U.S. Department of Health and Human Services
Health Resources and Services Administration

Office of Rural Health Policy

2007 Annual Report

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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. While located within the Health Resources and Services Administration (HRSA), the Office has a department-wide responsibility to analyze the impact of policy on rural communities. The Office's policy role is created by Section 711 of the Social Security Act, which charges the Office with advising the Secretary on rural health issues. In that role, the Office examines issues such as the effects of Medicare and Medicaid on rural citizens' access to health care, specifically on the viability of rural hospitals, and the availability of rural physicians and other health professionals.

ORHP serves as both a policy and programmatic resource for rural communities. In FY 2007, ORHP administered 16 grant programs with a focus on capacity building at the community and State levels.

The Office's grant programs provide funding at both the community and State levels to support improved rural health care delivery. The Office's hospital-State programs provide grants to the States to support State-wide activities via the 50 State Offices of Rural Health (SORH) and to work with rural hospitals across the Nation. Through its community-based programs, the Office supports projects that improve access to high quality health care services, encourage network development among rural health care providers, enhance delivery of emergency medical services and place and train people on the use of automatic external defibrillators. The Office also oversees the Black Lung Clinics grant program and the Radiation Exposure Screening and Education grant program. While these programs are not solely focused on rural health issues, many of the populations affected reside in rural areas.

In addition, the Office is also charged with two agency-wide coordinating functions: HRSA's border health activities and the Agency's intergovernmental affairs activities. Much of the 2,100-mile U.S.-Mexico border is rural and the urban regions face health care delivery challenges similar to rural areas, such as limited health workforce capacity and fragile infrastructure. Coordination of the agency's intergovernmental affairs activities resides with ORHP due to the office's interaction with many programs across the agency.

Authorizing Legislation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FY 2007 Overview

The Office had a variety of noteworthy programmatic and policy accomplishments in FY 2007 which addressed the Office's key priority areas for the year: health information technology (HIT), quality improvement, and performance measurement. Some examples of the Office's activities include funding a new HIT grant program, hosting the third bi-annual All-Programs Meeting, and creating an electronic performance improvement and measurement system (PIMS).

Flex Critical Access Hospital (CAH) HIT Network Grant

Through the new Flex Critical Access Hospital (CAH) HIT Network grant program, the Office awarded approximately $25 million to 16 State Offices of Rural Health. This program supports the development of Flex CAH-HIT Network pilot programs to promote and implement HIT and electronic health records in CAHs and the providers with which they work.

ORHP All-Programs Meeting

In August, over 800 ORHP community-based and State grantees attended the Office's All-Programs Meeting in Washington D.C., where they exchanged ideas with HRSA partners and learned from fellow grantees about best practices being implemented across rural America. The meeting highlighted various rural health issues, such as the changing demographics of rural, workforce, rural health policy, quality improvement, HIT, mental health, and veterans affairs. In addition to the All-Programs Meeting, a commemorative twentieth anniversary roundtable session was held in August, where past and current directors and deputy directors shared highlights from their years of service.

Performance Improvement and Measurement System (PIMS)

To enhance the Office's ability to report and track the progress of its programs, ORHP identified performance measures for all of its programs over the past year and is working with the HRSA Office of Information Technology to develop the performance improvement and measurement system (PIMS). This system will be compatible with the Electronic Handbook, which is currently used by grantees to submit their non-competing continuation guidance. The PIMS system is expected to be operational by FY 2009 and will help quantify the impact of ORHP funding on quality of services, access to health care and improvement of health outcomes.

ORHP Budget

Chart 1 – Budget Summary for Programs, FY 2006 and FY 2007 *(amounts in thousands)*

Rural Health Programs	FY 2006 Final Appropriation	FY 2007 Final Appropriation
Rural Health Outreach	38,885	38,885
Rural Health Research	8,737	8,737
Medicare Rural Hospital Flexibility	63,538	63,538
Rural and Community Access to Emergency Devices	1,485	1,487
Rural EMS Training and Assistance Equipment Program	0	0
State Offices of Rural Health	8,141	8,141
Denali Commission	39,283	39,283
Radiation, Screening, Exposure and Education Program	1,917	1,919
Black Lung	5,891	5,891
Total	**$ 167,877**	**$ 167,881**

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

Chart 2 – Total number of ORHP Grants and Amounts by State, FY 2007

Total number of Grants awarded: 399
Total amount Funding provided: $111,952,162

State	# Grants Awarded	FY 2006 Funding
AK	8	1,602,065
AL	12	3,310,117
AR	9	2,472,161
AZ	9	1,530,635
CA	7	1,792,809
CO	6	2,164,816
CT	2	298,500
DE	3	451,415
FL	7	1,214,459
GA	13	2,544,901
HI	4	2,294,450
IA	9	2,075,227
ID	5	1,020,735
IL	9	4,214,928
IN	9	3,231,429
KS	6	1,793,275
KY	10	2,824,139

State	# Grants Awarded	FY 2006 Funding
LA	14	4,288,849
MA	5	984,191
MD	5	999,854
ME	6	1,690,510
MI	18	4,509,305
MN	10	4,264,345
MO	9	2,300,538
MS	9	2,585,738
MT	12	2,393,988
NC	8	1,889,875
ND	8	2,825,353
NE	13	4,180,281
NH	8	1,387,426
NJ	2	248,294
NM	11	2,404,608
NV	7	1,273,805
NY	9	1,435,195

State	# Grants Awarded	FY 2006 Funding
OH	8	2,028,011
OK	7	1,273,805
OR	6	1,354,576
PA	10	1,751,016
RI	1	141,600
SC	9	3,524,792
SD	8	1,736,014
TN	8	3,556,620
TX	13	4,145,940
UT	6	1,370,214
VA	10	3,354,980
VT	4	982,853
WA	9	3,650,520
WI	8	3,374,829
WV	5	2,287,554
WY	5	1,023,091

Policy Activities

Key Regulatory Review and Policy Activities

In its policy role, the Office focuses on issues related to access to care for residents of rural areas. Because many of the policy levers at the Federal level are related to the Medicare program, Medicare policy review and analysis comprise much of the Office's policy work. However, significant time and attention are also devoted to other policy areas including Medicaid, the State Children's Health Insurance Program (SCHIP), workforce, quality, and health information technology (HIT). The Office advises the Secretary on the effects of current policies and proposed statutory, regulatory, administrative, and budgetary changes in previously mentioned areas.

- The specific Medicare regulations that come through ORHP for review vary somewhat from year to year. However, the major Medicare payment system regulations generally come through for review during both the proposed rule-making and final rule-making cycles. Recently, regulations relating to the Medicare Advantage, Medicare Drug Benefit, and various quality reporting programs also have been reviewed for comment.

- Medicaid and SCHIP are State-based programs. Therefore, much of the discretion for these programs is left to the States. However, ORHP does participate in the departmental review of Medicaid and SCHIP waiver proposals to assure that the interests of rural Medicaid beneficiaries are considered.

- The Office role in workforce policy encompasses a wide variety of issues including Medicare Graduate Medical Education, J1-Visa Waivers, the National Health Service Corps, and Title VII programs that provide support to rural providers.

- Rural Health quality issues are relatively new, yet important activity to the Office. ORHP participates in review and analysis of rural provider participation in quality measurement and reporting activities and value-based purchasing programs.

<u>Rural Medicare Payment</u>

During Fiscal Year 2007, the policy staff in ORHP reviewed approximately 150 draft Federal regulations and policies to determine how they might affect rural providers and the individuals they serve. Of these regulations, 26 included provisions ORHP staff felt had the potential to adversely affect rural providers or for which staff felt additional language should be added to provide adequate protections for rural providers.

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

- The FY 2008 Inpatient Prospective Payment System (IPPS) regulations implemented a new payment classification for IPPS diagnosis-related groups (DRGs) called the Medicare Severity, or MS-DRGs, which better accounts for the severity of each patient's condition. ORHP analyzed the impact of these changes on rural providers and will continue to monitor their impact as they are implemented in the coming years.

- The CY 2008, Outpatient Prospective Payment System (OPPS) regulations offered the continued opportunity to provide assistance to CMS in developing a payment add-on for certain rural hospitals. Additionally in this regulation, ORHP worked with CMS to develop reasonable standards for changes to Critical Access Hospital conditions of participation pertaining to requirements for co-location and off-campus provider-based facilities.

- During 2007, the Office continued to work with CMS on the CAH necessary provider facility relocation Interpretive Guidelines to encourage CMS to establish reasonable flexibility for CAHs as they proceed through the relocation process. Data provided by ORHP regarding CAH services, staffing, and geographic location assisted in CMS publishing revised guidance in September 2007.

- In 2007, ORHP identified small rural independent pharmacies as a key policy area to monitor. Recent policy changes impacting these providers include the implementation of Medicare Part D, as well as Medicaid program payment changes. ORHP has concern about the long-term viability of these providers and what their closure could mean for access to pharmaceutical services in remote areas.

Rural Health Care Quality

In 2007, the Quality Improvement Organizations (QIOs) continued their work with CAHs and small rural hospitals in order to improve quality and patient safety as part of the requirement under the CMS 8th Scope of Work (SOW). The CMS 8th SOW was the first time QIOs were required to engage CAHs. In 2007, CAHs continued to increase their participation in reporting quality measures to the Hospital Compare Web site operated by CMS. By the end of FY 2007, approximately 80 percent of CAHs were reporting on at least one measure, which is over a 20 percent increase in participation from 2006. This is significant since CAHs participate in the program on a voluntary basis compared to hospitals paid under the Medicare Inpatient Prospective Payment System (IPPS) who are required to participate in order to receive a full payment update.

