DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2013

Health Resources and Services Administration

Justification of Estimates for Appropriations Committees

MESSAGE FROM THE ADMINISTRATOR

I am pleased to present the FY 2013 Congressional Justification for the Health Resources and Services Administration (HRSA). This budget targets critical healthcare needs in underserved areas.

Millions of our fellow American neighbors will receive access to high quality, comprehensive and cost-effective primary health care through the HRSA funded Community Health Center program and the numbers continue to grow. Additional resources are also being provided for the Ryan White HIV/AIDS program to enhance prevention and treatment of people living with HIV/AIDS. Through the AIDS Drug Assistance Program, life-saving medications will reach approximately 236,000 needy Americans.

The FY 2013 budget invests resources to increase the number of doctors, nurses and dentists in areas of the country experiencing shortages of health professionals. This will ensure that qualified clinicians will be available to serve underserved populations in the future. The budget also includes $122 million to improve both access to and the quality of health care in rural areas. This will strengthen regional and local partnerships among rural health care providers, expand community-based programs and promote the modernization of the health care infrastructure in rural areas.

Under provisions of the Affordable Care Act, HRSA now has an even broader role, and an even bigger mandate. So our work is strengthened, by the historic Affordable Care Act and first of its kind initiatives like the National HIV/AIDS Strategy. HRSA is responsible for 50 individual provisions in the law that generally fall into three major categories:

- Expanding the primary care safety net for all Americans – especially those who are geographically isolated, economically disadvantaged or medically vulnerable – for example, through expansion of the Community Health Center program;

- Also, HRSA is responsible for helping to train the next generation of primary care professionals, while improving the diversity of the workforce and re-orienting it toward interdisciplinary, patient-centered care. We do this through targeted support to students and clinicians and grants to colleges, universities and other training institutions;

- Finally, HRSA, working with its partner agencies, is expected to greatly expand prevention and public health efforts to catch patients' health issues early – before they require major intervention; to improve health outcomes and quality of life; and to help contain health care costs in the years ahead.

Our FY 2013 budget request places a strong emphasis on investing in programs that improve access to health care in underserved areas and allows the Health Resources and Services Administration to take important steps toward implementing health care reform and improving healthcare access for underserved populations.

Mary K. Wakefield, Ph.D., R.N.
Administrator

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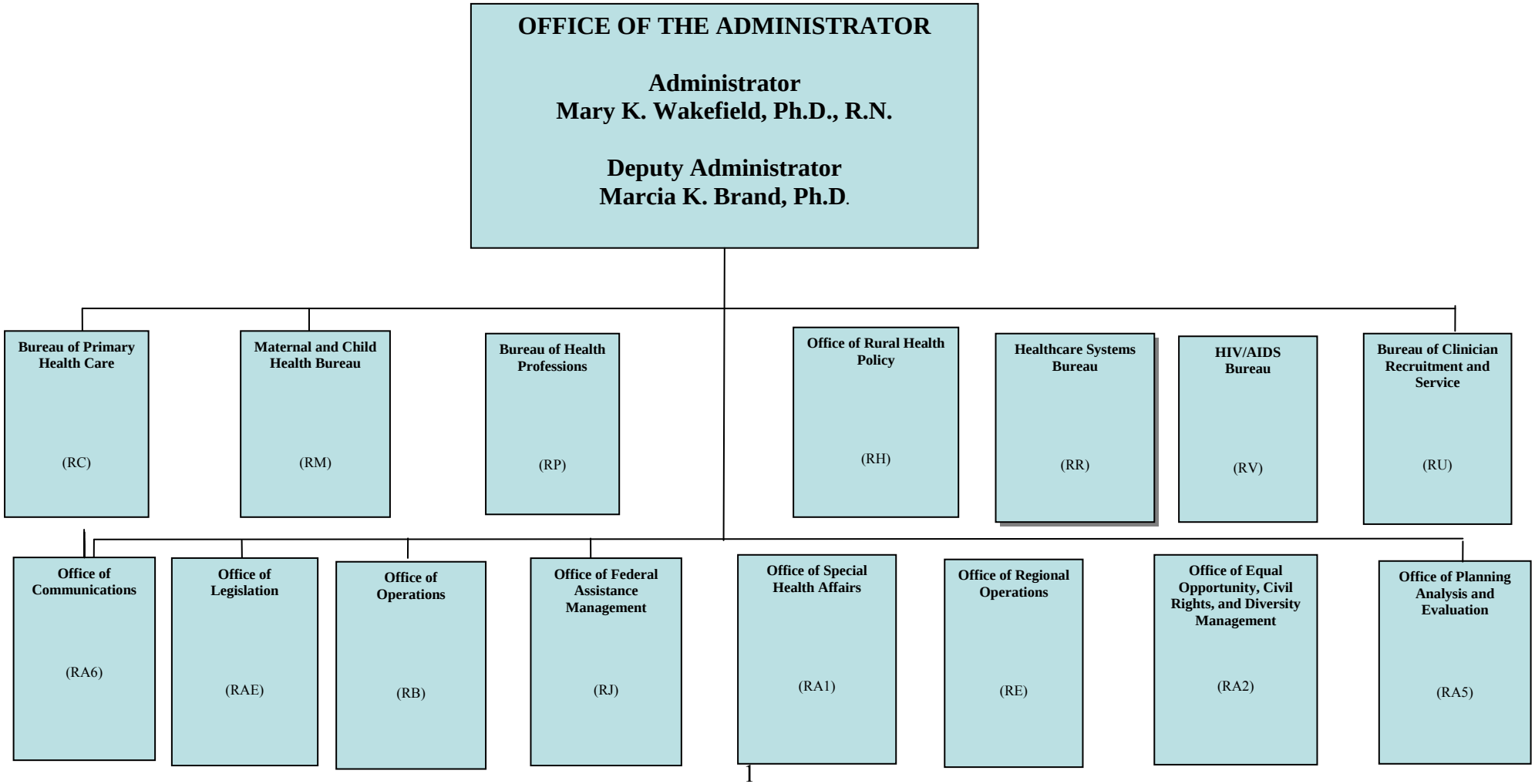
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration

Organizational Chart



Executive Summary

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Introduction and Mission

The Health Resources and Services Administration (HRSA), an Agency of the U.S. Department of Health and Human Services (DHHS), is the principal Federal Agency charged with increasing access to basic health care for those who are medically underserved. Health care in the United States is among the finest in the world but it is not accessible to everyone. Millions of families still face barriers to quality health care because of their income, lack of insurance, geographic isolation, or language and cultural barriers. The Affordable Care Act provides for a substantial investments in components of the HRSA-supported safety net, including the Health Centers program, the National Health Service Corps, and a variety of health workforce development programs, to address these and other access problems.

Assuring a safety net for individuals and families who live outside the economic and medical mainstream remains a key HRSA role. A 2009 *New England Journal of Medicine* article[1] concluded that the existing safety net is simply inadequate and is continuing to deteriorate. It further noted that, while implementation of health reforms and other factors will affect the structure, function, and mission of the safety net, the underlying problems that created the need for a safety net in the first place will not be solved in the near future.

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

- The nearly 50 million Americans who lack health insurance--many of whom are racial and ethnic minorities,
- Over 50 million underserved Americans who live in rural and poor urban neighborhoods where health care providers and services are scarce,
- African American infants who still are 2.4 times as likely as white infants to die before their first birthday,
- The more than 1 million people living with HIV/AIDS,
- The more than 100,000 Americans who are waiting for an organ transplant.

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

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

Overview of Budget Request

The FY 2013 Budget includes $8.4 billion for the Health Resources and Services Administration, net increase of $228 million above the FY 2012 enacted level. HRSA is the principal Federal agency charged with improving access to health care to those in medically underserved areas and enhancing the capacity of the health care workforce. The FY 2013 Budget prioritizes programs that will:

- Reduce barriers to care that contribute to disparities in health care utilization and health status;
- Provide healthcare to uninsured people by linking people to services and supports from other sectors that contribute to good health and wellbeing;
- Provide financial, professional and educational resources to medical, dental, and mental and behavioral health care providers who bring their skills to areas with limited access to health care; and
- Assist States and communities to identify and address unmet service needs and workforce gaps in the health care system.

Discretionary Program Increases:

AIDS Drug Assistance Program (+$66.701 million)
The FY 2013 President's Budget will support the provision life-saving medications and health care services to persons living with HIV in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam and five Pacific jurisdictions. As of January 20, 2012, AIDS Drug Assistance Program (ADAP) waiting lists have increased to 4,664 people in 11 states, with many other states curtailing their programs to avoid waiting lists. The budget maintains and bolsters the Federal commitment to supporting States and their ADAP programs. This Budget includes $1,000,000,000 for AIDS drug assistance programs to provide access to life saving HIV related medications for approximately 236,230 patients.

Ryan White Early Intervention – Part C (+$20,478 million)
The FY 2013 President's Budget for the Ryan White HIV/AIDS Part C Program will continue to support persons receiving primary care services under the Early Intervention Services programs for 251,390 persons living with HIV/AIDS at the 344 currently funded Part C programs. The FY 2013 President's Budget target for the number of people receiving primary care services under Early Intervention Services programs is 265,325.

Health Care Workforce Assessment (+$7.218 million)
The increase will support development of the National Center for Health Workforce Analysis

Pediatric Loan Repayment (+$5 million)
A new program initiated by the Affordable Care Act will provide loan repayment to individuals in return for delivering pediatric services in areas requiring such services. An

estimated 64 2-year awards will be made across the eligible specialties in the first year of implementation.

Primary Care Training and Enhancement (+$12 million)
The increase will sustain investments that will train 1,400 additional physician assistants over a five year period. Grants will develop the infrastructure necessary to expand and improve teaching quality at clinical sites for Physician Assistant students.

Public Health/Preventive Medicine (+$1.498 million)
The total request will continue the support for the 37 current PHTC grants, 30 PHT grantees and nine PMR training grants.

Maternal and Child Health Block Grant (+$1.452 million)
The FY 2013 target for the number of children served by the Title V Block Grant is 30 million.

340b Drug Pricing Program/Office of Pharmacy Affairs User Fees (+$6 million)
This reflects the estimate amount of user fees.

Program Management (+$2.623 million)
This increase supports increased funding for salaries, benefits and Parklawn expenses in FY 2013.

Family Planning (+$2.968 million)
This request includes $296 million to expand family planning services to low-income individuals by improving access to family planning centers and preventative services. This funding will provide services to nearly 5 million low-income women and men at more than 4,500 clinics each year.

Mandatory Program Increases:

Health Centers (ACA) (+300 million)
This increase will promote steady and sustainable Health Center growth. The ACA funds complement funds the program receives annually in the discretionary budget process. The Budget will enable health centers to continue to provide critical access and services to millions of Americans in FY 2013 and for many years to come.

Advanced Education Nursing (+$20 million)
The increase will provide funding for 29 grants for ANE Expansion II programs planned to begin in FY 2013 and contribute to the overall production goal of an additional 1,400 primary care APRNs.

Maternal, Infant and Early Childhood Visiting Program (ACA) (+$50 million)
This level of funding will provide: for awards to 56 State grantees and associated program technical assistance;

National Health Service Corps (ACA) (+$5 million)
Funds are projected to be used for over 1,100 new Loan Repayment awards and 3,400 Loan Repayment Continuation awards; an estimated 180 new Scholarship awards and 15 Continuations will also be made.

Discretionary Program Decreases:

Health Centers (-$5.089 million)
The request reflects a decrease due to the Secretarial transfer of funding to support enhanced care and treatment for individuals living with HIV and AIDS at health centers in FY 2012.

Children's Hospitals Graduate Medical Education Program (-$177.171 million)
The FY 2013 President's Budget Request of $88,000,000 is about one-third of the FY 2012 Enacted Level, which will allow for support of the direct medical expenses for graduate medical education. These include direct payment support expenditures related to stipends and fringe benefits for residents; salaries and fringe benefits of supervising faculty; costs associated with providing the GME training program; and allocated institutional overhead costs.

Area Health Education Centers (-$27.220 million)
No funds are requested for this program in FY 2013. While the AHEC Program continues to focus on exposing medical students and health professions students to primary care and practice in rural and underserved communities, there is a higher priority to allocate Federal resources to training programs that directly increase the number of primary care providers. It is anticipated that the AHEC Program grantees will continue their efforts to provide interprofessional/interdisciplinary training to health professions students with an emphasis on primary care; these activities may be supported through other funding sources.

Health Careers Opportunity Program (-$14.822 million)
No funds are requested for this program in FY 2013. The President's Budget is prioritizing investing in programs that have a more direct and immediate impact on the production of health professionals.

Mental & Behavioral Health (-$5.000 million)
The Budget will support 16 grants for the Mental and Behavioral Health Education and Training Program which will support the education and training of approximately 278 graduate students and health professionals in social work or graduate psychology, and professionals and paraprofessionals in child and adolescent mental health education.

Ryan White Children, Youth Women and Families – Part D (-$7.585 million)
This Budget will support primary health care and social support services available to 90,000 women, men, transgendered persons, infants, children, youth and adults living with HIV and AIDS and their affected families.

Rural Hospital Flexibility Grants (-$14.840 million)

The reduction would result in discontinuation of new grants in FY 2013 for the Small Hospital Improvement Program (SHIP). The budget request focuses on supporting CAHs by maintaining essential support for the Flex program and its focus on working with CAHs to improve quality. The program will award 45 grants in FY 2013.

Rural & Community Access to Emergency Devices (-$1.1 million)
There is no FY 2013 request for this program.

Mandatory Program Decreases:

Public Health/Preventive Medicine Prevention Fund (-$15 million)
The total request will continue the support for the 37 current Public Health Training Center Grants, 30 Public Health Traineeship grantees and nine PMR training grants at reduced levels than their FY 2012 awards. There is no request for the Integrative Medicine Program in the President's Budget Request for FY 2013.

Family to Family (-$5 million)
No funds are being requested for this program in FY 2013

Investments in Information Technology (IT):

Funding for many of the HRSA Programs includes IT funding for the continued development, operations and maintenance of the HRSA Electronic Handbooks (EHBs). The EHBs is an IT Investment that supports the strategic and performance outcomes of the HRSA Programs and contributes to their success by providing a mechanism for sharing data and conducting business in a more efficient manner. The EHBs supports HRSA with program administration, grants administration and monitoring, management reporting, and performance measurement and analysis.

Overview of Performance

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

Highlights of Performance Results and Targets (Planning Level)

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

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

- In FY 2013, the Health Center program projects that it will serve 20.9 million patients. This is an increase of 1.4 million over the 19.5 million persons served in FY 2010.

- Through the Health Center program, HRSA expects to provide access to care to 7.9 million uninsured individuals in FY 2013. In 2010, 7.4 million uninsured individuals (38% of total patients) were served by Health Centers.

- HRSA expects to serve 30 million children through the Maternal and Child Health Block Grant (Title V) in FY 2013, 4.5 million below the number served in FY 2010.

- By reaching out to low-income parents to enroll their children in the Children's Health Insurance Program (CHIP) and Medicaid, HRSA improves access to critically important health care. In FY 2013, the number of children receiving Title V services that are enrolled in and have Medicaid and CHIP coverage is expected to be 15 million. In FY 2010, the number was 14.3 million.

- In FY 2013, HRSA's Ryan White HIV Emergency Relief Grants (Part A) and HIV Care Grants to States (Part B) are projected to support, respectively, 2.63 million visits and 2.27 million visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health). Approximately 2.63 million visits and 2.20 million visits, respectively, were supported in FY 2010.

- By supporting AIDS Drug Assistance Program (ADAP) services to an anticipated 236,230 persons in FY 2013, HRSA expects to continue its contribution to reducing AIDS-related mortality through providing drug treatment regimens for low-income, underinsured and uninsured people living with HIV/AIDS. An estimated 208,809 persons were served through ADAP in FY 2010.

- The number of organ donors and the number of organs transplanted have increased substantially in recent years. In FY 2013, HRSA's Organ Transplantation program projects that 33,473 deceased donor organs will be transplanted, up from 24,598 in FY 2010.

- To increase the number of patients from racially and ethnically diverse backgrounds able to find a suitably matched unrelated adult donor for their blood stem cell transplants, HRSA's C.W. Bill Young Cell Transplantation program projects that it will have 2.85 million adult volunteer potential donors of minority race and ethnicity listed on the donor registry in FY 2013. Nearly 2.7 million were listed on the registry in FY 2011.

- In FY 2010, 383,776 persons received direct services through Rural Health Care Services Outreach, Network, and Quality Improvement Grants. The projection for FY 2013 is 395,000.

- In FY 2010, the Black Lung program supported services to more than 10,500 active and retired coal miners and others with occupation-related respiratory and pulmonary impairments. In FY 2013, an estimated 12,688 miners will be served.

HRSA Goal: Strengthen the health workforce.
HHS Objective: Ensure that the Nation's health care workforce meets increased demands.

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

- In FY 2011, the National Health Service Corps (NHSC) had a field strength of 10,279 primary care clinicians. The NHSC projects that a field strength of 7,128 primary care clinicians will be in health professional shortage areas in FY 2013.

- In FY 2011, 46% of Nursing Education Loan Repayment and Scholarship Program participants extended their service contracts and committed to work at a critical shortage facility for an additional year. The FY 2013 target is 52%.

- In FY 2010, 4,800 health care providers were deemed eligible for FTCA malpractice coverage through the Free Clinics Medical Malpractice program, which encourages providers to volunteer their time at sponsoring free clinics. The projection for this number is 5,100 in FY 2013.

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

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

- In FY 2013, 95.7% of Ryan White program-funded primary care providers will have implemented a quality management program, up from 95.2 % in FY 2010.

- In FY 2011, 57,227 licensing and credentialing decisions that limit practitioners' ability to practice were impacted by information contained in the National Practitioner Data Bank. The FY2013 target is 54,500.

- In FY 2013, 78% of Critical Access Hospitals (supported by the Rural Hospital Flexibility Grants program) will report at least one quality-related measure to Hospital Compare. This will be an increase from 72.6% in FY 2010.

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

- The National Hansen's Disease Program seeks to prevent and manage Hansen's disease (leprosy) though both clinical care and scientific research. The Program is conducting research that will ultimately permit development of the full animal model (armadillo) that will advance understanding of the disease in humans. In FY 2010, the Program met its goal of demonstrating defective nerve function in infected armadillos. In FY 2013, the Program will produce a relevant animal model for human leprosy.

In the ways highlighted above and others, HRSA will continue to strengthen the Nation's healthcare safety net and improve Americans' health, health care, and quality-of-life.

Performance Management

Achieving a high level of performance is a Strategic Plan principle and a major priority for HRSA. Performance management is central to the agency's overall management approach and performance-related information is routinely used to improve HRSA's operations and those of its grantees. HRSA's performance management process has several integrated elements, including priority setting, action planning, and regular monitoring and review with follow-up.

Priority setting is done each fiscal year in which goals, that are linked to HRSA's Strategic Plan, are defined through the process of establishing performance plans for Senior Executive Service (SES) personnel. This process identifies goals that are supported, to the greatest extent possible, by quantitative or qualitative measures and targets. Goal leaders plan for the major actions that must be accomplished to achieve goals. Many of the goals are outcome-oriented and their achievement is largely dependent upon the direct actions of grantees, supported by HRSA. Other

goals relate to internal processes and organizational functioning that reflect standards for how HRSA does its business.

Performance monitoring is done by:

(a) Assessing achievement of performance measure targets,

(b) Monitoring, through the work of project officers and progress reports, grantees' interim progress and challenges associated with goal achievement, and

(c) Tracking key milestones that indicate, for example, the advancement or completion of major deliverables linked to accomplishment of goals.

Regular reviews of performance occur between goal leaders and the Administrator/Deputy Administrator. These reviews include monthly one-on-one meetings, mid-year and year-end SES performance reviews, and ad hoc meetings called to address emerging issues/problems. The meetings cover progress, successes, challenges, and possible course-corrections. Focused discussions of performance, particularly related to cross-cutting goals, are also held at Senior Staff meetings.

HRSA will continue to produce an Annual Performance Report to show trends in performance related to priority goals and other goals of HRSA's Bureaus and Offices. The Report, posted on-line, will provide information for performance assessment purposes and also give transparency to HRSA's performance results.

All Purpose Table

(Dollars in Thousands)

Program	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
PRIMARY CARE:				
Health Centers	1,480,949	1,471,999	1,466,910	-5,089
Community Health Center Fund (ACA)	1,000,000	1,200,000	1,500,000	+300,000
Health Center Tort Claims	99,800	94,893	94,893	-
Total, Health Centers	**2,580,749**	**2,766,892**	**3,061,803**	**+294,911**
Health Centers - Facilities Construction/NHSC (ACA)	1,500,000	-	-	-
School-Based Health Centers - Facilities (ACA)	50,000	50,000	50,000	-
Free Clinics Medical Malpractice	40	40	40	-
Hansen's Disease Center	16,077	16,045	16,045	-
Payment to Hawaii	1,964	1,960	1,960	-
National Hansen's Disease Program - Buildings and Facilities	129	127	127	-
Subtotal, Bureau of Primary Health Care	**4,148,959**	**2,835,064**	**3,129,975**	**+294,911**
CLINICIAN RECRUITMENT & SERVICE:				
National Health Service Corps Recruitment	24,848	-	-	-
National Health Service Corps (ACA)	290,000	295,000	300,000	+5,000
Total, NHSC	**314,848**	**295,000**	**300,000**	**+5,000**
Nurse Loan Repayment and Scholarship Program	93,292	83,135	83,135	-
Loan Repayment/Faculty Fellowships	1,258	1,243	1,243	-
Pediatric Loan Repayment	-	-	5,000	+5,000
Subtotal, Clinician Recruitment & Service	**409,398**	**379,378**	**389,378**	**+10,000**
HEALTH PROFESSIONS:				
Health Professions Training for Diversity:				
Centers of Excellence	24,452	22,909	22,909	-
Scholarships for Disadvantaged Students	49,042	47,452	47,452	-
Health Careers Opportunity Program	21,998	14,822	-	-14,822
Health Professions Training for Diversity	**95,492**	**85,183**	**70,361**	**-14,822**
Health Care Workforce Assessment 1/	2,815	2,782	10,000	+7,218
PHS Evaluation Funds (non-add)	-	-	*10,000*	*+10,000*
Primary Care Training and Enhancement	39,036	38,962	50,962	+12,000
Oral Health Training Programs	32,781	32,392	32,392	-
Teaching Health Centers Graduate Medical Education Payment Program(ACA)	230,000	-	-	-

Health Resources and Services Administration

Program	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Interdisciplinary, Community-Based Linkages:				
Area Health Education Centers	33,142	27,220	-	-27,220
Geriatric Programs	33,542	30,629	30,629	-
Allied Health and Other Disciplines	1,933	-	-	-
Mental and Behavioral Health	2,927	2,892	7,892	+5,000
PHS Evaluation Funds (non-add)	-	-	*5,000*	*+5,000*
Mental and Behavioral Health Prevention Fund	-	10,000	-	-10,000
Subtotal, Mental and Behavioral Health	**2,927**	**12,892**	**7,892**	**-5,000**
Subtotal, Interdisciplinary, Community-Based Linkages	**71,544**	**70,741**	**38,521**	**-32,220**
Public Health Workforce Development:				
Public Health/Preventive Medicine	9,609	8,111	9,609	+1,498
Public Health/Preventive Medicine Prevention Fund	20,000	25,000	10,000	-15,000
Subtotal, Public Health/Prevention Medicine	**29,609**	**33,111**	**19,609**	**-13,502**
Nursing Workforce Development:				
Advanced Education Nursing	64,046	63,925	83,925	+20,000
PHS Evaluation Funds (non-add)	-	-	*20,000*	+20,000
Subtotal, Advanced Education Nursing	**64,046**	**63,925**	**83,925**	**+20,000**
Nursing Workforce Diversity	16,009	15,819	15,819	-
Nurse Education, Practice and Retention	39,653	39,182	39,182	-
Nurse Faculty Loan Program	24,848	24,553	24,553	-
Comprehensive Geriatric Education	4,539	4,485	4,485	-
Subtotal, Nursing Workforce Development	**149,095**	**147,964**	**167,964**	**+20,000**
Patient Navigator Outreach & Chronic Disease Prevention	4,990	-	-	-
Children's Hospitals Graduate Medical Education Program	268,356	265,171	88,000	-177,171
Subtotal, Bureau of Health Professions	**923,718**	**676,306**	**477,809**	**-198,497**
Health Workforce Evaluation Funding	-	-	*35,000*	*+35,000*
National Practitioner Data Bank (User Fees)	*22,161*	*28,016*	*28,016*	-
Healthcare Integrity & Protection Data Bank (User Fees)	*4,815*	-	-	-
MATERNAL & CHILD HEALTH:				
Maternal and Child Health Block Grant	656,319	638,646	640,098	+1,452
Autism and Other Developmental Disorders	47,708	47,142	47,142	-
Traumatic Brain Injury	9,878	9,760	9,760	-
Sickle Cell Service Demonstrations	4,721	4,665	4,665	-

Health Resources and Services Administration

Program	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
James T. Walsh Universal Newborn Hearing Screening	18,884	18,660	18,660	-
Emergency Medical Services for Children	21,369	21,116	21,116	-
Healthy Start	104,361	103,532	103,532	-
Heritable Disorders	9,952	9,834	9,834	-
Family to Family Health Information Centers (ACA)	5,000	5,000	-	-5,000
Maternal, Infant and Early Childhood Visiting Program (ACA)	250,000	350,000	400,000	+50,000
Subtotal, Maternal and Child Health Bureau	**1,128,192**	**1,208,355**	**1,254,807**	**+46,452**
HIV/AIDS:				
Emergency Relief - Part A	672,529	671,258	671,258	-
Comprehensive Care - Part B	1,308,141	1,355,640	1,422,341	+66,701
AIDS Drug Assistance Program (Non-Add)	*885,000*	*933,299*	*1,000,000*	+66,701
Early Intervention - Part C	205,564	215,086	235,564	+20,478
Children, Youth, Women & Families - Part D	77,313	77,167	69,582	-7,585
AIDS Education and Training Centers - Part F	34,607	34,542	34,542	-
Dental Reimbursement Program Part F	13,511	13,485	13,485	-
Subtotal, HIV/AIDS	**2,311,665**	**2,367,178**	**2,446,772**	**+79,594**
SPNS Evaluation Funding	*25,000*	*25,000*	*25,000*	-
Subtotal, HIV/AIDS Bureau	**2,336,665**	**2,392,178**	**2,471,772**	**+79,594**
HEALTHCARE SYSTEMS:				
Organ Transplantation	24,896	24,015	24,015	-
National Cord Blood Inventory	11,910	11,887	11,887	-
C.W. Bill Young Cell Transplantation Program	23,374	23,330	23,330	-
Poison Control Centers	21,866	18,830	18,830	-
340b Drug Pricing Program/Office of Pharmacy Affairs	4,480	4,472	4,472	-
340b Drug Pricing Program/Office of Pharmacy Affairs User Fees	-	-	*6,000*	*+6,000*
Subtotal, Healthcare Systems Bureau	**86,526**	**82,534**	**88,534**	**+6,000**
Rural Health:				
Rural Health Policy Development	9,885	9,866	9,866	-
Rural Health Outreach Grants	55,658	55,553	55,553	-
Rural & Community Access to Emergency Devices	236	1,100	-	-1,100
Rural Hospital Flexibility Grants	41,118	41,040	26,200	-14,840
State Offices of Rural Health	10,055	10,036	10,036	-
Radiation Exposure Screening and Education Program	1,939	1,935	1,935	-
Black Lung	7,153	7,140	7,140	-
Telehealth	11,524	11,502	11,502	-

Health Resources and Services Administration

Program	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Subtotal, Office of Rural Health Policy	**137,568**	**138,172**	**122,232**	**-15,940**
Public Health Improvement Projects	-	-	-	-
Program Management	161,815	159,894	162,517	+2,623
Family Planning	299,400	293,870	296,838	+2,968
Healthy Weight Collaborative Prevention Fund	-	-	-	-
HRS Program Level	**9,659,217**	**8,193,767**	**8,421,878**	**+228,111**
Appropriation Table Match	**6,262,241**	**6,205,751**	**6,067,862**	**-137,889**
Less Mandatory Programs	***3,345,000***	***1,935,000***	***2,260,000***	**+325,000**
Subtotal Affordable Care Act	***3,325,000***	***1,900,000***	***2,250,000***	***+350,000***
Subtotal Public Health Prevention Fund	***20,000***	***35,000***	***10,000***	***-25,000***
Discretionary Program Level:				
HRS	**6,314,217**	**6,258,767**	**6,161,878**	**-96,889**
Funds Appropriated to Other HRSA Accounts:				
Health Education Assistance Loans[1]:				
Liquidating Account	1,000	1,000	1,000	-
HEAL Credit Reform - Direct Operations	2,841	2,807	2,807	-
Subtotal, Health Education Assistance Loans	**3,841**	**3,807**	**3,807**	-
Vaccine Injury Compensation:				
Vaccine Injury Compensation Trust Fund (HRSA Claims)	220,000	235,000	235,000	-
VICTF Direct Operations - HRSA	6,489	6,477	6,477	
Subtotal, Vaccine Injury Compensation	**226,489**	**241,477**	**241,477**	-
Discretionary Program Level:				
HRS	**6,314,217**	**6,258,767**	**6,161,878**	**-96,889**
HEAL Direct Operations	2,841	2,807	2,807	-
Vaccine Direct Operations	6,489	6,477	6,477	-
Total, HRSA Discretionary Program Level	**6,323,547**	**6,268,051**	**6,171,162**	**-96,889**
Mandatory Programs:	3,345,000	1,935,000	2,260,000	+325,000
Total, HRSA Program Level	**9,668,547**	**8,203,051**	**8,431,162**	**+228,111**
Total HRSA Program Level (excluding Heal in FY2013)	**9,668,547**	**8,203,051**	**8,428,355**	**+228,111**

[1] The FY 2013 Budget includes General Provision language that would transfer the Health Education Assistance Loan (HEAL) program to the Department of Education. Funding for the HEAL is requested in FY 2013 and will be used by HRSA to administer the HEAL program until the point of transfer. At that time, all unobligated balances of these appropriated resources as well as all other assets and liabilities of the HEAL program will be transferred to the Department of Education.

Health Resources and Services Administration

Program	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
Less Programs Funded from Other Sources Mandatory:				
Prevention and Public Health Fund	-20,000	-35,000	-10,000	+25,000
Less Programs Funded from Other Sources:				
Evaluation - Special Projects of National Significance (SPNS)	*-25,000*	*-25,000*	*-25,000*	-
Evaluation - Health Workforce			*-35,000*	*-35,000*
National Practitioner Data Bank (User Fees)	*-22,161*	*-28,016*	*-28,016*	-
Healthcare Integrity and Protection Data Bank (User Fees)	*-4,815*	-	-	-
340b Drug Pricing Program/Office of Pharmacy Affairs (User Fees)		-	*-6,000*	*-6,000*
Total HRSA Discretionary Budget Authority	**6,271,571**	**6,215,035**	**6,077,146**	**-137,889**
HRSA Discretionary Budget Authority (Excluding HEAL in FY 2013)	**6,271,571**	**6,215,035**	**6,074,339**	**-140,696**

Health Resources and Services

Budget Exhibit

Appropriation Language
Primary Health Care

For carrying out titles II and III of the Public Health Service Act (referred to in this Act as the ``PHS Act'') with respect to primary health care and the Native Hawaiian Health Care Act of 1988, [$1,598,957,000] *$1,579,975,000*, of which [$129,000] *$127,000* shall be available until expended for facilities renovations at the Gillis W. Long Hansen's Disease Center: *Provided*, That no more than $40,000 shall be available until expended for carrying out the provisions of section 224(o) of the PHS Act, including associated administrative expenses and relevant evaluations: *Provided further*, That no more than [$95,073,000] *$94,893,000* shall be available until expended for carrying out the provisions of Public Law 104-73 and for expenses incurred by the Department of Health and Human Services (referred to in this Act as ``HHS'') pertaining to administrative claims made under such law.

Health Workforce

For carrying out titles III, VII, and VIII of the PHS Act with respect to the health workforce, section 1128E *and 1921(b)* of the Social Security Act, and the Health Care Quality Improvement Act of 1986, [$734,402,000]: *$522,187,000, Provided*, That sections 747(c)(2), [751(j)(2)] *340G-1(b) and (d)*, and the proportional funding amounts in paragraphs (1) through (4) of section 756(e) of the PHS Act shall not apply to funds made available under this heading: [*Provided further*, That for any program operating under section 751 of the PHS Act on or before January 1, 2009, the Secretary of Health and Human Services (referred to in this title as ``Secretary'') may waive any of the requirements contained in sections 751(d)(2)(A) and 751(d)(2)(B) of such Act for the full project period of a grant under such section: Provided further, That no funds shall be available for section 340G-1 of the PHS Act]: *Provided further*, That in addition to fees authorized by section 427(b) of the Health Care Quality Improvement Act of 1986, fees shall be collected for the full disclosure of information under such Act sufficient to recover the full costs of operating the National Practitioner Data Bank and shall remain available until expended to carry out that Act: *Provided further*, That fees collected for the full disclosure of information under the ``Health Care Fraud and Abuse Data Collection Program'', authorized by section 1128E(d)(2) of the Social Security Act, shall be sufficient to recover the full costs of operating the program, and shall remain available until expended to carry out that Act: *Provided further, That fees collected for the disclosure of information under the information reporting requirement program authorized by section 1921 of the Social Security Act shall be sufficient to recover the full costs of operating the program and shall remain available until expended to carry out that Act*: Provided further, That funds transferred to this account to carry out section 846 and subpart 3 of part D of title III of the PHS Act may be used to make prior year adjustments to awards made under such sections. *Provided further, that, in addition to amounts appropriated under this heading, $35,000,000 shall be available under*

section 241 of the PHS Act to carry out titles VII and VIII of the PHS Act: Provided further, That, of the amount appropriated under this heading, $88,000,000 shall be for payments to children's hospitals pursuant to section 340E of the PHS Act, all of which shall be for payments for direct graduate medical education as described in section 340E(c).

Maternal and Child Health

For carrying out titles III, XI, XII, and XIX of the PHS Act with respect to maternal and child health, title V of the Social Security Act, and section 712 of the American Jobs Creation Act of 2004, [$863,607,000] *$854,807,000*: *Provided*, That notwithstanding sections 502(a)(1) and 502(b)(1) of the Social Security Act, not more than [$79,586,000] *$78,641,000* shall be available for carrying out special projects of regional and national significance pursuant to section 501(a)(2) of such Act and [$10,400,000] *$10,276,000* shall be available for projects described in paragraphs (A) through (F) of section 501(a)(3) of such Act.

Ryan White [Hiv/Aids] *HIV/AIDS* Program

For carrying out title XXVI of the PHS Act with respect to the Ryan White HIV/AIDS program, [$2,326,665,000] *$2,446,772,000*, of which [$1,995,670,000] *$2,093,599,000* shall remain available to the Secretary [of Health and Human Services] through September 30, 2014, for parts A and B of title XXVI of the PHS Act. *Provided, That of the funds available for parts A and B of title XXVI of the PHS Act.* [and of which] not less than [$900,000,000] *$1,000,000,000* shall be for State AIDS Drug Assistance Programs [under the authority of] *pursuant to* section 2616 or 311(c) of such Act: *Provided*, That in addition to amounts provided herein, $25,000,000 shall be available from amounts available under section 241 of the PHS Act to carry out parts A, B, C, and D of title XXVI of the PHS Act to fund Special Projects of National Significance under section 2691.

Health Care Systems

For carrying out titles III and XII of the PHS Act with respect to health care systems, and the Stem Cell Therapeutic and Research Act of 2005, [$83,526,000] *$82,534,000*. *Provided, That the Secretary may collect a fee of 0.1 percent of each purchase of 340B drugs from entities participating in the Drug Pricing Program pursuant to section 340B of the PHS Act to pay for the operating costs of such program: Provided further, that fees pursuant to the 340B Drug Pricing shall be collected by manufacturers at the time of sale, and shall be credited to this account, to remain available until expended.*

Rural Health

For carrying out titles III and IV of the PHS Act with respect to rural health, section 427(a) of the Federal Coal Mine Health and Safety Act, the Cardiac Arrest Survival Act of 2000, and sections 711 and 1820 of the Social Security Act, [$139,832,000] *$122,232,000*, of which [$41,118,000] *$26,200,000* from general revenues, notwithstanding section 1820(j) of the Social Security Act, shall be available for carrying out the Medicare rural hospital flexibility grants program: *Provided*, That, of the funds made available under this heading for Medicare rural hospital

flexibility grants, [$15,000,000 shall be available for the Small Rural Hospital Improvement Grant Program for quality improvement and adoption of health information technology and] $1,000,000 shall be to carry out section 1820(g)(6) of the Social Security Act, with funds provided for grants under section 1820(g)(6) available for the purchase and implementation of telehealth services, including pilots and demonstrations on the use of electronic health records to coordinate rural veterans care between rural providers and the Department of Veterans Affairs electronic health record system: *Provided further*, That notwithstanding section 338J(k) of the PHS Act, [$10,055,000] *$10,036,000* shall be available for State Offices of Rural Health.

Family Planning

For carrying out the program under title X of the PHS Act to provide for voluntary family planning projects, [$297,400,000] *$296,838,000*: *Provided*, That amounts provided to said projects under such title shall not be expended for abortions, that all pregnancy counseling shall be nondirective, and that such amounts shall not be expended for any activity (including the publication or distribution of literature) that in any way tends to promote public support or opposition to any legislative proposal or candidate for public office.

Program Management

For program support in the Health Resources and Services Administration, [$161,815,000] *$162,517,000*: *Provided*, That funds made available under this heading may be used to supplement program support funding provided under the headings ``Primary Health Care'', ``Health Workforce'', ``Maternal and Child Health'', ``Ryan White HIV/AIDS Program'', ``Health Care Systems'', and ``Rural Health''. *Provided further, That the Administrator may transfer funds between any of the accounts of HRSA with notification to the Committees on Appropriations of both Houses of Congress at least 15 days in advance of any transfer, but no such account shall be decreased by more than 3 percent by any such transfer.*

Language Analysis

LANGUAGE PROVISION	EXPLANATION
Provided, That sections 747(c)(2), [751(j)(2)] *340G-1(b) and (d)*, and the proportional funding amounts in paragraphs (1) through (4) of section 756(e) of the PHS Act shall not apply to funds made available under this heading	Citation is added to include funding for Alternative Dental Provider Demonstration Program.
Provided further, that in addition to amounts provided herein, $35,000,000 shall be available under section 241 of the PHS Act to carry out titles VII and VIII of the PHS Act:	Citation is added to include evaluation funding as authorized by PHS Act section 241.
Provided further, That of the amount appropriated under this heading, $88,000,000 shall be for payments to children's hospitals pursuant to section 340E of the PHS Act, all of which shall be for payments for direct graduate medical education as described in section 340E(c).	Citation is added to target funding for payments to Children's Hospitals that operate graduate medical education programs to direct costs only.
Provided further, The Secretary may collect a fee of 0.1 percent of each purchase of 340B drugs from entities participating in the Drug Pricing Program pursuant to section 340B of the PHS Act to pay for the operating costs of such a program: Provided further, That fees pursuant to the 340B Drug Pricing Program shall be collected by manufacturers at the time of sale, and shall be credited to this account, to remain available until expended.	Citation is added to establish a cost recovery fee for the 340B Drug Pricing Program as authorized by P.L. 111-148.
[$15,000,000 shall be available for the Small Rural Hospital Improvement Grant Program for quality improvement and adoption of health information technology and]	Citation is not required as funding is not requested in FY 2013.

Amounts Available for Obligation[1]

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Estimate
Discretionary Appropriation:			
Annual……	$6,274,790,000	$6,206,204,000	$6,067,862,000
Across-the-board reductions (L/HHS/AG, or Interior)	-$12,549,000	-$11,730,000	
Transfers from Other Accounts		$11,277,000	
American Recovery and Reinvestment Act…	$73,600,000	-	
Subtotal, adjusted appropriation……	6,335,841,000	6,205,751,000	6,067,862,000
Mandatory Appropriation:			
Transfer from the Prevention/ Public Health Fund	+20,000,000	+35,000,000	+10,000,000
Family to Family Health Information Centers…	+5,000,000	+5,000,000	-
Primary Health Care Access:			
Community Health Center Fund	+1,000,000,000	+1,200,000,000	+1,500,000,000
Health Centers – Facilities Construction/NHSC	+1,500,000,000		
School-Based Health Centers - Facilities	+50,000,000	+50,000,000	+50,000,000
National Health Service Corps	+290,000,000	+295,000,000	+300,000,000
Teaching Health Centers GME Payment	+230,000,000		
Subtotal Primary Health Care Access	+3,070,000,000	+1,545,000,000	+1,850,000,000
Early Childhood Visitation	+250,000,000	+350,000,000	+400,000,000
Subtotal, adjusted budget authority……	+9,680,841,000	+8,140,751,000	+8,327,862,000
Offsetting Collections……	+49,364,000	+53,465,000	+94,465,000
Unobligated balance, start of year……	+272,000,000	+1,060,000,000	+345,000,000
Unobligated balance, end of year……	-1,060,000,000	-345,000,000	-565,000,000
Recovery of prior year obligations……	+3,000,000		
Unobligated balance, lapsing……	-3,000,000	-	-
Total obligations…….	**$8,942,205,000**	**$8,909,216,000**	**$8,202,327,000**

[1] / Excludes the following amounts for reimbursable activities carried out by this account: FY 2011 - $34,409,000 and 19 FTE; FY 2012 - $38,031,000 and 19 FTE; FY 2013 $38,044,000 and 19 FTE.

Summary of Changes

2012 Enacted	
Total estimated budget authority	$6,205,751,000
(Obligations)	(-$6,228,751,000)
2013 Estimate	$6,067,862,000
(Obligations)	(-$6,067,862,000)
2012 Mandatory	$1,935,000,000
(Obligations)	(-$2,627,068,000)
2013 Mandatory	$2,260,000,000
(Obligations)	(-$2,039,796,000)
Net Change	**+$187,111,000**
(Obligations)	**-$748,161,000**

	2012 Current		Changes from Base	
		Budget Authority		**Budget Authority**
Increases:	FTE		FTE	
A. Built in:	1,749		-17	
1. January 2013 Civilian Pay Raise		$233,889,512		$7,389,692
2. January 2013 Military Pay Raise		$233,889,512		465,183
3. Civilian Annualization of Jan. 2012		$233,889,512		-
4. Military Annualization of Jan. 2012		$233,889,512		124,049
Subtotal, built-in increases				**+$7,978,923**
B. Program:				
Discretionary Increases		**FY 2012**		
1 Pediatric Loan Repayment	-	-	-	+$5,000,000

2	Primary Care Training and Enhancement	3	38,962,000	-	+$12,000,000
3	Public Health/Preventive Medicine	1	8,111,000	-	+$1,498,000
4	Maternal and Child Health Block Grant	30	638,646,000	-3	+$1,452,000
5	Comprehensive Care - Part B	52	1,355,640,000	-	+$66,701,000
	AIDS Drug Assistance Program (Non-Add)		*933,299,000*		*+$66,701,000*
6	Early Intervention - Part C	31	215,086,000	-	+$20,478,000
7	Program Management	890	159,894,000	+ 2	+$2,623,000
8	Family Planning	30	293,870,000	-	+$2,968,000
	Subtotal Discretionary Program Increases			**-1**	**+$112,720,000**
	Mandatory Increases				
9	Community Health Center Fund (ACA)	56	1,200,000,000	+20	+$300,000,000
10	National Health Service Corps (ACA)	237	295,000,000	-	+$5,000,000
11	Maternal, Infant and Early Childhood Visiting Program (ACA)	19	350,000,000	-	+$50,000,000
	Subtotal Mandatory Program Increases			-	**+$355,000,000**
	Total Program Increases			**+19**	**+$467,720,000**
	Decreases:				
	A. Built in:				
	1. Pay Costs		-$233,889,512		**-$7,978,923**
	B. Program:				
	Discretionary Decreases				
12	Health Centers	135	1,471,999,000	-	-$5,089,000
13	Health Careers Opportunity Program	1	14,822,000	-1	-$14,822,000
14	Health Care Workforce Assessment 1/	6	2,782,000	-	-$2,782,000
15	Area Health Education Centers	2	27,220,000	-2	-$27,220,000
16	Children's Hospitals Graduate Medical Education Program	31	265,171,000	-10	-$177,171,000
17	Children, Youth, Women & Families - Part D	4	77,167,000	-	-$7,585,000
18	Rural & Community Access to Emergency Devices	2	1,100,000	-2	-$1,100,000
19	Rural Hospital Flexibility Grants	3	41,040,000	-	-$14,840,000
	Subtotal Discretionary Program Decreases			**-15**	**-$250,609,000**
	Mandatory Decreases				
20	Mental and Behavioral Health Prevention Fund		10,000,000	-	-$10,000,000
21	Public Health/Preventive Medicine Prevention Fund		25,000,000	-	-$15,000,000
22	Family to Family Health Information Centers	1	5,000,000	-1	-$5,000,000

(ACA)		
Subtotal Mandatory Program Decreases	**-1**	**-$30,000,000**
Total Program Decreases	**-16**	**-$280,609,000**
Net Change Discretionary	**-16**	**-$137,889,000**
Net Change Mandatory	**+19**	**+$325,000,000**
Net Change Discretionary and Mandatory	**+3**	**+$187,111,000**

1/ FY 2013 Funding Proposed in Health Workforce Evaluation

Budget Authority by Activity
(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
1. Primary Care:			
Health Centers	1,480,949	1,471,999	1,466,910
Community Health Center Fund (ACA)	1,000,000	1,200,000	1,500,000
Health Center Tort Claims	99,800	94,893	94,893
Total, Health Centers	**2,580,749**	**2,766,892**	**3,061,803**
Health Centers - Facilities Construction (ACA)	1,500,000	-	-
School-Based Health Centers - Facilities (ACA)	50,000	50,000	50,000
Free Clinics Medical Malpractice	40	40	40
Hansen's Disease Center	16,077	16,045	16,045
Payment to Hawaii	1,964	1,960	1,960
National Hansen's Disease Program - Buildings and Facilities	129	127	127
Subtotal, Bureau of Primary Health Care	**4,148,959**	**2,835,064**	**3,129,975**
2. Clinician Recruitment and Service			
National Health Service Corps Recruitment	24,848	-	-
National Health Service Corps (ACA)	290,000	295,000	300,000
Subtotal, National Health Service Corps	**314,848**	**295,000**	**300,000**
Nurse Loan Repayment and Scholarship Program	93,292	83,135	83,135
Loan Repayment/Faculty Fellowships	1,258	1,243	1,243
Pediatric Loan Repayment	-	-	5,000
Subtotal, Clinician Recruitment & Service	**409,398**	**379,378**	**389,378**
3. Health Professions:			
Health Professions Training for Diversity:			
Centers of Excellence	24,452	22,909	22,909
Scholarships for Disadvantaged Students	49,042	47,452	47,452
Health Careers Opportunity Program	21,998	14,822	-
Subtotal, Health Professions Training for Diversity	**95,492**	**85,183**	**70,361**
Health Workforce Assessment	2,815	2,782	10,000
Health Workforce Assessment Evaluation			*10,000*
Primary Care Training and Enhancement	39,036	38,962	50,962
Oral Health Training Programs	32,781	32,392	32,392
Teaching Health Centers Graduate Medical Education Payment Program (ACA)	230,000	-	-
Interdisciplinary, Community-Based Linkages:			
Area Health Education Centers	33,142	27,220	-
Geriatric Programs	33,542	30,629	30,629
Allied Health and Other Disciplines	1,933	-	-
Mental and Behavioral Health	2,927	2,892	7,892

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Mental and Behavioral Health Evaluation Funding			*5,000*
Mental and Behaviorial Health Prevention Funds	-	10,000	-
Subtotal, Interdisciplinary, Community-Based Linkages	**71,544**	**70,741**	**38,521**
Public Health Workforce Development:			
Public Health/Preventive Medicine	9,609	8,111	9,609
Public Health Training Centers Prevention Fund (ACA)	20,000	25,000	10,000
Subtotal, Public Health Workforce Development	**29,609**	**33,111**	**19,609**
Nursing Workforce Development:			
Advanced Education Nursing	64,046	63,925	83,925
Advanced Education Nursing Evaluation			*20,000*
Nursing Workforce Diversity	16,009	15,819	15,819
Nurse Education, Practice and Retention	39,653	39,182	39,182
Nurse Faculty Loan Program	24,848	24,553	24,553
Comprehensive Geriatric Education	4,539	4,485	4,485
Subtotal, Nursing Workforce Development	**149,095**	**147,964**	**167,964**
Patient Navigator Outreach & Chronic Disease Prevention	4,990	-	-
Children's Hospitals Graduate Medical Education Program	268,356	265,171	88,000
Teaching Health Centers Development Grants			
Subtotal, Bureau of Health Professions	**923,718**	**676,306**	**477,809**
Health Work Force Evaluation Funding			*35,000*
National Practitioner Data Bank (User Fees)	*22,161*	*28,016*	*28,016*
Healthcare Integrity & Protection Data Bank (User Fees)	*4,815*	-	-
4. Maternal and Child Health:			
Maternal and Child Health Block Grant	656,319	638,646	640,098
Autism and Other Developmental Disorders	47,708	47,142	47,142
Traumatic Brain Injury	9,878	9,760	9,760
Sickle Cell Service Demonstrations	4,721	4,665	4,665
James T. Walsh Universal Newborn Hearing	18,884	18,660	18,660
Emergency Medical Services for Children	21,369	21,116	21,116
Healthy Start	104,361	103,532	103,532
Heritable Disorders	9,952	9,834	9,834
Family to Family Health Information Centers (ACA)	5,000	5,000	-
Maternal, Infant and Early Childhood Visiting Program (ACA)	250,000	350,000	400,000
Subtotal, Maternal and Child Health Bureau	**1,128,192**	**1,208,355**	**1,254,807**

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
5. HIV/AIDS:			
Emergency Relief - Part A	672,529	671,258	671,258
Comprehensive Care - Part B	1,308,141	1,355,640	1,422,341
AIDS Drug Assistance Program (Non-Add)	*885,000*	*933,299*	*1,000,000*
Early Intervention - Part C	205,564	215,086	235,564
Children, Youth, Women & Families - Part D	77,313	77,167	69,582
Education and Training Centers - Part F	34,607	34,542	34,542
Dental Reimbursement Program Part F	13,511	13,485	13,485
Subtotal, HIV/AIDS	**2,311,665**	**2,367,178**	**2,446,772**
SPNS Evaluation Funding	*25,000*	*25,000*	*25,000*
Subtotal, HIV/AIDS Bureau	**2,336,665**	**2,392,178**	**2,471,772**
6. Healthcare Systems:			
Organ Transplantation	24,896	24,015	24,015
Cord Blood Stem Cell Bank	11,910	11,887	11,887
C.W. Bill Young Cell Transplantation Program	23,374	23,330	23,330
Poison Control Centers	21,866	18,830	18,830
340b Drug Pricing Program/Office of Pharmacy Affairs	4,480	4,472	4,472
340b Drug Pricing Program/Office of Pharmacy Affairs User Fees			*6,000*
Subtotal, Healthcare Systems Bureau	**86,526**	**82,534**	**88,534**
7. Rural Health:			
Rural Health Policy Development	9,885	9,866	9,866
Rural Health Outreach Grants	55,658	55,553	55,553
Rural & Community Access to Emergency Devices	236	1,100	-
Rural Hospital Flexibility Grants	41,118	41,040	26,200
State Offices of Rural Health	10,055	10,036	10,036
Radiation Exposure Screening and Education Program	1,939	1,935	1,935
Black Lung	7,153	7,140	7,140
Telehealth	11,524	11,502	11,502
Subtotal, Office of Rural Health Policy	**137,568**	**138,172**	**122,232**
8. Program Management	161,815	159,894	162,517
9. Family Planning	299,400	293,870	296,838
Total, Budget Authority	**6,271,571**	**6,215,035**	**6,077,146**
FTE	**1,825**	**1,814**	**1,797**

Authorizing Legislation

		FY 2012 Amount Authorized	FY 2012 Appropriations Act	FY 2013 Amount Authorized	FY 2013 Presidents Budget
	PRIMARY HEALTH CARE:				
1.	Health Centers: PHSA, Section 330, as added to the PHS Act by P.L. 104-299, Amended by sec. 5601 of P.L. 111-148	4,990,553,440	1,471,999,000	6,448,713,307	1,466,910,000
2.	Community Health Center Fund (ACA) P.L. 111-148, Section 10503, as further amended by P.L 111-152, Section 2303	1,200,000,000	1,200,000,000	1,500,000,000	1,500,000,000
3.	School Based Health Centers - Facilities Construction/NHSC Construction Grants Sec. 4101(a) of P.L. 111-148	50,000,000	50,000,000	50,000,000	50,000,000
4.	Health Center Tort Claims: (Defense of Certain Malpractice and Negligence Suits) PHSA, Section 224, PHS[a] Act, as added by P.L. 102-501 and amended by P.L. 104-73	permanent	94,893,000	permanent	94,893,000
5.	Free Clinic Medical Malpractice: PHSA, Section 224, as added to the PHS Act by P.L. 104-191, amended by sec. 10608, P.L. 111-148	permanent	40,000	permanent	40,000
6.	National Hansen's Disease Program: PHSA, Section 320, PHS Act as added to PHS Act by Sec. 211, P.L. 105-78	permanent	16,045,000	permanent	16,045,000
7.	Payment to Hawaii: Sec. 320(d), PHS Act as added to PHS Act by Sec. 211, P.L. 105-78	permanent	1,960,000	permanent	1,960,000
8.	National Hansen's Disease - Buildings and Facilities: PHSA, Section 320 and 321(a)	permanent	127,000	permanent	127,000

		FY 2012 Amount Authorized	FY 2012 Appropriations Act	FY 2013 Amount Authorized	FY 2013 Presidents Budget
	CLINICIAN RECRUITMENT & SERVICE:				
9.	National Health Service Corps (NHSC) PHSA, Sections 331-338, as amended by Health Care Safety Net Act of 2008, P.L. 110-355., as further amended by P.L. 111-148, Section 5207 NHSC Field	535,087,442	295,000,000	691,431,432	300,000,000
	NHSC Recruitment State Loan Repayment: PHSA, Section 338I National Health Service Corps – Fund P.L. 111-148, Section 10503(b)(2)	295,000,000		300,000,000	
10.	Nursing Education Loan Repayment and Scholarship Program Sec. 846(a), PHS Act as amended by Sec. 103, P.L. 107-205, sec, 846(a), PHS Act, as amended by Sec. 5310, P.L. 111-148	expired	83,135,000	expired	83,135,000
11.	Loan Repayments and Fellowships Regarding Faculty Positions PHSA, Section 738(a), PHS Act (authorized appropriation Sec. 740(b)), as amended by sec. 5402, and sec. 10501(d), P.L. 111-148,	5,000,000	1,243,000	5,000,000	1,243,000
12.	Pediatric Loan Repayment Sections 775 of the PHSA, as added by sec 5203, P.L. 111-148.	50,000,000	-	50,000,000	5,000,000
	HEALTH PROFESSIONS:				
	Health Professions Training for Diversity:				
13.	Centers of Excellence Sec. 736, PHS Act, as amended by sec. 5401, P.L. 111-148	50,000,000	22,909,000	50,000,000	22,909,000
14.	Scholarships for Disadvantaged Students PHSA, Section 737 (authorized appropriations Sec 740(a)), as amended by Sec. 5402, P.L. 111-148	SSAN	47,452,000	SSAN	47,452,000
15.	Health Careers Opportunity Program PHSA, Section 739 (authorized appropriation Sec. 740 (c)), as amended by Sec. 5402, P.L. 111-148	SSAN	14,822,000	SSAN	-

		FY 2012 Amount Authorized	FY 2012 Appropriations Act	FY 2013 Amount Authorized	FY 2013 Presidents Budget
16.	Health Care Workforce Assessment, PHSA, Section 761, as amended by Section 5103, P.L. 111-148	SSAN	2,782,000	SSAN	10,000,000
17.	Primary Care Training and Enhancement Sec. 747, PHS Act, as amended by sec. 5301, P.L. 111-148	SSAN	38,962,000	SSAN	50,962,000
18.	Oral Health Training Programs, PHSA Section 748, as added by Sec 5303, P.L. 111-148, and 340G, PHS Act, as amended by Sec. 403, P.L. 107-251	SSAN	32,392,000	SSAN	32,392,000
19.	Interdisciplinary, Community-Based Linkages: Area Health Education Centers PHSA, Section 751, as amended by Sec. 5403, P.L. 111-148	125,000,000	27,220,000	125,000,000	-
20.	Education and Training Related to Geriatrics PHSA, Section 753, as amended by P.L. 111-148	unspecified	30,629,000	unspecified	30,629,000
21.	Mental and Behavioral Health, PHSA Section 756,as added by Section 5306, P.L. 111-148	35,000,000	2,892,000	35,000,000	7,892,000
22.	Mental and Behavior Health, [Prevention Fund]	SSAN	10,000,000	SSAN	-
23.	Public Health/ Preventive Medicine: Sec. 765-768, PHS Act, as amended by sec. 10501, P.L. 111-148	SSAN	8,111,000	SSAN	9,609,000
24.	Public Health/Preventive Medicine [Prevention Fund]		25,000,000		10,000,000
25.	Nursing Workforce Development: Advanced Nursing Education PHSA, Section 811, PHS Act, as amended by Sec. 5308, P.L. 111-148	SSAN	63,925,000	SSAN	83,925,000
26.	Nursing Workforce Diversity PHSA, Section 821, as amended by Sec. 5404, P.L. 111-148	SSAN	15,819,000	SSAN	15,819,000

		FY 2012 Amount Authorized	FY 2012 Appropriations Act	FY 2013 Amount Authorized	FY 2013 Presidents Budget
27.	Nurse Education, Practice, Quality and Retention PHSA, Section 831, (Part D) amended by Sec. 201 of P.L. 107-205, as amended by Sec. 5309, P.L. 111-148	SSAN	39,182,000	SSAN	39,182,000
28.	Nurse Faculty Loan Program PHSA, Section 846A, as amended by Sec. 5311, P.L. 111-148	SSAN	24,553,000	SSAN	24,553,000
29.	Comprehensive Geriatric Education PHSA, Section 865, as redesignated by Sec. 5310(b), and amended by Sec. 5312, P.L. 111-148	SSAN	4,485,000	SSAN	4,485,000
30.	Children's Hospitals Graduate Medical Education Program: PHSA, Section 340E, as amended by Sec. 1, P.L. 108-490, as further amended by P.L. 109-307	expired	265,171,000	expired	88,000,000
31.	*National Practitioner Data Bank: (User Fees)* *Title IV, P.L. 99-660, Sec. 1921, SSA, as added by Sec. 5(b), P.L. 100-93, sec 6403, P.L. 111-148* *(also includes: Health Care Integrity and Protection Data Bank (HIPDB), Social Security Act (SSA), as added by P.L. 104-191, and amended by sec. 6403, P.L. 111-148)*	*indefinite*	*28,016,000* *(non-add)*	*indefinite*	*28,016,000* *(non-add)*
	MATERNAL & CHILD HEALTH:				
32.	Maternal and Child Health Block Grant: Social Security Act, Title V	indefinite	638,646,000	indefinite	640,098,000
33.	Autism and Other Developmental Disorders PHSA, Section 399BB, as added by Part R, Sec. 3, P.L. 109-416, Reauthorized sec. 2, P.L. 112-32	48,000,000	47,142,000	48,000,000	47,142,000
34.	Traumatic Brain Injury Program: PHSA, Sections 1252, as amended by sec. 1304, P.L. 106-310, as further amended by Sec. 6(a), P.L. 110-206[54]	SSAN	9,760,000	expired	9,760,000

		FY 2012 Amount Authorized	FY 2012 Appropriations Act	FY 2013 Amount Authorized	FY 2013 Presidents Budget
35.	Sickle Cell Service Demonstration Grants: Title VII, sec. 712(c), P.L. 108-357	expired	4,665,000	expired	4,665,000
36.	Universal Newborn Hearing Screening: PHSA, Section 399M as amended by sec. 702, P.L. 106-310, as amended by sec. 2, P.L. 111-337	SSAN	18,660,000	SSAN	18,660,000
37.	Emergency Medical Services for Children: PHSA, Section 1910, as amended by Sec. 415, P.L. 105-392 Reauthorized sec. 5603, P.L. 111-148	27,562,500	21,116,000	28,940,625	21,116,000
38.	Healthy Start: PHSA, Section 330H(a)-(d), as amended by sec. 1501, P.L. 106-310, as amended by sec 2, P.L. 110-339	126,216,695	103,532,000	127,732,532	103,532,000
39.	Heritable Disorders Sec. 1109, PHS Act, as amended by sec. 2601, P.L. 106-310, as amended by sec. 2, P.L. 110-204, and as further amended by sec. 1, P.L. 110-237	15,562,500	9,834,000	15,750,000	9,834,000
40.	Family to Family Health Information Centers (ACA) Social Security Act, Section 501, as amended by sec. 6064, P.L. 109-171, Reauthorized, Section 5507, P.L. 111-148	5,000,000	5,000,000	expired	-
41.	Maternal, Infant and Early Childhood Visiting Program: Sec 2951, P.L. 111-148	350,000,000	350,000,000	400,000,000	400,000,000
	HIV/AIDS:				
42.	Emergency Relief - Part A: Secs. 2601-10, PHS Act, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	751,877,000	671,258,000	789,471,000	671,258,000

		FY 2012 Amount Authorized	FY 2012 Appropriations Act	FY 2013 Amount Authorized	FY 2013 Presidents Budget
43.	Comprehensive Care - Part B: Secs. 2611-31, PHS Act, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	1,487,780,000	1,355,640,000	1,562,169,000	1,422,341,000
44.	Early Intervention – Part C Secs. 2651-67, PHS Act, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	272,158,000	215,086,000	285,766,000	235,564,000
45.	Coordinated Services and Access to Research for Women, Infants, Children and Youth - Part D: Sec. 2671, PHS Act, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	83,117,000	77,167,000	87,273,000	69,582,000
46.	*AIDS Drug Assistance Program (Non-Add)* *Secs. 2611-31, PHS Act, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87*	*940,000,000*	*933,299,000*	*950,000,000*	*1,000,000,000*
47.	Special Projects of National Significance - Part F: Sec. 2691, PHS Act, as amended by P.L. 104-146, as amended by P.L. 109-415, as amended by P.L. 111-87	25,000,000	25,000,000	25,000,000	25,000,000
48.	Education and Training Centers - Part F II: Sec. 2692(a), PHS Act, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	40,170,000	34,542,000	42,178,000	34,542,000
49.	Dental Reimbursement Program - Part F II: Sec. 2692(b), PHS Act, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	15,049,000	13,485,000	15,802,000	13,485,000
	HEALTHCARE SYSTEMS				
50.	Organ Transplantation: PHSA, Sections 371 - 378, as amended by P.L. 108-216 and 42 U.S.C. 274i -271i-4, as amended by P.L. 110-413	expired	24,015,000	expired	24,015,000

		FY 2012 Amount Authorized	FY 2012 Appropriations Act	FY 2013 Amount Authorized	FY 2013 Presidents Budget
51.	C.W. Young Cell Transplantation Program: National Cord Blood Inventory: As amended by sec 3, P.L. 109-129 as amended by sec. 2(a), P.L. 111-264	23,000,000	11,887,000	23,000,000	11,887,000
52.	C.W. Bill Young Cell Transplantation Program: Part 1, PHS Act, secs. 379-379B, as amended by sec 3, P.L. 109-129 as amended by sec. 2, P.L. 111-264	30,000,000	23,330,000	30,000,000	23,330,000
53.	Poison Control Centers: P.L. 106-174. repealed and replaced by P.L. 108-109, as amended by P.L. 110-377	28,600,000	18,830,000	28,600,000	18,830,000
54.	340B Drug Pricing Program: PHSA, Section 340B, as amended by secs. 7101-7103, as amended by P.L. 111-148, as further amendedby sec. 2302, P.L. 111-152, and as amended by sec. 204, P.L. 111-309	indefinite	4,472,000	indefinite	4,472,000
55.	340B Drug Pricing Program/Office of Pharmacy Affairs User Fees*, This is a draft legislative proposal for FY13, which would authorize $6,000,000 for FY 13.	SSAN	-	SSAN	6,000,000
	RURAL HEALTH:				
56.	Rural Health Policy Development: Social Security Act, Section 711, Section 301 of the PHSA	indefinite	9,866,000	indefinite	9,866,000
57.	Rural Health Outreach Network Development and Small Health Care Provider Quality Improvement: PHSA, Section 330A, as amended by sec. 201, P.L. 107-251, as amended by sec. 4, P.L. 110-355	45,000,000	55,553,000	expired	55,553,000
58.	Rural Access to Emergency Devices: sec. 413, P.L. 106-505	expired	1,100,000	expired	-

		FY 2012 Amount Authorized	FY 2012 Appropriations Act	FY 2013 Amount Authorized	FY 2013 Presidents Budget
59.	Rural Hospital Flexibility Grants: Sec. 1820(j), SSA, as amended by sec. 4201(a), P.L. 105-33 and sec. 405(f), P.L. 108-173, as amended by sec. 121, P.L. 110-275	SSAN	41,040,000	expired	26,200,000
60.	State Offices of Rural Health: PHSA, Section 338J, as amended by sec. 301, P.L. 105-392	expired	10,036,000	expired	10,036,000
61.	Radiogenic Diseases: Sec. 417C, PHS Act, as amended by sec. 4, P.L. 106-245, as further amended by sec. 103 and sec. 104, P.L. 109-482	indefinite	1,935,000	indefinite	1,935,000
62.	Black Lung: Sec. 427(a), P.L. 91-173 as amended by sec. 5(6), P.L. 92-303 amended by sec. 9, P.L. 95-239, as further amended by CFR Part 55A	indefinite	7,140,000	indefinite	7,140,000
63.	Telehealth: Sec. 330I, PHS Act, as amended by P.L. 107-251, as further amended by P.L. 108-163	expired	11,502,000	expired	11,502,000
64.	Family Planning: Grants: PHSA Title X	expired	293,870,000	expired	296,838,000
65.	Program Management:	indefinite	159,894,000	indefinite	162,517,000
66.	Health Education Assistance Loans Program:	SSAN	2,807,000	SSAN	2,807,000
67.	Vaccine Injury Compensation Program Trust Fund: Title XXI, Subtitle 2, Parts A and D Secs. 2110-19 and 2131-34, PHS Act	indefinite	6,477,000	indefinite	6,477,000
	<u>Unfunded Authorizations</u>:				
68.	Health Center Demonstration Project for Individualized Wellness Plans Sec. 330(s), PHS Act as added to PHS Act by sec. 4206 of P.L. 111-148	unspecified	-	unspecified	-

		FY 2012 Amount Authorized	FY 2012 Appropriations Act	FY 2013 Amount Authorized	FY 2013 Presidents Budget
69.	Health Information Technology Innovation Initiative Sec. 330(e)(1)(C), PHS Act (Grants for Operation of Health Center Networks and Plans), as amended by sec. 101, P.L. 107-251, as amended by sec. 2, P.L. 110-355, General Health Center funding authority made permanent by sec. 5601 of P.L. 111-148	permanent	-	permanent	-
70.	Health Information Technology Planning Grants Sec. 330(c)(1)(B) and Sec. 330(c)(1)(C), PHS Act, as amended by sec. 101, P.L. 107-251	permanent	-	permanent	-
71.	Electronic Health Record Implementation Initiative Sec. 330(e)(1)(C), PHS Act, as amended by sec. 101, P.L. 107-251, as amended by sec. 2, P.L. 110-355. General Health Center funding authority made permanent by sec. 5601 of P.L. 111-148	permanent	-	permanent	-
72.	Tax Exclusions, National Health Service Corp Scholarships (tuition, fees, ORC) Section 117 , Internal revenue Code, as amended by Sec. 413 and 901, P.L. 107-16 (Authority sunset 12/31/2010), as amended by sec. 101, P.L. 111-312	-	-	-	-
73.	National Health Service Corp Loan Repayment and State Loan Repayment Sec. 108, Internal Revenue Code, as amended by sec 32(a), P.L. 108-357	indefinite	-	indefinite	-
74.	Native Hawaiian Health Scholarships P.L. 100-579,as amended by sec. 9168, P.L. 102-396, Section 338K PHS Act, Amended by sec. 10221 of P.L. 111-148	-	-	-	-
75.	Students to Service (S2S) Loan Repayment Pilot Program Sec. 338B, PHS Act, as amended, and Sec. 331(i), PHS Act, as amended by P.L. 107-251	-	-	-	-
76.	Health Professions Education in Health Disparities and Cultural Competency Sec. 741, PHS Act as amended by sec. 401, P.L. 106-525, as amended by sec. 5307, P.L. 111-148	-	-	-	-

		FY 2012 Amount Authorized	FY 2012 Appropriations Act	FY 2013 Amount Authorized	FY 2013 Presidents Budget
77.	Training Opportunities for Direct Care Workers Sec. 747A, PHS Act, as added by sec. 5302, P.L. 111-148	-	-	-	-
78.	Continuing Ed Support for Health Professionals Serving in Underserved Communities Sec. 752, PHS Act, as mend by sec. 5403, P.L. 111-148	-	-	-	-
79.	Geriatric Career Incentive Awards Sec. 753(e), PHS Act, as amended by sec. 5305(a), P.L. 111-148	-	-	-	-
80.	Geriatric Academic Career Awards Sec. 753(c), PHS Act, as amended by sec. 5305(b), P.L. 111-148	unspecified	-	unspecified	-
81.	Rural Interdisciplinary Training (Burdick) Sec. 754, PHS Act	unspecified	-	unspecified	-
82.	Grants for Pain Care Education & Training Sec. 759, PHS Act, as added by sec. 4305, P.L. 111-148	-	-	expired	-
83.	Advisory Council on Graduate Medical Education Sec. 762(k), PHS Act, as amended by sec. 502, P.L. 107-251, as amended by sec. 5103, P.L. 111-148	unspecified	-	unspecified	-
84.	Health Professions Education in Health Disparities and Cultural Competency Sec. 807, PHS Act, as added by sec. 401(b) of P.L. 106-525, as amended by sec. 5307 of P.L. 111-148	-	-	-	-
85.	Minority Faculty Fellowship Program Sec. 738, PHS Act (authorized appropriation Sec. 740(b)), as amended by sec. 5104, sec. 5402, and sec. 10501, P.L.111-148	-	-	-	-
86.	State Health Care Workforce Development Grants [Prevention Fund], 42 U.S.C 294r, as added by Sec. 5102, P.L. 111-148	SSAN	-	SSAN	-
87.	Allied Health and Other Disciplines PHSA, Section 755	unspecified	-	unspecified	-
88.	Nurse Managed Health Clinics [Prevention Fund], PHSA Section 330A-1, as added by sec. 5208, P.L. 111-148	SSAN	-	SSAN	-

		FY 2012 Amount Authorized	FY 2012 Appropriations Act	FY 2013 Amount Authorized	FY 2013 Presidents Budget
89.	Patient Navigator Outreach & Chronic Disease Prevention Act of 2005: Sec. 340A, PHS Act as added by, P.L. 109-18, as amended by Sec. 3510, P.L. 111-148	SSAN	-	SSAN	-
90.	Teaching Health Centers Development Grants, PHSA Section 749A, as added by Sec. 5508, P.L. 111-148	50,000,000	-	expired	-
91.	Report on Long Term Effects of Living Organ Donation, PHSA Sec 371A.	indefinite	-	Indefinite	-
92.	Congenital Disabilities PHSA, Section 399T	indefinite	-	indefinite	-
	Total, Request Level……		8,150,035,000		8,393,146,000

Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2004				
General Fund Appropriation:				
Base	5,665,996,000[1]	6,499,987,000[2]	6,175,645,000[2]	6,805,127,000
Advance				
Supplementals				
Rescissions (L/DHHS/E)				-1,729,000
Rescissions.				-39,547,000
Secretary's Transfer Authority				-29,500,000
Subtotal	5,665,996,000	6,499,987,000	6,175,645,000	6,734,351,000
FY 2005				
General Fund Appropriation:				
Base	6,022,833,000	6,305,333,000	6,941,280,000	6,858,624,000
Advance				
Supplementals				
Rescissions (Government-Wide)				-54,862,000
Rescissions (L/DHHS/E)				-747,000
Transfers				
Subtotal	6,022,833,000	6,305,333,000	6,941,280,000	6,803,015,000
FY 2006				
General Fund Appropriation:				
Base	5,966,144,000	6,443,437,000	7,374,952,000	6,629,661,000
Advance				
Supplementals				3,989,000
Rescissions (Government-Wide)				-66,297,000
Rescission, CMS				-4,509,000
Subtotal	5,966,144,000	6,443,437,000	7,374,952,000	6,562,844,000
FY 2007				
General Fund Appropriation:				
Base	6,308,855,000	7,095,617,000	7,012,559,000	6,390,691,000
Mandatory Authority				3,000,000[3]
Advance				
Supplementals				
Rescissions				
Subtotal	6,308,855,000	7,095,617,000	7,012,559,000	6,393,691,000

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

[2] Excludes $50 million mandatory appropriation for Abstinence Education

[3] Family to Family Health Information Centers and CAHs to SNFs and Assisted Living Facilities

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2008				
General Fund Appropriation:				
Base	5,795,805,000	7,061,709,000	6,863,679,000	6,978,099,000
Mandatory Authority				9,000,000[1]
Advance				
Supplementals				
Rescissions (L/DHHS/E)				-121,907,000
Transfers				
Subtotal	5,795,805,000	7,061,709,000	6,863,679,000	6,865,192,000
FY 2009				
General Fund Appropriation:				
Base	5,864,511,000	7,081,668,000	6,943,926,000	7,234,436,000
Mandatory Authority				5,000,000[2]
Advance				
Supplementals (P.L. 111-5)				2,500,000,000
Rescission of Unobligated Funds				
Transfers				
Subtotal.	5,864,511,000	7,081,668,000	6,943,926,000	9,739,436,000
FY 2010				
General Fund Appropriation:				
Base	7,126,700,000	7,306,817,000	7,238,799,000	7,473,522,000
Advance				
Supplementals				
Rescissions				
Transfers				9,472,000
Subtotal.	7,126,700,000	7,306,817,000	7,238,799,000	7,482,994,000
[3]**FY 2011**				
General Fund Appropriation:				
Base	7,473,522,000		7,491,063,000	6,274,790,000
Supplementals				
Transfers				
Across-the-board reductions (L/HHS/AG, or Interior)				-$12,549,000
American Recovery and Reinvestment Act				$73,600,000
Subtotal.	7,473,522,000		7,491,063,000	6,335,841,000

[1] Family to Family Health Information Centers and CAHs to SNFs and Assisted Living Facilities.
[2] Family to Family Health Information Centers
[3] Continuing Resolution Level

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2012				
General Fund Appropriation:				
Base	6,801,262,000			6,206,204,000
Advance				
Supplementals				
Rescissions				
Across-the-board reductions (L/HHS/AG, or Interior)				-$11,730,000
Transfers				$11,277,000
Subtotal.	6,801,262,000			6,205,751,000
FY 2013				
General Fund Appropriation:				
Base	6,067,862,000			
Advance				
Supplementals				
Rescissions				
Transfers	6,067,862,000			

Appropriations Not Authorized by Law

		Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2012
1.	Nursing Education Loan Repayment and Scholarship Program Sec. 846(a), PHS Act as amended by Sec. 103, P.L. 107-205, sec, 846(a), PHS Act, as amended by Sec. 5310, P.L. 111-148	2007	SSAN	31,055,000	83,135,000
2.	Sickle Cell Service Demonstration Grants: Title VII, sec. 712(c), P.L. 108-357	2009	10,000,000	10,000,000	4,665,000
3.	Organ Transplantation: PHSA, Sections 371 - 378, as amended by P.L. 108-216 and 42 U.S.C. 274i - 271i-4, as amended by P.L. 110-413	1993	SSAN	expired	24,015,000
4.	Rural Access to Emergency Devices: PHSA, sec. 413, P.L. 106-505	2006	5,000,000	1,484,000	-
5.	State Offices of Rural Health: PHSA, Section 338J, as amended by sec. 301, P.L. 105-392	2002	SSAN	4,000,000	10,036,000
6.	Telehealth: Sec. 330I, PHS Act, as amended by P.L. 107-251, as further amended by P.L. 108-163	2006	SSAN	6,814,000	11,502,000
7.	Family Planning: Grants: PHSA Title X	1985	158,400,000	expired	296,838,000
8.	Children's Hospitals Graduate Medical Education Program: PHSA, Section 340E, as amended by Sec. 1, P.L. 108-490, as further amended by P.L. 109-307	2011	330,000,000	268,356,000	88,000,000

Primary Health Care Tab

Narrative by Activity

Primary Health Care

Health Centers

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY2013+/- FY 2012
BA	$1,480,949,000	$1,471,999,000	$1,466,910,000	-$5,089,000
ACA	$1,000,000,000	$1,200,000,000	$1,500,000,000	+$300,000,000
FTCA	$99,800,000	$94,893,000	$94,893,000	---
Total HC	$2,580,749,000	$2,766,892,000	$3,061,803,000	+ $294,911,000
FTE	191	191	211	+20

Authorizing Legislation: Section 330 of the Public Health Service Act; as amended by Public Law 110-355 of the Health Care Safety Net Act of 2008; the Native Hawaiian Health Care Act of 1988; as amended by Section 9168 of the Public Law 102-396, Section 224 of the Public Health Service Act; Public Law 111-148, the Affordable Care Act of 2010, Title V, Section 5601 and Title X, Section 10503. Public Law 111-152, Health Care and Education Reconciliation Act of 2010, Section 2303.

FY 2013 Authorization $6,448,713,307

FY 2013 CHC Fund Authorization.....$1,500,000,000

Allocation Method .....Competitive grants/cooperative agreements

Program Description and Accomplishments

For more than 40 years, health centers have delivered comprehensive, high-quality, cost-effective primary health care to patients regardless of their ability to pay. During that time health centers have become the essential primary care provider for America's most vulnerable populations: people living in poverty, uninsured, and homeless; minorities; farmworkers; public housing residents; geographically isolated; and people with limited English proficiency. Health centers advance the preventive and primary medical/health care home model of coordinated, comprehensive, and patient-centered care, coordinating a wide range of medical, dental, behavioral, and social services. Today, more than 1,100 health centers operate over 8,100 service delivery sites that provide care in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin. Nearly half of all health centers serve rural populations. In FY 2010, these community-based and patient-directed health centers served 19.5 million patients, providing almost 77 million patient visits, at an average cost of $630 (including Federal and non-Federal sources of funding). Patient services are supported through Federal

Health Center grants, Medicaid, Medicare, Children's Health Insurance Program (CHIP), other third party, self pay collections, other Federal grants, and State/local/other resources.

Health centers serve a diverse patient population:

- People of all ages: Approximately 32 percent of patients in FY 2010 were children (age 17 and younger); about 7 percent were 65 or older.

- People without and with health insurance: Almost four in 10 patients were without health insurance in FY 2010. While the proportion of uninsured patients of all ages has held steady at nearly 40 percent, the number of uninsured patients increased from 4 million in FY 2001 to approximately 7.3 million in FY 2010, proportionate to the growth in Federal health center funding.

- Special Populations: Some health centers also receive specific funding to focus on certain special populations including farmworkers, individuals and families experiencing homelessness, those living in public housing, and Native Hawaiians. In FY 2010 health centers served approximately 863,000 farmworkers and their families, more than 1 million individuals experiencing homelessness, 173,000 residents of public housing, and over 8,400 Native Hawaiians.

- Migrant Health Centers: In FY 2010, HRSA-funded health centers served nearly 863,000 migrant and seasonal farmworkers and their families. It is estimated that HRSA-funded health center programs serve more than one quarter of all migrant and seasonal farmworkers in the United States (National Agricultural Workers Survey – Department of Labor). The Migrant Health Center program provides support to health centers to deliver comprehensive, high quality, culturally-competent preventive and primary health services to farmworkers and their families with a particular focus on the occupational health and safety needs of this population. Principal employment for farmworkers must be in agriculture.

