

Office of Rural Health Policy 2010 Annual Profile



U.S. Department of Health and Human Services
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 (HHS). As part of the Health Resources and Services Administration (HRSA), ORHP has department-wide responsibility for analyzing effects of HHS 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 2010, the President introduced the *Improving Rural Health Care Initiative* with the objective of improving access to quality health care in rural areas by strengthening the regional and local partnerships among rural health care providers; improving recruitment and retention of health care professionals in rural areas, and by providing direct health care services.

ORHP Leadership:

Tom Morris
Sahi Rafiullah
Heather Dimeris

ORHP Administrative and Management Staff:

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

In support of this initiative, ORHP administered 17 grant programs, funded through 10 legislative authorities, designed to build health care capacity at both the local and State levels. ORHP grants provide funds to 50 State Offices of Rural Health to support on-going improvements in care, and to rural hospitals through the Medicare Rural Hospital Flexibility Grant and Small Rural Hospital Improvement programs. Through its community-based programs, ORHP encourages network development among rural health care providers, provides funds for emergency medical services, Black Lung Clinics, Radiation Exposure Screening and Education, as well as places and trains people in the use of automatic external defibrillators. ORHP also administers telehealth grant programs to increase and improve the use of telehealth to meet the needs of underserved populations in urban, rural, and frontier communities.

In July 2010, HHS Secretary Sebelius convened a new *HHS Rural Health Information Technology Task Force* to ensure that Federal resources are used effectively to help rural providers qualify for meaningful use incentive payments. The Task Force is jointly chaired by the National Coordinator for Health Information Technology and the HRSA Administrator.

ORHP also manages a cooperative agreement with the Denali Commission, an agency of the Department of Commerce, to provide funds to help develop and expand the rural health care infrastructure in Alaska. Funds support planning, construction and equipping of health, nutrition, and child care projects across the State.

Finally, ORHP coordinates HRSA's border health initiative, which 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.

ORHP Budget

Chart 1 – Budget Summary for Program Authorities, FY 2009 and FY 2010

(Amounts in thousands)

Rural Health Program Authorities	FY 2009 Final Appropriation	FY 2010 Final Appropriation
Rural Health Outreach	53,900	56,025
Rural Health Research and Policy	9,700	9,950
Medicare Rural Hospital Flexibility	39,200	41,200
Rural and Community Access to Emergency Devices	1,751	2,526
Delta Health Initiative	26,000	35,000
State Offices of Rural Health	9,201	10,075
Denali Commission	19,642	10,000
Radiation, Screening, Exposure and Education Program	1,952	1,952
Black Lung	7,200	7,200
Telehealth	7,550	11,600
Total	176,096	185,528

Chart 2 – Total number of ORHP Grants and Amounts by State, FY 2010

Total number of Grants awarded: 514

Total amount Funding provided: \$149,880,367

State	# Grant Awards	FY 2010 Funding
AK	14	3,962,911
AL	12	2,420,451
AR	13	3,098,153
AZ	9	1,766,574
CA	19	3,255,089
CO	14	2,726,386
CT	1	178,000
DE	3	405,000
FL	13	2,014,910
GA	17	3,351,953
HI	8	1,562,289
IA	8	2,726,269
ID	8	1,682,064
IL	11	3,825,588
IN	10	2,129,655
KS	8	2,715,535
KY	17	3,807,754
LA	13	3,028,579

State	# Grant Awards	FY 2010 Funding
MA	3	560,899
MD	10	1,164,501
ME	12	2,110,498
MI	15	2,430,863
MN	13	3,617,463
MO	15	2,989,463
MS	10	36,488,598
MT	20	6,725,010
NC	13	3,030,430
ND	11	2,324,551
NE	10	2,581,813
NH	11	1,715,479
NJ	1	170,000
NM	10	1,989,917
NV	6	1,171,512
NY	12	1,887,031
OH	10	2,415,690
OK	6	1,877,857

State	# Grant Awards	FY 2010 Funding
OR	10	2,016,143
PA	10	2,007,274
RI	1	165,000
SC	10	1,984,908
SD	9	2,000,467
TN	15	3,324,230
TX	12	3,319,233
UT	6	1,400,284
VA	13	2,691,033
VT	7	1,146,608
WA	13	3,434,638
WI	8	2,089,993
WV	6	2,633,559
WY	5	1,243,420
Washington DC	1	305,000
Puerto Rico	1	124,842
Northern Mariana Islands	1	85,000

Policy and Research Team

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).

ORHP often identifies issues of particular concern to rural communities during its review of the Medicare payment system regulations.

In FY 2010, ORHP administered two grant programs within the Policy and Research Team: the Frontier Extended Stay Clinic Demonstration Program and the Targeted Rural Health Research grant program. There were seven grants awarded in these two programs. 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 levels.

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, or 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.

Policy Research Team Members:	
Sahi Rafiullah, Team Lead	
Tom Morris	Heather Dimeris
Nicole Comeaux	Aaron Fischbach
Michelle Goodman	Erica Molliver
Paul Moore	Megan Meacham
Mike McNeely	Iran Naqvi
Truman Fellows: CJ Koozer, Natasha Scolnick	

Yearly Policy Projects

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

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.

The Flex Monitoring Team develops relevant quality, financial and community impact performance measures and reporting systems to help policy makers and rural providers understand the impact of the Flex Program. It executes research evaluating the impact of the Flex program on rural hospitals and communities in three core areas : quality health care services, improving financial and administrative performance, and engaging rural community in health care system development. It also assesses the ability of State Offices of Rural Health to achieve overall Flex Program objectives.

In fiscal year 2010, the Flex Monitoring Team continued to engage in the following three activities: 1) Maintain and update the National CAH database; 2) Measure financial performance in CAHs; and 3) Measure CAH quality performance nationally and state-wide. Its new research projects this past year focus on the following CAH subject areas: Delivery of safe care, EMS systems of care, partnering on activities related to the Flex Medicare Beneficiary Quality Improvement Project, investigating rural relevant quality measures, evidence-based programs and strategies to improve care, and improving financial performance.