Also in 2007, the National Quality Forum approved five emergency department acute myocardial infarction (AMI) transfer measures, often referred to as the Rural Emergency Department Transfer measures as they have particular relevance to the activities of rural hospitals. These measures have been incorporated in the Outpatient Prospective Payment System (OPPS) new quality reporting program which hospitals will begin reporting on in 2008.

Throughout 2007, ORHP worked with CMS to develop a Medicare Hospital Value-Based Purchasing (VBP) plan that is inclusive of rural facilities. CMS's VBP plan prepared in a Report to Congress developed a proposal that links payment more directly to the quality of care provided (i.e., pay-for-performance) under the Medicare program for hospitals beginning with FY 2009.

Health and Human Services (HHS) Rural Task Force

ORHP continues to coordinate the HHS Secretary's Rural Task Force. The HHS Rural Task Force, established in 2001, is comprised of representatives from each Agency and Office of the Secretary Staff Divisions. The Task Force continues to conduct department-wide quarterly meetings to encourage collaboration and partnership among HHS agencies on topics that affect rural communities. In 2007, a range of issues were presented, including:

1) Overview of the Medicare Advantage in rural America;
2) Overview of the National Advisory Committee on Rural Health & Human Services;
3) Human Services: A Look Inside the Administration on Children and Families (ACF);
4) Value-Driven Healthcare.

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

In 2007, ORHP continues to act as primary staff for the National Advisory Committee on Rural Health and Human Services. NACRHHS is a 21-member citizen's panel of nationally recognized rural health experts that provides recommendations on rural issues to the Secretary of the Department of Health and Human Services. Each year, the Committee produces a report for the Secretary on key health and human service issues affecting rural communities with recommendations on the selected issues.

The three topics that the *2007 Report to the Secretary: Rural Health and Human Services* focused on were Medicare Advantage, Substance Abuse, and Head Start in rural areas. The year 2007 marked the twentieth anniversary of the Office of Rural Health Policy. Accordingly, the 2008 Report will examine the past twenty years of rural health and human services, provide information on major structural changes, and analyze emergent trends.

Policy Related Projects and Partnerships

One of the unique aspects of the Office of Rural Health Policy is its entrepreneurial nature. Since its inception, the Office has put an emphasis on working with key partners and organizations to develop projects to address long-standing rural health problems. The Office uses a portion of its funding in the Policy/Research line to support these activities. The emphasis of these special projects is either to highlight an issue or work with key rural partners to develop services or resources that fill an identified need.

Some of these "special projects" are focused on the needs of all rural communities, such as the need for general information on rural health. Others may focus only on a specific issue such as the recruitment and retention of health workforce or the role of economic development in health care. Still, other activities focus on a particular type of health care providers. In each case, however, the projects and initiatives supported by the Office meet an identified rural health care need.

340B Technical Assistance

As a result of a change in the law in 2003, approximately 350 rural hospitals qualified to participate in the 340B Drug Pricing Program. To assist these facilities in signing up for the program, the ORHP provided supplemental funding to the HRSA Pharmacy Services Support Center (PSSC) in FY 2007 to assist rural hospitals in understanding and applying for participation in the 340B discount drug purchasing program. The PSSC is a resource established in 2002 to assist HRSA grantees and eligible health care sites to optimize the value of the 340B Program and provide clinically and cost effective pharmacy services that improve medication use and advance patient care. The PSSC operates under a contract between the American Pharmacists Association (APhA) and the Office of Pharmacy Affairs (OPA), in the HRSA Healthcare Systems Bureau. To date, over 180 rural hospitals are participating in the 340B program as a result of this assistance.

CAH Capital Replacement Manual

Cost based reimbursement, and the Flex Grant Program to States (administered by the Office), have allowed CAHs to improve their financial performance. Some are now considering replacing their facility, many of which were built in the 1950s. Such replacement has shown to dramatically increase admissions and outpatient visits; as well as allow improvements in staff recruitment, clinical performance and quality of care. Increasing market share also adds significantly to the local economy. To date, few lenders (Federal and private), architects and builders have had any experience with CAHs - which creates a real obstacle for rural hospital CEOs and Boards. To help them get started on the right path, a "Manual for CAH Replacement" is being developed. This manual will contain step-by-step guidance, simple tools and successful strategies for obtaining capital and building a replacement CAH.

Center for Rural Health Works (RHWks)

This long-standing effort of the Office examines the important link between economic development and health care in rural communities. The health sector is often one of the top employers in a rural economy, a role and relationship that often is not fully understood. The Center for Rural Health Works (RHWks) is an ongoing program that works to strengthen local systems of health. As the national focal point, it provides technical assistance, tools and training to help States measure the economic impact of the health-care sector on local, regional and State economies. It also develops feasibility studies for new health care services. During FY 2007, RHWks activities included conducting two regional workshops, responding to more than 300 requests for technical assistance, redesigning their Web site and developing four new applications for measuring the economic impact of health care on local communities. They shared the results of their studies and activities at numerous regional and national conferences.

Delta Regional Authority/ Appalachian Regional Authority Pharmacy Assist Demonstration

The ORHP has also partnered with the Appalachian Regional Commission (ARC) for a two-year pilot program to increase access to affordable medications by improving the management of patient assistance program (PAPs) at clinics located within the ARC and Delta Regional Authority (DRA). As a result of joint ARC/DRA PAP workshop meetings, enhancements to PAP programs have been identified and are being implemented at clinics in Kentucky, Ohio, Mississippi, and Missouri.

National Association of Counties (NACo)

The National Association of Counties (NACo) has established a partnership with the Center for Rural Health Works (RHWks) to help county elected officials take the lead in conducting a comprehensive community engagement process to improve health care and economic development. The purpose of this project is to help rural communities recognize that improving their health care system has a direct and positive impact on local economic growth. This was a new initiative for FY 2005 and continues in FY 2007. During this year, the NACo and RHWks provided on-site technical assistance to three rural counties. This project produced three county-level reports on economic impact, community need, a health services directory, and useable data/information. The reports were provided to each county and placed on the NACo Web site. NACo also disseminated information about this project through workshops at its Western Regional and Annual Conferences and through articles in NACo's publication "County News."

National Conference of State Legislatures (NCSL)

ORHP continues to work with the National Conference of State Legislatures (NCSL) to hold an annual meeting for rural legislators focusing on new and emerging issues. The annual meeting attracts 30-50 elected State officials who live and serve rural communities. In 2007, the meeting focused on the challenges facing rural emergency medical services and trauma care providers.

National Organization of State Offices of Rural Health (NOSORH)

The State Office of Rural Health (SORH) program continued to be enhanced in 2007 by a cooperative agreement with the National Organization of State Offices of Rural Health (NOSORH), which was designed to build and sustain rural health infrastructure in each State. Under the agreement, NOSORH coordinates the planning and logistics for five regional grantee meetings, a new SORH director orientation meeting and the annual grantee meeting. In addition, the peer-to-peer mentoring program has been strengthened and improved, EMS and GIS mapping sessions were held and five partnership / collaboration projects were funded.

National Rural Health Association (NRHA)

In 2007, ORHP collaborated with the National Rural Health Association (NRHA) to identify, analyze, and address rural health needs. Activities include identification and promotion of best practices for rural health care providers, promotion of rural quality initiatives and provision of resources to communities including skill building and leadership development. Other activities include promotion of best practices via teleconference or webinar series, treatment of agriculture-related disease and injury via access to AgriSafe Network Resources, and provision of technical assistance to and strengthen State-based entities such as State Offices of Rural Health (SORHs) and State Rural Health Associations (SRHAs). In addition, the NRHA was able to collect information about the effects of implementation of Medicare and Medicaid reforms on rural health access to services, providers, pharmacists and systems of care.

Specific and key accomplishments through NRHA activities in 2007 are very diverse. Site visits were conducted in six States (Georgia, Michigan, Mississippi, South Dakota, Vermont, and West Virginia) to identify models that work for improving rural health care quality. As result of this work, a manual entitled, "What Makes Rural Health Care Work" was developed based on the compilation of information obtained from the various site visits. The NRHA also supported the development of an outline and first chapter of a rural public health textbook highlighting topics of importance in rural communities. Additionally, NRHA provided of a total of thirty-six State Rural Health Associations or States which received technical assistance grants in the amount of $9,500. The NRHA also trained AgriSafe providers using a model which integrates behavioral health within AgriSafe services. Finally, NRHA hosted two policy meetings key policy issues pertaining to Medicare payment titled "Improving Options for Medicare Beneficiaries" and "Emerging Issues in Rural Pharmacy".

National Rural Recruitment and Retention Network

The National Rural Recruitment and Retention Network (3RNet) works to increase the number of providers practicing in rural America. The project consists of 48 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 Offices, Primary Care Associations, Area Health Education Centers, and other not-for-profit entities. The 3RNet coordinates workshops, training, and presentations for those interested in recruiting and keeping providers in rural communities.

During FY 2007, 3RNet helped States improve their retention and recruitment activities especially for primary care physicians, RNs, dentists, pharmacists, and mental health professionals. Members placed 750 medical professionals. This included 220 family practice physicians, 65 internal medicine physicians, 50 pediatricians, 100 dentists, 80 nurse practitioners, and 80 physician assistants. 3RNet also maintained a toll-free phone line to assist providers interested in serving rural America. Due to the recruitment and retention help from 3RNet, the cost savings to rural communities is substantial. Research from the 3RNet shows that physician recruitment costs often cost up to $28,000 and non-physician recruitment costs generally run up to 30 percent of the first year's salary. In FY 2007, it is estimated that the 750 placements through 3RNet will result in up to $9 million in saved recruiting costs for rural communities.

