rural communities face in assuring access to health care and strengthening health of their residents. These studies help to inform ORHP policy staff in their annual review of key Departmental regulations, and assists policymakers seeking to improve access to care in remote communities.

Initiated in 1987, the Research Centers Program is the only Federal effort dedicated entirely to producing policy-relevant research in this arena. Often housed at major U.S. universities, each Center has its own identity, Web site, and inter-disciplinary team of experts in health services research, epidemiology, public health, geography, medicine, and nursing. Over the 4-year award cycle, each team develops a portfolio of three projects annually in consultation with ORHP and its advisors. Projects are designed to address HHS, HRSA, and ORHP goals.

At a Glance

Grants Awarded:
- **2007:** 8 continuing awards
- **2008:** 6 new awards
- **2009:** 6 continuing awards

Amount Awarded: Prior to 2008, up to $550,000 per year, per grantee
- **2007:** $4 million

For 2008 and later, up to $660,000 per year, per grantee
- **2008:** $3.96 million
- **2009:** $3.96 million

Project Period: 4 years

Next Competitive Grant Application:
- **Year:** 2012
- **Anticipated Grants:** Up to 6
- **Anticipated Grant Amount:** Up to $660,000 per year, per grantee (up to $3,960,000 combined)

KEY PROGRAM ACCOMPLISHMENTS:
In 2009, the 6 Research Centers conducted 18 projects and wrote 30 policy briefs and reports. Over 20 of the Policy Briefs focused on health care reform issues in rural places. The Research Centers also authored 23 peer-reviewed journal articles in 2009, and another 11 have been accepted for publication and are in pre-press. To widen dissemination of these results, the Rural Health Research Gateway was updated in 2009. The Gateway is a Web site that allows "one-stop shopping" for all completed projects and reports produced by the respective research teams, as well as summaries of projects in progress. In 2009, the Gateway continued to issue *Research Alerts* each time a new report was issued. Additionally, the Centers each have Web sites that highlight and summarize their projects. There were over 104,000 visits to these sites in 2009. Staff also presented their findings to 111 policy, provider, payer, and academic audiences; and responded to over 200 requests for information from various national and State policymakers. In 2009, the 6 Research Centers were in the 2nd year of the 2008-2012 cycle. See the Research Gateway (http://www.ruralhealthresearch.org) for a list of the 6 Research Centers.

Targeted Rural Health Research Grant (TRHR)

AUTHORIZING LEGISLATION: Section 711 of the Social Security Act

PROGRAM OVERVIEW:
The Targeted Rural Health Research Grant Program (TRHR) funds policy-oriented projects which address critical issues facing rural communities in their quest to secure affordable, high quality health services. The program is unique in its dual purpose of enhancing policymakers' knowledge of rural health, and expanding the pool of experienced researchers in this complex field. Grantees' findings inform the ORHP, as well as National, State, and local decision makers. Grantees must address one of a selected group of topics, and all aspects of the project must be national in scope. Studies funded in FY09 included the following issues of national significance: Rural Health Clinics, Rural Health Workforce, Frontier Health Services Delivery, and Rural Hospital Leadership.

At a Glance

Grants Awarded:
- **2007 :** 2 new awards
- **2008 :** 2 new awards
- **2009 :** 3 new awards

Amount Awarded: Up to $150,000 per grantee
- **2007 :** $300,000
- **2008 :** $299,512
- **2009 :** $449,653

Project Period: 18 months

Next Competitive Grant Application:
- **None**

Originally entitled "Policy-Oriented Rural Health Services Research Grant Program," the Targeted Rural Health Research Grant Program was launched in 2003 on a single-year grant cycle. In 2007, however, it became apparent that the 12-month timeframe was unrealistic, considering the complexity of the research involved. Under expanded authority, ORHP notified grantees that they could extend their projects without formally requesting approval of a no-cost extension. Reflective of this shift, the name of the program was changed to "Targeted Rural Health Research Grant Program," and the grant budget & project periods were formally extended to 18 months, as of the FY2008 funding cycle. The Targeted Rural Health Research Grant Program will not be re-competed in FY2010.

KEY PROGRAM ACCOMPLISHMENTS:
Grantees' research findings have been instrumental in helping policy makers bridge conceptual gaps between abstract policy aims and the real-time needs of rural communities, while complimenting the larger scale projects conducted by the ORHP-funded Rural Health Research Centers. FY 2008 grantees generated research findings in the following areas:

- "Healthy Frontier and Rural Medical Services (Healthy FARMS): Securing access to health care in rural and frontier America"
- "How is the Economic Downturn Impacting Rural Health Clinics?"
- "A National Study of Nurse Leadership in Rural Hospitals: The Impact on Patient Safety"

FY2009 Study Topics Include:

- "Healthy Frontier and Rural Medical Services (Healthy FARMS): Securing access to health care in rural and frontier America"
- "How is the Economic Downturn Impacting Rural Health Clinics?"
- "A National Study of Nurse Leadership in Rural Hospitals: The Impact on Patient Safety"

Hospital State Division Grant Programs

In FY 2009, ORHP administered three grant programs within the Hospital State Division (HSD). The grant programs are: 1) Rural Hospital Medicare Flexibility (Flex); 2) Small Rural Hospital Improvement Program (SHIP); and 3) the State Office of Rural Health (SORH). Additionally, the Critical Access Hospital Health Information Technology (CAHHIT) Network grant program grantees completed their projects.

There were 141 grants awarded in these three programs with a budget of more than $45 million. In addition to the above grants, HSD members manage a wide range of cooperative agreements and contracts that support States with technical assistance, recruitment of health care providers, assistance in attaining funds to build replacement facilities and other activities.

Hospital State Division Members:

Kristi Martinsen, Division Director

Region A	
Jennifer Chang:	Connecticut, Delaware, Maine, Maryland, Rhode Island
Jeanene Meyers:	Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Vermont
Region B	
Samantha Williams:	Arkansas, Kentucky, North Carolina, Tennessee, Virginia, West Virginia
Bridget Ware:	Louisiana, Mississippi, South Carolina, Alabama, Georgia, Florida
Region C	
Megan Alavi:	Illinois, Indiana, Iowa, Minnesota, Nebraska
Michael McNeely:	Kansas, Michigan, Missouri, Ohio, Wisconsin
Region D	
Michelle Goodman:	Arizona, California, New Mexico, Texas
Steve Hirsch:	Hawaii, Nevada, Oklahoma
Region E	
Nancy Egbert:	Idaho, Montana, North Dakota, Washington, Wyoming
Keith Midberry:	Alaska, Colorado, Oregon, South Dakota, Utah

Critical Access Hospital Health Information Technology Network Grant Program (CAH-HIT)

AUTHORIZING LEGISLATION: Section 1820 (g) 3 of the Social Security Act

At a Glance

 # Grants Awarded:
- **2007:** 16 new awards
- **2008:** N/A
- **2009:** N/A

Amount Awarded: Up to $1.6M per grantee
- **2007:** $25 M
- **2008:** N/A
- **2009:** N/A

Project Period: 18 months

Next Competitive Grant Application:
- **None**

PROGRAM OVERVIEW:
This was a one-time only award that the Office of Rural Health Policy offered in FY 2007. The purpose of this 18-month pilot program is to support development of Health Information Technology (HIT) systems in rural communities through the 16 States that received CAH-HIT Network grants. The aim is to develop networks and implement HIT across the continuum of care to improve ORHP's case coordination and health outcomes for rural residents. HRSA's experience has shown that it is cost effective to utilize networks of providers to develop HIT. Therefore, grantees may focus their projects on any of the following systems:

- Practice management
- Disease registry
- Care management
- Clinical messaging
- E-prescription
- Telemedicine/Telepharmacy applications
- Personal health record
- Electronic health record
- Health information exchanges

The grantees have included various organizations in their "share" networks, such as public health departments, community-based clinics, faith-based organizations, and other HRSA grantees. These networks will enable quality improvement programs, linked to HIT tracking of five outcome measures, two of which will be diabetes control and health disease risk reduction.