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 information on rural health and social services programs, funding and research online. The RAC website is the most comprehensive source of reliable information on rural health and human services on the Internet. A

wide variety of rural-specific information from Federal and non-Federal sources is posted on the Internet, e.g., regulatory updates, funding announcements, conference and event dates, bibliographies, directories, and full-text documents on rural issues. 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 site averages 83,380 visits per month, totaling over a million visits in FY09. RAC also utilizes social media including Twitter and Facebook to engage and broaden its reach.

The RAC also assists individual communities and providers in identifying potential funding streams that best meet their needs. Staff researchers provide no-cost, customized assistance by performing database searches, locating statistics, data sources and maps, and referring users to qualified experts and organizations. The Center 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 2010, RAC responded to 889 individual requests for customized assistance.

340B Drug Pricing Technical Assistance Program

Section 7101 of the Affordable Care Act (ACA) expanded the definition of covered entities that are now eligible to participate in the 340B Drug Pricing Program. CAHs, Rural Referral Centers (RRC), and Sole Community Hospitals (SCH) were added as newly eligible entities. Enrollment for these newly eligible entities began on August 2, 2010. In the 4th quarter of FY10, 488 CAHs, 14 RRCs, and 86 SCHs enrolled in the 340B Program as a result of this expansion.

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 entities that are eligible for the 340B Program, including the 506 enrolled rural Disproportionate Share Hospitals (DSH), and now CAHs, RRCs, and SCHs. PSSC provided approximately 500 technical assistance services to rural entities in FY10, which included assistance to many of the newly eligible entities with the 340B Program enrollment process. PSSC operates under a contract between HRSA and the American Pharmacists Association (APhA).

Rural Health Clinic Technical Assistance

More than 3,700 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 2010, the RHC technical assistance conference call series provided five calls, with topics determined by an advisory group to address the most pressing concerns of rural providers. Discussions included: H1N1 Flu – Obtaining the vaccine; when to use the vaccine; how to pay for the vaccine and how to get reimbursed for vaccine administration; Medicaid Provisions in the CMS HITECH NPRM; Becoming a NHSC Approved Site; Ask the Experts; and ICD-10. 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.

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 2010, RHPI provided 50 consultations at 41 of the 171 eligible hospitals in DRA. To date, all but 17 of the eligible hospitals have received some sort of consultation. Thirty-five hospitals received on-site consultations, and fifteen received feedback assessments. The most common on-site consultation services are financial and operation performance improvement assessments, strategic planning projects, and revenue cycle process improvement projects. The feedback assessments were primary board self assessments of employee satisfaction assessments. The number of hospitals participating in all of the sessions in sustainability (webinars and conferences) increased by 60% from 2009.

The two year evaluation of this project ended and results indicate that this project has provided sustained performance improvement gains within hospitals served and that it is filling a void around hospital technical assistance within the Delta. Moving forward, Mountain States Group, the contractor tasked with managing this project, has a well developed tracking system to measure success around hospital achievement of meeting their pre-defined improvement goals.

Rural Health and Economic Development

The health sector is usually one of the top employers in a rural economy, a role and relationship that often are not fully understood. The National Center for Rural Health Works 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 2010, Rural Health Works conducted regional workshops in Nevada and Tennessee; responded to numerous requests for technical assistance and presented in webinars and exhibits on a variety of rural health and economic development topics. An Economic Costs of Physician Shortage and Primary Care Practitioners report was completed for a rural county in Oklahoma. An Assessment of Providing Mental Health Services in Rural Health Clinics was also completed. Additionally, the Center completed the Economic Impact of a General Surgeon on a Rural Community study which illustrates the impact of a general surgeon on a rural community in terms of the surgeon's office, as well as their activity at the local hospital.

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 2011 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 2010 with webinars and presentations to counties. These webcasts allow the Center to reach additional NACo members by having the broadcasts available at members' convenience and with access to Rural Health Works for additional assistance. The Center also presents at the NACo workshops at the Western Regional and Annual Conferences, as well as in articles for NACo's publication "County News."

Rural Recruitment and Retention:

3RNet (National Rural Recruitment and Retention Network) consists of 52 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 2010, 3RNet members placed 1,255 medical professionals, including 231 family practice physicians, 123 internal medicine physicians, 61 pediatricians, 134 dentists, 172 nurse practitioners, and 102 physician assistants. The placements of primary care providers have increased over previous years, even though economy meant fewer postings and fewer applicants.

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 \$30,000 (many are in excess of \$40,000 especially in rural areas), and members placed 601 physicians in FY2010. While taking into account that some 3RNet members have small posting or placement fees to support their recruitment programs, communities saved an estimated \$18,030,000 in recruitment fees. These savings are kept in communities for patient care services and community development. Over 90% of placements made by 3RNet members continue to be in designated underserved areas.

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.

- 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
- 2009: 5,449 postings, 22,227 applications and 1,253 placements
- 2010: 5,418 postings, 20,748 applications and 1,255 placements

Policy and Research Grant Projects

Policy Grant Projects:

Rapid Response to Requests for Rural Data Analysis

In 2010, 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 information databases. 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 to provide the information and analysis. Topics analyzed for policy makers in 2010 include the experience of rural independent pharmacies with Medicare Part D, a Rural Health at a Glance document, Medicare Advantage & Part D Rural Medicare beneficiary enrollment, and rural implications of health care reform.

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 2010, 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 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.

