DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2016

Health Resources and Services Administration

Justification of Estimates for Appropriations Committees

MESSAGE FROM THE ADMINISTRATOR

I am pleased to present the FY 2016 Congressional Justification for the Health Resources and Services Administration (HRSA). HRSA is the primary Federal agency for improving access to health care by strengthening the health care workforce, building healthy communities and achieving health equity. HRSA's programs provide health care to those that are medically underserved, uninsured or underinsured. The FY 2016 Budget requests $10.4 billion, including $4.1 billion in mandatory funding, to invest in and expand programs that will help individuals and families, including the newly insured, access services and providers that meet their health care needs.

In FY 2016, the Health Center program will continue to play a critical role in the health care system by proving high quality, affordable and comprehensive primary care services in medically underserved communities even as insurance coverage expands. The budget requests the resources needed to meet a surge in newly-insured patients seeking care at health centers across the country. Health centers remain a vital source of primary care for patients who cannot gain access to coverage, as well as insured patients seeking a quality source of care for services not covered by insurance. The Budget provides $4.2 billion for the Health Centers Program in FY 2016, including $2.7 billion in new mandatory resources. The Budget also requests $2.7 billion in each FYs 2017 and 2018, for a total of $8.1 billion in new mandatory funding over three years.

The FY 2016 Budget invests resources to increase the number of health care practitioners in areas of the country experiencing shortages. The FY 2016 Budget provides $1.8 billion for workforce programs in HRSA, a total that includes $923 billion in mandatory funding. The Budget requests strategic investments in graduate medical education, the National Health Service Corps, as well as workforce diversity efforts. The Budget provides $14 million to establish a new program to increase the diversity and cultural competence of the health professions workforce providing care to underserved communities. Additionally, the Budget invests in health workforce programs that target a number of specific disciplines and competencies, including oral health, mental and behavioral health, and geriatric medicine. By addressing the supply and distribution of certain health professionals, the diversity of the health workforce, and the need for training in contemporary practices focused on more efficient models of care, the Budget works toward ensuring that all Americans have access to quality clinicians.

The Budget requests $1.4 billion to improve the health of mothers and children. Of this amount, $500 million is requested in FY 2016 and $15 billion through FY 2025 to extend and expand the Maternal, Infant, and Early Childhood Home Visiting Program (Home Visiting), which allows states to implement voluntary, evidence-based home visiting services to women during pregnancy and to parents with young children.

The Budget includes $128 million to improve both access to and the quality of health care in rural areas. It 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. The Budget also provides $4 million to fund new Rural Health

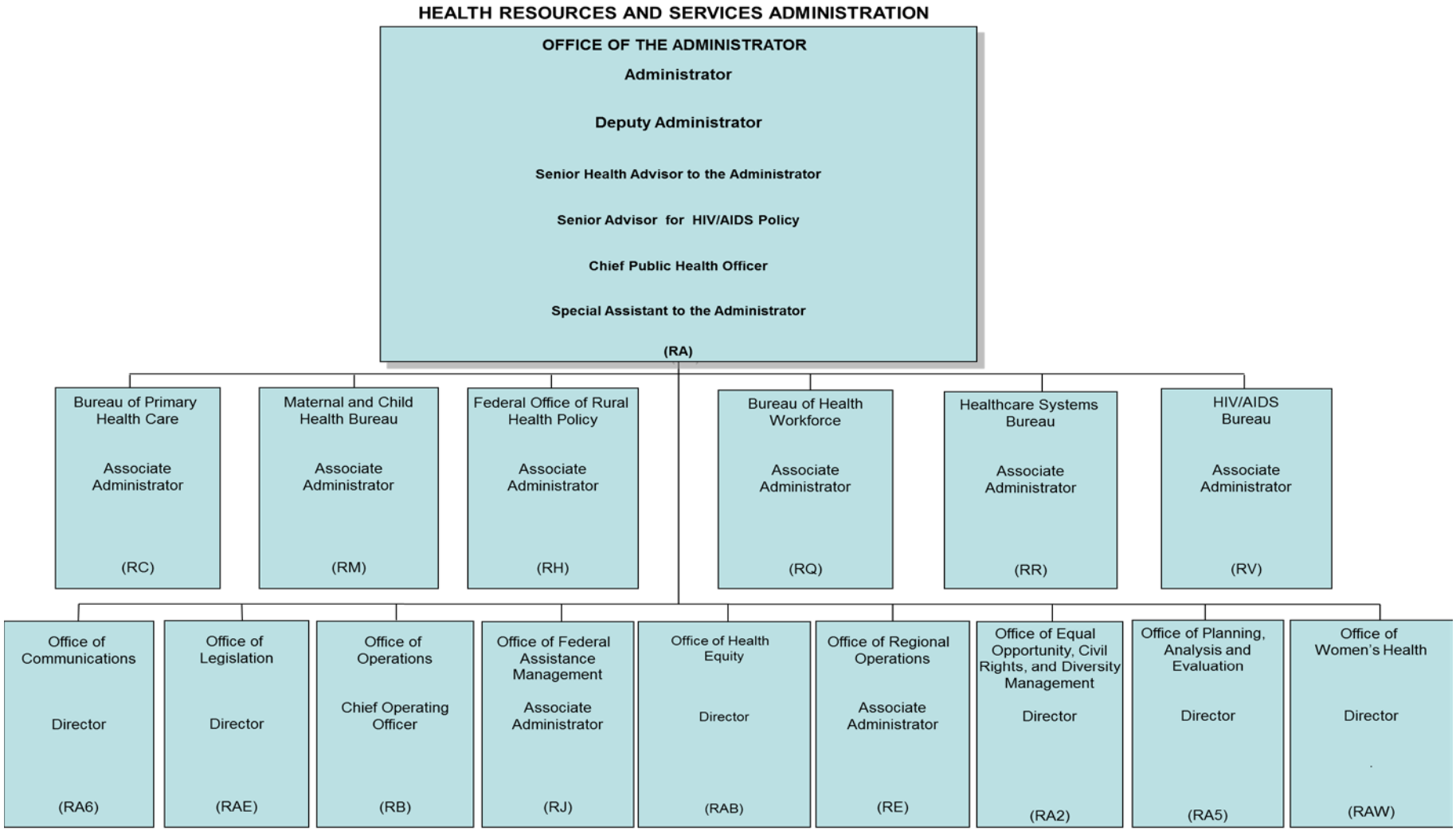
Physician grants to help rural-focused training programs recruit and graduate students most likely to practice medicine in underserved areas.

The Budget includes $2.3 billion for the Ryan White program to improve and expand access to care for persons living with HIV/AIDS. Of this amount, $900 million is included for the AIDS Drug Assistance Program. The Budget request also proposes to consolidate funds from Part D with Part C. By consolidating the two programs, resources can be better targeted to points along the care continuum and populations most in need, while reducing duplication of effort and administrative burden among grantees.

The FY 2016 Budget allows the Health Resources and Services Administration to take important steps toward improving health care access, particularly for underserved populations.

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

Organizational Chart



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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, 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, cultural, or other barriers. In recent years, components of the HRSA-supported safety net, including the Health Center Program, the National Health Service Corps, and a variety of health workforce programs, have expanded to address these and other access problems. However, there are still Americans without health insurance coverage and who need access to affordable health care. The FY 2016 Budget continues to make investments in Federal public health and safety net programs to help these individuals get the medical services they need.

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:

- Americans who have trouble accessing health care --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 infection,
- The more than 100,000 Americans who are waiting for an organ transplant.

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

Overview of Budget Request

The FY 2016 President's program level request is $10.4 billion for the Health Resources and Services Administration (HRSA). This is $45 million above the FY 2015 Enacted Level.

Highlights of the major programs are listed below:

Health Centers -$809 million in mandatory funding; total program $4.2 billion – This funding level is projected to serve approximately 28.6 million patients in 2016, an increase of 1.1 million patients over 2015. This request is projected to support 75 new access point grants, and continuation and quality improvement activities for more than 1,300 health centers operating over 9,000 primary care sites, including recognizing centers performing at exceptional levels.

Health Workforce +$105 million in discretionary funding; +$635 million in mandatory funding; +$0.914 million in user fees; total program; $1.8 billion

- *National Health Service Corps (NHSC)+$287 million in discretionary; +$235 million in mandatory; total program $810 million:* The budget request will fund 11,390 new and continuation loan repayment awards, over 343 new and continuation scholarship awards, approximately 464 state loan repayment awards and 125 students to service loan repayment awards. This request includes new investments to bolster the Nation's health workforce and to improve the delivery of health care across the country. Between FY 2016 and FY 2020, HRSA will devote a total of $2.6 billion in mandatory funding to the National Health Service Corps to address health professional shortages in high-need rural and urban communities across the country.

- *Targeted Support for the Graduate Medical Education Program*: +$400 million in new mandatory funding in FY 2016 and a total of $5.25 billion is requested over FY 2016-FY 2025. Over ten years, this program will support more than 13,000 in community-based ambulatory care settings that provide a range of training experiences that address key health care workforce development needs. The program will advance key workforce goals, including the training of more physicians in primary care and other high need specialties, aligning training with more efficient and effective care delivery models, and encouraging physicians to practice in rural and other underserved areas.

- *Health Professions Training for Diversity*: The Budget includes a net increase of $3 million for the health workforce diversity programs. The following programs reflects changes:

    - +$14 million for Health Workforce Diversity Program. This new program will fund activities that create a career pipeline for health professions students that lead directly to service in underserved communities.

- +$3 million for the Centers of Excellence. This request will provide additional support to qualifying health professions schools to facilitate faculty and student research on health issues particularly affecting Under Represented Minority (URM) groups, strengthen programs to enhance the academic performance of URM students attending the school, and promote faculty development in various areas, including diversity and cultural competency.

- -$14 million for Health Careers Opportunity Program (HCOP). Funding for this activity is eliminated as part of the Science, Technology, Engineering, and Mathematics Education consolidation.

- +$10 million for Clinical Training in Interprofessional Practice. The goal of this program is to increase the capacity of primary health care teams to: (1) deliver quality, coordinated, safe and efficient care to patients, families and communities and (2) inform academic institutions of the training needed to prepare future health care providers for practice in term-based health care. This request will support approximately 12 awards of approximately $750,000 per year.

  +$4 million Rural Physician Training Grants Program. This funding supports a new program that focuses on recruiting and training physician students in rural settings with the goal of increasing the number of medical school graduates who practice in rural communities. This request will support 10 grantees that will train a minimum of 100 students.

- -$30 million for Area Health Education Centers. It is anticipated that the AHEC Program grantees may be able to support on-going activities through other funding sources. The budget reflects the prioritization of funding to programs that directly increase the number of primary care providers.

- -$4 million for Public Health/Preventive Medicine. This request eliminates funding for the Integrated Medicine program.

- -$165 million for the Children's Graduate Medical Education Program. The request of $100 million will support the direct medical expenses for graduate medical education.

<u>Maternal and Child Health +$97.5 million Mandatory; total program $1.4 billion</u> – This funding level will support an increase of $100 million for the mandatory Home Visiting program, and a decrease of -$2.5 million for Family to Family Health Information Centers. The increase in the Home Visiting program will allow up to 10 additional competitive State awards with 130,000 more home visits and 35,000 more participants served compared to FY2015 targets. The target for Tribal grantees will increase by 11 grantees. The requested funding will continue to support States and Tribal entities as they work with local implementing agencies to maintain programs and to expand home visiting services to additional at-risk communities. The authorization for the Family to Family program expires in FY 2015 and additional funds are not requested.

Instead, families of children with special health care needs can seek support and wrap around services through state grants provided by the Maternal and Child Health Block Grant.

HIV/AIDS +$4 million; total program $2.3 billion – The FY 2016 Budget includes $900 million for the AIDS Drug Assistance Programs (ADAP) to provide access to life saving HIV related 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. The Budget proposes to consolidate the Part D Program with the Part C Program. The consolidation expands the focus on women, infants, children and youth across all the funded grantees and will increase points of access for the population. In addition, it reduces duplication of effort and reporting/administrative burden among currently co-funded grantees. By consolidating the two programs, resources are better targeted to points along the care continuum to improve patient outcomes. This will result in more funding for direct patient care services.

Healthcare Systems +$7 million in discretionary funding; +$7.5 million in user fees; total programs $118 million. The Budget includes an increase of $7 million in discretionary funding for the 340B Program as HRSA significantly increases its commitment to program integrity and compliance. The request would enable full implementation of the statutory obligations for the 340B Program, and enhance oversight of participating manufacturers and covered entities. The Budget also proposes a new cost recovery/user fee program as a long term financing strategy to support program activities.

Rural Health -$20 million; total program $128 million- No funding is requested for the Rural and Community Access to Emergency Device program. Activities related to access to emergency medical devices and training in FY 2016 may be addressed through other funding sources available to grantees, such as the Rural Outreach and Rural Network Development programs. The Budget also reflects a decrease of -$15million for the Rural Hospital Flexibility Grant program. The FY 2016 Budget for the Rural Hospital Flexibility Grant program allows core activities to be targeted to the area of greatest need with a focus on Critical Access Hospitals (CAHs). The Budget will continue to support 45 Flex grant programs to support critical access hospitals and 3 grants to support rural veterans.

Family Planning +$14 million; total program $300 million - The Budget will expand family planning services to low income individuals by improving access to family planning centers and preventive services. The Budget request is expected to support family planning services for approximately 4.7million persons, with approximately 90 percent having family incomes at or below 200 percent of the federal poverty level.

Program Management +$3 million; total program $157 million – This request supports program management activities to effectively and efficiently support HRSA's operations.

Overview of Performance

This Performance Budget documents the progress HRSA has made and expects to make in meeting the needs of 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, categorized by HRSA goals and HHS strategic objectives to indicate the close alignment of specific programmatic activities and objectives with broader HRSA and Departmental priorities. 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

HRSA Goals: *Improve access to quality health care and services; Improve health equity*
HHS Objectives: *Ensure access to quality, culturally competent care, including long-term services and supports, 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 2016, the Health Center program projects that it will serve 28.6 million patients. This is an expected increase of 6.9 million over the 21.7 million persons served in FY 2013.

- HRSA expects to serve 34 million children through the Maternal and Child Health Block Grant (Title V) in FY 2016.

- The Maternal, Infant, and Childhood Home Visiting Program made 746,000 home visits to families receiving services in FY 2014, exceeding the target of 450,000. In FY 2016 the number of home visits is expected to reach 935,000.

- In FY 2016, HRSA's Ryan White HIV Emergency Relief Grants (Part A) and HIV Care Grants to States (Part B) are projected to support, respectively, 1.963 million visits and 1.80 million visits for health-related care (primary medical, dental, mental health, substance abuse, and home health).

- By supporting AIDS Drug Assistance Program (ADAP) services to an anticipated 212,107 persons in FY 2016, 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.

- The number of organ donors and the number of organs transplanted have increased substantially in recent years. In FY 2016, HRSA's Organ Transplantation program projects that nearly 25,800 deceased donor organs will be transplanted, up from 25,435 in FY 2013.

- 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 3.34 million adult volunteer potential donors of minority race and ethnicity listed on the donor registry in FY 2016. Nearly 3.1 million were listed on the registry in FY 2013.

HRSA Goal: Strengthen the health workforce
HHS Objective: *Ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations*

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 2014, the National Health Service Corps (NHSC) had a field strength of 9,242 primary care clinicians. The NHSC projects that a field strength of 15,000 primary care clinicians will be in health professional shortage areas in FY 2016.

- In FY 2016, 7,800 health care providers are projected to be deemed eligible for FTCA malpractice coverage through the Free Clinics Medical Malpractice program, an increase of 1,020 providers over FY 2013. The program encourages providers to volunteer their time at sponsoring free clinics.

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 and many do this by focusing on improving the infrastructure of the health care system.

- In FY 2016, 95.7% of Ryan White Program-funded primary care providers are expected to have implemented a quality management program.

- In FY 2016, 93% 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 87.3% in FY 2012.

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, which 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 produces an *Annual Performance Report* that shows trends in performance of HRSA's Bureaus and Offices. The *Report*, posted on-line, provides information for performance assessment purposes and also gives transparency to HRSA's performance results.

All-Purpose Table
Health Resources and Services Administration

(Dollars in Thousands)

Program	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
PRIMARY CARE:				
Health Centers:				
Health Centers	1,396,827	1,391,529	1,391,529	-
Health Centers ACA Mandatory	2,144,716	3,509,111	-	-3,509,111
Health Centers Proposed Mandatory	-	-	2,700,000	+2,700,000
Health Center Tort Claims	94,655	99,893	99,893	-
Subtotal, Health Centers	***3,636,198***	***5,000,533***	***4,191,422***	***-809,111***
Free Clinics Medical Malpractice	40	100	100	-
Subtotal, PL Bureau of Primary Health Care (BPHC)	**3,636,238**	**5,000,633**	**4,191,522**	**-809,111**
Subtotal, Mandatory BPHC (non-add)	*2,144,716*	*3,509,111*	*2,700,000*	*-809,111*
Subtotal, Discretionary BA BPHC (non add)	*1,491,522*	*1,491,522*	*1,491,522*	-
HEALTH WORKFORCE:				
National Health Service Corps (NHSC):				
NHSC	-	-	287,370	+287,370
NHSC Current Law ACA Mandatory	283,040	287,370	-	-287,370
NHSC Proposed Mandatory	-	-	522,630	+522,630
Subtotal, NHSC	***283,040***	***287,370***	***810,000***	***+522,630***
Loan Repayment/Faculty Fellowships	1,187	1,190	1,190	-
Health Professions Training for Diversity:				
Centers of Excellence	21,657	21,711	25,000	+3,289
Scholarships for Disadvantaged Students	44,857	45,970	45,970	-
Health Careers Opportunity Program	14,153	14,189	-	-14,189
Health Workforce Diversity	-	-	14,000	+14,000
Subtotal, Health Professions Training for Diversity	***80,667***	***81,870***	***84,970***	***+3,100***
Health Care Workforce Assessment	4,651	4,663	4,663	-
Primary Care Training and Enhancement	36,831	38,924	38,924	-
Oral Health Training Programs	31,928	33,928	33,928	-
Rural Physician Training Grants	-	-	4,000	+4,000
Targeted Support for Graduate Medical Education Proposed Mandatory	-	-	400,000	+400,000
Interdisciplinary, Community-Based Linkages:				

Area Health Education Centers	30,250	30,250	-	-30,250
Geriatric Programs	33,237	34,237	34,237	-
Mental and Behavioral Health	7,896	8,916	8,916	-
Clinical Training in Interprofessional Practice	-	-	10,000	+10,000
Subtotal, Interdisciplinary, Community-Based Linkages	***71,383***	***73,403***	***53,153***	***-20,250***
Public Health Workforce Development:				
Public Health/Preventive Medicine	18,131	21,000	17,000	-4,000
Nursing Workforce Development:				
Advanced Nursing Education	61,089	63,581	63,581	-
Nursing Workforce Diversity	15,641	15,343	15,343	-
Nurse Education, Practice and Retention	37,913	39,913	39,913	-
Nurse Faculty Loan Program	24,500	26,500	26,500	-
Comprehensive Geriatric Education	4,350	4,500	4,500	-
NURSE Corps Scholarship and Loan Repayment Program	79,785	81,785	81,785	-
Subtotal, Nursing Workforce Development	***223,278***	***231,622***	***231,622***	**-**
Children's Hospitals Graduate Medical Education	264,335	265,000	100,000	-165,000
National Practitioner Data Bank (User Fees)	*27,456*	*18,814*	*19,728*	*+914*
Subtotal, PL Health Workforce	**1,042,887**	**1,057,784**	**1,799,178**	**+741,394**
Subtotal, User Fees HW (non-add)	*27,456*	*18,814*	*19,728*	*+914*
Subtotal, Discretionary HW (non-add)	*732,391*	*751,600*	*856,820*	*+105,220*
Subtotal, Mandatory HW (non-add)	*283,040*	*287,370*	*922,630*	*635,260*
MATERNAL & CHILD HEALTH:				
Maternal and Child Health Block Grant	632,409	637,000	637,000	-
Autism and Other Developmental Disorders	47,099	47,099	47,099	-
Traumatic Brain Injury	9,321	9,321	9,321	-
Sickle Cell Service Demonstrations	4,455	4,455	4,455	-
James T. Walsh Universal Newborn Hearing Screening	17,818	17,818	17,818	-
Emergency Medical Services for Children	20,162	20,162	20,162	-
Healthy Start	100,746	102,000	102,000	-
Heritable Disorders	11,883	13,883	13,883	-
Family to Family Health Information Centers Current Law Mandatory/1	5,000	2,500	-	-2,500
Maternal, Infant and Early Childhood Visiting Program Current Law Mandatory/1	371,200	400,000	-	-400,000
Maternal, Infant and Early Childhood Visiting Program Proposed Mandatory	-	-	500,000	+500,000
Subtotal, Maternal and Child Health Bureau	**1,220,093**	**1,254,238**	**1,351,738**	**+97,500**
Subtotal, Discretionary MCHB (non add)	*843,893*	*851,738*	*851,738*	-

Subtotal, Mandatory MCHB (non add)	*376,200*	*402,500*	*500,000*	*+97,500*
HIV/AIDS:				
Emergency Relief - Part A	649,373	655,876	655,876	-
Comprehensive Care - Part B	1,314,446	1,315,005	1,315,005	-
AIDS Drug Assistance Program (non-add)	*900,313*	*900,313*	*900,313*	-
Early Intervention - Part C	205,544	201,079	280,167	+79,088
Children, Youth, Women & Families - Part D	72,395	75,088	-	-75,088
AIDS Education and Training Centers - Part F	33,275	33,611	33,611	-
Dental Reimbursement Program Part F	12,991	13,122	13,122	-
Special Program of National Significance (SPNS)	-	25,000	25,000	-
SPNS Evaluation Funding	*25,000*	-	-	-
Subtotal, HIV/AIDS	**2,313,024**	**2,318,781**	**2,322,781**	**+4,000**
Subtotal, Discretionary HIV/AIDS Bureau (non-add)	*2,288,024*	*2,318,781*	*2,322,781*	*+4,000*
Subtotal, Evaluation Funding HIV/AIDS Bureau (non-add)	*25,000*	-	-	-
HEALTHCARE SYSTEMS:				
Organ Transplantation	23,490	23,549	23,549	-
National Cord Blood Inventory	11,238	11,266	11,266	-
C.W. Bill Young Cell Transplantation Program	22,054	22,109	22,109	-
Poison Control Centers	18,799	18,846	18,846	-
340B Drug Pricing Program/Office of Pharmacy Affairs	10,212	10,238	24,738	+14,500
340B Drug Pricing Program User Fees (non-add)	-	-	*7,500*	*+7,500*
Hansen's Disease Center	15,168	15,206	15,206	-
Payment to Hawaii	1,852	1,857	1,857	-
National Hansen's Disease Program - Buildings and Facilities	122	122	122	-
Subtotal, Healthcare Systems Bureau	**102,935**	**103,193**	**117,693**	**+14,500**
Subtotal, User Fees HSB	-	-	*7,500*	*+7,500*
Subtotal, Discretionary HSB	*102,935*	*103,193*	*110,193*	*+7,000*
RURAL HEALTH:				
Rural Health Policy Development	9,328	9,351	9,351	-
Rural Health Outreach Grants	56,857	59,000	59,000	-
Rural & Community Access to Emergency Devices	3,356	4,500	-	-4,500
Rural Hospital Flexibility Grants	40,507	41,609	26,200	-15,409
State Offices of Rural Health	9,487	9,511	9,511	-
Radiation Exposure Screening and Education Program	1,829	1,834	1,834	-
Black Lung	6,749	6,766	6,766	-

Telehealth	13,865	14,900	14,900	-
Subtotal, Office of Rural Health Policy	**141,978**	**147,471**	**127,562**	**-19,909**
PROGRAM MANAGEMENT	152,677	154,000	157,061	+3,061
FAMILY PLANNING	285,760	286,479	300,000	+13,521
Appropriation Table Match	**6,039,180**	**6,104,784**	**6,217,677**	**+112,893**
Funds Appropriated to Other HRSA Accounts:				
Vaccine Injury Compensation:				
Vaccine Injury Compensation Trust Fund (HRSA Claims)	224,000	230,000	237,000	+7,000
VICTF Direct Operations - HRSA	6,464	7,500	7,500	-
Subtotal, Vaccine Injury Compensation	**230,464**	**237,500**	**244,500**	**+7,000**
Discretionary Program Level:				
HRSA	**6,091,636**	**6,123,598**	**6,244,905**	**+121,307**
Vaccine Direct Operations	6,464	7,500	7,500	-
Total, HRSA Discretionary Program Level	**6,098,100**	**6,131,098**	**6,252,405**	**+121,307**
Mandatory Programs:	**2,803,956**	**4,198,981**	**4,122,630**	**-76,351**
Total, HRSA Program Level	**8,902,056**	**10,330,079**	**10,375,035**	**+44,956**
Less Programs Funded from Other Sources:				
PHS Evaluation Fund Appropriation	*-25,000*	-	-	-
User Fees	*-27,456*	*-18,814*	*-27,228*	*-8,414*
Mandatory Programs	*-2,803,956*	*-4,198,981*	*-4,122,630*	*+76,351*
Total HRSA Discretionary Budget Authority	**6,045,644**	**6,112,284**	**6,225,177**	**+112,893**

/1 FY 2015 amounts reflect funding appropriated by Congress in P.L. 113-93, the Protecting Access to Medicare Act of 2014

Health Resources and Services

TAB

Appropriations 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, $1,491,522,000: *Provided*, That no more than $100,000 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 $99,893,000 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. **[**: *Provided further*, That of funds provided for the Health Centers program, as defined by section 330 of the PHS Act, by this Act or any other Act for fiscal year 2015, not less than $165,000,000 shall be obligated in fiscal year 2015 as base grant adjustments and not less than $350,000,000 shall be obligated in fiscal year 2015 to support new access points including approved and unfunded applications from fiscal year 2014, grants to expand medical services, behavioral health, oral health, pharmacy, and vision services, and up to $150,000,000 shall be obligated in fiscal year 2015 for construction and capital improvement costs.**]**

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, **[**$751,600,000**]** *$856,820,000*: *Provided, That $287,370,000, to remain available until expended, shall be for the National Health Service Corp Program: Provided further*, That

sections 747(c)(2)**[**, 751(j)(2),**]** *and* 762(k), 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 may hereafter 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 fees collected for the disclosure of information under section 427(b) of the Health Care Quality Improvement Act of 1986 and sections 1128E(d)(2) and 1921 of the Social Security Act shall be sufficient to recover the full costs of operating the programs authorized by such sections and shall remain available until expended for the National Practitioner Data Bank: *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, of the amounts appropriated under this heading, $100,000,000 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.*

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, $851,738,000: *Provided*, That notwithstanding sections 502(a)(1) and 502(b)(1) of the Social Security Act, not more than $77,093,000 shall be available for carrying out special projects of regional and national significance pursuant to section 501(a)(2) of such Act and

$10,276,000 shall be available for projects described in *sub*paragraphs (A) through (F) of section 501(a)(3) of such Act.

RYAN WHITE HIV/AIDS PROGRAM

For carrying out title XXVI of the PHS Act with respect to the Ryan White HIV/AIDS program, **[**$2,318,781,000**]**, *$2,322,781,000,* of which $1,970,881,000 shall remain available to the Secretary through September 30, **[**2017**]** *2018,* for parts A and B of title XXVI of the PHS Act, and of which not less than $900,313,000 shall be for State AIDS Drug Assistance Programs under the authority of section 2616 or 311(c) of such Act.

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, [$103,193,000**]** *$110,193,000,* of which $122,000 shall be available until expended for facilities renovations at the Gillis W. Long Hansen's Disease Center*: 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 Program shall be collected by the Secretary based on sales data that shall be submitted by drug manufacturers 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 *of 1969,* **[**the Cardiac Arrest Survival Act of 2000,**]** and sections 711 and 1820 of the Social Security Act, **[**$147,471,000**]***$127,562,000*, of which **[**$41,609,000**]***$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, **[**$14,942,000 shall be available for the Small Rural Hospital Improvement Grant Program for quality improvement and adoption of health information technology and**]** up to $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, $9,511,000 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, [$286,479,000] *$300,000,000*: *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, [$154,000,000]*$157,061,000*: *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.*

GENERAL PROVISIONS

The following unobligated balances of amounts appropriated prior to fiscal year 2007 for "Department of Health and Human Services, Health Resources and Services Administration" are hereby permanently cancelled:

(1) $281,003 appropriated to carry out section 1610(b) of the PHS Act;

(2) $3,611 appropriated to carry out section 1602(c) of the PHS Act;

(3) $105,576 appropriated in section 167 of Division H of Public Law 108-199; and

(4) $55,793 appropriated to carry out the National Cord Blood Stem Cell Bank Program.

Language Analysis

LANGUAGE PROVISION	EXPLANATION
[including associated administrative expenses and relevant evaluations]	Cite removed as language is legally unnecessary.
[*Provided further*, That of funds provided for the Health Centers program, as defined by section 330 of the PHS Act, by this Act or any other Act for fiscal year 2015, not less than $165,000,000 shall be obligated in fiscal year 2015 as base grant adjustments and not less than $350,000,000 shall be obligated in fiscal year 2015 to support new access points including approved and unfunded applications from fiscal year 2014, grants to expand medical services, behavioral health, oral health, pharmacy, and vision services, and up to $150,000,000 shall be obligated in fiscal year 2015 for construction and capital improvement costs.**]**	Language removed that provided allocations specific to FY 2015.
section 1128E *and 1921(b)* of the Social Security Act	Section 1921(b) added to provide authorization and funding for the cost of additional queries of the National Practitioner Data Bank.
Provided, That $287,370,000, to remain available until expended, shall be for the National Health Service Corps Program	Language added to provide discretionary funding for National Health Service Corps Program.
Provided further, That sections 747(c)(2)**[**, 751(j)(2),**]** *and* 762(k), 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 may hereafter 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**]**	Language regarding the Area Health Education Centers is removed because no funding is requested for this program.
[*Provided further*, That no funds shall be available for section 340G-1 of the PHS Act**]**	Citation is removed to provide greater program flexibility.

LANGUAGE PROVISION	EXPLANATION
Provided further, That, of the amounts appropriated under this heading, $100,000,000 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.	Language added to direct Children's Hospitals Graduate Medical Education Program to use funding for only direct medical education costs.
$10,276,000 shall be available for projects described in *sub*paragraphs (A) through (F) of section 501(a)(3) of such Act.	Citation clarified as subparagraphs rather than paragraphs.
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 Program shall be collected by the Secretary based on sales data that shall be submitted by drug manufacturers and shall be credited to this account, to remain available until expended.	Language added to authorize the Secretary to collect and spend user fees for the 340B Drug Pricing Program.
the Federal Coal Mine Health and Safety Act *of 1969*	Clarifying citation.
[the Cardiac Arrest Survival Act of 2000]	Citation removed as no funding is requested for this program.
[$14,942,000 shall be available for the Small Rural Hospital Improvement Grant Program for quality improvement and adoption of health information technology and]	Citation removed as funding is not requested.
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 added to provide permissive authority to the HRSA administrator to transfer funds between HRSA accounts.

LANGUAGE PROVISION	EXPLANATION
The following unobligated balances of amounts appropriated prior to fiscal year 2007 for "Department of Health and Human Services, Health Resources and Services Administration" are hereby permanently cancelled: *(1) $281,003 appropriated to carry out section 1610(b) of the PHS Act;* *(2) $3,611 appropriated to carry out section 1602(c) of the PHS Act;* *(3) $105,576 appropriated in section 167 of Division H of Public Law 108-199; and* *(4) $55,793 appropriated to carry out the National Cord Blood Stem Cell Bank Program.*	Provision added to rescind unusable funding balances for Construction and Facilities, Cord Blood, Medical Facilities Loan, and Division H earmarks.

Amounts Available for Obligation [1]

	FY 2014 Operating Level	FY 2015 Omnibus	FY 2016 Estimate
Discretionary Appropriation Annual	$6,054,378,000	$6,104,784,000	$6,217,677,000
Transfer to Other Accounts	-$112,008,000	---	---
Transfer from Other Accounts	$96,810,000	---	---
Appropriations Permanently Reduced	---	---	---
Subtotal, adjusted appropriation……	**$6,039,180,000**	**$6,104,784,000**	**$6,217,677,000**
Mandatory Appropriation:			
Family to Family Health Information Centers	+5,000,000	+2,500,000	---
Primary Health Care Access:			
Community Health Center Fund	+2,200,000,000	+3,600,000,000	+2,700,000,000
National Health Service Corps	+305,000,000	+310,000,000	+522,630,000
Subtotal, Primary Health Care Access	**+2,505,000,000**	**+3,910,000,000**	**+3,222,630,000**
Early Childhood Visitation	+400,000,000	+400,000,000	+500,000,000
Targeted Support for Graduate Medical Education	---	---	+400,000,000
Appropriations Permanently Reduced	-106,044,000	-113,519,000	---
Subtotal, adjusted budget authority……	**+8,843,136,000**	**+10,303,765,000**	**+10,340,307,000**
Offsetting Collections	+52,452,000	+19,675,883	+28,089,883
Offsetting Collections Previously Unavailable	+ 565,000		
Subtotal Spending Authority from offsetting collections……	**+53,017,000**	**+19,675,883**	**+28,089,883**
Unobligated balance, start of year	+386,292,000	+325,000,000	+731,000,000
Unobligated balance, end of year	-325,000,000	-731,000,000	-550,000,000
Recovery of prior year obligations	+ 50,921,000	---	---
Unobligated balance, lapsing	-2,189,000	---	---
Total Obligations……	**$9,006,177,000**	**$9,917,440,883**	**$10,549,396,883**

[1] Excludes the following amounts for reimbursable activities carried out by this account: FY 2014- $15,061,000 and 38FTE; FY 2015 - $15,066,000 and 39 FTE; FY 2016 $15,071,000 and 45 FTE.

Summary of Changes

2015 Omnibus	
Total budget authority	$6,104,784,000
(Obligations)	(-$6,104,784,000)
2016 Estimate	$6,217,677,000
(Obligations)	(-$6,217,677,000)
2015 Mandatory	$4,198,981,000
(Obligations)	(-$4,198,981,000)
2016 Mandatory	$4,122,630,000
(Obligations)	(-$4,122,630,000)
Net Change	**+$36,542,000**
(Obligations)	**+$36,542,000**

	2015 Current		Changes from Base	
	FTE	**Budget Authority**	**FTE**	**Budget Authority**
Increases:				
A. Built in:	1,878		+ 89	
1. January 2016 Civilian Pay Raise		287,751,134		+ 2,440,343
2. January 2016 Military Pay Raise		287,751,134		+ 177,314
3. Civilian Annualization of Jan. 2015		287,751,134		+ 599,116
4. Military Annualization of Jan. 2015		287,751,134		+ 25,960
Subtotal, built-in increases				**+3,242,733**
B. Program:				
Discretionary Increases				
Clinical Training in Interprofessional Practice			+2	+10,000,000
National Health Service Corps			+102	+287,370,000
Rural Physician Training Grants			+2	+ 4,000,000
340B Drug Pricing Program	11	10,238,000	+4	+ 7,000,000
Centers for Excellence	1	21,711,000	-	+ 3,289,000
Early Intervention - Part C	38	201,079,000	+10	+79,088,000
Family Planning	35	286,479,000	-	+13,521,000
Program Management	799	154,000,000	-	+ 3,061,000
Training in Diversity			+1	+14,000,000
Subtotal	**884**	**673,507,000**	**+121**	**+421,329,000**

	2015 Current		Changes from Base	
	FTE	**Budget Authority**	**FTE**	**Budget Authority**
Mandatory Increases				
Maternal, Infant and Early Childhood Visiting Program	22	400,000,000	-	+100,000,000
National Health Service Corps	237	287,370,000	- 52	+235,260,000
Targeted Support for Graduate Medical Education			+32	+400,000,000
Subtotal	**259**	**687,370,000**	**-20**	**+ 735,260,000**
Total Increases	**1,143**	**1,360,877,000**	**+101**	**+1,156,589,000**
A. Built in:				**-**
1. Pay Costs		**-287,751,134**		**-3,242,733**
B. Program:				
Discretionary Decreases				
Area Health Education Centers	4	30,250,000	-4	-30,250,000
Children, Youth, Women & Families - Part D	10	75,088,000	-10	- 75,088,000
Children's Graduate Medical Education	22	265,000,000	-	-165,000,000
Health Careers Opportunity Program	1	14,189,000	-1	- 14,189,000
Public Health/Preventive Medicine	4	21,000,000	-	- 4,000,000
Rural Access to AED	2	4,500,000	-2	- 4,500,000
Flexibility Grants	2	41,609,000	-1	- 15,409,000
Subtotal Discretionary Decreases	**45**	**451,636,000**	**-18**	**-308,436,000**
Mandatory Decreases				
Community Health Center Fund	97	3,509,111,000	-	-809,111,000
Family to Family Health Information Center	1	2,500,000	-1	- 2,500,000
Subtotal Mandatory Decreases	**98**	**3,511,611,000**	**-1**	**-811,611,000**
Total Program Decreases	**+143**	**3,963,247,000**	**-19**	**-1,120,047,000**
Net Change Discretionary	**+929**	**1,125,143,000**	**+103**	**+112,893,000**
Net Change Mandatory	**+357**	**4,198,981,000**	**-21**	**- 76,351,000**
Net Change Discretionary and Mandatory	**+1,286**	**5,324,124,000**	**+82**	**+36,542,000**

Budget Authority by Activity

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
1. Primary Care			
Health Centers	1,396,827	1,391,529	1,391,529
Health Centers Current Law ACA Mandatory	2,144,716	3,509,111	---
Health Centers Proposed Mandatory	---	---	2,700,000
Health Center Tort Claims	94,655	99,893	99,893
Subtotal, Health Centers	***3,636,198***	***5,000,533***	***4,191,422***
Free Clinics Medical Malpractice	40	100	100
Subtotal, PL Bureau of Primary Health Care (BPHC)	**3,636,238**	**5,000,633**	**4,191,522**
2. Health Workforce:			
National Health Service Corps (NHSC):			
NHSC	---	---	287,370
NHSC Current Law ACA Mandatory	283,040	287,370	---
NHSC Proposed Mandatory	---	---	522,630
Subtotal, NHSC	***283,040***	***287,370***	***810,000***
Loan Repayment/Faculty Fellowships	1,187	1,190	1,190
Health Professions Training for Diversity:			
Centers of Excellence	21,657	21,711	25,000
Scholarships for Disadvantaged Students	44,857	45,970	45,970
Health Careers Opportunity Program	14,153	14,189	---
Health Workforce Diversity	---	---	14,000
Subtotal, Health Professions Training for Diversity	***80,667***	***81,870***	***84,970***
Health Care Workforce Assessment	4,651	4,663	4,663
Primary Care Training and Enhancement	36,831	38,924	38,924
Oral Health Training Programs	31,928	33,928	33,928
Rural Physician Training Grants	---	---	4,000
Targeted Support for Graduate Medical Education Proposed Mandatory	---	---	400,000
Interdisciplinary, Community-Based Linkages:			
Area Health Education Centers	30,250	30,250	---
Geriatric Programs	33,237	34,237	34,237
Mental and Behavioral Health	7,896	8,916	8,916
Clinical Training in Interprofessional Practice	---	---	10,000
Subtotal, Interdisciplinary, Community-Based Linkages	***71,383***	***73,403***	***53,153***

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Public Health Workforce Development:			
Public Health/Preventive Medicine	18,131	21,000	17,000
Nursing Workforce Development:			
Advanced Nursing Education	61,089	63,581	63,581
Nursing Workforce Diversity	15,641	15,343	15,343
Nurse Education, Practice and Retention	37,913	39,913	39,913
Nurse Faculty Loan Program	24,500	26,500	26,500
Comprehensive Geriatric Education	4,350	4,500	4,500
NURSE Corps Scholarship and Loan Repayment Program	79,785	81,785	81,785
Subtotal, Nursing Workforce Development	***223,278***	***231,622***	***231,622***
Children's Hospital Graduate Medical Education	264,335	265,000	100,000
National Practitioner Data Bank (User Fees)	*27,456*	*18,814*	*19,728*
Subtotal, PL Health Workforce	**1,042,887**	**1,057,784**	**1,799,178**
3. <u>Maternal and Child Health</u>			
Maternal and Child Health Block Grant	632,409	637,000	637,000
Autism and Other Developmental Disorders	47,099	47,099	47,099
Traumatic Brain Injury	9,321	9,321	9,321
Sickle Cell Service Demonstrations	4,455	4,455	4,455
James T. Walsh Universal Newborn Hearing Screening	17,818	17,818	17,818
Emergency Medical Services for Children	20,162	20,162	20,162
Healthy Start	100,746	102,000	102,000
Heritable Disorders	11,883	13,883	13,883
Family to Family Health Information Centers Current Law Mandatory/1	5,000	2,500	---
Maternal, Infant and Early Childhood Visiting Program Current Law Mandatory/1	371,200	400,000	---
Maternal, Infant and Early Childhood Visiting Program Proposed Mandatory	---	---	500,000
Subtotal, Maternal and Child Health Bureau	**1,220,093**	**1,254,238**	**1,351,738**
4. <u>HIV/AIDS</u>			
Emergency Relief - Part A	649,373	655,876	655,876
Comprehensive Care - Part B	1,314,446	1,315,005	1,315,005
AIDS Drug Assistance Program (non-add)	*900,313*	*900,313*	*900,313*
Early Intervention - Part C	205,544	201,079	280,167
Children, Youth, Women & Families - Part D	72,395	75,088	---
AIDS Education and Training Centers - Part F	33,275	33,611	33,611

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Dental Reimbursement Program Part F	12,991	13,122	13,122
Special Program of National Significance (SPNS)	25,000	25,000	25,000
PHS Evaluation Fund Appropriation (non-add)	*25,000*	---	-- -
Subtotal, HIV/AIDS	**2,313,024**	**2,318,781**	**2,322,781**
5. <u>Healthcare Systems</u>			
Organ Transplantation	23,490	23,549	23,549
National Cord Blood Inventory	11,238	11,266	11,266
C.W. Bill Young Cell Transplantation Program	22,054	22,109	22,109
Poison Control Centers	18,799	18,846	18,846
340B Drug Pricing Program/Office of Pharmacy Affairs	10,212	10,238	24,738
340B Drug Pricing Program User Fees (non-add)	---	---	*7,500*
Hansen's Disease Center	15,168	15,206	15,206
Payment to Hawaii	1,852	1,857	1,857
National Hansen's Disease Program - Buildings and Facilities	122	122	122
Subtotal, Healthcare Systems Bureau	**102,935**	**103,193**	**117,693**
6. <u>Rural Health:</u>			
Rural Health Policy Development	9,328	9,351	9,351
Rural Health Outreach Grants	56,857	59,000	59,000
Rural & Community Access to Emergency Devices	3,356	4,500	---
Rural Hospital Flexibility Grants	40,507	41,609	26,200
State Offices of Rural Health	9,487	9,511	9,511
Radiation Exposure Screening and Education Program	1,829	1,834	1,834
Black Lung	6,749	6,766	6,766
Telehealth	13,865	14,900	14,900
Subtotal, Office of Rural Health Policy	**141,978**	**147,471**	**127,562**
7. Program Management	152,677	154,000	157,061
8. Family Planning	285,760	286,479	300,000
TOTAL, Budget Authority	**6,039,180**	**6,104,784**	**6,217,677**
FTE (includes HEAL & Vaccine)	**1,856**	**1,985**	**2,072**

Authorizing Legislation

	FY 2015 Amount Authorized	FY 2015 Enacted	FY 2016 Amount Authorized	FY 2016 President's Budget
PRIMARY HEALTH CARE:				
Health Centers: PHS Act, Section 330, as amended by the Affordable Care Act, P.L. 111-148, Section 5601	8,332,924,155	1,391,529,000	Authorized for FY 2016 (and each subsequent year), an amount equal to the previous year's funding adjusted for any increase in the number of patients served and the per-patient costs	1,391,529,000
Community Health Center Fund (Affordable Care Act): P.L. 111-148, Section 10503; as further amended by the Health Care and Education Reconciliation Act, P.L 111-152, Section 2303	3,600,000,000	3,509,111,000	No authorization of mandatory appropriation	2,700,000,000
Federal Tort Claims Act Coverage for Health Centers: PHS Act, Section 224, as added by P.L. 102-501 and amended by P.L. 104-73	Appropriation - $10,000,000 per year is authorized under Section. 224; funding also comes from the Health Center line	99,893,000	Appropriation- $10,000,000 per year is authorized under Section 224; funding also comes from the Health Center line	99,893,000
Federal Tort Claims Act Coverage for Free Clinics: PHS Act, Section 224, as added to the PHS Act by P.L. 104-191; as amended by P.L. 111-148, Section 10608	Appropriation - $10,000,000 per year is authorized	100,000	Appropriation - $10,000,000 per year is authorized	100,000
BUREAU OF HEALTH WORKFORCE:				
National Health Service Corps (NHSC): National Health Service Corps (NHSC): PHS Act, Sections 331-338, as amended by the Health Care Safety Net Act of 2008, P.L. 110-355, Section 3(a)(1) and 3(b)-(d); as further amended by the Affordable Care Act, P.L. 111-148, Section 10501(n)(1)-(3) NHSC Scholarship Program, PHS Act, Sections 338A and 338C-H, as amended by P.L. 110-355, Section 3(a)(2); as further amended by P.L. 111-148, Section 5207, 5508(b), 10501(n)(5)	1,154,510,336	--	Authorized for FY 2016 (and subsequent years), based on previous year's funding, subject to adjustment	287,370,000

	FY 2015 Amount Authorized	FY 2015 Enacted	FY 2016 Amount Authorized	FY 2016 President's Budget
NHSC Loan Repayment Program: PHS Act, Sections 338B and 338C-H, as amended by P.L. 110-355, Section 3(a)(2); as further amended by P.L. 111-148, Sections 5207, 5508(b), 10501(n)(4) and (n)(5) Students to Service (S2S) Loan Repayment Program: PHS Act, Section 338B and Section 331(i) State Loan Repayment Program (SLRP): PHS Act, Section 338I(a)-(i), as amended by P.L. 107-251, Section 315; as further amended by P.L. 110-355, Section 3(e) National Health Service Corps – Fund (Mandatory): P.L. 111-148, Section 10503(b)(2)	Indefinite Expired 310,000,000	287,370,000	Indefinite Expired No authorization of mandatory appropriation	522,630,000
Loan Repayments and Fellowships Regarding Faculty Positions (Faculty Loan Repayment): PHS Act, Section 738(a) and 740(b), as amended by P.L. 111-148, Sections 5402 and 10501(d)	Expired	1,190,000	Expired	1,190,000
Pediatric Loan Repayment: PHS Act, Section 775, as added by P.L. 111-148, Section 5203	Expired	--	Expired	--
Centers of Excellence: Section 736, PHS Act, as amended by P.L. 111-148, Section 5401	50,000,000	21,711,000	SSAN	25,000,000
Scholarships for Disadvantaged Students: PHS Act, Section 737, as amended by P.L. 111-148, Section 5402(b)	Expired	45,970,000	Expired	45,970,000
Health Careers Opportunity Program: PHS Act, Section 739, as amended by P.L. 111-148, Section 5402	Expired	14,189,000	Expired	--
National Center for Workforce Analysis: PHS Act, Section 761(b), as amended by P.L. 111-148, Section 5103	Expired	4,663,000	Expired	4,663,000
Primary Care Training and Enhancement: PHS Act, Section 747, as amended by P.L. 111-148, Section 5301	Expired	38,924,000	Expired	38,924,000
Oral Health Training Programs (Training in General, Pediatric, and Public Health Dentistry): PHS Act, Section 748, as added by P.L. 111-148, Section 5303	SSAN	33,928,000	Expired (with provision for carryover funds)	33,928,000
Rural Physician Training Grants		--		4,000,000

	FY 2015 Amount Authorized	FY 2015 Enacted	FY 2016 Amount Authorized	FY 2016 President's Budget
Targeted Support for Graduate Medical Education		--		400,000,000
Interdisciplinary, Community-Based Linkages: Area Health Education Centers: PHS Act, Section 751, as amended by P.L. 111-148, Section 5403	Expired	30,250,000	Expired	--
Education and Training Related to Geriatrics: PHS Act, Section 753, as amended by P.L. 111-148, Section 5305	Expired	34,237,000	Expired	34,237,000
Mental and Behavioral Health Education and Training Grants: PHS Act, Section 756, as added by P.L. 111-148, Section 5306	Expired	8,916,000	Expired	8,916,000
Clinical Training in Interprofessional Practice		--		10,000,000
Public Health /Preventive Medicine PHS Act, Section 765-768, as amended by P.L. 111-148, Section 10501	SSAN	21,000,000	Expired	17,000,000
Nursing Workforce Development: Advanced Education Nursing PHS Act, Section 811, as amended by P.L. 111-148, Section 5308	SSAN through FY 2016	63,581,000	SSAN through FY 2016	63,581,000
Nursing Workforce Diversity PHS Act, Section 821, as amended by P.L. 111-148, Sec. 5404	SSAN through FY 2016	15,343,000	SSAN through FY 2016	15,343,000
Nurse Education, Practice, Quality and Retention : PHS Act, Section 831 and 831A, as amended by P.L. 111-148, Section 5309	SSAN through FY 2016	39,913,000	SSAN through FY 2016	39,913,000
Nurse Faculty Loan Program: PHS Act, Section 846A, as amended by P.L. 111-148, Section 5311	Expired	26,500,000	Expired	26,500,000
Comprehensive Geriatric Education: PHS Act, Section 865, as re-designated by P.L. 111-148, Section 5310(b)	Expired	4,500,000	Expired	4,500,000
NURSE Corps (formerly Nursing Education Loan Repayment and Scholarship Programs): PHS Act, Section 846(a), as amended by P.L. 107-205, Section 103; and NURSE Corps Loan Repayment only, as amended by P.L.	Expired	81,785,000	Expired	81,785,000

	FY 2015 Amount Authorized	FY 2015 Enacted	FY 2016 Amount Authorized	FY 2016 President's Budget
111-148, Section 5310				
Children's Hospitals Graduate Medical Education Program: PHS Act, Section 340E, as amended by P.L. 108-490; and amended by P.L. 109-307; and as further amended by P.L. 113-98 , Section 2	Direct GME: 100,000,000 Indirect Medical Education: 200,000,000	265,000,000	Direct GME: 100,000,000 Indirect Medical Education: 200,000,000	100,000,000
National Practitioner Data Bank: (User Fees) *Title IV, P.L. 99-660, SSA, Section 1921; P.L. 100-508, SSA, Section 1128E* *(also includes: Health Care Integrity and Protection Data Bank (HIPDB), SSA, Section 1128E*	Indefinite	18,814,000	Indefinite	19,728,000
MATERNAL & CHILD HEALTH:				
Maternal and Child Health Block Grant: Social Security Act, Title V	Indefinite at 850,000,000	637,000,000	Indefinite at 850,000,000	637,000,000
Autism Education, Early Detection and Intervention PHS Act, Section 399BB, as added by P.L. 109-416, Part R; reauthorized: P.L. 112-32, Section 2; reauthorized: P.L. 113-157, Section 4	Not Specified (sunset 9/30/19)	47,099,000	Not Specified (sunset 9/30/19)	47,099,000
Traumatic Brain Injury Program: PHS Act, Sections 1252 and 1253, as amended by P.L. 106-310, Section 1304; as further amended by P.L.110-206, Section 6; as further amended by P.L. 113-196, Sections 3 and 4	State grants for projects: 5,500,000; State grants for protection and advocacy services: 3,100,000	9,321,000	State grants for projects: 5,500,000; State grants for protection and advocacy services: 3,100,000	9,321,000
Sickle Cell Service Demonstration Grants: American Jobs Creation Act of 2004, P.L. 108-357, Section 712(c)	Expired	4,455,000	Expired	4,455,000
Universal Newborn Hearing Screening: PHS Act, Section 399M, as amended by P.L. 106-310, Section 702; as amended by P.L. 111-337, Section 2	SSAN	17,818,000	Expired	17,818,000
Emergency Medical Services for Children: PHS Act, Section 1910, as amended by P.L. 105-392, Section 415; as amended by P.L. 111-148, Section 5603; and as further amended by P.L. 113-180, Section 2	20,213,000	20,162,000	20,213,000	20,162,000

	FY 2015 Amount Authorized	FY 2015 Enacted	FY 2016 Amount Authorized	FY 2016 President's Budget
Healthy Start: PHS Act, Section 330H(a)-(d), as amended by P.L. 106-310, Section 1501; as amended by P.L. 110-339, Section 2	Expired	102,000,000	Expired	102,000,000
Heritable Disorders: PHS Act, Section 1109-1112 and 1114, as amended by P.L. 106-310, Section 2601; as amended by P.L. 110-204, Section 2; and as further amended by P.L. 110-237, Section 1; as further amended by P.L. 113-240, Section 10	Sections 1109-1112: 11,900,000; Section 1113: 8,000,000	13,883,000	Sections 1109-1112: 11,900,000; Section 1113: 8,000,000	13,883,000
Family to Family Health Information Centers: Social Security Act, Section 501(c)(1)(A), as amended by P.L. 109-171, Section 6064; reauthorized: Affordable Care Act, P.L. 111-148, Section 5507, as amended by P.L. 112-240, Section 624; and as amended by P.L. 113-67, Section 1203; and as further amended by P.L. 113-93, Section 207	2,500,000 for the portion of FY 2015 ending on 3/31/15	2,500,000	No authorized levels beyond 4/1/15	--
Maternal, Infant and Early Childhood Visiting Program: Section 511(j), Social Security Act, as added by Affordable Care Act, P.L. 111-148, Section 2951; as further amended by P.L. 113-93, Section 209	For FY 2015 ending on 3/31/15: an amount equal to FY 2014 (400,000,000)	400,000,000	No authorized levels beyond 4/1/15	500,000,000
HIV/AIDS:[2]				
Emergency Relief - Part A PHS Act, Section. 2601-10, as amended by P.L. 106-345; as amended by P.L. 109-415; as amended by P.L. 111-87	Expired	655,876,000	Expired	655,876,000
Comprehensive Care - Part B: PHS Act, Section. 2611-31, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	1,315,005,000	Expired	1,315,005,000
Early Intervention – Part C: PHS Act, Section. 2651-67, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	201,079,000	Expired	280,167,000
Coordinated Services and Access to Research for Women, Infants, Children and Youth - Part D: PHS Act, Section 2671, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	75,088,000	Expired	--
AIDS Drug Assistance Program (Non-Add) *PHS Act, Section. 2611-31 and 2616, as amended by P.L. 106-345, as amended by P.L.*	*Expired*	*900,313,000*	*Expired*	*900,313,000*

2 **Please note that the Ryan White Program was authorized through September 30, 2013. However, the program will continue to operate. The 2009 reauthorization or the Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87, October 30, 2009) does not include an explicit sunset clause. In the absence of a sunset clause, the program will continue to operate without a Congressional reauthorization.**

	FY 2015 Amount Authorized	FY 2015 Enacted	FY 2016 Amount Authorized	FY 2016 President's Budget
109-415, as amended by P.L. 111-87				
Special Projects of National Significance - Part F: PHS Act, Section 2691, as amended by P.L. 104-146, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	25,000,000	Expired	25,000,000
Education and Training Centers - Part F: PHS Act, Section 2692(a), as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	33,611,000	Expired	33,611,000
Dental Reimbursement Program - Part F: PHS Act, Section 2692(b), as amended by P.L. 106-345, as amended by P.L.109-415, as amended by P.L.111-87	Expired	13,122,000	Expired	13,122,000
HEALTHCARE SYSTEMS:				
Organ Transplantation: PHS Act, Sections 371-378, as amended	Expired	23,549,000	Expired	23,549,000
National Cord Blood Inventory: PHS Act, Section 379, as amended by P.L. 109-129, Section 3; as further amended by P.L. 111-264	20,000,000	11,266,000	Expired	11,266,000
C.W. Bill Young Cell Transplantation Program: PHS Act, Sections 379-379B, as amended by P.L. 109-129, Section 3; as further amended by P.L. 111-264	33,000,000	22,109,000	Expired	22,109,000
Poison Control Centers: PHS Act, Section 1271-1274, as amended by P.L. 106-174, as amended by P.L. 110-377; as further amended by P.L. 113-77	28,600,000	18,846,000	28,600,000	18,846,000
340B Drug Pricing Program: 340B Drug Pricing Program Discretionary: PHS Act, Section 340B, as amended by P.L. 111-148, Section 7101-7103; as further amended by P.L. 111-152, Section 2302; and as amended by P.L. 111-309, Section 204 *340B Drug Pricing Program/User Fees*	SSAN	10,238,000	SSAN	17,238,000 7,500,000
National Hansen's Disease Program: PHS Act, Section 320, as amended by P.L. 105-78, Section 211	Not Specified	15,206,000	Not Specified	15,206,000
Payment to Hawaii: PHS Act, Section 320(d), as amended by P.L. 105-78, Section 211	Not Specified	1,857,000	Not Specified	1,857,000
National Hansen's Disease - Buildings and Facilities: PHS Act, Section 320 and 321(a)	Not Specified	122,000	Not Specified	122,000
RURAL HEALTH:				
Rural Health Policy Development:	Indefinite	9,351,000	Indefinite	9,351,000

	FY 2015 Amount Authorized	FY 2015 Enacted	FY 2016 Amount Authorized	FY 2016 President's Budget
Social Security Act, Section 711, and PHS Act, Section 301				
Rural Health Outreach Network Development and Small Health Care Provider Quality Improvement: PHS Act, Section 330A, as amended by P.L. 107-251, Section 201; as amended by P.L. 110-355, Section 4	Expired	59,000,000	Expired	59,000,000
Rural Access to Emergency Devices: PHS Act, Section 313, and Public Health Improvement Act, P.L. 106-505, Section 413	Expired	4,500,000	Expired	--
Rural Hospital Flexibility Grants: SSA, Section 1820(j), as amended by P.L. 105-33, Section 4201(a), and P.L. 108-173, Section 405(f), as amended by, P.L. 110-275, Section 121	Expired	41,609,000	Expired	26,200,000
State Offices of Rural Health: PHS Act, Section 338J, as amended by P.L. 105-392, Section 301	Expired	9,511,000	Expired	9,511,000
Radiogenic Diseases (Radiation Exposure Screening and Education Program): PHS Act, Section 417C, as amended by P.L. 106-245, Section 4, as further amended by P.L. 109-482, Section 103 and Section 104	Indefinite	1,834,000	Indefinite	1,834,000
Black Lung: Federal Mine Safety and Health Act 1977, P.L. 91-173, Section 427(a)	Indefinite	6,766,000	Indefinite	6,766,000
Telehealth: PHS Act, Sec. 330I, as amended by P.L. 107-251, as amended by P.L. 108-163; as further amended by P.L. 113-55, Section 103	Expired	14,900,000	Expired	14,900,000
OTHER PROGRAMS:				
Family Planning: Grants: PHS Act Title X	Expired	286,479,000	Expired	300,000,000
Program Management:	Indefinite	154,000,000	Indefinite	157,061,000
Vaccine Injury Compensation Program Trust Fund: PHS Act, Title XXI, Subtitle 2, Section. 2110-34	Indefinite	235,000,000	Indefinite	235,000,000
UNFUNDED AUTHORIZATIONS:				
Health Center Demonstration Project for Individualized Wellness Plans PHS Act, Section 330(s), as added to PHS Act by P.L. 111-148, Section 4206	SSAN		SSAN	
School Based Health Centers - Facilities Construction Affordable Care Act, P.L. 111-148, Section 4101(a)	Expired		Expired	

	FY 2015 Amount Authorized	FY 2015 Enacted	FY 2016 Amount Authorized	FY 2016 President's Budget
School Based Health Centers - Operations PHS Act, Section 399Z-1, as added by Affordable Care Act, P.L. 111-148, Section 4101(b)	(available until expended)		(available until expended)	
Health Information Technology Innovation Initiative PHS Act, Section 330(e)(1)(C), (Grants for Operation of Health Center Networks and Plans), as amended	SSAN		SSAN	
Health Information Technology Planning Grants PHS Act, Section 330(c)(1)(B)-(C), as amended				
Electronic Health Record Implementation Initiative PHS Act, Section 330(e)(1)(C), as amended	SSAN		SSAN	
Native Hawaiian Health Scholarships: PHS Act, Section 338K 42 U.S.C. 11709, as amended by P.L. 111-148, Section 10221	SSAN(through FY 2019)		SSAN(through FY 2019)	
Health Professions Education in Health Disparities and Cultural Competency PHS Act, Section 741, as amended by P.L. 111-148, Section 5307	SSAN		Expired	
Training Opportunities for Direct Care Workers PHS Act, Section 747A, as added by P.L. 111-148, Section 5302	Expired		Expired	
Continuing Ed Support for Health Professionals Serving in Underserved Communities PHS Act, Section 752, as amended by P.L. 111-148, Section 5403	SSAN		SSAN	
Geriatric Career Incentive Awards PHS Act, Section 753(e), as amended by P.L. 111-148, Section 5305(a)	Expired		Expired	
Geriatric Academic Career Awards PHS Act, Section 753(c), as amended by P.L. 111-148, Section 5305(b)	Not Specified		Not Specified	
Rural Interdisciplinary Training (Burdick) PHS Act, Section 754	Not Specified		Not Specified	
Grants for Pain Care Education & Training, PHS Act, Section 759, as added by P.L.111-148, Section 4305	(amounts appropriated remain available until expended)		(amounts appropriated remain available until expended)	
Advisory Council on Graduate Medical Education PHS Act, Section 762, as amended by P.L. 111-148, Section 5103	(amounts otherwise appropriated may be utilized by the Secretary to support its		(amounts otherwise appropriated may be utilized by the Secretary to	

	FY 2015 Amount Authorized	FY 2015 Enacted	FY 2016 Amount Authorized	FY 2016 President's Budget
	activities)		support its activities)	
Health Professions Education in Health Disparities and Cultural Competency PHS Act, Section 807, as amended by P.L. 111-148, Section 5307	SSAN		Expired	
Minority Faculty Fellowship Program PHS Act, Section 738 (authorized appropriation Section 740(b)), as amended by P.L.111-148, Section 5402, and Section 10501	Expired		Expired	
State Health Care Workforce Development Grants and Implementation Grants 42 U.S.C. 294r, as added by P.L. 111-148, Section 5102	SSAN		SSAN	
Allied Health and Other Disciplines PHS Act, Section 755	Not Specified		Not Specified	
Nurse Managed Health Clinics [Prevention Fund], PHS Act, Section 330A-1, as added by P.L. 111-148, Section 5208	Expired		Expired	
Patient Navigator (Outreach & Chronic Disease Prevention Act of 2005): PHS Act, Section 340A, as amended by P.L. 111-148, Section 3510	SSAN		SSAN	
Teaching Health Centers Development Grants, PHS Act, Section 749A, as added by P.L. 111-148, Section 5508	SSAN		SSAN	
Report on Long Term Effects of Living Organ Donation, PHS Act, Section 371A	Not Specified		Not Specified	
Congenital Disabilities PHS Act, Section 399T	Not Specified		Not Specified	

Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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
Advance				
Supplementals				
Rescissions				
Subtotal	6,308,855,000	7,095,617,000	7,012,559,000	6,393,691,000
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
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
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

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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
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
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			6,194,474,000
Advance				
Supplementals				
Rescissions				-12,389,000
Transfers				-15,807,000

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
Sequestration				-311,619,000
Subtotal	6,067,862,000			5,854,664,000
FY 2014				
General Fund Appropriation:				
Base	6,015,039,000		6,309,896,000	6,054,378,000
Advance				
Supplementals				
Rescissions				
Transfers				-15,198,000
Subtotal	6,015,039,000		6,309,896,000	6,039,180,000
FY 2015				
General Fund Appropriation:				
Base	5,292,739,000		6,093,916,000	6,104,784,000
Advance				
Supplementals				
Rescissions				
Transfers				
Subtotal	5,292,739,000		6,093,916,000	6,104,784,000
FY 2016				
General Fund Appropriation:				
Base	6,217,677,000			
Advance				
Supplementals				
Rescissions				
Transfers				
Subtotal	6,217,677,000			

Appropriations Not Authorized by Law

	Last Year of Authorization	Last Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2015
National Health Service Corps • State Loan Repayment Program (SLRP) – PHS Act, Section 338I(a)-(i), as amended by P.L. 107-251, Section 315; as further amended by P.L. 110-355, Section 3(e)	2012	SSAN		
National Health Service Corps • NHCS (Field subpart) – Sec. 338 (a) of the Public Health Service Act	2012	--		
NURSE Corps (formerly Nursing Education Loan Repayment and Scholarship Programs) PHS Act, Section 846(a), as amended by P.L. 107-205, Section 103; and NURSE Corps Loan Repayment only, as amended by P.L. 111-148, Section 5310	2007	SSAN	31,055,000	81,785,000
Loan Repayments and Fellowships Regarding Faculty Positions (Faculty Loan Repayment) – PHS Act, Section 738(a) and 740(b), as amended by P.L. 111-148, Sections 5402 and 10501(d)	2014	5,000,000	1,187,000	1,187,000
Pediatric Loan Repayment – PHS Act, Section 775 (c)(1) (A) and (B),as added by P.L. 111-148, Section 5203	2014	30,000,000		
Scholarships for Disadvantaged Students – PHS Act, Section 737, as amended by P.L. 111-148, Section 5402(b)	2014	SSAN	44,857,000	45,970,000
Health Careers Opportunity Program – PHS Act, Section 739, as amended by P.L. 111-148, Section 5402	2014	SSAN	14,153,000	---
National Center for Workforce Analysis – PHS Act, Section 761(b), as amended by P.L. 111-148, Section 5103	2014	7,500,000	4,651,000	4,663,000
Primary Care Training and Enhancement -- PHS Act, Section 747, as amended by P.L. 111-148, Section 5301	2014	SSAN	36,831,000	38,924,000

	Last Year of Authorization	Last Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2015
Oral Health Training Programs (Grants for Innovative Programs for Dental Health) – PHS Act, Sec. 340G	2012	25,000,000 Total (for FY 2008-12)	31,928,000	33,928,000
Area Health Education Centers PHS Act, Section 751, as amended by P.L. 111-148, Section 5403	2014	125,000,000	30,250,000	30,250,000
Education and Training Relating to Geriatrics – PHS Act, Section 753, as amended by P.L. 111-148, Section 5305 • Geriatric Workforce Development • Geriatric Career Incentive Awards	2014 2013	10,800,000 10,000,000	33,237,000	34,237,000
Mental & Behavioral Health Education and Training Grants – PHS Act, Section 756, as added by P.L. 111-148, Section 5306	2013	35,000,000 Total (for FY 2010-13)	7,896,000	8,916,000
Nursing Workforce Development • Nurse Retention Grants – PHS Act, Section 831A	2012	SSAN		
Nursing Workforce Development • Nurse Education, Practice, and Quality grants – PHS Act, Section 831, as amended by P.L. 111-148, Section 5309	2014	SSAN	37,913,000	39,913,000
Nursing Workforce Development • Nurse Faculty Loan Program – PHS Act, Section 846A, as amended by P.L. 111-148, Section 5311	2014	SSAN	24,500,000	26,000,000
Nursing Workforce Development • Comprehensive Geriatric Education – PHS Act, Section 865, as re-designated by P.L. 111-148, Section 5310(b)	2014	SSAN	4,350,000	4,350,000
Sickle Cell Service Demonstration Grants – American Jobs Creation Act of 2004, P.L. 108-357, Section 712(c)	2009	10,000,000	4,455,000	4,455,000
Healthy Start – PHS Act, Section 330H(a)-(d), as amended by P.L. 106-310, Section 1501; as amended by P.L. 110-339, Section 2	2013	Amount authorized for the preceding FY increased by	100,746,000	102,000,000

	Last Year of Authorization	Last Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2015
		formula		
Emergency Relief - Part A – PHS Act, Section. 2601-10, as amended by P.L. 106-345; as amended by P.L. 109-415; as amended by P.L. 111-87	2013	789,471,000	649,373,000	655,876,000
Comprehensive Care - Part B – PHS Act, Section. 2611-31, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	1,562,169,000	1,314,446,000	1,315,005,000
Early Intervention – Part C – PHS Act, Section. 2651-67, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	285,766,000	205,544,000	201,079,000
Coordinated Services and Access to Research for Women, Infants, Children and Youth - Part D – PHS Act, Section 2671, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	87,273,000	72,395,000	75,088,000
Special Projects of National Significance - Part F – PHS Act, Section 2691, as amended by P.L. 104-146, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	25,000,000	25,000,000	25,000,000
Education and Training Centers - Part F – PHS Act, Section 2692(a), as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	42,178,000	33,275,000	33,611,000
Dental Reimbursement Program - Part F – PHS Act, Section 2692(b), as amended by P.L. 106-345, as amended by P.L.109-415, as amended by P.L.111-87	2013	15,802,000	12,991,000	13,122,000
Organ Transplantation – PHS Act, Sections 371 - 378, as amended by P.L. 108-216, P.L. 109-129, and P.L. 110-144; as amended by P.L. 110-413; as further amended by P.L. 113-51	1993 (Sec.'s 377, 377A, and 377B expired Sept 30, 2009)	377 5,000,000 377A SSAN 377B SSAN	2,767,000	23,549,000
Rural Health Outreach Network Development and Small Health Care Provider Quality Improvement – PHS Act, Section 330A, as amended by P.L.	2012	45,000,000	55,553,000	59,000,000

	Last Year of Authorization	Last Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2015
107-251, Section 201; as amended by P.L. 110-355, Section 4				
Rural Access to Emergency Devices – PHS Act, Section 313, and Public Health Improvement Act, P.L. 106-505, Section 413	2006	5,000,000	1,485,000	4,500,000
Rural Hospital Flexibility Grants – SSA, Section 1820(j), as amended by P.L. 105-33, Section 4201(a), and P.L. 108-173, Section 405(f), as amended by, P.L. 110-275, Section 121	2012	SSAN	41,040,000	41,609,000
State Offices of Rural Health: PHS Act, Section 338J, as amended by P.L. 105-392, Section 301	2002	SSAN	4,000,000	9,511,000
Telehealth – PHS Act, Section 330I, as amended by P.L. 107-251, as amended by P.L. 108-163; as further amended by P.L. 113-55, Section 103	2006	SSAN	6,814,000	14,900,000
School-Based Health Centers (facilities construction) – Affordable Care Act, P.L. 111-148, Section 4101 (a)	2013	50,000,000	47,450,000	---
Family Planning Grants – PHS Act Title X	1985	158,400,000	142,500,000	286,479,000

Primary Health Care

Tab

PRIMARY HEALTH CARE

Health Centers

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2015 +/- FY 2016
BA	$1,396,827,000	$1,391,529,000	$1,391,529,000	---
Current Law ACA Funding	$2,144,716,000	$3,509,111,000	---	-$3,509,111,000
Proposed Mandatory Funding	---	---	$2,700,000,000	+$2,700,000,000
Federal Tort Claims Act Program	$94,655,000	$99,893,000	$99,893,000	---
Total	**$3,636,198,000**	**$5,000,533,000**	**$4,191,422,000**	**-$809,111,000**
FTE	289	357	356	-1

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

FY 2016 Authorization: FY 2015 authorization level ($8,332,924,155) adjusted by the product of -

(i) One plus the average percentage increase in costs incurred per patient served; and
(ii) One plus the average percentage increase in the total number of patients served.