Although the CAH-HIT Network program is a one-time funding opportunity, it is being administered as a "test bed" pilot program on HIT network implementation in rural areas. A thorough evaluation has been completed with the intent to provide the outcomes to all the participants as well as to the general populace by February 2010. The evaluation report outlines the work of the 16 grantees and describes 16 separate successful templates of HIT implementation that can be duplicated.

KEY PROGRAM ACCOMPLISHMENTS:
At the close of 2009, all of the grantees had completed the implementation of their projects and were utilizing a fully operational HIT network. By the end of the grant cycle, it was anticipated that the grantees would have developed comprehensive management systems for medical information, and its secure exchange between and among consumers and providers. ORHP has funded an evaluation contract to document the process of the implementation of the program so that the projects' outcomes can be evaluated at a later date to determine if they succeed in improving quality of care, reduction in medical errors, administrative efficiencies, and overall access. ORHP has also funded a primer to be utilized by State Offices of Rural Health and rural health care providers to communicate the lessons learned from CAH HIT in a post-ARRA world. The primer is set for delivery at the end of the second quarter FY 2010.

Delta Health Initiative (DHI)

AUTHORIZING LEGISLATION: Public Law 109-149, Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2006

At a Glance

Grants Awarded:
- **2007:** no award
- **2008:** 1 continuing award
- **2009:** 1 continuing award

Amount Awarded:
- **2007:** $0
- **2008:** $23 million
- **2009:** $25 million

Project Period: 5 years

Next Competitive Grant Application:
- **Year:** 2011
- **Anticipated Grants:** Up to 1
- **Anticipated Grant Amount:** Up to $24,750,000 per year, per grantee

PROGRAM OVERVIEW:

The purpose of the Delta Health Initiative Cooperative Agreement Program is to fund an alliance of providers to address longstanding unmet rural health needs (access to health care, health education, research, job training and capital improvements) in the Delta. The goal of the DHI is to improve the health of people living in this historically distressed region.

HRSA's Office of Rural Health Policy funded a 5-year cooperative agreement in the amount of $23 million in FY 2008, and $25 million in FY 2009. The grantee is working with 10 partners on projects aimed at improving:

- Chronic disease management
- Health education
- Intervention
- Wellness promotion
- Access to health care services
- Health Information Technology
- Workforce training
- Care coordination
- Construction of health facilities.

The consortium proposed 26 projects, and devised communication and coordination systems among themselves. Three of these projects were major public works undertakings, entailing the construction of public health facilities. Through these projects, DHI supports multiple HHS, HRSA and ORHP goals and objectives, including improving the safety, quality and access to health care.

KEY PROGRAM ACCOMPLISHMENTS:

Since its initial funding in 2006, DHI has improved health outcome measures across a broad spectrum of the Delta population. Many projects continue to date as a result of this initial "seed" funding. The program also has fostered better collaboration between the partners through the grantee's continuing efforts to improve its organizational structures. The DHI has conducted 425 community-based wellness events and classes, and 399 professional education seminars. It has trained 4,562 health professionals, and 34,837 Delta residents. The consortium has conducted 4,471 screenings/patient interviews; accounted for 15,028 patient-encounters for medical services; held 1,607 community-based career recruitment events, and networked 669,803 patients into Electronic Health Records (EHR) systems.

Medicare Rural Hospital Flexibility Grant Program (Flex)

AUTHORIZING LEGISLATION: Section 1820(j) of the Social Security Act (42 U.S.C. 1395) as reauthorized in the Medicare Improvements for Patients and Providers Act of 2008

At a Glance

Grants Awarded:
- **2007:** 45 continuing awards
- **2008:** 45 continuing awards
- **2009:** 45 continuing awards

Amount Awarded: Up to $650,000 per year, per grantee, with an average grant of $490,000
- **2007:** $22.2 million
- **2008:** $22 million
- **2009:** $22.3 million

Project Period: 3 years

Next Competitive Grant Application:
- **Year:** 2010
- **Anticipated Grants:** 45
- **Anticipated Grant Amount:** Up to $750,000 per year, per grantee, with an average grant of $490,000

PROGRAM OVERVIEW:
The Rural Hospital Flexibility Program (Flex) provides funding to state governments to spur quality and performance improvement activities; stabilize rural hospital finance; and integrate emergency medical services (EMS) into their health care systems. Only States with Critical Access Hospitals (CAH) or potential CAHs are eligible for the Flex program.

Flex funding encourages the development of cooperative systems of care in rural areas -- joining together CAHs, EMS providers, clinics, and health practitioners to increase efficiencies and quality of care. The Flex program requires States to develop rural health plans, and funds their efforts to implement community-level outreach and technical assistance to advance the following goals:

- Improve quality of care and performance management
- Improve and integrate EMS
- Develop and implement rural health networks
- Support existing CAHs and eligible hospitals
- Designate CAHs in the State

Although focused on small, rural hospitals, the Flex program operates on the National, State, community, and facility levels to cover a broad range of fundamental health service issues and "modernization" goals. States use Flex resources for performance management activities, training programs, needs assessments, and network building. Efforts have included the use of a balanced scorecard approach, forming relationships with state Quality Improvement Organizations (QIOs), developing quality improvement-related networks, and participating in national quality improvement and reporting efforts.

KEY PROGRAM ACCOMPLISHMENTS:
Over 60 percent of CAHs voluntarily reported quality data to the Centers for Medicare and Medicaid Services' Hospital Compare Web site, even though they received no financial incentives. This increase may be due to the incorporation of new rural-relevant measures in Hospital Compare; the quality improvement focus added to the Flex program; and/or technical assistance from the TASC and the QIOs. More than 80 percent of CAHs have undertaken programs to improve their service standards. After two years of reporting these measures to ORHP, CAHs have shown significant increases in the percent of patients receiving care under recommended protocols.

Approximately 1,300 hospitals have converted to CAH status; and most have shown improvement in their financial status, while simultaneously expanding the array of services needed in their communities.