Rapid Response to Requests for Rural Data Analysis

In 2007, ORHP funded the Rapid Response to Requests for Rural Data Analysis to support quick turn around to assist with policy making. Due to the nature of rural policy analysis and formulation, policy makers often require information that is available only through specialized analysis of databases of information. In order to acquire the information from the data sets needed to identify trends, problems and progress in rural health care financing and access to care in rural areas, ORHP funds a consortium of research institutions that have access to the required data storage capacity, personnel, and computer resources to provide the information. Topics analyzed for policy makers in 2007 include rural Veteran services, Rural Health Clinic geographic locations and shortage designation status, Value Based Purchasing in rural hospitals, Medicare Advantage and CAHs, and the experience of rural independent pharmacies with Medicare Part D.

Rural Assistance Center

The Rural Assistance Center (RAC) staff helps rural residents seeking information to navigate the wide range of health policy and social services information available online, in the research literature, and within the Federal and State bureaucracies. With many different possible funding streams available for use by rural communities, RAC identifies those that best meet the needs of rural communities and directs users to those that best suit them. RAC staff provides free customized assistance such as performing database searches on rural health and services topics and funding resources, referring users to organizations or individuals for additional information, furnishing selected publications, and posting a wide variety of timely information on the Internet (funding resources, conference announcements, bibliographies, directories, and full-text documents). The RAC identifies and collects sources of information and research from a myriad of federal and non-federal sources; archives and provides easy access to that information; disseminates information and promotes the use of services available through RAC; and makes information actionable for rural stakeholders. During 2007, RAC responded to over 900 individual requests for information and assistance.

The RAC Web site is the most comprehensive source of information on rural health and human services on the Internet. RAC's extensive web site and electronic mailing lists are used to distribute information to a large number of rural health and human services resources such as news, documents, tools, funding opportunities, and events to a broad rural audience. RAC's Web site averages over 60,000 visits per month, while RAC's e-mail listservs have over 12,000 combined subscribers.

Rural Health Clinic Technical Assistance Series

More than 3,000 Rural Health Clinics (RHCs) nationwide are served by the Rural Health Clinic Technical Assistance (RHC TA) services funded by ORHP. As safety-net providers, RHCs play a key role in maintaining access to care for rural underserved populations, yet they face unique operational and administrative challenges in providing such care. The RHC TA Series is designed to assist RHCs in meeting those challenges by providing access to relevant and timely information. TA is provided through a combination of educational conference calls, as well as the use of a listserv, both of which are available free of charge to all RHCS and their staff. The RHC TA Web site posts written transcripts, speaker presentations, and audio transcripts of each call. The utilization of these methods allows ORHP to provide crucial TA to RHCs in an efficient and cost-effective manner.

In FY 2007, the RHC TA Conference Call series provided RHCs nationwide with seven conference calls on RHC-specific issues. The topics were determined approximately one month before each call by an advisory group of RHC experts. Topics addressed in these calls included RHC regulation updates, NPI requirements, Medicare Advantage reimbursement, access to capital, shortage designations, and various documentation requirements. The calls attracted an average of 230 participants per call. A recent estimate shows that these conference calls save RHCs an average of $900 per call compared to the cost of traveling staff to similar events held offsite. In the aggregate for FY 2007, this results in a savings of over $200,000 per call for the participating RHCs. In addition, it should be noted that the RHCs are allowed to take the cost of the educational programs as allowable cost on their cost report. By getting this information for free, clinics can use the $900 they save for the actual delivery of care to patients.

Rural Health Research Center Gateway

The Rural Health Research Gateway (Research Gateway) Web site was developed and went live in February 2007 to improve the dissemination of information and publications of the Rural Health Research Centers (Research Centers). The Research Gateway is a user-friendly Web site for many tasks. Users can access information about the Research Centers, including contacts and area of expertise. Searches can be conducted for summaries of research projects, both those underway and completed. The user can carry out searches several ways, by topic, researcher, Research Center, funding organization, and date. Users can also find and print Policy Briefs, Analytic Reports, Fact Sheets, and other publications resulting from the work of the Research Centers. The Research Gateway links to the Web sites of the Research Centers so the user can print a copy of the publications of interest.

The Research Gateway currently includes all projects and their related publications from the Research Centers from 2006 and later. Projects and publications from 2003-05 are being added as resources permit.

Rural Hospital Performance Improvement Project

The Rural Hospital Performance Improvement (RHPI) Project is a comprehensive and ongoing technical assistance to rural hospitals in the Mississippi Delta Region, defined by the Delta Regional Authority (DRA), for the purpose of improving financial, operation, and clinical performance. The RHPI Project coordinates the delivery of on-site technical assistance services. A range of performance improvement services are offered that respond to specific hospital performance needs. RHPI has developed performance improvement sustainability strategies at the State, regional (network) and local (internal hospital) levels. Primary players in these activities include the State Offices of Rural Health (SORH), the State Hospital Associations, and the State Quality Improvement Organizations (QIOs).

In 2007, RHPI completed seventy consultations, which included: five performance improvement assessments, 57 targeted consultations, and eight Balanced Scorecard (one specific type of healthcare management system) implementations. Follow-up performance improvement assessments of nine hospitals and employee feedback surveys of eleven hospitals were completed. Many conferences and workshops were held, including two “Balanced Scorecard” workshops, four Partnership Committee calls and one regional conference with 100 participants from the eligible hospitals, consultants, and State partners. RHPI also initiated a quality improvement project that focused on AMI presenting in ERs. In November of 2007, a program evaluation was completed entitled *The Relationship between Financial Status and Quality of Care in Rural Hospitals in the Delta*.

Rural Policy Analysis Cooperative Agreement

In FY 2007, ORHP funded the Rural Policy Analysis Cooperative Agreement to support research and analysis on key policy issues affecting rural communities. The 2007 funding supported several activities including work with rural community colleges on health workforce development, the Rural Policy Research Institute Rural Health Panel, and the Rural Hospital Issues Group. The RUPRI Rural Health Panel provides science-based, objective policy analysis to Federal policymakers. Panel members come from a variety of academic disciplines and create documents that reflect the consensus judgment of all panelists. The Rural Hospitals Issues Group, a panel of small rural hospital administrators and rural hospital finance experts from across the country, discuss issues such as the MMA, Medicare Advantage, and other policy issues affecting small rural hospitals.

Technical Assistance and Services Center

The Technical Assistance Services Center (TASC) provides assistance and information to Rural Hospital Flexibility Program (Flex Program) grantees on Medicare reimbursement policies, Federal regulations, hospital operations, and other issues that may arise. The staff of ORHP works closely with TASC to prioritize key issues and develop information resources to share with Flex grantees.

The Flex Program grantees frequently need assistance with detailed information on Medicare reimbursement policies, Federal regulations, hospital operations, and other issues that may arise.

TASC has supported the 45 participating State Flex Programs through the following activities: assistance in converting over 1,200 perspective payment hospitals to Critical Access Hospital (CAH) status; integration of emergency medical services into the rural medical delivery systems with more than 12 EMS educational sessions and three manuals for Flex Program and hospital leaders; building rural hospital networks to exchange information, provide economies of scale, obtain collective volume, and increase cost efficiency and overall effectiveness—TASC provides resources to hundreds of networks created throughout the country, and provides educational sessions; and, improving quality and performance improvement in rural hospitals and has coordinated three national rural quality forums and staff has presented at over 50 State quality and performance improvement events.

Grant Programs

Research and Policy Grant Programs

In FY 2007, ORHP administered three grant programs within the Policy Research Team. The grant programs are: 1) the Frontier Extend Stay Clinic Demonstration program; 2) the Rural Health Research Centers; and 3) the Targeted Rural Health Research grant programs. There were 10 grants awarded in these three programs with a total budget of almost 4.3 million dollars. In addition to the above grants, Policy Research Team members manage numerous cooperative agreements and contracts that support research and analysis of key policy issues affecting rural communities. These activities work to educate and inform rural decision makers and policy leaders at the local, State, and Federal level.

The management of the grants is done with a workforce composed of seven team members. In addition to their responsibilities, most members of the team also serve as policy analysts in reviewing of Medicare, Medicaid, and other regulations. Their familiarity with the development of current policy and the work done by the grantees allow team members to serve as a base of knowledge and expertise for rural health care policy decision making.

Policy Research Team Members:

Carrie Cochran, Team Lead

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

Truman Fellows: Judy Herbstman and Nina Meigs

Frontier Extended Stay Clinic Program (FESC)

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

At a Glance

Grants Awarded:
- **2005:** 1 continuing award
- **2006:** 1 continuing award
- **2007:** 1 continuing award

Amount Awarded: Up to $1.5 million per year per grantee
- **2005:** $1.5 million
- **2006:** $1.5 million
- **2007:** $1.5 million

Project Period: 4 years

Next Competitive Grant Application:
- **Year:** 2011
- **Anticipated # Grants:** 1
- **Anticipated Grant Amount:** Up to $1.5 million per year

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

FY 2007 program activities include, but are not limited to:
- Implementation and testing of FESC protocols;
- Evaluation of program and financial activities;
- Providing technical assistance to CMS FESC Demonstration 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 CAHs.

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

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

KEY PROGRAM ACCOMPLISHMENTS:
In 2007, ORHP continued the work started in 2004 by providing funding to the Alaska FESC Consortium for the participation of five clinic sites in frontier Alaska and Washington. Preliminary results of the second year of data collection indicate that the five clinics recorded 1,785 extended stays (two hours or greater duration). The mean length of encounter was 5.64 hours with only 9 percent of the stays were over 12 hours; 38 percent of the extended stays resulted in being discharged home, without further referral; 53 percent resulted in emergency transfer to a higher level of care.

