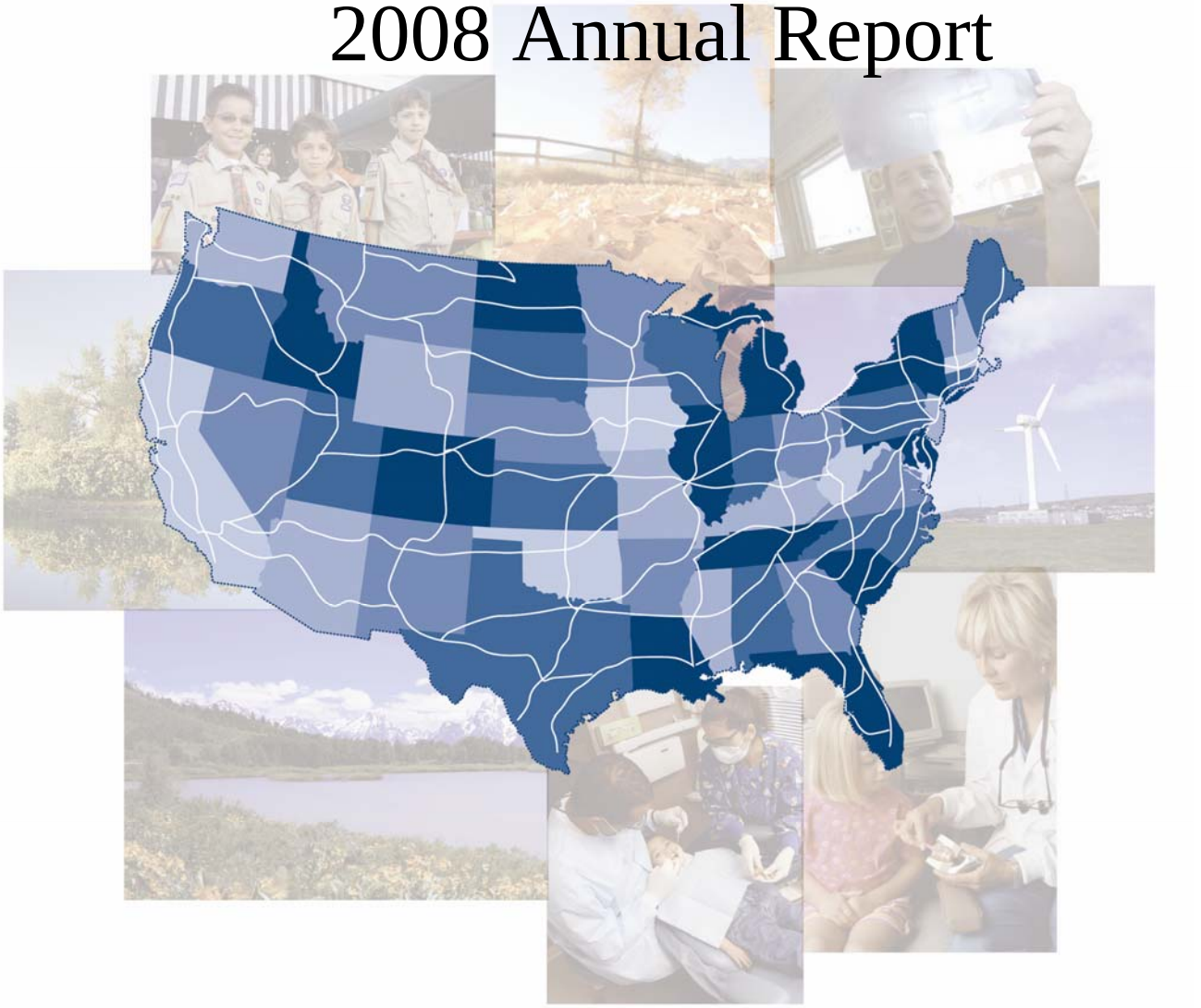
Office of Rural Health Policy
2008 Annual Report



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

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

In FY 2008, ORHP also administered 17 grant programs designed to build health care capacity at both the local and State levels.

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

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

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

Authorizing Legislation

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

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

Critical Access Hospitals Transitioning to Skilled Nursing Facilities and Assisted Living Facilities
Section 1820(g)(7) of the Social Security Act as amended, (42 U.S.C. 1395i–4(g)(7))

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 2008 Overview

ORHP advanced several key priority areas in FY 2008: health care workforce development; health information technology (HIT); and performance measurement and quality improvement for rural health care providers:

• **Workforce Development –** One out of five Americans lives in a rural area that historically have had trouble recruiting, supporting and retaining healthcare workers – a problem now heightened by a projected overall national shortage of clinicians and nurses. ORHP is at the forefront of efforts to monitor and address a scarcity of some 27,000 Primary Care providers already affecting 20 largely rural States.

In addition to supporting the National Rural Recruitment and Retention Network (3RNet), ORHP also worked with the National Conference of State Legislatures (NCSL) on a State-based workforce meeting last year that attracted legislators from more than 25 States. ORHP also supports the Rural Medical Educators (RME) Annual Conference in advancing the training of physicians for rural practice through network development and education. This year's meeting drew 75 attendees, the largest number to date.

• **HIT** – To further encourage rural hospitals to adopt health information technology (HIT), ORHP funded an evaluation of the Flex Critical Access Hospital (CAH) HIT Network grant program, which provided about $25 million to State Offices of Rural Health in FY 2007. At completion of the 18-month grant period, 12 of 16 grantees had a fully operational HIT network. The four remaining grantees were given 6-month extensions to overcome difficulties in securing a vendor. The ongoing evaluation effort will examine whether the program has been successful at implementing health information exchange in rural communities. The ultimate aim of the evaluation project is to serve as a reference guide for rural communities interested in developing HIT networks. The final report will be available by December 2009 on the ORHP Web site.

• **Quality Improvement --** ORHP made several significant investments in quality improvement and performance measurement for rural health care providers in FY 2008.

Among other efforts, ORHP awarded more than $4 million to 55 community-based organizations in the Rural Quality grant program. First piloted in FY 2006 with just 15 grantees, participation has increased by 73 percent. The funds assist primary care providers in improving health outcomes for patients with diabetes and cardiovascular disease (which disproportionately affect rural areas).

In an effort to reduce the adverse health consequences of pharmacy errors, ORHP and State Offices of Rural Health actively recruited rural providers to join the HRSA Patient Safety Pharmacy Services Collaborative. Of the 80 teams involved in this effort to improve patient safety and the cost-effectiveness of clinical pharmacy services, one third are located in rural communities.

In the past year, ORHP also developed performance measures for all 17 of its grants programs, and is now working with a contractor to develop a performance improvement and measurement system (PIMS) to demonstrate the success of these programs. This information has never been easily accessible before. But once PIMS is operational in February 2009, and the initial reporting cycle is completed, the aggregate data for each grant program will be available on the ORHP Web site.

ORHP Budget

Chart 1 – Budget Summary for Programs, FY 2007 and FY 2008 *(amounts in thousands)*

Rural Health Programs	FY 2007 Final Appropriation	FY 2008 Final Appropriation
Rural Health Outreach	38,885	48,031
Rural Health Research	8,737	8,584
Medicare Rural Hospital Flexibility	63,538	37,865
Rural and Community Access to Emergency Devices	1,487	1,461
Delta Health Initiative	0	24,563
State Offices of Rural Health	8,141	7,999
Denali Commission	39,283	38,597
Radiation, Screening, Exposure and Education Program	1, 919	1, 884
Black Lung	5,891	5,788
Federal Hospital Insurance Trust Funds	0	942,123
Total	**$ 167,881**	**$ 175,713**

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 2008

Total number of Grants awarded: 457
Total amount Funding provided: $115,869,683

State	# Grants Awarded	FY 2006 Funding
AK	10	1,695,871
AL	14	2,376,182
AR	13	2,572313
AZ	9	1,537,250
CA	16	2,278,155
CO	5	1,583,297
CT	2	272,700
DE	3	332,213
FL	11	1,795,511
GA	10	1,957,945
HI	4	433,023
IA	10	2,138,794
ID	5	1,165,596
IL	14	3,385,578
IN	10	1,872,180
KS	8	2,116,407
KY	16	3,201,377

State	# Grants Awarded	FY 2006 Funding
LA	12	2,540,419
MA	4	603,612
MD	5	528,855
ME	10	2,002,708
MI	16	2,340,254
MN	8	2,540,207
MO	10	2,297,739
MS	8	26,184,098
MT	17	2,836,343
NC	10	2,340,463
ND	11	3,767,476
NE	12	2,503,828
NH	9	1,325,365
NJ	2	244,092
NM	10	1,789,315
NV	8	1,303,809
NY	12	1,862,128