In FY2009, State Flex Programs distributed over $16 million from their grants to directly benefit CAHs, EMS providers and others organizations providing rural health care.

Small Rural Hospital Improvement Grant Program (SHIP)

AUTHORIZING LEGISLATION: Section 1820(g)(3) of the Social Security Act, 42 U.S.C. 1395i-

PROGRAM OVERVIEW:
The Small Rural Hospital Improvement Grant Program (SHIP) assists small rural hospitals in meeting the costs of implementing data systems required to meet requirements established under the Medicare program pursuant to amendments made by the Balanced Budget Act of 1997. Under this section, small rural hospitals may use funds to: 1) Purchase computer software and hardware (such as applications that focus on quality improvement, performance improvement and patient safety); 2) Educate and train hospital staff on computer information systems (such as using technology to improve patient outcomes); and 3) Offset costs related to the implementation of prospective payment systems (PPS) (such as updating chargemasters or providing training in billing and coding).

At a Glance

 # Grants Awarded:
- **2007:** 46 continuing awards
- **2008:** 46 new awards
- **2009:** 46 continuing awards

Amount Awarded:
- **2007:** $ 14.5 million
- **2008:** $ 14.2 million
- **2009:** $ 14.8 million

Program Duration: 5 years, starting with FY 2008 grants

Next Competitive Grant Application:
- **Year:** 2013
- **Anticipated # Grants:** Up to 46
- **Anticipated Grant Amount:** Up to approximately $9,000 per year per participating hospital.

PROGRAM BACKGROUND:
The SHIP Grant Program is authorized by section 1820(g)(3) of the SSA. Under this section, small rural hospitals may: pay for costs related to the implementation of prospective payment systems; purchase computer software and hardware that would protect patient privacy; educate and train hospital staff on computer information systems to protect patient privacy; and support quality improvement and computer assisted activities. Funding for this program was first provided by the Labor/HHS Appropriations Act for FY 2002 in which conference report language expanded the purpose of this grant program to also help small rural hospitals (1) comply with provisions of HIPAA and (2) reduce medical errors and support quality improvement.

Individual hospitals do not apply directly to ORHP for this grant. Instead, the SORH help rural hospitals to participate in the program. Eligible hospitals submit an application to their SORH, and the SORH prepares and submits a single grant application to HRSA on behalf of all hospital applicants in the State. The SHIP program addresses HHS, HRSA, and ORHP goals related to HIPAA and improving the quality, safety, cost, and value of health care services.

KEY PROGRAM ACCOMPLISHMENTS:
In 2009 1,635 hospitals in forty-six States were funded, an increase of 185 hospitals since the program's inception in 2002. Connecticut, Delaware, New Jersey and Rhode Island have no eligible rural hospitals.

State Offices of Rural Health Grant Program (SORH)

AUTHORIZING LEGISLATION: Public Health Service Act, Section 338J; (42 U.S.C. 254r).

PROGRAM OVERVIEW:
The State Offices of Rural Health Grant (SORH) Program creates a focal point within each State for rural health issues. The program provides an institutional framework that links communities with State and Federal resources to help develop long-term solutions to rural health problems.

The three core functions of the SORH program are to:

- Serve as a clearinghouse of information and innovative approaches to rural health services delivery
- Coordinate State activities related to rural health in order to avoid duplication of efforts and resources
- Identify Federal, State, and nongovernmental rural health programs and provide technical assistance to public and private, nonprofit entities serving rural populations.

At a Glance

Grants Awarded:
- **2007:** 50 continuing awards
- **2008:** 50 continuing awards
- **2009:** 50 continuing awards

Amount for SORH Grants:
- **2007:** $7.2 million
- **2008:** $7.2 million
- **2009:** $8.2 million

Project Period: New 5 year period started FY 2008.

Next Competitive Continuation (2 of 4) SORH Grant Application:
- **Year:** 2013
- **Grants:** 50
- **Amount available -** $8.9 million
- **Anticipated Amount per Grantee:** Up to $180,000

Additionally, the SORH program strengthens Federal, State, and partnerships in rural health; and promotes recruitment and retention of a competent health care workforce. Funds cannot be used for direct delivery of health care services, purchase of real property or equipment or to conduct any activity regarding a Certificate of Need. Up to 10% of funds may be used for research.

The SORH program was developed in 1991 as a Federal-State partnership. It features a single grantee from each State and requires a State match of $3 for each $1 in Federal funding. Over the past 18 years, this program has leveraged in excess of $250 million in State matching funds. Currently, 37 Offices are located in State health departments, 10 in academic settings and three in non-profit organizations.

KEY PROGRAM ACCOMPLISHMENTS:
During the FY 2008 budget period (7/1/08 - 6/30/09), SORHs started collecting new performance measurement information on the provision of technical assistance to clients within their States. This information will be used collectively to produce more detailed yearly reports about the SORH program. The following information was posted on the ORHP Performance Information Management System within 30 days of the end of grant period:

1. The total number of technical assistance (TA) encounters provided directly to clients within State by SORH. Total for all fifty SORHs - 61,934.

2. The total number of clients within State that received TA directly from SORH. Total for all fifty SORHs - 32,330.

Community-Based Grant Programs

The Community-Based Division programs provide funding to increase access to care in rural communities. ORHP currently administers 8 grant programs and multiple contracts through its Community-Based Division (CBD) which is made up of 15 project officers. The programs on the division include: Rural Health Care Services Outreach Grant Program, Delta States Rural Development Network Grant Program, Network Development Grant Program, Network Planning Grant Program, Small Health Care Provider Quality Improvement (SHCPQI) Grant Program, Radiation Exposure Screening and Education Program, Black Lung Clinics Program and the Rural Access to Emergency Devices (RAED) Grant Program. In FY 2009, approximately 305 grants were awarded from the Community-Based Division for a combined program budget of over $43 million. To find out further information on the Community-Based Programs, please click on Find Grants.

In FY 2008, ORHP's Community Based Division implemented a new strategy for the Outreach, Network Development and Quality programs to help manage them in a more effective way.. The grant cycles for these programs are now staggered instead of being competitive on an annual basis With this new strategy, ORHP will pay particular attention to the issue of sustainability and evaluation and also focus more on peer-peer learning and better coordinated technical assistance. Similar to the funding cycle of state and research grant opportunities, the efficiencies in funding will allow ORHP to award several more grants per year.