FY 2016 CHC Fund Authorization.....Expired

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

Program Description and Accomplishments

For nearly 50 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. 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, nearly 1,300 health centers operate approximately 9,000 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 2013, these community-based and patient-directed health centers served 21.7

million patients, providing almost 86 million patient visits, at an average cost of $721 (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 payments, 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 2013 were children (age 17 and younger); over 7 percent were 65 or older.

- People without and with health insurance: Almost four in 10 patients were without health insurance in 2013. 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 2001 to approximately 7.6 million in 2013, proportionate to the growth in Federal health center funding. The Health Center Program will continue to monitor the number of uninsured patients served on an annual basis, as it will continue to provide an understanding of the impact of Affordable Care Act on health center services in the future.

- Special Populations: Some health centers also receive specific funding to focus on certain special populations including agricultural workers, individuals and families experiencing homelessness, those living in public housing, and Native Hawaiians. In 2013 health centers served more than 1.1 million individuals experiencing homelessness, nearly 900,000 agricultural workers and their families, over 220,000 residents of public housing and more than 12,000 Native Hawaiians.

    - Health Care for the Homeless Program: Homelessness continues to be a pervasive problem throughout the U.S., 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 2013, more than 1.1 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 U.S., 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.

    - Migrant Health Centers: In 2013, HRSA-funded health centers served almost 900,000 migratory and seasonal agricultural workers and their families. It is estimated these health center programs serve more than one quarter of all migratory and seasonal agricultural workers in the U.S. (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 agricultural workers and their families with a particular focus on the occupational health and safety needs of this population.

- 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 2013, HRSA-funded health centers served over 220,000 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 2013, Native Hawaiian Health Care Systems provided medical and enabling services to more than 12,000 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 years). New health center grant opportunities are announced nationally and objective review committees (ORC), composed of experts who are qualified by training and experience in particular fields related to the Program, then review applications.

Funding decisions are made based on committee assessments, announced funding preferences and program priorities. In addition to the 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 projected patients 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 2013 was 21.7 million. This increased access beyond the 12.4 million patients served in 2003, and represents a 75 percent increase within a 10-year period. Of the 21.7 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 approximately 35 percent were uninsured, an increase of approximately 2.7 million

uninsured patients since 2003. 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 continues 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 2000 to 72 percent in 2013, exceeding the target of 64 percent. It should also be noted that health centers serve a higher risk prenatal population than seen nationally; making progress on this measure a significant 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 female patients of childbearing 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 2012, the health center rate was 7.1 percent, a rate that is 11 percent lower than the national rate. In 2013, the health center rate was 7.3 percent, but the national rate is not yet available.

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 2008. In 2013, 64 percent of adult health center patients with diagnosed hypertension had blood pressure under adequate control (less than 140/90). Additionally, 69 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 percent).

HRSA recognizes that there are many opportunities to maintain and improve the quality and effectiveness of health center care. In FY 2015, HRSA established an annual Health Center Quality Improvement Fund to recognize the highest clinically performing health centers nationwide as well as those health centers that have made significant quality improvement gains in the past year. Quality Improvement Fund awards are based on uniform clinical performance measures collected from all health centers, including measures on preventive health, perinatal/prenatal care, and chronic disease management, and designed to drive improvements in patient care and outcomes.

HRSA has also established a 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 PCMH by national/state accrediting organizations. At the end of FY 2014, 58 percent of health centers had at least one site recognized as a PCMH.

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 the analysis of the annual 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 2009, health center costs grew by two percent, well under the target growth rate of 5.8 percent. In 2011, the health center costs grew at a rate of 3.8 percent compared to a national rate of 3.9 percent. In 2012, the health center rate was 3.7 percent, equal to the national rate of 3.7 percent. In 2013 the health center rate was 4.8 percent, compared to a national rate of 4.5 percent. The results trend from 2009 reflects higher costs realized in the short-term that are associated with managing operations while also 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 even greater 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 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 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 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.

- Health centers add value to the health care system by providing socially and medically disadvantaged patients with care that results in lower utilization and maintained or improved preventive care. (Neda Laiteerapong, James Kirby, Yue Gao, Tzy-Chyi Yu, Ravi Sharma, Robert Nocon, Sang Mee Lee, Marshall H. Chin, Aviva G. Nathan, Quyen Ngo-Metzger, and Elbert S. Huang; *Health Services Research* 2014).

- FQHCs and look-alikes demonstrated equal or better performance than private practice primary care providers on select quality measures despite serving patients who have more chronic disease and socioeconomic complexity (Goldman LE, Chu PW, Tran H, Romano MJ, Stafford RS; 2. American Journal of Preventive Medicine 2012 Aug;43(2):142-9).

- 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.)

- 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).

- 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).

Federal Tort Claims Act (FTCA) Program: The Health Center Program administers the FTCA Program, under which employees and eligible contractors of participating 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 reviews of risk management plans 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, in FY 2011, 103 claims were paid totaling $82.8 million, in FY 2012, 107 claims were paid totaling $68.1 million, in FY 2013, 107 claims were paid totaling $50.6 million, and in FY 2014, 103 claims were paid totaling $72.2 million.

Affordable Care Act

The Affordable Care Act authorized and appropriated $11 billion in mandatory resources 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. Of this amount, $1.5 billion was appropriated to support major construction and renovation projects at community health centers nationwide and $9.5 billion to 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 Affordable Care Act did not provide mandatory funding beyond FY 2015.

Over the last four years, this mandatory funding has supported more than 550 new access points/health center service delivery sites approximately 1,200 expanded service grants, over 400 grants to expand behavioral health services, nearly 700 capital development and immediate facility improvement grants, more than 1,700 quality improvement grants targeting the development of PCMH, more than 150 expanded HIV treatment and care grants, outreach and enrollment activities in over 1,200 health centers nationwide, more than 40 health center controlled networks to promote health information technology (HIT) and EHR adoption, and ongoing health center operations in nearly 1,300 health centers nationwide.

In FY 2016, the Health Center program will continue to provide high quality, affordable and comprehensive primary care services in medically underserved communities across the country as insurance coverage expands. Health centers will also remain a vital source of primary care for insured patients seeking a quality source of care, often for services not covered by health insurance.

Funding History

FY	**Amount**
FY 2012	$1,566,892,000
FY 2012 ACA Funding	$1,200,000,000
FY 2013	$1,479,490,000
FY 2013 ACA Funding	$1,465,397,000
FY 2014	$1,491,482,000
FY 2014 ACA Funding	$2,144,716,000
FY 2015	$1,491,422,000
FY 2015 ACA Funding	$3,509,111,000
FY 2016	$1,491,422,000
FY 2016 Mandatory Funding	$2,700,000,000

Budget Request

The FY 2016 Budget Request is $4,191,422,000, which is $809,111,000 below the FY 2015 Enacted Level, and includes $2,700,000,000 in proposed mandatory funding. This request is projected to support 75 new access point grants, and continuation and quality improvement activities for more than 1,300 health centers operating over 9,000 primary care sites, including recognizing centers performing at exceptional levels, as well as continue support for outreach and enrollment activities. Funding will provide care to 28.6 million patients in FY 2016, 6.9 million more patients than were served in 2013. In addition to these funds, a total of $541 million is reserved in FY 2015to help sustain health center funding over FYs 2016- FY 2018. This funding will ensure that current health centers can continue to provide essential health care services to their patient populations.

The FY 2016 Budget also includes $2.7 billion in mandatory funding for each year in FY 2017 and FY 2018. Multi-year mandatory funding will provide health centers, which depend on

Federal resources to cover daily operational costs, with a stable source of funding with which to manage their operations.

Health Center Fund	FY 2016	FY 2017	FY 2018
Proposed Mandatory Funding	$2.7 billion	$2.7 billion	$2.7 billion
Reserve Funding	$178 million	$180 million	$183 million

Health centers will continue to be a critical element of the health system, largely because they can provide an accessible and dependable source of primary care services in underserved communities. In particular, health centers emphasize coordinated primary and preventive services or a PCMH that promotes reductions in health disparities for low-income individuals, racial and ethnic minorities, rural communities and other underserved populations. Health centers place emphasis on the coordination and comprehensiveness of care, the ability to manage patients with multiple health care needs, and the use of key quality improvement practices, including HIT. The health center model also overcomes geographic, cultural, linguistic and other barriers through a team-based approach to care that includes physicians, nurse practitioners, physician assistants, nurses, dental providers, midwives, behavioral health care providers, social workers, health educators, and many others. Health centers also reduce costs to health systems; the health center model of care has been shown to reduce the use of costlier providers of care, such as emergency departments (EDs) and hospitals.

Continued funding for the Health Center Program in FY 2016 and beyond will maintain this vital source of primary care for insured and medically underserved patients seeking a quality source of care, often for services not covered by health insurance. After the passage of health insurance reform in Massachusetts, health centers saw a significant increase in newly-insured patients. From 2005 to 2013, the overall number of health center patients increased by more than 225,000 patients (more than 50 percent), even while the overall percentage of uninsured patients decreased by over 19 percent.

The FY 2016 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. This request also supports $99,893,000 for the FTCA Program, which is the same level as the FY 2015 Enacted Level. Funding also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs. The Program will continue to achieve its goal of providing access to care for underserved and vulnerable populations.

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 2016 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 LBW and adverse birth outcomes. The FY 2016 target for the program's hypertension

measure is that 63 percent of adult patients with diagnosed hypertension will have blood pressure under adequate control. The FY 2016 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 percent). 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. It is important to have ambitious targets because of the population health centers serve and the importance of good chronic disease management.

The Program will also continue to promote efficiency and aims to keep cost per patient increases below annual national health care cost increases, as noted in the Center for Medicare and Medicaid Services' (CMS) 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 2016 is to keep the program's cost per patient increase below the 2016 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, the Health Center Program is able to serve 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 2016 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. Another key step 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; diabetes; weight assessment and counseling for children and adolescents; adult weight screening and follow up; tobacco use assessment and counseling; asthma treatment; coronary artery disease/cholesterol; ischemic vascular disease/aspirin; and colorectal cancer screening.

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, the Program will continue to facilitate national and State-level technical assistance 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 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's efforts to strengthen evidence-building capacity in the Health Center Program include enhancements to the Uniform Data System (UDS) reporting to reflect Affordable Care Act

impact. Beginning with 2013 UDS data, patients are reported by both ZIP code and primary medical insurance status. Data is now reported to show the number of persons living in each zip code, and breaks down that number into four categories: Medicare, Medicaid/S-CHIP/and Other Public insurance, Private insurance, and Uninsured. All UDS data continues to be aggregated at the health center/organizational level.

Funding will also support place-based demonstration projects targeting specific high-risk communities, and allow Community Health Centers to improve health outcomes for young children and coordinate with other HHS partners on early learning and other relevant services for those living in communities with highly concentrated poverty.

Funding will 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 CMS and the Office of the National Coordinator for Health Information Technology (ONC) on HIT, and the Centers for Disease Control and Prevention (CDC) to address HIV prevention and public health initiatives, and the National Institutes of Health (NIH) on clinical practice 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 FTCA Program. Additionally, the proposed Budget will allow coordination with programs in the Departments of Housing and Urban Development, Education, and Justice (HUD, Ed, and DOJ).

Sources of Revenue: ($ in millions)

	FY 2014 Enacted	**FY 2015 Enacted**	**FY 2016 Request Level**
Health Centers:	**$3,541.5**	**$4,210.0**	**$4,269.0**
Other Sources:			
Medicaid	7,430.0	8,910.0	9,650.0
Medicare	1,110.0	1,235.0	1,315.0
CHIP	270.0	320.0	340.0
Other Third	1,750.0	2,130.0	2,385.0
Self Pay Collections	1,000.0	1,045.0	1,115.0
Other Federal Grants	425.0	445.0	475.0
State/Local/Other	2,910.0	3,090.0	3,245.0
TOTAL	**$18,436.5**	**$21,385.0**	**$22,794.0**

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
1.I.A.1: Number of patients served by health centers (Output)	FY 2013: 21.7M Target: 22.2M (Target Not Met)	27.5M	28.6M	1.1M
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 2013: 89% Target: 88% (Target Virtually 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 2013: 74% Target: 70% (Target Exceeded)	70%	70%	Maintain
1.E: Percentage increase in cost per patient served at health centers compared to the national rate (Efficiency)	FY 2013: 4.8% Target: below national rate of 4.5% (Target Not Met)	Below national rate	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 2013: 7.3%, Target: 5% below national rate (National rate not yet available)	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 140/90) (Outcome)	FY 2013: 64% Target: 60% (Target Exceeded)	63%	63%	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 percent) (Outcome)	FY 2013: 69% Target: 71% (Target Virtually Met)	71%	71%	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
1.II.B.1: Percentage of pregnant health center patients beginning prenatal care in the first trimester (Output)	FY 2013: 72% Target: 64% (Target Exceeded)	66%	67%	+1 % point
1.II.A.1: Percentage of Health Center patients who are at or below 200 percent of poverty (Output)	FY 2013: 93% Target: 91% (Target Exceeded)	91%	91%	Maintain
1 II.A.2: Percentage of Health Center patients who are racial/ethnic minorities (Output)	FY 2013: 62% Target: 63% (Target Virtually Met)	62%	62%	Maintain
1.I.A.3: Percentage of health centers with at least one site recognized as a patient centered medical home (Outcome)	FY 2014: 58% Target: 40% (Target Met)	60%	65%	+ 5% points

Grants Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	1,289	1,349	1,379
Average Award	$2,500,000	$2,850,000	$2,850,000
Range of Awards	$200,000 - $15,000,000	$200,000 - $16,000,000	$200,000 - $16,000,000

Free Clinics Medical Malpractice

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2015 +/- FY 2016 Request
BA	$40,000	$100,000	$100,000	---
FTE	---	---	---	---

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

FY 2016 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 2013, 6,780 volunteer health care providers received Federal malpractice insurance through the Program, exceeding the Program target. In FY 2011, 168 free clinics operated with FTCA deemed volunteer clinicians; in FY 2012, 192 clinics participated; and in FY 2013, 227 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.

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 2011, the cost per provider was $109 per provider; in FY 2012 the cost was $71 per provider; and in FY 2013 the cost was $89 per provider. In each year, the Program performance target has been exceeded.

To date there have been three claims filed. One claim was dismissed, and the others are pending. There have been no paid claims under the Free Clinics Medical Malpractice Program. The Program Fund has a current balance of approximately $250,000.

Funding History

FY	Amount
FY 2012	$40,000
FY 2013	$38,000
FY 2014	$40,000
FY 2015	$100,000
FY 2016	$100,000

Budget Request

The FY 2016 Budget Request is $100,000, which is the same as the FY 2015 Enacted Level. The total request will support the Program's continued achievement of its performance targets addressing its goal of increasing access and capacity in the health care safety net.

Targets for FY 2016 focus on maintaining the number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage at 7,800 while also maintaining the number of free clinics operating with FTCA deemed volunteer clinicians to 250. 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 $89 administrative cost per provider in FY 2016.

The FY 2016 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.

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2105
2.I.A.1: Number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage (Outcome)	FY 2013: 6,780 Target: 5,100 (Target Exceeded)	7,800	7,800	Maintain
2.1: Patient visits provided by free clinics sponsoring volunteer FTCA deemed clinicians (Outcome)	FY 2013: 569,273 Target: 320,000 (Target Exceeded)	650,000	650,000	Maintain
2.I.A.2: Number of free clinics operating with FTCA deemed volunteer clinicians (Output)	FY 2013: 227 Target: 165 (Target Exceeded)	250	250	Maintain
2.I.A.3: Percent of volunteer FTCA deemed clinicians who meet certification and privileging requirements (Output)	FY 2013: 100% Target: 100% (Target Met)	100%	100%	Maintain
2.E: Administrative costs of the program per FTCA covered volunteer (Efficiency)	FY 2013: $89 Target: $155 (Target Exceeded)	$89	$89	Maintain

Health Workforce Tab

HEALTH WORKFORCE

Summary of Request

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$1,042,887,000	$1,057,784,000	$1,799,178,000	+741,394,000
FTE	372	393	468	+75

On May 27, 2014, HRSA's health workforce programs were merged to create a new Bureau within HRSA – the Bureau of Health Workforce (BHW). The new Bureau will help HRSA better achieve its mission of improving health and achieving health equity through access to quality services, a skilled health workforce and innovative programs. Integrating HRSA's workforce programs that were previously housed separately in the Bureau of Health Professions and the Bureau of Clinician Recruitment and Service will help HRSA better respond to the needs for a well-trained, well-distributed 21st century workforce.

The establishment of BHW in 2014 was an effort toward building organizational effectiveness. By co-locating the Agency's academic training programs and the scholarship and loan repayment clinician-based service programs under one umbrella, BHW will be better able to coordinate the alignment of academic training to develop curricula that best prepare its clinicians for service to underserved communities and vulnerable populations. Moreover, closer communication and coordination between the training and service programs will enable BHW to respond more quickly and flexibly to changes in the health care delivery environment.

HRSA workforce programs help to address the health workforce challenges and needs of the nation through a focus on three priority areas: 1) the inadequate supply and distribution of primary care physicians, nurses, dentists, public health and other professionals in certain areas of the United States; 2) the need for more diversity in the workforce; and 3) the need for health organizations and professionals to be trained for a contemporary practice environment focused on new and more efficient models of care that include interprofessional and team-based care, and an expanded and coordinated use of technology.

Cross-Cutting Performance Measurement

BHW has tracked and reported on three cross-cutting measures for more than 40 of its programs. The cross-cutting measures focus specifically on the diversity of individuals completing specific types of health professions training programs[3]; the rate in which individuals participating in

[3] BHW currently funds more than 40 health professions training and loan programs that have varying types of data reporting requirements based on their program's authorizing legislation. For the purposes of the cross-cutting measures, only programs that are required to report individual-level data are included in the calculation, as this ensures a higher level of accuracy and data quality, as well as consistency in the types of programs that are included in the calculation. Currently, at least 20 of the 40+ BHW-funded programs are required to report individual-level

specific types of health professions training programs are trained in medically underserved communities[4]; and the rate in which individuals who complete specific types of health professions training programs report being employed or pursuing further training in a medically underserved community. Note these measures do not currently include data from the following programs, which were previously part of the Bureau of Clinician Recruitment and Service: National Health Service Corps, NURSE Corps, and Faculty Loan Repayment Program.

During Academic Year 2013-2014, results showed that 46 percent of graduates and program completers participating in BHW-supported health professions training and loan programs were underrepresented minorities and/or from disadvantaged backgrounds[5]. While the FY 2013 target of 53 percent was not met, results showed that some programs had much greater diversity than others which can help identify areas where further investigation is needed. For example, while results showed that nursing programs had a rate of 67 percent, oral health programs had a rate of 35 percent, and the physician assistant program had a rate of 44 percent, medicine programs (including residency programs) had a rate of 32 percent, while public health and behavioral health programs collectively had a rate of 43 percent. Since these measures encompass underrepresented races/ethnicities, as well as those from disadvantaged backgrounds, a direct comparison using the most recent data for graduates of health professions training program is not feasible. Nonetheless, BHW will continue to use its new performance measures to further investigate potential reasons or factors associated with these profession-specific rates and identify strategies for improving program performance in this area.

With regard to the types of settings used to provide training, results showed that 66 percent of individuals participating in BHW-supported health professions training and loan programs received at least a portion of their training in a medically underserved community—exceeding the overall performance target of 44 percent. Results showed that nursing programs had a rate of 60 percent; medicine programs (including residency programs) had a rate of 64 percent; oral health programs had a rate of 71percent; public health and behavioral health programs collectively had a rate of 79 percent; and the physician assistant program had a rate of 54 percent. While the range of rates is smaller than the range observed for the first cross-cutting measure, further investigation is needed to better understand factors that either increase or decrease the rate in which individuals participating in a specific HRSA-supported program are exposed to training in this type of setting.

Lastly, results showed that 43 percent of individuals who graduated from or completed specific types of BHW-supported training programs by June 30, 2013[6] reported working in medically

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data and are included in these calculations. These programs are representative of the health professions and include oral health program's behavioral health programs, medicine programs, nursing programs, geriatric programs, and physician assistant programs, among others.

[4] A medically underserved community is an umbrella term that includes a medically underserved area, a health professional shortage area, and/or medically underserved populations.

[5] This measure includes individuals who graduated from or completed a specific type of HRSA-supported health professions training or loan program and identified as Hispanic (all races); Non-Hispanic Black or African American; Non-Hispanic American Indian or Alaska Native; Non-Hispanic Native Hawaiian or Other Pacific Islander; and/or identified as coming from a financially and/or educationally disadvantaged background (regardless of race).

[6] Measure is based on data reported about graduates and program completers from Academic Year 2012-2013.

underserved communities across the nation one year after graduation/completion. Profession-specific differences were observed that require further investigation to better understand factors associated with this outcome.

Outputs and Outcomes Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[7]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
6.I.B.1. Percentage of graduates and program completers of Bureau of Health Workforce-supported health professions training programs who are underrepresented minorities and/or from disadvantaged backgrounds.	46% Target: 53% (Target Not Met)	46%	46%	Maintain
6.I.C.1. Percentage of trainees in Bureau of Health Workforce-supported health professions training programs who receive training in medically underserved communities.	66% Target: 44% (Target Exceeded)	55%	55%	Maintain
6.I.C.2. Percentage of individuals supported by the Bureau of Health Workforce who completed a primary care training program and are currently employed in underserved areas.[8]	43% Target: 43% (Target Met)	34%	34%	Maintain
6.I.1. Percent of sites that provide interprofessional training to individuals enrolled in a primary care training program.	---	TBD[9]	TBD	N/A

[7] Most recent results are for Academic Year 2013-2014 and funded in FY 2013, excluding measure 6.I.C.2.
[8] 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 2013-2014 based on graduates from Academic Year 2012-2013.
[9] Baseline for this measure will be set in FY 2014.

National Health Service Corps (NHSC)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	---	---	$287,370,000	+287,370,000
Current Law ACA	$283,040,000	$287,370,000	---	-287,370,000
Proposed Mandatory	---	---	$522,630,000	+522,630,000
Total	$283,040,000	$287,370,000	$810,000,000	+522,630,000
FTE	219	237	287	+50

Authorizing Legislation: Public Health Service Act, Sections 331-338H, as amended by Health Care Safety Net Act of 2008, P.L. 110-355, as further amended by P.L. 111-148, Section 5207 and Section 10503(b) (2).

FY 2016 Authorization $287,370,000

FY 2016 Proposed Mandatory $522,630,000

Allocation Method ..... Competitive Awards to Individuals

Program Goal and Description: Since its inception in 1972, the National Health Service Corps (NHSC) has worked to build healthy communities by supporting qualified health care providers dedicated to working in areas of every State and Territory of the United States with limited access to care. The NHSC seeks clinicians who demonstrate the characteristics for an interest in serving the nation's medically underserved populations at NHSC-approved sites located in Health Professional Shortage Areas (HPSAs). HPSA designations are geographic areas, population groups, and facilities with a demonstrated shortage of health professionals. A HPSA is scored based on the degree of shortage; the higher the score, the greater the need. Since the NHSC statute requires that clinicians be placed in HPSAs of greatest need, this scoring system is used in determining priorities for the assignment of NHSC clinicians.

NHSC-approved sites provide care to individuals regardless of ability to pay. Eligible sites include Federally Qualified Health Centers (FQHC) and FQHC Look-Alikes, American Indian and Native Alaska Health Clinics, Certified Rural Health Clinics, Critical Access Hospitals

(CAH), School-Based Clinics, Mobile Units, Free clinics, Community Mental Health Centers, State or Local Health Departments, Correctional or Detention Facilities, and Community Outpatient Facilities and Private Practices.

The Affordable Care Act appropriated a total of $1.5 billion in new dedicated funding for the NHSC over five years starting in FY 2011 and allowed for programmatic changes to better support the recruitment and retention of primary care providers to communities in need. Changes to the program also included:

- Raising the maximum allowable annual award for the NHSC Loan Repayment Program (LRP) from $35,000 per year to $50,000.
- Allowing half-time loan repayment contracts.
- Allowing full-time NHSC participants to fulfill a portion of their 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.

The NHSC Scholarship Program provides financial support through scholarships, including tuition, 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 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 NHSC-approved sites in underserved communities.

The NHSC LRP offers fully trained primary care clinicians the opportunity to receive assistance to pay off qualifying educational loans in exchange for service in a Health Profession Shortage Area (HPSA) of greatest need. In exchange for an initial minimum of two years of service, loan repayers receive up to $50,000 in loan repayment assistance per year. 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 NHSC uses an enhanced award structure 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 are eligible to receive up to $50,000 for an initial two-year contract. Individuals working in HPSAs of 13 and below are eligible for loan repayment of up to $30,000 for a two-year contract. This policy has allowed the Corps to remain competitive with other loan repayment programs and help communities that have persistent workforce shortages. After the initial service period, NHSC loan repayers with additional eligible loans may apply for continuation awards in return for additional years of service.

The NHSC implemented the Critical Access Hospital (CAH) pilot program in FY 2012, which allows the inpatient setting of a CAH to qualify as an NHSC site. Prior to FY 2012, only the outpatient clinic of a CAH was eligible and NHSC clinicians were generally limited to no more than eight hours in the inpatient setting. With the pilot, clinicians may now spend up to 24 hours

per week in the CAH, with no fewer than 16 hours being spent in an affiliated outpatient clinic. As of September 30, 2014, the NHSC has approved 229 Critical Access Hospitals as NHSC service sites.

The NHSC Students to Service (S2S) Loan Repayment Program, which began in FY 2012, provides loan repayment assistance of up to $120,000 to allopathic and osteopathic medical students in their last year of school in return for selecting and completing a primary care residency and working in rural and urban HPSAs of greatest need for three years. The first cohort of these physicians will begin service in FY 2016, doubling the number of physicians available for placement in high-need areas. After the initial service period, physicians with additional eligible loans may apply for continuation awards in return for additional years of service.

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. SLRP grantees have the discretion to focus on one, some, or all of the eligible primary care disciplines and may also include pharmacists and registered nurses. In addition, the SLRP serves as a cost-efficient alternative to the NHSC, as the federal cost-per-clinician in SLRP is less given the matching requirement. The new grant competition in FY 2014 resulted in an increase in the number of awarded States from 32 to 38, with a commensurate increase in the budget allocation from $9.1 million in FY 2013 to $12.7 million in FY 2014.

The combination of these programs allows flexibility in meeting the future needs (through scholars and S2S awardees) and the immediate needs (through loan repayers) of underserved communities. Tables 1 and 2 illustrate the students in the NHSC pipeline training to serve the underserved. Tables 3 and 4 illustrate the number and type of primary care providers serving in the NHSC.

Table 1. NHSC Student Pipeline by Program as of 09/30/14

Programs	**No.**
Scholarship Program	932
Students to Service Program	222
Total	**1,154**

Table 2. NHSC Student Pipeline by Discipline as of 09/30/14

Disciplines	**No.**
Allopathic/Osteopathic Physicians	818
Dentists	187
Nurse Practitioners	24
Physician Assistants	116
Certified Nurse Midwives	9

Total	**1,154**

Table 3. NHSC Field Strength by Program as of 09/30/14

Programs	**No.**
Scholarship Program Clinicians	459
Loan Repayment Program Clinicians	7,648
State Loan Repayment Clinicians	1,135
Total	**9,242**

Table 4. NHSC Field Strength by Discipline as of 09/30/14

Disciplines	**No.**
Allopathic/Osteopathic Physicians	2,405
Dentists	1,088
Dental Hygienists	220
Nurse Practitioners	1,628
Physician Assistants	1,102
Nurse Midwives	143
Mental and Behavioral Health Professionals	2,630
Other State Loan Repayment Clinicians	26
Total	**9,242**

In FY 2014:

Mandatory Funds*:*

- The Affordable Care Act provides $283,040,000 for the NHSC. These funds are projected to be distributed as follows:

    - Field Line - $61.6 million is used to directly support the NHSC Recruitment Line in the form of staffing, acquisition contracts, Primary Care Office cooperative agreements, and other support activities.
    - Scholarships - $43.3 million = 171 new awards and 14 continuations.
    - Loan Repayment - $156.2 million = 2,775 new awards (average of $43,459) and 2,105 continuations (average of $15,868).
    - Students to Service Loan Repayment - $9.3 million = 87 new awards (average of $116,694).
    - State Loan Repayment - $12.7 million = 464 Awards.

By the end of FY 2014, the Affordable Care Act allowed for a significant expansion of the NHSC Field Strength, over 9,200 and serving the primary care needs of 9.7 million patients.

In FY 2015:

Mandatory Funds:

- The Affordable Care Act provides $287,370,000 for the NHSC. These funds are projected to be distributed as follows:
  - Field Line - $64.7 million is used to directly support the NHSC Recruitment Line in the form of staffing, acquisition contracts, Primary Care Office cooperative agreements, and other support activities.
  - Scholarships - $38.5 million = 163 new awards and 14 continuations.
  - Loan Repayment - $159.2 million = 2,272 new awards and 1,629 continuations.
  - Students to Service Loan Repayment - $12.0 million = 100 new awards.
  - State Loan Repayment - $13.0 million = 464 Awards.

By the end of FY 2015, the NHSC Field Strength is projected to be more than 8,400 and serving the primary care needs of 8.9 million patients.

Need: Across the Nation, the NHSC clinicians serve patients in communities with limited access to health care. As of September 30, 2014, there were more than 59 million people living in primary care HPSAs, more than 47 million people living in dental HPSAs, and more than 96 million people living in mental health HPSAs. In order for the nation to no longer have these designations, it would take over 8,100 new primary care physicians, 7,300 new dental providers, and over 2,700 behavioral and mental health providers practicing in their respective HPSAs.

As of September 30, 2014, more than 9,200 primary care medical, dental, and mental and behavioral health practitioners providing service nationwide at NHSC-approved sites in rural, urban, and frontier areas.

In addition, there are more than 9.7 million people who rely on NHSC providers. These providers work at NHSC-approved sites, all of which must provide care to patients, regardless of their ability to pay. About half of all NHSC-approved sites are HRSA-supported Health Centers, known as Federally Qualified Health Centers (FQHCs).

Eligibility: Eligible participants for the NHSC Scholarship Program are U.S. citizens (either U.S. born or naturalized), U.S. Nationals or Lawful Permanent Residents enrolled or accepted for enrollment as a full-time student pursuing a degree in a NHSC-eligible discipline at an accredited health professions school or program located in a State, the District of Columbia, or a U.S. territory.

Eligible participants for the NHSC LRP are U.S. citizens (either U.S. born or naturalized), U.S. Nationals or Lawful Permanent Residents practicing in a NHSC-eligible discipline, maintaining a current, full, unencumbered, unrestricted health professional license, certificate, or registration to practice in the discipline and State in which the loan repayer is applying to serve, and currently working in a NHSC approved site in a HPSA.

Eligible participants for the NHSC S2S Loan Repayment Program are U.S. citizens (either U.S. born or naturalized), U.S. Nationals or Lawful Permanent Residents enrolled as a full-time student in the final year at a fully accredited medical school located in an eligible allopathic or osteopathic degree program, and planning to complete an accredited primary medical care residence in a NHSC-approved specialty.

Eligible entities for the SLRP are States, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, Palau, the Marshall Islands and the Commonwealth of the Northern Mariana Islands that obtain matching funds from the state and/or territory to fund the program, ensure the SLRP will be administered by a state agency, and agree to use federal funds received through the SLRP to make loan repayment awards only.

Program Accomplishments: Over its 42-year history, the NHSC offered recruitment incentives, in the form of scholarship and loan repayment support, to more than 47,000 health professionals committed to providing care to underserved communities. In 2014, NHSC clinicians working at NHSC service sites provided primary medical, oral, and mental and behavioral health care to more than 9.7 million underserved people in these communities, known as HPSAs. There are currently more than 15,000 NHSC-approved sites.

In particular, the NHSC has partnered closely with the HRSA-supported Health Centers to help meet their staffing needs. Approximately 50 percent of 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.

In addition to the recruitment of providers, the NHSC also works to retain primary care providers in underserved areas after their service commitment is completed to further leverage the Federal investment and to build more integrated and sustainable systems of care. Retention in the Corps is defined as the percentage of NHSC clinicians who remain practicing in underserved areas after successfully completing their service commitment to the Corps. The NHSC does not provide Corps members with any additional financial incentives to remain in these underserved communities when promoting retention and in capturing retention rates. In FY 2012, the NHSC completed a long-term retention study, noting a 55 percent retention rate for clinicians remaining in service to the underserved 10 years after completing their NHSC commitment. This is a 6 percent increase compared to the 2000 rate of 52 percent. Moreover, the FY 2014 NHSC Participant Satisfaction Study reported a short-term retention (defined as up to two years after service completion) rate of 86 percent.

Funding History

FY	Amount
FY 2012	---
FY 2012 Mandatory Funding	$295,000,000
FY 2013	---
FY 2013 Mandatory Funding	$284,700,000
FY 2014	---
FY 2014 Mandatory Funding	$283,040,000
FY 2015	---
FY 2015 Mandatory Funding	$287,370,000
FY 2016	$287,370,000
FY 2016 Mandatory Funding	$522,630,000

Budget Request

The FY 2016 Budget Request is $810,000,000, which includes $287,370,000 in Base funding and $522,630,000 in Mandatory funding. The FY 2016 Budget is $522,630,000 above the FY 2015 Enacted level. This request will fund 9,658 new and 1,732 continuation loan repayment awards, 330 new and 13 continuation scholarship awards, 464 state loan repayment awards and 125 students to service loan repayment awards. This request is part of new investments beginning in this year to bolster the Nation's health workforce and to improve the delivery of health care across the country. Between FY 2016 and FY 2020, HRSA will devote a total of $2.61 billion in mandatory funding to the NHSC to address health professional shortages in high-need rural and urban communities across the country.

NHSC Fund ($ millions)	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Affordable Care Act	$287					
Proposed Mandatory		$523	$523	$523	$523	$523

This funding addresses ongoing challenges in the American health care system that even as more health professionals are trained, most do not choose to practice in areas where they are most needed. This funding improves the distribution of health care providers into high-need areas. This funding will also address increased demands for health care services from an aging population. As a significant source of highly qualified, culturally competent clinicians for the Health Center Program, rural areas, and other safety net providers, the NHSC can build on its success in assuring access to health care services for 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 2016 for the NHSC Programs will support efforts to work with Health Centers and other community-based systems of care located in rural and urban areas to improve the quality of care provided and reduce the health disparities gap. As measurement of these efforts:

In FY 2016:

Base Funds:

- The annual appropriation provides $287,370,000 for the NHSC. These funds are projected to be distributed as follows:
    - Field Line - $64.8 million is used to directly support the NHSC Recruitment Line in the form of staffing, acquisition contracts, and other support activities.
        - Scholarships - No scholarship awards with annual appropriation.
        - Loan Repayment - 194.5 million = 2,914 new awards and 1,732 continuations.
    - State Loan Repayment - $13 million = 464 Awards.
    - Students to Service Loan Repayment - $15 million = 125 new awards.

Mandatory Funds:

- Mandatory funding provides $522,630,000 for the NHSC. These funds are projected to be distributed as follows:
    - Field Line - $97.2 million is used to directly support the NHSC Recruitment Line in the form of staffing, acquisition contracts, Primary Care Office cooperative agreements, and other support activities.
    - Scholarships - $79.6 million = 330 new awards and 13 continuations.
    - Loan Repayment - $345.8 million = 6,744 new awards.

In FY 2016, the annual and mandatory appropriations will allow for a significant growth in NHSC Field Strength, which is projected to be at an historic high of more than 15,000 and serving the primary care needs of more nearly 16 million patients. This request would increase the FY 2015 NHSC Field Strength of 8,495 by more than 75 percent, allowing the program to address the anticipated increased demand for access to primary care services in underserved communities and vulnerable populations including the newly insured. This will also allow the NHSC to explore the feasibility of expanding the eligible disciplines in high need specialties in the NHSC program on a temporary basis. A total budget of $810 million will allow the NHSC to sustain a projected yearly Field Strength of more than 15,000, and allow the NHSC to continue to grow the pipeline of primary care clinicians through the Scholarship and Students-to-Service Loan Repayment programs.

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

Table 5. Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
4.I.C.1: Number of individuals served by NHSC clinicians *(Outcome)*	FY 2014: 9.7 Million Target: 7.9 Million (Target Exceeded)	8.9 Million	15.9 Million	+7.0 Million
4.I.C.2: Field strength of the NHSC through scholarship and loan repayment agreements. *(Outcome)*	FY 2014: 9,242 Target: 7,522 (Target Exceeded)	8,495	15,159	+6,664
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 2014: 86% Target: 80% (Target Exceeded)	80%	80%	Maintain
4.E.1: Default rate of NHSC Scholarship and Loan Repayment Program participants. *(Efficiency)* (Baseline: FY 2007 = 0.8%)	FY 2014: 1.0% Target: ≤2.0% (Target Exceeded)	≤ 2.0%	< 2.0%	Maintain
4.I.C.6: Number of NHSC sites *(Outcome)*	FY 2014: 15,687 Target: 14,000 (Target Exceeded)	14,000	14,000	Maintain

Table 6. Loans/Scholarships Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Loans Repayments			$194,500,000
State Loans Repayments			$13,000,000
Scholarships			
Students to Service Loan Repayment			$15,000,000
Mandatory Loans	$156,200,000	$159,200,000	$345,830,000

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Mandatory State Loans	$12,700,000	$13,000,000	
Mandatory Scholarships	$43,300,000	$38,500,000	$79,600,000
Mandatory Students to Service Loan Repayment	$9,300,000	$12,000,000	

Table 7. NHSC Awards, by program and funding category, FYs 2009-2016

Fiscal Year	2009	2010	2011	2012	2013	2014	2015	2016
AWARDS:								
Scholarship	88	25	5	-	-	-		
Scholarship Continuation	8	5	1	-	-	-	-	-
Loan Repayment	949	1,335	448	-	-	-	-	2,914
Loan Repayment Continuation	705	701	-	-	-	-	-	1,732
State Loan Repayment	400	285	-	-	-	-		464
Students to Service Loan Repayment	-	-	-	-	-	-		125
ARRA Scholarship	70	185	-	-	-	-	-	-
ARRA Loan Repayment	829	2,214	1,053	-	-	-	-	-
ARRA State Loan Repayment	-	161	171	-	-	-	-	-
ACA Scholarships	-	-	248	212	180	190	163	-
ACA Scholarship Continuation	-	-	8	10	16	7	14	-
ACA Loan Repayment	-	-	2,612	2,342	2,106	2,775	2,272	-
ACA Loan Repayment Continuation	-	-	1,305	1,925	2,399	2,105	1,629	-
ACA State Loan Repayment	-	-	223	281	447	464	464	-
ACA Students to Service Loan Repayment	-	-	-	69	78	79	100	-
Mandatory Scholarships								330

Mandatory Scholarship Continuation								13
Mandatory Loan Repayment								6,744
Total Awards	**3,049**	**4,911**	**6,074**	**4,839**	**5,226**	**5,620**	**4,642**	**12,322**

Table 8. NHSC Field Strength, by program and funding category, FYs 2009-2016

Fiscal Year	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
FIELD STRENGTH:								
Scholars	582	523	495	425	359	249	198	166
Loan Repayers	2,597	3,201	2,010	754	271	-	-	4,646
State Loan Repayment	763	581	285	-	-	-	-	
USPHS Commissioned Corps Ready Responders	37	30	23	17	-	-	-	-
Base Field Strength (as of 9/30)	**3,979**	**4,335**	**2,813**	**1,196**	**630**	**249**	**198**	**4,812**
ARRA Loan Repayers	829	3,032	3,267	1,089	59	-	-	-
ARRA State Loan Repayment	-	161	278	130	106	-	-	-
ARRA Scholars	-	2	4	71	103	77	101	267
ARRA Field Strength	**829**	**3,195**	**3,549**	**1,290**	**268**	**77**	**101**	**267**
ACA Scholars				6	31	133	241	246
ACA Loan Repayment	-	-	3,917	6,791	7,217	7,648	7,223	2,272
ACA State Loan Repayment	-	-	-	625	753	1,135	732	749
ACA Students to Service Loan Repayment	-	-	-	-	-	-	-	69

Table 8. NHSC Field Strength, by program and funding category, FYs 2009-2016

ACA Field Strength	**-**	**-**	**3,917**	**7,422**	**8,001**	**8,916**	**8,196**	**3,336**
Mandatory Loan Repayment								6,744
Mandatory Field Strength								**6,744**
Total Field Strength	**4,808**	**7,530**	**10,279**	**9,908**	**8,899**	**9,242**	**8,495**	**15,159**

Faculty Loan Repayment Program

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$1,187,000	$1,190,000	$1,190,000	---
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Sections 738(a), Public Health Service Act (authorized appropriation Section 740(b)), as amended by Section 5402, and Section 10501(d), P.L. 111-148

FY 2016 Authorization…….……..Expired

Allocation Method ..... Competitive Awards to Individuals

Program Goal and Description: 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 that matches the principal and interest amount paid by HHS 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.

Need: FLRP participants contribute to the Bureau of Health Workforce's goal of increasing the recruitment and retention of health professions faculty. A sufficient supply and diversity of health professions educators is vital to ensure that the health profession training system is able to preparing the next generation of health care professionals. FLRP encourages participants to promote careers in their respective health care fields.

Eligible Entities: U.S. citizens (either U.S. born or naturalized), U.S. Nationals or Lawful Permanent Residents from a disadvantaged background with an eligible health professions degree or certificate, an employment commitment for a full-time or part-time faculty position for a minimum of two years from an eligible health professions school, and a written agreement with the school in which the school has agreed to match funds to pay principal and interest due on the applicant's educational loans, unless the school has been granted a full or partial waiver of this requirement.

Program Accomplishments: The ACA included physician assistants as an eligible discipline for the FLRP program. In FY 2010, FLRP began accepting applications from physician assistants.

In FY 2013:
The FLRP program made 21 new loan repayment awards.

In FY 2014:
The FLRP program made 19 new loan repayment awards.

In FY 2015:
The FLRP program is expected to make 20 new loan repayment awards.

Funding History

FY	Amount
FY 2012	$1,243,000
FY 2013	$1,177,000
FY 2014	$1,187,000
FY 2015	$1,190,000
FY 2016	$1,190,000

Budget Request

The FY 2016 Budget Request is $1,190,000. The FY 2016 Budget is equal to the FY 2015 Enacted level. This budget will fund 20 awards to health profession graduates from disadvantaged backgrounds who serve as faculty at an eligible health professions college or university. The availability of pipeline programs, and the faculty to support them, are imperative to ensuring a sufficient primary care workforce.

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	19	20	20
Average Award	$57,346	$59,853	$59,853
Range of Awards	$39,222 - $59,853	$59,853	$59,853

Health Professions Training for Diversity

Centers of Excellence

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$21,657,000	$21,711,000	$25,000,000	+$3,289,000
FTE	1	1	1	---

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

FY 2016 Authorization ..... Indefinite

Allocation Method ..... Competitive Grant/Contract

Program Goal and Description: The Centers of Excellence (COE) Program seeks to increase the supply and competencies of underrepresented minorities (URM) in the health professions workforce by providing grants to health professions schools and other public and nonprofit health or educational entities that meet the eligibility requirements described in the "Eligible Entities" section below. Funds support programs of excellence that enhance the academic performance of URM students, support URM faculty development, and facilitate research on minority health issues.

Need: Diversity among medical school students is associated with higher levels of cultural sensitivity of all students and greater willingness to serve diverse populations.[10] Studies have found that greater diversity among health professionals is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better patient-clinician communication. In addition, 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.[11]

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 (HBCUs), (b) Hispanic COEs, (c) Native American COEs, and d) Other COEs.

[10] Colorado Health Institute, Denver Colorado. 2nd Annual Colorado Health Professions Workforce Summit. October 22, 2009. Citation is taken Institute of Medicine (2004); Saha, Guiton, Wimmers and Wilkerson (2008).
[11] 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.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Allopathic medicine • Dentistry • Graduate programs in behavioral or mental health • Osteopathic medicine • Pharmacy	• Undergraduate • Graduate • Faculty development	• Increase outreach to URM students to enlarge the competitive applicant pool. • Develop academic enhancement programs for URM students. • Train, recruit, and retain URM faculty. • Improve information resources, clinical education, cultural competency, and curricula as they relate to minority health issues. • Facilitate opportunities for faculty and student research on minority health issues. • Train students at community-based health facilities serving minority individuals. • Provide stipends and fellowships to URM students and faculty.

Program Accomplishments: In Academic Year 2013-2014, the Centers of Excellence (COE) program supported more than 230 different training programs and activities designed to prepare individuals to either apply to a health professions training program (academic recruitment) or maintain enrollment in such programs during the academic year (academic retention). Overall, programs and activities supported through the COE program reached more than 10,100 trainees across the country. Results showed that 25 percent of trainees reached through the COE program identified as Hispanic; 18 percent identified as Non-Hispanic Black or African American; 23 percent identified as Non-Hispanic American Indian or Alaska Native; and 1 percent identified as Non-Hispanic Native Hawaiian or Other Pacific Islander. The significant increase in participation from American Indians or Alaska Natives was a result of a special program by one of our grantees that focused on health career enrichment activities for underrepresented minorities. Overall, it is estimated that 67 percent of the trainees reached through the COE program were considered underrepresented minorities in the health professions and approximately 58 percent of the trainees reported coming from a financially and/or educationally disadvantaged background.

Data were collected about other types of training activities carried out through the COE program. For example, COE program grantees provided clinical training to students in providing healthcare services to underrepresented communities. Results showed that COE grantees partnered with over 330 healthcare delivery sites, providing over 4,700 clinical training experiences to healthcare trainees. It is estimated that 54 percent of training sites used by COE grantees were in primary care settings and approximately 69 percent were located in medically underserved communities.

Grantees of the COE program also improved curricular design in local campuses and enhanced the capacity and opportunity for faculty development. Results showed that COE grantees developed or enhanced and implemented over 110 different curricular activities—most of which were new academic courses and clinical rotations for health professions students, residents and fellows. It is estimated that more than 11,800 trainees were reached through curricular activities supported through the COE program during the academic year. Finally, with regard to faculty development, results showed that COE grantees supported more than 420 different faculty-focused training programs and activities during the academic year. It is estimated that over 2,800 faculty-level trainees were reached through structured and unstructured faculty development activities supported through the program. In addition, grantees supported over 380 different faculty-student research projects related to minority health issues such as "*Psychological and Social Stressors among Young African-American Adults and Effects on their Health-Related Practices"* and "*Impact of Language Concordant Care for Hispanic Pediatric Surgery Patients."* In total, more than 550 faculty members and over 540 health professions students, residents, and fellows participated in collaborative research projects supported through the program during the AY 2013-2014.

Funding History

FY	Amount
FY 2012	$22,909,000
FY 2013	$21,482,000
FY 2014	$21,657,000
FY 2015	$21,711,000
FY 2016	$25,000,000

Budget Request

The FY 2016 Budget Request is $25,000,000. The FY 2016 Budget is $3,289,000 above the FY 2015 Enacted level. This request will enable HRSA to increase the award size for its estimated 17 grants to provide additional support to qualifying 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, including diversity and cultural competency. In FY 2015, the four designated Historically Black Colleges and Universities (HBCUs) will re-compete through a new award cycle to more equitably distribute the available funding of $12,000,000.

As a result of the AY 2012-2013 data, the Agency began an evaluation of the COE program in FY 2014. The retrospective-to-prospective evaluation of the COE program will primarily focus on identifying how grantees have carried out each of the activities identified in the program's authorizing legislation; in turn, this data will be used to identify how specific approaches and strategies used by grantees are associated with the degree to which program participants (i.e. students who are considered underrepresented minorities in the health professions) successfully apply to or maintain enrollment in a health professions training program. The retrospective portion of the evaluation was completed in calendar year 2014. The prospective portion of the

evaluation of the COE program is expected to begin in FY 2015 and is supported with FY 2015 funds.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [12]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Percent of program participants who completed pre-health professions preparation training and intend to apply to a health professions degree program	---	Set Baseline	TBD	---
Percent of program participants who received academic retention support and maintained enrollment in a health professions degree program	---	Set Baseline	TBD	---
Percent of health professions students participating in research on minority health-related issues	---	Set Baseline	TBD	---
Percent of faculty members participating in research on minority health-related issues	---	Set Baseline	TBD	---
Number of URM students participating in research on minority health issues	465 Target: 536 (Target Not Met)	N/A[13]	N/A	---
Number of URM faculty participating in research on minority health issues	323 Target: 323 (Target Met)	N/A[3]	N/A	---

[12] Most recent results are for Academic Year 2013-2014 and funded in FY 2013.
[13] Measure is discontinued in FY15.

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	17	13[14]	13
Average Award	$1,207,000[15]	$691,000	$891,000
Range of Awards	$590,000-$4,172,000	$656,000-$700,000	$860,000-$900,000

Awards for Designated Historically Black Colleges and Universities

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	---	4	4
Average Award	---	$3,000,000	$3,000,000
Range of Awards	---	$2,000,000 -$3,000,000	$2,000,000 -$3,000,000

[14] For FY 2015 and FY 2016, the awards to the four designated HBCUs are listed separately in the table below.
[15] This average includes the $12 million awarded to four designated Historically Black Colleges and Universities (HBCUs), which makes the average significantly higher than the $700,000 ceiling per budget period.

Health Professions Training for Diversity

Scholarships for Disadvantaged Students

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$44,857,000	$45,970,000	$45,970,000	---
FTE	4	4	4	---

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

FY 2016 Authorization ..... Unspecified

Allocation Method .....Competitive Grant

Program Goal and 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 who have financial need, many of whom are underrepresented minorities (URMs). 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.

Need: Greater diversity among health professionals is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better patient-clinician communication. In addition, 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.[16] The SDS Program tackles a major barrier for a disadvantaged student's access to a health professions education because of high tuition costs.

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

[16] 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.

Designated Health Professions:	Targeted Educational Levels:	Grantee 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	• Provide scholarships to eligible full-time students. • Recruit and retain students from disadvantaged backgrounds including students who are members of racial and ethnic minority groups.

Program Accomplishments:
In Academic Year 2013-2014, the SDS Program provided scholarships to 4,913 students from disadvantaged backgrounds, exceeding the program performance target by 36 percent. Results of performance data showed that the majority of students were female (79 percent); between the ages of 20 and 29 (65 percent); and were provided a median award amount of $7,500. Further analyses showed that approximately 3 out of every 5 students who received an SDS-funded scholarship are considered underrepresented minorities in their respective professions. Additionally, 1,922 students who received a SDS-funded scholarship successfully graduated from their degree program by the end of Academic Year 2013-2014. Of those students who graduated, 55 percent are considered underrepresented minorities in their prospective professions, and 66 percent of graduates indicated an intention to work or pursue training in medically underserved communities. This continues to build upon the program redesign in FY 2012 which focused the program on becoming a competitive, primary care grant program.

Grantees of the SDS program partnered with over 3,900 different sites to provide clinical training to over 6,000 students who received an SDS-funded scholarship during the academic year. Further analyses of data submitted by grantees about the characteristics of sites used to train students who received SDS-funded scholarships showed that 53 percent of training sites were located in a medically underserved community and 45 percent of training sites were in primary care settings.

Funding History

FY	Amount
FY 2012	$47,452,000
FY 2013	$44,497,000
FY 2014	$44,857,000
FY 2015	$45,970,000
FY 2016	$45,970,000

Budget Request

The FY 2016 Budget Request is $45,970,000. The FY 2016 Budget is the same as the FY 2015 Enacted level. For FY 2016, a new competition will be held to make new grant awards. This request will fund 99 new grant awards, supporting approximately 2,940 students, consistent with previous funding levels.

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[17]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Number of disadvantaged students	4,913 Target: 3,620 (Target Exceeded)	2,940	2,940	Maintain
Number of URM students	3,031 Target: 2,350 (Target Exceeded)	1,820	1,820	Maintain
Percent of students who are URMs	62% Target: 65% (Target Not Met)	62%	62%	Maintain

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	99	99	99
Average Award	$424,000	$434,000	$434,000
Range of Awards	$40,000-$650,000	$40,000-$650,000	$40,000-$650,000

[17] Most recent results are for Academic Year 2013-2014 and funded in FY 2013.

Health Professions Training for Diversity

Health Careers Opportunity Program

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$14,153,000	$14,189,000	---	-$14,189,000
FTE	1	1	---	-1

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

FY 2016 Authorization .....Expired FY 2014

Funding Allocation .....Competitive Grant

Program Goal and Description: The Health Careers Opportunity Program (HCOP) seeks to increase the diversity of the health professions workforce by providing grants that improve the recruitment and enhance the academic preparation of students from economically and educationally disadvantaged backgrounds into the health professions.

In FY 2015, programmatic changes are underway to focus on activities that have a more direct impact on expanding the primary care workforce. In order to accomplish the goal of the program, the HCOP redesign will direct grantees to focus on specific entry points along a shorter educational pipeline that begins in the latter years of high school.

Need: Greater diversity among health professionals is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better patient-clinician communication.

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

Program Accomplishments: In Academic Year 2013-2014, the Health Careers Opportunity Program (HCOP) supported over 260 different training programs and activities to promote interest in the health professions among prospective students. In total, HCOP grantees reached more than 13,600 trainees across the country. Results showed that 24 percent of trainees reached through the HCOP identified as Hispanic; 23 percent identified as Non-Hispanic Black or African American; less than one percent identified as Non-Hispanic Native Hawaiian or Other Pacific Islander; and 2 percent identified as Non-Hispanic American Indian or Alaska Native. Overall, it is estimated that approximately 50 percent of all trainees reached through training programs and activities supported by the HCOP are considered underrepresented minorities in the health professions, and approximately 77 percent of trainees identify as coming from a

financially and/or educationally disadvantaged background. HCOP did not meet its target of 4,435 disadvantaged students in structured programs (FY 2013 result is 3,873) as a significant number of HCOP grantees completed their funding cycles just prior to this academic year.