State	# Grants Awarded	FY 2006 Funding
OH	11	2,246,166
OK	7	1,762,525
OR	9	1,664,618
PA	9	1,548,216
RI	1	147,700
SC	9	1,982,098
SD	8	1,621,793
TN	8	1,951,282
TX	13	3,506,917
UT	6	1,191,052
VA	9	1,747,609
VT	7	1,077,136
WA	12	2,721,437
WI	8	1,533,832
WV	9	3,152,823
WY	5	1,135,696

Policy Activities

Key Regulatory Review and Policy Activities

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

Rural Medicare Payment

During Fiscal Year 2008, the policy staff in ORHP reviewed approximately 150 drafts of Federal regulations and policies to determine how they might affect rural providers and the individuals they serve. Of these regulations, 16 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. ORHP often identifies issues of particular concern to rural communities during its review of the Medicare payment system regulations. In 2008, ORHP worked with CMS on the development of a proposed rule to update certification and participation regulations, and payment provisions, for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). Key terms of the proposed rule include location and shortage area requirements, contracting with non-physician practitioners, and establishment of a Quality Assurance/Performance Improvement program. Also in 2008, ORHP identified independent pharmacies in rural areas as a key policy area to monitor. Recent policy changes affecting 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 pharmacies and what their closure could mean for access to pharmaceutical services in remote areas.

Rural Health Care Quality

In 2008, the Quality Improvement Organizations (QIOs) continued their work with Critical Access Hospitals (CAHs) and small rural hospitals under the CMS 8th Scope of work. CAHs continued to increase their participation in reporting quality measures to the Hospital Compare Web site operated by CMS. For 2006 discharges, 63 percent submitted data for at least one patient on one measure. This total does not include 289 CAHs that did not consent to have their 2006 discharge data publicly reported. Submission rates vary by State and by CAH organizational characteristics. By State, the percentage of participating CAHs ranged from 7.7 to 100 percent. Seven States had all of their CAHs participating. CAHs were more likely to report data on pneumonia and heart failure measures than on AMI and surgical infection prevention measures. Participation in the program is significant since CAHs submit data on a voluntary basis, unlike hospitals paid under the Medicare Inpatient Prospective Payment System (IPPS), who are required to participate in order to receive a full payment update.

Throughout 2008, ORHP continued to work with CMS and others on rural issues related to a prospective Value-Based Purchasing (VBP) plan. CMS's VBP plan, described in a 2007 Report to Congress, proposed to link payments more directly to the quality of care (i.e., pay-for-performance) under the Medicare program for hospitals. Congress discussed a VBP plan in 2008, but did not pass legislation.

ORHP contributed funds to the HRSA Patient Safety and Pharmacy Serves Collaborative (PSPC) began in August, 2008 with a mission to eliminate adverse drug events and improve patient outcomes. There are 79 teams representing 230 organizations in 40 States and Puerto Rico. Approximately 40 percent of the teams serve rural populations and include CAHs, FQHCs, and RHCs.

Health and Human Services (HHS) Rural Task Force

ORHP continues to coordinate the HHS Secretary's Rural Task Force. Established in 2001, it 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 2008, a range of issues were presented, including the implementation of Health Information Technology in rural America.

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

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

The year 2008 marked the 20th anniversary of ORHP. Accordingly, the 2008 Report provided a retrospective of rural health and human services, key changes that have affected the health of rural people, and analysis of emerging issues and trends. The 2009 Report topics include:

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

Policy Related Projects and Partnerships

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

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

• **340B Technical Assistance --** As a result of a 2003 change in the law, approximately 350 rural hospitals qualified for the 340B Drug Pricing Program. ORHP provided supplemental funding to the HRSA Pharmacy Services Support Center (PSSC) in FY 2008 to assist grantees and other eligible providers in securing 340B discount drug purchasing. Established in 2002, the aim of PSSC is to expand pharmacy services in needy populations. The Center operates under a contract between HRSA and the American Pharmacists Association (APhA). To date, it has helped almost 200 hospitals enter the 340B program.

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

• **National Technical Assistance to Rural Communities --** In 2008, ORHP joined with the National Rural Health Association (NRHA) to identify and promote useful administrative and clinical practices for rural providers; advance health quality initiatives; and increase leadership and skills development training. Through teleconference and Webinar series, this initiative extends continuing education to providers in remote communities, while affording ongoing technical assistance to entities like the State Offices of Rural Health (SORHs) and State Rural Health Associations (SRHAs). Example technical assistance includes new treatment protocols for agriculture-related diseases and injury via AgriSafe Network Resources.

Through these innovative networks, technical assistance was provided to nine SRHAs (NY, SC, AZ, FL, WA, ID, TN, IN, and TX) in such areas as board leadership development, organizational development, strategic planning and membership growth and retention. Other accomplishments due to the technical assistance provided to the networks include North Dakota becoming an official SRHA in March, the Rural Medical Educators Annual Conference had its largest turnout in history, and 20 small rural hospitals agreed to participate in a rigorous efficiency and patient safety assessment project undertaken by the University of Nebraska Medical Center under a contract with the NRHA.

This national effort also provided training grants to 40 State-based organizations, and underwrote a 40-credit hour Agricultural Health Training for rural health professionals offered by the University of Iowa's Center for Agricultural Safety and Health. Finally, NRHA hosted two policy meetings on access to rural trauma services and value-based purchasing and rural hospitals.

• **Rapid Response to Requests for Rural Data Analysis --** In 2008, ORHP funded the Rapid Response to Requests for Rural Data Analysis to support quick turn around requests for rural data analysis to assist with policy making. Due to the nature of rural policy analysis and formulation, policymakers often require information that is available only through specialized analysis of databases of information. In order to acquire the information from the data sets needed to identify trends, problems and progress in rural health care financing and access to care in rural areas, ORHP funds a consortium of research institutions that have access to the required data storage capacity, personnel, and computer resources to provide the information. Topics analyzed for policy makers in 2008 include the experience of rural independent

pharmacies with Medicare Part D, Medicare Advantage and CAHs, Rural Health Clinic geographic locations and shortage designation status, and Value Based Purchasing in rural hospitals.

• **Rural Assistance Center –** Based at the University of North Dakota School of Medicine and Health Sciences, the ORHP Rural Assistance Center (RAC) helps rural residents navigate a wide range of health policy and social services information online. RAC assists individual communities and providers in identifying potential funding streams that best meet their needs. Staff researchers also provide no-cost, customized assistance, performing database searches; referring users to qualified experts and organizations; furnishing publications; and posting a wide variety of timely information on the Internet (regulatory updates, conference announcements, bibliographies, directories, and full-text documents). The Center also acts as a repository and retrieval portal for information and research from a myriad of Federal, State, and private sources, and makes that information actionable for rural stakeholders. In 2008, RAC responded to over 900 individual requests for assistance.

The RAC Web site is the most comprehensive source of reliable information on rural health and human services on the Internet. To ensure timely and widespread distribution to often-remote communities, the Center maintains an electronic mailing list that reaches a broad audience across the breadth of rural America. The RAC site averages over 70,000 visits per month, while its e-mail listservs have over 14,000 combined subscribers.

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

During FY 2008, RHW conducted regional workshops in Pennsylvania and Colorado; responded to more than 250 requests for technical assistance; and updated their Web site to keep current with the latest research in this area. A new economic impact application is under development to calculate the value of rural residency programs to local economies. A new feasibility study nearing publication will quantify the costs and revenues for a rural physician practice. RHW sends representatives to conferences nationwide to actively promote the tools and applications it has developed over the past 9 years.

RHW also has joined The National Association of Counties (NACo) in an outreach campaign to elected county officials interested in launching community engagement projects to help rural communities recognize that improving their health care systems boosts local economic growth generally. A new initiative in FY 2005, it continued through FY 2008 with on-site technical assistance to nine rural counties. Three more counties will be funded in FY 2009. For each, the project has produced a county-level report covering such topics as economic impact, community need, and a health services directory. All are posted on the NACo Web site and were featured in workshops at the Western Regional and Annual Conferences, as well as in articles for NACo's publication "County News."

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

In FY 2008, the RHC Conference Call series provided seven sessions, with topics determined by an advisory group of national experts versed in the most pressing concerns of rural providers. Discussions included: cost reporting guidance; electronic health record implementation; rural health information resources; proposed rule changes affecting rural communities; and health professions shortage area designations. An average of 286 providers nationwide dialed in for each session, saving rural clinics about $900 per conference compared to the cost of sending staff to off-site training. In the aggregate, this savings amounted to over $250,000 per session, substantially extending local patient care budgets.