Rural Training Track Technical Assistance Demonstration Project (RTT-TA)

The purpose of the RTT-TA Demonstration Program is to form a consortium of organizations to better understand the challenges that Rural Training Track (RTT) residency program sites have when recruiting family physicians to train and practice in rural settings. This consortium will work to identify and analyze the key policy issues affecting these rural training sites and, once these challenges and barriers are identified, to provide technical assistance to increase the number of family medicine physicians that choose to practice in rural areas. As part of the Improving Rural Health Care Initiative, ORHP seeks to use this Cooperative Agreement as a pilot program to determine if targeted policy and technical assistance for the nation's RTTs can affect their viability and fill rate and ultimately their ability to produce the maximum number of rural physicians. The intent of this pilot is to create a strong national network of RTTs in the hope it could be self sustaining after an initial Federal investment, either through consortium members themselves or through cost savings associated with decreased recruitment fees.

The Rural Training Track Technical Assistance (RTT-TA) Demonstration Program requires the establishment of a consortium to encourage creative and lasting relationships among all or almost all

RTT programs across the nation. The consortium must be composed of a central entity that coordinates all cooperative agreement activities and that serves as the applicant of record with the expectation that the applicant will have relationships with, and develop a consortium of, all or almost all RTT programs across the nation as well as any other partner entities necessary to establish the consortium of RTTs. ORHP is defining, for the purposes of this cooperative agreement, a Rural Family Medicine Residency Program - Rural Training Track (RTT) program as a “1+2 program” where the first year of training is done at a central, usually urban, site and the last two years are based at rural training sites.

There are currently 25 RTT programs operational in the U.S. RTT programs have a successful record of placing graduates in rural practice locations; historically, approximately 75% practice in a rural community and 60% practice in Federally designated health professional shortage areas. This demonstration is funded as part of President Obama’s Improving Rural Health Care Initiative.

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.

Frontier Community Health Integration Demonstration Program

The Frontier Community Health Integration Demonstration Program is authorized under Section 330A(f) of the Public Health Service (PHS) Act, as amended (42 U.S.C. 254(c)). The activities in this demonstration are also guided by authorization of Section 123 of P.L. 110-275, the Medicare Improvements to Patients and Provider’s Act of 2008 (MIPPA). The purpose of this Cooperative Agreement is aid ORHP and CMS in the development of a demonstration to test new models for the delivery of health care services in frontier areas through improved access and better integration of the delivery of health care to Medicare beneficiaries. The primary focus areas of the demonstration are to explore ways to improve the adequacy of and payments for acute care, extended care, and other essential health care services provided under the Medicare and Medicaid programs in frontier areas and to evaluate regulatory challenges facing frontier providers and the communities they serve. This is the first year of funding for this cooperative Agreement.

Frontier Extended Stay Clinic Program (FESC)

The purpose of the Frontier Extended Stay Clinic cooperative agreement demonstration program is to examine the effectiveness of a new type of provider 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 2010 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.

In 2010, 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. The 4th year of data collection indicates that the five clinics recorded 940 FESC encounters. The mean length of monitoring and observation encounters was 8.1 hours and 5.0 hours for patients who were transferred. Monitoring and observation accounted for 47% of the project's overall encounters. The most frequent diagnoses for FESC encounters were cardiovascular, gastrointestinal, and injury. The data show that 32.8% of FESC encounters were eligible for Medicare reimbursement.

Research Grant Projects:

Rural Health Research Centers Program

The ORHP-funded Rural Health Research Centers conduct and disseminate policy-relevant research on the problems that rural communities face 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 rural relevant regulations, and assist rural stakeholders and policymakers in improving access to care in remote communities.

Initiated in 1987, the Rural Research Centers Grant Program Cooperative Agreement 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 subject area expertise, Web site, and inter-disciplinary team 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. Projects are designed to address HHS, HRSA, and ORHP goals.

Rural Health Research Center Gateway

In Fiscal Year (FY) 2010, the 6 Research Centers conducted 18 projects and wrote 48 products which includes policy briefs, full reports, and journal published studies. Rural-specific topics in FY 2010 include skilled nursing facility trends, nurse staffing, access to primary care physicians, ambulatory surgery centers, and food insecurity. The dissemination of these products occurs through the vehicle of the Rural Health Research Gateway website. The Gateway serves as a “one-stop shop” for all completed projects produced by the research centers and includes summaries of projects in progress. In 2010, 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 157,000 visits collectively to the individual research center sites and over 50,000 visits to the Gateway in 2010. Staff also presented their findings to 140 policy, provider, payer, and academic audiences; and responded to 266 requests for information from various national and State policymakers. In FY 2010, the 6 Research Centers were in the 3rd year of the 2008-2012 cycle. See the Research Gateway (www.ruralhealthresearch.org) for a list of the 6 Research Centers.

Hospital State Division

In FY 2010, ORHP administered four grant programs within the Hospital State Division (HSD): 1) the Rural Hospital Medicare Flexibility (Flex); 2) the Small Rural Hospital Improvement Program (SHIP); 3) the State Office of Rural Health (SORH); and 4) The Flex Rural Veterans Health Access Program.

There were 144 grants awarded in these four programs with a budget of more than \$46 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 Bowman:	Arkansas, Kentucky, North Carolina, Tennessee, Virginia, West Virginia
Bridget Ware:	Louisiana, Mississippi, South Carolina, Alabama, Georgia, Florida
Region C	
Megan Meacham:	Illinois, Indiana, Iowa, Minnesota, Nebraska
Michael McNeely:	Kansas, Michigan, Missouri, Ohio, Wisconsin
Region D	
Aaron Fischbach:	Arizona, California, New Mexico, Texas
Steve Hirsch:	Hawaii, Nevada, Oklahoma
Region E	
Iran Naqvi:	Idaho, Montana, North Dakota, Washington, Wyoming
Keith Midberry:	Alaska, Colorado, Oregon, South Dakota, Utah

Hospital-State Division Yearly Projects

Rural Health Care Quality

During Fiscal Year 2010, ORHP launched the Medicare Beneficiary Quality Improvement Project (MBQIP) as a Flex Grant Program activity within the core area of quality improvement. Eighty percent of Flex funded states agreed to partake in this project. The primary goal is for critical access hospitals (CAHs) to implement quality improvement initiatives to improve their patient care and operations. MBQIP will provide Flex funding to support CAHs with technical assistance and national benchmarks to improve health care outcomes. CAHs opting to participate are requested to report a specific set of annual measures in a three phase approach. These measures predominantly include those prescribed on the Center for Medicaid and Medicare's Hospital Compare website. With the anticipated health care environment changing likely influencing more pay for performance policy, CAHs will be more prepared to respond to future federal demands such as public reporting and engagement in quality improvement activities.