Rural Health Research Centers Program (Research Centers)

PROGRAM COORDINATOR: Joan F. Van Nostrand, DPA
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AUTHORIZING LEGISLATION: Section 711 of the Social Security Act

At a Glance

 # Grants Awarded:
- **2005:** 8 continuing awards
- **2006:** 8 continuing awards
- **2007:** 8 continuing awards

Amount Awarded: Up to $550,000 per year per grantee
- **2005:** $4.4 million
- **2006:** $4 million
- **2007:** $4 million

Project Period: 4 years

Next Competitive Grant Application:
- **Year:** 2008
- **Anticipated # Grants:** Up to 6
- **Anticipated Grant Amount:** Up to $660,000 per year per grantee (up to $3,960,000 combined)

PROGRAM OVERVIEW:
The purpose of the Rural Health Research Centers Program (Research Centers) is to help policy makers better understand the problems that rural communities face in assuring access to health care and strengthening health of their residents. The goals of the Research Centers are to conduct and disseminate policy-relevant research on health care and health of residents in rural areas.

The Research Centers engage in activities to *understand* the ways in which the health of rural Americans can be improved, *analyze* the implications of national and State policy options, and *communicate* research results to policy-makers and others who may take action based on research results. The research conducted by the Centers provides important data and findings to the office's policy staff which they bring to bear in their annual review of key Departmental regulations. The Research Centers bring to the forefront the health care challenges facing rural America.

The Research Centers Program, initiated in 1987, is the only Federal program dedicated entirely to producing policy-relevant research on health care and health in rural areas. Each Research Center has its own identity (although it may be part of a larger organization), Web site, and core staff. Research Centers often are located in universities across the United States. Staff includes a disciplinary mix of health services research, epidemiology, public health, geography, medicine, and nursing. Over the four-year award cycle, each Research Center develops a portfolio of three research projects per year in conjunction with input from the office and other experts. With its overarching emphasis on research about access to health care, the Research Centers Program addresses HHS, HRSA, and ORHP goals.

KEY PROGRAM ACCOMPLISHMENTS:
In 2007, the 8 Research Centers conducted 24 research projects and wrote 30 policy briefs and research reports. They also authored 17 articles which were published in 2007 in peer-reviewed journals, and another 13 articles were accepted for publication and are in-press. To strengthen dissemination of research results of the Research Centers, the Gateway to Rural Health Research was launched in 2007. The Gateway is a Web site which allows "one stop shopping" about the eight Research Centers. The Gateway provides easy access to the Centers' publications and authors, as well as to summaries of research in progress or completed. All Research Centers have Web sites which highlight their rural research results and in 2007, there were over 161,000 visits to these sites. Research Center staff presented research findings to 185 policy, provider, payer, and academic audiences. They also responded to over 400 requests for information concerning rural issues from various national and State policy makers.

Targeted Rural Health Research Grant (TRHR)

PROGRAM COORDINATOR: Erica Molliver, M.H.S.
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AUTHORIZING LEGISLATION: Section 711 of the Social Security Act

At a Glance

 # Grants Awarded:
- **2005:** 4 new awards
- **2006:** 3 new awards
- **2007:** 2 new awards

Amount Awarded: Up to $150,000 per grantee
- **2005**: $590,574
- **2006:** $449,923
- **2007:** $300,000

Project Period: 1 year

Next Competitive Grant Application:
- **Year:** 2008
- **Anticipated # Grants:** Up to 5
- **Anticipated Grant Amount:** Up to $150,000 per grantee (up to $750,000 combined)

PROGRAM OVERVIEW:
The Targeted Rural Health Research Grant Program (TRHR) provides funding for policy-oriented rural health care services research projects which address critical issues facing rural communities in their quest to secure affordable, high quality health services. The program is unique in its dual mission of both enhancing policymakers' knowledge of rural health, and expanding the pool of experienced rural health care services researchers. Grantee's research findings help to inform the Office as well as National, State, and local decision makers about current rural health care services issues. In order to ensure policy relevancy at the national level, grantees must address one of a selected number of topics, and all aspects of the research must be national in scope. For 2007, grant recipients conducted policy-relevant research on issues of national significance in the area of rural health services as they relate to the following topic areas: Rural Health Clinics, Public Health Workforce, Oral Health, HIT Implementation, and Emergency Medical Services (EMS).

This program originated in 2003 as a single year grant program entitled Policy-Oriented Rural Health Services Research Grant Program. The name was revised in 2005 to the One-Year Rural Health Research Grant Program. In 2007 however, it became apparent that the 12-month timeframe was unrealistic considering the nature of the work being done and the inherent challenges involved. Applicants for the 2007 funding cycle were therefore notified that under expanded authority, grantees would have the ability to extend their project period without the need to formally request for prior approval of a no-cost extension. In order to reflect this change, the grant name was changed to the Targeted Rural Health Research Grant Program. Beginning with the Fiscal Year 2008 competitive funding cycle, project and budget periods will be 18 months, as opposed to 12 months.

KEY PROGRAM ACCOMPLISHMENTS:
Grantees' research findings have been instrumental in bridging the gaps between policy and program needs, and have complemented the larger scale projects conducted by the eight ORHP-funded Rural Health Research Centers. FY 2007 grantees generated research findings in the following areas:
- "Preventive Care: Supports and Barriers to Best Practices for a National Sample of Rural Medicare Beneficiaries"
- "Diabetes and Obesity: Is There a Rural-Urban Difference in the Burden?"
- "Descriptive Analysis of the Health Status of a National Asbestos-Related Cohort"

For additional information on program background, eligibility, and other requirements, please contact the Program Coordinator listed above, or refer to *http://ruralhealth.hrsa.gov/funding/GrantPrograms.htm*

Hospital State Team Grant Programs

In FY 2007, ORHP administered four grant programs within the Hospital State Team (HST). The grant programs are: 1) the Critical Access Hospital Health Information Technology (CAH HIT) Network; 2) Medicare Rural Hospital Flexibility (Flex); 3) Small Rural Hospital Improvement Program (SHIP); and 4) the State Offices of Rural Health (SORH). The CAH HIT program is a new 18 month, $25 million competitive program in which 16 awards were made.

There were 157 grants awarded in these 4 programs with a budget of almost $69 million dollars. In addition to the above grants, HST members manage numerous cooperative agreements and contracts that support States with technical assistance, recruitment of health care providers, assistance in attaining funds to build replacement facilities and numerous other activities that support States and rural health care providers.

The management of the grants is done with a workforce composed of 12 project officers with 4 individuals serving as program coordinators. In addition to their grant responsibilities, most of the team also serves as Regional Liaisons to the States in five regions. This enables the staff to build relationships with the State partners and keep abreast of State and regional specific rural health issues through regional calls and meetings. Collectively, the HST serves as a base of knowledge and expertise on State and regional rural health issues.

Hospital State Team Members:

Nancy Egbert, Team Lead

Anthony Achampong	Steve Hirsch
George Brown	Michael McNeely
Karen Beckham	Jeanene Meyers
Jennifer Chang	Keith Midberry
Jerry Coopey	Kathryn Umali
Michelle Goodman	

Critical Access Hospital Health Information Technology Network Grant Program (CAHHIT)

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

At a Glance

 # Grants Awarded:
- **2005:** N/A
- **2006:** N/A
- **2007:** 16 new awards

Amount Awarded: Up to $1.6M per grantee
- **2005:** N/A
- **2006:** N/A
- **2007:** $24 M

Project Period: 18 months

Next Competitive Grant Application:
- **Year:** TBD
- **Anticipated # Grants:** TBD
- **Anticipated Grant Amount:** TBD

PROGRAM OVERVIEW:
The Rural Hospital Flexibility Program's Critical Access Hospital Health Information Technology Network Grant Program (Flex CAH-HIT Network) was a one-time only award that the Office of Rural Health Policy offered in FY 2007. The purpose of this 18-month, patient-centered pilot program is to provide funds to support the development of HIT in rural communities through the 16 States that received the CAH-HIT Network grant. The purpose of the grant is to develop networks and implement HIT across the continuum of care, which will lead to improved care coordination and health outcomes for rural residents. In addition, HRSA's experience has shown that it is cost effective to utilize networks of health care providers to develop HIT systems; therefore, the following types of HIT may be used by the CAH-HIT Network grantees:

- Practice management systems;
- Disease registry systems;
- Care management systems;
- Clinical messaging systems;
- Personal health record systems;
- Electronic health record systems; and
- Health information exchanges.

The CAH-HIT Network grantees have included various organizations in their networks, such as public health departments, community-based clinics, faith-based organizations, and other HRSA grantees. These networks will use quality improvement programs along with HIT to track five performance outcome measures, two of which will be diabetes control and health disease risk reduction.

The CAH-HIT Network program is a one-time funding opportunity; however, it is being administered as a pilot program from which lessons can be learned on HIT network implementation in rural areas. A thorough evaluation is underway that will offer lessons learned to the rural community.

KEY PROGRAM ACCOMPLISHMENTS:
At the conclusion of the project, it is expected that the grantees will have each developed a more comprehensive management of medical information and its secure exchange between health care consumers and providers. It is anticipated that the expanded use of HIT will:

- Improve health care quality;
- Prevent/reduce medical errors;
- Increase administrative efficiencies; and
- Expand access to affordable care.

Medicare Rural Hospital Flexibility Grant Program (Flex)

PROGRAM COORDINATOR: Steven Hirsch, MSLS
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AUTHORIZING LEGISLATION: Section 1820(j) of the Social Security Act (42 U.S.C. 1395)

PROGRAM OVERVIEW:
The Rural Hospital Flexibility Program (Flex) provides funding to State governments to stabilize rural hospital finance, integrate emergency medical services (EMS) into the health care system, and improve the quality of care. The Flex program supports a variety of activities, including conversion of small rural hospitals to Critical Access Hospital (CAH) status; CAH status allows hospitals the benefit of receiving cost-based reimbursement from Medicare for inpatient, outpatient, and swing bed services. Only States with CAHs or potential CAHs are eligible for the Flex program.