CBD Structure

Project officers on CBD manage grants based on the primary issue area addressed in the application, instead of focusing solely on one program or one geographic area. This ensures that all project officers understand the CBD programs and develop an area of expertise for the division and ORHP. Below are some topic areas addressed through the Community Based programs:

- Access to care
- Cardiovascular health
- Case management
- Chronic disease
- Diabetes
- Emergency management services and trauma care
- Health information technology
- Maternal and child health
- Mental health and substance abuse
- Nutrition
- Obesity
- Oral health
- Pharmacy
- Quality
- Recruitment and retention
- "Safety net" collaboration
- School-based health centers
- Transportation
- Uninsured
- Women's health

Community-Based Team Members:

Nisha Patel, Division Director

Karen Beckham	Eileen Holloran	Lilly Smetana
Sonja Carter-Taylor	Vanessa Hooker	Sheila Tibbs
Valerie Darden	Leticia Manning	Kathryn Umali
Ann Ferrero	Sherilyn Pruitt	Christina Villalobos
Marcia Green	Elizabeth Rezai-zadeh	Sheila Warren

Black Lung Clinics Program (BLCP)

AUTHORIZING LEGISLATION: Black Lung Benefits Reform Act of 1977**,** Section 427(a), and 42 CFR Part 55a

At a Glance

Grants Awarded:
- **2007:** 15 new awards
- **2008:** 15 continuing awards
- **2009: 15 new awards**

Amount Awarded:
- **2007:** $5.65 million
- **2008:** $ 5.62 million
- **2009: $ 7.2 million**

Project Period: 3 years (with possibility of competitive continuation)

Next Competitive Grant Application:
- **Year:** 2010
- **Anticipated Grants:** Up to 15
- **Anticipated Grant Amount:** Varies by grantee

PROGRAM OVERVIEW:
The purpose of the Black Lung Clinics Program (BLCP) is to seek out and provide services to miners (active and inactive) to minimize the effects of job-related respiratory impairment, improve the health status of miners exposed to coal dust, and to increase coordination with other benefit programs to meet the special health needs of this population.

Grantees have varied models of service delivery. BLCP services may be provided either directly or through formal arrangements with appropriate health care providers. Current clinics include Federally Qualified Health Centers, hospitals, state health departments, mobile vans, and clinics.

Programs meet the health care needs of the population through services that include:

- Outreach
- Primary care (including screening, diagnosis and treatment)
- Patient and family education and counseling (including anti-smoking education)
- Patient care and coordination (including individual patient care plans for all patients and referrals as indicated)
- Pulmonary rehabilitation

In 1972, Congress amended the Federal Coal Mine Health and Safety Act of 1969 to establish a program of grants and contracts to fund clinics to treat coal miners with respiratory diseases. The “Black Lung Benefits Reform Act of 1977" (Public Law 95-239) was intended by Congress to ensure the continued expansion of the program. The Federal Register (50 FR 7913) in 1985 clarified the authority of the HHS Secretary to support clinics that evaluate and treat coal miners with respiratory impairments. Formerly administered by HRSA’s Bureau of Primary Health Care, the program was moved to the Office of Rural Health Policy in 2006, as most affected constituents reside in rural areas.

The program addresses the HHS strategic plan goal of increasing health care service availability and accessibility, and improving health care quality, as well as the HRSA goals of improving access to health care and improving health outcomes.

KEY PROGRAM ACCOMPLISHMENTS:
ORHP contract with John Snow Inc. to map out the location of miners to make sure that the location of miners were being targeted that is most need. The outcome of the research was a success and the result shows that the populations most need is being targeted.

Delta States Rural Development Network Grant Program (Delta)

AUTHORIZING LEGISLATION: Public Health Service Act, Section 330A (e) (42 U.S.C. 254c)

PROGRAM OVERVIEW:
The purpose of the Delta States Rural Development Network Grant Program (Delta) is to fund organizations located in the eight Delta States (Alabama, Arkansas, Illinois, Kentucky, Louisiana, Mississippi, Missouri, and Tennessee) which address unmet local health care needs and prevalent health disparities through the development of new and innovative projects.

The Delta grant program fosters collaborative efforts among rural providers, as many of these disparities could not be solved by single entities working alone. In the current grant cycle, grantees are expected to propose multi-county projects that address the following key areas:

- Delivery of preventative or clinical health services surrounding chronic disease
- Increase access to prescription drugs for the medically indigent
- Practice management technical assistance services.

At a Glance

Grants Awarded:
- **2007:** 12 new awards
- **2008:** 12 continuing awards
- **2009:** 12 continuing awards

Amount Awarded: Award range $400,000 - $1,000,000 per grantee
- **2007:** $5.1 million
- **2008:** $5.1 million
- **2009:** $5.1 million

Project Period: 3 years

Next Competitive Grant Application:
- **Year:** 2010
- **Anticipated Grants:** Up to 12
- **Anticipated Grant Amount:** between $300,000 - $430,000 per grantee.

Grantees may also focus grant activities around the following priorities: oral health improvement, school-based health services, mental health, and/or teenage pregnancy prevention efforts.

The Delta Grant Program was first competed in FY 2001 when the Senate Appropriations Committee allocated $6.8 million towards addressing health care needs in the Mississippi Delta. The current grantees have identified specific targeted focus areas for their project activities. This change has served as a better fit for performance measurement activities within ORHP. More applicants were also funded in the current cycle to bring about greater impact and service delivery capacity in the Delta region than in previous grant cycles.

KEY PROGRAM ACCOMPLISHMENTS:
The Delta Grant Program had many successes in working toward eliminating health disparities in the Delta Region. There have been marked achievements particularly in oral health care, chronic disease management and school-based health services. The Program has reached over 6.1 residents and has services in 224 counties and parishes. Most notably the Delta Grant Program has saved approximately 32,132 Delta residents an estimated $4,702,837.00 is savings on prescriptions.

Radiation Exposure Screening and Education Program (RESEP)

AUTHORIZING LEGISLATION: Public Health Service Act Section 417C; 42 USC 285(a)-9

At a Glance

Grants Awarded:
- **2007:** 7 continuing awards
- **2008:** 1 new/ 6 continuing awards
- **2009:** 1 new/6 continuing awards

Amount Awarded:
- **2007:** $1.586 million
- **2008:** $1.517 million
- **2009:** $1.642 million

Project Period: 3 years

Next Competitive Grant Application:
- **Year:** 2011
- **Anticipated # Grants:** 7-10
- **Anticipated Grant Amount:** Up to $300,000 per year, per grantee

PROGRAM OVERVIEW:
The purpose of the Radiation Exposure Screening and Education Program (RESEP) is to help individuals adversely affected by mining, transport, and processing of uranium, or the testing of nuclear weapons, receive medical care and compensation for illnesses that may have resulted from these activities. This is accomplished by providing competitive grant opportunities to States, local governments, and other health care organizations for cancer screening programs.

The major objectives of the programs are to:

- Screen individuals for cancer and other radiogenic diseases;
- Provide referrals for diagnostic testing or medical treatment of individuals screened;
- Develop and disseminate public information and education programs for the detection, prevention, and treatment of radiogenic cancers and diseases; and
- Facilitate medical documentation of claims for the Radiation Exposure Compensation Act (RECA) program

There are seven organizations in five southwestern States (Arizona, Colorado, Nevada, New Mexico and Utah) participating in the RESEP Program. These organizations include hospitals, universities, Indian Health Service facilities, medical centers and community health centers. In FY 2009, one new competitive award in the amount of $235,000 and six non-competitive awards in the amount of $1,407,032 were issued, totaling $1,642,032.00.