• **Rural Health Research Center Gateway** -- The Rural Health Research Gateway (Research Gateway) Web site was developed to speed the dissemination of information and publications of the Rural Health Research Centers, including contact information for subject-area experts; summaries of research projects, both those underway and completed; full text versions of reports; Policy Briefs; Analytic Reports; Fact Sheets, and other products of the Research Centers. In 2008, the Gateway added a *Research Alert* feature to notify listserv members about the availability of recently released reports. The Gateway includes all projects and their related publications dating from 2006. Earlier publications are being added as resources permit.

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

In 2008, RHPI provided 48 consultations at 41 of the 171 eligible hospitals in DRA. Thirty-eight hospitals received on-site consultations, and 10 received feedback assessments. Of the on-site visits, 10 were general Performance Improvement Assessments, and 27 were consultations for specified issues, with one "Balanced Scorecard" review. Of the feedback assessments, three each were conducted for community and trustees, and four were employee assessments. There were 7 Webex calls with 39 hospitals participating. Sixteen "Sessions in Sustainability" conferences and workshops were held. In 2008, ORHP launched an initiative to have the project's various efforts formally evaluated. RHPI has developed performance improvement strategies at the State, regional and local (internal hospital) levels in conjunction with State offices of rural health (SORH) and State hospital associations.

• **Rural Policy Analysis Cooperative Agreement --** ORHP funds the Rural Policy Analysis Cooperative Agreement to support research and analysis on key policy issues affecting rural communities. In 2008, this funding supported activities with rural community colleges health workforce development; the Rural Policy Research Institute (RUPRI) Rural Health Panel; the Rural Hospital Issues Group; and the creation of a RUPRI Rural Human Services Panel. The RUPRI Rural Health Panel provides science-based, objective analysis to Federal policymakers. Panel members come from a variety of academic disciplines and author documents that reflect the consensus judgment of all panelists. The Rural Hospitals Issues Group, a panel of hospital administrators and finance experts from across the country, discuss issues such as the Medicare reimbursement, Medicare Advantage, and other policy issues affecting small rural hospitals. The Rural Human Services Panel met for the first time in August and November 2008. This Panel also will work to provide background, advice and presentations to the National Advisory Commission on Rural Health and Human Services.

• **State Partnerships --** The State Office of Rural Health (SORH) network funded by ORHP entered into a cooperative agreement with the National Organization of State Offices of Rural Health (NOSORH) to assist in the development of State-level leadership and create further partnerships between national and State-level interest groups. The Technical Assistance to States cooperative agreement coordinated five regional grantee meetings in 2008, a new SORH director orientation meeting and an annual grantee meeting. In addition, the partners developed a curriculum for rural health grant writing and a Promising Practices Evaluation of SORHs. The creation of a Leadership Institute also is being explored.

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

TASC supported 45 participating State Flex Programs in 2008 through the following activities: converting rural prospective payment hospitals to Critical Access Hospital (CAH) status; integrating emergency medical services into rural medical delivery systems with more than 12 EMS educational sessions and 3 manuals for hospital leaders; building rural hospital networks to exchange information, provide economies of scale, obtain collective volume, and increase cost efficiency. TASC provides advice to hundreds of these networks in rural America, in addition to educational sessions, and has coordinated three national quality forums. Staff also has presented papers at over 50 State performance improvement events.

• **Workforce –** In conjunction with the National Conference of State Legislatures (NCSL), ORHP holds an annual meeting for an average of 30-50 elected State officials from rural communities. In 2008, the conference focused on the continuing health care workforce recruitment challenges faced by their constituents, *The Rural Physician Pipeline: Increasing the Number of Physicians Practicing in Rural Areas.* This meeting provided an overview of the family physician shortage in the United States and how State lawmakers might contribute to ameliorating chronic clinician scarcities in rural communities.

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

During FY 2007, 3RNet placed 750 medical professionals, including 220 family practice physicians, 65 internal medicine physicians, 50 pediatricians, 100 dentists, 80 nurse practitioners, and 80 physician assistants. The 3RNet also maintained a toll-free phone line to assist providers interested in serving rural America, saving rural communities substantial recruitment costs. Analysis shows that physician placement fees average about $28,000, while non-physician recruitment costs are generally 30 percent of the first year's salary. Thus, total recruitment costs for the workforce above would have been over $18 million. Of the 564 communities in which professionals were placed by 3RNet members, 524 (or 93 percent) are federally designated health professional shortage areas.

Grant Programs

Research and Policy Grant Programs

In FY 2008, ORHP administered four grant programs within the Policy Research Team. The grant programs are: 1) the Frontier Extended Stay Clinic Demonstration program; 2) the Rural Health Research Centers; 3) the Targeted Rural Health Research grant program; and 4) Critical Access Hospitals Transitioning to Skilled Nursing Facilities and Assisted Living Facilities program. There were 10 grants awarded in these 3 programs with a total budget of almost $7 million. In addition to the above grants, Policy Research team members manage numerous cooperative agreements and contracts that support research and analysis of key policy issues affecting rural communities. These activities work to educate and inform rural decision makers and policy leaders at the local, State, and Federal level.

Policy Research Team Members:

Carrie Cochran, Team Lead

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

Truman Fellows: Jenna Kennedy, Meghana Desale

Frontier Extended Stay Clinic Program (FESC)

PROGRAM COORDINATOR: Carrie Cochran, MPA
Email: ccochran@hrsa.gov
Phone: (301) 443-4701

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

At a Glance

Grants Awarded:
- **2006:** 1 continuing award
- **2007:** 1 continuing award
- **2008:** 1 continuing award

Amount Awarded: Up to $1.5 million per year, per grantee
- **2006:** $1.5 million
- **2007:** $1.5 million
- **2008:** $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 Frontier Extended Stay Clinic cooperative agreement demonstration program is to examine the effectiveness of a new type of provider in providing health care services in certain remote clinic sites. The FESC is designed to address the needs of patients who are unable to be transferred to an acute care facility because of adverse weather conditions, or who need monitoring and observation for a limited period of time.

FY 2008 program activities include, but are not limited to:
- Implementation and testing of FESC protocols;
- Evaluation of program and financial activities;
- Provision of technical assistance to CMS FESC Demonstration Project and participating organizations;
- Developing or continuing Health Information Technology (HIT) and quality initiatives; and
- Exploring the FESC model in the lower 48 states, including the relationship with Critical Access Hospitals.

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

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

KEY PROGRAM ACCOMPLISHMENTS:
In 2008, ORHP continued the work started in 2004 by providing funding to the Alaska FESC Consortium for the participation of five clinic sites in frontier Alaska and Washington. Preliminary results of the 3rd year of data collection indicate that the 5 clinics recorded 1,449 Monitoring and Observation stays of 2 hours or greater duration, and 1,397 Transfer stays (no minimum stay length). The mean length of these encounters was 6.76 hours for Monitoring and Observation and 3.97 for Transfers. Only 9 percent of the stays were over 12 hours. While 37 percent of the extended stays resulted in patients being discharged without further referral, 53 percent resulted in emergency transfer to a higher level of care.

Rural Health Research Centers Program

PROGRAM COORDINATOR: Joan F. Van Nostrand, DPA
Email: jvan_nostrand@hrsa.gov
Phone: (301) 443-0613

AUTHORIZING LEGISLATION: Section 711 of the Social Security Act

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

At a Glance

Grants Awarded:
- **2006:** 8 continuing awards
- **2007:** 8 continuing awards
- **2008:** 6 new awards

Amount Awarded: Prior to 2008, up to $550,000 per year, per grantee
- **2006:** $4 million
- **2007:** $4 million

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

Project Period: 4 years

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

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

KEY PROGRAM ACCOMPLISHMENTS:
In 2008, the 8 Research Centers conducted 24 projects and wrote 30 policy briefs and reports. They also authored 27 peer-reviewed journal articles in 2008, and another 15 that have been accepted for publication and are in pre-press. To widen dissemination of these results, the Rural Health Research Gateway was updated in 2008. The Gateway is a Web site that allows "one-stop shopping" for all projects produced by the respective research teams, as well as summaries of projects in progress. In 2008, the Gateway began to issue *Research Alerts* each time a new report is issued. Additionally, the Centers each have Web sites that highlight and summarize their projects. There were over 163,000 visits to these sites in 2008. Staff also presented their findings to 176 policy, provider, payer, and academic audiences; and responded to over 300 requests for information from various national and State policymakers. In September 2008, competitive awards were made to six new Research Centers for the 2008-2012 cycle. See the Research Gateway (www.ruralhealthresearch.org) for a list of the new Research Centers.