At a Glance

 # Grants Awarded:
- **2005:** 45 continuing awards
- **2006:** 45 continuing awards
- **2007:** 45 new awards

Amount Awarded: Up to $650,000 per year per grantee, with an average grant of $490,000
- **2005:** $22.2 million
- **2006:** $22.2 million
- **2007:** $22 million

Project Period: 3 years

Next Competitive Grant Application:
- **Year:** 2010
- **Anticipated # Grants:** 45
- **Anticipated Grant Amount:** Up to $650,000 per year per grantee, with an average grant of $490,000

Flex funding to the States also encourages the development of collaborative systems of care in rural areas, including the CAHs, EMS providers, clinics, and other providers of necessary health care services. The Flex program requires States to develop rural health plans, and funds the States to support and implement community-level outreach and technical assistance. The goals of the Flex program are to:

1. Designate CAHs in the State
2. Develop and implement rural health networks
3. Support existing CAHs and eligible hospitals
4. Improve and integrate EMS services
5. Improve quality of care

Although focused on small, rural hospitals, the Flex program operates on the National, State, community, and facility levels and covers a broad range of health service issues. Since the program's inception in 1999, its focus has shifted from CAH conversions toward its broader goals related to EMS and quality and performance management. States have increasingly used their Flex resources for EMS activities, including training programs, needs assessments, and network building. Performance improvement has also been a significant program goal for CAHs, EMS providers and other health care providers involved in the Flex program. Efforts have included using a balanced scorecard approach, development of relationships with State Quality Improvement Organizations, development of quality improvement-related networks, and participation in national quality improvement and reporting efforts.

KEY PROGRAM ACCOMPLISHMENTS:
Since the Flex program's inception, more than 1,200 hospitals have converted to CAH status. Most of these hospitals have shown improvement in their financial status and have offered new, needed services to their communities. More than 80 percent of CAHs report engaging in activities to improve the quality of care provided to patients. Over half of CAHs report data to CMS's Hospital Compare Web site even though they receive no financial advantage for doing so. Over two years of reporting, CAHs have shown significant increases in the percent of patients receiving recommended care for most quality measures.

For additional information on program background, eligibility, and other requirements, please contact the Program Coordinator listed above, or refer to *http://ruralhealth.hrsa.gov/funding/GrantPrograms.htm*

Small Rural Hospital Improvement Grant Program (SHIP)

PROGRAM COORDINATOR: Jennifer L. Chang, MPH
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AUTHORIZING LEGISLATION: Section 1820(g)(3) of the Social Security Act, 42 U.S.C. 1395i-4

At a Glance

 # Grants Awarded:
- **2005:** 47 new awards
- **2006:** 47 continuing awards
- **2007:** 46 continuing awards

Amount Awarded: Up to $1,200,000 per year per State grantee
- **2005:** $ 14.8 million
- **2006:** $ 14.5 million
- **2007:** $ 14.5 million

Project Period: 5 years, starting with FY 2008 grants (previously, project period was 3 years)

Next Competitive Grant Application:
- **Year:** 2008
- **Anticipated # Grants:** Up to 47
- **Anticipated Grant Amount:** Average of $315,400 per year per State grantee, up to $14.5 million, combined

PROGRAM OVERVIEW:
The Small Rural Hospital Improvement Grant Program (SHIP) is available to assist small rural hospitals that are essential access points for Medicare and Medicaid beneficiaries. Each State Office of Rural Health (SORH) coordinates participation of the small rural hospitals within its State. For example, $14.5 million was awarded across 46 States in FY 2007, which the SORHs then disbursed across 1,622 eligible hospitals within these 46 States. Each hospital received approximately $8,930.

The purpose of the SHIP program is to help small rural hospitals do any or all of the following:

1. Pay for costs related to the implementation of the Medicare Prospective Payment System (PPS)
2. Comply with provisions of the Health Information Portability and Accountability Act (HIPAA) of 1996
3. Reduce medical errors and support quality improvement (QI)

Unlike many grant programs, the SHIP program allows funds to purchase equipment and software for regulatory compliance and improvements that can be cost-prohibitive for small hospitals. The goal of the program is to allow small rural hospitals to purchase equipment and materials, information technology, training and education, technical assistance, consultants or assessments within the areas of PPS implementation, HIPAA compliance and QI. Examples of allowable activities include: 1) purchase of billing and coding software and charge-master review for PPS implementation; 2) purchase of security applications and workspace modifications to increase security and privacy for HIPAA compliance, and 3) purchase of electronic health record systems and providing staff training and educational materials in QI.

First authorized by the Balanced Budget Refinement Act of 1999 of the Social Security Act, the original purpose of the SHIP program was to help small rural hospitals meet PPS requirements. Funding was first provided by the Labor/HHS Appropriations Act for FY 2002, along with an expanded program purpose to include assistance for HIPAA compliance and QI. The SHIP program addresses HHS, HRSA, and ORHP goals related to HIPAA and improving the quality, safety, cost, and value of health care services.

KEY PROGRAM ACCOMPLISHMENTS:
To maximize purchasing power through economies of scale, eligible hospital grantees are encouraged to form consortiums in order to pool grant funds for the purchase of services. For the most recent reporting year, a reported $2.4 million was invested in consortiums; this comprises 16 percent of FY 2006 funds. In the most recent award cycle (FY 2007), 31 more hospitals were funded than in the previous year.

For additional information on program background, eligibility, and other requirements, please contact the Program Coordinator listed above, or refer to *http://ruralhealth.hrsa.gov/funding/GrantPrograms.htm*

State Offices of Rural Health Grant Program (SORH)

PROGRAM COORDINATOR: Keith J. Midberry, MHSA
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AUTHORIZING LEGISLATION: Public Health Service Act, Section 338J; 42 U.S.C. 254r

At a Glance

 # Grants Awarded:
- **2005:** 50 continuing awards
- **2006:** 50 continuing awards
- **2007:** 50 continuing awards

Amount Awarded: Up to $150,000 per year per grantee
- **2005:** $7.4 million
- **2006:** $7.2 million
- **2007:** $7.2 million

Project Period: 5 years

Next Competitive Continuation Grant Application:
- **Year:** 2008
- **Anticipated # Grants:** 50
- **Anticipated Grant Amount:** Up to $150,000 per year per grantee

PROGRAM OVERVIEW:
The purpose of the State Offices of Rural Health Grant (SORH) Program is to strengthen rural health care delivery systems by creating a focal point for rural health within each State. The program provides an institutional framework that links rural 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:
1. Serve as a clearinghouse of information and innovative approaches to rural health services delivery
2. Coordinate State activities related to rural health in order to avoid duplication of efforts and resources
3. Identify Federal, State, and nongovernmental programs about rural health and provide TA to public and nonprofit private entities on participation within them.

Additionally, the SORH program encourages strengthening State, local, and Federal partnerships in rural health, and promotes rural 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 (vehicles, medical, communications), or to conduct any activity regarding a Certificate of Need.

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 of Federal funding. Over the past 16 years, this program has leveraged in excess of $200 million in State matching funds. Currently, 36 Offices are located in State health departments, 11 in academic settings, and 3 in non-profit organizations.

KEY PROGRAM ACCOMPLISHMENTS:
A SORH Performance Measurement workgroup was formed to revise and update the SORH Government Performance and Results Act (GPRA) measures. ORHP is seeking approval of the measures from the Office of Management and Budget (OMB). The new measures will be used collectively to produce more detailed yearly reports about the SORH program. The workgroup also created comprehensive definitions for the terms *technical assistance* (TA) and *client.*

Beginning with the budget period July 1, 2008 - June 30, 2009, SORHs will:

1) Report the total number of technical assistance (TA) encounters provided directly to clients within their State by SORH
2) Provide several specific examples of different types of TA provided.
3) Report the total number of clients within the State that received TA directly from SORH.
4) Provide several specific examples of different types of clients that received TA.

For additional information on program background, eligibility, and other requirements, please contact the Program Coordinator listed above, or refer to *http://ruralhealth.hrsa.gov/funding/GrantPrograms.htm*

Community-Based Grant Programs

In FY 2007, ORHP administered nine community-based grant programs through its Community-Based Team (CBT), made up of 14 project officers. The programs are: the Black Lung Clinics Program; Delta Health Initiative; Delta States Rural Development Network Grant Program; Radiation Exposure Screening and Education Program; Rural Health Outreach Grant Program; Network Development Grant Program; Network Development Planning Grant Program; Rural Access to Emergency Devices (RAED) Grant Program; and the Small Health Care Provider Quality Improvement (SHCPQI) Grant Program. Each community-based grant program administered by the CBT have differences, but each is predicated upon on a defined underserved population, a commitment to change and a set of linked objectives designed to build on local assets while addressing the improvement of health status for rural residents. This year, 232 grants and a combined program budget of over $39 million was awarded for community-based programs.

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

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

Community-Based Team Members:

Sherilyn Pruitt, Team Lead

Julia Bryan	Lilly Smetana
Eileen Holloran	Lakisha Smith
Vanessa Hooker	Sonja Carter Taylor
Kristi Martinsen	Shelia Tibbs
Nisha Patel	Kathryn Umali
Elizabeth Rezai-zadeh	Shelia Warren
Jacob Rueda	

Black Lung Clinics Program (BLCP)

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

At a Glance

 # Grants Awarded:
- **2005:** 3 new, 12 continuing awards
- **2006:** 15 continuing awards
- **2007:** 15 new awards

Amount Awarded:
- **2005:** $5.8 million
- **2006:** $5.7 million
- **2007:** $5.65 million

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

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

PROGRAM OVERVIEW:
The purpose of the Black Lung Clinics Program (BLCP) is to seek out and provide services to miners (active and inactive) with the intention of minimizing the effects of respiratory impairment or improving the health status of miners or coal miners exposed to coal dust as a result of employment and to increase coordination with other services and benefits programs to meet the health-related 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 stand alone clinics.