- Health Care for the Homeless Program: Homelessness continues to be a pervasive problem throughout the United States, affecting rural as well as urban and suburban communities. According to the HUD 2010 Annual Homeless Assessment Report to Congress, it was estimated that 1.6 million people were homeless. In FY 2010, more than 1 million persons experiencing homelessness were served by HRSA-funded health centers. In particular, the Health Care for the Homeless Program is a major source of care for homeless persons in the United States, serving patients that live on the street, in shelters, or in transitional housing. Health Care for the Homeless grantees recognize the complex needs of homeless persons and strive to provide a coordinated, comprehensive approach to health care including substance abuse and mental health services.

- Public Housing Primary Care Health Centers: The Public Housing Primary Care Program provides residents of public housing with increased access to comprehensive primary health care services through the direct provision of health promotion, disease

prevention, and primary health care services. Services are provided on the premises of public housing developments or at other locations immediately accessible to residents. In FY 2010, HRSA-funded health centers served approximately 173,000 residents of public housing through these grants.

- Native Hawaiians: The Native Hawaiian Health Care Program, funded within the Health Center appropriation, improves the health status of Native Hawaiians by making health education, health promotion, and disease prevention services available through the support of the Native Hawaiian Health Care Systems. Native Hawaiians face cultural, financial, social, and geographic barriers that prevent them from utilizing existing health services. In addition, health services are often unavailable in the community. The Native Hawaiian Health Care Systems use a combination of outreach, referral, and linkage mechanisms to provide or arrange services. Services provided include nutrition programs, screening and control of hypertension and diabetes, immunizations, and basic primary care services. In FY 2010, Native Hawaiian Health Care Systems provided medical and enabling services to more than 8,400 people.

Allocation Method: Public and non-profit private entities, including tribal, faith-based and community-based organizations are eligible to apply for funding under the Health Center Program. New health center grants are awarded based on a competitive process that includes an assessment of need and merit. In addition, health center grantees are required to compete for their existing service areas at the completion of every project period (generally every 3 to 5 years). New health center grant opportunities are announced nationally and applications are then reviewed by objective review committees, composed of experts who are qualified by training and experience in particular fields related to the Program.

Funding decisions are made based on committee assessments, announced funding preferences and program priorities. In addition to the Objective Review Committee (ORC) score, various statutory awarding factors are applied in the selection of health center grants. These include funding priorities for applications serving a sparsely populated area; consideration of the rural and urban distribution of awards (no more than 60 percent and no fewer than 40 percent of people served come from either rural or urban areas); and a requirement for continued proportionate distribution of funds to the special populations served under the Health Center Program. Health centers demonstrate performance by increasing access, improving quality of care and health outcomes, and promoting efficiency.

Increasing Access: Health centers continue to serve an increasing number of the Nation's medically underserved. The number of health center patients served in FY 2010 was 19.5 million. This increased access beyond the 10.3 million patients served in FY 2001 represents over an 89 percent increase within a 9-year period, and an increase of approximately 3.3 million uninsured patients since FY 2001. Of the 19.5 million patients served and for those for whom income status is known, 93 percent were at or below 200 percent of the Federal poverty level and 38 percent were uninsured. Success in increasing the number of patients served has been due in large part to the development of new health centers, new satellite sites, and expanded capacity at existing clinics.

Improving Quality of Care and Health Outcomes: Health centers continue to provide quality primary and related health care services, improving the health of the Nation's underserved communities and vulnerable populations. For example, by monitoring timely entry into prenatal care, the program assesses both quality of care as well as health center outreach efforts. Identifying maternal disease and risks for complications of pregnancy or birth during the first trimester can also help improve birth outcomes.

Results over the past few years demonstrate improved performance as the percentage of pregnant health center patients that began prenatal care in the first trimester grew from 57.8 percent in FY 2000 to 69 percent in FY 2010, exceeding the target of 61.3 percent. It should also be noted that health centers serve a higher risk prenatal population than seen nationally, making progress on this measure a particular accomplishment.

Appropriate prenatal care management can also have a significant effect on the incidence of low birth weight (LBW), the risk factor most closely associated with neonatal mortality. Monitoring birth weight rates is one way to measure quality of care and health outcomes for health center women of child-bearing age, a key group served by the Program. This measure is benchmarked to the national rate to demonstrate how health center performance compares to the performance of the nation overall. In FY 2009, 7.3 percent of babies born to health center prenatal care patients were low birth weight, a rate that is 11 percent lower than seen nationally (8.2 percent).

Health center patients, including low-income individuals, racial/ethnic minority groups, and persons who are uninsured, are more likely to suffer from chronic diseases such as hypertension and diabetes. Clinical evidence indicates that access to appropriate care can improve the health status of patients with chronic diseases and thus reduce or eliminate health disparities. The Health Center Program began reporting data from all grantees on the control of hypertension and diabetes via its Uniform Data System in FY 2008. In FY 2010, 63 percent of adult health center patients with diagnosed hypertension had blood pressure under adequate control (less than or equal to 140/90). Additionally, 71 percent of adult health center patients with type 1 or 2 diabetes had their most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9%).

Promoting Efficiency: Health centers provide cost effective, quality primary health care services. The Program's efficiency measure focuses on maximizing the number of health center patients served per dollar as well as keeping cost increases below annual national health care cost increases while maintaining access to high quality services. In looking at growth in total cost per patient, the full complement of services (medical, dental, mental health, pharmacy, outreach, translation, etc.) that make health centers a "health care home" is captured. In FY 2009, health center costs grew by 2 percent, well under the target growth rate of 5.8 percent. In FY 2010, health center costs grew by 5%, which is above the national rate. This reflects the short term costs associated with managing operations while implementing significant facility improvements, including major construction and renovation projects. It is expected that as health center capital improvement projects are completed, the long term benefits of increased capacity and improved quality of care will be realized, and cost increases will remain below national comparison data, as has been the case historically. By keeping increases in the cost per individual served at health centers better than 20 percent below national per capita health care cost increases, the Program has served more patients that otherwise would have required

additional funding to serve annually, and demonstrates that it delivers its high quality services at a more cost-effective rate. Success in achieving cost-effectiveness may in part be related to health centers' use of a multi- and interdisciplinary team that treats the "whole patient." This, in turn, is associated with the delivery of high quality, culturally competent and comprehensive primary and health care services that not only increases access and reduces health disparities, but promotes more effective care for health center patients with chronic conditions.

The Program is implementing improvements that include: 1) a Patient-Centered Medical Home (PCMH) initiative designed to improve the quality of care in health centers and support their efforts to achieve national PCMH recognition or accreditation; and 2) program-wide collection of core quality of care and health outcome performance measures, such as hypertension and diabetes-related outcomes, from all grantees.

External Evaluation: In addition to internal monitoring of health center performance, peer reviewed literature and major reports continue to document that health centers successfully increase access to care, promote quality and cost-effective care, and improve patient outcomes, especially for traditionally underserved populations.

- Rural counties with a community health center site had 33 percent fewer uninsured emergency department (ED) visits per 10,000 uninsured populations than those rural counties without a health center site. Rural health center counties also had fewer ED visits for ambulatory care sensitive visits – those visits that could have been avoided through timely treatment in a primary care setting. (Rust George, et al. "Presence of a Community Health Center and Uninsured Emergency Department Visit Rates in Rural Counties." Journal of Rural Health, Winter 2009 25(1):8-16.)

- Uninsured health center patients were more likely than similar patients nationally to report a generalist physician visit in the past year (82 percent vs. 68 percent), have a regular source of care (96 percent vs. 60 percent), receive a mammogram in the past 2 years (69 percent vs. 49 percent), and receive counseling on exercise (68 percent vs. 48 percent) (Shi L., Stevens G.D., and Politzer R.M. Medical Care 2007; 45(3): 206-213).

- Health centers are positively associated with "better primary care experiences" in comparison with similar patients nationally. There is also a positive association between seeking care in health centers and self-reported access to care for both uninsured and Medicaid patients (Shi L, Stevens GD, Journal of Ambulatory Care Management 2007;30(2): 159-170).

- Health center uninsured patients are more likely to have a usual source of care than the uninsured nationally (98 percent vs. 75 percent) (Carlson et al. Journal of Ambulatory Care Management 24, 2001, Starfield and Shi. Pediatrics 113, 2004).

- Health centers provide continuous and high quality primary care and reduce the use of costlier providers of care, such as emergency departments and hospitals (Proser M. Journal of Ambulatory Care Management 28(4), 2005).

- Uninsured people living within close proximity to a health center are less likely to have an unmet medical need (Hadley J and Cunningham P. Health Services Research 39(5): 2004).

- Health centers have demonstrated success in chronic disease management. A high proportion of health center patients receive appropriate diabetes care (Maizlish et al. American Journal of Medical Quality 19(4), 2004).

- Health centers providing enabling services that were linguistically appropriate helped patients obtain health care (Weir R, et al. Use of Enabling Services by Asian American, Native Hawaiian, and Other Pacific Islander Patients at 4 Community Health Centers. Am J Public Health 2010 Nov; 100(11): 2199 – 2205).

- Medicaid beneficiaries receiving care from a health center were less likely to be hospitalized than Medicaid beneficiaries receiving care elsewhere (Falik M. et al. Medical Care 39(6), 2001).

- Health center Medicaid patients were 11 percent less likely to be inappropriately hospitalized and 19 percent less likely to visit the emergency room inappropriately than Medicaid beneficiaries who had another provider as their usual source of care (Falik M. et al. Journal of Ambulatory Care Management 29, 2006).

- Emergency department visits are higher in counties with limited access to primary care (Hossain MM, Laditka JN. Using hospitalization for ambulatory care sensitive conditions to measure access to primary health care: an application of spatial structural equation modeling. Int J Health Geogr. 2009 Aug 28;8:51).

- Health centers have been found to improve patient outcomes and reduce racial and ethnic disparities in health care (O'Malley AS, et al. Health Affairs 24(2): 2005, Shin P, Jones K, and Rosenbaum S. George Washington University: 2003, Shi, L., J. Regan, R. Politzer, and J. Luo. International Journal of Health Services 31(3): 2001).

- Health center low birth weight rates continue to be lower than national averages for all infants. In particular, the health center low birth weight for African American patients is lower than the rate observed among African Americans nationally (10.7 percent vs. 14.9 percent, respectively) (Shi et al. Health Services Research, 39:2004).

- Health center patient rates of blood pressure control were better than rates in hospital affiliated clinics, the Veterans Affairs health system, or in commercial managed care populations (Hicks LS. et al. Health Affairs 25, 2006).

- *Federal Tort Claims Act (FTCA) Program:* The Health Center Program administers the FTCA program, under which employees of eligible health centers may be deemed to be federal employees qualified for malpractice coverage under the FTCA. The health center, its employees, and eligible contractors are considered Federal employees immune from suit for medical malpractice claims while acting within the scope of their

employment. The Federal government assumes responsibility for such claims. Key program activities for risk mitigation include risk management of reviews and sites visits as well as risk management technical assistance and resources to support health centers. In FY 2009, 107 claims were paid through the FTCA program, totaling approximately $45.6 million, in FY 2010, 103 claims were paid totaling $52.6 million, and in FY 2011, 103 claims were paid totaling $82.8 million.

The Affordable Care Act: The Affordable Care Act authorized and appropriated $11 billion over five years to establish a Community Health Center Fund to provide for expanded and sustained national investment in health centers under section 330 of the Public Health Service Act. $1.5 billion will support major construction and renovation projects at community health centers nationwide. $9.5 billion will support ongoing health center operations, the establishment of new health center sites in medically underserved areas and expand preventive and primary health care services at existing health center sites. The amount appropriated to support health center services is $1 billion in FY 2011, $1.2 billion in FY 2012, and $1.5 billion in FY 2013.

In FY 2011, approximately $732 million in Affordable Care Act funding supported awards to 144 health centers for the construction and renovation of 190 new or improved sites. Additionally, 67 health center new access point grants, 129 health center planning grants, as well as continuation activities for over 1,100 health centers were supported by the Affordable Care Act in FY 2011. Over 200,000 additional patients are estimated to have been served in FY 2011.

In FY 2012, additional ACA funding is projected to support health center new access point grants, expanded health services, health center controlled networks to support health information technology and quality improvement activities in health centers. In FY 2012, approximately$700 million in ACA funding is expected to be awarded through two FY 2012 funding opportunities for health centers to address capital development needs. The Health Center Capital Development - Building Capacity Program will provide approximately $600 million to an estimated 125-150 health centers to improve their capacity to provide primary and preventive health services to medically underserved populations. The Health Center Capital Development - Immediate Facility Improvement Program will provide approximately $100 million to an estimated 250-300 health centers to improve immediate facility needs within existing health center sites. *Enhancing HIV/AIDS Care:* In FY 2012, the Health Center program will provide $5 million in support of the President's National HIV/AIDS Strategy, for a joint effort with the Ryan White Part C Program to enhance care and treatment for individuals living with HIV and AIDS at health centers that are also service providers under Ryan White Part C HIV/AIDS.

Funding History

FY	Amount
FY 2008	$2,065,022,000
FY 2009	$2,190,022,000
FY 2009 Recovery Act	$2,000,000,000
FY 2010	$2,185,146,000
FY 2011	$2,580,749,000
FY 2012	$2,766,892,000

Budget Request

ACA Health Center Fund
($ Millions)

2011	2012	2013	2014	2015	2011-2015
$1,000	$1,200	$1,500	$2,200	$3,600	$9,500

*All ACA Health Center resources are available until expended

The FY 2013 Budget Request of $3,061,803,000 is $294,911,000 over the FY 2012 Enacted Level, and includes $1,500,000,000 from ACA mandatory funding. The FY 2013 Budget Request will support the Program's achievement of its ambitious performance targets and continue to enable the provision of access to primary health care services and the improvement of the quality of care in the health care safety net. The FY 2013 Budget Request also supports $94,893,000 for the FTCA program, which is equal to the FY 2012 appropriated level.

The FY 2013 Budget Request promotes a long-term strategy to manage mandatory resources appropriated to Health Centers through Section 10503 of the ACA. This strategy will promote steady and sustainable Health Center growth. In total, the ACA appropriates $9,500,000,000 for Health Centers over the FY 2011 – FY 2015 period. These resources are available until expended and are for expanded and sustained national investment. The ACA funds complement funds that the program received annually in the discretionary budget process. As these mandatory appropriations will cease after FY 2015, it is important that they are carefully utilized to avoid a large funding shortfall in FY 2016. Such a large reduction in resources would cause a significant disruption in services for millions of medically underserved people nationwide Therefore, the FY 2013 Budget policy is to manage ACA resources over the long-term, including in years after FY 2015. In FY 2013, $280 million will be reserved for future fiscal years. Additional funding will be reserved in FY 2014 and FY 2015 to sustain health center funding and ensure that current health centers can continue to provide essential health care services to their patient populations.

Health centers will continue to be a critical element of the health system as the United States expands insurance coverage through the ACA, largely because they can provide an accessible and dependable source of primary care services in underserved communities. As such, the long-term strategy for Health Centers takes into account the need to open new health centers in areas in the country where they do not currently exist. Funding is available in the FY 2013 Budget request to open 25 new health center sites in FY 2013, and funding will be available to continue

to open new sites in future years as well. The Budget will enable health centers continue to provide critical access and services to millions of Americans in FY 2013 and for many years to come.

The FY 2013 Budget Request will support the Program's achievement of its performance targets including the performance improvement efforts within health centers. Funding also includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up site visits. The Program will continue to achieve its goal of providing access to care for underserved and vulnerable populations. Health centers served an estimated 19.7 million patients in FY 2011, and are projected to serve approximately 20.6 million patients in FY 2012, and approximately 20.9 million patients under the FY 2013 Budget Request level.

As part of the Program's efforts to improve quality of care and health outcomes, the health center program has established ambitious targets for FY 2013 and beyond. For low birth weight, the Program seeks to be at least 5 percent below the national rate. This is ambitious because health centers continue to serve a higher risk prenatal population than represented nationally in terms of socio-economic, health status and other factors that predispose health center patients to greater risk for low birth weight and adverse birth outcomes. The FY 2013 target for the Program's hypertension measure is that 60 percent of adult patients with diagnosed hypertension will have blood pressure under adequate control. The FY 2013 target for the Program's diabetes management measure is 71 percent of adult patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9%). These targets will be challenging to achieve because chronic conditions require treatment with lifestyle modifications, usually as the first step, and, if needed, with medication.

The Program will also continue to promote efficiency and aims to keep cost per patient increases below annual national health care cost increases, as provided by the Center for Medicare and Medicaid Services' National Health Expenditure Amounts and Projections. By benchmarking the health center efficiency to national per capita health care cost increases, the measure takes into account changes in the healthcare marketplace while demonstrating the Program's continued ability to deliver services at a more cost-effective rate. The target for FY 2013 is to keep the Program's cost per patient increase at least 20 percent below the 2013 national health care cost increase. To assist in areas of cost-effectiveness, the program offers technical assistance to grantees to review costs and revenues and develop plans to implement effective cost containment strategies. By restraining increases in the cost per individual served at health centers below the national per capita health care cost increases, the Health Center Program serves a volume of patients that otherwise would have required additional funding to serve, and demonstrates that it delivers its high quality services at a more cost effective rate.

The FY 2013 Budget Request will also support the Program's ongoing involvement in an agency-wide effort to improve quality and program integrity in all HRSA-funded programs that deliver direct health care. One of the key steps the Health Center Program has taken in this area is to establish a core set of clinical performance measures for all health centers. The Program has aligned its required clinical performance measures with the Department's Meaningful Use measures. These measures are also consistent with the overarching goals of Healthy People 2020, and include: immunizations; prenatal care; cancer screenings; cardiovascular

disease/hypertension; and diabetes. In FY 2011, the Health Center Program began collecting data on four additional clinical performance measures: weight assessment and counseling for children and adolescents, adult weight screening and follow up, tobacco use assessment and counseling, and asthma treatment.

In addition to tracking these core clinical indicators, health center grantees also report their health outcome measures (low birth weight, diabetes, and hypertension) by race/ethnicity in order to demonstrate progress towards eliminating health disparities in health outcomes. To support quality improvement across all, the Program will continue to support national and State-level technical and training programs that promote quality improvements in health center data and quality reporting, clinical and quality improvement, and implementation of innovative quality activities. The Program continues to promote the integration of Health Information Technology (HIT) into health centers as part of HRSA's strategy to assure that key safety-net providers are not left behind as this technology advances.

HRSA has established a new goal related to the Health Center Program Patient Centered Medical Home (PCMH) Initiative. Since FY 2011, data has been collected on the percentage of health centers recognized as a patient centered medical home by a national accrediting organization. The FY 2013 target for this goal is for 25 percent of health centers to be recognized as PCMHs. This is a Priority Goal for FY 2013.

Funding will also allow the Program to continue to coordinate and collaborate with related Federal, State, local, and private programs in order to further leverage and promote efforts to expand and improve health centers. The Program will continue to work with the Centers for Medicaid and Medicare Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) on HIT, the Centers for Disease Control and Prevention (CDC) to address Migrant Stream Farmworker issues and HIV prevention initiatives, and the National Institutes of Health (NIH) on U.S.-Mexico Border health issues, among others. In addition, the Program will continue to coordinate with CMS to jointly review section 1115 Medicaid Demonstration Waivers. The Program will also work closely with the Department of Justice on the Federal Tort Claims Act (FTCA) program, which provides medical malpractice liability protection to section 330 supported health centers. Additionally, the proposed Budget will allow coordination with programs in the Departments of Housing and Urban Development, Education, and Justice (HUD, Ed, and DOJ) as part of the Administration's place-based initiative on Neighborhood Revitalization.

Sources of Revenue

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Health Centers	$2,480.9	$2,671.9	$2,686.9
Other Sources:			
Medicaid	4,830.0	5,130.0	5,295.0
Medicare	760.0	805.0	835.0
CHIP	300.0	315.0	325.0
Other Third	1,100.0	1,185.0	1,225.0
Self Pay Collections	765.0	805.0	830.0
Other Federal Grants	230.0	240.0	250.0
State/Local/Other	2,240.0	2,350.0	2,450.0
TOTAL ($ in millions)	$12,705.9	$13,501.9	$13,896.9

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
1.I.A.1: Number of patients served by health centers (Output)	FY 2010: 19.5 million Target: 20.15 (Target Not Met)	20.6 million	20.9 million	+ .3 million
1.I.A.2.b: Percentage of grantees that provide the following services either on-site or by paid referral: (b) Preventive Dental Care (Output)	FY 2010: 88 % Target: 88% (Target Met)	88%	88%	Maintain
1.I.A.2.c: Percentage of grantees that provide the following services either on-site or by paid referral: (c) Mental Health/Substance Abuse (Output)	FY 2010: 72% Target: 68% (Target Exceeded)	70%	70%	Maintain
1.E: Percentage increase in cost per patient served at health centers compared to the national rate (Efficiency)	FY 2010: 5%, 1.1% above national rate Target: 20% below national rate (Target Not Met)	20% below national rate	20% below national rate	Maintain

1.II.B.2: Rate of births less than 2500 grams (low birth weight) to prenatal Health Center patients compared to the national low birth weight rate (Outcome)	FY 2009: 7.3%, 11% below national rate Target: 11% below national rate (Target Met)	5% below national rate	5% below national rate	Maintain
1.II.B.3: Percentage of adult Health Center patients with diagnosed hypertension whose blood pressure is under adequate control (less than or equal to 140/90) (Outcome)	FY 2010: 63% Target: 50% (Target Exceeded)	60%	60%	Maintain
1.II.B.4: Percentage of adult Health Center patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9%) (Outcome)	FY 2010: 71% Target: 73% (Target Not Met)	71%	71%	Maintain
1.II.B.1: Percentage of pregnant Health Center patients beginning prenatal care in the first trimester (Output)	FY 2010: 69% Target: 61.3% (Target Exceeded)	61.3%	64.3%	+3% points
1.II.A.1: Percentage of Health Center patients who are at or below 200% of poverty (Output)	FY 2010: 93% Target: 91% (Target Exceeded)	91%	91%	Maintain
1 II.A.2: Percentage of Health Center patients who are racial/ethnic minorities (Output)	FY 2010: 62% (Baseline)	63%	63%	Maintain
1.II.A.3: Percentage of Health Center patients who are uninsured (Output)	FY 2010: 38% Target: 38% (Target Met)	38%	38%	Maintain
1.I.A.3: Percentage of health centers with at least one site recognized as a patient centered medical home (Outcome)	FY 2010: 1% (Baseline)	13%	25%	12% points

Grants Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Number of Awards	1,134	1,219	1,229
Average Award	$2 million	$2 million	$2 million
Range of Awards	$250,000 - $13.3 million	$250,000 - $13.3 million	$250,000 - $ 13.3 million

Program Outputs

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
New Access Points	67	220	25
Expanded Sites	---	---	---
Total New/Expanded	67	220	25
Total Sites	8,501	8,721	8,746
Estimated Patients Served	19.7 million	20.6 million	20.9 million

Community Health Center Fund – Construction

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$1,500,000,000	---	---	---
FTE	20	20	---	-20

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

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

Allocation Method Competitive grants/cooperative agreement

Program Description and Accomplishments

The Construction section of the Community Health Center (CHC) Fund was established under the Affordable Care Act to provide for expanded and sustained national investment in health centers funded under section 330 of the Public Health Service Act. Grant opportunities supported by the CHC Fund Construction program were implemented in FY 2011. Approximately, $732 million in Affordable Care Act funding supported awards to 144 health centers for the construction and renovation of 190 sites. In FY 2012, Health Center Capital Development grant opportunities are expected to provide approximately $700 million for capital development needs at health centers.

Budget Request

The Affordable Care Act CHC Fund authorized and Enacted $1,500,000,000 for FY 2011 through 2015 with funds available until expended for construction. It is expected that a portion of the funding that remains available in FY 2013 will be used to support facility construction and renovation projects for health centers funded under section 330 of the Public Health Service Act.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
39.I: Number of new/improved sites	FY 2011: 2 (Baseline)	22	52	+ 30

School Based Health Centers – Facilities

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$50,000,000	$50,000,000	$50,000,000	---
FTE	9	9	9	---

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

FY 2013 Authorization $50,000,000

Allocation Method ..... Competitive grants

Program Description and Accomplishments

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

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

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

In FY 2011, approximately $95 million was awarded to 278 SBHC across the country. These SBHCs currently served more than 790,000 patients and through this funding will expand their capacity to serve an additional 440,000 people. In FY 2012, more than $14 million was awarded to 45 school-based health centers across country. This funding will enable these centers to expand their capacity and modernize their facilities allowing them to treat an estimated additional 53,000 children, above the 112,000 currently being served at these centers.

Funding History

FY	Amount
FY 2008	---
FY 2009	---
FY 2010	$50,000,000
FY 2011	$50,000,000
FY 2012	$50,000,000

Budget Request

The Affordable Care Act authorized and Enacted amount for FY 2013 is $50,000,000, which is available until expended. This funding is expected to support expenditures for school based health center facilities, including equipment, the acquisition or improvement of land, or the acquisition, construction, expansion, replacement, or other improvement of a school based health center facility. This requested FY2013 level, is expected to fund approximately 95 SBHC awards. Combined with the remaining $36 million in FY 2012 program funding, a total of approximately 160 SBHC awards are expected to be funded in FY 2013.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
40.I: Number of new/improved sites (Developmental)	FY 2012: TBD, November 2012 (Baseline)	N/A	TBD	N/A

Free Clinics Medical Malpractice

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$40,000	$40,000	$40,000	---
FTE	2	2	2	---

Authorizing Legislation: Section 224 of the Public Health Service Act.

FY 2013 Authorization ..... indefinite

Allocation Method ..... Other

Program Description and Accomplishments

The Free Clinics Medical Malpractice Program encourages health care providers to volunteer their time at free clinics by providing medical malpractice protection at sponsoring health clinics, thus expanding the capacity of the health care safety net. In many communities, free clinics assist in meeting the health care needs of the uninsured and underserved. They provide a venue for providers to volunteer their services. Most free clinics are small organizations with annual budgets of less than $250,000.

In FY 2004, Congress provided first-time funding for payments of free clinic provider's claims under the Federal Tort Claims Act (FTCA). The appropriation established the Free Clinics Medical Malpractice judgment fund and extended FTCA coverage to medical professional volunteers in free clinics in order to expand access to health care services for low-income individuals in medically underserved areas.

Allocation Method: Qualifying Free Clinics submit applications to the Department of Health and Human Services to have volunteer providers that they sponsor deemed. Qualifying 'free clinics' or health care facilities operated by nonprofit private entities must be licensed or certified in accordance with applicable law regarding the provision of health services. They cannot: accept reimbursements from any third-party payor (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program including Medicare or Medicaid); or impose charges on the individuals to whom the services are provided, or impose charges according to the ability of the individual involved to pay the charge.

Increasing Access: In FY 2010, 4,800 volunteer health care providers received Federal malpractice coverage through the Program, exceeding the Program target and representing an increase of more than 1,000 volunteer providers over FY 2009, and almost 1,800 providers over the FY 2008 level.

In FY 2009 121 free clinics operated with FTCA deemed volunteer clinician, and in FY 2010 132 clinics participated, exceeding the Program's annual target. The Program also examines the quality of services annually by monitoring the percentage of free clinic health professionals

meeting licensing and certification requirements. Performance continues to meet the target with 100 percent of FTCA-deemed clinicians meeting appropriate licensing and credentialing requirements. In FY 2010, the Program supported 312,317 patient visits provided by free clinics sponsoring volunteer FTCA deemed clinicians.

Promoting Efficiency: The Free Clinics Medical Malpractice Program is committed to improving overall efficiency by controlling the Federal administrative costs necessary to deem each provider. By restraining these annual administrative costs, the Program is able to provide an increasing number of clinicians with malpractice coverage, thus building the free clinic workforce capacity nationwide and increasing access to care for the vulnerable populations served by these clinics. In FY 2009, the cost per provider was $154, and in FY 2010, the result was $115 per provider, Each year, the program performance target has been exceeded.

Through FY 2011 there has been one claim filed, which is awaiting adjudication. There have been no paid claims under the Free Clinics Medical Malpractice Program.

Funding History

FY	Amount
FY 2008	$40,000
FY2009	$40,000
FY 2010	$40,000
FY 2011	$40,000
FY 2012	$40,000

Budget Request

The FY 2013 Budget Request is $40,000. The FY 2013 Budget Request will support the Program's continued achievement of its ambitious performance targets addressing its goal of increasing access and capacity in the health care safety net.

Targets for FY 2013 focus on increasing the number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage to 5,100 while also increasing the number of free clinics operating with FTCA-deemed volunteer clinicians to 165. The focus on quality will continue to hold the Program to a target of 100 percent for FTCA-deemed clinicians meeting appropriate licensing and certification requirements. The Program will also continue to promote efficiency by restraining growth in the annual Federal administrative costs necessary to deem each provider, with a target of $155 administrative cost per provider in FY 2013.

The FY 2013 Budget Request will also support the Program's continued coordination and collaboration with related Federal programs in order to further leverage and promote efforts to increase the capacity of the health care safety net. Areas of collaboration include coordination with the Health Center FTCA Program, also administered by HRSA, to share program expertise. In addition, the two programs control costs by sharing a contract to process future claims, and by providing technical support and outreach. The Program will coordinate with non-profit free clinic-related umbrella groups on issues related to program information dissemination and outreach and will continue to collaborate with the Department of Justice (DOJ) and the HHS

Office of General Counsel (HHS/OGC) to assist in drafting items including deeming applications and related policies. The Program continues to work with the HHS/OGC to answer legal technical assistance issues raised by free clinics in the program and clinics interested in joining the program.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2011
2.I.A.1: Number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage (Outcome)	FY 2010: 4,800 Target: 4,000 (Target Exceeded)	4,800	5,100	+ 300
2.1: Patient visits provided by free clinics sponsoring volunteer FTCA-deemed clinicians (Outcome)	FY 2010: 312,317 (Baseline)	320,000	332,000	+12,000
2.I.A.2: Number of free clinics operating with FTCA-deemed volunteer clinicians (Output)	FY 2010: 132 Target: 130 (Target Exceeded)	155	165	+10
2.I.A.3: Percent of volunteer FTCA-deemed clinicians who meet certification and privileging requirements (Output)	FY 2010: 100% Target: 100% (Target Met)	100%	100%	Maintain
2.E: Administrative costs of the program per FTCA-covered volunteer (Efficiency)	FY 2010: $115 Target: 170 (Target Exceeded)	$155	$155	Maintain

National Hansen's Disease Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$16,077,000	$16,045,000	$16,045,000	---
FTE	64	64	64	---

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

FY 2013 Authorization ..... indefinite

Allocation Method .....Contract

Program Description and Accomplishments

The National Hansen's Disease Program (NHDP) has been providing care and treatment for Hansen's Disease (leprosy) and related conditions since 1921. The Program provides medical care to any patient living in the United States or Puerto Rico through direct patient care at its facilities in Louisiana, through grants to an inpatient program in Hawaii and by contracting with 11 regional outpatient clinics. Currently there are approximately 3,000 patients cared for through the NHDP's outpatient clinics. The Program also provides training to health professionals, and conducts scientific research at the world's largest and most comprehensive laboratory dedicated to Hansen's Disease. The Program is the only dedicated provider of expert Hansen's Disease treatment services in the United States and a crucial source of continuing education for providers dealing with the identification and treatment of the disease in the United States.

Increasing Quality of Care: Early diagnosis and treatment helps reduce Hansen's Disease-related disability and deformity. This can only be achieved if there are enough health care providers in the U.S. with knowledge of the disease and access to the support provided by the NHDP though its function as an outpatient clinic, training, education, and referral center. Increasing knowledge about Hansen's Disease in the U.S. medical community is expected to lead to earlier diagnosis and intervention, resulting in a decrease in Hansen's Disease-related disabilities. In FY 2010, the NHDP exceeded its program performance target of 150, and trained 220 private sector physicians, an increase over the 157 physicians trained in FY 2009, the 146 physicians trained in FY 2008 and the 135 physicians trained in FY 2007.

Improving Health Outcomes: Hansen's Disease is a life-long chronic condition which left untreated and unmanaged will usually progress to severe deformity.

Through its focus on early diagnosis and treatment, the NHDP is monitoring its impact on improving health outcomes for Hansen's Disease patients through the prevention of increases in the percentage of patient with grades 1 or 2 disability/deformity. In FY 2005, 51 percent of patients had grades 1 or 2 disability. In FY 2006 that figure was 46 percent, in FY 2007 that

figure was 47 percent, and in FY 2008 the result was 45 percent, exceeding the target of 50 percent each year. In FY 2009 the result was 53 percent.

The Program is also working to improve health outcomes through advances in Hansen's Disease research. The Program is measuring its advances in scientific knowledge through breakthroughs in genomic and molecular biology. The key performance measure examines the development of six protective biological response modifiers (BRMs) and six white blood cell subtype markers (CMs) that are important in host resistance to Hansen's Disease. These markers and other progress will aid in the study of defective nerve function in infected armadillos which will ultimately permit development of a full animal model for human Hansen's Disease. In FY 2007, the program met its target and developed the second of the 12 reagents (BRM-2) needed to produce a relevant animal model, as well as the first of six white blood cell subtype markers (CM-1). In FY 2008, the Program met its target and developed the third of the 12 reagents (BRM-3) needed to produce a relevant animal model, as well as the second and third of six white blood cell subtype markers (CM-2 and CM-3). In FY 2009, the Program met its target and developed BRM-4 and CM-4. In FY 2010, the Program demonstrated defective nerve function in infected armadillos.

Promoting Efficiency: The National Hansen's Disease Program outpatient care is comprehensive and includes treatment protocols for multi-drug therapy, diagnostic studies, consultant ancillary medical services, clinical laboratory analysis, hand and foot rehabilitation, leprosy surveillance, and patient transportation for indigent patients. The National Hansen's Disease Program is committed to improving overall efficiency by controlling the cost of care at all of its outpatient clinics while keeping increases in the cost per patient served at or below the national medical inflation rate.

By restraining increases in the cost per individual served by the Ambulatory Care Program Clinics and at the NHDP's outpatient centers below the national medical inflation rate, the Program can continue to serve more patients that otherwise would have required additional funding to serve in the fiscal year. In FY 2009, the cost per patient served through outpatient services was $1,088, reflecting a reduction of 12.5% and bettering the target of $1,676. In FY 2010, the cost per patient served through outpatient services were $1,142, reflecting an increase of 4.9% and slightly higher than the national medical inflation rate of 3.9%.

Funding History

FY	Amount
FY 2008	$15,693,000
FY 2009	$16,109,000
FY 2010	$16,075,000
FY 2011	$16,077,000
FY 2012	$16,045,000

Budget Request

The FY 2013 Budget Request is the same as the FY 2012 Enacted level. The entire FY 2013 Budget Request will support the Program's achievement of its performance targets. The

Program will continue its goals in the area of increasing quality of care and improving health outcomes for Hansen's Disease patients.

A target for FY 2013 is to train 150 physicians, improving their knowledge and ability to diagnose and treat Hansen's Disease. A national promotion effort targeted at physicians whose practice may include individuals with Hansen's Disease (e.g., dermatologists) is underway, as well as targeted efforts to train health care providers in Hansen's Disease where clusters of newly diagnosed cases are appearing.

In the area of Hansen's Disease disability/deformity[1] prevention, it is expected that both the program's existing case management efforts as well as its activities to train more private sector physicians to recognize Hansen's Disease and initiate treatment earlier, will help prevent further increases in the level of disability/deformity among Hansen's patients, maintaining the Grade 1 and Grade 2 levels of deformity at 50% in FY 2013. The Program's FY 2013 target for its research measure is to produce a relevant animal model for human leprosy. The Program will also continue to promote efficiency by targeting in FY 2013 cost per patient increases below the national medical inflation rate.

The FY 2013 funding will support the Program's continued coordination and collaboration with related Federal, State, local, and private programs to further leverage and promote efforts to improve quality of care, health outcomes, and research related to Hansen's Disease.

Areas of collaboration include a partnership with the Food and Drug Administration (FDA) Drug Shortage Program to distribute the clofazimine to over 500 providers nationally. At the request of the FDA, the Program has also agreed to manage the investigational new drug (IND) application that makes clofazimine available in the United States for treatment of leprosy.

The Program is the sole worldwide provider of reagent grade viable leprosy bacilli, and continues to collaborate with researchers worldwide to further the study of and scientific advances related to the disease. To support the program training initiative of increasing the awareness of leprosy in the U.S. the program has facilitated outpatient management of leprosy in the U.S. by providing to private sector physicians additional laboratory, diagnostic, consultation and referral services.

The Program continues to share its expertise in treatment of the Hansen's Disease insensitive foot to the more prevalent insensitive diabetic foot by providing multilingual training and education on the prevention and care of the diabetic insensitive foot.

[1] Disability/deformity is measured based on the World Health Organization scale, which ranges from 0-2. Patients graded at 0 have protective sensation and no visible deformities. Patients graded at 1 have loss of protective sensation and no visible deformity. Patients graded at 2 have visible deformities secondary to muscle paralysis and loss of protective sensation.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2011
3.E.: Maintain increases in the cost per patient served in the outpatient clinics to below the medical inflation rate (Efficiency)	FY 2010: 4.9% Target: Below national medical inflation rate 3.9% (Target not met)	Below national medical inflation rate	Below national medical inflation rate	Maintain
3.II.A.2.: Number of private sector physicians who have received training from the NHDP (Output)	FY 2010: 220 Target: 150 (Target Exceeded)	150	150	Maintain
3.II.A.3.: Number of patients provided Hansen's Disease outpatient care through the National Hansen's Disease Program (Output)	FY 2010: 3,117 Target: 3,000 (Target Exceeded)	3,000	3,000	Maintain
3.III.A.1.: Develop an animal model for the full spectrum of clinical complexities of human Hansen's Disease (Output)[2]	FY 2010: Defective nerve function demonstrated Target: Demonstrate defective nerve function in infected armadillos (Target Met)	Pursue the integration of BRM, CM, and molecular reagent breakthroughs	Produce relevant animal model for human leprosy	N/A
3.II.A.1.: Percent increases in the level of Hansen's Disease related disability and deformity among patients treated and managed by the National Hansen's Disease Program (NHDP) (Percentage of patients at grades 1 and 2)	FY 2009: 53% Target: 50% (Target Virtually Met)	50%	50%	Maintain

Program Outputs

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
NHDP Resident Population	18	15	15
NHDP Non-Residential Outpatients	180	177	177
Ambulatory Care Program (ACP) Clinics	13	13	13
ACP Clinic Patients (Outpatients)	3,000	3,000	3,000
ACP Clinic Patient Visits	16,000	16,000	16,000
NHDP Non-Residential Outpatient Visits	19, 308	19,000	19,000

National Hansen's Disease Program by Sub – Activity

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Administration	1,492,000	1,460,000	1,460,000
Clinical Care	5,743,000	5,743,000	5,743,000
Regional Centers	2,428,000	2,428,000	2,428,000
Research	2,562,000	2,562,000	2,562,000
Facility Operations	2,446,000	2,446,000	2,446,000
Assisted Living Allowance	1,406,000	1,406,000	1,406,000
Total	16,077,000	16,045,000	16,045,000

National Hansen's Disease Program – Buildings and Facilities

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$129,000	$127,000	$127,000	---
FTE	---	---	---	---

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

FY 2013 Authorization ..... indefinite

Allocation Method .....Direct Federal

Program Description and Accomplishments

This activity provides for the renovation and modernization of buildings at the Gillis W. Long Hansen's Disease Center at Carville, Louisiana to eliminate structural deficiencies under applicable laws in keeping with accepted standards of safety, comfort, human dignity, efficiency, and effectiveness. The projects are intended to assure that the facility provides a safe and functional environment for the delivery of patient care and training activities; and meets requirements to preserve the Carville historic district under the National Historic Preservation Act.

Funding History

FY	Amount
FY 2008	$157,000
FY 2009	$129,000
FY 2010	$129,000
FY 2011	$127,000
FY 2012	$127,000

Budget Request

The FY 2013 Budget Request is $127,000, equal to the FY 2012 Enacted level. The request is required for continued renovation and repair work on patient areas, to complete minor renovation work on the Carville museum, and to continue regular renovation and repair work on clinic areas and offices.

Outcomes and Outputs Tables

See National Hansen's Disease Program.

Payment to Hawaii

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$1,964,000	$1,960,000	$1,960,000	---
FTE	---	---	---	---

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

FY 2013 Authorization ..... indefinite

Allocation Method .....Direct Federal

Program Description and Accomplishments

Payments are made to the State of Hawaii for the medical care and treatment of persons with Hansen's Disease in its hospital and clinic facilities at Kalaupapa, Molokai, and Honolulu. Expenses above the level of the Federal funds appropriated for the support of medical care are borne by the State of Hawaii.

Funding History

FY	Amount
FY 2008	$1,961,000
FY 2009	$1,976,000
FY 2010	$1,976,000
FY 2011	$1,964,000
FY 2012	$1,960,000

Budget Request

The FY 2013 Budget Request is $1,960,000, which is equal to the FY 2012 enacted level.

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Average daily HD Kalaupapa patient load	19	19	19
Total Kalaupapa and Halemohalu patient hospital days	2,900	2,900	2,900
Total Kalaupapa homecare patient days	3,400	3,400	3,400
Total Hawaiian HD program outpatients	250	250	250
Total outpatient visits	5,600	5,600	5,600

Health Workforce Tab

Clinician Recruitment and Services

National Health Service Corps

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
NHSC Field BA	---	---	---	---
NHSC Recruitment BA	$24,848,000	---	---	---
NHSC - Mandatory	$290,000,000	$295,000,000	$300,000,000	+$5,000,000
Total NHSC	$314,848,000	$295,000,000	$300,000,000	+$5,000,000
Total FTE	190	237	237	---
Ready Responders (non-add)	23	23	23	---

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

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

FY 2013 Authorization $691,431,432

FY 2013 Authorization (ACA) $300,000,000

Allocation Method ..... Competitive Awards to Individuals

Program Description and Accomplishments

The National Health Service Corps (NHSC) offers assistance to underserved communities in every State, Territory, and Possession of the United States to recruit and retain qualified primary care providers. These communities, known as Health Professional Shortage Areas (HPSAs) provide primary medical, oral, and mental and behavioral health care to approximately 10.0 million underserved people. By the end of FY 2012, the NHSC expects that it will have offered recruitment incentives, in the form of scholarship and loan repayment support, to more than 40,000 health professionals committed to providing care to underserved communities over its 40 year history. NHSC clinicians have expanded access to high quality health services and improved the health of underserved people.

The NHSC has, since its inception in 1972, worked closely with the Federally-funded Health Centers to help meet their staffing needs. Currently, approximately 41 percent of the NHSC clinicians serve in Health Centers around the Nation. The NHSC also places clinicians in other

community-based systems of care that serve underserved populations, targeting HPSAs of greatest need.

The NHSC Scholarship Program provides financial support through scholarships, other reasonable education expenses, and a monthly living stipend to health professions students committed to providing primary care in underserved communities of greatest need. Awards are targeted to individuals who demonstrate characteristics that are indicative of probable success in a career in primary care in underserved communities. The Scholarship Program provides a predictable supply of clinicians who will be available over the next one to eight years, depending on the length of their training programs. Upon completion of training, NHSC scholars become salaried employees of organized systems of care in underserved communities.

The NHSC Loan Repayment Program offers fully-trained primary care clinicians the opportunity to receive assistance to pay off qualifying educational loans in exchange for service in a HPSA of greatest need. In exchange for a minimum of two years of service, loan repayers receive up to $60,000 in loan repayment assistance. The loan repayment program recruits clinicians as they complete training and are immediately available for service, as well as seasoned professionals seeking an opportunity to serve the Nation's most vulnerable populations.

The State Loan Repayment Program (SLRP) is a grant program which offers a dollar-for-dollar match between the State and the NHSC for loan repayment contracts to clinicians who practice in a HPSA in that State. The SLRP serves as a complement to the NHSC and provides flexibility to States to help meet their unique primary care workforce needs. In addition, the SLRP serves as a cost-efficient alternative to the NHSC, as the cost-per-clinician in SLRP is less given the matching requirement.

The combination of these programs allows flexibility in meeting the future needs (through scholars) and the immediate needs (through loan re-payers) of underserved communities. Tables 1 and 2 illustrate the number and type of primary care providers serving in the NHSC.

Table 1. NHSC Field Strength by Program as of 09/30/11

Programs	**No.**
Scholarship Program clinicians	499
Loan Repayment Program clinicians	9,194
Ready Responders	23
State Loan Repayment clinicians	563
Total	**10,279**

Table 2. NHSC Field Strength by Discipline as of 09/30/11

Disciplines	**No.**
Allopathic/Osteopathic physicians	2,431
Dentists	1,207
Dental Hygienists	242
Nurse Practitioners	1,751
Physician Assistants	1,402
Nurse Midwives	201
Mental and Behavioral Health professionals	3,045
Total	**10,279**

In FY 2011:

Base Funds*:*

- The NHSC Scholarship Program made 5 new awards.
- The NHSC Loan Repayment Program made 448 new awards.

ARRA Funds*:*

- The NHSC Scholarship Program made no new awards.
- The NHSC Loan Repayment Program made 1,053 new awards in FY 2011.

In FY 2011, the NHSC nearly tripled its Field Strength from 3,601 in FY 2008 to 10,279. The primary care needs of over 10.5 million patients were served through the placement and retention of the NHSC clinicians. The program has been as flexible as possible under the current law to allocate more funds to loan repayers to meet more of the immediate need in underserved communities, and is endeavoring to replace its legacy information system to further increase management efficiencies.

In FY 2012:

Base Funds*:*

- The NHSC Scholarship Program is projected to make no new or continuation awards.
- The NHSC Loan Repayment Program is projected to make no new or continuation awards.

ACA Funds*:*

- The ACA provides $295,000,000 for the NHSC. These funds are projected to be distributed as follows:
  - Field Line - $73.5 M Expenditures from the NHSC Field Line are used to directly support the NHSC Recruitment Line in the form of staffing, acquisition contracts, and other support activities.

- Scholarships - $38.3 M = 183 new awards and 20 continuations.
- Loan Repayment - $161.2 M = 1,551 new awards and 2,600 continuation awards.
- State Loan Repayment - $10.0 M = 285 awards
- Students to Service Loan Repayment - $12.0 M = 100 new awards

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

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

In total, the NHSC projects a decrease in its Field Strength in FY 2012 to nearly 9,200 clinicians, who will provide primary care to approximately 9.7 million underserved people.

In FY 2012 the NHSC has implemented the **Students to Service (S2S) Loan Repayment Program**. Under this program, allopathic and osteopathic medical students in their last year of school are eligible to receive loan repayment assistance in return for completing a primary care residency and working in rural and urban HPSAs of greatest need. Contract awards will be up to $120,000 in return for 3 years of full-time or 6 years of half-time service which will begin upon completion of the residency; it is anticipated that the majority of these clinicians will begin service in FY 2016. After the initial service period, physicians with additional eligible loans may apply for continuation awards in return for additional years of service.

In addition, the NHSC plans to implement an enhanced award structure in the Loan Repayment Program to encourage clinicians to seek placement in high-need HPSAs across the United States. Individuals who are employed in NHSC service sites with HPSA scores of 14 and higher will receive $60,000 for an initial two-year contract. Individuals working in HPSAs of 13 and below will be eligible for loan repayment of up to $40,000 for a two-year contract. This will allow the Corps to remain competitive with other loan repayment programs and help communities that have persistent workforce shortages. This new policy will also provide the NHSC with the opportunity to make additional awards since the structure is likely to reduce the average initial, two-year, loan repayment award amount to $55,000. In FY 2011, all LRP participants were eligible for an initial award of up to $60,000 for a two-year, full-time contract.

Funding History

FY	Amount
FY 2008	$123,477,000
FY 2009	$134,966,000
FY 2009 Recovery Act	$300,000,000
FY 2010	$141,420,000
FY 2011	$24,848,000
FY 2011 ACA	$290,000,000
FY 2012	---
FY 2012 ACA	$295,000,000

Budget Request

The FY 2013 Request of is unchanged from FY 2012 Enacted Level. In addition, the Affordable Care Act has appropriated $300,000,000 for the NHSC in FY 2013, which will fund 179 new scholarships, 15 scholarship continuations, 1,136 new loan repayment awards, 3,400 loan repayment continuations, 100 new Students to Service loan repayment awards, and 285 new State loan repayment awards. The total appropriation for the NHSC in FY 2013 will be $300,000,000, an increase of $ 5,000,000 above the FY 2012 level.

As a significant source of highly qualified, culturally competent clinicians for the Health Center Program, as well as other safety net providers, the NHSC can build on its success in assuring access to residents of HPSAs, removing barriers to care and improving the quality of care to these underserved populations. The NHSC Program is working with many communities in partnership with State, local, and National organizations to help address their health care needs.

Funding in FY 2013 for the NHSC Programs will support efforts to work with Health Centers and other community-based systems of care to improve the quality of care provided and reduce the health disparities gap. As measurement of these efforts:

In FY 2013:

Base Funds*:*

- The NHSC Scholarship Program is projected to make no new or continuation awards.
- The NHSC Loan Repayment Program is projected to make no new or continuation awards.

ACA Funds*:*

- The ACA provides $300,000,000 for the NHSC. These funds are projected to be distributed as follows:
  - Field Line - $74.3 M Expenditures from the NHSC Field Line are used to directly support the NHSC Recruitment Line in the form of staffing, acquisition contracts, and other support activities.
  - Scholarships - $39.1 M = 179 new awards and 15 continuations
  - Loan Repayment - $164.6 M = 1,136 new awards and 3,400 continuations
  - Students to Service Loan Repayment - $12.0 M = 100 new awards.

- State Loan Repayment - $10.0 M = 285 Awards

The NHSC Field Strength is projected to be 7,128 and will serve the primary care needs of over 7.48 million patients.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
4.I.C.1: Number of individuals served by NHSC clinicians *(Outcome)*	FY 2011: 10.5 Million[1] Target: 9.7 Million (Target Exceeded)	9.66 Million1[2,3]	7.48. Million[1,2]	-2.18 Million
4.I.C.2: Field strength of the NHSC through scholarship and loan repayment agreements. *(Outcome)*	FY 2011: 10,279 [1] Target: 9,203 (Target Exceeded)	9,193[1,2]	7,128[1,2]	- 1,591
4.I.C.4: Percent of NHSC clinicians retained in service to the underserved for at least one year beyond the completion of their NHSC service commitment. *(Outcome)*	FY 2010: 82% Target: 79% (Target Exceeded)	79%	80%	+1.0% point
4.E.1: Default rate of NHSC Scholarship and Loan Repayment Program participants. *(Efficiency)* (Baseline: FY 2007 = 0.8%)	FY 2010: 0.0% (Target Not in Place)	≤ 2.0%	≤ 2.0%	Maintain
4.I.C.6: Number of NHSC sites *(Outcome)*	FY 2011: 14,000 (Target Not in Place)	14,000	14,000	Maintain

Loans/Scholarships Table

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Loans	$24,848,000	-	-
State Loans	-	-	-
Scholarships	-	-	-
ARRA Loans	$56,700,000	-	-
ARRA State Loans	-	-	-

[1] Reflects American Recovery and Reinvestment funding.
[2] Reflects Affordable Care Act funding.
[3] Target changed to reflect revision of Measure.

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
ARRA Scholarships	-	-	-
ACA Loans	$172,544,830	$161,217,280	$164,556,800
ACA State Loans	$7,800,470	$10,000,000	$10,000,000
ACA Scholarships	$47,565,700	$38,304,320	$39,139,200
ACA Students to Service Loan Repayment	-	$12,000,000	$12,000,000

Waterfall Table

Table 3. Impact on NHSC Field Strength of FY 2013 Request Awards

Fiscal Year	2008	2009	2010	2011	2012	2013
AWARDS:						
Scholarship	76	88	25	5	-	-
Scholarship Continuation	18	8	5	1	-	-
Loan Repayment	867	949	1,335	448	-	-
Loan Repayment Continuation	668	705	701	-	-	-
State Loan Repayment	280	400	285	-	-	-
ARRA Scholarship	-	70	185	-	-	-
ARRA Loan Repayment	-	829	2,214	1,053	-	-
ARRA State Loan Repayment	-	-	161	171	-	-
ACA Scholarships	-	-	-	248	183	179
ACA Scholarship Continuation	-	-	-	8	20	15
ACA Loan Repayment	-	-	-	2,612	1,551	1,136
ACA Loan Repayment Continuation	-	-	-	1,305	2,600	3,400
ACA State Loan Repayment	-	-	-	223	285	285
ACA Students to Service Loan Repayment	-	-	-	-	100	100

Table 4. Impact on NHSC Field Strength of FY 2013 Request

Fiscal Year	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
FIELD STRENGTH:						
Scholars	598	582	523	495	485	394
Loan Repayers	2,451	2,597	3,201	2,010	448	-
State Loan Repayment	514	763	581	285	-	-
USPHS Commissioned Corps Ready Responders	37	37	30	23	23	23
Community Scholarship Clinicians	1	-	-	-	-	-
Base Field Strength (as of 9/30)	**3,601**	**3,979**	**4,335**	**2,813**	**956**	**417**
ARRA Loan Repayers		829	3,032	3,267	1,053	-
ARRA State Loan Repayment	-	-	161	278	171	-
ARRA Scholars		-	2	4	27	97
ARRA Field Strength	-	**829**	**3,195**	**3,549**	**1,251**	**97**
ACA Scholars		-	-	-	-	19
ACA Loan Repayment		-	-	3,917	6,763	6,087
ACA State Loan Repayment	-	-	-	-	223	508
ACA Field Strength	-	-	-	**3,917**	**6,986**	**6,614**
Total Field Strength	**3,601**	**4,808**	**7,530**	**10,279**	**9,193**	**7,128**
Placements:						
Grant	1,944	2,149	1,777	1,407	478	209
Non-Grant	1,657	1,830	2,558	1,406	478	208
ARRA Grant	-	448	1,310	1,775	627	49
ARRA Non-Grant	-	381	1,885	1,774	624	48
ACA Fund Grant	-	-	-	1,959	3,493	3,307
ACA Non-Grant	-	-	-	1,958	3,493	3,307

Nursing Education Loan Repayment and Scholarship Programs

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$93,292,000	$83,135,000	$83,135,000	---
FTE	29	29	29	---

Authorizing Legislation: Section 846 of the Public Health Service Act

FY 2013 Authorization ..... Expired

Allocation Method .....Competitive Awards to Individuals

Program Description and Accomplishments

The Nursing Education Loan Repayment Program (NELRP) is a financial incentive program under which individual registered nurses (RNs) and advanced practice RNs (APRNs) such as nurse practitioners (NPs) enter into a contractual agreement with the Federal government to work full-time in a health care facility with a critical shortage of nurses, also known as a critical shortage facility, in return for repayment of qualifying nursing educational loans. NELRP repays 60 percent of the principal and interest on nursing education loans of RNs and APRNs such as NPs with the greatest financial need in exchange for two years of full-time service at a health care facility with a critical shortage of nurses. Participants may be eligible to receive an additional 25 percent of the original loan balance for an additional year of full-time service in a critical shortage facility. A funding preference is given to those with the greatest financial need.

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

The Nursing Scholarship Program (NSP) offers scholarships to individuals attending accredited schools of nursing in exchange for a service commitment payback of at least two years in health care facilities with a critical shortage of nurses after graduation. The NSP award reduces the financial barrier to nursing education for all levels of professional nursing students, thus increasing the pipeline. A funding preference is given to qualified applicants who have zero expected family contribution and who are enrolled full-time in an undergraduate nursing program.

NELRP and NSP work together in an effort to address the need for nurses in Critical Shortage Facilities. The programs receive assistance in application processing and scholar and clinician support through its contracts.

As measurements of that effort:

In FY 2011:

- NELRP made 919 new loan repayment awards and 385 continuation awards.
- NSP made 395 scholarship awards and 17 continuation awards.
- The average new NELRP award was $50,316. The average NELRP continuation was $23,675.
- The average new NSP award was $67,744. The average NSP continuation was $20,848.

In FY 2011, 46 percent of NELRP participants who initially received awards in FY 2009 came in for a continuation and committed to work at a critical shortage facility for an additional year. In addition, 74 percent of NSP awards were given to students obtaining their baccalaureate degree.

In FY 2012:

- NELRP expects to make 749 new loan repayment awards and 445 continuation awards.
- NSP expects to make 347 scholarship awards.

To increase the number of NPs participating in the program, the NELRP and NSP will actively recruit NPs through outreach efforts to colleges, universities and associations. In FY 2012, 50% of the NELRP and NSP funding will be targeted to support NPs.

To contribute to program performance, NELRP and NSP have finalized the methodology for identifying Critical Shortage Facilities (CSFs) for nurses, in order to better target program resources to areas and facilities of greatest need. Beginning in FY 2012, CSFs will be defined to be a health care facility located in, designated as, or serving a primary medical care or mental health Health Professional Shortage Area.

Funding History

FY	Amount
FY 2008	$30,512,000
FY 2009	$37,128,000
FY 2009 Recovery Act	$27,000,000
FY 2010	$93,864,000
FY 2011	$93,292,000
FY 2012	$83,135,000

Budget Request

The FY 2013 Budget Request of $83,135,000 is equal to the FY 2012 Enacted Level.
There is a shortage of nurses, including advanced practice registered nurses, such as NPs, at health facilities in certain areas of the United States. The demand has intensified for nurses

prepared in programs that emphasize leadership, patient education, case management, and care across a variety of delivery settings. National and State studies, including the HRSA's *Findings from the National Sample Survey of Registered Nurses - March 2008* demonstrate that the aging nursing workforce could reduce the supply of RNs in the future. Further, as the demand for primary health care services continues to grow, NPs play a critical role in offering these services, as evidenced by many States expanding the role of these providers in recent years. Both the NELRP and the NSP are part of the National strategy to alleviate the immediate shortfall in the number of working nurses and to assure an adequate supply of nurses in the future.

Funding for NELRP and NSP will continue to address the areas with a critical shortage of nurses across the U.S. As a measurement of that effort:

In FY 2013, the proportion of NELRP participants who come in for a continuation and commit to work at a critical shortage facility for an additional year is projected to be 52%. The proportion of NSP awardees obtaining their baccalaureate degree is projected to be 80%.

In FY 2013:

- NELRP expects to make 779 new loan repayment awards and 385 continuation awards.
- NSP expects to make 347 scholarship awards.

The NELRP and the NSP are authorized under Section 846 of the Public Health Service Act [42 USC 297n] to work in partnership with other HHS programs to encourage more people to consider nursing careers and motivate them to serve in areas of critical shortage. The Performance measures gauge these programs' contribution to the HRSA strategic goals of improving access to health care and improving the health care systems through the recruitment and retention of nurses working in Critical Shortage Facilities. Increasing the number of nurses at facilities with a critical shortage of nurses will be a key output.

The BCRS has implemented a new information management system which currently allows the NSP application process to be accessible online and automate interactions with program participants via the internet. NELRP applications will also be accessible and processed with the new information management system in FY 2012.

The NELRP and NSP programs funds the BCRS Management Information System Support (BMISS) Investment. BMISS is a large scale multiyear IT modernization effort that has replaced dozens of legacy systems and tools for HRSA/BCRS. BMISS supports the strategic and performance outcomes of the Program and contribute to its success by establishing a single, scalable and flexible technical architecture, improving data quality and access to the data, enabling effective case management and improving process visibility and self service functionality.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
5.I.C.4: Proportion of NELRP participants who extend their service contracts to commit to work at a critical shortage facility for an additional year. *(Outcome)*	FY 2011: 46% Target:: 50% (Target Not Met)	50%	52%	+2% points
5.IC.5: Proportion of NELRP/NSP participants retained in service at a critical shortage facility for at least one year beyond the completion of their NELRP/NSP commitment. *(Developmental- baseline to be established by September 2012)*	N/A	N/A	TBD	N/A
5.I.C.6: Proportion of NSP awardees obtaining their baccalaureate degree. *(Outcome)*	FY 2011: 74% Target: 75% (Target Not Met)	75%	80%	+5% points
5.E.1: Default rate of NELRP and NSP participants. *(Efficiency)*	NELRP FY 2011: 3.4% Target: 3.5% (Target Exceeded)	NELRP: 3.5% NSP: 17%	NELRP: 3% NSP: 15%	NELRP: -0.5% point NSP: -2.0% points

Loans/Scholarships Table

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Loans	$57,458,892	$50,989,467	$50,989,467
Scholarships	$28,125,272	$25,494,733	$25,494,733

Faculty Loan Repayment Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$1,258,000	$1,243,000	$1,243,000	---
FTE	---	---	---	---

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

FY 2013 Authorization ..... Expired

Allocation Method ..... Competitive Awards to Individuals

Program Description and Accomplishments

The Faculty Loan Repayment Program (FLRP) is a loan repayment program for health profession graduates from disadvantaged backgrounds who serve as faculty at an eligible health professions college or university for a minimum of two years. In return, the Federal Government agrees to pay up to $20,000 of the outstanding principal and interest on the individual's health professions education loans for each year of service. The employing institution must also make payments to the faculty member equal to the principal and interest amount made by the HHS Secretary for each year in which the recipient serves as a faculty member. The Secretary may waive the institution's matching requirements if the Secretary determines it will impose an undue financial hardship. The OIG found in 2002 that institutions participating in the faculty loan repayment program frequently receive full or partial waivers of the matching requirements, reducing the impact per Federal investment.

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

In FY 2011:
The FLRP program made 20 new loan repayment awards.

In FY 2012:
The FLRP program is expected to make 20 new loan repayment awards.

In FY 2013:
The FLRP program is expected to make 20 new loan repayment awards.

Funding History

FY	Amount
FY 2008	$1,266,000
FY 2009	$1,266,000
FY 2009 Recovery Act	$1,200,000
FY 2010	$1,266,000
FY 2011	$1,258,000
FY 2012	$1,243,000

Budget Request

The FY 2013 Budget Request of $1,243,000 is equal to the FY 2012 Enacted Level. The program expects to make an estimated 20 new awards under the FY 2013 Budget Request to health profession graduates from disadvantaged backgrounds who serve as faculty at an eligible health professions college or university.

Loans Table

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Loans	$1,165,794	$1,130,000	$1,130,000

Pediatric Specialty Loan Repayment Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	---	---	$5,000,000	+ $5,000,000
FTE	---	---	---	---

Authorizing Legislation: Sections 775 of the Public Health Service Act, as amended by P.L. 111-148.

FY 2013 Authorization $50,000,000
Allocation Method .....Competitive Awards to Individuals

Program Description

The Pediatric Specialty Loan Repayment Program (PLRP) was created in the Affordable Care Act (Sec. 5203) to provide loan repayment to individuals in return for delivering pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care, including substance abuse prevention and treatment services, in an area with a shortage of the specified pediatric subspecialty that has a sufficient pediatric population to support such pediatric subspecialty. Maximum loan repayment award is $ 35,000 per year with a minimum length of service of 2 years and a maximum of 3 years participation in the program; service may be in either a HPSA or medically underserved area/population (MUA/P). Funding priorities are to be given to applicants who ''(1) are or will be working in a school or other pre-kindergarten, elementary, or secondary education setting; (2) have familiarity with evidence-based methods and cultural and linguistic competence health care services; and (3) demonstrate financial need."

Funding History

This is the first year that funding has been requested for this Program.

Budget Request

The FY 2013 Budget Request is the first to fund this Program. Research has indicated that there is a significant shortage of pediatric subspecialists, resulting in children with serious illnesses being forced to travel long distances – or wait for several months – to see a pediatric specialist. In order to strengthen the pediatric workforce, the FY 2013 budget provides $5 million for the Pediatric Loan Repayment Program (PLRP).

The PLRP anticipates making 64 initial 2-year awards in FY 2013, without projecting the distribution of awards across the eligible specialties in this first year of implementation. The PLRP will evaluate the interest generated in this Program from both the eligible disciplines and the underserved communities in an effort to establish guidelines for making awards in future years.

Health Professions

The Bureau of Health Professions (BHPr) programs support the training and development of health professionals (particularly primary care providers) to improve the health care of our Nation's communities and vulnerable populations. The BHPr programs award grants to health professions schools and training programs across the United States to develop, expand and enhance training and to strengthen the distribution of the health care workforce. These programs serve as a catalyst to advance changes in health professions training responsive to the evolving needs of the health care system.

In addition, the BHPr provides a number of services including identification of geographic shortage designations, the development and analysis of important health workforce studies, and the maintenance of a database intended to facilitate a review of health professionals' credentials.

Summary of Request

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$673,718,000	$641,306,000	$432,809,000	- $208,497,000
Evaluation Funds	---	---	$35,000,000	+$35,000,000
Mandatory (ACA)	$230,000,000	---	---	---
Prevention/Public Health Fund	$20,000,000	$35,000,000	$10,000,000	-$25,000,000
Total Program Level	$923,718,000	$676,306,000	$477,809,000	-$198,497,000
FTE	116	113	100	-13

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

Allocation Method .....Competitive Grants/Contracts

State of the Health Professions Workforce

Shortages in the health care workforce are expected to worsen with the increased needs of a growing and aging population, along with the retirement of current providers. Access to health care services for rural and certain inner-city populations is an additional concern.

There are health workforce shortages in many States across many disciplines. The distribution of primary care providers is a particular concern. As new models of care, new technologies and

updated efficiencies are put into place as part of an evolving health care system, a well trained, strategically deployed workforce will be required to deliver services. There will be a greater need for workforce planning that involves understanding and anticipating trends through data collection, analysis and dissemination, and preparation of the workforce pipeline to accommodate anticipated needs.

Numerous factors will influence the number and types of health professionals needed in the workforce. The changes brought about by the Affordable Care Act, including expansions in insurance coverage, will certainly increase the demand for health professionals in future years. Attention to the primary care workforce, is a key component of the Affordable Care Act.

The emphasis on primary care is supported by ample research that the Nation's over reliance on specialty care services at the expense of primary care leads to a health care system that is less efficient and more costly.[1] A variety of factors, including subspecialty salaries and high student debt, have affected the practice choices of physicians, creating market forces that favor sub-specialization over primary care.

If the health care system is to meet the growing demand for health care, it will need to train and use an efficient mix of providers. The health care system must support an educational pipeline of sufficient size coupled with a delivery system that efficiently deploys health care workers with varied capabilities to work effectively in teams. Ensuring the skill set and division of labor is optimally applied requires fully engaging each health care team member in collaborative models of coordinated care. The health care system must also encourage State regulations and reimbursement policies that support health professionals working at the top of their education and license.

Primary Care Clinician Supply

Most leading authorities recognize that there will be a shortage of primary care providers over the next decade. Depending on the models employed, there are varying estimates regarding the number and the appropriate ratio of the three professions that provide the vast majority of primary care visits: primary care physicians, advanced practice nurses (including nurse practitioners and certified nurse midwives) and physician assistants. The Health Resources and Services Administration (HRSA) is working closely with States, academic institutions, professional organizations, other Federal agencies, and key stakeholders to build capacity to address current and anticipated shortages of doctors, nurses, and other providers in the health professions workforce.

The HRSA has invested in the production of new primary care providers, including physicians, nurse practitioners (NPs), certified nurse midwives (CNMs), and physician assistants (PAs) through programs authorized by Titles VII and VIII of the Public Health Service Act. The NPs, CNMs, and PAs may play an increasingly important role in service delivery as more of these practitioners enter the workforce. The NPs, CNMs, and PAs have demonstrated flexibility as

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

they practice independently or partner with physicians in both primary care and specialty areas. Greater use of these providers has the potential to improve access, reduce expenditures, and change patterns of care.[2]

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

Primary Care Clinician Distribution

Although primary care clinician shortages affect the entire Nation, the most severe impact is felt in those parts of the country that are currently experiencing shortages of health care providers. Primary care providers, particularly physicians, tend to practice in areas where supply is already high, leaving many areas of the country experiencing shortages of health professionals. As of December 14, 2011, approximately 58.4 million Americans were living in rural or inner-city locations designated as primary care health professional shortage areas.[3] Without attention shortages in certain parts of our Nation and among certain populations are likely to worsen.

Major Issues of Focus for BHPr in 2013

Given the demands on the health care system described above, HRSA has identified certain strategies that can be employed to strengthen the health professions workforce and improve the delivery of health care. These strategies are designed to:

1) Increase capacity and improve distribution of the primary care workforce through enhanced education and training opportunities;
2) Support innovations in health professions training that include team-based models of care founded on interprofessional education and clinical training experiences;
3) Reduce health disparities by increasing health care workforce diversity;
4) Enhance geriatric/elder care training and expertise; and,
5) Continue development of the National Center for Health Care Workforce Analysis to improve data collection to inform policy makers and other stakeholders on health workforce issues.

The Affordable Care Act directed the BHPr to be a part of a national effort to increase the supply of the health care workforce and enhance training opportunities to improve access to care for a Nation with diverse and complex needs. Ensuring a diverse and adequate health care workforce equipped to implement innovative care models requires stronger educational and training opportunities. Through its programs, BHPr will encourage low income, rural, and minority students to pursue health careers. Strategies to address these priorities will lead to a re-shaping of BHPr programs to strengthen alignment and accountability.

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

[3] *Shortage Designation: Health Professional Shortage Areas and Medically Underserved Areas and Populations.* Date Retrieved: Jan. 12, 2012. Web Site: http://bhpr.hrsa.gov/shortage/.

Priority #1: Increase capacity and improve distribution of the primary care workforce supply through enhanced education and training opportunities

The FY 2013 Request builds on the effort that began in 2010 and proposes additional investments that when sustained over five years (FYs 2013-2017) will increase the primary care workforce by 2,800 primary care providers (1400 primary care PAs, and 1400 advanced practice RNs). Resources were shifted from other program areas to meet this goal. The Administration's efforts to increase the number of primary care providers were initiated in FY 2010 with funds from the Affordable Care Act's Prevention and Public Health Fund. The FY 2013 Request proposes to use similar strategies as in FY 2010 to expand training capacity, so that more primary care providers can complete their training and enter service to improve access to primary health care. Strategies implemented to increase the number of primary care providers include:

- Funding to support primary care residencies designed to grow the primary care workforce;
- Funding community-based ambulatory care facilities to establish primary care residency programs;
- Supporting opportunities for training in underserved areas;
- Funding to expand clinical training capacity for physician assistants to increase enrollment capacity;
- Funding schools of nursing to educate additional primary care nurse practitioners and certified nurse midwives by providing student traineeships; and
- Restructuring the Scholarships for Disadvantaged Students and the Advanced Nursing Education Traineeship programs giving greater focus to primary care.

Many BHPr programs focus on both capacity and workforce redistribution. Key workforce programs that are helping improve capacity and distribution are:

1) Primary Care Training and Enhancement
2) Oral Health Training
3) Teaching Health Centers –Graduate Medical Education Program
4) Children's Hospital Graduate Medical Education Program
5) Nursing Workforce Development

Priority #2: Foster innovations in health professions training

The steady production of primary care providers alone will not ensure that the nation has access to high quality health care. The BHPr is investing in curricular and program innovations that will develop a health professions workforce proficient in team-based practice, care management, and community-focused care. While many agree that interprofessional team-based primary care offers the most effective model for delivering primary care, it has yet to diffuse into mainstream clinical practice.

Key BHPr programs have a long history of supporting interprofessional education and teamwork. For example, the Nurse Education, Practice, Quality and Retention Program supports

projects to develop and disseminate interprofessional and collaborative practice models. Likewise, Title VII, Part D of the PHS Act, focuses on Interdisciplinary Community-Based Linkages. Part D programs include the Geriatric Education Centers Program which requires funding recipients to provide interdisciplinary/interprofessional training.

Other investments and strategies to promote training innovation include:

- In 2011 a BHPr collaboration engaged foundations, other Federal agencies, and health care professional organizations to develop interprofessional team based competencies to be used in health professions education and practice. This collaborative is committed to educating and advancing interprofessional health care teams that are prepared to provide patient-centered care in new delivery system models that improve care coordination, quality and safety of care as well as affordability;
- Emphasizing interprofessional training and community-based training in primary care physician training programs and nursing training programs; and,
- Improving evaluation and performance measures to better track outputs, outcomes, and training effectiveness.

Priority #3: Reduce health disparities by increasing health care workforce diversity

Disparities in health and health care in the United States are persistent and well documented. A report by the Institute of Medicine, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*[4] illustrates that patients of color receive a lower quality of care and are less likely to receive routine care. HRSA continues a strong focus on reducing disparities in the workforce. Increasing the diversity of the health professions workforce is one key to reducing health disparities due to socioeconomic, geographic, race, and ethnicity factors, as research demonstrates that health professionals who identify as racial/ethnic minorities are more likely to serve in areas of need. Increasing cultural competency training of all health professionals to identify and address health care disparities is another key strategy being implemented.

The BHPr has increasingly focused on diversity across all program areas. The BHPr also administers several programs specifically designed to increase the diversity of the health care workforce and increase cultural competency among health care workers. These programs include:

1) Centers of Excellence
2) Scholarships for Disadvantaged Students
3) Nursing Workforce Diversity

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

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

The population of United States aged 65 and older is projected to grow by more than 14 million between 2010 and 2020, a 36 percent increase.[5] Those aged 65 and older made about twice as many visits to physician offices as their younger counterparts; just under half of these visits were to primary care physicians.[6] These data emphasize the growing demand for a health workforce that is sufficiently prepared to meet the specialized needs of an aging population. The BHPr supports four programs whose primary goal is to improve access to quality health care for America's elderly by educating both students and current practitioners in the care of the geriatric patient. Sustained funding for these programs is critical to updating both students and practitioners with new knowledge that is rapidly increasing regarding this population. The BHPr's geriatric programs emphasize interprofessional training, as care for geriatric patients must be coordinated among a wide range of providers who address various needs. These programs address both supply and education of geriatric specialists, while also increasing geriatrics competencies among the generalist workforce through education and training.

Key programs that will help BHPr increase the strength and quality of the geriatric workforce are:

1) Comprehensive Geriatric Education (for nurses)
2) Geriatric Education Centers
3) Geriatric Training for Physicians, Dentists, and Behavioral and Mental Health Professionals
4) Geriatric Academic Career Awards

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

Given the central role of the health workforce in assuring access to care in a more effective health care system, the Nation needs to be able to assess and determine whether current production of health workers is likely to be sufficient to meet expected needs. The HRSA will track current and future workforce needs and the production of providers to serve as a resource to the Nation. While the National Center is assessing needs across all of the health professions, special attention is being given to the important role of the primary care workforce in a more effective health care system. The National Center, created by the Affordable Care Act, has developed systems to track primary care workforce supply and distribution. The National Center will also support research on factors most likely to influence the future supply, demand and distribution as well as the effectiveness of alternative strategies for more efficient and effective primary care. This data and knowledge are needed to guide policy development and inform investments.

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

[5] U.S. Census Bureau, Population Division. (2008). Table 2. Projections of the Population by Selected Age Groups and Sex for the United States: 2010 to 2050 retrieved April 13, 2011 from http://www.census.gov/population/www/projections/files/nation/summary/np2008-t2.xls

[6] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. (2010). "Population Aging and the Use of Office-based Physician Services" retrieved April 13, 2011 from http://www.cdc.gov/nchs/data/databriefs/db41.htm

- Improve health workforce data management, data analysis, modeling and projections to support analysis and decision making as well as evaluation of the effectiveness of workforce programs and policies;
- Support implementation of a minimum data set (MDS) for health professionals and technical assistance and guidance to States and professional associations on the use of the MDS;
- Collaborate on Federal inter-agency workforce data collection, data warehousing, and data sharing;
- Support health workforce data analysis and research to support improved assessment of priority workforce needs; and
- Increase data and information distribution of health workforce data and information to decision makers in the public and private sector to support policies and investments to meet health workforce needs.

Workforce decision making is a shared Federal and State responsibility. The National Center will work closely with and share data and information to support effective State decision making.

Evaluation of Program Activities

Evaluation identifies programs that promote the BHPr mission of enhancing the supply of quality trained health professionals integral to increasing access to care for the Nation's population and meeting health care needs. It is a driving force for developing effective workforce and training strategies, improving existing programs, and demonstrating the results of resource investments. Evaluation also focuses attention on the common purpose of the BHPr programs and asks whether the magnitude of investment matches the tasks to be accomplished. The Health Care Workforce Assessment Program is responsible for the development, maintenance, and collection of annual performance measures from BHPr grantees, as well as the conduct of longitudinal evaluations. The BHPr monitors progress towards meeting this mission through the use of a number of performance measures.

Ongoing performance data collected by HRSA on its programs include: (a) the number of trainees and graduates in fields such as primary care, general and pediatric dentistry, nursing, and geriatrics, along with the number and percentage of those receiving clinical training in medically underserved areas; (b) the number and percentage of trainees who are underrepresented minority and disadvantaged students; and (c) the percentage of graduates and residents who are practicing in underserved areas one year following completion of their education. Collection of this data is on-going. Some of the performance measures are included in the Outcomes and Outputs table below.

Improving evaluation measures is also an ongoing effort as the practice of evaluation evolves with new definitions, methods, and approaches. New data measures have been developed and include: (a) proportion of BHPr funded students receiving training in primary care. This measure will assess the Bureau's goal to support a larger primary care workforce; (b) the number of professionals trained in geriatric care, which aligns with the need to respond to the Nation's growing elderly population; and, (c) proportion of trainees receiving preparation in team-based models of care from interprofessional education. Development of longitudinal program

measures is underway and will enable BHPr to assess program impact by tracking the students participating in BHPr programs, graduating and how many enter into, as well as, remain in practice in primary care and/or in underserved areas. The BHPr is building capacity to monitor the state of the health professions workforce and evaluate the Bureau's programs in achieving its mission.

Program Accomplishments

The number of graduates and program completers of Titles VII and VIII programs who are underrepresented minorities has increased since 2007. With the increase in the number of underrepresented minorities, the percentage of underrepresented minorities and/or disadvantaged graduates was 53 percent in FY 2008 and FY 2009 and 58% in FY 2010. The portion of all trainees in Titles VII and VIII programs that received training in medically underserved areas increased to 52% for FY 2010 which is up from 37 percent in FY 2007. From FY 2007 to 2008, programs that monitor students who are out of the HRSA funded programs for one year showed a four percentage point increase in the health professionals who enter practice in underserved areas, increasing from 43 percent in FY 2007 to 47 percent in FY 2008. In FY 2009, 43% of professionals supported by the HRSA programs entered practice in underserved areas.

Veterans Initiatives

Many Veterans received training as health care providers during their deployments to Iraq and Afghanistan. The BHPr is committed to helping veterans translate their health care skills learned during enlistment into health professions jobs on the home front. The Division of Nursing in HRSA's BHPr provided funding for a nursing school to work with key military leadership to identify strategies to align enlisted health care training and academic nursing training. The BHPr also made it easier for veterans to become physician assistants by giving funding priorities to universities and colleges that support veterans.

IT Investments

The specific BHPr funding for the HRSA OIT – Electronic Handbooks Investment listed below supports the development and ongoing maintenance of system functionality that supports BHPr program management functions. The functionality includes the collection of data from applicants that is used in the peer review process; the establishment of output and outcome targets by new grantees; and the collection of annual performance data (including outputs and outcomes) from grantees. It also provides internal reports for program management and analytic functionality for ad-hoc reports and evaluation studies. More generally, BHPr provides funding for the HRSA Electronic Handbooks (EHBs) as the HRSA enterprise system that supports BHPr in the areas of program administration, grants administration and monitoring, and management reporting.

Funding History

FY	Amount
FY 2008	$318,225,000
FY 2009	$354,332,000
FY 2009 Recovery Act	$170,813,000
FY 2010	$723,494,000
FY 2010 Prevention Fund	$265,400,000
FY 2011	$673,718,000
FY 2011 (ACA)	$230,000,000
FY 2011 Prevention Fund	$20,000,000
FY 2012	$641,306,000
FY 2012 Prevention Fund	$35,000,000

Budget Request

The FY 2013 Budget Request of $ 477,809,000 is a decrease of $198,497,000 below the FY 2012 Enacted level. The FY 2013 request includes funding to support an initiative that with sustained investments will train 2,800 additional primary care providers over five years (FYs 2013-2017). The FY 2013 request does not provide funding for the Health Careers Opportunity Program, the Area Health Education Centers Program, the Patient Navigator Outreach and Chronic Disease Prevention Program, or the Chiropractic Demonstration Grants Program. In some cases, the request also limits new Title VII and VIII grants due to noncompeting continuation award funding requirements. The resource shifts within the health professions programs help sustain the priority investment goals of increasing the capacity and diversity of the primary care workforce and training innovations including interprofessional education.