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*

Targeted Rural Health Research Grant (TRHR)

PROGRAM COORDINATOR: Erica Molliver, MHS
Email: Emolliver@hrsa.gov
Phone: (301) 443-1520

AUTHORIZING LEGISLATION: Section 711 of the Social Security Act

PROGRAM OVERVIEW:
The Targeted Rural Health Research Grant Program (TRHR) funds policy-oriented projects which address critical issues facing rural communities in their quest to secure affordable, high quality health services. The program is unique in its dual purpose of enhancing policymakers' knowledge of rural health, and expanding the pool of experienced researchers in this complex field. Grantees' findings inform the ORHP, as well as National, State, and local decision makers. Grantees must address one of a selected group of topics, and all aspects of the project must be national in scope. Studies in 2008 included the following issues of national significance: Rural Health Clinics, Frontier Health Services Delivery, EMS, Rural Health Leadership, Allied Health Workforce, and Public Health.

At a Glance

Grants Awarded:
- **2006:** 3 new awards
- **2007:** 2 new awards
- **2008:** 2 new awards

Amount Awarded: Up to $150,000 per grantee
- **2006:** $449,923
- **2007:** $300,000
- **2008:** $299,512

Project Period: 18 months

Next Competitive Grant Application:
- **Year:** 2009
- **Anticipated # Grants:** Up to 3
- **Anticipated Grant Amount:** Up to $150,000 per grantee (up to $450,000 combined)

Originally entitled Policy-Oriented Rural Health Services Research Grant Program, TRHR was launched in 2003 on a single-year grant cycle. In 2007, however, it became apparent that the 12-month timeframe was unrealistic, considering the complexity of the research involved. Under expanded authority, ORHP notified grantees that they could extend their projects without formally requesting approval of a no-cost extension. Reflective of this shift, the name of the program eventually was changed, and the FY 2008 competitive funding cycle and budget periods were formally extended to 18 months.

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

- "Organizational Impact of the Deployment of Ambulance Quality Feedback Systems (QFS) on Rural Volunteer EMS Agencies"
- "Rural Health Clinics: Measuring Efficiency & Effectiveness"

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*

Critical Access Hospitals Transitioning to Skilled Nursing Facilities and Assisted Living Facilities (CAH SNF)

PROGRAM COORDINATOR: Heather Dimeris, MS, RD
Email: hdimeris@hrsa.gov
Phone: (301) 443-4657

AUTHORIZING LEGISLATION: Section 1820(g)(7) of the Social Security Act as amended, (42 U.S.C. 1395i–4(g)(7))

At a Glance

Grants Awarded:
- **2006:** N/A
- **2007:** N/A
- **2008:** 1 new award

Amount Awarded: Up to $1,000,000 per year, per grantee
- **2006:** N/A
- **2007:** N/A
- **2008:** $942,123

Project Period: 1 year

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

PROGRAM OVERVIEW:
Section 121 of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) included a provision for the Health Resources and Services Administration to support eligible critical access hospitals (CAH) in making the transition to Skilled Nursing Facilities (SNF) and/or Assisted Living Facilities (ALF).

There are more than 1,290 CAHs across the country. These facilities can have up to a maximum of 25 beds available for any combination of acute and/or swing-bed nursing care. As population demographics and service areas change, some CAHs face higher demand for swing-bed nursing, rather than acute care services. These facilities may find the costs of maintaining acute care and emergency room status difficult. Particularly as their local populations age, they may better serve community needs by shifting their mission to that of either a nursing home or an assisted living facility. This especially is true if there is another acute care facility nearby. These grants are designed to help defray the cost of shifting a CAH to an SNF or ALF.

To be eligible for this program, a CAH must have an average daily acute census of less than 0.5 and an average daily swing-bed census of greater than 10.0. An eligible hospital also must provide assurance that it will surrender its Critical Access Hospital status within 180 days of receiving the grant.

KEY PROGRAM ACCOMPLISHMENTS:
Key program accomplishments are yet to be demonstrated for the CAH SNF grantee, as the grant was awarded in September of the 2008 fiscal year.

Hospital State Team Grant Programs

In FY 2008, ORHP administered four grant programs within the Hospital State Team (HST). The grant programs are: 1) the Critical Access Hospital Health Information Technology (CAHHIT) Network; 2) Rural Hospital Medicare Flexibility (Flex); 3) Small Rural Hospital Improvement Program (SHIP); and 4) the State Office of Rural Health (SORH).

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

Hospital State Team Members:

Nancy Egbert, Team Lead

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

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

PROGRAM COORDINATOR: Michael McNeely, MBA, MPH
Email: mmcneely@hrsa.gov
Phone: (301) 443-5812

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

At a Glance

 # Grants Awarded:
- **2006:** N/A
- **2007:** 16 new awards
- **2008:** N/A

Amount Awarded: Up to $1.6M per grantee
- **2006:** N/A
- **2007:** $25 M
- **2008:** N/A

Project Period: 18 months

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

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

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

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

Although the CAH-HIT Network program is a one-time funding opportunity, it is being administered as a "test bed" pilot program on HIT network implementation in rural areas. A thorough evaluation is underway to provide lessons learned for similar projects in future.

KEY PROGRAM ACCOMPLISHMENTS:
At completion of the 18-month grant period, 12 of the 16 grantees had a fully operational HIT network. The four remaining grantees experienced early delays in securing vendors, so ORHP approved a 6-month extension for them to complete the Flex CAH-HIT Network activities. By the end of the grant cycle, it was anticipated that the grantees would have developed comprehensive management systems for medical information, and its secure exchange between and among consumers and providers. ORHP also funded an evaluation contract to document whether the program succeeds in improving quality of care, reduction in medical errors, administrative efficiencies, and overall access.

Delta Health Initiative (DHI)

PROGRAM COORDINATOR: Kathryn Umali, MPH
Email: kumali@hrsa.gov
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

At a Glance

Grants Awarded:
- **2006:** 1 new award
- **2007:** no award
- **2008:** 1 continuing award

Amount Awarded:
- **2006:** $24.75 million
- **2007:** $0
- **2008:** $23 million

Project Period: 5 years

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

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

HRSA's Office of Rural Health Policy funded a 5-year cooperative agreement in the amount of $24.75 million in FY 2006, and $23 million in FY 2008. The grantee is working with 10 partners on projects aimed at improving:

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

The consortium proposed 24 projects, and devised communication and coordination systems among themselves. Three of these projects were major public works undertakings, entailing the construction of public health facilities. Through these projects, DHI supports multiple HHS, HRSA and ORHP goals and objectives, including improving the safety, quality and access to health care.

KEY PROGRAM ACCOMPLISHMENTS:
Since its initial funding in 2006, DHI has improved health outcome measures across a broad spectrum of the Delta population. Many projects continue to date as a result of this initial "seed" funding. The program also has fostered better collaboration between the partners through the grantee's continuing efforts to improve its organizational structures. The DHI has conducted 156 community-based wellness events and classes, and 146 professional education seminars. It has trained 1,812 health professionals, and 20,978 Delta residents. The consortium has conducted 2,321 screenings/patient interviews; accounted for 7,062 patient-encounters for medical services; and held 117 community-based career recruitment events.

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

Medicare Rural Hospital Flexibility Grant Program (Flex)

PROGRAM COORDINATOR: Steven Hirsch, MSLS
Email: shirsch@hrsa.gov
Phone: (301) 443-7322

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

At a Glance

Grants Awarded:
- **2006:** 45 continuing awards
- **2007:** 45 continuing awards
- **2008:** 45 new awards

Amount Awarded: Up to $650,000 per year, per grantee, with an average grant of $490,000
- **2006:** $22.2 million
- **2007:** $22.2 million
- **2008:** $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

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

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

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

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

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

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

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: Jeanene Meyers, MPH
Email: jmeyers@hrsa.gov
Phone: (301) 443-2482

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

At a Glance

Grants Awarded:
- **2006:** 47 continuing awards
- **2007:** 46 continuing awards
- **2008:** 46 new awards

Amount Awarded: Up to $1,200,000 per year, per State grantee
- **2006:** $ 14.5 million
- **2007:** $ 14.5 million
- **2008:** $ 14.2 million

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

Next Competitive Grant Application:
- **Year:** 2013
- **Anticipated Grants:** Up to 47
- **Anticipated Grant Amount:** Average of $309,500 per year, per State grantee, up to $14.5 million, combined

PROGRAM OVERVIEW:
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, $14.2 million was awarded across 46 States in FY 2008, which the SORHs then disbursed across 1,633 eligible hospitals.