Data were collected on other training-related activities that are required to be carried out by HCOP grantees. Results showed that HCOP grantees partnered with over 360 sites including academic institutions, hospitals, and community health centers. Approximately 43 percent of these training sites were in primary care settings and approximately 48 percent were located in medically-underserved communities. It is estimated that over 6,900 clinical training experiences were provided by HCOP grantees.

Funding History

FY	Amount
FY 2012	$14,779,000
FY 2013	$14,039,000
FY 2014	$14,153,000
FY 2015	$14,189,000
FY 2016	---

Budget Request

No funding is requested in FY 2016. The FY 2016 Budget is $14,189,000 below the FY 2015 Enacted level. Funding for the HCOP program is eliminated as part of the Science, Technology, Engineering, and Mathematics Education (STEM) consolidation. The Budget includes funding for the new Health Workforce Diversity Program (HWDP) which will build on the experience gained from the HCOP program.

Outcomes and Outputs Tables

Measure[18]	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [19]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Total number of disadvantaged students in structured programs	3,873 Target: 4,435 (Target Not Met)	3,800	N/A	---

[18] Program was discontinued in FY 2016.
[19] Most recent results are for Academic Year 2013-2014 and funded in FY 2013.

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	30[20]	30	---
Average Award	$464,000	$455,000	---
Range of Awards	$150,000-$750,000	$150,000-$700,000	---

[20] The number of awards, average award and range of award reflect "HCOP - Skills Training and Health Workforce Development of Paraprofessionals" a new grant award to train and expand the health paraprofessional workforce, particularly in rural and underserved areas and to Promote employment and a career ladder for graduates of health paraprofessional training programs. A total of 13 new grants were awarded in FY 2014.

Health Professions Training for Diversity

Health Workforce Diversity Program

	FY 2014 Final	FY 2015 Enacted	FY President's Budget	FY 2016 +/- FY 2015
BA	---	---	$14,000,000	+$14,000,000
FTE	---	---	1	+1

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

FY 2016 Authorization ..... Indefinite

Funding Allocation ..... Competitive Grant

Program Goal and Description: The goal of the Health Workforce Diversity Program (HWDP) is to increase the diversity and cultural competence of the health professions workforce providing care in underserved communities. This new program is expected to leverage or establish partnerships, including public-private partnerships, in academic training and workforce development to serve in underserved rural or urban communities Building on the experience gained from the Health Careers Opportunity Program, grant activities and partnerships will be focused on supporting the education, training, licensure, and career placement of health professions students from disadvantaged backgrounds, including racial and ethnic minorities underrepresented among health professionals.

Specifically, grant projects will demonstrate and implement evidence informed strategies to improve academic performance and graduation rates for disadvantaged students so they may progress through and successfully complete health professions education and training leading to licensure and job placement in underserved rural and urban communities.

Program activities and components will include:

- Recruitment of individuals from disadvantaged backgrounds in health professional degree programs leading to licensure for professional practice.

- Financial support in the form of stipends and/or scholarships to be used for tuition, other reasonable academic expenses (books, required fees and supplies, etc.), living expenses and licensure preparation expenses.

- Academic enrichment and support during the education and training period, which will help disadvantaged students successfully progress through the health professions educational pipeline to graduation.

- Establish public-private partnerships to form co-operative education opportunities or other models by which disadvantaged students gain experience through working in the health professions field of study during the academic training period at a health care employer that provides services in an underserved rural or urban community or HPSA.

- Academic instruction and support outside of the normal health professions education course of study that is specifically designed to prepare students for professional licensing and/or certification exams.

- Specialized training and preparation, including direct assistance with job placement in a health care facility serving an underserved rural or urban community or HPSA.

- Service monitoring of individuals for up to 2 years post-job placement.

The focus of HWDP is to provide academic support and pre-professional engagement to prepare individuals from disadvantaged backgrounds for health professions careers, including opportunities in underserved rural or urban communities such as HPSAs.

Need: Factors that negatively influence the college enrollment and graduation of students from disadvantaged backgrounds have been well documented in the research literature. These include: lower socio-economic status; inadequate academic preparation in high school; breaks in college attendance or enrollment; lower parental educational attainment; poor parental involvement in the college preparation process; attending underperforming schools; and poor academic preparation.[21]

According to U.S. Census Bureau 2010 census projections, "the U.S. population will be considerably older and more racially and ethnically diverse by 2060, when minorities are projected to comprise 57% of the population as compared to 37% currently."[22] This increase in population diversity and in the demand for health care services for minority patients underscores the need to have a diverse and culturally competent health care workforce in place.

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

Program Accomplishments: This is a new initiative with no programmatic history.

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[21] Cabrera, A.F., Burkum, K.R., & La Nasa, S.M. (2003). *Pathways to a Four-Year Degree: Determinants of Degree Completion among Socioeconomically Disadvantaged Students.* Paper presented at the 2003 annual meeting of the Association for the Study of Higher Education, Portland, OR.

[22] United States Census Bureau. (2012, December 12). *U.S. Census Bureau Projections Show aSlower Growing, Older, More Diverse Nation a Half Century from Now.* Retrieved from United States Census Bureau Web site: https://www.census.gov/newsroom/releases/archives/population/cb12-243.html

Funding History

FY	Amount
FY 2012	---
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	$14,000,000

Budget Request: The FY 2016 Budget Request is $14,000,000. The FY 2016 Budget is $14,000,000 above the FY 2015 Enacted level. This request will fund activities for approximately 25 grantees to create a career pipeline for health professions students that lead directly to service in underserved communities. Through these activities, the HWDP seeks to increase the diversity and cultural competence of the health professions workforce providing care in underserved communities.

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

Health Care Workforce Assessment

The National Center for Health Workforce Analysis

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$4,651,000	$4,663,000	$4,663,000	---
FTE	5	7	7	---

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

FY 2016 Authorization .....Expired FY 2015

Allocation Method…….……..Competitive Grants/Contract

Program Description: The National Center for Health Workforce Analysis collects and analyzes health workforce data and information in order to provide National and State policy makers, researchers, and the public with information on health workforce supply and demand. The Center also evaluates the effectiveness of workforce policies in addressing workforce issues. The Center is focused on:

- Informing the public on the current state and trends of the U.S. health workforce through timely dissemination of reports and data;
- Building National capacity for health workforce data collection by working with professional associations and others to develop and promote guidelines for data collection and analysis;
- Improving 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;
- Building health workforce research capacity, and;
- Responding to information and data needs by translating data and findings to inform policies and programs.

Need: Producing a workforce of sufficient size and skills is essential to meeting the Nation's health care needs. Policy makers and other decision makers need high-quality information about the health workforce that incorporates up-to-date research, modeling, and trends. This information can help inform how the Nation spends billions of dollars each year on the education and training of the health workforce. Since the healthcare system and workforce is constantly changing, effective decision making at the Federal, State and local level requires that we continue to develop new and more sophisticated understanding about the current workforce, healthcare delivery systems and estimates of future demands for health professionals.

Program Accomplishments:

The National Center will continue to model supply and demand of health professionals across a range of health occupations.

The National Center makes health workforce information available through reports and on-line databases. Several publications were released during Calendar Year 2014: (1.) The U.S. Health Workforce State Profiles; (2.) Supply of Nurse Practitioners in the U.S.; (3.) Future of Nursing Workforce: National- and State-level Projections, 2012-2025; (4.) Supply of Non-Primary Care Specialty and Subspecialty Clinicians, 2010-2025; (5.) Distribution of U.S. Healthcare Providers Residing in Rural and Urban Areas; and (6.) factsheets on supply and demand of Pharmacists, Optometrists, Opticians, and Physical and Occupational Therapists.

Continuing its work to expand the range of data available through the Area Health Resources Files, the National Center has added country, state, and national-level data and improved the availability of on-line comparison and mapping tools for analyzing data.

The National Center has funded a total of six Health Workforce Research Centers to perform research and data analysis on health workforce issues of national importance and one cooperative agreement to provide technical assistance to states working on data collection and health workforce planning. In FY 2014, HRSA funded two new centers to support research on Oral Health and Allied Health.

Funding History

FY	Amount
FY 2012	$2,782,000
FY 2013	$2,635,000
FY 2014	$4,651,000
FY 2015	$4,663,000
FY 2016	$4,663,000

Budget Request

The FY 2016 Budget Request is $4,663,000. The FY 2016 Budget is the same as the FY 2015 Enacted level. As the Nation's health care system continues to change, State and National level analysis of healthcare workforce needs will be critical to making investments in the health workforce. To support these needs, the National Center continues to develop a projections model which allows a more sophisticated modeling of health workforce supply and demand, taking into account changing National demographics, the effects of health reform on demand for health care services, and the impact that changes in the delivery of health care. The NCHWA Area Health Resources File continues to expand its focus on specific priority areas for health workforce development such as behavioral and mental health workforce needs, allied health professions, and oral health workforce. In FY 2016, the National Center plans to support

additional research on the health workforce with a focus on behavioral and mental health research as well as new and emerging health care occupations.

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

Health Workforce Research Centers Grants Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	6	6	6
Average Award	$438,000	$438,000	$438,000
Range of Awards	$357,000-$500,000	$357,000-$500,000	$357,000-$500,000

Primary Care Training and Enhancement Program

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$36,831,000	$38,924,000	$38,924,000	---
FTE	3	5	5	---

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

FY 2016 Authorization .....Expired FY 2014

Allocation Method .....Competitive Grant/Contract

Program Goal and Description: The purpose of the Primary Care Training and Enhancement (PCTE) program is to strengthen medical education for physicians and physician assistants (PA) to improve the quantity, quality, distribution, and diversity of the primary care workforce. PCTE grants help produce future primary care providers that are prepared to meet the changing healthcare needs of the nation by supporting the development of innovative medical education for physicians and physician assistants.

The PCTE program supports a range of activities, including:

- pre-doctoral training;
- residency training;
- physician and PA faculty development;
- support for academic administrative units;
- PA education; and
- interprofessional joint graduate degree programs.

These activities vary in eligible applicants, trainees, and approved activities, allowing for grant activities to specifically address local, community, and trainee needs.

In FY 2015, HRSA streamlined the PCTE program by combining previously separate funding announcements in order to support projects that propose training across the training continuum (student, resident, faculty development, and practicing primary care physician or physician assistants), and across primary care disciplines and professions (family medicine, general internal medicine, general pediatrics, physician assistants, and other primary care professions). In addition, applicants for the PCTE program must focus on training for transforming health care systems, particularly enhancing the clinical training experience of trainees. In FY 2016, programmatic modifications are planned to further support training in interprofessional practice for the transforming health care systems, and to align the two years of grant cycles.

Need: National and international research demonstrate that high quality, accessible primary care improves health and reduces costs, with improved satisfaction for both recipients and providers of healthcare services.

Difficulty recruiting students to become primary care physicians is a principle obstacle to improving the primary care system. Of the 25,687 positions filled in the 2014 National Residency Match Program, 3,777 (14.7 percent) were in family medicine, internal medicine, and pediatrics.[23] It is critical to note that only a small portion of the incoming primary care residents will choose generalist careers that will address the nation's primary care need; the majority will choose to pursue a sub-specialty.

Recent projections published by HRSA indicate that without changes to how primary care is delivered, the growth in primary care physician supply will not be adequate to meet the demand in 2020, with a projected shortage of 20,400 physicians.[24]

Geographic maldistribution also contributes to the shortage of primary care providers in many communities, both rural and urban. Even as the number of physicians increases nationally, they tend to practice in areas where the supply is already high, as opposed to rural and inner city areas where need has been demonstrated and is reflected by suboptimal health outcomes.[25]

The physician and PA workforce must be prepared for the expected increase in demand for healthcare and to help develop the delivery system and practice models that will yield higher quality and improve efficiency. PAs are valuable primary care team members that are helping increase the capacity and quality of the healthcare system. The trends disfavoring primary care practice and working in underserved communities seen in physicians have been mirrored in PAs. Investments in the primary care workforce are needed to increase the number of practicing physicians and PAs and to enhance their educational experience.

Eligible Entities: Accredited 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.

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[23] American Academy of Family Physicians. http://www.aafp.org/medical-school-residency/residency/match/nrmp.html#outlook. Accessed 5/20/2014.

[24] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. Projecting the Supply and Demand for Primary Care Practitioners Through 2020. Rockville, Maryland: U.S. Department of Health and Human Services, 2013.

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

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Physicians, including family medicine, general internal medicine, general pediatrics, and combinations of these specialties • Physician assistants	• Medical school • Graduate physician assistant education • Physician residency training • Academic and community faculty development	• Support innovations in primary care curriculum development, education, and practice for physicians and physician assistants. • 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.

Program Accomplishments: Grant activities funded through the PCTE program support education in primary care for physician and PA students, residents, and faculty. Educational programs with a PCTE grant provide learning activities that teach knowledge and skills essential to primary care, including interprofessional education and practice, team-based clinical models, and public health. In addition, grant activities may support training in a variety of settings (e.g., hospitals, patient-centered medical homes, medically underserved communities, and community-based sites) with vulnerable populations, including the homeless, the chronically ill, individuals with HIV/AIDS, and older adults.

In Academic Year 2013-2014, grantees of the PCTE program[26] trained a total of 30,236 physician and PA students, medical residents, fellows and faculty.[27] Of those trained, 7,735 completed their training program by the end of the academic year. Almost one out of every three graduates were underrepresented minorities and/or from disadvantaged backgrounds (31 percent). Trainees across the PCTE programs had over 1 million primary care patient encounters during the academic year. Just over half of all physician and physician assistant trainees received at least a portion of their training in medically underserved communities (55 percent), and 43 percent of physician and physician assistant graduates of PCTE programs currently practice in medically underserved areas.

[26] Includes Pre-Doctoral Training, Residency Training, Physician Assistant Training, Physician Faculty Development, Interprofessional Joint Graduate Degree, and Academic Administrative Units in Primary Care grant activities.

[27] Includes trainees who received direct financial support (e.g., stipends, tuition support) as well as trainees enrolled in or trained through the academic program supported by the grant.

In Academic Year 2013-2014, grantees of the Academic Administrative Units in Primary Care program trained 7,219 medical students, residents and fellows. Of those trained, 2,038 medical students, residents and fellows completed their degree or training program at the end of the academic year. One quarter of the graduates and the program completers were underrepresented minorities and/or from disadvantaged backgrounds (26 percent). The majority of training sites for this program were located in a primary care setting (79 percent), a medically underserved area (55 percent) or a rural setting (28 percent). A total of 3,911 faculty member physicians were trained through the faculty development activities funded by the program, and 64 faculty completed structured programs. Grantees supported five different types of faculty development activities including grand rounds, professional conferences, workshops, clinical rotations, and academic courses. The majority of faculty physicians training in these programs specialized in either family medicine (27 percent) or geriatrics (59 percent).

In Academic Year 2013-2014, grantees of the Interdisciplinary and Interprofessional Joint Graduate Degree program trained 2,330 medical students who were dually enrolled in public health degree programs. Of those trained, 496 of those students graduated from their degree program at the end of the academic year. More than one-third of graduates were underrepresented minorities and/or from disadvantaged backgrounds (35 percent). A number of training sites for this program were located in a primary care setting (45 percent), a medically underserved area (39 percent) and/or a rural setting (21 percent). Grantees of this program implemented 43 courses and training activities during the academic year toward their goal of integrating public health curriculum into the clinical practice model. Lastly, 21 faculty members completed structured faculty development programs sponsored by grantees, and 22 additional faculty were trained at professional conferences and workshops.

In Academic Year 2013-2014, grantees of the Physician Assistant Training in Primary Care program trained 4,071 physician assistant students. Of those trained, 1,196 of those students graduated from their degree program at the end of the academic year. About one-quarter of enrollees (27 percent) reported coming from a disadvantaged background, and more than one in 10 enrollees reported coming from a rural background (15 percent). Almost half of graduates were underrepresented minorities and/or from disadvantaged backgrounds (42 percent). The majority of training sites for this program were located in a primary care setting (58 percent), a medically underserved area (58 percent) or a rural setting (19 percent). Grantees implemented 78 courses and training activities to PA students during the academic year as part of integrating primary care curriculum into PA training. Lastly, 314 faculty members were trained through the faculty development activities funded by the program, and 61 faculty members completed structured faculty programs. Grantees supported five different types of faculty development activities, the majority of which were professional conferences (49 percent), workshops (37 percent), and academic courses (10 percent).

In Academic Year 2013-2014, the Physician Faculty Development in Primary Care program trained 2,521 faculty-level physicians, fellows, and community physicians through a number of structured programs, faculty development activities, and formal coursework. Of those physicians trained, a total of 715 physicians completed the program during the academic year. Of the faculty and fellows who received direct financial support and completed the program, 61

percent indicated their intention to practice in a medically underserved area and 88 percent intend to practice in a primary care setting. Analysis of one-year follow-up data on employment location setting for those who completed the program in Academic Year 2012-2013 showed that two-thirds of faculty graduates are now practicing in a medically underserved area (67 percent) and/or in a primary care setting (67 percent). Overall, the program offered 211 faculty development activities during the academic year that included academic courses, clinical rotations, grand rounds, professional conferences, and professional workshops. A total of 2,146 faculty-level physicians participated in these training activities with the majority of participants from the primary care disciplines of Family Medicine (42 percent), Pediatrics (22 percent) or Internal Medicine (11 percent). The program also offered 96 structured faculty programs that trained 375 physicians and 249 faculty-level physicians completed. The majority of these physicians were also from Family Medicine (39 percent), Pediatrics (23 percent) or Internal Medicine (nine percent).

In Academic Year 2013-2014, grantees of the Pre-doctoral Training in Primary Care program trained 12,370 medical students. Of those trained, 2,480 medical students graduated from their degree program at the end of the academic year. One quarter of graduates were underrepresented minorities and/or were from disadvantaged backgrounds (25 percent). The majority of clinical training sites for this program were located in a primary care setting (80 percent), a medically underserved community (57 percent) and/or a rural setting (33 percent). The program implemented 226 courses and training activities during the academic year to medical students as part of integrating primary care and innovative teaching into the medical school curriculum. Grantees of the program also trained a total of 834 physician faculty members through workshops, professional conferences, and grand rounds.

In Academic Year 2013-2014, grantees of the Residency Training in Primary Care program trained 1,725 primary care residents. Additionally, 485 of those residents completed their residency program at the end of the academic year. Almost half of the graduates were underrepresented minorities and/or from disadvantaged backgrounds (46 percent). The majority of clinical training sites for this program were located in a medically underserved area (68 percent), a primary care setting (55 percent), or a rural setting (26 percent). Grantees of this program offered 302 courses and training activities during the academic year to both medical residents and interprofessional trainees reaching over 8,000 participants. In addition to the courses and training activities offered, 15 additional training activities were under development and 34 were developed but not yet implemented. In terms of faculty development, grantees offered 33 structured faculty development programs during the academic year of which 179 faculty and community physicians completed. Lastly, 124 faculty development activities offered by grantees including professional conferences, workshops, grand rounds, and academic courses provided training to over 2,000 primary care faculty and community physicians training to become instructors.

Two additional grant programs - the Primary Care Residency Expansion Program (PCRE) and the Expansion of Physician Assistant Training Program (EPAT) - were funded in 2010 and will continue to increase the number of physician and PA students trained in primary care through 2015.

In Academic Year 2013-2014, the Expansion of Physician Assistant Training (EPAT) in Primary Care supported a total of 429 physician assistant students across 11 different types of Physician Assistant programs. Of the 429 students supported, a total of 120 graduated by the end of the academic year. Results showed that the majority of students supported were female (75 percent); between the ages of 20 and 29 (67 percent); and almost half (48 percent) received clinical training in medically underserved communities, over half received clinical training in a primary care setting (59 percent), and over one-quarter (28 percent) received training in a rural area during the academic year. Of the 120 students who graduated in Academic Year 2013-2014, almost half (44 percent) of students intend to practice in a medically underserved area; more than half (65 percent) intend to practice in a primary care setting; and over one-quarter (26 percent) intend to practice in a rural setting. Of the Academic Year 2012-2013 graduates whose follow-up employment data are available, the majority are either practicing in a primary care setting (71 percent), in a medically underserved area (59 percent), or in a rural setting (53 percent).

The EPAT program was unable to meet its performance target of producing 280 new physician assistants by the end of Academic Year 2013-2014. The primary reason for this is that performance targets assumed that the physician assistant training programs that were funded were only two academic years in length. As documented by the Physician Assistant Education Association (2013), over 75 percent of physician assistant programs in the US are between 24 and 29 months in length—though the total length in programs can range from 15 to 40 months. At the end of Academic Year 2013-2014, there were 89 physician assistant students in the second year of their program; it is very likely that these students are enrolled in programs that last slightly over 24 months and graduated at the very beginning of Academic Year 2013-2014. It is expected that the program can and will produce 600 new Physician Assistants; however, the cumulative target may not be reached until the beginning of Academic Year 2016-2017 rather than at the end of Academic Year 2015-2016 as previously identified due to the varying length of participating programs.

In Academic Year 2013-2014, the Primary Care Residency Expansion (PCRE) program provided direct financial support to 504 medical residents. Results showed that over half of residents were female (60 percent) and almost half were between the ages of 30 and 39 years (48 percent). They received an average award amount of $63,836. More than eight out of ten residents received clinical training in a medically underserved community (84 percent), and nearly all residents (99 percent) received training in a primary care setting. Further analyses of data showed that 16 percent of residents reported coming from a financially or educationally disadvantaged background and about 19 percent reported coming from a rural background. Of the 156 residents who completed the program in Academic Year 2013-2014 more than half intend to practice in a primary care setting (67 percent), almost half intend to practice in either a medically underserved area (46 percent), and almost one-fifth (17 percent) intend to practice in a rural setting.

Funding History

FY	Amount
FY 2012	$38,962,000
FY 2013	$36,535,000
FY 2014	$36,831,000
FY 2015	$38,924,000
FY 2016	$38,924,000

Budget Request

The FY 2016 Budget Request is $38,924,000. The FY 2016 Budget is the same as the FY 2015 Enacted level. This request will fund activities that aim to improve the quality of primary care providers, increase the capacity of PA education programs, promote interprofessional practice, enhance medical education through curriculum innovations and improve the distribution and diversity of the healthcare workforce. Through these activities, the PCTE programs seek to improve primary care quality and increase the appeal of primary care to students and current practitioners.

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Tables

The PCTE program supports primary care workforce growth and diversification, curricular innovations, and development of academic infrastructure. The current outcome measures reflect these objectives. As PCTE awards continue to emphasize new and evidence-based education strategies such as interprofessional education and care, community based practice experience, and education responsive to learners' and patients' needs, the evaluation and outcome measures are adjusted accordingly. Effective September 2012, grantees reported new performance measures that better assess grant impact. New measures include individual level data on specialty and practice setting selection, and details of didactic, clinical, and research training.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[28]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
6.I.C.4.a. Number of primary care physicians receiving training through HRSA's Bureau of Health Workforce programs supported with Prevention and Public Health funding: Primary Care Residency Expansion (PCRE) (cumulative)	504[29] Target: 515 (Target Not Met)	N/A	N/A	N/A
6.I.C.4.b. Number of primary care physician assistants receiving training through HRSA's Bureau of Health Workforce programs supported with Prevention and Public Health funding: Physician Assistance Expansion (EPAT) (cumulative)	458[30] Target: 445 (Target Exceeded)	N/A	N/A	N/A
6.I.C.3.a: Number of primary care physicians who complete their education through HRSA's Bureau of Health Workforce programs supported with Prevention and Public Health funding (PCRE) (cumulative)	156 Target: 166 (Target Not Met)	500[31]	N/A[32]	N/A
6.I.C.3.b: Number of physician assistants who complete their education through HRSA's Bureau of Health Workforce programs supported with Prevention and Public Health funding (EPAT) (cumulative)	157 Target: 280 (Target Not Met)	600[33]	N/A[34]	N/A
6.I.C.8: Number of Primary Care Patient Encounters	1,164,248 Target: 30,000 (Target Exceeded)	180,000	N/A[35]	N/A

[28] Most recent results are for Academic Year 2013-2014 and funded in FY 2013.
[29] Measure is cumulative and captures the training of the three cohorts of residents funded through the PCRE program. Targets regarding the training of each cohort are applicable for FY 2011, FY 2012, and FY 2013.
[30] Measure is cumulative and captures the training of the four cohorts of physician assistant students funded through the EPAT program. Targets regarding the training of each cohort are applicable for FY 2011, FY 2012, FY 2013, and FY 2014
[31] Outputs based on forward-funded grants.
[32] Measures for the PCRE program will be discontinued in FY 2016, as no new funding for this program is anticipated.
[33] Outputs based on forward-funded grants.
[34] Measures for the EPAT program will be discontinued in FY 2016, as no new funding for this program is anticipated.
[35] Measure will be discontinued in FY 2016.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[28]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Number of physicians completing a Bureau of Health Workforce-funded residency or fellowship	---	Set Baseline	TBD	---
Number of physicians graduating from a Bureau of Health Workforce-funded medical school	---	Set Baseline	TBD	---
Number of physician assistants graduating from a Bureau of Health Workforce-funded program	---	Set Baseline	TBD	---
Number of graduates from a Bureau of Health Workforce-funded joint public health degree program	---	Set Baseline	TBD	---
Percent of physician and physician assistant trainees receiving at least a portion of their clinical training in an underserved area	55% Target: 60% (Target Not Met)	55%	55%	Maintain
Percent of physician and physician assistant graduates who practice in medically underserved areas	43% Target: 46% (Target Not Met)	38%	38%	Maintain
Percent of graduates and program completers who are minority and/or from disadvantaged backgrounds	31% Target: 31% (Target Met)	35%	35%	Maintain
Number of graduates and program completers	7,735 Target: 7,600 (Target Exceeded)	N/A[36]	N/A	---

[36] Measure discontinued in FY15.

Grant Awards Table – Physician Training Grants

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	133	130	130
Average Award	$202,000	$234,000	$234,000
Range of Awards	$93,000-$490,000	$93,000-$491,000	$93,000-$491,000

Grant Awards Table – Physician Assistant Training Grants

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	29	35	35
Average Award	$150,000	$155,000	$155,000
Range of Awards	$18,000-$220,000	$96,000-$250,000	$96,000-$250,000

Oral Health Training Programs

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$31,928,000	$33,928,000	$33,928000	---
FTE	2	2	2	---

Authorizing Legislation: Sections 748 and 340G of the Public Health Service Act

FY 2016 Authorizations:
Section 748……...Such Sums as Necessary
Section 340G…….……...Expired FY 12

Allocation Method: …….…Competitive Grant/Contract

Program Goal and Description: The Oral Health Training Programs are designed to increase access to culturally competent, high-quality dental health services to rural and other underserved communities by increasing the number of oral healthcare providers working in underserved areas and improving training programs for oral health care providers. The Oral Health Training Programs are comprised of the following:

- Training in General, Pediatric, Public Health Dentistry and Dental Hygiene Program - Provides funding in the form of grants or contracts to plan, develop, and operate, or participate in, approved professional training programs in the fields of general, pediatric, or public health dentistry for dental students, residents, practicing dentists, dental hygienists, or other approved primary care dental trainees. Training areas within this program include:
    - Pre-doctoral Training
    - Post-doctoral Training
    - Faculty Development
    - Dental Faculty Loan Repayment

- State Oral Health Workforce Improvement Program - Awards grants to States to help them develop and implement innovative programs to address the dental workforce needs of designated Dental Health Professional Shortage Areas (D-HPSAs) in a manner that is appropriate to the states' individual needs. There are twelve specific available activities listed in the authorizing legislation for this program and a thirteenth that allows the Secretary to fund innovative projects that are not specified in the law.

In FY 2015, the goal of the Pre-doctoral Training program is to help better prepare pre-doc dentists and dental hygienists to practice in new and emerging models of care. Emphasis will be on training dental hygienists for advanced roles as allowed under State practices and models that stress the integration of oral health into larger care delivery systems. A cross cutting priority

will be to include innovative recruitment and retention programs focused on students from underrepresented minorities and rural or disadvantaged backgrounds.

In FY 2015, the goal of the Post-doctoral Training area is to prepare post-doctoral trained dentists to practice in and lead new and innovative models of oral health care delivery to underserved and vulnerable groups. This training area will support the development of training programs that incorporate and test new and innovative models of care delivery for vulnerable and underserved groups, including programs that focus on this at the population level.

The FY 2015 State Oral Health Workforce Improvement program will continue to focus on innovative projects. Applicants must choose from six focus areas including a new emphasis on supporting underserved communities by integrating oral and primary care medical delivery systems, by supporting oral health providers practicing in advanced roles specifically designed to improve oral health access, or on tele-dentistry.

Need: Oral health is an essential component of overall health. Untreated oral diseases and conditions can have significant impacts on quality of life. Yet, according to a July 2011 study published by the Institute of Medicine (IOM) entitled, *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*,[37] 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. For example:

- In 2011, 6.1 percent of children and 16.4 percent of adults under the age of 65 did not receive needed dental care because their families could not afford it.[38]
- The percentage of adults (age 65 or older) who reported they did not get dental care because they could not afford it, doubled from 3.5 percent in 2001 to 7.0 percent in 2011.[39]
- In 2011, there were approximately 33.3 million underserved individuals living in D-HPSAs.[40]

A large proportion of dental school faculty and practicing dentists are nearing retirement age and will soon leave the workforce without adequate replacements to meet the growing the oral health needs of the U.S. population. 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.

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[37] Institute of Medicine and National Research Council. *Improving access to oral health care for vulnerable and underserved patients*. Washington, DC: The National Academies Press, 2011.
[38] National Center for Health Statistics. Health, United States, 2012: With Special Feature on Emergency Care. Hyattsville, MD. 2013.
[39] National Center for Health Statistics. Health, United States, 2012: With Special Feature on Emergency Care. Hyattsville, MD. 2013.
[40] Institute of Medicine and National Research Council. *Improving access to oral health care for vulnerable and underserved patients*. Washington, DC: The National Academies Press, 2011.

Discipline	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Training in General, Pediatric, and Public Health Dentistry	$20,566,000	$20,970,000	$20,970,000	---
State Oral Health Workforce Improvement	$11,362,000	$12,958,000	$12,958,000	---

Training in General, Pediatric, and Public Health Dentistry

The Training in General, Pediatric, and Public Health Dentistry program aims to increase the number of dental students, residents, practicing dentists, dental faculty, dental hygienists, or other approved primary care dental trainees 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:	Grantee Activities:
• General dentists • Pediatric dentists • Public health dentists • Dental hygienists	• Dental Hygiene Training Programs • Undergraduate • Graduate School (dental schools) • Pre- and Post-Doctoral Programs • 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 and 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 to individuals who agree to serve as full-time dental faculty members in exchange for repayment of outstanding student loans based on each year of service. • Partner with schools of public health to permit the education of dental students, residents, and dental hygiene students for a master's year in public health at a school of public health.

Program Accomplishments:

In Academic Year 2013-2014, grantees of the Oral Health-sponsored programs trained a total of 2,419 dental and dental hygiene students in pre-doctoral training degree programs; 488 dental residents in advanced primary care dental residency programs; 1,744 dental faculty members in faculty development activities; and provided loan repayments to 36 dentists who have agreed to serve as teaching faculty.

Dental Faculty Loan Repayment Program

In Academic Year 2013-2014, the Dental Faculty Loan Repayment Program provided loan repayment to 36 dentists serving as teaching faculty. Results showed that over half of the faculty who received direct financial support were female (58 percent), between the ages of 30-39 years (50 percent), were provided a mean loan repayment of $20,111 and the majority were either General Dentists (61 percent) or Pediatric Dentists (25 percent). Further analyses of data showed that almost a quarter (22 percent) who received direct financial support reported coming from a financially or educationally disadvantaged background and 1 out of 4 faculty dentists reported coming from a rural background. The Dental Faculty Loan Repayment program teaching faculty taught 126 courses during the academic year, with over half of the courses offered as classroom-based (53 percent) or clinical rotation (34 percent). The majority of trainees enrolled in courses taught by these teaching faculty were dental school students (34 percent), general dentistry residents (30 percent) and pediatric dentistry residents (16 percent).

Faculty Development in General, Pediatric, and Public Health Dentistry and Dental Hygiene

In Academic Year 2013-2014, the Faculty Development in General, Pediatric, and Public Health Dentistry and Dental Hygiene program trained a total of 1,744 faculty members through faculty development activities funded by the program. Grantees supported five different types of faculty development activities, the majority being professional workshops (48 percent) and academic courses (46 percent). Faculty development focused on a range of topics from emergency room supervision to oral radiology. Grantees also offered 30 structured faculty development programs, which had 295 program completers during the academic year. Of those who participated in a faculty development program, the majority were General Dentists (37 percent), Public Health Dentists (32 percent) or Pediatric Dentists (15 percent). More than 4,000 general and pediatric dentistry residents as well as dental students were trained in courses and workshops offered by faculty who received direct financial support from the program to teach.

Pre-doctoral Training in General Dentistry, Pediatric Dentistry, and Dental Public Health and Dental Hygiene

In Academic Year 2013-2014, grantees of the Pre-doctoral Training in General Dentistry, Pediatric Dentistry, and Dental Public Health and Dental Hygiene program trained 2,419 dental and dental hygiene students. Additionally, 782 of those students completed their degree program at the end of the academic year. Almost a third (32 percent) of students were underrepresented

minorities and/or from a disadvantaged background, and more than a quarter of the graduates were underrepresented minorities and/or from disadvantaged backgrounds (27 percent). Grantees utilized 168 clinical training sites for this program that were located in medically underserved communities (64 percent), primary care settings (51 percent), and/or rural settings (20 percent). During Academic Year 2013-2014, grantees offered 44 courses and training activities that they developed or enhanced to promote primary care dentistry and public health.

Post-doctoral Training in General, Pediatric, and Public Health Dentistry

In Academic Year 2013-2014, grantees of the Post-doctoral Training in General, Pediatric and Public Health Dentistry trained 488 dental residents. Of those residents trained, 298 dental residents completed their training program at the end of the academic year. Almost two-thirds of residents were underrepresented minorities and/or from a disadvantaged background (63 percent). Grantees utilized 117 clinical training sites located in medically underserved communities (67 percent), primary care settings (41 percent) and/or rural settings (11 percent). During Academic Year 2013-2014, grantees offered 80 courses and training activities that they developed or enhanced to promote primary care dentistry and public health for advanced dental residents.

State Oral Health Workforce Improvement Grant Program

The State Oral Health Workforce Improvement Grant Program—which falls under BHW's Oral Health Training Programs—aims to enhance dental workforce planning and development to meet the unique needs of each State.

Eligible Entities: Eligible applicants include Governor-appointed, State governmental entities. A 40 percent match by the State is required for this program.

Designated Health Professions:	**Targeted Educational Levels / Oral Health Service Development[41]:**	**Grantee Activities:**
• Dentistry	• Primary and Secondary Education • Pre- and Post-Doctoral Programs • Residency Programs • Continuing Education	• Loan forgiveness and repayment provided to dentists who practice in D-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 student recruitment and retention efforts. • Grants and low or no-interest student 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.

[41] Varies based on grantee activities.

Designated Health Professions:	Targeted Educational Levels / Oral Health Service Development[41]:	Grantee Activities:
		• Continuing dental education. • Tele-dentistry. • Community-based prevention such as water fluoridation and dental sealants. • Programs that promote young students to pursue 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. • Other activities deemed appropriate by the Secretary.

Program Accomplishments:

In Academic Year 2013-2014, the State Oral Health Workforce Program continued carrying out various community-based prevention activities authorized under statute. Analysis of performance measures showed that grantees established one new oral health facility for children with special needs in dental health profession shortage areas (HPSAs). Grantees also expanded three oral health facilities in dental HPSAs and treated over 2,000 patients in these expanded facilities providing education, prevention, and restoration services; supported two tele-dentistry facilities; replaced 10 water fluoridation systems to provide optimally fluoridated water to over 365,000 individuals; provided dental sealants to over 22,000 children; provided topical fluoride to over 29,000 individuals; provided diagnostic or preventive dental services to over 57,000 persons and oral health education to over 82,000 persons. The program also held 28 promotional events attended by over 1,000 children. Additionally, state grantees hired two new state dental officers, 16 new dentists or hygienists, three fluoridation experts, one statistician, one epidemiologist, and 12 administrative and other staff members in state dental offices. States also retained 62 positions in state dental offices that had been hired in previous years.

The State Oral Health Workforce Program provided direct financial support to 160 dental students and six residents. Results showed that of these 166 students and residents, 51 percent were female and 72 percent were between the ages of 20-29 years old. Further analysis of the data showed that 27 percent of students and residents reported coming from a rural background, 10 percent reported coming from a disadvantaged background, and 13 percent were an underrepresented minority.

The State Oral Health Workforce Program also provided loan repayment to 57 practicing dentists. Results showed that of these 57 dentists, 51 percent were female and 46 percent were between the ages of 30-39 years old. Further analysis of the data showed that the majority of practicing dentists (68 percent) reported coming from a rural background. All of the dentists

were enrolled in the Medicaid program and had over 32,000 Medicaid patient encounters during the year. Nearly half of these dentists (44 percent) reported practice settings in rural areas, dental HPSAs, or public health facilities.

Funding History

FY	Amount
FY 2012	$32,392,000
FY 2013	$30,681,000
FY 2014	$31,928,000
FY 2015	$33,928,000
FY 2016	$33,928,000

Budget Request

The FY 2016 Budget Request is $33,928,000. The FY 2016 Budget is the same as the FY 2015 Enacted level. This request will fund continuing and new awards in the Training in General, Pediatric and Public Health Dentistry and State Oral Health Workforce Improvement programs, and will aim to increase access to culturally competent, high-quality, dental health services to rural and other underserved communities by increasing the number, and improving the diversity and distribution, of oral health care providers and improving the training programs for future oral health care providers.

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[42]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Number of students trained	2,419 Target: 1,810 (Target Exceeded)	2,200	2,200	Maintain
Number of residents trained	488 Target: 534 (Target Not Met)	534	534	Maintain
Number of faculty trained	1,744 Target: 200 (Target Exceeded)	190	190	Maintain
Number of faculty	36	36	N/A[43]	---

[42] Most recent results are for Academic Year 2013-2014 and funded in FY 2013.
[43] The target for the Dental Faculty Loan Repayment will be discontinued as this program will not be re-competed.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[42]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
receiving loan repayments	Target: 28 (Target Exceeded)			

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

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	55	50	50
Average Award	$326,000	$386,000	$386,000
Range of Awards	$6,000-$985,000	$93,000-$750,000	$93,000-$750,000

Grant Awards Table – State Oral Health Workforce Improvement

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	28	28	28
Average Award	$430,000	$430,000	$430,000
Range of Awards	$205,000-$500,000	$306,000-$500,000	$306,000-$500,000

Rural Physician Training Grants Program

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	---	---	$4,000,000	+$4,000,000
FTE	---		2	+2

Authorizing Legislation: Section 749B of the Public Health Service Act

FY 2016 Authorization .....Expired FY 2013

Allocation Method .....Competitive Grant

Program Goal and Description: The Rural Physician Training Grants Program seeks to increase the number of medical school graduates practicing in underserved rural communities. Grants funded through this program support the planning, development, and operation of a medical education program to encourage students to practice in these areas. Funded grantees recruit students most likely to practice medicine in underserved rural communities, and support innovations in medical school curriculum development. These grantees prepare physicians with the unique skill set required for rural practice, and develop rural-focused longitudinal clinical training activities and experiences. The grantees also target students with a continuum of rural practice and professional development that includes mentorship and career planning. Funds assist students in obtaining post-graduate rural residency placements to achieve program goals. Successful grantees in this program collaborate with appropriate partners such as other health professions programs, Area Health Education Centers, student loan and scholarship programs including the National Health Service Corps, awardees in the Targeted Support for Graduate Medical Education program, and rural graduate medical education programs, such as rural training tracks.

Need: There are nearly 50 million people living in rural America who face ongoing challenges in accessing health care.[44] Rural residents have higher rates of age-adjusted mortality, disability, and chronic disease than their urban counterparts.[45] 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.[46,47] Of the 2,052 rural counties in the

[44] 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).
[45] 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.
[46] Area Resource File (ARF). 2008. US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Rockville, MD.
[47] Doescher, M., Fordyce, M., Skillman S., WWAMI Rural Health Research Center Presentation: The Aging of the Rural Generalist Workforce. February 2009.

United States (U.S.), 1,582 (77 percent) are primary care health professional shortage areas (HPSAs).[48]

Eligible Entities: Accredited schools of allopathic or osteopathic medicine, or association approved by the Secretary for this purpose, or any combination or consortium of such schools.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Allopathic and Osteopathic physicians	• Allopathic and Osteopathic medical schools	• Recruit medical school students who are most likely to practice medicine in underserved rural communities. • Plan, develop and operate a medical school education program to prepare students to practice in underserved rural areas. • Implement curricula to prepare physicians with the unique skill sets required for rural practice. • Develop longitudinal clinical experiences and activities. • Assist students in obtaining post-graduate residency placements in underserved rural communities. • Link targeted students with a supportive continuum of professional development that includes mentorship and career planning. • Establish collaborative partnerships to achieve program goals.

Program Accomplishments: N/A

Funding History

FY	Amount
FY 2012	---
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	$4,000,000

Budget Request

The FY 2016 Budget Request is $4,000,000. The FY 2016 Budget is $4,000,000 above the FY 2015 Enacted level. The Rural Physician Training Grants Program will focus on recruiting and training physician students in rural settings with the goal of increasing the number of medical

[48] WWAMI Rural Health Research Center. Aging of the rural generalist workforce. Seattle, WA: WWAMI Rural Health Research Center, University of Washington; July, 2009.

school graduates who practice in rural communities. This request will support 10 grantees who are statutorily required to enroll no fewer than 10 students per class year into the Program.

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Number of medical students trained in a rural curriculum	---	Set Baseline	TBD	---
Number of medical students receiving clinical training at rural sites	---	Set Baseline	TBD	---
Number of faculty trained to provide rural or primary care curriculum	---	Set Baseline	TBD	---
Number of medical students matching to primary care residencies	---	Set Baseline	TBD	---
Number of medical students matching to primary care residencies in rural areas	---	Set Baseline	TBD	---

Grant Awards Table – Rural Physician Training Grants

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	---	---	10
Average Award	---	---	$350,000
Range of Awards	---	---	$300,000-$400,000

Teaching Health Centers Graduate Medical Education Payment Program

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	---	---	---	---
FTE	5	6	---	---

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

FY 2016 Authorization .....Expired

Allocation Method .....Formula Based Payments

Program Goal and Description: The Teaching Health Centers Graduate Medical Education Payment Program (THCGME) provides funding for residency training in primary care and dentistry in community-based, ambulatory settings. The THCGME program seeks to both bolster the primary care workforce through support for new and expanding primary care and dental residency programs and to improve the distribution of that workforce into needed areas through emphasis on underserved populations. In FY 2015**,** HRSA prioritized supporting existing residents and approved residency slots for the THCGME program. The program will award the remaining funds to support approximately 700 resident FTE fully utilizing the $230 million appropriated to the program by the Affordable Care Act.

Need: Access to high quality primary care is associated with improved health outcomes and lower costs. There is evidence that physicians who receive training in community and underserved settings are more likely to practice in such environments, for example Health Centers.[49] Though Health Centers receive Federal funding to improve access to care, they have difficulty recruiting and retaining primary care professionals.[50] The THCGME program was established by the Affordable Care Act to increase and enhance the primary care workforce and to improve its distribution into underserved communities. Appropriated funding for this program was authorized for the period of FY 2011 through FY 2015. Interest in the program has grown considerably, with the number of supported programs growing from 11 residency programs in the first year of funding, Academic Year 2011-2012, to 60 in Academic Year 2014-2015. This growth in the THCGME program has translated to an increase in resident full time equivalents (FTEs) from 63 in Academic Year 2011-2012 to more than 550 in Academic Year 2014-2015. No new residency programs will be added in FY 2015. However, the number of FTEs in training will continue to expand as programs fill all of their approved training slots.

[49] Morris CG and Chen FM. Training Residents in Community Health Centers: Facilitators and Barriers. Annals of Family Medicine 2009; 7:488-94.
[50] 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.

Eligible Entities: Community-based ambulatory patient care centers that operate an accredited primary care residency program in one or more of the following specialties: family medicine, general dentistry, geriatrics, internal medicine, internal medicine-pediatrics, obstetrics and gynecology, pediatrics, psychiatry, and pediatric dentistry. Eligible entities include, but are not limited to: Federally Qualified Health Centers (FQHCs), 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:**	**Grantee Activities:**
• Family medicine • General dentistry • Geriatrics • Internal medicine • Internal medicine-pediatrics • Obstetrics and gynecology • Pediatrics • Psychiatry • Pediatric dentistry	• Post graduate medical and dental education	• Operate an accredited residency program. • Medical and dental residents will provide patient care services during their training under supervision of program faculty.

Program Accomplishments:

In FY 2011, 11 THCs began receiving payments and training 63 primary care medical and dental resident Full Time Equivalents (FTEs) in Academic Year 2011-2012. The program has grown significantly and in FY 2014 supported 60 residency programs and more than 550 resident FTEs during Academic Year 2014-2015. The awardees include 36 FQHCs, 2 FQHC Look-Alikes, 5 Area Health Education Centers (AHECs), 2 Native American Health Authorities, 1 Community Mental Health Clinic, 2 Rural Health Clinic, and 12 additional community-based entities.

In Academic Year 2013-2014, the THCGME program awarded 327 resident FTE slots that provided funding to 361 primary care medical residents. Demographic analysis shows that more than half (51 percent) of the residents were male and between 30 and 39 years (54 percent). Nearly all residents received training in a primary care setting (99 percent), providing over 180,000 contact hours with patients. In addition to primary care training, nearly all residents received training in a medically underserved community (88 percent), and just over one out of every four (27 percent) received training in a rural area. Results also showed that THCGME residents continue to serve a number of specialized populations including veterans and their families, older adults, as well as children and adolescents. Further analysis of the data showed that one out of every five (21 percent) residents reported coming from a financially or educationally disadvantaged background and more than one out of every four (27 percent) residents reported having a rural background. Of the 47 residents who completed the program in Academic Year 2013-2014, more than three-quarters intend to practice in a primary care setting (77 percent), and half intend to practice in a medically underserved area (50 percent). Of the 23

residents who completed the THCGME program in Academic Year 2012-2013 whose employment data is available, almost all are practicing in a primary care setting (91 percent) and/or in a medically underserved community (76 percent).

Data continue to be collected regarding activities that can be carried out through the THCGME program to support residency training. For example, programs may use funds to develop and implement curricular and other educational activities to train primary care medical and dental residents as well as other students, fellows, and residents across the health professions in primary care related topics. Results showed that THCGME programs developed or enhanced 383 courses and training activities that were implemented during the reporting period. It is estimated that more than 4,500 healthcare trainees, mostly primary care residents, were trained as a result of these activities.

Research has highlighted the curricular and organizational innovations in many of the THCs, enabled by the THCGME's support for community-based training, rather than traditional Medicare GME which is paid only to hospitals.[51] These innovations included quality improvement and patient-centered medical home development.

Funding History

FY	Amount
FY 2011 ACA	$230,000,000
FY 2012	---
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	---

Budget Request

In FY 2016, HRSA will establish a new Targeted Support for Graduate Medical Education Program to expand residency training, with a focus on ambulatory and preventive care, in order to advance the goals of higher value health care that reduces long term costs. TSGME will be a competitive program that builds upon the successes of the THCGME program. The program funds new residency slots using a competitive approach in which applicants demonstrate how their training of residents addresses key workforce objectives. While no new funding is requested for the THCGME program in FY 2016, THCGME grantees will be eligible to apply for the new Targeted Support for Graduate Medical Education program.

[51] Chen et al. Teaching Health Centers: A new paradigm in graduate medical education. Acad Med 2012; 87

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[52]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
6.I.C.5: Number of resident positions supported by Teaching Health Centers (Cumulative)[53]	327 Target: 300 (Target Exceeded)	620	---	-620

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	60	60[54]	---
Average Award	$956,875	$1,846,667	---
Range of Awards	$37,500-$4,238,000	$356,000-$9,205,000	---

[52] Most recent results are for Academic Year 2013-2014 and funded in FY 2011.
[53] Measure captures the number of full-time equivalent (FTEs) resident slots supported and not the number of individuals receiving direct financial support through the program.
[54] In FY 2015, HRSA is supporting October – June of AY 14-15 payments to FY 2014 awardees (approx. $63 million) as well as full year AY 15-16 awards (approx. $50 million). As a result, the FY 2015 payments are higher than in previous years.

Targeted Support for Graduate Medical Education

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Proposed Mandatory	---	---	$400,000,000.	+$400,000,000
FTE	---	---	32	32

Authorizing Legislation: ….....New Authority

FY 2016 Authorization….....Unspecified

Allocation Method.....Competitive Grant/Contract

Program Goal and Description: The Targeted Support for Graduate Medical Education Program supports community-based consortia of teaching hospitals and/or other health care entities to expand residency training in primary care or high-need specialties, in order to focus on ambulatory and preventive care and advance the goals of higher value health care that reduces long-term costs.

The program funds new residency slots using a competitive approach in which applicants demonstrate how their training of residents addresses key workforce objectives, such as: training and retaining residents in primary care; training and retaining residents in underserved rural and urban areas; and, providing comprehensive primary care and other high need health care services.

The Targeted Support for Graduate Medical Education program encourages innovation in training models and greater accountability in the use of GME funds. Funds are targeted to training programs that feature concepts such as team-based care, the effective incorporation of health information technology into clinical practice, population health, and telemedicine.

The program builds upon the work of the Teaching Health Centers Graduate Medical Education Payment Program whose funding ends in FY 2015. Awardees from the Teaching Health Center Graduate Medical Education (THCGME) program will be eligible to compete for funding through the Targeted Support's competitive grant program. In addition, teaching hospitals or other health entities developing new programs in outpatient or community-based settings are eligible for limited, short-term (no more than two years) "capacity building" grants to seek accreditation or modify their existing accreditation.

Need: Studies indicate that primary care providers improve health outcomes and reduce mortality rates, utilization of health care services, and health care costs. And yet, research indicates a continued shortage of primary care providers. Additionally, evidence shows that physicians who train in community-based and underserved settings are more likely to practice in those facilities and areas. Current residency training is predominately hospital-focused so that

residents have limited opportunities to provide continuous, on-going care to individuals such as those with chronic conditions in a range of community-based settings. In a June 2010 report, the Medicare Payment Advisory Committee recommended changes to the nation's GME funding in order to support the workforce skills needed for a changing healthcare system.[55] The report specifically called for changes to GME funding to meet goals such as community-based care and giving students a broader set of training experiences. A July 2014 Report by the Institute of Medicine, *Graduate Medical Education That Meets the Nation's Health Needs*, recommended that graduate medical education support take "essential steps to modernize GME payment methods based on performance, to ensure program oversight and accountability, and to incentivize innovation in the content and financing of GME".[56]

Eligible Entities: Community-based ambulatory patient care centers, teaching hospitals, children's hospitals, and community-based consortia of teaching hospitals and/or other health care entities.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Primary care physicians • Other health care professionals of high need.	• Residents	• Operate an accredited residency program. • Residents in community-based settings will provide patient care services during their training. • Provide financial support to programs seeking to obtain accreditation for their new or expanding community-based residency program.

Program Accomplishments: This is a new initiative with no programmatic history.

Funding History

FY	**Amount**
FY 2012	---
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	$400,000,000 (proposed mandatory)

[55] Report to the Congress: Aligning Incentives in Medicare (June 2010). Medicare Payment Advisory Commission. (available at http://www.medpac.gov).
[56] *Graduate Medical Education That Meets the Nation's Health Needs:* Recommendations, Goals, and Next Steps (July 2014). Institute of Medicine (available at http://www.iom.edu/Reports/2014/Graduate-Medical-Education-That-Meets-the-Nations-Health-Needs.aspx).

Budget Request

The FY 2016 Budget Request is $400,000,000 in mandatory funding. The FY 2016 Budget is $400,000,000 above the FY 2015 Enacted level. A total of $5.25 billion is requested for a period of ten years starting in FY 2016. Over ten years, the program is expected to support more than 13,000 residents to complete their training in community-based ambulatory care settings that provide a range of training experiences to address key health care workforce development needs. The program will advance key workforce goals, including the training of more physicians in primary care and other specialties with shortages, aligning training with more efficient and effective care delivery models, and encouraging physicians to practice in rural and other underserved areas.

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

Projected Funding for FY 2016-FY 2025 (in millions)

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
TSGME program	$400	$450	$450	$500	$500	$550	$550	$600	$600	$650

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Number of primary care residents trained (Cumulative)	N/A	N/A	Set Baseline	---
Number of residents trained in an underserved area (Cumulative)	N/A	N/A	Set Baseline	---
Number of residents trained in a team-based setting (Cumulative)	N/A	N/A	Set Baseline	---

Grants Awards Table

To Be Determined

Interdisciplinary, Community-Based Linkages

Area Health Education Centers Program

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$30,250,000	$30,250,000	---	-$30,250,000
FTE	4	4	---	-4

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

FY 2016 Authorization.....Expired FY 2014

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

Program Goal and Description: The Area Health Education Centers (AHEC) Program seeks to enhance access to high quality, culturally competent health care through community-based interprofessional clinical training, continuing education (CE), and outreach activities that will ultimately improve the distribution, diversity, quality and supply of the primary care health professions workforce serving in rural and underserved health care delivery sites. The AHEC Program supports two types of awards: Infrastructure Development, and Point of Service Maintenance and Enhancement. The Infrastructure Development funds are used to plan, develop and implement AHEC centers that link the grantee school and at least two other disciplines with local educational and clinical sites. The Point of Service funds are awarded to AHEC programs and centers that have completed the Infrastructure Development phase to stabilize and evaluate evolving conditions that impact the outcomes of the program.

Need: A growing and aging U.S. population, and to a lesser extent increased access to insurance coverage, is expected to increase the demand for primary care services over the next decade.[57] Although the supply of other primary care providers is growing, ensuring an adequate supply of primary care providers for the future remains key to providing high quality health care. Ensuring an adequate supply of well-trained primary care providers is a particular concern for 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. [58]

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.

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[57] Peterson, S., Liaw, W., Phillips, R., Rabin, D., Meyers, D., & Bazemore, A. (2012). Projecting US Primary Care Physician. *Annals of Family Medicine*, *10*(6), 503-509.

[58]HRSA Bureau of Health Workforce, *Designated Health Professional Shortage Areas Statistics*, http://ersrs.hrsa.gov/reportserver/Pages/ReportViewer.aspx?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry_HTML&rs:Format=HTML4.0 (Accessed 8/9/2013).

Designated Health Professions:	Targeted Educational Levels:	Grantee 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 residents • Medical students • Health professions students • CE 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 . • Provide clinical rotations in primary care and community-based, interprofessional training. • Disseminate CE 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 Academic Year 2013-2014, the Area Health Education Centers (AHEC) program supported various types of pre-pipeline, pipeline, and continuing education (CE) training activities for thousands of trainees across the country. Results showed that the AHEC program supported community-based clinical training in primary care for over 13,300 medical school students and an additional 10,700 students from varying types of health professions training programs (e.g., nursing, physician assistant, and behavioral health, among others).

Data were also collected on community-based training in primary care implemented through local practica and field placements. Results showed that AHEC grantees partnered with over 10,000 sites, including ambulatory practice sites, hospitals, and community health centers. Approximately 72 percent of these training sites were in primary care settings; 61 percent were located in medically-underserved communities; and 42 percent were set within rural areas. It is estimated that more than 34,400 clinical training experiences were provided to trainees by AHEC grantees.

Finally, the AHEC program also implemented over 3,800 unique continuing education courses that were delivered to over 242,000 practicing professionals nationwide. It is estimated that approximately 85,500 trainees who participated in a CE offering were concurrently employed in a medically-underserved community.

The AHEC program received a $1.8 million increase in FY 2014. The funds were used to support 16 new regional AHEC centers, as well as to enhance overall support for the existing program.

Funding History

FY	Amount
FY 2012	$27,230,000
FY 2013	$28,211,000
FY 2014	$30,250,000
FY 2015	$30,250,000
FY 2016	---

Budget Request

No funding is requested in FY 2016. The FY 2016 Budget is $30,250,000 below the FY 2015 Enacted level. While the AHEC Program exposes medical students and health professions students to primary care and practice in rural and underserved communities, the FY 2016 President's Budget reflects the prioritization of funding to programs that directly increase the number of primary care providers. It is anticipated that the AHEC Program grantees may be able to support on-going activities through other funding sources.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[59]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
No. of medical school trainees participating in community-based clinical training	13,343 Target: 17,022 (Target Not Met)	N/A[60]	N/A	---
No. of other health professions trainees participating in community-based clinical training	10,731 Target: 23,260 (Target Not Met)	N/A[61]	N/A	---
Number of trainees who received continuing education (CE) on topics including Cultural Competence, Women's Health, Diabetes, Hypertension, Obesity, and Health Disparities	252,995 Target: 289,638 (Target Not Met)	250,000	N/A[62]	---
Percent of CE trainees who report being	34%	34%	N/A[63]	---

[59] Most recent results are for Academic Year 2013-2014 and funded in FY 2013.
[60] Measure discontinued in FY14.
[61] Measure discontinued in FY14.
[62] Program was discontinued in FY 16.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[59]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
currently employed in medically underserved areas	Target: 12.5% (Target Exceeded)			
No. of trainees receiving health career guidance and information from the AHEC Programs	327,142 Target: 245,000 (Target Exceeded)	300,000	N/A[64]	---

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	53	55	--
Average Award	$541,000	$510,000	--
Range of Awards	$102,000- $1,856,000	$102,000- $1,224,000	--

[63] Program was discontinued in FY 16.
[64] Program was discontinued in FY 16.

Interdisciplinary, Community-Based Linkages

Geriatric Programs

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$33,237,00	$34,237,000	$34,237,000	---
FTE	3	5	5	---

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

FY 2016 Authorization:
Geriatric Education Centers……..….Expired FY 2014
Geriatric Training for Physicians, Dentists, and
Behavioral/Mental Health Professionals……Expired FY 2014
Geriatric Academic Career Awards……..….Expired FY 2014

Allocation Method .....Cooperative Agreements

Program Goal and Description: The Geriatrics programs seek to improve high quality, interprofessional geriatric education and training to the health professions workforce, including geriatric specialists, as well as increase geriatrics competencies of primary care providers and other health professionals to improve care for this often underserved population.

In FY 2015, HRSA combined the Comprehensive Geriatric Education Program, Geriatrics Education Centers program, Geriatric Training for Physicians, Dentists, and Behavioral/Mental Health Professionals program, and the Geriatric Academic Career Awards programs into one competition, the Geriatric Workforce Enhancement Program, to improve health outcomes for older adults by integrating geriatrics with primary care, maximizing patient and family engagement, and transforming the healthcare system. Special emphasis is on providing the primary care workforce with the knowledge and skills needed to care for older adults and on collaborating with community partners to address gaps in health care through individual, system, community and population level changes. The program will support approximately 44 cooperative agreements. It is an expectation that health care professionals, such as clinical psychologists or dentists, will train and educate direct service workers, and lay and family caregivers, as well as provide significant levels of support and guidance to these individuals.

Need: The Institute of Medicine identified three shortfalls that the health care system will face as the number of older Americans increases: 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.[65]

Through training provided to the entire provider pipeline (students, faculty, providers, direct service workers, and lay and family caregivers) in the community, improved geriatrics care becomes widely available to an ever-increasing cohort of aging Americans. As the number of competent providers increases, the providers' work can add to the evidence base of which practices are appropriate and which need to be adapted or abandoned. HRSA-funded geriatrics program participants have established themselves as credible, capable educators who can facilitate the transfer of research and clinical knowledge using both established and innovative educational methodologies.

Geriatrics Education Centers Program

The GEC program aims to provide high-quality interprofessional geriatrics education and training to the health professions workforce for both geriatrics specialists and non-specialists. GECs provide interprofessional continuing education to health care practitioners on Alzheimer 's disease and related dementias.

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 • Direct service workers • Lay and family caregivers	• Interprofessional geriatrics 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 for students in geriatrics in nursing homes, chronic and acute disease hospitals, ambulatory care centers, and senior centers.

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

Program Accomplishments: In Academic Year 2013-2014, the Geriatrics Education Centers (GEC) program supported various types of geriatrics-specific training for health professions students and faculty, as well as for current community-based providers. With regard to the continuing education (CE) of the current workforce, GEC grantees delivered more than 2,700 different continuing education courses to more than 130,000 trainees. The continuing education courses focused on emerging issues in the field of geriatrics (e.g., Alzheimer's disease, dementia, advances in palliative care, among others).

Data were collected on other training-related activities that are required to be carried out through the GEC program. For example, the authorizing legislation for the GEC program requires grantees to use funds to provide health professions students with clinical training in nursing homes, chronic and acute disease hospitals, ambulatory care centers, and senior centers. Results showed that GEC grantees partnered with more than 1,900 healthcare delivery sites across the country to provide clinical and experiential training to more than 36,000 trainees. It is estimated that two out of every three sites used by GEC grantees for the purposes of offering these types of training were primary care settings and approximately 25 percent were located in medically underserved communities.

In addition to training students, grantees are also required by law to use funds to support the training and retraining of faculty in geriatrics. Results showed that GEC grantees implemented more than 1,300 different faculty development activities and training programs (e.g., workshops, conferences, professional development activities, among others) during the academic year. It is estimated that more than 16,500 faculty received training on geriatric-related topics as a result of these types of activities.

Geriatrics Training for Physicians, Dentists, and Behavioral and Mental Health Professionals

The GTPD program aims to increase the supply of quality, culturally-competent geriatrics 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:**	**Grantee Activities:**
• Dentistry • Medicine • Counseling - Marriage & family - Professional - Substance abuse • Osteopathic	• Graduate • Post-graduate • Faculty	• Provide intensive one-year mid-career faculty retraining and/or two-year fellowship training in geriatrics. • Provide training in and exposure to the physical and mental disabilities of elderly individuals through a variety of service rotations, such as, geriatric consultation services, acute care services, dental services,

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
medicine • Psychology • Psychiatric nursing • Psychiatry • Social work		geriatric behavioral or mental health units, day and home care programs, rehabilitation services, geriatric ambulatory care and comprehensive evaluation units, and community care programs for elderly individuals with developmental disabilities. • Apply contemporary educational delivery methods to interprofessional audiences. • Demonstrate application of administrative, clinical, teaching, and research skills as academic and clinical faculty.