Outputs and Outcomes Table

Measure	Year and Most Recent Result[7]/ Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
6.I.B.1: Proportion of graduates and program completers of Title VII and VIII supported programs who are underrepresented minorities and/or from disadvantaged backgrounds.[8]	58% Target: 53% (Target Exceeded)	53%[9]	52%	-1% point

[7] Most recent result is for Academic Year 2010-2011 and funded in FY 2010, excluding measure 6.I.C.2.
[8] Recovery Act Funds will impact total numbers, but will not change the proportions targeted for each measure.
[9] This figure differs from the FY 2012 Congressional Justification to better reflect realistic projections based on trend data.

Measure	Year and Most Recent Result[7]/ Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
6.I.C.1: Proportion of trainees in Title VII and VIII supported programs training in medically underserved communities.[8]	52% Target: 54% (Target Not Met)	45%[9]	44%	-1% point
6. I.C.2: Percentage of health professionals supported by the program who enter practice in underserved areas.[8, 10] *(HHS OPPR)*	43% Target: 35% (Target Exceeded)	43%[9]	43%	Maintain

[10] Service location data are collected on students who have been out of the HRSA program for 1 year. The results are from programs that have ability to produce clinicians with one-year post program graduation. Results are from academic year 2009 - 2010

Proposed Allocation from the Prevention and Public Health Funding (PPHF)

Activities to be Completed and Objectives to be Attained:
The Prevention and Public Health Fund (PPHF) supports the following programs:
The PPHF supports the *Public Health Training Centers (PHTC) Program* which focuses on preparing the current and future public health workforce with the goals of strengthening the public health infrastructure throughout the United States and its territories, expanding the capacity of the PHTCs to provide continuing education for the current and future public health workforce, and providing support for field placements for students in public health agencies serving medically underserved communities.

In FY 2012, the PPHF supports the *Integrative Medicine Residency (IMR) Program* which provides grants to accredited medical residency programs to incorporate competency-based integrative medicine curricula in graduate medical education; and a *National Coordinating Center (NCC)* which collects data, provides technical assistance, and evaluates the IMR training.

Level of Funding Allocated from the PPHF for Each Activity in FY 2011, Planned in FY 2012, and Proposed in FY 2013.
In FY 2011, there were 37 PHTC grantees: 32 grantees received $20M from the PPHF and five grantees received $4.189M from the regular appropriations.
In FY 2012, 37 PHTC grantees are planned: 33 grantees will be supported with $21.498M from the PPHF and four grantees with $2.691M from the regular appropriation; $3.502M will support grantees from the IMR Program and a NCC.
In FY 2013 President's budget, 37 PHTC grantees are proposed with $10M in support from the PPHF and $4.189M from the regular appropriation.

Response to the Purpose of the ACA and the PPHF
These activities respond to the purpose of the ACA and the PPHF by providing a sustained investment in prevention and public health programs. In FY 2013, the PHTCs will continue to collaborate with partners to assess health workforce development needs and develop continuing education sessions designed to meet the public health workforce development needs.

Funding Mechanism: The PHTCs will be funded by cooperative agreement; The IMR will be funded by competitive grant; and, the NCC will be funded by contract.

Method of Selection: Selection will be made by competitive grant process and a HRSA technical review committee for the NCC contract.

Intended Award Recipients: PHTC Program – accredited schools of public health or another public or nonprofit private institution accredited for the provision of graduate or specialized training in public health; IMR Program – accredited residency programs; and, NCC – entities with expertise in interprofessional education and practice, integrative medicine, evaluation, and data collection.

Health Professions and Diversity

Increasing the number of minority health professionals is a key strategy to help eliminate health disparities. In 2011, the U.S. Department of Health and Human Services (HHS) launched the **National Partnership for Action to End Health Disparities** to improve nationwide coordination of strategies to eliminate health disparities and achieve health equity. Consistent with HRSA's commitment to this action plan, BHPr enhanced its focus on increasing the diversity and cultural competency of health professionals and on assessing the impact of its programs on increasing the number of underrepresented minority health professionals.

The HHS action plan defines health disparities as, "differences in health outcomes that are closely linked with social, economic, and environmental disadvantage —often driven by the social conditions in which individuals live." Compared to whites, minority populations have less access to health care, receive lower-quality health care, and experience higher rates of chronic disease, higher mortality, and poorer health outcomes.

Evidence suggests that minority health professionals are more likely to serve in areas with a high proportion of uninsured and underrepresented racial and ethnic groups. Greater diversity among health professionals is also associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better patient-clinician communication. [1] Although underrepresented minorities (URMs) comprise more than 25 percent of the U.S. population and are projected by the Census Bureau to increase to 39 percent by 2050, URMs account for only approximately 10 percent of the physician workforce. URMs are only about 7 percent of the nursing professions, 7 percent of dentistry, and 7 percent of psychology health professions. Further, in 2008, African Americans represented 12 percent of the U.S. population, but only 3.5 percent of U.S. physicians.[2] Similarly, Hispanics/Latinos made up 15 percent of the U.S. population, yet comprised 4.9 percent of physicians.[3] The number of African American, Hispanic, and Native American students in dental schools remains disproportionately low compared to their numbers in the U.S. population.

The BHPr has increasingly focused on diversity across all program areas in addition to having several programs such as the Nursing Workforce Diversity Program, the Centers of Excellence Program, and the Scholarships for Disadvantaged Students Program specifically designed to increase diversity among health professionals. The BHPr employs strategies such as recruiting racially and ethnically diverse students and supporting cultural competency training.

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

Health Professions Training for Diversity

Centers of Excellence

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$24,452,000	$22,909,000	$22,909,000	---
FTE	1	1	1	---

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

FY 2013 Authorization $50,000,000

Allocation Method .....Competitive Grant/Contract

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

Need: Please see previous section titled "Health Professions and Diversity."

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

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

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

Program Accomplishments: In Academic Year 2010-2011, 18 COE grantees provided academic enrichment training to 3,579 URM students in health professions programs and 171 URM faculty.

Funding History

FY	Amount
FY 2008	$12,773,000
FY 2009	$20,602,000[1]
FY 2009 Recovery Act	$ 4,924,000
FY 2010	$24,550,000
FY 2011	$24,452,000
FY 2012	$22,909,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES), and HRSA's electronic handbook, and program oversight activities.

Budget Request

The FY 2013 Budget Request of $22,909,000 is the same as the FY 2012 Enacted Level. The total request will support competitive grants and will continue to provide support to the health professions schools to facilitate faculty and student research on health issues particularly affecting URM groups, strengthen programs to enhance the academic performance of URM students attending the school, and promote faculty development in various areas such as diversity and cultural competency.

[1] Regular Appropriation Only

Outcomes and Outputs Table

Measure	Year and Most Recent Result[2]/ Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Number of URM students participating in research on minority health issues	631 Target: 573 (Target exceeded)	536	536	Maintain
Number of URM faculty participating in research on minority health issues	355 Target: 345 (Target exceeded)	323	323	Maintain

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	18	19	19
Average Award	$1,313,300	$1,205,736	$1,205,736
Range of Awards	$417,800-$4,913,500	$700,000 - $4,913,500	$700,000 - $4,913,500

[2] Most recent result is for Academic Year 2010-2011 and funded in FY 2010.

Health Professions Training for Diversity

Scholarships for Disadvantaged Students

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$49,042,000	$47,452,000	$47,452,000	---
FTE	3	3	3	---

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

FY 2013 Authorization ..... Unspecified

Allocation Method .....Competitive Grant

Program Description: The Scholarships for Disadvantaged Students (SDS) Program increases diversity in the health professions and nursing workforce by providing grants to eligible health professions and nursing schools for use in awarding scholarships to students from disadvantaged backgrounds with financial need, many of whom are underrepresented minorities (URMs).

Need: Please see previous "Health Professions and Diversity" section.

Goal: The SDS program aims to increase: 1) the number of graduates practicing in primary care, 2) enrollment and retention of URMs and 3) the number of graduates working in medically underserved communities.

Eligible Entities: Eligible entities are accredited schools of medicine, osteopathic medicine, dentistry, nursing, pharmacy, podiatric medicine, optometry, veterinary medicine, public health, chiropractic, and allied health, and schools offering a graduate program in behavioral and mental health practice.

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Allied health • Behavioral and mental health • Chiropractic • Dentistry • Allopathic medicine • Nursing • Optometry • Osteopathic medicine • Pharmacy • Physician assistants • Podiatric medicine • Public health • Veterinary medicine	• Undergraduate • Graduate	• Makes grants to eligible entities to provide scholarships to eligible full-time students • Grantees recruit and retain students from disadvantaged backgrounds including students who are members of racial and ethnic minority groups

Program Accomplishments: In Academic Year 2010-11, 50 percent of health professions graduates who had received SDS funding entered service in medically underserved communities, five times the national average. Additionally, 59 percent of students receiving SDS support were URMs, almost meeting the 62 percent target. The other two FY 2010 targets (number of disadvantaged students and minority students) were not met because some schools used their discretion to award larger scholarship amounts to fewer students. Some of the largest increases were for the primary care disciplines such as allopathic medicine and physician assistants whose awards almost doubled and more than tripled, respectively.

IT Investments

The SDS Program funds two IT Investments. The HRSA OIT – Electronic Handbooks Investment supports the SDS Program with program administration including applications and review processes, monitoring, and management reporting. The Electronic Handbooks supports the strategic and performance outcomes of the program and contributes to its success by providing a mechanism for sharing data and conducting business in a more efficient manner.

The SDS Program's investment in the HRSA - BHPr Campus Based Branch Document Management System provides electronically archived reports that are used to assess the institution's historical use of HRSA funds. Correspondence and notes regarding the school's activities within each program are also electronically stored and retrieved from the Document Management System.

Funding History

FY	Amount
FY 2008	$45,842,000
FY 2009	$45,842,000[1]
FY 2009 Recovery Act	$40,000,000
FY 2010	$49,236,000
FY 2011	$49,042,000
FY 2012	$47,452,000

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

Budget Request

The FY 2013 Budget Request of $47,452,000 is the same as the FY 2012 Enacted Level. In FY 2012, HRSA is reforming this program to make grant awards through a competitive process instead of using a formula to distribute grant award amounts. The current formula allocation results in many students receiving fairly small scholarship amounts relative to their tuition and other costs. The new competitive approach will provide an increased award amount to students. It is anticipated that the increased student award will lead to an increase in the percentage of graduates completing their education and receiving degrees and ultimately an increased number of primary care professionals serving in underserved areas. A competitive grant process will create a stronger incentive and accountability structure for grantees to ensure that funded programs achieve their intended goals: 1) to augment the number of students trained as primary care providers, 2) to increase the enrollment and retention of disadvantaged and URM students to enhance diversity within the health care workforce, and 3) to raise the number of providers who go on to work in underserved areas. Program reforms implemented in FY 2012 will change the number of grant awards. The FY 2012 Enacted Level will produce 120 grants supporting approximately 3,620 students. The total request for FY 2013 will continue support to these grants and students.

[1]Regular Enacted only.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result[2]/ Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Number of disadvantaged students	15,926 Target: 18,000 (Target not met)	3,620	3,620	Maintain
Number of URM students	9,372 Target: 11,200 (Target not met)	2,350	2,350	Maintain
Percent of students who are URM	59% Target: 62% (Target not met)	65%	65%	Maintain

[2] Most recent result is for Academic Year 2010-2011 and funded in FY 2010.

Health Professions Training for Diversity

Health Careers Opportunity Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$21,998,000	$14,822,000	---	-$14,822,000
FTE	1	1	---	-1

Authorizing Legislation: Sections 739 and 740 of the Public Health Service Act, as amended by the Affordable Care Act

FY 2013 Authorization .....Such Sums as Necessary

Funding Allocation .....Competitive Grant

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

Need: Please see previous section titled "Health Professions and Diversity"

Goal: To increase the diversity of the health care workforce

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

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Allopathic medicine • Osteopathic medicine • Public health • Dentistry • Pharmacy • Allied health • Behavioral and mental health • Chiropractic • Optometry • Physician assistants • Veterinary medicine • Podiatric medicine	• Elementary school • Middle school • High school • Undergraduate • Graduate	• Identify, recruit, and select individuals from disadvantaged backgrounds for academic enhancement • Facilitate entrance to health professions schools • Publicize information on financial aid • Provide stipends and scholarships • Provide experience at community-based primary health service facilities • Provide counseling, mentoring, or other services to assist individuals to successfully complete their education • Develop larger competitive applicant pool through partnerships with institutes of higher education, school districts, and other community-based

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
		linkages Provide for a period prior to the entry of individuals into the regular course of education of a school, preliminary education and health research training to assist students to successfully complete regular courses of education at such a school, or refer individuals to institutions providing such preliminary education

Program Accomplishments: In Academic Year 2010-2011, 7,564 economically or educationally disadvantaged students participated in structured programs. A structured program is a formal student enhancement program of a specified length with a specially designed curriculum or set of activities to enhance participants' academic performance

Funding History

FY	Amount
FY 2008	$9,825,000
FY 2009	$19,133,000[1]
FY 2009 Recovery Act	$2,517,000
FY 2010	$22,086,000
FY 2011	$21,998,000
FY 2012	$14,822,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES), HRSA's electronic handbook, and program oversight activities.

Budget Request

No funds are requested for this program in FY 2013. The President's Budget is prioritizing investing in programs that have a more immediate impact on the production of health professionals by supporting students who have committed to and are in training as health care professionals. Federally funded health workforce development programs will continue to promote training of individuals from disadvantaged backgrounds. For example, Primary Care Training and Enhancement grantees must have in place recruitment and retention strategies to increase the representation of underrepresented or disadvantaged minority trainees. In addition, the Department of Education provides support to students from disadvantaged backgrounds though activities aimed at enhancing their general academic preparedness and many health professions training institutions have initiatives aimed at recruiting students from disadvantaged backgrounds.

[1] Regular Appropriation Only

Outcomes and Outputs Tables

Measure		FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Number of disadvantaged students in structured programs:	7,564 Target: 6,328 (Target exceeded)	4,435	---	-4,435
Post-secondary	2,880 Target: 2,005 (Target exceeded)	1,405	---	-1,405
Secondary education (K-12)	3,286 Target: 2,992 (Target exceeded)	2,097	---	-2,097

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	33	20	--
Average Award	$643,455	$722,499	---
Range of Awards	$251,973-$1,036,481	$585,667-1,077,561	---

[2] Most recent result is for Academic Year 2010-2011 and funded in FY 2010.

Health Care Workforce Assessment

The National Center for Health Workforce Analysis

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$2,815,000	$2,782,000	---	- $2,782,000
Evaluation Funds	---	---	$10,000,000	+ $10,000,000
Total Program Level	$2,815,000	$2,782,000	$10,000,000	+ 7,218,000
FTE	6	6	6	---

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

FY 2013 Authorization ..... (see below)
National Center for Health Care Workforce Analysis $7,500,000
State and Regional Centers $4,500,000
Increase in Grants for Longitudinal Evaluations ..... Such Sums as Necessary

Allocation Method……Grants/Contract

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

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

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

Program Activities: The National Center continues to engage in a broad range of activities that:

- Build National capacity for health workforce data collection by working with States, professional associations, and others to develop and promote guidelines for data collection and analysis
- Improve data management, data analysis, modeling and projections to support analysis and decision making as well as evaluation of the effectiveness of workforce programs and policies
- Build health workforce research capacity
- Respond to information and data needs and translate data and findings into useful information to inform policies and programs
- Inform the Nation through reports and timely dissemination

Program Accomplishments: In FY 2011 the National Center expanded its data collection and analysis and dissemination activities. This included expanding the content of the Area Resource File and making it downloadable for free. This valuable data source is used by thousands of researchers, planners and policy analysts across the Nation. Partnerships were developed with States, National associations and other Federal agencies to strengthen health workforce data collection and analysis. Working with these partners, the National Center was able to support development of the National Minimum Data Set for Health Professions for physicians and nurses and improved data analysis.

In FY 2012 work continues on several projects to improve and update projections and expand the availability of data including development of a new Health Occupations Report, a State health workforce data base, a nursing facts and figures report and a report on diversity in the health professions. In addition, new integrated workforce projections by specialty for physicians, PAs and NPs as well as new nursing projections are being developed. BLS data on health occupations employment by State was added to the HRSA website and a new National Nurse Practitioner survey is under way.

Funding History

FY	Amount
FY 2008	---
FY 2009	---
FY 2010	$2,826,000
FY 2011	$2,815,000
FY 2012	$2,782,000

Budget Request

The FY 2013 Budget Request of $10,000,000 is an increase of $7,218,000 above the FY 2012 Enacted Level. The increase will support development of the National Center for Health Workforce Analysis with the following planned activities:

Improved and expanded data and data analysis- Funding will allow the NCHWA to continue to develop the data available for analysis by Federal agencies, researchers and policy analysts across the country. Specific activities include:
a) implementation of the National Minimum Data Set for Health Professions across additional health professions including dentists, pharmacists, and allied health professionals;
b) obtaining updated data on the primary care workforce to improve measurement, tracking and assessment of the supply of health professionals able to provide primary care services;
c) steps to significantly expand the data available to the larger community such as through expanded and improved Area Resource File;
d) continued collaboration with other Federal agencies, and health workforce researchers to promote collaboration around data collection and analysis.

These activities will support updates and expansions of the Health Occupations Report; the State health workforce data bases, and Nursing Workforce Facts and Figures Report. These activities allow the National Center, and HRSA more broadly, to track workforce supply and distribution as well as assess the outcomes of publicly supported programs.

Development of Federal-State infrastructure - Coordinating and collaborating with State partners is a crucial part of the National Center's strategy to build the foundation for more effective and useful health workforce analysis. Funding will allow the National Center to continue to work closely with States by providing them with the necessary data and technical assistance to build their workforce data and analytical capacity. In return, through these Federal-State partnerships, the National Center will continue to encourage the implementation of the minimum data set and development of more comprehensive National data bases to more accurately assess the Nation's health workforce landscape and needs.

Primary Care Training and Enhancement Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$39,036,000	$38,962,000	$50,962,000	+$12,000,000
FTE	3	3	3	---

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

FY 2013 Authorization .....Such Sums as Necessary

Allocation Method .....Competitive Grant/Contract

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

Need: National and international research demonstrate high quality accessible primary care improves health and reduces costs, with improved satisfaction for both recipients and providers. The persistent decline in the quality of the U.S. primary care system has perpetuated poorer health outcomes, including decreased longevity and increased infant mortality.

Difficulty recruiting students planning to become primary care physicians is a principle obstacle to improving the primary care system. In 2010 and 2011, however, the number of medical students selecting a primary care residency program increased slightly (2.3% in 2010).[1,2] These small gains are nonetheless promising as they occurred despite an undergraduate medical education culture that emphasizes hospital-based clinical experiences and subspecialty care and despite a lack of primary care role models.[3] After years of losing training positions and programs, this trend reversal suggests that primary care medical education and practice is ripe for aggressive growth and enhancement.[4]

Another factor that results in inadequate supply of primary care providers is geographic mal-distribution. Even as the number of physicians increases, new physicians tend to practice in

[1] O'Reilly K. "Primary care gets a boost in resident Match." American Medical News. 29 Mar 2010. www.ama-assn.org/amednews/2010/03/29/prsa0329.htm.
[2] Ward L. "For second year. More US medical school seniors match to primary care residencies." NRMP Press Release. 17 Mar 2011. http://www.nrmp.org/pressrelease2011.pdf
[3] Council on Graduate Medical Education (COGME), Twentieth Report. "Advancing Primary Care." December 2010.
[4] Council on Graduate Medical Education (COGME), Twentieth Report. "Advancing Primary Care." December 2010.

areas where the supply is already high[5], as opposed to rural and inner city areas where need is great and some health outcomes are poorer than national averages.

Physician assistants are valuable primary care team members that are helping increase the capacity and quality of the health care system. Over the past decade, the physician assistant workforce has doubled in size. However, the trends disfavoring primary care practice and underserved communities seen in physicians have been mirrored in physician assistants. Current educational experiences must be adapted to prepare a skilled and adequate primary care physician and physician assistant workforce.

Physicians and physician assistants must be prepared for the expected increase in patients accessing health care and to help develop the system and practice models that will yield higher quality and improve cost efficacy. The Primary Care Training and Enhancement Program supports the innovative education required to achieve this goal.

Goal: The Primary Care and Training Enhancement (PCTE) Program deploys its resources to strengthen medical education for physicians and physician assistants to improve the quantity, quality, distribution, and diversity of the primary care workforce.

Eligible Entities: Public or nonprofit private hospitals, schools of allopathic or osteopathic medicine, academically affiliated physician assistant training programs, or public or private nonprofit entities determined eligible by the Secretary.

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
•Physicians (family medicine, general internal medicine, general pediatrics, and combined internal medicine andpediatrics (Meds-Peds))	•Medical school	• Support innovations in primary care curriculum development, education, and practice for physicians and physician assistants.
•Physician assistants	• Graduate physician assistant education • Physician residency training • Academic and community faculty development	•Community based training in medical schools, physician assistant education, residencies, and faculty development programs. •Primary care academic and community faculty development. •Support development and enhancement of infrastructure in primary care academic administrative units. •Support expansion of training opportunities by funding primary care physician residency positions and physician assistant stipends.

[5] Academic Medicine (November, 2008). History of the Title VII Section 747 Grant Programs, 1963-2008 and their impact, Vol. 83, No.11.

Program Accomplishments: Studies[6] of the Public Health Service Act, Section 747 programs show that grantees more often have graduates enter primary care graduate medical education and practice and are more likely to practice primary care in rural areas and community health centers.

Five PCTE funding opportunities were competed in 2011. Newly awarded grants emphasize interprofessional education, the patient-centered medical home, and community based training. Others integrate public health into primary care curricula and support recruitment and education for under-represented minority trainees.

PCTE outcome data provided below were collected in 2011 and reflect outputs from the first or second year of grantees' project periods. The focus of these early years is often planning and infrastructure development to support grant activities. Therefore, these data do not reflect the full potential impact of the grants. We anticipate projected outcomes will be met in outlying grant years.

To expand health professions school enrollment and produce more primary care providers, resources from the Prevention and Public Health Fund were used in FY 2010 to support five-year grants in two programs: the Primary Care Residency Expansion (PCRE) Program and the Expansion of Physician Assistant Training (EPAT) Program. In 2011, PCRE and EPAT grantees used their funding to expand their class sizes by adding 172 residents and 140 physician assistant students, respectively. This investment will result in an additional 500 primary care physicians and 600 physician assistants by FY 2015. While the actual number of expanded residency positions is less than the original target, PCRE remains on track to produce 500 primary care physicians by 2015.

Funding History

FY	Amount
FY 2008	$37,998,000
FY 2009	$38,425,000
FY 2009 Recovery Act	$40,800,000
FY 2010	$38,923,000
FY 2010 Prevention Fund	$198,122,000
FY 2011	$39,036,000
FY 2012	$38,962,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbook (EHB), program oversight activities, Advisory Committee on Training in Primary Care Medicine and Dentistry, and the Council on Graduate Medical Education.

[6] Rittenhouse DR, et al. "Impact of Title VII Training Programs on Community Health Center Staffing and the National Health Service Corp Participation." *Annals of Family Medicine*. 2008;(6)5: 397-405.

Budget Request

The FY 2013 Budget Request of $50,962,000 is an increase of $12,000,000 above the FY 2012 Enacted Level. The total will increase the quality of primary care providers, promote interprofessional practice, enhance medical education by supporting innovation and flexibility, and improve the distribution and diversity of the health care workforce. The PCTE programs will support medical education advancements that will improve the quality of primary care providers and increase the appeal of primary care to students and current practitioners.

The increase will support the initiative that with sustained investments will train 1,400 additional physician assistants over a five year period. Grants will develop the infrastructure necessary to expand and improve teaching quality at clinical sites for PA students. The size of PA education programs is currently limited by inadequate practice sites for students to perform the required hours of direct patient care for graduation and certification and variable quality of the teachers at these sites. Faculty development will be encouraged by supporting instruction on learning theory, teaching strategies, cultural competency, and new models of care (including interprofessional, team based care and the patient-centered medical home), for clinicians supervising and teaching the PA students. Awards will target programs that demonstrate ability to increase clinical training leading to more graduates per year, improve training quality, and achieve greater access to care, particularly in rural and other underserved communities.

Outputs and Outcomes Tables

PCTE programs support primary care workforce growth and diversification, curricular innovations, and development of academic infrastructure. The current outcome measures reflect these objectives. As PCTE awards evolve to emphasize interprofessional education and care, community based practice experience, and needs-based training, the evaluation and outcome measures will be adjusted accordingly.

Measure	Year and Most Recent Result[7] Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Number of primary care physicians whose training or stipend is primarily funded by Prevention and Public Health Fund (cumulative): Primary Care Residency Expansion (PCRE)	172 expanded positions Target: 177 (Target not met)	344	517	+173
Number of primary care physicians assistants whose training or stipend is primarily	140 expanded positions	280	420	+140

[7] Most recent result is for Academic Year 2010-2011 and funded in FY 2010.

Measure	Year and Most Recent Result[7] Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
funded by Prevention and Public Health fund (cumulative): Physician Assistance Expansion (EPAT)	Target: 140 (Target met)			
6.I.C.3.a: Number of primary care physicians who complete their education through HRSA's Bureau of Health Professions Programs supported with Prevention and Public Health funding (PCRE)[8]	N/A	N/A	172	+172
6.I.C.3.b: Number of physician assistants who complete their education through HRSA's Bureau of Health Professions Programs supported with Prevention and Public Health funding (EPAT)[9] (cumulative)	N/A	140	280	+140
Number of primary care physicians and physician assistants with some portion or aspect of their training funded by PCTE	28,230 Target: 30,255 (Target not met)	49,000	49,320	+320
Percent receiving at least a portion of their clinical training in an underserved area	55% Target: 63% (Target not met)	59%	60%	+1%
Percent of physician and physician assistant graduates who practice in medically underserved areas	41% Target: 47% (Target not met)	45%	46%	+1%
Number of graduates and program completers	7,477 Target: 7,600 (Target not met)	7,500	7,600	+100
Percent of graduates and program completers who are	28% Target: 27%	30%	31%	+1%

[8] As a new program in FY 2010, the first program completers will report in FY 2013.
[9] As a new program in FY 2010, the first program completers will report in FY 2012.

Measure	Year and Most Recent Result[7] Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
minority and/or from disadvantaged backgrounds	(Target met)			

Grant Awards Table – Physician Training Grants
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	156	139	139
Average Award	$190,000	$220,000	$214,000
Range of Awards	$70,000-$338,000	$111,000-487,000	$90,000-475,000

Grant Awards Table – Physician Assistant
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	18	27	32
Average Award	$110,000	$150,000	$270,000
Range of Awards	$95,000-$130,000	$93,000-$220,000	$93,000-$370,000

Oral Health Training Programs

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$32,781,000	$32,392,000	$32,392,000	---
FTE	3	3	3	---

Authorizing Legislation: Sections 748, 340G, and 340G-1 of the Public Health Service (PHS) Act

FY 2013 Authorization: Section 748……Such Sums as Necessary
Section 340G……..……...Expired
Section 340G-1……..Such Sums as Necessary
Allocation Method: ……..…Competitive Grant/Contract

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

Need: Oral health is an essential component of overall health status, and poor oral health and untreated oral diseases and conditions can have significant impacts on quality of life. Access to oral health services is a problem for many segments of the U.S. population and is typically related to geography and mal-distribution of providers, insurance status, socio-demographic characteristics, and low income levels. According to a recent study published by the Institute of Medicine entitled, *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*, vulnerable and underserved populations face persistent and systemic barriers to accessing oral health care. These barriers are numerous and complex and include social, cultural, economic, structural, and geographic factors, among others. The IOM report specifically indicates that:

- In 2008, 4.6 million children did not obtain needed dental care because their families could not afford it.
- In 2011, there were approximately 33.3 million underserved individuals living in dental Health Professional Shortage Areas.
- In 2006, only 38 percent of retired individuals had dental coverage.

Also, for the first time, the Health People ten-year goal setting effort has identified Oral Health as a leading health indicator for 2020 (http://healthypeople.gov/2020/default.aspx).
Dental school faculty and practicing dentists are quickly nearing retirement age and will leave the workforce, yet the oral and general overall health needs of the population are growing. With the oral health care needs of this growing population increasing, production of dentists are just not keeping pace. Additional challenges to improving access to oral health services include the

lack of coordination and integration of oral health, public health, and medical health care systems.

Discipline	FY 2011Enacted	FY 2012 Enacted	FY 2013 PB
Training in General, Pediatric, and Public Health Dentistry	$16,733,406	$20,048,000	$20,228,000
State Oral Health Workforce	$16,047,594	$12,344,000	$10,702,000
Alternative Dental Health Care Provider Demonstration	---	---	$1,462,000

Training in General, Pediatric, and Public Health Dentistry

Goal: To increase the number of dental students, residents, practicing dentists, dental faculty, and dental hygienists qualified to practice in general, pediatric and dental public health fields and thus increase access to oral health care.

Eligible Entities: Schools of dentistry, public or non-profit private hospitals, and public or non-profit private entities that have approved residency or advanced education programs and others determined eligible by the Secretary

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• General dentists • Pediatric dentists • Public health dentists • Dental hygienists	• Dental Hygiene Training Programs • Undergraduate • Graduate School (dental schools) • Pre- and Post-Doctoral • Residency Programs	• Funds to plan, develop and operate or participate in approved dental training programs in the fields of general, pediatric or public health dentistry • Provide financial assistance to dental students, residents, practicing dentists, and dental hygiene students who are in need, who are participants in any such program, and who plan to work in the practice of general, pediatric, or public health dentistry, or dental hygiene. • Provide traineeships and fellowships to dentists who plan to teach or are teaching in general, pediatric, or public health dentistry. • Provide loan repayment for faculty in the dental programs when individuals agree to serve as full-time faculty members in exchange for repayment of outstanding student loans based on each year of service.

Program Accomplishments: In FY 2011, 41 continuations and eight new grants were awarded in the Training in General, Pediatric and Public Health Dentistry programs and were divided among four specific program areas: 1) Predoctoral Training in General, Pediatric and Public

Health Dentistry and Dental Hygiene, 2) Postdoctoral Training in General, Pediatric and Public Health Dentistry, 3) Faculty Development in General, Pediatric and Public Health Dentistry and Dental Hygiene, and 4) Dental Faculty Loan Repayment. These programs have set the foundation for training students, residents and faculty as indicated by first-year performance outcomes. Many of the awards utilized a planning year prior to beginning full implementation of their grant objective(s).

State Oral Health Workforce Improvement Grant Program

Goal: To help States develop and implement innovative programs to address the dental workforce needs of designated Dental HPSAs in a manner that is appropriate to the State's individual needs. States may receive funding to conduct the activities described below in Program Activities.

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

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Dentistry	• N/A	• Loan forgiveness and repayment provided to dentists who practice in HPSAs; serve as public health dentists for the Federal, State or local government; and/or provide services to patients regardless of their ability to pay. • Dental recruitment and retention efforts • Grants and low or no-interest loans • The establishment or expansion of dental residency programs • Expand or establish oral health services and facilities for children with special needs • Placement and support of dental trainees • Continuing dental education • Practice support through tele-dentistry • Community-based prevention services • Programs that promote children going into oral health or science professions • Faculty recruitment programs at accredited dental training institutions • The development of a State dental officer position or the augmentation of a State dental office

Program Accomplishments: A preliminary report providing a summary description of the programs' first two funding cycles (FY 2006 and FY 2008) was submitted to Congress in August of 2010. While it should be noted that all 13 available activities were utilized by grantees in the 2006 and 2008 cycles, there were a few of these activities that were selected for funding more than others. The most utilized activity was Community-Based Prevention, which resulted in nearly 20,000 children receiving dental sealants. More than 80,000 children were provided dental screenings, preventative services and referrals to dental professionals for treatment plans

under this activity. The second most utilized activity was the Placement and Support of Dental Trainees, resulting in the placement of over 90 oral health care providers into community health settings. The third most utilized activity for the 2006 cycle was Continuing Dental Education with more than 540 dental professionals and physicians receiving training and continuing education units in pediatric dentistry.

Alternative Dental Health Care Provider Demonstration Project

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

Designated Health Professions:	**Targeted Educational Levels:**	**Program Activities:**
• Alternative Dental Health Care Providers	• Post high school • College	Grants will be awarded for a five-year project period to: • Establish a demonstration program to train, or to employ alternative dental health care providers. • Create, or expand innovative models training new oral health care providers, who are not dentists or physicians, to deliver oral health preventative and limited restorative services to underserved communities.

Funding History

FY	**Amount**
FY 2008	$15,000,000
FY 2009	$20,000,000
FY 2010	$32,920,000
FY 2011	$32,781,000
FY 2012	$32,392,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and program oversight activities.

Budget Request

The FY 2013 Budget Request of $32,392,000 is the same as the FY 2012 Enacted Level. Funding will be used to support continuation grants for the Training in General, Pediatric and Public Health Dentistry and Dental Hygiene Programs and the State Oral Health Workforce Improvement Grant Program; as well as supporting the proposed new competitive grant funding

opportunities for the State Oral Health Workforce Improvement Grant Program, and the Alternative Dental Health Care Provider Demonstration Program. In FY 2012, 25 State Oral Health Workforce grants, funded in FY 2011, will complete their grant cycle. The FY 2012 Enacted Level for this program will fund 17 new State Oral Health Workforce grant awards and the remaining balance will be used to support Faculty Development in General, Pediatric, and Public Health Dentistry and Dental Hygiene grant programs. This distribution of funding promotes equality across the programs and allows for all eligible disciplines to apply for competitive funding for this cycle.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result[1]/ Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Number of students trained (new)	1,722 Target: 1,218 (Target exceeded)	1,800	1,810	+10
Number of residents trained (new)	417 Target: 334 (Target exceeded)	534	534	Maintain
Number of faculty trained (new)	187 Target: 86 (Target exceeded)	190	200	+10
Number of faculty receiving loan repayments (new)	26 Target: 18 (Target exceeded)	28	28	Maintain

Grant Awards Table – Training in General, Pediatric, and Public Health Dentistry Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	49	55	55
Average Award	$318,000	$345,000	$345,000
Range of Awards	$169,000-$347,000	$170,000-$375,000	$170,000-$375,000

[1] Most recent result is for Academic Year 2010-2011 and funded in FY 2010.

Grant Awards Table – State Oral Health Workforce Improvement
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	35	27	24
Average Award	$488,000	$474,000	$489,000
Range of Awards	$225,000-$496,000	$225,000-$505,000	$225,000-$505,000

Grant Awards Table – Alternative Dental Health Care Provider Demonstration Project
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	--	--	5
Average Award	--	--	$250,000
Range of Awards	--	--	$200,000-$300,000

Teaching Health Centers Graduate Medical Education Payment Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$230,000,000	---	---	---
FTE	4	4	4	---

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

FY 2013 Authorization .....Such Sums as Necessary
(Not to exceed $230,000,000, for the period of fiscal years 2011 through 2015)

Allocation Method .....Formula Based Payments

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

Need: Poor health outcomes are linked to lack of reliable access to primary care. Rural and inner-city areas are particularly hard hit. There is good evidence that physicians who receive training in community and underserved settings tend to practice in such environments, for example Community Health Centers (CHCs).[1] Though CHCs receive Federal funding to improve access to care, they have difficulty recruiting and retaining primary care professionals.[2] The THCGME Program is designed to address primary care workforce distribution by increasing residency training in community-based settings.

To address the need to expand residency training into underserved and community-based settings, the June 2010 Medicare Payment Advisory Commission (MedPAC) report called for increasing the amount of GME time spent in non-hospital settings, changes to GME funding to meet goals such as community-based care, and increasing the diversity of the pipeline of health professionals.[3] In its 19th Report to Congress[4], the Council on Graduate Medical Education (COGME) concluded that resident physicians must be trained in environments which are more reflective of the evolving health care delivery system.

[1] Morris CG and Chen FM. Training Residents in Community Health Centers: Facilitators and Barriers. Annals of Family Medicine 2009; 7:488-94.
[2] Rosenblatt RA, Andrilla CH, Curtin T, Hart LG. Shortages of medical personnel at community health centers: Implications for planned expansion. JAMA 2006; 295:1042-9.
[3] Report to the Congress: Aligning Incentives in Medicare (June 2010). Medicare Payment Advisory Commission. (available at http://www.medpac.gov).
[4] Enhancing Flexibility in Graduate Medical Education (September 2007), COGME Nineteenth Report, (available at http://www.cogme.gov/pubs.htm).

Teaching Health Centers (THCs) have demonstrated progress toward innovative models of patient care delivery such as the patient-centered medical home, implementation of electronic health records, population-based care management, and use of interdisciplinary team-based care[5.] The growth of THCs has been limited due to difficulty bringing together the dual mission of training and service in health centers, administrative complexity, and a lack of financial resources.[5] Successful THCs have common elements, foremost of which is an institutional commitment to a dual mission of medical education and service to an underserved patient population, including underrepresented minority and other high risk populations.

Goal: To bolster the primary care workforce and improve the distribution of that workforce into needed areas. THCGME payments support the costs of new and expanded resident and dental training in community-based ambulatory primary care settings, such as health centers.

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

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

Program Accomplishments:

In FY 2011, 11 THCs began receiving payments and training 63 primary care medical and dental residents in July 2011. In FY 2012, 11 additional THCs will begin receiving payments for a total of 22 programs supported. The awardees include nine Federally-Qualified Health Centers (FQHC), one FQHC look alike, one Area Health Education Center (AHEC), two Native American Health Authorities, and nine other outpatient clinics. The awards will support primary care residency programs in Family Medicine, Internal Medicine, Obstetrics/Gynecology, Pediatrics, Psychiatry and General Dentistry.

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

IT Investments

Implementation of the THC GME program requires HRSA to create the first outpatient federal GME payment system. In 2011 HRSA initiated an IT investment to automate the THCGME funding cycle, to include calculation and award of Direct Medical Education (DME) and Indirect Medical Education (IME) payments and the mandated annual reconciliation to each eligible center. This investment is designed to improve the oversight of funding and accuracy of formula derived payments by linking the application, eligibility, funding award and reconciliation activities, as well as support program administration, grants administration and monitoring, management reporting and performance measurement data collection.

Funding History

FY	Amount
FY 2008	---
FY 2009	---
FY 2010	---
FY 2011	$230,000,000
FY 2012	---

Funding includes costs associated with processing of payments through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and program oversight activities.

Budget Request

No funds are requested for this program in the FY 2013 Request. In FY 2011, the THCGME Payment Program received a $230,000,000 mandatory appropriation that is available through FY 2015.

The approximate annual training cost per resident is $150,000 (combined direct graduate medical education expenses and indirect medical education expenses). Residency training programs vary in length depending on specialty. This request assumes the majority of payments will be for primary care physicians who require three years of training. In FY 2013, $44,099,000 will support approximately 300 training positions, as well as evaluation, administrative, and oversight activities.

Outcomes and Outputs Table

Measure		FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
6.1.C.5: Number of primary care residents trained (Cumulative)	63	143	300	+157

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	11	22	40
Average Award	$214,000	$689,000	$875,000
Range of Awards	$40,000-$625,000	$233,000-2,472,000	$233,000-2,472,000

[6] Most recent result is for Academic Year 2011-2012 and funded in FY 2011.

Interdisciplinary, Community-Based Linkages

Area Health Education Centers (AHEC) Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$33,142,000	$27,220,000	---	-$27,220,000
FTE	2	2	---	-2

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

FY 2013 Authorization.....$125,000,000

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

Program Description: The AHEC Programs and Centers promote a National role in addressing health care workforce shortages, particularly in the areas of health career awareness and interdisciplinary/interprofessional community-based primary care training. The AHEC Program supports two types of awards: infrastructure development, and point of service maintenance and enhancement. The AHEC Program grantees support the recruitment and retention of physicians, students, faculty and other primary care providers in rural and medically underserved areas by providing local, community-based, interdisciplinary/interprofessional primary care training.

Need: The Association of American Medical Colleges projected a shortage of 45,000 primary care physicians by 2020. The shortage of primary care physicians will most severely impact vulnerable and underserved populations, which include approximately 20 percent of Americans who live in rural or inner-city locations designated as health professional shortage areas[1].

Goal: The AHEC Program provides access to high quality, culturally competent health care through community-based interprofessional/interdisciplinary training, continuing education, and health careers outreach activities that will ultimately improve the distribution, diversity, quality and supply of the primary care health professions workforce who serve in rural and underserved health care delivery sites.

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

[1] American Association of Medical Colleges, (2010). Physician Shortages to Worsen Without Increases in Residency Training, available online at https://www.aamc.org/download/150584/data/physician_shortages_factsheet.pdf (accessed 12/20/11).

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
Allied health Community health workers Dentists Nurse midwives Nurse practitioners Optometrists Pharmacists Physicians Physician assistants Psychologists Public health Other health professions	All education levels are targeted to provide primary care workforce development for the following trainees: • Medical students • Health professions students • Continuing education for primary care providers in underserved areas • High school students (9-12)	• Plan, develop, operate and evaluate AHEC Center(s) • Address health care workforce needs in the service areas coordinating with local workforce investment boards (WIBs) • Provide clinical rotations in primary care and community-based, interdisciplinary training • Disseminate continuing education courses for health professionals with an emphasis on underserved areas and for health disparity populations • Promote health careers including public health in the high school grades

Program Accomplishments: In FY 2011, 60 AHEC Program grantees and their 253 affiliated AHECs provided health professions training in 48 States, the District of Columbia, and the territories of Guam, Palau, and Puerto Rico. Grantees of the AHEC and the Health Careers Opportunities (HCOP) programs, with legislative mandates to provide high school health career recruitment activities, have established collaborations to improve efficiencies. In addition, through cooperative efforts between SAMHSA and HRSA/BHPr, the AHEC program established a new initiative to address the post-deployment mental and behavioral health and substance abuse issues of veterans and their families. This initiative involves training 200 AHEC program and center staff to expand the participating AHEC programs and centers' capacity to provide training on Post-Traumatic Stress Disorders (PTSD), Traumatic Brain Injury (TBI) and other related areas (i.e., preventing prescription medication misuse, military sexual trauma). The participating AHEC programs and centers will provide or facilitate continuing education programs to 10,000 health care providers in the 10 HRSA regions on PTSD and TBI along with other mental and behavioral health issue topics affecting veterans and their families. In Academic Year 2010-2011 several AHEC programs had established their targets based upon estimated matching funds in excess of the required levels. However, due to decreases in State and local budgets, as well as reduced funds available from private sources, many AHECs did not receive these anticipated increases in matching funds, resulting in some targets not being met.

Funding History

FY	Amount
FY 2008	$28,180,000
FY 2009	$32,540,000
FY 2010	$33,274,000
FY 2011	$33,142,000
FY 2012	$27,220,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and program oversight activities.

Budget Request:

No funds are requested for this program in FY 2013. While the AHEC Program continues to focus on exposing medical students and health professions students to primary care and practice in rural and underserved communities, there is a higher priority to allocate Federal resources to training programs that directly increase the number of primary care providers. It is anticipated that the AHEC Program grantees will continue their efforts to provide interprofessional/interdisciplinary training to health professions students with an emphasis on primary care; these activities may be supported through other funding sources.

Outcomes and Outputs Table

Measure	Year and Most Recent Result[2]/ Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
No. of medical students trained in community sites in rural/underserved areas	20,758 Target: 21,999 (Target not met)	17,022	--	-17,022
No. of associated health professions students trained in community sites in rural/underserved areas	28,366 Target: 33,036 (Target not met)	23,260	--	-23,260
No. of training partnerships with community/migrant health centers and other underserved area sites	10,340 Target: 11,155 (Target not met)	8,479	--	-8,479
No. of local providers who received continuing education (CE),on Cultural competence, Women's Health, Diabetes, Hypertension, Obesity, Health Disparities and related topics.	353,217 Target: 365,137 (Target not met)	289,638	--	-289,638
Percent of local providers receiving continuing education in medically underserved areas	15.3% Target: 15.3% (Target met)	12.5%	--	-12.5%
No. of elementary/high school students receiving health career guidance and information from the AHEC Programs	520,205 Target: 453,638 (Target exceeded)	426,568	--	-426,568
No. of high school students (grade 9-12) participating in ≥	19,038 Target: 25,319	15,611	--	-15,611

[2] Most recent result is for Academic Year 2010-2011 and funded in FY 2010.

Measure	Year and Most Recent Result[2]/ Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
20 hours of health career training and/or academic enhancement experience	(Target not met)			

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	60	60	--
Average Award	$518,748	$425,373	---
Range of Awards	$100,129-1,516,424	$100,000-$1,243,468	---

Interdisciplinary, Community -Based Linkages

Geriatric Programs

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$33,542,000	$30,629,000	$30,629,000	---
FTE	5	5	5	---

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

FY 2013 Authorization:
Geriatric Education Centers……...Unspecified
Geriatric Training for Physicians, Dentists,
Behavioral/Mental Health Professionals……Unspecified
Geriatric Academic Career Awards……...Unspecified

Allocation Method .....Competitive Grants/Contracts

Program Description: Geriatric Programs improve access to quality health care to America's elderly and include the Geriatric Education Centers (GEC), Geriatric Training for Physicians, Dentists, and Behavioral/Mental Health Professionals (GTPD), and Geriatric Academic Career Awards (GACA) Programs. These programs focus on increasing the number of geriatric specialists and increasing geriatrics competencies in the generalist workforce through education and training to improve care to this often vulnerable, underserved population.

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

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

Geriatric Programs

Programs	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Geriatric Education Centers	$19,836,000	$16,320,140	$16,320,140
Geriatric Training for Physicians, Dentists, and Behavioral/Mental Health Professionals	$8,418,000	$8,830,490	$8,830,490
Geriatric Academic Career Awards	$5,288,000	$5,478,370	$5,478,370

Geriatric Education Centers Program (GEC)

Program Description: This program provides support to establish or operate GECs to train health professional faculty, students, and practitioners in the interdisciplinary/interprofessional diagnosis, treatment and prevention of disease, disability, and other health problems of the elderly. They provide services to and foster collaborative relationships among health professions educators within defined geographic areas.

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

Eligible Entities: Accredited schools of multiple health disciplines

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Allied health • Allopathic medicine • Behavioral and mental health • Chiropractic • Clinical psychology • Clinical social work • Dentistry • Health administration • Marriage and family therapy • Nursing • Optometry • Osteopathic medicine • Pharmacy • Physician assistant • Podiatric medicine • Professional counseling • Public health • Veterinary medicine	• Undergraduate • Graduate • Post-graduate • Practicing health care providers • Faculty	• Support eligible GECs to provide interdisciplinary geriatric education and training to students, faculty and practitioners • Curricula development relating to the treatment of the health problems of elderly individuals • Faculty development in geriatrics • Continuing education for health professionals who provide geriatric care • Clinical training in geriatrics in nursing homes, chronic and acute disease hospitals, ambulatory care centers, and senior centers

Program Accomplishments: In Academic Year 2010-2011, the 45 GEC grantees developed and provided 2,103 education and training offerings to health professions students, faculty, and practitioners related to care of the older adult. Interdisciplinary education and training was provided to 10,703 interdisciplinary teams. The grantees provided education and training to 64,414 health professions students, faculty, and practitioners.
A contract, the National Training and Coordination Collaborative (NTACC), has been implemented and funded to improve evaluation planning for GEC grantees by linking the education and training provided by GECs to provider practice improvement and improved health outcomes. For example, in FY 2012, NTACC is providing technical support to all GEC grantees in their mandated and self-identified area of focus in which they will implement evidenced-based practices and assess whether their practice has changed.

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

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

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

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

Designated Health Professions:	Targeted Educational Levels:	Program Activities:

• Dentistry
• Medicine
• Counseling
  - Marriage & family
  - Professional
• Osteopathic medicine
• Psychology
• Psychiatric nursing
• Psychiatry
• Social work
• Substance abuse
	• Graduate
	• Post-graduate
	• Faculty
		• Provide intensive one-year mid-career faculty retraining and two-year fellowship training in geriatrics
		• Provide community service to minority and underserved elderly
		• Practice the delivery of longitudinal geriatrics in ambulatory care and comprehensive evaluation units, day and home care programs, dental services, acute care, rehabilitation services, community-care, extended care facilities and long term care settings
		• Apply contemporary educational delivery methods to interdisciplinary audiences
		• Demonstrate application of administrative, clinical, teaching, and research skills as academic and clinical faculty
		• Engage in scholarly research in the field of aging

Program Accomplishments: In Academic Year 2010-2011, 13 non-competing continuation grants were supported. A total of 54 physicians, dentists and psychiatry fellows provided geriatric care to 24,139 older adults across the care continuum. Geriatric physician fellows

provided health care to 13,788 older adults; geriatric dental fellows provided health care to 4,834 older adults; and geriatric psychiatric fellows provided health care to 5,516 older adults.

Geriatric Academic Career Awards Program (GACA)

Program Description: This program supports the career development of physicians, nurses, social workers, psychologists, dentists, pharmacists, and allied health professionals in academic geriatrics who provide training in clinical geriatrics including the training of interdisciplinary teams of health professionals.

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

Eligible Entities: See Designated Health Professions listed below

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

Program Accomplishments: In Academic Year 2010-2011, the GACA Program funded 68 full time junior faculty awardees. These awardees provided interdisciplinary training in geriatrics to 38,392 health professionals in clinical geriatrics; provided interdisciplinary team training to 6,617 clinical staff in various geriatric clinical settings; and provided geriatric services to 57,364 geriatric patients who are underserved and uninsured patients in acute care, geriatric ambulatory care, long-term care, and geriatric consultation services settings.
The FY 2010 target was based upon previous performance data that reflected duplicative participants. Beyond FY 2012, targets will better reflect actual program performance.
With regard to the GEC program, there was difficulty in recruiting for geriatric dental fellowship positions and geriatric psychiatric fellowship positions; therefore fellowships were unfilled.

Funding History

FY	Amount
FY 2008	$30,997,000
FY 2009	$30,997,000
FY 2010	$33,675,000
FY 2011	$33,542,000
FY 2012	$30,629,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and program oversight activities.

Budget Request

The FY 2013 Budget Request of $30,629,000 is the same as the FY 2012 Enacted Level. The total request will provide continuation support for 45 Geriatric Education Center cooperative agreements, 13 Geriatric Training for Physician, Dentists, and Behavioral and Mental Health Professional grants, and 66 Geriatric Academic Career Awards. The amount of the award for GACA recipients is statutorily required to reflect any annual increases in the Consumer Price Index. However, award amounts to the GEC and GTPD programs are subject to reductions in their continuation funding if there is a reduction in annual appropriation. In FY 2012 the cost of living adjustment (COLA) was 3.6 percent. The COLA for FY 2013 will be announced in October, 2012.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result[2]/ Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Number of health care providers receiving training through the GEC Program	62,160 Target: 70,755 (Target not met)	Target: 59,413	Target: 59,413	Maintain
Number of GTPD Fellows	49 Target: 78 (Target not met)	45	45	Maintain

Grant Awards Table – Geriatric Education Centers Program
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	45	45	45
Average Award	$408,200	$362,669	$362,266
Range of Awards	$216,000-$432,000	$199,848-$403,360	$199,848 - $403,369

[2] Most recent result is for Academic Year 2010-2011 and funded in FY 2010.

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

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	13	13	13
Average Award	$729,600	$679,268	$679,268
Range of Awards	$418,000-$1,434,200	$551,048 - $1,359,664	$551,048 - $1,359,664

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

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PresidB
Number of Awards	68	66	66
Average Award	$74,991	$77,691	$77,691
Range of Awards	N/A	N/A	N/A

Interdisciplinary Community-Based Linkages

Allied Health and Other Disciplines – Chiropractic Demonstration Grants

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$1,933,000	---	---	---
FTE	1	---	---	---

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

FY 2013 Authorization ..... Unspecified

Allocation Method ..... Competitive Grants

Program Description: This program funds demonstration projects to identify the most effective treatment of spinal and lower-back conditions by linking schools of chiropractic and schools of allopathic and osteopathic medicine in collaborative research projects. This program is scheduled to end on August 31, 2012.

Need: Low-back pain is a major cause of functional disability representing one-quarter of all disabling work injuries. Approximately 80 percent of Americans experience at least one episode of back pain at some time in their lives. The direct economic impact of low pain was estimated at $24 billion while indirect costs associated with lower back pain is speculated to be as high as $50 billion.[1]

Significant numbers of Americans suffer from spinal and lower-back conditions, with seniors commonly reporting impaired activity due to musculoskeletal pain or stiffness, including spinal pain.[2]

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

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

[1]Lorig, L. K., Laurent, L. D., Deyo, D. R., Marnell, M. M., Minor, M. M., Ritter, R. P. (2002). Can a Back Pain E-Mail Discussion Group Improve Health Status and Lower Health Care Costs? *ARCH INTERN MED, volume 162*, pages 792-796

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

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

Program Accomplishments: During Academic Year 2010-2011, the grantees developed biomechanical outcome measures to assess seniors' physical function and balance, and participated in the development of qualitative interview questions and interviewing techniques. Two publications resulted from these grants including one in the *Journal of Allied Health* and another in the *Topics in Integrative Health Care Journal*. The grantees plan to have 439 total research participants by the end of their project period on August 31, 2012. It is anticipated that the conclusions drawn from the clinical studies will make a significant scientific contribution to the treatment of lower back conditions in adolescent and elderly populations.

Funding History

FY	Amount
FY 2008	$1,817,000
FY 2009	$1,945,000
FY 2010	$1,940,000
FY 2011	$1,933,000
FY 2012	----

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and program oversight activities.

Budget Request

The Chiropractic Demonstration Project Program has shown effective programmatic models over the life of the program and has been successfully implemented. No funds are requested for this program in FY 2013.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result[3]/ Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
No. of Chiros. involved in research projects	37 Target: 17 (Target exceeded)	--	--	--

[3] Most recent result is for Academic Year 2010-2011 and funded in FY 2010.

Grant Awards Table – Chiropractic Demonstration Projects Program
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	4	--	--
Average Award	$521,622	---	---
Range of Awards	$368,938-$543,741	---	---

Interdisciplinary, Community-Based Linkages

Mental and Behavioral Health Education and Training

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$2,927,000	$2,892,000	$2,892,000	---
Evaluation Funds	---	---	$5,000,000	+$5,000,000
Prevention and Public Health Fund	---	$10,000,000	---	-$10,000,000
Total Program Level	$2,927,000	$12,892,000	$7,892,000	-$5,000,000
FTE	1	1	1	--

Authorizing Legislation: Section 756 of the Public Health Service Act

FY 2013 Authorization: $35,000,000
Allocation Method: Competitive Grant/Cooperative Agreement; Contract

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

Need: Mental disorders rank in the top five chronic illnesses in the U.S. The National Alliance on Mental Illness reported approximately 6 percent, or 1 in 17 Americans suffer from a serious mental illness.[1] Serious mental illnesses cost society approximately $193.2 billion in lost earnings per year. Individuals suffering from a serious mental illness earned at least 40 percent less than people in good mental health, confirming that mental disorders contribute to significant losses of human productivity.[2]

[1] National Alliance on Mental Illness. (2008). What is Mental Illness? Mental Illness Fact Sheet, November 4, 2008.
[2] Kessler, R.C., Heeringa, S., Lakoma, M.D., Petukhova, M., Rupp, A.E., Schoenbaum, M., Wang, P.S., and Zasavslu. A.M. (2008). The individual-level and societal-level effects of mental disorders on earnings in the United States: Results from the National Comorbidity Survey Replication. American Journal of Psychiatry; June; 165(6): 703-711.

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Mental and Behavioral Health Education and Training Program	---	$10,000,000	$5,000,000
Graduate Psychology Education Program	$2,927,000	$2,892,000	$2,892,000

Mental and Behavioral Health Education and Training Program

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

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

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

Program Accomplishments: This is a new program that will be implemented in FY 2012; therefore, no accomplishments are identified.

Graduate Psychology Education Program

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

Eligible Entities: Eligible entities include accredited health professions schools, universities, and other public or private non-profit entities, which include faith-based and community based organizations. Eligible applicants must demonstrate that the training within an accredited graduate program in clinical psychology will occur in collaboration with two or more disciplines other than psychology.

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

Program Accomplishments: During Academic Year 2010-2011, 20 grantees taught 620 trainees and graduated 90 psychologists through the Graduate Psychology Education Program. Over 90 percent of the trainees received their education in medically underserved areas. These students received interdisciplinary training from physicians and other health professionals to prepare them to effectively integrate quality health care to treat vulnerable populations.
In Academic Year 2010-2011, these trainees provided clinical psychology services to approximately 46,200 people including: special minority populations such as Native Americans, African American children living with Sickle Cell Anemia, and children and families with diabetes, HIV/AIDS, burns, injuries, trauma, amputations, or Attention Deficit Disorder (ADD). Some awardees implemented exemplary models including training in integrative care, gero-psychology, holistic care and bio-psychosocial methodologies; these models demonstrate potential for replicability and sustainability. The 20 GPE grantees were in their first year of funding for Academic Year 2010-2011. Delays associated with start-up resulted in lower than estimated performance.

Funding History

FY	Amount
FY 2008	$1,851,000
FY 2009	$1,945,000
FY 2010	$2,939,000
FY 2011	$2,927,000
FY 2012	$2,892,000
FY 2012 Prevention Fund	$10,000,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and program oversight activities.

Budget Request

The FY 2013 Budget Request of $7,892,000 is a decrease of $5,000,000 below the FY 2012 Enacted Level. The Budget will support 16 grants for the Mental and Behavioral Health Education and Training Program which will support the education and training of approximately 278 graduate students and health professionals in social work or graduate psychology, and professionals and paraprofessionals in child and adolescent mental health education. Additionally, $2,892,000 will support 20 Graduate Psychology Education Program grantees and train 614 students and 90 graduates.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result[3]/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Graduate Psychology Education				
Number of Trainees	620 Target: 726 (Target not met)	614	614	Maintain
Number Graduates	90 Target: 108 (Target not met)	90	90	Maintain
Number of Graduates entering practice in MUCs	75 Target: 75 (Target met)	75	75	Maintain
Percent of Graduates entering practice in MUCs	83% (Target met)	83	83	Maintain

[3] Most recent result is for Academic Year 2010-2011 and funded in FY 2010.

Measure	Year and Most Recent Result[3]/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
	Target: 83%			
Mental and Behavioral Health	TBD	TBD	TBD	TBD

Mental and Behavioral Health Education and Training Program

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	--	TBD	16
Average Award	---	TBD	$300,000
Range of Awards	N/A	TBD	$250,000 - $350,000

Graduate Psychology Education

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	20	20	20
Average Award	$137,000	$137,000	$137,000
Range of Awards	$80,000 - $190,000	$80,000 - $190,000	$80,000 - $190,000

Public Health Workforce Development

Public Health and Preventive Medicine

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$9,609,000	$8,111,000	$9,609,000	+$1,498,000
Prevention and Public Health Fund	$20,000,000	$25,000,000	$10,000,000	-$15,000,000
Total Program Level	$29,609,000	$33,111,000	$19,609,000	-$13,502,000
FTE	1	1	1	--

Authorizing Legislation: Sections 765, 766, 767 and 768 of the Public Health Service (PHS) Act, as amended by the Affordable Care Act

FY 2013 Authorization……..Unspecified

Funding Allocation.....Competitive Grant

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

[1]Bodenheimer T, Chen E, Bennett HD. Confronting the Growing Burden of Chronic Disease: Can the U.S. Health Care Workforce Do the Job? *Health Affairs* January 2009 vol. 28 no. 1 64-74.

[2] Institute of Medicine. Committee on Training Physicians for Public Health Careers. *Training Physicians for Public Health Careers.* The National Academies Press. 2007

Program	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Public Health Training Center (PHTC) Program	$24,189,000	$24,189,000	$14,189,000
Public Health Traineeships	$1,607,000	$1,607,000	$1,607,000
Preventive Medicine Residency Program	$3,813,000	$3,813,000	$3,813,000
Integrative Medicine Residency	---	$3,502,000	---

Public Health Training Center Program

Program Description: The Public Health Training Center (PHTC) Program focuses on the technical, scientific, managerial and leadership competencies and capabilities of the current and future public health workforce with emphasis on the existing public health workforce. Education and training provided by the PHTC Program reflect the core public health competencies as defined by the Council on Linkages between Academia and Public Health Practice.[3] Training topics addressed by the PHTCs include environmental health, public health leadership, nutrition, management, cultural competency, and risk communication. The PHTCs strive to strengthen the workforce in State and local health departments to improve the capacity and quality of a broad range of personnel to carry out core public health functions and essential public health services.
Goal: To support the ongoing education of the current and future public health workforce with emphasis on the existing public health workforce to ensure competent practice.

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

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

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

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

Program Accomplishments: During Academic Year 2010-2011, there were 33 PHTCs that trained more than 180,000 public health professionals. Of the 33 PHTCs, 58 percent or 19 were new starts as of FY 2009; they only reported minimal data because of significant delays with infrastructure development that included getting started with hiring staff, gathering resources, conducting a detailed needs assessment, and developing and implementing trainings. As indicated in the Outcomes and Output Tables below, these infrastructure activities adversely impacted the goal, thus resulting in reaching less participants than projected based on the inappropriate estimates based on equally weighing the capability of the 19 new starts with the 14 longer term, more experienced and established PHTCs.

Public Health Traineeship Program

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

Goal: To increase the number of professionals trained in public health fields of which there is a shortage in the U.S.

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

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

Program Accomplishments: During Academic Year 2010-2011, the 30 PHT grantees supported approximately 500 enrollees in 21 States and Puerto Rico; and 113 graduates received some form of financial support as a result of participating at a PHT supported training site.

The 2010-2011 data does not meet the target because the data reported by three grantees in previous reporting periods included all enrollees, graduates, and URM graduates versus only those that received financial support from PHT. BHPr provided technical assistance and accurate information was reported.

Preventive Medicine Residency Program

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

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

Eligible Entities: Accredited schools of public health, allopathic or osteopathic medicine; accredited public or private nonprofit hospitals; State, local or Tribal health departments or a consortium of two or more of the above entities.

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

Program Accomplishments: During Academic Year 2010-2011, nine residency programs provided training to 49 residents. Of these 49 residents, 26 completed the residency program and nine of the 26 were from underrepresented minority populations. The two newly accredited Preventive Medicine Residency Training programs funded in FY 2010 enrolled their first cohort of residents on July 1, 2011.

Funding History

FY	**Amount**
FY 2008	$8,273,000
FY 2009	$9,000,000[4]
FY 2009 Recovery Act	$10,500,000
FY 2010	$9,647,000
FY 2010 Prevention Fund	$14,829,000
FY 2011	$9,609,000
FY 2011 Prevention Fund	$20,000,000
FY 2012	$8,111,000
FY 2012 Prevention Fund	$25,000,000

[4] Regular Enacted Only

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and program oversight activities.

Budget Request

The FY 2013 Budget Request of $19,609,000 is $13,502,000 below the FY 2012 Enacted Level. The total request will continue the support for the 37 current PHTC grants, 30 PHT grantees and nine PMR training grants. The decrease for the PHTC Program will result in each of the continuing 37 grantees receiving approximately $268,000 less than their FY 2012 awards. The FY 2013 budget for the PHT and the PMR programs will be maintained at FY 2012 levels. The new Integrative Medicine Program (IMR) appropriated in FY 2012 will support $2.5 million in grants to incorporate competency-based curricula into graduate medical edutation, while the remaining funds will support a National Coordinating Center for Integrative Medicine. There is no request for the IMR program in the President's Budget Request for FY 2013.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result[5]/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Public Health Training Center				
6.I.C.9: Number of existing public health workers retrained (Prevention Fund)	185,266 Target: 428,264 (Target not met)	205,645	84,520	-121,125
Public Health Traineeships				
Number of students supported with traineeship funds	501 Target: 2,500 (Target not met)	501	501	Maintain
Number of graduates supported with traineeship funds	113 Target: 840 (Target not met)	119	119	Maintain
Number of URM graduates supported with traineeship funds	38 Target: 230 (Target not met)	40	40	Maintain
Preventive Medicine Residency Training				
Number of residents participating in residencies	49 Target: 40 (Target Exceeded)	45	40	-5

[5] Most recent result if the Academic Year 2010-2011 and funded in FY 2010.

Measure	Year and Most Recent Result[5]/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Number of residents completing training	26 Target: 20 (Target exceeded)	25	20	-5
Number of URM residents completing training	9 Target: 10 (Target not met)	9	9	Maintain
Percent of URM residents completing training	35 Target: 50% (Target not met)	35	35	Maintain
Number of residents entering practice in MUCs	9 Target: 8 (Target exceeded)	5	4	-1
Percent of residents entering practice in MUCs	16 Target: 40 (Target not met)	18	20	+2
Average cost per resident	$71,114	$71,114	$71,114	Maintain

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

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	37	37	37
Average Award	$628,358	$651,108	$383,486
Range of Awards	$129,748-$650,000	$142,722-$715,000	$129,748-$445,162

Grant Awards Table – Public Health Traineeships
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	30	30	30
Average Award	$47,880	$47,880	$47,880
Range of Awards	$2,313-$204,541	$2,313-$204,541	$2,313-$204,541

Grant Awards Table – Preventive Medicine Residency Program
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	9	9	9
Average Award	$423,666	$423,666	$423,666
Range of Awards	$190,000-$782,889	$190,000-$782,889	$190,000-$782,889

Nursing Workforce Development

Advanced Nursing Education

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$64,046,000	$63,925,000	$63,925,000	---
Evaluation Funds	---	---	$20,000,000	+$20,000,000
Total Program Level	$64,046,000	$63,925,000	$83,925,000	+$20,000,000
FTE	4	4	4	--

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

FY 2013 Authorization ..... Such Sums as Necessary

Allocation Method ..... Formula Grant/Competitive Grant/Contract

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

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

The nurse faculty shortage continues to inhibit nursing schools from educating the number of nurses needed to meet projected demand. According to the American Association of Colleges of Nursing, almost 68,000 qualified applicants were turned away from baccalaureate and graduate nursing programs in 2010 primarily due to an insufficient number of faculty.[1] Most of the vacancies (90.6%) were faculty positions requiring or preferring a doctoral degree. Among the

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

top reasons cited by schools having difficulty finding faculty was the limited pool of faculty prepared at the doctoral level.

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

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

Designated Health Professions:	**Targeted Educational Levels:**	**Program Activities:**
• Nurse practitioners • Clinical nurse specialists • Nurse midwives • Nurse anesthetists • Nurse educators • Nurse administrators • Public health nurses	• Masters programs in nursing Doctoral programs	• Supports education of nurses to provide quality primary health care in homes, ambulatory care, long-term care, acute care, and other health care settings. • Provides schools of nursing with infrastructure grants to build and enhance advanced nursing education programs. • Provides traineeships for tuition, fees, books, and reasonable living expenses. • Provides schools of nursing with funds to support advanced nursing education students.

Advanced Nursing Education Programs

Programs	**FY 2011 Enacted**	**FY 2012 Enacted**	**FY 2013 PB**
Advanced Nursing Education	$46,796,000	$38,925,000	$38,925,000
Advanced Education Nursing Traineeship	$16,000,000	$22,750,000	$22,750,000
Nurse Anesthetist Traineeship	$1,250,000	$2,250,000	$2,250,000
Advanced Nursing Education Expansion II	---	---	$20,000,000

Program Accomplishments: In Academic Year 2010-11, the ANE Program supported 151 advanced nursing education projects and enrolled 7,863 advanced nursing education students. The AENT and NAT programs provided direct financial support to 12,325 advanced nursing education and nurse anesthesia students and 7,744 graduates ready to enter into the workforce. The increase in applicants in FY 2010 resulted in a substantial increase in the number of students and graduates receiving traineeship support, surpassing the targets based on the prior year. In

FY 2010, 26 schools of nursing received ANEE grants, funded through the Affordable Care Act, to support the production of over 600 primary care APRNs during their fully-funded five-year grants.

IT Investments

The Advanced Nursing Education Program funds HRSA OIT – Electronic Handbooks Investment. The HRSA OIT – Electronic Handbooks Investment supports the Advanced Nursing Education Program with program administration, grants administration and monitoring, management reporting, and grantee performance measurement and analysis. The Electronic Handbooks supports the strategic and performance outcomes of the Program and contributes to its success by providing a mechanism for sharing data and conducting business in a more efficient manner. In addition, HRSA-OIT investment supports the Nurse Traineeship Database and procedures to execute formula for NAT awards.

Funding History

FY	Amount
FY 2008	$61,875,000
FY 2009	$64,438,000
FY 2010	$64,301,000
FY 2010 Prevention Fund	$31,431,000
FY 2011	$64,046,000
FY 2012	$63,925,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, technical assistance and related program outreach activities, and activities of the National Advisory Council on Nurse Education and Practice which is charged with the responsibility of advising on PHS Title VIII Nursing Workforce Development programs.

Budget Request

The FY 2013 Budget Request of $83,925,000 is an increase of $20,000,000 above the FY 2012 Enacted Level. The total request supports investments to expand the production and skills of the advance practice nursing workforce needed to meet the public's growing demand for accessible effective health care services.

The increase will provide funding for 29 grants for ANE Expansion II programs planned to begin in FY 2013 and contribute to the overall production goal of an additional 1,400 primary care APRNs . In addition, the total request will provide traineeships for primary care APRN students through the AENT Program at the enhanced level of funding initiated in FY 2012.

The AENT Program was restructured in FY 2012 in two ways: 1) it was converted from a formula-based to competitive grant program; and 2) traineeship support was targeted to primary

care APRNs. Funds for the first year of training for nurse anesthesia students, which had been provided under the AENT program prior to FY 2012, were shifted to the NAT program. This shift in resources allows the NAT program, which continues as a formula-based program, to provide full two-year traineeship support for nurse anesthesia students.

Funding for the ANE Program, which supports projects to build and enhance the capacity of advanced nursing education programs, was reduced in FY 2012 compared with FY 2011 and shifted funds to the AENT Program to support greater production of primary care APRNs. Available funds for the AENT program were increased to incentivize schools to increase the number of students in primary care and encourage full-time enrollment to accelerate the production of new primary care APRNs. The funding levels across the various advanced nursing programs will be maintained in FY 2013.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result[2]/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Advanced Nursing Education Program[3]:				
Number of students	7,863 Target: 7,518 (Target exceeded)	6,255	6,255	Maintain
Number of minority or disadvantaged students enrolled	3,605 Target: 1,875 (Target exceeded)	1,560	1,560	Maintain
% minority/disadvantaged enrollment	38% Target: 24% (Target exceeded)	24%	24%	Maintain
Number of graduates	1,840 Target: 1,785 (Target exceeded)	1,785	1,485	-300
Traineeship Programs[4]:				
Number of students supported	12,325 Target: 8,820 (Target exceeded)	2,910[5]	2,910[4]	Maintain
Number of graduates supported	7,744 Target: 3,918 (Target exceeded)	1,510[4,6]	1,965[4,5]	+455
Number of graduates practicing in underserved areas	7,548 Target: 5,298	780[4,5]	920[4,5]	+140

[2] Most recent result is for Academic Year 2010-2011 and funded in FY 2010.
[3] ANE Program outputs include trainees across all specialties
[4] Traineeship programs include the AENT and NAT programs
[5] Targets reflect program restructuring.
[6] NAT Program only. AENT Program will not have graduates until FY 2013.

Measure	Year and Most Recent Result[2]/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
	(Target exceeded)			
ANEE Program:[7](cumulative)				
Number of students supported	152	980	980	Maintain
6.I.C.3.c: Number of nurse practitioners who complete their education through HRSA's Bureau of Health Professions programs supported with Prevention and Public Health funding	N/A[8]	110	150	+40

Grant Awards Table – ANE

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	150	125	125
Average Award	$278,300	$278,300	$278,300
Range of Awards	$79,500-589,400	$79,500-589,400	$79,500-589,400

Grant Awards Table – AENT

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	350	65	65
Average Award	$45,600	$330,000	$330,000
Range of Awards	$2,000-$282,300	$330,000	$330,000

Grant Awards Table – NAT

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	82	82	82
Average Award	$15,260	$25,000	$25,000
Range of Awards	$1,700-$42,000	$2,800-$69,000	$2,800-$69,000

[7] Target data for student supported in FY 2013 includes the PPHF funded students in FY 2010 and the ANE Expansion II students.
[8] Stipends for this program began and AY 2011-2012, therefore data is not available.

Grant Awards Table – ANE Expansion II

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	--	--	29
Average Award	---	---	$576,000
Range of Awards	---	---	$576,000

Nursing Workforce Development

Nursing Workforce Diversity

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$16,009,000	$15,819,000	$15,819,000	---
FTE	1	1	1	--

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

FY 2013 Authorization .....Such Sums as Necessary

Allocation Method .....Competitive Grant/Contract

Program Description: The Nursing Workforce Diversity (NWD) Program increases nursing education opportunities for individuals from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among registered nurses) by providing student stipends and scholarships; stipends for diploma or associate degree nurses to enter a bridge or degree completion program; and, student scholarships or stipends for accelerated nursing degree programs, pre-entry preparation, advanced education preparation, and retention activities.

Need: A diverse health care workforce with diverse executive leadership and governance is necessary to help meet the needs of a diverse minority population and reduce health disparities and inequities. A U.S. Department of Health and Human Services report identifies 14 principles for minority health equity, including the recommendation for health care professional schools and the health care workforce to represent and reflect the diverse communities.[1] The 2008 National Sample Survey of Registered Nurses reports that only 17 percent of the nursing workforce comes from racial/ethnic minority groups. While there has been a modest increase, additional efforts are needed to ensure a more diverse nursing workforce. An estimated 500,000 registered nurses from racial/ethnic minority groups would be needed if the nurse population were to reflect the U.S. population as a whole.

Goal: To increase nursing education opportunities for individuals from disadvantaged backgrounds, including racial and ethnic minorities underrepresented among registered nurses to improve the diversity of the health care workforce and to improve the diversity of the nursing workforce to meet the increasing need for culturally sensitive and quality health care.

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

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

Designated Health Professions:	**Targeted Educational Levels:**	**Program Activities:**
• Registered Nurses (RNs) • Second degree students	• Pre-Entry Preparation - middle school students - high school students - high school graduates or equivalent - certified nursing assistants - licensed practical or vocational nurses • Diploma or Associate Degree RNs • Individuals with bachelors degree in another discipline • RNs who matriculate into accredited bridge or degree completion program within the three-year project period. • Baccalaureate degree • Advanced nursing education	• Grantees use academic, social and financial supports through academic pipeline to support basic preparation and educational advancement of disadvantaged and minority nurses for leadership positions within the nursing profession and the health care community. • Support pre-entry academic advising, mentoring, and enrichment activities. • Prepare diploma or associate degree RNs to become baccalaureate-prepared RNs. • Prepare practicing RNs for advanced nursing.

Program Accomplishments: In FY 2010, 45 grantees provided academic enrichment support, financial assistance, and coaching and mentoring services for 5,938 middle school and high school students; 1,344 post high school, college, and pre-entry nursing students; 3,341 nursing students and produced 1,051 nursing graduates.

Program engagement of underrepresented minority students has grown relative to disadvantaged white students, resulting in the percent of underrepresented minority students exceeding their targets while not meeting the targets for other disadvantaged students. Level program funding and rising educational costs has likely affected the ability of grantees to meet the targets for the number of student participants.

Funding History

FY	**Amount**
FY 2008	$15,826,000
FY 2009	$16,107,000[2]
FY 2009 Recovery Act	$2,756,000
FY 2010	$16,073,000
FY 2011	$16,009,000
FY 2012	$15,819,000

[2]Regular Appropriation only.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, technical assistance and related program outreach activities, and activities of the National Advisory Council on Nurse Education and Practice which is charged with the responsibility of advising on PHS Title VIII Nursing Workforce Development programs

Budget Request

The FY 2013 Request of $15,819,000 is the same as the FY 2012 Enacted Level. The total request will continue to support the education of pre-nursing and nursing students to become registered nurses and the preparation of participants for entry into a professional nursing program through pre-entry preparation, retention and stipend/scholarship program activities.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result[3]/ Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Disadvantaged Students/Participants				
Number (percent) of underrepresented minority students	8,161 (77%) Target: 6,120 (70%) (Target exceeded)	8,000	8,000	Maintain
Number (percent) of white disadvantaged students/participants	2,470 (23%) Target: 3,061 (26%) (Target not met)	2,500	2,500	Maintain
Level of Students/Participants				
Number of nursing program students	3,349 Target: 3,628 (Target not met)	3,350	3,350	Maintain
Number of post high school, college, and pre-entry nursing students	1,344 Target: 1,882 (Target not met)	1,300	1,300	Maintain
Number of K-12 students/participants	5,938 Target: 6,128 (Target not met)	5,900	5,900	Maintain
Number of nursing students graduating from nursing programs	1,051[4]	950	950	Maintain

[3] Most recent result is for Academic Year 2010-2011 and funded in FY 2010.
[4] There was no target for this measure in FY 2010.

Measure	Year and Most Recent Result[3]/ Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Student Financial Support				
Number of nursing students expected to receive scholarships	735 Target: 814 (Target not met)	735	735	Maintain

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	45	45	45
Average Award	$316,000	$316,000	$316,000
Range of Awards	$134,600-$528,000	$134,600-$528,000	$134,600-$528,000

Nursing Workforce Development

Nurse Education, Practice, Quality and Retention Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$39,653,000	$39,182,000	$39,182,000	---
FTE	2	2	2	--

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

FY 2013 Authorization Section 831 .....Such Sums as Necessary

FY 2013 Authorization Section 831A…….....Expired

Allocation Method .....Competitive Grant/Contract

Program Description: The Nurse Education, Practice, Quality and Retention (NEPQR) Program is broad in scope and supports initiatives to expand the nursing pipeline, promote career mobility, enhance nursing practice, provide continuing education and support retention.

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

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

Eligible Entities: Accredited schools of nursing, health care facilities, and partnerships of a nursing school and health care facility.

Designated Health Professions:	**Targeted Educational Levels:**	**Program Activities:**
• Registered nurses • Certified nursing assistants • Home health aides • Licensed practical nurses • Licensed vocational nurses	• Baccalaureate education • Advanced nursing education • Licensed practical nurses • Certified nursing assistants • Home health aides	• Expand enrollment in baccalaureate nursing programs • Provide education in new technologies including distance learning methodologies • Develop internships and residency programs • Provide continuing education and training

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
		• Develop cultural competencies • Offer programs to promote nurse retention • Increase access to primary care and clinical training sites for primary care advanced practice nurses

Program Accomplishments: In FY 2011, the NEPQR Program funded 106 projects that supported training and educational innovations for pre-licensure nursing students, continuing education for registered nurses, and expanded services and skill development opportunities for the care of high-risk and vulnerable populations. In FY 2010, in response to instructions in the Senate Appropriations language, this program expanded beyond the scope of registered nurse training to include training grants for nursing aides and home health aides; funding was continued for these training grants in FY 2011.

Funding History

FY	Amount
FY 2008	$36,640,000
FY 2009	$37,291,000
FY 2010	$39,811,000
FY 2011	$39,653,000
FY 2012	$39,182,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, technical assistance and related program outreach activities, and activities of the National Advisory Council on Nurse Education and Practice which is charged with the responsibility of advising on PHS Title VIII Nursing Workforce Development programs.

Budget Request

The FY 2013 President's Budget Request of $39,182,000 is the same as the FY 2012 Enacted Level. The total request will support projects to increase the educational opportunities, clinical practice skills, and utilization of the nursing workforce and to enhance the quality of patient care. Projects to develop and disseminate interprofessional collaborative practice models to improve patient care are of particular interest.

Outcomes and Outputs Tables

The NEPQR program solicits applications addressing any of its education, practice and retention purposes, one of which is accelerated BSN education projects. The program accepts all

applications that are eligible and does not have a funding preference among them. Consequently, achieving the target number of expanded BSN programs is fully dependent upon the eligible

applications submitted. The purposes of the NEPQR are broad and flexible, allowing the program to address the emerging needs in nursing workforce development to advance education and practice priorities. As the program adapts to these emerging needs and priorities in the future, new outcome measures will be added as appropriate.

Measure	Year and Most Recent Result[1]/ Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Number of expanded BSN education projects	22 Target: 20 (Target exceeded)	22	22	Maintain
Number of BSN student participants	4,860 Target: 4,700 (Target exceeded)_	4,860	4,860	Maintain

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	106	105	105
Average Award	$296,000	$296,000	$296,000
Range of Awards	$195,000-$667,000	$195,000-$667,000	$195,000-$667,000

[1] Most recent result is for Academic Year 2010-2011 and funded in FY 2010.