The SHIP program is authorized by section 1820(g)(3) of the Social Security Act to help small rural hospitals pay costs related to the implementation of prospective payment systems; the purchase of computer software and hardware that would protect patient privacy; educating and training hospital staff on computer information systems to protect patient privacy; purchase of computer software and hardware to help reduce medical errors and support quality improvement; and/or educating and training hospital staff on computer information systems to help reduce medical errors and support quality improvement.

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, and consultants or assessments within the areas of PPS implementation, protection of patient privacy and quality improvement support. Examples of allowable activities include: 1) purchase of billing and coding software and charge-master review for PPS implementation, 2) purchase of security application software to increase security and privacy for patients, and 3) purchase of electronic health record systems and providing staff training and educational materials on information systems.

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 2007 funds. In the most recent award cycle (FY 2008), 11 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
Email: kmidberry@hrsa.gov
Phone: (301) 443-2669

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

PROGRAM OVERVIEW:

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

The three core functions of the SORH program are to:

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

At a Glance

Grants Awarded:
- **2006:** 50 continuing awards
- **2007:** 50 continuing awards
- **2008:** 50 continuing awards

Amount Awarded: Up to $150,000 per year per grantee
- **2006:** $7.4 million
- **2007:** $7.2 million
- **2008:** $7.2 million

Project Period: 5 years

Next Non- competitive Continuation Grant Application:
- **Year:** 2009
- **Anticipated Grants:** 50
- **Anticipated Grant Amount:** Up to $150,000 per year, per grantee

Additionally, the SORH program strengthens Federal, State, and partnerships in rural health; and promotes recruitment and retention of a competent health care workforce. Funds cannot be used for direct delivery of health care services, purchase of real property or equipment (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 in 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 three in non-profit organizations.

KEY PROGRAM ACCOMPLISHMENTS:

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

1. The total number of technical assistance (TA) encounters provided directly to clients within State by SORH.
2. The total number of clients within the State that received TA directly from SORH.

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 2008, ORHP administered 9 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; Network Development Grant Program; Network Development Planning Grant Program; Radiation Exposure Screening and Education Program; Rural Access to Emergency Devices (RAED) Grant Program; Rural Health Outreach Grant Program; and the Small Health Care Provider Quality Improvement (SHCPQI) Grant Program. This year, 305 grants (for a combined program budget of over $43 million) were awarded.

In FY 2008, ORHP implemented a new strategy for managing the community-based grant programs which staggers the competitive cycle between programs. By doing this, ORHP will bring consistency to its grant funding cycle and each program (Quality, Network Development and Outreach) will be able to fund grantees in the same cycle, allowing for more peer-to-peer learning and better coordinated technical assistance. This approach is the same used by ORHP in funding the State and Research grant opportunities, and allows ORHP to achieve efficiencies that permit additional grant awards.

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 ORHP. 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

Karen Beckham	Vanessa Hooker	Lakisha Smith
George Brown	Kristi Martinsen	Sonja Carter Taylor
Julia Bryan	Nisha Patel	Shelia Tibbs
Eileen Holloran	Elizabeth Rezai-zadeh	Shelia Warren
	Lilly Smetana	

Black Lung Clinics Program (BLCP)

PROGRAM COORDINATOR: Kristin Martinsen, MPM
Email: kmartinsen@hrsa.gov
Phone: (301) 594-4438

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

At a Glance

Grants Awarded:
- **2006:** 15 continuing awards
- **2007:** 15 new awards
- **2008:** 15 continuing awards

Amount Awarded:
- **2006:** $5.7 million
- **2007:** $5.65 million
- **2008:** $ 5.62 million

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

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

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

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

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

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

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

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

KEY PROGRAM ACCOMPLISHMENTS:
In 2008, ORHP sponsored a contract to locate potentially affected miners, improve outreach, and increase participation in the BLCP by targeting information at likely populations. Grantees provided a total of 22,488 medical encounters -- an increase of 17 percent from 2006 – and served 11,110 miners.

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: Heather Dimeris, MS, RD
Email: hdimeris@hrsa.gov
Phone: (301) 443-4657

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

At a Glance

Grants Awarded:
- **2006:** 8 continuing awards
- **2007:** 12 new awards
- **2008:** 12 continuing awards

Amount Awarded: Award range $400,000 - $1,000,000 per grantee
- **2006:** $5.1 million
- **2007:** $5.1 million
- **2008:** $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 projects.

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

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

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

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

KEY PROGRAM ACCOMPLISHMENTS:
The Delta grant program had success in providing needed health services to rural communities in this hard hit region. There have been marked achievements particularly in oral health care, chronic disease management and school-based health services. Most notably, approximately 3 percent of the Delta population (an estimated 181,000 people) have been served or reached by this program over the past year by a variety of community-based institutions. Since the grant's inception in 2001, several organizations continue to implement successful projects and partnerships as a result of initial funding from the Delta Grant program. During the 2008 Delta Grantees Meeting, participants obtained tools and key resources on developing a sustainability plan, which continued into a broader sustainability series as highlighted in their technical assistance site visits and quarterly conference calls.

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:
- **2006:** 7 continuing awards
- **2007:** 7 continuing awards
- **2008:** 1 new/ 6 continuing awards

Amount Awarded:
- **2006:** $1.917 million
- **2007:** $1.586 million
- **2008:** $1.517 million

Project Period: 3 years

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

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

The major objectives of the programs are to:

● Screen individuals for cancer and other radiogenic diseases

● Provide referrals for diagnostic testing medical treatment of individuals screened

● Develop and disseminate public information and education programs for the detection, prevention, and treatment of radiogenic cancers and diseases; and

● Facilitate medical documentation of claims for the Radiation Exposure Compensation Act (RECA) program

There are seven health care organizations in five southwestern States (Arizona, Colorado, Nevada, New Mexico and Utah) participating in the RESEP Program. These organizations include hospitals, universities, Indian Health Service facilities, medical centers and community health centers. In FY 2008, competitive grants totaling $1,517,931 were awarded to these organizations for a total of $1,917,000.

KEY PROGRAM ACCOMPLISHMENTS:
The following accomplishments support the program's long-term and annual performance measures:

- Launched a National Outreach effort to identify potentially eligible individuals no longer residing in the area served by program grantees
- "*HRSA Outreach Seeks to Raise Cancer Awareness Among People Who Lived Near Nuclear Sites and Mined Uranium*"- Inside HRSA article on the University of Nevada RESEP Center activities, located on the Web site at: http://newsroom.hrsa.gov/insidehrsa/may2008/default.htm
- Implemented depression screening in accordance with the US Preventative Services Task Force (USPSTF) at every RESEP clinic
- Screened 1,464 individuals for radiogenic disease; made 2,001 referrals for additional diagnostic testing; provided assistance to 7,183 individuals; and informed more than 41,347 residents about the program through brochures, presentations, and letters during the previous program 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*

Rural Health Care Services Outreach Grant Program

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:
- **2006:** 65 new / 43 continuing
- **2007:** 27 new / 95 continuing
- **2008:** 0 new/ 122 continuing

Amount Awarded: Up to $150,000 in Year 1; $125,000 in Year 2; and $100,000 in Year 3, per grantee
- **2006:** $17.9 million
- **2007:** $17.6 million
- **2008:** $17.7 million

Project Period: 3 years

Next Competitive Grant Application:
- **Year:** FY 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 toward a common goal, which is to improve the health and well-being of rural populations. Although the Outreach program is a 3-year grant, many of the programs have continued success beyond the project period and Federal funding. The grantees are encouraged to develop creative sustainability and evaluation plans that allow their program to be expanded and enhanced. Since the program's inception in FY 1991, to-date funding has been provided to 683 grantees in 48 States and 3 Territories.

In FY 2008, ORHP awarded a Sustainability Technical Assistance Contract to Georgia State University. The purpose of the contract is to provide extensive technical assistance around sustainability so that the grantees are able to sustain their program once Federal funds have ended. The contract will conduct workshops, peer-to-peer learning seminars and webinars to help grantees develop and implement a sustainability plan. In addition, ORHP has awarded an Economic Impact Analysis contract. This contractor will work with grantees to conduct an analysis on grantees to help determine the impact of the program in their community.