HRSA Patient Safety and Clinical Pharmacy Services Collaborative

ORHP contributed funds to the HRSA Patient Safety and Clinical Pharmacy Services Collaborative (PSPC) for the third PSPC Collaborative session that began in October 2010. The aim of the PSPC collaborative is to eliminate adverse drug events and improve patient outcomes. PSPC 3.0 has expanded to 127 active teams participating in 43 States, including the District of Columbia and Puerto Rico. These teams have partnered with over 320 organizations. There are four rural teams and nine CAHs participating in PSPC.

CAH Replacement Manual and Roadmap

ORHP published a "Roadmap and Manual for CAH Replacement" containing step-by-step guidance, simple tools and successful strategies for obtaining capital and building new facilities. As CAHs age, many consider replacement or renovation as options to improve service quality and meet community needs. Such projects have proven to increase admissions and outpatient visits; and improve staff recruitment and clinical performance, and boost local economies. However, hospital CEOs and Boards in rural settings often encounter technical and financial hurdles because they lack the experience with such projects. The Manual and Roadmap will help address these issues and are now available via hardcopy and electronically at <http://www.ruralcenter.org/tasc/resources/critical-access-hospital-cah-replacement-process-manual-and-roadmap>.

State Partnerships

For the fifth 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) and 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.

In 2010 NOSORH built on the foundation of last year's pilot and formed a Rural Health Clinic Technical Advisory Team, strengthening their partnership with the National Association of Rural Health Clinics. Two of NOSORH's board positions are now responsible for maintaining direct linkages with the National Rural Health Association – the State Office Council Chair and a State Rural Health Association Liaison.

NOSORH planned and offered a Leadership Institute in 2010. This leadership program is unique in that it is primarily online, includes an assigned mentor and incorporates a capstone project. Although the first class consisted of nine staff members from various SORHs, the program shows enormous potential expansion and future plans include reaching out to other state-level leaders and partners.

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 2010 as they: converted prospective payment hospitals to Critical Access Hospital (CAH) status; integrated emergency medical services into rural medical delivery systems; built 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 1,324 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 FY2010, 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 FY2010, provided three conference presentations, facilitated numerous conference calls and face-to-face meetings for states and their partners, and produced three technical assistance manuals.

Hospital-State Division Grant Programs

Delta Health Initiative (DHI)

AUTHORIZING LEGISLATION:

Public Law 109-149, Departments of Labor, HHS, and Education, and Related Agencies Appropriations Act, 2006

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.

ORHP funded a 5-year cooperative agreement in the amount of \$25 million in FY 2009 and \$34 million in FY2010. The grantee is working with 13 partners on projects aimed at improving:

- *Chronic disease management (e.g. asthma, cardiovascular)*
- *Health education, wellness promotion and care coordination*
- *Intervention*
- *Access to health care services*
- *Health Information Technology*
- *Workforce training*
- *Construction of health facilities.*
- *Oral health for children.*
- *Childhood obesity and Healthy Start – education and health care activities.*

For FY10, the consortium proposed 33 projects with highly structured communication and coordination systems designed to leverage, support, and sustain. Several of these projects continue major public works efforts, including 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 services and information.

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 1227 community-based wellness events and classes, and 1129 professional education seminars. It has trained 10,724 health professionals, and 83,676 Delta residents. The consortium has conducted 10,370 screenings/patient interviews, accounted for 48,772 patient-encounters for medical services, held 8,349 community-based career recruitment events, and networked 891,104* patients into Electronic Health Records (EHR) systems.

***cumulative total since project inception includes Jackson, MS. In FY10, 251,000 EHR records were added.**

At a Glance

Grants Awarded:

- **2008:** 1 continuing award
- **2009:** 1 continuing award
- **2010:** 1 continuing award

Amount Awarded:

Up to \$1.5 million per year, per grantee

- **2008:** \$23 million
- **2009:** \$25 million
- **2010:** \$34 million

Project Period: 5 years

Next Competitive Grant Application:

- **Year:** 2011
- **Anticipated Grants:** Up to 1
- **Anticipated Grant Amount:** Up to \$34,000,000 per year, per grantee

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

PROGRAM OVERVIEW:

Flex program 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 CAHs 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 focuses on four core areas:

1. *Support for Quality Improvement in CAHs*
2. *Support for Operational and Financial Improvement in CAHs*
3. *Support for Health System Development and Community Engagement, including integrating EMS in regional and local systems of care*
4. *Designation of CAHs in the State*

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. The Flex Program is also beginning a new special project, the Medicare Beneficiary Quality Improvement Project (MBQIP) focused on Medicare Beneficiary Health Status improvement.

KEY PROGRAM ACCOMPLISHMENTS:

Over 70 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.

More than 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.

At a Glance

Grants Awarded:

- **2008:** 45 continuing awards
- **2009:** 45 continuing awards
- **2010:** 45 continuing awards

Amount Awarded:

- **2008:** \$22 million
- **2009:** \$22.3 million
- **2010:** \$22.8 million

Project Period: 5 years

Next Competitive Grant Application:

- **Year:** 2015
- **Anticipated Grants:** 45
- **Anticipated Grant Amount:** Up to \$750,000 per year, per grantee, with an average grant of \$490,000

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. Grant funds are available for costs related to: (1) the implementation of prospective payment systems (PPS) (such as updating chargemasters or providing training in billing and coding) and (2) to pay for costs related to delivery system changes outlined in the Patient Protection and Affordable Care Act (PPACA) (such as value-based purchasing (VBP), accountable care organizations (ACO) and the National pilot program on payment bundling).