Nursing Workforce Development

Nurse Faculty Loan Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$24,848,000	$24,553,000	$24,553,000	---
FTE	1	1	1	--

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

FY 2013 Authorization ..... Such Sums as Necessary

Allocation Method ..... Formula Grant

Program Description: The Nurse Faculty Loan Program (NFLP) supports the establishment and operation of a loan fund within participating schools of nursing to assist nurses in completing their graduate education to become qualified nurse faculty. Eligible schools receiving awards under the NFLP Program are required to contribute to the loan fund no less than one-ninth of the award amount. Following graduation from the nursing program, the nursing school will cancel up to 85 percent of the loan principal and interest in exchange for the loan recipient's service as a full-time nursing faculty at a school of nursing, with a certain percentage cancelled each year for up to four years. The NFLP loans are repayable and/or cancelled over a ten-year repayment period.

Need: An insufficient number of qualified nursing faculty continues to be the primary barrier to accepting all qualified students at nursing colleges and universities. The current nurse faculty vacancy rate is estimated at nearly seven percent and is particularly acute among doctorally-prepared faculty. Between 200-300 doctorally prepared faculty were eligible for retirement annually over the past decade and between 200-280 mastered-prepared faculty will be eligible over the next five years.[1]

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

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

[1]American Association of Colleges of Nursing (http://www.aacn.nche.edu/media-relations/fact-sheets/nursing-faculty-shortage). Nurse Faculty Shortage Fact Sheet (updated April 14, 2011).

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Nursing	• Graduate (masters and doctoral)	• **Loan Fund:** - Provides funding to nursing schools to establish and operate revolving loan fund - Provide low interest rate loans to nursing students - Loans may be used to pay costs of tuition, fees, books, laboratory expenses, and other education expenses. - Requires institutional match of at least 1/9 of the Federal contribution to loan fund - Students are limited to four years of loan support • **Loan Cancellation Provision:**

Program Accomplishments: In FY 2010, 1,551 students pursuing faculty preparation, including 1,063 in doctoral programs and 488 in masters programs were supported.

IT Investments

The Nurse Faculty Loan Program funds HRSA OIT – Electronic Handbooks Investment. The HRSA OIT – Electronic Handbooks Investment supports the Nurse Faculty Loan Program with program administration, grants administration and monitoring, management reporting, and grantee performance measurement and analysis. In addition, this investment supports the procedures used to execute the formula for NFLP awards, and for tracking awards and their cancellation. The Electronic Handbooks supports the strategic and performance outcomes of the Program and contributes to its success by providing a mechanism for sharing data and conducting business in a more efficient manner.

Funding History

FY	Amount
FY 2008	$7,860,000
FY 2009	$11,500,000[2]
FY 2009 Recovery Act	$12,000,000
FY 2010	$24,947,000
FY 2011	$24,848,000
FY 2012	$24,553,000

Funding includes costs associated with processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, program oversight activities, technical assistance and related program outreach activities, and activities of the

[2] Regular Appropriations only

National Advisory Council on Nurse Education and Practice which is charged with the responsibility of advising on PHS Title VIII Nursing Workforce Development programs.

Budget Request

The FY 2013 Budget Request of $24,553,000 is the same as the FY 2012 Enacted Level. The total request will support schools of nursing to establish and operate loan funds. The number of grantee schools is not anticipated to increase as many of the schools offering faculty preparation are already funded, and each has additional unmet need. The number of schools receiving awards in any year may be lower than the total number of schools providing funds to students that year. Some schools may have sufficient funds in their loan account from the prior year so they do not require additional funds to continue to make awards.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result[3]/ Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Number of schools providing NFLP awards	114 Target: 114 (Target met)	114	114	Maintain
Number of students supported	1,551 Target: 1,518 (Target exceeded)	1,510	1,510	Maintain
Number of graduates	271[4]	275	275	Maintain

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	114	114	114
Average Award	$205,970	$205,970	$205,970
Range of Awards	$1,000-$1,790,000	$1,000-$1,790,000	$1,000-$1,790,000

[3] Most recent result is for Academic Year 2010-2011 and funded in FY 2010.
[4] This measure does not a comparable FY 2010 target.

Nursing Workforce Development

Comprehensive Geriatric Education

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$4,539,000	$4,485,000	$4,485,000	---
FTE	1	1	1	--

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

FY 2013 Authorization .....Such Sums as Necessary

Allocation Method .....Competitive Grant/Contract

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

Need: More than 65 million people, 29 percent of the adult U.S. population, provide care for a chronically ill, disabled or an aged family member or friend during any given year and spend an average of 20 hours per week providing care for their loved one.[1] In addition, the Institute of Medicine[2] reported that direct-care workers, also referred to as paraprofessionals, are the primary providers of paid hands-on care, supervision, and emotional support for older adults in the U.S., primarily in nursing homes, assisted living facilities, and home and community-based settings. Projected employment for home health aides and personal and home care aides in 2018 will reach 2,575,600. This represents an almost 50 percent growth in the number of jobs available in these occupations and makes them among the fastest growing jobs in the country.

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

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

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

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

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• All health professions • Direct service workers • Individuals	• Certificate • Diploma • Undergraduate • Graduate • Post-graduate • Individuals with no professional education	• Provide training to individuals who will provide geriatric care for the elderly • Develop and disseminate curricula relating to treatment of health problems of elderly individuals • Train faculty in geriatrics • Provide continuing education to individuals who provide geriatric care • Establish traineeships for individuals preparing for advanced education nursing degrees in geriatric nursing, long-term care, gero-psychology nursing or other nursing areas that specialize in the care of the elderly population.

Program Accomplishments: In Academic Year 2010-2011, 27 non-competing Comprehensive Geriatric Education (CGEP) grantees provided education and training to 3,645 registered nurses, 1,238 registered nursing students, 870 direct service workers, 569 licensed practical/vocational nurses, 264 faculty and 5,344 allied health professionals.

Funding History

FY	Amount
FY 2008	$3,333,000
FY 2009	$4,567,000
FY 2010	$4,557,000
FY 2011	$4,539,000
FY 2012	$4,485,000

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and program oversight activities.

Budget Request

The FY 2013 President's Budget Request of $4,485,000 is the same as the FY 2012 Enacted Level. The total request will provide support for 16 new Comprehensive Geriatric Education Program grantees. The Affordable Care Act expanded the use of funds for the Comprehensive Geriatric Education Program to include the establishment of traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing, long-term care, gero-

psychiatric nursing or other nursing areas that specialize in the care of the elderly population. An increase in the amount of $153,312 per project to support an estimated increase of two individuals in each project will increase each award from $127,000 in FY 2011 to $280,312 in FY 2013. As a result of the increase in the amount of each award, the number of awards will decrease from 27 to 16.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result[3]/ Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Number of CGEP Grantees	27 Target: 27 (Target met)	16	16	Maintain

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	27	16	16
Average Award	$127,000	$280,312	$280,312
Range of Awards	$120,025-$172,800	$246,100-$320,100	$246,100-$320,100

[3] Most recent result is for Academic Year 2010-2011 and funded in FY 2010.

Patient Navigator Outreach and Chronic Disease Prevention Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$4,990,000	---	---	---
FTE	2	---	---	---

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

FY 2013 Authorization .....Such Sums as Necessary

Allocation Method .....Grant/Contract

Program Description: The Patient Navigator Outreach and Chronic Disease Prevention (Patient Navigator) Program, a demonstration grant program, makes available grants which provide training to individuals to reduce barriers to care, promote health education, and encourage the use of primary care services to populations with health disparities. By coordinating health care services and community resources, the patient navigators assist patients in receiving prompt diagnosis and treatment. Demonstration grants are scheduled to end on August 30, 2012.

Need: Widespread failings in chronic care management are a major National concern. Many of these failings stem from systemic problems, rather than a lack of effort or intent by providers to deliver high quality care. In addition, patients with multiple chronic disease co-morbidities are often disproportionately affected, because of the complexity of their self-care regimes and medical care needs.[1] They have a higher risk of developing co-morbid conditions, complications, and acute care crises. Controlling these conditions successfully may require ongoing guidance and support beyond individual provider settings.

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

Eligible Entities: Public and nonprofit private health centers, health facilities operated by or pursuant to a contract with the Indian Health Service, hospitals, cancer centers, rural health clinics, academic health centers, or nonprofit entities that enter into partnerships or coordinates referrals with such centers, clinics, facilities, or hospitals to provide patient navigation services.

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

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
Paraprofessional	N/A	• Recruit, train and employ patient navigators who have direct knowledge of the communities they serve to facilitate the care of patients • Develop and operate patient navigator programs • Identify and help patients overcome barriers within the health system • Conduct ongoing outreach to health disparities populations • Coordinate with relevant health insurance ombudsman programs • Evaluate outcomes of program

Program Accomplishments: Funds were first appropriated in FY 2008 for six grants with two-year project periods. The initial six grantees trained 37 navigators who provided outreach to about 20,000 patients and navigated about 6,500 patients over the two-year project period. The reauthorized Patient Navigator Demonstration Program supported 10 grantees that employed approximately 44 navigators. At the close of FY 2011 a total of 1,359 patients with chronic illness have been navigated.

Funding History

FY	Amount
FY 2008	$2,948,000
FY 2009	$4,000,000
FY 2010	$4,965,000
FY 2011	$4,990,000
FY 2012	---

Funding includes costs associated with processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and program oversight activities.

Budget Request

No funds are requested for this program in FY 2013. The Patient Navigator Program was authorized in FY 2005 as a demonstration program and has been successful in accomplishing its goal and may serve as a model for future efforts. A Report to Congress, to be submitted after the completion of the program, will describe patient navigator services as a promising model for chronic disease prevention and management.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	10	--	--
Average Award	$400,000	---	---
Range of Awards	$400,000	---	---

Children's Hospitals Graduate Medical Education Payment Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB	FY 2013 + / - FY 2012
BA	$268,356,000	$265,171,000	$88,000,000	-$177,171,000
FTE	31	31	21	-10

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

FY 2013 Authorization ..... Expired

Allocation Method ..... Formula Based Payment

Program Description: The Children's Hospitals Graduate Medical Education (CHGME) Payment Program supports graduate medical education (GME) in freestanding children's teaching hospitals. It supports the training of residents and fellows and enhances the supply of primary care and pediatric medical and surgical subspecialties.

Need: The CHGME Payment Program addresses the disparity in Federal support for GME between freestanding children's hospitals and other teaching hospitals supported by Medicare. These children's hospitals are considered safety net hospitals as they serve a large number of Medicaid and uninsured patients and provide charity care.

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

Eligible Entities: Freestanding children's teaching hospitals

Designated Health Professions:	**Targeted Educational Levels:**	**Program Activities:**
• Pediatric • Pediatric medical • subspecialties • Pediatric surgical • subspecialties • Adult primary care • Adult Medical subspecialties • Adult surgical subspecialties • Dentistry	• Graduate medical education	• Monthly payments to the participating children's hospitals • The CHGME program established a Resident Assessment Program and hospitals are audited during the period of October through March of each fiscal year as required by Public Law 109-307. The audits focus only on the number of resident FTEs being claimed for GME support. • Submit an annual report on the status and expansion of GME in their institutions

Program Accomplishments: In FY 2010, the CHGME Payment Program supported 55 freestanding children's hospitals located in 30 States and Puerto Rico. These children hospitals were responsible for the training of about 6,000 full-time equivalent (FTE) residents on and off site: Approximately 46 percent of the FTEs were pediatric residents, 28 percent were pediatric subspecialty residents, and 26 percent non-pediatric residents such as family practice residents or cardiology residents rotating in children hospitals to learn about care of children is their respective areas of expertise.

IT Investments

The CHGME Payment Program funds two IT Investments. HRSA has established a CHGME Payment Program System that computes CHGME interim and final payments and helps determine if any recoupment and redistribution of funds are necessary. Children's hospitals, HRSA staff and fiscal intermediaries currently utilize an EHB web-based application to apply for funds, process and review applications, and document audit results. In order to increase oversight of the program, this functionality has been integrated with the Electronic Handbooks (EHBs), HRSA's centralized system for grants management.

The HRSA OIT – Electronic Handbooks Investment will support the CHGME Payment Program with program administration, grants administration and monitoring, management reporting, and grantee performance measurement The Electronic Handbooks supports the strategic and performance outcomes of the program and contributes to its success by providing a mechanism for sharing data and conducting business in a more efficient manner.

Funding History

FY	Amount
FY 2008	$301,646,000
FY 2009	$310,000,000
FY 2010	$316,824,000
FY 2011	$268,356,000
FY 2012	$265,171,000

Funding includes costs associated with processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and program oversight activities.

Budget Request

The FY 2013 Budget Request of $88,000,000 is a decrease of $177,171,000 below the FY 2012 Enacted Level. The total request is about one-third of the FY 2012 Enacted Level, which will allow for support of the direct medical expenses for graduate medical education. There are two types of GME funding, direct and indirect. Direct medical education spending includes expenditures related to stipends and fringe benefits for residents; salaries and fringe benefits of supervising faculty; cost associated with providing the GME training program; and, allocated institutional

overhead costs. "Indirect medical education (IME) spending includes expenditures associated with the reduced productivity of the hospital staff because they are helping train residents, and the processing of additional diagnostic tests that residents may order during their clinical experience. Indirect medical education costs are not well-documented and studies indicate that they may be overstated. (MedPac Report to Congress, June 10, 2010 Chapter 4. See: http://www.medpac.gov/chapters/Jun10_CH04.pdf.) The elimination of support for IME in FY 2013 may not have a substantial impact on the number of residents trained in the short-run as programs have infrastructure in place to support specific residency class sizes.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result[1]/ Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
7.I.A.1: Maintain the number of FTE residents in training in eligible children's teaching hospitals	6,040 Target: 5,900 (Target exceeded)	5,900	5,900	Maintain
7.VII.C.1: Percent of hospitals with verified FTE residents counts and caps	100% Target: 100% (Target met)	100%	100%	Maintain
7.E: Percent of payments made on time	100% Target: 100% (Target met)	100%	100%	Maintain

Grant Awards Table
Size of Award

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Number of Awards	55	55	55
Average Award	$4,598,544	$4,339,162	$1,600,000
Range of Awards	$24,476-$17,706,486	$23,094-$16,707,755	$8,516 - $6,160,731

[1] Most recent result is for Academic Year 2010-2011 and funded in FY 2010.

National Practitioner Data Bank

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$26,976,194	$28,016,000	$28,016,000	---
FTE	41	41	41	---

Authorizing Legislation: Section IV, P.L. 99-660; Healthcare Quality Improvement Act of 1986, as amended by P.L. 100-177; Section 1921 of the Social Security Act as amended by Section 5(b), Medicare and Medicaid Patient Protection Act of 1987 (P.L. 100-93), and Omnibus Budget Reconciliation Act of 1990 (P.L. 100-508); Subtitle C of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104-191), establishes Section 1128E of the Social Security Act; and Section 6403 of the Affordable Care Act of 2010.

FY 2013 Authorization ..... Indefinite

Allocation Method ..... User Fee Program

Program Description: The National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) serve as a flagging system intended to prompt a comprehensive review of health care practitioners' licensure activity, medical malpractice payment history and record of clinical privileges. The NPDB and HIPDB aim to alert users to the value of completing a thorough review of past actions of health care practitioners, providers and suppliers. Used in conjunction with information from other sources, the NPDB and HIPDB assist in promoting quality health care, and deterring fraud and abuse in the health care delivery system.

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

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

Consolidation: The Affordable Care Act requires that the HIPDB be merged into the NPDB, thus ending the duplication of effort and cost between the two Data Banks. This will effectively move HIPDB revenue and associated costs into the NPDB. The users that currently query both Data Banks will receive the same information with one query, thereby reducing their cost by half. The merger of the two Data Banks is scheduled to occur after the publication of final regulations in late FY 2012.

For comparability purposes, FY 2011 user fees for each data banks have been added together.

Program Accomplishments:

- Enhanced security of the NPDB-HIPDB system by the implementation of identity proofing and second factor authentication for approximately 46,000 users and added a Fraud Detection Service.
- Collaborated on a project with the Federation of State Medical Boards to compare the accuracy and completeness of reports submitted to the NPDB and State Medical Boards by other mandated reports: medical malpractice payers and hospitals.
- Partnered with State licensing boards to strengthen compliance efforts which resulted in a 23 percent increase, from FY 2010 to FY 2011, in health care professions that had never reported to the Data Bank.
- Conducted a comprehensive review comparing publicly available adverse action data to data in the Data Bank resulting in a 96 percent compliance rate for 11 professions: nurses, pharmacists, physician assistants, podiatrists, psychologists, social workers, physicians, dentists, chiropractors, optometrists, and physical therapists.
- Implemented process efficiencies and an internal web based application to perform daily work resulting in an increase in completed dispute cases.

IT Investments: The NPDB is a web based electronic reporting and querying system that has been operational since 1999. Reports and queries can be submitted interactively using the web-based Integrated Query and Reporting Services (IQRS) over the internet or via electronic file transfer using a transmission protocol and format specified by the Data Banks. Credit card and Electronic Funds Transfer (EFTs) transactions are securely processed using the U.S. Department of Treasury's Pay.gov service. The IT investment supports the Data Banks' strategic mission by providing information to the users expeditiously.

Funding History

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

FY	Amount
FY 2008	$24,545,442
FY 2009	$25,457,130
FY 2010	$27,717,315
FY 2011	$26,976,194
FY 2012	$28,016,000

Budget Request

As mandated by the Health Care Quality Improvement Act, the NPDB does not receive appropriated funds. Instead, the NPDB is financed by the collection of user fees. Annual Appropriations Act language since FY 1993 requires that user fee collections cover the full cost of NPDB operations; therefore, there is no request for appropriation for operating the NPDB. It is anticipated that with the implementation of Section 6403 of the Affordable Care Act, the HIPDB will be terminated and merged into the NPDB. User fees are established at a level to cover all program costs to allow the Data Banks to meet annual and long term program performance goals. Fees are established based on query volume to result in adequate, but not

excessive, revenues to pay all program costs to meet program performance goals. The NPDB estimate for FY 2013 is 5,306,000 queries, resulting in projected user fee collections of $28,016,000.

Outcomes and Outputs Tables
This program will be developing new measures that will better reflect program performance based on the merger proposed to occur in FY 2012.

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
8.III.B.1: Increase annually the use of the NPDB and HIPDB for licensing and credentialing decision-making, operationalized as the number of licensing and credentialing decisions which limit practitioner's ability to practice.	FY 2011: 57,227 Decisions Target: 54,500 Decisions (Target Exceeded)	54,500 Decisions	54,500 Decisions	Maintain
8.III.B.5: Increase the number of practitioners enrolled in Continuous Query, (which is a subscription service for queriers that notifies them of new information on enrolled practitioners within 24 hours of the Data Bank receipt of the information).[1]	FY 2011: 899,149 Enrolled practitioners (Target Not in Place)	999,000 Enrolled practitioners	1,074,000 Enrolled practitioners	+75,000
8.E: Increase annually the number of queries for which NPDB and HIPDB responded within 240 minutes	FY 2011: 5,405,184 Queries Target: 5,306,000 Queries (Target Exceeded)	5,306,000 Queries	5,306,000 Queries	Maintain

[1] This is a new measure.

Maternal and Child Health

Tab

Maternal and Child Health

Maternal and Child Health Block Grant

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$656,319,000	$638,646,000	$640,098,000	+$1,452,000
FTE	30	30	27	-3

Authorizing Legislation - Title V of the Social Security Act.

FY 2013 Authorization $850,000,000
Allocation Methods:

- Direct federal/intramural
- Contract
- Formula grant/co-operative agreement
- Competitive grant/co-operative agreement

Program Description and Accomplishments

The mission of the Maternal and Child Health (MCH) Block Grant Program, as authorized under Title V of the Social Security Act, is to improve the health of all mothers, children, and their families. These legislated responsibilities reduce health disparities, improve access to health care, and improve the quality of health care. Specifically the program seeks to: (1) assure access to quality care, especially for those with low-incomes or limited availability of care; (2) reduce infant mortality; (3) provide and ensure access to comprehensive prenatal and postnatal care to women (especially low-income and at risk pregnant women); (4) increase the number of children receiving health assessments and follow-up diagnostic and treatment services; (5) provide and ensure access to preventive and primary care services for low income children as well as rehabilitative services for children with special health needs; (6) implement family-centered, community-based, systems of coordinated care for children with special health care needs (CSHCN); and (7) provide toll-free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Title XIX (Medicaid).

Section 502 of the Social Security Act states that of the amounts appropriated, up to $600,000,000, 85% is for allocation to the States, and 15 % is for Special Projects of Regional and National Significance (SPRANS) activities. Any amount appropriated in excess of $600,000,000 is distributed as follows: 12.75% is for Community Integrated Service Systems (CISS) activities; of the remaining amount, 85% is for allocation to the States, and 15% is for SPRANS activities.

The MCH Block Grant is at its core a public health program that reaches across economic lines to improve the health of all mothers and children. Created as a partnership with State MCH

programs and with broad State discretion, State Title V programs use appropriated formula grant funds for: capacity and systems building, public information and education, knowledge development, outreach and program linkage, technical assistance, provider training, evaluation, support for newborn screening and genetic services, lead poisoning and injury prevention, additional support services for children with special health care needs, and promotion of health and safety in child care settings.

Special efforts are made to build community capacity to deliver such enabling services as care coordination, transportation, home visiting, and nutrition counseling. Where no services are available, States also use Title V to provide categorical direct care such as prenatal care or services for children with special health care needs.

Table 1. Maternal and Child Health Block Grant Activities ($ in thousands)

MCHB Activities	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB	FY 2013+/- FY 2012
State Block Grant Awards[1]	$555,716	$549,729	$551,181	+$1,452
SPRANS	$90,224	$78,641	$78,641	---
CISS	$10,379	$10,276	$10,276	---
Total	$656,319	$638,646	$640,098	+$1,452

Additional activities that support the improved health care of mothers and children are SPRANS and CISS. SPRANS funds support projects (through grants, contracts, and other mechanisms) in research, training, genetic services and newborn screening and follow-up, sickle cell disease, hemophilia, and maternal and child health improvement. SPRANS projects must:

- Support national needs and priorities or emerging issues;
- Have regional or national significance; and
- Demonstrate ways to improve State systems of care for mothers and children.

CISS projects (through grants, contracts, and other mechanisms) seek to increase the capacity for service delivery at the local level and to foster formation of comprehensive, integrated, community level service systems for mothers and children using one or more of six specified strategies:

- Provide maternal and infant home health visiting, health education, and related support services for pregnant women and infants up to one year old;
- Increase participation of obstetricians and pediatricians under Titles V and XIX;
- Integrate MCH service delivery systems;

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

- Operate MCH centers under the direction of not-for-profit hospitals;
- Increase MCH projects in rural areas; and
- Provide outpatient and community-based services for children with special healthcare needs.

Table 2. Maternal and Child Health Block Grant SPRANS Set-Aside Grants ($ in thousands)

MCH SPRANS Set-Aside Programs	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB	FY 2013+/- FY 2012
SPRANS	$72,817	$67,786	$67,786	---
SPRANS - Oral Health	$3,821	$3,775	$3,775	---
SPRANS – Epilepsy	$3,685	$3,642	$3,642	---
SPRANS - Sickle Cell	$2,997	$2,961	$2,961	---
SPRANS - Fetal Alcohol	$483	$477	$477	---
SPRANS – Doula	$1,495	---	---	---
SPRANS - 1st time Motherhood	$4,926	---	---	---
Total SPRANS	$90,224	$78,641	$78,641	---
CISS	$10,379	$10,276	$10,276	---

The MCH Block grant program provides support to all 59 States and jurisdictions. Consistent with other HRSA programs, the MCH Block grant addresses three overarching goals: 1) improving access to quality health care and services; 2) improving health equity; and 3) building healthy communities.

Funds are allotted to States based on a legislated formula which provides the amount allotted to each State in 1983, and when the amount available exceeds that level, the excess is distributed based on the States' proportion of children in poverty. Historically, the State Title V MCH Block Grant allocations were calculated based on the child poverty data reported in the U.S. Census Bureau's decennial census. The American Community Survey (ACS) replaced the decennial census long form as the source for annual State-specific child poverty statistics. Beginning in FY 2013, data from the ACS will be used as the reference data for calculating the annual State Title V MCH Block Grant formula allocations. The state table reflects the child poverty data based on the 2010 estimates as of November 2011.

Accomplishments

By working to improve access to quality health care and services, the program has been able to exceed the targets for both the number of children served by the States under Title V (34.5 million in FY 2010) and the number of children receiving Title V services who have Medicaid and Child Health Insurance Program (CHIP) coverage (14.3 million in FY 2010). In FY 2008,

the Title V MCH Block Grant Program served the largest number of children (35 million) since data collection began in the Title V Information System in the 1990's. Despite a decrease in FY 2009 to 33.3 million, the number of children served by Title V increased by 1.2 million from FY 2009 to FY 2010. Increased coverage under Medicaid and CHIP for children receiving Title V services better assures access, availability, and continuity of care to a wide range of preventive and acute care services. Exceeding the targets is significant as these increases occurred in a period of severe financial constraints at the State and local levels. In FY 2009, 15.2 million children who received Title V services had Medicaid and CHIP coverage. Fewer of the children served by Title V in FY 2010 had Medicaid and CHIP coverage than in FY 2009. However, the number served in FY 2010 is a significant increase over the FY 2002 baseline of 5.9 million.

Health Equity

Title V programs work to improve health equity and eliminate disparities in health outcomes through the removal of economic, social, and cultural barriers to receiving comprehensive, timely, and appropriate healthcare. The ratio of the black infant mortality rate to the white infant mortality rate decreased from 2.48:1 to 2.38:1 from FY 2002 to FY 2009. Preliminary data indicate that the ratio decreased further in 2010 to 2.24:1 (National Vital Statistics Reports).

The Title V program plays an important role in the delivery of appropriate and effective care for high-risk pregnant women and infants. Efforts to reduce the overall infant mortality rate continue, with the rate having decreased from 9.2 per 1,000 live births in 1990 to 6.4 per 1,000 live births in 2009. Based on preliminary data, the infant mortality rate decreased to an all-time low of 6.1 infant deaths per 1,000 births in 2010 (National Vital Statistics Report). With the exception of 2002 and 2005, the infant mortality rate either statistically remained the same or it decreased significantly for each successive year between 1958 through 2010. An increase in the infant mortality rate to 7.0 per 1000 in 2002 reversed, temporarily, a long-term downward trend. Analysis of the 2002 increase concluded that factors contributing to the increase included the higher risk profile of multiple births and an increase in the number of very small infants (less than 750 grams).

HRSA has identified infant mortality as a priority issue and is working collaboratively with the Association of State and Territorial Health Officials (ASTHO), the Association of Maternal and Child Health Programs (AMCHP) and the March of Dimes (MOD) to sponsor an Infant Mortality Summit in the U.S. Department of Health and Human Services' (HHS) Region IV and Region VI States in FY 2012 and to ultimately develop a national strategy for addressing infant mortality and reducing existing disparities observed by race.

Opportunities to Reduce Low Birth Weight

The Bureau continues to explore and promote evidence-based practices to reduce the incidence and better understand the causes of low birth weight. Nationally, the number of low birth weight infants (less than 2500 grams) has been steadily increasing. From 2002 to 2006, the rate of low birth weight infants increased from a baseline of 7.8 percent to 8.3 percent. The low birth weight rate improved slightly in 2007 to 8.2 percent and remained unchanged in 2008 and 2009 (National Vital Statistics Report). Based on preliminary data, the rate of low birth weight

remained at 8.2 percent in 2010. Increases in the number of low birth weight infants have been influenced by: 1) the rise in the multiple birth rate; 2) greater use of obstetric interventions; 3) increases in maternal age at childbearing; and 4) increased infertility therapies. The delivery of very low birth weight infants (i.e. babies born weighing less than 1500 grams) at facilities with specialized equipment and personnel significantly contributes to reducing the risk of mortality. The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates increased in 2006 to 74.7 percent, following a decline from 75.2 percent to 71.7 percent between 2002 and 2004. Since 2007, the rate has steadily increased from 74.8 percent in FY 2007 to 77.3 percent in FY 2009.

The program is partnering with State programs, the Centers for Disease Control and Prevention, and the Association of Maternal and Child Health Programs to assess influential factors in providing risk-appropriate care for very low birth weight infants. These efforts led to an article published in the December 22, 2010 issue of the Maternal and Child Health Journal which examined State measures of risk-appropriate care for very low birth weight infants and identified potential areas for improvement. State regionalization models and measures of risk-appropriate care were found to vary greatly. Mechanisms identified for better measurement of risk-appropriate care included regulation of regionalization programs, data surveillance, review of adverse events, and consideration of geography and demographics. Specific State actions included antenatal or neonatal transfer arrangements, telemedicine networks, acquisition of funding, provision of financial incentives, and patient education.

A 2009 study conducted by the Cecil G. Sheps Center and supported by the Bureau examined the trends in the rate of very low birth weight deliveries in an appropriate hospital and explored reasons that States give for change in this marker. States report that systems exist for coordinating care among multiple providers, but the extent to which regionalized perinatal care systems are regulated and prescribed varies considerably. States are examining where very low birth weight births occur and why some do not occur in facilities for high-risk deliveries. Understanding if health care systems factors have played a role in a poor outcome and identifying which factors could potentially be modified would be an important contribution to improving this indicator. Surveillance of very low birth weight births is necessary for the quality improvement initiatives that are frequently cited by States as processes by which they hope to improve neonatal health and health care.

Prenatal Care for Pregnant Women and their Infants

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

Based on the 27 States for which 2008 revised prenatal care data were available (which represented 65 percent of all 2008 births), almost three-fourths (71 percent) of women reportedly began care within the first 3 months of pregnancy. For the 22 States that reported Revised Birth Certificate data in both 2007 and 2008, the percentage of women who received first trimester care remained essentially unchanged. Early initiation into prenatal care was less common among American Indian/Alaskan Native (53 percent), black (60 percent) and Hispanic (65 percent) women compared with white (77 percent) and Asian (78 percent) women. Given the increasing prevalence of diabetes, obesity and pregnancy-induced hypertension during pregnancy, there is a need for such risk factors to be monitored and for timely and appropriate prenatal care to be provided.

Building State MCH Data Capacity

The Maternal and Child Health Bureau (MCHB) has worked with the State MCH programs to build a data capacity that supports the performance elements in the Title V MCH Block Grant. Efforts have centered on the development of client-based data systems that more accurately capture the direct, enabling and population-based services provided, as required. Previously reported data on the number of children served by Title V and the number of children served who have Medicaid and CHIP coverage were often based on the direct services provided. In addition, increases in the number of children served by Title V who have Medicaid and CHIP coverage reflect the ongoing efforts of the States to do outreach to eligible populations and to increase participation in these programs. MCHB regularly provides technical support to the States around the priorities identified in their comprehensive five-year needs assessments and the areas of needed technical assistance outlined in their annual applications. In the FY 2011 and FY 2012 MCH Block Grant applications, frequently identified areas of needed technical assistance were health disparities, which included disparities in the Black and White Infant Mortality Rates, and healthy perinatal and birth outcomes.

The FY 2011 Actual level included appropriations language which provided SPRANS set aside funds for Oral Health ($3.8 million); Sickle Cell ($3.0 million); Epilepsy ($3.7 million); Fetal Alcohol ($0.48 million); Doula ($1.5 million); and First Time Motherhood ($4.9 million).

Funds were also used to support a survey using the State and Local Area Integrated Telephone Survey (SLAITS) mechanism, which utilizes the sampling frame of the ongoing CDC-Sponsored Immunization Survey (CSIS). SLAITS provides the capacity to field surveys on a wide range of health and welfare related topics using the CSIS screening sample. The survey provides representative, reliable and previously unavailable information on: 1) special healthcare needs among children in 50 States and the District of Columbia, and 2) the competency of the service system in meeting the needs of these children and their families.

Funding History

FY	Amount
FY 2003	$730,710,000
FY 2004	$729,817,000
FY 2005	$723,928,000
FY 2006	$692,521,000
FY 2007	$693,000,000
FY 2008	$666,155,000[2]
FY 2009	$662,121,000[3]
FY 2010	$660,710,000
FY 2011	$656,319,000
FY 2012	$638,646,000

Budget Request

The FY 2013 Request of $640,098,000 is an increase of $1,452,000 from the FY 2012 Enacted Level.

Title V is the only Federal program that focuses solely on improving the health of all mothers, adolescents and children, whether insured or not, through a broad array of public health and community-based programs that are designed and carried out through well-established Federal/State partnerships. The budgeted funds will help State Title V programs support capacity and infrastructure building, population-based and enabling services, as well as direct healthcare services where no services are available. In these latter roles, Title V programs serve as a safety net for uninsured and underinsured children, including CSHCN. Title V continues to play a valuable, complementary role to CHIP and Medicaid programs.

The FY 2013 target for the number of children served by the Title V Block Grant is 30 million. Between 2004 and 2008, the number of children served by Title V steadily increased. There was a slight decrease between 2008 and 2009 which was partially reversed in FY 2010. While the cost of health care has continued to increase, funding for the MCH Block Grant has been relatively level in recent years. The potential for annual increases in the number of children served by the Title V Block Grant may be limited.

The FY 2013 target of 15 million for the number of children receiving Title V services who are enrolled in and have Medicaid and CHIP coverage was set based on the FY 2007, FY 2008, and FY 2009 performance levels of 12.8 million, 14.7 million and 15.2 million, respectively. Steady increases occurred between 2003 and 2009 due to a change in reporting methods by several large States which previously did not report many recipients because of reliance on the use of reimbursement data. Consistent with the observed decrease in the number of children served by Title V since 2008, the number of children served by the program who had Medicaid and CHIP

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

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

coverage fell slightly to 14.3 million in FY 2010. The impact of Medicaid and CHIP expansions in 2009 and the potential for shifts in children served from Title V to Title XIX and Title XXI programs are not yet fully known.

The FY 2013 target for the rate of infant mortality is 6.5 per 1,000 births. Between FY 2009 and FY 2010, preliminary data indicate that the rate of infant mortality decreased by 3.9% from 6.39 to 6.14 per 1,000 live births. Infant mortality continues to be an extremely complex problem with many medical, social and economic determinants, including race/ethnicity, maternal age, education, smoking and economic status. Given the relatively slow rate of progress, the FY 2013 performance target is ambitious and reflects the program's ongoing commitment for continued progress in this area.

The MCHB will continue to monitor emerging issues and areas of needed technical assistance in providing technical support to the States. In addition, the MCHB will continue to explore promising models and effective strategies that promote improved maternal and child health outcomes.

SPRANS and CISS funds will support innovative projects in the areas of: applied MCH research; MCH workforce training in areas such as pediatric pulmonary centers, oral health, behavioral health, nursing, nutrition, schools of public health, and adolescent health; and a variety of MCH Improvement Projects (MCHIP) including: adolescent health; SIDS; "Bright Futures" guidelines for practitioners; medical homes; early childhood comprehensive care systems; and oral health disease prevention and early treatment interventions. SPRANS and CISS both complement and help ensure the success of State Title V, Medicaid, and CHIP programs, building community capacity to create family-centered, integrated systems of care for mothers and children, including children with special healthcare needs.

In addition, Title V funds the only statutorily required genetic services program. This program funds initiatives to facilitate the early identification of children with genetic conditions and works to increase public and professional knowledge of how genetic risk factors affect health in order to create more responsive systems of care. The newborn screening and genetics public health infrastructure activities are to help support State newborn screening and genetics programs, integrate newborn and genetic screening programs with other community services and medical homes, and strengthen existing newborn and genetic screening and service programs. The programs also are established to aid State MCH officials, health care providers, public health professionals and families, and individuals respond to new scientific findings and technologies in the fields of genetic medicine and newborn screening. Special emphasis is being given to the financial, ethical, legal, and social implications of these issues and technologies for maternal and child health populations.

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

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
10.I.A.1: Increase the number of children served by Title V. *(Output)*	FY 2010: 34.5 M Target: 30M (Target Exceeded)	33M	30M	-3M
10.I.A.2: Increase the number of children receiving Title V services who are enrolled in and have Medicaid and CHIP coverage *(Output)*	FY 2010: 14.3 M Target: 12M (Target Exceeded)	14M	15M	+1M

Long Term Objective: Promote outreach efforts to reach populations most affected by health disparities

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
10.IV.B.1: Decrease the ratio of the black infant mortality rate to the white infant mortality rate *(Output)*	FY 2010: 2.2 to1[4] Target: 2.1 to 1 (Target Not Met)	2.1 to 1	2.1 to 1	Maintain

[4] Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2012. Deaths: Preliminary Data for 2010, National Vital Statistics Reports, Vol. 60, No. 4, January 2012.

Long Term Objective: Promote effectiveness of healthcare services.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
10.III.A.1: Reduce the infant mortality rate (Baseline - 2005: 6.9/1,000) *(Outcome)*	FY 2010: 6.1 per 1,000[4] Target: 6.7 per 1,000 (Target Exceeded)	6.6 per 1,000	6.5 per 1,000	-0.1 per 1000
10.III.A.2: Reduce the incidence of low birth weight births *(Outcome)*	FY 2010:[5] 8.2% Target : 8.2% (Target Met)	8.2%	8.1%	-0.1 % point
10.III.A.3: Increase percent of pregnant women who received prenatal care in the first trimester *(Outcome)* (New Baseline- FY 2006: 69%)[6]	FY 2008: 71%[7] (Target Not In Place)	70%	71%	+1% point
10.III.A.4: Increase percent of very low-birth weight babies who are delivered at facilities for high-risk deliveries and neonates *(Outcome)*	FY 2009: 77.3%[8] Target: 75.5% (Target Exceeded)	76%	77%	+1% point
10.3: Increase maternal survival rate (deaths/100,000 live births) *(Outcome)*[9]	FY 2007: 12.7 to 100,000[10] (Baseline)	N/A	N/A	N/A

[5] Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC) 2011. Births: Preliminary Data for 2010, National Vital Statistics Reports, Vol. 60, No. 2, November 201
[6] A new FY 2006 baseline and the FY 2007 result for this measure are based on the use of the 2003 Revised U.S. Standard Birth Certificate. The FY 2007 – FY 2010 targets were established based on the use of the 1989 unrevised Birth Certificate. Therefore, the targets and results should not be compared until FY 2011 when targets and results are both based on the Revised Birth Certificate.
[7] Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention. Expanded Data from the New Birth Certificate, 2008, Vol. 59, No. 7, July 2011.
[8] Source: Title V Information System, HRSA/MCHB (https://mchdata.hrsa.gov/TVISReports).
[9] This is a long-term measure with no annual targets.
[10] Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention. Deaths: Final Data for 2007, Vol. 58, No. 19, May 2010.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	59	59	59
Average Award	$9,267,653	$9,160,454	$9,184,107
Range of Awards	$147,634 - $42,300,762	$145,927 – $41,389,219	$146,303 – $39,074,885

State Table

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

State	FY 2011 Estimate	FY 2012 Estimate	FY 2013 Estimate	Difference +/- 2012
Alabama	11,583,959	11,460,552	11,426,654	-33,898
Alaska	1,103,380	1,091,945	1,052,119	-39,826
Arizona	6,941,708	6,808,014	7,179,930	371,916
Arkansas	7,013,299	6,937,391	6,931,469	-5,922
California	42,300,762	41,389,219	39,074,885	-2,314,334
Colorado	7,178,335	7,115,244	7,477,213	361,969
Connecticut	4,698,533	4,653,966	4,578,188	-75,778
Delaware	1,952,995	1,940,853	1,982,202	41,349
District of Columbia	7,047,135	7,028,787	6,909,239	-119,548
Florida	18,799,951	18,474,161	19,147,112	672,951
Georgia	16,071,007	15,881,443	16,808,865	927,422
Hawaii	2,250,730	2,229,697	2,138,132	-91,565
Idaho	3,206,492	3,179,584	3,264,509	84,925
Illinois	21,430,236	21,193,206	21,153,687	-39,519
Indiana	11,662,428	11,565,001	12,249,019	684,018
Iowa	6,483,179	6,442,068	6,517,972	75,904
Kansas	4,670,131	4,626,576	4,773,227	146,651
Kentucky	11,236,886	11,131,291	11,080,283	-51,008
Louisiana	13,176,265	13,010,428	12,102,880	-907,548
Maine	3,378,028	3,357,188	3,316,849	-40,339
Maryland	11,872,051	11,798,448	11,689,325	-109,123
Massachusetts	11,349,031	11,257,008	11,006,089	-250,919
Michigan	18,669,851	18,486,757	19,007,016	520,259
Minnesota	9,002,379	8,939,248	9,167,833	228,585
Mississippi	9,616,373	9,509,272	9,274,929	-234,343
Missouri	12,259,237	12,144,817	12,135,301	-9,516
Montana	2,410,034	2,387,773	2,292,158	-95,615
Nebraska	3,992,877	3,964,615	4,036,191	71,576
Nevada	1,752,177	1,715,978	2,095,252	379,274
New Hampshire	1,989,112	1,976,851	1,954,835	-22,016
New Jersey	11,552,092	11,433,939	11,386,665	-47,274
New Mexico	4,286,183	4,221,223	4,130,569	-90,654
New York	40,508,072	40,033,023	37,740,395	-2,292,628

State	FY 2011 Estimate	FY 2012 Estimate	FY 2013 Estimate	Difference +/- 2012
North Carolina	16,434,955	16,273,588	17,356,228	1,082,640
North Dakota	1,805,231	1,793,733	1,755,236	-38,497
Ohio	21,882,298	21,670,282	22,273,583	603,301
Oklahoma	7,190,901	7,101,708	7,093,330	-8,378
Oregon	6,155,398	6,092,388	6,260,340	167,952
Pennsylvania	24,147,277	23,928,485	23,659,751	-268,734
Rhode Island	1,746,392	1,725,038	1,634,715	-90,323
South Carolina	11,298,304	11,201,150	11,417,861	216,711
South Dakota	2,238,302	2,220,682	2,154,369	-66,313
Tennessee	11,554,708	11,426,365	11,787,305	360,940
Texas	33,750,193	33,132,883	34,411,329	1,278,446
Utah	5,971,915	5,934,685	6,231,326	296,641
Vermont	1,684,954	1,676,345	1,670,137	-6,208
Virginia	12,268,838	12,160,138	12,064,493	-95,645
Washington	8,904,678	8,799,423	8,910,806	111,383
West Virginia	6,377,020	6,327,167	6,095,598	-231,569
Wisconsin	10,737,136	10,659,233	11,031,903	372,670
Wyoming	1,245,715	1,236,266	1,200,470	-35,796
SUBTOTAL	**526,839,123**	**520,745,125**	**522,089,772**	**1,344,647**
American Samoa	492,112	486,420	487,676	1,256
Guam	760,041	751,249	753,189	1,940
Marshalls	229,651	226,995	227,581	586
Micronesia	519,453	513,444	514,770	1,326
Northern Marianas	464,773	459,397	460,584	1,187
Palau	147,634	145,927	146,303	376
Puerto Rico	15,846,019	15,662,727	15,703,170	40,443
Virgin Islands	1,492,742	1,475,475	1,479,285	3,810
SUBTOTAL	**19,952,425**	**19,721,634**	**19,772,558**	**50,924**
TOTAL Resources	**546,791,548**	**540,466,759**	**541,862,330**	**1,395,571**

Autism and Other Developmental Disorders

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$47,708,000	$47,142,000	$47,142,000	---
FTE	7	7	7	---

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

FY 2013 Authorization $48,000,000

Allocation Methods:
- Direct federal/intramural
- Contract
- Competitive grant/co-operative agreement
- Other

Program Description and Accomplishments

The Combating Autism Act of 2006 authorized a program for early detection, education and intervention activities on autism and other developmental disorders. This program supports activities to:
- provide information and education on autism spectrum disorders (ASD) and other developmental disabilities to increase public awareness;
- promote research into the development and validation of reliable screening tools and interventions for autism spectrum disorders and other developmental disabilities and disseminate information;
- promote early screening of individuals at higher risk for autism spectrum disorders and other developmental disabilities as early as practicable, given evidence-based screening techniques and interventions;
- increase the number of individuals who are able to confirm or rule out a diagnosis of autism spectrum disorders and other developmental disabilities; and
- increase the number of individuals able to provide evidence-based interventions for individuals diagnosed with autism spectrum disorders or other developmental disabilities.

In FY 2008, Congress appropriated $36,354,000 for this program of which approximately $20 million was moved from the Maternal and Child Health Block Grant training programs for Leadership Education in Neurodevelopmental and Related Disabilities (LEND) and Developmental Behavioral Pediatrics. Funds were used to expand these interdisciplinary training programs as well as support the following programs: autism intervention research network grants to study the effectiveness of interventions for autism and related developmental disabilities; demonstration grants to develop models of systems of services for children with autism and other developmental disabilities; grant(s) to disseminate current and accurate information to families and consumers on early identification, diagnosis and access to services;

grants to disseminate screening intervention and guideline information; and other technical assistance and evaluation. In FY 2009, Congress appropriated an additional $6,000,000 to expand the LEND program, support autism intervention research grants to study evidence-based practices for interventions to improve the health and well-being of children and adolescents with ASD and other developmental disabilities, support grants that analyze secondary data, expand demonstration grants to develop models of systems of services for children with ASD and other developmental disabilities, expand grants to resource centers to disseminate ASD information to families and consumers and to disseminate screening intervention and guideline information, and support for other technical assistance and evaluation activities. In FY 2010, Congress appropriated an additional $6,000,000 to expand the LEND interdisciplinary training programs, including four new planning grants; expand the autism intervention research grants, and to support additional State demonstration grants, supplements to developmental-behavioral pediatrics training programs, resource centers and a national evaluation. Developmental-behavioral pediatrics training programs have developed nine case studies on ASD and will disseminate to pediatric residency training programs and practicing primary care providers to improve screening, diagnosis and treatment of ASD. In FY 2011, Congress appropriated $47,708,000. This budget supports 43 LEND interdisciplinary training programs, providing services and training to 41 States, and their reach extends beyond those States because of partnerships formed and services provided across State lines; 3 research networks and 12 autism intervention research projects examining areas of particular interest to families as outlined in the Interagency Autism Coordinating Committee's 2010 Strategic Plan for Autism Spectrum Disorder Research; and 13 State demonstration grants, resource centers, and a national evaluation. All activities continue to be coordinated with the Centers for Disease Control and Prevention's (CDC) Learn the Signs. Act Early. public awareness campaign; the State Demonstration Program jointly sponsors the campaign in 4 States – Washington, Missouri, Utah, and Alaska.

Progress Report – Selected Findings

A Report to Congress with findings to date was submitted to the National Institute of Mental Health (NIMH) in December 2010. An updated Report to Congress including findings from HRSA's Combating Autism Act investments through September 30, 2011 will be sent to Congress in early 2012. Selected findings are presented here.

REDUCING BARRIERS

Reported increases in the number of children that received diagnostic evaluations over the course of the grant period provide an early indication of progress toward the goal of reducing barriers to ASD services. In 2009–10, the 39 LEND grantees supported with CAAI [(Combating Autism Act Initiative)] funding collectively provided diagnostic evaluations to more than 35,000 children. The following year, the number of diagnostic evaluations provided through a LEND program-affiliated clinic exceeded 44,000. Including the children who received diagnostic evaluations from a CAAI-supported LEND program in 2008–09, nearly 92,000 children were evaluated over the 3-year grant period.

Grantees further worked to improve access to ASD services in several ways. To enable more families to get the services they need regardless of their ability to pay, the grantees helped advance health insurance and billing reforms. To create more coordinated systems of care for ASD, they mapped existing resources, identified gaps in services, and worked to build more interdisciplinary collaboration among providers from different disciplines, such as medicine and education. The LEND and DBP [(Developmental-Behavioral Pediatrics)] grantees provided Title V and other agencies with technical assistance to expand community-based services for ASD. The research grantees developed and disseminated ASD toolkits and clinical guidelines to support health care providers and families. Finally, all grantees focused on the particular needs of underserved populations as a means of reducing disparities in access to ASD services.

TRAINING

To address the shortage of health care professionals who are qualified to provide screening and diagnostic evaluation for ASD and other DD, the LEND and DBP programs expanded their training resources and assisted local agencies and practices in building their capacity to provide community-based ASD services. The LEND and DBP programs expanded the number of professionals in the pipeline by:

- Increasing the number of trainees enrolled in their programs. During the 2009–10 grant year, the LEND and DBP programs collectively trained close to 2,500 medium-term and 1,400 long-term trainees.[1] The following grant year, the number of medium- and long-term trainees increased by 13 percent and 22 percent, respectively.
- Increasing the number of trainees that received ASD-focused didactic training. Between the 2009–10 and 2010-11 grant years, the number of medium-term trainees enrolled in ASD-focused coursework increased by 8.2 percent and the number of long-term trainees increased by 13.6 percent.
- Providing more clinical training opportunities focused on ASD screening and diagnosis. In the final year of the grant, close to 1,500 medium-term trainees and more than 1,100 long-term trainees had participated in clinical practices covering ASD screening, diagnostic evaluation, and/or intervention.

The grantees also responded to the training needs of practicing pediatricians and other professionals who had limited experience identifying ASD in children. Between 2009 and 2011, the LEND and DBP grantees collectively offered more than 1,600 continuing education events pertaining to ASD screening, diagnostic evaluation, and evidence-based interventions for children with ASD. During the same timeframe, these grantees also offered more than 4,000 outreach trainings related to valid and reliable screening and diagnostic tools, and/or evidence-based interventions for ASD and other DD, with the numbers increasing from year to year.

[1] Medium-term trainees are those who complete between 30 and 200 hours of training during 1 academic year. Long-term trainees are those who complete more than 300 hours of training.

AWARENESS BUILDING

To promote early screening, diagnostic evaluation, and intervention, the grantees engaged in various strategies aimed at building awareness of ASD among providers, parents, and the public. A few of their accomplishments are highlighted below.

- To raise public awareness, the State grantees disseminated messages about ASD through various media outlets, including film events, radio and televised public service announcements, and library campaigns. They also developed web sites and web portals for online dissemination of ASD materials. Additionally, they distributed screening kits, autism toolkits, as well as print materials and resources to medical providers and other professionals. Family-focused materials included resource roadmaps, directories, navigator guides, and autism guidebooks.
- During the grant period, the LEND and DBP training programs developed and/or disseminated close to 2,000 ASD-related educational products to health care practices and providers, educators, and parents.
- The research grantees reached more than 4,000 health professionals through various training events, such as grand rounds presentations and scientific conference presentations. Collectively, they reached more than 6,000 individuals through community outreach sessions.

RESEARCH

To improve the health and well-being of children with ASD, the research grantees conducted studies on the efficacy of ASD interventions and developed consensus-based guidelines to support medical professionals in providing treatment for children with ASD. These tools may, for example, help to quickly assess a child's engagement level on the playground or help parents manage their children's sleep behavior. Fifty-four manuscripts were prepared over the course of the grant period, and 13 have been published to date.

In addition to conducting studies, the research grantees developed guidelines to support evidence-based clinical decision-making, and toolkits to support clinicians and parents in identifying and treating the medical and behavioral issues that commonly occur in children with ASD. Together, the research grantees developed 8 medical guidelines, 1 comprehensive guideline report, 14 toolkits for providers and parents to use in monitoring and managing ASD symptoms, and 7 new behavioral measures for assessing a child's progress over time. More specifically:

- The Autism Intervention Research Network on Physical Health (AIR-P) drafted eight clinical guidelines in the areas of sleep, gastrointestinal problems, neurology, genetics and metabolic screening decisions, and medication choice and monitoring.
- The Autism Intervention Research Network on Behavioral Health (AIR-B) network developed a comprehensive consensus-based guidelines report assessing the scientific evidence on behavioral, educational, and medical interventions and their impact on ASD symptoms.
- To help parents and professionals manage health-related concerns that are commonly associated with ASD, the AIR-P network developed toolkits on medication management, sleep management, behavioral management, and tools for day-to-day living.

- The AIR-B network developed new validated measures to track a child's progress and assess the effectiveness of behavioral ASD interventions over time. These new measures can be used by a diverse group of care providers in a variety of settings.

Other significant R40 research projects explore comparative outcomes of parent-mediated vs. center-based interventions for minority and underserved toddlers with ASD and evaluation of interactive tele-video technology to deliver mental health interventions to families of children with ASD who are geographically removed from specialty medical centers."[2]
Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, and follow-up performance reviews.

Funding History

FY	Amount
FY 2008	$36,354,000
FY 2009	$42,000,000
FY 2010	$47,898,000
FY 2011	$47,708,000
FY 2012	$47,142,000

Budget Request

In FY 2013, funds will be used to continue and expand activities initiated in FY 2008 to:

- Provide information, education and coordination;
- Promote research into evidence based practices for interventions and the development of reliable screening tools;
- Promote the development, dissemination and implementation of guidelines;
- Promote early screening and intervention;
- Train providers to diagnose and provide care for individuals with autism spectrum disorder and other developmental disorders;
- Develop innovative strategies to integrate and enhance existing investments, including translating research findings to training settings and into practice; and
- Promote lifecourse considerations, from developmental screening in early childhood to transition to adulthood issues.

The FY 2013 Request of $47,142,000 is the same as the FY 2012 Enacted Level. Comparable activities will be supported in FY 2013 including 43 LEND training programs, 10 developmental-behavioral pediatrics training programs, 8 active State implementation grants and 4 State planning grants, and 3 autism intervention research networks and 12 research demonstration grants examining areas of particular interest to families as outlined in the

[2] Wilson, C., Peterson, A., McGill, B., Suchman, A., Thorn, B., Irvin, C., Hargreaves, M. (2011). Results of the Combating Autism Initiative: HRSA's Efforts to Improve ASD Service Delivery Through Research, Training, and State Implementation Grants. Prepared by Insight Policy Research under Contract No. HHSH240200865007C. Rockville, MD: Health Resources and Services Administration, Maternal and Child Health Bureau.

Interagency Autism Coordinating Committee's 2010 Strategic Plan for Autism Spectrum Disorder Research. All activities will continue to be coordinated with the Interagency Autism Coordinating Committee and, in particular, with the Centers for Disease Control and Prevention's Learn the Signs. Act Early. public awareness campaign.

A program evaluation was completed in fall 2011 and assessed all aspects of the program (research, training and State demonstration efforts). A Report to Congress including these full results will be submitted in early 2012.

Grant Awards Table
Size of Awards

(whole dollars)	**FY 2011 Enacted**	**FY 2012 Enacted**	**FY 2013 President's Budget**
Grants:			
LEND	28,311,286	28,311,286	28,311,286
DBP	$1,856,667	2,000,000	2,000,000
Research	10,178,252	10,178,252	10,178,252
State Demonstration	3,146,000	3,146,000	2,546,000
Resource Centers	912,641	912,641	912,641
Number of Awards	86	86	85
Average Award	516,335	518,002	517,037

Traumatic Brain Injury

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
BA	$9,878,000	$9,760,000	$9,760,000	---
FTE	---	---	---	---

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

FY 2013 Authorization ..... Expired

Allocation Methods:

- Formula grant
- Competitive grant

Program Description and Accomplishments

The Traumatic Brain Injury (TBI) Grant Program funds the development and implementation of statewide systems that ensures access to comprehensive and coordinated TBI services including: transitional services, rehabilitation, education and employment, and long-term community support. On average, 1.7 million Americans will sustain a TBI each year[1]. It is estimated that up to 90,000 of these individuals will experience long-term, sometimes life-long, impairments as a result of their injury[2]. Such statistics likely underestimate the actual incidence of TBI because surveillance only captures injuries for which medical treatment is sought. Timely, comprehensive treatment is vital not only to save lives, but also to improve the quality of life for TBI survivors. TBI can cause a range of symptoms, which may include, but is not limited to, memory loss, difficulty concentrating, confusion, irritability, personality changes, fatigue, and headaches. Individuals with TBI may need a variety of services and supports, including rehabilitation, counseling, academic and vocational accommodations, independent living assistance, transportation assistance, and vocational training. These services and supports are often fragmented across different State systems of care, making access difficult for families. Through the TBI Program, State and Territorial governments receive funding to help individuals with TBI and their families receive the comprehensive care and services they need to manage ongoing conditions caused by the injury.

[1] Faul M, Xu L, Wald MM, Coronado VG. Traumatic Brain Injury in the United States: Emergency Department Visits, Hospitalizations and Deaths 2002–2006. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2010.
Traumatic Brain Injury in the United States: A Report to Congress. December 1999. http://www.cdc.gov/ncipc/pub-res/tbi_congress/TBI_in_the_US.PDF

[2] Traumatic Brain Injury in the United States: A Report to Congress. December 1999. http://www.cdc.gov/ncipc/pub-res/tbi_congress/TBI_in_the_US.PDF

The TBI Program consists of two distinct grant programs: 1) the State Implementation Partnership Grants (competitive grant), and 2) the TBI Protection & Advocacy Grants (formula grant).

State Implementation Partnership Grants

Each State Implementation Partnership grantee must have or develop the following four core components: 1) a Statewide Needs and Resources Assessment, 2) a Statewide action plan, 3) a Statewide Advisory Board, and 4) a designated State agency responsible for carrying out the activities of the grant. A performance goal for this program is to "increase the number of total State partnerships and/or collaborations with governmental and non-governmental organizations." The FY 2010 baseline data show that 131 total partnerships were forged by grantees, and FY 2011 data show that 200 partnerships have been forged since the beginning of the current project period.

Since the program's inception in 1996, it has evolved from being a demonstration program to a full implementation program with the grants developing from planning grants to full implementation partnership grants. The current authorization for the program is more prescriptive in terms of both sustainable systems change in states and in how grant funds ought to be used to accomplish this over-arching goal. For 2009, the guidance for new awards was changed to reflect an increased emphasis on those special populations with high rates of TBI that have not necessarily received adequate attention in the past, including veterans, children and youth, incarcerated juveniles, those with substance abuse problems, as well as Native Americans and African Americans. The amount of each award was raised to $250,000 per State, and 17 new awards were made in FY 2009. There were three new awards made in 2010 and one additional award in 2011. Most of the states funded have made remarkable progress in developing and linking accessible TBI services and supports, as well as educating consumers, families and professionals about the needs of individuals with TBI. Other activities include screening for TBI in criminal/juvenile justice facilities, homeless shelters, and schools, training health professionals in various disciplines to identify and effectively serve individuals with TBI, providing case management services to coordinate care across treatment areas, and assisting families who are transitioning from one system to another (e.g., military discharge to community re-entry, hospital acute care to school re-entry).

State Protection and Advocacy Systems Grants

Section 1253 of the Public Health Service Act recognizes that State Protection and Advocacy (P&A) systems are critical to achieving the goals and objectives of the TBI program. In FY 2003, grants were awarded to all 57 P&A systems to evaluate capacity and to develop plans to ensure P&A services, including individual and family advocacy, self-advocacy training, specific self-advocacy assistance, information and referral services, and legal representation. These formula grants continue to be awarded to 57 States, Territories, and 1 Native American Consortium. The performance measure for this program is to "increase the number of trainings conducted by the TBI Protection and Advocacy Grant Program." By definition, training would include educating professionals of various disciplines who provide services to individuals with TBI, training family members and the public about the signs, symptoms, and services available

for TBI, training individuals and families to self-advocate for needed services and supports, and providing information and referrals.

The TBI program also provides for a National Technical Assistance Center.

Programs	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB	FY 2013 +/- FY 2012
State Grants for Demonstration Projects	$5,251,690	$5,188,955	$5,188,955	---
Protection and Advocacy Grants	$3,273,589	$3,234,484	$3,234,484	---

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

Funding History

FY	Amount
FY 2008	$8,754,000
FY 2009	$9,877,000
FY 2010	$9,918,000
FY 2011	$9,878,000
FY 2012	$9,760,000

Budget Request

The FY 2013 Request of $9,760,000 is the same as the FY 2012 Enacted Level. The TBI program expires in FY 2012, but this does not preclude the program from operating if an appropriation is provided in FY 2013.

Starting in FY 2009, as grants were competed for new awards the amount of the grant award was increased to $250,000, which resulted in awards to 17 States. This competition required larger grant awards to allow the States to create a statewide system of care that can work with all the state-level agencies (Education, Vocational Rehabilitation, Social Services, Mental Health and Substance Abuse, the State Corrections System, Housing, and Transportation) that play a role in the overall state plan that ensures a comprehensive and sustainable system of care for individuals with TBI and their families. TBI Protection and Advocacy grants will continue to receive a total of $3.2 million in FY 2013 the same as FY 2012 Enacted. The program anticipates that the number of collaborations/partnerships in which TBI grantees participate will be 175 in FY 2013.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
11.V.B.6 Percentage of grantees that complete the 4 core components of the TBI Implementation Partnership Grant Program within the 4 year project period.[3] (Developmental) (*Output)*	N/A	N/A	N/A	N/A
11.V.B.4. Increase the number of total State partnerships and/or collaborations with governmental and non-governmental organizations. (*Output)*	FY 2011: 200 Target: 154 (Target Exceeded)	154	175	+21
11.V.B.7. Increase the number of trainings conducted by the TBI Protection and Advocacy Grant Program. [4](Developmental) (*Outcome)*	N/A	N/A	TBD	N/A
11. E.1 Percentage of information requests from grantees and the public that is resolved within 7 calendar days. (Efficiency)	100% (Baseline)	100%	100%	Maintain

[3] This developmental long-term measure does not currently have targets. FY 2012 baseline data from grantees' progress reports will be available in 2013 and future year targets will be established.
[4] This developmental measure does not currently have annual targets. Baseline data for FY 2012 will be available in 2013 and future year targets will be established.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	21/57[5]	21/57[5]	21/57[5]
Average Award	$250,000/$50,000[5]	$250,000/$50,000[5]	$250,000/$50,000[5]
Range of Awards	$245,000-$250,000/ $20,000-$184,000[5]	$245,000-$250,000/ $20,000-$184,000[5]	$245,000-$250,000/ $20,000-$184,000[5]

[5] State Grantees/Protection and Advocacy Grantees

Sickle Cell Services Demonstration Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$4,721,000	$4,665,000	$4,665,000	---
FTE	2	2	2	---

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

FY 2013 Authorization ..... Expired

Allocation Methods:

- Competitive co-operative agreement
- Contract

Program Description and Accomplishments

The Sickle Cell Service Demonstration Program was created in FY 2005 to develop systemic mechanisms for treatment of Sickle Cell Disease (SCD) and the prevention of morbidity and mortality associated with the condition. Investments in SCD service delivery, safety net access points, and the preparation of primary care clinicians have been created to serve this underserved population. Over the past seven years, this program has expanded service outreach through the development of infrastructure utilizing three separate grantee network cohorts [Cohort I; 2006-2010; Cohort II: 2009-2013; Cohort III: 2010-2014]. Service infrastructure has included: identification and establishment of genetic counseling, testing and other education opportunities for individuals, families and communities; provision of educational training sessions; and engagement opportunities for health care providers. During the two years of data collection [2008-2010] through Cohort I, some demonstrated successes include: an increase in the provision of preventive care; the establishment of written care plans and use of care coordinators; and a decrease in emergency room visits. Over the past four years, the Sickle Cell Service Demonstration Program has been involved in the following activities to meet objectives and address priority areas of the program:

- Technical assistance/information exchange
- Developing and sustaining partnerships
- Materials review and development
- Collection, coordination, and distribution of Sickle Cell Service Demonstration Program data, best practices, and findings of particular note, this program is addressing the elimination of health disparities for individuals with Sickle Cell Disease. The program has received continual funding allowing the continuation of addressing activities and priorities described above. This funding has also provided for an increase in the number of grantees for a current total of nine. Funding includes costs associated with awards to grantee networks, a contract, HRSA staff salaries and grant related activities including grant reviews, processing of grants through the

Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbooks, and follow-up performance reviews.

In 2008, the Sickle Cell Demonstration Program received a two year Office of Management and Budget (OMB) clearance to begin data collection for evaluation of the program. Renewal of clearance from OMB currently is in process for continued data collection. This data will be collected under the National Coordinating Center (NCC) [contract with National Initiative for Children's Health Care Quality (NICHQ)]. To date, over 400 individuals reflecting services across the lifespan have participated in the program. In 2010, follow-up data analysis provided findings which were incorporated into a report to Congress. In addition, evaluation of the demonstration network development and provider capacity occurred through the assessment of health care provider's co-management and coordination.

Funded grantee networks will be supported by the NCC. HRSA's multi-layered approach to the program utilizes the HRSA funded hemoglobinopathies (for sickle cell disease and thalassemia) programs along with NICHQ, in partnership with the Sickle Cell Disease Association of America, the Federally Qualified Health Centers (FQHC's), the HRSA funded Rural Health Centers (RHC's), Ryan White Clinics (RWC), the National Health Services Corps (NHSC) and the HRSA Regional offices. Efforts involve surveillance and analysis of hemoglobinopathy data; Quality Improvement (QI) Learning Collaborative sessions and targeted technical assistance; evaluation of treatment and management guidelines; translation, dissemination and education; and practice innovation. HRSA is collaborating with the National Institutes of Health (NIH) and the Centers for Disease Control (CDC) to ensure data elements can be used across programs as well as address Healthy People 2020 objectives.

Funding History

FY	Amount
FY 2008	$2,653,000
FY 2009	$4,250,000
FY 2010	$4,740,000
FY 2011	$4,721,000
FY 2012	$4,665,000

Budget Request

The FY 2013 Request of $4,665,000 is the same as the FY 2012 Enacted Level. Funding will allow: (1) continued funding of a stable number of regional networks. Program will continue to fund nine geographically distributed demonstration projects for enhanced access to comprehensive, coordinated, culturally-effective, and family centered high quality services for individuals with sickle cell disease; (2) expansion and upgrade of data collection efforts, capacity and analysis to more fully achieve the evidence to evaluate the network activities and outcomes; and (3) expertise in informatics for data elements, interoperability and messaging capabilities in order to ensure that the data elements can be used across programs.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	9	9	9
Average Award	$386,000	$386,000	$386,000
Range of Awards	$386,000 – $390,000	$386,000 – $390,000	$386,000 – $390,000

James T. Walsh Universal Newborn Hearing Screening

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$18,884,000	$18,660,000	$18,660,000	---
FTE	4	4	4	---

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

FY 2013 Authorization ..... SSAN

Allocation Methods:

- Competitive grant/co-operative agreement
- Contract

Program Description and Accomplishments

The James T. Walsh Universal Newborn Hearing Screening program began in FY 2000 and supports the following Healthy People 2010 Objectives: (1) physiologic testing of newborn infants prior to their hospital discharge; (2) audiologic evaluation by three months of age; and (3) entry into a program of early intervention by six months of age with linkages to a medical home and family-to-family support.

In FY 2008, the Maternal and Child Health Bureau awarded competitive grants to states to implement the program, and to one national technical assistance center. Collaboration with the Centers for Disease Control and Prevention (CDC) and National Institutes of Health's National Institute on Deafness and Other Communication Disorders is ongoing to coordinate programs at the national and state levels. For FY 2009 and FY 2010, additional supplemental funds were directed toward reducing loss-to-follow-up by implementing strategies to assure that infants identified through screening receive timely diagnosis and early intervention, and that parents are connected to ongoing family-to-family support. In 2011, 49 currently funded States competitively applied for continuation of their grants. One new application was received. Forty eight awards were made.

The Universal Newborn Hearing Screening program has been successful in increasing the percentage of newborns screened for hearing loss prior to hospital discharge. In 2005, 95% of newborns were screened for hearing loss prior to hospital discharge, exceeding the target of 94% according to data collected by the National Center for Hearing Assessment and Management. In FY 2006, the (CDC's) National Center for Birth Defects and Developmental Disabilities (NCBDDD) began collecting State data for the first time on newborn hearing screening services. For FY 2009, data from the 50 States, two territories and the District of Columbia responding to the survey indicated the number of infants screened was 97% falling slightly short of the target of 98%. Although most of the States now have laws mandating hearing screening for newborns, few have comprehensive reporting provisions. Hospitals report screening in nearly all US hospitals, save military birthing hospitals. Service providers (audiologists, primary care

practitioners and Early Intervention providers) in the continuum of services do not routinely report in many places.

An independent evaluation of the program was completed in 2006. Findings were used to implement a quality improvement initiative. This initiative focuses on implementation of recommendations for programmatic changes which have proven to be effective in reducing loss to follow-up. These strategies have been incorporated into subsequent grant guidances. Program funding includes a National Resource Center, staffing, costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbooks, and follow-up performance reviews.

Funding History

FY	Amount
FY 2008	$11,790,000
FY 2009	$19,000,000
FY 2010	$18,960,000
FY 2011	$18,884,000
FY 2012	$18,660,000

Budget Request

The FY 2013 Request of $18,660,000 is the same as the FY 2012 Enacted Level.
FY 2013 funding will support 57 awards to assist the program in achieving the FY 2013 target of screening 98% of infants prior to hospital discharge.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
13.1: Increase the percentage of children with non-syndromic hearing loss entering school with developmentally appropriate language skills.[1] *(Outcome)*	FY 2004: 20% (Baseline)	N/A	85%	---
13.2: Increase the percentage of infants with hearing loss enrolled in early intervention before 6 months of age. *(Output)*	FY 2004: 57% (Baseline)	N/A	65%	---

[1] This long-term measure does not have annual targets. The first long-term target was set for FY 2013.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
13.III.A.1: Percentage of infants suspected of having a hearing loss with a confirmed diagnosis by 3 months of age. *(Output)*	FY 2008: 68% Target: 63% (Target Exceeded)	70%	65%	-5 % points
13.III.A.2: Percentage of infants with a suspected or confirmed hearing loss referred to an ongoing source of comprehensive health care (i.e. medical home). *(Output)*	FY 2008: 94% Target: 88% (Target Exceeded)	95%	90 %	-5 % points
13.III.A.3: Percentage of infants screened for hearing loss prior to hospital discharge. *(Output)*	FY 2009: 97% Target: 98% (Target Not Met but Improved)	98%	98%	Maintain
13.E: Increase the percentage of infants suspected of having hearing loss (based on the results of their newborn hearing screen) who receive a confirmed diagnosis by 3 months of age while maintaining a constant Federal expenditure *(Efficiency)*	FY 2008: 68% Target: 63% (Target Exceeded)	70%	65%	-5 % points

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	57	57	57
Average Award	$267,000	$267,000	$267,000
Range of Awards	$19,000-$300,000	$19,000-$300,000	$19,000-$300,000

Emergency Medical Services for Children

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$21,369,000	$21,116,000	$21,116,000	---
FTE	4	4	4	---

Authorizing Legislation - Section 1910 of the Public Health Service Act.

FY 2013 Authorization $28,940,625

Allocation Method ..... Competitive grant/cooperative agreement

Program Description and Accomplishments

Emergency Medical Services for Children (EMSC) Program under section 1910 of the Public Health Service Act (42 U.S.C. 300w-9) is the only Federal program that focuses specifically on improving the pediatric components of emergency medical care. The program was created due to the gaps that exist and continue to exist in providing quality care to children and the need to address the specific anatomical, physiological and developmental needs of children. Pediatric emergency care begins with the 911 call to the delivery of the patient to the appropriate hospital and ultimately returning the child to the community. To improve the quality of pediatric emergency care, the EMSC program focuses on generating evidence on best practices regarding pediatric emergency care as well as direct outreach to the States, territories and District of Columbia to implement these best practices.

To measure the impact on improving access to quality health care and services, the program monitors performance measures that assess program objectives. One measure supports the development of improved emergency procedures and protocols in the pre-hospital setting to guide BLS/ALS providers in the appropriate care of children. In FY 2011, the number of State EMS systems that demonstrated the operational capacity to support pre-hospital providers with online pediatric medical direction improved to 35 States and off line protocols improved to 37 States.

Also in FY 2011, 40 awardees had adopted requirements for pediatric emergency education for recertification of paramedics. Both these measures exceeded the targets for FY 2011.

The EMSC program also tracks other health quality indicators that address the quality of care being delivered in States and territories as well as the permanence of EMSC in State systems. These include the availability of medical direction for prehospital personnel, appropriate pediatric equipment on ambulances, hospital designation for pediatric care, inter-facility transfer agreements and guidelines, and continuing pediatric education for prehospital providers. In FY 2011, national survey data demonstrated the following results: among 2,633 Basic Life Support (BLS) agencies, 87% had access to online medical direction and among 3,651 Advanced

Life Support (ALS) agencies, 91% had access to online medical direction. For agencies responding to 911 calls for pediatric patients, which is represented by 22,067 vehicles, BLS transport vehicles had 91% of all the recommended pediatric equipment and ALS transport vehicles had 96% of all the recommended pediatric equipment. Among the 2,644 hospital emergency departments responding to the survey, over half (59%) had inter-facility transfer agreements allowing a child to be transferred to a facility with the appropriate specialty care.

The EMSC program administers four main grant programs: 1) 55 State Partnership grants, 2) nine Targeted Issues grants that address issues of national significance, 3) four State Partnership Regionalization of Care demonstration grants improving pediatric emergency care capacity in rural, insular, and tribal communities, and 4) seven grants for the Pediatric Emergency Care Applied Research Network to conduct meaningful and rigorous multi-institutional studies in the management of acute illness and injury in children across the continuum of emergency medicine.

The EMSC Program collaborated with the Department of Transportation's National Highway Traffic Safety Administration since its inception and is a partner in the implementation of the National EMS Information System. The EMSC Program collaborated with the Indian Health Service (IHS) in order to ensure the availability of pediatric-specific training initiatives tailored to the needs of tribal EMS and IHS medical facility professionals. The EMSC Program collaborated with the Agency for Health Care Research and Quality (AHRQ) to provide national data on childhood mortality secondary to injury and referral patterns of pediatric patients among various designations of Trauma Centers. AHRQ also provides the EMSC Program grantees training in analysis of pediatric administrative data sets.

The Institute of Medicine completed a study of the Nation's emergency care system entitled "The Future of Emergency Care in the U.S. Health System" in 2006. The study included an examination of the unique challenges associated with the provision of emergency services to children and adolescents. The study noted that "the program has broadly advanced the state of pediatric emergency care nationwide."

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

Funding History

FY	Amount
FY 2008	$19,454,000
FY 2009	$20,000,000
FY 2010	$21,454,000
FY 2011	$21,369,000
FY 2012	$21,116,000

Budget Request

The FY 2013 Request of $21,116,000 is the same as the FY 2012 Enacted Level. This request will assist the program in achieving its FY 2013 target of 32 awardees that demonstrate the operational capacity to provide pediatric emergency care in the form of on-line consultation or off-line protocols in the pre hospital setting. A target of 3 has been set for the number of awardees that have adopted requirements for having the essential pediatric emergency equipment on their patient care units and a target of 11 has been established for the designation of pediatric specialty care hospitals which have inter-facility transfer agreements.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
14.V.B.2: Increase the number of awardees that have adopted requirements for pediatric emergency education for the re-certification of paramedics. *(Outcome)*	FY 2011: 40 Target: 37 (Target Exceeded)	39	41	+2
14.1: Mortality rate for children with an injury severity score (greater than 15 *(Outcome)*[1] Baseline- FY 2005: 6.05%	FY 2009: 5.97% Target: 8.7% (Target Exceeded)	8.4%	5.91%	-2.49% points
14.V.B.1a: Increase the number of awardees that demonstrate the operational capacity to provide pediatric emergency care, including all core capacity elements related to on-line and off-line medical direction at the scene of an emergency for (BLS) and (ALS) Baseline – 2005: 20 *(Output)*[2]	FY 2011: 35 Target: 28 (Target Exceeded)	30	32	+2
14.V.B.1b: Increase the number of awardees that demonstrate the operational	FY 2011: 2 (Target Not In	2	3	+1

[1] The new data sources for this measure are the National Inpatient Sample (NIS); Kids Inpatient Database (KID) Nationwide Emergency Department Sample (NEDS), and the Trauma Information Exchange Program (TIEP).
[2] States collect data through four different sources (Online: BLS, Online: ALS, Off-line: BLS, and Online: ALS), resulting in four different State counts. Reporting here is for the ALS online medical direction count.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
capacity to provide pediatric emergency care regarding essential pediatric equipment on transport vehicles. *(Output)*	Place)			
14.V.B.1c: Increase the number of awardees that demonstrate the operational capacity to provide pediatric emergency care regarding designation of pediatric specialty care hospitals and inter-facility transfer agreements *(Output)*	FY 2011: 9 (Target Not in Place)	10	11	+1

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	75	75	75
Average Award	$256,000	$256,000	$256,000
Range of Awards	$20,500 - $1,860,000	$20,500 - $1,860,000	$20,500 - $1,860,000

Healthy Start

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$104,361,000	$103,532,000	$103,532,000	---
FTE	4	4	4	---

Authorizing Legislation - Section 330H of the Public Health Service Act.

FY 2013 Authorization ..... $127,732,532[1]

Allocation Method ..... Competitive grant/co-operative agreement

Program Description and Accomplishments

The Children's Health Act of 2000 (P. L. 106-310) amended the Public Health Service Act to provide "such sums as necessary" for continuation and expansion of a distinct Healthy Start program of grants that use community-designed and evidence-supported strategies aimed at reducing infant mortality and improving perinatal outcomes in project areas with high annual rates of infant mortality.

Today, through a lifespan approach and a focus on the interconception health of women, the Healthy Start program (HS) aims to reduce disparities in access to and utilization of health services, improve the quality of the local health care system, empower women and their families, and increase consumer and community voices and participation in health care decisions. Through grants to communities with exceptionally high rates of infant mortality (at least 1 ½ times the U.S. national average), HS continues to focus on the contributing factors that research shows are associated with poor perinatal outcomes, particularly among non-Hispanic black and other disproportionately affected populations. In these geographically, racially, ethnically, and linguistically diverse low income communities, HS provides intensive services tailored to the needs of high risk pregnant women, infants and mothers.

Adverse Pregnancy Outcomes in United States

Each year in the United States, more than four million women become pregnant, according to data from National Center for Health Statistics. This resulted in 4.13 million live births in 2009, a 3% percent decrease from 2008. In comparison, in 2007 there were 4.3 million live births, a 1% increase in births from 2006 and the highest number of births ever registered in the United

[1]The Healthy Start authorization is $120,000,000 for FY 2008 and for FY 2009 through 2013, the amount authorized for the preceding fiscal year increased by the percentage increase in the Consumer Price Index for all urban consumers for such year. The CPIU estimate included in the FY 2011 Mid-Session Review is -0.3 for FY 2009. The CPIU estimates included in the FY 2012 Analytical Perspectives is 1.6 for FY 2010, 1.3 for FY 2011, 1.8 for FY 2012, and 1.9 for FY 2013.

States.[2] While most women have a safe pregnancy and deliver a healthy infant, that is not the experience for all women. Major and persistent racial and ethnic disparities exist in the proportion of pregnancy-related maternal deaths, in preterm births, and in infant mortality. Preterm birth (births at less than 37 completed weeks of gestation) is a key risk factor for infant death. Since the mid-1980s, the percentage of preterm births in United States has been rapidly increasing. For example, from 2000 to 2005, the percentage of preterm births increased from 11.6% to 12.7% representing almost one percent increase. In 2005, 68.6% of all infant deaths occurred to preterm infants, up from 65.6% in 2000.[3] The 2009 overall national preterm rate was 12.18%. Although a portion of the increase in preterm births over the last decade was due to increases in multiple births, the percentage of preterm births also increased among single births.

Racial Disparities in Pregnancy Outcomes

There are significant racial disparities in preterm births and infant death rates in the United States. For example, the preterm birth rate for non-Hispanic white infants was 10.92% compared to 17.47% for non-Hispanic black infants. Similarly, the preterm-related infant mortality rate for non-Hispanic black infants was 3.4 times higher than that of non-Hispanic white infants.[4] Despite considerable research efforts to understand and prevent these adverse outcomes, the factors that make some pregnancies more vulnerable than others have not been clearly identified or defined. Emerging research indicates that environmental, biological and behavioral stressors occurring over the life span of the mother from her earliest life experiences until she delivers her own child may account for a significant portion of the disparities. Moreover, it may take specific consistently provided interventions to several generations to reduce and eliminate the factors responsible for the disparities in adverse birth outcomes.

Lifespan Approach and Interconception Healthcare

The interconception period (the time between the end of a woman's pregnancy to the beginning of her next pregnancy) is a critical time to modify risk factors, particularly those such as tobacco use, that are causally associated with infant mortality. Interconception healthcare may improve complications from a recent pregnancy and/or prevent the development of a new health problem (obesity, diabetes, depression, and hypertension) in both the woman and her children. Additionally, interconception healthcare provides a valuable opportunity to reduce or eliminate risks before one or more future pregnancies to ensure healthier (full term) infants and mothers.