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

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:
- **2006:** 23 new / 15 continuing
- **2007:** 5 new / 33 continuing
- **2008:** 51 new/ 28 continuing

Amount Awarded: Up to $180,000 per year per grantee (3 year award)
- **2006:** $6.7 million
- **2007:** $6.5 million
- **2008:** $13.7 million

Project Period: 3 years

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

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

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

The Network Development Grant Program was started in 1997 with 34 grantees and $6.1 million. To-date, the program has awarded almost $89 million to support 210 Network Development grants.

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

KEY PROGRAM ACCOMPLISHMENTS:
Due to an increase in funding, 51 new grants were funded in 2008 – an increase of 21 over the 30 grants that were anticipated to be awarded. One-hundred eighty grantees attended a Network Development Grantee Conference held in Washington, DC in August 2008. Grantees learned techniques to become an effective Network Director, and learned strategies to sustain their Networks after Federal funding ceases. ORHP collaborated with the Georgia Health Policy Center and the National Cooperative of Health Networks to provide joint technical assistance to grantees at this meeting.

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.

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

At a Glance

Grants Awarded:
- **2006:** 15 new awards
- **2007:** 10 new awards
- **2008:** 33 new awards

Amount Awarded: Up to $85,000 per year, per grantee
- **2006:** $1.2 million
- **2007:** $841,391
- **2008:** $2.7 million

Project Period: 1 year

Next Competitive Grant Application:
- **Year:** FY 2009
- **Anticipated Grants:** Up to 10
- **Anticipated Grant Amount:** Up to $100,000 per year. per grantee

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. The average award for FY 2008 was $82,400.

KEY PROGRAM ACCOMPLISHMENTS:
Two Grantee Meetings were held in FY 2008. The first meeting was held in conjunction with the National Cooperative of Health Networks (NCHN) annual meeting in April 2008. Several of the NCHN members served as Peer Counselors to the new Network Planning Grantees to assist the new grantees in understanding what a formal health network is and some of the issues surrounding working with other organizations for a common good. The grantees also received information on how to develop boards and the legal consequences of incorporating. The second meeting was held separately in June 2008 and was identical to the first in substance. Evaluation analysis showed that the grantees were very satisfied with both meetings.

Five, of thirteen, FY 2007 Network Planning Grantees received FY 2008 Network Development Grants; and 4, of 16, FY 2006 Network Planning Grantees received FY 2008 Network Development Grants. This indicates that the grantees successfully completed their Planning projects and were able to continue to develop their fledgling networks.

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:
- **2006:** 4 new awards
- **2007:** 4 continuing/ 9 new awards
- **2008:** 13 continuing awards

Amount Awarded:
- **2006:** $309,408
- **2007:** $1.2 million
- **2008:** $1.2 million

Project Period: 2 - 3 years

Next Competitive Grant Application:
- **Year:** 2009
- **Anticipated Grants:** 10
- **Anticipated Grant Amount:** Up to $99,900 per year, per grantee for up to 2 years

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:
The RAED Program has increased public awareness of the poor outcomes of persons suffering sudden cardiac arrest in rural areas. The program increased the number of AEDs available and the number of fire, rescue, police, first responders, and lay persons trained in using an AED to decrease mortality rates in the event of sudden cardiac arrests in isolated rural areas. In 2008 we continued to fund 13 grantees. In FY 2008 we anticipate approximately 700 new AEDs to be purchased with an additional 2,100 persons trained; this is an increase from FY 2007 levels: 675 AEDs were purchased and an estimated 2,000 persons were trained in their use.

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

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

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

At a Glance

Grants Awarded:
- **2006:** 15 new awards
- **2007:** 15 continuing awards
- **2008:** 55 new awards

Amount Awarded: Up to $75,000 per year, per grantee
- **2006:** $ 737,757
- **2007:** $ 680,202
- **2008:** $ 4,026,691

Project Period: 2 years

Next Competitive Grant Application:
- **Year:** 2010
- **Anticipated Grants:** Up to 60
- **Anticipated Grant Amount:** Up to $75,000 per year, per grantee (up to $4.5 million, combined)

PROGRAM OVERVIEW:
The purpose of the program is to help rural primary care providers implement quality improvement strategies in the practice of chronic disease management by the following means:

- Adoption of electronic patient registry systems
- Tracking specific health indicators using nationally-accepted measures
- Performing routine needs assessments as part of a continuous quality improvement program
- Participating in monthly conference calls and peer-learning workshops with fellow program grantees, facilitated by a quality improvement specialist.

The Rural Quality program was sponsored by ORHP for the first time in FY 2006 under a 2-year grant cycle. The grantees' focus was on diabetes in the first learning year and cardiovascular disease (CVD) in the second.

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, stressed that rural health care organizations can be leaders in quality improvement.

While many initiatives focus on in-patient hospital care, improvement also is 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 decreases expensive emergency room visits and hospital admissions, which often result from deferred primary care. The Rural Quality program addresses this need for continuous improvement in primary care in distant communities.

KEY PROGRAM ACCOMPLISHMENTS:
Since the inception of the Rural Quality program in FY 2006, over 2,400 patients have been served by the 15 grantee organizations. Among patients with measured HbA1c lab values, the annual average was 7.1 (slightly above the goal of <7.0). This average was maintained as new patients were added throughout the year to the patient registry. Other goals for clinical measures that were met or nearly achieved include:

- 40 percent of patients with BP <130/80
- 75 percent of patients with LDL < 100

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 of Rural Health Policy 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. The regions along the border face similar health care delivery challenges as rural areas, such as limited health workforce capacity and a fragile infrastructure. ORHP coordinates these activities through its Division of Border Health in Dallas, Texas.

Office of Intergovernmental Affairs (IGA)
ORHP 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 affairs, stakeholder association and interest group activities, and all internal activities, such as cooperative agreements and activities related to HRSA's offices and bureaus.

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

Border Team Members:

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

Denali Commission Team Members:

Carrie Cochran

Heather Dimeris

Tom Morris

Sonja Carter-Taylor

IGA Team Members:

Karen Beckham

Tom Morris

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

Julia Bryan	Michele Pray-Gibson	Amal Thomas
Mary Collier	Lilly Smetana	April Williams
Keith Midberry	Sonja Carter-Taylor	Sheila Warren

Border Health

PROGRAM COORDINATOR: Frank Cantu
FCantu@hrsa.gov
Phone:(214) 767-8068

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

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

KEY PROGRAM ACCOMPLISHMENTS:
The inter-agency agreement with the Environmental Protection Agency represents an 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 4 years, FY 2005 to FY 2008, 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 inoculation of children and adults in local clinics and community health centers along the U.S.-Mexico border.

In FYs 2006 and 2007, ORHP organized an expert meeting, *Improving Knowledge Transfer among Health Researchers and Decision Makers 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 decision makers 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 discuss their experiences and 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.

A follow-up meeting, *Options for Improving Access to Clinical Information for Border Health Grantees,* was held on December 8-9, 2008 at HRSA's Headquarters in Rockville, MD. The purpose of this meeting was to examine options to transfer new and emerging clinical information into the hands of clinicians working on HRSA funded projects along the U.S.–Mexico border.

Denali Commission

PROGRAM COORDINATOR: Tom Morris, MPA
Email: tmorris@hrsa.gov
Phone: (301) 443-4269

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

At a Glance

Grants Awarded:
- **2006:** 1 new award
- **2007:** 1 new award
- **2008:** 1 new award

Amount Awarded:
- **2006:** $39,283,000
- **2007:** $39,283,000
- **2008:** $38,597,000

Project Period: 1 year

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

This program, which began in 2001, is modeled on the Appalachian Regional Commission and directed by Federal and State (Alaska) co-chairs. Its core mission is economic development in rural Alaska. The $38,597,000 appropriated to HRSA for the Commission in FY 2008 was combined with other resources for planning, designing and constructing primary health care facilities in the State. Resources were also used to assist other facilities, such as hospitals and facilities that provide mental health services. The program makes a single annual award to the Commission to support up to 35 projects each year.

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

KEY PROGRAM ACCOMPLISHMENTS:
The Denali Commission made 28 sub-awards to Alaskan communities in 2008. The Commission recognized the Primary Care Clinic program as a priority funding area within health. New clinic construction grants were dedicated to the communities of Kasigluk, Hughes, Selawik, Skagway, Craig, Levelock, and Nanwalek.

Other priority areas included construction funding for a new domestic violence shelter in Bethel, construction funding for a youth psychiatric facility in South Central Alaska, design funding for a new Indian Health Service hospital in Nome, and funding for a grant program providing construction funding to elder housing projects, as well as a grant program providing renovation and/or equipment upgrades for primary care in hospitals.