Programs meet the health care needs of the population through services that include:
1. Outreach
2. Primary care (including screening, diagnosis and treatment)
3. Patient and family education and counseling (including anti-smoking education)
4. Patient care and coordination (including individual patient care plans for all patients and referrals as indicated)
5. 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), signed March 1, 1978, was intended by Congress to ensure the continued expansion of the program initiated under the 1969 law. A Federal Register (50 FR 7913) on February 27, 1985, clarified the authority of HHS's Secretary to support clinics to evaluate and treat coal miners with respiratory impairments, with administrative jurisdiction delegated to HRSA's Bureau of Primary Health Care. In FY 2006, the program was moved to the Office of Rural Health Policy to better serve the needs of its constituents, most of whom are located 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:
The program added a long term health outcome measure around improving pulmonary function and began a study to determine the location of miners to best target resources. Between 2003 and 2006, there was a 5.6 percent increase in the number of active and retired miners seen each year in the clinics.

For additional information on program background, eligibility, and other requirements, please contact the Program Coordinator listed above, or refer to *http://ruralhealth.hrsa.gov/funding/GrantPrograms.htm*

Delta Health Initiative (DHI)

PROGRAM COORDINATOR: Kathryn Umali, MPH
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Phone: (301) 443-7444

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

PROGRAM OVERVIEW:
The purpose of the Delta Health Initiative Cooperative Agreement Program is to provide funding to an alliance addressing longstanding unmet rural health needs (access to health care, health education, research, job training, and capital improvements) of the Mississippi Delta. The goal of the DHI is to improve the health status of the people living in the rural Mississippi Delta.

In response to the notable poor health status of the Mississippi Delta Region, HRSA's Office of Rural Health Policy funded a five-year cooperative agreement in the amount of $24,750,000 in FY 2006.

At a Glance

 # Grants Awarded:
- **2005:** N/A
- **2006:** 1 new award
- **2007:** 1 continuing award

Amount Awarded:
- **2005:** N/A
- **2006:** $24.75 million
- **2007:** N/A

Project Period: 5 years

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

With this funding, the grantee worked with nine other partners on projects concerning:
- chronic disease management,
- health education,
- intervention,
- wellness promotion,
- access to health care services,
- health information technology,
- workforce training,
- care coordination and
- construction of public health related facilities.

The partners proposed 27 projects and have worked on communication and coordination systems among themselves. Three of these projects entailed construction of public health related facilities.

By addressing the rural health needs of the people living in the Mississippi Delta through the program's 27 projects, DHI supports multiple HHS, HRSA, and ORHP goals and objectives, including improving the safety, quality, and access to health care.

KEY PROGRAM ACCOMPLISHMENTS:
Since its initial funding in 2006, DHI has enhanced numerous health outcomes in improving the health of the people living in the Mississippi Delta. Of the three construction projects, one is completely finished and the rest are progressing accordingly. Furthermore, the program has fostered better collaboration between the partners through the grantee's efforts in improving its organizational and infrastructure capacity. The DHI has conducted 156 community-based events/classes to promote well-being, held 86 professional education/training seminars, trained or educated 1,035 health professionals, and 17,018 Delta residents, conducted 1,553 screenings/patient interviews, accounted for 5,435 patient-encounters for medical services, held 61 community-based health career recruitment events, and recruited 195 school counselors and county personnel to promote health career programs.

For additional information on program background, eligibility, and other requirements, please contact the Program Coordinator listed above, or refer to http://ruralhealth.hrsa.gov/funding/GrantPrograms.htm

Delta States Rural Development Network Grant Program (Delta)

PROGRAM COORDINATOR: Lakisha M. Smith, MPH
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AUTHORIZING LEGISLATION: Public Health Service Act, Section 330A (e) (42 U.S.C. 254c)

At a Glance

 # Grants Awarded:
- **2005:** 8 continuing awards
- **2006:** 8 continuing awards
- **2007:** 12 new awards

Amount Awarded: Award range $400,000 - $1,000,000 per grantee
- **2005:** $5.1 million
- **2006:** $5.1 million
- **2007:** $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.

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 project activities in rural Delta communities. The Delta program supports projects that strengthen community organizations' ability to develop and implement projects to address local health care needs.

In accordance with ORHP's goal to improve the health and wellness of people living in rural communities, the Delta grant program fosters the development of new collaborative efforts amongst a variety of rural providers within the Delta Region to address health problems that 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 focus areas:

1.) delivery of preventative or clinical health services surrounding chronic disease,
2.) increase access to prescription drugs for the medically indigent, and/or
3.) practice management technical assistance services.

Grantees may also focus grant activities around the following other priority health areas: 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. In FY 2007, the Delta grant sought to define specific targeted focus areas for grantees to concentrate their project activities. This change will prove to serve as a better fit for performance measurement activities within ORHP. More applicants were also funded to bring about greater impact and service delivery capacity in the Delta region than in previous grant cycles.

KEY PROGRAM ACCOMPLISHMENTS:
The Delta grant program had success in providing needed health services to rural communities within the Delta region. There have been marked achievements particularly in oral health care, chronic disease management and school based health services. Many projects continue to date as a result of initial funding provided by the Delta Grant program. By the end of year three of the most recent three-year funding cycle, 93 percent of Delta counties and parishes were involved in network supporting programs or services, versus 87 percent in the previous year. The outcome is that the Delta grant surpassed its target of reaching 331,100 people, or 7 percent of the population by serving an actual amount of 395,000 people within the region, or 8.4 percent of the Delta population. The program reached approximately 82,000 more people in year three than reported in year two.

For additional information on program background, eligibility, and other requirements, please contact the Program Coordinator listed above, or refer to *http://ruralhealth.hrsa.gov/funding/GrantPrograms.htm*

Radiation Exposure Screening and Education Program (RESEP)

PROGRAM COORDINATOR: Vanessa Hooker
Email: vhooker@hrsa.gov
Phone: (301) 594-5105

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

At a Glance

 # Grants Awarded:
- **2005:** 1 new / 6 continuing awards
- **2006:** 7 continuing awards
- **2007:** 7 continuing awards

Amount Awarded:
- **2005:** $1.958 million
- **2006:** $1.917 million
- **2007:** $1.917 million

Project Period: 3 years

Next Competitive Grant Application:
- **Year:** 2008
- **Anticipated # Grants:** 7-10
- **Anticipated Grant Amount:** Up to $300,000 per year per grantee

PROGRAM OVERVIEW:
The purpose of the Radiation Exposure Screening and Education Program (RESEP) is to support appropriate healthcare organizations to improve the knowledge base and health status of persons adversely affected by the mining, milling, or transporting of uranium and the testing of nuclear weapons for the Nation's weapons arsenal.

The major objectives of the programs are to:

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

Currently, there are seven health organizations in five southwestern States (Arizona, Colorado, Nevada, New Mexico and Utah) participating in the RESEP Program. These organizations are comprised of one medical center, one research hospital, one Indian Health Service facility, two community health centers, and two universities. In FY 2007, non-competing continuation grants were awarded to these organizations for a total of $1,917,000.

KEY PROGRAM ACCOMPLISHMENTS:
Annual and long-term performance measures were established for the program in the 2006 Performance Assessment Rating Tool (PART) evaluation. These measures are updated in PARTweb bi-annually. The program is currently working on a national outreach activity to identify eligible individuals no longer residing in the local affected areas. The RESEP grantees currently collect local outreach information, but there is no program-wide data collection system. This annual measure will seek to implement a streamlined process of data collection.

For additional information on program background, eligibility, and other requirements, please contact the Program Coordinator listed above, or refer to *http://ruralhealth.hrsa.gov/funding/GrantPrograms.htm*

Rural Health Care Services Outreach Grant Program (Outreach)

PROGRAM COORDINATOR: Nisha Patel, MA, CHES
Email: npatel@hrsa.gov
Phone: (301) 443-6894

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

At a Glance

 # Grants Awarded:
- **2005:** 30 new / 71 continuing
- **2006:** 65 new / 43 continuing
- **2007:** 27 new / 95 continuing

Amount Awarded: Up to $150,000 in Year 1, $125,000 in Year 2 and $100,000 in Year 3 per grantee
- **2005:** $18.8 million
- **2006:** $17.9 million
- **2007:** $17.6 million

Project Period: 3 years

Next Competitive Grant Application:
- **Year:** 2009
- **Anticipated # Grants:** Up to 90
- **Anticipated Grant Amount:** Up to $150,000 in Year 1, $125,000 in Year 2 and $100,000 in Year 3 per grantee

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

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

KEY PROGRAM ACCOMPLISHMENTS:
The Outreach grant program has success in providing needed health services to rural communities. The program has helped to bring rural communities together to work towards a common goal, which is to improve the health and well-being of rural populations. Although the Outreach program is a three-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 683 grantees in 48 States and 3 Territories.