Program Accomplishments: In Academic Year 2013-2014, the Geriatric Training for Physicians, Dentists and Behavioral/Mental Health Providers (GTPD) program directly funded 60 fellows: 18 in Geriatric Medicine; 17 in Dentistry; 13 in Geriatric Psychiatry; three in Internal Medicine; four in Family Medicine; three in General Psychiatry; one in Internal Medicine/Family Medicine; and one in Clinical Psychology. The majority of GTPD fellows were females (68 percent), between the ages of 30 and 39 (76 percent), and were either non-Hispanic White (58 percent) or Non-Hispanic Asian (23 percent). Approximately 98 percent of fellows received clinical training in medically-underserved communities and/or a primary care setting (83 percent) during the academic year.

Data were collected on other training-related activities that are required to be carried out through the GTPD program. Results showed that GTPD grantees partnered with over 550 healthcare delivery sites, providing over 920 clinical training experiences to GTPD fellows. The most common types of sites where fellows trained included Veteran's Affairs hospitals and clinics, ambulatory care sites, and academic institutions. Approximately 43 percent of the sites where GTPD fellows received clinical training were located in medically-underserved communities. The GTPD program is multi-purposed in that the program not only supports the training of fellows in specific types of geriatric settings, but also requires that each fellow dedicate at least 25 percent of their time for teaching health professions students about geriatric-related topics. Results obtained showed that GTPD fellows delivered more than 440 courses, workshops and other training activities focused on topics including oral health, chronic disease management and geriatric medicine, among others. It is estimated that more than 9,300 trainees were trained as a result of these activities—the most common of which included medical school students, dental school students, residents in geriatrics and residents in geriatric psychiatry.

Geriatrics Academic Career Awards Program

The GACA program aims to promote the development of academic clinician educators who provide clinical training in geriatrics, including the interprofessional education teams of health professionals.

Eligible Entities: Eligible entities are schools of allopathic medicine, osteopathic medicine, nursing, social work, psychology, dentistry, pharmacy or other allied health disciplines in an accredited health professions school.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Allied health • Allopathic medicine • Dentistry • Nursing • Osteopathic medicine • Pharmacy • Psychology • Social work	• Faculty	• Promote the career development of junior faculty as academic clinician educators in geriatrics. • Provide training in clinical geriatrics, including training of interprofessional teams of health professionals. • Provide junior faculty with opportunities to focus on teaching activities such as interprofessional geriatrics curricula development and integrating geriatrics into health professions curricula.

Program Accomplishments: In Academic Year 2013-2014, the Geriatrics Academic Career Award (GACA) program funded 53 faculty in geriatrics medicine, one faculty in clinical psychology, one faculty in geriatric psychiatry, and one faculty in geriatrics physical therapy—for a total of 56 awardees. In total, GACA awardees delivered more than 1,700 different courses, workshops and other types of training activities to more than 65,000 trainees across the health professions—the most common of which included medical school students, residents in internal medicine and residents in geriatrics. The training activities focused on topics such as geriatric medicine, oral health and mental health in older adults.

In addition to training health professions students, residents and fellows, GACA awardees are highly encouraged to engage in professional development and scholarly activities during each academic year as a way of advancing the field of geriatrics. Results obtained showed that GACA awardees conducted presentations about their own research and other related topics at 170 conferences at the local, state or national level and published a total of 70 peer-reviewed publications during the academic year.

Funding History

FY	**Amount**
FY 2012	$30,629,000
FY 2012 (PPHF)	$2,000,000
FY 2013	$29,011,000
FY 2013 (PPHF)	$1,847,000
FY 2014	$33,237,000
FY 2015	$34,237,000
FY 2016	$34,237,000

Budget Request

The FY 2016 Budget Request is $34,237,000. The FY 2016 Budget is the same as the FY 2015 Enacted level. The Budget will provide funding to approximately 44 grantees seeking to improve high quality, interprofessional geriatric education and training as well as increase geriatrics competencies of primary care providers and other health professionals serving the geriatric community.

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Tables

The table below includes some performance measures that are still under development since the Alzheimer's education activities have only recently been initiated and baselines have not yet been established.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[66]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
6.I.C.12: Number of Bureau of Health Workforce-sponsored interprofessional continuing education sessions provided on Alzheimer's disease	--[67]	TBD	TBD	---
6.I.C.13: Number of trainees participating in interprofessional continuing education on Alzheimer's disease	--[68]	TBD	TBD	---
Number of continuing education trainees[69]	131,850 Target: 59,413 (Target Exceeded)	79,521	79,521	Maintain
Number of GTPD Fellows	60 Target: 45 (Target Exceeded)	45	45	Maintain
Number of continuing education offerings delivered by GEC grantees	--	Set Baseline	TBD	---

[66] Most recent results are for Academic Year 2013-2014 and funded in FY 2013.
[67] Baseline for this measure will be in FY 2014.
[68] Baseline for this measure will be in FY 2014.
[69] The wording of the measure has been revised to better reflect measures used for data collection.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[66]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Number of students who received geriatric-focused training in geriatric nursing homes, chronic and acute disease hospitals, ambulatory care centers, and senior centers	--	Set Baseline	TBD	---
Number of faculty members participating in geriatric trainings offered by GEC grantees	--	Set Baseline	TBD	---
Number of individuals trained by GTPD fellows in geriatrics	--	Set Baseline	TBD	---
Number of geriatric-focused presentations at professional meetings by GACA awardees	--	Set Baseline	TBD	---
Number of geriatric-focused articles published by GACA awardees	--	Set Baseline	TBD	---
Number of GACA Awardees	56 Target: 68 (Target Not Met)[70]	N/A[71]	N/A	---

Grant Awards Table – Geriatric Education Centers Program[72]

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	45	---	---
Average Award	$437,000	---	---
Range of Awards	$189,000-$503,000	---	---

[70] The target was not met because GACA awardees relinquished their grants to take positions, usually promotions, in other institutions.
[71] Measure was discontinued in FY15.
[72] In FY 2015, the Geriatric Education Centers program, Geriatric Training for Physicians, Dentists and Behavioral and Mental Health Professionals program, Geriatric Academic Career Awards program and the Geriatric Education Center program were combined into a new program—the Geriatric Workforce Enhancement Program.

Grant Awards Table – Geriatric Training for Physicians, Dentists, and Behavioral and Mental Health Professionals[73]

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	12	---	---
Average Award	$621,000	---	---
Range of Awards	$333,000-$934,000	---	---

Grant Awards Table – Geriatric Academic Career Awards Program[74]

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	51	---	---
Average Award	$65,000	---	---
Range of Awards	$5,000-$76,000	---	---

Grant Awards Table – Geriatric Workforce Enhancement Program[75]

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	---	44	44
Average Award	---	$790,000	$790,000
Range of Awards	---	$500,000-$850,000	$500,000-$850,000

[73] In FY 2015, the Geriatric Education Centers program, Geriatric Training for Physicians, Dentists and Behavioral and Mental Health Professionals program, Geriatric Academic Career Awards program and the Geriatric Education Center program were combined into a new program—the Geriatric Workforce Enhancement Program.
[74] In FY 2015, the Geriatric Education Centers program, Geriatric Training for Physicians, Dentists and Behavioral and Mental Health Professionals program, Geriatric Academic Career Awards program and the Geriatric Education Center program were combined into a new program—the Geriatric Workforce Enhancement Program.
[75] The Geriatric Workforce Enhancement Program is also supported by the Comprehensive Geriatric Education Program.

Interdisciplinary, Community-Based Linkages

Mental and Behavioral Health Education and Training Programs

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$7,896,000	$8,916,000	$8,916,000	---
FTE	1	1	1	---

Authorizing Legislation: Section 755(b)(1)(J) of the Public Health Service Act.

FY 2016 Authorization: ..... Unspecified

Allocation Method: ..... Competitive Grant/Co-operative Agreement/Contract

Program Goal and Description: The Mental and Behavioral Health Education and Training Programs work to close the gap in access to mental and behavioral health services by increasing the number of adequately trained mental and behavioral health (including substance abuse) providers. This funding supports the following activities:

- Leadership in Public Health Social Work Education grants, which fund centers of excellence at schools of social work to help develop the next generation of public health social workers and to provide critical leadership, resources, and training.

- Graduate Psychology Education (GPE) grants, which are awarded to doctoral psychology schools and programs to train psychologists to work with underserved populations. The GPE grants are designed to foster an integrated and interprofessional approach to addressing access to behavioral health care for vulnerable and underserved populations.

In addition, as part of the President's *Now Is The Time* initiative, HRSA is partnering with the Substance Abuse and Mental Health Services Administration (SAMHSA) to expand the behavioral health workforce by supporting clinical training for behavioral health professionals, including masters level social workers, psychologists, marriage and family therapists, psychiatric mental health nurse practitioners, professional counselors, as well as doctoral-level psychologists and paraprofessionals. Funding for this joint effort is provided by SAMHSA. This activity, Behavioral Health Workforce Education and Training (BHWET) Program, builds on HRSA's Mental and Behavioral Health Education and Training (MBHET) grants, funded in FY 2012 for three years through the Prevention and Public Health Fund.

Need: The demand for behavioral health services will grow as more individuals are covered under the Affordable Care Act (ACA), and the Mental Health Parity and Addiction Equity Act (MHPAEA) is fully implemented. The projected national growth in behavioral health employment opportunities from 2010-2020, according to the Bureau of Labor Statistics, is

provided below. It must be noted that these numbers only represent some of the disciplines that are needed, and cannot be assumed to satisfy supply as these employees may go to work in other sectors of the economy apart from the safety net:

- Psychologists: 22 percent increase (+37,000 positions more than 2010);
- Mental Health Counselors/Marriage and Family Therapists: 27 percent increase (+58,500 positions more than 2010);
- Substance Abuse and Behavioral Disorder Counselors: 27 percent increase (+23,400 positions more than 2010); and
- Social Workers: 25 percent increase (161,200 positions more than 2010).

	FY 2014 Final	**FY 2015 Enacted**	**FY 2016 President's Budget**	**FY 2016 +/- FY 2015**
Leadership in Public Health Social Work Education program	$1,000,000	$1,000,000	$1,000,000	---
Graduate Psychology Education Program	$6,896,000	$7,916,000	$7,916,000	---

Leadership in Public Health Social Work Education

The purpose of the Leadership in Public Health Social Work Education Program is to provide training and education, faculty development, and curriculum enhancement to prepare students for leadership roles in public health social work through enrollment in a dual master's degree program in both social work and public health. Students benefit from dual enrollment in accredited schools of social work and public health, and receive training, education, and practice experience in interprofessional practice, cultural competency, leadership and management, research and evaluation, and policy development.

Eligible Entities:
An eligible applicant for this program is a social work school/program that offers a dual master's degree in an accredited graduate school/program in social work ***and*** in an accredited graduate school/program in public health.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Social Work • Public Health	• Masters in social work and public health	• Placement of dual-degree master's students into required field placements/internships to enhance skills in leadership, management, policy development and analysis, and research and evaluation. Field placements in underserved communities working with diverse populations are highly encouraged. • Provide stipend support to master's level dual-degree students who are enrolled in both an accredited school of social work and an accredited school of public health and are participating in a practice-based experience. • Develop curricula for public health social work programs to prepare students for roles in leadership and management in health care and social service organizations. • Develop the skills and expertise of faculty for the different facets of the curricula.

Program Accomplishments: Program accomplishments from FY 2014 (Academic Year 2014-2015) will be reported in the 2017 Congressional Justification.

Graduate Psychology Education Program

The Graduate Psychology Education program aims to increase the supply of trained doctoral-level psychologists prepared to address the behavioral health needs of vulnerable and underserved populations.

Eligible Entities: Eligible entities include accredited doctoral psychology programs within institutions of higher education, and other public or private non-profit entities accredited as doctoral psychology internship programs. 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:	Grantee Activities:
• Graduate Psychology (doctoral)	• Accredited Graduate Psychology	• Provide integrated and interprofessional education and clinical training leading to a doctoral degree in psychology.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
	(Doctoral level) Schools and Programs • Accredited internships in public and private nonprofit institutions	• Increase access to quality behavioral health services to vulnerable, underserved, and needy populations. • Increase the number of prepared psychologists with doctoral degrees serving the medically underserved communities.

Program Accomplishments: In Academic Year 2013-2014, the Graduate Psychology Education (GPE) program provided stipend support to 95 students and fellows participating in a practicum, pre-degree internship or post-doctorate fellowship in clinical psychology. Results showed that the majority of students and fellows who received a stipend were female (87 percent); between the ages of 20 and 29 (58 percent); were provided a median award amount of $6,815; and received clinical training in a medically underserved community (97 percent) and/or a primary care setting (84 percent) during the academic year. Further analyses of data showed that one third of the students and fellows who received a stipend reported coming from a financially or educationally disadvantaged background, and approximately one out of every five students and fellows who received a stipend are considered underrepresented minorities in their prospective profession.

Follow-up employment data were collected from individuals who completed training programs in AY 2012-13. Of the 25 prior year program completers with available employment data, 64 percent entered practice in medically-underserved communities. A total of 44 students and fellows completed their GPE training programs in Academic Year 2013-14. Of these program completers, approximately 89 percent intended to become employed or pursue further training in a medically-underserved community and approximately 61 percent intended to become employed or pursue further training in a primary care setting. Employment status will be assessed for these individuals one year after program completion (during Academic Year 2014-2015). Across all GPE program activities in Academic Year 2013-2014, 138 individuals graduated from their practica, internships, and fellowships, exceeding the target of 90 by 53 percent.

Data were collected regarding other types of activities that are required to be carried out through the GPE program. For example, the GPE program requires that grantees use funds to develop and implement curricular and other educational activities to train students, residents and fellows across the health professions in behavioral health-related topics. Results showed that GPE grantees developed or enhanced and implemented 120 different curricular and educational activities—most of which were new academic courses and clinical rotations for health professions students. It is estimated that more than 2,500 trainees participated in courses or training activities that were developed or enhanced by GPE grantees. In addition to training students, grantees also are required to use funds to support the training and ongoing professional development of faculty at their local institutions. Results showed that GPE grantees supported

more than 25 different types of faculty development activities (e.g., conferences, workshops, among others) focused on topics that ranged from rural mental health to parent-child interaction therapy. It is estimated that more than 230 faculty-level trainees were trained as a result of these activities.

Program Accomplishments for the Mental and Behavioral Health Education and Training Grants - In Academic Year 2013-2014, the Mental and Behavioral Health Education and Training (MBHET) grants supported more than 190 graduate-level students participating in either a social work practicum or a pre-degree internship in clinical psychology. Results showed that the majority of students who received a stipend were female (82 percent); between the ages of 20 and 29 (79 percent); were provided a median award amount of $10,000; and received clinical training in a medically underserved community (82 percent). Further analyses of data showed that more than one third of the students who received a stipend reported coming from a financially or educationally disadvantaged background and about 36 percent of the students are considered underrepresented minorities in their prospective professions.

Follow-up employment data were collected from individuals who completed training programs in AY 2012-13. Of the 12 prior year program completers with available employment data, 91 percent entered practice in medically-underserved communities. A total of 110 students completed their MBHET training programs in Academic Year 2013-14. Of these program completers, approximately 75 percent intended to become employed or pursue further training in a medically-underserved community; 28 percent intended to become employed or pursue further training in a primary care setting; and 25 percent intended to become employed or pursue further training in a rural area. Employment status will be assessed for these individuals one year after program completion (during Academic Year 2014-2015).

Data were collected regarding other types of activities that may be carried out through the MBHET program. For example, the authorizing legislation for the MBHET program requires that grantees use funds to develop and implement curricular and other educational activities to train students, residents and fellows across the health professions in behavioral health-related topics. Results showed that MBHET grantees developed or enhanced and implemented more than 160 different curricular and educational activities—most of which were new academic courses, clinical rotations and field placements for behavioral health students. It is estimated that more than 3,100 trainees participated in courses or training activities that were developed or enhanced by MBHET grantees.

Funding History

FY	Amount
FY 2012	$2,892,000
FY 2012 (PPHF)	$10,000,000
FY 2013	$2,740,000
FY 2014	$7,896,000
FY 2015	$8,916,000
FY 2016	$8,916,000

Budget Request

The FY 2016 Budget Request is $8,916,000. The FY 2016 Budget is the same as the FY 2015 Enacted level. This funding will continue to support grants in the Graduate Psychology Education and Leadership in Public Health Social Work Education programs.

In FY 2016, HRSA also will continue to partner with SAMHSA to expand the behavioral health workforce through continued funding to Behavioral Health Workforce Education and Training (BHWET) Program grantees, which were initially funded in FY 2014 and will receive continued funding in FY 2015. With the proposed $56 million in FY 2016 through SAMHSA, HRSA and SAMHSA will continue to support the clinical training for approximately 2,850 additional behavioral health professionals and approximately 2,750 additional paraprofessionals.

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[76]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
6.I.C.16: Number of students receiving training via clinical internships in Psychology or field placements in Social Work focused on working with high need and high demand populations.	---	N/A[77]	N/A	---
6.I.C.17: Number of graduates entering practice with high need and high demand populations	---	N/A[78]	N/A	---
6.I.2: Percent of graduates entering practice with high need and high demand populations	---	N/A[79]	N/A	---
Number of graduate-level psychology students supported	---	TBD[80]	TBD	---

[76] Most recent results are for Academic Year 2013-2014 and funded in FY 2013.
[77] Measures for the MBHET program will be discontinued in FY 2015, as no new funding for this program is anticipated. HRSA will report on outcomes associated with the MBHET program for FY 2012, FY 2013, and FY 2014.
[78] Measure will be discontinued in FY 2015.
[79] Measure will be discontinued in FY 2015.
[80] Baseline for this measure will be set in FY 2014.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[76]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Number of interprofessional students trained	---	TBD[81]	TBD	---
Percent of graduate-level psychology students supported who complete a pre-degree internship in a primary care setting	---	TBD[82]	TBD	---
Percent of grantees who develop or enhance curriculum that integrates behavioral health into primary care	---	TBD[83]	TBD	---
Number of Trainees	2,570 Target: 614 (Target Exceeded)	N/A[84]	N/A	---
Number Graduates	138 Target: 90 (Target Exceeded)	N/A[85]	N/A	---
Number of Graduates entering practice in MUCs	16[86] Target: 75 (Target Not Met)	N/A[87]	N/A	---
Percent of Graduates entering practice in MUCs	64%[88] Target: 83% (Target Not Met)	N/A[89]	N/A	---

[81] Baseline for this measure will be set in FY 2014.
[82] Baseline for this measure will be set in FY 2014.
[83] Baseline for this measure will be set in FY 2014.
[84] Measure will be discontinued in FY 2015.
[85] Measure will be discontinued in FY 2015.
[86] Based on 1-year follow-up data reported for students who completed training requirements in Academic Year 2012-2013. Data available only for 25 out of the 52 graduates reported in the FY 2015 Congressional Justification.
[87] Measure will be discontinued in FY 2015.
[88] Based on 1-year follow-up data reported for students who completed training requirements in Academic Year 2012-2013. Data available only for 25 out of the 52 graduates reported in the FY 2015 Congressional Justification.
[89] Measure will be discontinued in FY 2015.

Grant Award Table – Leadership in Public Health Social Work Education

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	3	3	3
Average Award	$289,000	$300,000	$300,000
Range of Awards	$270,000-$300,000	$275,000-$325,000	$275,000-$325,000

Grant Award Table - Graduate Psychology Education

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	41	37-45	37-45
Average Award	$163,000	$168,000	$168,000
Range of Awards	$52,000-$190,000	$128,000-$190,000	$128,000-$190,000

Interdisciplinary, Community-Based Linkages

Clinical Training in Interprofessional Practice

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	---	---	$10,000,000	+$10,000,000
FTE	---		2	+2

Authorizing Legislation**:** Sections 755, 765, and 831 of the Public Health Service Act, as amended by the Affordable Care Act.

FY 2015 Authorization….....Such Sums as Necessary

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

Program Goal and Description: The Clinical Training in Interprofessional Practice Program (CTIPP) will support community-based clinical training in interprofessional, team-based care. The goal is to increase the capacity of primary health care teams to: (1) deliver quality, coordinated, safe and efficient care to patients, families and communities and (2) inform academic institutions of the training needed to prepare future health care providers for practice. Eligible applicants are primary care delivery sites located in underserved and/or rural areas that have an existing relationship with an academic institution to train health professions students. Funding will be provided to the primary care delivery site to: (1) train current and future health clinicians based on new team-based models of health care delivery, and (2) develop a formalized partnership with an academic institution. The partnership with the academic institution will help to: 1) facilitate recruitment of students, and 2) ensure a functional feedback loop between the practice site and the academic institution. The grantees will be required to ensure that this feedback loop informs curricular enhancements at the academic institution to better prepare future health professionals for practice.

The teams will include, at a minimum, current and future physicians, physician assistants, oral health practitioners, nurse practitioners and nurses, and may also include behavioral health, allied health and other practitioners (e.g., community health workers), as well as health care administrators. The practice-based experience is to be 1-2 semesters in length, and should be in the latter part of the degree program. During this experience, a cohort of health professional students works with existing health care providers to engage in interprofessional, team-based care, and the students become part of the staff and team at the practice site.

To support the team-based training goals, the CTIPP grants also will support the development of new programmatic infrastructure and other supports (e.g., recruitment, retention and training strategies) needed for interprofessional practice.

This initiative will help bring to scale the findings of the National Center for Interprofessional Practice and Education at the University of Minnesota. Funded in FY 2012, the National Center serves as a hub for generating high-quality, efficient and equitable practice models for interprofessional education and practice that will be ready for broader implementation in the field. The program may complement the Teaching Health Center Graduate Medical Education program which supports clinical training for medical residents.

Need: New models of interprofessional clinical practice are needed that achieve the Triple Aim—better care, better population health, at a lower cost. Interprofessional education and training experiences in interprofessional collaborative practice environments can facilitate the development of a health care workforce that is capable of providing high quality, high-value care to patients, families and communities in delivery systems that are transforming. Many academic health centers, where most health professionals are trained, have embraced the principles and elements of interprofessional education (IPE) and the need for delivery systems to achieve the Triple Aim.

HRSA has made investments through its grant programs to provide increased interprofessional education opportunities for physicians, dentists, nurses, and public and behavioral health providers to increase their exposure to the concepts of interprofessional education and collaborative team-based care. Still, HRSA-supported trainees too often have limited opportunities to get experiential clinical training in collaborative, team-based care delivery environments. Establishing and supporting a network of interprofessional clinical practice environments is necessary to better leverage HRSA's existing interprofessional education training investments and to forge efficient partnerships between academia and health care delivery systems.

Eligible Entities: Eligible applicants are primary care delivery sites, including community health centers, nurse managed health clinics, and other community-based ambulatory care sites located in underserved and/or rural areas. Applicants must have an existing relationship with an academic institution(s) to train health professions students.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Physicians (family medicine, general internal medicine, general pediatrics, and combined internal medicine and pediatrics) • Physician assistants • Nurses (including advanced practice nurses) • Dentists • Dental hygienists • Behavioral Health • Allied Health	• Graduate students in medicine, nursing, dentistry, behavioral health, and other health care fields, and associates/undergraduate level students in allied health and paraprofessional fields	• Train current and future health clinicians based on team-based care. • Develop a formalized partnership with an academic institution to facilitate recruitment of students, and ensure a functional feedback loop between the practice site and the academic institution. • Provide community based practice training for interprofessional primary care teams.

Program Accomplishments: This is a new initiative in FY 2016, with no programmatic history.

Funding History

FY	Amount
FY 2012	---
FY 2013	---
FY 2014	---
FY 2015	---
FY 2016	$10,000,000

Budget Request
The FY 2016 Budget Request is $10,000,000. The FY 2016 Budget is $10,000,000 above the FY 2015 Enacted level. This request will support approximately 12 awards of approximately $750,000 per year, which will be awarded in FY 2016 for a period of three years. The funding announcement developed for this initiative will prioritize applications from organizations that develop their projects in partnership with HRSA-funded service delivery programs (e.g., Community Health Centers, Ryan White programs) that have achieved documented quality standards (e.g., designation as a patient-centered medical home (PCMH) or achievement of key patient outcome performance measures).

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
To Be Determined	---	---	Set Baseline	---

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	---	---	12
Average Award	---	---	$750,000
Range of Awards	---	---	$600,000-$900,000

Public Health Workforce Development

Public Health and Preventive Medicine

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$18,131,000	$21,000,000	$17,000,000	-$4,000,000
FTE	2	4	4	---

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

FY 2016
Authorization…….……...……...Unspecified

Funding Allocation.....Competitive Grant/Cooperative Agreement/Contract

Program Goal and Description: The Public Health and Preventive Medicine program includes funding for the following four grant programs:

- Public Health Training Centers (PHTC) Program - Funds schools of public health and other programs that provide graduate or specialized training in public health to expand and enhance training opportunities focused on the technical, scientific, managerial and leadership competencies and capabilities of the current and future public health workforce.

- Public Health Traineeship (PHT) Program - Provides grants to accredited schools and programs for the provision of graduate or specialized training in public health through traineeships for students in biostatistics, epidemiology, environmental health, toxicology, nutrition, or maternal and child health.

- Preventive Medicine Residency (PMR) Program - Supports post-graduate physician training by funding the planning, development, operation, or participation in approved residency programs in preventive medicine and public health. 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.

- Integrative Medicine Program (IMP) - Supports a national center of excellence for integrative medicine in primary care, funded for 3 years in FY 2014, for the purpose of developing and disseminating best practices for integrative medicine training for physicians, nurses, psychologists, and other primary care and behavioral health professionals. The national center will actively promote the use of evidence-based curricula for integrative primary care in primary care residency programs.

Need: The public health and health care environment continues to change and evolve. Public health professionals are working in a rapidly changing health care environment where public health roles and activities are being revised and refined. These forces and events are challenging the skills and abilities of the public health professionals currently employed in tribal, state and local public health agencies. To deliver essential services of high quality, while continuing to meet community expectations, professionals need to master new information and approaches. With the loss of resources to support public health at the state and local levels, there are fewer staff to carry out many of the core functions. New and innovative ways to provide training and education are needed. Although much of this is incumbent upon health department leadership to establish a culture of learning where continuing education and training opportunities are encouraged, Public Health and Preventive Medicine programs play a pivotal role in training the current and future workforce through pioneering new training content and delivery and through the development and coordination of student placements and collaborative projects.

Program	FY 2014 Enacted	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Public Health Training Centers Program	$9,818,000	$9,864,000	$9,864,000	---
Public Health Traineeships	$2,500,000	---	---	
Preventive Medicine Residency Program	$3,813,000	$7,136,000	$7,136,000	---
Integrative Medicine Program	$2,000,000	$4,000,000	---	-$4,000,000

Public Health Training Centers Program

The Public Health Training Centers (PHTC) program aims to strengthen the workforce in state, local, and Tribal health departments to improve the capacity and quality of a broad range of public health personnel to carry out core public health functions. To ensure the PHTC program is aligned with emerging public health needs, the changing healthcare environment, HRSA convened stakeholders and grantees in 2013 to redesign the program for FY 2014. As a result, each of the ten Regional PHTCs funded in 2014 have a multi-state service area model with the grantee serving as the "central office" or administrator/coordinator. The grantees have contractual relationships with education and training sites, called Local Performance Sites. The goal of the Regional PHTC program is accomplished by providing education, training and consultation to state, local, and tribal health department staff. The primary target for education and training through the Regional PHTC Program are frontline public health workers and middle managers.

In addition to the ten Regional PHTCs, a National Coordinating Center for Public Health Training (NCCPHT) was formed to ensure a shared vision and mission across all Regional PHTCs. The NCCPHT will: provide technical assistance; coordinate the standardization and vetting of course offerings, evaluations and needs assessments nationally; spearhead the replication of evidence-based products; serve as a clearing house for public health education and training; find creative ways to convene Regional PHTC grantees on a regular basis and improve the collection of data to demonstrate program impact. This Center is jointly funded with CDC.

Eligible Entities:
Regional PHTCs: Eligible applicants are schools of public health accredited by the Council on Education for Public Health (CEPH), or another public health or nonprofit institution accredited for the provision of graduate or specialized training in public health. There is statutory funding preference for CEPH accredited schools of public health.

NCCPHT: A health professions school, including an accredited school or program of public health, health administration, preventive medicine, or dental public health, or a school providing health management programs; an academic health center; a state or local government; or any other appropriate public or private nonprofit entity.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Primary Target Audience: Frontline and Middle Managers in state, local, and tribal health departments • Public health workforce including nurses, physicians, dentists, veterinarians, social workers, epidemiologists, nutritionists, sanitarians, and others	• Graduate students in public health • Existing public health professionals at all levels in the workforce	• Establish or strengthen field placements for students in public or nonprofit private health agencies or organizations. • Involve faculty members and students in collaborative projects to enhance public health services to medically underserved communities. • Provide services to a specifically designated geographic area or medically underserved population that is physically removed from the main location of the teaching facility. • Assess the training needs of health personnel in the area to be served by the center and assist in planning and developing the training.

Program Accomplishments: In Academic Year 2013-2014, grantees of the Public Health Training Centers (PHTC) program supported various types of training activities for public health students and their faculty, as well as for members of the current public health workforce. With regard to the continuing education (CE) of the current workforce, PHTC grantees delivered more than 2,200 CE courses to more than 249,900 trainees during the academic year. The courses

focused on competencies in the areas of either analytics, community dimensions of practice, or public health sciences. More than 29,000 practicing professionals who were trained through CE activities reported being employed in medically underserved communities.

As required by the authorizing legislation for the PHTC program, grantees used funds to coordinate field placements for 925 graduate-level public health students across the country. Results showed that the majority of students who participated in field placements were female (80 percent); between the ages of 20-29 (70 percent); and were in the second year of their graduate program (73 percent). Further analyses of data showed that 18 percent of students who participated in field placements coordinated through the PHTC program reported coming from a financially and/or educationally disadvantaged background and 15 percent are considered underrepresented minorities in their public health profession. Grantees partnered with more than 1,300 different public health organizations at more than 750 sites. Approximately 40 percent of these training sites were located in a medically underserved community.

PHTC grantees are required to use funds to support faculty-student collaboration projects that address emerging public health issues in communities located in each grantee's geographical service area. Results showed that PHTC grantees supported more than 230 different faculty-student collaboration projects that primarily focused on community health assessment, development of evidence-based programs for community partners, or development of materials supporting health department accreditation. More than 490 faculty members and more than 1,600 students from a variety of health professions participated in these collaborative projects.

Public Health Traineeship Program

The Public Health Traineeship (PHT) program aims to address the shortage of professionals trained in public health fields by increasing their numbers. The PHT program was not funded in FY 2013 and was revamped in FY 2014 with additional funding. This program provides grants to accredited schools and programs of public health and to other public or nonprofit private institutions accredited for the provision of graduate or specialized training in public health. The PHT Program provides traineeship support by covering tuition, fees, stipends and allowances for students pursuing graduate training or specialized education in five core public health disciplines. The core disciplines (epidemiology, environmental health, biostatistics, toxicology, nutrition, and maternal and child health) represent severe workforce shortage areas. Students receiving traineeship support also must participate in public health practice-based field placements particularly in state and local health departments and/or in underserved communities.

Eligible Entities: Eligible applicants are schools and programs of public health accredited by the CEPH, and/or other public or nonprofit private institutions accredited by a body recognized for the purpose of providing graduate or specialized training in public health.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Public health workforce in the designated public	• Graduate (Post-bachelor's certificate, Master's	• Support graduate education in public health in the fields of epidemiology, environmental health, biostatistics,

health shortage fields	and doctoral)	toxicology, nutrition, and maternal and child health. • Award traineeships to individuals to provide for tuition, fees, stipends, and allowances for reasonable living expenses. • Participate in public health practice-based field placements particularly in state and local health departments and/or in underserved communities.

Program Accomplishments: In Academic Year 2013-2014 (FY 2013), the PHT program was not funded. It was supported again in FY 2014. Program accomplishments from Academic Year 2014-2015 (FY 2014) will be reported in the 2017 Congressional Justification.

Preventive Medicine Residency Program

The Preventive Medicine Residency (PMR) program aims 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:**	**Grantee 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. • Plan, develop, operate, and/or participate in an accredited residency program. • 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: In Academic Year 2013-2014, the Preventive Medicine Residency (PMR) grant program supported a total of 56 residents – most of which were completing dual-focused residencies in either Preventive Medicine and Occupational Medicine or Preventive Medicine and Public Health. The majority of residents supported through the program were female (54 percent); between the ages of 30 and 39 (41 percent); in the last year of their residency (53 percent); and received clinical or experiential training in a primary care

setting (68 percent) and/or a medically underserved community (55 percent). Further analyses of data showed that 16 percent of residents supported through the program reported coming from a financially or educationally disadvantaged background and about 28 percent of residents are considered underrepresented minorities in their prospective profession. During the academic year, 26 out of the 56 residents completed their residency training programs. Of these completers, approximately 26 percent indicated an intention to work or pursue further training in a medically underserved community, while 15 percent of residents indicated an intention to work or pursue further training in primary care. Employment status will be assessed for these residents one year after program completion (Academic Year 2014-2015). Follow-up employment data were collected from residents who completed training programs in AY 2012-13. Of the 14 prior year program completers with available employment data, 50 percent entered practice in medically-underserved communities, 25 percent entered practice in primary care settings, and 21 percent entered practice in rural areas.

Data were collected regarding other types of required grant activities. For example, PMR grantees are required to use funds to support infrastructure-related activities (e.g., curriculum development and enhancement) as well as faculty development. A total of 41 curricula were developed or enhanced and implemented during the academic year. It is estimated that over 240 trainees participated in courses and training activities that were developed or enhanced by PMR grantees. Finally, PMR grantees supported a total of14 different structured and unstructured faculty development programs and activities. It is estimated that over 40 faculty members received training during this academic year.

Integrative Medicine Program

The Integrative Medicine Program (IMP) program in 2014 provided 3 years of funding to support a Center for Integrative Medicine in Primary Care (CIMPC). The purpose of the CIMPC is to incorporate evidence-based Integrative Medicine (IM) curricula into existing primary care residency and other health professions training programs. Health professions training programs can include pediatrics, internal medicine, family medicine, preventive medicine, nursing, physician assistant, public health, and behavioral health, among others. The CIMPC is expected to contribute to the evidence-base for IM, and identify and disseminate promising practices related to the integration of IM into primary care.

In 2012, HRSA provided 2 years of funding to support 12 grants to preventive medicine residency programs to integrate IM into their curricula. A national coordinating center for IM cooperative agreement (known as IM in Preventive Medicine Education or IMPriME) was awarded to the American College of Preventive Medicine (ACPM) to provide technical assistance to these preventive medicine grantees, to develop core competencies for these programs, and to evaluate their efforts. The CIMPC will build upon the IMPriME grantees by expanding beyond preventive medicine into other primary care and health care disciplines and thus, enhancing the ability of the workforce to meet national, state, and local health care needs related to IM.

Eligible Entities: An eligible applicant for this program shall be: 1) a health professions school, including an accredited school or program of public health, health administration, preventive

medicine, or dental public health or a school providing health management programs; 2) an academic health center; 3) a state or local government; 4) any other appropriate public or private nonprofit entity; or 5) a consortium of eligible entities.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Primary care physicians • Nurses • Psychologists • Other primary care and behavioral health professionals	• Residency training • Continuing Education	• Formally partner with existing primary care residency and other health professions training programs. • Deliver continuing education to current primary care and other health professionals and faculty members. • Develop an education and dissemination plan to increase awareness among providers and consumers regarding IM. • Identify successful and promising practices in IM education and practice; and increase attention to interprofessional educational opportunities in IM. • Provide technical assistance to primary care residency programs and health professions education programs on the integration of IM into the established curricula and training. • Convene the broader IM learning community to provide oversight and guidance to the NCEIPC including ways to reach diverse and underserved populations. • Generate and/or disseminate educational resources and research on the incorporation of IM into interprofessional practice, and ultimately add to the evidence-based around IM.

Program Accomplishments: In Academic Year 2013-2014, the Integrative Medicine Program (IMP) supported the training of 61 residents across 11 different types of preventive medicine residency programs. The majority of residents trained through the program were female (53 percent); between the ages of 30 and 39 (56 percent); and received clinical or experiential training in a primary care setting (61 percent) and/or a medically underserved community (63 percent). Further analyses of data showed that approximately 19 percent of residents supported through the program reported coming from a financially or educationally disadvantaged background and about 28 percent of residents were considered underrepresented minorities in their prospective profession.

Follow-up employment data were collected from individuals who completed training programs in AY 2012-13. Of the 16 prior year program completers with available employment data, 50 percent entered practice in medically-underserved communities and 19 percent entered practice

in primary care settings. During Academic Year 2013-2014, 26 out of the 61 residents completed their residency training programs. Of these program completers, 26 percent of residents indicated an intention to work or pursue further training in a medically underserved community, while 23 percent of residents indicated an intention to work or pursue further training in primary care. Employment status will be assessed for these individuals one year after program completion (during Academic Year 2014-2015).

Data were collected regarding other types of required grant activities. For example, IMP grantees are required to use funds to support infrastructure-related activities (e.g., curriculum development and enhancement), as well as faculty development. A total of 64 curricula were developed or enhanced and implemented during the academic year. It is estimated that over 640 trainees participated in courses and training activities that were developed or enhanced by IMP grantees. Finally, the IMP supported over 65 different structured and unstructured faculty development activities across the 12 grants that focused on providing specialized training opportunities on integrative medicine to current preventive medicine faculty. It is estimated that approximately 500 faculty members received training as a result of these activities.

Funding History

FY	Amount
FY 2012	$8,144,000
FY 2012 (PPHF)	$25,000,000
FY 2013	$7,683,000
FY 2014	$18,131,000
FY 2015	$21,000,000
FY 2016	$17,000,000

Budget Request

The FY 2016 Budget Request is $17,000,000. The FY 2016 Budget is $4,000,000 less than the FY 2015 Enacted level. The FY 2016 President's Budget will support the Public Health Training Centers and the Preventive Medicine Residency programs. Funding for the Public Health Traineeship program was eliminated in FY 2015 as part of the Science, Technology, Engineering, and Mathematics (STEM) Education consolidation. Funding is not requested for the Integrative Medicine Program, as funding from previous years is sufficient to demonstrate the impact of incorporating integrative medicine into health profession training programs.

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[90]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
6.I.C.9: Number of trainees participating in continuing education sessions delivered by PHTCs	249,933 Target: 84,520 (Target Exceeded)	23,000[91]	23,000	Maintain
6.I.C.18: Number of instructional hours offered by PHTCs	10,123 Target: 9,320 (Target Exceeded)	9,320	9,320	Maintain
6.I.C.19: Number of PHTC-sponsored public health students that completed field placement practicums in State, Local, and Tribal Health Departments	278 Target: 150 (Target Exceeded)	150[92]	150	Maintain
6.I.C.14: Number of residents enrolled in preventive medicine programs that have incorporated evidence-based integrative medicine principles into the curriculum (including both practical and didactic academic course work)	61 (Baseline)	N/A[93]	N/A	---
6.I.C.15: Number of technical assistance consultations provided by the National Coordinating Center for Integrative Medicine (NccIM)	800 (Baseline)	N/A[94]	N/A	---
Number of residents participating in residencies	56 Target: 40 (Target Exceeded)	55	55	Maintain
Number of residents completing training	26 Target: 20 (Target	20	20	Maintain

[90] Most recent results are for Academic Year 2013-2014 and funded in FY 2013.
[91] Targets reduced to reflect cohort effects.
[92] Target reflects cohort effects.
[93] Program was discontinued in FY 2014. HRSA will report outputs for FY 2013.
[94] Program was discontinued in FY 2014. HRSA will report outputs for FY 2013.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[90]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
	Exceeded)			
Number of URM residents completing training	9 Target: 9 (Target Met)	N/A[95]	N/A	---
Percent of URM residents completing training	34% Target: 35% (Target Not Met)	N/A[96]	N/A	---

Grant Awards Table – Public Health Training Centers Program

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	11	11	11
Average Award	$850,000	850,000	850,000
Range of Awards	705,000-$1,005,000	$705,000-$1,005,000	$705,000-$1,005,000

Grant Awards Table – Public Health Traineeships

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	16	---	---
Average Award	$131,000	---	---
Range of Awards	$77,000-$150,000	---	---

[95] Measure will be discontinued in FY 2015.
[96] Measure will be discontinued in FY 2015.

Grant Awards Table – Preventive Medicine Residency Program

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	10	10	10
Average Award	$410,500	$450,000	$450,000
Range of Awards	$230,000-$562,000	$340,000-$610,000	$340,000-$610,000

Grant Awards Table – Integrative Medicine Program

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	1	3	---
Average Award	$2,000,000	$1,200,000	---
Range of Awards	$2,000,000	$1,000,000-$1,400,000	---

Nursing Workforce Development

Advanced Nursing Education

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$61,089,000	$63,581,000	$63,581,000	---
FTE	5	6	6	---

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

FY 2016 Authorization ..... Such Sums as Necessary

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

Program Goal and Description: The Advanced Nursing Education Programs provide funding for institutions to create or expand projects that support the enhancement of advanced nursing education and practice. The Advanced Nursing Education Programs are comprised of the following:

- Advanced Nursing Education (ANE) Grants – The goal of the ANE grants is to improve the number of qualified nurses in the primary care workforce by improving nursing education through curriculum and faculty development. These grants provide funding for institutions to enhance their instructional programs for advanced nursing education and practice, including nurse practitioners, clinical nurse specialists, nurse midwives, nurse anesthetists, nurse administrators, public health nurses and other specialties requiring advanced education. In FY 2015, HRSA is focusing on projects that develop and test innovative academic-practice partnership models for clinical training within the graduate nursing education programs in order to prepare graduate nursing students to provide safe, quality care within the complex practice-based environment of the nation's evolving healthcare system. Awardees will create one or more innovative partnerships between academic institutions and rural or underserved clinical practice sites to improve the quality of clinical sites and preceptors, improve preceptor training and promote students' readiness to practice upon graduation.

- The Advanced Education in Nursing Traineeship (AENT) – This program aims to increase the number of advanced education nurses or nurse midwives who are trained to practice in primary care. The program awards grants to accredited institutions in order to provide traineeships. The grants support all or part of the costs of tuition, books, and fees of the program of advanced nurse education, and the reasonable living expenses of the individual during the traineeship.

- Nurse Anesthetist Traineeship (NAT) – The goal of the NAT program is to increase the number of nurse anesthetists especially for underserved populations or for people who are underrepresented in the health care workforce. The program awards grants to accredited institutions that train nurse anesthetists in order to support traineeships. The grants support all or part of the costs of tuition, books, fees and reasonable living expenses of the individual during the traineeship.

Need: The combined factors of an aging workforce and population growth 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. In addition, this program is responsive to the evolving health care needs of patients and families and to ensure that advanced nursing education programs prepare nurses with the skills to meet these needs and provide care in complex, high-tech health care systems that are moving to team-based models of care.

Advanced Nursing Education Programs

Programs	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Advanced Nursing Education	$26,906,729	$38,581,000	$38,581,000	---
Advanced Education Nursing Traineeship	$31,239,763	$22,750,000	$22,750,000	---
Nurse Anesthetist Traineeship	$2,942,508	$2,250,000	$2,250,000	---

Advanced Nursing Education Grants

The ANE grants support advanced education program development in schools of nursing and seek to increase the size and quality of the advanced practice nurse workforce.

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:	Grantee Activities:
• Nurse practitioners • Clinical nurse specialists	• Graduate (master's and doctoral)	• Build and enhance advanced nursing education programs.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Nurse midwives • Nurse anesthetists • Nurse educators • Nurse administrators • Public health nurses		

Program Accomplishments: The Advanced Nursing Education (ANE) grants fund a number of activities—including several traineeships and an expansion program with the aim to increase the size of the advanced nursing workforce. In Academic Year 2013-2014 (FY 2013), grantees of the ANE program trained 10,504 nursing students and this exceeded the program's performance target of 6,255 by 68 percent. This program also produced a total of 2,475 graduates—exceeding program performance target of 1,785. In addition, 36 percent of students trained were underrepresented minorities and/or from disadvantaged backgrounds, exceeding the performance target of 24 percent. The majority of ANE students were female (90 percent) and between ages 20 and 29 (31 percent). Further analysis showed that ANE grantees partnered with over 5,100 healthcare delivery sites, providing clinical and experiential training to approximately 10,500 trainees. It is estimated that approximately 46 percent of sites used by ANE grantees were located in a medically underserved community and 4 out of every 10 sites were located in primary care settings.

In Academic Year 2013-2014, the Advanced Nursing Education Expansion (ANEE) program supported a total of 374 graduate-level nursing students across 43 different types of Nurse Practitioner programs. Of the 374 students supported, 175 graduated by the end of the academic year. Results showed that majority of the students supported were female (86 percent); between the ages of 20 and 29 (35 percent); and received clinical training in a primary care settings (75 percent) and/or medically underserved communities (57 percent) during the academic year. Further analysis showed that the majority (81 percent) of students graduated with a Master's level Nurse Practitioner degree. It is estimated that one out of every four students who graduated are considered an underrepresented minority in the field of nursing and reported a financially and/or educationally disadvantaged background. Data reported at the time of graduation showed that about 55 percent of graduates intend to pursue employment or further training in medically underserved communities across the country. Additionally, the data show that 54 percent of academic year 2012-2013 graduates are currently employed or pursuing further training in a medically underserved community.

To date, the ANEE program has produced a total of 424 Nurse Practitioners—101 in Academic Year 2011-2012, 148 in Academic Year 2012-2013 and 175 in Academic Year 2013-2014. While the program was not projected to produce this many Nurse Practitioners by this date, difficulties in recruitment led to grantees distributing funds to first and second year nursing students during the initial year of the program; as a result, 101 second-year nursing students were supported and ultimately graduated from their nursing programs in Academic Year 2011-2012. The funding of these 101 students has caused the program to significantly exceed the number of Nurse Practitioners it was expected to produce by the end of Academic Year 2013-2014 (Target: 260; Actual: 424).

Advanced Education Nursing Traineeship Program

The Advanced Education Nursing Traineeship (AENT) program aims to increase the number of advanced education nurses trained to practice as primary care nurse practitioners or nurse midwives by supporting tuition, textbooks and reasonable living expenses for traineeships.

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:**	**Grantee Activities:**
• Nurse practitioners • Clinical nurse specialists • Nurse midwives • Nurse educators • Nurse administrators • Public health nurses	• Graduate (master's and doctoral)	• Provide education and training for nurses to provide quality primary health care in homes, ambulatory care, long-term care, acute care, and other health care settings. • Provide traineeships for tuition, fees, books, and reasonable living expenses.

Nurse Anesthetist Traineeship Program

The NAT program aims to increase access to nurse anesthetist care for underserved populations who are underrepresented in the health care workforce by supporting the costs of tuition, textbooks and reasonable living expenses for nurse anesthetist traineeships.

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 anesthetists	• Graduate programs in nurse anesthesia (master's and doctoral)	• Supports education of nurse anesthetists to provide quality health care in underserved areas, including Health Professional Shortage Areas (HPSAs). • Provide traineeships for tuition, fees, books, and reasonable living expenses.

Program Accomplishments:

In Academic year 2013-2014 (FY 2013), grantees of the AENT and the NAT programs provided direct financial support to 5,650 nursing and nurse anesthesia students—exceeding the program's performance target of 2,910 by 94 percent. Among students supported, 2,486 graduated and were ready to enter the workforce, exceeding the performance target of 1,965 by 27 percent. The

number of minority and disadvantaged students supported in academic year 2013-2014 was 2,241—exceeding the performance target by 44 percent. Results showed that the majority of the students supported were female (74 percent); between the ages of 20 and 29 (39 percent); and received clinical training in medically underserved communities (56 percent) or primary care settings (48 percent) during the academic year.

Lastly, follow-up employment data were collected from individuals who completed training programs in AY 2012-2013. Of the prior year graduates with employment data, 514 former nursing students (37 percent) entered into practice in medically-underserved communities. AY 2013-2014 data show that at the time of graduation about one in five graduates intend to pursue employment or further training in medically underserved communities across the country. Employment status will be assessed for these individuals one year after graduation (during AY 2014-2015).

Funding History

FY	Amount
FY 2012	$63,469,000
FY 2013	$59,943,000
FY 2014	$61,089,000
FY 2015	$63,581,000
FY 2016	$63,581,000

Budget Request

The FY 2016 Budget Request is $63,581,000. The FY 2016 Budget is the same as the FY 2015 Enacted level, which will allow HRSA to continue investing in advanced nurse education and support training for more than 6,255 students through the Advanced Nurse Education grants. The request will also allow HRSA to support nursing traineeships. In FY 2015, HRSA will set baselines for the number of traineeships in NAT and AENT and will provide FY 2016 targets at that time.

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[97]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
6.1.C.7: Number of Primary Care Nurse Practitioner students supported[98]	374 Target: 300 (Target Exceeded)	300	N/A[99]	N/A
6.1.C.3.c: Number of nurse practitioners who complete their education through HRSA's Bureau of Health Workforce programs supported with Prevention and Public Health funding (cumulative)[100]	424 Target: 260 (Target Exceeded)	600	N/A[101]	N/A
6.1.C.4.c: Number of nurse practitioners receiving training through HRSA's Bureau of Health Workforce programs supported with Prevention and Public Health funding (Cumulative)[102]	623 Target: 430 (Target Exceeded)	N/A[103]	N/A	---
Number of students trained	10,504 Target: 6,255 (Target Exceeded)	6,255	6,255	Maintain
Proportion of students trained who are underrepresented minorities and/or from disadvantaged backgrounds[104]	36% Target: 24% (Target Exceeded)	24%	24%	Maintain
Number of graduates from advanced nursing degree programs[105]	2,475 Target: 1,785 (Target	1,485	1,485	Maintain

[97] Most recent results are for Academic Year 2013-2014 and funded in FY 2013.
[98] Outputs are based on forward-funded grants.
[99] This measure will be discontinued in FY 2016 as no further funding is anticipated for the ANEE program.
[100] Outputs are based on forward-funded grants.
[101] This measure will be discontinued in FY 2016 as no further funding is anticipated for the ANEE program.
[102] This measure reflects the number of nurse practitioner and nurse midwife students who received funding through the ANEE program annually.
[103] This measure will be discontinued in FY 2015 as no further funding is anticipated for the ANEE program.
[104] The wording for this measure has been revised from previous budget documents to better reflect measures collected.

[105] The wording for this measure has been revised from previous budget documents to better reflect measures collected.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[97]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
	Exceeded)			
Number of students supported in AENT program	---	Set Baseline	TBD	---
Number of graduates from AENT program	---	Set Baseline	TBD	---
Number of students supported in NAT program	---	Set Baseline	TBD	---
Number of graduates from NAT program	---	Set Baseline	TBD	---
Percent of graduates from AENT and NAT programs employed in underserved areas	---	Set Baseline	TBD	---
Number of students supported	5,650 Target: 2,910 (Target Exceeded)	N/A[106]	N/A	---
Number of graduates supported	2,486 Target: 1,965 (Target Exceeded)	N/A[107]	N/A	---
Number of graduates practicing in underserved areas	514 Target: 920 (Target Not Met)	N/A[108]	N/A	---
Number of minority or disadvantaged students trained	2,241 Target: 1,560 (Target Exceeded)	N/A[109]	N/A	---

[106] Measure will be discontinued in FY 2015.
[107] Measure will be discontinued in FY 2015.
[108] Measure will be discontinued in FY 2015.
[109] Measure will be discontinued in FY 2015

Grant Awards Table – ANE

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	76	84	84
Average Award	$330,250	$650,000	$650,000
Range of Awards	$139,250-$375,000	$400,000-$700,000	$400,000-$700,000

Grant Awards Table – AENT

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	89	66	66
Average Award	$328,000	$342,000	$342,000
Range of Awards	$69,000-$350,000	$220,000-$440,000	$220,000-$440,000

Grant Awards Table – NAT

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	82	80	80
Average Award	$33,500	$27,439	$27,439
Range of Awards	$6,000-$125,000	$2,800-$69,000	$2,800-$69,000

Nursing Workforce Development

Nursing Workforce Diversity

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$15,641,000	$15,343,000	$15,343,000	---
FTE	1	1	1	---

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

FY 2016 Authorization ..... Such Sums as Necessary

Allocation Method ..... Competitive Grant/Contract

Program Goal and Description: The Nursing Workforce Diversity (NWD) program helps create a more diverse nursing workforce by increasing nursing education opportunities for individuals from disadvantaged backgrounds, including racial and ethnic minorities underrepresented among registered nurses. The program supports: student stipends and scholarships, pre-entry preparation, advanced education preparation, and retention activities. The program helps meet the increasing need for culturally competent, quality health care for the nation's rapidly diversifying population and help close the gap in health disparities.

Need: A diverse health care workforce with diverse leadership is necessary to help meet the needs of a diverse population and reduce health disparities and inequities. An HHS Office of Minority Health report identifies 20 strategies for improving minority health equity, including the recommendation for health care professional schools and the health care workforce to represent and reflect the diverse communities.[110] A 2013 HRSA report on the nursing workforce shows that only 24 percent of the Registered Nurses come from racial/ethnic minority groups compared with 30 percent of the working-age population.[111]

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.

[110] U.S. Department of Health and Human Services, Office of Minority Health, (April, 2011). National Partnership for Action to End Health Disparities. National Stakeholder Strategy for Achieving Health Equity, Available at: http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286

[111] Health Resources and Services Administration (October 2013) The U.S. Nursing Workforce: Trends in Supply and Education, Available at: http://bhpr.hrsa.gov/healthworkforce/supplydemand/nursing/nursingworkforce/nursingworkforcefullreport.pdf

Designated Health Professions:	Targeted Educational Levels:	Program Activities:
• Registered Nurses (RNs)	• Pre-Entry Preparation - certified nursing assistants - licensed practical or vocational nurses • Diploma or Associate Degree RNs • RNs who matriculate into accredited bridge or degree completion program within the three-year project period. • Baccalaureate degree	• Use academic, social and financial supports 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.

Program Accomplishments: In Academic Year 2013-2014, (FY 2013) the focus of the Nurse Workforce Diversity program continued to reflect a higher emphasis on students and graduates of diploma and college-level nursing programs over those at the elementary/secondary levels. Changes in the focus of the program were made in an attempt to ultimately increase the number of nursing graduates eligible to take the licensing exam. As a result, FY 2013 performance targets regarding the number of program participants at the elementary/secondary levels were not met; however the number of college and pre-entry nursing program participants was 3,295, and this exceeded the performance target of 1,300.

Results showed that number of nursing program students trained was 6,691—exceeding the target of 3,350 by 51 percent. Furthermore, 2,419 nursing students graduated from nursing programs and this also exceeded the program target of 950 by over 100 percent. Analysis of performance data for FY 2013 revealed that grantees of the NWD program provided scholarships to 1,416 students—exceeding the program's performance target of 735 by 93 percent.

Grantees of the NWD program partnered with over 1,000 different training sites during the academic year to provide clinical training to over 14,000 trainees across all training programs during the academic year. Further analyses of data about the characteristics of training sites showed that 54 percent of training sites were located in a medically underserved community. Performance measures and related targets for FY 2015 and beyond will be adjusted to reflect modifications in the focus of the NWD program so as to better capture appropriate outputs and outcomes.

Funding History

FY	Amount
FY 2012	$15,819,000
FY 2013	$14,984,000
FY 2014	$15,641,000
FY 2015	$15,343,000
FY 2016	$15,343,000

Budget Request

The FY 2016 Budget Request is $15,343,000. The FY 2016 Budget is the same as the FY 2015 Enacted level. This request will fund the education of 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. In FY 2016, the program will continue to encourage grantees to support diverse students to overcome structural and systematic factors that inhibit health equity in order to succeed.

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[112]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Percent of program participants who are underrepresented minorities and/or from disadvantaged backgrounds	---	95%	95%	Maintain
Percent of program participants who completed pre-college preparation training and intend to apply to a nursing degree program	---	Set Baseline	TBD	---
Percent of program participants who received academic retention support and maintained enrollment in a nursing degree program	---	Set Baseline	TBD	---
Percent of underrepresented minority students	51% Target: 70% (Target Not Met)	N/A[113]	N/A	---
Percent of white disadvantaged	39%	N/A[114]	N/A	---

[112] Most recent results are for Academic Year 2013-2014 and funded in FY 2013.
[113] Measure will be discontinued in FY15.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[112]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
students/participants	Target: 27% (Target Exceeded)			
Number of nursing program students	6,691 Target: 3,350 (Target Exceeded)	N/A[115]	N/A	---
Number of post high school, college, and pre-entry nursing students	3,295 Target: 1,300 (Target Exceeded)	N/A[116]	N/A	---
Number of K-12 students/participants	4,592 Target: 5,900 (Target Not Met)	N/A[117]	N/A	---
Number of nursing students graduating from nursing programs	2,419 Target: 950 (Target Exceeded)	N/A[118]	N/A	---
Number of nursing students expected to receive scholarships	1,416 Target: 735 (Target Exceeded)	N/A[119]	N/A	---

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	45	45	45
Average Award	$333,500	$316,000	$316,000
Range of Awards	$137,500-$567,000	$135,000-$528,000	$135,000-$528,000

[114] Measure will be discontinued in FY15.
[115] Measure will be discontinued in FY15.
[116] Measure will be discontinued in FY15.
[117] Measure will be discontinued in FY15.
[118] Measure will be discontinued in FY15.
[119] Measure will be discontinued in FY15.

Nursing Workforce Development

Nurse Education, Practice, Quality and Retention Program

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$37,913,000	$39,913,000	$39,913,000	---
FTE	3	4	4	---

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

FY 2016 Authorizations:
Section 831.....Expired FY 2015
Section 831A……..Expired FY 2012

Allocation Method .....Competitive Grant/Contract

Program Goal and Description: The Nurse Education, Practice, Quality and Retention (NEPQR) Program seeks to build and expand nursing educational programs to increase the number of qualified nurses in the health care workforce through academic, service, and continuing professional training projects designed to enhance nursing education, improve the quality of patient care, increase nurse retention and strengthen the nursing workforce. The program is particularly focused on helping health care providers collaborate in interprofessional teams through its work with nurse managed health centers, and also helping nursing schools work with veterans and service members to transition their medical training into the civilian nursing workforce to help meet our Nation's health workforce needs. NEPQR also invests in the National Center for Interprofessional Practice and Education (IPE) which supports health care transformation to collaborative team-based care by addressing the disconnect between health professions education and practice communities. The Center also makes a difference in the health of people and communities by integrating interprofessional practice and education to enhance patient care, control costs, and improve health outcomes.

Need: A growing and aging population and changing models of primary care practice continue to increase the demand for high-quality nursing services and coordinated interprofessional care. At the same time, the nursing workforce is steadily aging and projected retirements from the workforce are expected to significantly shrink the supply of qualified personnel. The NEPQR program seeks to address this gap by increasing our nation's nursing workforce and improving the skills and capabilities of the workforce. The program also addresses the inequitable distribution of the nursing workforce by working with grantees that have a proven track record in underserved areas, rural populations and public health nursing needs.

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:**	**Grantee Activities:**
• Licensed practical nurses • Registered nurses • Advanced practice registered nurses	• Baccalaureate education • Advanced nursing education • Continuing professional training	• Expand enrollment in baccalaureate nursing programs. • Provide education in new technologies including simulation learning and distance learning methodologies. • Develop internships and residency programs. • Develop career ladder programs to promote career mobility in nursing. • Develop cultural competencies. • Offer programs to promote nurse retention. • Develop skills in care enhancements congruent with emerging health care systems. • Increase access to care for underserved and high-risk populations • Increase access to interprofessional clinical training and practice for basic and advanced practice nurses.

Program Accomplishments: The Nurse Education, Practice, Quality and Retention program (NEPQR) program has a variety of legislative goals and purposes that ultimately aim to increase the size, preparation and quality of the nursing workforce. In Academic Year 2013-2014, a number of grants were funded to support several of the program's legislative purposes such as supporting nurse-managed health clinics that serve as primary care access points in areas where primary care providers are in short supply and supporting the new Veterans' Bachelor of Science in Nursing (VBSN) program. Other purposes of the program including expansion of BSN degree programs, recruiting and training personal and home care aides, and training nursing assistants and home health aides are either completing their funding cycles or no longer a focus as other purposes (i.e., VBSN program) are now being emphasized.

With regard to the expansion of BSN degree programs, the NEPQR program funded seven expansion projects which resulted in the training of more than 1,289 BSN students during academic year. Of these, a total of 490 graduated and may enter the workforce as baccalaureate-level nurses. The NEPQR program was not able to meet its goal of funding 22 expansion projects as the program focused its efforts on supporting VBSN projects that seek to expand the nursing workforce and improve employment opportunities for veterans.

The NEPQR program also funded a number of grants to focus on the recruitment and training of individuals as qualified nursing assistants and personal and home care aides. These grants concluded during Academic Year 2013-2014. The program achieved an overall result of 7,013 new nursing assistants and personal and home health care aides entering the workforce and exceeding the program goal of 5,169.

The NEPQR program funded the Veterans' Bachelor of Science in Nursing (VBSN) program for the first time during Academic Year 2013-2014 and made awards to nine schools. This program is designed to increase enrollment, progression, and graduation of veterans from BSN degree programs. Data was collected over a nine month period and showed that a total of 45 veterans were enrolled in BSN degree programs and that five graduated with a BSN degree. Further analysis showed that 53 percent were female and between the ages of 20-29 years (51 percent). It is estimated that 42 percent of participating veterans were underrepresented minorities in the field of nursing, and 56 percent reported coming a financially and/or educationally disadvantaged background. About half of the veterans received clinical training in a primary care setting during the academic year. VBSN grantees enhanced or developed a total of 11 academic courses that trained a total of 66 participants (participants may have taken more than one course and are counted in each course taken). Grantees also implemented two structured faculty development programs and supported 22 faculty development conferences and workshops designed to enhance the teaching of veterans. A total of 241 faculty were trained as a result of these faculty development programs and activities.