KEY PROGRAM ACCOMPLISHMENTS:
National Jewish Health (NJH) in Denver, Colorado was successfully awarded as a new grantee of the program in August 2009. NJH has more than two decades of experience in providing services to miners in Colorado and the Intermountain West. The physicians are trained and certified in pulmonary and occupational medicine; and allergic diseases. NJH will be an asset to the program in the provision of services to individuals affected by radiogenic disease.

RESEP Program accomplishments include:
- Screened 1,270 individuals for radiogenic disease and made 2,663 referrals for diagnostic testing and/or treatment,
- Provided Radiation Exposure Compensation Act (RECA) eligibility assistance to 5,178 individuals, and
- Informed more than 36,000 individuals about the program through brochures, presentations, and letters.

Rural Health Care Services Outreach Grant Program

AUTHORIZING LEGISLATION: Section 330A (e) of the Public Health Service Act 42 U.S.C 254c (E).

At a Glance

Grants Awarded:
- **2007:** 27 new / 95 continuing
- **2008:** 0 new/ 122 continuing
- **2009:** 111 new/ 27 continuing

Amount Awarded: Up to $150,000 in Year 1; $125,000 in Year 2; and $100,000 in Year 3, per grantee
- **2007:** $17.6 million
- **2008:** $17.7 million
- **2009:** $19.1 million

Project Period: 3 years

Next Competitive Grant Application:
- **Year:** FY 2012
- **Anticipated Grants:** Up to 100
- **Anticipated Grant Amount:** Up to $150,000 in Year 1; $125,000 in Year 2; and $100,000 in Year 3, per grantee

PROGRAM OVERVIEW:
The purpose of the Outreach program is to promote rural health care services outreach by expanding the delivery of health care services to include new and enhanced services in rural areas. The Outreach program supports projects that demonstrate creative or effective models of outreach and service delivery in rural communities. Applicants may propose projects to address the needs of a wide range of population groups including, but not limited to, low-income populations, the elderly, pregnant women, infants, adolescents, rural minority populations, and rural populations with special health care needs. All projects should be responsive to any unique cultural, social, religious, and linguistic needs of the target population.

The goal of the Outreach grant program is to improve the health status and outcome in rural areas by providing diverse health services on a variety of health topics to the community. The services may include: health education and promotion; health screenings; health fairs; and training and education to providers, among other activities. Grantees may focus on health topics that include primary health care, dental care, mental health services, home health care, emergency care, health promotion and education programs, outpatient day care, and other services not requiring in-patient care.

KEY PROGRAM ACCOMPLISHMENTS:
The Outreach grant program has success in providing needed health services to rural communities. The program has helped to bring rural communities together to work toward a common goal, which is to improve the health and well-being of rural populations. Although the Outreach program is a 3-year grant, many of the programs have continued success beyond the project period and Federal funding. The grantees are encouraged to develop creative sustainability and evaluation plans that allow their program to be expanded and enhanced. Since the program's inception in FY 1991, to date funding has been provided to 794 grantees in 48 States and 3 Territories.

In FY 2009, the program launched its Performance Improvement Measurement System (PIMS). PIMS was developed to quantify the impact of the program's funding on access to health care, quality of services, and improvement of health outcomes. ORHP hopes to use the PIMS data to assess the impact that ORHP programs have on rural communities and to enhance ongoing quality improvement. ORHP has incorporated these performance measures as a requirement for all ORHP grant programs in order to achieve the stated objectives. Based on the PIMS data collected in 2009, the number of people (total) in the target population for all Outreach Program projects in the last year is 1,425,601. The number of people (total) in the target population with access to new/expanded programs/services in the last year through the Outreach grant program is 844,570.

Rural Health Network Development Grant Program

AUTHORIZING LEGISLATION: Section 330A(f) of the Public Health Service Act, as amended

At a Glance

Grants Awarded:
- **2007:** 5 new / 33 continuing
- **2008:** 51 new/ 28 continuing
- **2009:** 49 continuing

Amount Awarded: Up to $180,000 per year per grantee (3 year award)
- **2007:** $6.5 million
- **2008:** $13.7 million
- **2009:** $ 8.7 million

Project Period: 3 years

Next Competitive Grant Application:
- **Year:** 2011
- **Anticipated Grants:** Up to 30
- **Anticipated Grant Amount:** Up to $180,000 per year, per grantee (up to $540,000, combined)

PROGRAM OVERVIEW:
The purpose of the Rural Health Network Development Grant Program is to expand access to, coordinate and improve the quality of essential health care services, and enhance the delivery of health care in rural areas. These grants support rural providers who work in formal networks, alliances, coalitions or partnerships to integrate administrative, clinical, technological, and financial functions. Funds provided through this program are not used for direct delivery of services. The ultimate goal is to strengthen the rural health care delivery system by 1) improving the viability of the individual providers in the network, and/or 2) improving the delivery of care to people served by the network. Networks must consist of at least three separately owned entities, and each must sign a memorandum of agreement or similar document. Upon completion of the grant program, a network should have completed a thorough strategic planning process, business planning process, be able to clearly articulate the benefits of the network to its network partners/members and to the community it serves, and have a sound strategy in place for sustaining its operations.

Some anticipated outcomes of supporting the development of rural health networks include:
- Achieving economies of scale and cost efficiencies of certain administrative functions
- Increasing the financial viability of the network; enhancing workforce recruitment and retention
- Sharing staff and expertise across network members; enhancing the continuum of care
- Providing services to the underinsured and uninsured; improving access to capital and technologies
- Ensuring continuous quality improvement of the care provided by network members
- Enhancing the ability of network members to respond positively to rapid and fundamental changes in the health care environment

The Network Development Grant Program was started in 1997 with 34 grantees and $6.1 million. To-date, the program has awarded almost $97 million to support 210 Network Development grants.

The Network Development program supports HRSA goals of improving access and quality of health care, improving health outcomes, and improving public health and health care systems. The Program also supports HHS goals to improve the safety, quality, affordability and accessibility of health care; and to promote the economic and social well-being of individuals, families, and communities.

KEY PROGRAM ACCOMPLISHMENTS:
Due to an increase in funding, 51 new grants were funded in 2008 – an increase of 21 over the 30 grants that were anticipated to be awarded. Representatives from the Network projects were among over 900 ORHP grantees that participated in a Grantee Partnership meeting held in Washington, D.C. in August 2009. Grantees learned techniques to become an effective Network Director, and learned strategies to sustain their Networks after Federal funding ceases. ORHP collaborated with the Georgia Health Policy Center and the National Cooperative of Health Networks to provide joint technical assistance to grantees at this meeting.

Rural Health Network Development Planning Grant Program (Network Planning)

AUTHORIZING LEGISLATION: Public Law 107-251m 116 Stat. 1621, Section 330A(f) of the Public Health Service Act, 42 U.S.C. 254c.