For additional information on program background, eligibility, and other requirements, please contact the Program Coordinator listed above, or refer to *http://ruralhealth.hrsa.gov/funding/GrantPrograms.htm*

Rural Health Network Development Grant Program (Network Development)

PROGRAM COORDINATOR: Sherilyn Z. Pruitt, MPH
Email: spruitt@hrsa.gov
Phone: (301) 594-0819

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

At a Glance

 # Grants Awarded:
- **2005:** 10 new / 27 continuing
- **2006:** 23 new / 15 continuing
- **2007:** 5 new / 33 continuing

Amount Awarded: Up to $180,000 per year per grantee (3 year award)
- **2005:** $7 million
- **2006:** $6.7 million
- **2007:** $6.5 million

Project Period: 3 years

Next Competitive Grant Application:
- **Year:** 2008
- **Anticipated # Grants:** Up to 30
- **Anticipated Grant Amount:** Up to $180,000 per year per grantee (up to $540,000, combined)

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

Some anticipated outcomes of supporting the development of rural health networks include:
- achieving economies of scale and cost efficiencies of certain administrative functions;
- increasing the financial viability of the network; enhancing workforce recruitment and retention;
- sharing staff and expertise across network members; enhancing the continuum of care;
- providing services to the under- and uninsured; improving access to capital and technologies;
- ensuring continuous quality improvement of the care provided by network members; and
- enhancing the ability of network members to respond positively to rapid and fundamental changes in the health care environment.

The Network Development Grant Program was started in 1997 with 34 grantees and $6.1 million. To-date, the program has awarded almost $75 million to support 159 Network Development grants.

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

KEY PROGRAM ACCOMPLISHMENTS:
In addition to the technical assistance that is provided to all first and second year Network Development grantees, all grantees were invited to participate in free quarterly conference calls arranged by the National cooperative of Health Networks, a national association of health network executives and strategic health partners. Additionally, grantees with a focus on Health Information Technology (HIT) participated in the HRSA-sponsored HIT meeting, attended by over 500 HRSA grantees.

For additional information on program background, eligibility, and other requirements, please contact the Program Coordinator listed above, or refer to *http://ruralhealth.hrsa.gov/funding/GrantPrograms.htm*

Rural Health Network Development Planning Grant Program (Network Planning)

PROGRAM COORDINATOR: Eileen Holloran
Email: eholloran@hrsa.gov
Phone: (301) 443-7529

AUTHORIZING LEGISLATION: Public Law 107-251m 116 Stat. 1621, Section 330A(f) of the Public Health Service Act, 42 U.S.C. 254c. The Catalog of Federal Domestic Assistance Number is 93.912.

At a Glance

 # Grants Awarded:
- **2005:** 19 new awards
- **2006:** 12 new awards
- **2007:** 10 new awards

Amount Awarded: Up to $85,000 per year per grantee
- **2005:** $1.6 million
- **2006:** $1.2 million
- **2007:** $841,391

Project Period: 1 year

Next Competitive Grant Application:
- **Year:** FY 2008
- **Anticipated # Grants:** Up to 12
- **Anticipated Grant Amount:** Up to $85,000 per year per grantee. Estimated total funds available to award: $960,000

PROGRAM OVERVIEW: The legislative purpose of the Rural Health Network Development Planning Grant Program (Network Planning) program is to expand access to, coordinate and improve the quality of essential health care services and enhance the delivery of health care, in rural areas. The program provides one-year grants to rural entities to plan, develop, and operationalize a formal health care network, and is only for formative networks that do not yet have a formalized structure. 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 three-year Network Development implementation grant to continue the work they started under the Network Planning grant.

Network Planning grantees use the planning grant to lay the foundation of a rural health network by:
1. Identifying potential collaborating network partners in the community/region;
2. Convening potential collaborating network partners;
3. Conducting planning activities; and
4. Begin carrying out network activities, including activities to promote the network's sustainability.

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

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

KEY PROGRAM ACCOMPLISHMENTS:
A Grantee Meeting held in April 2007 fostered new collaborations and sharing of best practices among grantees, and one successful grantee was asked to present their best practices at the National Rural Health Association's Annual Meeting. In addition, multiple former grantees are continuing their network development work through the three-year Network Development implementation grant. Of the five new Network Development grantees in FY 2007, one was a former Network Planning grantee; also six current and one former Network Planning grantees have applied for the FY 2008 Network Development grant.

For additional information on program background, eligibility, and other requirements, please contact the Program Coordinator listed above, or refer to *http://ruralhealth.hrsa.gov/funding/GrantPrograms.htm*

Rural Access to Emergency Devices (RAED)

PROGRAM COORDINATOR: Eileen Holloran
Email: eholloran@hrsa.gov
Phone: (301) 443-7529

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.

At a Glance

 # Grants Awarded:
- **2005:** 48 continuing awards
- **2006:** 4 new awards
- **2007:** 4 continuing/ 9 new awards

Amount Awarded:
- **2005:** $7.4 million
- **2006:** $309,408
- **2007:** $1.2 million
- **2008: No funds available**

Project Period: 3 years

Next Competitive Grant Application:
- **Year:** 2009
- **Anticipated # Grants:** 7-10
- **Anticipated Grant Amount:** Up to $120,000 per year per grantee

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

The 13 current RAED grantees are located in 12 States across the nation: Alaska, Arizona, Delaware, Florida, Iowa, Illinois, Louisiana, New Jersey, Nevada, Pennsylvania, Texas, and Utah.

KEY PROGRAM ACCOMPLISHMENTS:
Approximately 275 AEDs were placed and approximately 650 lay persons and first responders were trained in their utilization in 2006. In 2007, the numbers of placements and trainings increased in size and diversity of audience. The RAED Program has increased public awareness, the number of AEDs available and the number of persons, first responders, and lay persons trained in using an AED in the event of sudden cardiac arrest.

For additional information on program background, eligibility, and other requirements, please contact the Program Coordinator listed above, or refer to *http://ruralhealth.hrsa.gov/funding/GrantPrograms.htm*

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

PROGRAM COORDINATOR: Elizabeth Rezai-zadeh, MPH
Email: erezai@hrsa.gov
Phone: (301) 443-4107

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

At a Glance

 # Grants Awarded:
- **2005:** N/A
- **2006:** 15 new awards
- **2007:** 15 continuing awards

Amount Awarded: Up to $50,000 per year per grantee
- **2005:** N/A
- **2006:** $ 737,757
- **2007:** $ 680,202

Project Period: 2 years

Next Competitive Grant Application:
- **Year:** 2008
- **Anticipated # Grants:** Up to 60
- **Anticipated Grant Amount:** Up to $75,000 per year per grantee (up to $4.5m, combined)

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

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

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

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

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

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

KEY PROGRAM ACCOMPLISHMENTS:
Since the inception of the Rural Quality program in FY 2006, over 2,000 diabetic patients have been served by the 15 grantee organizations. Among patients with measured HbA1c lab values, the annual average HbA1c was 7.1 (slightly above the goal of <7.0). This average was maintained as new patients were added throughout the year to the patient registry.

For additional information on program background, eligibility, and other requirements, please contact the Program Coordinator listed above, or refer to *http://ruralhealth.hrsa.gov/funding/GrantPrograms.htm*

Other HRSA Initiatives Administered by ORHP

The Office manages two agency-wide HRSA activities: border health and intergovernmental affairs (IGA).

Border Health

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

Border Team Members:

Frank Cantu, Team Lead

Margarita Figueroa-Gonzalez
Michelle Goodman
Michelle Mellen
Elizabeth Rezai-zadeh
Lilia Salazar
Erma Woodard

Office of Intergovernmental Affairs (IGA)

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

IGA Team Members:

Tom, Morris, Team Lead

Karen Beckham
Kathryn Umali

Administrative Team

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

Administrative Team Members:

Heather Dimeris, Team Lead

Mary Collier
Michele Pray-Gibson
Amal Thomas
April Ward

Border Health

PROGRAM COORDINATORS: Frank Cantu, FCantu@hrsa.gov, Phone:(214) 767-8068; Elizabeth Rezai-zadeh, erezai@hrsa.gov, Phone:(301) 443-4107; Michelle Goodman, MGoodman@hrsa.gov, Phone:(301) 443-7440

PROGRAM OVERVIEW:

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

- Provide leadership and direction to coordinate the Agency's assets in border regions;
- Assures that the Agency's engagement with regions of the border is strategic, performance-based, build partnerships and alliances, and maximizes utilization of Agency assets;
- Assures agency-wide coordination by establishing border health program policies and procedures including tracking mechanisms.

KEY PROGRAM ACCOMPLISHMENTS:

The inter-agency agreement with the Environmental Protection Agency represents on innovative part of Border Health activities. One Border Environmental Health Coordination Program Cooperative Agreement award was made to Texas A & M University to test the effectiveness of environmental health education and training by promatoras (lay community health workers) in reducing pesticide exposure and illness in residents of border colonias.

Over the past three years (FYs 2005-2007), ORHP has supported two annual events; the *U.S.-Mexico Border Health Association Meeting,* and the Pan-American Health Organization's *Immunizations in the Americas Weeks.* The purpose of the former was to further educate clinicians and community workers about HRSA programs and the progress toward achieving U.S.-Mexico Border 2010 Health Objectives. The purpose of the Pan-American Health Organization's event is to further educate clinicians and community workers in the appropriate use of vaccines and to facilitate the vaccination of children and adults in local clinics and community health centers along the US-Mexico border.

In FYs 2006 and 2007, ORHP organized an expert meeting, *Improving Knowledge Transfer among Health Researchers and Decisionmakers at the Border* in Dallas, TX on June 26, 2007. The purpose of this meeting was to identify ways to improve the translation and dissemination of border health research produced in the United States so as to maximize its use by decisionmakers in health policy and practice. This invitational meeting brought together representatives from government agencies and foundations that fund research, leading researchers and university officials, health policymakers, program administrators, and health care providers to examine their experience and discuss ways to improve the flow of knowledge among stakeholders at the border. A report of this meeting is posted on the ORHP Web site at: http://ruralhealth.hrsa.gov/border/dallasmeeting.htm. Follow-up activities are being planned in FY 2008.