Lastly, the NEPQR program funded several Nurse Managed Health Clinics (NMHC) with the primary purpose of creating infrastructure and also serving as clinical training sites for students across the health professions. It is estimated that more than 900 health professions students were trained as a result of these activities—though the majority of students trained at BHW-supported NMHCs were nursing students pursuing a graduate-level nurse practitioner degree. Results from the analyses of demographic data showed that the majority of students trained at HRSA-supported NMHCs were female (91 percent) and between the ages of 20-29 (70 percent). Further analyses of data showed that the majority of NMHCs and associated training sites were primarily located in medically underserved communities (94 percent) and served as a primary care setting for their local community (54 percent). Across HRSA-supported training sites, 40 percent of vulnerable populations treated by NMHCs were to provide service to veterans and their families.

Funding History

FY	Amount
FY 2012	$39,638,000
FY 2013	$37,113,000
FY 2014	$37,913,000
FY 2015	$39,913,000
FY 2016	$39,913,000

Budget Request

The FY 2016 Budget Request is $39,913,000. The FY 2016 Budget is the same as the FY 2015 Enacted level. This request will enable HRSA to provide nursing educational opportunities, train nurses in clinical practice skills, and provide continuing professional training to the nursing workforce to enhance the quality of patient care. Projects will particularly focus on supporting veterans to become nurses and on developing and disseminating collaborative practice models that incorporate the full range of health care workers in team-based care. HRSA is also continuing support for the National Center for Interprofessional Practice and Education to enhance the coordination and capacity building for interprofessional practice and education among health professions across the U.S.

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Tables

The NEPQR program has several purposes and solicits applications addressing any of its education, practice and retention purposes, one of which is accelerated BSN education projects. 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 /Target for Recent Result (Summary of Result)[120]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
6.I.C.6: Number of Personal Care and Home Health Aides completing training program	403 Target: 1,723 (Target Not Met)	N/A[121]	N/A	---
Number of nursing students trained in interprofessional team-based care	---	Set Baseline	TBD	---
Number of nurses and nursing students trained in interprofessional team-based care	---	Set Baseline	TBD	---

[120] Most recent results are for Academic Year 2013-2014 and funded in FY 2013.
[121] Program will be discontinued in FY13.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[120]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Number of expanded BSN education projects	7 Target: 22 (Target Not Met)	N/A[122]	N/A	---
Number of BSN student participants	1,289 Target: 4,860 (Target Not Met)	N/A[123]	N/A	---

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	83	90	90
Average Award	$411,000	$435,000	$435,000
Range of Awards	$40,500-$790,000	$134,000-$788,000	$134,000-$788,000

[122] Measure will be discontinued in FY 15.
[123] Measure will be discontinued in FY 15.

Nursing Workforce Development

Nurse Faculty Loan Program

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$24,500,000	$26,500,000	$26,500,000	---
FTE	1	1	1	---

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

FY 2016 Authorization .....Expired FY 2015

Allocation Method .....Formula Grant

Program Goal and Description: The Nurse Faculty Loan Program (NFLP) seeks to increase the number of qualified nursing faculty by helping participating schools of nursing to provide student loans to assist nurses in completing their graduate education. Grantee schools establish and manage a loan fund and are required to contribute at least one-ninth of the award amount from their institution into the loan fund. Following graduation, the nursing school will cancel up to 85 percent of the loan principal and interest over four years in exchange for the loan recipient serving as full-time faculty service at an accredited school of nursing.

Need: The primary barrier to accepting all qualified students at nursing colleges and universities continues to be an insufficient number of qualified nursing faculty. According to two 2013 studies of nursing schools, almost two-thirds of nursing schools could not accept all of their qualified applicants because of faculty shortages, which includes at least 1,358 faculty vacancies across 680 schools. [124,125] Faculty diversity is also an essential ingredient in the efforts to diversify the nursing education workforce overall.

Eligible Entity: Accredited schools of nursing that offer advanced nursing education degree program(s) that prepare graduate students for roles as nurse educators.

[124] American Association of Colleges of Nursing (Nurse Faculty Shortage Fact Sheet (updated December 2013).http://www.aacn.nche.edu/media-relations/fact-sheets/nursing-faculty-shortage).
[125] American Association of Colleges of Nursing. Special Survey on Vacant Faculty Positions for Academic Year 2013-2014. http://www.aacn.nche.edu/leading-initiatives/research-data/vacancy13.pdf

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
• Nursing	• Graduate (master's and doctoral)	**Loan Fund:** • Provide funding to nursing schools to establish and operate revolving loan fund. • Provide low interest rate loans to nursing students that may be used to pay costs of tuition, fees, books, laboratory expenses, and other education expenses. • Match of at least 1/9 of the Federal contribution to the loan fund. **Loan Cancellation Provision:** • Provide loan cancellation upon completion of service with 85 percent cancellation after 4 years of service.

Program Accomplishments: In Academic Year 2013-2014, the Nurse Faculty Loan Program (NFLP) supported a total of 2,401 nursing students pursuing a graduate-level degree as nurse faculty—exceeding the program's performance target of 1,510 by 59 percent. Results showed that the majority of students (73 percent) who received loans during the academic year were those pursuing doctoral level nursing degrees (e.g., PhD, DNP, or EdD). The majority of NFLP loan recipients were female (92 percent); between the ages of 40 and 59 (60 percent); and received a median loan amount of $10,855. Further analyses of data showed that 17 percent of students who received a loan reported coming from a disadvantaged background and about 1 out of every 4 students are considered underrepresented minorities. Of the 2,401 students who received a NFLP-funded loan, a total of 579 graduated from their degree programs by the end of academic year—exceeding the program's performance target. It is estimated that about 1 out of every 5 NFLP loan recipients who graduated is considered an underrepresented minority in the nursing profession.

Results indicated that 92 percent of graduates who are NFLP loan recipients intend to teach nursing. Further analysis showed that 47 percent of students who graduated in academic year 2012-2013 have obtained a full-time faculty appointment.

The number of schools that received new NFLP grant awards in FY 2013 was 103. While the performance target of 114 was not met, it is important to clarify that the number of schools receiving a new NFLP award does not equate to the number of schools providing NFLP loans to graduate-level nursing students. In order to receive a new NFLP award, schools must meet certain criteria with regard to available fund balances. However, even schools that do not receive new awards may continue giving out loans with the accounts they have already established. Therefore, although 103 schools received a NFLP award this academic year, 173 schools provided NFLP loans to nursing students in Academic Year 2013-2014.

Funding History

FY	Amount
FY 2012	$24,553,000
FY 2013	$23,256,000
FY 2014	$24,500,000
FY 2015	$26,500,000
FY 2016	$26,500,000

Budget Request

The FY 2016 Budget Request is $26,500,000. The FY 2016 Budget is the same as the FY 2015 Enacted level. This request will fund schools of nursing in establishing and operating loan funds that support 2,200 nurses training to become nurse faculty. In FY 2016, the program will continue to implement the redesigned approach that was started in FY 2015. The redesigned program focuses on better preparing students to teach and enables both tenure track and non-tenure track faculty to be eligible for loan forgiveness. The program will also continue its focus on efforts to increase the number of doctorally prepared nurse faculty.

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[126]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Number of graduate-level nursing students who received a loan[127]	2,401 Target: 1,510 (Target Exceeded)	2,200	2,200	Maintain
Number of loan recipients who graduated from an advanced nursing degree program[128]	579 Target: 275 (Target Exceeded)	275	275	Maintain
Percent of loan recipients who graduated from an advanced nursing degree program and obtained a full-time faculty appointment within 12	---	Set Baseline	TBD	---

[126] Most recent results are for Academic Year 2013-2014 and funded in FY 2013.
[127] The wording for this measure has been revised from previous budget documents to better reflect measures collected.
[128] The wording for this measure has been revised from previous budget documents to better reflect measures collected.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[126]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
months				
Number of schools receiving NFLP awards	103[129] Target: 114 (Target Not Met)	N/A[130]	N/A	---

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	93	114	114
Average Award	$250,000	$225,000	$225,000
Range of Awards	$5,000-3,167,000	$5,900-$2,550,000	$5,900-$2,550,000

[129] An additional 70 schools had sufficient loan funds from previous NFLP awards and did not request funds this year. A total of 173 schools gave NFLP awards to students.
[130] Measure will be discontinued in FY15.

Nursing Workforce Development

Comprehensive Geriatric Education

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$4,350,000	$4,500,000	$4,500,000	---
FTE	4	4	4	---

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

FY 2016 Authorization .....Expired FY 2014

Allocation Method ..... Cooperative Agreement

Program Goal and Description: This program provides support to train and educate individuals in providing geriatrics care for the elderly. Program goals are accomplished through curriculum development and dissemination, continuing education, and traineeships for individuals preparing for advanced nursing education degrees in geriatric nursing, long-term care, gero-psychiatric nursing or other nursing areas that specialize in the care of the elderly population.

In FY 2015, HRSA combined the Comprehensive Geriatric Education Program, Geriatrics Education Centers program, Geriatric Training for Physicians, Dentists, and Behavioral/Mental Health Professionals program, and the Geriatric Academic Career Awards programs into one competition, the Geriatric Workforce Enhancement Program, to improve health outcomes for older adults by integrating geriatrics with primary care, maximizing patient and family engagement, and transforming the healthcare system. Special emphasis is on providing the primary care workforce with the knowledge and skills needed to care for older adults and on collaborating with community partners to address gaps in health care through individual, system, community and population level changes. The program will support approximately 40 cooperative agreements. It is an expectation that health care professionals, such as nurses, will train and educate direct service workers, and lay and family caregivers, as well as provide significant levels of support and guidance to these individuals.

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.[131] More recent data from the Pew Research Center (2013) indicate that nearly half of all American adults expect to provide

[131] 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

care to their older parents at some point in their lives.[132] In addition, the Institute of Medicine[133] 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 2020 will reach 3,191,900. This represents an increase of approximately 70 percent in the growth of jobs available in these occupations between 2010 and 2020 and makes them among the fastest growing jobs in the country.[134]

The need for direct service workers does not obviate the need for health care professionals with expertise in geriatrics. Nurses with specialized training about older adults are instrumental in improving outcomes such as pain management, incidence of delirium, and functional status.[135] Advanced practice nurses are also associated with improved outcomes for older adults, such as lower rates of depression, urinary incontinence, and pressure ulcers.[136] Educating health care workers as team members, and supporting and educating family and lay caregivers, are expected competencies for this cadre of professionals.[137]

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

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee 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-

[132] Pew Research Center (2013). The Sandwich Generation: Rising Financial Burdens for Middle-Aged Americans. Pew Social Trends, Washington, D.C.
[133] Institute of Medicine (2008). Retooling for an Aging America: Building the Health Care Workforce. National Academies Press, Washington, DC.
[134] Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2012-13 Edition*, Home Health and Personal Care Aides, on the Internet at http://www.bls.gov/ooh/healthcare/home-health-and-personal-care-aides.htm (visited *May 22, 2012*).
[135] St. Pierre, J., & Twibell, R. (2012). Developing nurses' geriatric expertise through the geriatric resource nurse model. *Geriatric Nursing*, *33*(2), 140-149.
[136] Donald, F., Martin-Misener, R., Carter, N., Donald, E.E., Kaasalainen, S., Wickson-Griffiths, A., & Lloyd, M. (2013). A systematic review of the effectiveness of advanced practice nurses in long-term care. *Journal of Advanced Nursing*, *69*, 2148 – 2161.
[137] American Association of Colleges of Nursing. (2008). *The essentials of baccalaureate education for professional nursing*. Washington, D.C.: Author. AND (2011). *The essentials of master's education in nursing*.

Designated Health Professions:	Targeted Educational Levels:	Grantee Activities:
		psychiatric nursing or other nursing areas that specialize in the care of the elderly population.

Program Accomplishments: In Academic Year 2013-2014, the Comprehensive Geriatric Education Program (CGEP) supported numerous types of geriatric-related training programs and activities for health professions students and their faculty, as well as for community-based healthcare providers across the country. With regard to the continuing education (CE) of the current workforce, CGEP grantees offered more than 260 unique CE courses to more than 14,200 trainees across the health professions. These continuing education activities were primarily focused on emerging issues in the field of geriatrics (e.g., advances in geriatric medicine, palliative care, and healthy aging, among others).

Data were collected about other training-related activities that are required to be carried out through the CGEP. For example, CGEP grantees use funds to support traineeships for individuals who are preparing for advanced nursing degrees in geriatric nursing, long-term care, gero-psychiatric nursing or other nursing areas that specialize in the care of the elderly population. Results showed that CGEP grantees awarded traineeships to a total of 77 students—the majority of whom (70 percent) are pursuing a Master's Degree in Nursing to become Nurse Practitioners in the fields of Adult Gerontology or Acute Care in Adult Gerontology. It is estimated that the median award amount provided to students was $14,000 and that approximately one out of every four students who received a traineeship award is considered an underrepresented minority in their prospective profession. Finally, a majority of students received clinical training in a medically underserved community (62 percent) and/or a primary care setting (74 percent) during the academic year.

Grantees of the CGEP developed or enhanced and implemented more than 100 different geriatric-focused training activities to include new continuing education courses for current providers, as well as new academic courses and clinical rotations for health professions students, residents and fellows across the country focused on the treatment of health problems among the elderly. It is estimated that a total of 3,900 trainees were reached as a result of these activities. Lastly, grantees of the CGEP are also required to use funds to train faculty members in geriatrics. Results showed that CGEP grantees supported more than 80 different faculty development activities and programs. It is estimated that more than 1,450 faculty-level trainees were trained on emerging issues in the field of geriatrics (e.g., pain management among the elderly, advances in patient engagement, among others) as a result of these activities.

Funding History

FY	Amount
FY 2012	$4,485,000
FY 2013	$4,248,000
FY 2014	$4,350,000
FY 2015	$4,500,000
FY 2016	$4,500,000

Budget Request

The FY 2016 Budget Request is $4,500,000. The FY 2016 Budget is the same as the FY 2015 Enacted level. The Budget will provide grants to approximately 44 grantees seeking to improve high quality, interprofessional geriatric education and training as well as increase geriatrics competencies of primary care providers and other health professionals serving the geriatric community.

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[138]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Number of CGEP Grantees	12 Target: 16 (Target Not Met)	16	16	Maintain

Grant Awards Table[139]

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	18	---	---
Average Award	$218,000	---	---
Range of Awards	$126,000-$253,000	---	---

[138] Most recent results are for Academic Year 2013-2014 and funded in FY 2013.
[139] In FY 2015, the Geriatric Education Centers program, Geriatric Training for Physicians, Dentists and Behavioral and Mental Health Professionals program, Geriatric Academic Career Awards program and the Geriatric Education Center program were combined into a new program—the Geriatric Workforce Enhancement Program.

Nursing Workforce Development

NURSE Corps *(Formerly known as the Nursing Education Loan Repayment and Scholarship Program)*

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$79,785,000	$81,785,000	$81,785,000	---
FTE	32	32	32	---

Authorizing Legislation: Public Health Service Act, Section 846(a) as amended by Section 103, P.L. 107-205,Section 846(a), and Public Health Service Act, as amended by Section 5310, P.L. 111-148

FY 2016 Authorization ..... Expired

Allocation Method ..... Competitive Awards to Individuals

Program Goal and Description: In 2002, the Nurse Reinvestment Act amended Section 846 of the Public Health Service Act, adding the Nursing Scholarship Program to complement the established Nursing Education Loan Repayment Program. This section of the Nurse Reinvestment Act (Section 103) was referred to as the "National Nurse Service Corps" in the legislation. Reflecting the statute section title and goals of the program, NURSE Corps was chosen as the umbrella term referring to both loan repayment and scholarship programs. The programs formerly known as the Nursing Education Loan Repayment Program and the Nursing Scholarship Program were renamed and are now the NURSE Corps Loan Repayment Program and NURSE Corps Scholarship Program. This change in name does not reflect any changes in the program requirements or policies.

The NURSE Corps Loan Repayment Program (LRP) 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. NURSE Corps LRP 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 ACA amended the NURSE Corps LRP to extend loan repayment to nurse faculty. FY 2010 was the first year NURSE Corps LRP made awards to nurse faculty. These awards 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 NURSE Corps Scholarship Program (SP), formerly known as the Nursing Scholarship Program, 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 NURSE Corps SP award reduces the financial barrier to nursing education for all levels of professional nursing students, thus increasing the pipeline. A first funding preference is given to qualified applicants with the greatest financial need and who are enrolled full-time in an undergraduate nursing program or a Master's NP program.

Need: HRSA will continue to support the training of nurses at all levels to ensure an adequate supply of nurses across the country and, in particular, within underserved communities. By 2025, nursing projections show that 16 states will still have shortages in registered nurses and 22 states will have shortages in licensed practical/vocational nurses. Even in states with sufficient nurses overall, there will be a need for health care providers in underserved areas or for underserved populations. Emerging care delivery models will likely contribute to new growth in demand for nurses. The trends in nursing projections suggest that there is a greater need to focus on distribution and diversity in the RN and LPN workforce. NURSE Corps is well aligned with these goals and includes priorities and preferences for supporting nursing in rural and underserved areas and improving the diversity of the nursing field. NURSE Corps also supports the adoption of new, innovative models of practice and training. The Administration is committed to working with states, academic institutions, professional organizations, and other key stakeholders to address current and anticipated regional shortages of nurses.

Eligible Entities: U.S. citizens (either U.S. born or naturalized), U.S. Nationals or Lawful Permanent Residents with a current license to practice as a registered nurse and a bachelor's degree, a master's degree, an associate degree, a diploma, or a doctoral degree in professional nursing, is employed full time (at least 32 hours per week) at a public or private nonprofit Critical Shortage Facility or is employed full time at an accredited, public or private nonprofit school of nursing, has outstanding qualifying educational loans leading to a diploma or degree in nursing, and has completed the nursing education program for which the loan balance applies.

Program Accomplishments:
In FY 2014:

- NURSE Corps LRP made 667 new loan repayment awards (average award = $57,353) and 412 continuation awards (average award = $20,404).
- NURSE Corps SP made 242 new scholarship awards (average award = $92,289) and 13 continuation awards (average award = $32,937).

Funding History

FY	Amount
FY 2012	$83,135,000
FY 2013	$77,957,000
FY 2014	$79,785,000
FY 2015	$81,785,000
FY 2016	$81,785,000

Budget Request

The FY 2016 Budget Request is $81,785,000. The FY 2016 Budget is equal to the FY 2015 Enacted level. This request will fund 222 scholarship (new and continuation) and 920 loan repayment (new and continuation). This request will allow the program to maintain its efforts to address the anticipated demand for access to primary care services in Critical Shortage Facilities resulting from the implementation of the ACA.

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

The demand has intensified for nurses prepared in programs that emphasize leadership, patient education, case management, and care across a variety of delivery settings. The National Sample Survey of Nurse Practitioners report[140] indicates that more than a third of the NP workforce is over age 55 and likely to retire soon; however, there is a fair representation of younger NPs entering the workforce. However, there are still projected to be shortages of nurses in 16 states and even variations within states, which highlights the Nation's workforce distribution issues rather than production concerns.[141] Further, as the demand for primary health care services continues to grow as the population ages, NPs play a critical role in offering these services, as evidenced by many States expanding the role of these providers in recent years. The NURSE Corps is a part of the National strategy address the maldistribution issues across the nation, particularly in underserved communities.

To increase the number of NPs participating in the program, the NURSE Corps will actively recruit NPs through outreach efforts to colleges, universities and associations. In FY 2016, up to 50 percent of the NURSE Corps LRP and SP funding will be targeted to support NPs.

Funding for the NURSE Corps will continue to address the facilities with a critical shortage of nurses across the U.S. As a measurement of that effort:

In FY 2016:

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[140] U.S. Department of Health and Human Services, HRSA, NCHWA, Highlights From the 2012 National Sample Survey of Nurse Practitioners. (2014) Rockville, Maryland, http://bhpr.hrsa.gov/healthworkforce/supplydemand/nursing/nursepractitionersurvey/ Accessed December, 2014

[141] U.S. Department of Health and Human Services, HRSA, NCHWA, Future of the Nursing Workforce: National- and State-level Projections, 2012-2025. (2014) Rockville, Maryland, http://bhpr.hrsa.gov/healthworkforce/supplydemand/nursing/workforceprojections/index.html Accessed December, 2014

- NURSE Corps LRP expects to make 682 new loan repayment awards and 271 continuation awards.
- NURSE Corps SP expects to make 211 new scholarship awards and 21 continuation awards.

The NURSE Corps expects the cost of nursing education to continue to rise, increasing the average award, and thereby decreasing the total number of awards for the NURSE Corps within a given funding amount. This will decrease the number of RNs and APRNs the NURSE Corps can support in health care facilities with a critical shortage of nurses.

The NURSE Corps LRP and SP 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 facilities 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.

In FY 2016, the proportion of NURSE Corps LRP 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 percent.

Another measure of program performance is the number of NURSE Corps SP awards that are issued to participants pursuing a baccalaureate degree or advanced practice degree in nursing. This measure was initially developed in 2010 when the program only included undergraduate degrees in its first funding preference, resulting in a baccalaureate being the highest attainable degree in the first funding preference. In FY 2012, program shifted its focus to also include master's level Nurse Practitioners (NPs) in the first funding preference. As a result, the program is projecting that the proportion of NURSE Corps SP awardees obtaining their baccalaureate degree or advanced practice degree to be 85 percent in FY 2016. The program has created a new measure to reflect this programmatic shift to account for master's level NPs.

Table 1. Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
5.I.C.4: Proportion of NURSE Corps LRP participants who extend their service contracts to	FY 2013: 70% Target: 52%	52%	52%	Maintain

commit to work at a critical shortage facility for an additional year. *(Outcome)*	(Target Exceeded)			
5.I.C.5: Proportion of NURSE Corps LRP/SP participants retained in service at a critical shortage facility for at least one year beyond the completion of their NURSE Corps LRP/SP commitment.	FY 2014: 77% (Target Not Met)	80%	80%	Maintain
5.I.C.7: Proportion of NURSE Corps SP awardees obtaining their baccalaureate degree or advanced practice degree in nursing. *(Outcome)*	FY 2013: 93% Target: 80% (Target Exceeded)	85%	85%	Maintain
5.E.1: Default rate of NURSE Corps LRP and SP participants. *(Efficiency)*	FY 2013: LRP: 0.96% Target: 3% (Target Exceeded) SP: 8.7% Target: 15% (Target Exceeded)	LRP: 3% SP: 15%	LRP: 3% SP: 15%	Maintain

Table 2. Loans/Scholarships Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Loans	$47,991,600	$47,991,600	$47,991,600
Scholarships	$23,995,800	$23,995,800	$23,995,800

Table 3. NURSE Corps Awards, by program, FYs 2009-2016

AWARDS	2009	2010	2011	2012	2013	2014	2015	2016
Scholarships								
New – RN	189	458	395	134	148	152	134	128
New – APRN				99	91	90	88	83
Continuations – RN	15	18	17	31	20	9	11	13
Continuations - APRN					1	4	7	8
Loan Repayment								
New – RN	717	842	671	272	161	240	373	375
New – APRN	121	112	85	234	292	300	170	171
New – NF		185	163	214	127	126	135	136
Continuations – RN	147	115	314	533	470	210	155	149

AWARDS	2009	2010	2011	2012	2013	2014	2015	2016
Continuations - APRN	24	20	71	97	12	83	71	68
Continuations – NF				102	124	119	56	54
Total	**1213**	**1750**	**1716**	**1716**	**1,446**	**1,333**	**1,200**	**1,185**

*Key: **APRN**: Advanced Practice Registered Nurses; **NF**: Nurse Faculty; **RN**: Registered Nurses*

Table 4. NURSE Corps Field Strength, by program, FYs 2009-2016

FIELD STRENGTH[142]	2009	2010	2011	2012	2013	2014	2015	2016
Scholarship	285	252	282	475	558	458	245	200
Loan Repayment	1243	2112	2443	2592	2,001	1,510	1,449	1,565
Total	**1528**	**2364**	**2725**	**3067**	**2,559**	**1,986**	**1,765**	**1,765**

[142] Field Strength for FYs 2007-2010 are estimates. The NURSE Corps did not begin to capture field strength numbers until FY 2011.

Children's Hospitals Graduate Medical Education Payment Program

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$264,335,000	$265,000,000	$100,000,000	-$165,000,000
FTE	22	22	22	---

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

FY 2016 Authorization $300,000,000

Allocation Method ..... Formula Based Payment

Program Goal and Description: The Children's Hospitals Graduate Medical Education (CHGME) Payment Program supports graduate medical education (GME) in freestanding children's teaching hospitals. CHGME helps 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. It supports the training of residents who are either pediatric or pediatric subspecialty residents and enhances the supply of primary care and pediatric medical and surgical subspecialties. In FY 2014, the CHGME program was reauthorized for five years (FY 2014 through 2018) and program eligibility was expanded.

Need: Adequate residency training in pediatric care is important for residents who pursue a variety of specialties. Compared with other teaching hospitals, freestanding children's hospitals receive little to no GME funding from Medicare because children's hospitals have such a low Medicare caseload.

Eligible Entities: Freestanding children's teaching hospitals.

Designated Health Professions:	**Targeted Educational Levels:**	**Grantee Activities:**
• Pediatric • Pediatric medical subspecialties • Pediatric surgical subspecialties	• Graduate medical education	• Operate accredited graduate medical education programs for residents and fellows. • Submit an annual report on the status and expansion of GME in their institutions.

Program Accomplishments: In FY 2013, 54 children's hospitals received CHGME funding. Based on the most recent year for which performance information was reported, these children's hospitals reported being responsible for the training of 6,535 full-time equivalent (FTE) residents

on and off site.[143] Approximately 44 percent of the FTEs were pediatric residents, 29 percent were pediatric subspecialty residents, and 27 percent were non-pediatric residents such as family practice residents or cardiology residents rotating in children hospitals to learn about care of children in their respective areas of expertise.

Funding History

FY	Amount
FY 2012	$265,171,000
FY 2013	$251,166,000
FY 2014	$264,335,000
FY 2015	$265,000,000
FY 2016	$100,000,000

Budget Request

The FY 2016 Budget Request is $100,000,000 in discretionary funding. The FY 2016 Budget is $165,000,000 below the FY 2015 Enacted level. The request 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; costs 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. IME costs are not well-documented and studies indicate that they may be overstated in certain programs.[144] The FY 2016 funding request will support the FTE verification contract to ensure funded FTEs are not funded by other federal programs.

The funding request also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

[143] Each of the children's hospitals report the number of full-time equivalent residents trained during the latest filed (completed) Medicare Cost Report period.
[144] MedPac Report to Congress, June 10, 2010 Chapter 4. See: http://www.medpac.gov/chapters/Jun10_CH04.pdf

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[145]	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
7.I.A.1: Maintain the number of FTE residents training in eligible children's teaching hospitals	6,535 Target: 5,900 (Target Exceeded)	6,300	6,300	Maintain
7.VII.C.1: Percent of hospitals with verified FTE residents counts and caps	100% Target: 100% (Target Met)	100%	100%	100%
7.E: Percent of payments made on time	100% Target: 100% (Target Met)	100%	100%	100%

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	54	57	55
Average Award	$4,978,475	$4,649,000	$1,819,000
Range of Awards	$36,907-$20,463,507	$36,907-$20,463,507	$13,914-$7,714,742

[145] Most recent results are for Academic Year 2013-2014 and funded in FY 2013.

National Practitioner Data Bank

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Discretionary Collections	$27,456,000	$18,814,000	$19,728,000	+914,000
FTE	43	46	46	---

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 Patient Protection and Affordable Care Act of 2010, Public Law 111-148 (ACA).

FY 2016 Authorization ..... Indefinite

Allocation Method ..... User Fee Program

Program Goal and Description: The purpose of the National Practitioner Data Bank (NPDB) is to improve health care quality, promote patient safety, and deter fraud and abuse in the health care system by providing information about past adverse actions of practitioners, providers, or suppliers to authorized health care entities and agencies. The NPDB serves 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. Used in conjunction with information from other sources, the NPDB assists in promoting quality health care.

The NPDB is a web-based electronic reporting and querying system. Reports and queries can be submitted interactively on-line or via XML-based batch electronic file transfer. Credit card and Electronic Funds Transfer (EFT) transactions are securely processed using the U.S. Department of Treasury's Pay.gov service. The NPDB program supports HRSA Strategic Goal 1 (Improve access to quality health care and services), Subgoal D (Strengthen health systems to support the delivery of quality health services).

Need: The Nation must have ongoing protections to best ensure the safety and integrity of health care. To this end, State licensing boards, hospitals and other health care entities, and professional societies must be encouraged to identify and discipline those who engage in unprofessional behavior. The NPDB provides vital information to authorized users that impedes the ability of incompetent health care practitioners to move from State to State without discovery of previous substandard performance or unprofessional conduct. Further, the Data Bank is designed to reduce health care fraud and abuse by collecting and disclosing to authorized entities information on health care-related civil judgments and criminal convictions, adverse licensure

and certification actions, exclusions from health care programs, and other adjudicated actions taken against health care providers, suppliers, and practitioners.

Program Accomplishments:

In FY 2013, HRSA developed economic forecasting software to model estimated revenue under various fee scenarios. The software can calculate fees that balance income and expenses several years into the future. HRSA calculated a new fee schedule that keeps fee collections in balance with lower operating expenses. The new reduced fees were published in the Federal Register on April 18, 2014 with an effective date of October 1, 2014.

A new NPDB query fee structure was devised for implementation in FY 2015 which will:

- Simplify the pricing model;
- Promote greater NPDB query volume based on lower pricing; and,
- Achieve NPDB's revenue neutrality by optimizing the NPDB fee structure and achieving break-even status for NPDB operations.

The *State Adverse Action Comparison Project* was fully implemented. This Project focuses on optimizing reporting of adverse licensure and certification actions to the NPDB for the 12 most-queried professions (i.e., physicians, nurses, pharmacists, physician assistants, podiatrists, psychologists, social workers, dentists, chiropractors, optometrists, physical therapists, and behavioral health professionals). Entities that license health professionals in each State are evaluated on two-year cycles (a quarter of all States every six months) to ensure their compliance with NPDB reporting requirements.

The quantity and quality of reporting to the NPDB through rigorous State board compliance activities was increased.

NPDB system modules were streamlined to reduce reliance on paper, encourage self-service, reduce help desk volume, increase efficiency, and lower costs. Examples include:

- On-line registration renewals (94% reduction in paper for this process);
- Fully electronic self-queries (70% reduction in paper for this process); and
- Self-service password wizard (43% reduction in password-related help desk calls).

The NPDB system was upgraded to improve data integrity with point-of-entry data validation, standardization of professional school names, and geocoding. The impact of these changes is that Data Bank queriers now receive more accurate information for their hiring, licensing, and credentialing decisions.

Data Bank server hardware was upgraded to a secure FedRAMP cloud service, which will improve system performance and save an estimated $900,000 over the next three years.

Data visualization tools were enhanced to present summarized data on medical malpractice and adverse actions in new and interactive ways. These self-service tools are available to the public,

allowing researchers to create custom extracts of unique data sets. HRSA was awarded an HHS Entrepreneur project during FY 2014 to expand this effort with additional dashboards and geographic information system maps.

Funding History

The table below shows the user fees (revenue) collected (or expected to be collected) during the last five years:

FY	Amount
FY 2012	$29,242,584
FY 2013	$29,747,615
FY 2014	$27,456,000
FY 2015	$18,814,000
FY 2016	$19,728,000

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. User fees are established at a level to cover all program costs to allow the Data Bank to meet annual and long term program performance goals. Fees are established based on forecasts of 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 2016 is 6,411,000 queries on practitioners and organizations, and 99,000 self-queries. Under this estimated scenario, HRSA projects fee collections of $19,728,000.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
8.III.B.5: Increase the number of practitioners enrolled in Continuous Query (which is a subscription service for Data Bank queries that notifies them of new information on enrolled practitioners within one business day.)	FY 2013 Result: 1,524,696 Enrolled Practitioners FY 2013 Target: 1,074,000 Enrolled Practitioners (Target Exceeded)	1,675,000	1,750,000	+75,000
8.III.B.6: Increase annually the number of reports disclosed to health care organizations through Continuous Query.	FY 2013 Result: 15,348 Disclosures FY 2013 Target: 13,800 Disclosures (Target Exceeded)	21,000	22,000	+1,000

Maternal and Child Health Tab

MATERNAL AND CHILD HEALTH

Maternal and Child Health Block Grant

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$632,409,000	$637,000,000	$637,000,000	---
FTE	31	31	31	---

Authorizing Legislation - Title V of the Social Security Act

FY 2016 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. The federal Title V MCH Block Grant funds, combined with state investments, provide the most significant funding source to help reduce health disparities, improve access to health care, and improve the quality of health care for the MCH populations in 59 states and territories.

Specifically, the Title V program is mandated 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 infant sand children who are eligible for Title XIX (Medicaid).

The Title V Block Grant program at its core serves as the public health system within states aimed at improving the health of all mothers, children, and families through its support of multiple state and local MCH programs, health care systems, and providers. State Title V programs use their federal appropriated formula grants, which they are required to match with non-federal dollars, for the following types of activities: 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.

The Title V program is also the payer of last resort. In cases where no resources or services are available, States use Title V to fund direct care services, such as prenatal care, pediatric specialty care, or services for children with special health care needs. The majority of Title V dollars are used by States to fund services often times not covered by public or private health insurance, such as dental services, physical and occupational therapy, and durable medical equipment (e.g., wheelchairs, walkers and orthotics) with respect to Medicaid and the Children's Health Insurance Program (CHIP).

In an era of expanding health care coverage under the Patient Protection and Affordable Care Act (ACA), the MCH programs and services supported under the Title V Block Grant to the states and Title V's discretionary components, Special Projects of Regional and National Significance (SPRANS) and Community Integrated Service Systems (CISS), will serve to assure continuity of care and to reduce coverage gaps created by shifts in the insurance eligibility status of individuals.

Program Formula:

Funds are allotted to States based on a legislated formula which provides the amount allotted to each State in FY 1983, and when the amount available exceeds that level, the excess is distributed based on the States' proportion of children in poverty. Historically, the Title V Block Grant allocations to States 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, 3-year child poverty data from the ACS are being used for calculating the poverty-based portion of the annual State Title V Block Grant formula allocations. The State table reflects the use of 3-year ACS child poverty data, based on the 2011 3-year estimates released in October 2012 for the FY 2014 allocations. Planning estimates for FY 2015 are based on the 2012 3-year poverty estimates, and planning estimates for FY 2016 are based on the 2013 3-year poverty estimates that were released in October 2014. . Three-year estimates are used, as opposed to one- or five-year estimates, to strike a balance between timeliness and reliability.

Table 1. Maternal and Child Health Block Grant Activities ($ in thousands)

MCH Activities	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
State Block Grant Awards[146]	$545,259	$549,631	$549,631
SPRANS	$76,900	$77,093	$77,093
CISS	$10,250	$10,276	$10,276
Total	$632,409	$637,000	$637,000

Additional activities beyond the Title V Block Grant to States that support the improved health care of mothers and children are SPRANS and CISS.

SPRANS funds projects (through grants, contracts, and other mechanisms) in research, training, genetic services and newborn screening/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 eight 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;
- Operate MCH centers under the direction of not-for-profit hospitals;
- Increase system building for children from birth to three across states and territories in the areas of mitigating toxic stress, expanding developmental screening, and incorporating evidence based practices in early care and education quality improvement efforts;
- Promote evidence based practice in health and safety in early care and education settings;

[146] 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.

- 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 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
SPRANS	$66,072	$66,238	$66,238
SPRANS - Oral Health	$3,766	$3,775	$3,775
SPRANS – Epilepsy	$3,632	$3,642	$3,642
SPRANS - Sickle Cell	$2,954	$2,961	$2,961
SPRANS - Fetal Alcohol	$476	$477	$477
Total SPRANS	$76,900	$77,093	$77,093
CISS	$10,250	$10,276	$10,276

Under SPRANS, Congressional appropriations action has set-aside funds specifically for oral health, epilepsy, sickle cell and fetal alcohol.

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) building healthy communities; and
3) improving health equity

Accomplishments

As a long standing source of funding for MCH populations the Title V Program supports a wide range of services for millions of children annually. By working to improve access to quality health care and services, the Program was able to exceed the target for FY 2013 by serving 34.3 million children. Of the total number of children who received a Title V service in FY 2013, 14.9 million children had Medicaid and Child Health Insurance Program (CHIP) coverage. The number of children served by Title V with Medicaid/CHIP coverage was slightly less than the target of 15 million.

After years of steady increases, the number of children served by the Title V MCH Block Grant Program has fluctuated since 2008. Totals have ranged between 33.3 million in FY 2009 and 37.4 million in FY 2011. The total reported for FY 2011 represents the largest number of children served by the Program since data collection began in the Title V Information System in the 1990s. Approximately 1.6 million fewer children were served by the MCH Block Grant Program in FY 2013 than in FY 2012. At the same time, the number of children served by Title

V who had Medicaid/CHIP coverage increased by approximately 700,000. The number of children served by the Program who had Medicaid and CHIP coverage in FY 2012 (14.2 million) was the lowest reported level since FY 2007. Annual fluctuations in the number of screening services provided to children, an increasing focus on the delivery of population-based services, and changes in funding environments, at federal, state and local levels, were likely contributors to the reporting of fewer children served by the Program in FY 2013. Despite this decrease, the number of children served in FY 2013 reflects an increase of more than 28 million over the FY 2002 baseline of 5.9 million. Increased coverage under Medicaid and CHIP for children receiving Title V services assures better access, availability, and continuity of care to a wide range of preventive and acute care services.

Transformation in Progress

The Maternal and Child Health Bureau (MCHB) initiated efforts to transform the Title V MCH Block Grant to States program in 2013 for the purpose of ensuring its continued effectiveness and readiness to respond to current and future needs facing the Nation's mothers and children, including CSHCN.

The proposed new framework, which will be implemented by States beginning with the submission of their FY 2016 Applications, aims to: 1) reduce burden to States and territories; 2) maintain State flexibility; and 3) improve accountability. This transformation will bring major revisions to the National Performance Measures (NPMs) in the Block Grant to States program. These revisions are intended to enhance the ability of States to demonstrate the impact and value of this investment in improving MCH outcomes within a State as well as to tell a national story about the impact of Title V funding across the country.

One area of focus in revising the National measures is for the federal Title V program to assume lead responsibility in ensuring that each measure has a national data source, which will allow for measurement that is timely, reliable and valid. In addition to increasing accountability, the new NPMs are intended to track areas where State Title V programs can demonstrate the impact of their MCH Block Grant investments. Further information regarding the transformation of the MCH Services Block Grant can be accessed at http://mchb.hrsa.gov/blockgrant/index.html.

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 compared to the White infant mortality rate decreased from 2.4:1 to 2.24:1 from 2002 to 2010. While the infant mortality rate did not change significantly for white infants between 2009 and 2010, there was an 8.0 percent decrease for black infants. Final data (most current) for 2012 indicate that the ratio of black-to-white infant mortality rates at 2.2:1 has not changed significantly since 2010.[147]

The infant mortality rate is a widely used indicator of the Nation's health. The State 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

[147] National Vital Statistics Reports

the rate having decreased from 9.2 per 1,000 live births in 1990 to 6.0 per 1,000 live births in 2012. Between 2011 and 2012, the infant mortality rate decreased 1.5 percent from 6.07 infant deaths per 1,000 live births to a historic low of 5.98 infant deaths per 1,000 live births. [147]

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), CityMatCH, the March of Dimes (MOD) and other non-Federal/Federal partners, including the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS), to support a Collaborative Improvement and Innovation Network (CoIIN) to reduce infant mortality. The Infant Mortality CoIIN was launched in the U.S. Department of Health and Human Services' (HHS) Region IV and Region VI States in FY 2012 and in Region V in FY 2013. Expansion of the Infant Mortality CoIIN to the remaining HHS Regions occurred in FY 2014 and was supported by a cooperative agreement with the National Institute for Children's Health Quality (NICHQ); it also included support through HRSA's Healthy Start program which is referenced below.

States have long been engaged in activities to reduce infant mortality and to address the disparities that exist among racial groups relative to birth outcomes. The CoIIN provides an opportunity to move beyond the traditional dissemination of information, by engaging self-motivated participants from multiple settings in the full spectrum of change implementation – from defining the problem, to crafting an intervention, to implementation and evaluation and, finally, to the diffusion and adaptation of effective innovations in new settings. Key elements of a CoIIN include: 1) reliance on distance-based technology for almost all Team activities; 2) expectation of transparency and rapid, on-going communication across all levels of the Team with its members being part of the solution; and 3) commitment to sharing and using "real time" data to drive improvement and decision making. The CoIIN is designed to facilitate collaborative learning and the adoption of proven quality improvement principles and practices among participating States to reduce infant mortality and improve birth outcomes.

In FY 2015, the CoIIN moved from a Regional to a national approach, and States identified the following six strategic priority topic areas to reduce infant mortality and improve birth outcomes:

1. **SIDS/SUID/Safe Sleep**
   Primary focus is to improve safe sleep practices

2. **Smoking Cessation**
   Primary focus is to reduce smoking before, during and/or after pregnancy

3. **Preconception/Interconception Health**
   Primary focus is to promote healthy birth spacing and reduce unintended pregnancy, including focus on Postpartum Visits (content and frequency), Adolescent Well Visits (content and frequency) and Long Acting Reversible Contraception (LARC)

4. **Prevention of Preterm and Early Term Births**
   Primary focus is to increase appropriate utilization of 17 OH progesterone, a drug used to prevent preterm birth and/or reduce early elective deliveries

5. **Risk Appropriate Perinatal Care (Perinatal Regionalization)**
   Primary focus is to increase the delivery of higher risk infants and mothers at appropriate level facility

6. **Social Determinants of Health**
   Primary focus is to incorporate evidence-based policies/programs and place-based strategies to improve social determinants of health and equity in birth outcomes

Comprised of representatives from various States from across all of the ten HHS Regions, each of the six "Learning Networks" that are focused on the priority topics mentioned above is supported by content, data, and methods experts in addition to support staff from NICHQ and partner organizations. State representatives in each of the CoIIN Learning Networks include individuals in leadership positions within their State and the Regions as a whole, such as Title V Directors, State Health Officials, Medicaid Directors, representatives from the Governor's office, academics, researchers, consumer/family representatives, and other Federal partners.

Results in Regions IV and VI after two years of participation in the infant mortality CoIIN showed there has been a three percent decline in infant mortality overall, and a seven percent decline for non-Hispanic Blacks. This represented a decline of 14 percent in the black-white disparity. Looking at State-level detail, seven out of the 13 States had overall declines in infant mortality, and three States had declines of 10 percent or more. Six States reduced the black-white disparity by 25 percent or more. In addition, data from the CoIIN Strategy Teams of Region IV and Region VI showed a 29 percent total decline in non-medically indicated early term deliveries, translating to approximately 85,000 early elective deliveries averted since 2011. Furthermore, Regions IV and VI saw about a 12 percent total decline in smoking during pregnancy across the two Regions, translating to approximately 17,000 fewer women smoking in pregnancy since 2011.

While not all of this decline could be attributed to the CoIIN, this effort provides a platform and infrastructure for collaborative learning and innovation, strong leadership at many levels and increased partnerships, which accelerates and sustains improvement in these strategy areas across the two Regions.

Opportunities to Reduce Infant Mortality among Infants Born Preterm and/or Low Birth Weight

The MCHB continues to explore and promote evidence-based practices that reduce the incidence and better understand the causes of low birth weight. Nationally, the rate of low birth weight among infants (less than 2500 grams) steadily increased between 2002 and 2006 from 7.8 percent to 8.3 percent. Starting in 2007 this trend began to reverse largely due to reductions in the number of infants who were delivered at moderately low birth weight (i.e., 1500 - 2499 grams). The rate of low birth weight slightly increased again from 7.99 percent in 2012 to 8.02 percent in 2013.

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. Assuring 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 a reduced risk of mortality. The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates increased annually between FY 2004 (71.7 percent) and FY 2009 (77.3 percent.) Despite a decrease in FY 2010 to 74.5 percent, the percent of very low birth weight infants delivered in risk-appropriate care facilities reached the highest reported level (80.0 percent) in FY 2012 since States began reporting on this measure in the 1990s.

The Bureau continues to work with the States on prevention of, and appropriate care of, preterm and early term births and low birth weight infants. One strategy is to monitor and better understand the factors that contribute to risk appropriate care for very low birth weight infants. One of the Strategy Teams within the Region IV and Region VI infant mortality CoIIN was focused on increasing the percent of mothers who delivered very low birth weight infants at appropriate level of care facilities to 90 percent. This would be a 20 percent increase above baseline in the Region IV and Region VI States. The Region IV and Region VI Perinatal Regionalization CoIIN Strategy Team, which consisted of State Health Officers, Medicaid Directors, physician organizations, MCH Directors, community leaders and many others, engaged in a 24-month collaborative effort to identify or develop and implement strategies for increasing appropriate maternal and neonatal care in the 13 southern States.

Establishing a comprehensive prenatal and perinatal care system has helped to ensure that very low birth weight infants are delivered in risk-appropriate care facilities. The Federal Title V Program partnered with CDC and AMCHP to publish an article in the December 22, 2010 issue of the Maternal and Child Health Journal, examining State measures of risk-appropriate care for very low birth weight infants and identified potential areas for improvement. State regionalization models (concept of organizing comprehensive prenatal and perinatal care systems across a geographic region) 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 actions reported by the States included antenatal or neonatal transfer arrangements, telemedicine networks, acquisition of funding, provision of financial incentives, and patient education.

The Region IV and Region VI Perinatal Regionalization CoIIN Strategy Team mentioned above engaged national, state and local leaders (e.g., American Congress of Obstetricians and Gynecologists [ACOG], American Academy of Pediatrics [AAP], State Medicaid and hospital associations) to advocate for changes in perinatal regionalization with a focus on adoption of the 2012 AAP guidelines for risk-appropriate care. States also met with a subset of their hospitals to review hospital-level data on very low birth weight infants born in their facilities and to discuss options for improvement, i.e. develop transport systems, increase hospital reimbursement for antenatal care and transport. Key achievements for the team were identifying a short menu of specific strategies for implementation by all Region IV and Region VI states, active engagement

of all 13 states in peer learning, and development of a simple hospital assessment tool that examines equipment, personnel, and/or capacity to handle high risk births/deliveries.

In FY 2015, moving to a regionalized approach to perinatal care remains a priority strategy area as the infant mortality CoIIN expands nationally and as States continue to identify and share best practices, lessons learned, and strategies for improvement.

In the area of preventing low birth weight, the Bureau works with States on reducing smoking during pregnancy. This topic area remains a focus of the infant mortality CoIIN as it expands in FY 2015. Results among the States in Region IV and Region VI after two years of participating in the CoIIN showed about a 12 percent total decline in smoking during pregnancy, translating to approximately 17,000 fewer women smoking in pregnancy since 2011.

In addition, strategies to prevent preterm and early term births, such as reducing non-medically indicated early elective deliveries at <39 weeks and increasing access and appropriate use of 17 OH progesterone, are a focus of the States and supported through the Bureau in the national infant mortality CoIIN. Results among the States of Regions IV and VI after two years of participating in the CoIIN showed about 29 percent total decline in non-medically indicated early term deliveries, translating to approximately 85,000 early, elective deliveries averted since 2011.

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 have historically been derived from the 1989 and the 2003 Revisions of the U.S. Standard Certificate of Live Birth. Substantive changes were made to the 2003 Certificate in how states report on the timing of prenatal care. Compared to the 1989 unrevised certificate, prenatal care data based on the 2003 revised certificate has shown a less favorable picture of prenatal care utilization in the U.S. However, most of the noted decrease can be attributed to changes in reporting rather than to actual changes in prenatal care utilization.

The staggered implementation of the 2003 revised birth certificates by States has impacted the availability of current prenatal care utilization data. Based on the 2013 Natality Public Use file, almost three-fourths of women began care within the first 3 months of pregnancy. Representing approximately 90 percent of all U.S. births, these data reflect the revised birth certificate assessment of prenatal care timing from 41 States and the District of Columbia. Early initiation into prenatal care was less common among Black and Hispanic women compared with White women. Prevalence of diabetes, obesity and pregnancy-induced hypertension during pregnancy has also been increasing nationally. There is a need for States to continue to monitor such risk factors and to assure the provision of timely and appropriate prenatal care.

In addition to their participation in the infant mortality CoIIN Learning Networks, State Title V programs work with other Federal, State and local partners to promote access to early prenatal care. These efforts include coordinating/linkage with Medicaid programs to streamline access to early prenatal care for pregnant women, providing support for outreach and case management services to improve access and entry into early prenatal care, establishing collaborative relationships with State and local resources (e.g., Healthy Start coalitions, Home Visiting programs, WIC services and Family Planning Programs), developing and implementing perinatal

collaboratives/quality improvement initiatives and working to reduce access to care barriers and improve disparities in early enrollment in prenatal care.

Building State MCH Data Capacity

The MCHB continues to work with the State Title V programs to expand their MCH data capacity and to provide needed technical support for addressing the performance and programmatic requirements of the Title V MCH Block Grant. Since 2003, the Title V Information System (TVIS) has provided a Web-based interface for the submission of the State Title V MCH Program annual applications and reports. Integrated with HRSA's grants management system (the HRSA Electronic Handbooks (EHB)), the TVIS makes available to the public, through its web reports, the key financial, program, performance, and health indicator data reported by States.

Changes in the nation's public health care systems, population demographics, health care financing systems and information technology have created new opportunities for improving access to health care and delivering quality public health services to the nation's MCH population. In capitalizing on these opportunities and in an effort to promote continued transformation and quality improvement in the MCH Block Grant to States program, MCHB is in the process of re-designing its performance measure framework. The revised performance measure framework is intended to enable States in their yearly applications/annual reports to more directly reflect on the contributions of their Title V programs in impacting public health outcomes for the MCH population. States will begin implementing the new performance measure framework in conjunction with the reporting on their 2015 Needs Assessments as part of their FY 2016 Applications.

MCHB regularly provides technical support to the States around the priorities identified in their comprehensive five-year needs assessments and other areas of requested technical assistance. State requests for technical assistance have frequently focused on such programmatic areas as health disparities and healthy perinatal/birth outcomes. In anticipation of the implementation of the ACA in 2010, States increasingly have requested technical assistance to assess potential impact on MCH populations and the delivery of Title V services. Building on a history of continuous re-evaluation of MCH population needs, State Title V programs are making needed transitions to support the building of new infrastructures that will help to ensure the efficiency and effectiveness of the ACA by better leveraging existing resources, addressing gaps in services delivery and promoting optimal health outcomes for all MCH populations.

Early Childhood Comprehensive Systems

The purpose of the Early Childhood Comprehensive Systems program (ECCS), funded out of CISS funding, is to assist States and territories in addressing gaps in age-appropriate preventive health services and consistent positive early childhood developmental experiences for all children. By addressing gaps in early childhood development screening and prevention and treatment services, the ECCS program is working to increase the percentage of children across the Nation who are healthy and ready to learn upon school entry. In FYs 2013 - 2015, ECCS grants were awarded not only to State/Territorial Maternal and Child Health agencies but also to other State agencies, such as State Departments of Education and non-profit organizations that

focus on early childhood learning and development. The program also addresses gaps in early childhood development services by improving coordination among multiple, but historically non-integrated state funding streams for early childhood services and increasing the integration of early childhood service systems at the State and community levels.

In FY 2015, 53 States and Territories/Jurisdictions are funded. Grantees could choose from among the following three strategies to further their systems work: 1) Mitigating toxic stress (25 states); 2) Expand developmental screening in the State/Territory (19 states); and 3) Incorporate evidence based standards to improve the quality of child care (9 states). In FY 2015, the ECCS program is being analyzed and redesigned to ensure that States are integrating their coordinated system of State/local health, medical, and social service programs with the Home Visiting program using quality improvement approaches.

Child Care Health and Safety

Building on 20 years of MCHB support for the improvement of the health and safety of children who attend child care/early care and education settings, HRSA is planning to combine two National Centers (one from MCHB and one from ACF) into one in 2015. This new National Center for Early Childhood Health and Wellness will develop resources on evidenced based research and best practices in the pediatric health and early childhood education fields, provide technical assistance, and promote best practices for building health and wellness and supporting school readiness for the youngest children. The Center will provide targeted technical assistance to early childhood education programs (i.e., Head Start and Early Head Start agencies, state/tribal and territory child care agencies, other early care and education settings) and establish best practices for the coordination, communication and collaborations between child health professionals (i.e., pediatricians, family practitioners, nurse practitioners, etc.) and these programs. These activities are designed to ensure that children have access to health services and are cared for in safe, nurturing out-of-home early care and education settings. These settings seek to that promote their social/emotional and behavioral health, nutritional and physical development.

Title V continues to be a primary source of support for ensuring the health and well-being of the nation's MCH population. While the ACA has provided improved coverage of health care services for a greater percentage of the MCH population, Title V remains an essential source of support for the States' public health infrastructure in providing for care coordination and case management and other MCH population-based services, such as preconception care, oral health, newborn screening, Birth Defects Registry and Child Death Reviews. The Title V Block Grant program plays a lead role in improving access to and quality of preventive services for women, children, and adolescents, promoting perinatal regionalization, safe sleep, breastfeeding, oral health, and physical activities, supporting children and youth with special healthcare needs, and reducing preventable injuries, bullying, and exposure to smoking among pregnant women and children.

Funding History

FY	Amount
FY 2007	$693,000,000
FY 2008	$666,155,000[148]
FY 2009	$662,121,000[149]
FY 2010	$660,710,000
FY 2011	$656,319,000
FY 2012	$638,646,000
FY 2013	$604,917,000
FY 2014	$632,409,000
FY 2015	$637,000,000
FY 2016	$637,000,000

Budget Request

The FY 2016 Budget Request is $637,000,000. The FY 2016 Request is the same as the FY 2015 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 budget request will help State Title V programs support capacity and infrastructure building, population-based and enabling services, as well as the provision of 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.

The FY 2016 targets for the number of children served by the Title V Block Grant and the number of children receiving Title V services who are enrolled in and have Medicaid and CHIP coverage are 34 million and 15 million, respectively. For the rate of infant mortality, the FY 2016 target is 5.8 per 1,000 births. The FY 2016 targets were set based on the reported levels of performance for FY 2012, which were the most currently available program data at the time that the targets were established. While there was a decline in performance between FY 2011 and FY 2012, the targets were increased for FY 2016 to better reflect the current levels of performance.

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: collaborative and quality improvement efforts in MCH programs. SPRANS and CISS both complement and help ensure the success of State Title V, Medicaid, and CHIP programs, building community capacity

[148] Reflects moving $20 million to the Autism and Other Developmental Disorders Program.
[149] Reflects moving $6.9 million to the Newborn Screening for Heritable Disorders Program.

to create family-centered, integrated systems of care for mothers and children, including children with special healthcare needs.

CISS will continue to fund the Early Childhood Comprehensive Systems Program to assist States and territories in their efforts to build and implement Statewide Early Childhood Systems that support families and communities in developing children who are healthy and ready to learn at school entry. There will be a focus on integration with state home visiting programs. CISS will also continue to fund the ACF/HRSA National Center for Early Childhood Health and Wellness which will create resources, provide technical assistance, and promote best practices for building health and wellness and supporting school readiness for the youngest children.

In addition, Title V funds the only statutorily required genetic services program. This program funds initiatives to facilitate the adoption of genomic advances into clinical care and public health systems to improve the health of the population.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
10.I.A.1: The number of children served by the Maternal and Child Health Block Grant *(Output)*	FY 2013: 34.3M Target: 30M (Target Exceeded)	32M	34M	+2M
10.I.A.2: Increase the number of children receiving Maternal and Child Health Block Grant services who are enrolled in and have Medicaid and CHIP coverage *(Output)*	FY 2013: 14.9M Target: 15M (Target Not Met)	14.5M	15M	+0.5M

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 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
10.IV.B.1: Decrease the ratio of the Black infant mortality rate to the White infant mortality rate *(Output)*	FY 2012: 2.2 to 1[150] Target: 2.1 to 1 (Target Not Met)	2.1 to 1	2.0 to 1	-0.1

Long Term Objective: Promote effectiveness of healthcare services.

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
10.III.A.1: Reduce the infant mortality rate (Baseline - 2005: 6.9/1,000) *(Outcome)*	FY 2012: 6.0 per 1,000[151] Target: 6.6 per 1,000 (Target Exceeded)	6.0 per 1,000	5.8 per 1,000	-0.2 per 1,000
10.III.A.2: Reduce the incidence of low birth weight births *(Outcome)*	FY 2013:[152] 8.0% Target: 8.1% (Target Exceeded)	8.0%	7.8%	-0.2% point
10.III.A.3: Increase percent of pregnant women who received prenatal care in the first trimester *(Outcome)* (New Baseline- FY 2006: 69%)[153]	FY 2013: 74.2%[154] Target: 71% (Target Exceeded)	73%	76%	+3% point

[150] Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC). Deaths: Final Data for 2012, National Vital Statistics Reports, Vol. 63, No. 9,.
[151] Vital Statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC). Mortality in the United States, 2012. NCHS Data Brief, No.168, October 2014.
[152] Detailed Technical Notes prepared by the National Center for Health Statistics, Centers for Disease Control and Prevention. User Guide to the 2013 Natality Public Use File.
[153] A new FY 2006 baseline was established for this measure based on the use of the 2003 Revised U.S. Standard Birth Certificate.
[154] Detailed Technical Notes prepared by the National Center for Health Statistics, Centers for Disease Control and Prevention. User Guide to the 2013 Natality Public Use File.

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
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 2012: 80.0%[155] Target: 76% (Target Exceeded)	77%	80%	+3% point
10.3: Increase maternal survival rate (deaths/100,000 live births) *(Outcome)*[156]	FY 2007: 12.7 per 100,000[157]	13.1 per 100,000	N/A	N/A

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	59	59	59
Average Award	$9,094,176	$9,136,466	$9,136,466
Range of Awards	$144,871 - $38,295,099	$145,545 - $38,843,420	$145,545 - $38,978,495

[155] Source: Title V Information System, HRSA/MCHB (https://mchdata.hrsa.gov/TVISReports).
[156] This is a long-term measure with no annual targets.
[157] 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.

State Table

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
	FY 2014 Estimate[158]	FY 2015 Estimate[159]	FY 2016 Estimate[160]	Difference +/- 2015
Alabama	11,257,910	11,301,519	11,251,852	-49,667
Alaska	1,050,528	1,056,279	1,051,258	-5,021
Arizona	7,129,955	7,215,984	7,269,079	53,095
Arkansas	6,885,834	6,887,383	6,889,931	2,548
California	38,295,099	38,843,420	38,978,495	135,075
Colorado	7,430,330	7,451,143	7,439,177	-11,966
Connecticut	4,580,696	4,608,115	4,620,176	12,061
Delaware	1,968,990	1,959,443	1,957,829	-1,614
District of Columbia	6,907,278	6,897,858	6,895,015	-2,843
Florida	18,838,298	19,086,474	19,166,381	79,907
Georgia	16,611,128	16,809,482	16,851,715	42,233
Hawaii	2,156,997	2,174,459	2,167,385	-7,074
Idaho	3,239,672	3,269,252	3,257,365	-11,887
Illinois	21,086,346	21,141,333	21,147,239	5,906
Indiana	12,146,218	12,185,624	12,195,929	10,305
Iowa	6,511,706	6,497,909	6,492,264	-5,645
Kansas	4,736,507	4,752,026	4,750,948	-1,078
Kentucky	11,029,949	11,022,748	10,978,859	-43,889
Louisiana	11,986,827	12,052,729	12,052,388	-341
Maine	3,304,042	3,319,295	3,309,536	-9,759
Maryland	11,610,475	11,653,420	11,677,310	23,890
Massachusetts	10,960,440	11,000,039	11,036,307	36,268
Michigan	18,873,669	18,914,225	18,847,325	-66,900
Minnesota	9,099,446	9,088,789	9,049,110	-39,679
Mississippi	9,177,718	9,207,650	9,183,061	-24,589
Missouri	12,099,814	12,109,514	12,125,939	16,425
Montana	2,284,817	2,279,345	2,283,339	3,994
Nebraska	3,982,922	4,006,966	3,996,665	-10,301
Nevada	1,998,800	2,078,345	2,070,405	-7,940
New Hampshire	1,962,851	1,984,555	1,978,119	-6,436

[158] Based on ACS 2011 3-year poverty data.
[159] Based on ACS 2012 3-year poverty data.
[160] Based on ACS 2013 3-year poverty data.

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
	FY 2014 Estimate[158]	FY 2015 Estimate[159]	FY 2016 Estimate[160]	Difference +/- 2015
New Jersey	11,264,791	11,311,988	11,399,033	87,045
New Mexico	4,048,292	4,068,379	4,062,914	-5,465
New York	37,530,701	37,661,289	37,741,170	79,881
North Carolina	17,130,221	17,252,422	17,235,144	-17,278
North Dakota	1,733,663	1,733,099	1,726,867	-6,232
Ohio	22,088,265	22,065,655	21,973,462	-92,193
Oklahoma	6,964,925	6,977,455	6,960,706	-16,749
Oregon	6,192,746	6,252,155	6,231,571	-20,584
Pennsylvania	23,442,305	23,504,281	23,475,870	-28,411
Rhode Island	1,626,757	1,630,185	1,635,642	5,457
South Carolina	11,375,247	11,392,214	11,403,320	11,106
South Dakota	2,144,111	2,140,225	2,147,981	7,756
Tennessee	11,669,610	11,680,662	11,684,254	3,592
Texas	33,850,560	33,984,138	33,906,884	-77,254
Utah	6,123,558	6,174,629	6,161,802	-12,827
Vermont	1,646,142	1,648,819	1,641,668	-7,151
Virginia	12,025,842	12,060,536	12,084,127	23,591
Washington	8,774,366	8,833,309	8,830,870	-2,439
West Virginia	6,053,034	6,051,811	6,053,797	1,986
Wisconsin	10,886,236	10,890,870	10,843,651	-47,219
Wyoming	1,200,795	1,212,033	1,210,343	-1,690
SUBTOTAL	**516,977,429**	**519,381,477**	**519,381,477**	**0**
American Samoa	482,901	485,146	485,146	0
Guam	745,814	749,282	749,282	0
Marshalls	225,352	226,400	226,400	0
Micronesia	509,729	512,100	512,100	0
Northern Marianas	456,074	458,194	458,194	0
Palau	144,871	145,545	145,545	0
Puerto Rico	15,549,404	15,621,712	15,621,712	0
Virgin Islands	1,464,800	1,471,611	1,471,611	0
SUBTOTAL	**19,578,945**	**19,669,990**	**19,669,990**	**0**
TOTAL Resources	**536,556,374**	**539,051,467**	**539,051,467**	**0**

Autism and Other Developmental Disabilities

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$47,099,000	$47,099,000	$47,099,000	---
FTE	7	7	7	---

Authorizing Legislation - Section 399BB of the Public Health Service Act.