At a Glance

Grants Awarded:
- **2007:** 10 new awards
- **2008:** 33 new awards
- **2009:** 19 new awards

Amount Awarded: Up to $85,000 per year, per grantee
- **2007:** $841,391
- **2008:** $2.7 million
- **2009:** $1.6 million

Project Period: 1 year

Next Competitive Grant Application:
- **Year:** FY 2010
- **Anticipated Grants:** Up to 20
- **Anticipated Grant Amount:** Up to $85,000 per year, per grantee

PROGRAM OVERVIEW: The legislative purpose of the Rural Health Network Development Planning Grant Program (Network Planning) program is to expand access to, coordinate and improve the quality of essential health care services and enhance the delivery of health care, in rural areas. The program provides 1-year grants to rural entities to plan and develop a formal health care network. Grant funds typically are used to acquire staff, contract with technical experts, and purchase resources to "build" the network (funds cannot be used for direct delivery of health care services). Successful grantees often apply for the 3-year Network Development implementation grant to continue the work they started under the Network Planning grant.

Network Planning grantees use the planning grant to lay the foundation of a rural health network by:

1. Identifying potential collaborating network partners in the community/region;
2. Convening potential collaborating network partners;
3. Conducting planning activities, such as developing Strategic and Business Plans; and
4. Begin carrying out network activities, including activities to promote the network's sustainability.

In addition to the activities mentioned above, for the 2010 application cycle, projects can also focus on community needs assessments, HIT readiness and Economic Impact Analyses.

By helping rural providers develop formal integrated health care networks, the Network Planning program supports multiple HHS, HRSA, and ORHP goals and objectives, including improving the health care system, access to care, the continuity and quality of care, and the financial viability of health care providers in underserved areas.

Network Planning Grants were first awarded in 2004. The maximum award in FY 2004 was $100,000. In FY 2005, the maximum award was lowered to $85,000. The average award for FY 2009 was $82,800.

KEY PROGRAM ACCOMPLISHMENTS:

Key representatives of the Network Planning projects participated in a Grantee Partnership Meeting held in Washington, D.C. in August 2009 that was attended by over 900 ORHP Grantees. The new Network Planning Grantees were provided educational opportunities that would assist them with the development and successful outcome of their grant projects. Among the topics offered was information on how to develop boards, the legal consequences of incorporation, and Strategic and Business Plan development.

The Network Development Grantees continue to apply for and receive additional Office of Rural Health Policy grant funds that assist in the sustainability and growth of their projects.

Rural Access to Emergency Devices (RAED)

AUTHORIZING LEGISLATION: Public Health Improvement Act Title IV, Subtitle B, 42 U.S.C. 254c note, Public Law 106-505

PROGRAM OVERVIEW:
The purpose of the Rural Access to Emergency Devices (RAED) Grant Program is to provide funding to rural community partnerships to purchase automated external defibrillators (AEDs) that have been approved, or cleared for marketing by the Food and Drug Administration; and provide defibrillator and basic life support training in AED usage through the American Heart Association, the American Red Cross, or other nationally-recognized training courses.

A community partnership is composed of local emergency response entities such as community training facilities, local emergency responders, fire and rescue departments, police, community hospitals, and local non-profit entities and for-profit entities.

In the past, AEDs have been placed in colleges, universities, community centers, local businesses, law enforcement and ambulance vehicles, fire trucks, 911 dispatch centers, and offices. The grant creates opportunities to educate the public on AEDs via advertisements, news media, schools, churches, shopping malls, restaurants, home owner associations, businesses, local government bodies, security firms, etc.

At a Glance

Grants Awarded:
- **2007:** 4 continuing/ 9 new awards
- **2008:** 13 continuing awards
- **2009:** 5 new awards

Amount Awarded:
- **2007:** $1.2 million
- **2008:** $1.2 million
- **2009:** $ .5 Million

Project Period: 2 - 3 years

Next Competitive Grant Application:
- **Year:** 2011
- **Anticipated Grants:** 10
- **Anticipated Grant Amount:** Up to $100,000 per year, per grantee for up to 3 years

KEY PROGRAM ACCOMPLISHMENTS:
The RAED Program has increased public awareness of the poor outcomes of persons suffering sudden cardiac arrest in rural areas. The program increased the number of AEDs available and the number of fire, rescue, police, first responders, and lay persons trained in using an AED to decrease mortality rates in the event of sudden cardiac arrests in isolated rural areas. In 2008 we continued to fund 13 grantees. In FY 2009 we anticipate approximately 100 new AEDs to be purchased with an additional 500 persons trained. For the years FY2006 through 2008 over 1000 new AEDs were purchased and over 5,000 persons were trained in their use.

Small Health Care Provider Quality Improvement Grant Program (Rural Quality)

AUTHORIZING LEGISLATION: Section 330A (g), Title II of the Public Health Service Act, as amended

At a Glance

Program Duration: 2 years

 # Grants Awarded:
- **2007:** 15 continuing awards
- **2008:** 55 new awards
- **2009:** 55 continuing awards

Amount Awarded:
- **2007:** $ 680,202
- **2008:** $ 4,026.691
- **2009:** $ 4,003,244

Next Competitive Grant Application:
- **Year:** 2010
- **Anticipated # Grants:** Up to 60
- **Anticipated Grant Amount:** Up to $75,000 per year per grantee

PROGRAM OVERVIEW:
The Rural Quality Grant Program (Rural Quality) is available to support rural public, rural non-profit, or other providers of healthcare services, such as critical access hospitals or rural health clinics. The purpose of the program is to improve patient care and chronic disease outcomes by assisting rural primary care providers with the implementation of quality improvement strategies, with a focus on quality improvement for chronic disease management.

The goal of the Rural Quality program is to improve health outcomes through enhanced chronic disease management in rural primary care settings by:

1. Implementing and using an electronic patient registry system;
2. Tracking and reporting specific health indicators by using nationally-accepted performance measures;
3. Assessing the need for and implementing additional quality improvement activities; and
4. Participating in technical assistance through monthly conference calls and peer-learning workshops with fellow Rural Quality grantees, facilitated by a quality improvement specialist.

The Rural Quality program was sponsored by ORHP for the first time in Federal fiscal year (FY) 2006 as a two-year grant program. The grantees' focus was on diabetes in the first learning year and cardiovascular disease (CVD) in the second learning year.

The Institute of Medicine's (IOM) reports, "To Err is Human" and "Crossing the Quality Chasm", highlight the urgency of improving the quality of health care in the United States. As identified by the IOM reports, patient care should be safe, timely, effective, efficient, patient-centered, and equitable (STEEPE). The IOM report, "Quality Through Collaboration: The Future of Rural Health," released in November 2004, identified that rural health care organizations can be leaders in quality improvement.

While many quality improvement initiatives focus on in-patient hospital care, quality improvement is also needed in the primary care setting to decrease morbidity and mortality and foster cost-effective care. Timely disease prevention and management in the primary care setting can improve patient health and decrease costly emergency room visits and hospital admissions that often follow deferred primary care. The Rural Quality program addresses this need for quality primary care in the rural setting.

KEY PROGRAM ACCOMPLISHMENTS:
Since the inception of the Rural Quality program in FY 2006, over 10,000 diabetic patients have been served. Among patients from the 2006 pilot with measured HbA1c lab values, the annual average HbA1c was 7.1 (slightly above the goal of <7.0). This average was maintained as new patients were added throughout the year to the patient registry.