Healthy Start-Community Collaborations to Address Pregnancy Outcomes

The Healthy Start Program works with individual communities to build upon their existing resources (including outreach, health education, case management, and utilization of prenatal/postnatal care) to improve the quality of, and access to, healthcare for women and infants at both service and system levels through the implementation of innovative community-driven and community-based interventions. At the service level, beginning with direct outreach by community health workers to women at high risk, Healthy Start projects ensure that the mothers and infants have ongoing sources of primary and preventive healthcare and that their basic needs (housing, psychosocial, nutritional and educational support and job skill building)

[2] Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary data for 2009. National Vital Statistics Reports Web release; vol. 59 no. 3. Hyattsville, MD: National Center for Health Statistics. 2010.
[3] MacDorman MF, Mathews TJ. Recent Trends in Infant Mortality in the United States. NCHS Data Brief, no 9. Hyattsville, MD: National Center for Health Statistics. 2008.
[4] National Center for Health Statistics, Infant Mortality Statistics from the 2005 Period Linked Birth/Infant Death Data set, NVSR, vol. 57 no. 2, revised July, 2008.

are met. Following assessments and screening for perinatal depression and other risk factors, case managers provide linkages with appropriate services and health education for risk reduction and prevention. Mothers and infants are linked to a medical home and followed, at a minimum, from entry into prenatal care through two years after delivery.

At the system level, every Healthy Start project has developed a consortium composed of neighborhood residents, community key leaders, perinatal care clients or consumers, medical and social service providers, as well as faith-based and business community representatives. Together these key stakeholders and change agents address the system barriers in their community, such as fragmentation in service delivery, lack of culturally appropriate health and social services, and barriers to accessing care. Healthy Start projects are required to have strong collaborative linkages with State programs including Title V MCH Block Grant, Medicaid, Children's Health Insurance Program, and local perinatal systems such as those in community health centers. The close connection between these services assists in reducing significant risk factors, such as tobacco and alcohol use, while promoting behaviors that can lead to healthy outcomes for women and their families. These positive relationships and effects, beginning during the perinatal period, continue to be monitored for both mother and baby for two years post-delivery to ensure that they remain linked to ongoing sources of primary care.

Populations Served by Healthy Start Program

Communities in the 39 States, the District of Columbia, and Puerto Rico that are served by Healthy Start have large minority populations with high rates of unemployment, poverty and major crime. Parents at highest risk typically have less than a high school education, are low income and have limited access to safe housing. Medical healthcare providers are limited and often can only be reached after long commutes on crowded public transportation.

Selected Healthy Start Successes

Genesee County Michigan Healthy Start serves a predominantly African American population. In the target area there is 41% unemployment for those 16 years and older.
Families in the Healthy Start project area continue to fare worse than their counterparts in Genesee County and significantly worse than others in Michigan. The Healthy Start project area has fewer high school graduates compared to the rest of the county. For example, only 76% of those 25 and older graduated from high school which is below the figure of 83.4% for the State of Michigan and 83.1% for Genesee County. Currently, 20% of the target area population lives below the Federal Poverty Level. The household income in the project area is $29,982 which is considerably lower than the county and the state. In 2001, the Genesee County Health Department in Flint, Michigan became the lead agency for the Genesee County Healthy Start project and, even with the challenges described above, has since proven to be effective in reducing infant mortality rates and low birth weight (LBW) rates among program participants. The infant mortality rate for the project years 2001-2007 has averaged 2.7 per 1,000 live births, well below the Healthy People 2010 Objective of 4.5 per 1,000 live births. For the years 2001-2007, the low birth weight rate averaged 14.1%, and the very low birth weight rate averaged 2.3%. Additionally, low and very low birth weight (VLBW) rates have remained on a downward trend. For 2004-2009, for Healthy Start program participants in Genesee County

there were a total of 952 births (including twins) and 932 births (excluding twins). Of the 932 singleton births, the LBW rate averaged 10.5% and the VLBW rate averaged 9.65%. Of all births, including twins, the infant mortality rate averaged 4.2 per 1,000 live births during the same period of time. The LBW rate has remained on a downward trend with a three year (2007-09) average of 8.84%.

Reduction in Infant Deaths in Healthy Start Project Areas

There are achievements linked to HS in other communities as well, most significantly, a decrease in the number of infant deaths of Healthy Start participants. In fact, thirteen Healthy Start communities report no infant deaths among program participants for the three years 2007-2009: Mississippi County, AR; Maricopa County, AZ; Mary's Center, Washington, DC; Honolulu, HI; Chicago, IL; Tougaloo, MS; all three HS sites in Raleigh, NC; Pembroke, NC; Las Cruces, NM; Portland, OR; and Philadelphia, PA; an additional ten communities reported no infant deaths over the two years 2008-2009: Mobile, AL; Fresno, CA; Washington, DC; Pennsauken, NJ; Memphis, TN; Atlanta, GA; Whichita, KA; New Orleans, LA; Boston, MA; and Pennsauken, NJ.

Among African Americans in 2007, the infant mortality rate for the program participants in *Saginaw County's (MI) Great Beginnings Healthy Start* was only 5.8 per 1,000 live births. In the *Jacksonville (FL) Healthy Start*, a program that focuses on high risk interconceptional women and which also serves a predominantly African American population, the infant mortality rate was reported at 15.6 per 1,000 live births in 2001, 14.0 per 1000 live births in 2005 and no infant deaths in 2009. The infant mortality rate for the northern Wisconsin tribes served by the *Great Lakes Intertribal Councils Honoring Our Children Project* for 2007 was 17.1 per 1,000 live births; in contrast, the infant mortality rate was only 6 per 1,000 live births among program participants for 2009. (see Outcomes and Outputs tables)
Overall, Healthy Start is successful in reducing infant mortality in the Nation's highest risk populations for adverse outcomes (African-Americans, American Indians/Native Americans). In contrast to the total national infant mortality rate of 6.42 in 2009, the infant mortality rate for Healthy Start participants was 6.0 infant deaths per 1,000 live births for 2009.

Low birth weight (LBW), or birth weight less than 2,500 grams, is a major contributor to infant mortality and has been dramatically reduced among Healthy Start participants. The national LBW rate increased more than 20% from the mid 1980s through 2006 but has recently shown a slight decrease. In 2009, the most recent year for which data are available, the national LBW rate was 8.16% which was a slight decrease from the 2008 rate of 8.18%. However, racial disparities persist in LBW rates. For example, in 2009, the LBW rate among non-Hispanic white was 7.19% compared to 13.61% for non-Hispanic black infants. Similarly, in 2009, the very low birth weight (VLBW) or birth weight of less than 1,500 grams was 1.16% for non-Hispanic white infants compared to 3.06% for non-Hispanic black infants. In 1998, the National LBW was 7.6%, and 65% of all infant deaths were attributed to LBW (Source: NVSS, NC). The *Mississippi County Arkansas EOC, Inc* in Blytheville, AR, improved its LBW rate from a high of 12.5% in 2006 to 0% in 2009. *Baltimore Healthy Start* decreased its LBW rate from 13.2% in 2006 to 4.9% in 2009. The percent of African-American babies born VLBW in Baltimore is now 1.5% which is approaching that of non-Hispanic white babies citywide. In the *Pittsburgh*

Healthy Start, Inc. project, the percent of very low birth weight live births decreased between 2005 and 2008 from 2.9% to 1.7%. In addition, among the *Pittsburgh Healthy Start, Inc.* participants, the VLBW rate is similar to the VLBW for the entire Healthy Start program which was 1.76% in 2009. *Kalamazoo (MI) Healthy Baby Healthy Start* has reduced the racial disparity in prematurity to the point that non-Hispanic black Healthy Start participants have pregnancies that are as healthy (i.e., full term and normal weight) as their non-Hispanic neighbors.

Increasing Prenatal Care

Another risk factor for infant mortality is late entry into prenatal care. In 2004, the mortality rate for infants of mothers who began prenatal care after the first trimester of pregnancy or not at all was 8.35 per 1,000. This rate was 37% higher than the rate for infants of mothers who began care in the first trimester (NVSS, NCHS, 2007). While nationally, 82.8% of pregnant women received prenatal care in the first trimester in 1998, first trimester entry into prenatal care for Healthy Start projects participants was only 41.8%. By 2007, the Healthy Start projects had increased first trimester early-entry into prenatal care (EPNC entry) to 68.5% and in 2009, EPNC climbed to 70.9%. *Luna County Healthy Start*, located along the New Mexico-Mexico border, increased the percentage of clients entering prenatal care during the first trimester from 69% in 2004 to 85.4% in 2009. Between 2006 and 2008, several Healthy Start projects more than doubled their EPNC rate including: the *City of New Orleans Healthy Start* project whose EPNC rate increased from 23.6% to 72.3%; the *Maricopa Department of Health, Tempe, AZ Healthy Start Project* whose EPNC rate increased from 32.1% to 71% in 2009; and the *Family Road of Greater Baton Rouge (LA) Inc* increased from 56.6% in 2006 to 77% in 2009. The *Laurens County Heart of Georgia Healthy Start Initiative* increased first trimester entry among its participants from 21.6% in 2003 to 91.5% in 2009.

Addressing Barriers to Healthcare Access

Focusing on systems development and coordination improves maternal and infant outcomes. Decreasing the inter pregnancy interval increases a woman's chances of having a better birth outcome with a subsequent pregnancy. *Healthy Start, Chester, PA*, identified the lack of health insurance as a significant barrier to utilizing care resulting in delayed initiation of prenatal care and pediatric care. This financial barrier to care is compounded by the extremely limited healthcare services for the under/uninsured in the project area. Prenatal and pediatric care is provided by private practice groups. Many of these groups are reluctant to see uninsured women and children. During a recent project period (FY 2001 - 2005), 74% of the pregnant women enrolled in Healthy Start had no health insurance at the time of enrollment. Healthy Start staff completed Medicaid or CHIP applications on all uninsured Healthy Start participants. In total, 969 (98%) of 991 Medicaid/CHIP applications submitted by Healthy Start were approved for Medicaid or CHIP coverage. By reducing a significant barrier to utilizing appropriate healthcare, Healthy Start projects have made important strides in helping at-risk mothers have healthy babies and families.

To improve quality, the Healthy Start program is also identifying and synthesizing evidence-based practices that contribute to improved perinatal outcomes and it will disseminate this

information to Healthy Start communities. The program has launched a 27 month quality learning community initiative to translate the Select Panel on Preconception evidenced-based practices related into reality in the Healthy Start projects. HS has also undertaken several steps, including providing training for grantees to assure the quality of grantee-reported data reported on MCHB Discretionary Grant Information System website. Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbook, and follow-up programmatic support and performance reviews.

Funding History

FY 2008	$ 99,744,000
FY 2009	$102,372,000
FY 2010	$104,776,000
FY 2011	$104,361,000
FY 2012	$103,532,000

Budget Request

The FY 2013 Request of $103,532,000 is the same as the FY 2012 Enacted Level to continue to support 105 Healthy Start sites. Each of the Healthy Start projects has committed to reducing disparities in perinatal health and infant mortality by transforming their communities, strengthening community-based systems to enhance perinatal care and improving the health of the young women and infants in their vulnerable communities. To assist projects, HS will provide support for peer mentoring, technical assistance, the Healthy Start Leadership Training Institute, 5 to 8 webcasts, site visits and sharing of best practices among projects. Although the Interconception Care Learning Community Collaborative is scheduled to be completed in 2012, the program will continue to enhance the project's ability to unify the varied systems of maternal and infant care in their communities and increase the capacity of local providers to incorporate emerging evidence-based health guidelines into practice to improve preconception and interconception care.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
12.1: Reduce the infant mortality rate (IMR) among Healthy Start program clients.[5] *(Outcome)* (Baseline- 2004: 7.65 per 1000 live births)	FY 2009: 6.00 per 1,000 live births. (Target not in place)	N/A	4.3 per 1,000	N/A
12.III.A.1: Increase annually the percentage of women participating in Healthy Start who have a prenatal care visit in the first trimester. *(Outcome)*	FY 2009: 70.9% Target: 75% (Target Not Met but Improved)	75%	75%	Maintain
12.III.A.2: Decrease annually the percentage of low birth weight infants born to Healthy Start program participants. *(Outcome)*	FY 2009: 10.1% Target: 9.6% (Target Not Met but Improved)	9.6%	9.6%	Maintain
12.II.B.1: Increase annually the number of community members (providers and consumers, residents) participating in infant mortality awareness public health information and education activities. *(Output)*	FY 2009: 389,460 Target: 350,000 (Target Exceeded)	376,000	354,000	-22,000
12.E: Increase the number of persons served by the Healthy Start program with a	FY 2009: 570,927 persons Served ($172,8 /participant)	532,500	547,317	+14,817

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

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
(relatively) constant level of funding. (Baseline – FY 2002: 288,800 ($343/participant) *(Efficiency)*	Target: 485,000 (Target Exceeded)			

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	105	105	105
Average Award	$750,000	$750,000	$750,000
Range of Awards	$100,000- $2,350,000	$255,000- $2,350,000	$255,000-$2,350,500

Heritable Disorders Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/ - FY 2012
BA	$9,952,000	$9,834,000	$9,834,000	---
FTE	3	3	3	---

Authorizing Legislation - Sections 1109 – 1112 & 1114 of the Public Health Service Act.
Authorization: 1109 .....……..……$15,750,000
Authorization: 1110……...…….……..…...$5,250,000
Authorization: 1111 .....……..…$1,050,000
Authorization: 1112 .....……..…$2,625,000
Authorization: 1114… .....……..…$1,050,000

Allocation Methods:

- Contract
- Competitive grant/co-operative agreement

Program Description and Accomplishments

The programs and activities under this Act are established to improve the ability of States to provide newborn and child screening for heritable disorders and affect the lives of all of the nation's infants and children. Newborn and child screening occur at intervals across the life span of every child. Newborn screening universally provides early identification and follow-up for treatment of infants affected by certain genetic, metabolic, hormonal and/or functional conditions. It is expected that newborn and child screening will expand as the capacity to screen for genetic and congenital conditions expands.

- Improved Newborn and Child Screening For Heritable Disorders, Section 1109
- Regional Genetic and Newborn Screening Service Collaboratives (RCs) and a NationalCoordinating Center (NCC) were established in 2004 to support the Heritable Disorders Program and were awarded in 2012 for a third cycle of funding. These Collaboratives take a regional, collaborative approach to address the misdistribution of genetic resources and services, the quality of the services, and the problems families and primary health care providers have in accessing and utilizing those services. Special emphasis is given to underserved populations and those families and providers in rural areas. The Collaboratives include all States, U.S.Territories ,and the District of Columbia. The stakeholders include State public health professionals, genetics and primary care providers, and individuals affected with heritable disorders and their families. The Collaborative projects utilize long distance strategies (telemedicine), advanced newborn screening technologies, quality assurance, and quality improvement measures. The (NCC) serves as the primary vehicle for information sharing among the

Regional Collaboratives and for the collaborative development, implementation, dissemination, and evaluation of projects of interregional and national significance.

A national evaluation report of the accomplishments of the Regional Collaboratives on four primary program outcome measures, covering December 1, 2008 to November 30, 2010 showed an overall increase from baseline in activities as follows:

- 70 percent of States/Territories had collaborations facilitated by their Regional Collaborative between primary care providers and specialty (including genetic) providers to improve care coordination for people with heritable disorders. This was an increase from the 67 percent of States/Territories reported to have these collaborations during the second year of the evaluation.
- 100 percent of States/Territories had systems in place to assure entry of newborns that are diagnosed with condition(s) mandated by their State-sponsored newborn blood spot screening programs into clinical management systems. In the first year of the evaluation, 93 percent of the States/Territories had such tracking systems.
- 17 percent of States/Territories had systems in place to track receipt of clinical services and/or health outcomes for all children diagnosed with any of the conditions mandated by their State-sponsored newborn blood spot screening program and/or with hearing loss through their State-sponsored newborn hearing screening programs. This a four percent increase over the baseline
- 96 percent of States/Territories had newborn screening programs that disseminated just-in-time/point-of-care information on specific heritable disorders to primary care providers.
- Critical Congenital Heart Disease Newborn Screening-Demonstration Program

The purpose of the Demonstration Project for State Newborn Screening is to support demonstration projects in States that choose to implement newborn screening for Critical Congenital Heart Disease [CCHD] using the CCHD Workgroup endorsed protocol. The program includes seven individual grants awarded to eligible entities as defined by the PHS Act.

The CCHD Demonstration Project will be established in FY 2012 to:

(1) enhance, improve or expand the ability of State and local public health agencies' infrastructure to provide screening, counseling, or health care services to newborns and children having or at risk for critical congenital heart disease;
(2) assist in providing health care professionals with education in newborn screening for critical congenital heart disease and training in use of the endorsed protocol for detection screening in newborns
(3) develop and deliver educational programs (at appropriate literacy levels) about critical congenital heart disease newborn screening counseling, testing, follow-up, treatment, and specialty services to parents, families, and patient advocacy and support groups; and
(4) establish, maintain, and operate a system to assess and coordinate treatment relating to critical congenital heart disease.

- Evaluating the Effectiveness of Newborn and Child Screening Programs, Section 1110

- Early and Continuous Screening through the Medical Home
- This initiative began in 2010; one grantee was awarded $500,000 per year for 4 years. The grant activities for the Early and Continuous Screening in the Medical Home initiative focus on improving screening and surveillance practices within the medical home for all children and adolescents. At its completion the initiative's products are:
- 1) promote greater understanding among key stakeholders of the need for and benefits of early and continuous screening for conditions, including congenital and heritable disorders, sensory impairments, developmental delay, autism, mental health disorders, sexually transmitted infections and psychosocial problems; and 2) promote healthcare professionals' use of evidence-based screening guidelines such as Bright Futures and validated screening tools in their practices.
- The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, Section 1111

In accordance with the Act, the Committee will continue to: 1) make recommendations to enhance, expand or improve the ability of the Secretary to reduce the mortality or morbidity in newborns and children from heritable disorders; 2) develop a model decision-matrix for newborn screening expansion and the public health impact of addition of new disorders; and 3) consider ways to ensure that all States attain the capacity to screen for the recommended conditions.

In February 2008, the Committee finalized its nomination and evidence review process for candidate conditions to be considered for addition to the recommended uniform screening panel. In 2012, the decision matrix will be expanded to include a process for evaluation of the public health impact for addition of disorders to the Recommended Uniform Screening Panel (RUSP).

On May 21, 2010, the Secretary adopted the Committee's recommendations to adopt the Committee's Recommended Uniform Screening Panel (screen for the identified 30 core conditions; report on the identified 26 secondary conditions) as a national standard for newborn screening programs and to facilitate the adoption of the Committee's Recommended Uniform Screening Panel by all State newborn screening programs. This included the adoption of SCID as a core condition to the RUSP.

- The Clearinghouse of Newborn Screening Information, Section 1112

The Clearinghouse is a central repository of current educational and family support and services information, materials, resources and research, for the following purposes: 1) increase awareness, knowledge, and understanding of newborn screening by parents and family members of newborns, health professionals, industry representatives, and the public; 2) increase expectant individuals and families' awareness, knowledge, and understanding of newborn disease and screening services; and it also links with the public site of the National Newborn Screening Information Systems which maintains current data on quality indicators of newborn screening performance.

Newborn Screening Data Repository and Technical Assistance Center

The newest competition and award for an updated information system will be completed in 2012. The data repository is a basis for the State Newborn Screening programs reporting efforts and supports a technical assistance and data collection mechanism for collecting quality indicators related to newborn screening performance by the states, such as false-positive rates and other measures determined to be important in assessing newborn screening, as determined by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. The

technical assistance activity will continue with currently funded efforts for: 1) a system for continuous quality enhancement related to the newborn screening system, from birth to confirmation; 2) maintenance of a newborn screening program expert team for site visits; and 3) development of a certification program for newborn screening programs that meet the quality enhancement measures.

- The Interagency Coordinating Committee (ICC) on Newborn and Child Screening, Section 1114

The Act specifies that the ICC be composed of the Administrator of HRSA, the Director of CDC, the Director of AHRQ, and the Director of NIH. Other federal agencies have liaisons on the committee as well. The ICC was delegated to HRSA and CDC to serve as co-chairs on March 2, 2011. As per the legislation, the ICC serves to: 1) assessing existing newborn and child screening data, in order to make recommendations for programs to collect, analyze,; 2) making data available on the heritable disorders recommended by the Committee, including data on the incidence and prevalence of, as well as poor health outcomes resulting from such disorders; and 3) making recommendations for the establishment of regional centers for the conduct of applied epidemiological research on effective interventions to promote the prevention of poor health outcomes resulting from such disorders, as well as providing information and education to the public on such effective interventions. The ICC also serves to coordinate collaborative efforts for newborn and child screening among all agencies in HHS and serves to identify policy issues requiring attention by federal agencies. Initial activities in 2011 were at the request of the Secretary, and concerned the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children recommendations on newborn screening for critical congenital heart disease and the use and storage of newborn screening residual blood samples.

Funding History

FY	Amount
FY 2008	---
FY 2009	$10,013,000
FY 2010	$9,992,000
FY 2011	$9,952,000
FY 2012	$9,834,000

Budget Request

The FY 2013 Request of $9,834,000 is the same as the FY 2012 Enacted Level.

Improved Newborn and Child Screening For Heritable Disorders, Section 1109

Regional Genetic and Newborn Screening Services Collaborative

The Regional Collaborative Program began its third cycle in 2012 [2017]. With stable funding the Regional Collaborative will continue to provide the services and projects outlined to complete their 3rd grant cycle. As health care reform matures, and as its capacity to personalize health care is realized, the integration of genetic medicine, into the health care delivery system is essential.

Demonstration Project for State Newborn Screening-Critical Congenital Heart Disease Newborn Screening

Continued funding will allow for a second grant cycle at a similar level of projects and funding. This will provide for continued integration of activities that enhance or expand the ability of State and local public health agencies to provide screening, counseling, and/or health care services to newborns and children having or at risk for CCHD. Funded states may continue to develop education trainings to health care professionals on CCHD newborn screening as well as on the use of pulse Oximetry in newborns. States may also continue developing educational programs to parents, families, and patient advocacy and support groups. Funding will also allow grantees to establish, maintain, and operate a health information technology system that will collect information on the detection of critical congenital heart disease and patient outcomes and utilize the data to assess and coordinate treatment relating to critical congenital heart disease.

Evaluating the Effectiveness of Newborn and Child Screening Programs, Section 1110

Early and Continuous Screening through the Medical Home

FY 2013 is Year 4 of 5 of the program. Continued stable funding will allow for continued integration of screening in the Medical Home model with outcomes being a complete review of the methodology employed and measurement of impact.

The Advisory Committee on Heritable Disorders in Newborns and Children, Section 1111

In accordance with the Act, the Committee will continue to: 1) make recommendations to enhance, expand or improve the ability of the Secretary to reduce the mortality or morbidity in newborns and children from heritable disorders; 2) develop a model decision-matrix for newborn screening expansion; and 3) consider ways to ensure that all States attain the capacity to screen for the recommended conditions. The Act also requires the Committee to address other legislative requirements toward facilitating the harmonization of newborn screening standards and quality measures for newborn screening programs. For example, at this time there is no consensus on diagnostic criteria, so calculations of incidence and prevalence of disorders are inaccurate. There are no established criteria for acceptable screening rates, or for that matter, an ability to calculate how many infants are unscreened each year. The development of quality measures requires a process for input from multiple stakeholder groups, which requires expertise, staff time and logistics. The Committee management capacity would not be able to fully address the legislative requirements with a reduction in budget.

The Clearinghouse of Newborn Screening Information, Section 1112

The Clearinghouse is in year 4 of 5 for FY 2013. Continued stable funding will allow for the Clearinghouse to continue to be a central repository of current educational and family support and services information, materials, resources and research, for the following purposes: 1) increase awareness, knowledge, and understanding of newborn screening by parents and family members of newborns, health professionals, industry representatives, and the public; 2) increase expectant individuals and families' awareness, knowledge, and understanding of newborn disease and screening services; and 3) link with the public site of the National Newborn Screening Information Systems which maintains current data on quality indicators of newborn screening performance.

Newborn Screening Data Repository and Technical Assistance Center

With stable funding, the Center will continue to provide technical assistance and programmatic support for the State public health programs, particularly as new conditions for newborn screening are considered and implemented throughout the United States. The continued Quality Enhancement Program will be able to continue to function and work to insure the quality of the State newborn screening programs that includes all portions of the public health program, including short term follow-up. The data repository with continued support will be able to continue to collect the critical data needed for evaluation and quality assessment of newborn screening across the US. With continued financial support the Center will continue to interface at multiple levels with various other HRSA funded programs, including but not limited to the Clearinghouse for Newborn Screening Information as required by the authorizing legislation.

The Interagency Coordinating Committee (ICC) on Newborn and Child Screening, Section 1114

The ICC will continue to undertake relevant activities including: 1) assessing existing newborn and child screening data, in order to make recommendations for data for programs to collect and analyze; 2) making data available on the heritable disorders recommended by the Committee under section 1111, including data on the incidence and prevalence of, as well as poor health outcomes resulting from such disorders; and 3) making recommendations for the establishment of regional centers for the conduct of applied epidemiological research on effective interventions to promote the prevention of poor health outcomes resulting from such disorders, as well as providing information and education to the public on such effective interventions. The ICC also serves to coordinate collaborative efforts for newborn and child screening among all agencies in HHS and serve to identify policy issues requiring attention by federal agencies. The Act specifies that the ICC be composed of the Administrator of HRSA, the Director of CDC, the Director of AHRQ, and the Director of NIH. CMS and ASPE staff serve as liaisons to the ICC.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	13	13	13
Average Award	$612,000	$612,000	$612,000
Range of Awards	$400,000-$1,000,000	$400,000-$1,000,000	$400,000-$1,000,000

Family-To-Family Health Information Centers

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$5,000,000	$5,000,000	---	-$5,000,000
FTE	1	1	---	-1

Authorizing Legislation - Section 501(c)(1)(A) of the Social Security Act.

FY 2013 Authorization ..... Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Family-to-Family Health Information Centers (F2F HICs) program is funded through FY 2012 by the Patient Protection and Affordable Care Act (ACA) of 2010 (P.L. 111-148), Sec. 5507- at a funding level of 5 million dollars. ACA supports these grants to family-staffed family-run organizations to ensure families have access to adequate information about healthcare, community resources and supports in order to make informed decisions around their children's healthcare.

The program for FY 2010-2012 supported centers in 50 States and the District of Columbia to: (1) assist families of children with special healthcare needs (CSHCN) make informed choices about healthcare in order to promote good treatment decisions, cost effectiveness and improved health outcomes; (2) provide information regarding the healthcare needs of and resources available for CSHCN; (3) identify successful health delivery models; (4) develop, with representatives of healthcare providers, managed care organization, healthcare purchasers, and appropriate State agencies, a model for collaboration between families of CSHCN and health professionals; (5) provide training and guidance regarding the care of CSHCN; (6) conduct outreach activities to families, health professionals, schools and other appropriate entities; and (7) be staffed by such families who have expertise in Federal and State public and private healthcare systems and by health professionals.

The evidence indicates a strong rationale for this type of program, indicating that: parent to parent support increased parents' confidence and problem-solving capacity[1]; family-to-family support can also have beneficial effects on the mental health status of mothers of children with chronic illness[2]; and that family participation and family-centered providers are associated with improved transition, less unmet needs, better community based systems, and fewer problems with specialty referrals.[3]

[1] Singer GHS, Marquis J, Powers LK, et al A multi-site evaluation of parent to parent programs for parents of children with disabilities. *J Early Intervent.* 1999; 22:217-229[ISI]; Ainbinder JG, Blanchard LW, Singer GH, et al
[2] Ireys H, Chernoff R, DeVet KA, Kim Y. Maternal outcomes of a randomized controlled trial of a community-based support program for families of children with chronic illness. *Arch Pediatr Adolesc Med.* 2001; 155:771-777
[3] Ngui, 2006; Scale, 2005; Helsiin, 2006; Baruffi, 2005; Smaldone, 2005; Young, 2005

Currently, 51 centers are collecting data on the issues facing families regarding services and financing of those services while working with Medicaid, Education, Title V, and other agencies to inform them of families' needs. Centers are also disseminating information on the implementation of ACA and encouraging family leaders to be involved in the planning within their states such as planning for health insurance Exchanges and Navigator Programs. Other information disseminated through fact sheets, newsletters and listservs are helping families understand the new provisions and how they impact individual access to coverage, such as the extension of Federal dependant coverage to age 26. In addition, many are working with Bureau of Primary Health Care's Federally Qualified Health Centers to implement medical/health homes through training and providing materials. Some of the centers are also working with the Administration on Aging's *Aging and Disability Resource Center*s on the "no wrong door" approach for sharing resource information across the life span for people with disabilities.

Program continues working with grantees, in collaboration with the National Center for Family/Professional Partnerships (NCFPP), on monthly technical assistance calls to enhance program content and data collection, including impact data.

In FY 2008, 75,532 families with CSHCN were provided information, education and/or training from Family-to-Family Health Information Centers. In FY 2009 more than 92,000 families were provided information. These exceeded the targets set for those years. In addition, for FY 2009, 65% of families responded that their center's assistance was useful to extremely useful in helping them be better partners in decision-making with their child's provider), exceeding the target. In FY 2010, no targets were set due to the fact that the program funding was scheduled to end. But the number of families served was 121,476. In FY 2011, almost 146,813 families were provided information (one-on-one assistance, unduplicated count) by 50 centers, exceeding the target for that year. In addition, for FY 2011, approximately 86% (in comparison to 81% in FY 2010) of families served responded that their center's assistance was useful to extremely useful in helping them be better partners in decision-making at any level. The target of 83% was exceeded.

Funding also is obligated for costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, follow-up performance reviews, and an FTE.

Funding History

FY	Amount
FY 2008	$4,000,000
FY 2009	$5,000,000
FY 2010	$5,000,000
FY 2011	$5,000,000
FY 2012	$5,000,000

Budget Request

No funds are being requested for this program in FY 2013; the authorization for this program expires at the end of FY 2012.

Targets for the upcoming fiscal years are: 1) for FY 2012, to provide information to 123,000 families with CSHCN and for 85% of families served reporting that they are better able to partner in decision making; and 2) for FY 2013, no targets are set as authorization is scheduled to expire at the end of FY 2012

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
15.III.C.1: Number of families with CSHCN who have been provided information, education and/or training from Family-to-Family Health Information Centers	FY 2011: 146,813 Target: 122,000 (Target Exceeded)[4]	123,000[4]	N/A	N/A
15.III.C.2: Proportion of families with CSHCN who received services from the Family-to-Family Health Information Centers reporting that they were better able to partner in decision making at any level. *(Outcome)*	FY 2011: 86% Target: 83% (Target Exceeded)[4]	85%[4]	N/A	N/A

[4] These targets reflect Affordable Care Act funding.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	51[5]	51[5]	N/A
Average Award	$95,300	$95,300	N/A
Range of Awards	$33,300-$95,700	$33,300-$95,700	N/A

[5] The number of anticipated awards

Maternal, Infant, and Early Childhood Home Visiting Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$250,000,000	$350,000,000	$400,000,000	+$50,000,000
FTE*	19	19	19	---

- * excludes 10 FTEs for ACF.

Authorizing Legislation - Section 511 of the Social Security Act.

FY 2013 Authorization $400,000,000

Allocation Methods:

- Direct federal/intramural
- Contract
- Formula grant/co-operative agreement
- Competitive grant/co-operative agreement

Program Description and Accomplishments

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, established in FY 2010, is a collaborative between the Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF). The MIECHV program is designed: (1) to improve coordination of services for at-risk communities; (2) to identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities; and (3) to strengthen and improve the programs and activities carried out under Title V.

At-risk communities are identified through a statewide assessment of needs and existing resources to meet those needs. HRSA and ACF intend that the MIECHV program will result in a coordinated system of early childhood home visiting in every State that has the capacity and commitment to provide infrastructure and supports to assure high-quality, evidence-based practice.

There are 56 eligible entities for this program: the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa. While most of the program funds are allocated to the State home visiting grants and general technical assistance, 3% is set aside for grants available to Indian Tribes, Tribal Organizations, and Urban Indian Organizations and 3% is set aside for Research, Evaluation, and Technical Assistance to State grantees.

The program enables eligible entities to provide evidence-based home visiting programs to promote: improvement in maternal and newborn health; prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic violence; improvements in family

economic self-sufficiency; and improvement in coordination and referrals for other community resources and supports.

This program requires participating States to utilize evidence-based home visiting models and provides an exciting opportunity for States and the Federal government to work together to deploy proven programs and to build upon the existing evidence base. The program allows for continued experimentation with new home visiting models and evaluation of both new and existing approaches so that, over time, policymakers and practitioners will have more refined information about the approaches that work best, how different approaches work for different kinds of target populations or targeted outcomes, and the relative costs and benefits of different models.

The target areas for this program, which have been identified by a needs assessment, are communities with concentrations of: premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health; poverty; crime; domestic violence; high rates of high-school drop-outs; substance abuse; unemployment; or child maltreatment.

Grants to States are available to be administered by the lead State agency designated by the Governor to act on behalf of the State. American Indian grants can be awarded to an Indian Tribe, Tribal Organization, or Urban Indian Organization as defined in section 4 of the Indian Health Care Improvement Act.

In FY 2010, 56 State and territory formula grants and 13 American Indian grants were awarded. In FY 2011, 55 State and territory formula grants, 22 State and territory competitive grants, and 19 American Indian grants were awarded. In FY 2012, 55 State and territory formula grants, 20 new State and territory competitive grants (22 competitive continuation grants), and 26 American Indian grants are anticipated to be awarded.

Funding History

FY	Amount
FY 2008	---
FY 2009	---
FY 2010	---
FY 2010 Health Reform	$100,000,000
FY 2011 Health Reform	$250,000,000
FY 2012 Health Reform	$350,000,000

Budget Request

The Affordable Care Act authorized and appropriated $400,000,000 for the Maternal, Infant, and Early Childhood Home Visiting program for FY 2013, which is an increase of $50,000,000 from the FY 2012 Enacted Level. This level of funding will provide: $360 million for awards to 55 State and territory grantees (55 formula grants and 41 competitive grants) and associated program technical assistance; $12 million for 24 to 26 awards to American Indian tribes, and

associated tribal technical assistance, a contract for tribal evaluation of their promising practices and a contract to support a tribal resource center, and $12 million for research, evaluation, and corrective action technical assistance for States not meeting benchmarks. The funding allocated toward research and evaluation will specifically support a number of activities including the national evaluation, a home visiting research network, investigator initiated research grants, contracts to support review of models as evidence based and for continued technical assistance to States and territories for benchmark measures. The remaining funds will be used for administrative costs.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
37.1: Number of children and families receiving services through evidence-based home visiting models. (*Output-Developmental*)	N/A[1]	N/A	TBD	N/A
37.2: Number and percent of grantees that meet benchmark requirements for demonstrating improvements. (*Outcome-Developmental)*	N/A[1]	N/A	TBD	N/A

Grant Awards Tables
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	96	123	122
Average Award	$2.41M	$2.64M	$3.05M
Range of Awards	$0.1M - $11.5M	$0.1M - $11.5 M	$0.1M - $11.5 M

[1] Data are anticipated to be available in FY 2014-2015 when States are required to report on benchmarks (i.e., after the end of the 3rd year of program operations).

Ryan White HIV/AIDS

Tab

Ryan White HIV/AIDS Treatment Extension Act of 2009 Overview

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$2,311,665,000	$2,367,178,000	$2,446,772,000	+$79,594,000
ADAP (non add)	885,000,000	933,299,000	1,000,000,000	+66,701,000
MAI (non add)	153,358,000	160,722,000	169,077,000	+8,355,000
SPNS	25,000,000	25,000,000	25,000,000	---
Total Funding	$2,336,665,000	$2,392,178,000	$2,471,772,000	+$79,594,000
FTE	110	110	110	---

**The amounts include funding for Special Projects of National Significance (SPNS) funded from Department PHS Act evaluation set-asides in FY 2012 and proposed for FY 2013.*

Authorizing Legislation: The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Title XXVI of the Public Health Service Act) was enacted on October 30, 2009.

FY 2013 Authorization……...$2,782,659,000

Allocation Method .....Competitive and Formula Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

The purpose of the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White HIV/AIDS Program) is to address the unmet care and treatment needs of persons living with HIV/AIDS (PLWH) who are uninsured or underinsured and, therefore, have limited or no resources to pay for HIV/AIDS health care and vital health-related supportive services. Ryan White HIV/AIDS Program funding pays for primary health care and treatment including referrals to specialty care and for support services that enhance access to and retention in care. The Ryan White HIV/AIDS Program fills gaps in care for PLWH not covered by other resources or payers. The Program serves more than half a million low-income people with HIV/AIDS in the U.S. each year. Twenty-nine percent of those served by the Ryan White HIV/AIDS Program are uninsured and an additional 56 percent are underinsured. Ryan White HIV/AIDS Program services are intended to increase access to care for underserved populations thereby decreasing mortality, reduce the use of more costly emergency services and inpatient care, and improve the quality of life for PLWH and for those affected by the HIV/AIDS epidemic.

The Ryan White Comprehensive AIDS Resources Emergency Act was first enacted in August 1990. It was amended and reauthorized for five years in May 1996 and for an additional five

years in October 2000. The Program was reauthorized again in December 2006 for three years as the Ryan White HIV/AIDS Treatment Modernization Act of 2006 and for another four years in October 2009 as the Ryan White HIV/AIDS Treatment Extension Act of 2009. The Ryan White HIV/AIDS Program is administered by the HRSA's HIV/AIDS Bureau (HAB).

In July 2010, the Administration released the first comprehensive *National HIV/AIDS Strategy (NHAS) for the United States*. The NHAS was the result of unprecedented public input, including 14 HIV/AIDS community discussions held across the country, an online suggestions process, various expert meetings and other inputs. Senior officials at HRSA were involved in a Federal interagency working group that reviewed recommendations from the public and worked with the Office of National AIDS Policy to develop the NHAS.

The NHAS has three primary goals: 1) reducing the number of people who become infected with HIV; 2) increasing access to care and optimizing health outcomes for people living with HIV; and 3) reducing HIV-related health disparities.

Reaching these goals requires broad support across federal, state, local, and tribal governments, business, faith-based communities, philanthropy, the scientific and medical communities, educational institutions, people living with HIV, and others. The HIV/AIDS Bureau (HAB) and the Ryan White HIV/AIDS Program is playing an essential role in meeting these NHAS goals, both because of its critical role in filling gaps in the health system, but also the unique capacity, experience, and expertise of the Ryan White HIV/AIDS Program to meet the diverse and challenging health care and related needs of people living with HIV/AIDS.

New research findings released over the past year have further confirmed the effectiveness of drug treatment in preventing the spread of HIV. The essential role played by the HIV/AIDS Bureau and Ryan White HIV/AIDS program in linking and retaining people living with HIV/AIDS into care and providing life-saving HIV/AIDS medications to underserved populations is also crucial to preventing new infections. In addition, because one of the core missions of the Ryan White HIV/AIDS program is to expand access to care for some of the nation's most underserved populations through activities such as the Ryan White Minority AIDS Initiative and Part C Early Intervention grants, it plays a direct role in reducing HIV-related health disparities.

The second goal of the NHAS, to increase access to care and improve health outcomes for people living with HIV, has two targets directly related to the mission of the HIV/AIDS Bureau (HAB): to increase the proportion of newly diagnosed patients linked to care within three months of their HIV diagnosis from 65% to 85% and to increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care from 73% to 80%. HAB is working closely with its grantees and partners to meet these goals.

The Ryan White HIV/AIDS Program demonstrates a comprehensive and aggressive approach in how government has targeted dollars toward the development of a highly effective service delivery system. By funding and partnering with community, faith based, and not-for-profit organizations and with local and State governments, the Ryan White HIV/AIDS Program provides primary medical care and support services, health care provider training, and technical

assistance to help funded programs address current and emerging HIV care and treatment needs. The distinct components of the Ryan White HIV/AIDS Program serve very specific purposes. The FY 2013 Budget Request of $2.47 billion for the Ryan White HIV/AIDS Program includes:

- Part A -- $671.3 million, which provides grants for 24 Eligible Metropolitan Areas (EMAs) and 28 Transitional Grant Areas (TGAs) disproportionately affected by HIV/AIDS. In addition, 4 states (New York, New Jersey, California, and Puerto Rico) that previously had a TGA receive Part A grants to fund a variety of medical and support services;
- Part B -- $1,422.3 million, which provides grants to 59 States and Territories to improve the quality, availability, and organization of HIV/AIDS health care and support services; this includes $1,000 million to provide access to FDA approved, HIV-related medications through the AIDS Drug Assistance Program (ADAP). The ADAP serves primarily low-income PLWH who have limited or no access to needed medication, and is the nation's prescription drug safety net for PLWH;
- Part C -- $235.6 million, which provides grants directly to 344 service providers (i.e. Federally-qualified health centers, family planning clinics, rural health clinics, Indian Health Service facilities; community-based organizations, and nonprofit faith-based organizations) to support outpatient HIV early intervention services and ambulatory care;
- Part D -- $69.6 million, which provides grants to 81 community based and non-profit private and public organizations to support family-centered, comprehensive care to HIV-infected women, infants, children and youth and support to their affected family members.
- Part F -- $34.5 million for AIDS Education and Training Center (AETC) grants to organizations to support education and training of health care providers through 11 Regional Centers, 130 Local Performance Sites and 5 National Centers;
- $13.5 million for the HIV/AIDS Dental Reimbursement Program, a program that provides reimbursement to dental schools, hospitals with postdoctoral dental education programs, and colleges with dental hygiene programs for uncompensated costs incurred in providing oral health treatment to patients with HIV disease; and for 12 Community-Based Dental Partnership Grants to provide support to dental clinicians to provide increased access to oral health care services for HIV-positive individuals while providing education and clinical training for dental care providers, especially those located in community-based settings; and
- $25 million for Special Projects of National Significance (SPNS) funded from the Department PHS Act evaluation set-aside. Examples of SPNS initiatives include expanding the capacity of grantees to: 1) utilize standard electronic client information data systems to report client level data; 2) take a more systems level/public health approach to test people who do not know their status and link them to care; 3) develop innovative models to reach women of color and link them to and retain them in care; and 4) expand access to HCV treatment through the development of models to integrate HCV care into HIV primary care. These SPNS initiatives reflect priorities of the NHAS, Patient Protection and Affordable Care Act, and the Departmental Hepatitis Plan.

Ryan White Minority AIDS Initiative (MAI): Within the total amount included for the Ryan White HIV/AIDS Program, the FY 2013 President's Budget requests $169.1 million to address

the disproportionate impact of HIV/AIDS on communities of color. Ryan White MAI dollars focus specifically on the elimination of racial and ethnic disparities in the delivery of comprehensive, culturally and linguistically appropriate HIV/AIDS care and treatment in the United States. To achieve this objective, the Ryan White HIV/AIDS Program uses MAI funds to conduct the following activities:

- Provide service grants to health care providers who have a history of providing culturally and linguistically appropriate care and services to racial and ethnic minorities;

- Increase the training of health care professionals in order to expand the number of them with HIV treatment expertise who are then better able to provide medical care for racial and ethnic minority adults, adolescents, and children with HIV disease; and

- Support education and outreach services to increase the number of eligible racial and ethnic minorities who have access to the AIDS Drug Assistance Program (ADAP).

Minority AIDS Initiative (MAI) Funding

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Part A	$49,075,000	$51,431,000	$54,105,000
Part B	9,202,000	9,644,000	10,145,000
Part C	64,410,000	67,503,000	71,012,000
Part D	21,470,000	22,500,000	23,671,000
Part F – AETC	9,201,000	9,644,000	10,144,000
Part F – Dental	---	---	---
Total MAI Funding	$153,358,000	$160,722,000	$169,077,000

Program Accomplishments

The Ryan White HIV/AIDS Program has developed outcome measures and other indicators that allow for ongoing monitoring of the MAI program's effectiveness. These indicators include: 1) client-level health outcomes (the MAI client-level health outcomes indicators facilitate improving and stabilizing client CD4 counts and reducing client viral load counts); 2) rates of kept appointments and retention in care; and 3) the proportion of health care providers trained in the clinical management of HIV/AIDS who serve primarily uninsured and underinsured minority populations.

Program Performance: The HIV/AIDS Bureau (HAB) continues to demonstrate outstanding performance in improving access to health care, improving health outcomes, improving quality of health care, and promoting efficiency. The Ryan White HIV/AIDS Program uses various strategies to achieve its performance goals including: 1) targeting resources to high-risk areas; 2) ensuring availability, access to and excellence of critical HIV-related care and support services and optimizing health outcomes for people living with HIV; 3) working to assure patient adherence; 4) directing outreach and prevention education and testing to populations at

disproportionate risk for HIV infection; 5) tailoring services to populations known to have delayed care-seeking behaviors (e.g., by varying hours; offering care in various sites, offering linguistically and culturally appropriate services); and 6) collaborating with other programs and providers for referrals to Ryan White HIV/AIDS Program service providers.

Improving Access to Health Care: The Ryan White HIV/AIDS Program works to improve access to health care by addressing the disparities in access, treatment, and care for populations disproportionately impacted by HIV/AIDS including racial/ethnic minorities and women. The Ryan White HIV/AIDS Program provides HIV/AIDS care and treatment services to a significantly higher proportion of racial/ethnic minorities and women than their representation among AIDS cases as reported by the Centers for Disease Control and Prevention (CDC). The proportion of Ryan White clients who were racial/ethnic minorities in 2007 was 72%, compared to the 64.1% of CDC-reported AIDS cases. In 2008, 73% of the Ryan White HIV/AIDS Program clients were racial/ethnic minorities compared to 65.9% of CDC-reported AIDS cases. In FY 2009, 73% of the Ryan White HIV/AIDS Program clients were racial/ethnic minorities, compared to 66.4% of CDC-reported AIDS cases. In FY 2010, the proportion of racial/ethnic minorities in Ryan White HIV/AIDS-funded programs was 72%, at the time of this reporting the CDC data are not available for comparison.

In 2007 and 2008, 33% of persons served by the Ryan White HIV/AIDS Program were women. This compares to 23% of CDC reported AIDS cases among women in 2007 and 2008. In FY 2009, 32% of the Ryan White HIV/AIDS Program clients were women, compared to the 23.3% of CDC-reported AIDS cases. In FY 2010, the proportion of women in Ryan White HIV/AIDS funded programs was 31%, at the time of this reporting the CDC data are not available for comparison.

Improving Health Outcomes: The number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs in FY 2010 was 208,809, exceeding the target. In FY 2009, the AIDS Drug Assistance Program (ADAP) served 194,039 clients through State ADAPs. In FY 2008, the AIDS Drug Assistance Program (ADAP) served 175,194 clients through State ADAPs. The number of ADAP clients served through State ADAPs annually in 2010 was 14,770 persons above the 2009 annual results. In 2007, the ADAP served 163,925 clients through State ADAPs. FY 2007 results cannot be compared with the FY 2007 target because the actual performance is based on the revised measure using annual data and the target is based on the previous measure utilizing quarterly Program data. FY 2007 – FY 2010 represent a substantial growth in the persons served in the State ADAP programs of 21.5% or 44,884 additional ADAP clients served in these four years. About 46 percent of HIV positive people in care in the U.S. receive their medications through State ADAPs in 2010.

CDC estimates that 1.039 to 1.185 million people in the United States are living with HIV/AIDS, of whom an estimated 21 percent are unaware of their serostatus. In FY 2009, 871,696 persons learned their serostatus from the Ryan White HIV/AIDS Program, exceeding the target by 299,299 persons. The number of persons learning their serostatus from the Ryan White HIV/AIDS Program was 739,779 in FY 2008. In 2007, the number of persons who learned their serostatus from Ryan White HIV/AIDS Programs was 738,181. These three years represent a growth of 135,515 persons who learned their serostatus or 18.4%. These efforts demonstrate that

the Ryan White HIV/AIDS Program has made important strides in testing people in the United States who do not know their serostatus.

Mother-to-child transmission in the U.S. has decreased dramatically since its peak in 1992 due to the use of anti-retroviral therapy which significantly reduces the risk of HIV transmission from the mother to her baby. The proportion of Ryan White HIV-positive pregnant women receiving anti-retroviral medications in both 2008 and 2009 was 87%. In FY 2007, the Ryan White HIV/AIDS Program provided 85.1% of HIV-positive pregnant women in the Program with anti-retroviral medications. The percentage of HIV-positive pregnant women in the Ryan White HIV/AIDS Program receiving anti-retroviral medication has grown 1.9 percentage points in the years FY 2007 – FY 2009.

Improving the Quality of Health Care: A major focus of the Ryan White HIV/AIDS Program is to improve the quality of care that its clients receive. The Ryan White HIV/AIDS Treatment Modernization Act of 2006 directed grantees to develop, implement, and monitor clinical quality management programs to ensure that service providers adhere to established HIV clinical practices and quality improvement strategies; and that demographic, clinical, and health care utilization information is used to monitor trends in the spectrum of HIV-related illnesses and the local epidemic. This legislative requirement continues in the Ryan White HIV/AIDS Extension Act of 2009. The proportion of new Ryan White HIV/AIDS Program-funded primary care medical providers that implemented a quality management program by 2008 was 92.3%. In 2009, 94.5% of Ryan White HIV/AIDS Program-funded primary medical care providers had implemented a quality management program. Improvements continued in 2010 with 95.2% of medical care providers implementing a quality management program, falling short of the target by 0.5 percentage points.

CD4 cell measurement is a key test used to assess the functioning of the immune system, guide decisions about when to start HIV treatment, and monitor effectiveness of HIV treatment. Viral load tests measure the amount of HIV in the blood and are used along with CD4 cell counts to decide when to start HIV treatment and to monitor response to therapy. The proportion of new Ryan White HIV/AIDS Program clients who were tested for CD4 and viral load in 2008 and 2009 were: CD4-86.4% and Viral Load-84.4% and CD4-84.7% and Viral Load-81.3%, respectively. In 2010, the Ryan White HIV/AIDS Program provided CD4 count testing to 84.7% of new clients and viral load testing to 82.9% of these new clients. These 2010 results fell short of the target for CD4 tests by 3.5 percentage points and fell short of the target for viral load tests by 1.4 percentage points.

Promoting Efficiency: State ADAPs use a variety of strategies to contain costs which results in a more effective use of funding, and enables ADAPs to serve more people. Cost-containment measures used by ADAPs include: using drug purchasing strategies like seeking cost recovery through drug rebates and third party billing; direct negotiation of pharmaceutical pricing; reducing ADAP formularies; capping enrollment; and lowering financial eligibility. ADAPs' savings strategies on medications resulted in a savings of $265.2 million in 2007 and a $374.2 million savings in 2008. In 2009, the ADAP program had cost-savings on medications of $487.3 million, exceeding the target by $113.1 million.

Funding History

FY	Amount[1]
FY 2003	$2,017,966,000
FY 2004	$2,044,861,000
FY 2005	$2,073,296,000
FY 2006	$2,061,275,000
FY 2007	$2,137,795,000
FY 2008	$2,166,792,000
FY 2009	$2,238,421,000
FY 2010	$2,312,179,000
FY 2011	$2,336,665,000
FY 2012	$2,392,178,000

Budget Request

The FY 2013 President's Budget for the HIV/AIDS Programs of $2,471,772,000 is $79,594,000 above the FY 2012 Enacted Level.

As previously mentioned, the National HIV/AIDS Strategy (NHAS) has three primary goals: 1) reducing the number of people who become infected with HIV; 2) increasing access to care and optimizing health outcomes for people living with HIV; and 3) reducing HIV-related health disparities.

The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of getting people with HIV into care early after infection to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to reduce HIV infection in high-risk communities and reduce stigma and discrimination against people living with HIV.

In FY 2013, the Program will continue its central goals of providing access to care for uninsured and underserved populations, and improving the quality of life for those infected with HIV or affected by the epidemic. Some ongoing challenges faced in meeting performance targets include the following: many persons are unaware of their serostatus; persons who know they are infected are reluctant to seek HIV/AIDS care; medical and prescription drug costs are rising; and some PLWH are unaware of the availability of Ryan White HIV/AIDS Program services. To the extent possible, the Program targets resources to address these challenges.

The Minority AIDS Initiative (MAI) budget will continue the Ryan White HIV/AIDS Program's efforts to reduce HIV/AIDS-related health disparities in communities of color, strengthen organizational capacity, and expand HIV-related services to minority populations. The MAI

[1] Includes SPNS

funds will support primary health care and related services; outreach and education to improve minority access to HIV/AIDS treatment medications; and targeted, multidisciplinary education and training programs for health care providers treating minority PLWH.

The Program will continue to appropriately target men who have sex with men, racial/ethnic minorities and women because these groups are disproportionately impacted by HIV/AIDS. In addition, the NHAS targets these populations for more resources given their increased risk for HIV. Although new HIV infections have remained fairly stable among blacks, from 2005–2008 estimated HIV diagnoses increased approximately 12%. At some point in their lifetimes, 1 in 16 black men will be diagnosed with HIV infection, as will 1 in 32 black women. With regard to women, data from the 2009 CDC Surveillance Report show that together, black and Hispanic women represent 25% of all U.S. women. However, women in these 2 groups accounted for 81% of the estimated total of AIDS diagnoses for women. The FY 2013 targets for the proportion of racial/ethnic minorities and women served in Ryan White HIV/AIDS-funded programs are 5 percentage points above CDC reported national AIDS prevalence data.

In FY 2013, the Program will aim to reach the following performance targets. The number of clients served by ADAPs given the FY 2013 President's Budget is predicted to be 236,230 clients. The ADAP target reflects adjustment for our current performance and increased resources, in addition to medical inflation, rising health insurance premiums, reported decreases in state contributions and decreases in drug rebates, and increased costs of laboratory testing associated with antiretroviral use (e.g. resistance, tropism and Human Leukocyte Antigen (HLA) testing for patients). The FY 2013 President's Budget target for persons who learn their serostatus from Ryan White HIV/AIDS programs is 595,405. The budget will also support the Program's ongoing efforts to improve the quality of health care for PLWH. The FY 2013 President's Budget target for the percentage of Ryan White HIV/AIDS Program-funded primary care providers that will have implemented a quality management program is 95.7%. The FY 2013 President's Budget targets for new HIV infected clients who are tested for CD4 and for viral load are 88.2% and 84.3%, respectively.

In FY 2013, the Ryan White HIV/AIDS Program will continue to coordinate and collaborate with related Federal, State, and local entities as well as national AIDS organizations in order to further leverage and promote efforts to address the unmet care and treatment needs of persons living with HIV/AIDS who are uninsured or underinsured. The Program's work in collaboration with others has been a key to its success. Federal partners include the Office of the Assistant Secretary for Health (OASH), the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare and Medicaid Service, (CMS), Indian Health Service (IHS), the National Institutes of Health (NIH), Agency for Healthcare Research and Quality (AHRQ), the Department of Housing and Urban Development (HUD), the Department of Veterans Affairs (VA), and the Department of Justice (DOJ) as well as other HRSA-funded programs.

The Ryan White HIV/AIDS Program funds two IT Investments. It funds the HRSA-HAB Upgrading & Maintaining RW CAREWare investment, which directly supports the strategic and performance outcomes of the HIV/AIDS Bureau (HAB) by providing to grantees and providers a free and technically-supported software to manage their HIV care, treatment, and services data at

the clinic level and be able to report these data in the required format to HAB at the end of the year. The software also generates HAB's performance measures in a standardized fashion, outcomes that are essential for monitoring and ultimately improving the quality of HIV care.

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

Outcomes and Output Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
16.1: Number of racial/ethnic minorities and the number of women served by Ryan White HIV/AIDS-funded programs.[2] *(Outcome)*	FY 2005: 412,000/ 195,000 (Baseline)	N/A	N/A	N/A
16.I.A.1: Proportion of racial/ethnic minorities in Ryan White HIV/AIDS-funded programs served. *(Outcome)*	FY 2010: 72% (CDC= Not Yet Available For Comparison)	5 percentage points above CDC data	5 percentage points above CDC data	Maintain
16.I.A.2: Proportion of women in Ryan White HIV/AIDS funded-programs served. *(Outcome)*	FY 2010: 31% (CDC= Not Yet Available For Comparison)	5 percentage points above CDC data	5 percentage points above CDC data	Maintain
16.III.A.2: Proportion of new Ryan White HIV/AIDS Program HIV-infected clients who are tested for CD4 count and viral load. *(Output)*	FY 2010: CD4 – 84.7%Viral Load – 82.9% Target: CD4-88.2%, Viral Load-84.3% (Target Not Met but Improved)	CD4 = 88.2% Viral Load = 84.3%	CD4 = 88.2% Viral Load = 84.3%	Maintain
16.2: Reduce deaths of persons due to HIV	FY 2003: 4.7 per 100,000	N/A	N/A	N/A

[2] These are long-term measures without annual targets. Long-term targets for FY 2014 are as follows: measure 16.1 = 422,300/199,875; measure 16.2=3.1 per 100,000; measure 16.3 = 90%.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
infection.[2] *(Outcome)*	(Baseline)			
16.II.A.1: Number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs annually. (Output)	FY 2010: 208,809 Target: 149,946 (Target Exceeded)	217,324	236,230	+18,906
16.II.A.2: Number of persons who learn their serostatus from Ryan White HIV/AIDS Programs. *(Output)*	FY 2009: 871,696 Target: 572,397 (Target Exceeded)	872,565	877,525	+4,960
16.II.A.3: Percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive anti-retroviral medications. *(Output)*	FY 2009: 87 % Target; 89.3% (Target Not Met)	90%	90%	Maintain
16.3: Ryan White HIV/AIDS Program-funded HIV primary medical care providers will have implemented a quality management program and will meet two "core" standards included in the October 10, 2006 "Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents".[3]	FY 2005: 63.7% (Baseline)	N/A	N/A	N/A
16.III.A.1: Percentage of Ryan White HIV/AIDS Program-funded primary medical care providers that will have implemented a quality management program. *(Output)*	FY 2010: 95.2% Target: 95.7% (Target Not Met but Improved)	95.7%	95.7%	Maintain

[3] These are long-term measures without annual targets. Long-term targets for FY 2014 are as follows: measure 16.1 = 422,300/199,875; measure 16.2=3.1 per 100,000; measure 16.3 = 90%.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
16.E: Amount of savings by State ADAPs' participation in cost-savings strategies on medications. *(Efficiency)*	FY 2009: $487.3M Target: $374.2M (Target Exceeded)	Sustain FY 11 results	Sustain FY 12 results	Sustain

Emergency Relief Grants – Part A

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$672,529,000	$671,258,000	$671,258,000	---
MAI (non add)	49,075,000	51,431,000	54,105,000	+$2,674,000
SPNS	7,588,000	7,588,000	7,588,000	---
Total Funding	$680,117,000	$678,846,000	$678,846,000	---
FTE	19	19	19	---

Authorizing Legislation: The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Title XXVI of the Public Health Service Act) was enacted on October 30, 2009.

FY 2013 Authorization……..…….$789,471,000

Allocation Method ..... Competitive and Formula Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

Part A funds are used to provide a continuum of care for people living with HIV disease who are primarily low income, underserved, uninsured and underinsured. Part A grants are distributed to metropolitan areas experiencing the greatest burdens of the country's HIV/AIDS epidemic, and provide those communities with resources they need to confront the highly concentrated epidemic within the jurisdiction. Part A grantees in New York, Los Angeles, Washington, D.C., Chicago, Atlanta, Miami, Philadelphia, Houston, San Francisco, Baltimore, Dallas, and San Juan will also play a vital role in implementation of the National HIV/AIDS Strategy through the mobilization of the Ryan White resources in the "Twelve Cities Initiative." This initiative is a key part of the Department of Health and Human Services (DHHS) strategy to better coordinate HIV prevention, care, and treatment across DHHS, state, and local partners.

Part A of the Ryan White HIV/AIDS Program prioritizes primary medical care, access to anti-retroviral therapies, and other core services as the areas of greatest need for persons with HIV disease. The grants fund systems of care to provide 13 core medical services and additional support services for individuals with HIV/AIDS in 24 Eligible Metropolitan Areas (EMAs), which are jurisdictions with 2,000 or more AIDS cases over the last five years, and 28 transitional grant areas (TGAs) (jurisdictions with at least 1,000 but fewer than 2,000 AIDS cases over the last five years). In addition, Part A funds 4 states (California, New Jersey, New York and Puerto Rico) that have a city that was previously a TGA. Two-thirds of the funds available for EMAs and TGAs are awarded according to a formula based on the number of living cases of HIV/AIDS in the EMAs and TGAs. The statute also includes a hold harmless provision which limits a potential loss in EMA's formula award to a specific percentage of the amount of the formula award in the previous year. The remaining funds are awarded as discretionary

supplemental grants based on the demonstration of additional need by the EMAs and TGAs, as Minority AIDS Initiative (MAI) grants and as grants to the 4 specific states. MAI grant awards are determined based on the number of minorities living with HIV and AIDS in a jurisdiction.

More than eighty percent of Part A clients are people of color and 30 percent are women. In 2007, Part A provided 2.65 million visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health) and 2.60 million visits were provided in 2008. In FY 2009, Part A provided 2.59 million visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health). In FY 2010, Part A provided 2.63 million visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health). This met the FY 2010 target.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, technical assistance, and program monitoring including performance reviews.

Funding History

FY	Amount[1]
FY 2003	$618,693,000
FY 2004	$615,023,000
FY 2005	$610,094,000
FY 2006	$603,576,000
FY 2007	$603,993,000
FY 2008	$627,149,000
FY 2009	$663,082,000
FY 2010	$678,074,000
FY 2011	$672,529,000
FY 2012	$671,258,000

Budget Request

The FY 2013 President's Budget for the Ryan White HIV/AIDS Part A Program of $671,258,000 is equal to the FY 2012 Enacted Level and will support program activities and services for PLWH in the 24 Eligible Metropolitan Areas (EMAs), 28 Transition Grant Areas (TGAs), and 4 states.

The FY 2013 President's Budget target for the number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health) is 2.63 million visits. Part A funding will also contribute to achieving the FY 2013 targets for the Ryan White HIV/AIDS Program's over-arching performance measures, including proportion of racial/ethnic minorities and women served, persons tested for CD4 count and viral load, and providers

[1] Excludes comparable amounts for SPNS.

implementing a quality management program. (See Summary for targets and for strategies and challenges.)

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
17.I.A.1: Number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative[2], and home health). (Output)	FY 2010: 2.63 M Target: 2.63 M (Target Met)	2.63 M	2.63 M	Maintain

Grant Awards Table – Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards[3]	52	52	52
Average Award	$12,410,574	$12,410,574	$12,410,574
Range of Awards	$2,025,807 - $120,936,183	$2,025,807 - $120,936,183	$2,025,807 - $120,936,183

Part A – FY 2011 Formula, Supplemental & MAI Grants[4]

Table 1. Eligible Metropolitan Areas

EMAs	Formula[5]	Supplemental	MAI	Total
Atlanta, GA	$13,744,460	$5,901,310	$1,932,101	$21,577,871
Baltimore, MD	13,876,932	5,140,096	2,080,356	21,097,384
Boston, MA	9,212,901	3,653,098	903,367	13,769,366
Chicago, IL	17,548,172	6,511,397	2,191,752	26,251,321
Dallas, TX	9,955,487	3,621,567	1,048,028	14,625,082
Detroit, MI	5,788,239	2,372,430	778,987	8,939,656
Ft. Lauderdale, FL	10,129,211	3,670,716	1,206,334	15,006,261

[2] Rehabilitative services are a support service and visit data is not collected for support services.
[3] Awards to 24 EMAs and 28 TGAs in FY 2011 = 52.
[4] Awards to EMAs and TGAs include prior year unobligated balances.
[5] EMAs Hold Harmless Amount is included in their Formula Award; TGAs are not eligible for Hold Harmless.

EMAs	Formula[5]	Supplemental	MAI	Total
Houston, TX	13,017,374	5,015,324	1,703,286	19,735,984
Los Angeles, CA	26,057,989	10,828,921	3,177,249	40,064,159
Miami, FL	16,201,594	6,383,368	2,536,059	25,121,021
Nassau-Suffolk, NY	4,459,968	1,554,249	433,336	6,447,553
New Haven, CT	5,121,929	1,457,498	463,053	7,042,480
New Orleans, LA	4,930,405	1,839,286	601,020	7,370,711
New York, NY	84,645,850	26,711,296	9,579,037	120,936,183
Newark, NJ	9,486,484	3,244,130	1,323,397	14,054,011
Orlando, FL	5,956,976	2,249,188	706,671	8,912,835
Philadelphia, PA	15,657,185	6,345,442	2,099,786	24,102,413
Phoenix, AZ	5,665,271	2,181,107	422,827	8,269,205
San Diego, CA	7,735,965	3,387,853	654,670	11,778,488
San Francisco, CA	20,125,642	4,726,102	789,044	25,640,788
San Juan, PR	11,226,497	2,928,622	1,274,018	15,429,137
Tampa-St. Petersburg, FL	6,461,583	2,352,333	597,630	9,411,546
Washington, DC-MD-VA-WV	20,687,494	7,618,920	3,080,130	31,386,544
West Palm Beach, FL	6,505,288	1,597,498	679,100	8,781,886
Subtotal EMAs	**$344,198,896**	**$121,291,751**	**$40,261,238**	**$505,751,885**

Table 2. Transitional Grant Areas[6]

TGAs	Formula	Supplemental	MAI	Total
Austin, TX	$3,015,261	$1,125,908	$258,872	$4,400,041
Baton Rouge, LA	2,792,631	822,594	389,381	4,004,606
Bergen-Passaic, NJ	2,889,485	1,084,057	339,550	4,313,092
Charlotte-Gastonia, NC-SC	3,940,757	1,314,110	493,675	5,748,542
Cleveland, OH	3,043,510	1,052,975	323,279	4,419,764
Denver, CO	5,684,806	1,813,339	328,815	7,826,960
Ft. Worth, TX	2,745,549	864,147	254,578	3,864,274
Hartford, CT	2,931,697	1,025,200	292,591	4,249,488
Indianapolis, IN	2,773,798	920,357	219,097	3,913,252
Jacksonville, FL	3,941,430	1,400,760	463,731	5,805,921

[6] Note: In FY 2011, Caguas, PR; Dutchess County, NY; Vineland, NJ; and Santa Rosa, CA did not receive TGA grants. Rather, Part A funds were awarded to PR, NY, NJ, and CA. These funds could be used to maintain services in these areas.

TGAs	Formula	Supplemental	MAI	Total
Jersey City, NJ	3,422,856	1,216,462	440,567	5,079,885
Kansas City, MO	3,071,760	1,009,860	237,854	4,319,474
Las Vegas, NV	4,047,028	1,501,722	332,431	5,881,181
Memphis, TN	4,648,332	1,613,720	658,422	6,920,474
Middlesex-Somerset-Hunterdon, NJ	1,904,128	640,916	212,544	2,757,588
Minneapolis-St. Paul, MN	3,848,611	1,500,910	302,375	5,651,896
Nashville, TN	3,204,934	1,235,296	280,567	4,720,797
Norfolk, VA	4,155,989	1,360,056	528,817	6,044,862
Oakland, CA	4,389,873	1,862,783	542,116	6,794,772
Orange County, CA	3,919,897	1,689,752	366,341	5,975,990
Ponce, PR	1,365,135	442,705	217,967	2,025,807
Portland, OR	2,576,887	1,062,836	103,081	3,742,804
Riverside-San Bernardino, CA	5,172,678	2,221,624	430,635	7,824,937
Sacramento, CA	1,777,832	738,999	138,036	2,654,867
St. Louis, MO	4,413,594	1,686,133	428,669	6,528,396
San Antonio, TX	3,132,293	910,866	370,285	4,413,444
San Jose, CA	1,917,357	722,761	204,691	2,844,809
Seattle, WA	4,959,072	1,644,851	266,103	6,870,026
Subtotal TGAs	**$95,687,180**	**$34,485,699**	**$9,425,070**	**$139,597,949**
Total EMAs/TGAs	**$439,886,076**	**$155,777,450**	**$49,686,308**	**$645,349,834**

HIV Care Grants to States – Part B

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$1,308,141,000	$1,355,640,000	$1,422,341,000	+$66,701,000
ADAP (non add)	885,000,000	933,299,000	1,000,000,000	+66,701,000
MAI (non add)	9,202,000	9,644,000	10,145,000	+501,000
SPNS	14,077,000	14,077,000	14,077,000	--
Total Funding	$1,322,218,000	$1,369,717,000	$1,432,868,000	+$66,701,000
FTE	52	52	52	--

Authorizing Legislation: The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Title XXVI of the Public Health Service Act) was enacted on October 30, 2009.

FY 2013
Authorization……$1,562,169,000

Allocation Method ..... Competitive and Formula Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

Part B, the largest of the Ryan White HIV/AIDS programs, provides grants to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam and 5 U.S. Pacific Territories or Associated Jurisdictions to provide services for people living with HIV/AIDS, including outpatient medical care, oral health care, home- and community-based services, continuation of health insurance coverage, prescription drugs, HIV care consortia, and support services.

Part B includes the AIDS Drug Assistance Program (ADAP), which supports the provision of HIV medications and related services. Seventy-five percent of Part B funds must be used to support 13 core medical services. Part B funds are distributed through base and supplemental grants, ADAP and ADAP supplemental grants, Emerging Communities (ECs) grants, and Minority AIDS Initiative grants**.** Additionally**,** the statute includes a hold harmless provision which limits a potential loss in State's award to a specific percentage of the amount of the award in the previous year. The FY 2013 Hold Harmless amount is 92.5%. The FY 2012 Hold Harmless amount is 100%. In FY 2011, the Hold Harmless amount was 100%. In FY 2010, the Hold Harmless amount was 95%. The base awards are distributed by a formula based on a state or territory's living HIV/AIDS cases weighted for cases outside of Part A-funded jurisdictions. Supplemental grants are available to states with demonstrated need and less than 5% unobligated prior year funds. Emerging communities are metropolitan areas that do not qualify as EMAs or TGAs but have 500-999 cumulative reported AIDS cases over the last five years and apply for supplemental funding through a grant application.

Over the past three years, the convergence of several factors has resulted in significant budget challenges for the Part B program. These include the economic downturn, a national HIV testing initiative that has brought more people infected with HIV into care, federal recommendations for earlier treatment of HIV, and continued improvements in HIV care and treatment that has prolonged survival, increasing HIV prevalence. Part B grants provide critical resources for States and territories to meet these increased demands and provide life-saving HIV/AIDS care, treatment, and support for people living with HIV/AIDS without access to health care.

Congress designates a portion of the Part B award to support the ADAPs. The ADAPs provide FDA-approved, prescription medications for people with HIV/AIDS who have limited or no prescription drug coverage. The majority of ADAP funds are distributed by a formula based on living HIV/AIDS cases, although 5% of the funds are set aside for states with severe need. ADAP funds also may be used to purchase health insurance for eligible clients or to pay for services that enhance access, adherence, and monitoring of drug treatments. Individual ADAPs operate in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, Commonwealth of the Northern Mariana Islands, and the Republic of the Marshall Islands.

Due to the combination of factors mentioned above, a number of States have started or significantly increased waiting lists for people to enroll in their ADAP programs and have implemented other cost-containment mechanisms such as restricting the income eligibility for their programs. DHHS took several actions to address the ADAP crisis:

- In FY 2010, DHHS used emergency authority to redistribute and transfer $25 million from other DHHS resources to provide direct assistance to help State ADAP programs eliminate their waiting lists and to address cost containment measures.

- The FY 2011 Budget included an additional $50 million for State ADAPs.

The Part B programs have been successful in helping to ensure that people living with HIV/AIDS can get the care and services they need to stay healthy longer. The number of visits for health-related services demonstrates the effectiveness of the Part B program in delivering primary care and related services for individuals infected with HIV by increasing the availability and accessibility of care. Part B programs provided 2.06 million visits in 2007. In FY 2008, Part B provided 2.02 million visits for health-related care. In FY 2009, the Part B program provided 2.11 million visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health). In FY 2010, the Part B program provided 2.20 million visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health), which met the FY 2010 target. Additionally, the 2.20 million visits in FY 2010 was an increase of 90,000 visits over the number of visits in FY 2009. ADAP served 163,925 clients in 2007 and 175,194 clients in 2008. In FY 2009, 194,039 clients were served through State ADAPs. In 2009, sixty-four percent of those served by ADAPs are people of color. Nationally, more than 83 percent of ADAP clients have incomes at or below 200 percent of the federal poverty level. In FY 2010, the AIDS Drug Assistance Program (ADAP) clients served through State ADAPs was 208,809, exceeding the target.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, technical assistance and program monitoring including performance reviews.

Funding History

FY	Amount[1]	ADAP (Non-Add)
FY 2003	$1,053,393,000	($714,326,000)
FY 2004	$1,085,900,000	($748,872,000)
FY 2005	$1,121,836,000	($787,521,000)
FY 2006	$1,119,744,000	($789,005,000)
FY 2007	$1,195,500,000	($789,546,000)
FY 2008	$1,195,248,000	($794,376,000)[2]
FY 2009	$1,223,791,000	($815,000,000)
FY 2010	$1,276,791,000	($858,000,000)
FY 2011	$1,308,141,000	($885,000,000)
FY 2012	$1,355,640,000	($933,299,000)

Budget Request

States continue to face fiscal challenges and shortfalls in meeting the growing HIV epidemic in their jurisdictions. In addition, as a result of the clinical trial – HPTN O52 – which showed that antiretrovirals used by HIV-infected individuals substantially reduced transmission to their partners, the demand for ADAP will increase. This Budget Request reflects a strong commitment to partnering with States to respond to the HIV epidemic.

The FY 2013 President's Budget for the Ryan White HIV/AIDS Part B Program of $1,422,341,000 is $66,701,000 above the FY 2012 Enacted Level and will support the provision life-saving medications and health care services to persons living with HIV in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam and five Pacific jurisdictions.

As of January 20, 2012, AIDS Drug Assistance Program (ADAP) waiting lists have increased to 4,664 people in 11 states, with many other states curtailing their programs to avoid waiting lists. The budget maintains and bolsters the Federal commitment to supporting States and their ADAP programs. The FY 2013 President's Budget includes $1,000,000,000 for AIDS drug assistance programs to provide access to life saving HIV related medications for approximately 236,230 patients. This significant federal investment will provide access to lifesaving pharmaceuticals for all people living with HIV/AIDS eligible for ADAP, including those individuals who have had difficulties getting medicines as states curtailed their programs. Based on current projections and with continued sufficient state contributions, these resources will enable all people living with HIV/AIDS who lack access to health care to obtain life-saving medications. This is consistent with the National HIV/AIDS Strategy (NHAS), which notes that success in reaching the goals is dependent on commitments from all parts of society.

[1] Excludes comparable amounts for SPNS.

[2] FY 2008 actual expenditure was $813,858,028 due to the hold harmless provision. For FY 2008, the statute requires that the grant not be less than 100% of the FY 2007 total grant.

HRSA has developed a model for estimating the marginal cost of serving ADAP clients. The model takes into account many of the factors affecting purchasing power, such as increases in cost of HIV/AIDS drugs; the legislative requirement that all State ADAPs maintain a minimum drug formulary, including new drug classes; and the impact of Medicare Part D, rebates, medical inflation and insurance coverage. The marginal cost model provided cost estimates based on the application of the model to informs the Program's projected target for number of ADAP clients from 2008 - 2012. During the FY 2013 budget process, the cost and program indexes and assumptions made in the marginal cost model were reviewed and the model retains utility in predicting ADAP performance targets, thus models projection of the total ADAP earmark cost to support serving ADAP clients was extended through 2013 by using a linear trend model to estimate the per client costs. The FY 2013 target for the number of visits for health related care (primary, medical, dental, mental health, substance abuse, rehabilitative and home health) is 2.27 million visits.

Part B funding will also contribute to achieving the FY 2013 targets for the Ryan White Program's over-arching performance measures, including proportion of racial/ethnic minorities and women served, persons tested for CD4 count and viral load, and providers implementing a quality management program. (See Summary for targets and for strategies and challenges.)

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
18.I.A.1: Number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, [3]and home health). *(Output)*	FY 2010: 2.20 M Target: 2.19 M (Target Met)	2.19 M	2.27 M	+80,000

Grant Awards Table – Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	59	59	59
Average Award	$21,241,718	$22,046,785	$23,117,141
Range of Awards	$25,479-$163,839,381	$50,000-$169,787,000	$50,000-$177,695,000

[3] Rehabilitative services are a support service and visit data is not collected for support services.

Part B – FY 2011 State Table[4]

State/ Territory	Base	Base Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
Alabama	$8,050,988	$82,731	$11,477,033	$295,647	$135,684	$20,042,083
Alaska	500,000	5,699	634,180	-	-	1,139,879
American Samoa	44,284	-	2,663	-	-	46,947
Arizona	4,038,207	141,165	11,952,142	-	-	16,131,514
Arkansas	3,574,096	-	4,755,503	-	43,755	8,373,354
California	35,289,596	1,376,784	114,352,669	171,123	1,138,194	152,328,366
Colorado	3,655,590	104,962	10,764,509	-	68,032	14,593,093
Connecticut	3,500,189	119,410	10,972,770	-	126,883	14,719,252
Delaware	2,407,139	-	3,146,550	201,054	40,184	5,794,927
District of Columbia	4,540,467	179,596	16,432,779	-	255,930	21,408,772
F. States Micronesia	44,254	-	8,595	-	-	52,849
Florida	31,750,741	1,077,279	99,825,670	472,094	1,222,115	134,347,899
Georgia	12,067,420	382,700	36,087,518	176,708	-	48,714,346
Guam	200,000	-	86,530	-	-	286,530
Hawaii	1,366,324	-	2,444,420	-	16,737	3,827,481
Idaho	572,542	8,202	1,210,420	-	-	1,791,164
Illinois	9,582,663	344,830	32,481,700	-	397,602	42,806,795
Indiana	3,534,561	87,164	8,277,357	-	-	11,899,082
Iowa	1,258,207	17,986	2,385,418	-	-	3,661,611
Kansas	1,157,844	27,595	2,498,752	-	-	3,684,191
Kentucky	3,508,359	-	6,641,644	211,526	33,565	10,395,094
Louisiana	6,146,153	203,993	19,808,112	-	229,579	26,387,837
Maine	775,182	-	958,813	-	-	1,733,995
Marshall Islands	25,479	-	-	-	-	25,479
Maryland	9,496,763	-	30,408,708	-	520,842	40,426,313
Massachusetts	5,275,152	-	15,013,298	-	168,726	20,457,176
Michigan	5,082,352	161,353	12,574,251	-	167,337	17,985,293
Minnesota	1,918,199	71,908	5,738,727	-	54,667	7,783,501
Mississippi	6,219,673	-	6,507,264	263,535	116,458	13,106,930
Missouri	3,809,187	126,843	10,553,866	-	102,426	14,592,322
Montana	500,000	3,562	704,522	-	-	1,208,084
N. Marianas	43,334	-	8,845	-	-	52,179
Nebraska	1,182,792	-	1,532,773	-	12,679	2,728,244

[4] Awards include prior year unobligated balances.

State/ Territory	Base	Base Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
Nevada	2,189,758	57,198	6,212,826	-	59,483	8,519,265
New Hampshire	500,000	-	1,007,461	-	-	1,507,461
New Jersey	12,127,026	367,128	34,767,390	-	489,802	47,751,346
New Mexico	1,819,976	-	2,199,786	-	-	4,019,762
New York	40,081,817	1,401,646	119,859,704	664,683	1,831,531	163,839,381
North Carolina	11,245,753	236,542	26,156,405	264,669	325,747	38,229,116
North Dakota	200,000	1,322	252,465	-	-	453,787
Ohio	7,866,073	176,553	17,461,256	637,718	153,197	26,294,797
Oklahoma	3,618,532	-	4,610,704	202,712	-	8,431,948
Oregon	1,725,556	56,298	5,240,322	-	20,200	7,042,376
Pennsylvania	12,372,951	-	30,028,414	258,473	408,171	43,068,009
Puerto Rico	10,199,369	199,352	23,119,190	-	327,316	33,845,227
Republic of Palau	47,198	-	2,654	-	-	49,852
Rhode Island	1,295,617	26,795	2,861,562	206,988	25,629	4,416,591
South Carolina	11,224,926	149,981	17,047,406	349,750	201,263	28,973,326
South Dakota	500,000	-	383,908	-	-	883,908
Tennessee	5,364,347	168,479	15,861,819	-	172,442	21,567,087
Texas	21,625,309	584,119	63,661,568	-	771,902	86,642,898
Utah	1,709,161	26,006	2,998,161	-	-	4,733,328
Vermont	500,000	-	392,356	-	1,136	893,492
Virgin Islands	500,000	3,848	821,138	-	9,307	1,334,293
Virginia	7,539,290	230,895	22,599,303	375,842	255,930	31,001,260
Washington	3,610,260	121,213	10,885,632	-	60,583	14,677,688
West Virginia	1,061,758	-	1,473,753	-	-	2,535,511
Wisconsin	3,726,374	55,203	5,068,181	247,478	49,004	9,146,240
Wyoming	500,000	-	370,817	-	-	870,817
Total	**$334,268,788**	**$8,386,340**	**$895,592,182**	**$5,000,000**	**$10,014,038**	**$1,253,261,348**

Early Intervention Services – Part C

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$205,564,000	$215,086,000	$235,564,000	+$20,478,000
MAI (non add)	64,410,000	67,503,000	71,012,000	+3,509,000
SPNS	2,433,000	2,433,000	2,433,000	---
2011 World AIDS Day Initiative (non add)[1]	---	15,000,000	---	-15,000,000
Total Funding[2]	$207,997,000	$217,519,000	$237,997,000	+$20,478,000
FTE	31	31	31	---

Authorizing Legislation: The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Title XXVI of the Public Health Service Act) was enacted on October 30, 2009.