FY 2016 Authorization ..... $48 million

Allocation Methods:

- Direct Federal/intramural
- Contract
- Competitive grant/co-operative agreement
- Other

Program Description and Accomplishments

This Program supports activities to:

- provide information and education on autism spectrum disorders (ASD) and other developmental disabilities (DD) 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 professionals who are able to confirm or rule out a diagnosis of autism spectrum disorders and other developmental disabilities; and

- increase the number of professionals able to provide evidence-based interventions for individuals diagnosed with autism spectrum disorder or other developmental disabilities.

In 2014, the Act was reauthorized as the Autism Collaboration, Accountability, Research, Education and Support Act, or, Autism CARES Act. The FY 2015 budget will support 43 Leadership Education in Neurodevelopmental and Related Disabilities (LEND) interdisciplinary training programs, providing services and training to 37 States, with many extending training and services across multiple States; 10 Developmental-Behavioral Pediatrics (DBP) training programs;

5 research networks and 13 autism intervention research projects to improve the health and well-being of children and adolescents with ASD and other developmental and to advance best practices for early identification and treatment of autism and related developmental disabilities including areas of particular interest to families and many addressing the needs of underserved populations; 9 State systems grants providing support to improve the system of health care including early identification and coordination of care; 2 resource centers; and a national evaluation. All activities continue to be coordinated with the CDC's activities and with priorities of the Interagency Autism Coordinating Committee (IACC).

Progress Report – Selected Findings

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 have expanded the number of professionals in the pipeline to provide these services. In addition, these training programs increased the number of children who received diagnostic evaluations.

- From FY 2009-2013, these programs have collectively trained over 6,400 pediatricians, developmental-behavioral pediatrics specialists, and other health professionals.
- They have provided more than 3,400 continuing education events (reaching over 306,000) and more than 9,200 outreach trainings (reaching over 285,000) to community pediatricians and other health professionals on early screening, early diagnosis, and early intervention.
- In all, over 224,000 children received diagnostic evaluations from these programs between FY 2009-2013.

Research

Research grantees (both research networks and investigator-initiated autism intervention research projects) conduct studies to advance the evidence base on effective interventions to improve the health and well-being of children and adolescents with ASD and other DD, with many studies addressing the unique and unaddressed needs of underserved populations by considering ethnic/racial, cultural, linguistic, socioeconomic, literacy and geographic (e.g., rural/urban) diversity of individuals. Other achievements include development of consensus-based guidelines to support families and professionals in providing treatment for children with ASD and development and validation of tools for use by providers, researchers, and families. To date, over one hundred manuscripts have been published by the research grantees.

State Systems Grants

State systems grants are designed to improve access to comprehensive, coordinated health care and related services for children and youth with ASD and other DDs. The program facilitates improved state systems of services and the implementation of activities focused on improving early and continuous screening, coordination of family-centered services through a medical home, and increasing ASD/DD awareness with parents and professionals. Through the state systems program, grantees promote access to a comprehensive system of services by: 1)

Conducting comprehensive statewide needs assessments and aligning project goals to needs; 2) Building coalitions with stakeholders (such as State public health and mental health programs, American Academy of Pediatrics, education agencies, family support and advocacy groups, provider groups, community-based organization, etc.) to increase awareness and promote improved policies and the organization of services that support early identification and access to care; 3) Implementing practice level interventions, data tracking, and statewide dissemination of successful practice improvement strategies through coalition partners/stakeholders; and 4) Promoting awareness of the signs and symptoms of ASD/DDs by disseminating messages about ASD through various media outlets, including film events, radio and televised public service announcements, and library campaigns. They also develop web sites and web portals for online dissemination of ASD materials in addition to disseminating screening kits, autism toolkits, as well as print materials and resources to providers and families. According to a 2012 systematic review of screening interventions, those most successful tended to emphasize collaborative learning, office-systems changes, and tracking progress over time. These three areas are core components of the state systems program.[161] Future grants to states will also focus on using innovative models, including telehealth, to improve identification and treatment of autism spectrum disorders, particularly in minority and rural communities.

GAO Review: In calendar year 2012, the GAO reviewed HRSA's oversight of the Combating Autism Act programs. On February 27, 2013, the GAO released its report entitled: "Combating Autism Act: HHS Agencies Responded with New and Continuing Activities, Including Oversight." There were no recommendations from the GAO review, and the full report is available here: http://www.gao.gov/products/GAO-13-232.

Report to Congress: In October 2013, HRSA submitted a detailed account of HRSA's progress on its autism activities from 2008-2011 in a Report to Congress titled: Results of the Combating Autism Act Initiative: HRSA's Efforts to Improve ASD Service Delivery Through Research, Training, and State Implementation Grants Fiscal Year(s) 2008-2011. A Report to Congress with findings through 2012 was submitted to the National Institute of Mental Health (NIMH) in September 2013. A new HRSA study starting with investments from September 30, 2011 to present is currently underway and contributed to the HHS 2013 Report to Congress. Selected findings from the completed evaluation are presented here.

Reducing Barriers

An early indication of progress toward the goal of reducing barriers to ASD services is evidenced by reported increases in the number of children that received diagnostic evaluations over the course of the grant period provide. In 2009–2010, the 39 LEND grantees 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. From FY 2009-2013, over 224,000 children received diagnostic evaluations from these programs.

[161] Cleave, J; Kuhlthau K. etc. Academic Pediatrics. 2012. Interventions to Improve Screening and Follow-up in Primary Care: A Systematic Review of the Evidence. 12 (4).269-282

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 improvements. 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 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 and utilized innovative strategies including telehealth and culturally competent family navigators to reduce barriers for underserved rural and racial/ethnic minority communities.

State systems grantees worked at the local, regional, and State levels to improve access to coordinated, comprehensive, timely, and evidence-based screening, diagnostic, and intervention services for ASDs and other DDs. By taking a public health approach that includes identifying available resources and gaps in services, building awareness among professionals and the public of the need for early identification and intervention for ASD, and building a more integrated system of services for ASD, the state grantees have achieved significant gains that will continue to spur improvements past their grant periods. For example, the Connecticut State Systems Grantee noted a 29% increase in developmental screenings for children ages 0-6 enrolled in its HUSKY Health Program, its Medicaid and Children's Health Insurance Program (CHIP). States implemented different approaches in their efforts to improve services. Strategies included: partnering with existing programs, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to promote regular developmental screenings for this underserved population; training primary care practices on medical home concepts and how to develop care coordination plans for children with special health care needs; development of community-based diagnostic teams to decrease wait times for diagnosis and increase capacity; and implementing quality improvement learning collaboratives to increase early screening and decrease age of entry into services.

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 2009–2010 grant year, the LEND and DBP programs collectively trained close to 2,500 medium-term and 1,400 long-term trainees.[162]

- Increasing the number of medium- and long-term trainees increased by 13 percent and 22 percent, respectively, in the following year.

- By the 2011-2012 grant year, trained 3,039 medium-term and 1,474 long-term trainees through the LEND and DBP programs.

- From FY 2009-2013, these programs collectively trained over 6,400 pediatricians, developmental-behavioral specialists, and other health professionals.

- Increasing the number of trainees that received ASD-focused didactic training. Between the 2009–2010 and 2010-2011 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 (CE) events pertaining to ASD screening, diagnostic evaluation, and evidence-based interventions for children with ASD. In 2012, the LEND and DBP grantees provided 917 CE events. From 2009-2011, 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. From 2009-2013, they provided more than 3,400 continuing education events (reaching over 306,000) and more than 9,200 outreach trainings (reaching over 285,000) to community pediatricians and other health professionals on early screening, early diagnosis, and early intervention.

[162] 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 strategies and accomplishments are highlighted below:

- To raise public awareness, the State grantees 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 addressing such topics as the efficacy of ASD interventions, early identification of ASD in minority populations, family well-being, and transition, and developed consensus-based guidelines and tools to support families and 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.

The Autism Intervention Research Network on Physical Health (AIR-P Network) has provided national leadership to strengthen the evidence base for interventions through research, development of clinical practice guidelines, and the dissemination and transfer of findings on interventions, guidelines, tools and systems management approaches broadly into practice settings and communities in order to promote the implementation of evidence-based practices and improve care. The AIR-P Network has developed three clinical guidelines on insomnia, constipation and medication choice and has implemented intensive quality improvement efforts to improve the content and process of health care and improve clinical outcomes for individuals with ASD.

The Autism Intervention Research Network on Behavioral Health (AIR-B Network) has established strong partnerships with underserved and under-represented communities and schools to provide better behavioral and social communication outcomes for children with ASD and to equip parents, professionals, educators, and community members with effective interventions that are practical in real-world settings. The 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, published in November 2012.

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.

The Developmental-Behavioral Pediatrics Research Network (DBPNet) has established a collaborative scientific and clinical research network to foster research activities to improve care and treatment for children with ASD and other developmental disabilities.[163] DBPNet has developed the national research agenda for Developmental-Behavioral Pediatrics research and has completed two studies on Research Training in DBP fellowship programs and the Nature of Referrals to DBP clinicians. The DBPNet has successfully leveraged NIH funding for support of a multi-site protocol on use of family navigators to reduce disparities in timely autism diagnosis and access to early intervention.

In collaboration with all HRSA/MCHB funded autism intervention research programs, the AIR-P Network spear-headed the development of a journal supplement on HRSA autism intervention research findings. The journal supplement was published in *Pediatrics* in November 2012 and covers a rich and diverse compilation of research and practice improvement related to the care and well-being of children and youth with autism and related neurodevelopmental disorders.

The R40 Autism Intervention Research Program has maintained a critical focus on advancing the evidence base on the effectiveness of interventions and advancing best practices for early identification and access to treatment for ASD and other developmental disabilities. Consistent with HRSA's goal to improve health equity, the program has focused on addressing the needs of underserved populations, by considering ethnic/racial, cultural, linguistic, socioeconomic, literacy and geographic (e.g., rural/urban) diversity of individuals for whom there is limited evidence of the effectiveness of interventions or for whom disparities in identification of ASD and other developmental disabilities exist. Significant R40 research projects explore intervention strategies for improving the health care transition for youth with ASD; a culturally compatible parent to parent model of support and service coordination for families with a preschool child with ASD; family support and well-being; teleconsultation training for parents to perform Applied Behavior Analysis (ABA) therapy for their rural, underserved children with ASD; and home-based intervention for rural families to address barriers to accessing early intervention.

Funding History

FY	Amount
FY 2012	$47,142,000
FY 2013	$44,652,000
FY 2014	$47,099,000
FY 2015	$47,099,000
FY 2016	$47,099,000

[163] Blum, N.J.; DBPNet Steering Committee (2012) The Developmental-Behavioral Pediatrics Research Network: another step in the development of the field. Journal of Developmental Behavioral Pediatrics.33(1):78-83.

Budget Request

The FY 2016 Budget Request is $47,099,000. The FY 2016 Request is the same as the FY 2015 Enacted level. Comparable activities will be supported in FY 2016 including 43 LEND training programs, 10 developmental-behavioral pediatrics training programs, 10 State systems grants, 5 autism intervention research networks, 2 resource centers, and 14 research grants. Grantees will participate in a national program evaluation and all activities will continue to be coordinated with the Interagency Autism Coordinating Committee and, in particular, with the CDC's Learn the Signs Act Early public awareness campaign.

A contract for a new program evaluation was initiated in FY 2013, examining program findings from 2011 forward. Results from this evaluation will be included in the next Report to Congress.

In FY 2016 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 early identification 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 ASD and other DD;
- Develop innovative strategies to integrate and enhance existing investments, including translating research findings on interventions, guidelines, tools and systems management approaches to training settings, communities and into practice; and
- Promote life-course considerations, from developmental screening in early childhood to transition to adulthood issues.

Funding also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs

Grant Awards Table

(whole dollars)	**FY 2014 Final**	**FY 2015 Enacted**	**FY 2016 President's Budget**
LEND	$27,938,271	$27,938,271	$27,938,271
DBP	$1,903,362	$1,903,362	$1,903,362
Research	$9,480,831	$9,480,831	$9,480,831
State Systems	$2,956,984	$2,956,984	$2,956,984
Resource Centers	$931,285	$931,285	$931,285
Number of Awards	91	82	84
Average Award	$474,843	$526,960	$514,413

Traumatic Brain Injury

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$9,321,000	$9,321,000	$9,321,000	---
FTE	2	2	2	---

Authorizing Legislation – The Traumatic Brain Injury Reauthorization Act of 2014.

FY 2016 Authorization $8,800,000

Allocation Methods……..….Formula grant/Competitive grant/Contract

Program Description and Accomplishments

The purpose of the HRSA Traumatic Brain Injury (TBI) Program is to increase access to health, rehabilitation, and other services for individuals with traumatic brain injury through development and support of state-level infrastructure and service delivery systems. The majority of TBIs are considered mild although an estimated 80,000-90,000 of individuals who sustain a TBI annually will experience long-term, possibly life-long, impairments due to their injury. In the United States, it is estimated at least 3.2 million Americans require long-term or life-long assistance to perform activities of daily living as a result of TBI[164]. These statistics are likely an underestimate of the actual incidence of TBI because surveillance only captures injuries for which medical treatment is sought. Individuals that experience what they believe to be a minor injury may not seek medical attention or may not exhibit overt symptoms that are required for a diagnosis of TBI, and as such would not be captured by national surveillance measures that count only diagnosed TBI incidents. In addition, these national estimates do not include individuals with TBI who are treated in military hospitals. TBI affects all age groups and can cause a range of symptoms, which may include 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.

HRSA's program addresses TBI from a public health perspective. The CDC's March 2014 Morbidity and Mortality Weekly Report (MMWR) noted that reducing the burden of TBI requires an integration of public health and health care delivery systems to ensure efficient,

[164] 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

effective care and rehabilitation is delivered to those who need it. Public health interventions include primary prevention, early management, and comprehensive approaches to rehabilitation and community reintegration. This approach is closely aligned with the HRSA TBI Program's emphasis on early diagnosis and intervention, and access to medical home and a system of care.

The Program helps states build public health system capacity for a broad population of individuals with and at risk for TBI. Specifically, the Program funds the development of comprehensive and coordinated statewide systems including: early diagnosis and intervention, professional training, care coordination and referrals, and resource facilitation including transitional services, rehabilitation, education and employment, and long-term community support for individuals with TBI.

The TBI Program consists of two distinct grant efforts: 1) the State Implementation Partnership Grants (competitive grant), and 2) the State Protection and Advocacy (P&A) Systems Grants (formula grant).

State Implementation Partnership Grants

The goal of State Implementation Partnership Grants is to address barriers to needed services encountered by children, youth, and adults with TBI. States and Territories receive funds to assess the need for TBI services and the resources within their State or Territory. This is done through a needs and resource assessment designed to facilitate the development or expansion of a comprehensive, multidisciplinary, and easily accessible systems of care for individuals with TBI and their families. The system of services emphasizes early diagnosis, intervention and resource facilitation consistent with the model of medical home. HRSA's multi-year evaluation of state needs and resources indicated the need to focus on four areas for increasing access to rehabilitation and other services for individuals with TBI. The areas are as follows: 1) screening to identify individuals with TBI, 2) building a trained TBI workforce by providing professional training, 3) providing information about TBI to families and referrals to appropriate service providers, and 4) actively assisting families in navigating service systems to access resources for care, treatment, and support.

In line with the focus areas of the program, two developmental measures have been established to assess 1) whether individuals with TBI and their families are able to access needed services as a result of their interaction with grantees, and 2) whether professionals receiving training from grantees report that they are better able to assess and meet the needs of individuals with TBI and their families. These two focus areas were chosen for developmental measures initially while the remaining two areas – screening and resource facilitation – will be considered for use as developmental measures in the future. FY 2014 baseline data for these measures will be available in FY 2015, at which time annual targets will be established.

In addition to measuring the discrete focus areas listed above, a performance measure was added to this program – to "increase the number of total State partnerships and/or collaborations with governmental and non-governmental organizations." This is an important goal given that establishing state level partnerships is believed to be central to conducting all focus area activities, as well as securing support for program activities after federal funding ends. The FY 2012 data showed that 441 partnerships have been forged since 2009, a number that gradually

increased during the project period. The Program anticipates that the number of collaborations and partnerships in which TBI grantees participate will be 350 in FY 2014 because a new cohort of grantees began this year and forging new partnerships will continue through FY 2017. This target for the first year of the new grantee cohort was based on planned partnerships outlined in competitive grant applications for the new cohort. The targets for FY 2015 and FY 2016 will be the same as FY 2014.

State Protection and Advocacy Systems Grants

The P&A Program is the second component grant of the HRSA TBI Program. 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. The P&A Program was authorized as a component of the Federal TBI Program in the Children's Health Act of 2000 to support and protect the rights of individuals with TBI. Since the inception of the program, HRSA has awarded grants to P&A organizations in states, territories, the District of Columbia, and one Native American Consortium to provide advocacy support for individuals with TBI and their families. Formula grants continue to be awarded to 57 States, Territories, and one Native American Consortium 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 . P&A grants are formula based, with an average award of $50,000 for state grantees and $20,000 for territory grantees.

A vital part of P&A activities is providing training and education to consumers and providers. TBI training is tailored to meet the needs of specific audiences, and is intended to increase awareness about legal concerns and individual rights around TBI, provide information on identification and funding of services, and provide support to facilitate full participation in all aspects of life. In FY 2014, P&A grantees provided training to nearly 60,000 individuals. Topics addressed included:

- Signs and symptoms of TBI;
- Disability rights;
- Brain injury supports and services;
- Medicaid waivers;
- Transition planning; and
- Special education services.

These trainings were provided to support groups, independent living centers, service providers, caregivers, individuals with TBI, family members, state employees, hospital staff, university staff, and community representatives. They have resulted in greater awareness for training participants of the needs of persons with TBI and the availability of resources and support services.

While the most recent data indicate that a large number of individuals receive training by these grantees, an additional performance measure will be added to assess the impact of these

trainings. Training participants will be asked if the training helped them to better provide services (in the case of professionals serving individuals with TBI) or access services (in the case of individuals with TBI and their families). This is a developmental measure. Baseline data for FY 2015 will be available in 2016, when future year targets will be established..

Programs	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
State Grants for Demonstration Projects	$5,065,314	$5,065,314	$5,065,314
Protection and Advocacy Grants	$3,099,589	$3,099,589	$3,099,589

Funding History

FY	Amount
FY 2012	$9,760,000
FY 2013	$9,245,000
FY 2014	$9,321,000
FY 2015	$9,321,000
FY 2016	$9,321,000

Budget Request

The FY 2016 Budget Request is $9,321,000. The FY 2016 Request is the same as the FY 2015 Enacted level. This funding level will support approximately 21 State Implementation Partnership grants which are anticipated to be awarded in FY 2016. These awards will allow the States to create a statewide system of care that links agencies including Education, Vocational Rehabilitation, Social Services, Mental Health, Substance Abuse, Corrections, Housing, and Transportation to ensure a comprehensive and sustainable system of care is navigable for individuals with TBI and their families.

TBI Protection and Advocacy grants will receive approximately $3.1 million in FY 2016 awarded to 57 States and Territories, the same as FY 2014 and FY 2015.

The TBI program also provides funding for a TBI technical assistance center (TBITAC) which is being renamed the Traumatic Brain Injury Coordinating Center (TBICC). The center was funded at approximately $442,000 for FY 2014 and is budgeted at $500,000 for FY 2015 and FY 2016 provided funds are available. The TBITAC has been responsible for providing technical assistance to grantees, maintaining a national listserv on issues that affect TBI service delivery with approximately 1,500 subscribers, maintaining an online collaboration space for grantees to share best practices for building and maintaining service-delivery infrastructure, and developing educational materials for the public about TBI.
This request supports the program's efforts to achieve its FY 2016 performance targets. Funding also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
11.V.B.6 Percentage of grantees that achieve the 4 core components of the TBI Implementation Partnership Grant Program within the 4 year project period. (*Output)*	FY 2012: 100% Target: N/A (Baseline)	100%	100%	Maintain
11.V.B.4. Number of total State partnerships and/or collaborations with governmental and non-governmental organizations. (*Output)*	FY 2012: 441 Target: 154 (Target Exceeded)	350[165]	350[166]	Maintain
11.V.B.8. Increase the number of individuals that receive trainings conducted by the TBI Protection and Advocacy Grant Program. (*Outcome)*	FY 2014: 59,746 Target: 38,000 (Target Exceeded)	38,000	40,000	+2,000
11.V.B.9 Proportion of individuals with TBI and/or their families who report that a State Implementation Partnership grantee helped them to better access TBI-related services.[167] (Developmental)	N/A	N/A	TBD	N/A
11.V.B.10 Proportion of individuals participating in training sponsored by a State Implementation Partnership or Protection and Advocacy grantee who report that they are better able to assess the needs of TBI survivors and/or their families and	N/A	N/A	TBD	N/A

[165] This target is lower than the FY 2012 result because it reflects the activities of a new cohort of grantees.
[166] This target is lower than the FY 2012 result because it reflects the activities of a new cohort of grantees.
[167] This developmental measure does not currently have annual targets. Baseline data for 2014 will be available in 2015 when future year targets will be established.

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
facilitate improved access to rehabilitative and other services.[168] (Developmental)				
11.V.B.11 Proportion of persons with TBI and/or their families who report that a HRSA TBI Protection and Advocacy Grantee helped them to better access services.[169] (Developmental)	N/A	N/A	TBD	N/A

Grant Awards Table[170]

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	21/57	21/57	21/57
Average Award	$241,205/ $54,379	$250,000/ $54,379	$250,000/ $54,379
Range of Awards	$224,344-$250,000/ $20,000-$145,854	$250,000-$250,000/ $20,000-$146,000	$250,000-$250,000/ $20,000-$146,000

[168] This developmental measure does not currently have annual targets. Baseline data for 2014 will be available in 2015 when future year targets will be established.
[169] This developmental measure does not currently have annual targets. Baseline data for 2014 will be available in 2015 when future year targets will be established.
[170] State Implementation Partnership Grantees/Protection and Advocacy Grantees

Sickle Cell Services Demonstration Program

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$4,455,000	$4,455,000	$4,455,000	---
FTE	2	2	2	---

Authorizing Legislation - Section 712(c) of the American Jobs Creation Act of 2004.

FY 2016 Authorization .....Expired

Allocation Methods……..……Competitive co-operative agreement/Contract

Program Description and Accomplishments

The legislative requirement of the Sickle Cell Disease Demonstration Program is to improve care for individuals with sickle cell disease through the establishment of systemic mechanisms to improve the prevention and treatment of Sickle Cell Disease and its complications, including the coordination of service delivery for individuals with Sickle Cell Disease; genetic counseling and testing; bundling of technical services related to the prevention and treatment of sickle cell disease; training of health professionals; and identifying and establishing efforts related to the expansion and coordination of education, treatment, and continuity of care for individuals with Sickle Cell Disease as authorized in Public Law 108-357, Section 712(c). Funds for this program support the Sickle Cell Regional Collaboratives activity which utilizes a regional approach to improve patient outcomes.

Life expectancy for persons with sickle cell has increased; however, the benefits from improved therapies to treat the disease have not been realized equally across the population affected. Since its creation in FY 2005, the Sickle Cell Disease Demonstration Program has developed multiple strategies to disseminate information to providers regarding prevention of morbidity and mortality associated with the sickle cell disease. These strategies have included improving the use of hydroxyurea in medical homes co-managed by primary care providers and hematologists; decreasing time to first pain medicine in the emergency room setting; and improving provider education through curriculum development and networking strategies. In FY 2014, the program was reorganized to support geographically distributed HHS regions to fund regional demonstration projects. The new structure is intended to create regional collaboratives using a Collective Impact approach to create partnerships between grantees, sickle cell centers, and FQHCs. This will expand the national reach of the program allowing the Sickle Cell Disease Treatment Demonstration Program (SCDTDP), to improve sickle cell care delivery and data collection on a broader scale. The new structure reduces the number of grantees while increasing the amount of funds per grantee. The purpose of the program is to increase access to care for individuals with sickle cell disease nationwide through the development of Sickle Cell Regional Collaboratives. The goals of the program are to: (1) increase the number of providers that are treating sickle cell patients in the region; (2) increase the number of providers prescribing disease-modifying therapies, such as hydroxyrea; and (3) increase the number of sickle cell

patients receiving care from providers with adequate knowledge of how to treat sickle cell disease.

Awardees are expected to: (1) establish strong regional collaborations and partnerships and provide sub-awards to a lead state-level partner from each state in the region; (2) work with stakeholders in the region, including patients and primary care providers using strategies such as the Primary Care Extension for Community Healthcare Outcomes (ECHO) to develop a common regional agenda to increase the number of providers treating sickle cell patients, increase the number sickle cell patients receiving hydroxyurea, and increase the number of patients receiving care from providers knowledgeable about sickle cell; (3) provide a communication strategy that engages the entire region; (4) implement quality improvement teams to improve sickle cell care; (5) develop and implement a regional data collection system that will support a national data system; and (6) provide technical assistance for the region. The awardees are expected to work with a national coordinating center and HRSA Programs, State Medicaid agencies, State Primary Care Associations (PCAs) and Primary Care Offices (PCOs) in the region, and with State-level partners to form partnerships with CBOs in their respective states.

FY 2016 activities will focus on maintaining the efforts started in FY 2014 to increase the number of sickle cell patients that have access to a sickle cell medical home by increasing co-management of sickle cell disease by hematologists and primary care providers.

HRSA has strengthened its collaborative efforts with other HHS agencies to improve sickle cell care. NIH has developed sickle cell disease clinical management guidelines and HRSA is currently collaborating with NIH, CDC and other HHS partners to adapt and institutionalize the sickle cell practice guidelines into a national strategy. This strategy will include data elements that can be used across HHS programs.

Funding History

FY	Amount
FY 2012	$4,665,000
FY 2013	$4,419,000
FY 2014	$4,455,000
FY 2015	$4,455,000
FY 2016	$4,455,000

Budget Request

The FY 2016 Budget Request is $4,455,000. The FY 2016 Request is the same as the FY 2015 Enacted level and will (1) support four geographically distributed regional projects with nationwide exposure for enhanced access to comprehensive, coordinated, culturally-effective, and family centered high quality services for individuals with sickle cell disease; (2) expand and upgrade data collection efforts and improve capacity to generate evidence of effectiveness through evaluating network activities and outcomes; and (3) focus on increasing the number of providers that are involved with the care of individuals with sickle cell disease by increasing capacity of university medical centers and hematologists to provide technical assistance and educational opportunities.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs

Grant Awards Table

(whole dollars)	**FY 2014 Final**	**FY 2015 Enacted**	**FY 2016 President's Budget**
Number of Awards	4	4	4
Average Award	$849,918	$850,000	$850,000
Range of Awards	$849,673 – $850,000	$825,000 - $875,000	$825,000 - $875,000

James T. Walsh Universal Newborn Hearing Screening

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$17,818,000	$17,818,000	$17,818,000	---
FTE	4	4	4	---

Authorizing Legislation - Section 399M of the Public Health Service Act.

FY 2016 Authorization .....Expired

Allocation Methods……Competitive grant/Co-operative agreement

Program Description and Accomplishments

The James T. Walsh Universal Newborn Hearing Screening Program (UNHS) began in FY 2000 with the purpose of assisting states to develop newborn hearing screening and early intervention programs. The program supports the following Healthy People 2020 Objectives: Increase the proportion of newborns who are screened for hearing loss by no later than age 1 month, have audiologic evaluation by age 3 months, and are enrolled in appropriate intervention services no later than age 6 months.

To implement the program, the Maternal and Child Health Bureau awards competitive grants to states and territories and funds one national technical assistance center. In addition to funds being utilized to strengthen state screening efforts and reduce loss-to-follow-up, supplemental funding has been provided since 2009 to a total of 11 Leadership Education in Neurodevelopmental and Related Disabilities (LEND) programs to expand and augment their pediatric audiology training efforts. Collaboration with the Centers for Disease Control and Prevention (CDC), the Administration for Children and Families, and National Institutes of Health's National Institute on Deafness and Other Communication Disorders is ongoing to coordinate programs and leverage resources at the national and State levels. In FY 2015, non-competing continuation and competing continuation awards will be made to 58 state and territorial grantees and 1 national resource center in the form of a cooperative agreement.

The UNHS has been successful in increasing the percentage of newborns screened for hearing loss prior to hospital discharge. In FY 2005, 95 percent of newborns were screened for hearing loss prior to hospital discharge, exceeding the target of 94 percent 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. NCBDDD data from 2012 indicate 97 percent of newborns were screened prior to 1 month of age, most before discharge from the newborn nursery. NCBDDD data also show the percentage of Loss to Documentation/Follow-up (LTF/D) has been steadily declining. The CDC Early Hearing Detection and Intervention (EHDI) data also show that for the 50 states and territories the percentage of LTF/D has been steadily declining. In 2005, the percentage was 64%; in 2011, the

percentage was 35.3%; and in 2012, the percentage was 37%. The improvement is not universal among the states. There are states that are performing extremely well in reducing and keeping their LTF/D percentage low while some states have an extremely high LTF/D percentage and are not demonstrating a decrease (e.g. Massachusetts's 2012 LTF/D percentage is 2.5%; Texas's 2012 LTF/D percentage is 77%). Most States now have legislation mandating hearing screening for newborns, and most U.S. hospitals, with the exception of military facilities, have implemented newborn hearing screening programs. However, few states and territories have comprehensive data reporting requirements for service providers (audiologists, physicians, and early intervention providers) thus making accurate and timely monitoring of follow-up and intervention difficult. The current UNHS program focuses on supporting timely screening and diagnosis and addressing issues related to loss-to-follow-up. It is critical that the program be continued so that all children with or suspected to have a hearing loss receive timely diagnostic and early intervention services, including early access to language development supports.

Funding History

FY	Amount
FY 2012	$18,660,000
FY 2013	$17,674,000
FY 2014	$17,818,000
FY 2015	$17,818,000
FY 2016	$17,818,000

Budget Request

The FY 2016 Budget Request is $17,818,000. The FY 2016 Request is the same as the FY 2015 Enacted level. The FY 2016 Request will support 58 grant awards and 1 national resource center in the form of a cooperative agreement to assist the program in achieving the FY 2016 target of screening 98 percent of infants prior to one month of age.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
13.1: Increase the percentage of children with non-syndromic hearing loss entering school with developmentally appropriate language skills.[171] *(Outcome)*	FY 2004: 20% estimated (Baseline)	N/A	N/A	N/A
13.2: Increase the percentage of infants with hearing loss enrolled in early intervention before 6 months of age.[172] [173] (Baseline – FY 2009: 68%) *(Output)*	FY 2012: 66% Target: 67% (Target Not Met)	72%	72%	Maintain
13.III.A.1: Percentage of infants suspected of having a hearing loss with a confirmed diagnosis by 3 months of age. *(Output)*	FY 2012: 70% Target: 70% (Target Met)	77%	77%	Maintain
13.III.A.3: Percentage of infants screened for hearing loss prior to one month of age. *(0utput)*	FY 2012: 97% Target: 98% (Target Not Met)	98%	98%	Maintain

Grant Awards Table[174]

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	59 (58 grants and 1 cooperative agreement)	59 (58 grants and 1 cooperative agreement)	59 (58 grants and 1 cooperative agreement)
Average Award	$247,179 (grants) $1,225,000 (cooperative agreement)	$240,337 (grants) $1,200,000 (cooperative agreement)	$240,337 (grants) $1,200,000 (cooperative agreement)

[171] This long-term measure does not have annual targets. The first long-term target of 85% was set for FY 2013.
[172] CDC has been collecting data annually since 2006. Baseline updated to reflect annual data collection. Previously data were collected by the National Center for Hearing Assessment and Management.
[173] This measure is to be tracked annually in light of new Part C of the Individuals with Disabilities Act (IDEA) regulations which mandate collaboration with Title V programs and newborn hearing screening programs.
[174] Does not include $700,000 for LEND supplements and $350,000 for medical home capacity building and support for pediatric audiology supplements.

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Range of Awards	$175,000-$265,897 (grants) $1,225,000 (cooperative agreement)	$175,000-250,000 (grants) $1,200,000 (cooperative agreement)	$175,000-$250,000 (grants) $1,200,000 (cooperative agreement)

Emergency Medical Services for Children

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$20,162,000	$20,162,000	$20,162,000	---
FTE	4	4	4	---

Authorizing Legislation – The Emergency Medical Services for Children Reauthorization Act of 2014

FY 2016 Authorization $20,213,000

Allocation Method ..... ….Competitive grant/cooperative agreement

Program Description and Accomplishments

The Emergency Medical Services for Children (EMS-C) Program, established in 1984, is the only Federal program that focuses specifically on improving the pediatric components of the emergency medical services (EMS) system. The Institute of Medicine (IOM) and other national experts have stated that there are significant gaps across the country in providing quality care to children in emergencies. Pediatric emergency care begins with the 911 call through the delivery of the patient to the appropriate hospital and ultimately returning the child to the community. The mission of the EMS-C program is to reduce child and youth mortality and morbidity resulting from severe illness or trauma.

The EMS-C Program currently provides infrastructure support to 49 states, all territories and the Freely Associated States to ensure that pediatric emergency care provided in these locales is integrated into the larger emergency medical services system. By having a universal presence across the United States, the program aims to reach its goal of ensuring that all children receive optimal emergency care no matter where they are. Each of these entities works towards implementing the same prehospital and hospital quality performance measures, which represents the largest national effort for standardized pediatric emergency care. Unfortunately, variability in care continues to exist due to geographical, jurisdictional and workforce issues that can prevent children receiving the right care at the right time[175]. To improve the quality of pediatric emergency care, the EMS-C Program continues to invest in initiatives that promote pediatric emergency care evidence-based or evidence-informed practices in the field.

The EMS-C Program allocates funds through competitive grants and cooperative agreements to state governments, institutions of higher learning, and schools of medicine. The four main programs are: 1) State Partnership grants (States, Territories and the Freely Associated States) (58); 2) Targeted Issues grants that address pediatric emergency care issues of national significance (6); 3) State Partnership Regionalization of Care demonstration grants that develop

[175] Health Aff (Millwood).2013Dec;32(12):2109-15

models to improve pediatric emergency care capacity in rural and tribal communities (6): and 4) Pediatric Emergency Care Applied Research Network (PECARN) grants (6) to conduct meaningful and rigorous multi-institutional studies in the management of acute illness and injury in children across the continuum of emergency medicine.

In FY 2014, the EMS-C investment resulted in the following accomplishments:

- In a joint effort, States, with their EMS-C State Partnership grantees, have partnered with the American Academy of Pediatrics, the Emergency Nurses Association, the American College of Emergency Physicians and others to ensure all emergency departments meet the 2009 joint policy statement of 22 national organizations for "The Care of Children in the Emergency Department" (Pediatrics, 2009). Through a coalition process these groups are engaging hospital emergency departments to participate in a quality improvement initiative called "The National Pediatric Readiness Project" that supports improving delivery systems at the local level to ensure children receive the right care at the right time. Simple system changes such as weighing a child in kilograms rather than pounds to prevent medical errors, ensuring that interfacility transfer agreements are in place, and that at the local level emergency departments have a physician or nurse champion for pediatric emergency care can greatly improve the care provided to children. Over 4,000 emergency departments across the nation have participated in assessing their readiness to care for children which represents approximately 80% of the nation's emergency departments. Approximately half of these emergency departments see less than 15 pediatric patients a day.

- The State Partnership Regionalization of Care (SPROC) demonstration grantees are working on models to bring urban, rural and tribal communities together to provide seamless care for children. They are exploring avenues to expand healthcare networks within and beyond their state borders; establish pediatric medical recognition systems; expand access to EMS education through distance learning; expand the use of tele-consultation and novel referral structures to prevent unnecessary transport of children from their community; and systematically evaluate these initiatives. They are partnering with cultural liaisons to assure the integration and representation of tribal and rural communities in project development and implementation. The goal is for these demonstration projects to serve as models for other communities in the country.

- To address the lack of evidence-based practices in pediatric prehospital care, six grants were launched in FY 2013, which represents the only federal funding opportunity focusing on increasing the evidence and quality of pediatric prehospital care. Grantees are focusing on feasibility of pediatric prehospital research, use of oral steroids for pediatric asthma in the prehospital setting, use of a community paramedicine model to improve asthma care among children who are discharged from the emergency department, development and implementation of evidence-based pediatric prehospital protocols in six states, development of online pediatric training for rural EMS providers and development of models of compassionate care when a pediatric death occurs in the prehospital setting. Each of these projects addresses current gaps in care for children. These projects will conclude in FY 2016, and the results will have cross-cutting benefits for the field.

- The PECARN grantees have established an efficient multi-center research network (18 sites representing over one million pediatric visits annually) that participates in multiple forms of research: randomized controlled trials, implementation as well as translational research. The network investigates topics related to cardiac arrest; management of trauma including cervical spine care, traumatic brain injury, blunt abdominal injury; management of pediatric seizures; evaluation of febrile illness in the infant; non-opioid management of sickle cell pain crisis; management of diabetic ketoacidosis; implementation and evaluation of clinical decision rules and patient safety. The network published multiple peer-reviewed articles that will impact the quality of care provided to children. A randomized controlled trial demonstrated no difference of two medications for the management of pediatric seizures[176] which allows providers to balance the different side effects and cost to optimize care for the child. Multiple studies distinguish clinical factors to aid providers in the use of radiographic imaging in trauma patients thus decreasing unnecessary radiation exposure or transport to trauma specialty centers[177,178,179]. Further funding supports the evaluation of this decision the integration of this tool into electronic medical records to provide point of care support in the clinical management of mild traumatic brain injury[180,181]. The change in clinical practice from these studies has resulted in improved safety for children by decreasing inappropriate use of medications or radiological studies as well as potentially decreasing inappropriate use of health care resources.

- Continued engagement of newly funded grantees in the Freely Associated States (Republics of Palau and Marshall Islands, and the Federated States of Micronesia) to develop formal plans to address the needs of children in the emergency care setting, linking the grantees of the Pacific Basin to address the challenges of access to pediatric care, inter-island transport and workforce development. Positive outcomes from this partnership will be essential in providing models to other regions that face similar jurisdictional and geographical challenges.

The work of the EMS-C program and its collaboration with partner organizations resulted in many seminal publications. The first evidence-based guidelines (EBGs) for prehospital care were published in a supplementary issue of Prehospital Emergency Care[182]. Using the National Prehospital Evidence-based Guidelines Model Process, with funding provided by NHTSA and EMSC, the supplement covered the topics of prehospital analgesia in trauma and air medical transportation of prehospital trauma. A collaboration with NHTSA, EMSC and the American College of Surgeons led to the publication of evidence based guideline on prehospital external hemorrhage control[183]. This publication incorporated the military evidence for hemorrhage control and is now being used in practice for the civilian setting especially in active shooting or explosion settings where immediate hemorrhage control can be lifesaving. Fifteen previous EMS-C program grantees authored articles that highlighted the advances in the field of pediatric

[176] JAMA. 2014 Apr 23-30;311(16):1652-60
[177] Acad Emerg Med. 2014 Jan;21(1):55-64
[178] Ann Emerg Med. 2014 Feb 12
[179] Ann Emerg Med. 2013 Sep;62(3):276-7
[180] J Biomed Inform. 2013 Oct;46(5):905-13
[181] Acad Emerg Med. 2013 Apr;20(4):352-60
[182] Prehospital Emergency Care Jan 2014, Vol. 18, No. Supplement 1;1-51
[183] Prehospital Emergency Care Apr 2014, Vol. 18, No. 2: 163–173

emergency medicine in Clinical Pediatric Emergency Medicine[184]. The impact of the program continues to be highlighted in multiple care settings and among different specialties that care for children.

Collaborations

To further achieve system improvements, the Emergency Medical Services for Children (EMS-C) Program works in collaboration with the Federal Interagency Committee on Emergency Medical Services, a legislated federal entity with a composite of key agencies that intersect with the emergency medical services system. The Federal Interagency Committee on Emergency Medical Services ensures collaboration and integration of Federal activities within the Department of Health and Human Services, Health Resources and Services Administration, Office of the Assistant Secretary for Preparedness and Response, Centers for Disease Control and Prevention, Indian Health Service, and Centers for Medicare & Medicaid Services, and between Department of Transportation, Department of Homeland Security, Department of Defense, and Federal Communications Commission. EMS-C brings the only pediatric perspective to this Federal group which sets national agendas and policies for emergency medical services. In addition to Federal Interagency Committee on Emergency Medical Services, EMS-C works with individual Federal agencies to ensure the integration of pediatric priorities in the overall Emergency Medical Services system.

A primary federal partner within the Department of Transportation's National Highway Traffic Safety Administration is the Office of Emergency Medical Services. EMS-C collaborates with Office of Emergency Medical Services on the advancement of standardized and evidence based prehospital medical protocols, strategies that support regionalization of trauma care, instituting a culture of safety in the EMS setting, and partnering in the implementation of the National EMS Information System. EMS-C Program's partnership with Office of Emergency Medical Services ensures pediatric relevant issues are integrated into the larger Emergency Medical Services policies, education agendas and guidelines.

The EMS-C Program partnerships with Indian Health Service, the Agency for Health Care Research and Quality, Department of Defense, and the Office of the Assistant Secretary for Preparedness and Response, Hospital Preparedness Program have provided opportunities for synergy. Working with the Indian Health Service, EMS-C assures the availability of pediatric-specific training initiatives tailored to the needs of tribal Emergency Medical Services and Indian Health Service medical facility professionals. The collaboration with Indian Health Service also provides opportunities to evaluate health care facilities to ensure they are prepared to care for pediatric patients. The EMS-C Program utilizes Agency for Healthcare Research & Quality to provide national data on childhood mortality secondary to injury and referral patterns of pediatric patients among various designations of Trauma Centers. The most recent collaborations are with the Department of Defense United States Uniformed Health Services, School of Medicine and the Hospital Preparedness Program. Collaborations with the United States Uniformed Health Services are focused on the development of a pediatric trauma curriculum for trauma surgeons and nurses. The military experience abroad has highlighted the gap in pediatric trauma training for nurses and surgeons and is similar to workforce shortages domestically in rural communities. The development of this pediatric trauma curriculum will be integrated into established training

[184] Clinical Pediatric Emergency Medicine.2014 Mar;15(1):1-114

supported by the American College of Surgeons Committee on Trauma. This will ensure dissemination and integration into practice. The Office of the Assistant Secretary for Preparedness and Response, Hospital Preparedness Program Healthcare Coalitions, which are formal organizations consisting of healthcare members such as acute care hospitals, Emergency Medical Services, specialty and primary care providers, long term care facilities, behavioral health, public agencies, and private organizations that come together to prepare for, respond to, and recover from disaster. As one entity, a Healthcare Coalition assesses local risks, develops protocols, conducts exercises and trainings, and assesses its performance after an exercise or real-life event. The goal of Hospital Preparedness Program and the Healthcare Coalitions they support is to comprehensively care for all patients, those affected by a disaster and those who were already part of the medical system. EMS-C has a similarly comprehensive role in emergency medical care. EMS-C addresses the entire continuum of pediatric emergency services, from injury prevention through pre-hospital and emergency department care, intensive care, rehabilitation and reintegration into the community. In partnership, EMS-C and Hospital Preparedness Program are connecting the expertise and networks to strengthen pediatric preparedness efforts across the nation.

Measuring Impact

Systematically, the EMS-C Program measures its impacts through the results of performance measures. In the short term, the program focuses on the quality of care provided in the pre-hospital and hospital settings by assuring continuing pediatric education. Performance measures that require survey assessment are collected every 3 years (FY 2013-2014 is the most recent reporting period), while self-reported data is collected annually. Each year, State grantees assess the adoption of required pediatric training for Basic Life Support (BLS) and Advanced Life Support (ALS) providers during recertification (Measure 14.V.B.2A & 2B). Through FY 2013, 46 grantees had adopted requirements for recertification of BLS providers and 45 grantees had adopted requirements for recertification of ALS providers. States' grantees also assess yearly their recognition system to address pediatric medical emergencies and traumatic emergencies (Measure 14V.B.4A & 4B). In FY 2013, 25 grantees made significant progress in implementing a pediatric medical recognition system and 43 grantees for a trauma system capable of caring for pediatric emergencies. All of these reported annual measures met or exceeded the established targets except 14V.B.4B which measures the impact of the states and territories to establish a pediatric trauma recognition system. The Program intends to work more closely with states and territories reporting lower achievement scores from previous years, in order to more clearly understand the findings and to assist grantees that were unable to make greater progress in establishing a pediatric trauma recognition system.

Decreasing pediatric mortalities due to serious injury is a long-term outcome of the EMS-C Program that is tracked annually. Data from the Healthcare Cost Utilization Project (HCUP) is utilized to assess trends in pediatric mortality due to injuries. The EMS-C Program annually assesses the percent reduction in pediatric injury mortality using the HCUP administrative data (Measure 14.1.A). In CY 2011, there was a 2.4% reduction in mortality compared to CY 2009 for children ages 0-15 years with an injury severity score greater than 15 when they presented to the emergency department. This equates to an estimated 16 lives saved in FY 2011.

The EMS-C program tracks other health quality indicators that address the quality of care being delivered in States and territories as well as the permanence of EMS-C in State systems. Program management requires all State/Territory grantees to collect data every three years for some measures.

In FY 2013, national survey data collected by Program grantees demonstrated the following results:

- Each State determines whether its ambulances that transport children have all of the appropriate pediatric equipment available. Success for this performance measure is noted when all ambulances transporting children in a State carry all of the necessary pediatric equipment. The results are presented first as the proportion of equipment carried on ambulances nationally, the proportion that has all of the equipment, and finally, the number of States with 100% compliance. Of the EMS vehicles responding to 911 calls for pediatric patients, representing 21,255 ambulances, Basic Life Support (BLS) ambulances had 92 percent of all the recommended pediatric equipment and Advanced Life Support (ALS) ambulances had 96 percent of all the recommended pediatric equipment. Although a majority of ambulances have the majority of essential equipment, 25% of BLS ambulances and 38% of ALS ambulances had 100 percent of the recommended pediatric equipment. Only two entities, Hawaii and the District of Columbia, have all of the BLS and ALS recommended pediatric equipment and supplies (Measure 14.V.B.3A and Measure 14.V.B.3B). Missing items include essential lifesaving equipment and therefore the Program continues to direct efforts to assure that 100 percent of the recommended equipment is on 100 percent of the ambulances in every State/Territory.

Funding History

FY	Amount
FY 2012	$21,116,000
FY 2013	$20,000,000
FY 2014	$20,162,000
FY 2015	$20,162,000
FY 2016	$20,162,000

Budget Request

The FY 2016 Budget Request is $20,162,000. The FY 2016 Request is the same as the FY 2015 Enacted level. This request supports the program's efforts to achieve its FY 2016 performance targets. The EMS-C Program will continue to support and strengthen its presence in States, territories and Freely Associated States to ensure the attainment of the results of program performance measures. Engagement of the prehospital community to include family representatives and cultural liaisons representing the families and children in all funded jurisdictions, as well as emergency departments and hospitals, is vital to a high quality continuum of care for children. The development and dissemination of models of regionalized care are needed to address variability in pediatric emergency care. Additionally, continued support of evidence-based practices in emergency medical services for children is needed to

provide the most appropriate care. Due to the success of the state grantees attaining the prehospital performance measures (medical online and offline direction, presence of pediatric equipment on ambulances), the program will develop new measures to access the process of care provided in the prehospital setting expanding on the previous structural measures.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
14.V.B.2.A: Increase the number of awardees that have adopted requirements for pediatric emergency education for the re-certification of BLS providers. *(Output)*	FY 2013: 46 Target: 42 (Target Exceeded)	45	46	+1
14.V.B.2.B: Increase the number of awardees that have adopted requirements for pediatric emergency education for the re-certification of ALS providers. *(Output)*	FY 2013: 45 Target: 42 (Target Exceeded)	47	48	+1
14.1.A: Percent reduction in mortality rate for children with an injury severity score greater than 15. *(Outcome)*[185]	CY 2010: 2.4% reduction [186] Target: 0.5% reduction from prior year (Target Exceeded)	0.5% reduction from prior year	0.5% reduction from prior year	Maintain

[185] The new data source for this measure is the National Emergency Department Sample (NEDS). Data is reported from the most currently available pediatric mortality data. Source: Healthcare Cost and Utilization Project (HCUP), Agency for Healthcare Research and Quality.

[186] The annual percent reduction is calculated by the difference in mortality rate from the previous year divided by the base year rate, the reference Mortality Rate for FY 2009 is 5.72% and Mortality Rate in FY 2010 is 4.87% among children 0-15 years of age.

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
14.V.B.3A: Increase the number of awardees that demonstrate the operational capacity to provide pediatric emergency care based on nationally-recommended pediatric equipment available on BLS ambulances. *(Output)*	FY 2013 Result: 2 Target: 2 (Target Met)	N/A[187]	3	N/A
14.V.B.3B: Increase the number of awardees that demonstrate the operational capacity to provide pediatric emergency care based on nationally-recommended pediatric equipment available on ALS ambulances. *(Output)*	FY 2013 Result: 2 Target: 2 (Target Met)	N/A	3	N/A
14.V.B.4A: Increase the number of awardees that have made significant progress in implementing a pediatric recognition system for hospitals capable of dealing with pediatric medical emergencies. *(Output)*	FY 2013 Result: 25 Target: 16 (Target Exceeded)	26	27	+1
14.V.B.4B: Increase the number of awardees that have made significant progress in implementing a pediatric recognition system for hospitals capable of dealing with pediatric traumatic emergencies. *(Output)*	FY 2013 Result: 43 Target: 46 (Target Not Met)	44	44	Maintain

[187] Data on measures (14.V.B.3A & B) collected every three years. N/A is listed for non-data collection years. Data collected for the grant project period 3-1-2013 to 2-28-2014 (EMSC program FY 2013) and will be validated by August 2014. The next data collection cycle is in FY 2016 (3-1-2016 to 2-28-2017) and will be validated by August 2017, FY 2017.

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	78	78	75
Average Award	$230,007	$238,553	$240,553
Range of Awards	$40,000 - $3,065,000	$130,000-$3,000,000	$130,000-$3,000,000

Healthy Start

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$100,746,000	$102,000,000	$102,000,000	---
FTE	5	5	5	---

Authorizing Legislation - Section 330H of the Public Health Service Act.

FY 2016 Authorization .....Expired

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 continue and expand the Healthy Start (HS) program, which provides grants to support 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 and disparities in other perinatal indicators. HS works to reduce "the disparity in health status between the general population and individuals who are members of racial or ethnic minority groups…" 42 U.S.C. § 254 c-8(e)(2)(B). HS services begin in the preconception period and follow the woman and child after the end of pregnancy for two years.

Using a lifespan approach and a focus on the interconception health of women, HS aims to reduce disparities in access and utilization of health services, to improve the quality of the local health care system, to empower women and their families, and to increase consumer and community participation in health care decisions.

Grants to communities are targeted based on exceptionally high rates of infant mortality (at least 1½ times the U.S. national average) and other negative perinatal outcomes (such as low birthweight, preterm delivery, maternal morbidity and mortality), and/or high indicators of poor perinatal outcomes (such as poverty, education, access to care, and other socioeconomic factors), particularly among non-Hispanic Black and other disproportionately affected populations. In these geographically, racially, ethnically, and linguistically diverse low income and low resource communities, HS supports communities to address the needs of high risk women and their families before, during, and after pregnancy.

Adverse Pregnancy Outcomes in United States

More than 6.7 million women become pregnant each year in the United States . According to data from National Center for Health Statistics, there were 3.93 million live births in 2013. While most women have a safe pregnancy and deliver a healthy infant, that is not the experience for all women. 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 the U.S. has been rapidly increasing, reaching a peak of 12.8 percent in 2006. Since then, the preterm delivery rate has decreased slowly with the 2013 overall national preterm rate at 11.39 percent.[188] Although a portion of preterm births over the last decade was due to an increase in multiple births, the percentage of preterm births has also increased among singleton births.

There are significant racial disparities in preterm births and infant death rates in the U.S. For example, in 2012 the preterm birth rate for non-Hispanic White infants was 10.29 percent compared to 16.53 percent for non-Hispanic Black infants.[189] Similarly, in 2010 the preterm-related infant mortality rate for non-Hispanic Black infants was 3.1 times higher than that of non-Hispanic White infants.[190] 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 lifespan of the mother – from her earliest life experiences until she delivers her own child – may account for a significant portion of the disparities. These social determinants of health may hold the key to reducing infant mortality – which is why HS grantees focus on addressing these factors. Moreover, it may take specific interventions that are consistently provided over several generations to reduce and eliminate the factors responsible for the disparities in adverse infant mortality rates.

Healthy Start - Community Collaborations to Address Pregnancy Outcomes

HS 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 the service- and system-levels through the implementation of innovative community-driven and community-based interventions.

At the service-level, beginning with direct outreach by HS community health workers to women at high risk for poor perinatal outcomes, HS projects ensure that the mothers and infants have ongoing sources of primary and preventive healthcare and that their basic needs (e.g., housing, psychosocial, nutritional and educational support, and job skill building) are addressed. Following assessments and screening for perinatal depression and other risk factors, HS 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 HS project has developed a Community Action Network 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 identify and address the system-level barriers

[188] Martin JA, Hamilton BE, Osterman MKJ. Births in the United States, 2013. NCHS Data Brief #175. Published online December 2014.
[189] Martin JA, Hamilton BE, Osterman MJK, et al. Births: Final data for 2012. National vital statistics reports; vol 62 no 9. Hyattsville, MD: National Center for Health Statistics. 2013..
[190] Mathews TJ, MacDorman MF. Infant mortality statistics from the 2010 period linked birth/infant death data set. National vital statistics reports; vol 62 no 8. Hyattsville, MD: National Center for Health Statistics. 2013.

in their community, including fragmentation in service delivery, lack of culturally appropriate health and social services, and barriers to accessing care.

HS projects are required to have strong collaborative linkages with State programs, including the Title V Maternal and Child Health 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. By knowing the importance of a healthy family and healthy home, as appropriate, the needs of the entire family are addressed by HS.

Healthy Start Transformation

In 2014, HRSA undertook a major effort to transform the Healthy Start program to ensure maximum benefit to the communities the program serves and to prevent overlap and duplication with other federal programs. Changes were introduced based on recommendations of Healthy Start leadership at the national and community levels, national experts and leaders in the larger MCH community, as well as recommendations from external evaluations, and the January 2013 report of the Secretary's Advisory Committee on Infant Mortality (SACIM). The primary goal of the HS program continues to be Eliminating Disparities in Perinatal Health.

The transformed HS approach builds on the program's long-standing focus on individual and family health by adding greater emphasis to evidence-based practice, standardized approaches, and quality improvement. Grantees will increase their roles as leaders and drivers of community change, accountability, and collective impact. To achieve this the role of Healthy Start grantees is being reframed in that they will serve as hubs responsible for coordinating all available maternal and child health services (Federal, state, private, non-profit) in their communities. In this way HS grantees will assist in the achievement of collective impact and play a key role in creating the foundation for delivering optimal community-wide health and development services for infants and children, including early learning.

The transformation also includes an increased emphasis on strong and ongoing evaluations, increased accountability at both the local and Federal levels, and the ability to demonstrate community-wide impact. Key to achieving these objectives will be the creation and implementation of the:

- Healthy Start Performance Project: To provide assistance to grantees to ensure skilled, well qualified workers at all levels of the program, identify and better define effective services and interventions, offer mentoring, education, and training to staff delivering these interventions and services, and provide shared resources.

- Healthy Start Monitoring and Information System: To collect program data from all grantees on a monthly basis to monitor program activities and identify technical assistance needs. The HSMIS will also collect data from clients served by HS to monitor

services and health outcomes and enable HRSA and grantees to better utilize information for ongoing program monitoring, quality improvement and local and national evaluation.

Reduction in Infant Mortality Rates in Healthy Start Project Areas

Overall, HS has been successful in reducing infant mortality in the Nation's highest risk populations for adverse outcomes (African Americans, American Indians/Native Americans). By design, Healthy Start funds are provided to communities with exceptionally high infant mortality rates. Healthy Start communities were successful in reducing their infant mortality rates so that in 2012 the infant mortality rate among HS program participants of 5.0 infant deaths per 1,000 live births was lower than the national rate of 6.0.

In addition, the following HS communities reported no infant deaths among program participants for the three years 2008-2010: Mississippi County, AR; Chicago, IL; all three HS sites in Raleigh, NC; Pembroke, NC; Las Cruces, NM; Portland, OR; Philadelphia, PA; Fresno, CA; Atlanta, GA; and Wichita, KS.

Increasing Access to Early Prenatal Care

An important risk factor for infant mortality is late entry into prenatal care. The population served by the HS projects is, by eligibility criteria definition, disadvantaged and high risk. The proportion of Healthy Start clients receiving early prenatal care has historically been very low. Through outreach, health education and care coordination, Healthy Start grantees have played an important role in connecting their clients to services and improving access to, and the utilization of, prenatal care services for members of the communities served by their programs.

Addressing Barriers to Healthcare Access

Lack of health insurance coverage has not been a major barrier for low-income to receiving care during pregnancy through 60 days following delivery, as most high risk women served by Healthy Start are eligible for Medicaid. However, many of low-income/high-risk women do not enroll in Medicaid and/or do not access any health care services during their pregnancy. To overcome these barriers and ensure that women access the care they need, Healthy Start grantees focus on helping eligible women and children enroll in Medicaid or in private insurance through their state's health insurance marketplace. HS grantees also work to help women and children find health care providers that accept the type of insurance they have or have obtained. Finally, HS staff plays a critical role in providing case management and care coordination that enable women to access appropriate pre-natal and other health care services essential to improving maternal and infant health outcomes.

Currently, 101 HS grants serve high risk communities in 37 states and the District of Columbia. These programs will deliver uniform, standardized interventions, ensuring that services are delivered by a competent workforce, and support ongoing evaluation and quality improvement at the local and national levels.

Funding History

FY	Amount
FY 2012	$103,532,000
FY 2013	$98,064,000
FY 2014	$100,746,000
FY 2015	$102,000,000
FY 2016	$102,000,000

Budget Request

The FY 2016 Budget Request is $102,000,000. The FY 2016 Request is the same as the FY 2015 Enacted level. The requested funding will support up to 101 HS sites in 37 states and the District of Columbia. Significantly more program participants will receive case managed Healthy Start services every year at maximum program operations, while another 550,000 HS community participants will receive outreach and health education services.

The FY 2016 Budget will allow HRSA to continue to build on the successes and lessons learned over the past 24 years of HS. HS will include activities and components that will support the Administration's priorities of building a ladder of opportunity for all children.

The FY 2016 Budget will enable HRSA to conduct an objective evaluation of the Healthy Start program to determine the extent to which Healthy Start grantees provided services to the highest risk target populations, implemented the program's interventions and strategies as designed, and were able to improve the perinatal outcomes among the population they serve identifying the critical ingredients of HS programs that facilitate success and that should be replicated in other high risk communities.

The FY 2016 Budget will also support efforts to further strengthen evaluation, oversight, and accountability activities and efforts and the continued development and implementation of the Healthy Start Performance Project and Healthy Start Monitoring and Information System. Funding also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs

HS projects are 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 women and infants in their communities. HS promotes the uniform implementation of well-defined evidence-supported interventions and the ongoing monitoring of the impact of these interventions on the perinatal outcomes and factors that contribute to these outcomes. To achieve this goal, HS will continue to support staff training and education through the development of standardized HS curricula, practice tool kits, technical assistance, and peer to peer mentoring.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
12.1: The infant mortality rate (IMR) per 1,000 live births among Healthy Start Program clients.[191] *(Outcome)* (Baseline- 2004: 7.65 per 1000 live births)	FY 2012: 5.0 per 1,000 live births	N/A	N/A	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 2012: 75% Target: 75% (Target Met)	75%	75%	Maintain
12.III.A.2: Percent of singleton births weighing less than 2,500 grams (low birth weight) *(Outcome)*	FY 2012: 10% Target: 9.6% (Target Not Met)	9.6%	9.6%	Maintain
12.E: Increase the number of persons served by the Healthy Start Program with a (relatively) constant level of funding.(*Efficiency)*	FY 2012: 419,126 Persons Served Target: 532,500 (Target Not Met)	550,000	550,000	Maintain

Grant Awards Table

(whole dollars)	FY 2014 Final[192]	FY 2015 Enacted[192]	FY 2016 President's Budget
Number of Awards	96 / 31	102 / 7	101
Average Award	$877,219 / $238,009	$941,117 / $130,334	$959,468
Range of Awards	$63,916 - $2,008,655 / $38,135-$587,500	$400,000 - $2,000,000 / $52,211 / $312,500	$750,000 - $2,000,000

[191] This long-term measure does not have annual targets.
[192] New, competing continuation, and non-competing continuation awards / extension with funds awards

Heritable Disorders Program

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$11,883,000	$13,883,000	$13,883,000	---
FTE	3	4	4	---

Authorizing Legislation –The Newborn Screening Saves Lives Reauthorization Act of 2013

FY 2016 Authorization……$11,900,000

Allocation Methods……..…….Contract/Competitive grant/Co-operative agreement

Program Description and Accomplishments

The programs and activities under this Act are established to enhance, improve or expand the ability of States and local public health agencies to provide screening, counseling or health care services to newborns and children having or at risk for heritable disorders. Universal newborn screening provides early identification and follow-up for treatment of infants affected by certain genetic, metabolic, hormonal and/or functional conditions.

Every year over 4 million infants are born in the U.S. and each infant is screened for certain heritable disorders and medical conditions. Newborn screening saves or improves the lives of more than 12,000 babies in the U.S. each year. For babies who test positive for one of these conditions, they receive rapid identification, early intervention and potentially life-saving treatments. Currently, the majority of states are testing for at least 29 of the 31 conditions on the Recommended Uniform Screening Panel (RUSP).