Other HRSA Initiatives Administered by ORHP

In 2009, The Office of Rural Health Policy managed two agency-wide HRSA activities: border health and intergovernmental affairs (IGA).

Border Health

In 2009, ORHP is charged with managing border health activities for the Agency, as much of the 2,100-mile U.S.-Mexico border is rural. The regions along the border face similar health care delivery challenges as rural areas, such as limited health workforce capacity and a fragile infrastructure. ORHP coordinates these activities through its Division of Border Health in Dallas, Texas.

Border Team Members:

Frank Cantu	Lilia Salazar
Margarita Figueroa-Gonzalez	Christina Villalobos
Erma Woodard	Michelle Mellen

Office of Intergovernmental Affairs (IGA)

ORHP served as the primary coordinator of all IGA activities for HRSA. This includes serving as HRSA's primary liaison to the U.S. Department of Health and Human Services' Office of Intergovernmental Affairs. In addition, ORHP is the single point of contact for HRSA on all external activities, such as State and local governmental affairs, stakeholder association and interest group activities, and all internal activities, such as cooperative agreements and activities related to HRSA's offices and bureaus.

IGA Team Members:

Karen Beckham

Tom Morris

Kathryn Umali

Denali Commission

ORHP also manages a cooperative agreement with the Denali Commission for just under $40 million. The Denali Commission is an agency of the Department of Commerce which provides funds to Alaska to help develop and expand the rural health care infrastructure.

Administrative Team

ORHP is staffed by an Administrative Team responsible for office functions such as phone reception, travel processing, and day-to-day office operation. Staff on this team is also responsible for budget development, contracts, grants, and inter-agency agreement processing, and human resources.

Administrative Team Members:

Heather Dimeris, Team Lead

Julia Bryan	Debbie DeMasse-Snell
Mary Collier	Michele Pray-Gibson

Amal Thomas

Border Health

PROGRAM OVERVIEW:
In September 2004, the Office of Rural Health Policy (ORHP) assumed responsibility for coordinating border health activities for HRSA. Border Health initiatives are supported through cooperative and inter-agency agreements, and/or contracts. The purpose of the Division is to:

- Ensure agency-wide coordination by creating a focal point for HRSA activities
- Track health issues along the U.S.-Mexico border that affect HRSA grantees.

KEY PROGRAM ACCOMPLISHMENTS:
HRSA continued its annual support for several key border health meetings. This included the Binational Border Health Week as well as the *U.S.-Mexico Border Health Association Meeting* and the Pan-American Health Organization's *Immunizations in the Americas Weeks.* Bi-National Border Health Week continues to be a key joint annual health event between the United States and Mexico. This week-long event highlights key policy issues and focuses on promoting access to high quality health services for the populations that live along the border. HRSA also continues its longstanding support of the Pan-American Health Organization and its work on immunizations. Through this event, HRSA works with other key partners to further educate clinicians and community workers in the appropriate use of vaccines, and to facilitate the inoculation of children and adults in local clinics and community health centers along the U.S.-Mexico border.

HRSA's Border Health Division staff continue to play a critical role in linking with their respective partners in the four Border Health Offices for Texas, New Mexico, Arizona and California. In addition, HRSA Border Health Staff also serve as the key link between the agency and the U.S.-Mexico Border Health Commission in El Paso, Texas.

Denali Commission

AUTHORIZING LEGISLATION: Section 309 of Public Law 105-277, Denali Commission Act of 1998, 42 U.S.C. 3121 note,

At a Glance

Grants Awarded:
- **2007:** 1 new award
- **2008:** 1 new award
- **2009:** 1 new award

Amount Awarded:
- **2007:** $39,283,000
- **2008:** $38,597,00
- **2009: $**19,642,000

Project Period: 1 year

PROGRAM OVERVIEW:
Through an agreement with the Denali Commission, an agency of the Department of Commerce, HRSA provides funds to help develop and expand the rural health care infrastructure in Alaska. In 1999, the Commission was granted authority by Congress to address rural Alaskan health care issues. The funds in this program, which are transferred to the Denali Commission via an inter-agency agreement with HRSA, support planning, construction and equipping of health, nutrition, and child care projects across the State. Potential venues include hospitals, health care clinics, and mental health facilities, including drug and alcohol treatment centers.

This program, which began in 2001, is modeled on the Appalachian Regional Commission and directed by Federal and State (Alaska) co-chairs. Its core mission is economic development in rural Alaska. The $19,642,000 appropriated to HRSA for the Commission in FY 2009 was combined with other resources for planning, designing and constructing primary health care facilities in the State. Resources were 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 to support up to 35 projects each year.

Project selection is made through an advisory panel, the Health Steering Committee, which is composed of a panel of health experts in Alaska. Recommendations are forwarded to the full Commission and leadership prior to incorporation into an Annual Work Plan, which is then forwarded to the Secretary of Commerce for approval. Projects are first vetted by staff to ensure they demonstrate sustainability and feasibility, and criteria are developed and updated through the advisory committee process.

KEY PROGRAM ACCOMPLISHMENTS:
The Denali Commission contributed to 20 health-related projects across Alaska in 2009. The Commission recognized the Primary Care Clinic program as a priority funding area within health. The communities of Mountain Village, Nunapitchuk, Ouzinkie, Hydaburg, Noorvik, and New Stuyahok all received new facility construction awards. The Commission also supported the construction of elder supportive housing projects in Ketchikan and Togiak. Grant awards also complemented rural hospital purchases of diagnostic equipment in Juneau, Kodiak Island, Petersburg, Wrangell, Nome and Valdez.

Intergovernmental Affairs (IGA)

PROGRAM OVERVIEW:
Located in the Office of Rural Health Policy (ORHP), the mission of the Health Resources and Services Administration's (HRSA) Office of Intergovernmental Affairs (IGA) is to facilitate and coordinate HRSA's programmatic interaction with organizations that represent units of State and local government.

The purpose of HRSA's Intergovernmental Affairs is to:

- Provide the HRSA Administrator with a single point of contact on all activities related to important State and local governmental, stakeholder association and interest group activities.
- Coordinate Agency cross-Bureau cooperative agreements and activities with organizations representing units of State and local governments, including such entities as the National Governors Association (NGA), National Conference of State Legislatures (NCSL), Association of State and Territorial Health Officials (ASTHO), National Association of Counties (NACo), National Association of County and City Health Officials (NACCHO), and National Association of Local Boards of Health (NALBOH).
- Interact with health-focused Federal Commissions such as the Delta Regional Authority, Appalachian Regional Commission, Denali Commission and United States-Mexico Border Health Commission.
- Serve as primary liaison to the U.S. Department of Health and Human Services' Office of Intergovernmental Affairs.