PROGRAM BACKGROUND:

The SHIP Grant Program is authorized by section 1820(g)(3) of the SSA. Under this section small rural hospitals could use SHIP 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).

The PPACA signed by President Obama on March 23, 2010, amended provisions of Section 1820(g)3 of the Social Security Act. Specifically, the purposes for which funds could be used were amended to include: 1) value-based purchasing programs, 2) accountable care organizations, 3) the National pilot program on payment bundling. As in previous years, funds are available to support costs related to implementation of PPS.

Individual hospitals do not apply directly to ORHP for SHIP funding. 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 eligible hospital applicants in the State.

KEY PROGRAM ACCOMPLISHMENTS:

In 2010 1,673 small rural 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. Funds were allocated across the new funding categories at \$2 million to PPS, \$1.8 million to VBP, \$10.3 million to ACO, and \$500,000 to support payment bundling.

- **2008:** 46 new awards
- **2009:** 46 continuing awards
- **2010:** 46 continuing awards

- **2008:** \$ 14.2 million
- **2009:** \$ 14.8 million
- **2010:** \$ 14.6 million

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

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.*

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 2009 budget period (7/1/09 - 6/30/10), SORHs collected performance measurement information on the provision of technical assistance to clients within their States. This collective information helps demonstrate the nationwide impact of the SORH program. The following information was posted on the ORHP Performance Information Management System within 30 days of the end of the grant period:

1. *The total number of technical assistance (TA) encounters provided directly to clients within State by SORH. Total for all fifty SORHs - 64,321.*
2. *The total number of clients within State that received TA directly from SORH. Total for all fifty SORHs - 29,920.*

At a Glance

Grants Awarded:

- **2008:** 50 continuing awards
- **2009:** 50 continuing awards
- **2010:** 50 continuing awards

Amount Awarded:

- **2008:** \$7.2 million
- **2009:** \$7.2 million
- **2010:** \$8.2 million

Project Period: New 5 year period started 2008.

Next Non-Competing Continuation (4 of 5) SORH Grant Application:

- **Year:** 2011
- **Grants:** 50
- **Amount available:** \$8.0 million
- **Anticipated Amount per Grantee:** Up to \$180,000

Community-Based Division

The Community-Based Division (CBD) programs provide funding to increase access to care in rural communities. ORHP currently administers nine grant programs and multiple contracts through CBD. In FY 2010, approximately 300 grants were awarded from CBD for a combined program budget of over \$43 million. To find out further information on the Community-Based Programs, please click on the Find Grantees link on the ORHP website.

With the exception of an annual competition for the Network Planning Grant Program, the grant cycles for all other CBD's programs are competed on a staggered basis. Under this new strategy, ORHP has increased its focus on the issues of sustainability, evaluation, peer-to-peer learning and better coordinated technical assistance. In FY 2011, ORHP and the National Opinion Research Center (NORC) plan to develop a rural community health gateway which will serve as a resource and tool for rural communities. The gateway will include proven evidence-based models so that rural communities can learn and build upon successful practices rather than reinventing the wheel. In addition, ORHP plans to release an economic impact analysis tool developed by The Lewin Group. This tool will allow rural communities an opportunity to see the flow and impact of their dollars in the community which will lead to a stronger sustainability plan. Both tools will be hosted on the Rural Assistance Center website (www.raconline.org).

CBD STRUCTURE

CBD is made up of 15 staff members. Project officers in CBD manage grants on the basis of the primary issue area addressed in the grantee's application, instead of focusing solely on one program or geographic area. This ensures that all project officers are versed in different 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 IT*
- *Maternal and child health*
- *Mental health and substance abuse*
- *Nutrition*
- *Obesity*
- *Oral health*
- *Pharmacy*
- *Quality*
- *Recruitment & retention*
- *"Safety net" collaboration*
- *School-based health centers*
- *Transportation*
- *Uninsured*
- *Women's Health*

Community-Based Division Members:		
Nisha Patel, Division Director		
Karen Beckham	Sonja Carter-Taylor	Valerie Darden
Ann Ferrero	Marcia Green	Eileen Holloran
Vanessa Hooker	Nadia Ibrahim	Leticia Manning
Lilly Smetana	Sheila Tibbs	Kathryn Umali
Christina Villalobos		Sheila Warren

Black Lung Clinics Program (BLCP)

AUTHORIZING LEGISLATION:

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

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*
- *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 ORHP 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 has a contract with John Snow Inc. to map out and ensure that the locations of the miners targeted are those of most need. The outcome of the research was a success and the result shows that the populations of most need are being targeted. In 2009 the BLCP grantees served a total of 12,436 miners.

At a Glance

Grants Awarded:

- **2008:** 15 continuing awards
- **2009:** 15 continuing awards
- **2010:** 15 new awards

Amount Awarded:

- **2008:** \$ 5.62 million
- **2009:** \$ 7.09 million
- **2010:** \$7.05 million

Project Period: 3 years (possibility of competitive continuation)

Next Competitive Grant Application:

- **Year:** 2013
- **Anticipated Grants:** Up to 15
- **Anticipated Grant Amount:** Varies by grantee

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.*

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 has 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 22,000 Delta residents an estimated \$21 million in savings on prescriptions through the program's pharmacy assistance program.

At a Glance

Grants Awarded:

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

Amount Awarded:

\$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.