Intergovernmental Affairs (IGA)

PROGRAM COORDINATORS: Kathryn Umali, MPH, CHES
Email: kumali@hrsa.gov
Phone: (301) 443-7444

Karen Beckham, MA
Email: kbeckham@hrsa.gov
Phone: (301) 443-0502

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

The purpose of HRSA's Intergovernmental Affairs is to:

- Provide the HRSA Administrator with a single point of contact on all activities related to important State and local governmental, stakeholder association, and interest group activities.
- Coordinate Agency cross-Bureau cooperative agreements and activities with organizations representing units of State and local governments, including but not limited to the National Governors Association (NGA), National Conference of State Legislatures (NCSL), Association of State and Territorial Health Officials (ASTHO), National Association of Counties (NACo), National Association of County and City Health Officials (NACCHO), and National Association of Local Boards of Health (NALBOH).
- Interact with health-focused Federal Commissions such as the Delta Regional Authority, Appalachian Regional Commission, Denali Commission, and United States-Mexico Border Health Commission.
    - The Denali Commission was appropriated $39,283,000 in funds in FY 2007 for health care facility construction and health care services. ORHP handles the awarding of these funds.
- Serve as primary liaison to the U.S. Department of Health and Human Services' Office of Intergovernmental Affairs.

Prior to November 2006, the IGA role of HRSA was informally divided between HRSA's Office of Planning and Evaluation (OPE), Office of Communications (OC), and Office of Legislation (OL). In centralizing this effort, the Office of Rural Health Policy believed there is an added value in coordinating the programmatic aspect of IGA. Thus, through the office's involvement with the regional commissions, commitment in the HHS Rural Task Force and efforts to centralize the IGA role, ORHP embarked on fulfilling HRSA's intergovernmental affairs mission. On November 15, 2006 a Federal Register Notice was officially released stating the transfer of the agency's IGA function to ORHP.

KEY PROGRAM ACCOMPLISHMENTS:
Some of the primary functions of HRSA IGA are to respond and coordinate information and meeting requests. ORHP has developed a systematic process in managing the coordination of these requests which entail responding to a variety of problems, questions, or situations relevant to health services and intra-governmental affairs. This may involve program planning and implementation for which there may not be established criteria. The work facilitates national dissemination of information about HRSA's programs, functions, and activities to partnering organizations and agencies. Therefore, ORHP developed a Strategic and Operational Plan for HRSA's Intergovernmental Affairs to serve as a management guide and system of performance and outcome measure.

Appendix A: ORHP Staff

Office of Rural Health Policy and Intergovernmental Affairs
Staff List as of March 2008

1. The Team Structure: All staff are assigned to specific teams within the Office. These teams are: the Community-Based Team (CBT)(which includes all staff who work on the community based grant programs under the jurisdiction of the Office); the Hospital-State Team (HST) (which includes all staff who serve as regional liaisons and project officers for the Office's State-based programs), the Policy-Research Team (PRT) (which includes staff who oversee either regulatory issues or research issues), the Intergovernmental Affairs (IGA) Team (which includes all staff who coordinate HRSA's intergovernmental affairs activities), the Administrative Team (Admin) (which includes all staff who are charged with overseeing specific administrative duties) and the Management Team (Mgt) (which includes all staff who are charged with overseeing management duties). There are also five staff, based in Dallas, assigned to the Division of Border Health (BH). Two staff are also assigned to working with the Director to coordinate HRSA's Intergovernmental Affairs Activities (IGA).

2. How Issues Are Assigned: All staff are also assigned issue areas. For members of the Community-Based Team, this relates to the focus areas of the grants on which they serve as project officers. For members of the Policy-Research team, this relates to policy areas they oversee. For members of the Management, IGA and Administrative Teams, this relates to those issues for which they bear responsibility.

Name and Title	Team	Program or Policy Assignments	Issue Areas	Phone	Email
Tom Morris, Acting Associate Administrator	Mgt; PRT; IGA	Oversees all aspects of the Office, including rural health policy and programs; border health, international health and intergovenrmental affairs; primary staff to HHS Rural Task Force	Budget, Personnel, Operations oversight; Legislation; Policy	(301) 443-0835	tmorris@hrsa.gov
Heather Dimeris, Associate Director	Mgt; PRT; Admin	Oversees the Administrative Team; quality-related policy activities; grants processes	Budget; personnel; Operations oversight; Regulation review; Quality improvement	(301) 443-4657	hdimeris@hrsa.gov
Staff					
Anthony Achampong	HST; Mgt	Region B Co-Regional Liaison (project officer for that region's Flex, SORH and SHIP grants); Data and Performance Measurement Coordinator; Liaison to OIT for the ORHP PIMS Contract, Representative on the HRSA IT Internal Review Board	Data and Performance Measurement Coordinator	(301) 594-4429	aachampong@hrsa.gov
George Brown	HST	Flex Critical Access Hospital-Health Information Technology Network (CAHHITN) Coordinator; Region B Co-Regional Liaison (project officer for that region's Flex, SORH and SHIP grants)	Delta Small Rural Hospital Performance Improvement Initiative	(301) 443-7321	gbrown@hrsa.gov
Karen Beckham	HST; IGA	Region E Co-Regional Liaison (project officer for that region's Flex, SORH and SHIP grants); Rural Best Practices Cooperative Agreement	Intergovernmental Affairs coordination for HRSA	(301) 443-0502	kbeckham@hrsa.gov
Julia Bryan	Mgt; CBT	Liaison to Grants Management, Division of Independent Review, Office of Financial Assistance Management	Grants Coordinator; Grants technical assistance; Recruitment and Retention; Women's Health	(301) 443-6707	jbryan@hrsa.gov
Jennifer Chang	HST	Small Rural Hospital Improvement Grant Program (SHIP) Coordinator; Executive Secretary, National Advisory Committee on Rural Health and Human Services; Region A Co-Regional Liaison (project officer for that region's Flex, SORH and SHIP grants)	Grant Program performance measures, OMB approval	(301) 443-0736	jchang@hrsa.gov
Carrie Cochran	Mgt; PRT	Policy Coordinator; Quick Data Turnaround Cooperative Agreement; Frontier Extended Stay Clinic Cooperative Agreement; Rural Policy Analysis Cooperative Agreement; National Advisory Committee on Rural Health and Human Services staff	Medicare reimbursement including inpatient and outpatient hospital reimbursement; Skilled Nursing Care; Home Health; Medicare Advantage; Medicare GME; Supervisor for interns	(301) 443-4701	ccochran@hrsa.gov
Mary Collier	Admin	Phones; meeting scheduling; travel; timekeeping; correspondence (SWIFT); FOIA requests; conference room reservations and IT equipment; mail pick up and distribution; meet and greet visitors.	Administrative; provide services and support to ORHP staff and external customers.	(301) 443-0836	mcollier@hrsa.gov
Jerry Coopey	HST	Region C Co-Regional Liaison (project officer for that region's Flex, SORH and SHIP grants)	Rural Recruitment and Retention Network (3RNet) liaison; Access to Capital; Rural Health and Economic Development; safety-net collaboration; hospital performance improvement	(301) 443-7306	jcoopey@hrsa.gov
Nancy Egbert	HST	Region E Co-Regional Liaison (project officer for that region's Flex, SORH and SHIP grants); Flex Monitoring Cooperative Agreement	Clinical Advisor; health quality; nursing; pandemic influenza	(301) 443-0614	negbert@hrsa.gov
Michelle Goodman	HST; PRT	Region D Co-Regional Liaison (project officer for that region's Flex, SORH and SHIP grants)	Health Workforce; Communications Coordinator	(301) 443-7440	mgoodman@hrsa.gov
Steve Hirsch	HST	Rural Hospital Flexibility (Flex) Program Coordinator; Rural Assistance Center Cooperative Agreement	Definitions of Rural	(301) 443-7322	shirsch@hrsa.gov
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Erica Molliver	PRT	Targeted Rural Health Research grants; National Advisory Committee on Rural Health and Human Services, Rural Health Clinic Technical Assistance	Physician and ambulance fee schedule(s); Medicare Part D; Medicaid waivers; HHS J1 Visa waivers; health professional shortage areas; Frontier health	(301) 443-1520	emolliver@hrsa.gov
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Jacob Rueda	CBT	Project Officer for Black Lung, RESEP, Outreach and Network Development grant	Emergency medical services and trauma; pharmacy; Medicaid	(301) 443-0649	jrueda@hrsa.gov
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Shelia Tibbs	CBT	Project Officer for Network Development and Black Lung grant programs	Public health; capital construction monitoring for Delta Health Initiative	(301) 443-4304	stibbs@hrsa.gov
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Kathryn Umali	CBT; HST; IGA	Delta Health Initiative Program Coordinator; Region D Co-Regional Liaison (project officer for that region's Flex grants, SORH grants and SHIP grants)	Intergovernmental Affairs coordination for HRSA	(301) 443-7444	kumali@hrsa.gov
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April Ward	Admin	Phones; meeting scheduling; travel; NAC administrative duties; timekeeping; correspondence backup; conference room reservations and IT equipment; mail pick up and distribution; meet and greet visitors.	Administrative; provide services and support to ORHP staff and external customers.	(301) 443-3999	award@hrsa.gov
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Division of Border Health					
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Lilia Salazar	Border	CA border health liaison	Travel, administrative	(214) 767-3073	lsalazar@hrsa.gov
Erma Woodard	Border	Administrative support	Phones, scheduling, meetings	(214) 767-3171	ewoodard@hrsa.gov