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

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

The purpose of HRSA's Intergovernmental Affairs is to:

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

KEY PROGRAM ACCOMPLISHMENTS:
Some of the primary functions of HRSA IGA are to respond and coordinate information and meeting requests. In 2008, 19 information requests and 4 meeting requests were processed. ORHP has developed a systematic process in managing the coordination of these requests, which entails responding to a variety of problems, questions, or situations relevant to health services and intra-governmental affairs. This may involve program planning and implementation for which there may not be established criteria. The work facilitates national dissemination of information about HRSA's programs, functions, and activities to partnering organizations and agencies.

Appendix A: Contracts

Title of Procurement	Description of Product or Service
Rural Health Clinic Technical Assistance	This contract supports the development of a Rural Health Clinic Technical Assistance Series. It also supports a quarterly series of conference calls to provide technical assistance (TA) to rural health clinics. Many of these RHCs lack the resources to attend national conferences for training and TA. This series provides the clinics with assistance on a range of topics including finance, regulation, health information technology, and quality improvement.
Contract for Services of Technical Assistance for the Office of Rural Health Policy	The purpose of this contract is to provide TA to the State Rural Health Associations and to support analysis of emerging rural health issues.
Logistical Support Services for Functions of the National Advisory Committee on Rural Health and Human Services and Rural Health Policy Activities	The purpose of this contract is to provide logistical and administrative support to facilitate the functions of the National Advisory Committee on Rural Health and Human Services and to support the rural health policy functions of ORHP.
Rural Counties and Economic Development (RHWs)	The purpose of this contract is to raise awareness to county officials about the Rural Health Works (RHWks) projects by conducting a RHWks demo in three rural counties, educating county officials on the benefits of the program, and providing opportunities for peer-to-peer learning about RHW through the National Association of Counties (NACo) conferences and publications.
WWAMI Work Related Inquiries	The purpose of this contract is to provide general TA to researchers, policy makers and grant program applicants (i.e. the general public) about the Rural Urban Commuting Areas (RUCAs) methodology for identifying rural and urban areas in the United States.
Frontier Extended Stay Clinics (FESC) National Partners' Meeting	The contractor provides logistical support related to meetings focusing on the Frontier Extended Stay demonstration project.
Black Lung Evaluation	The purpose of this contract is to provide evaluative services around the Black Lung Clinics Program. The evaluation activities involve answering questions around two specific issues. The activities also involve gathering data from government resources, stakeholder organizations and from the 15 existing grantee programs.
Rural Hospital Performance Improvement Project	The purpose of this contract is to support the provision of targeted TA to eligible rural hospitals in the Delta region.
Tracking and Best Practices	The purpose of this contract is to track progress of hospitals taking part in the Small Hospital Improvement program.
Rural Hospital Issues Group Logistics	The purpose of this contract is to provide logistical and administrative support to facilitate meetings of the Rural Hospital Issues Group. The work group meets twice a year for 1 to 2 days in order to discuss emerging issues facing rural hospitals.
Chronic Disease Self Management	The purpose of this contract is to analyze existing data about a model of care by a health promotion nurse for self-management of chronic conditions by the rural elderly. The goal of the refined model is to reduce limitations while not increasing health care costs for rural elderly with chronic conditions.
Delta States Rural Development Network Grant Program Evaluation	The evaluation of the Delta States Grant Program is needed to gauge the program's effectiveness upon the Delta Region. The main purpose is to examine TA previously provided to the grantees and to identify ways to improve the performance and outcomes of the project.
Analysis of Elderly in Rural Hospitals for Respiratory Conditions	The purpose of this contract is to support the contractor in a 2-year effort to do further analysis on an existing data set dealing with the care of elderly in rural hospitals due to respiratory conditions.
EHB - Web Based Data Management System	The purpose of this contract is to support the development of a Web-based data management system for the ORHP's 12 grant programs in conjunction with OIT.
Access to Oral Health Care and the Oral Health Workforce	The purpose of this contract is to form a consensus committee to evaluate the current oral health care workforce and consider how that workforce contributes to problems of access to oral health care services. This contract is being implemented in partnership with BHPr.

U.S. Mexico Border Health Conference	The purpose of this contract is to support two educational workshops during the United States Mexico Border Association (USMBHA) sponsored conference in Laredo, Texas in June 2008. At these workshops local providers from both sides of the border received current information regarding the progress made and future plans to achieve U.S.-Mexico Border 2010 Health Objectives.
Immunization Week in the Americas	The purpose of this contract is to support educational workshops during the Pan American Health Organization (PAHO) sponsored Immunization Week in the Americas at the U.S.-Mexico Border. The contract provides PAHO with funds to coordinate the implementation of the educational workshops that are conducted in the border area.
Center for Rural Health Works (RHWKs)	The purpose of this contract is to support ongoing analysis of the link between health care services and rural economic development. The Center for Rural Health Works collaborates with State Offices of Rural Health and rural communities on planning and economic development/health care issues. Additionally, the contract demonstrates the effectiveness of using County Executives to provide leadership in the Rural Health Works process.
ORHP Grant Program Support	The purpose of this contract is Logistical support related to holding HRSA All Programs Meetings, grantee and other meetings for the Office of Rural Health Policy's grant programs.
Rural Outreach Grantee Technical Assistance Contract	The purpose of this contract is to provide TA for up to 91 Rural Health Care Services Outreach Grantees to help further develop and implement program goals and objectives. The contract will also support sustainability for the 30 grantees that close-out in FY 2008.
Rural Quality Improvement Technical Assistance Contract	The purpose of this contract is to provide TA for up to 60 Small Health Care Provider Quality Improvement Grantees to help them implement quality improvement strategies.
Rural Hospital Performance Improvement Evaluation	The purpose of this contract is to evaluate the effectiveness of the Delta Rural Hospital Performance Improvement (RHPI) program. The RHPI works with eligible rural hospitals in the eight Delta States to help these facilities improve their financial and clinical operations. This evaluation examines the impact of the program to date and make recommendations on ensuring that the program continues to meet the need in coming years.
National Rural and Underserved Workforce Summit	The purpose of this contract is to support a logistic contract that is used to help plan and conduct a meeting looking at the emerging workforce needs for health care providers in rural and underserved communities with an emphasis on "Safety Net" Providers.
Federally Qualified Health Centers (FQHC)-Critical Access Hospitals (CAH) Collaboration	The purpose of this contract is to examine and disseminate information about how critical access hospitals and Federally Qualified Health Centers in rural underserved areas can work together to jointly meet health care needs.
Rural Health Outreach Manual on HIV Care in Rural Communities	The purpose of this contract is to develop a manual examining effective programs in rural and frontier HIV care and disseminate findings among current and future grantees. It provides assistance to potential rural grant applicants focusing on HIV care in rural communities.
Rural Health Outreach Manual on Mental Health Best Practices	The purpose of this contract is to examine effective programs in rural and frontier mental health to disseminate among current grantees and future rural health applicants.
Best Practices and Economic Impact Analysis	The purpose of this contract is to collect best practices from current ORHP grantees and disseminate those findings. An analysis of the economic and service impact of the grantees and a formula for quantifying the impact of the programmatic investment on rural communities is in production.
Rural Recruitment and Retention	The purpose of this contract is to support collaboration with the State Offices of Rural Health, the State Primary Care Associations, and others involved in rural recruitment and retention of health care professionals. This also includes working with professional organizations and health professional training programs to focus on rural recruitment and retention issues.
Logistical Support Services for Appalachian Region Prescription Drug Abuse and Best Practices Dissemination	The purpose of the contract is to support logistical, technical, and administrative support to facilitate holding meetings of grantees and applicants for funding to address prescription drug abuse and methamphetamine abuse in the Appalachian Region and for the producing and disseminating best practice materials on how to address issues relating to prescription drug abuse and methamphetamine abuse.

Logistical Support Services for the development of a frontier definition	The purpose of this contract is to support logistical and administrative support to facilitate holding meetings with HRSA, USDA, and other Federal and private sector experts to identify potential models for a census-tract based frontier definition and examine how to define service need for isolated islands.
Analysis of a Frontier Definition	The purpose of this contract is to support the examination of various definitions of frontier areas and assess new approaches for how to define frontier areas and for identifying how to best define island communities in terms of access to health services.
A State Perspective on Frontier Issues	The purpose of this contract is to fund expert consultations at the State level regarding access to care issues in frontier areas and to develop white papers on their findings.