FY 2013
Authorization……..……..$285,766,000

Allocation Method ..... Competitive Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

Part C of the Ryan White HIV/AIDS Program provides direct grants to 344 community and faith-based primary health clinics and public health providers in 49 states, Puerto Rico, the District of Columbia, and the US Virgin Islands. Part C programs are the primary means for targeting HIV medical services to underserved and uninsured people living with HIV/AIDS in specific geographic communities, including rural and frontier communities. Part C programs target the most vulnerable communities, including people of color, men-who-have-sex-with men (MSM), women, and low-income populations. Part C programs have the cultural competency and expertise to provide care to these underserved and vulnerable populations. Seventy percent of those served by Part C clinics are people of color and 29 percent are female. Part C providers are central to the nation's HIV testing initiatives, providing HIV counseling and testing to more than 751,400 people in 2010. Additionally, the Part C grantees in New York, Los Angeles, Washington, D.C., Chicago, Atlanta, Miami, Philadelphia, Houston, San Francisco, Baltimore, Dallas, and San Juan play an important role in implementation of the National HIV/AIDS Strategy through continued provision of HIV testing, care and treatment to those infected with HIV in the "Twelve Cities Initiative." This initiative is a key part of the DHHS strategy to better coordinate HIV prevention, care, and treatment across DHHS, state, and local partners.

[1] This funding is a joint effort between the Ryan White and Health Center programs. Part C grantees will receive $10 million from the Ryan White Program and $5 million from Health Centers.
[2] Included in the FY 2012 Total is $5 million from Health Centers BA.

The number of persons receiving primary care services under Early Intervention Services programs was 236,745 in FY 2007 and 247,133 in FY 2008. The 2009 results show 255,429 clients were served by the Early Intervention Services program, exceeding the target by 7% and representing an increase of 3% in clients served compared to FY 2008.

Funding includes costs associated with FTEs, grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, technical assistance and program monitoring including performance reviews.

Funding History

FY	Amount[3]
FY 2003	$198,374,000
FY 2004	$197,170,000
FY 2005	$195,578,000
FY 2006	$193,488,000
FY 2007	$193,721,000
FY 2008	$198,754,000
FY 2009	$201,877,000
FY 2010	$206,383,000
FY 2011	$205,564,000
FY 2012[4]	$215,086,000

On World AIDS Day, December 1, 2011, the President announced an additional $15 million for Ryan White Part C grantees to support and expand care provided by HIV medical clinics across the country. In response to the President's announcement, total funding for Part C grantees will be increased by $15 million above the FY 2012 Part C appropriation, through a joint effort between the Ryan White and Health Center Program.

Budget Request

The FY 2013 President's Budget for the Ryan White HIV/AIDS Part C Program of $235,564,000 is $20,478,000 above the FY 2012 Enacted Level and will continue to support persons receiving primary care services under the Early Intervention Services programs for 251,390 PLWH at the 344 currently funded Part C programs.

The FY 2013 President's Budget target for the number of people receiving primary care services under Early Intervention Services programs is 265,325. Part C funding will also contribute to achieving the FY 2013 targets for the Ryan White HIV/AIDS Program's over-arching performance measures including, proportion of racial/ethnic minorities and women served, persons learning of their serostatus from Ryan White programs, persons tested for CD4 count and viral load, and providers implementing a quality management program. (See Summary for targets and for strategies and challenges.)

[3] Excludes comparable amounts for SPNS.
[4] Reflects Ryan White BA only (does not include $5 million in Health Centers BA for Part C grantees in FY 2012)

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
19.II.A.1: Number of people receiving primary care services under Early Intervention Services programs. *(Output)*	FY 2009: 255,429 Target: 236,745 (Target Exceeded)	257,053	265,325	+8,272

Grant Awards Table – Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	344	344	344
Average Award	$559,435	$587,000	$645,000
Range of Awards	$18,500-$1,169,666	$18,500-$1,252,805	$18,500-$1,340,363

Women, Infants, Children and Youth – Part D

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$77,313,000	$77,167,000	$69,582,000	-$7,585,000
MAI (non add)	21,470,000	22,500,000	23,671,000	+$1,171,000
SPNS	902,000	902,000	902,000	---
Total Funding	$78,215,000	$78,069,000	$70,484,000	-$7,585,000
FTE	4	4	4	---

Authorizing Legislation: The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Title XXVI of the Public Health Service Act) was enacted on October 30, 2009.

FY 2013 Authorization……$87,273,000

Allocation Method ..... Competitive Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

The Part D program focuses on providing access to coordinated, family-centered primary medical care and support services for HIV-infected women, infants, children, and youth (WICY) and their affected family members. It also funds support services, like case management and childcare that help clients get the care they need. Eligible organizations are public or private nonprofit entities that provide or arrange for primary care for HIV-positive women, infants, children, and youth. Part D programs include community based organizations, hospitals, and State and local governments. Currently, there are 81 WICY programs in 31 states, the District of Columbia, Puerto Rico, and the Virgin Islands.

The Part D grantees play a role in implementation of the National HIV/AIDS Strategy through continued provision of care, treatment and support services for women, children and youth living with HIV/AIDS.

The number of female clients provided comprehensive services, including appropriate services before and during pregnancy, to reduce perinatal transmission in FY 2010 was 53,753. The number exceeded the FY 2010 target by 2,437 clients or 4.5%. In FY 2009, the Part D program provided comprehensive services, including treatment before and during pregnancy to reduce perinatal transmission, to 55,335 female clients. In FY 2008, 57,773 females received such services. In FY 2007, Part D programs provided services 48,485 female clients. The results for the FY 2007, FY 2008, and FY 2009 also exceeded the targets. The total number of clients served in Part D in FY 2009 was 89,965. This number includes 4,766 infants (ages 0-2 years), 10,849 children (ages 2-12 years), 19,662 youth (ages 13-24 years), and 54,688 persons ages 25 years and older. Of the 89,965 persons served in Part D in FY 2009, 70% were female and 29%

were males, and about 1% were transgendered or unknown/unreported. Seventy-one percent of all Part D clients served were HIV infected, with the remainder largely affected family members. Of the clients with known race and ethnicity, the majority (86%) were members of racial or ethnic minority groups.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, technical assistance and program monitoring including performance reviews.

Funding History

FY	Amount[1]
FY 2003	$73,551,000
FY 2004	$73,108,000
FY 2005	$72,519,000
FY 2006	$71,744,000
FY 2007	$71,794,000
FY 2008	$73,690,000
FY 2009	$76,845,000
FY 2010	$77,621,000
FY 2011	$77,313,000
FY 2012	$77,167,000

Budget Request

The FY 2013 President's Budget for the Ryan White HIV/AIDS Part D Program of $69,582,000 is $7,585,000 below the FY 2012 Enacted Level and will support primary health care and social support services available to 90,000 women, men, transgendered persons, infants, children, youth and adults living with HIV and AIDS and their affected families.

The FY 2013 President's Budget target for the number of female clients provided comprehensive services through Part D, including appropriate services before or during pregnancy to reduce perinatal transmission, is 49,802. Part D funding will also contribute to achieving the FY 2013 targets for the Ryan White Program's over-arching performance measures including, proportion of racial/ethnic minorities and women served, HIV-positive women who receive anti-retroviral medications, persons tested for CD4 count and viral load, and providers implementing a quality management program. (See Summary for targets and for strategies and challenges.)

[1] Excludes comparable amounts for SPNS.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
20.II.A.1 Number of female clients[2] provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission. (Output)	FY 2010: 53,753 Target: 51,316 (Target Exceeded)	53,753	49,802	-3,951

Grant Awards Table – Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	98	98	98
Average Award	$735,112	$735,112	$657,714
Range of Awards	$22,485-$2,297,660	$22,485-$2,297,660	$22,485-$2,100,000

[2] Female clients counted are age 13 and above.

AIDS Education and Training Programs – Part F

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$34,607,000	$34,542,000	$34,542,000	---
MAI (non add)	9,201,000	9,644,000	10,144,000	+$500,000
Total Funding	$34,607,000	$34,542,000	$34,542,000	---
FTE	3	3	3	---

Authorizing Legislation: The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Title XXVI of the Public Health Service Act) was enacted on October 30, 2009.

FY 2013 Authorization……..….$42,178,000

Allocation Method ..... Competitive Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

The AETCs—a network of 11 regional centers with more than 130 local performance sites and five national centers—offer specialized clinical education and consultation on HIV/AIDS transmission, treatment, and prevention to front-line health care providers, including physicians, nurses, physician assistants, dentists and pharmacists.

AETCs provide a critical area of support for the National HIV/AIDS Strategy (NHAS) by increasing access to quality HIV/AIDS care through the provision of clinical HIV/AIDS training for providers who serve the most vulnerable and hard to reach populations. The clinical management of HIV/AIDS, particularly the use of highly-active antiretroviral therapy (HAART) is the central focus of training. This is increasingly important as the HIV epidemic expands in the United States with improved testing rates and prolonged survival. In addition, the number of trained HIV care professions is projected to decease as many of those who have worked in the epidemic since its inception reach retirement age. Training an expanded cadre of culturally competent, high quality providers will be vital to meet the NHAS goals of expanding access to quality HIV/AIDS care and treatment.

The AETCs target training to providers who serve minority populations, the homeless, rural communities, incarcerated persons, federally qualified community and migrant health centers, and Ryan White HIV/AIDS Program sites. AETC-trained providers are more competent with regard to HIV issues and more willing to treat persons living with HIV than other primary care providers. The AETCs provide education in a variety of formats including skills building workshops, hands-on preceptorships and mini-residencies, on-site training and technical assistance. Clinical faculty also provide timely clinical consultation in person or via the telephone or internet. Based in leading academic centers across the country, the AETCs use

nationally recognized faculty and HIV researchers in the development, implementation, and evaluation of the education and training offered.

During the period July 1, 2009 through June 30, 2010, AETCs conducted 17,122 training sessions with a total of 141,751 trainees.

Forty-three percent of the AETC program training interventions were provided to racial/ethnic minorities in 2007, and the 2008 results show 44% of those trained were racial/ethnic providers. The 2009 results show the AETC program training interventions comprised 43% racial/ethnic minorities which met the target.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, technical assistance and program monitoring including performance reviews.

Funding History

FY	Amount
FY 2003	$35,550,000
FY 2004	$35,335,000
FY 2005	$35,051,000
FY 2006	$34,646,000
FY 2007	$34,701,000
FY 2008	$34,094,000
FY 2009	$34,397,000
FY 2010	$34,745,000
FY 2011	$34,607,000
FY 2012	$34,542,000

Budget Request

The FY 2013 President's Budget for the Ryan White HIV/AIDS AETC Program of $34,542,000 is equal to the FY 2012 Enacted Level and will support targeted, multidisciplinary education and training programs for health care providers treating people living with HIV/AIDS. The AETCs are an important part of the Ryan White HIV/AIDS Program and play a vital role in ensuring the highest quality of care among providers. HRSA will continue to prioritize for the AETCs interactive training that demonstrates effectiveness to change provider behavior. This funding will help meet the program's performance goal to "Maintain the proportion of racial/ethnic minority health care providers participating in the AETC intervention programs."

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
21.V.B.1: Proportion of racial/ethnic minority health care providers participating in AETC training intervention programs. *(Output)*	FY 2009: 43% Target: 43% (Target Met)	43%	43%	Maintain

Grant Awards Table – Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	16	16	16
Average Award	$2,017,923	$2,017,923	$2,017,923
Range of Awards	$450,000-$4,313,615	$450,000-$4,313,615	$450,000-$4,313,615

Dental Reimbursement Program – Part F

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$13,511,000	$13,485,000	$13,485,000	---
FTE	1	1	1	---

Authorizing Legislation: The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Title XXVI of the Public Health Service Act) was enacted on October 30, 2009.

FY 2013 Authorization……..…..$15,802,000

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The HIV/AIDS Dental Reimbursement Program provides access to oral health care for people living with HIV/AIDS by reimbursing dental education programs for the non-reimbursed costs they incur providing such care. By offsetting the costs of non-reimbursed HIV care in dental education institutions, the Dental Reimbursement Program improves access to oral health care for people living with HIV and trains dental and dental hygiene students and dental residents to provide oral health care services to people living with HIV. The care provided through the program includes a full range of diagnostic, preventive, and treatment services, including oral surgery, as well as oral health education and health promotion.

The Community-Based Dental Partnership Program supports collaborations between dental education programs and community-based partners to deliver oral health services in community settings while training students and residents enrolled in accredited dental educations programs. Dental schools, post-doctoral dental education programs, and dental hygiene education programs accredited by the Commission on Dental Accreditation that have documented non-reimbursed costs for providing oral health care to people living with HIV are eligible to apply for reimbursement. Funds are then distributed to eligible organizations taking into account the number of people served and the cost of providing care.

Dental Reimbursement Program

Programs	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Dental Reimbursement Program	$9,046,000	$9,046,000	$9,046,000
Community-Based Dental Partnership Program	$4,465,000	$4,439,000	$4,439,000

In FY 2010, the Dental Reimbursement Program awards met 32.3% of the total non-reimbursed costs reported by 56 participating institutions in support of oral health care. These institutions reported providing care to 35,659 HIV-positive individuals, for whom no other funded source was available. This number exceeded the goal by 2,151 individuals or 6.0%. This represents a 0.5% increase from FY 2009 for persons whom a portion/percentage of their unreimbursed oral health costs was reimbursed. The Community Dental Partnership Program funded 12 partnership grants to collaborate and coordinate between the dental education programs and the community-based partners in the delivery of oral health services. Community-Based Dental Partnership grants are intended for a period of up to three years. In FY 2010, the demographic characteristics of patients who were cared for by institutions participating in the DRP were: 33.8% women, 56.96% minority. Therefore, the DRP served a higher proportion of women than the representation of women among all AIDS cases in the nation, as reported by CDC. CDC reports 23.3% of AIDS cases in 2009 were among women and 66.4% of AIDS cases were among racial/ethnic minorities.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's electronic handbook, technical assistance and program monitoring including performance reviews.

Funding History

FY	Amount
FY 2003	$13,405,000
FY 2004	$13,325,000
FY 2005	$13,218,000
FY 2006	$13,077,000
FY 2007	$13,086,000
FY 2008	$12,857,000
FY 2009	$13,429,000
FY 2010	$13,565,000
FY 2011	$13,511,000
FY 2012	$13,485,000

Budget Request

The FY 2013 President's Budget for the Ryan White HIV/AIDS Dental Service Program of $13,485,000 is equal to the FY 2012 Enacted Level and will support oral health care for people with HIV. This program will continue to support the reimbursement of applicant institutions, outreach to people with HIV/AIDS who need dental care, and continued efforts to improve service coordination among reimbursement recipients and other community-based health service providers. The FY 2013 President's Budget target for the number of persons for whom a portion of their unreimbursed oral health costs will be reimbursed is 33,316.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
22.I.D.1: Number of persons for whom a portion/ percentage of their unreimbursed oral health costs were reimbursed. *(Output)*	FY 2010: 35,659 Target: 33,508 (Target Exceeded)	33,316	33,316	Maintain

Grant Awards Table – Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Awards	68	68	68
Average Award	$188,239	$188,239	$188,239
Range of Awards	$76-$1,003,417	$76-$1,003,417	$76-$1,003,417

Health Care Systems

Tab

Organ Transplantation

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$24,896,000	$24,015,000	$24,015,000	---
FTE	---	---	---	---

Authorizing Legislation - Sections 371 - 378 of the Public Health Service Act, (P.L. 98-507 and P.L. 108-216), as amended.

FY 2013 Authorization…….....Expired

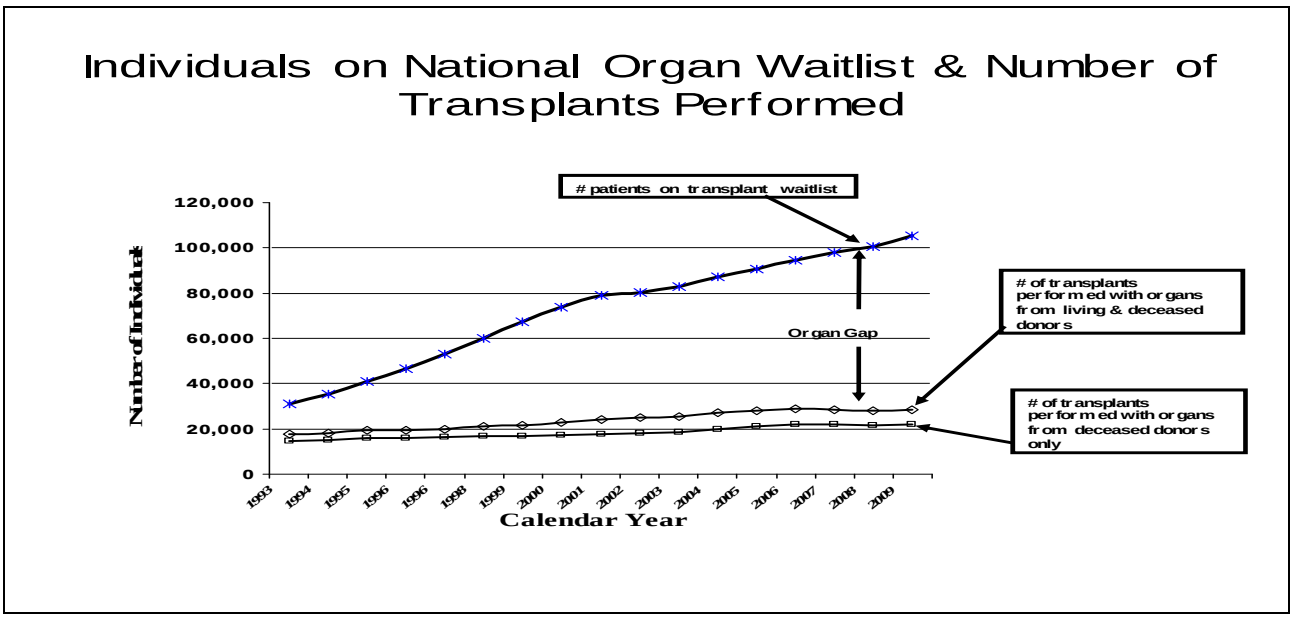
Allocation Method……...…Contracts, Competitive Grants and Cooperative Agreements

Program Description and Accomplishments

The National Organ Transplant Act of 1984 (NOTA), as amended, provides the authorities for the Program. The primary purpose of the Program is to extend and enhance the lives of individuals with end-stage organ failure for whom an organ transplant is the most appropriate therapeutic treatment. The Program works towards achieving this goal by providing for a national system, the Organ Procurement and Transplantation Network (OPTN), to allocate and distribute donor organs to individuals waiting for an organ transplant. The allocation of organs is guided by organ allocation policies developed by the OPTN with analytic support provided by the Scientific Registry of Transplant Recipients (SRTR). In addition to the efficient and effective allocation of donor organs through the OPTN, the Program also supports efforts to increase the supply of deceased donor organs made available for transplantation and to ensure the safety of living organ donation.

Ideally, an organ that provides optimal benefit would be available for every transplant candidate at the most appropriate time. Unfortunately, the demand for organ transplantation greatly exceeds the available supply of organs (see Figure 1). This trend is anticipated to continue, unless there is a major breakthrough in medical technology that will obviate the need for donor organs or the incidence of end-stage organ failure in the U.S. dramatically declines. At the end of 2010, there were 110,370 patients listed on the waiting list and 6,549 individuals died (approximately 18 per day) while waiting for a donor organ.

Figure 1. Individuals on National Organ Waitlist & Number of Transplants Performed



These Program goals are summarized by two overarching measures: (1) increase the annual number of deceased donor organs transplanted; and (2) increase the total number of expected life-years gained in the first 5 years after the transplant for all kidney and kidney-pancreas transplant recipients (from deceased donors) as compared to what would be expected for these recipients had they remained on the waiting lists.

The first goal of increasing the annual number of deceased donor organs transplanted is based on converting the number of 'eligible deaths' into actual donors (donor conversion rate). An 'eligible donor' is defined as any heart-beating individual meeting the criteria for neurological death, age 70 years or under, who has not been diagnosed with exclusionary medical conditions published by the OPTN. In 2010, 24,598 deceased donor organs were transplanted, 15 percent below the target of 29,084; however, it is a 2 percent increase above the 2009 result and 21 percent increase above the 2003 baseline level of 20,392. In 2009, 24,116 deceased donor organs were transplanted, a slight increase over the 23,933 deceased donor organs transplanted in 2008. The number of deceased organs transplanted in both 2008 and 2009 were less than the 24,230 deceased organs transplanted in 2007.

The number of deceased donor organs made available for transplantation is primarily dependent on the number of eligible donors. Since 2002, the number of eligible donors has decreased. The number of eligible deaths in 2002 was in excess of 12,000. The number decreased to 9,800 in 2008, to 9,400 in 2009, and to 9,000 in 2010. Improved prevention and treatment efforts have in part contributed to the decrease in the number of eligible donors. Fewer severe head traumas and improved management of brain injuries have resulted in fewer patients proceeding to brain death. The National Highway and Safety Administration reports traffic accident deaths in 2010 fell to the lowest level ever in the United States since 1949. In 2008, the eligible deaths consisted of

3,281 head trauma deaths. In 2010, head trauma deaths decreased to 2,978. From 2008 to 2010, head trauma deaths made up approximately 33 percent of eligible deaths. Another reason for the decrease in the number of eligible deaths is that first-time cardiovascular events (resulting in anoxic brain injuries that may lead to brain death) have seen a 28 percent reduction in the event fatality rate since 1990 as a result of improvements in emergency and acute care. Hospital deaths have also been declining, which is congruent with the trend of the decreasing number of eligible deaths.

A major component of efforts to increase organ donation in the last decade was a series of Breakthrough Collaboratives that began in late 2003 to rapidly increase the number of deceased donors and number of donor organs made available for transplant through the sharing of best practices. Breakthrough Collaboratives apply a proven methodology, established by the Institute for Healthcare Improvement (IHI), to successfully generate and sustain improvements in healthcare systems. The first Collaborative, the Organ Donation Breakthrough Collaborative, was initiated in September of 2003 and established a goal of increasing the organ donation conversion rate from 52 percent in 2003 to 75 percent by FY 2013. While the number of eligible deaths has been decreasing, the donor conversion rate has increased steadily. The conversion rate was 66.5 percent in 2008, 69.1 percent in 2009, and 71.2 percent in 2010, representing a 36.9 percent improvement from the 52 percent baseline in 2003. Since the first Collaborative, the focus has changed over time to include efforts to improve: 1) the number of organs made available; 2) the capacity of organ procurement organizations (OPOs) and transplant centers to effectively manage more organ donors and perform more organ transplants; and 3) efforts to expand the use of other types of organ donors such as cardiac-death donors and expanded criteria donors.

HRSA has continued to invest in several activities to sustain and improve upon the gains of the Breakthrough Collaboratives. The umbrella for these activities is the "Organ Donation and Transplantation Community of Practice" (Community of Practice). The major focus of the Community of Practice is to sustain and increase the achievements of the Collaboratives and institutionalize identified best practices. The Community of Practice continues the "all teach, all learn" knowledge-sharing model through local and regional networks and interaction known as the Donation Service Area (DSA) Action Teams and Regional Collaboratives. The 58 DSAs are the areas served by each OPO. The Action Team consists of representatives of the OPO, donor hospitals, transplant centers, and in some cases, other partners in the donation process (e.g., eye and tissue banks, state hospital association members, donor registry professionals). Successful strategies at the DSA level are shared at the regional level – there are 11 regions designated by the OPTN in the United States. These local (DSA) and regional efforts culminate in the National Learning Congress (NLC), HRSA's major event educating and recognizing organizations that have met national goals in increasing organ and tissue donation: 75 percent conversion rate, 3.75 organs transplanted per donor, and 10 percent of donors being donated after cardiac death. Through the NLC, best practices identified and refined through DSA action and regional strategies are shared nationally. Attendees include professionals from OPOs, hospitals, transplant centers, eye and tissue banks, hospital associations, donor designation entities, and others. In addition, several topic-specific sharing and educational experiences are convened during the year.

Additionally, HRSA is seeking and sustaining partnerships with key organizations that touch the donation and transplantation processes, including entities with capabilities in professional development, healthcare, and public education. In FY 2011, HRSA initiated an education program to leverage web-based technological capabilities to better meet the educational needs of the community. HRSA has implemented programs to improve enrollment in donor registries, to educate healthcare professionals about honoring donor designation, and to increase support of potential donor families, all of which have an impact on conversion rate. Other programs share best practices in the medical management of organ donors to increase the number of organs that can be recovered from each donor. Maximizing donor potential is especially critical because more donors are being accepted under extended medical, age, and recovery criteria. In July 2010, HRSA provided additional funding through the OPTN contract to conduct a 2-year scientifically rigorous study employing demographic and epidemiological methods to better define deceased donor potential in the United States. In FY 2013, HRSA will use the results from the donor potential study and a donation-specific Gallup survey, initiated in 2010, to refine the strategic approaches to maximize deceased donor potential, to increase the number of organs available for transplantation and to modify Program performance measures.

The Program is also making progress towards achieving its second long-term goal of increasing the total number of expected life-years gained in the first 5 years after the transplant for all kidney and kidney-pancreas transplant recipients (from deceased donors) as compared to what would be expected for these recipients had they remained on the waiting lists. The goal is to increase the total lifetime benefit achieved by all transplant recipients.

As with the first long-term goal of increasing the number of deceased donor organs transplanted, the life-years-gained goal has annual targets representing incremental marginal gain (i.e., the average number of life-years gained for each kidney transplant recipient) and the total number of expected life-years gained for all individuals receiving a kidney transplant in a given year. Therefore, achieving the long-term goal is dependent on the marginal improvement gained via each transplant performed, as well as by increasing the total number of kidney transplants performed.

The FY 2008 and 2009 results have been revised upward based on calculations by the new Scientific Registry of Transplant Recipients (SRTR) contractor. In FY 2008, the average number of life-years gained per transplant was revised upward from 0.410 to 0.430 and the total expected life-years gained was revised upward from 4,586 years to 4,835 years. In FY 2009, the average number of life-years gained per transplant was revised upward from 0.420 to 0.430 and the total expected life-years gained was revised upward from 4, 851 years to 4,868 years. In FY 2010, the Program fell short of its average number of life-years gained per transplant target (0.380 average, actual vs. 0.427 average, target) and its total expected life-years gained (4,381 years, actual vs. 6,213 years, target).

The decrease in the average and total expected life-years gained in FY2010 is partly because of improvements by transplant centers in prolonging the expected life-years for patients on the waitlist. This is likely related to improvements in dialysis management resulting in reductions in relative waitlist death. While life-years gained on the waitlist have improved, the benefits of transplant in terms of life years gained still exceed the increased life-years gained on the waitlist.

Comparatively, in FY 2008, the average number of life-years gained on the waitlist was 4.05 years vs. 4.48 years with a transplant. In FY 2009, the average number of life-years gained on the waitlist was 4.06 years vs. 4.50 years with a transplant. In FY 2010, the average number of life-years gained on the waitlist was 4.14 years vs. 4.53 years with a transplant.

An important component of the total expected life-years gained is the number of kidney transplants performed. The main reason the performance goal was not met is because fewer than the projected number of deceased kidney transplants were performed in FY 2010. Increasing the marginal improvement gained by each kidney transplant may also be improved by revising how kidneys are allocated. Over the past several years, the OPTN has made incremental improvements to the kidney allocation policy. Even with these improvements, the current policy still places great emphasis on the amount of time individuals wait for an organ transplant as opposed to the differential clinical benefit which may be afforded for each individual waiting for a transplant. The OPTN is currently working on a new kidney policy that will place less emphasis on time on the waiting list and more emphasis on medical determinants that will seek to maximize benefit to the patient and maximize the use of deceased donor kidneys. Depending on the final construct of this allocation policy, which must balance many issues in addition to survival benefit, it is anticipated that this new policy will improve the expected five-year survival benefit post transplant.

Funding History

FY	Amount
FY 2008	$22,646,000
FY 2009	$24,049,000
FY 2010	$25,991,000
FY 2011	$24,896,000
FY 2012	$24,015,000

Budget Request

The FY 2013 Budget Request of $24,015,000 is the same level as the FY 2012 Enacted Level.

Funding includes costs associated with grant reviews, processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbook (EHB), and follow-up performance reviews. The EHB supports the Organ Transplantation Program with program administration, grants administration and monitoring, management reporting, and grantee performance measurement and analysis. The funding also includes IT investment costs to support the strategic and performance outcomes of the Program and contributes to its success by providing a mechanism for sharing data and conducting business in a more efficient manner.

The FY 2013 Request will continue support for the Organ Transplantation Program in achieving the FY 2013 performance targets: transplant 33,473 deceased donor organs and achieve 7,299 expected life-years gained for the five-year post-transplant period for kidney and kidney/pancreas transplants performed.

The following activities will be supported with the requested funding:

Contract to Operate the OPTN ($2.56 million) — The OPTN is the critical nexus between individuals needing an organ transplant and donor organs made available from deceased donors. Organ allocation policies developed by the OPTN prioritize the allocation of deceased donor organs to individuals waiting for an organ. The policies are under continual review and refinement to achieve the best outcomes for patients. Given the critical shortage of organs, these policies strive to achieve the maximum benefit for the recipient as well as make the best use of donor organs. HRSA utilizes a competitive contracting process to award the contract to operate the OPTN. The OPTN contract is a cost-share, cost-reimbursement contract. The costs of operation of the OPTN are funded with revenues generated by fees collected by the OPTN to register patients on the national donor waiting list and with appropriated funds. The Stephanie Tubbs Jones Organ Transplantation Authorization Act of 2008 (P.L. 110-426) authorizes appropriated funds up to $7 million annually for the operation of the OPTN. In FY 2012, HRSA will award a new competitive contract to continue the operation of the OPTN. The projected cost of operating the OPTN in FY 2013 is approximately $37.5 million. The funding includes IT support for the OPTN system.

Contract to Operate the SRTR ($4.25 million) — The major purpose of the SRTR is to provide analytic support to the OPTN in the development and evaluation of organ allocation and other OPTN policies. Additionally, the SRTR provides analytic support to HHS, including the Advisory Committee on Organ Transplantation. In an effort to make information about the performance of the OPTN more widely available to the public, the SRTR publishes on the Internet organ transplant program risk-adjusted patient and graft outcomes and risk-adjusted organ procurement organization performance, including comparison of the actual vs. expected number of donors and donor organs retrieved. HRSA has chosen to use a competitive contracting process in lieu of a grant to provide greater oversight and control over this critical function. The existing contract is from September 2010 through September 2015 including option periods. The funding includes IT support for the SRTR system.

Efforts to Institutionalize Best Practices to Improve Organ Donation Processes and Outcomes ($3.6 million) – From 2003-2008, HRSA conducted a series of Breakthrough Collaboratives intended to identify and rapidly disseminate best practices to increase the number of organs available for transplantation. This series of frequent and intense sharing and learning experiences was effective in stimulating change in organ donation processes. The Donation and Transplantation Community of Practice (DTCP), established in 2009, is the method by which these successful practices are hardwired into organizational processes. The DTCP is a community-driven network of individuals and organizations whose missions are relevant to the donation process. Its scope reaches the full range of the donation continuum, from the declaration of intent to donate via donor registries to outcomes related to transplant patient and graft survival. The DTCP is focused on sustaining the drive to examine successful practices and integrating them into practice. Founded in principles of the Breakthrough Collaboratives, the DTCP incorporates an "all teach, all learn" knowledge-sharing model through local and regional interaction known as the Donation Service Area (DSA) and Regional Action Teams, which represent the range of partners in the community. The 58 DSAs are the areas served by each OPO and are grouped into 11 Regions. In 2011, HRSA initiated a formal partnership with a

community organization to carry out activities of the DTCP via a cooperative agreement. Through this partnership, HRSA will meet the needs of the community in a cost-effective manner through action-oriented and educational experiences, including conferences and leveraging technology in Internet-based learning. The DTCP is supported by logistics and technical assistance contracts to provide for meeting and consultant support.

Grants to Support Projects to Increase Organ Donation ($7.616 million) — HRSA awards three types of competitive, peer-reviewed grants to public and nonprofit private entities to test and replicate new approaches for increasing organ donation, promote public awareness about organ donation, and support development and improvements of state donor registries:

1) Social and Behavioral Interventions to Increase Solid Organ Donation grants implement and evaluate social and behavioral strategies to increase family and/or individual consent for donation.

2) Clinical Interventions to Increase Organ Procurement grants focus on clinical activities that begin after consent is determined or given at time of death and extend until transplantation. These donor-management-related activities influence whether a potential donor actually progresses to become a donor and the number and quality of organs that may be procured for transplantation.

3) Public Education Efforts to Increase Organ and Tissue Donation grants fund the implementation of public education strategies to increase organ and tissue donation as evidenced by increased enrollment in State donor registries or by other means.

Cooperative Agreement to Provide Support for Reimbursement of Travel and Subsistence Expenses toward Living Organ Donation ($2.0 million) — This is a cooperative agreement with the Regents of the University of Michigan (Michigan) initiated in FY 2006 to provide reimbursement of travel and subsistence expenses to living organ donors in accordance with 42 U.S.C. 274f. Michigan, in collaboration with the American Society of Transplant Surgeons, established the National Living Donor Assistance Center to operate this national program. While the Program does not promote living organ donation and has no performance goals for increasing the number of living organ donors, this activity helps increase access to transplantation, particularly for individuals of lesser financial means. The Program facilitated 908 living donor transplants from October 2007 through May 2011. As of the end of May 2011, an additional 212 prospective living donors have been approved for reimbursement pending the organ donation procedures. The median household income for transplant recipients who received an organ facilitated by NLDAC is $25,476.

Activities to Support Public and Professional Education ($3.839 million) — The Program, independently and in collaboration with the organ donation and transplant community and other stakeholders, supports a variety of public and professional education and outreach efforts designed to increase organ donation. Included in this category are projects designed to educate various segments of the population using communication options appropriate to the message and audience including: public service announcements broadcast via electronic media, printed materials, documentaries, educational programs for the classrooms, national organ donation

events, and Web sites. HRSA will continue to support innovative strategies for outreach efforts to encourage public commitment to organ donation. The Program supports education initiatives and other activities in collaboration with the OPTN and with major medical and professional organizations that are influential in organ and tissue donation. These activities are designed to increase the number of organ donors and number of deceased donor organs made available for transplantation.

Advisory Committee on Organ Transplantation and Interagency Activities to Support Donation and Transplantation ($0.15 million) — The OPTN final rule (42 CFR ' 121.12) authorizes the creation of an Advisory Committee on Organ Transplantation (ACOT) to provide recommendations to the Secretary on issues related to organ donation and transplantation. The Program supports the activities of the ACOT including the logistics for periodic meetings and analytic requirements.

The Organ Transplantation Program funds two IT Investments. The overarching goal of the Program is to increase the annual number of organs transplanted. The Program has adopted multiple strategies to achieve this goal. These strategies include investments in public education activities, partnering with various entities in the transplant community, and implementing organ donation and allocation policies. The HRSA - HSB National Organ Procurement and Transplantation Network (OPTN) IT investment supports these strategies and performance goals through effective and efficient allocation of available organs to patients on the national organ waitlist. The HRSA - HSB Scientific Registry of Transplantation Recipients (SRTR) Investment supports these strategies and performance goals through the support to the OPTN in effecting evidence based organ allocation policies.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2011
23.II.A.1: Increase the annual number of deceased donor organs transplanted.	FY 2010: 24,598 Target: 29,084 (Target Not Met)	31,979	33,473	+1,494
23.II.A.7: Increase the total number of expected life-years gained in the first 5 years after the transplant for all deceased kidney and kidney-pancreas transplant recipients compared to what would be expected for	FY 2010: 4,381 Target: 6,213 (Target Not Met)	6,928	7,299	+371

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2011
these patients had they remained on the waiting list.				
23.II.A.8: Increase the annual conversion rate of eligible donors.	FY 2010: 71.2% Target: 68.6% (Target exceeded)	72.9%	75%	+2.1% point

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Estimate	FY 2013 Request
Number of Awards	25	25	24
Average Award	$513,028	$511,105	$513,316
Range of Awards	$183,048-$2,756,942	$185,000-$2,997,744	$185,000-$2,983,975

National Cord Blood Inventory

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$11,910,000	$11,887,000	$11,887,000	---
FTE	3	3	3	---

Authorizing Legislation - Section 379 of the Public Health Service Act, as amended and Public Law 111-264.

FY 2013 Authorization…….....$23,000,000

Allocation Method……..... Contract

Program Description and Accomplishments

The National Cord Blood Inventory (NCBI) Program, established through legislation renewed on October 8, 2010, is charged with building a genetically and ethnically diverse inventory of at least 150,000 new units of high-quality umbilical cord blood for transplantation. These cord blood units, as well as other units in the inventories of participating cord blood banks, are made available to physicians and patients for blood stem cell transplants through the C.W. Bill Young Cell Transplantation Program (the Program), which is authorized by the same law. Cord blood banks participating in the NCBI Program also make cord blood units available for preclinical and clinical research focusing on cord blood stem cell biology and the use of cord blood stem cells for human transplantation and cellular therapies. A small portion of FY 2007–2009 funds were also used to initiate a Related Cord Blood Donor Demonstration Project.

Blood stem cell transplantation is potentially curative therapy for many individuals with leukemia and other life-threatening blood and genetic disorders. Each year nearly 18,000 people in the U.S. are diagnosed with illnesses for which blood stem cell transplantation from a matched donor is their best treatment option. Often, the first choice donor is a sibling, but only 30 percent of people have a fully tissue-matched brother or sister. For the other 70 percent, or approximately 12,600 people, a search for a matched unrelated adult donor or a matched umbilical cord blood unit must be performed.

The tissue types of blood stem cell donors must be closely matched with those of their recipients in order for the transplant to be successful. Since tissue types are inherited, patients are more likely to find a closely matched donor within their own racial and ethnic group. However, due to the high rate of diversity in the tissue types of racial and ethnic minorities, especially African-Americans, racial and ethnic minorities are less likely to find a suitably matched adult marrow donor on the Registry of the C.W. Bill Young Cell Transplantation Program. Because it can be used with a less perfect match in tissue type between donor and recipient than is the case for adult marrow donors, umbilical cord blood offers a chance of survival for patients who lack a suitably tissue-matched relative and who cannot find an adequately matched unrelated adult

donor through the Program. Minority patients, especially African-American patients, are especially likely to benefit from additional cord blood units. For these reasons, HRSA policy for the NCBI continues to emphasize increasing the number of cord blood units collected from minority donors. In the earlier years, the majority of cord blood transplants were performed for pediatric recipients because of the smaller number of stem cells present in cord blood relative to adult marrow. However, the introduction of multiple cord blood unit transplants and NCBI-led increases in the cord blood inventory, including units with larger cell counts, have increased the availability of cord blood for adult recipients. During FY 2009 and FY 2011 the number of adult patients surpassed the number of pediatric patients receiving cord blood transplants.

The NCBI provides funds through competitive contracts for the collection and storage of qualified cord blood units by a network of cord blood banks in the United States. Requests for proposals have been announced almost every year since the inception of the Program to add additional cord blood banks to the NCBI Program for the collection of additional cord blood units. These proposals have been evaluated by technical review committees composed of individuals qualified by training and experience in fields related to blood stem cell transplantation and cord blood banking. Funding decisions are made based on assessments of technical merit, overall quality, ability to collect from diverse populations, geographic dispersion of offerors, evaluation of past performance including progress toward achieving self-sufficiency of collections and banking operations, and evaluation of proposed costs. When exercising option years beyond the original one-year base period of the contracts, current performance including progress toward self-sustainability and compliance with contract terms are carefully considered. Additionally, HRSA continues to place particular emphasis on the demonstrated ability of offerors to collect and bank significant numbers of cord blood units from African-American donors.

HRSA awarded six contracts to the first cohort of umbilical cord blood banks to collect for the National Cord Blood Inventory in November 2006. Two additional banks were added in September 2007, and five more banks were added in FY 2008 through FY 2010. Currently, 13 banks hold NCBI contracts. No new cord blood banks were added in the FY 2011 competition. HRSA awarded six contracts (five were new contracts to current NCBI banks) in September 2010. As of September 30, 2011, 43,340 NCBI cord blood units were available through the Program. An additional 17,206 units will be collected with funds already awarded through FY 2011. A cumulative total of 60,546 units of cord blood will be put into the NCBI with all funds awarded during the period FY 2007 - FY 2011. We estimate that approximately 7,500 additional units will be banked with funds awarded in FY 2012, assuming an average price to RSA of $1,500 per cord blood unit.

During the first year of collections for the NCBI (FY 2007), four cord blood units from this then-very-small inventory were released for transplantation, with an additional 104 units released for transplantation during FY 2008. During FY 2009, 458 units were released for transplantation, 530 units were released in FY 2010, and 690 were released in FY 2011 with many units currently under evaluation for use by patients in need of transplant. The benefit of large volume units, such as those collected with HRSA funds, is demonstrated by the fact that all of the NCBI units released for transplantation have cell counts well above the levels generally available prior to implementation of the NCBI Program. Many recipients of these cord blood units, especially

those patients whose ancestry is not from northwest Europe, had no well-matched adult donor. As the inventory continues to grow, the diverse units comprising the NCBI will serve an increasing number of patients from populations that have difficulty obtaining cells from a well-matched adult donor. Of the cord blood units collected with funds awarded from FY 2007 - FY 2011, over 60 percent will be from racial and ethnic minorities.

The potential of cord blood to sharply increase access to transplantation is being realized in several ways. First, cord blood has accounted for about one half of the growth in transplants over the life of the NCBI Program, and 27 percent of all transplants facilitated through the C.W. Bill Young Cell Transplantation Program during FY 2011. Multiple-unit transplants continue to rise, from 29 percent of all cord blood transplants during FY 2009 to nearly 42 percent in FY 2011.

For minority patients, cord blood has been especially critical in increasing access to transplantation, with 44 percent of the transplants for minority patients facilitated through the C.W. Bill Young Cell Transplantation Program in FY 2011 utilizing umbilical cord blood, up from 34 percent in FY 2008. Regional studies in areas with diverse patient populations (e.g., New York City and Houston) have shown that the majority of adult patients receiving cord blood transplants lacked adequately matched adult donors; thus cord blood was their only chance for life-saving transplants.

In addition to directly growing the NCBI inventory, the support provided to NCBI-contracted banks has played an important role in stimulating the collection and banking of many other (non-NCBI) units. Typically, these cord blood units do not meet the minimum cell content threshold established for the NCBI. While these other units may not meet this threshold, they remain a suitable source of blood stem cells, especially for smaller patients where an acceptable cell dose can still be achieved using these units. Finally, NCBI banks have provided to researchers more than 21,000 non-NCBI units, for a wide variety of pre-clinical and clinical research.

Table 1. Cord Blood Collection

FY	Cumulative Units Made Available
FY 2005	---
FY 2006	---
FY 2007	2,017
FY 2008	11,870
FY 2009	22,920
FY 2010	34,744
FY 2011	43,340

Funding History

FY	Amount
FY 2008	$8,843,000
FY 2009	$11,983,000
FY 2010	$11,957,000
FY 2011	$11,910,000
FY 2012	$11,887,000

Budget Request

The FY 2013 Budget Request of $11,887,000 is the same level as the FY2012 Enacted Level. This funding will be used to support progress toward the statutory goal of building a genetically diverse inventory of at least 150,000 new units of high-quality cord blood for transplantation and will, therefore, increase the number of patients in all population groups who are able to obtain life-saving transplants. Cell dose and degree of match between patient and cord blood unit are both strongly associated with transplant outcomes. Therefore, a larger inventory of publicly available cord blood units also will contribute to improved patient survival after transplant because a growing inventory of high cell count cord blood units will allow better tissue matches between patients and cord blood units. We estimate funding at the requested level will support the collection and banking of approximately 7,500 additional cord blood units assuming an average price to HRSA of $1,500 per cord blood unit. This represents the same number of cord blood units as will be collected using FY 2012 funds.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target[1]	FY 2013 +/- FY 2012
Increase the cumulative number of minority cord blood units available through the C.W. Bill Young Cell Transplantation Program (NCBI & non-NCBI)	FY 2011: 68,509 (Target Exceeded)	62,500	75,000	+12,500
Increase the size of the National Cord Blood Inventory (cumulative # of units banked and available through the C.W. Bill Young Cell Transplantation Program)	FY 2011: 43,340 (Target Exceeded)	46,800	55,500	+8,200
Increase the number of sites where NCBI participating	FY 2010: 107(Target	118	120	+2

[1] Several targets for FY 2011exceeded or nearly exceeded established targets for FY 2012; FY 2013 targets adjusted to reflect projected program growth in FY 2013 based on FY 2011 actual or projected numbers.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target[1]	FY 2013 +/- FY 2012
banks collect cord blood units	Exceeded; FY 2011 Available Jan 2012)			
Increase the annual number of NCBI cord blood units released for transplant	FY 2011: 690(Target Exceeded)	650	725	+75

Contracts Awards Table
Size of Contracts

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Number of Contracts	12	13	13
Average Contract	$948,685	$868,231	$868,231
Range of Contracts	$148,478$3,107,100	$200,000-$3,000,000	$200,000-$3,000,000

C.W. Bill Young Cell Transplantation Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$23,374,000	$23,330,000	$23,330,000	---
FTE	7	7	7	---

Authorizing Legislation - Section 379 of the Public Health Service Act as amended, and P. L. 111-264.

FY 2013 Authorization……..$30,000,000

Allocation Method……..…….Contract

Program Description and Accomplishments

The primary goal of the C.W. Bill Young Cell Transplantation Program is to increase the number of transplants for recipients suitably matched to biologically unrelated donors of bone marrow and cord blood. The Program works towards this goal by: providing a national system for recruiting potential bone marrow donors; tissue typing potential donors; coordinating the procurement of bone marrow and umbilical cord blood units for transplantation; offering patient and donor advocacy services; providing for public and professional education; and collecting, analyzing, and reporting data on transplant outcomes. Blood stem cell transplantation is potentially curative therapy for many individuals with leukemia and other life-threatening blood and genetic disorders. Each year nearly 18,000 people in the U.S. are diagnosed with life-threatening illnesses where blood stem cell transplantation from a matched donor is their best treatment option. Often, the ideal donor is a sibling, but only 30 percent of people have a fully tissue-matched brother or sister. For the other 70 percent, or approximately 12,600 people, a search for a matched unrelated adult donor or a matched umbilical cord blood unit must be performed.

Per authorizing legislation renewed on October 8, 2010 (The Stem Cell Therapeutic and Research Reauthorization Act of 2010, P.L. 111-264), the C.W. Bill Young Cell Transplantation Program is the successor to the National Bone Marrow Donor Registry. While the scope of activities required of the Program is similar to that of the Registry, the Program has expanded responsibility for collecting, analyzing, and reporting data on transplant outcomes, now including all allogeneic transplants and other therapeutic uses of blood stem cells. The Program is operated through four major contracts that require close coordination and oversight. The authorizing legislation also requires an Advisory Council at the Department level to provide recommendations to the Secretary and to HRSA on activities related to the Program.

Since passage of the Stem Cell Therapeutic and Research Act of 2005, the Program has: (1) ensured a seamless transition from the Registry structure to the more complex C.W. Bill Young Cell Transplantation Program structure; (2) developed initiatives to meet and/or exceed

established long-term and short-term goals; (3) established a methodology for comparing one-year patient survival rates over time and established baselines and targets for this performance measure; (4) updated and implemented a comprehensive plan to increase transplants; (5) begun collecting comprehensive transplant outcomes data through the Stem Cell Therapeutic Outcomes Database; and (6) established an Advisory Council for Blood Stem Cell Transplantation which provides recommendations to the Secretary on matters related to the Program.

The major components of the Program are: (1) a Cord Blood Coordinating Center responsible for facilitating transplants with blood stem cells from cord blood units (including National Cord Blood Inventory units) and providing expectant mothers with information on options regarding the use of umbilical cord blood (i.e., public donation, private storage, research and discard); (2) a Bone Marrow Coordinating Center responsible for recruiting adult potential donors of blood stem cells, especially from underrepresented ethnic and racial minority populations and for facilitating transplants with blood stem cells from adult donors; (3) a combined Office of Patient Advocacy and Single Point of Access to assist patients from diagnosis to survivorship, identifying the gaps in services and offering programs to help meet the needs of patients, and to enable physicians to search for and obtain a suitable blood stem cell product from an adult donor or cord blood unit; and (4) a Stem Cell Therapeutic Outcomes Database responsible for continuing and extending the collection of outcomes data on unrelated donor blood stem cell transplants using cells from adult donors and cord blood, developing and implementing data collection for related donor blood stem cell transplants, and developing and implementing an approach to collect data on emerging therapeutic uses of blood stem cells from a donor.

Contracts for all components of the Program are awarded through a competitive contracting process that emphasizes technical merit. Contract opportunities are announced nationally and proposals are evaluated by technical review committees composed of individuals with expertise in fields related to the Program. Funding decisions are made based on committee assessments of technical merit, evaluation of past performance, and evaluation of proposed costs. When exercising option years beyond the original base period of the contracts, HRSA considers contractor performance and compliance with contract terms. These contracts will be due for re-competition during FY 2012. FY 2013 funds will be used to support the second year of contract activities for the Program.

Performance measures are incorporated into the contracts and monitored quarterly to ensure that the Program meets its three long-term goals which concern: (1) increasing the number of blood stem cell transplants facilitated annually; (2) increasing the number of transplants facilitated annually for minority patients; and (3) increasing patient survival at one-year post-transplant. The Program's long term goals are supported by two annual measures: (1) the increase in the number of adult volunteer potential donors of minority race and ethnicity on the Registry; and (2) the decrease in the unit cost for human leukocyte antigen (HLA) tissue typing needed to match patients and donors. Additional performance standards are developed and monitored under each contract. The Program continues to serve a diverse patient population, with cord blood transplants playing a vital role for minority patients. Notably, survival at one year after unrelated donor transplants, for standard risk patients, has been improving steadily and now is essentially the same as for sibling donor transplants.

The purpose of the Program is to increase the number of unrelated blood stem cell transplants facilitated for patients in need. The Program exceeded the FY 2010 long-term goal of 4,500 transplants by facilitating a total of 5,228 transplants. The Program also exceeded the FY 2010 long-term goal of facilitating 636 minority transplants, by completing 820 transplants for minority patients. Increasing the number of blood stem cell transplants facilitated for patients from racially and ethnically diverse backgrounds addresses the statutory aim of ensuring comparable access for patients from all populations. Adding adult volunteer blood stem cell donors helps accomplish both of the preceding goals. As of the end of FY 2011, 9,574,929 adult volunteer donors were listed on the registry of whom 2,672,907 (28 percent) self-identified as belonging to racial/ethnic minority populations, exceeding the goal of 2.48 million. The cost of tissue typing strongly influences the number of potential volunteer donors who can be recruited to the registry. Reductions in the cost of typing make it possible to recruit more donors for a given level of funding. The FY 2011 cost for each donor's tissue typing remained at $52.00, meeting the established target.

Funding History

FY	Amount
FY 2008	$23,517,000
FY 2009	$23,517,000
FY 2010	$23,517,000
FY 2011	$23,374,000
FY 2012	$23,330,000

Budget Request

The FY 2013 Request of $23,330,000 is the same level as the FY 2012 Enacted Level. This funding will be used to support progress toward the Program's ambitious performance targets of 5,513 transplants facilitated by the Program and 845 transplants for minority patients. The funding will also support progress towards the FY 2013 goal of 2,850,000 adult minority volunteers on the Registry. These funds also will support the major Program components (Cord Blood Coordinating Center, a Bone Marrow Coordinating Center, Office of Patient Advocacy, Single Point of Access, and Stem Cell Therapeutic Outcomes Database). The majority of the funds will be used to recruit and tissue-type new donors. Additionally, the Program will continue to collect comprehensive outcomes data on related-donor transplants as well as unrelated-donor transplants, assess quality of life for transplant recipients, work with foreign transplant centers to obtain data on U.S. stem cell products provided to them for transplant, and collect data on emerging therapies using cells derived from bone marrow and umbilical cord blood.

FY 2013 funding will also allow the Program to continue critical planning to respond to a radiation or chemical emergency that would leave some casualties with temporary or permanent marrow failure, and to facilitate emergency transplants for those casualties who would not otherwise recover marrow function.

The Authorization for the Program (P.L. 111-264) expires September 30, 2015.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
24.II.A.2: Increase the number of adult volunteer potential donors of blood stem cells from minority race and ethnic groups[1]. (Outcome)	FY 2011: 2.67 Million Target: 2.48 (Target Exceeded)	2.66 Million	2.85 Million	0.19 Million
24.1: Increase the number of blood stem cell transplants facilitated annually by the Program.[2] (Outcome)	FY 2010: 5,228 Target: 4500 (Target Exceeded)	N/A	5,513	N/A
24.2: Increase the number of blood stem cell transplants facilitated annually by the Program for minority patients. [2] (Outcome)	FY 2010: 820 Target: 636 (Target Exceeded)	N/A	845	N/A
24.3: Increase the rate of patient survival at one year, post transplant. [2] (Outcome)	FY 2003: 62% (Baseline)	N/A	69%	NA
24.E: Decrease the unit cost of human leukocyte antigen (HLA) typing of potential donors. (Efficiency)	FY 2011: $52 Target: $52 (Target Met)	$50.44	$49.93	-$.51

[1] A long-term target was set for FY 2013.
[2] This is a long term measure. FY 2013 is the first year for which there is a target.

Contracts Awards
Table Size of Contracts

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Number of Contracts	7	8	8
Average Contract	$3,052,668	$3,052,560	$2,688,010
Range of Contracts	$15,000-$15,640,305	$15,000-$15,800,000	$15,000-$13,000,000

Poison Control Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB	FY 2013 + / - FY 2012
BA	$21,866,000	$18,830,000	$18,830,000	---
FTE	4	4	4	---

Authorizing Legislation - Section 1271-1274 of the Public Health Service Act, as amended by P.L. 110-377.

FY 2013 Authorization .....National Toll Free Number - $700,000

FY 2013 Authorization .....Nationwide Media Campaign - $800,000

FY 2013 Authorization .....Poison Control Center Grant Program - $28,600,000

Allocation Method .....Contracts and Competitive Grants/Co-operative Agreements

Program Description and Accomplishments

For over 50 years, poison control centers (PCCs) have been our Nation's primary defense against injury and death from poisonings. Today there is a national network of 57 PCCs that provides cost effective, quality health care to the general public and health care providers alike across the entire United States (U.S.) including American Samoa, the District of Columbia, the Federated States of Micronesia, Guam, Puerto Rico, and the U.S. Virgin Islands. Twenty-four (24) hours a day, seven days a week, health care providers and other specially trained poison experts provide poisoning triage and treatment recommendations at no cost to the caller. PCCs are not only consulted when children get into household products, but also when seniors and people of all ages take too much medicine or the wrong medication or when workers are exposed to harmful substances on the job. Emergency 911 operators refer poison-related callers to PCCs and health care professionals regularly consult PCCs for expert advice on complex cases. The government also relies on PCCs. For example, PCCs were designated by the Centers for Disease Control and Prevention (CDC) as the contact point for public queries about the hazards of radiation in 2011. Additionally, they are a critical resource for emergency preparedness and response as well as for other public health emergencies.

According to the American Association of Poison Control Center (AAPCC) in 2010, more than 3.9 million calls were managed by poison centers, an average of nearly 11,000 calls per day. Among those calls, approximately 2.4 million poisonings were reported, 93 percent of all poisoning exposures occurred in people's homes, and 1.7 million unnecessary visits to healthcare facilities were avoided.

Multiple studies have demonstrated that accurate assessment and triage of poison exposures by poison centers save dollars by reducing severity of illness and death, and eliminating or reducing the expense of unnecessary trips to an emergency department. Consultation with a poison center

can also significantly decrease the patient's length of stay in a hospital and decrease hospital costs. In fact, utilization of poison centers by health care facilities continues to increase highlighting the increase in the severity of poisonings and the need for toxicological expertise in clinical settings. It is estimated that for every dollar invested in a poison center, $7 in unnecessary health care expenses is saved. In 2005, over $525,000,000 in direct Federal health care spending was saved as a result of the poison centers' services to Medicare and Medicaid beneficiaries. Inflation would make this number higher today.

In addition to providing the public and health care providers with treatment advice on poisonings, a second critical function of the PCCs is the collection of poison exposure and disease surveillance data. Multiple Federal agencies, including the CDC, Consumer Product Safety Commission, Environmental Protection Agency, Food and Drug Administration, Substance Abuse and Mental Health Services Administration, use these data for public health surveillance, including timely identification, characterization, or ongoing tracking of outbreaks and other public health threats. In addition, many state health departments collaborate directly with poison centers within their jurisdictions. For example, states and Federal agencies used data from PCCs to track exposures related to synthetic marijuana in recent years, the Deepwater Horizon oil spill in 2010, and toxic products marketed as "bath salts" in 2011.

Additionally, PCCs provide public and health care provider education. Health educators actively work to change behaviors to reduce poisonings and promote awareness and utilization of poison center services in their communities. PCCs also provide training and programs in clinical toxicology for many different health care professionals to help clinicians better manage poisoning and overdose cases.

Health Resources and Services Administration's (HRSA) Poison Control Program (PCP) is authorized through Public Law 110-377, the Poison Center Support, Enhancement, and Awareness Act of 2008. The Program is legislatively mandated to fund poison centers; establish and maintain a single, national toll-free number (800-222-1222) to ensure universal access to poison center services and connect callers to the poison center serving their area; and implement a nationwide media campaign to educate the public and health care providers about poison prevention, poison center services, and the 800 number.

The Poison Help line, 800-222-1222, was established in 2001 to ensure universal access to PCC services. Individuals can call from anywhere in the U.S. and will be connected to the poison center that services their local area. The PCP maintains the number and provides translation services in over 150 languages. Services are also provided for the hearing impaired.

Through the nationwide Poison Help media campaign, the PCP has been working to educate the public about the 800 number and increase awareness of poison center services. In FY 2006, the percent of inbound call volume on the toll-free number was 66 percent. This has increased to over 80 percent in FY 2011. In FY 2006, only 19 percent of national survey respondents were aware that PCC calls are handled by health care professionals. The PCP aims to exceed its target of 25 percent by FY 2016.

The PCP aims to maintain the 71 percent of human poison exposure calls made to PCCs that were managed outside of a health care facility, as reported by the AAPCC. This will be a challenge because the U.S. is in the grip of an epidemic of prescription drug overdoses, which is increasing emergency room visits. According to the CDC, in 2008, for the first time in nearly 30 years, more people died of poisoning than in car crashes. Poisoning is now the leading cause of injury death, and 90 percent of poisonings were caused by prescription drugs. Opioid analgesics accounted for more than 40 percent of drug poisonings. These drugs were implicated in more poisoning deaths than heroin and cocaine combined. In 2011, the Office of National Drug Control Policy released the prescription drug abuse prevention plan, Epidemic: Responding to America's Prescription Drug Abuse Crisis, which expands upon the Administration's National Drug Control Strategy. Among the actions outlined in the plan are educating parents, youth, and patients about the dangers of abusing prescription drugs, educating prescribers about the safe and appropriate use of these drugs, and developing convenient and environmentally responsible medication disposal programs. PCCs are active partners in these efforts and both the PCCs and the PCP have participated in the National Prescription Drug Take Back events sponsored by the Department of Justice's Drug Enforcement Administration.

Funding History

FY	Amount
FY 2008	$26,528,000
FY 2009	$28,314,000
FY 2010	$29,250,000
FY 2011	$21,866,000
FY 2012	$18,830,000

Budget Request

The FY 2013 Request of $18,830,000 is equal to the FY 2012 Enacted Level. Funding for the PCP will be used to support PCCs' efforts to prevent poisonings, provide treatment recommendations, and comply with accreditation requirements. Poison control centers primarily rely on state and local funding, as Federal funding accounts for less than 20 percent of total funding for the majority of PCCs. While PCCs have innovatively secured funding from a variety of local sources, including philanthropic organizations, their financial stability is tenuous. Many state funded poison control centers have faced termination due to state budgetary shortfalls in recent years. Federal funding is necessary to help sustain the valuable nationwide PCC infrastructure, which enables PCCs to sustain their public health and toxico-surveillance efforts.

Ninety-five (95) percent of PCCs are now accredited, up from 78 percent in 2001. Many centers have implemented strategic planning initiatives and business plans, and increased access to services through outreach and education programs. In FY 2013, the Program proposes to continue to support initiatives that focus on preventing poisonings, providing treatment recommendations, complying with operational requirements needed to attain or sustain accreditation and implementing leading practices that enhance the quality and accessibility of poison education, prevention, and treatment. HRSA will also use funding to maintain and

promote the Poison Help line, provide translation services for non-English speaking callers, and raise awareness of poison center services.

The FY 2013 Request will support the following:

Support and Enhancement Grant Program and Incentive Cooperative Agreement Program ($17.33 million): Grant funds will be used to continue supporting PCCs efforts to prevent poisonings, provide treatment recommendations, and comply with operational requirements needed to attain or sustain accreditation.

This request also includes costs associated with processing of grants through the Grants Administration Tracking and Evaluation System (GATES) and HRSA's Electronic Handbooks (EHBs), and follow-up performance reviews.

National Toll-Free Hotline Services and Promotion of Number and Services ($1.5 million): Ensuring access to PCCs through the national toll-free hotline is a critical public health service that improves the quality of healthcare. The Program will fund and manage the toll-free number. Funding will also be used to support translation services for non-English speaking callers.

As legislatively mandated, the Program will also continue to fund the nationwide media campaign to educate the public and health care providers about poison prevention, poison control resources, and the national toll-free number. To that end, the Program will also provide technical expertise in the development of the media campaign and will continue to raise awareness about poison prevention and the availability of the toll-free number among the general public, health care providers including pharmacists and 340B participants. The FY 2013 target is to maintain the percent of all calls routed to the PCCs using the toll-free number at 75 percent.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
25.III.D.3: Increase percent of inbound volume on the toll-free number. (Output)	FY 2011: 81% Target: 73.7% (Target Exceeded)	75%	75%	Maintain
25. III.D.4: Percent of national survey respondents who are aware that calls to poison control centers are handled by	FY 2006: 19% (Baseline)	N/A	N/A	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
health care professionals. (Outcome)[1]				
25. III.D.5: Percent of human poison exposure calls made to PCCs that were managed by poison centers outside of a healthcare facility. (Output)[2]	FY 2010: 71% (Target not in Place)	N/A	71%	N/A

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Estimate	FY 2013 Request
Number of Awards	53[3]	53[4]	53[5]
Average Awards	$379,415	$326,981	$326,981
Range of Awards	$12,466-$2,404,875	$12,466-$1,972,281	$12,466-$1,972,281
Number of Cooperative Agreements	---	---	---
Range of Contracts	$24,500-$150,000	$6,000-$200,000	$6,000-$200,000

[1] This is a long term measure. FY 2016 is the first year for which there is a target. The FY 2016 target is 25 percent. Interim data from FY 2011 will be available February 15, 2012.
[2] This is an annual measure with FY 2010 as the first year for which data will be reported. The first target is set for FY 2013.
[3] In FY 2011, there are 57 PCCs across the Nation. Fifty-three (53) awards were made under the Support and Enhancement Grant Program, representing 56 of the 57 centers. For grant purposes, HRSA counts the California Poison Control System as a single entity, but it encompasses four California poison centers.
[4] In FY 2012, we expect that there will be 57 PCCs across the Nation. Fifty-three (53) awards will be made under the Support and Enhancement Grant Program, representing 56 of the 57 centers. For grant purposes, HRSA counts the California Poison Control System as a single entity, but it encompasses four California poison centers
[5] In FY 2013, we expect that there will be 57 PCCs across the Nation. Fifty-three (53) awards will be made under the Support and Enhancement Grant Program, representing 56 of the 57 centers. For grant purposes, HRSA counts the California Poison Control System as a single entity, but it encompasses four California poison centers.

Office of Pharmacy Affairs/340B Drug Pricing Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$4,480,000	$4,472,000	$4,472,000	---
FTE	1	1	1	---

Authorizing Legislation - Section 340B of the Public Health Service Act as amended by the Affordable Care Act (P.L. 111-148), as further amended by the Health Care and Education Reconciliation Act (P.L. 111-152).

FY 2013 Authorization……..…….….Indefinite

Allocation Method……...…….…….…. Contract

Program Description and Accomplishments

The 340B Drug Pricing Program requires drug manufacturers to provide discounts or rebates to a specified set of HHS-assisted programs and hospitals that meet the criteria in the Public Health Service Act and the Social Security Act for serving a disproportionate share of low income patients. The following health care providers are eligible to purchase outpatient drugs at 340B prices: all Health Resources Services Administration (HRSA)-assisted Federally Qualified Health Centers; Black Lung Clinics; Ryan White HIV/AIDS Programs including AIDS Drug Assistance Programs; Comprehensive Hemophilia Treatment Centers; Indian Health Service tribal organizations and Urban Indian Programs; Centers for Disease Control and Prevention-assisted sexually transmitted disease (STD) and tuberculosis (TB) clinics; Native Hawaiian Centers; Title X Family Planning Clinics; certain disproportionate share hospitals; children's hospitals; Federally Qualified Health Center Look-A-Likes; Free-Standing Cancer Centers; Critical Access Hospitals; Rural Referral Centers; and Sole Community Hospitals.

The 340B Program requires drug manufacturers to give covered entities a discount that is at least 23.1 percent below Average Manufacturer Price (AMP) for brand name drugs; 13 percent below AMP for generic drugs; and 17.1 percent below AMP for clotting factor and pediatric drugs. From FY 2010 through FY 2011, covered entities will save an estimated $3 billion on their $6 billion outpatient drug expenditures by participating in the 340B Program. The total savings in FY 2012 and FY 2013 are expected to increase as participation in the 340B Program increases. Drug purchases under the 340B Program represent approximately 2 percent of all U.S. drug purchases.

The Prime Vendor Program (PVP) established under Section 340B (a) (8) is responsible for the negotiation of pharmaceutical prices below the 340B ceiling price as well as contracting for wholesale distribution of pharmaceuticals to covered entities. The PVP is free and voluntary. The PVP contract was re-competed and awarded in 2009 to Apexus, a non-profit organization. As of March 2011, the PVP had over 3,800 drugs under contract with an estimated average savings of 15 percent below the 340B ceiling price. In addition, the PVP has contracts for other

value-added pharmacy products and services such as vaccines, diabetic supplies, pharmacy software, and outpatient pharmacy automation. Historically, the PVP contracts provided over $30 million in additional savings for covered entities enabling them to further expand their pharmacy programs and address growing patient needs during difficult economic times. Apexus has also established "shareback" payments of $4.5 million to participating covered entities. These funds allow the covered entities to purchase more medications at a reduced cost for their patients. The 340B Prime Vendor continues to build on the value that this public/private business arrangement brings to covered entities and the government. Current PVP trends are expected to continue, and savings are expected to increase substantially in subsequent years.

The Pharmacy Services Support Center (PSSC) was established in FY 2002 under a HRSA contract with the American Pharmacists Association to provide guidance and technical assistance to 340B covered entities. The PSSC contract was modified to accommodate the Office of Inspector General (OIG) recommendations that HRSA provide 340B Program education and training activities for covered entities. The technical assistance assists newly eligible safety-net providers to fully utilize the 340B Drug Pricing Program. It also is important to maximize their savings and minimize their expenditures through the use of all available tools, including multiple contract pharmacies since April 2010 and integrating leading patient safety practices to avoid serious adverse events.

Program Growth

By the end of FY 2011, over 16,500 covered entities sites were registered in the 340B Program. The 340B Program is expected to continue experiencing a three to four percent growth per year. The number of contract pharmacies registered in the 340B Program serving covered entities has increased to over 7,800 and continues to grow since the final publication of guidance in March 2010.

Funding History

FY	Amount
FY 2008	---
FY 2009	$1,470,000
FY 2010	$2,220,000
FY 2011	$4,480,000
FY 2012	$4,472,000

Budget Request

The FY 2013 Budget Request of $4,472,000 is equal to the FY 2012 Enacted Level.

From the inception of the 340B Program in 1992, the entire cost of administering the Program, including the development of guidelines and the provision of technical assistance to eligible grantees, has been borne by HRSA program management funds until FY 2009 when a line item of $1,470,000 was established. The line item was expanded to $2,220,000 in FY 2010 because of the need to make major improvements in program operations as identified by audits and

evaluations conducted by the OIG. In addition, $1.584M of ACA funds was used to design systems and begin enrolling and supporting the five new eligible entity-types identified in ACA. Continued funding in FY 2013 is necessary to continue to implement major improvements in the 340B Program operations and to resolve identified deficiencies of the current level of operations. The areas of focus include:

Non-compliance with the 340B pricing requirements - 340B Program pricing errors are caused by a variety of problems including: incorrect package size data; omissions in data needed to compute 340B ceiling prices; and mistakes in 340B prices offered by drug manufacturers and/or wholesalers. HRSA computes the 340B ceiling prices using data that manufacturers' supplied to CMS. Funds from the FY 2013 appropriation request will continue to support the 340B pricing system, publication of policies regarding the computation of 340B ceiling prices, implement a systematic quarterly comparison of 340B ceiling prices with the selling prices offered by manufacturers and drug wholesalers, and follow-up efforts to resolve problems wherever they arise in the data supply chain.

Errors and omissions in HRSA's covered entity database - HRSA's staff and its contractors have continued to take a number of steps to improve the integrity and reliability of the database of covered entities. This includes purging duplicate and obsolete entity records and adding updated entity information. While there have been great advances in improving the integrity and accuracy of the 340B database in response to deficiencies identified by the OIG, a sustained and systematic approach is needed to maintain this accuracy and integrity. HRSA will continue to require the verification of eligibility of entity types in FY 2013. In FY 2013, the continued administration of a systematic verification system will allow annual online verification of all records in the 340B database. HRSA considers the integrity of the 340B database to be a crucial responsibility that requires ongoing maintenance and development in order to effectively administer the 340B Program and meet the obligations of the Secretary and the law.

Program Regulations and Guidance - In FY 2013, HRSA will continue to support the implementation of program regulations and guidance to provide oversight to maintain the integrity of the 340B Program.

The 340B Drug Pricing Program funds the HRSA - HSB Office of Pharmacy Affairs Information System (OPAIS) IT Investment. OPAIS is a multi-function web-based database system that provides information on covered entities, contracted pharmacy arrangements, and manufacturers who have signed agreements with DHSS. This IT Investment supports the strategic and performance outcomes of the program by facilitating access to clinically and cost effective pharmacy services among safety-net clinics and hospitals (known as the covered entities) that participate in the 340B Program.

HRSA-Supported Performance Outcomes

The primary products are the 340B online public access database, required by legislation, for use by stakeholders of the 340B Program, and the pricing module to be used to validate manufacturers' calculation of the 340B ceiling price. This investment allows OPA to improve its ability to respond to customer needs and improve 340B Program integrity. This project supports

element 1.1 – to ensure accountability for business results by making sure stakeholders have accurate 340B Program data on which to base their sales projections or other business decisions.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Covered Entity Sites Served	FY 2010 15,530 Target: 14,400 (Target Exceeded)	15,996[1]	16,970	+974
TA Consultations	FY 2010 6,346 Target: 2,610 (Target Exceeded)	6,5361	6,933	+397

Contracts Awards Table
Size of Contracts

(whole dollars)	FY 2011 Enacted	FY 2012 Estimate	FY 2013 Request
Number of Contracts	2	2	2
Average Contract	$3,859,565	$2,408,949	$2,408,949
Range of Contracts	$1,950,000 - $5,769,130	$1,350,000 – $3,467,897	$1,350,000 – $3,467,897

[1] These numbers reflect an increase in the reported targets in the FY 2012 due to the program exceeding the established FY 2010 targets.

Office of Pharmacy Affairs/340B Drug Pricing Program User Fees

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	---	---	$6,000,000	$6,000,000
FTE	---	---	---	---

Authorizing Legislation - Section 340B of the Public Health Service Act as amended by the Affordable Care Act (P.L. 111-148), as further amended by the Health Care and Education Reconciliation Act (P.L. 111-152).

FY 2013 Authorization……Indefinite

Allocation Method .....Contract

Program Description and Accomplishments

HRSA requires significant additional ongoing funding sources to be able to administer the new authorities and responsibilities. Funds are also needed to address longstanding recommendations by the OIG to make major improvements in program integrity. The cost recovery fee provides the resources needed to address both long standing problems and the expanded authorities while reducing the government expenditure of taxpayer dollars.

The 340B cost recovery fee in FY 2013 is 0.1 percent of the total 340B drug purchase paid by participating covered entities. These funds shall be available until expended. The fee will be collected from the covered entities by the manufacturers who will then deposit the cost recovery fee into a no year account established by the Secretary for use by the Secretary and designees for use in administering operations of the 340B Program including integrity provisions and access to covered drugs and services for 340B eligible entities.

The administration of the cost recovery system will include the reporting of sales under the 340B Program and establish the cost recovery fee as a percent of the drug purchases under the Program paid to the manufacturer. The collected fee is in addition to the cost to purchase the drug at the 340B price. This fee will be paid by the entity and remitted by the manufacturer to the Secretary. The Secretary will establish a mechanism to ensure that the full cost recovery fee is clearly identified on billing and fully remitted to the Secretary. The calculation of the 340B price level is not affected by this provision. The 340B entities receive a significant benefit and the cost recovery fee is designed to ensure the cost of administering the Program is paid for with a small fraction of the received benefit. Without the cost recovery fee, the funding necessary to administer this Program comes exclusively from the taxpayers. The cost recovery fee will create a sustainable funding source to meet the demands of the existing growth of the Program, the changing marketplace, and the new statutory program requirements.

The FY 2013 cost recovery fee set at the 0.1 percent level, in addition to OPA's proposed line item budget, will fund the program's current and increased program integrity.

Program Growth

In FY 2011, approximately 1,480 newly eligible covered entity sites were registered in the 340B Program bringing the program total to over 16,700 sites by the end of FY 2011. While the 340B Program is expected to continue experiencing a 3 to 4 percent growth per year for existing categories of eligible entities, the covered entities that are newly eligible are expected to increase at an accelerated rate of at least 10 percent for the first two to three years. The number of contract pharmacies registered in the 340B Program serving covered entities has increased to over 7,800 and is expected to continue growing at an accelerated rate for the newly eligible covered entities. This is a result of the March 2010 publication of a FRN allowing multiple contract pharmacy arrangements.

Funding History

FY	Amount
FY 2008	---
FY 2009	---
FY 2010	---
FY 2011	---
FY 2012	---

Budget Request

The FY 2013 Budget proposes of $6,000,000 in collected user fees, an increase above the FY 2012 Enacted Level to establish a cost recovery system that will finance the 340B Drug Pricing program.

The 340B cost recovery fee system will establish the necessary requirements for manufacturers and covered entities to efficiently administer this cost recovery system that will provide operations, oversight and integrity for the 340B Drug Pricing Program. The cost recovery fee will support the natural growth of the 340B Program and fund new authority, responsibilities, and oversight. The Secretary will set the cost recovery fee at a rate up to 0.5 percent and can fully fund the operations of the program at that level, therefore, eliminating the need for a line item appropriation. We are requesting .1 percent in FY 2013 as implementation of these authorities will be phased in as regulations and policies are promulgated and systems are designed and implemented.

The cost recovery fee will ensure a reliable and continuous funding source for HRSA to fully administer the 340B Program and will allow HRSA to better monitor compliance among both manufacturers and covered entities. Having manufacturers collect the fees from covered entities as part of the payment process for covered drugs is the most efficient approach to ensure the accuracy and timeliness of the fee collection. In anticipation of expected further growth of the Program and additional responsibilities relating to increased eligibility and maintaining integrity

and compliance, this funding mechanism will ensure the Program continues to operate successfully and effectively.

A legislative proposal has also been proposed to establish a sustainable 340B sales reporting process and a cost recovery fee mechanism from manufacturers to be collected from 340B participating entities for the purpose of administering Section 340B of the Public Health Service Act. The statutory change would ensure the cost recovery fee is both efficiently and effectively implemented. With statutory language, HRSA would have additional authority to enforce program requirements and implement the program integrity provisions as outlined by the OIG. The collected fee will be remitted by the manufacturer to the Secretary for use in administering all operations of the Program including program integrity measures and providing access to covered drugs and services for 340B eligible entities. This amount would be added to the price of the 340B drug, but would not affect the calculation of the entity's total acquisition cost of a 340B drug.

The cost recovery fee would address current information deficiencies as well as provide significant resources needed to address both long- term goals to improve the program by addressing OIG requirements and the expanded statuary requirements of Affordable Care Act

As stated in P.L. 111-148, HRSA is required to develop and implement a system to verify the accuracy of the 340B ceiling price in the marketplace. HRSA needs to develop and publish defined standards and methodology for the calculation of ceiling prices as well as put in place a new transparent system to calculate the official federal 340B ceiling price and make it available to the covered entities through the secured internet website that protects privileged pricing data. HRSA also needs to perform oversight activities such as spot checks of sales transactions by covered entities, selective auditing of manufacturers and wholesalers, inquire into the cause of any pricing discrepancies and take necessary corrective actions. The corrective actions include making sure the manufacturers issue timely refunds for routine retroactive adjustments and for exceptional circumstances such as erroneous or intentional overcharges. In addition, all covered entities are required to be recertified and their information updated on an annual basis or sooner to ensure the integrity of the system and information in the HRSA database is accurate.

Specifically, the user fee collected will cover the long-term goals of the program that include expanded authority under ACA and recommendation from the FY XXX OIG report

Cost Recovery System – HRSA needs to develop and publish defined standards and methodology for the calculation of ceiling prices as well as put in place a new transparent system to calculate the official federal 340B ceiling price and make it available to the covered entities through the secured internet website that protects privileged pricing data.

Office of Pharmacy Affairs Information Systems (OPAIS) - Manufacturer's are required to report their 340B ceiling prices directly to HHS, HRSA must develop a system of verifying ceiling price calculations, post 340B ceiling prices to a secure website, utilize spot checks of sales, and develop a system of refunds where appropriate. HRSA is also required to establish a single, universal, and standardized identification system by which each covered entity site can be identified by manufacturers, distributors, and covered entities for purposes of facilitating

ordering, purchasing, and delivery of covered drugs, including the processing of charge-backs for such drugs. In addition, HRSA is required to make system improvements and add procedures to enable and require covered entities to regularly update the information via the internet website. The system will verify the accuracy of information regarding covered entities that are listed on the website.

Compliance and Oversight - Compliance issues are addressed primarily when they emerge as complaints from manufacturers, covered entities, or non-governmental interest groups. HRSA currently has no systematic method of monitoring manufacturer or covered entity compliance with the 340B law, P.L. 111-148, and HRSA's published guidelines. OIG reports on October 18, 2005, titled "Deficiencies in the Oversight of the 340B Drug Pricing Program (OEI-05-02-00072)"; and on July 14, 2006, titled "Review of 340B Prices (OEI-05-02-00073)"have outlined recommendations for Program oversight and compliance. Among five recommendations to correct non-compliance among manufacturers, the OIG urged HRSA to institute oversight mechanisms to validate its 340B price calculations and the prices charged by manufacturers to participating entities. HRSA has not been able to fully implement these recommendations due to limited resources.

Administrative Dispute Resolution Process - HRSA is authorized by P.L 111-148 to establish and implement an administrative process for the resolution of claims by covered entities that they have been overcharged for drugs purchased and claims by manufacturers of violations, including appropriate procedures for the provision of remedies and enforcement of such process through mechanisms and sanctions.