Radiation Exposure Screening and Education Program (RESEP)

AUTHORIZING LEGISLATION:

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

PROGRAM OVERVIEW:

The purpose of the Radiation Exposure Screening and Education Program (RESEP) is to assist with the medical care and compensation for individuals adversely affected by mining, transporting, and processing of uranium; as well as, the testing of nuclear weapons during the cold war. The program offers competitive grant opportunities to support health care organizations implement programs to provide cancer screening programs. The objectives of the programs are to:

- *Screen individuals for cancer and other radiogenic diseases;*
- *Provide referrals for 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 documentation of claims for the Radiation Exposure Compensation Act (RECA) program.*

The seven organizations in five southwestern States (Arizona, Colorado, Nevada, New Mexico and Utah) participate in the RESEP Program. The organizations include hospitals, universities, Indian Health Service facilities, medical centers and community health centers. In FY 2010, HRSA awarded continuation grants to these organizations totaling \$1,714,525.00.

KEY PROGRAM ACCOMPLISHMENTS:

The RESEP grant program has achieved huge success in providing the needed services to the target population. The program has increased awareness about the services provided through various outreach and education strategies and reaching more individuals eligible for the program. Program operations from September 2005 through August 2010 resulted in 7,347 medical screening exams for radiogenic disease and approximately 30,000 individuals were provided assistance with the RECA compensation claims process. Outreach activities include mailings, community meetings, television and newspaper ads. The program results demonstrate the impact of these activities on the target population and the continued need for services provided.

At a Glance

Grants Awarded:

- **2008:** 1 new/6 continuing awards
- **2009:** 1 new/6 continuing awards
- **2010:** 7 continuing awards

Amount Awarded:

- **2008:** \$ 1.517 million
- **2009:** \$ 1.642 million
- **2010:** \$ 1.714 million

Program Duration: 3-year project periods

Next Competitive Grant Application:

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

Rural Health Care Services Outreach Grant Program (Outreach)

AUTHORIZING LEGISLATION:

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

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 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 over 1000 grantees in 50 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 2010, the number of people (total) served through the Outreach grant program more than doubled from 2009 to 2010, from 1,425,601 in 2009 and 4,030,386 in 2010. In addition, there was more than a two-fold increase in new clinical staff placed in rural areas from 2009 to 2010. Grantees are encouraged to employ sustainability strategies throughout their grant period for the continuity of their services after the grant funding ceases. It was reported that eighty-eight percent (88 %) of the previous grantee cohort were able to sustain at least one or more of their activities after the grant period.

At a Glance

Grants Awarded:

- **2008:** 122 continuing
- **2009:** 111 new/ 27 continuing
- **2010:** 111 new

Amount Awarded:

- **2008:** \$17.7 million
- **2009:** \$19.1 million
- **2010:** 13.7 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 Year 3, per grantee

Rural Health Network Development Grant Program

AUTHORIZING LEGISLATION:

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

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.

At a Glance

Grants Awarded:

- **2008:** 51 new/ 28 continuing
- **2009:** 49 continuing
- **2010:** 49 continuing

Amount Awarded:

- **2008:** \$13.7 million
- **2009:** \$8.7 million
- **2010:** \$8.7 million

Project Period: 3 years

Next Competitive Grant Application:

- **Year:** 2011
- **Anticipated Grants:** Up to 20
- **Anticipated Grant Amount:** Up to \$180,000 per year, per grantee (up to \$540,000, combined)

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*
- *Implementation of shared Electronic Health Records (EHRs) and Electronic Medical Records (EMRs) across network members*

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. 88 percent of the grantees in the 2000, 2002 and 2004 cohort reported having sustained all or some of their ORHP-funded activities.

KEY PROGRAM ACCOMPLISHMENTS:

The 49 continuing grantees have enabled 2.3 million people in rural access to new and/or expanded health programs. These grantees were able to generate \$10,112,534 in annual project revenue and grantees estimated \$5,347,254 in cost savings due to participation in a Network, and estimated an annual average of approximately \$13,244 saved through joint purchasing of drugs.

Rural Health Workforce Development Grant Program

AUTHORIZING LEGISLATION:

Public Health Service Act, Section 330A(f) (42 U.S.C. 254(c)), as amended by Sec. 201, P.L. 107-251

PROGRAM OVERVIEW:

The purpose of the Rural Health Workforce Development Program is to support the development of rural health networks that focus on activities relating to the recruitment and retention of primary and allied health care providers in rural communities. This Program will provide support to established and sustainable rural health networks that can develop innovative community-based educational and clinical health training programs to encourage the recruitment and retention of emerging health professionals (students and residents) in rural communities to train and eventually practice.

At a Glance

Grants Awarded:

- **2008:** N/A
- **2009:** N/A
- **2010:** 20 new

Amount Awarded: Up to \$200,000 per year per grantee

- **2008:** N/A
- **2009:** N/A
- **2010:** \$3.9 million

Program Period: 3 years

Next Competitive Grant Application:
N/A

The program's goals are the following:

- *Providing students and residents training opportunities and experiences within culturally-competent, community-focused rural setting that will build and reinforce ties within these rural communities;*
- *Improving the viability of the network partners by enhancing recruitment and retention of needed health care professionals within their rural communities;*
- *Identifying innovative approaches for using a network model to train health care professionals in rural community-based clinical settings;*
- *Providing an opportunity for students/residents to become involved in community activities so that they become engaged in the community; and/or*
- *Establishing viable rural health networks within the community that can serve as an ongoing vehicle for addressing workforce challenges.*

The President's 2010 Budget created a new "Improve Rural Health Care Initiative," which will re-organize the way rural programs are currently administered to focus on building an evidence base for ways to improve health care in rural communities. Workforce and rural recruitment and retention are a critical component of the 2010 President's Rural Initiative. As part of the Initiative, the Office of Rural Health Policy (ORHP) created the Rural Health Workforce Development Program during FY 2010.