Improved Newborn and Child Screening For Heritable Disorders, Section 1109
The Severe Combined Immunodeficiency (SCID) Program began in FY 2014 to support wider implementation, education, and awareness of newborn screening for SCID and related disorders. The purpose of this program is to increase the number of states and/or territories that include screening for SCID as part of their newborn screening program. This results in a greater number of newborns that are screened, identified, and referred for treatment for SCID. Specifically, the program is focused on increasing the capacity of the following:

1. Newborn screening programs with laboratory capacity and performance capability to conduct newborn screening for SCID,
2. Active, sustainable SCID newborn screening programs,
3. Newborns screened for SCID,
4. Newborns referred to the medical community for SCID follow-up,
5. Newborns with SCID that demonstrate improved health outcomes and/or receive life-saving treatment, and

6. National, regional, and state education and awareness programs for parents, families, and patient advocacy and support groups.

Improving Timeliness of Newborn Screening Diagnosis, Section 1109
The Improving Timeliness of Newborn Screening Diagnosis initiative was awarded in FY 2015 as a cooperative agreement to improve the time to diagnosis and treatment for infants undergoing newborn screening who receive a presumptive positive result. Activities will include coordinating collaborative learning and quality improvement activities in newborn screening programs using practice-based strategies that improve timeliness. The overall goals for this initiative are to increase the number of states that meet the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children's recommendations on timeliness and the number of infants receiving timely diagnosis and treatment.

Newborn Screening Data Repository and Technical Assistance Center, Section 1109
The Newborn Screening Data Repository and Technical Assistance Center was awarded in FY 2014 as a cooperative agreement to provide technical assistance on the implementation of State-based public health newborn screening and other genetics programs, as appropriate, through resource development, State education and training, policy initiatives, disorder surveillance, evidence-based data collection, evaluation, and collaborative efforts with stakeholders. Activities support the collection of data to: increase awareness and understanding of newborn screening, to facilitate harmonization of newborn screening activities, and to improve the quality of newborn screening and related genetic services across the United States through innovation and technology.

Key goals of the program include:

1. Develop, coordinate, and provide technical assistance through innovative educational and quality improvement activities related to newborn screening and short term follow-up that are responsive to information gaps identified by providers and public health professionals; provide technical assistance and relevant resources so that States may assess and address their needs and challenges.
2. Incorporate current technology to develop a national newborn screening data repository to standardize, maintain, and analyze quantitative quality measures, case definitions and other data to evaluate the impact of State and Territorial newborn screening programs.
3. Support activities that strengthen the integration of child health information systems, laboratory performance and quality assurance, short and long term newborn screening follow-up and public health interactions at the community, state, regional, and national levels.
4. Provide a forum for timely, interactive communication between state and public health stakeholders.
5. Develop an innovative methodology for states to assess quality assurance and improvement within their newborn screening systems.

One of the accomplishments of the Newborn Screening Data Repository and Technical Assistance Center has been to establish a data repository that supports standardization, data-driven quality improvement, evaluation, bi-directional communication and information sharing. The repository has over 180 users and information from states across the nation. The Newborn

Screening Data Repository and Technical Assistance Center has also finalized newborn screening case definitions for public health surveillance.

Regional Genetic and Newborn Screening Service, Section 1109

Established in 2004, the grant program includes seven Regional Genetic Service Collaboratives (RCs) and a National Coordinating Center. The program supports newborn screening and long-term follow-up activities for infants and children with rare genetic conditions. The RCs continue to undertake a regional, collaborative approach to address the misdistribution of genetic resources and services, the quality of services, and issues in accessing and utilizing services faced by families and primary health care providers. Collaborative projects focus on the life course of the individuals affected with or at risk of heritable disorders and their families. Special emphasis is given to medically underinsured and rural populations with attention to cultural sensitivity.

The Collaboratives include all States, U.S. Territories, and the District of Columbia. The stakeholders represent State public health professionals, genetics specialists, primary care providers, consumers, and the public. Accomplishments include using telemedicine to increase newborn screening follow-up and genetic service visits to individuals with heritable disorders, developing standardized data sets and definitions of conditions on the RUSP for long-term monitoring of follow-up and treatment of inborn errors of metabolism by provider access, and developing an international informatics system for the collection and display of data from true positive patients identified through newborn screening.

The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, Section 1111

The Committee continues to: 1) provide advice, technical information and systematic evidence-based and peer-reviewed recommendations to the Secretary of Health and Human Services to enhance, expand or improve the ability of the Secretary to reduce the mortality or morbidity from heritable disorders; 2) address the public health impact of newborn screening expansion; 3) periodically update the RUSP, as appropriate, based on a decision-matrix to assess the net benefit of adding a condition to the RUSP and 4) consider ways to ensure that all States attain the capacity to screen for conditions on the RUSP.

In 2012, the Committee's decision matrix was refined in order to better serve the Committee as a methodological tool for systematically evaluating the magnitude and certainty of the net benefit of screening and the capacity of state newborn screening programs to implement screening for nominated conditions. In 2014, the Committee created a detailed assessment of the public health system impact of expanding newborn screening for conditions under review for the RUSP. The assessment includes a new process of evaluating the readiness and feasibility of adding new conditions within state newborn screening programs.

The Clearinghouse of Newborn Screening Information, Section 1112

The Clearinghouse cooperative agreement was re-competed and awarded in FY 2014 in order to establish and maintain a central, online clearinghouse of current educational newborn screening

information on information such as family support services; follow-up services; and other related materials, resources, and research. The intent is to increase awareness, knowledge and understanding of newborn screening for parents, family members, expectant individuals and families, and health professionals.

Key goals of the Clearinghouse include:

1. Create an interactive, web-based forum organized for multiple audiences that promotes information sharing and dissemination of authoritative and/or evidence-based materials. Special emphasis is given to lay informational and educational materials, community training initiatives, health care provider educational materials, newborn screening best practices and guidelines, and other information and tools that promote culturally sensitive education and decision-making regarding newborn screening for heritable disorders.
2. Conduct activities to increase awareness, knowledge and understanding of: 1) newborn screening for parents and family members of newborns, health professionals, industry representatives, policy-makers, and other members of the public; 2) newborn screening polices determined by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and 3) newborn genetic conditions and screening services for expectant individuals and families.
3. Promote and support communities in their efforts to understand the newborn screening process that is specific to their community, region and/or State.

One major accomplishment of the Clearinghouse is the development of a fully functional website, known as Baby's First Test, which houses all of the information for the Clearinghouse. The Clearinghouse also created a Spanish version of Baby's First Test. Using social media of the 21st century, the Clearinghouse has created a network of awareness and action. Since the Clearinghouse went live in 2011, there have been over 500,000 users of the Clearinghouse.

The Interagency Coordinating Committee (ICC) on Newborn and Child Screening, Section 1114

The ICC is composed of the Administrator of HRSA, the Director of CDC, the Director of AHRQ, and the Director of NIH. In addition there are other federal liaisons who inform the deliberations of the ICC. The ICC was delegated to HRSA and CDC to serve as co-chairs. Per the legislation, the ICC serves to respond to Secretarial requests to assess existing activities and infrastructure in order to make recommendations for programs to collect, analyze and make data available on the heritable disorders recommended by the Committee and coordinate collaborative efforts for newborn and child screening among all agencies in HHS.

Activities to date include responding to Secretarial requests to provide input regarding recommendations from the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children concerning: newborn screening for critical congenital heart disease, the use and storage of newborn screening residual blood samples, data quality assurance in newborn screening and newborn screening for Pompe disease.

Funding History

FY	Amount
FY 2012	$9,834,000
FY 2013	$9,314,000
FY 2014	$11,883,000
FY 2015	$13,883,000
FY 2016	$13,883,000

Budget Request

The FY 2015 Budget Request is $13,883,000. The FY 2016 Request is the same as the FY 2015 Enacted level.

Improved Newborn and Child Screening For Heritable Disorders, Section 1109

Continued funding for the SCID Program will support wider implementation, education, and awareness of newborn screening for SCID. The program can continue to assist states and territories to include screening for SCID as part of their newborn screening program so that more newborns are screened, identified, and referred for the appropriate treatment.

The Improving Timeliness of Newborn Screening Diagnosis initiative will allow for the continued development and implementation of quality improvement activities to improve the time to diagnosis and treatment for infants undergoing newborn screening who receive a presumptive positive result.

The 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 U.S. The Center will also be able to continue to work to ensure the quality of the newborn screening process including facilitating the harmonization of newborn screening standards and quality measures for newborn screening programs.

Regional Genetic and Newborn Screening Services Collaborative - 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. Continued funding will support the Collaboratives to provide a regional infrastructure of public health genomics to improve, expand, strengthen, and evaluate access and quality of a system of genetic services that improve health outcomes for children, youth and adults. The Collaboratives will continue to identify insurance coverage gaps for genetic testing and treatment services and analyze the impact of the ACA and State options on individuals with heritable disorders.

The Advisory Committee on Heritable Disorders in Newborns and Children, Section 1111

In accordance with the Newborn Screening Saves Lives Reauthorization Act of 2014, the Committee will continue to provide evidence based recommendations as well as technical

information to the Secretary regarding the heritable disorders and the implementation of newborn screening.

The Clearinghouse of Newborn Screening Information (Clearinghouse), Section 1112

Continued stable funding of the Clearinghouse will allow for ongoing support of a central repository of current educational and family support and services information, materials, resources and research.

The Interagency Coordinating Committee (ICC) on Newborn and Child Screening, Section 1114

The ICC will continue to undertake relevant activities authorized by the Newborn Screening Saves Lives Reauthorization Act of 2014 to collect and assess information regarding heritable disorders.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs

Grant Awards Table

(whole dollars)	**FY 2014 Final**	**FY 2015 Enacted**	**FY 2016 President's Budget**
Number of Awards	18	14	12
Average Award	$558,428	$863,071	$1,006,917
Range of Awards	$107,321 – $1,992,518	$107,321 – $2,000,000	$600,000 – $2,000,000

Family-To-Family Health Information Centers

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$5,000,000	$2,500,000*	---	-$2,500,000
FTE	1	1	---	-1

*The FY 2015 amount reflects funding appropriated by Congress in P.L. 113-93, the Protecting Access to Medicare Act of 2014.

Authorizing Legislation - Section 501(c)(1)(A) of the Social Security Act, as amended.

FY 2016 Authorization .....Expired[193]

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Family-to-Family Health Information Centers (F2F HICs) Program is authorized by the Family Opportunity Act of 2005 (P.L. 109-171, Sec. 6064) to fund family-staffed/run centers that provide information, education, technical assistance and peer support to families of children and youth with special health care needs (CSHCN). This program accomplishes this intent by assisting families and professionals so that "families of CSHCN will partner in decision making at all levels" of health care decision making.

The Program was extended through the Protecting Access to Medicare Act of 2014 (P.L.113-93, Sec. 207) with $2,500,000 for a portion of FY 2014 and $2,500,000 for a portion of FY 2015.[194]

In FYs 2010-2015, the Program supported F2F HICs in 50 States and the District of Columbia to: (1) assist families of CSHCN to 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 organizations, 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 be staffed by health professionals.

[193] Last fiscal year authorized was FY 2015.

[194] Previously, the Program was funded at $5 million per year by the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148, Sec. 5507(b)) through FY 2012 and the American Taxpayer Relief Act of 2012 (P.L. 112-240, Sec. 624) through FY 2013. It was additionally funded at $2.5 million for a portion of FY 2014 by the Sustainable Growth Rate Reform Act of 2013 (P.L. 113-67, Sec. 1203).

The evidence supporting the approach adopted by the Program includes National Survey studies, a multi-site study, Institute of Medicine Reports, the National Quality Forum, the Joint Commission, and the Agency for Healthcare Research and Quality (AHRQ).[195] Research also shows associations of family participation and family-centered care with improved transition to adult health care, fewer unmet needs, better community based systems, fewer problems with specialty referrals, lower out-of-pocket costs, improved patient (physical and behavioral) function, and increased adoption of a medical home/access to preventive health care.[196] Additionally, family/professional partnerships, shared decision making, and patient/family-centered care are regarded as national quality indicators.[197] The AHRQ endorses the need to help families navigate the health care system, recognize high-quality health care, become informed health care consumers, and develop skills in selecting a hospital, doctor, and health plan (highlighted also as a priority within the National Quality Strategy).[198]

Currently, 51 F2F HICs are collecting data on the issues facing families regarding services and the financing of those services, while working with state Medicaid, Education, and Title V offices, and other agencies to inform them of families' needs. In addition to serving on state-appointed task forces and Marketplace committees, the F2F HICs are disseminating information on the implementation of ACA and gathering feedback on family experiences as a result of ACA implementation in their respective states. Other information disseminated through fact sheets, social media, newsletters and listservs is helping families understand the new provisions and how they impact individual access to coverage. In addition, many F2F HICs are working with HRSA-funded Federally Qualified Health Centers to implement medical/health homes by providing training and educational materials. Some of the F2F HICs are working with the U.S. Department of Health and Human Services' Administration on Community Living's *Aging and Disability Resource Center*s on the "no wrong door" approach for sharing resource information across the lifespan for people with disabilities.

In the first year of the program (FY 2008), 75,532 families with CSHCN received information, education and/or training from F2F HICs.[199] In FY 2014, 178,539 families were served, exceeding the target of 124,000 families. In addition, 96% of families reported they were better able to partner in decision making, which exceeds the target of 87%. With the implementation of ACA, the number of families of CSHCN who are requesting F2F HIC assistance has increased, which was anticipated, and which is reflected in the notable increase in both program measures from FY 2013 to FY 2014. Since its inception, the F2F HICs Program has more than doubled the number of families served and realized an increase of over 36 percentage points in the proportion of families served who report F2F HICs assistance helped them be better partners in decision making at any level (i.e. shared decision making can occur at the individual family's level, peer level, community-, and/or systems-level).

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[195] Kenney et al. (2011); Singer et al. (1999); Kuo et al. (2012); IOM (2001); National Priorities Partnership (2008); Joint Commission (2010); AHRQ (2011).
[196] Ngui (2006); Scal (2005); Baruffi (2005); Smaldone (2005); Young (2005); Fiks et. al. (2012); Fiks et al. (2010); Jassen et al. (2007); Wilson et al. (2010); Smalley et al. (2013).
[197] IOM (2001); National Priorities Partnership (2008).
[198] AHRQ (2011).
[199] The baseline for the second measure (proportion of families served who reported the assistance received was either useful to extremely useful in helping them be better partners in decision making at any level) was established in FY 2009; 59.8% families reported a positive outcome for this measure.

FY 2015 data will be collected and reported in the fall of 2015.

Funding History

FY	Amount
FY 2012	$5,000,000
FY 2013	$4,745,000
FY 2014	$5,000,000
FY 2015	$2,500,000
FY 2016	---

Budget Request

The authorization for this program expires in FY 2015 and additional funds are not requested. Instead, families of children with special health care needs can seek support and wrap around services through state grants provided by the Maternal and Child Health Block Grant.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
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 (*Output)*	FY 2014: 178,539 Target: 124,000 (Target Exceeded)	137,000 [200]	N/A [201]	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 2014: 96% Target: 87% (Target Exceeded)	90%	N/A	N/A

[200] This target assumes F2F HICs will be operational for the entire FY.
[201] No targets are established for FY 2016 because the program is scheduled to expire in the previous FY.

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards[202]	51	51	N/A
Average Award	$95,700	$47,850[203]	N/A
Range of Awards	$95,700	$45,000 - $48,000	N/A

[202] The number of actual base awards.
[203] Estimate based on funding authorized through the Protecting Access to Medicare Act of 2014.

Maternal, Infant, and Early Childhood Home Visiting Program

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$371,200,000	$400,000,000*	$500,000,000	+$100,000,000
FTE	22	22	22	---

*The FY 2015 amount reflects funding appropriated by Congress in P.L. 113-93, the Protecting Access to Medicare Act of 2014.

Authorizing Legislation - Section 511 of the Social Security Act.

FY 2016 Authorization .....Expired

Allocation Methods:

- Direct federal/intramural
- Contract
- Formula grant/co-operative agreement
- Competitive grant/co-operative agreement

Program Description

The Maternal, Infant, and Early Childhood Home Visiting Program (the Home Visiting Program), administered by the Health Resources and Services Administration (HRSA) in close partnership with the Administration for Children and Families (ACF), supports voluntary, evidence-based home visiting services during pregnancy and to parents with young children up to kindergarten entry. States, territories, and tribal entities are eligible to receive funding through the Home Visiting Program and have the flexibility to tailor the program to serve the specific needs of their communities.

The HV Program provides voluntary, evidence-based home visiting services during pregnancy and to parents and primary caregivers with young children up to kindergarten entry.
The HV Program builds upon decades of scientific research, which shows that home visits by a nurse, social worker, or early childhood educator during pregnancy and in the first years of life provide important support services to children and families. Home visits improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness. Research shows that home visiting provides a positive return on investment to society through savings in public expenditures on things like emergency room visits, public benefits, child protective services, as well as increased tax revenues from parents' earnings.

By equipping parents with the skills they need to support the cognitive, socio-emotional and physical health and development of their children, the HV program works as part of a prenatal to age five continuum with the other parts of the President's Early Learning Initiative.

The HV Program requires States and tribal entities to direct their home visiting efforts to at-risk communities. The statute defines at-risk communities as those 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.[204]

States and tribal entities are eligible to receive funding through the HV Program and have the flexibility to tailor the program to serve the specific needs of their communities. In order to meet those needs, the statute required States and tribal entities to conduct needs assessments to identify eligible at-risk communities, determine priority populations, and choose which approved evidence-based models and promising and new approaches. Following the needs assessments, grantees worked with local implementing agencies to build infrastructure, train a high-quality home visiting workforce, establish data reporting and financial accountability systems, and develop referral networks to enroll families and facilitate service coordination in local communities.

Program Accomplishments

The HV Program provided nearly 1.4 million visits in three years of implementation. In 2014, States reported serving more than 115,000parents and children in 721 counties in all 50 States, the District of Columbia, and five jurisdictions as a result of the HV Program. This is compared to approximately 76,000 participants in 2013 and 34,000 in 2012. (See Figure 1 and 2 below) The first few years of the program were focused on building infrastructure in the States, and now programs are able to focus on expanding the number of families they serve, and sustaining services to those already served.. [205]

[204] 42 U.S.C. § 711(b)(1)(A).

[205] There are also 25 grants to tribes, tribal organizations, and urban Indian organizations funded through the HV program, and 2014 data for these grantees will be ready by the first quarter of 2015.

Figure 1: Growth in the Number of Participants (2012-2014)

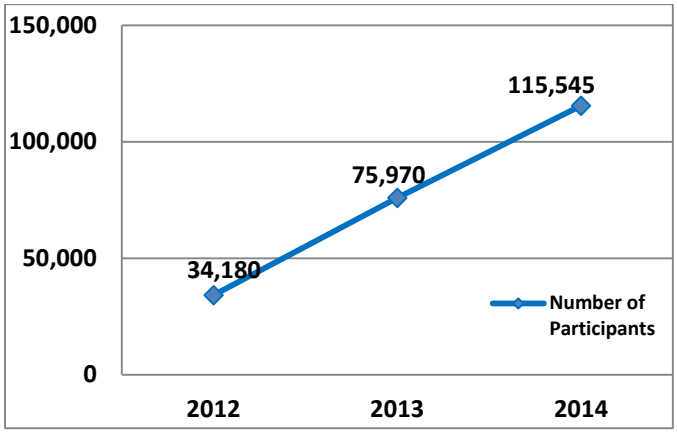
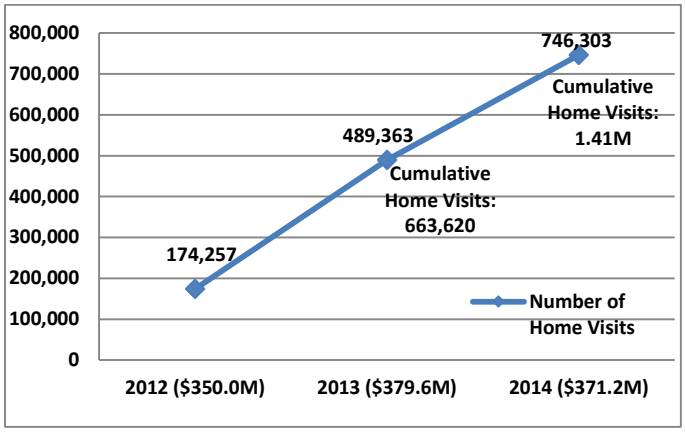


Figure 2: Growth in Number of Home Visits (2012-2014)



The Home Visiting Program currently serves approximately one third of the highest risk counties in the country as defined by the following indicators: low birth weight, teen birth rate, living in poverty and infant mortality rates.

The statute requires States and tribal grantees to report on quantifiable, measurable 3- and 5-year benchmarks for demonstrating that the program improves the health and well-being of families participating in the program. HHS will provide a report to Congress containing this data. HHS will continue to work with stakeholders to review and redesign the benchmark measures and reporting system to improve grantee performance measure reporting.

The statute also requires a full evaluation of the HV program. The Mother and Infant Home Visiting Program Evaluation (MIHOPE) will complete an analysis of the State needs assessments, review implementation of the program, and perform both an impact analysis and an economic analysis. MIHOPE will produce a report to Congress that includes information about families served as well as how States are spending their HV program funds. A full evaluation report on program implementation and impacts will be available in 2018.

Grant Information

Home Visiting grants are allocated to and support HV programs in all fifty States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa. Additionally, while most of the program funds are allocated to State home visiting grants and general technical assistance, three percent is set aside for awards available to Indian tribes (or a consortium of Indian tribes), tribal organizations, and urban Indian organizations and three percent is set aside for Research, Evaluation, and Corrective Action Technical Assistance to grantees.

Grants to States and territories are administered by the lead State agency designated by the Governor or by a nonprofit organization in those States or territories that opted not to participate in the formula grant program.

Tribal Home Visiting awards are awarded to an Indian Tribe (or a consortium of Indian Tribes), Tribal Organization, or Urban Indian Organization as defined in section 4 of the Indian Health Care Improvement Act.

A brief summary of Home Visiting grant allocations from FY 2010 to FY 2015 is provided below:

- In FY 2010, 56 State and territory formula grants and 13 Tribal Home Visiting cooperative agreements were awarded.

- In FY 2011, 55 State and territory formula grants, 22 State and territory competitive grants, and 6 new and 13 continuing Tribal Home Visiting cooperative agreements were awarded.

- In FY 2012, 53 State and territory formula grants; one grant (based on the State formula) to a non-profit organization to provide services in the State that relinquished funds (North Dakota); 16 new State and territory competitive grants in addition to 22 competitive continuation grants; and, 6 new awards to American Indian tribes (in addition to the 19 existing continuing Tribal Home Visiting awards).

- In FY 2013, 52 State and territory formula grants, and two new grants (based on the State formula) to non-profit organizations to provide services in the States that relinquished funds (Florida and Wyoming) in addition to one continuing nonprofit award (North Dakota); 13 new State and territory competitive grants in addition to 22 competitive continuation grants; and 25 continuing Tribal Home Visiting awards were awarded.

- In FY 2014, 52 State and territory formula grants, one new grant (based on the State formula) to a non-profit organization to provide services in Oklahoma, three continuing nonprofit awards, 33 continuing competitive grants to States, and 25 continuing Tribal Home Visiting awards were awarded.

- For FY 2015, Congress appropriated $400 million for the Home Visiting program for the period from October 1, 2014 through March 31, 2015 as part of the Protecting

Access to Medicare Act of 2014. All FY 2015 funds must be obligated prior to March 31, 2015. In FY 2015, we expect to award formula funds to 53 State and territory grantees and three nonprofit organizations, and approximately 35 competitive grants to expand the reach of voluntary, evidence-based home visiting programs. In addition, 25 continuing Tribal Home Visiting cooperative agreements will be awarded.

Funding History

FY	Amount
FY 2012 ACA Funding	$350,000,000
FY 2013 ACA Funding*	$379,600,000
FY 2014 ACA Funding*	$371,200,000
FY 2015**	$400,000,000
FY 2016	$500,000,000

*****The ACA included $400 million for the Maternal, Infant, and Early Childhood Home Visiting program in FY 2013 and FY 2014, but those amounts were reduced by 5.1% and 7.2%, respectively, due to sequestration in accordance with the Budget Control Act of 2011.
**The FY 2015 amount reflects funding appropriated by Congress in P.L. 113-93, the Protecting Access to Medicare Act of 2014.

Budget Request

The FY 2016 Budget Request is $500,000,000. The FY 2016 Request is $100,000,000 above the FY 2015 appropriation. The increased funding will allow up to 10 additional competitive State awards, and up to 11 additional Tribal awards, that would provide an estimated 130,000 additional home visits, and serve an estimated 35,000 additional families ,compared to FY2015 targets. . The requested funding will continue to support States and Tribal entities as they work with local implementing agencies to serve currently enrolled families, and to expand home visiting services to additional at-risk communities. This level of funding will provide:

- Awards to 53 State and territory grantees, and three non-profit organizations, and up to 10 additional competitive awards for a total of approximately 45 awards to expand the reach of voluntary, evidence-based home visiting programs to serve more at-risk communities and families;
- 6 continuation awards, and up to 30 new awards to American Indian tribes;
- Support for research, evaluation, and technical assistance for both corrective action and program improvement and enhancement for State and Tribal Home Visiting grantees.

Voluntary evidence-based home visiting services provided through home visiting programs are a critical element of the President's Early Learning initiative. These programs have been critical in improving maternal and child health outcomes in the early years, resulting in long-lasting, positive impacts on parenting skills, children's cognitive, language, social-emotional development, and school readiness. Home visiting programs have also been found to reduce Medicaid costs through fewer preterm births and emergency room use.

In FY 2016, the Budget proposes $15 billion for the HV program for FY 2016 to FY 2025, as follows:

FY 2016 - 2025 Total Mandatory Funding

FY	Amount (in millions)
2016	$500
2017	$500
2018	$1,000
2019	$1,000
2020	$1,500
2021	$1,500
2022	$2,000
2023	$2,000
2024	$2,500
2025	$2,500
	$15,000

The increased and sustained funding will allow HRSA and ACF to continue to support the State-, tribally- and locally-run evidence-based home visiting services that have been proven to prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness. Increased funding allows both State and tribal home visiting programs to reach additional at-risk communities and increase capacity in the communities they already serve, reaching greater numbers of families. And, additional funding will support the investments already made by the HV Program to develop a solid infrastructure at the State and community level to integrate home visiting with other comprehensive maternal and child health programs.

The funding for research and evaluation will continue to support activities such as the statutorily required national evaluation, a home visiting research network, contracts to support review of models as evidence-based and an early childhood research center. Technical assistance to grantees is of vital importance to ensure that home visiting services are provided with quality and fidelity to evidence-based models. The funding supports contracts for technical assistance around data analysis and systems, site visits, performance measurement, and quality improvement, as well as to evaluate promising practices, to support a tribal resource center, and to enhance the efficiency and effectiveness of home visiting programs through learning and improvement collaboratives.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
37.1: Number of home visits to families receiving services under the Home Visiting program.[206] (*Output*)	State/ Territory/ Tribal: FY 2014: 746,000 Target: 450,000 (Target Exceeded)	State/ Territory/ Tribal: 805,000	State/ Territory/ Tribal: 935,000	State/ Territory/ Tribal: +130,000
37.2: Number and percent of grantees that meet benchmark area data requirements for demonstrating improvement. (*Outcome-Developmental)*	N/A[207]	State/ Territory: 45 (80%) Tribal: N/A	State/ Territory: 50 (89%) Tribal: N/A	State/ Territory: +5 (9% point) Tribal: N/A
Number of participants served by the Home Visiting Program	State/ Territory[208]: FY 2014: 115,545	State/ Territory/ Tribal: 125,000	State/ Territory/ Tribal: 160,000	State/ Territory/ Tribal: +35,000

Grant Awards Tables

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	114	116	137
Average Award	$3,032,859	$3,215,014	$3,284,672
Range of Awards	$265,000-$11,923,154	$265,000-$9,400,000	$265,000-$10,000,000

[206] A home visit is the service provided by qualified professionals, delivered over time within the home to build relationships with the enrolled caregiver and the index child for improved outcomes. The number of "home visits" demonstrates the level of effort and service utilization for all enrollees and index children participating in the Home Visiting program.

[207] 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).

[208] Tribal data for 2014 will be available in the first quarter of 2015.

Ryan White HIV/AIDS

Tab

RYAN WHITE HIV/AIDS

Ryan White HIV/AIDS Treatment Extension Act of 2009 Overview

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$2,288,024,000	$2,318,781,000	$2,322,781,000	+$4,000,000
ADAP (non add)[209]	$900,313,000	$900,313,000	$900,313,000	---
MAI (non add)	$168,587,435	$169,077,000	$169,077,000	---
PHS Evaluation Fund Appropriation[210]	$25,000,000	---	---	---
Total Funding	$2,313,024,000	$2,318,781,000	$2,322,781,000	+$4,000,000
FTE	171	176	176	---

**The amounts include funding for Special Projects of National Significance (SPNS) funded from Department PHS Act evaluation set-asides in FY 2014. SPNS included in budget authority in FY 2015 and FY 2016.*

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 2016 Authorization……...…...Expired

Allocation Method .....Competitive and Formula Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP), the largest Federal program focused exclusively on domestic HIV/AIDS care, provides services that are intended to 1) reduce the use of more costly inpatient care; 2) increase access to care for underserved populations; and 3) improve the quality of life for people living with HIV (PLWH). Recent studies have demonstrated that individuals with HIV on antiretroviral medications who achieve viral load suppression are less likely to transmit HIV to others, reducing the chance of other Americans becoming infected. The RWHAP coordinates with cities, states, and local community-based organizations to deliver a comprehensive system of HIV care, treatment and support that are critical to ensuring that individuals with HIV are linked to and retained in care, able to adhere to their medication regimens, and ultimately, remain virally suppressed. This has important

[209] AIDS Drug Assistance Program (ADAP) Authorizing Legislation: 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.
[210] Special Projects of National Significance (SPNS) Authorizing Legislation: 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.

implications for both individual health outcomes as well as a significant public health impact on HIV incidence. The RWHAP serves as a payer of last resort. In 2012, the Program served approximately 536,000 low-income people with HIV/AIDS in the United States, 28 percent of which were uninsured, and an additional 59 percent are underinsured. The Ryan White HIV/AIDS Program is administered by the HIV/AIDS Bureau (HAB).

National HIV/AIDS Strategy: 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.

HIV disproportionately affects people who have less access to healthcare prevention and treatment services and, as a result, often have poorer health outcomes. The NHAS advocates adopting community-level approaches to reduce HIV infection in high-risk communities and to reduce stigma and discrimination against people living with HIV.

Studies have demonstrated that antiretroviral treatment reduces HIV transmission by more than 96 percent. Thus, the Ryan White HIV/AIDS Program plays a central role in meeting the first NHAS goal- preventing new HIV infections- by ensuring that individuals living with HIV have access to regular care and are started on and adhere to their antiretroviral medications.

The RWHAP plays a critical role in filling gaps in the health care system and reaching out to underserved and difficult to reach populations, as such, the program and the HAB have taken a leading role among agencies across the Federal government in meeting the second and third NHAS goals. HAB is working closely with its grantees to meet all three goals. The RWHAP demonstrated progress in successfully reaching and retaining people living with HIV, the second goal in NHAS. In 2012, the Program served 60% of the estimated persons that have been diagnosed with HIV infection in the United States and retained 82.1% of them in care.

HAB supports the White House Executive Order to accelerate improvements in HIV prevention and care in the United States through the HIV Care Continuum Initiative. Within the HIV care continuum, viral suppression is the key goal to improve individual health outcomes and reduce HIV transmission. In 2012, 75.1% of clients served by the RWHAP achieved viral suppression an increase from 69.5% seen in 2010.Individuals receiving HIV care through the RWHAP achieve higher viral suppression, in comparison to the national average of 30%. The Ryan White

Program‘s expert care model and comprehensive services are crucial to retaining and engaging PLWH in care as well as improving the health outcomes of those in care. The Ryan White Program system of care remains necessary to improve health outcomes such as linkage to, and retention in care, and access to medications that suppress viral load, reducing HIV transmission, and leading to fewer new HIV infections. Given there are still significant gaps in the HIV care continuum – the sequential stages of care from diagnosis to optimal treatment necessary for an AIDS-free generation – HAB refined its focus in its efforts to prevent and treat HIV infection.

The Minority AIDS Initiative (MAI) budget will continue the Ryan White HIV/AIDS Program's efforts to reduce HIV/AIDS-related health disparities, the third goal in NHAS, in communities of color, strengthen organizational capacity, and expand HIV-related services to minority populations. The MAI funds will support primary health care and related services; outreach and education to improve minority access to HIV treatment medications; and targeted, multidisciplinary education and training programs for health care providers treating minority PLWH.

Ryan White HIV/AIDS Program Budget Request: The RWHAP demonstrates a comprehensive and data-driven approach in how government has targeted dollars toward the development of a highly effective service delivery system. The distinct components of the Program serve very specific purposes. The FY 2016 Budget Request of $2.32 billion for the Ryan White HIV/AIDS Program includes:

Part A: $655.9 million, which provides grants for 24 Eligible Metropolitan Areas (EMAs) and 29 Transitional Grant Areas (TGAs) disproportionately affected by HIV/AIDS;

Part B: $1.315 billion, 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 $900.3 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: $280.2 million, which provides grants directly to 400 grantees (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 services. The request consolidates the Part D Program with the Part C Program to better target resources to points along the care continuum and populations most in need. Savings are expected by grantees and by the Federal government through increased efficiencies and decreased reporting burden;

Part F:

- $33.6 million for AIDS Education and Training Center (AETC) grants to organizations to support education and training of health care providers through regional centers, local performance sites, and national centers;
- $13.1 million for the HIV/AIDS Dental Reimbursement Program and the Community-Based Dental Partnership Program, both programs provide oral health treatment to patients with HIV disease; and

- $25.0 million for Special Projects of National Significance (SPNS). Examples of SPNS initiatives include expanding the capacity of grantees to:
    - 1) transform their clinical practice to improve the outcomes along the HIV care continuum;
    - 2) guide clinical care providers as they integrate behavioral health into their primary care; and
    - 3) utilize standard electronic client information data systems to report client level data. These SPNS initiatives reflect priorities of the NHAS.

*Ryan White Minority AIDS Initiative (MAI)**:*** Within the total amount included for the Ryan White HIV/AIDS Program, the FY 2016 Budget requests $169.1 million to address the disproportionate impact of HIV/AIDS on communities of color. Ryan White HIV/AIDS Program 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 RWHAP 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 2014	FY 2015	FY 2016
Part A	$53,876,000	$54,105,000	$54,105,000
Part B	$10,128,251	$10,145,000	$10,145,000
Part C	$71,012,000	$71,012,000	$94,683,000 *
Part D	$23,452,536	$23,671,000	N/A
Part F – AETC	$10,118,648	$10,144,000	$10,144,000
Part F – Dental	---	---	---
Total MAI Funding	$168,587,435	$169,077,000	$169,077,000

* Part C and Part D consolidated in FY 2016.

MAI 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 (only reported in the MAI Report; will be integrated into Ryan White Service Report (RSR) for reporting in 2016); and
3. the proportion of health care providers trained in the clinical management of HIV/AIDS who serve primarily uninsured and underinsured minority populations.

Ryan White HIV/AIDS Program Performance: The HIV/AIDS Bureau continues to demonstrate excellent performance in improving access to health care, improving health outcomes, improving quality of health care, and promoting efficiency. The RWHAP uses various strategies to achieve its performance goals including:

1. Targeting resources to high-risk, high-need 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 RWHAP works to improve access to health care by addressing the disparities in access, treatment, and care for populations disproportionately affected by HIV/AIDS including racial/ethnic minorities. The Program provides HIV/AIDS care and treatment services to a significantly higher proportion of racial/ethnic minorities than their representation among AIDS cases as reported by the Centers for Disease Control and Prevention (CDC):

- In FY 2008, 73 percent of the Ryan White HIV/AIDS Program clients were racial/ethnic minorities compared to 65.9 percent of CDC-reported AIDS cases.
- In FY 2009, 73 percent of the Ryan White HIV/AIDS Program clients were racial/ethnic minorities, compared to 66.4 percent of CDC-reported AIDS cases.
- In FY 2010, the proportion of racial/ethnic minorities in Ryan White HIV/AIDS-funded programs was 72 percent, compared to 66.5 percent of CDC-reported AIDS cases among racial/ethnic minorities.

- In FY 2011, 72.2 percent of Ryan White HIV/AIDS Program clients were racial/ethnic minorities, compared to 66.7 percent of CDC-reported AIDS cases among racial/ethnic minorities.

- In FY 2012, 72.6 percent of Ryan White HIV/AIDS Program clients were racial/ethnic minorities; compared to 67.1 percent of CDC – reported AIDS cases among racial/ethnic minorities.

The Program also serves a higher proportion of women relative to the number of AIDS cases reported nationally by the CDC:

- In FY 2008, 33 percent of persons served by the Ryan White HIV/AIDS Program were women, compared to 23 percent of CDC reported AIDS cases.

- In FY 2009, 32 percent of the Ryan White HIV/AIDS Program clients were women, compared to the 23.3 percent of CDC-reported AIDS cases.

- In FY 2010, the proportion of women in Ryan White HIV/AIDS funded programs was 31 percent, compared to 23.5 percent of CDC-reported AIDS cases among women.

- In FY 2011, 30.1 percent of Ryan White HIV/AIDS Program clients were women; compared to 24.8 percent of CDC-reported AIDS cases.

- In FY 2012, 29.1 percent of Ryan White HIV/AIDS Program clients were women; compared to 24.7percent of CDC-reported AIDS cases.

Improving Health Outcomes: From FY 2008 through FY 2012, State ADAP programs served 69,242 additional clients, an increase of 28.4 percent:

- FY 2008: 175,194 clients served through State ADAPs.

- FY 2009: 194,039 clients served through State ADAPs.

- FY 2010: 208,809 clients served through State ADAPs.

- FY 2011: 211,037 clients served through State ADAPs.

- FY 2012: 244,436 clients served through State ADAPs, exceeding the target by 27,112 clients.

Over these past five years, the convergence of several factors has resulted in significant growth in the persons served by ADAP including the economic downturn, a national HIV testing initiative that has brought more people infected with HIV into care, Federal recommendations for treatment of HIV regardless of CD4 count, continued improvements in HIV care and treatment that has prolonged survival, and increasing HIV prevalence. About 60 percent of HIV positive people in regular care in the United States received their medications through State ADAPs in 2012.

CDC estimates that more than 1.2 million people aged 13 years and older in the United States are living with HIV infection, and almost 1 in 7 (14 percent) are unaware of their HIV infection. Approximately 50,000 new infections occur each year. Beginning in FY 2011, HAB implemented changes for how HIV testing data is reported through the RSR. Prior to 2010, RWHAP-funded providers reported on all HIV testing, regardless of the source of funding for the testing, and approximately 40 percent of HIV testing reported was supported by funds other than RWHAP. Under the new RSR requirements, only HIV testing funded by the Program is reported, causing a decrease in the FY 2012 and FY 2011 figures relative to previous years. However, the new data provides a more accurate depiction of the impact of Ryan White HIV/AIDS Program funding, and demonstrates the important strides the Program has made in testing people who do not know their serostatus. The data below reflects the number of individuals tested for HIV antibodies both with positive and negative results:

- FY 2008: 739,779 persons learned their serostatus from the Ryan White HIV/AIDS Program.
- FY 2009: 871,696 persons learned their serostatus from the Ryan White HIV/AIDS Program.
- FY 2010: 1,205,257 persons learned their serostatus from the Ryan White HIV/AIDS Program.
- FY 2011: 679,531 persons learned their serostatus from Ryan White HIV/AIDS Programs.
- FY 2012: 657,596 persons learned their serostatus from the Ryan White HIV/AIDS Program, missing the target by 214,969.

Mother-to-child transmission in the U.S. has decreased dramatically since its peak in 1992 due to the implementation of universal testing for HIV for all pregnant women and the use of anti-retroviral therapy which significantly reduces the risk of HIV transmission from the mother to her baby. The percentage of HIV-positive pregnant women in the Ryan White HIV/AIDS Program receiving antiretroviral medication has grown 8.6 percent from FY 2008 through FY 2012.

- In FY 2011, 92.3 percent of HIV-positive pregnant women served by the Ryan White HIV/AIDS Program received antiretroviral medications, an increase above the FYs 2008, 2009, and 2010 level of 87 percent.
- In FY 2012, 95.6 percent of HIV-positive pregnant women in the Ryan White HIV/AIDS Program were prescribed antiretroviral therapy to prevent maternal to child (vertical) transmission of HIV, exceeding the target.

Improving the Quality of Health Care: A major focus of the RWHAP is improving the quality of care that participating 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. The Act also required 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. In FY 2012, 96.8 percent of Ryan White HIV/AIDS Program-funded primary care medical providers had implemented a quality management program, exceeding the FY 2012 target, and demonstrating a 4.5 percent increase over FY 2008.

CD4 cell measurement is a test used to assess the functioning of the immune system. Viral load tests measure the amount of HIV in the blood and are used along with CD4 cell counts to monitor response to therapy. In FY 2012, 87.4 percent of clients were tested for CD4 and 86.0 percent were tested for viral load, falling short of the target for CD4 tests by 0.8 percentage points and exceeding the target of clients receiving viral load testing by 1.7 percentage points. In FY 2011, HAB implemented a client-level data reporting system, the RSR, requiring CD4 count and viral load data to be collected by all clients that are served.

Containing Costs: Across the RWHAP, grantees are encouraged to maximize resources and leverage efficiencies. One example of this is within Part B, where State ADAPs use a variety of strategies to maximize resources, which results in a more effective use of funding and enables ADAPs to serve more people. Cost-containment approaches 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 levels. In 2012, State ADAPs participating in cost-savings strategies on medications saved $989.8 million, exceeding the FY 2012 target by $373.7 million.

Funding History

FY	Amount[211]
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
FY 2013	$2,248,638,000
FY 2014	$2,313,024,000
FY 2015	$2,318,781,000
FY 2016	$2,322,781,000

Budget Request

The FY 2016 Budget Request for the Ryan White HIV/AIDS Programs of $2,322,781,000 is $4,000,000 above the FY 2015 Enacted level.

In FY 2016, the RWHAP will continue its central goals of:

[211] Includes SPNS.

1) ensuring that individuals living with HIV have access to care, and
2) improving the quality of life of those infected with HIV and those affected by the epidemic.

In cities and states where the number of insured RWHAP clients begins to increase, the Program will continue to provide services not covered by insurance but which are critical to providing quality comprehensive HIV care and improved health outcomes.

In FY 2016, the HAB will work with grantees to increase their focus on and support of services along the HIV care continuum that are not covered by insurance but which are critical to ensuring that HIV positive individuals are linked into care and started on antiretroviral medications as early as possible. This work will ensure that individuals living with HIV are linked into care and begin and adhere to life-saving antiretroviral medications. Achieving this goal is not only crucial to ensuring the health and wellbeing of individuals living with HIV, but to preventing further transmission of the virus and ultimately ending the HIV epidemic.
The RWHAP provides as system of primary medical care, treatment and supportive services to 2 out of 3 people in the United States who have been diagnosed with HIV. The RWHAP serves low-income PLWH who are uninsured or have some kind of healthcare coverage. A majority of the clients served by the Ryan White Program rely on the program for services not typically covered by private health insurers, Medicaid, or Medicare. The RWHAP has developed a robust system of care that provides the services needed to help keep people in care and achieve quality health outcomes like viral suppression.

People Living with HIV/AIDS who are on the appropriate medications are less infectious and reduce the chance of other Americans becoming infected. The importance of helping PLWH reach viral suppression through antiretroviral medications and other supports has been highlighted by studies demonstrating that antiretroviral treatment reduces HIV transmission by more than 96 percent. The RWHAP will continue to meet this mission until we get to zero new infections.

The RWHAP will continue to appropriately target men who have sex with men, youth (age 13 – 24), racial/ethnic minorities, specifically Black and Latino populations, 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. Men who have sex with men are over forty times more likely to become infected with HIV compared with other men, and young black men are the only population in the United States in which the rate of new HIV infections are increasing. In 2012, an estimated 64% of all diagnosed infections were attributed to male-to-male sexual contact. At some point in their lifetimes, 1 in 16 black men will be diagnosed with HIV infection, as will 1 in 32 black women. The estimated rate of new HIV infections for African American women was 20 times that of white women and almost 5 times that of Hispanic/Latino women. With regard to women, data from the 2011 year end CDC Surveillance Report show that together, black and Hispanic women represent 28 percent of all U.S. women. However, women in these two groups accounted for 79 percent of the estimated total of all women diagnosed with HIV infection. The FY 2016 targets for the proportion of racial/ethnic minorities and women served in Ryan White HIV/AIDS-funded programs are within three percentage points of national HIV/AIDS prevalence data provided to HRSA by CDC. With FY 2016 resources, the RWHAP will also target youth. Youth aged 13 to 24 made up 17% of the

U.S. population, but accounted for an estimated 26% (12,200) of all new HIV infections (47,500) in the United States in 2010. Appropriate care and treatment services are needed to protect the health of this generation at risk.

In FY 2016, the Ryan White HIV/AIDS Program will aim to reach the following performance targets. The number of clients served by ADAPs given the FY 2016 Budget Request is predicted to be 212,107 clients. The ADAP target reflects adjustments for our current performance and 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 2016 target for persons who learn their serostatus from Ryan White HIV/AIDS programs is 676,003. The Budget will also support the Program's ongoing efforts to improve the quality of health care for PLWH. The FY 2016 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 percent. The FY 2016 targets for HIV infected clients who are tested for viral load is 84.3 percent.

In FY 2016, the RWHAP will continue to coordinate and collaborate with other 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 who are uninsured or underinsured. The HIV/AIDS Bureau'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 Services (CMS), Indian Health Service (IHS), the National Institutes of Health (NIH), the 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.

Funding in FY 2016 also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs. The funding request supports our improved RSR data collection and reporting system for reporting unduplicated, client-level data. The RSR allows the RWHAP and its grantees to track true numbers of clients in care, as well as the services received by each client, the quality of those services, and health outcomes. From identifying populations that fell out of care to charting a clients' response to a new treatment regimen, the client-level data provide a picture of what Ryan White providers are doing well and what they can do better, thereby supporting quality improvement efforts. RSR data assists HAB in ensuring the most effective use of its funding in increasing access to treatment and care and addressing health disparities. This is supportive of HRSA's agency-wide aim to strengthen its capacity to assess program quality, reach, and impact.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
16.1: Number of racial/ethnic minorities and the number of women served by Ryan White HIV/AIDS-funded programs.[212] *(Outcome)*	FY 2005: 412,000/ 195,000 (Baseline)	N/A	N/A	N/A
16.I.A.1: Proportion of persons served by the Ryan White HIV/AIDS Program who are racial/ethnic minorities. *(Outcome)*	FY 2012: 72.6% CDC = 67.1% (Target Exceeded)	Within 3 percentage points of CDC data[213]	Within 3 percentage points of CDC data	Maintain
16.I.A.2: Proportion of persons served by the Ryan White HIV/AIDS Program who are women. *(Outcome)*	FY 2012: 29.1% CDC = 24.7% (Target Not Met)	Within 3 percentage points of CDC data[214]	Within 3 percentage points of CDC data	Maintain
16.III.A.3: Proportion of HIV infected Ryan White HIV/AIDS Program clients that received medical care who were tested for viral load. *(Output*	FY 2012: 86.0% [215] Target: 84.3% (Target Exceeded)	84.3%	84.3%	Maintain
16.2: Reduce deaths of persons due to HIV infection.[216] *(Outcome)*	FY 2003: 4.7 per 100,000 (Baseline)	N/A	N/A	N/A

[212] This is a long-term measure without annual targets. FY 2014 is the long-term target year. The FY 2014 target is 422,300/199,875.

[213] This is a new FY 2015 target "Within 3 percentage points of CDC data" and it will be reported using national HIV/AIDS prevalence data provided to HRSA by CDC rather than previous target through FY 2014 of "5 percentage points above CDC data" as reported by national AIDS prevalence data reported in CDC's HIV Surveillance Report. HAB will report on this measure using the "5 percentage points above CDC data" as reported by national AIDS prevalence data from CDC's HIV Surveillance Report through FY 2014. The FY 2014 data from HABs RSR will be available in October 2015 and the CDC comparison data from the HIV Surveillance Report may be available around July 2016.

[214] This is a new FY 2015 target "Within 3 percentage points of CDC data" and it will be reported using national HIV/AIDS prevalence data rather than previous target through FY 2014 of "5 percentage points above CDC data" as reported by national AIDS prevalence data. HAB will report on this measure using the "5 percentage points above CDC data" as reported by national AIDS prevalence data through FY 2014. The FY 2014 data from HABs RSR will be available in October 2015 and the CDC comparison data may be available around July 2016.

[215] The results differ from that shown in the FY 2015 CJ due to data corrections.

[216] This is a long-term measure without annual targets. FY 2014 is the long-term target year. The FY 2014 target is 3.1 per 100,000.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
16.II.A.1: Number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs annually. *(Output)*	FY 2012: 244,436 Target: 217,324 (Target Exceeded)	212,107	212,107	Maintain
16.II.A.2: Number of persons who learn their serostatus from Ryan White HIV/AIDS Programs. *(Output)*	FY 2012: 657,596 Target: 872,565 (Target Not Met)	676,003	676,003	Maintain
16.II.A.3: Percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive antiretroviral medications. *(Output)*	FY 2012: 95.6% Target: 90% (Target Exceeded)	90%	90%	Maintain
16.3: Percentage of Ryan White HIV/AIDS Program- funded HIV primary medical care providers that have implemented a quality management program and will meet two "core" standards included in the "Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents".[217]	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 2012: 96.8%[218] Target: 95.7% (Target Exceeded)	95.7%	95.7%	Maintain
16.E: Amount of savings by State ADAPs' participation in cost-savings strategies on medications. *(Containing Costs)*	FY 2012: $989.8M Target: $616.1M (Target Exceeded)	Sustain prior year results	Sustain prior year results	Maintain

[217] This is a long-term measure without annual targets. FY 2014 is the long-term target year. The FY 2014 target is 90%. The wording of this measure was changed to delete the "October 10, 2006" date because these Guidelines were reissued May 1, 2014.
[218] The results differ from that shown in the FY 2015 CJ due to data corrections.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
Discontinued Measure[219] 16.III.A.2: Proportion of HIV infected Ryan White HIV/AIDS Program clients that received medical care who were tested for CD4 count and viral load. (Output)	FY 2012: CD4 – 87.4%[220] Viral Load – 86.0%[221] Target: CD4-88.2% Viral Load-84.3% (CD4 Target Not Met but Improved; Viral Load Target Exceeded)	CD4=88.2% Viral Load = 84.3%	N/A	N/A

[219] HHS Treatment Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents have changed in recommended frequency of CD4 Count Monitoring. This change emphasizes that viral load is the most important measure of response to ART, and should be monitored during therapy to assure consistent viral suppression. CD4+ T-lymphocyte cell count (CD4 count) monitoring is recommended less frequently and therefore is being removed from this measure.
[220] The results differ from that shown in the FY 2015 CJ due to data corrections.
[221] The results differ from that shown in the FY 2015 CJ due to data corrections.

Emergency Relief Grants – Part A

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$649,373,000	$655,876,000	$655,876,000	---
MAI (non add)	$53,876,000	$54,105,000	$54,105,000	---
Total Funding	$649,373,000	$655,876,000	$655,876,000	---
FTE	48	49	49	---

Authorizing Legislation: 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.

FY 2016 Authorization…….……..…….Expired

Allocation Method ..... Competitive and Formula Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

Ryan White HIV/AIDS Program Part A funds provide direct financial assistance to an Eligible Metropolitan Area (EMA) or a Transitional Grant Area (TGA) that has been severely affected by the HIV epidemic. Formula and supplemental grants assist eligible areas in developing or enhancing access to a comprehensive continuum of high quality, community-based care for low-income individuals with HIV. The Ryan White HIV/AIDS Program (RWHAP) requires EMAs and TGAs, as population centers that experience a high burden of HIV/AIDS, to develop coordinated service delivery systems of care for persons living with HIV/AIDS.

Part A of RWHAP prioritizes primary medical care, access to anti-retroviral therapies, and other core services as the areas of greatest medical 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 EMAs, which are jurisdictions with 2,000 or more AIDS cases over the last five years, and 28 TGAs (jurisdictions with at least 1,000 but fewer than 2,000 AIDS cases over the last five years). 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 remaining funds are awarded as discretionary supplemental grants based on the demonstration of additional need by the eligible EMAs and TGAs, and as Minority AIDS Initiative (MAI) grants. MAI grant awards are determined based on the number of minorities living with HIV and AIDS in a jurisdiction.

In 2012, 76 percent of Part A clients were people of color and 28 percent were women. In 2008, Part A provided 2.6 million visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health), 2.59 million visits in FY 2009, 2.63 million

visits in FY 2010, and 1.994 million visits in 2011. In FY 2012, Part A provided 2.28 million visits for health-related care (primary medical, oral health, mental health, substance abuse, home health, and home and community based services). This did not meet the target due to change in the data source used for measuring HAB's performance, resulting in a lower number of calculated visits. In the historic data source (RDR), the data were limited to funding source. However, visit data were provided in the aggregate. In the current data source (RSR), the data are filtered at a more precise level resulting in the exclusion of data that may have been included in the historical aggregate data run.

Part A supports a comprehensive continuum of high-quality, community-based care for low-income individuals and families with HIV/AIDS. Eligible service categories include core medical services and support services, as defined by the legislation. Use of Part A RWHAP funds is locally determined, guided by a Planning Council, mandated by statute for EMA grantees and established by the chief elected official of each EMA or TGA. Eligible organizations for sub-grants under Part A include ambulatory care facilities, community health centers, and a variety of other organizations serving PLWH.

Funding History

FY	Amount
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	$666,071,000
FY 2013	$624,262,000
FY 2014	$649,373,000
FY 2015	$655,876,000
FY 2016	$655,876,000

Budget Request

The FY 2016 Budget Request for the Ryan White HIV/AIDS Part A Program of $655,876,000 is equal to the FY 2015 Enacted level and will support program activities and services for PLWH in the 24 Eligible Metropolitan Areas (EMAs) and 29 Transitional Grant Areas (TGAs).

This request addresses ongoing program implementation during a period of significant change. An estimated 71 percent of all persons living with HIV infection reside in 1 of the 52 metropolitan areas funded under the Part A Program and increasingly diverse and challenging (from the perspective of service delivery) populations are impacted with an ever-changing epidemiologic profile. The clinical paradigm has changed significantly such that ongoing and effective treatment can not only enhance the quality and length of life but can suppress the virus and reduce further infections. Thus, the Part A program has a significant public health impact on HIV incidence. A national framework and set of goals have been established through the National HIV/AIDS Strategy and White House Continuum of Care Initiative as a new lens

through which to consider programming. These factors provide a new context which will shape the future role of the Ryan White Part A program, one uniquely focused on heavily impacted metropolitan areas that must further develop and sustain a comprehensive system of HIV care.

In FY 2016, Part A grantees will continue to provide services not covered by private or public coverage but which are essential to:

1) providing quality comprehensive HIV care such as intensive case management and care coordination services, and
2) linking individuals living with HIV into care, initiating ART as early as possible, and retaining them in care.

Supporting interventions that get people linked into care and on medications is critical to prevent the spread of the epidemic as studies have found that treatment reduces HIV transmission by more than 96 percent. Cities in jurisdictions without significant Medicaid expansion will continue to use their RWHAP Program funds to provide critical primary care services and life-saving medication.

Part A jurisdictions are experienced in data-driven, community-based needs assessment, responsive procurement of a variety of direct medical and supportive services, working with a set of providers to weave together a constellation of services, serving diverse populations and continuing to improve efforts to positively impact the continuum of HIV care. The Part A program will have an even greater role, focused within individual jurisdictions, to address movement along the HIV care continuum for individuals living with HIV and improvements overall at the community or systems level. Part A uniquely retains requirements and structures that can address the establishment of an effective HIV continuum of care, set targets, measure and evaluate improvement and consider performance against the care continuum and established HHS measures.

The FY 2016 target for the number of visits for health-related care (primary medical, dental, mental health, substance abuse, and home health) is 1.963 million visits. Part A funding will also contribute to achieving the FY 2016 targets for the RWHAP's over-arching performance measures, including proportion of racial/ethnic minorities and women served, persons tested for viral load, and providers implementing a quality management program.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
17.I.A.1: Number of visits for health-related care (primary medical; oral health; mental health; substance abuse; home health; and home and community based services). *(Output)*	FY 2012: 2.28 M Target: 2.63 M (Target Not Met but Improved)	1.963 M	1.963 M	Maintain

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	52	53	53
Average Award	$11,894,084	$11,950,000	$11,950,000
Range of Awards	$2,758,503-$103,919,569	$2,748,000-$104,959,000	$2,748,000-$104,959,000

Part A – FY 2014 Formula, Supplemental & MAI Grants[222]

Table 1. Eligible Metropolitan Areas

EMAs	Formula[223]	Supplemental	MAI	Total
Atlanta, GA	$13,765,356	$6,421,008	$2,099,546	$22,285,910
Baltimore, MD	10,059,984	5,265,590	1,669,979	16,995,553
Boston, MA	8,651,252	4,738,951	932,112	14,322,315
Chicago, IL	16,546,056	8,874,633	2,351,365	27,772,054
Dallas, TX	9,956,934	4,354,017	1,200,537	15,511,488
Detroit, MI	5,486,201	2,772,927	798,173	9,057,301
Ft. Lauderdale, FL	9,738,020	5,021,110	1,253,632	16,012,762
Houston, TX	13,116,972	6,503,414	1,930,538	21,550,924
Los Angeles, CA	25,021,844	11,670,428	3,264,249	39,956,521

[222] Awards to EMAs and TGAs include prior year unobligated balances.
[223] Hold Harmless expired in FY 2014.

EMAs	Formula[223]	Supplemental	MAI	Total
Miami, FL	15,237,033	8,325,166	2,607,226	26,169,425
Nassau-Suffolk, NY	3,400,676	1,868,449	438,525	5,707,650
New Haven, CT	3,497,042	1,797,254	473,157	5,767,453
New Orleans, LA	4,632,272	2,436,383	629,383	7,698,038
New York, NY	61,418,269	32,679,058	9,822,242	103,919,569
Newark, NJ	7,708,198	3,828,097	1,313,719	12,850,014
Orlando, FL	5,904,531	2,974,244	746,717	9,625,492
Philadelphia, PA	14,034,402	7,398,245	2,082,613	23,515,260
Phoenix, AZ	5,523,522	2,761,425	478,838	8,763,785
San Diego, CA	6,919,442	3,515,958	658,662	11,094,062
San Francisco, CA	9,888,419	5,252,145	756,986	15,897,550
San Juan, PR	6,706,656	3,430,108	1,313,609	11,450,373
Tampa-St. Petersburg, FL	6,116,203	3,177,568	628,509	9,922,280
Washington, DC-MD-VA-WV	18,686,170	9,125,111	2,923,611	30,734,892
West Palm Beach, FL	4,554,845	2,415,725	682,915	7,653,485
Subtotal EMAs	**$286,570,299**	**$146,607,014**	**$41,056,843**	**$474,234,156**

Table 2. Transitional Grant Areas[224]

TGAs	Formula	Supplemental	MAI	Total
Austin, TX	$2,846,002	$1,355,193	$285,686	$4,486,881
Baton Rouge, LA	2,709,164	1,264,734	433,063	4,406,961
Bergen-Passaic, NJ	2,556,802	1,305,924	346,538	4,209,264
Charlotte-Gastonia, NC-SC	3,736,025	1,649,382	537,286	5,922,693
Cleveland, OH	2,836,803	1,348,819	348,941	4,534,563
Columbus, OH	2,866,700	1,250,767	250,945	4,368,412
Denver, CO	5,195,822	2,437,074	357,463	7,990,359
Fort Worth, TX	2,622,922	1,221,444	297,485	4,141,851
Hartford, CT	2,150,313	1,069,152	284,593	3,504,058
Indianapolis, IN	2,611,998	1,295,568	249,634	4,157,200
Jacksonville, FL	3,661,281	1,782,196	499,486	5,942,963
Jersey City, NJ	3,158,775	1,671,436	463,762	5,293,973
Kansas City, MO	2,840,253	1,382,260	263,945	4,486,458

[224] Note: In FY 2014, Ponce, PR was not eligible for a Part A grant. Rather, a one-time transfer of Part A funds was made to Part B.

TGAs	Formula	Supplemental	MAI	Total
Las Vegas, NV	3,722,801	1,618,311	366,749	5,707,861
Memphis, TN	4,343,747	2,019,747	703,345	7,066,839
Middlesex-Somerset-Hunterdon, NJ	1,689,778	852,303	216,422	2,758,503
Minneapolis-St. Paul, MN	3,645,183	1,727,141	336,705	5,709,029
Nashville, TN	2,969,041	1,394,104	299,124	4,662,269
Norfolk, VA	3,650,932	1,752,595	528,765	5,932,292
Oakland, CA	4,233,931	1,939,987	516,092	6,690,010
Orange County, CA	3,914,834	1,846,847	391,439	6,153,120
Portland, OR	2,663,168	1,342,878	117,989	4,124,035
Riverside-San Bernardino, CA	4,910,072	2,236,482	448,030	7,594,584
Sacramento, CA	2,118,116	983,920	171,193	3,273,229
Saint Louis, MO	3,926,333	1,855,820	443,660	6,225,813
San Antonio, TX	2,998,939	1,438,558	423,777	4,861,274
San Jose, CA	1,888,136	900,693	205,607	2,994,436
Seattle, WA	4,624,322	2,139,760	295,191	7,059,273
Subtotal TGAs	**$91,092,193**	**$43,083,095**	**$10,082,915**	**$144,258,203**
Subtotal EMAs/TGAs	**$377,662,492**	**$189,690,109**	**$51,139,758**	**$618,492,359**

HIV Care Grants to States – Part B

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$1,314,446,000	$1,315,005,000	$1,315,005,000	---
ADAP (non add)	$900,313,000	$900,313,000	$900,313,000	---
MAI (non add)	$10,128,251	$10,145,000	$10,145,000	---
Total Funding	$1,314,446,000	$1,315,005,000	$1,315,005,000	---
FTE	71	73	73	--

Authorizing Legislation: 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.

FY 2016 Authorization……Expired

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 five U.S. Pacific Territories or Associated Jurisdictions to provide services for people living with HIV, including outpatient ambulatory medical care, HIV-related prescription medications, case management, oral health care, health insurance premium and cost-sharing assistance, mental health and substance abuse services, and support services.