Civil Monetary Penalties - HRSA has new authority to impose sanctions in the form of civil monetary penalties for manufacturers and covered entities. HRSA will have the authority, under P.L. 111-148, to impose up to $5,000 of penalty to manufacturers for each instance of overcharging a covered entity knowingly and intentionally. In addition, HRSA will have the authority, under P.L. 111-148 to require covered entities to pay monetary penalties to manufacturers in the form of compounded interest for knowing and intentional violations of diversion and/or removing and disqualifying the covered entity from the 340B Program for a designated period of time as penalty when violations are found to be systematic and egregious.

Non-compliance with the 340B pricing requirements - 340B Program pricing errors are caused by a variety of problems including: incorrect package size data, omissions in data needed to compute 340B ceiling prices, and mistakes in 340B prices offered by drug manufacturers and/or wholesalers. As a first step in correcting these problems, HRSA negotiated an intra-agency agreement with CMS, permitting HRSA to compute the 340B ceiling prices using data that manufacturers' supplied to CMS. Funds from the FY 2013 appropriation request will continue to support publication of policies regarding the computation of 340B ceiling prices; implement a systematic quarterly comparison of 340B ceiling prices with the selling prices offered by manufacturers and drug wholesalers, and follow-up efforts to resolve problems wherever they arise in the data supply chain.

Errors and omissions in HRSA's covered entity database - HRSA's staff and its contractors have continued to take a number of steps to improve the integrity and reliability of the database of covered entities. This includes purging duplicate and obsolete entity records and adding updated entity information. While there have been great advances

in improving the integrity and accuracy of the 340B database in response to deficiencies identified by the OIG, a sustained and systematic approach is needed to maintain this accuracy and integrity. HRSA will continue to require the verification of eligibility of entity types in FY 2013. In FY 2013, the continued administration of a systematic verification system will allow annual online verification of all records in the 340B database. HRSA considers the integrity of the 340B database to be a crucial responsibility that requires ongoing maintenance and development in order to effectively administer the 340B Program and meet the obligations of the Secretary and the law.

Program Regulations and Guidance - In FY 2013, HRSA will continue to support the implementation of program regulations and guidance to provide oversight to maintain the integrity of the 340B Program.

Outcomes and Outputs Tables

The Program measures are under development.

Rural Health

Tab

Office of Rural Health Policy

Summary of the Request

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$137,568,000	$138,172,000	$122,232,000	-$15,940,000
FTE	7	9	7	-2

Established in 1987, the Office of Rural Health Policy (ORHP) serves as a focal point for rural health activities within the Department. The Office is specifically charged with serving as a policy and research resource on rural health issues as well as administering grant programs that focus on supporting and enhancing health care delivery in rural communities.

ORHP advises the Secretary and other components of the Department on rural health issues with a particular focus on working with rural hospitals and other rural health care providers to ensure access to high quality care in rural communities. The Department has maintained a significant focus on rural activities for more than 20 years. Historically, rural communities have struggled with issues related to access to care, recruitment and retention of health care providers and maintaining the economic viability of hospitals and other health care providers in isolated rural communities.

There are nearly 50 million people living in rural America who face ongoing challenges in accessing health care.[1] Rural residents have higher rates of age-adjusted mortality, disability, and chronic disease than their urban counterparts. [2] Rural areas also continue to suffer from a shortage of diverse providers for their communities' health care needs and face workforce shortages at a greater rate than their urban counterparts. [3,4] Of the 2,052 rural counties in the U.S., 1,582 (77 percent) are primary care health professional shortage areas (HPSAs).[5]

The ORHP programs (excluding the Radiation Exposure Screening, Black Lung, and Telehealth programs) have two annual performance measures representing rural health activities as reflected in the Rural Health Services Outreach Grant Program and Rural Hospital Flexibility Grant

[1] Population and Percent Distribution by Core Based Statistical Area (CBSA) Status for the United States, Regions, and Divisions, and for Puerto Rico: 2000 and 2009 (CBSA-EST2009-11).
[2] Economic Research Service (August 2009). Health Status and Health Care Access of Farm and Rural Populations. Economic Information Bulletin Number 57. Washington, D.C. U.S. Department of Agriculture.
[3] Doescher, M., Fordyce, M., Skillman S., WWAMI Rural Health Research Center Presentation: The Aging of the Rural Generalist Workforce. February 2009.
[4] Area Resource File (ARF). 2008. US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Rockville, MD.
[5] WWAMI Rural Health Research Center. Aging of the rural generalist workforce. Seattle, WA: WWAMI Rural Health Research Center, University of Washington; July, 2009.

Programs. The Rural Health Care Services Outreach Program provided both direct and indirect services for 2,451,969 individuals in FY 2009, which exceeded the target of 828,360. This is a substantial improvement from FY 2006 in which 627,120 individuals were served. This measure was revised to examine the increase in the number of people receiving direct services through the Outreach grant. This measure focuses on only direct patient care such as screenings and treatment which is clearer, easier to interpret, easier to quantify, and, thus, more accurate. In FY 2010, 383,776 people received direct services through this program exceeding the target of 380,000 people. The Rural Hospital Flexibility Grant Program has helped improve operating margins for Critical Access Hospitals (CAHs) with these facilities reporting a -3.3 percent operating margin in 2009 and a -2.04 percent operating margin in 2010, both of which demonstrate improvement from FY 2006 when CAHs had an average operating margin of -8.8 percent. This reflects a continued improvement trend as the targets have been exceeded almost each year since the benchmark of -14.05 percent operating margin was set based on 1999 data.

Improving Rural Health Initiative

The goal for the President's "Improving Rural Health Care Initiative" is to build healthier rural populations and communities through evidence-based practices. The Office of Rural Health Policy (ORHP) will improve the coordination of rural health activities within Health Resources and Services Administration (HRSA), across the Department of Health and Human Services (DHHS), as well as other Federal Departments by leveraging rural health funds to improve the health of rural populations. Approximately $77 million of the total amount requested for the ORHP supports the President's initiative to improve rural health; specifically, $55,553,000 from Rural Health Care Services Outreach; $10,036,000 from the State Offices of Rural Health; and, $11,502,000 from Telehealth.

The goal of the initiative is to improve the access to and quality of health care in rural areas. To achieve this goal, the initiative focuses on five activities:

- Strengthening rural health care infrastructure;
- Improving the recruitment and retention of health care providers in rural areas;
- Building an evidence base for programs that improve rural community health;
- Providing direct health care services; and
- Improving the coordination of rural health activities within HRSA, the Department of Health and Human Services, and across the Federal Government.

The following four programs within the Office of Rural Health Policy support these five activities.

Rural Health Care Services Outreach, Network, and Quality Improvement

The Rural Health Outreach authority includes a range of programs designed to improve access to care, coordination of care, integration of services and to focus on quality improvement in health care for rural communities. These programs are among the only non-categorical grants within DHHS, which allows grantees to determine the best way to meet local need. This flexibility in funding reflects the unique nature of health care challenges in rural communities and the need to

allow communities to determine the best approach to addressing local health concerns. The broad non categorical nature of the programs also allows ORHP to focus funding on key emerging needs. For example, in the first couple of years of the Improving Rural Health Care Initiative, ORHP was able to focus funding on two key areas of need through funding of Network Development grants. The first focused on health care workforce development in 2010; the second on the adoption of health information technology in 2011. These programs help to improve access to and the quality of, health care in rural areas by supporting three of the initiative's five components: strengthening rural health care infrastructure, providing direct health care service, and improving the recruitment and retention of health care providers in rural areas.

State Offices of Rural Health Grants

This program provides funding to the State Office of Rural Health located in each state to provide technical and other assistance, information dissemination to rural health providers and helps rural communities recruit and retain health care professionals. This program also supports the improving the recruitment and retention of health care providers in rural areas component of the initiative.

Rural Training Track Technical Assistance Grant-New Program for Rural Physician Training Grants

This pilot program provides technical assistance to new and established Rural Training Track (RTT) residency programs. The technical assistance is provided to help RTT programs across the Nation promote the training of physicians in rural areas; increase the number of physician residents that match to their open rural training slots; and work with additional rural communities that have an interest in creating new Rural Training Tracks to help attract physicians. This program also supports the improving the recruitment and retention of health care providers in rural areas component of the initiative.

Telehealth Grants

This program expands the use of telecommunications technologies within rural areas that can link rural health providers with specialists in urban areas, thereby increasing access and the quality of healthcare provided to rural populations. Telehealth technology also offers important opportunities to improve the coordination of care in rural communities by linking rural health care providers with specialists and other experts not available locally. These grants support the initiative by strengthening rural health care infrastructure

Coordinating Programs for a Targeted Investment

The programs listed above support the initiative. In addition, ORHP will use the existing funds to conduct program evaluations and build an evidence base for new ways to improve health care in rural communities. Evaluations will focus on measuring:

- The program impact on the health status of rural residents with chronic conditions such as diabetes, cardiovascular disease, and obesity;
- The return on investment for rural grantees and communities; and
- The economic impact of the Federal investment in rural communities.

The initiative will also identify successful models, lessons learned and common challenges faced by rural grantees. These best practices will be disseminated across the Nation as models that can be replicated.

Finally, as part of the initiative, ORHP will work to increase coordination with other agencies that fund programs that benefit rural communities within HRSA, DHHS, and across the Federal Government. This will include increasing rural participation in health professional training and service programs in Title VII and VIII of the Public Health Service Act as well as the National Health Service Corps. In 2010, ORHP began working collaboratively with the Department of Agriculture on a variety of issues ranging from defining frontier communities to coordinating telehealth and broadband access. ORHP expanded its work with the Department of Veteran Affairs in 2011 while also reaching out to work collaboratively with the Departments of Labor, Education and Transportation.

Funding History

FY	**Amount**
FY 2008	$179,772,000
FY 2009	$176,096,000
FY 2009 Recovery Act	$ 1,008,000
FY 2010	$184,910,000
FY 2011	$137,568,000
FY 2012	$138,172,000

Budget Request

The FY 2013 Request of $122,232,000 is a reduction of $15,940,000 from the FY 2012 Enacted Level. The Request includes funding for the following rural health activities:

- $55,553,000 for the Rural Health Care Services Outreach, Network, and Quality Improvement Programs, which is equal to the FY 2012 Enacted Level. This funding will continue to support key activities for Rural Health care Services Outreach, Network and Quality Improvement Grants Programs. One of the goals of the Improve Rural Health Initiative is to help existing rural networks improve the coordination of health services in rural communities and strengthen the rural health care systems as a whole. This effort supports that goal. ORHP expects that 395,000 people will receive direct services in FY 2013.
- $9,866,000 for Rural Health Policy Development, which is equal to the FY 2012 Enacted Level. Funding will support activities such as the rural health research center grant program as well as policy analysis and information dissemination activities on a range of rural health issues. The FY 2013 target for these activities is 35 reports.

- $26,200,000 for Rural Hospital Flexibility Grants, which is $14,840,000 below the FY 2012 Enacted Level. This request provides level funding for the Rural Hospital Flexibility Program, which provides grants to support a range of activities focusing on Critical Access Hospitals (CAHs). The activities supported through this funding will continue to support efforts by CAHs to report quality data to Hospital Compare. In FY 2010, 72.6 percent of CAHs reported at least one measure to Hospital Compare. The FY 2013 target for this activity is 78 percent.
- $10,036,000 for the State Offices of Rural Health Grants, which is equal to the FY 2012 Enacted Level. This funding will continue to support key activities for the State Offices of Rural Health Program and will support a grant award to each of the 50 states. It is part of HRSA's Improve Rural Health Initiative to provide technical and other assistance to rural health providers and help rural communities recruit and retain health care professionals. The SORH program anticipates that it will provide 66,932 technical assistance encounters directly to clients in FY 2013. The program also expects that 31,134 clients (unduplicated) that will receive technical assistance directly from SORHs in FY 2013.
- $1,935,000 for Radiation Exposure Screening and Education Program (RESEP), which is equal to the FY 2012 Enacted Level. The purpose of this program is to provide grants to States, local governments, and appropriate health care organizations to support programs for individual cancer screening for individuals adversely affected by the mining, transport and processing of uranium and the testing of nuclear weapons for the Nation's weapons arsenal. The RESEP grantees also help clients with appropriate medical referrals, engage in public information development and dissemination, and facilitate claims documentation to aid individuals who may wish to apply for support under the Radiation Exposure Compensation Act. This program expects to screen 1,450 individuals in FY 2013.
- $7,140,000 for Black Lung Clinics, which is equal to the FY 2012 Enacted Level. The purpose of this program is to commit funds through project grants for establishing clinics that provide for the outreach and education, diagnosis, treatment, rehabilitation, and benefits counseling of active and retired coal miners and other with occupation-related respiratory and pulmonary impairments. This program expects to serve 12,688 miners in FY 2013.
- $11,502,000 for the Telehealth Grants, which is equal to the FY 2012 Enacted Level. The funds will support: (1) TNGP grantees (26 grants, including grants to specifically examine the cost-effectiveness of telehomecare and tele-monitoring services); (2) TRCGP grantees (up to 13 grants); and (3) the Licensure Portability Grant Program (one grant), as well as associated technical assistance and evaluation activities. Funds will also be allocated to support an Interagency Agreement with the Indian Health Service to continue to support the Telehealth Technology Assessment Center. It is expected that the proportion of diabetic patients enrolled in a Telehealth diabetes management program will be 21 percent by FY 2013 for the FY 2012-2015 cohort.

The request includes no funding for the Rural and Community Access to Emergency Devices, for the Small Hospital Improvement Program, for the Denali Commission and for the Delta Health Initiative.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/-FY 2012
27.1: Reduce the proportion of rural residents of all ages with limitation of activities caused by chronic conditions.[1] (Outcome)	FY 2000: 14.67% Target: N/A (Baseline)	N/A	13%	N/A
29.IV.A.3. Increase the number of people receiving direct services through Outreach grants. (Outcome)	FY 2010: 383,776 Target: 380,000 (Target Met)	390,000	395,000	+5,000
27.2: Increase the proportion of critical access hospitals with positive operating margins. (Outcome)	FY 1999: 10% Target: N/A (Baseline)	N/A	60%	N/A
27.V.B.1: Increase the average operating margin of critical access hospitals (Outcome)	FY 2010: -2.04 Target: 0.5% points below FY 2009 (-3.3) (Target Met)	0.5% points below FY 2011	0.5% points below FY 2012	Maintain

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Number of Awards	401	380	360
Average Award	$175,000	$175,000	$175,000
Range of Awards	$75,000-$640,000	$75,000-$640,000	$75,000-$640,000

[1] This is a long-term measure with FY 2013 as a long-term target date. FY 2010 was an earlier long-term target date. The FY 2010 result will be reported in FY 2012.

Grant Awards Table - Telehealth
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Number of Awards	40	40	40
Average Award	$262,195	$262,195	$262,195
Range of Awards	$250,000-$325,000	$250,000-$325,000	$250,000-$325,000

Rural Health Policy Development

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$9,885,000	$9,866,000	$9,866,000	---
FTE	---	---	---	---

Authorizing Legislation - Section 301 of the Public Health Service Act, Section 711 of the Social Security Act.

FY 2013 Authorization ..... Indefinite

Allocation Method ..... Competitive Grant

Program Description and Accomplishments

Rural Health Policy Development activities are a key component of the Office of Rural Health Policy (ORHP) and support a range of policy analysis, research and information dissemination. The Office is charged in its authorizing language to advise the Secretary on how Departmental policies affect rural communities and to conduct research to inform its policy analysis activities. The Office is also charged with supporting information dissemination and the operation of a clearinghouse on national rural health initiatives.

The ORHP Rural Health Research Center Grant Program is a major component of Rural Health Policy Development activities. It is the only Federal research program specifically designed to provide both short- and long-term policy relevant studies on rural health issues. Grants are awarded to six research centers annually. In the past, efforts to understand and appropriately address the health needs of rural Americans were severely limited by the lack of information about the rural population and the impact of Federal policies and regulations on the rural health care infrastructure. The work of the centers is published in policy briefs, academic journals, research papers, and other venues and is made available to policy makers at both the Federal and State levels. In addition to the research center grants, the Rural Health Policy Development Activities also support two additional cooperative agreements that focus on data and trend analysis on new and ongoing policy issues. These agreements are used to support data needs across the Department.

Another major component of Rural Health Policy Development is the Office's work in staffing the National Advisory Committee on Rural Health and Human Services, which advises the Secretary on rural health and human service programs and policies and produces an annual report on critical rural issues for the Secretary.

Rural Health Policy Development also plays an important role in serving as a broker of information on rural health issues through a cooperative agreement with the Rural Assistance Center (RAC). In keeping with the statutory mandate, the office established the RAC as a clearinghouse for anyone in need of rural health policy and program information. The RAC responds individually to hundreds of inquiries each month by both phone and e-mail and disseminates information through its web site and various reports and information guides on a range of key rural health issues.

In FY 2010, the program produced 48 research reports, exceeding the target of 30 reports. This increase is due to improved tracking and monitoring of final reports, policy briefs, manuals, and other resources for rural communities.

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

Funding History

FY	Amount
FY 2008	$8,584,000
FY 2009	$9,700,000
FY 2010	$9,929,000
FY 2011	$9,885,000
FY 2012	$9,866,000

Budget Request

The FY 2013 Request of $9,866,000 is equal to the FY 2012 Enacted Level. Funding will support activities such as the rural health research center grant program as well as general technical assistance and information dissemination related to these issues. This program will support the production of 35 reports in FY 2013 as well as manuals and other resources focusing on identifying best practices in rural communities.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/-FY 2012
28.V.A.1: Conduct and disseminate policy relevant research on rural health issues. (Outcome)	FY 2010: 48 Target: 30 (Target Exceeded)	30	35	+5

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Number of Awards	12	12	12
Average Award	$750,000	$750,000	$750,000
Range of Awards	$150,000-$200,000	$150,000-$200,000	$150,000-$200,000

Rural Health Care Services Outreach, Network and Quality Improvement Grants

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$55,658,000	$55,553,000	$55,553,000	---
FTE	2	2	2	---

Authorizing Legislation - Section 330A of the Public Health Service Act, as amended by P.L. 110-355.

FY 2013 Authorization ..... Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Rural Health Care Services Outreach, Network and Quality Improvement Grants are a subcomponent of the Office of Rural Health Policy (ORHP). The purpose of the grants is to improve access to care, coordination of care, integration of services and to focus on quality improvement. The grants began as a demonstration program in 1993 and were formally authorized in 1996. There are multiple grant programs administered under this authority. All of the grants support collaborative models to deliver basic health care services to the 55 million Americans living in rural areas. The Outreach authority includes a range of programs designed to improve access to and coordination of health care services in rural communities. Four of these programs are part of HRSA's "Improve Rural Health" Initiative to strengthen the regional and local partnerships among rural health care providers, improve recruitment and retention of health care professionals in rural areas, and provide direct health care services. The program supports a wide range of services, including primary medical and dental care, mental health treatment, and health promotion and health education services.

These programs are among the only non-categorical grants within HHS and that allows the grantees to determine the best way to meet local need. This flexibility in funding reflects the unique nature of health care challenges in rural communities and the need to allow communities to determine the best approach to addressing need. Each of the programs focus on making the initial investment in a rural area with the expectation that the community will continue to provide the services at the conclusion of the grant funding. ORHP has begun to focus a great deal on sustainability to demonstrate the impact these programs make in rural communities. ORHP has seen a tremendous increase in the percent of programs that continue once federal funding has ended. Many of these grantees are success stories that may be replicated in other communities.

In addition, ORHP has worked with The Lewin Group and The University of Washington Research Center to develop a generalizable formula which will allow rural communities to

measure the economic impact their community investment makes. The tool will translate project specific impacts into community wide effects such as the number of jobs created, new spending and the impact of new and expanded services. The easy-to-use tool will assist rural programs in assessing their own performance and advocate for resources that contribute to the sustainability of programs and better health care for rural populations. A preliminary retrospective analysis of Outreach grants showed that for every HRSA dollar investment, approximately a $1.40 was generated in the community.

The Rural Health Care Services Outreach program legislation includes five key programs:

Outreach Services Grants, which focus on improving access to care in rural communities through the work of community coalitions and partnerships. These grants often focus on disease prevention and health promotion but can also support expansion of services such as primary care, mental and behavioral health as well as oral health care services. This program is part of the 'Providing direct health care services' and 'Building an evidence base for programs that improve rural community health.' The program will award approximately 80 continuation grants in FY 2013.

Rural Network Development Grants, which support building regional or local partnerships among local hospitals, physician groups, long-term care facilities and public health agencies to improve management of scarce health care resources. This program is part of the 'Strengthening Rural Health Care Infrastructure' component of the "Improve Rural Health initiative." The program expects to award 20 continuation awards in FY 2013. In addition, the program supports a new grant program, the Rural Health Information Technology (HIT) pilot program. The Rural HIT pilot program supports the widespread adoption and use of electronic health records in coordination with the ongoing DHHS activities related to the Health Information Technology for Economic and Clinical Health (HITECH) Act. The program plans to make 40 continuation awards in FY 2013.

Network Planning Grants Program, which began in 2004, provides funds to bring together key parts of a rural health care delivery system so they can work in concert to establish or improve local capacity and coordination of care. In addition, the program supports joint purchasing, bench-marking, and recruitment and retention efforts. This program is part of the 'Strengthening Rural Health Care Infrastructure' component of the "Improve Rural Health" Initiative. The program will award as many as 15 new grants in FY 2013.

Small Health Care Provider Quality Improvement Grants, which began in 2006. These grants help small health care providers focus on specific interventions to improve health care quality in specific chronic disease since rural communities have higher rates of chronic diseases relative to urban areas. Specifically, the program focuses on addressing obesity, cardiovascular disease and diabetes given that rural residents tend to have higher rates of these diseases than their urban counterparts. This program is part of the 'Improving the Quality of Health Care Services in Rural Areas' component of the "Improve Rural Health" Initiative. The program expects to make 60 awards in FY 2013.

The Delta States Network Grant Program, which began in 2001 and provides network development grants to the eight states in the Mississippi Delta for network and rural health infrastructure development. In addition, the program supports chronic disease management, oral health services, and recruitment and retention efforts. Unlike the programs mentioned above, this program is more geographically targeted given the health care disparities across this eight-state region. The program will award 12 grants in FY 2013.

The Rural Health Care Services Outreach Program provided either indirect or direct services for 2,451,969 individuals in FY 2009, which exceeded the target of 930,000. This is a substantial improvement from FY 2008 in which 828,360 individuals were served. This measure was revised to examine the increase in the number of people receiving direct services through the Outreach grant. This measure focuses on only direct patient care such as screenings and treatment which is clearer, easier to interpret, easier to quantify, and, thus, more accurate. In FY 2010, 383,776 people received direct services through this program exceeding the target of 380,000 people.

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

Funding History

FY	Amount
FY 2008	$48,031,000
FY 2009	$53,900,000
FY 2010	$55,905,000
FY 2011	$55,658,000
FY 2012	$55,553,000

Budget Request

The FY 2013 Request of $55,553,000 is equal to the FY 2012 Enacted Level. This funding will continue to support key activities for Rural Health Care Services Outreach, Network and Quality Improvement Grants Programs. In FY 2013, the program will support approximately 80 Outreach Services grants, 12 Delta grants, 60 Network Development grants (which include 40 HIT grants), 60 Quality Improvement grants, and 15 Network Planning grants. ORHP expects that 395,000 people will receive direct services in FY 2013.

Outcomes and Outputs Table

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/-FY 2012
29.IV.A.3. Increase the number of people receiving direct services through Outreach grants. (Outcome)	FY 2010: 383,776 Target: 380,000 (Target Met)	390,000	395,000	+5,000
29.IV.A.2: Increase the proportion of the target population served through Outreach Authority grants. (Outcome)	FY 2010: 4.3% (Baseline)	5%	6%	+1% point
29.IV.A.4: Percent of Outreach Authority grantees that will continue to offer services after the Federal grant funding ends. (Outcome)	FY 2010: 75% Target: N/A (Baseline)	75%	68%	-7% points

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Number of Awards	267	247	227
Average Award	$175,000	$175,000	$175,000
Range of Awards	$75,000-$350,000	$75,000-$350,000	$75,000-$350,000

Rural Access to Emergency Devices

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$236,000	$1,100,000	---	-$1,100,000
FTE	---	2	---	-2

Authorizing Legislation - Section 313 of the Public Health Service Act and Section 413 of the Cardiac Arrest Survival Act of 2000.

FY 2013 Authorization – Rural Access to Emergency Devices.....Expired

FY 2013 Authorization – Public Access Defibrillation Demonstration .....Expired

Allocation Method .....Competitive Grants

Program Description and Accomplishments

The Rural Access to Emergency Devices (RAED) Grant Program began in 2002 and provides funds to community partnerships which then purchase and distribute automatic external defibrillators (AEDs) to be placed in rural communities. The grants also provide training in the use of AEDs by emergency first responders. For the first four years of this program, large grants were given to States through a competitive process and the States then worked with their rural communities to identify where to place the AEDs and how to conduct training in their use. In FY 2006, the program was restructured and began making direct grants to community partnerships.

In FY 2004, additional funding was allocated for the Public Access to Defibrillation Demonstration Projects (PADDP). The purpose of this program is to support grants to political subdivision of states, federally-recognized Native American Tribes, or Tribal Organizations to develop and implement innovative, comprehensive, community-based public access defibrillation demonstration projects. The intent of the grant program is to support projects that will increase public access to emergency medical devices and services.

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

Funding History

FY	Amount
FY 2008	$1,461,000
FY 2009	$1,751,000
FY 2010	$2,521,000
FY 2011	$236,000
FY 2012	$1,100,000

Budget Request

There is no request in FY 2013 for Rural Access to Emergency Devices program and the Public Access Defibrillation Demonstration Project. This is a decrease of $1,100,000 from the FY 2012 Enacted Level. The discontinuation of funding for this program reflects a reprioritization of these funds to other activities within the Office of Rural Health Policy. Activities related to access to emergency medical devices and training in FY 2013 may be addressed through other funding sources available to grantees, such as the Rural Outreach and Rural Network Development programs. Rural residents could use both of these program authorities to support projects that include the purchase of AEDs and training in their use. In FY 2010, the total number of AEDs that were placed in rural communities was 800 which was an increase from 572 in FY 2008. Since the RAED Program was authorized in FY 2002, approximately $32,000,000 has been invested in rural communities to purchase, place and train providers to use AEDs.

Rural Hospital Flexibility Grants

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$41,118,000	$41,040,000	$26,200,000	-$14,840,000
FTE	3	3	3	---

Authorizing Legislation - Section 1820(j), Title XVIII of the Social Security Act.

FY 2013 Authorization ..... Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Rural Hospital Flexibility activities are a component of the Office of Rural Health Policy (ORHP) and support a range of activities focusing primarily on Critical Access Hospitals (CAHs). There are two grant programs administered under this authority. These grant programs are also a part the Improve Rural Health Initiative to strengthen the regional and local partnerships among rural health care providers, improve recruitment and retention of health care professionals in rural areas, and provide direct health care services.

The Medicare Rural Hospital Flexibility (Flex) Grant Program targets funding to over 1,300 critical access hospitals in 45 states. The re-authorization of the Flex Program in 2008 took into account that most conversions of hospitals to critical access hospital status have taken place. The new focus of the program includes providing support for CAHs for quality improvement, quality reporting, performance improvements and benchmarking. This program is part of the Improving the Quality of Health Care Services in Rural Areas' component of the Improve Rural Health Initiative. The Flex Program targets performance improvement and quality improvement activities within the CAH and the community through technical assistance and some direct support to hospitals.

In the past 12 years, the Flex Program and CAH designation has been instrumental in strengthening the infrastructure of these small rural hospitals, as evidenced in the trend of the operating margins improving from operating margins in negative double digits to close to zero. Economic viability is important in ensuring continued access to care, but quality improvement is now just as important. CAHs are not required to report to the Centers for Medicare and Medicaid Hospital Compare quality measures, but are encouraged to do so. The Flex Program includes a benchmarking and quality improvement project this grant cycle, expanding on the existing efforts to increase the percent of CAHs reporting on at least one measure to Hospital Compare, and making quality improvements around the measures reported.

The second program is the Flex Rural Veterans Health Access Program which began in 2010. This three-year program provides grants to three states with high percentage of veterans compared to the total population (Alaska, Montana and Virginia) and focuses on increasing the delivery of mental health services or other health care services deemed necessary to meet the needs of veterans of Operation Iraqi Freedom and Operation Enduring Freedom living in rural areas. The program is targeting increased access for veterans through investments in telehealth and electronic health records for both access to needed services and continuity of care for veterans in rural communities. This program supported three continuation grants in FY 2011 and FY 2012.

Given the larger trends in health care, the Flex Program provides essential support to CAHs and help to prepare them to successfully navigate a future that will emphasize pay for performance and value based purchasing, while improving outcomes and managing growth in health care spending.

Programs	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Rural Hospital Flexibility (Flex) Grant Program	$25,118,000	$25,200,000	$25,200,000
Small Hospital Improvement Program (SHIP)	$15,000,000	$14,840,000	---
Flex Rural Veterans Health Access Program	$1,000,000	$1,000,000	1,000,000

The Flex performance measures also reflect efforts to increase CAH participation in reporting at least one measure to CMS's Hospital Compare. The data posted on the Hospital Compare Website is a key part of the Department's ongoing efforts to increase transparency in the health care system by measuring all hospitals. The FY 2006 baseline for this measure is 63.14 percent of CAHs reporting at least one measure to Hospital Compare. Since FY 2006, there has been a steady progression each year of CAHs reporting at least one measure: 69 percent in FY 2007; 70 percent in FY 2008; 70.3 percent in FY 2009; and 72.6 percent for FY 2010.

Emergency medical services (EMS) are also an important part of the Flex program and help to support quality and viability of rural communities across the continuum of care. The baseline of 3,615 individuals trained in emergency medical services leadership and/or trauma courses was established for FY 2010. The initial result of 3,613 in FY 2008 has declined to 3,002 in FY 2009 and 2,996 in FY 2010. Given the consistency in the last two years of data, grantees have established more accurate reporting on this measure. Program will look into updating the target to reflect the more accurate counts.

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

Funding History

FY	Amount
FY 2008	$37,865,000
FY 2009	$39,200,000
FY 2010	$40,915,000
FY 2011	$41,118,000
FY 2012	$41,040,000

Budget Request

The FY 2013 Request of $26,200,000 is $14,840,000 below the FY 2012 Enacted Level. The reduction would result in discontinuation of new grants in FY 2013 for the Small Hospital Improvement Program (SHIP). The enhancements in the Affordable Care Act for rural hospitals focus heavily on enhancing payment for rural hospitals paid under the Medicare Inpatient Prospective Payment system for inpatient and outpatient services. This lessens the need for the SHIP grants. In addition, 1,300 of the approximately 1,600 hospitals eligible for funding through the SHIP are CAHs and have access to the funding from the Flex Program. The budget request focuses on supporting CAHs by maintaining essential support for the Flex program and its focus on working with CAHs to improve quality. The FY 2013 target for the average operating margin of CAHs is 0.5 percentage point below the FY 2012 result. This funding will continue to support a range of activities focusing on CAHs. The activities supported through this funding will encourage hospitals to report quality data to Hospital Compare and to invest grant dollars in Emergency Medical Services (EMS) training and trauma system development. The program will award 45 grants in FY 2013. Support for the Rural Veterans Health Access Program will allow for continued efforts to increase access for rural veterans to needed services. The program will be competitive in FY 2013, and will support approximately three grants.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
30.V.B.1: Increase the average operating margin of critical access hospitals. (Output)	FY 2010: -2.04% Target: 0.5% points below FY 2009 (-3.3%) (Target Met)	0.5% points below FY 2011	0.5% points below FY 2012	Maintain
30.V.B.4: Increase the percent of Critical Access Hospitals reporting at least	FY 2010: 72.6% Target: 72% (Target Exceeded)	76%	78%	+2% points

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
one measure to Hospital Compare. (Outcome)				
30.V.B.5: Number of individuals trained in emergency medical services leadership and/or trauma courses. (Outcome)	FY 2010: 2,996 Target: 3,615 (Target Not Met)	3,615	3,615	Maintain

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Number of Awards	49	49	48
Average Award	$490,000	$490,000	$490,000
Range of Awards	$256,000-$640,000	$256,000-$640,000	$256,000-$640,000

State Offices of Rural Health

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$10,055,000	$10,036,000	$10,036,000	---
FTE	---	---	---	---

Authorizing Legislation - Section 338J of the Public Health Service Act.

FY 2013 Authorization ..... Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The State Offices of Rural Health (SORH) Grant Program is a key component of the Office of Rural Health Policy (ORHP). The SORH Program was created in 1992 to support rural health care in each of the 50 states by providing grants to states to establish and maintain SORHs. The grantees collect and disseminate health-related information in rural areas. They also provide technical and other assistance to rural health providers, including small rural hospitals. SORHs also help communities recruit and retain health professionals. Each dollar of Federal support for the program is matched by three state dollars. The SORH Program is part of the Improve Rural Health Initiative to strengthen the regional and local partnerships among rural health care providers, improve recruitment and retention of health care professionals in rural areas, and provide direct health care services and falls under the Improve the Recruitment and Retention of Health Care Providers in Rural Areas component of the Initiative.

Two of the SORH measures reflect the technical assistance activities and focus on the number of technical assistance encounters provided directly to clients by SORHs as well as the number of clients (unduplicated) that receive technical assistance directly from SORHs. The number of technical assistance encounters provided directly to clients was has increased from 54,689[1] in FY08 to 64,321 in FY 2009 and to 77,036 in FY 2010. The number of clients receiving technical assistance directly has varied, from was 27,259[2] in FY 2008, increasing in FY 2009 to 29,920, with a decline in FY10 to 22,731. The decline is the result of the better clarification and more accurate counts of the number of unduplicated clients. The third measure reflects the work facilitated by the SORHs through recruitment initiatives in the number of clinician placements. The FY 2008 baseline for this measure is 1,023 and the FY 2009 result is 1,256. The SORHs have been instrumental in helping rural constituents to meet the challenges through sharing

[1,2] These results differ from those shown in the FY 2012 HRSA Online Performance Appendix. They have been adjusted to reflect the accurate count of clients served based on updated information.

information and providing technical assistance around the changing environment that rural health providers face, both with the passage of meaningful use requirements under the American Recovery and Reinvestment Act and the Affordable Care Act.

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

Funding History

FY	Amount
FY 2008	$7,999,000
FY 2009	$9,201,000
FY 2010	$10,005,000
FY 2011	$10,055,000
FY 2012	$10,036,000

Budget Request

FY 2013 Request of $10,036,000 is equal to the FY 2012 Enacted Level. This funding will continue to support key activities for the State Offices of Rural Health Program and will support a grant award to each of the 50 states. It is part of HRSA's Improve Rural Health Initiative to provide technical and other assistance to rural health providers and help rural communities recruit and retain health care professionals. The SORH program anticipates that it will provide 66,932 technical assistance encounters directly to clients in FY 2013. The program also hopes to target 31,134 clients that will receive technical assistance directly from SORHs. Additionally, the program hopes to facilitate 1,260 clinician placements in FY 2013.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/-FY 2012
31.V.B.3: Number of technical assistance (TA) encounters provided directly to clients by SORHs. (Outcome)	FY 2010: 77,036 Target: 68,990 (Target Exceeded)	66,269	66,932	+663
31.V.B.4: Number of clients (unduplicated) that received technical assistance directly from SORHs. (Outcome)	FY 2010: 22,731 Target: 35,225 (Target Not Met)	30,826	31,134	+308
31.V.B.5: Number of clinician placements facilitated by the SORHs through their recruitment initiatives.	FY 2009: 1,256 Target: N/A (Target Not In Place)	1,053	1,260	+207

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/-FY 2012
(Outcome)				

Grant Awards Table
Size of Award

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Number of Awards	50	50	50
Average Award	$178,000	$178,000	$178,000
Range of Awards	$$160,000-$180,000	$$160,000-$180,000	$$160,000-$180,000

Radiation Exposure Screening and Education Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$1,939,000	$1,935,000	$1,935,000	---
FTE	1	1	1	---

Authorizing Legislation - Section 417C of the Public Health Service Act, as amended by P.L. 109-482.

FY 2013 Authorization ..... Indefinite

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Radiation Exposure Screening and Education Program (RESEP), which began in 2002, provides grants to States, local governments, and appropriate health care organizations to support programs for cancer screening for individuals adversely affected by the mining, transport and processing of uranium and the testing of nuclear weapons for the Nation's weapons arsenal. The RESEP grantees also help clients with appropriate medical referrals, engage in public information development and dissemination, and facilitate claims documentation to aid individuals who may wish to apply for support under the Radiation Exposure Compensation Act.

The program measures the total number of individuals screened at RESEP centers each year and demonstrated a steady number in users between FY 2009 (1,373) and FY 2010 (1,371). These results are somewhat lower than the targets due to the rapidly aging former uranium mine worker population in which potential patients have passed away as well as the relocation of this population from the original mining sites. The program partners with the Department of Justice to collect data in support of these measures and has adopted steps to ensure that grantees comply with uniform screening guidelines. In addition, the program has undertaken new outreach strategies to identify where this patient population has relocated and to make them aware of available screening sites.

The program also measures the average cost of the program per individual screened and the results have been shown to be higher in FY 2009 ($1,249) and FY 2010 ($1,251) than the targets. The total number of individuals screened at RESEP centers each year greatly impacts the results for this measure.

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

Funding History

FY	Amount
FY 2008	$1,884,000
FY 2009	$1,952,000
FY 2010	$1,948,000
FY 2011	$1,939,000
FY 2012	$1,935,000

Budget Request

The FY 2013 Request of $1,935,000 is equal to the FY 2012 Enacted Level. This funding will continue to support key activities for Radiation Exposure Screening and Education Program. The program will continue to support eight grantees in FY 2013 and the target for the number of individuals screened is 1,450.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/-FY 2012
32.1: Percent of RECA successful claimants screened at RESEP centers.) [1] (Outcome)	FY 2008: 8.5% Target: N/A (3-year rolling baseline)	N/A	8.8%	N/A
32.2: Percent of patients screened at RESEP clinics who file RECA claims that receive RECA benefits. [1] (Outcome)	FY 2008: 70% Target: N/A (Baseline)	N/A	72%	N/A
32.I.A.1: Total number of individuals screened per year. (Output)	FY 2010: 1,371 Target: 1,400 (Target Not Met)	1,400	1,450	+50
32.E: Average cost of the program per individual screened (Efficiency)	FY 2010: $1,251 Target: $720 (Target Not Met)	$1,397	$1,397	Maintain

[1] This is a long-term measure with FY 2013 as a long-term target date.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Number of Awards	8	8	8
Average Award	$235,827	$235,827	$235,827
Range of Awards	$180,000-$279,000	$180,000-$279,000	$180,000-$279,000

Black Lung

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$7,153,000	$7,140,000	$7,140,000	---
FTE	1	1	1	---

Authorizing Legislation - Federal Mine, Health, and Safety Act of 1977, Section 427(a).

FY 2013 Authorization ..... Indefinite

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Black Lung Program was established in 1980 and provides funds through project grants to public and private entities, including faith-based and community-based organizations, for the purpose of establishing and operating clinics that provide for the outreach and education, diagnosis, treatment, rehabilitation, and benefits counseling of active and retired coal miners and others with occupation-related respiratory and pulmonary impairments. Other patients include steel mill workers, agricultural workers, and others with occupationally-related respiratory and pulmonary disease. As persons with respiratory and pulmonary disease age, their disease severity progresses and their need for health care services increase along with the cost of those services.

In FY 2010, the program supported services to 10,554 miners, below the target of 12,088 miners. The program also provided 23,109 medical encounters in FY 2010, which was slightly below its target of 24,403. These numbers represent a decrease from FY 2009. The decreases are due to the closing of a clinical site and the absence of a staff pulmonologist. It is anticipated that these numbers will increase in the coming year because the clinic has already moved to a new location and the pulmonologist has been replaced.

To target resources and further enhance outreach, the Office of Rural Health Policy (ORHP) conducted an independent evaluation of the program which resulted in the establishment of baselines and targets for its new long-term performance measure, and collection of data on the location of miners.

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

Funding History

FY	Amount
FY 2008	$5,788,000
FY 2009	$7,200,000
FY 2010	$7,185,000
FY 2011	$7,153,000
FY 2012	$7,140,000

Budget Request

The FY 2013 Request of $7,140,000 is equal to the FY 2012 Enacted Level. This funding will continue to support key activities for Black Lung Program. The program expects to fund 15 continuation awards in FY 2013 and meet the target of 12,688 miners served. In addition, the program expects to reach the target of 27,403 medical encounters in FY 2013.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/-FY 2012
33.1: Percent of miners that show functional improvement following completion of a pulmonary rehabilitation program. [1] (Outcome)	FY 2008: 80% Target: N/A (Baseline)	N/A	N/A	N/A
33.I.A.1: Number of miners served each year. (Output)	FY 2010: 10,554 Target: 12,088 (Target Not Met)	12,836	12,688	-148
33.I.A.2: Number of medical encounters from Black Lung each year. (Output)	FY 2010: 23,109 Target: 24,403 (Target Not Met)	26,403	27,403	+1,000
33.E: Increase the number of medical encounters per $1 million in federal funding. (Efficiency)	FY 2008: 80% Target: N/A (Baseline)	4,272	4,372	+100

[1] The target for this measure long-term is 85% (FY 2014).

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Number of Awards	15	15	15
Average Award	$381,562	$381,562	$381,562
Range of Awards	$116,742-$697,740	$116,742-$697,740	$116,742-$697,740

Telehealth

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$11,524,000	$11,502,000	$11,502,000	---
FTE	---	---	---	---

Authorizing Legislation: Section 330I of the Public Health Service Act; as amended by Public Law 107-251, and 330L of the Public Health Service Act; as amended by Public Law 108-163.

FY 2013 Authorization ..... Expired

Allocation Method ..... Competitive Grants/Cooperative Agreements and Contracts

Program Description and Accomplishments

The Office for the Advancement of Telehealth (OAT) administers three grant programs that support telehealth technologies:

- Telehealth Network Grant Program (TNGP), which includes funding for pilot projects to examine the cost impact and value-added from telehome care and tele-monitoring services (Telehealth Networks-Telehomecare). The TNGP also supports activities such as chronic disease management and distance learning.
- Telehealth Resource Center Grant Program (TRCGP), which provides technical assistance to communities wishing to establish telehealth services.
- Licensure Portability Grant Program (LPGP), which assists states to improve clinical licensure coordination across state lines.

As of FY 2009[1], this cohort of TNGP grantees provided a total number of 134 clinical services, across 921 sites in underserved rural communities for a total of 1,055 sites and services. When added to the FY 2008 baseline of 1,295, TNGP grantees supported 2,350 sites and services in these communities since FY 2005, exceeding the target for FY 2009. As a result, a gradual expansion of sites and/or services is evident across the three year project period (FY 2006-2009). In FY 2009, 323 communities had access to pediatric services and 322 communities had access to adult mental health services for which they otherwise would not have had access in the absence of the TNGP grants. Between FY 2008 and FY 2009, these results show a relative increase due to an additional cohort of new grantees that began their project in FY 2009.

In addition, the Program began in FY 2006 to collect data on a long-term measure to assess the program's impact on clinical outcomes in diabetic patients served by the grantees of the TNGP program, targeting control of hemoglobin A1c levels in patients. Since then, ideal glycemic

[1] The OAT next set of results for FY 2010 will be available in March 2012.

control has been gradually achieved, while in FY 2008, 41 percent were able to achieve ideal glycemic control compared to a target of 30 percent. In FY 2009, 44 percent achieved ideal glycemic control, highlighting a continual upward trend.

The OAT Programs are an integral component of the Improve Rural Health Care Initiative to expand the use of telecommunications technologies that increase the access to and quality of health care provided to rural populations. The Telehealth Programs strengthen partnerships among rural health care providers, recruit and retain rural health care professionals, and modernize the health care infrastructure in rural areas. Under the current authorization of the TNGP, the authority allows HRSA to fund both urban and rural sites. In FY 2011, HRSA supported networks in urban underserved communities that are experiencing severe shortages of health care professionals.

In FY 2011, OAT awarded 25 grants that supported telehealth networks and telehomecare networks, 11 Telehealth Resource Grant Program grants were awarded, and one grant to improve licensure coordination among states. A Telehealth Technology Assessment Center was also funded under an interagency agreement with the Indian Health Service to assist the resource centers in providing technical assistance in the selection and evaluation of telehealth technologies.

Table 1. Actual Grant Dollars to be awarded for grants

Programs	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget
Telehealth Network Grant Program	$6,250,000	$6,250,000	$6,250,000
Licensure Portability Grant Program	$350,000	$350,000	$350,000
Telehealth Resource Center Grant Program	$4,150,000	$4,150,000	$4,150,000
Contracts	$449,000	$427,000	$427,000
Interagency Agreements	$325,000	$325,000	$325,000

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

Funding History

FY	Amount
FY 2008	$6,700,000
FY 2009	$7,550,000
FY 2009 Recovery Act	$1,000,000
FY 2010	$11,575,000
FY 2011	$11,524,000
FY 2012	$11,502,000

Budget Request

The FY 2013 Request of $11,502,000 is equal to the FY 2012 Enacted Level. The funds will support: (1) TNGP grantees (26 grants, including grants to specifically examine the cost-effectiveness of telehomecare and tele-monitoring services); (2) TRCGP grantees (up to 13 grants); and (3) The Licensure Portability Grant Program (one grant), as well as associated technical assistance and evaluation activities. Funds will also be allocated to support an Interagency Agreement with the Indian Health Service to continue to support the Telehealth Technology Assessment Center. Through these programs, OAT hopes to increase the proportion of diabetic patients enrolled in a telehealth diabetes case management program to 21 percent in FY 2013 (for the FY 2012-2015 cohort). Additionally, OAT anticipates that 202 communities will have access to adult mental health services and 239 communities will have access to pediatric and adolescent mental health services by FY 2013.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
34.II.A.1: Increase the proportion of diabetic patients enrolled in a telehealth diabetes case management program with ideal glycemic control (defined as hemoglobin A1c at or below 7%). (Outcome)	FY 2009: 44% Target: 14.5% (Target Exceeded)	20%[1]	21%[1]	+1% points[1]

[1] FY 2012 represents a new cohort of patients. It is estimated that in the new cohort 10% of the patients enter in telehealth diabetes case management program with ideal glycemic control (hemoglobin A1c at or below 7%) and, during the first year, this cohort will achieve 21 percent with ideal control.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
34.1: The percent of TNGP grantees that continue to offer services after the TNGP funding has ended. [1] (Outcome)	FY 2005: 100% (Baseline) Target: N/A (Target Not In Place)	N/A	95%	N/A
34.III.D.2: Expand the number of telehealth services (e.g., dermatology, cardiology) and the number of sites where services are available as a result of the TNGP program. [2] (Outcome)	FY 2009: 2,350 Target: 1,371 (Target Exceeded)	2,556	2,565	+9
34.III.D.1: Increase the number of communities that have access to pediatric and adolescent mental health services where access did not exist in the community prior to the TNGP grant. (Outcome)	FY 2009: 323 Target: 207 (Target Exceeded)	223	239	+16
34.III.D.1.1: Increase the number of communities that have access to adult mental health services where access did not exist in the community prior to the TNGP grant. (Outcome)	FY 2009: 322 Target: 175 (Target Exceeded)	188	202	+14
34.E: Expand the number of services and/ or sites provide access to health care as a result of the TNGP program per Federal program dollars expended. [3] (Efficiency)	FY 2009: 250 per Million $ Target: 106 per Million $ (Target Exceeded)	202 per Million $	203 Per Million $	+1 Per Million $

[1] This is a long term measure with FY 2013 as a long-term target date.

[2] Please note: Because this is a demonstration program, every three years each cohort of TNGP grantees "graduates" from its three-year grant while a new cohort of grantees commences a new three-year cycle of grant-supported Telehealth activities. The data are calculated as a cumulative number. However, with each new cohort, the distribution of these services is uncertain. Therefore, the targets for FY2013 may need to be revised if there is evidence of a significant increase in grantees that are providing mental health services.

[3] This measure provides the number of sites and services made available to people who otherwise would not have access to them per million dollars of program funds spent. Every three years a new cohort of grantee commences with a new three-year cycle of grant supported activities, gradually expanding sites and services per dollar invested. With each new cohort, there is a start-up period where services are being put in place but are not yet implemented.

Grant Awards Table
Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Number of Awards	40	40	40
Average Award	$262,195	$262,195	$262,195
Range of Awards	$250,000-$325,000	$250,000-$325,000	$250,000-$325,000

Program Management

Tab

Other Programs

Program Management

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$161,815,000	$159,894,000	$162,517,000	+$2,621
FTE	889	890	892	+2

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

FY 2013 Authorization……...…Indefinite

Allocation Method…….. Other

Program Description and Accomplishments

HRSA's Program Management activity operates programs budgeted in FY 2013 at more than $6 billion. HRSA's mission is to provide the National leadership, resources and services necessary to improve and expand access to quality healthcare for all Americans. To achieve its mission, HRSA requires qualified staff to operate at maximum efficiency. Program Management activity is the primary means of support for FTEs and overhead expenses such as rent, utilities and miscellaneous charges.

Program Management personnel plan, coordinate, and direct technical assistance and program guidance to clients of all of HRSA's authorized programs.

In addition, Program Management supports agency oversight of a broad variety of program operations funded from other sources, which include:
National Practitioner Data Bank;

Health Education Assistance Loan Program; and

Vaccine Injury Compensation Program.

Significant progress has been made in a range of Program Management activities. The effort to continuously improve and secure the Information Technology infrastructure includes improving the perimeter protection through implementation of additional security tools that provide HRSA with a state of the art Intrusion Detection System, while simultaneously reducing physical servers as part of ongoing virtualization and consolidation initiative. The Agency has continued to mature the processes for the initiation, execution, management and oversight of IT Investments through the continued implementation of the HRSA Enterprise Architecture and Capital Planning and Investment Control (CPIC) processes and the more recent implementation of an Enterprise Performance Life Cycle (EPLC) Framework.

Funding for Program Management includes IT funding for the continued development, operations and maintenance of enterprise functionality of the HRSA Electronic Handbooks (EHBs). The EHBs is an IT Investment that supports the strategic and performance outcomes of the HRSA Programs and contributes to their success by providing a mechanism for sharing data and conducting business in a more efficient manner.

The EHBs supports HRSA with program administration, grants administration and monitoring, management reporting, and performance measurement and analysis. The HRSA Data Warehouse is the official repository for current HRSA data and promotes maximum operating efficiency through centralization, reconciliation, and standardization of data across HRSA's various transactional business systems. The Data Warehouse cleanses and standardizes data, applies established business rules to validate the data, and enriches and expands the data available from the sources. The Data Warehouse promotes openness and transparency of government by providing HRSA and the general public with a single source of HRSA programmatic information, related health resources, demographic, and statistical data for analyzing and reporting on HRSA activities with easily accessible, readily-available pre-designed tools, charts, maps, and reports.

The Agency has moved forward with its plans for strategic management of human capital. Substantial progress has been made in terms of de-layering and streamlining. Grants management activities have been standardized and consolidated across the Agency through the Office of Federal Assistance Management. This office plans, awards, and manages HRSA's portfolio of grants and cooperative agreements. It provides leadership, direction and coordination to all phases of grants policy, administration and independent review with oversight for all HRSA activities to ensure that resources are properly used and protected.

HRSA is responsible for oversight of over $1 billion worth of Federal interest. This function is funded out of program management.

Funding History

FY	Amount
FY 2008	$141,087,000
FY 2009	$142,024,000
FY 2010	$147,052,000
FY 2011	$161,815,000
FY 2012	$159,894,000

Budget Request

The FY 2013 Budget Request of $162,517,000 is $2,623,000 above the FY 2012 Enacted level. The total request will support funding for salaries, benefits and Parklawn expenses.

HRSA is committed to improving the quality of output at a lower cost and improving the speed of government operations. As a part of the SAVE award initiative, HRSA has launched different

programs to maximize energy efficacy and reduce travel costs and support of Telehealth participation. HRSA is working towards its goal to reduce the IT network infrastructure and data center footprint by twenty percent. In addition, HRSA is reducing travel costs and supporting telework participation by increasing the agency- wide utilization of web collaboration tools by twenty- five percent, which will lead to greater business productivity.

Outcomes and Outputs Table

Measure	Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2011
35.VII.B.1.: Ensure Critical Infrastructure Protection: Security Awareness Training (Output)	FY 2011: Full participation in Security Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation in Executive Awareness training by 100% of HRSA executive staff. (Target Met)	Full participation in Security Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation in Executive Awareness training by 100% of HRSA executive staff.	Full participation in Security Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation in Executive Awareness training by 100% of HRSA executive staff.	---
35.VII.B.2: Ensure Critical Infrastructure Protection: Security Authorization to Operate(Output)	FY 2011: 100% of HRSA information systems have been Certified and Accredited and granted Authority to Operate. (ATO). (Target Met)	All HRSA new systems will be assessed and authorized to operate prior to going into production. All existing systems that are due for re-authorization will be reassessed and reauthorized to operate.	100% of HRSA information systems will be assessed and authorized to operate (ATO).	---

Measure	Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2011
35.VII.B.3: Capital Planning and Investment Control (Output)	FY 2011: 1)100% of major/tactical IT investments with acceptable business cases; 2) 0% of major/tactical investments on the Management Watch List (MWL)/High Variance List; 3) 50% of all DME projects from major/tactical investments executed in alignment with EPLC; 4) All IT Project managers are trained in EPLC framework and the use of the selected PPM tool. (Target Met)	1) 100% of major investments will receive an IT Dashboard Overall Rating of "Green", which indicates an acceptable cost, schedule and Agency CIO Rating; 2) 100% of major Investment Managers will be in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM).	1) 100% of major investments will receive an IT Dashboard Overall Rating of "Green", which indicates an acceptable cost, schedule and Agency CIO Rating; 2) 100% of major Investment Managers will be in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM).	---
35.VII.A.3: Strengthen Program Integrity (PI) Activities	FY 2011: (1) Six additional PI staff added to regions and three added to HQ to increase auditing/site visit capability.(2) HRSA PI Workgroup initiated development of online PI toolkit to provide standardized PI information and reference tools (Target Not in Place)	Add 4 PI staff to result in one per region. Implement Phase 1 of the online PI toolkit, including HHS and HRSA-wide guidance, information and reference tools.	1) Maintain regional PI staffing at one per region. 2) Implement Phase 2 of the online PI toolkit through the addition of program specific guidance, information, and reference tools.	---

Family Planning

Tab

Family Planning

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 +/- FY 2012
BA	$299,400,000	$293,870,000	$296,838,000	+$2,968,000
FTE	30	30	30	---

Authorizing Legislation: Title X of the Public Health Service Act

FY 2013 Authorization…….expired

Allocation Method ..... Competitive Grant, Contract, Direct

Program Description and Accomplishments

The Title X Family Planning program is the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. Enacted in 1970 as part of the Public Health Service Act, the Title X program is designed to provide access to contraceptive services, supplies and information to all who want and need them. By law, priority is given to persons from low-income families.

The public health value of family planning services is well documented. Cited by the Centers for Disease Control and Prevention (CDC) in 1999 as one of the greatest public health achievements of the 20th century, family planning services have been used by millions of individuals in the United States and around the world (CDC, 1999). In this spirit, the Title X Family Planning program is committed to the delivery of high-quality family planning and reproductive health services to all women and men who want them. Guided by nationally recognized standards of care, all Title X funded family planning centers provide contraceptive methods, education and counseling, as well as related preventive health services to their clients.

The Title X program has greatly contributed to decreasing unintended pregnancy among women and families, as well as significantly reducing these rates among teens and young adults. Historically, of the more than 5 million individuals served each year in Title X clinics, approximately 1.15 million are adolescents (under 20 years of age) and more than 2.7 million are under 25 years of age. By providing comprehensive family planning and related reproductive and preventive health services (such as STD and HIV prevention, education and screening), unintended pregnancy, infertility and related morbidity have been reduced for these populations.

In order to ensure that the Title X family planning program is responsive to the ever-changing needs of the public, as well as adhering to the letter and spirit of the statute, the program commissioned a two-year independent evaluation by the Institute of Medicine (IOM), completed in May 2009. The IOM committee found the Title X program to be extremely resilient and valuable, especially in providing family planning services to its priority population, individuals from low-income families. In addition, the IOM offered several recommendations supporting

the Secretary's Strategic Initiative - to accelerate the process of scientific discovery through the use of evidence-based practices, and Interagency Collaborations to reduce teen and unintended pregnancy. Some of the IOM recommendations include:

- Reassert family planning as a core value in public health practice;
- Increase program funding so statutory responsibilities can be met;
- Improve the continuity of products provided to clients of Title X clinics (increase range of highly effective contraceptives available at Title X clinics); and
- Develop and implement a multi-year strategic planning process.

As a result of the IOM study, the program has begun to address a number of recommendations that emerged. In addition, the program has contracted with the IOM to form a Standing Committee to assist the Title X program in strategic planning and conducting additional studies related to strengthening the infrastructure and long-term goals of the Title X family planning program.

The Title X program is able to fulfill its mission by awarding grant funds to public and private not-for-profit organizations to support the provision of family planning clinical services and information. Services are provided through 92 service delivery grants that support a nationwide network of approximately than 4,400 community-based clinics that provide services to more than 5,000,000 persons annually. Grantees include State and local health departments, hospitals, community health centers, Planned Parenthoods, and other private nonprofit agencies. There is at least one Title X services grantee in every state and U.S. Territory. Title X Family Planning program regulations require that projects provide a broad range of effective and acceptable family planning methods and related preventive health services. At least 90 percent of Title X program funds are used to provide clinical services, and findings from a Guttmacher Institute study found that for more than half of clients, publicly funded family planning clinics such as Title X clinics, are reported to be their "usual" or only continuing source of health care and/or health education. Historically, at least 90 percent of the clients served each year have family incomes at or below 200 percent of the Federal poverty level.

The Title X program also supports three key functions aimed at assisting clinics in responding to clients' needs: (1) training for all levels of family planning clinic personnel through training programs; (2) information dissemination and community-based education and outreach activities; and (3) data collection and research to improve the delivery of family planning services.

In addition, each year the Program establishes a set of program-wide priorities that provide guidance to ensure high-quality, responsive and appropriate family planning service delivery. In the past several years, the priorities have focused on long-term and capacity building goals, including expanding access to a broad range of effective and acceptable family planning methods, ensuring that services are provided in accordance with nationally recognized standards of care and identifying specific strategies for addressing specific provisions of health care reform ("the Patient Protection and Affordable Care Act").

As healthcare costs continue to rise, the ability to address and meet the service needs of individuals within communities that Title X family planning centers serve, has become more

difficult. Since FY 2007, the program has focused on improving clinic efficiency in an effort to address increasing cost of health care without sacrificing quality. As a result, the program has directed its national training priority to develop region-specific plans to address clinic efficiency, quality assurance/continuous quality improvement, appropriate staffing patterns, purchasing strategies, and other cost saving measures, all aimed at more effectively addressing client needs and mitigating the effects of medical cost increases. By reducing the amount of time it takes a client to complete his or her appointment, reducing operating costs, and creating more efficient administrative procedures, more clients can receive services. In FY 2010, the program began assessing and evaluating these efforts and the impact on Title X family planning service delivery. The final analyses of the evaluations are in the process of being completed but it appears that these targeted training strategies have contributed to some extent to a decrease in the cost per client via controlling cost and increasing clinic efficiency.

In 2010, the most recent year for which final data are available, the program accomplished the following: Served 5,224,862 clients (an increase of approximately 38,600); averted approximately 996,000 unintended pregnancies, more than 219,000 among teens; and prevented at least 570 cases of invasive cervical cancer through the services provided by Title X funded centers. In addition, over 1.41 million screenings for Chlamydia infection were performed in 15 – 24 year old females, contributing to the prevention of 570 cases of STD-related infertility. Targets were exceeded for the number of unduplicated clients served in Title X clinics and the number of screenings for Chlamydia infection in females ages 15 – 24. Though the number of unintended pregnancies averted did not meet the target, the number increased by over 2,200 from 2009. Based on epidemiological data, in 2003 and most recently in 2009, changes in recommendations were issued by nationally recognized organizations that establish standards of care for cervical cancer screening (e.g., ACOG, ACS, USPSTF), resulting in cervical cancer screening being initiated later in life, and performed less frequently. As a result, fewer overall screening tests for cervical cancer are being performed in Title X clinics. This is illustrated by data indicating the proportion of women who were screened for cervical cancer in Title X family planning centers decreased from 52 percent in 2005 to 36 percent in 2010, down from 42% in 2009. In addition, the number of cases of invasive cervical cancer prevented each year is calculated based on the unduplicated number of female clients who received a Pap test during the year.

Despite the rise in medical care costs at the National level, the family planning program has historically been able to maintain the average cost per Title X client at or below the medical care rate of inflation. In 2010, the program preformed better than its projected target, however its costs grew at a rate slightly faster than the Consumer Price Index (CPI) for medical care (4.3% versus 3.4). Over the past three years the program has had a net growth. In 2008, the average cost per Title X client was $239.83, and in 2009, it actually decreased to $237.42, a $2.41 decrease (1.0% decrease). Then in 2010, the average cost per client rose to $247.63, an increase of $10.21 or 4.3% over the previous year. However over the three years, the net increase was 3.25%, significantly lower than the net increase in the Consumer Price Index for Medical Care over the same period of time (2008 – 2010) of 6.69% or $24.37% (source: Bureau of Labor Statistics). Though the reason for the rise from 2009 to 2010 can likely be attributed to multiple influences, over the past year many Title X agencies have begun investing in technology and

other infrastructure advancements to prepare for electronic medical records and other aspects of the Affordable Care Act.

Funding History

FY	Amount
FY 2008	$299,981,000
FY 2009	$307,491,000
FY 2010	$316,832,000
FY 2011	$299,400,000
FY 2012	$293,870,000
FY 2013	$296,838,000

Budget Request

The FY 2013 Budget Request of $296,838,000 is $2,968,000 above the FY 2012 Enacted Level. The budget request provides funding for family planning methods and related preventive health services, as well as related training, information and education and research to improve family planning service delivery. Family planning service projects enable the program to achieve the overall goal of providing family planning and related preventive health services to individuals in the communities served by Title X family planning centers.

The FY 2013 request is expected to support family planning services for approximately 5,000,000 persons, with at least 90 percent having family incomes at or below 200 percent of the federal poverty level. These services include the provision of family planning methods, education, counseling and related preventive health services. The performance of the program is reflected in the outcome measures developed during its performance assessment. These outcomes include preventing approximately 1,600 cases of infertility through Chlamydia screening of 1,340,000 females ages 15 - 24, preventing 519 cases of invasive cervical cancer through cervical cancer screening, and preventing approximately 961,000 unintended pregnancies in 2013. Although the program will continue to emphasize efficiency, the targets for FY 2013 are ambitious and assume that other sources of revenue that contribute to the family planning program at the grantee level will remain at historical proportions of the total Title X revenue.

At least 90 percent of funding will continue to be used for clinical family planning services as defined under Section 1001 of the Title X statute. Funding will continue for Chlamydia screening in an effort to decrease infertility related to untreated Chlamydia infection, screening for undiagnosed cervical tissue abnormalities (ultimately reducing the morbidity related to the number of cases of invasive cervical cancer), and providing a broad range of contraceptive methods and related education and counseling, thereby reducing the number of unintended pregnancies. The request includes plans to continue working with a Standing Committee of the Institute of Medicine to advise the program on a range of scientific, workforce, health services and education issues relevant to the family planning program. Specifically, the Standing Committee will address the following topics: strategic planning for advancing the Title X program, workforce planning, improving data collection on program performance, and

improving communication and transparency within the Title X program, all recommendations offered as part of the IOM independent evaluation. In addition, the committee will examine the role of family planning/reproductive health (including the Title X program) in health care reform. Family planning centers will be encouraged and trained to provide a broad range of contraceptives, with a focus on expanding the availability of long-acting reversible methods, and will also be encouraged to transition to use of electronic health records and electronic practice management systems. In addition, special emphasis will be placed on Title X family planning centers to maximize their ability to bill third parties, including becoming engaged in insurance exchanges.

In addition, the program aims to have new Title X Family Planning Services Guidelines by the beginning of FY 2013. This will culminate a two-year process consisting of technical panels made up of subject matter experts as well as examinations of thousands of relevant, evidence-based publications and resources, systematic reviews of scientific evidence and consideration of innovative approaches. All of this information will lead to a set of revised guidelines with a foundation of empirical evidence and information supporting clinical practice. This will ultimately contribute widely to guiding the provision of family planning and reproductive health services regardless of the service setting.

The program will continue to seek ways to increase efficiencies to maximize the level of services despite the increasing costs of pharmaceuticals, providers and screening and diagnostic technologies with the goal of maintaining the actual cost per client below the medical care inflation rate. The continued increase to the already elevated cost of highly effective contraceptive and diagnostic methods and the increasing costs for medical providers as well as the added expenses of electronic systems are significant challenges to maintaining the level of services to clients or to serving additional clients. The program will continue to seek ways to increase competition for family planning service funds, targeting areas that currently lack access to family planning services.

Outputs and Outcomes Tables

Long Term Objective: Increase the number of unintended pregnancies averted by providing Title X family planning services, with priority for services to low-income individuals.

Measure	Year and Most Recent Result/ Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
36.II.A.1: Increase the total number of unduplicated clients served in Title X clinics by 5% over five years. *(Outcome)*	FY 2010: 5,224,862 Target: 5,223,000 (Target Exceeded)	4,969,600	4,996,600	+27,000
36.II.A.2: Maintain the proportion of clients served who are at or	FY 2010: 90% Target: 90% (Target Met)	90%	90%	Maintain

Measure	Year and Most Recent Result/ Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
below 200% of the Federal poverty level at 90% of total unduplicated family planning users. *(Outcome)*				
36.II.A.3: Increase the number of unintended pregnancies averted by providing Title X family planning services, with priority for services to low-income individuals. *(Outcome)*	FY 2010: 995,861 Target: 1,024,000 (Target Not Met but Improved)	949,300	961,300	+12,000

Long Term Objective: Reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15 – 24.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
36.II.B.1: Reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15-24. *(Outcome)*	FY 2010: 1,417,219 Target: 1,413,000 (Target Exceeded)	1,296,300	1,340,300	+44,000

Long Term Objective: Reduce invasive cervical cancer among women attending Title X family planning clinics by providing Pap tests.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
36.II.C.1: Increase the number of unduplicated female clients who receive a Pap test. *(Outcome)*	FY 2010: 1,727,251 Target: 2,478,000 (Target Not Met)	1,654,900	1,571,400	-83,500
36.II.C.2: Reduce invasive cervical cancer among women attending Title X family planning	FY 2010: 570 Target: 835 (Target Not Met)	546	519	-27

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
clinics by providing Pap tests. *(Outcome)*				

Efficiency Measure:

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
36.E: Maintain the actual cost per Title X client below the medical care inflation rate. *(Efficiency)*	FY 2010: $247.63 Target: $258.87 (Target Exceeded)	$280.66	$292.23	+$11.57

Grant Awards Tables - Size of Awards

(whole dollars)	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Number of Awards	90	94	94
Average Award	$2,994,000	$2,813,600	$2,842,600
Range of Awards	$169,800 - $21,238,000	$166,700 - $20,800,000	$168,300 - $21,050,000

Supplementary Tables

TAB

Budget Authority by Object Class
Discretionary
(Dollars in thousands)

Personnel compensation:	**FY 2012 Enacted**	**FY 2013 Request**	**Increase or Decrease**
Full-time permanent (11.1)	122,448	125,076	+2,628
Other than full-time permanent (11.3)	5,466	5,473	+7
Other personnel compensation (11.5)	4,098	4,231	+133
Military personnel (11.7)	14,267	14,496	+229
Special personnel services payments (11.8)	662	496	-166
Subtotal personnel compensation	**146,941**	**149,772**	**+2,831**
Civilian benefits (12.1)	34,790	35,425	+635
Military benefits (12.2)	7,664	7,793	+129
Benefits to former personnel (13.1)	56	58	+2
Total Pay Costs	**189,451**	**193,048**	**+3,597**
Travel and transportation of persons (21.0)	2,954	2,914	-40
Transportation of things (22.0)	220	220	--
Rental payments to GSA (23.1)	20,099	20,099	--
Rental payments to Others (23.2)	1,722	1,722	--
Communication, utilities, and misc. charges (23.3)	1,404	1,404	--
Printing and reproduction (24.0)	504	431	-73
			--
Other Contractual Services: 25.0	1	1	--
Advisory and assistance services (25.1)	38,321	38,320	-1
Other services (25.2)	122,644	121,249	-1,395
Purchase of goods and services from			--
government accounts (25.3)	175,160	168,750	-6,410
Operation and maintenance of facilities (25.4)	1,494	1,494	--
Research and Development Contracts (25.5)	-	-	--
Medical care (25.6)	2,908	2,908	--
Operation and maintenance of equipment (25.7)	12,691	12,651	-40
Subsistence and support of persons (25.8)	44	44	--
Discounts and Interest (25.9)	330	330	--
Supplies and materials (26.0)	1,238	1,238	--
Subtotal Other Contractual Services	**354,831**	**346,985**	**-7,846**
Equipment (31.0)	2,293	2,292	-1
Investments and Loans (33.0)	-	-	--
Grants, subsidies, and contributions (41.0)	5,543,299	5,409,782	-133,517
Insurance Claims and Indemnities (42.0)	88,974	88,965	-9
Total Non-Pay Costs	**6,016,300**	**5,874,814**	**-141,486**
Total Budget Authority by Object Class	**6,205,751**	**6,067,862**	**-137,889**

Salaries and Expenses

Discretionary

(Dollars in thousands)

Personnel compensation:	**FY 2012 Enacted**	**FY 2013 Request**	**Increase or Decrease**
Full-time permanent (11.1)	122,448	125,076	+ 2,628
Other than full-time permanent (11.3)	5,466	5,473	+ 7
Other personnel compensation (11.5)	4,098	4,231	+ 133
Military personnel (11.7)	14,267	14,496	+ 229
Special personnel services payments (11.8)	662	496	-166
Subtotal personnel compenstion	**146,941**	**149,772**	**2,831**
Civilian benefits (12.1)	34,790	35,425	+ 635
Military benefits (12.2)	7,664	7,793	+ 129
Benefits to former personnel (13.1)	56	58	+ 2
Total Pay Costs	**189,451**	**193,048**	**3,597**
			-
Travel and transportation of persons (21.0)	2,954	2,914	-40
Transportation of things (22.0)	220	220	-
			-
Rental payments to Others (23.2)	1,722	1,722	-
Communication, utilities, and misc. charges (23.3)	1,404	1,404	-
Printing and reproduction (24.0)	504	431	-73
			-
Contractual Services:			-
Other Contractual Services: 25.0	1	1	-
Advisory and assistance services (25.1)	38,321	38,320	-1
Other services (25.2)	122,644	121,249	-1,395
Purchase of goods and services from			-
government accounts (25.3)	88,160	84,750	-3,410
Operation and maintenance of facilities (25.4)	1,494	1,494	-
Medical care (25.6)	2,908	2,908	-
Operation and maintenance of equipment (25.7)	12,691	12,651	-40
Subsistence and support of persons (25.8)	44	44	-
Discounts and Interest (25.9)	330	330	-
Supplies and materials (26.0)	1,238	1,238	-
Subtotal Other Contractual Services	**267,831**	**262,985**	**-$4,959**
			-
Total Non-Pay Costs	**274,635**	**269,676**	**-$4,959**
Total Budget Authority by Object Class	**464,086**	**462,724**	**-$1,362**

Health Resources and Services Administration

Detail of Full Time Equivalents (FTE)

Programs	2011 Actual Civ	2011 Actual Mil	2011 Actual Total	2012 Enacted Civ	2012 Enacted Mil	2012 Enacted Total	2013 PB Civ	2013 PB Mil	2013 PB Total
Bureau of Primary Health Care:									
Direct:									
Health Centers/Tort	117	18	135	117	18	135	117	18	135
Free Clinics Medical Malpractice	2	-	2	2	-	2	2	-	2
Community Health Center Fund (ACA)	55	1	56	55	1	56	73	3	76
HC- Facilities Construction/NHSC (ACA)	18	2	20	18	2	20	-	-	-
School-based Health Centers- Facilities (ACA)	9	-	9	9	-	9	9	-	9
Hansen's Disease Center	54	7	61	54	7	61	54	7	61
Reimbursable:									
Hansen's Disease Center.	3	-	3	3	-	3	3	-	3
Total:	**258**	**28**	**286**	**258**	**28**	**286**	**258**	**28**	**286**
Bureau of Health Professions:									
Direct:									
Health Workforce Information Analysis	6	-	6	6	-	6	-	-	-
Scholarships for Disadvantaged Students	3	-	3	3	-	3	3	-	3
Centers for Excellence	1	-	1	1	-	1	1	-	1
Health Careers Opportunity	1	-	1	1	-	1	-	-	-
Training in Primary Care Medicine/ Dentistry	3	-	3	3	-	3	3	-	3
Children's Hospitals Medical Education	29	2	31	29	2	31	19	2	21
Nurse, Education, Practice	2	-	2	2	-	2	2	-	2
Advanced Education Nursing Program	4	-	4	4	-	4	4	-	4
Geriatrics Program	3	2	5	3	2	5	3	2	5
Patient Navigator Outreach	2	-	2	-	-	-	-	-	-
GME Payments for Teaching Health Ctrs (ACA)	4	-	4	4	-	4	4	-	4
State Grants for Personal Home Hlth Aids (ACA)	2	-	2	2	-	2	2	-	2
Public Health/Preventive Medicine	1	-	1	1	-	1	1	-	1
Nurse Workforce Diversity	1	-	1	1	-	1	1	-	1
Nurse Faculty Loan	1	-	1	1	-	1	1	-	1
Allied Health	1	-	1	-	-	-	-	-	-
Area Health Education Centers	2	-	2	2	-	2	-	-	-
Oral Health Training	3	-	3	3	-	3	3	-	3
Mental and Behavioral Health	1	-	1	1	-	1	1	-	1
Comprehensive Geriatric Education	1	-	1	1	-	1	1	-	1
HEAL	13	-	13	13	-	13	13	-	13
Reimbursable:									
Health Workforce Information Analysis	-	-	-	-	-	-	6	-	6
National Practitioner Data Bank	36	1	37	40	1	41	40	1	41
Healthcare Integrity & Protection Data Bank	4	-	4	-	-	-	-	-	-
Total:	**124**	**5**	**129**	**121**	**5**	**126**	**108**	**5**	**113**

Programs	2011 Actual Civ	2011 Actual Mil	2011 Actual Total	2012 Enacted Civ	2012 Enacted Mil	2012 Enacted Total	2013 PB Civ	2013 PB Mil	2013 PB Total
Bureau of Clinician Recruitment & Service:									
Direct:									
National Health Service Corps (ACA)	140	50	190	186	51	237	186	51	237
Total:	**140**	**50**	**190**	**186**	**51**	**237**	**186**	**51**	**237**
Nurse Loan Repayment & Scholarships	25	4	29	25	4	29	25	4	29
Maternal and Child Health Bureau:									
Direct:									
Autism and Other Developmental Disorders.	6	1	7	6	1	7	6	1	7
Heritable Disorder Newborn Screening	3	-	3	3	-	3	3	-	3
Universal Newborn Screening	4	-	4	4	-	4	4	-	4
Block Grant	29	1	30	29	1	30	26	1	27
Healthy Start .	4	-	4	4	-	4	4	-	4
Family to Family Health Info Centers (ACA)	1	-	1	1	-	1	-	-	-
Maternal, Infant & Early Childhood Visitation (ACA)	16	3	19	16	3	19	16	3	19
Emergency Medical Services for Children	4	-	4	4	-	4	4	-	4
Sickle Cell Program	2	-	2	2	-	2	2	-	2
Traumatic Brain Injury	-	-	-	-	-	-	-	-	-
Total:	**69**	**5**	**74**	**69**	**5**	**74**	**65**	**5**	**70**
HIV/AIDS Bureau:									
Direct:									
Ryan White Part A	18	1	19	18	1	19	18	1	19
Ryan White Part B	51	1	52	51	1	52	51	1	52
Ryan White Part C	25	6	31	25	6	31	25	6	31
Ryan White Part D	4	-	4	4	-	4	4	-	4
Ryan White Part F	3	-	3	3	-	3	3	-	3
Ryan White Part F Dental	1	-	1	1	-	1	1	-	1
Reimbursable:									
OGAC Global AIDS	12	3	15	12	3	15	12	3	15
Total:	**114**	**11**	**125**	**114**	**11**	**125**	**114**	**11**	**125**
Healthcare Systems Bureau:									
Direct:									
C.W.Bill Young Cell Transplantation Program	7	-	7	7	-	7	7	-	7
Cord Blood Stem Cell Registry	3	-	3	3	-	3	3	-	3
Poison Control Centers	4	-	4	4	-	4	4	-	4
Covered Countermeasures Compensation	4	1	5	4	1	5	4	1	5
340B Drug Pricing Program/Office of Pharmacy Affairs	1	-	1	1	-	1	1	-	1
Reimbursable:									
Vaccine	20	2	22	20	2	22	20	2	22
DHHS/ACYF	1	-	1	1	-	1	1	-	1
Total:	**40**	**3**	**43**	**40**	**3**	**43**	**40**	**3**	**43**
Office of Rural Health Policy:									

Programs	2011 Actual Civ	2011 Actual Mil	2011 Actual Total	2012 Enacted Civ	2012 Enacted Mil	2012 Enacted Total	2013 PB Civ	2013 PB Mil	2013 PB Total
Direct:									
Outreach	2	-	2	2	-	2	2	-	2
Radiogenic Diseases	1	-	1	1	-	1	1	-	1
Black Lung	1	-	1	1	-	1	1	-	1
Rural AED	-	-	-	2	-	2	-	-	
Rural Hospital Flexibility Grants.	3	-	3	3	-	3	3	-	3
State Office of Rural Health	-	-	-	-	-	-	-	-	-
Rural Health Policy Development	-	-	-	-	-	-	-	-	-
Telehealth	-	-	-	-	-	-	-	-	-
Total:	**7**	-	**7**	**9**	-	**9**	**7**	-	**7**
Family Planning (Direct)	22	8	30	22	8	30	22	8	30
Program Management (Direct)	792	97	889	793	97	890	795	97	892
Subtotal Reimbursables (non add)	76	6	82	76	6	82	82	6	88
Subtotal Direct (non add)	1515	205	1720	1561	206	1767	1538	206	1744
OPDIV FTE Total (including HEAL)	**1591**	**211**	**1802**	**1637**	**212**	**1849**	**1620**	**212**	**1832**
Recovery Act FTE	57	1	58	-	-	-	-	-	-
Total:	**1648**	**212**	**1860**	**1637**	**212**	**1849**	**1620**	**212**	**1832**
OPDIV FTE Total (excluding HEAL)	**1648**	**212**	**1860**	**1637**	**212**	**1849**	**1607**	**212**	**1819**

	Average GS Grade
2009	12.50
2010	12.50
2011	12.50
2012	12.50
2013	12.50

Programs Proposed for Elimination

The following list shows the programs proposed for elimination or consolidation in the FY 2013 Budget Request. Termination of these programs frees up approximately $43.1 million (discretionary) and $5.0 million (mandatory) based on the FY 2012 levels for priority health programs that have demonstrated a record of success or that hold significant promise for increasing accountability and improving health outcomes. Following each program is a brief summary and the rationale for its elimination.

Program	FY 2012 Dollars in Millions
Discretionary	
Health Careers Opportunity Program	$ 14.8
Area Health Education Centers	$ 27.2
Rural & Community Access to Emergency Devices	$ 1.1
Total Discretionary	**$ 43.1**
Mandatory	
Family to Family Health Information Centers	$ 5.0
Total Mandatory	**$ 5.0**

Program Descriptions

Discretionary

Health Careers Opportunity Program (-$14.8 million)

Although increasing diversity in the health professions is a high priority, expenditure of health professions funds is better spent on service providing clinicians at this tight budgetary time.

Area Health Education Centers (-$27.2 million)

Although expanding the dispersal of health professions trainees is a high priority, expenditure of health professions funds is better spent on service providing clinicians at this tight budgetary time.

Rural & Community Access to Emergency Devices (-$1.1 million)

Activities related to access to emergency medical devices and training in FY 2013 may be addressed through other funding sources available to grantees, such as the Rural Outreach and Rural Network Development programs.