KEY PROGRAM ACCOMPLISHMENTS:

The Workforce Development Program is a pilot program. The ORHP recently awarded 20 new grants within 18 different States on September 1, 2010. The workforce projects vary around primary care and allied health student and resident rural, community-based practical trainings in the medical, dental and mental health fields.

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.

PROGRAM OVERVIEW: The legislative purpose of the Rural Health Network Development Planning Grant Program (Network Planning) program is to expand access and to coordinate and improve the quality of essential health care services and delivery 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:

- *Identifying potential collaborating network partners in the community/region;*
- *Convening potential collaborating network partners;*
- *Conducting planning activities, such as developing strategic and business plans; and*
- *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.

KEY PROGRAM ACCOMPLISHMENTS:

Key representatives of the Network Planning projects participated in a Grantee Partnership Meeting held in San Antonio, TX. in April 2010 where they were given the opportunity to hear from experienced and successful Network Directors that helped them develop strong network partnerships.

In the last two years over 100 organizations have participated in Network Planning grants. Also, although the Network Planning funds do not provide for direct service delivery, the grantees report that in FY09 the funds provided expanded access to over 50 services in their communities as a result of their grant funds.

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.

At a Glance

Grants Awarded:

- **2008:** 33 new awards
- **2009:** 19 new awards
- **2010:** 30 new awards

Amount Awarded:

- **2008:** \$2.7 million
- **2009:** \$1.6 million
- **2010:** \$2.5 million

Project Period: 1 year

Next Competitive Grant Application:

- **Year:** FY 2011
- **Anticipated Grants:** Up to 12
- **Anticipated Grant Amount:** Up to \$85,000 per year, per grantee

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.

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.

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 2010 we anticipate over 900 new AEDs to be purchased with an additional 1000 persons trained. For the years FY2006 through 2008 over 1000 new AEDs were purchased and over 5,000 persons were trained in their use.

At a Glance

Grants Awarded:

- **2008:** 13 continuing awards
- **2009:** 5 new awards
- **2010:** 15 new awards and 4 continuing awards

Amount Awarded:

- **2008:** \$1.2 million
- **2009:** \$.5 Million
- **2010:** \$ 1.7Million

Project Period: 15 one year and 4 two year budget periods

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

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

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 (QI) strategies for chronic disease management.

The Rural Quality program improves health outcomes through by:

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

The Rural Quality program was first sponsored by ORHP in FY 2006 as a two-year pilot program, and increased to a three-year grant program beginning in FY 2010. The first year is dedicated to choosing and implementing an electronic patient registry, training staff, and identifying an initial patient population of focus. Grantees collect data on patients with a diagnosis of diabetes during the second year, and broaden to cardiovascular disease (CVD) during the third year.

While many QI initiatives focus on in-patient hospital care, QI 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 ER 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 start of the program, 129 providers in rural underserved areas have been supported through the Rural Quality Program. Over 40,000 patients with a diagnosis of diabetes or CVD have been monitored through an EPR funded by the Rural Quality Program. Many providers have continued tracking patients and performing quality improvement activities beyond their project period and Federal funding. During the 2009-2010 project year, grantees reported adopting 369 clinical benchmarks and estimated earning \$368,491 in project revenue due to implementation of the QI project. The Peer Learning Workshop was held in July 2010, and focused on patient self-management, sustainability, and information technology.

At a Glance

Program Duration: 3 years as of FY2010

Grants Awarded:

- **2008:** 55 new awards
- **2009:** 55 continuing awards
- **2010:** 59 new awards

Amount Awarded:

- **2008:** \$ 4,026,691
- **2009:** \$ 4,003,244
- **2010:** \$ 5,844,717

Next Competitive Grant Application:

- **Year:** 2013
- **Anticipated # Grants:** Up to 60
- **Anticipated Grant Amount:** Up to \$100,000 per year per grantee

Office for the Advancement of Telehealth

The Office for the Advancement of Telehealth (OAT), promotes the use of telehealth technologies for health care delivery, education, and health information services. Telehealth is defined as the use of telecommunications and information technologies to share information, and to provide clinical care, education, public health, and administrative services at a distance. The office is part of the Health Resources and Services Administration (HRSA) at the U.S. Department of Health and Human Services. HRSA's mission is to assure quality health care for underserved, vulnerable, and special needs populations.

In FY 2010, ORHP administered three grant programs within OAT. The grant programs are: 1) Telehealth Network Grant Program; 2) Telehealth Resource Center Grant Program; and 3) the Licensure Portability Grant Program. There were 36 grants awarded in these three programs with a budget of approximately \$9.5 million. OAT has responsibility for managing all health information technology-related congressionally mandated projects for HRSA and awarded \$26.2 million to 59 grantees. In addition to the above grants, OAT members manage contracts and interagency agreements that evaluate outcome data from grantees, examine the use of telemedicine intensive care units and their impact on health in rural areas, and support the assessment of telehealth technologies.

OAT Team Members:	
Sherilyn Pruitt, Division Director	
Lawrence Bryant	Makeda Clement
Monica Cowan	Carlos Mena
Bert Pié	

Telehealth Network Grant Program

AUTHORIZING LEGISLATION:

Section 330I(d)(1) of the Public Health Service Act (42 U.S.C. 254c-14), as amended.

PROGRAM OVERVIEW:

The primary objective of the Telehealth Network Grant Program (TNGP) is to demonstrate how telehealth programs and networks can improve access to quality health care services in underserved rural and urban communities.

Applicants can apply for the TNGP in one of two areas:

1. **Telehealth Networks** – grants for the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration.
2. **Telehomecare Networks** – grants to evaluate the cost and effectiveness of remote vital sign monitoring of individual patients and the delivery of healthcare services to individuals in their place of residence by a healthcare provider using telecommunications technologies to exchange healthcare information over a distance.