Appendix B: ORHP Staff

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

1. The Team Structure: All staff are assigned to specific teams within ORHP. These teams are: the Community-Based Team (which includes all staff who work on the community based grant programs under the jurisdiction of the ORHP); the Hospital-State Team (which includes all staff who serve as regional liaisons and project officers for the ORHP's State-based programs), the Policy-Research Team (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 (which includes all staff who are charged with overseeing specific administrative duties) and the Management Team (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. 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, Associate Administrator	Mgt; PRT; IGA; Border	Oversees all aspects of ORHP, including rural health policy and programs; border health, international health and intergovernmental affairs; primary staff to HHS Rural Task Force; National Advisory Committee on Rural Health and Human Services Ex Officio Staff.	Budget, Personnel, Operations oversight; Legislation; Policy	(301) 443-0835	tmorris@hrsa.gov
Staff					
Anthony Achampong	HST	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	CBT	Project Officer for Network Planning and Small Health Care Provider Quality Improvement grants	Delta Rural Hospital Performance Improvement Project; HIT; Access to Care	(301) 443-7321	gbrown@hrsa.gov
Karen Beckham	CBT; IGA	Project Officer for Rural Health Outreach and Rural Health Network Development grants; Rural Best Practices Cooperative Agreement	Intergovernmental Affairs coordination for HRSA; Women's Health; EMS	(301) 443-0502	kbeckham@hrsa.gov
Julia Bryan	Mgt	Liaison to Grants Management, Division of Independent Review, Office of Financial Assistance Management, Division of Grants Policy, OPR	Grants Coordinator; Grants technical assistance	(301) 443-6707	jbryan@hrsa.gov
Jennifer Chang	HST	Executive Secretary, National Advisory Committee on Rural Health and Human Services; Region A Co-Regional Liaison (project officer for that region's Flex grants, SORH grants and SHIP grants)	National Advisory Committee on Rural Health and Human Services	(301) 443-0736	jchang@hrsa.gov
Carrie Cochran	Mgt; PRT	Quick Data Turnaround Cooperative Agreement; Frontier Extended Stay Clinic Cooperative Agreement; National Advisory Committee on Rural Health and Human Services staff	Budget; Personnel; Operations oversight; Medicare reimbursement including inpatient hospital reimbursement; 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

Staff					
Heather Dimeris	Mgt; PRT; CBT; Admin	Oversees the Administrative Team; CAHs Transitioning to Skilled Nursing Facilities Grant Program Coordinator; quality-related policy activities; grants processes; Delta Network Development Program Coordinator; Delta Liaison to HST	Budget; Personnel; Operations oversight; Regulation review; Quality improvement	(301) 443-4657	hdimeris@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 grants, SORH grants and SHIP grants); Rural Policy Analysis Cooperative Agreement; National Advisory Committee on Rural Health and Human Services staff; and U.S.-Mexico Border Health staff	Health Workforce; Communications Coordinator; Border Health	(301) 443-7440	mgoodman@hrsa.gov
Steve Hirsch	HST	Rural Hospital Flexibility (Flex) Program Coordinator; Region B Co-Regional Liaison (project officer for that Flex grants, SORH grants and SHIP grant); Rural Assistance Center Cooperative Agreement	Definitions of Rural	(301) 443-7322	shirsch@hrsa.gov
Eileen Holloran	CBT	Network Planning Grants Coordinator; Rural AED Coordinator; Project Officer for the Outreach programs	Transportation; EMS; chronic disease management; Alzheimer's	(301) 443-7529	eholloran@hrsa.gov
Vanessa Hooker	CBT	Radiation Exposure Screening and Education Program (RESEP) Coordinator; Project Officer for Outreach and Network Development grant programs	Diabetes, Recruitment and Retention	(301) 594-5105	vhooker@hrsa.gov
Kristi Martinsen	CBT	Black Lung Program Coordinator; Project Officer for Outreach and Network Development grant programs; National Advisory Committee on Rural Health and Human Services staff	Mental health; Substance Abuse	(301) 594-4438	kmartinsen@hrsa.gov
Michael McNeely	HST	Flex Critical Access Hospital-Health Information Technology Network (CAHHITN) Coordinator; Region C Co-Regional Liaison (project officer for that region's Flex, SORH and SHIP grants)	HIT; OIT Liaison including web material coordinator	(301) 443-5812	mmcneely@hrsa.gov
Jeanene Meyers	HST	Small Rural Hospital Improvement Grant Program (SHIP) Coordinator; Region A Co-Regional Liaison (project officer for that region's Flex grants, SORH grants and SHIP grants)	Pharmacy & 340B	(301) 443-2482	jmeyers@hrsa.gov
Keith J. Midberry	HST; Mgt	State Offices of Rural Health Program Coordinator; (project officer for that Flex grants, SORH grants and SHIP grants); NOSORH Cooperative Agreement	Human Resources Coordinator	(301) 443-2669	kmidberry@hrsa.gov
Erica Molliver	PRT	Targeted Rural Health Research grants; National Advisory Committee on Rural Health and Human Services staff, Rural Health Clinic Technical Assistance, Rural Hospital Issues Group.	Physician fee schedule; ambulance fee schedule; outpatient hospital reimbursement; Medicare Part D; Medicaid waivers; health professional shortage areas; frontier health	(301) 443-1520	emolliver@hrsa.gov
Nisha Patel	CBT	Rural Health Care Services Outreach Grant Program Coordinator; Project Officer for Network Development and Network Planning grant programs	Cardiovascular health; obesity; nutrition; elder care	(301) 443-6894	npatel@hrsa.gov
Michele Pray-Gibson	Mgt; Admin	Budget Coordinator; National Advisory Committee on Rural Health and Human Services Administrative Coordinator	Executive Officer; Budget Coordinator; backup on contracts coordination	(301) 443-7320	mpray@hrsa.gov
Sherilyn Pruitt	CBT	Grants Files coordinator; Electronic Handbook Liaison; Grants Program Administrator; Outreach programs	Health information technology; telehealth	(301) 594-0819	sadams@hrsa.gov
Elizabeth Rezai-zadeh	CBT	Small Health Care Provider Quality Improvement Program Coordinator; Project Officer for Quality and Outreach grant programs	Quality Improvement	(301) 443-4107	erezai@hrsa.gov
Lilly Smetana	CBT	Grants Files coordinator; Electronic Handbook Liaison; Grants Program Administrator; Outreach programs	Earmarks; health literacy; health professions education; oral health	(301) 443-6884	lsmetana@hrsa.gov
Sonja Carter Taylor	CBT; Mgt	Project Officer for Rural Health Outreach, Small Health Care Provider Quality Improvement, and Rural Health Network Development grant programs	General rural health; school-based health; Inter-Agency agreement coordinator	(301) 443-1902	staylor@hrsa.gov
Shelia Tibbs	CBT	Project Officer for Network Development, Small Health Care Provider Quality Improvement, and Black Lung grant programs	Public health; capital construction monitoring for Delta Health Initiative	(301) 443-4304	stibbs@hrsa.gov

Staff					
Amal Thomas	Admin	Phones; meeting scheduling; travel; Com. Corps timekeeping; Sec. Forecast; training coordinator; HR assistant; supplies; correspondence backup; conference room reservations & IT equipment; mail pick up and distribution; meet and greet visitors;	Administrative coordinator; provide services and support to ORHP staff and external customers	(301) 443-0139	athomas@hrsa.gov
Kathryn Umali	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
Christina Villalobos	Mgt	Special Assistant for Management Team; Annual Report; U.S.-Mexico Border Health staff	Border Health	(301) 443-3590	cvillalobos@hrsa.gov
Joan Van Nostrand	PRT	Rural Health Research Coordinator; Rural Health Research Center Cooperative Agreement	Disability; long-term care; research data; Healthy People 2010-access chapter	(301) 443-0613	jvan_nostrand@hrsa.gov
Bridget Ware	HST	Region E Co-Regional Liaison (project officer for that region's Flex grants, SORH grants and SHIP grants)	Access to Capital; HIV/AIDS; minority health and cultural competence	(301) 594-4241	bware@hrsa.gov
April Williams	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
Sheila Warren	CBT; Mgt	Project Officer for Outreach, Small Health Care Provider Quality Improvement, and Network Development grant programs	Contracts Coordinator; Health promotion and disease prevention; Health education	(301) 443-0246	swarren@hrsa.gov
Division of Border Health					
Frank Cantu	Border	Coordinates HRSA's border health activities	Budget, personnel, administration	(214) 767-3881	fcantu@hrsa.gov
Margarita Figueroa-Gonzalez	Border	Pan-American Health Organization contract project officer; NM border health liaison	HIV/AIDS	(214) 767-8068	mfigueroa@hrsa.gov
Michelle Mellen	Border	AZ border health liaison	Maternal and Child Health	(214) 767-3070	mmellen@hrsa.gov
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