KEY PROGRAM ACCOMPLISHMENTS:
One of the primary functions of HRSA IGA is to respond and coordinate information and meeting requests. In FY 2009, 36 IGA requests were processed. In addition, HRSA IGA has coordinated 117 IGA activities since 2007. ORHP has developed a systematic process in managing the coordination of these requests, which entails responding to a variety of problems, questions, or situations relevant to health services and intra-governmental affairs. This may involve program planning and implementation for which there may not be established criteria. The work facilitates national dissemination of information about HRSA's programs, functions, and activities to partnering organizations and agencies.

Appendix A: Contracts

Title of Procurement	Description of Product or Service
Development and Implementation of a Rural Health Network, Network Planning, and Outreach Technical Assistance Program	The purpose of this contract is to provide TA for the Network, Network Planning, and the Rural Health Care Services Outreach Grantees to help further develop and implement program goals and objectives. This contract also supports sustainability for the grantees.
Rural Health Clinic Technical Assistance	This contract supports the development of a Rural Health Clinic Technical Assistance Series. It also supports a quarterly series of conference calls to provide technical assistance (TA) to rural health clinics. Many of these RHCs lack the resources to attend national conferences for training and TA. This series provides the clinics with assistance on a range of topics including finance, regulation, health information technology, and quality improvement.
Contract for Services of Technical Assistance for the Office of Rural Health Policy	The purpose of this contract is to provide technical assistance to the State Rural Health Associations and to support analysis of emerging rural health issues.
Tracking and Best Practices	The purpose of this contract is to track progress of hospitals taking part in the Small Hospital Improvement program.
Rural Hospital Issues Group Logistics	The purpose of this contract is to provide logistical and administrative support to facilitate meetings of the Rural Hospital Issues Group. The work group meets twice a year for 1 to 2 days in order to discuss emerging issues facing rural hospitals.
Delta States Rural Development Network Grant Program Evaluation	The purpose of this contract is for an evaluation of the Delta States Grant Program which is needed to gauge the program's effectiveness upon the Delta Region. The main purpose is to examine technical assistance previously provided to the grantees and to identify ways to improve the performance and outcomes of the project.
EHB - Web Based Data Management System	The purpose of this contract is to support the development of a Web-based data management system for the ORHP's 12 grant programs in conjunction with OIT.
WWAMI Work Related Inquiries	The purpose of this contract is to provide general TA to researchers, policy makers and grant program applicants (i.e. the general public) about the Rural Urban Commuting Areas (RUCAs) methodology for identifying rural and urban areas in the United States.
ORHP Grant Program Support	The purpose of this contract is Logistical support related to holding HRSA All Programs Meetings, grantee and other meetings for the Office of Rural Health Policy's grant programs.
Rural Outreach Grantee Technical Assistance Contract	The purpose of this contract is to provide TA for Rural Health Care Services Outreach Grantees to help further develop and implement program goals and objectives. The contract will also support sustainability for the grantees that close-out in FY 2008.
Rural Quality Improvement Technical Assistance Contract	The purpose of this contract is to provide TA for Small Health Care Provider Quality Improvement Grantees to help them implement quality improvement strategies.
Rural Hospital Performance Improvement Evaluation	The purpose of this contract is to evaluate the effectiveness of the Delta Rural Hospital Performance Improvement (RHPI) program. The RHPI works with eligible rural hospitals in the eight Delta States to help these facilities improve their financial and clinical operations. This evaluation examines the impact of the program to date and make recommendations on ensuring that the program continues to meet the need in coming years.
Rural Hospital Performance Improvement Project	The purpose of this contract is to support the provision of targeted TA to eligible rural hospitals in the Delta region.
National Rural and Underserved Workforce Summit	The purpose of this contract is to support a logistic contract that is used to help plan and conduct a meeting looking at the emerging workforce needs for health care providers in rural and underserved communities with an emphasis on primary care providers.
Logistical Support Services for the Development of a Frontier Definition	The purpose of this contract is to support logistical and administrative support to facilitate holding meetings with HRSA, USDA, and other Federal and private sector experts to identify potential models for a census-tract based frontier definition and examine how to define service need for isolated islands.

Title of Procurement	Description of Product or Service
Analysis of a Frontier Definition	The purpose of this contract is to support the examination of various definitions of frontier areas and assess new approaches for how to define frontier areas and for identifying how to best define island communities in terms of access to health services.
Logistical Support Services for the Development of a Frontier Definition	The purpose of this contract is to support logistical and administrative support to facilitate holding meetings with HRSA, USDA, and other Federal and private sector experts to identify potential models for a census-tract based frontier definition and examine how to define service need for isolated islands.
Analysis of a Frontier Definition	The purpose of this contract is to support the examination of various definitions of frontier areas and assess new approaches for how to define frontier areas and for identifying how to best define island communities in terms of access to health services.
Analysis of Elderly in Rural Hospitals for Respiratory Conditions	This contract modifies the CMS demonstration model of primary care physician health promotion nurse team to develop the new rural intervention to prevent functional decline in a frail elderly population and assess the intervention in a sample of frail rural elderly receiving care at rural community health centers, a primary care setting generally available in many rural areas.
Logistical Support for Rural Networks	The purpose of this contract is to support rural network planning capacity and development. Primary activities that include funding a document highlighting successful rural networks and community partners.
Rural Health Outreach Manual on Mental Health Best Practices	The purpose of this contract is to examine effective programs in rural and frontier mental health to disseminate among current grantees and future rural health applicants.
Immunization Week in the Americas	The purpose of this contract is to support educational workshops during the Pan American Health Organization (PAHO) sponsored Immunization Week in the Americas at the U.S.-Mexico Border. The contract provides PAHO with funds to coordinate the implementation of the educational workshops that are conducted in the border area.
U.S. Mexico Border Health Conference	The purpose of this contract is to support two educational workshops during the United States Mexico Border Association (USMBHA) sponsored conference in Laredo, Texas in June 2008. At these workshops local providers from both sides of the border received current information regarding the progress made and future plans to achieve U.S.-Mexico Border 2010 Health Objectives.
Rural Counties and Economic Development (RHWs)	The purpose of this contract is to raise awareness to county officials about the Rural Health Works (RHWks) projects by conducting a RHWks demo in three rural counties, educating county officials on the benefits of the program, and providing opportunities for peer-to-peer learning about RHW through the National Association of Counties (NACo) conferences and publications.
Rural Health Outreach Tracking and Evaluation	This contract supports a contract to track, assess, and evaluate the impact of the Public Health Service Section 330A grant programs.
Logistical Support for Frontier Technical Assistance Workshops and the Development of White papers on Frontier Issues	This contract supports a contract to provide logistical support for a consortium of community and research partners to develop frontier technical assistance workshops for grantees and to produce white papers on key frontier issues.
Rural Health Analysis, Issues, and Logistics	This contract provides logistical and administrative services for meetings with consortiums comprised of community and research.
Rural Pharmacy Best Practices	The purpose of this contract is to provide logistical and administrative support to develop a document highlighting rural pharmacy best practices that work across the continuum of care.
State- Based Agricultural Health and Safety Technical Assistance	The purpose of this contract is to expand AgriSafe Network Services to rural providers in at least six additional states.