TNGP grants demonstrate how telehealth networks improve healthcare services to:

- Expand access to, coordinate, and improve the quality of health care services
- Improve and expand the training of health care providers
- Expand and improve the quality of health information available to health care providers, patients, and their families

The TNGP seeks to fund nonprofit organizations with a demonstrable successful track record in implementing telehealth technology and with a network of partners in place. The intent is to fund network expansion and/or to increase the breadth of services of existing successful telehealth networks.

KEY PROGRAM ACCOMPLISHMENTS:

TNGP performance measure data shows a vast expansion in the number of telehealth services (e.g., dermatology, cardiology) and the number of sites where services are available as a result of the TNGP program, over the last 7 years. In addition, 100% of former TNGP grantees continue to provide some level of telehealth services, after OAT funding has ended.

At a Glance

Grants Awarded:

- **2008:** 16 continuing awards
- **2009:** 17 new awards
- **2010:** 9 new / 17 continuing

Amount Awarded: Up to \$250,000 per year per grantee

- **2008:** \$ 3.7 million
- **2009:** \$ 4.2 million
- **2010:** \$ 6.5 million

Program Duration: 3 years

Next Competitive Grant Application:

- **Year:** 2012
- **Anticipated # Grants:** Up to 15
- **Anticipated Grant Amount:** Up to \$250,000 per year per grantee

Telehealth Resource Center Grant Program

AUTHORIZING LEGISLATION:

Sec. 3301(d)(2) of Public Health Service Act, as amended, 42 USC 254c-1

PROGRAM OVERVIEW:

The purpose of the Telehealth Resource Center Grant Program (TRCGP) is to support the establishment and development of Telehealth Resource Centers (TRCs). The Centers are to be an impartial, independent source of technical assistance to health care organizations, health care networks, and health care providers in the implementation of cost-effective telehealth programs to serve rural and medically underserved areas and populations. The program is designed for entities with a successful history of providing technical assistance in the field of telehealth/telemedicine, which enables them to give guidance to both new and existing programs in the development and implementation of an effective sustainable telehealth program.

TRC grantees have five or more years experience in providing technical assistance related to the provision of Telehealth services. In addition, consortium members have a track record of working together on common projects. The agreement reflects the clear organizational relationships within the consortium and the defined organizational role of each member in the Telehealth Resource Center.

KEY PROGRAM ACCOMPLISHMENTS:

The Telehealth Resource Centers are collaborating in their efforts to provide telehealth technical assistance to numerous regions throughout the U.S. Each organization has developed tool kits and resources that are readily available to HRSA grantees, health care organizations, health care networks and health care providers as a means to improve existing telehealth services or implementation for new telehealth services. The one national TRC provides a mechanism for sharing experiences across the nation in addressing legal and regulatory barriers to the effective implementation of telehealth technologies. The Resource Centers are also working with Telehealth Technical Assistance Center (T-TAC) to evaluate telehealth technologies, especially evaluating equipment designed to facilitate clinical services via Telehealth.

At a Glance

Grants Awarded:

- **2008:** 5
- **2009:** 5
- **2010:** 9 new/continuing

Amount Awarded:

- **2008:** \$2.0 million
- **2009:** \$2.0 million
- **2010:** \$2.9 million

Program Duration: 3 years

Next Competitive Grant Application:

- **Year:** 2011
- **Anticipated # Grants:** Up to 3
- **Anticipated Grant Amount:** Up to \$325,000 per year per grantee

Licensure Portability Grant Program

AUTHORIZING LEGISLATION:

Section 330L of Public Health Service Act as amended, (42 USC 254c-18)

PROGRAM OVERVIEW:

The primary purpose of the Licensure Portability Grant Program (LPGP) is to provide support for State professional licensing boards to carry out programs under which licensing boards of various States cooperate to develop and implement State policies that will reduce statutory and regulatory barriers to telemedicine.

Under a second 3-year Licensure Portability grant that began in FY 2009, the Federation of State Medical Boards (FSMB) is developing model agreements in two regions of the country (Northeast and West) to:

- *Expedite the licensure process and endorsement agreements*
- *Eliminate redundancies associated with applying for licenses in multiple jurisdictions*
- *Build on the successes of the first grant*
- *Encourage states to adopt the Uniform Application (UA)*

FSMB is a national non-profit organization representing medical boards in the United States and its territories, and is encouraging states to adopt the model of expedited endorsement.

KEY PROGRAM ACCOMPLISHMENTS:

The level of cooperation among medical licensing boards has improved significantly since the initial telehealth program was funded. Over the last five years, regulatory boards have worked together to improve the license portability process and promote the effective use of technologies to improve access to health services. Expedited endorsement is a method of setting criteria to approve a valid license of another state. FSMB is currently working with a consortium of 19 State Medical Boards, for which 13 have already adopted the model of expedited endorsement.

At a Glance

Grants Awarded:

- **2008:** 1 continuing award
- **2009:** 1 new award
- **2010:** 1 continuing award

Amount Awarded:

- **2008:** \$350,000
- **2009:** \$350,000
- **2010:** \$350,000

Program Duration: 3 years

Next Competitive Grant Application:

- **Year:** 2012
- **Anticipated # Grants:** Up to 2
- **Anticipated Grant Amount:** Up to \$350,000 per year per grantee

Border Health Division

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.*

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.

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 members 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.

Border Team Members:	
Frank Cantu	Lilia Salazar
Margarita Figueroa-Gonzalez	Christina Villalobos
Erma Woodard	Michelle Mellen

Appendix: 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 (P.H.S. Act) 42 U.S.C. 254c

Frontier Extended Stay Clinics Demonstration

Section 301 and 330A of the P.H.S. 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 P.H.S. Act 42 U.S.C. 254c

Network Development Planning Grant Program

Section 330A of the P.H.S. Act 42 U.S.C. 254c

Public Access to Defibrillation Demonstration Projects

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

Radiation Exposure, Screening and Education Program

Section 417C of the P.H.S. 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 P. H.S. 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.