Mandatory

Family to Family Health Information Centers: (-$5.0 million)

Centers disseminating family based information may work through state and FQHCs to implement medical/health homes without separate Federal MCH funding.

Health Professions Loan Programs

HRSA is responsible for the administration of the following revolving loan programs: Health Professions Student Loan (HPSL) Program, the Nursing Student Loan (NSL) Program, Loans for Disadvantaged Students (LDS), and the Primary Care Loans (PCL).

These programs were initially financed through appropriations to the revolving loan funds. Appropriations ceased in 1984.

These programs are financed through revolving accounts (Federal Capital Contribution) and do not receive annual appropriations. Through these revolving fund accounts, the HPSL, PCL, LDS, and NSL programs award funds to institutions that in turn provide loans to individual students. As borrowers pay back loans the program's revolving account gets replenished, and the collected funds are then used to make new loans in the following academic year. If the program's revolving account has excess funds that will not be used to provide new loans, these excess funds are returned to HRSA. Funds returned to HRSA are then awarded to programs that are in need of additional funds. Therefore, the funding awarded each year fluctuates and is dependent upon the amount of loans repaid into the revolving account. The HPSL, PCL, LDS, and NSL programs aim to expand high-quality educational opportunities to those students, including racial and ethnic minorities and disadvantaged students, who otherwise could not afford a health professions education.

The information below reflects preliminary data for Academic Year 2010-2011and was derived from the 2011 Annual Operating Report.

	Number of Programs[1]	Number of Borrowers	Account Balance
HPSL	154	33,204	$370,561,960
PCL	132	4,107	$249,867,755
LDS	175	7,324	$129,792,459
NSL	373	43,833	$168,762,018
Total	834	88,468	$918,984,192

New Awards in Academic Year 2010-2011 were as follows:

	Number of New Loans	Amount of New Funds Awarded
HPSL	13,666	$42,610,113
PCL	1,416	$24,858,322
LDS	1,685	$20,614,459
NSL	12,443	$26,641,387
Total	29,210	$114,724,281

[1] Programs refer to the number of disciplines (e.g., allopathic medicine, nursing, etc.) that maintained a revolving fund account)

Physicians' Comparability Allowance (PCA) Worksheet

Table 1

		PY 2011 (Actual)	CY 2012 (Estimates)	BY 2013* (Estimates)
1) Number of Physicians Receiving PCAs		36	41	45
2) Number of Physicians with One-Year PCA Agreements		4	4	4
3) Number of Physicians with Multi-Year PCA Agreements		32	37	41
4) Average Annual PCA Physician Pay (without PCA payment)		$146,628	$147,896	$148,402
5) Average Annual PCA Payment		$ 23,500	$24,381	$24,622
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	2	2	2
	Category II Research Position	0	0	0
	Category III Occupational Health	0	0	0
	Category IV-A Disability Evaluation	0	0	0
	Category IV-B Health and Medical Admin.	33	38	42

*FY 2013 data will be approved during the FY 2014 Budget cycle.

7) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

The necessity for the 1 extra category, are due to the special projects in the Bureaus that require a wide range of specialties.

	2011	2012	2013
Category IV – C	1	1	1

8) Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

For each category, the amount of PCA given is to retain highly qualified medical officers that could potentially be paid more in the private sector.
Category IV – B - $30,000
Category IV – C - $30,000

9) Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist).

PCA is used to recruit and retain highly qualified medical officers. It is difficult to compete with private industry salaries. If we weren't able to use PCA, we would lose many talented medical officers that help HRSA meet our goals and mission.

10) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

HRSA had one retiree and one medical officer who resigned receiving PCA. HRSA has been able to retain a high rate of our medical officers using this mechanism.

11) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

N/A

FY 2013 Budget by HHS Strategic Goal

(Dollars in Millions)

HHS STRATEGIC GOALS AND OBJECTIVES	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
1 Strengthen Health Care	$6,625.076	5,179.029	5,296.751
1.A: Make coverage more secure for those who have insurance and extend affordable coverage to the uninsured			
1.B: Improve health care quality and patient safety	367.849	376.365	429.994
1.C: Emphasize primary and preventive care linked with community prevention	399.125	397.083	468.522
1.D: Reduce the growth of health care costs while promoting high-value, effective care			
1.E: Ensure access to quality, culturally competent care for vulnerable populations	5,764.841	4,304.426	4,285.382
1.F: Promote the adoption and meaningful use of health information technology	93.261	101.186	112.855
2 Advance Scientific Knowledge and Innovation	31.837	33.856	37.555
2.A: Accelerate the process of scientific discovery to improve patient care	2.166	2.222	2.548
2.B: Foster innovation at HHS to create shared solutions	20.605	22.491	24.363
2.C: Invest in the regulatory sciences to improve food and medical product safety			
2.D: Increase our understanding of what works in public health and human services	9.066	9.144	10.644
3 Advance the Health, Safety and Well-Being of Our People	1,598.107	1,746.485	1,720.391
3.A: Promote the safety, well-being, resilience and healthy development of children and youth	1,100.298	1,221.707	1,135.640
3.B: Promote economic and social well-being for individuals, families, and communities			
3.C: Improve the accessibility and quality of supportive services for people with disabilities and older adults			
3.D: Promote prevention and wellness	497.809	524.778	584.751
3.E: Reduce the occurrence of infectious diseases			
3.F: Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies			
4 Increase Efficiency, Transparency and Accountability of HHS Programs	6.769	23.013	7.743
4.A: Ensure program integrity and responsible stewardship of resources	2.507	2.720	3.035
4.B: Fight fraud and work to eliminate improper payments	0.627	0.680	0.759
4.C: Use HHS data to improve the health and well-being of the American people	2.581	18.749	3.029
4.D: Improve HHS environmental, energy, and economic performance to promote sustainability	1.054	.864	.920
5 Strengthen the Nation's Health and Human Services Infrastructure and Workforce	1,406.757	1,260.667	1,368.720
5.A: Invest in the HHS Workforce to meet America's health and human service needs today and tomorrow			
5.B: Ensure that the Nation's health-care workforce meets increased demands	1,380.160	1,191.265	1,336.844
5.C: Enhance the ability of the public health workforce to improve health at home and abroad	26.597	69.403	31.876
5.D: Strengthen the Nation's human services workforce			
5.E: Improve national, State, and local surveillance and epidemiology capacity			
Total Program Level	$9,668.547	$8,243.051	$8,431.162

Drug Budget

Resource Summary

	Budget Authority (in Millions)		
	FY 2011 Final	**FY 2012 Enacted**	**FY 2013 Request**
Drug Resources by Function			
Treatment	$16.900	18.100	18.300
Total Drug Resources by Function	**$16.900**	**$18.100**	**$18.300**
Drug Resources by Decision Unit			
Bureau of Primary Health Care	$16.900	18.100	18.300
Total Drug Resources by Decision Unit	**$16.900**	**$18.100**	**$18.300**

Drug Resources Personnel Summary			
Total FTEs (direct only)	170	181	183
Drug Resources as a Percent of Budget			
Total Agency Budget (in Billions)	$6.272	$6.215	$6.074
Drug Resources Percentage	0.27%	0.29%	0.30%

Source: Estimates based on 2010 HRSA Health Centers information reported in the Uniform Data System (UDS) on their patient services, revenues and expenditures.

Program Summary

MISSION

The Health Resources and Services Administration is the principal Federal agency charged with increasing access to basic health care for those who are underserved. For more than 40 years, HRSA-funded health centers have delivered comprehensive, high-quality, cost-effective primary health care to patients regardless of their ability to pay. Access to substance abuse services is critical to ensuring overall health and well-being of health center populations.

METHODOLOGY

The Uniform Data System (UDS) tracks a variety of information, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues. UDS data are collected from grantees and reported at the grantee, state, and national levels. The UDS reporting provides a reasonable basis for estimating the share of the Primary Health Care Grants used for substance abuse treatment. Using the data reflected on page 2, Line 7 of the Financial report, 0.75% represents the dollars expended by health centers on substance abuse in 2010 divided by the total cost of all services provided. To calculate the total drug control estimates, the 0.75% is multiplied by the Health Center Program grant dollars awarded to

health centers in FY 2011, and the projected amount of Health Center Program grant dollars to be awarded to health centers in FY 2012 and FY 2013.

BUDGET SUMMARY

The total drug control budget for the Health Resources and Services Administration for FY 2013 is $18.3 million, an increase of $0.2 million over the FY 2012 enacted level.

Bureau of Primary Health Care

Total FY 2013: $18.3 million (Reflects $0.2 million increase from FY 2012)

In FY 2013, The Health Center program plans to support more than 1,200 grantees and provide comprehensive primary health care services to more than 21 million patients, including access to substance abuse treatment.

FY2012 Total Change (+$0.2 million): The increase reflects the addition of funding from the Affordable Care Act.

Significant Items

TAB

HEALTH RESOURCES AND SERVICES ADMINISTRATION

SIGNIFICANT ITEMS IN HOUSE AND SENATE APPROPRIATION COMMITTEE REPORTS

The following section represents FY 2012 Congressional requirements for reports and significant items derived from Senate Report 112-84

FY 2012 Senate Appropriations Committee Report Language (Senate Report 112-84)

Item 1

Rural Access to Emergency Devices. -- The Committee provides $2,500,000 for rural access to emergency devices. The fiscal year 2011 comparable level was $236,000. The budget for fiscal year 2012 did not request funds for this program. This appropriation funds the Rural Access to Emergency Devices Act, authorized under section 413 of the Cardiac Arrest Survival Act of 2000. Funding will be used to purchase automated external defibrillators [AED], place them in public areas where cardiac arrests are likely to occur and train lay rescuers and first responders in their use. Only an estimated 8 percent of victims who suffer a sudden cardiac arrest outside of a hospital survive. Immediate cardiopulmonary resuscitation and early intervention, using an AED, can more than double a patient's chance of survival. Communities with comprehensive AED programs, including training of anticipated rescuers, have achieved survival rates of nearly 40 percent. The Committee directs HRSA to prepare and submit within 90 days after the enactment of this act a report on the impact of this program since its inception, similar to the one released in 2005. The report should include the locations where AEDs were placed, the grant dollars requested and awarded, and the number of applications received and awards granted, lay rescuers and first responders trained in their use, and an estimate of the number of individuals saved under this program. This information, comparable to that requested in its January 2011 Funding Opportunity Announcement, should be shown by State and grantee as in the 2005 report. (Page 56/67)

Action Taken or To Be Taken

ORHP is working on the requested report and will submit within 90 days after the enactment of this Act.

Item 2

Base Grants--The Committee recognizes the importance of maintaining a solid foundation of stable, viable existing health centers and urges HRSA to increase base funding to existing health centers due to increasing demands. The Committee also urges HRSA to use additional programmatic funding to expand access to health centers in those areas of the country with high need and inadequate access to services to meet such need. The Committee expects HRSA to implement any new expansion initiative using the existing, and statutorily required, proportionality for urban and rural communities, as well as migrant, homeless and public housing health centers. (page 37)

Action Taken or To Be Taken
For FY 2012, HRSA recognizes the importance of providing funds to support ongoing health center operations and the establishment of new health center sites in medically underserved areas. All FY 2012 awards will be consistent with existing statutory requirements for urban/rural populations and proportionate distribution of funds among migrant, homeless and public housing centers.

Item 3
Nurse-Managed Health Clinics.-- Nurse-managed health clinics [NMHCs] strengthen nursing workforce development efforts by acting as clinical education sites for nursing students. The Committee strongly encourages HRSA to prioritize funding for NMHCs within any competition for new access points in fiscal year 2012. Expanding services this way will help expand coverage to underserved populations, including native and rural communities. The Committee also believes that supporting the nurse-managed model will facilitate the implementation the recommendations in the Institute of Medicine's report on the future of nursing. (Page 38)

Action Taken or To Be Taken
HRSA recognizes that Nurse-Managed Health Centers (NMHCs) serve an important role in improving the overall access to care for the Nation's underserved populations. NMHC's are eligible to apply for any new funding opportunities supported under the Health Center Program and for designation under the Federally Qualified Health Center Look-Alike Program. HRSA also provides technical assistance to potential applicants for funding and for FQHC Look-Alike designation via direct communication, web-based information, interactive conference calls and state/national technical assistance cooperative agreements.

Item 4
Workforce.-- The Committee encourages HRSA to continue with these improvements, as well as collaborate with the Health Centers program in order to maximize the investment in both programs. (Page 38/39)

Action Taken or To Be Taken
HRSA will ensure that the Health Center Program is involved in the collaborative efforts around workforce development and improvement.

Item 5
Native Hawaiian Health Care. -- Medicare payment policy that blocks implementation of a Hawaii State law allowing advanced practice registered nurses to practice without the physical supervision of a physician. Given the remote locations of many of the grantees of the Native Hawaiian Health Care program and the barrier imposed by island geography, enforcing the physical requirement may have the unintended consequence of reducing access to care. The Committee urges HRSA to work with the Centers for Medicare and Medicaid Services to find a suitable resolution that maximizes access to care in remote locations. (Page 39)

Action Taken or To Be Taken
HRSA will continue to work with CMS to determine an appropriate resolution for the Native Hawaiian Health Care grantees.

Item 6

Demonstrations.-- An essential component of patient-centered, team-based care is the appropriate management of medications. This management also improves healthcare quality and lowers costs. The Committee has included funding in the past to conduct demonstration programs on the benefits of including pharmacists and chiropractic care into primary care teams through NHSC. The Committee is impressed by the results of those demonstrations and urges the Secretary to offer pharmacists and chiropractors loan repayment through NHSC so that eligible entities may be able to improve the quality of care for underserved patients and populations. (Page 40)

Action Taken or To Be Taken

The statute requires that NHSC members be utilized by the Secretary to provide primary health services in health professional shortage areas (HPSAs), and defines primary health services as "health services regarding family medicine, internal medicine, pediatrics, obstetrics and gynecology, dentistry or mental health, that are provided by physicians or other health professionals." To date, the interpretation of the statute has been that clinical specialties, such as pharmacy and chiropractic care, do not qualify as providing "primary health services." With that being said, the NHSC is reviewing the disciplines that the Loan Repayment Program and the State Loan Repayment Program support. Any modifications to the eligible disciplines will be announced through program guidance.

Item 7

Centers of Excellence. -- The Committee encourages HRSA to continue to support minority health professions schools' work to diversify and improve the healthcare workforce, focusing the Centers of Excellence Program on institutions with a historic mission of promoting health professions diversity. (Page 40)

Action Taken or To Be Taken

In FY 2012 the Centers of Excellence (COE) Program will hold a competition for new awards. HRSA plans to award 19 COE grants; four continuation awards and approximately 14 new awards. As authorized in the legislation, funding will be awarded to institutions with a historic mission of promoting diversity in the health professions. These eligible institutions must strengthen and expand academic enhancement to underrepresented minority (URM) individuals to successfully enter and graduate with a degree from their health professions training program, as well as increase career training opportunities for URM faculty.

Additionally, applicants to the FY 2012 competition will have to meet recently revised eligibility criteria which will further focus the program on such institutions. Specifically, the thresholds that must be met for eligibility have been updated based on more recent data and refocused on the percentage of URM students each school graduates from their health professions training program. For most COE designations and health professions disciplines, schools must be in the top 75 percent of schools based on URM student graduation rates in order to be eligible for the program.

Item 8

Mid-Career Support. --The Committee is aware that unemployment is particularly high among minority populations at a time of acute shortages in health professionals. The Committee urges HRSA to encourage health professions schools to develop innovative programs for recruiting and supporting individuals, particularly underrepresented minorities, who decide to switch to a career in primary care or allied health professions. (Page 40)

Action Taken or To Be Taken

One of the goals of HRSA's health professions training programs is to increase the diversity of the health professions workforce so that it better reflects the population it serves. Several health professions programs have the specific focus of recruiting disadvantaged and/or under-represented minority students into the health professions programs and providing support so that they can successfully complete the programs. Many health professions activities also help individuals who want to change careers and enter the health professions, or advance in the health professions through career ladders.

For example, the BHPr provided funding for a nursing school to work with key military leadership to identify strategies to align enlisted health care training and academic nursing training. The BHPr also made it easier for veterans to become physician assistants by giving funding priorities to universities and colleges that support veterans.

Additionally, the AHEC Program statute requires AHEC programs and centers to collaborate with Workforce Investment Boards (WIB) to recruit individuals from underrepresented minority populations or from disadvantaged or rural backgrounds into health professions. The Eastern Shore AHEC in Maryland has served as a model in developing and implementing a health careers retraining program for displaced workers. This model was presented at a national AHEC conference and a national WIB conference to support its broader dissemination.

Item 9

Primary Care Training and Enhancement. -- The Committee provides $39,036,000, the same as the fiscal year 2011 comparable level, for Primary Care Training and Enhancement programs. The budget request for fiscal year 2012 proposed $53,018,000 in budget authority and another $86,914,000 in transfers available under section 241 of the PHS Act for this program. This program supports the expansion of training in internal medicine, family medicine, pediatrics and physician assistance. Funds may be used for developing training programs or providing direct financial assistance to students and residents. The Committee urges HRSA to prioritize the training of physician assistants and has included bill language allowing HRSA to determine the funding amount for this activity. (Page 41)

Action Taken or To Be Taken

FY 2012 funding will support continuation grant awards advancing physician and physician assistant (PA) education, as well as new awards that will integrate public health into primary care curricula for medical and PA students. In addition, planned grant awards for PA training programs will focus on enhancing community based training opportunities and improving the quality of training through faculty development activities. In addition, HRSA will host webinars

and a website that identify and disseminate best practices for improving the success of veterans entering the PA workforce.

Item 10

Quality Improvements.-- The Committee continues to support efforts to develop and implement national quality measures for clinical practice. The Committee urges HRSA to require that primary care physicians and dentists be educated and trained in relevant quality measures in use for clinical practice. (Page 41)

Action Taken or To Be Taken

Improving the quality of health care and implementing practices for measuring that quality are important priorities for HRSA. For instance, applicants to the Primary Care Training and Enhancement programs are asked to describe the degree to which they incorporate clinical quality measures in their grant funded activities. The merit of the described activity is determined during the objective peer review process and review points are awarded accordingly.

The HRSA will continue to explore and assess efforts associated with training physicians and dentists in the areas of patient quality and patient safety.

Item 11

Understanding Basic Science.--The Committee encourages HRSA to give preference to applicants that seek to develop or expand a research infrastructure, critical appraisal and evidence-based curricula, and longitudinal research opportunities for students. (Page 41)

Action Taken or To Be Taken

HRSA supports the development and expansion of a research infrastructure through the Ruth L. Kirchstein National Research Service Award (NRSA) Institutional Training grant program. This program awards funding to eligible institutions to develop or enhance postdoctoral research training opportunities for individuals who are planning to pursue careers in primary care research. These longitudinal research opportunities for postdoctoral fellows typically span 2-3 year periods. The NRSA postdoctoral fellows are students as they participate in training programs with curriculum, requirements, and evaluation criteria.

All recipients of HRSA funding are encouraged to utilize evidence-based curricula.

Item 12

Training in Oral Health Care. -- The Committee supports opportunities for advanced training for dentists and faculty loan repayment programs because it recognizes that there is a shortage of pediatric and public health dentists. Dentists who complete a general residency receive additional training that allows them to take on complex cases of patients with autoimmune or systemic diseases. The Committee remains concerned about the growing aging population and encourages HRSA to initiate training programs that target vulnerable populations in risk-based clinical disease management of all populations. The Committee further encourages HRSA to create a grant program to provide access to unpaid, volunteer dental services for medically necessary but otherwise uncovered and unaffordable dental treatment. Grant costs may include the salaries and other employment costs of professionals who verify the medical and financial needs, including

the absence of other insurance coverage, of individual patients potentially eligible for such services. (Page 42)

Action Taken or To Be Taken
HRSA's Health Center Program provides grant funding to health centers nationwide, which offer dental services to underserved and vulnerable populations on a sliding fee schedule based on income levels. In 2010, health centers provided dental services to more than 3.7 million medically underserved, vulnerable people. HRSA will continue to provide grant support for dental services provided in health centers in FY 2012.

HRSA is taking several actions to support advanced training for dentists and faculty loan repayment. For FY 2012, HRSA anticipates providing nearly $10.5 million in continuation funding for the advanced training of dentists through the Postdoctoral and Dental Faculty Loan Repayment Programs. For FY 2012, HRSA will also be providing $10 million for new grants under the Dental Health Improvement Act, State Oral Health Workforce grant program, and the Faculty Development in General, Pediatric, and Public Health Dentistry and Dental Hygiene Program. These two programs work directly at addressing shortages of dental providers in underserved areas.

Item 13
Career Pathways and Articulation Agreements.--The Committee is concerned that many graduates of certificate and 2-year degree programs are often unable to pursue more advanced degrees in one of the health professions. The Committee urges HRSA to support programs that encourage graduates of certificate and 2-year community college programs to enroll in baccalaureate degree-granting programs and health professions schools and to encourage articulation agreements between community colleges and baccalaureate-degree granting programs and health professions schools that allow for transfer of credits earned in the certificate and associate degree programs. (Page 42/43)

Action Taken or To Be Taken
The Nurse Education, Practice, Quality, and Retention Program provides grants for career ladder programs to promote career advancement for nursing personnel—licensed practical nurses, licensed vocational nurses, certified nurse assistants, home health aides, diploma degree or associate degree nurses—to become baccalaureate or advanced education nurses. In addition, the Nursing Workforce Diversity Program can fund stipends for diploma or associate degree nurses to enter a bridge or degree completion program, and student scholarships or stipends for accelerated nursing degree program students. The HRSA supports the efforts of schools of nursing to explore innovative pathways and articulation agreements to support the full and diverse range of interested individuals in pursuing careers in nursing.

Item 14
Vacancy Rates.-- The Committee remains concerned that many allied health professions continue to experience high vacancy rates and encourages HRSA to give priority consideration to schools that are educating and training people in these professions. (Page 43)

Action Taken or To Be Taken

The Bureau of Labor Statistics projects a shortage of at least 1.6 million to 2.5 million allied health workers by 2020. They predict a growing demand for allied health workers with varying ranges by discipline from an 11.9 percent for medical and clinical laboratory technologists to a 50 percent increase for home health aides. HRSA recognizes that the demand for allied health professionals is growing; however, no funding was appropriated for allied health programs in FY 2012.

Item 15

Graduate Psychology Education Program.-- The Committee is concerned that the Nation's mental health infrastructure will experience increased strain for years to come as individuals and their families increasingly turn to behavioral healthcare professionals in local communities. The Nation's population is rapidly aging and significant numbers of veterans are returning from war. Ramifications of current economic conditions also are significantly increasing the numbers of people seeking mental health services as they struggle with unemployment, job and income loss, and the many associated problems that result. The Committee supports efforts by HRSA that would expand training sites, reinstate the neuropsychology component, initiate a new focus on veterans and help integrate health service psychology trainees at federally Qualified Health Centers to provide behavioral and mental health services to underserved populations. (Page 43)

Action Taken or To Be Taken

The Graduate Psychology Education (GPE) Program encourages grantees to address the growing needs for behavioral and mental health services for returning war veterans and other underserved populations in medically underserved communities.

The GPE applicants decide the types of training students receive and where they conduct their clinical psychology services. Out of 20 current GPE grantees, one reported training psychology students to provide neuropsychology evaluations and assessments for trauma brain injuries of combat veterans. Students supported by this grantee facilitated a support group for World War II veterans suffering from Post-Traumatic Stress Disorder (PTSD).

In addition, through an inter-agency agreement with the Substance Abuse and Mental Health Services Administration, HRSA is implementing a program to train primary care and mental and behavioral health care providers on the unique mental and behavioral and substance abuse needs of returning veterans and their families. The program will train staff from Area Health Education Centers in each of the 10 Public Health Service Regions, to provide continuing education to these providers on issues surrounding the behavioral health of veterans and will follow-up with a sample of trained providers to assess the level of change in their practice.

Item 16

Innovation.-- The Committee remains concerned that 7 out 10 deaths among older Americans each year are from chronic diseases. The Committee urges HRSA to support projects that propose innovative educational and practice techniques with regard to treating at least one of the 10 most prevalent chronic diseases (such as, heart disease, stroke, diabetes and cancer) in order to improve the quality of care for that condition and have an effect on primary care and the health of the general public. (Page 43/44)

Action Taken or To Be Taken
The prevalence of chronic diseases in Americans makes chronic disease management a key part of primary care training. Several grantees in the Primary Care Training and Enhancement as well as the Advanced Nursing Education program focus on training to provide patient-center, coordinated care and chronic disease management. Interprofessional team-based care is also a focus for health professions programs and especially important for patients with chronic diseases.

The Area Health Education Center Program grantees offer a broad range of continuing education programs in local community settings to physicians and other health professionals in rural and underserved areas. These topics include the ten most prevalent chronic diseases, as identified by ongoing needs assessments.

In FY 2011, BHPr's Geriatrics Programs grantees provided education and training offering that addressed the top 10 leading causes of death for older adults. In FY 2012, grantees will continue to be encouraged to provide education and training to health professions students, faculty, practitioners, direct service workers, and caregivers on caring for older adults with the top 10 leading causes of death.

Item 17
Reducing Hospital Readmission Rates.-- Approximately 20 percent of hospitalized Medicare patients are readmitted within 30 days. The Committee urges HRSA to support curriculum projects that examine innovative educational and practice techniques with regard to preventing hospital readmissions among older Americans. (Page 44)

Action Taken or To Be Taken
Best practices for reducing hospital readmissions include discharge planning, medication reconciliation, care transitions, identifying high-risk individuals, and home health care. The PHS Act Title VII and Title VIII geriatrics programs currently provide training to health professions students, faculty, practitioners, direct service workers, and caregivers in these areas. The HRSA will continue to encourage grantees to address training needs to prevent rehospitalizations in older adults.

Item 18
Health Professions Workforce Information and Analysis. -- The Committee commends HRSA for the information that the National Center for Health Workforce Analysis has collected and disseminated. The Committee encourages HRSA to make their Web site "one-stop shopping" for any researcher or policy-maker on health workforce issues. For that reason, the Committee encourages HRSA to integrate data from the Bureau of Labor Statistics and other Federal agencies to the greatest extent possible. (Page 44)

Action Taken or To Be Taken
The National Center for Health Workforce Analysis (the Center) is increasing the availability of data and information for researchers and policy-makers interested in health workforce issues and has developed a plan to move towards "one stop shopping". In FY 2011, for example, the Center updated and expanded the Area Resource File (ARF) and made it downloadable for free. The

ARF is a comprehensive source of health-related data on the Nation's health workforce, health care delivery system and factors impacting health status and heath care in the U.S. The ARF is available at http://arf.hrsa.gov/. In addition, the Center compiled health care occupations information from the Bureau of Labor Statistics and will make it available on the HRSA web-site, including interactive maps and data on employment in healthcare occupations by State.

In FY 2012 the Center will continue to expand the information and data available through its website making it into a "one-stop shopping" site. These efforts will involve continued use of BLS data.

Item 19

Nursing Workforce Development Programs. --The Committee provides $242,387,000 for the Nursing Workforce Development programs, the same as the fiscal year 2011 comparable level. The budget request for fiscal year 2012 was $224,550,000 in budget authority and $108,525,000 in transfers available under section 241 of the PHS Act. The Committee directs HRSA to maintain all Nursing Workforce Development programs at no less than last year's level. (Page 45)

Action Taken or To Be Taken

HRSA is complying with this request.

Item 20

Advanced Nursing Education Grants.-- The Committee is concerned that masters and doctoral programs lack the resources necessary to keep pace with the demand for new nurse faculty. Doctoral prepared nurse educators are in especially high demand, as the majority of vacant faculty positions require this level of education. The Committee notes that lack of faculty is often cited as the reason why community colleges tum away potential nursing students, despite severe shortages at all levels of nursing. Therefore, the Committee encourages the Division of Nursing to establish a priority for funding full-time doctoral nursing students including Ph.D. or the doctor of nursing practice [DNP]. The Committee further encourages HRSA to give priority to nursing students who indicate an interest in teaching. (Page 45)

Action Taken or To Be Taken

The Nurse Faculty Loan Program seeks to increase the number of nurse faculty by providing registered nurses with financial support to purse graduate education to become qualified nurse faculty. This program includes a funding priority for schools of nursing that support doctoral nursing students.

Item 21

Baccalaureate Nursing Degrees.-- In recognition of the Institute of Medicine [10M] and the Robert Wood Johnson Foundation report, "The Future of Nursing: Leading Change, Advancing Health," the Committee urges the Division of Nursing to enhance programsthat increase the number of nurses with baccalaureate degrees. Research has shown that nurses who hold a bachelor of nursing have better patient outcomes such as lower mortality and failure to rescue rates. The Committee further concurs with the 10M report recommendation that the Division's programs need to encourage nurses with associate degrees and diplomas to enter baccalaureate

programs. For that reason, the Committee encourages HRSA to focus grants in nursing education to create and support career ladder programs. (Page 45)

Action Taken or To Be Taken
The Nurse Education, Practice, Quality, and Retention Program and the Nursing Workforce Diversity Program supports career advancement for nursing personnel—licensed practical nurses, licensed vocational nurses, certified nurse assistants, home health aides, diploma degree or associate degree nurses—to become baccalaureate or advanced education nurses. In FY 2011 three new projects supporting advancement to baccalaureate and advanced education preparation were made to nurses under the Nursing Workforce Diversity Program.

Item 22
Innovative Entry Points.-- The Committee is encouraged by various innovative models in K-12 education that allow students to take college courses while in high school, some of which are partnerships with nursing programs. The Committee urges HRSA to partner with the Department of Education to promote innovative programs that support K-12 students as they transition into nursing education. (Page 45)

Action Taken or To Be Taken
The Nursing Workforce Diversity Program requires grantees to include activities to identify, recruit, and select potential candidates for pre-entry preparation, including students in K-12 education, and motivate them towards professional nursing education. The approach includes innovative interventions that are designed to enhance the academic abilities and preparation of students from disadvantaged backgrounds, including racial and ethnic minorities, and to increase their competitiveness for entry into and graduation from a professional nursing program. The HRSA will work with the Department of Education to identify additional opportunities for collaboration in this area.

Item 23
Nurse Practitioners.-- In the presence of an acute shortage of primary care providers, the need to prepare quality, cost effective clinicians such as nurse practitioners continues to be severe. Nurse practitioners are primary care providers who can assist in meeting the needs of our communities and help to increase access to primary care. The Committee urges HRSA to support educational programs and traineeships for nurse practitioners to help meet the growing health needs of the Nation particularly in rural America. (Page 45/46)

Action Taken or To Be Taken
For FY 2012, the Advanced Education Nursing Traineeship Program is targeting traineeship support to the production of primary care advanced practice registered nurses. In addition, a funding preference is given to programs that provide clinical training in rural and underserved communities and those that demonstrate success in post-graduation employment of their advanced practice registered nurse (APRN) trainees in underserved communities.

Item 24

Global Health Strategies.-- The Committee recognizes that some global models of healthcare have been proven to be cost effective and provide a high level of quality care. The Committee urges the Department to consider projects that demonstrate and pilot global health strategies in underserved domestic healthcare markets. These projects should include programs that improve overall community health and wellness; increase access to primary health services; support innovative payment models that offer affordable healthcare payment options for low-income families; and improve access to immunizations. (Page 48)

Action Taken or To Be Taken

HRSA is reviewing lessons learned from the global models of health care in an effort to determine how to incorporate those models of care in domestic programs. Specific examples of ideas that might be considered include:

- Completion of a study of multidisciplinary teams to determine if tasks might be shifted to increase efficiency of service delivery and increase access to care;
- Use of patient navigators to assist with health education and service coordination;
- Use of home visiting for rural, hard to reach, and out of care populations to improve access to and retention in care, improve quality of care and health outcomes;
- Reviewing models to bring marginalized populations into care by integrating HIV primary care, substance abuse services, and mental health; and
- Use mobile phone technology for phone interventions
- Use of community involvement models to enhance access and adherence to treatment and address stigma.

Item 25

Healthy Homes.-- The Committee supports efforts by HRSA to fund evidence-based maternal, infant and early childhood home visiting programs that are consistent with the Patient Protection and Affordable Care Act. The Committee is aware of nurse home visiting programs in New York State, Rhode Island and Oklahoma that have adopted healthy homes activities as part of their programming. This integrative approach of identifying and preventing environmental health and safety hazards in the homes of high-risk pregnant mothers and their babies is a cost-effective and efficient strategy for preventing disease and injury among the Nation's most vulnerable families. The Committee recommends that HRSA expand and incentivize the implementation of these integrative programs in consultation with the Centers for Disease Control and Prevention. (Page 48)

Action Taken or To Be Taken

The ACA Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program is committed to exploring avenues for incorporating the identification and prevention of environmental health and safety hazards during home visits of high risk families. There are currently nine home visiting models that have been deemed evidence based according to HHS criteria. Four of these are being actively implemented by the states and territories participating in the program. The challenge for adding activities to the home visits is that the ACA MIECHV legislation requires that these models be implemented with fidelity and therefore this limits what can be added or changed within the models. In fact, there is variability in the willingness of the

model developers to vary in their protocols with some being open to additions while others will not consider any changes at all.

In consultation with staff of the CDC's Healthy Homes program, MIECHV program staff will work with the home visiting model developers to identify those components of the CDC's Healthy Homes program that may be feasible and appropriate for home visitors to address. Also, MIECHV program staff will also determine how the MIECHV technical assistance center (Zero to Three) could be deployed to disseminate Healthy Homes information to state grantees.

Item 26

Mobile Health Messaging.-- The Committee is concerned that the United States now ranks 33rd among industrialized and developed Nations in its infant mortality rate. The Committee notes the successful use of mobile health outreach programs that send cell phone text messages to low-income women to provide advice to help keep the mothers and their babies healthy. The Committee encourages HRSA to engage and support mobile health messaging programs that target the goals of the title V program in areas with the worst overall outcomes. (Page 48)

Action Taken or To Be Taken

The Health Resources and Services Administration (HRSA) has identified infant mortality as a priority issue and is working collaboratively with the Association of State and Territorial Health Officials (ASTHO), the Association of Maternal and Child Health Programs (AMCHP) and the March of Dimes (MOD) to sponsor an Infant Mortality Summit in the U.S. Department of Health and Human Services' (HHS) Region IV and Region VI States in FY 2012 and to ultimately develop a national strategy for addressing infant mortality and reducing existing disparities observed by race.

Title V of the Social Security Act authorizes appropriations to States to improve the health of all mothers and children. Decreasing the national rate of infant deaths has been and continues to be one of the primary focuses of the Title V Maternal and Child Health program. Five of the six National Outcome Measures in the State Maternal and Child Health Block Grant program relate to infant mortality.

The U.S. Department of Health and Human Services (HHS) has been a key partner in the text4baby program since its February 2010 launch. Through its Title V Maternal and Child Health programs and Healthy Start projects, HRSA has helped to promote the text4baby program among its State and community partners. While the effectiveness of the text4baby messages on reducing infant mortality has not yet been demonstrated, a national evaluation is currently underway. The results of this evaluation are expected in 2013.

In their FY 2012 Maternal and Child Health Block Grant Applications and FY 2010 Annual Reports, 24 of 59 States and jurisdictions cited the text4baby program in describing their program activities. Examples of these activities are provided below.

Arkansas: Community education for evidence based programs to reduce Infant Mortality Rates (IMR) is being continued and improved (Back-To-Sleep and Folic Acid supplementation before pregnancy), text4baby is now available to all Arkansas pregnant women and families with an

infant less than 1 year old as a free cell phone texting service that provides them with 3 free text messages each week with health information geared to their gestational age or the age of the infant (reminders of when immunizations are due and to take prenatal/folic acid vitamins).

California: Text4baby provides pregnant women and new moms with information they need to take care of their health and give their babies the best possible start in life. Of the 42,518 who enrolled in text4baby nationwide as of May 2010, 9.5% (4,024) of women were from California.

Hawaii: Hawaii is participating in the national text4baby campaign. This free service sends free text health messages to pregnant women and new parents through mobile devices. Messages include information to access free or low cost health insurance and infant check-up reminders.

Kansas: Kansas is participating as a State partner in the text4baby free text messaging program for pregnant women and new moms. Health messages discouraging smoking during pregnancy and around children are some of the messages provided.

Louisiana: MCH is an official State-level partner for the national text4baby program and actively promotes the program via local partnerships.

Mississippi: With low birth weight being an important predictor of infant mortality, MSDH has initiated several projects to assure quality, competent care to improve health outcomes. The implementation of text4baby, developed by the Healthy Mothers, Healthy Babies Coalition, has helped with the number of pregnant women receiving early and regular messages about prenatal care.

New Hampshire: Among populations that Title V has a more direct relationship with through the support of community health centers (CHCs) with prenatal programs, several factors may be present that put women at risk for negative birth outcomes, including very low birthweight. Innovative strategies like text4baby are being explored to engage women early in their pregnancy.
Nevada: The Bureau promotes early prenatal access for underserved pregnant women through our MCH information and referral line, direct services, and outreach and education initiatives such as text4baby.

Item 27
Traumatic Brain Injury Program. -- The Committee supports the efforts of HRSA to develop a long range plan for the Traumatic Brain Injury program. The Committee encourages HRSA to collaborate with other Federal agencies during this process and to solicit broad input from consumers, States, professionals and care providers in order to ensure that the program maximizes resources related to the treatment and prevention of traumatic brain injury. (Page 49)

Action Taken or To Be Taken
The TBI Program created and facilitates the Federal Interagency Committee on TBI. It consists of representatives from several Operating Divisions of the Department of Health and Human Services, Department of Defense, Department of Education, Department of Veterans Affairs, and the Social Security Administration with a charge to:

- Create and contribute to a centralized online repository of federal resources pertaining to TBI;
- Share information regarding upcoming agency activities or events related to TBI;
- Review program strategic plans, materials, and funding opportunities to facilitate collaboration, minimize duplication of efforts and fill service gaps; and
- Develop and disseminate media to build awareness and promote greater visibility of TBI and associated Federal Programs.

HRSA and this committee solicit input from stakeholders, consumers, and providers and incorporate the input into program and policy planning. In addition to this committee, the TBI program continues to collaborate with other Federal and public agencies. The program is currently working with the Department of Justice's Office of Juvenile Justice to establish partnerships on the State level addressing TBI in the Juvenile Justice Facilities. The TBI program is also working on establishing a partnership with the Department of Education around screening and providing services and supports for children in the school system with TBI. In addition to the steps already taken, the TBI program will continue to build upon and implement the following activities:

- Expand partnerships with national professional organizations and their State and local chapters;
- Identify and actively collaborate with other Federal entities on State and national programs and initiatives that focus on special needs populations in order to promote a system agenda;
- Link family organizations and the Family-To-Family Health Information Centers with other Division, MCHB, and HRSA grantees;
- Train and educate current and "future" professionals to utilize validated screening tools and evidence-based best screening practices by developing online, on-demand educational modules;
- Identify high risk populations and link to appropriate screening at the community level;
- Promote the use of health information technology to standardize, maintain, link, and analyze quantitative and qualitative data on screening;
- Create a public awareness campaign using new and traditional media to highlight challenges and hardships faced by families;
- Pinpoint specific barriers to integrated services by capturing real family experiences navigating the system; and
- Use emerging technologies to link families to services in rural, frontier, and underserved urban communities.

If reauthorized in 2013, the TBI program plans to focus grant activities on high risk/targeted populations and, with partners, fund sustainable programs in States to ensure that all persons with TBI and their families have access to needed services and supports.

Item 28

Congenital Disabilities Program.-- The Committee has not provided funding for the congenital disabilities program. The budget request for fiscal year 2012 included $499,000 for these activities. The program was discontinued in fiscal year 2011.

The purpose of the program is to provide information and support services to families receiving a

positive test diagnosis for down syndrome, spina bifida, dwarfism, or other prenatally and postnatally diagnosed conditions. The Committee is pleased with the materials created in this program and encourages HRSA to distribute them through the Maternal Child Health Bureau's programs. (page 50)

Action Taken or To Be Taken
Title V of the Social Security Act supports States and other grantees in their efforts to provide and to promote family-centered, community-based, coordinated care for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families. Information on evidence-based practices and scientifically accurate resources can be shared with Maternal and Child Health program grantees through such venues as grantee list serves, grantee meetings/conference calls, technical assistance provided to individual grantees, and through other stakeholder and partnership groups.

Item 29
Healthy Start. -- The Committee is aware that racial disparities in stillbirth and sudden unexpected infant deaths [SUIDs] persist and significantly contribute to the more than 25,000 stillbirths and over 4,000 SUIDs each year. The Committee encourages HRSA to support training and assistance that will enhance cooperative partnerships among local community health professionals, public health officers, community advocates and consumers to address racial disparities in SUIDs and stillbirth. In addition, the Committee encourages Healthy Start grantees to promote local efforts to review stillbirth and SUIDs, especially in addressing racial disparities. (Page 50)

Action Taken or To Be Taken
The Division of Healthy Start and Perinatal Services (DHSPS) addresses the issue of SUIDS in a variety of ways:

- provides training to grantees during Annual Grantee Meetings and through webinars
- provides training to the grantees so they have the knowledge and ability to go back to their communities and train (Train the Trainer):
    - their staff
    - key partners (including members of their consortium which is comprised of local community health professionals, public health officers, community advocates, and program participants)
    - community members (including grandparents who have an influence in parenting/sleep practices
- advocates the National Institute of Child Health & Human Development (NICHD) Back to Sleep Campaign and regularly reviews the Back to Sleep materials and provide comments to our federal partners
- funds the National Fetal and Infant Mortality Review Resource Center (www.nfimr.org)

Item 30
Emergency Medical Services for Children. -- The Committee commends the program's efforts to improve the evidence base for pediatric emergency care and urges HRSA to continue creating

innovative initiatives to improve evidence-based pediatric emergency care and be cognizant of the educational and training needs of those serving in rural America. (Page 51)

Action Taken or To Be Taken
Emergency Medical Services for Children (EMSC) expanded the Pediatric Emergency Care Applied Research Network (PECARN) to six academic institutions that comprise a network of 18 hospitals representing over a million pediatric visits annually. This patient population allows for conducting rigorous multi-site studies. In addition, EMSC supports seven Targeted Issue grants focusing on pediatric care topics of national significance.

EMSC is addressing the needs of those in rural America through two initiatives. First, EMSC is collaborating with Indian Health Service to increase awareness and access to pediatric education and quality improvement in the prehospital and hospital settings. Second, EMSC intends to fund four pediatric regionalization of care demonstration grants to improve the access to pediatric care in rural communities. Each of these efforts focuses on innovative solutions to improve the capacity to care for children in all settings.

Item 31
Organ Donation and Transplantation. -- The Committee is aware of the large and growing national organ transplantation waiting list, in part due to the unavailability of organs. Healthcare professionals, particularly physicians, nurse, and physician assistants, if given enhanced knowledge and training, can positively impact organ donation. Therefore, the Committee encourages HRSA to develop curriculum and continuing education programs for targeted health professionals. (Page 53)

Action Taken or To Be Taken
HRSA acknowledges the need for expanded education of health care professionals with a focus on increasing organ donation. In 2012, HRSA will solicit proposals for the continued operation of the national Organ Procurement and Transplantation Network (OPTN). HRSA intends to include a sub-task in the statement of work for the next OPTN contract to require the OPTN contractor to develop curriculum and continuing education programs for targeted health professionals focused on organ, tissue, and eye donation consistent with this conference report language and the requirements of section 4(d) of PL108-216 – the Organ Donation and Recovery Improvement Act, which requires:

> *The Secretary, in coordination with the Organ Procurement and Transplantation Network and other appropriate organizations, shall support the development and dissemination of educational materials to inform health care professionals and other appropriate professionals in issues surrounding organ, tissue, and eye donation including evidence-based proven methods to approach patients and their families, cultural sensitivities, and other relevant issues.*

Item 32
Vascularized Composite Allografts Rulemaking Process.-- The Committee notes that more than 3 years ago, on March 3, 2008, the Department published a Request for Information in the Federal Register to assist the Department in determining whether it should engage in a

rulemaking with respect to the growing field of transplantation referred to as vascularized composite allografts [YCAs]. The Committee believes that this rulemaking process is necessary to bring this growing category of transplantation, which includes the transplantation of hands, arms and faces, under the policy umbrella of the National Organ Transplantation Act. The Committee therefore urges the Department to proceed with rulemaking to place VCA transplants under the policy oversight of the Organ Procurement Transplant Network. (Page 53)

Action Taken or To Be Taken
On December 16, 2011, the Secretary of the Department of Health and Human Services issued a notice of proposed rulemaking in the Federal Register to include vascularized composite allografts (VCA) in the definition of "organs" for the purpose of coverage under the National Organ Transplant Act (NOTA, 1984) and the Organ Procurement and Transplantation Network (OPTN) final rule (42 CFR Part 121). The comment period will close on February 14, 2012.

Item 33
Office of Pharmacy Affairs.-- The Committee strongly supports the efforts of the Office of Pharmacy Affairs to ensure the integrity of the 340B program. The Committee is particularly supportive of HRSA's plan to develop a transparent system to verify the accuracy of the 340B ceiling price. Therefore, the Committee has included bill language, requested by the administration, to allow a nominal cost recovery fee to fund the implementation of program integrity provisions recommended by the inspector general and included in the Patient Protection and Affordable Care Act. The fee will be set at 0.1 percent for covered entities and is expected to generate $5,000,000. The Committee expects HRSA to report the expected and actual amounts generated by the fee in HRSA's annual budget justification. (Page 54)

Action Taken or To Be Taken
The user fee proposal was not included in the final FY 2012 appropriation. The 340B cost recovery fee system will establish the necessary requirements for manufacturers and covered entities to efficiently administer this cost recovery system that will provide operations, oversight and integrity for the 340B Drug Pricing Program. The cost recovery fee, in addition to OPA's line item budget, will support the natural growth of the 340B Program and fund new authority, responsibilities, and oversight. The cost recovery fee of 0.1 percent would be calculated on and added to the price of the 340B drug. Covered entities would have to pay the user fee to continue to participate in the 340B Program. The fee would be collected by the manufacturer (the manufacturer does not pay the fee) and submitted to the Treasury into an account that HRSA would use to operate the 340B Program and undertake program integrity activities. These activities include beginning: development of the cost recovery system; development of an on-line, secure system to post 340B ceiling prices for access by participating covered entities; establishment of an administrative dispute resolution process for claims of overcharges; and establishment of civil monetary penalties for manufacturers who overcharge or covered entities who intentionally divert drugs to ineligible patients.

It will take several years to fully implement all of the program integrity provisions to be undertaken with resources from the cost recovery fee as regulatory and programmatic changes are necessary. Based on the experience with the Vaccine Injury Compensation Program, it

would take approximately one-year from enactment to implement the user fee system and begin collecting the fees.

Item 34
New Access Points.-- The Committee is strongly supportive of efforts to expand access to care, particularly for those who are currently uninsured. Therefore, HRSA is encouraged to review its application policy and guidance to find opportunities to move more expeditiously in making 340B available to new clinics and access points. For example, the Committee is aware that HRSA requires a filed Medicare cost report for all hospital-affiliated clinic applications, which can take up to a year after the clinic opens. The Committee encourages HRSA to explore other forms of documentation that might be available more quickly upon the opening of a new access point. (Page 54)

Action Taken or To Be Taken
HRSA continues to research and review the available mechanisms and documentation that might more quickly admit new points of access into the 340B Drug Pricing Program. We also invite suggestions from our various stakeholders on viable options.

Item 35
Outpatient Coverage.-- The Committee is aware that treatment guidelines over the last few decades have been moving to provision of care from inpatient to outpatient. The Committee encourages HRSA to review the definition of patient to ensure that the 340B program continues to serve the population it was intended to serve, even as that population accesses care in different ways. In any guidance that HRSA might issue, the Committee recommends that HRSA keep an eye trained on preventing society's most vulnerable patients from losing access to affordable drugs. (Page 54)

Action Taken or To Be Taken
HRSA is reviewing the patient definition guidance. If HRSA determines a new patient definition is needed, it would be published as a proposed guidance and/or a proposed regulation depending on the scope of the definition.

Item 36
Supplanting.-- The Committee remains strongly supportive of the 340B program and its emphasis on helping hospitals, health centers and other safety net providers extend care to those who need it most. For that reason, the Committee is troubled by reports of health care insurers and other third party payers setting reimbursement rates that discriminate against 340B covered entities and supplant the benefit of the 340B discounts. The Committee urges HRSA to clarify to healthcare insurers and other third party payers that discriminatory reimbursement rates for 340B covered entities is inconsistent with Congressional intent. (Page 55)

Action Taken or To Be Taken
HRSA will issue a policy release to all 340B stakeholders including healthcare insurers and other third party payers restating the Congressional intent of the program.

Item 37

Mental Health Outreach.-- The Committee urges HRSA to support programs that demonstrate new and innovative models of regional outreach to meet the behavioral and mental health needs of rural America. In particular, HRSA is encouraged to give priority to clinical training sites that encompass a multicounty area; train students to use secure telemedicine applications that result in timely triage, disposition and treatment; and provide outreach to veterans, older Americans and underserved populations with limited or no access to behavioral health services. (Page 55/56)

Action Taken or To Be Taken

The Rural Health Care Services Outreach Program authority allows eligible entities to promote health care services outreach through expanding health care services delivery as well as implementing integrated health care networks. The programs under this authority receive applications from rural communities that focus on a variety of topics including mental health outreach which range from direct services to training opportunities. This program has historically had a mental health focus within the Outreach Services, Network Development and Network Planning programs and we expect that to continue. The program has supported 37 organizations in 2010 focused on mental health activities and will continue to fund a number of mental health projects that support innovative models. In addition, the Telehealth Network Grant Program awards projects that demonstrate how telehealth technologies can be used through telehealth networks for various issues, including mental health, that support improved access to and quality of health care services, training and health information technology.

Item 38

Oral Health.-- The Committee recognizes that access to oral health providers can be particularly challenging in rural areas. The Committee encourages HRSA to consider supporting oral healthcare outreach to underserved communities by accredited dental schools. (Page 56)

Action Taken or To Be Taken

The Rural Health Care Services Outreach Program authority allows eligible entities to promote health care services outreach through expanding health care services delivery as well as implementing integrated health care networks. The programs under this authority receive applications from rural communities that focus on a variety of topics including oral health and we expect that to continue. ORHP awarded 17 organizations that focus on a variety of activities related to oral health including dental screening, outreach and health education.

Item 39

Rural Hospital Flexibility Grants. -- The Committee encourages HRSA to coordinate with the Department of Veterans Affairs to ensure that this equipment furthers the goal of treating the illnesses and disabilities of our Nation's veterans. The Committee is particularly concerned with ensuring that veterans receive appropriate mental healthcare. (Page 56)

Action Taken or To Be Taken

HRSA originally met with the VA at the inception of the grant program planning, and has maintained contact throughout the first year. HRSA met with the VA again on December 21, 2011 to explain the refocused grant activities to focus on investments in telehealth and electronic

health records to increase the availability of needed services to veterans living in rural areas. All three grant projects will have a focus on telehealth and/or electronic health records equipment investment going forward, and coordinating with the Veterans Health Administrations within their states to ensure the equipment is located in facilities that were not already targeted through VA funds.

Item 40

Telehealth.-- The Committee is aware of various telemonitoring demonstration programs, including programs for non-homebound patients with chronic heart failure. The Committee believes that telemonitoring has the potential to reduce healthcare costs and improve patient outcomes in rural and frontier areas. The Committee encourages the Office for the Advancement of Telehealth to develop best practices that can reduce healthcare costs throughout the Federal Government. In particular, the Committee encourages HRSA to examine how these programs can scale across a large population, including patient identification and enrollment, communications with treating physicians, technology inventory management, customer support, and program evaluation. (Page 57/58)

Action Taken or To Be Taken

The Office for the Advancement of Telehealth (OAT), located within HRSA's Office of Rural Health Policy (ORHP), provides grant support for the Telehealth Network Grant Program (TNGP) that funds projects that demonstrate the use of telehealth networks to improve healthcare services for medically underserved populations in urban, rural, and frontier communities. Currently OAT has 25 active TNGP grantees that utilize telehealth services to: (a) expand access to, coordinate, and improve the quality of health care services; (b) improve and expand the training of health care providers; and/or (c) expand and improve the quality of health information available to health care providers, patients, and their families. Nine of the 25 grantee focus on the cost and effectiveness of remote vital sign monitoring of individual patients and the delivery of healthcare services to individuals in their place of residence by a healthcare provider using telecommunications technologies to exchange healthcare information over a distance. At this time, OAT does not fund specific projects that conduct remote telemonitoring services which occur outside of the home.

Additionally, OAT administers the Telehealth Resource Center (TRC) grant program, which has funded regional and national centers of excellence. The TRCs provide technical assistance to health care organizations, health care networks, and health care providers in the implementation of telehealth best practices to serve rural and medically underserved areas and populations. As we learn more about telemonitoring from our grantees, we will share those findings with the TRCs so those lessons learned can be shared more broadly within the telehealth field. We will also continue to evaluate the use of this technology to improve health outcomes.

Health Education Assistance Loans
Tab

Health Education Assistance Loans

Table of Contents

FY 2013 Budget

APPROPRIATIONS LANGUAGE

Such sums as may be necessary to carry out the purpose of the program, as authorized by title VII of the PHS Act. For administrative expenses to carry out the guaranteed loan program, including section 709 of the PHS Act, [$2,841,000] *$2,807,000*.

Amounts Available for Obligation
Program and Financing Accounts

	FY 2011 Enacted	FY 2012 Enacted	[1]FY 2013 PB
Balance, start of year	$48,565,000	$69,262,000	-
Appropriation	2,841,000	2,807,000	-
Total Appropriation	2,841,000	2,807,000	-
Collections:			
Upward Re-estimate	26,492,000		-
Downward Re-estimate		-12,013,000	
Interest	4,068,000	4,162,000	
Repayments/Recoveries	5,852,000	3,622,000	
Total collections	36,412,000	-4,229,000	-
Borrowing Authority, Mandatory			
Total available	87,818,000	67,840,000	-
Claims:			
Death and disability	-1,000,000	-3,843,000	-
Defaults	-14,288,000	-9,896,000	
Total claims	-15,288,000	-13,739,000	
Principle Payments on Borrowing			
Administrative BA	-2,841,000	-2,807,000	
Ending balance	$71,238,000	$52,003,000	

[1] The FY 2013 Budget includes General Provision language that would transfer the Health Education Assistance Loan (HEAL) program to the Department of Education. Funding for the administration of HEAL is requested in FY 2013 and will be used by HRSA to administer the HEAL program until the point of transfer. At that time, all unobligated balances of these appropriated resources as well as all other assets and liabilities of the HEAL program will be transferred to the Department of Education.

Amounts Available for Obligation
Liquidating Account

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 PB
Balance, start of year	---	---	---
Appropriation	$1,000,000	$1,000,000	-
Collections:			
Repayments/Recoveries	8,953,000	10,000,000	-
Total available	9,953,000	11,000,000	-
Total claims	-2,689,000	-2,154,000	-
Sweep-up to Treasury	$7,264,000	$8,846,000	-

Summary of Changes

Discretionary Appropriation:		
Increase:	**FTE**	**BA**
2011 HEAL Program Account	13	$2,841,000
2012 HEAL Program Account	-	-
Total Change	-13	-$2,807,000

Budget Authority by Activity

(Dollars in thousands)

	FY 2011 Enacted	**FY 2012 Enacted**	**FY 2013 PB**
Liquidating Account SLIA	$1,000,000	$1,000,000	-
HEAL Program Account:			
Administrative Expenses	$2,841,000	$2,807,000	-

Budget Authority by Object

Liquidating Account

Object Class (33.0)	**FY 2011 Enacted**	**FY 2012 Enacted**	**Increase or Decrease**
Investments and loans	$1,000,000	$1,000,000	---

Budget Authority by Object
Program Account

	FY 2011 Enacted	FY 2012 Enacted	Decrease or Increase
Full-time equivalent employment 1/	12.5	12.5	-
Average GS Grade	12.5	12.5	-
Average GS Salary	$84,800	$84,855	55

1/ Includes 7 FTEs for the Office of HEAL Default Reduction.

Personnel compensation:	FY 2011 Enacted	FY 2012 Enacted	Decrease
Full-time permanent (11.1)	$1,259,000	$1,259,000	-
Other than full-time perm (11.3)			
Other personnel comp (11.5).			
Total personnel comp (11.9)	**$1,259,000**	**$1,259,000**	-
Personnel benefits (12.1)	304,000	304,000	-
Benefits for Former Personnel(13.1)			
Subtotal Pay Costs.	**$1,563,000**	**$1,563,000**	-
Travel and transportation of Persons (21.0)			
Transportation of things (22.0)			
Rental payments to GSA (23.1)	152,000	152,000	-
Printing (24.0)			
Other Contractual Services:			
Other services (25.2)	1,124,000	1,090,000	-34,000
Purchase of goods and services from other Government accounts (25.3)			
Operation and Maintenance of Equipment (25.7)			
Discounts and Interest (25.9)			
Supplies and Materials (26.0)	2,000	2,000	-
Subtotal Other Contractual Services	**$1,278,000**	**$1,244,000**	**-$34,000**
Equipment (31.0)			
Total Budget Authority by Object Class.	**$2,841,000**	**$2,807,000**	**-$34,000**

Salaries and Expenses

Personnel compensation:	FY 2011 Enacted	FY 2012 Enacted	Increase or Decrease
Full-time permanent (11.1)	$ 1,259,000	$1,259,000	
Other than full-time perm (11.3)			
Other personnel comp (11.5).			
Total personnel comp (11.9)	**$1,259,000**	**$1,259,000**	-
Personnel benefits (12.1)	304,000	304,000	
Benefits for Former Personnel(13.1)			-
Subtotal Pay Costs.	**$1,563,000**	**$1,563,000**	-
Travel and transportation of persons (21.0)			
Transportation of things (22.0)			
Rental payments to GSA (23.1)	152,000	152,000	-
Printing (24.0)			
Other Contractual Services:			
Other services (25.2)	1,124,000	1,090,000	-34,000
Purchase of goods and services from other Government accounts (25.3)			
Operation and Maintenance of Equipment (25.7)			
Discounts and Interest (25.9)			
Supplies and Materials (26.0)	2,000	2,000	-
Subtotal Other Contractual Services	1,126,000	1,092,000	-34,000
			-
Subtotal Non-Pay Cost	**$1,278,000**	**1,244,000**	**-$34,000**
Total Salaries and Expenses	**$2,841,000**	**$2,807,000**	**-$34,000**

Authorizing Legislation

	FY 2011 Amount Authorized	FY 2011 Enacted	FY 2012 Amount Authorized	FY 2013 Pres. Budget
Health Education Assistance Loans and Student Loan Insurance Account:				
Appropriation:				
Liquidating Account (SLIA):				
PHS Act, Sec. 710	---[1]	1,000,000	---[1]	1,000,000
Program Account:				
PHS Act, Secs. 709, 720	SSAN[2]	2,841,000	SSAN	2,807,000
Borrowing authority (SLIA):				
PHS Act, Sec 710(b)	---[3]	---	---	---

[1] Sec 710(a)(2) states, "Except as provided in subparagraph (B), all amounts received by the Secretary as premium charges for insurance and as receipts, earnings, or proceeds derived from any claim or other assets acquired by the Secretary in connection with his operations under this subpart, and any other moneys, property, or assets derived by the Secretary from the operations of the Secretary in connection with this section, shall be deposited in the Account."

[2] Such Sums as Necessary

[3] Sec 710(b) states, "If at any time, the moneys in the Account are insufficient to make payments in connection with the collection or default of any loan insured by the Secretary under this subpart, the Secretary of the Treasury may lend the Account such amounts as may be necessary to make the payments involved, subject to the Federal Credit Reform Act of 1990."

APPROPRIATION HISTORY
HEAL Program Account

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2002	3,792,000	3,792,000	3,792,000	3,792,000
Rescission				-1,000
2003	3,914,000	3,914,000	3,914,000	3,914,000
Rescission				-25,000
2004	3,389,000	3,389,000	3,389,000	3,389,000
Rescission				-36,000
2005	3,270,000	3,270,000	3,270,000	3,270,000
Rescission				-26,000
2006	2,916,000	2,916,000	2,916,000	2,916,000
Rescission				-31,000
2007	2,887,000	2,887,000	2,887,000	2,898,000
2008	2,906,000	2,906,000	2,906,000	2,847,000
2009	2,847,000	2,847,000	2,847,000	2,847,000
2010	2,847,000	2,847,000	2,847,000	2,847,000
2011	2,841,000	2,841,000	2,841,000	2,841,000
2012	2,841,000	2,841,000	2,841,000	2,841,000
Rescission				-34,000

APPROPRIATION HISTORY
Liquidating Account

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2002	10,000,000	10,000,000	10,000,000	10,000,000
2003	7,000,000	7,000,000	7,000,000	7,000,000
2004	4,000,000	4,000,000	4,000,000	4,000,000
2005	4,000,000	4,000,000	4,000,000	4,000,000
2006	4,000,000	4,000,000	4,000,000	4,000,000
2007	4,000,000	1,000,000	1,000,000	1,000,000
2008	1,000,000	1,000,000	1,000,000	1,000,000
2009	1,000,000	1,000,000	1,000,000	1,000,000
2010	1,000,000	1,000,000	1,000,000	1,000,000
2011	1,000,000	1,000,000	1,000,000	1,000,000
2012	1,000,000	1,000,000	1,000,000	1,000,000

General Statement

Health Education Assistance Loans (HEAL)

To assist in training students in various health fields, the HEAL program was authorized to provide insured loans for students enrolled in schools of allopathic and osteopathic medicine, dentistry, veterinary medicine, optometry, podiatry, public health, pharmacy, chiropractic, and graduate programs in health administration, clinical psychology and allied health.

Eligible student borrowers obtain loans, to be used for tuition and other reasonable educational and living expenses, from participating commercial lenders, educational institutions, State agencies, insurance companies and pension funds. The repayment of principal and interest is guaranteed by the Federal Government if the borrower becomes permanently disabled, dies, or defaults on the repayments.

Student Loan Insurance Account (SLIA)

The SLIA provides repayments to the lenders on defaulted HEAL loans, and for claims due to the death or disability of student borrowers. Deposits to the fund are derived from insurance premiums charged to the borrowers when the loans are made, repayments of defaulted claims, and if necessary, from borrowing authority and/or appropriations.

Health Education Assistance Loans[1]

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013+/- FY 2012
Liquidating Account	$1,000,000	$1,000,000	$1,000,000	---
HEAL Credit Reform-Direct Operations	$2,841,000	$2,807,000	$2,807,000	---
FTE	13	13	13	---

Authorizing legislation: Sections 701-720 of the Public Health Service Act
FY 2011 Authorization ..... Such Sums as Necessary
FY 2011 Authorization - Liquidating Account..... Such Sums as Necessary
Allocation Method .....Other

Program Description: The Health Education Assistance Loan (HEAL) Program insures loans made by participating lenders to eligible graduate students from 1978 through 1998. Authority to make new loans expired September 30, 1998 and refinancing ended September 30, 2004.

Need: The HEAL program continues to maintain oversight for an outstanding loan portfolio valued at $730 million.

Goal: Maintain oversight for an outstanding loan portfolio, some of which may not be fully repaid until 2037.

Eligible Entity: Designated health professions students.

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Allopathic Medicine • Osteopathic Medicine • Dentistry • Veterinary Medicine Optometry • Podiatry • Public Health • Pharmacy • Health Administration • Clinical Psychology	• Graduate	• Monitor loan payback and pursue defaulters • Maintain and publish list of defaulted borrowers • Process lender claims and borrower requests for forbearance and disability and default reduction activities • Provide technical assistance to States regarding licensing sanctions

[1] The FY 2013 President's Budget transfers the functions, assets and liabilities to the Department of Education.

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Chiropractic Medicine		

Program Accomplishments: Between 1978 and 1998 the program provided $4 billion in loans to help 157,000 students of diverse socio-economic backgrounds pay for their health professions education. Approximately $7.2 billion of HEAL loans were refinanced.

The HEAL Program maintains, and updates quarterly, a list of defaulted HEAL borrowers on the internet. This site includes approximately 959 health professionals who owe the Federal Government approximately $118 million on their defaulted HEAL loans as of November 2011. Millions of dollars have been received from defaulters as a result of the activities associated with publicizing their names.

The Program is scheduled to move to the Department of Education in FY 2013.

Funding History

FY	Amount	Liquidating Account
2008	$2,847,000	$1,000,000
2009	$2,847,000	$1,000,000
2010	$2,847,000	$1,000,000
2011	$2,847,000	$1,000,000
2012	$2,807,000	$1,000,000

Budget Request
The FY 2013 Budget requests $2,807,000 to administer the HEAL program. The FY 2013 Budget also includes General Provision language that would transfer the HEAL program to the Department of Education. Funding for the administration of HEAL will be used by HRSA to administer the HEAL program until the point of transfer. At that time, all unobligated balances of these appropriated resources as well as all other assets and liabilities of the HEAL program will be transferred to the Department of Education.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
9.VII.C.1: Conduct an orderly phase out of the outstanding loan portfolio, resulting in a reduction in the Federal liability associated with the HEAL Program (balance in the portfolio, dollars in millions). (Outcome)	FY 2011: $609 Target: $682 (Target exceeded)	$567	$527	-$40
9.E: Improve claims processing efficiency through implementation of an online processing system (HOPS). (Av. Number of days to process claims)(Efficiency)	FY 2011: 5 days Target: 8 days (Target exceeded)	8 days	8 days	Maintain

Vaccine Injury Compensation Program

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FY 2013 Budget Page

APPROPRIATION LANGUAGE

For payments from the Vaccine Injury Compensation Program Trust Fund (``Trust Fund''), such sums as may be necessary for claims associated with vaccine-related injury or death with respect to vaccines administered after September 30, 1988, pursuant to subtitle 2 of title XXI of the PHS Act, to remain available until expended: Provided, That for necessary administrative expenses, not to exceed $6,489,000 shall be available from the Trust Fund to the Secretary. (Department of Health and Human Services Appropriations Act, 2012.)

Amounts Available for Obligation

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Pres. Budget
Unobligated Balance, Start of Year	16,000,000	19,000,000	9,000,000
Receipts	274,000,000	283,000,000	293,000,000
Interest Income	71,000,000	74,000,000	16,000,000
Total, Receipts/Collections			
Total Balance/Net Collections	361,000,000	376,000,000	318,000,000
Claims Appropriation (Obligation)	$220,000,000	$235,000,000	$235,000,000
Total Admin.DOJ/Claims Ct/HRSA	17,000,000	19,000,000	19,000,000
Total New Obligations	$248,000,000	$254,000,000	$261,000,000
Unobligated Balance, End of Year	19,000,000	9,000,000	1,000,000

Budget Authority by Activity

	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 Pres. Budget
Trust Fund Obligations: Post-10/1/88 claims	$220,000,000	$235,000,000	$235,000,000
Administrative Expenses: HRSA Direct Operations	$6,489,000	$6,477,000	$6,477,000
Total Obligations	$226,489,000	$241,477,000	$241,477,000

Budget Authority by Object

	FY 2011 Appropriation	FY 2013 Pres. Budget	Increase or Decrease
Insurance claims and indemnities	$220,000,000	$235,000,000	$15,000,000
Other Services (25.2)	$6,489,000	$6,477,000	$-120,000
Total	$199,502,000	$241,502,000	$15,000,000

Authorizing Legislation

	FY 2011 Amount Authorized	FY 2012 Enacted	FY 2013 Amount Authorized	FY 2013 Pres. Budget
(a) PHS Act, Title XXI, Subtitle 2, Parts A and D:				
Pre-FY 1989 Claims	110,000,000	---	110,000,000	---
Post-FY 1989 Claims	Indefinite	SSAN	Indefinite	$235,000,000
(b) Sec. 6601 (r)d ORBA of 1989 (P.L. 101-239):				
HRSA Operations	Indefinite	6,489,000	Indefinite	6,477,000

Appropriation History Table
(Pre-1988 Claims Appropriation)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1996	110,000,000	110,000,000	110,000,000	110,000,000
1997	110,000,000	110,000,000	110,000,000	110,000,000
1998	---	---	---	---
1999	---	---	100,000,000	100,000,000
2000	---	---	---	---
2001	---	---	---	---
2002	---	---	---	---
2003	---	---	---	---
2004	---	---	---	---
2005	---	---	---	---
2006	---	---	---	---
2007	---	---	---	---
2008	---	---	---	---
2009	---	---	---	---
2010	---	---	---	---
2011	----	----	---	----
2012	----	----	---	----

Vaccine Injury Compensation Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget	FY 2013 + / - FY 2012
Claims BA	$220,000,000	$235,000,000	$235,000,000	---
Admin BA	$6,489,000	$6,477,000	$6,477,000	---
Total BA	$226,489,000	$241,477,000	$241,477,000	---
FTE	22	22	22	---

Authorizing Legislation – Title XXI, Subtitle 2, Parts A and D, of the Public Health Service Act as amended, and related legislation.

FY 2013 Authorization ..... Such Sums as Necessary

Allocation Method .....Other

Program Description and Accomplishments

The National Childhood Vaccine Injury Act of 1986 (the Act) established the National Vaccine Injury Compensation Program (VICP) to equitably and expeditiously compensate individuals, or families of individuals, who have been injured by childhood vaccines, and to serve as a viable alternative to the traditional tort system. The Health Resources and Services Administration (HRSA) administers the VICP in conjunction with the Department of Justice (DOJ) and the U.S. Court of Federal Claims (Court). HRSA has been delegated the authority to administer Parts A and D of Subtitle 2. Consistent with this delegation, HRSA:

- Receives petitions for compensation served on the Secretary of HHS (the Secretary);
- Arranges for medical review of each petition and supporting documentation by physicians with special expertise in pediatrics and adult medicine, and develops recommendations to the Court regarding the eligibility of petitioners for compensation;
- Publishes notices in the Federal Register of each petition received;
- Promulgates regulations to modify the Vaccine Injury Table;
- Provides administrative support to the Advisory Commission on Childhood Vaccines (ACCV), composed of nine voting members, including health professionals, attorneys, and parents of children who have suffered a vaccine-related injury or death, and specified HHS agency heads (or their designees);
- Informs the public of the availability of the Program; and
- Processes award payments to petitioners, and their attorneys, for judgments entered by the Court; and informs the public of the availability of the VICP.

As of October 2011, close to 2,800 families and individuals have been awarded compensation totaling over $2.2 billion since the Program's inception. FY 2007 through FY 2010 resulted in the largest outlays since VICP's inception, with over $457.2 million in compensation awards to more than 527 families and individuals. Over 420 claims were filed in FY 2010 (versus an average of 161 non-autism claims filed annually over the preceding five years) and over 170 families and individuals were awarded compensation totaling $189 million, which is approximately $100 million more than the average amount of outlays from FY's 2000-2009. In FY 2011, over 382 non-autism claims were filed and 250 families and individuals have been awarded compensation totaling over $234 million. (Yearly outlay totals include payments for attorneys' fees and costs.)

In August 2011, the Institute of Medicine (IOM) released its third consensus report on the epidemiological, clinical, and biological evidence surrounding adverse events associated with 12 vaccines covered by the VICP. The vaccines are varicella zoster, influenza, hepatitis B, human papillomavirus, measles-mumps-rubella, hepatitis A, meningococcal, and tetanus-containing vaccines such as diphtheria and tetanus toxoids and-acellular pertussis vaccines. Two previous IOM reports published in 1991 and 1994 led to the Secretary adding injuries/conditions to the Vaccine Injury Table. The Table provides petitioners with a presumption of vaccine causation (and entitlement to compensation), if certain legal requirements are met. Since the last set of IOM report-related Table modifications in 1997, nine vaccines have been added to VICP, but there has been no independent examination of the adverse events associated with the use of these vaccines. As mandated under the Act, the Secretary must consult with the ACCV and seek public comment before any modifications to the Table are made.

The VICP performance measures are focused on the timely adjudication of vaccine injury claims and monetary awards. From FY 2005-2009, the target for the percentage of eligible claimants who were awarded compensation, but opted to reject awards and elected to pursue civil action has been zero percent, and the VICP has met its target each of these fiscal years. In FY 2007, the VICP did not meet its target of 1,213 days for the average time to process claims due to petitioner and Court-driven delays in adjudicating claims. For the time period of FY 2007, the performance outcome was 1,337 days. However, the VICP target average time to process claims was successfully met for FY 2006, FY 2008, FY 2009, FY 2010 and FY 2011, with the FY 2011 result being 993 days. The VICP has consistently exceeded its targets for the percentage of cases where the deadline for the Rule 4(b) report is met once the case has been deemed complete. In FY 2010, the Rule 4(b) report deadline was met for nearly 96 percent of the cases that were deemed complete (which is slightly more than in FY 2009), and performance remained steady once again in FY 2011 at nearly 96 percent. Quickly and efficiently processing settlements is a top priority for the VICP. In FY 2011, the percentage of cases in which settlements were processed within 15 weeks was 100 percent which surpassed the target of 92 percent.

Performance outcome data are reported to HHS Office of General Counsel (OGC), as a participant in the process, and to the Healthcare Systems Bureau (HSB), on a regular basis. In FY 2011, VICP paid lump sum only awards within an average of 4.9 days, exceeding the eight day target. Additionally, with an average time of 9.4 days, VICP exceeded the FY 2011 target to approve settlements within an average of ten days. During FY 2011, the VICP received more than double the average number of claims and processed twice as many negotiated settlements

over the last three fiscal years. This level of filed claims and settlements is expected to be maintained through FY 2013. Each DOJ settlement proposal requires OGC review and preparation of a legal opinion for VICP. In addition, consultation with DOJ attorneys to clarify or amend elements in the settlement proposal is often required during the approval process. To reflect the increased rate of claims, settlements, and time needed for review and processing, the FY 2011 target was revised to ten days.

Funding History

VICP Awards

FY	Amount
FY 2008	$90,402,646
FY 2009	$89,706,702
FY 2010	$193,906,900
FY 2011	$234,991,887
FY 2012	$235,000,000

Budget Request

The FY 2013 Claims Awards Request of $235,000,000 is equal to the FY 2012 Enacted Level.

The FY 2013 Administrative Request of $6,477,000 is equal to the FY 2012 Enacted Level.

The FY 2013 Request will fund the following:

VICP Claims Awards - The VICP awards payments to individuals or families of individuals, who have thought to have been injured, or have died, as the result of receiving a vaccine(s) recommended by the Centers for Disease Control and Prevention (CDC) for routine administration to children. In FY 2013, HRSA estimates that $235,000,000 will be paid out of the Vaccine Injury Compensation Trust Fund (Trust Fund) for payment of Court-ordered awards for alleged vaccine-related injuries or deaths. These funding levels are necessary to account for potential outlays resulting from the processing of claims ordered by the Court that require medical reviews of increasing numbers of non-autism claims filed annually, medical reviews for certain autism claims, and compensation for injuries and attorneys' fees and costs. The significant increase in non-autism claims is primarily the result of the addition of the influenza vaccine to the VICP, which now accounts for approximately 50 percent of claims filed annually.

This Claims Award funding level will ensure adequate funds are available to pay awards allowing the VICP to continue to meet its zero percent target for the percentage of eligible claimants who opt to reject awards and elect to pursue civil action.

Administrative Expenses - HRSA anticipates using $6,477,000 from the Trust Fund for administrative expenses to cover costs associated with the internal medical review of claims, external medical review of claims by outside consultants (including, where warranted, expert testimony to the Court), professional and administrative support to the ACCV, meeting specific

administrative requirements of the Act, processing award payments, maintaining necessary records, and informing the public of the availability of the VICP.

Non-autism claim filings have increased significantly over the past three years, primarily due to the addition of influenza vaccines in 2005. Over 400 claims were filed in FY 2010 versus an average of 161 non-autism claims filed annually from FY 2000-2008. As of October 2011, 382 non-autism claims had been filed in FY 2011. This upward trend is likely to continue with the February 2010 recommendation by CDC of universal use of influenza vaccines for all individuals over the age of six months. Further, claims alleging injury from the influenza pandemic H1N1 vaccine, which were initially filed with the Countermeasures Injury Compensation Program in 2009 when it was a single virus vaccine, will now be filed with the VICP, since the H1N1 vaccine virus was made part of the 2010 seasonal influenza vaccine.

The Administrative funding level will allow the utilization of medical experts to consult and provide testimony in defending claims on behalf of the Secretary before the U. S. Court of Federal Claims, targeting the number of claims compensated near FY2011 levels.

Work on updating the Vaccine Injury Table following release in August 2011 of the IOM's report on vaccines and adverse events will be initiated. Many stakeholders, including Congress have voiced interest and concern over keeping the Vaccine Injury Table in line with current science, a program objective that is included as a strategy in Goal 4 of the HHS' National Vaccine Plan. However, medical reviews, meeting court deadlines, and defending claims take priority over updating the Table.

Beginning in 2001, parents began filing petitions under the VICP alleging autism (or autism spectrum disorder) from either measles-mumps-rubella (MMR) vaccine or thimerosal-containing vaccines, or from both. In 2002, the Chief Special Master of the Court created the Omnibus Autism Proceeding to adjudicate the thousands of claims that were expected. As of December 2011, over 5,600 cases have been filed, and approximately 3,000 cases are pending. Some Petitioners have withdrawn, as is the Petitioners' statutory right, and may be pursuing claims against vaccine manufacturers in civil court, and some petitions have been dismissed because they were filed after the statute of limitations had expired.

Omnibus hearings on entitlement to compensation for two theories of causation were held in 2007 and 2008. Three test cases were utilized for each theory and three special masters issued opinions on general causation, and causation in one of the three test cases for each theory. Theory 1 hearings looked at whether MMR vaccine, administered alone or in conjunction with thimerosal-containing vaccines, can cause autism or autism spectrum disorders, while the Theory 2 hearings determined whether thimerosol-containing vaccines can cause autism or autism spectrum disorders. Decisions in the six test cases in favor of the respondent were handed down by the U.S. Court of Federal Claims in 2009 and 2010. Appeals of the Theory 1 test cases were decided in favor of the respondent, and affirmed on appeal. Petitioners chose not to appeal the Theory 2 test case decisions.

Although test case proceedings have ended, the disposition of thousands of pending autism claims remains uncertain. In 2010, the Court began issuing orders to determine which petitioners

want to pursue other theories of causation. Of the 3,000 autism claims pending it is uncertain how many will require medical reviews to determine if they were timely filed. Some petitioners are electing to pursue other theories, such as mitochondrial or metabolic disorders. Such claims will be tried on an individual basis and will require HRSA medical reviews and may require the use of medical experts for hearings.

HRSA will continue efforts to better publicize the VICP. HRSA has been criticized for not adequately promoting public awareness of the VICP. With this funding, HRSA will continue to develop a comprehensive national outreach campaign in an effort to better inform the public and health professionals about the VICP.

The Vaccine Injury Compensation Program co-funds the HRSA - HSB Injury Compensation System Information Technology Investment. The Injury Compensation System (ICS) supports the strategic and performance outcomes of both the VICP and Countermeasures Injury Compensation Program (CICP) by efficiently and effectively facilitating program administration, claims administration and monitoring, management reporting, and secure document management. The ICS will ensure there are not duplicate claims filed under both the VICP and CICP and will capture critical data on people adversely affected after receipt of vaccines or countermeasures. Funding for the CICP comes from the Public Health and Social Services Emergency Preparedness Fund.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
26.II.A.1: Percentage of cases in which judgment awarding compensation is rejected and an election to pursue a civil action is filed.	FY 2011: 0% Target: 0% (Target Met)	0%	0%	Maintain
26.II.A.2: Average claim processing time.	FY 2011: 993 days Target: 1,300 days (Target Exceeded)	1,300 days	1,300 days	Maintain
26.II.A.3: Percentage of cases where the deadline for the Rule 4(b) report is met once the case has been deemed complete.	FY 2011: 95.7% Target: 86% (Target Exceeded)	86%	86%	Maintain
26.II.A.4: Decrease the average time settlements are approved from the date of receipt of the DOJ	FY 2011: 9.4 days Target:10 days (Target Exceeded)	10 days	10 days	Maintain

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
settlement proposal.				
26.II.A.5: Decrease the average time that lump sum only awards are paid from the receipt of all required documentation to make a payment.	FY 2011: 4.9 days Target: 8 days (Target Exceeded)	8 days	8 days	Maintain
26.E: Percentage of cases in which case settlements are completed within 15 weeks.	FY 2011: 100% Target: 92% (Target Exceeded)	92%	92%	Maintain