Part B includes the AIDS Drug Assistance Program (ADAP), which supports the provision of HIV medications and related services, including health insurance premium and cost-sharing assistance. 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 base and ADAP supplemental grants, Emerging Communities (ECs) grants, and Minority AIDS Initiative grants. 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. The ECs are metropolitan areas that do not qualify as EMAs or TGAs but have 500-999 cumulative reported AIDS cases over the last five years. States apply on behalf of the ECs for funding through the Part B base grant application. Part B Supplemental grants are available through a competitive process to eligible states with demonstrated need.

Congress designates a portion of the Part B appropriation to support the ADAPs. The ADAPs provide FDA-approved prescription medications for people with HIV/AIDS who have limited or no prescription drug coverage or who need assistance with insurance cost-sharing to afford HIV medications. The ADAP funds are distributed by a formula based on living HIV/AIDS cases; ADAP Supplemental funds are a five percent 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, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, the Republic of Palau, and the Republic of the Marshall Islands.

In FY 2012, the ADAPs served 244,436 clients, exceeding the target. In FY 2011, the ADAPs served 211,037 clients. The number of ADAP clients served in FY 2010 was 208,809. In FY 2009, the ADAPs served 194,039 clients. In FY 2008, the ADAP served 175,194 clients. In the period, FY 2008 – FY 2012 substantial growth occurred in the persons served in the State ADAP programs of 28.3% percent or 69,242 additional ADAP clients. About 60 percent of HIV positive people in regular care (defined as two or more medical visits per year) in the United States received their medications through State ADAPs in 2012. In FY 2012, 62.3 percent of the 244,436 clients served by ADAPs were people of color. Nationally, more than 79.2 percent of ADAP clients had incomes at or below 200 percent of the federal poverty level.

Over the past four years, the convergence of several factors has resulted in significant budget challenges for the Ryan White HIV/AIDS Program Part B program. These include the economic downturn, a national HIV testing initiative that has diagnosed and brought more people infected with HIV into medical care and medication treatment, federal recommendations for treatment of HIV regardless of CD4 count, continued improvements in HIV care and treatment that has prolonged survival and therefore, increasing HIV prevalence, and decreased investments over time. Ryan White HIV/AIDS Program 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.

Due to the combination of factors mentioned above, a number of States implemented cost-containment measures for their Part B ADAPs. Cost-containment measure include: reducing ADAP formularies, capping enrollment, lowering financial eligibility levels, implementing waiting lists for people to enroll in their ADAP. In addition, States implemented cost-savings strategies such as recovering costs when another payor was primary, coordinating benefits with Medicare Part D, and improving drug purchasing models. In particular, State ADAPs reported savings by participating in manufacturer rebate programs and recovering costs through insurance reimbursement of $989 million in 2012.

Since FY 2010, HHS has taken several actions to address the ADAP crisis:

- In FY 2010, HHS used emergency authority to redistribute and transfer $25 million from other HHS resources to provide direct assistance to help State ADAP programs eliminate their waiting lists and to address cost containment measures.

- The FY 2011 appropriation provided an increase of $50 million for State ADAPs, including $40 million in emergency relief funding.

- In FY 2012, $75 million in emergency funding was provided for ADAPs, including $35 million in redirected funding announced by President Obama on World AIDS Day and $40 million in continuation emergency funding first appropriated in FY 2011.
- In FY 2013, HHS redirected an additional $35 million above the FY 2013 appropriations for State ADAPs, bringing the total for ADAP emergency relief funding to $75 million.
- In FY 2014, HHS leveraged $73 million from the ADAP appropriation to support emergency relief efforts to help State ADAP programs eliminate their waiting lists and to address cost containment measures.

As a result of the increased investments in ADAP and the increased technical assistance activities for cost-containment measures, the program was able to serve 244,436 clients with HIV-related medications in FY 2012 and thousands more were provided with insurance coverage. ADAP waiting lists decreased from a peak of 9,310 in September, 2011, to zero in November, 2013, because of these directed efforts. In February 2014, Utah re-opened it ADAP waiting list with three individuals and by July, 2014 Utah's ADAP waiting list grew to 23 individuals. With technical assistance provided by HAB, Utah eliminated its waiting list, and now ADAP waiting lists nationwide are once again zero.

The Ryan White HIV/AIDS Program Part B programs have been successful in helping to ensure that people living with HIV have access to the care and treatment services they need to live longer, healthier lives. Recent studies have demonstrated that individuals with HIV on antiretroviral medications who achieve viral load suppression are less likely to transmit HIV to others. The Ryan White HIV/AIDS Program provides the care and treatment services that support the achievement of viral suppression and therefore, has a significant public health impact on HIV incidence as well. These efforts demonstrate the central role of the Ryan White HIV/AIDS Program in meeting the NHAS goals by ensuring that individuals living with HIV have access to regular care, are started on, and adhere to their antiretroviral medications.

The number of visits for health-related services demonstrates the scope of the Part B program in delivering primary care and related services for people living with HIV by increasing the availability and accessibility of care. In FY 2008, Part B provided 2.02 million visits for health-related care (primary medical; oral health; mental health; substance abuse; home health; and home and community based services); 2.11 million visits for health-related care in FY 2009; 2.20 million visits were provided for health-related care in FY 2010 and Part B program provided 1.086 million visits for health-related care in FY 2011. In FY 2012, the Part B program provided 2.04 million visits for health-related care. This did not meet the FY 2012 target due to the change in the data source used for measuring HAB's performance, resulting in a lower number of calculated visits. In the historic data source (RDR), the data likely over included visits. In the current data source (RSR), the data are filtered at a more precise level resulting in the exclusion of data that may have been included in the historical run given the way the analysis was done with aggregate data or data combined from several elements. The change in the data source from RDR to RSR resulted in a lower number of calculated visits which is attributed to using client-level data (RSR) and how the data analysis is done.

Funding History

FY	Amount	ADAP (Non-Add)
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)[225]
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	$1,360,827,000	($933,299,000)
FY 2013	$1,287,535,000	($886,313,000)
FY 2014	$1,314,446,000	($900,313,000)
FY 2015	$1,315,005,000	($900,313,000)
FY 2016	$1,315,005,000	($900,313,000)

Budget Request

The FY 2016 Budget Request for the Ryan White HIV/AIDS Part B Program of $1,315,005,000 is equal to the FY 2015 Enacted level. The FY 2016 Budget Request includes $900,313,000 for ADAPs to provide access to life saving HIV related 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. Studies have shown that successful treatment of HIV infection can reduce the risk of HIV transmission by more than 96percent; therefore, the Ryan White HIV/AIDS Program plays a key role in controlling the epidemic and achieving an AIDS-free generation.

In FY 2016, Part B/ADAP grantees will continue to work directly with uninsured individuals living with HIV/AIDS to enroll them in private health insurance or expanded Medicaid. ADAP will continue to support combination HIV medications not on health insurance formularies, and the costs associated with copays, deductibles, and co-insurance.

These resources will also support:

1) the continued increase in program growth as more people living with HIV are diagnosed, linked to care, and retained in care;
2) the continued increase in program growth as more people entering the health care system with coverage and require assistance with premiums and cost-sharing, and;;
3) the continued need for ADAP for clients who are unable to transition to new health care coverage options due to the lack of Medicaid expansion or other barriers.

The FY 2016 ADAP clients served target is 198,041. The FY 2016 Part B target for number of visits for health-related care (primary medical; oral health; mental health; substance abuse; home health; and home and community based services) is 1.80 million visits.
Part B/ADAP funding will also contribute to achieving the FY 2016 targets for the Ryan White HIV/AIDS Program's over-arching performance measures, including proportion of racial/ethnic

[225] 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 percent of the FY 2007 total grant.

minorities and women served, persons receiving a viral load test, and providers implementing a quality management program.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
18.I.A.1: Number of visits for health-related care (primary medical; oral health; mental health; substance abuse; home health; and home and community based services). *(Output)*	FY 2012: 2.04 M Target: 2.19 M (Target Not Met but Improved)	1.63 M	1.80 M	+171,150

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	59	59	59
Average Award	$21,511,441	$21,511,441	$21,511,441
Range of Awards	$2,049-$163,029,284	$50,000-$163,000,000	$50,000-$163,000,000

Part B – FY 2014 State Table[226]

State/ Territory	Base	Base Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
Alabama	$8,034,924	$0	$14,469,865	$322,462	$135,844	$22,963,095
Alaska	500,000	45,852	1,281,965	-	-	1,827,817
American Samoa	50,000	-	1,651	-	-	51,651
Arizona	3,901,998	-	11,614,865	-	94,212	15,611,075
Arkansas	3,127,933	-	4,355,519	-	40,079	7,523,531
California	32,255,254	2,000,000	118,090,743	167,862	1,060,583	153,574,442
Colorado	3,512,226	601,617	9,727,071	-	67,770	13,908,684
Connecticut	2,941,033	534,793	9,109,479	-	118,349	12,703,654
Delaware	2,145,908	296,394	2,680,084	210,126	37,310	5,369,822
District of Columbia	4,003,842	-	9,449,635	-	212,450	13,665,927
F. States Micronesia	50,000	-	-	-	-	50,000
Florida	30,526,541	7,615,616	103,174,926	490,067	1,164,111	142,971,261
Georgia	12,118,088	2,691,765	36,468,630	155,798	470,533	51,904,814
Guam	200,000	-	69,355	-	-	269,355
Hawaii	1,580,673	-	1,974,147	-	17,447	3,572,267
Idaho	577,795	-	1,559,653	-	-	2,137,448
Illinois	9,594,991	1,196,500	37,102,883	-	391,206	48,285,580
Indiana	3,409,192	500,000	8,507,723	-	-	12,416,915
Iowa	1,359,207	58,240	2,753,544	-	-	4,170,991
Kansas	1,142,887	-	2,522,384	-	-	3,665,271
Kentucky	3,868,055	-	4,830,922	261,717	39,167	8,999,861
Louisiana	6,221,277	1,459,800	20,374,954	-	229,352	28,285,383
Maine	814,467	-	1,017,210	-	-	1,831,677
Marshall Islands	50,000	-	826	-	-	50,826
Maryland	7,879,471	-	25,072,742	-	411,262	33,363,475
Massachusetts	4,912,477	750,000	14,426,714	-	157,917	20,247,108
Michigan	4,857,132	631,733	12,409,633	-	159,133	18,057,631
Minnesota	1,993,354	496,098	5,979,412	-	56,118	8,524,982
Mississippi	5,914,066	-	7,603,480	286,186	116,173	13,919,905

[226] Awards include prior year unobligated balances.

State/ Territory	Base	Base Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
Missouri	3,517,892	-	9,872,387	-	-	13,390,279
Montana	500,000	-	622,668	-	-	1,122,668
N. Marianas	50,000	-	9,082	-	-	59,082
Nebraska	1,025,537	-	1,670,631	-	13,701	2,709,869
Nevada	2,068,941	-	6,118,122	-	59,639	8,246,702
New Hampshire	500,000	-	965,194	-	-	1,465,194
New Jersey	10,614,655	1,498,782	38,650,078	-	454,959	51,218,474
New Mexico	1,841,144	-	2,299,456	-	-	4,140,600
New York	37,258,191	12,179,085	111,252,394	639,105	1,700,509	163,029,284
North Carolina	11,244,914	1,747,084	27,215,402	291,405	319,595	40,818,400
North Dakota	500,000	12,152	188,070	-	-	700,222
Ohio	6,816,286	-	15,879,871	308,345	159,197	23,163,699
Oklahoma	3,524,287	-	4,401,580	219,452	-	8,145,319
Oregon	1,727,335	165,928	4,645,149	-	-	6,538,412
Pennsylvania	11,094,691	-	28,128,501	265,824	374,480	39,863,496
Puerto Rico	6,366,885	1,923,247	20,824,907	-	308,262	29,423,301
Republic of Palau	1,396	-	653	-	-	2,049
Rhode Island	1,606,125	-	1,918,436	178,727	18,391	3,721,679
South Carolina	10,114,219	1,075,188	13,908,775	555,432	189,993	25,843,607
South Dakota	500,000	33,699	396,316	-	-	930,015
Tennessee	5,283,858	1,268,395	22,837,764	-	170,353	29,560,370
Texas	21,561,446	3,500,000	65,608,816	-	793,344	91,463,606
Utah	1,685,126	204,193	3,599,516	-	-	5,488,835
Vermont	500,000	-	370,720	-	-	870,720
Virgin Islands	377,523	-	537,207	-	8,835	923,565
Virginia	7,145,766	1,786,515	30,586,730	385,604	240,380	40,144,995
Washington	3,610,610	-	9,721,292	-	62,808	13,394,710
West Virginia	1,027,810	-	1,400,315	-	-	2,428,125
Wisconsin	3,647,741	306,000	5,421,361	261,888	48,018	9,685,008
Wyoming	500,000	-	258,303	-	-	758,303
Total	**$313,755,169**	**$44,578,676**	**$895,939,71**	**$5,000,000**	**$9,901,480**	**$1,269,175,036**

Early Intervention Services – Part C

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$205,544,000	$201,079,000	$280,167,000	+$79,088,000
MAI (non add)	$71,012,000	$71,012,000	$94,683,000	+$23,671,000
Total Funding	$205,544,000	$201,079,000	$280,167,000	+$79,088,000
FTE	37	38	48	+10

Authorizing Legislation: 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.

FY 2016 Authorization……..……..…….…...Expired

Allocation Method ..... Competitive Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

Part C of the Ryan White HIV/AIDS Program provides grants directly to community and faith-based primary health clinics and public health providers in 49 states, Puerto Rico, the District of Columbia, and the U.S. 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 populations, including people of color, men who have sex with men (MSM), women, infants, children and youth as well as low-income populations. Part C programs have the cultural competency and expertise to provide care to these underserved and vulnerable populations. In 2012, 72 percent of those served by Part C clinics were people of color and 29 percent were female. Part C providers are central to the nation's HIV testing initiatives, performing 544,755 HIV tests in 2012.

The number of persons receiving primary care services under Part C Early Intervention Services programs was 273,157 FY 2010 and 256,347 clients FY 2011. In FY 2012, 288,347 clients were served by the Part C Early Intervention Services program, exceeding the target of 257,053 by 31,294
As part of a $15 million initiative named *Increasing Access to HIV Care and Treatment (IAHCT)*, HRSA recruited and enrolled HIV positive clients into primary care through 275 Ryan White Part C funded clinical sites. In FY 2013, 19,589 clients were enrolled or re-engaged with this funding, which exceeded the initial goal of 7,500 people. The program engaged clients along the HIV continuum of care by linking those who tested positive to care as soon as they

received their diagnosis, enrolled patients in care who were aware of their positive diagnosis but were not yet in care, and re-engaged those who had fallen out of care.

In FY 2015, the Part C Program increased points of access for women, infants, children and youth. HRSA streamlined the funding opportunities and grants management processes while creating a model of care that continued to target points along the HIV Care Continuum to improve patient outcomes.

Funding History

FY	Amount
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[227]	$215,086,000
FY 2013	$194,444,000
FY 2014	$205,544,000
FY 2015	$201,079,000
FY 2016	$280,167,000

Budget Request

The FY 2016 Budget Request for the Ryan White HIV/AIDS Part C Program of $280,167,000 is $79,088,000 above the FY 2015 Enacted level. The Budget proposes to consolidate the Part D Program with the Part C Program to expand the focus on women, infants, children and youth across all the funded grantees and increase points of access for the population and reduce duplication of effort and reporting/administrative burden among currently co-funded grantees to improve medical outcomes.

In 2014, approximately 67 percent of Part D programs funded by the RWHAP were dually funded by Part C. HIV infected clients served under Part D are eligible for services under the consolidated program, and the merged program emphasizes care across all vulnerable populations, genders and ages. By consolidating the two programs, resources are better targeted to points along the care continuum to improve patient outcomes. This will result in more funding for direct patient care services. The Part C Program will provide 1.45 million visits for health-related care (primary medical; oral health; mental health; and substance abuse) in FY 2016. Part C funding will also contribute to achieving the FY 2016 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 HIV/AIDS Programs, persons tested for viral load, and providers implementing a quality management program.

[227] Reflects Ryan White BA only (does not include $5.089 million in Health Center Program BA for Part C grantees in FY 2012).

In FY 2016, many Part C grantees will continue to see the benefits of health care coverage expansions that allow uninsured individuals living with HIV to enroll in private health insurance or expanded Medicaid. The Part C Program funds services that may not be fully covered by public or private health care coverage but are considered essential to reducing the burden of HIV/AIDS. The Part C program allows for flexibility that may be needed by grantees depending on local factors. In states and cities where the number of insured RWHAP clients increases, Part C grantees will continue to provide services along the HIV care continuum that are not covered by private or public health care coverage but which are 1) critical to providing quality comprehensive HIV care such as intensive case management and care coordination services, and 2) linking and retaining individuals living with HIV into care and started on and adhering to ART regimens as early as possible. In addition, funded Part C grantees are a crucial part of the care network that links and retains individuals living with HIV into care and initiates ART regimens as early as possible.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Table

Measure	**Year and Most Recent Result / Target for Recent Result/ (Summary of Result)**	**FY 2015 Target**	**FY 2016 Target**	**FY 2016 Target +/- FY 2015 Target**
19.II.A.2: Number of visits for health-related care (primary medical; oral health; mental health; and substance abuse). *(Output)*	FY 2012: 1.6 M (Baseline)	N/A	1.45 M	Maintain
Retired Measure[228] 19.II.A.1: Number of people receiving primary care services under Early Intervention Services programs. *(Output)*	FY 2012: 288,347 Target: 257,053 (Target Exceeded)	288,347	N/A	N/A

[228] This measure will be retired given the Part C and Part D consolidation. HAB will report on this measure through FY 2015. The FY 2015 data will be available in in May 2017.

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	351	350	400
Average Award	$536,995	$536,995	$650,000
Range of Awards	$95,000-$1,578,446	$95,000-$1,578,446	$100,000-$1,600,000

Women, Infants, Children and Youth – Part D

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$72,395,000	$75,088,000	---	-$75,088,000
MAI (non add)	$23,452,536	$23,671,000	---	-$23,671,000
Total Funding	$72,395,000	$75,088,000	---	-$75,088,000
FTE	10	10	---	-10

Authorizing Legislation: 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.

FY 2016 Authorization…….……Expired

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, such as case management and childcare that help clients obtain needed care. 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 115 WICY programs located in 39 states and Puerto Rico.

Funding History

FY	Amount
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
FY 2013	$72,361,000
FY 2014	$72,395,000
FY 2015	$75,088,000
FY 2016	---

Budget Request

The FY 2016 Budget Request for the Ryan White HIV/AIDS Part D Program of $0 is $75,088,000 below the FY 2015 Enacted level, and includes a proposal to consolidate the Part D program with the Part C program in FY 2016. The consolidation will expand the focus on women, infants, children and youth across all the funded grantees, increase points of access for these populations and reduce duplication of effort and reporting/administrative burden among co-funded grantees.

In 2014, approximately 67 percent of Part D programs funded by the Ryan White HIV/AIDS Program were dually funded by Part C. Under the proposed consolidation, current Part D programs will be eligible to apply for grant funding under the Part C program requirements. These programs will be able to provide services to HIV positive clients with supplemental expansion funds. Along with all Part C programs, grantees are focused on improving outcomes along the care continuum, including improving viral load suppression, and each grantee is encouraged to examine the specific populations they serve.

Outcomes and Outputs Table

Retired Measure[229]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
20.II.A.1 Number of female clients[230] provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission. *(Output)*	FY 2012: 66,672 Target: 53,753 (Target Exceeded)	66,672	N/A	N/A

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	115	115	---
Average Award	$561,430	$609,190	---
Range of Awards	$94,829-$2,143,182	$94,829-$2,143,182	N/A

[229] This measure will be retired given the Part C and Part D consolidation. HAB will report on this measure through FY 2015. The FY 2015 data will be available in in May 2017.
[230] Female clients counted are age 13 and above.

AIDS Education and Training Programs – Part F

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$33,275,000	$33,611,000	$33,611,000	---
MAI (non add)	$10,118,648	$10,144,000	$10,144,000	---
Total Funding	$33,275,000	$33,611,000	$33,611,000	---
FTE	5	5	5	---

Authorizing Legislation: 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.

FY 2016 Authorization……...….Expired

Allocation Method ..... Competitive Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

The mission of the AIDS Education and Training Center (AETC) program of the Ryan White HIV/AIDS Program (RWHAP) is to improve health care outcomes among underserved people living with HIV (PLWH). The AETC network offers 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 currently train providers through a variety of training modalities, including didactics, clinical preceptorships, self-study, clinical consultation, communities of practice and distance-based technologies.

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 anti-retroviral therapy 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 professionals is projected to decrease 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 RWHAP sites. AETC-trained providers are more competent with regard to HIV care 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, tele-education and technical assistance. Clinical faculty also provides 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 opinion leaders and HIV researchers in the development, implementation, and evaluation of the education and training offered.

In 2010, the proportion of racial/ethnic minority health care providers participating in AETC training intervention programs was 42 percent. In 2011 and 2012, the proportion of racial/ethnic minority health care providers participating in AETC training intervention programs was 43.4 percent. In 2013 the proportion of racial/ethnic minority health care providers participating in AETC training programs was 44.5 percent, exceeding the target by 1.5 percent.

Funding History

FY	Amount
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
FY 2013	$32,390,000
FY 2014	$33,275,000
FY 2015	$33,611,000
FY 2016	$33,611,000

Budget Request

The FY 2016 Budget Request for the RWHAP AETC Program of $33,611,000 is equal to the FY 2015 Enacted level. The Budget will support targeted, multidisciplinary education and training programs for health care providers treating people living with HIV/AIDS. Funding will support the training of additional health care providers to deliver high quality HIV/AIDS care and treatment services in primary care settings that have not typically provided services to people living with HIV. HRSA will continue to prioritize for the AETCs interactive training that results in health system strengthening and transformation. This funding will support the goal of 43 percent as the proportion of AETC training intervention participants that are racial/ethnic minorities.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
21.V.B.1: Proportion of AETC training intervention participants that are racial/ethnic minorities. *(Output)*	FY 2012: 44.5% Target: 43% (Target Exceeded)	43%	43%	Maintain

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	31	20	20
Average Award	$1,000,000	$1,500,000	$1,500,000
Range of Awards	$142,500-$4,290,000	$250,000-$4,500,000	$250,000-$4,500,000

Dental Reimbursement Program – Part F

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$12,991,000	$13,122,000	$13,122,000	---
FTE	---	1	1	---

Authorizing Legislation: Sec. 2692(b), PHS Act, as amended by P.L. 106-345, as amended by PL109-415, as amended by P.L.111-87.

FY 2016 Authorization…….…….…..Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Part F Dental funding supports two programs: the HIV/AIDS Dental Reimbursement Program and the Community-Based Dental Partnership Program. 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.

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

In FY 2013, the Dental Reimbursement Program (DRP) awards met 26.1 percent of the total non-reimbursed costs reported by 53 participating institutions in support of oral health care. These institutions reported providing care to 41,464 HIV-positive individuals, for whom no other funded source was available. This number exceeded the goal by 8,148 individuals or 19.6 percent. This represents a 3.9 percent increase from FY 2011 for persons whom a portion/percentage of their unreimbursed oral health costs was reimbursed. In FY 2013, the

demographic characteristics of patients who were cared for by institutions participating in the DRP were: 31.2 percent women, 56.3 percent minority.

The Community-Based Dental Partnership Program (CBDP) 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. In FY 2013, CBDP 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. CBDP grants have a three year project period.

Funding History

FY	Amount
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
FY 2013	$12,646,000
FY 2014	$12,991,000
FY 2015	$13,122,000
FY 2016	$13,122,000

Budget Request

The FY 2016 Budget Request for the Ryan White HIV/AIDS Dental Service Program of $13,122,000 is equal to the FY 2015 Enacted level and will support oral health care for people with HIV. This budget supports the reimbursement of applicant institutions through the Dental Reimbursement Program and funding of the Community Based Dental Partnership Program. Part F Dental Reimbursement is a cost-effective way to provide dental care. The FY 2016 target for the number of persons for whom a portion of their unreimbursed oral health costs will be reimbursed is 39,810.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
22. I.D.1: Number of persons for whom a portion/ percentage of their unreimbursed oral health costs were reimbursed. *(Output)*	FY 2013: 41,464 Target: 33,316 (Target Exceeded)	39,810	39,810	Maintain

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	68	68	68
Average Award	$180,212	$180,212	$180,212
Range of Awards	$907-$864,222	$907-$864,222	$907-$864,222

Special Projects of National Significance – Part F

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	---	$25,000,000	$25,000,000	---
PHS Evaluation Fund Appropriation	$25,000,000	---	---	---
Total Funding	$25,000,000	$25,000,000	$25,000,000	---
FTE	---	---	---	---

Authorizing Legislation: Sec. 2691, PHS Act, as amended by P.L. 106-345, as amended by PL109-415, as amended by P.L.111-87.

FY 2016 Authorization…….…….…..Expired

Allocation Method……. Competitive Grants

Program Description and Accomplishments

The Special Projects of National Significance (SPNS) Program funds the development of innovative models of HIV care to quickly respond to the emerging needs of clients served by the Ryan White HIV/AIDS Program. SPNS evaluates the effectiveness of the models' design, implementation, utilization, cost, and health related outcomes, while promoting the dissemination and replication of successful models. Through these special projects, SPNS grantees implement a variety of community and individual-level interventions gathering best practices and lessons learned on issues related to access, linkage, and retention of hard-to-reach populations, aimed at improving the health outcomes and viral load suppression of HIV-infected populations. SPNS initiatives continue to address the emerging needs of the most disenfranchised populations living with HIV including women of color, transgender people, homeless persons with multiply-diagnosed co-morbidities, Latinos, young men who have sex with men, individuals with opioid abuse, and HIV/HCV co-infected persons, and actively promotes and evaluates state-wide innovative system strategies to reach people who are unaware of their HIV-positive status or out of care.

As of 2014, of the current SPNS sites: 13 percent are community-based organizations, 28 percent are state or county departments of health, 21percent are community health centers, 25 percent are academic-based clinics and evaluation and technical assistance centers, and 13precent are AIDS service organizations.

The SPNS program provides a critical area of support for the National HIV/AIDS Strategy (NHAS) by increasing access to quality HIV/AIDS care through the provision of innovative service models for providers who serve the most vulnerable and hard to reach populations. SPNS will be vital to meet the NHAS goals of expanding access to quality HIV/AIDS care and treatment.

Funding History

FY	Amount
FY 2005	$25,000,000
FY 2006	$25,000,000
FY 2007	$25,000,000
FY 2008	$25,000,000
FY 2009	$25,000,000
FY 2010	$25,000,000
FY 2011	$25,000,000
FY 2012	$25,000,000
FY 2013	$25,000,000
FY 2014	$25,000,000
FY 2015	$25,000,000
FY 2016	$25,000,000

Budget Request

The FY 2016 Budget Request for the SPNS Program of $25,000,000 is equal to the FY 2015 Enacted level. Prior to FY 2015, SPNS was funded from Department of Health and Human Services' PHS Act evaluation set-asides. The Budget supports the advancement of knowledge, skills and systems in the delivery of health care and support services to underserved populations diagnosed with HIV infection.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Grant Awards Table

(whole dollars)	FY 2014 Final*	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	58	64	64
Average Award	$420,320	$377,017	$377,269
Range of Awards	$247,168-$1,494,450	$271,754-$3,050,000	$279,488-$3,050,000

*In FY 2014, SPNS was funded from Department PHS Act evaluation set-asides.

Health Care Systems

Tab

HEALTHCARE SYSTEMS

Organ Transplantation

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$23,490,000	$23,549,000	$23,549,000	---
FTE	2	2	2	---

Authorizing Legislation: Public Health Service Act, Sections 371-378, as amended by P.L. 108-216, P. L. 109-129 and P.L. 110-144, as further amended by P.L. 110-413

FY 2016 Authorization…….……..……..... Expired

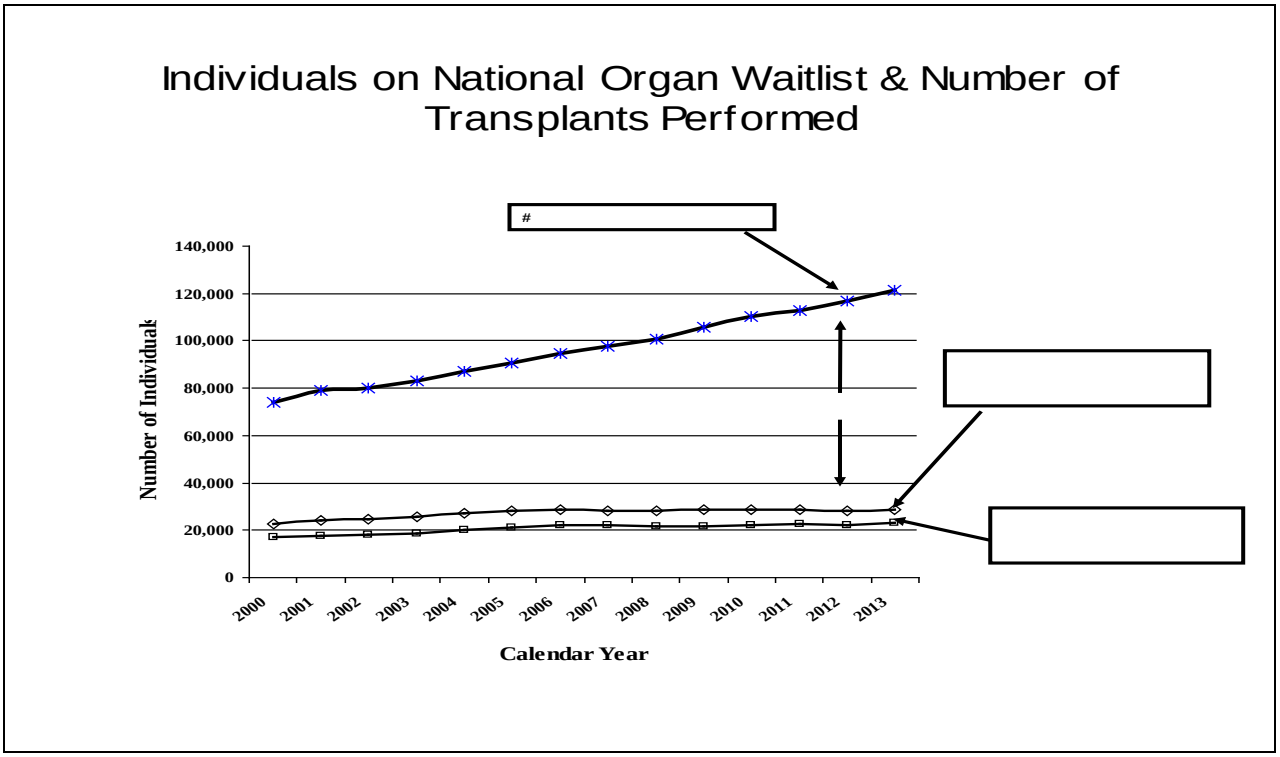
Allocation Method…….....Contracts/Competitive Grants/Cooperative Agreements

Program Description and Accomplishments

The National Organ Transplant Act of 1984 (NOTA), as amended, provides the authorities for the Organ Transplantation Program (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. According to OPTN data, at the end of 2013 (the most recent year for which full-year data are available), there were 121,272 patients listed on the waiting list and 6,188 individuals died (approximately 17 per day) while waiting for a donor organ (http://optn.transplant.hrsa.gov).

Figure 1. Individuals on National Organ Waitlist & Number of Transplants Performed



The 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 five 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 death' 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 2013 (the most recent year for which full-year data are available), 25,435 deceased donor organs were transplanted, 3.58 percent over the 2012 result. In 2012, 24,557 deceased donor organs were transplanted, a 1.67 percent decrease over the 2011 result. In 2011, 24,973 deceased donor organs were transplanted, a 1.5 percent increase above the 2010 result. In 2010, 24,598 deceased donor organs were transplanted, a two percent increase above the 2009 result of 24,116 deceased donor organs transplanted.

The number of deceased donor organs made available for transplantation is primarily dependent on the number of eligible deaths. Since 2002, the number of eligible deaths has decreased. The number of eligible deaths in 2002 was in excess of 12,000. This number has steadily decreased to slightly above 9,000 in 2013. Improved prevention and treatment efforts have in part contributed to the decrease in the number of eligible deaths. 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 (NHTSA) reports traffic accident deaths in 2011 fell to the lowest level ever in the U.S. since 1949. More recently, the NHTSA reported that highway deaths once again decreased to 33,719 in 2013, after a one-year increase from 2011 to 2012. There were 33,782 fatalities in 2012 – the first increase since 2005, Highway deaths over the past five years continue to remain at historic lows.

In 2008, the eligible deaths consisted of 3,281 head trauma deaths. In 2013, the number of head trauma deaths was 2,886, which is on par with the number of head trauma deaths in 2012 (2,879). From 2008 to 2013, head trauma deaths made up 29 percent of eligible deaths. 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 took place between 2003 and 2008 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 an intensive 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 increased significantly as a result of the Breakthrough Collaboratives and those increases have been maintained overtime. The conversion rate was 71.2 percent in 2010, 72.71 percent in 2011, 72.60 percent in 2012, and 71.0 percent in 2013 representing a 36.53 percent improvement from the 52 percent baseline in 2003. The collaborative model has been very successful in attaining significant improvement early as best practices have become institutionalized. More recently the gains have plateaued as natural boundaries are reached beyond which only marginal gains can be attained. 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.

The Program has continued to invest in several activities to sustain and improve upon the gains of the Breakthrough Collaboratives. From 2009 to 2014, the umbrella for these activities is the "Donation and Transplantation Community of Practice" (DTCP). The major focus of the DTCP is to sustain and increase the achievements of the Collaboratives and institutionalize identified best practices. The DTCP 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 the foundation for continued work toward surpassing national goals of 75 percent conversion rate, 3.75 organs transplanted per donor, and 10 percent of donors being donated after cardiac death.

Additionally, the Program 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. A key partnership was realized through a cooperative agreement with the Organ Donation and Transplantation Alliance from 2011 through 2014. The Alliance and a range of partner organizations shared 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. HRSA has established three task forces composed of experts in the community to focus and optimize efforts to increase the number of organs recovered and transplanted. Of the three, the Transplant Center Task Force and Donor Management Task Force will continue to focus on one to three key efforts, and the Quality Improvement Task Force will consider revision of its current focus. The HRSA cooperative agreement supported the development of an education program to leverage web-based technological capabilities to better meet the educational needs of the community. This program is available to the community through the grantee. It is hoped that the community will continue HRSA-sponsored activities 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.

Although the cooperative agreement that funded the public-private partnership between HRSA and the Organ Donation and Transplantation Alliance ended December 31, 2014, it established the foundation for the transplant community to continue efforts going forward to increase organ donation and transplantation. A key component of the three-year process of moving this effort to the community was the development of a network known as the Donation and Transplantation Community of Practice (DTCP). HRSA's role going forward will be to continue to interact with community organizations as a strategic partner, participate in and provide content for educational opportunities, and provide data for performance improvement efforts and community-based recognition of high performance on goals for organ donation and transplantation.

The Program has engaged in numerous outreach initiatives to increase the number of Americans enrolled in their state-specific donor registry as potential donors. Registries are state-specific because organ donation follows state law and organ procurement organizations are state-specific. Registry enrollment is a key goal and outcome measure of most of Program's public outreach strategies. It is widely recognized within the donation community that 99 percent of individuals who die and are medically eligible, and enrolled in a state-specific donor registry, actually become donors. In the case of people who die without some type of donor designation, the family must decide whether to donate those organs. With this in mind, the Program has supported, through grants and contracts, a wide array of outreach initiatives with the ultimate goals of increasing state-specific donor registry enrollment. While some effort also is given to increasing family consent and knowledge about living donation, the preponderance of the Program's outreach efforts focus on registry enrollment. As examples, the many print and electronic materials produced by the Program all encourage the public to go to organdonor.gov and sign up in their state-specific donor registry. In 2012, more than 50,000 visitors to organdonor.gov clicked through to their state registry.

Because segments of the population consume information differently, the Program has employed a variety of strategies for promoting the donation message, including radio, television, Internet

and social media. The Program posts downloadable materials on the Internet, so that individuals and organizations may print them for their own outreach activities.

In response to the increasing presence and influence of social media in this society, the Program launched a Facebook page for organdonor.gov in February 2012. Since that time, the Program's "likes" have risen to more than 180,000. The Program maintains a very active public presence nationally by strategically posting attractive and interesting messages and graphics to engage others in sharing our posts. Purchasing advertising, to reach certain harder to reach demographics, has proved to be a fruitful way to get the message out to the public. HRSA's purchased advertising during one week in May 2014, Older Americans Month, reached about 766,000 individuals, with 42,000 of them being actively engaged by "liking", commenting on, and sharing the Program's posts.

In 2012, the Program supported an evaluation study in four regions of the country to evaluate the utility and comprehensiveness of our outreach materials and strategies. One finding of this study was that the public wants to hear about positive results of organ donation and transplantation, and preferably through a story-telling modality. In response to this finding, the Program developed a new campaign, "Made Possible By an Organ Donor," which features downloadable print, radio, and television public service announcements (PSAs) about real recipients and how a donor and a transplant changed their lives. Dr. Howard Koh, then HHS Assistant Secretary for Health, launched this campaign during a radio media tour in 2014 during Donate Life Month (April). During this tour, he participated in 19 interviews that were aired by 2,112 stations for a total of 2,974 broadcasts, reaching 4.4 million listeners.

The Program conducted an internal evaluation of organdonor.gov and developed strategies for making it more streamlined and relevant to the HRSA's primary audience, the public. Information for donation professionals will continue to be available, but as a secondary audience. Also in response to the burgeoning use of mobile devices in this country, and especially by minorities and lower income brackets, in April 2013, the Program launched a mobile version of organdonor.gov. The redesigned version will be more adaptive so the contents will be accessible on all mobile devices of various sizes.

The Program sponsors two long-term national campaigns, one targeting the 50+ population and the other involving hospitals and state and local hospital associations throughout the nation in encouraging donation among their staff, patients, and communities. The American Hospital Association and 10 other national associations collaborate with the Program on this initiative. More than 1,000 hospitals, transplant programs, and hospital associations across the country are actively involved and enrollment continues to grow. The primary goal for the hospital campaign is increasing donor registry enrollment. Launched in 2011, this campaign has stimulated over 300,000 new donor registry enrollments.

The Program is collaborating with the Agency for Community Living and the National Institutes of Health/National Institute on Aging on a national campaign to inform the 50+ population that they are not too old to be donors and to encourage them to enroll in their state-specific donor registry. This campaign was launched in May 2012.

In response to cases about children in need of an organ transplant, findings from the program evaluation study, and specific direction from former HHS Secretary Sebelius, the Program has been further developing and implementing a national initiative on pediatric donation. The objective is to reach parents of minor children with messages about the need for, and success of, transplants among minors. A focus group of nine individuals with young children revealed that all of them think about adults, not children, when they think about organ donation. Therefore, part of the Program's strategy is to focus on young children whose lives have been saved by a transplant. The Program has begun the process to capture stories on film that can be attached in video format to organdonor.gov, Facebook, and the mobile version of organdonor.gov.

HRSA also supported in 2012 the repetition of a national survey of donation attitudes and practices that was previously conducted in 2005. Both surveys were conducted under contract by the Gallup Organization. Results of the 2012 survey were compared to the 2005 results and a 1993 survey sponsored by a private sector organization also conducted by Gallup using a similar survey instruments.

Highlights from the 2012 report include the following:

- General support for organ donation was strong and sustained for nearly the last 20 years with 94.9 percent supporting or strongly supporting organ donation in 2012. There has been an increase, however, since 2005 in the percentage of the population that strongly supports the donation of organs for transplant.

- There was an increase from 2005 (51.3 percent) to 2012 (60.1 percent) in the percentage of the population that had indicated their intent to donate on their driver's license. African Americans (39.6 percent) were the least likely to have indicated their intent to donate on their license with Whites (67.2 percent) and Asians (54.1 percent) being most likely.

- In 2012, roughly twice the percentage of respondents age 66 and over reported having granted permission for organ donation on their driver's license as that same age group did in 2005.

- Willingness to be a living donor for a family member increased from 29.0 percent in 2005 to 73.3 percent in 2012.

- There was strong and considerable consistency in the percentage of respondents in 2005 (80.4 percent) and 2012 (80.0 percent) who believed a system of presumed consent would result in an increased number of organs. While the percentage who indicated they would support or strongly support such a system in the U.S. was higher in 2012 (51.1 percent) than in 2005 (41.9 percent), it was still considerably lower in both years than the percentage of respondents who thought presumed consent would be a more effective system.

- There was a significant increase from 2005 (16.7 percent) to 2012 (25.4 percent) in the fraction of the population reporting that a financial incentive would make them more

likely to donate their own organs. However, the majority of the population (63.6 percent) in 2012 reported that financial incentives would have no effect on their decision.

- Eighty percent of the population would be willing to donate their hands for transplantation and 58 percent would be willing to donate their face.

- When asked if they would prefer whether their organs be used by the most medically urgent or in their local area, 82 percent of those who had not already registered as donors preferred medically urgent usage while 16 percent preferred local usage.

The Program is making progress towards achieving its second long-term goal of increasing the total number of expected life-years gained in the first five 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.

In FY 2010, the Program fell short of its average number of life-years gained per transplant target (0.380 average, actual versus 0.427 average, target) and its total expected life-years gained (4,381 years, actual versus 6,213 years, target). In FY 2011, the average number of life-years gained per transplant was .340 and the total expected life-years gained decreased to 4,069 years compared to a target of 6,565 years. In FY 2012, the average number of life-years gained per transplant was .320 and the total expected life-years gained decreased to 3,709 years compared to a target of 6,928 years. In FY 2013, the average number of life years gained per transplant was .300 and the total life-years gained decreased to 3,518 years compared to a target of 4,367 years.

The decrease in the average and total expected life-years gained in FY 2013 is because of further 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. In FY 2010, the average number of life-years gained on the waitlist was 4.14 years versus 4.53 years with a transplant. In FY 2011, the average number of life-years gained on the waitlist was 4.19 years versus 4.54 years with a transplant. In FY 2012, the average number of life-years gained on the waitlist was 4.26 years versus 4.58 years with a transplant. In FY 2013, the average number of life-years gained on the waitlist was 4.29 years versus 4.59 years with a transplant.

Funding History

FY	Amount
FY 2012	$24,015,000
FY 2013	$23,301,000
FY 2014	$23,490,000
FY 2015	$23,549,000
FY 2016	$23,549,000

Budget Request

The FY 2016 Budget Request is $23,549,000. The FY 2016 Request is equal to the FY 2015 Enacted level. The FY 2016 President's Budget will continue support for the Organ Transplantation Program in achieving the FY 2016 performance targets: Transplant 25,796 deceased donor organs and achieve 4,572 expected life-years gained for the five year post-transplant period for kidney and kidney/pancreas transplants performed.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs. 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 following activities will be supported with the requested funding:

Contract to operate the OPTN ($5.400 million) — The OPTN is a critical system necessary to facilitate the matching of individuals needing an organ transplant and donor organs. 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, consistent with the policy development requirements of the OPTN final rule (42 CFR §121). The costs of operation of the OPTN are funded with appropriated funds and revenues generated by patient registration fees collected by the contractor under authority of 42 CFR §121.5(c).

IT Support for the Organ Transplantation Systems ($0.4002 million) — The purpose of this contract is to provide independent validation and verification (IV&V) services, IT security certification and accreditation (C&A) services, 508 compliance services, and other IT services as necessary in the oversight of the OPTN.

Contract to operate the SRTR ($5.200 million) — The major purpose of the SRTR is to provide analytic support to the OPTN in the development of organ allocation policies and program performance evaluation. 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 transplant programs and organ procurement organizations more widely available to the public, the SRTR publishes on the Internet transplant program risk-adjusted patient and graft outcomes and organ procurement organization risk-adjusted organ transplanted per donor. The SRTR also publishes online a comprehensive Annual Data Report that includes most current ten years of data on waitlist, transplant and deceased donor organ donation.

Grants to Support Projects to Increase Organ Donation ($4.683 million) — The Program awards 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 improvements and upgrades to state-specific donor registries:

1) Social and Behavioral Interventions to Increase Solid Organ Donation: This is a research grant program to implement and test the effectiveness of social and behavioral strategies for increasing individual or family consent for organ donation. Beginning in FY 2013, the program provided the option for applicants to conduct projects to educate parents about the need for pediatric donors.

2) Public Education Efforts to Increase Organ Donation: This program supports projects to replicate on a broader scale, strategies found to be successful in the research grant program or strategies or models that have demonstrated effectiveness in other areas of health behavior change. Beginning in FY 2013, the program provided the option for applicants to conduct projects that educated parents about the need for pediatric donors.

3) Donor Registry Support Program: This program supports the development or enhancement of donor registries. In FY 2016, the Program will explore funding grant projects to support the nation's donor registry system to facilitate improvements related to public as well as donation professional access.

Cooperative Agreement to Provide Support for Reimbursement of Travel and Subsistence Expenses toward Living Organ Donation ($3.5 million) — The purpose of this cooperative agreement is to provide reimbursement of travel and subsistence expenses to living organ donors, in accordance with 42 U.S.C. 274f. Support will only be provided to those who are not able to receive travel and subsistence expenses support under any state compensation program, insurance policy, or under any Federal or state health benefits program; by an entity that provides health services on a prepaid basis; or by the recipient of the organ.

The Regents of the University of Michigan (Michigan), in partnership with the American Society of Transplant Surgeons (ASTS), has been the lone award recipient of this cooperative agreement with HRSA since FY 2006. Michigan and ASTS established the National Living Donor Assistance Center (NLDAC) to carry out the purpose of this cooperative agreement. While this cooperative agreement does not promote living organ donation and has no performance goals for increasing the number of living organ donors, it helps increase access to transplantation, particularly for individuals of lesser financial means. HRSA renewed the cooperative agreement with Michigan in September 2014 through a competitive grant cycle for an additional five years to continue to carry out the purpose of the cooperative agreement through the NLDAC.

Activities to Support Public and Professional Education ($3.506 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 to educate the general public and specific segments of the population using communication options appropriate to the message and audience including: public service announcements broadcast via electronic media, virtual meetings, webinars, printed materials, documentaries, educational programs for the classrooms, national organ donation events, and websites. 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 ($0.260 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 FY 2016 request includes funds to support interagency activities in support of the Program's mission.

Efforts to Evaluate Long-term Impact of Living Organ Donation ($0.600 million) — The funds will support a living donor registry to facilitate collection of data of long term living donor outcomes to include indications of organ donation related morbidities (e.g., hypertension, diabetes, chronic kidney disease) that develop at any time between organ donation and the death of the donor, as well as psychosocial and socioeconomic impacts that may have resulted from organ donation. The registry will maintain an adequate sample of living donors to be representative of the universe of living organ donors in the United States, including representation of minority populations.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
23.II.A.1: Increase the annual number of deceased donor organs transplanted.	FY 2013: 25,435 Target: 24,638 (Target Met)	25,400	25,796	+396
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 these patients had they remained on the waiting list.	FY 2013: 3,518 Target: 4,367 (Target Not Met)	4,502	4,572	+70
23.II.A.8: Increase the annual conversion rate of eligible donors.	FY 2013: 71.0% Target: 73.00% (Target Not Met)	73.50%	73.75%	+0.25% points

Grants Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	17	15	16
Average Award	$491,214	$583,929	$484,791
Range of Awards	$209,522-$3,000,000	$138,194-$3,500,000	$225,000-$3,500,000

National Cord Blood Inventory

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$11,238,000	$11,266,000	$11,266,000	---
FTE	3	4	4	---

Authorizing Legislation - Public Health Service Act, Section 379, as amended by Section 3, P.L. 109-129 as amended by P.L. 111-264

FY 2016 Authorization…….....$20,000,000

Allocation Method…….…….....……Contract

Program Description and Accomplishments

The National Cord Blood Inventory (NCBI) Program, established through the Stem Cell Therapeutic and Research Act of 2005, enacted December 20, 2005, and reauthorized by the Stem Cell Therapeutic and Research Reauthorization Act of 2010, enacted 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 (CBUs), 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 (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.

Blood stem cell transplantation is potentially a 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 Program. Because umbilical cord blood 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 CBUs. For these reasons, the Health Resources and Services Administration's (HRSA's) policy for the NCBI continues to emphasize increasing the number of CBUs collected from minority donors.

In the early years of umbilical cord blood transplantation, the majority of transplants were performed for pediatric recipients because of the smaller number of blood 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 size of the cord blood inventory, including units with a larger concentration of blood stem cells, have increased the availability of cord blood for adult recipients. Consequently, in each fiscal year since FY 2008, the number of adult patients receiving cord blood transplants has surpassed the number of pediatric recipients.

The NCBI provides funds through competitive contracts for the collection and storage of qualified CBUs by a network of cord blood banks in the U.S. Contract awards are made based on assessment of technical merit, overall quality, ability to collect from diverse populations, geographic dispersion of offerors, evaluation of past performance, and evaluation of proposed costs. When exercising option years beyond the original one-year base period of a contract, current performance including progress toward financial self-sufficiency 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 CBUs from African-American donors.

HRSA awarded six contracts to the first cohort of umbilical cord blood banks to collect for the NCBI in November 2006. Two additional banks were added in September 2007, and five more banks were added in FY 2008 through FY 2010. No new cord blood banks were added during the period FY 2011 – FY 2013. Currently, 13 banks hold NCBI contracts. As of September 30, 2013, 63,960 NCBI CBUs were available through the Program (Table 1). An additional 15,632 units will be collected with funds already awarded through FY 2013. A cumulative total of 92,600 units of cord blood will be collected with all funds awarded during the period FY 2007 – FY 2016. HRSA estimates that approximately 5,500 additional units will be collected with funds awarded in FY 2016.

During the first year of collections for the NCBI (FY 2007), four CBUs 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, 690 units were released in FY 2011, and 714 were released in FY 2012 and FY 2013 (Table 2). In FY 2013, it was projected that 725 NCBI CBUs would have been selected for transplantation; however, only 714 units were selected (a variance of 1 percent or 11 CBUs). The primary reason for the small variance was a decrease in requests from international transplant centers.

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 17 percent of all transplants facilitated through the

Program during FY 2013 utilized cord blood. Multiple-unit transplants continue to rise, from approximately 21 percent of all cord blood transplants during FY 2007 to approximately 30 percent in FY 2013. A primary reason for the increase in the number of NCBI CBUs selected for transplantation (compared to non-NCBI units) is the larger volumes and higher cell counts contained in the NCBI CBUs, which are collected with HRSA funds. The NCBI units released for transplantation had cell counts well above the levels generally available prior to implementation of the NCBI Program. Many recipients of these CBUs had no well-matched adult donor. As the inventory continues to grow, the diverse units comprising the NCBI will continue to serve an increasing number of patients from populations that have difficulty obtaining cells from well-matched adult donors. Of the cord blood units collected with funds awarded from FY 2007 - FY 2013, over 60 percent will be from racial and ethnic minorities.

For minority patients, cord blood has been especially critical in increasing access to transplantation, with approximately 33 percent of all cord blood transplants facilitated by the Program in FY 2013 being for minority patients. In comparison, only 29 percent of the cord blood transplants facilitated by the Program in FY 2007 were for minority patients. 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 CBUs 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 smaller units. Finally, NCBI banks have provided to researchers more than 30,000 non-NCBI units, for a wide variety of pre-clinical and clinical research.

Table 1. Cord Blood Collections

Fiscal Year	Cumulative Units Made Available[231]
2007	2,017
2008	11,870
2009	22,920
2010	34,744
2011	43,340
2012	53,609
2013	63,960

[231] Due to the lag between when cord blood units are collected and when they have been fully tested and qualified for listing on the public registry, all of the units collected with funds from a given fiscal year will not be made available on the registry during that same fiscal year.

Table 2. Cord Blood Units Released for Transplantation

Fiscal Year	NCBI Units Released for Transplantation
2007	4
2008	104
2009	458
2010	530
2011	690
2012	714
2013	714

Funding History

FY	Amount
FY 2012	$11,887,000
FY 2013	$11,147,000
FY 2014	$11,238,000
FY 2015	$11,266,000
FY 2016	$11,266,000

Budget Request

The FY 2016 Budget Request is $11,266,000. The FY 2016 Request is equal to the FY 2015 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, as a result, 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 CBUs also will contribute to improved patient survival after transplant because a growing inventory of high cell count CBUs will allow better tissue matches between patients and CBUs. Funding at the requested level is estimated to support the collection and banking of approximately 5,500 additional CBUs assuming an average price to HRSA of $1,800 per cord blood unit. The average price is expected to increase by approximately $300 per cord blood unit in FY 2016. The price increase for NCBI CBUs, which are obtained through contracts, is anticipated for several reasons, including: 1) to account for the additional costs for cord blood banks to comply with new federal regulatory requirements (finalized in 2011) to obtain biologics license applications (BLA) from the Food and Drug Administration; 2) to maintain the stringent and ongoing criteria required by a banks' BLA; and, 3) to offset the fact that cord blood banks are not financially positioned to offer the government the same significant discounts as provided previously. However, HRSA will continue to seek substantial discounts for each cord blood unit through competitive negotiations.

With the addition of the CBUs added in FY 2016, approximately 76,000 NCBI units will be available for patients searching for an appropriately matched cord blood unit through the C.W. Bill Young Cell Transplantation Program.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Increase the cumulative number of minority cord blood units available through the C.W. Bill Young Cell Transplantation Program (NCBI & non-NCBI	FY 2013: 87,763 Target: 75,000 (Target Exceeded)	89,300	92,600	+3,300
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 2013: 63,960 Target: 55,000 (Target Exceeded)	70,500	76,000	+5,500
Increase the annual number of NCBI cord blood units released for transplant	FY 2013: 714 Target: 725 (Target Not Met)	750	750	0

Contracts Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Contracts	13	13	13
Average Contract	$794,000	$793,800	$793,800
Range of Contracts	$400,000-$2,160,000	$260,000-$1,870,000	$260,000-1,870,000

C.W Bill Young Cell Transplantation Program

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$22,054,000	$22,109,000	$22,109,000	---
FTE	5	5	5	---

Authorizing Legislation: Public Health Service Act, Sections 379-379B, as amended by Section 3, P.L.109-129, as amended by P.L. 111-264

FY 2016 Authorization……..$33,000,000

Allocation Method……..……..……Contract

Program Description and Accomplishments

The primary goal of the C.W. Bill Young Cell Transplantation Program (Program) is to increase the number of transplants for recipients suitably matched to biologically unrelated donors of bone marrow[232] and umbilical cord blood. The Program works toward this goal by: (1) providing a national system for recruiting potential bone marrow donors; (2) tissue typing potential donors; (3) coordinating the procurement of bone marrow and umbilical cord blood units for transplantation; (4) offering patient and donor advocacy services; (5) providing for public and professional education; and (6) 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 its predecessor, the Program has expanded responsibility for collecting, analyzing, and reporting data on transplant outcomes, to include all allogeneic blood stem cell transplants as well as 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 to provide recommendations to the Secretary of Health and Human Services and to the Health Resources and Services Administration (HRSA) on activities related to the Program.

[232] Public Health Service Act, Sections 379-379B, as amended by Section 3, P.L.109-129, as amended by P.L. 111-264 states that the term 'bone marrow' means the cells found in the adult bone marrow and peripheral blood.

The major components of the Program are: (1) a Cord Blood Coordinating Center responsible for facilitating transplants with blood stem cells from umbilical cord blood units (including HRSA-funded 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 collecting outcomes data on related and unrelated donor blood stem cell transplants and implementing an approach to collecting data on emerging therapeutic uses of donated blood stem cells.

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 committees' 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. During FY 2012, four new infrastructure contracts were awarded, with a one-year base period and four possible one-year options. In late FY 2016, the Program will undergo another competitive contracting process and funds will be used to support the continuation of contract activities for the Program.

Performance measures are incorporated into the contracts and monitored quarterly to ensure that the Program meets its long-term goals to: (1) increase the number of blood stem cell transplants facilitated annually; (2) increase the number of transplants facilitated annually for minority patients; (3) increase the number of domestic transplants facilitated annually; and (4) increase one-year post-transplant patient survival. The Program's long-term goals are supported by two annual measures: (1) increase in the number of adult volunteer potential donors of minority race and ethnicity on the Program's registry; and (2) maximize the per 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 purpose of the Program is to increase the number of unrelated blood stem cell transplants facilitated for patients in need. The Program exceeded all three of its FY 2013 long-term goals, which were to: (1) facilitate 5,513 transplants (6,283 were facilitated); (2) facilitate 845 minority transplants (992 transplants for minority patients were facilitated); and (3) increase the rate of patient survival at one-year post-transplant from 62 percent in 2003 to 69 percent in 2013 (the survival rate was 71 percent). After FY 2013, the next year for which long-term targets are established for the Program is FY 2017.

The Program continues to serve a diverse patient population, with umbilical cord blood playing a vital role in expanding access to transplant 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 to transplantation for patients from all populations. Adding to the pool of potential adult volunteer blood stem cell donors also helps accomplish this goal. As of the end of FY 2014, more than 12.4 million potential adult volunteer donors were listed on the Program's registry. More than 3.25 million (26 percent) of the 12.4 million potential adult donors listed on the Program's registry self-identify as belonging to a racial/ethnic minority group. This exceeded the FY 2014 goal of 3.18 million by 2.2 percent. The cost of tissue typing strongly influences the number of potential volunteer donors who can be recruited to the Program's registry. Reductions in the cost of typing make it possible to recruit more donors for a given level of funding. The FY 2016 cost for each donor's tissue typing will remain at $58.00, the same level negotiated and achieved in FY 2015. The cost of tissue typing increased from $40.81 in FY 2014 to $58.00 in FY 2015 as a result of a change in the way in which tissue typing was performed, from an allele-based, high-resolution technology to an improved, DNA-based, sequencing platform. Also, more genetic markers are being examined to assist physicians in conducting donor searches on behalf of patients. This change in tissue typing technology, will likely result in more rapid matching between potential donors and searching patients, thus allowing patients to move toward transplantation quicker. Though the goal of typing costs are to remain the same, cost may be increased if it is determined that the level of tissue typing specificity needs to increase (due to technological advances) that could result in more rapid matching between potential donors and searching patients.

Funding History

FY	Amount
FY 2012	$23,330,000
FY 2013	$21,877,000
FY 2014	$22,054,000
FY 2015	$22,109,000
FY 2016	$22,109,000

Budget Request

The FY 2016 Budget Request is $22,109,000. The FY 2016 Request is equal to the FY 2015 Enacted level. This funding will be used to support the Program's performance target of having 3,340,000 adult volunteers from racially/ethnically diverse minority population groups listed on the Program's registry (an increase of 3 percent over the 3.25M achieved by the end of FY 2014). These funds also will support the major Program components (Cord Blood Coordinating Center, Bone Marrow Coordinating Center, Office of Patient Advocacy, Single Point of Access, and Stem Cell Therapeutic Outcomes Database). The majority of funds will be used to recruit and tissue-type new donors. The Program will also continue: (1) collecting comprehensive outcomes data on both related and unrelated-donor blood stem cell transplants; (2) assessing quality of life for transplant recipients; (3) working with foreign transplant centers to obtain data on U.S. stem cell products provided to them for transplant; and (4) collecting data on emerging therapies using cells derived from bone marrow and umbilical cord blood.

Importantly, FY 2016 funding will allow the Program to continue the critical planning it has been involved in with the Department of Health and Human Services to respond to a national radiation or chemical emergency that could 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 funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
24.II.A.2: Increase the number of adult volunteer potential donors of blood stem cells from minority race and ethnic groups. (Outcomes)	FY 2014: 3.25M Target: 3.18M (Target Exceeded)	3.26M	3.34M	+0.08M
24.1: Increase the number of blood stem cell transplants facilitated by the Program[233](Outcome)	FY 2013: 6,283 Target: 5,513 (Target Exceeded)	N/A	N/A	N/A
24.2: Increase the number of blood stem cell transplants facilitated by the Program for minority patients.[234] (Outcome)	FY 2013: 992 Target: 845 (Target Exceeded)	N/A	N/A	N/A
24.3: Increase the rate of patient survival at one year, post-transplant.[235] (Outcome)	FY 2013: 71% Target 69% (Target Exceeded)	N/A	N/A	N/A
24.4: Increase the number of blood stem cell transplants facilitated by the Program for domestic patients. [236]	FY 2013: (baseline) 3,918	N/A	N/A	N/A
24.E: Decrease the unit cost of human leukocyte antigen (HLA) typing of potential donors.	FY 2014: $40.81 Target: $40.81 (Target Met)	$58.00	$58.00	$0

[233] This is a long-term measure. After FY 2013, the next year for which long-term targets are set is FY 2017. The FY 2017 target has been established at 6,960.
[234] This is a long-term measure. After FY 2013, the next year for which long-term targets are set is FY 2017. The FY 2017 target has been established at 1,150.
[235] This is a long-term measure. After FY 2013, the next first year for which long-term targets are set is FY 2017. The FY 2017 target remains 69%.
[236] This is a new long-term measure. The first year for which long-term targets are set is FY 2017. The FY 2017 target is 5,135.

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
(Efficiency)				

Contracts Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	5	5	5
Average Award	$3,933,000	$3,933,000	$3,933,000
Range of Awards	$32,000-$13,600,370	$35,000-$13,437,000	$35,000-$13,437,000

Poison Control Program

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$18,799,000	$18,846,000	$18,846,000	---
FTE	3	3	3	---

Authorizing Legislation – Public Health Service Act, Sections 1271-1274, as amended by Public Law 106-174, as amended by Public Law 110-377, as amended by Public Law 113-77.

FY 2016 Authorization .....National Toll Free Number - $700,000

FY 2016 Authorization .....Nationwide Media Campaign - $800,000

FY 2016 Authorization .....Poison Control Center Grant Program – $28,600,000

Allocation Method ..... Contracts/Competitive Grants/Co-operative Agreements

Program Description and Accomplishments

The Poison Control Program (PCP) is authorized through Public Law 113-77, the Poison Center Network Act. 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 grant program supports poison control centers' (PCCs) efforts to 1) prevent, and provide treatment recommendations for, poisonings; 2) comply with operational requirements needed to sustain accreditation and or achieve accreditation; and 3) improve and enhance communications and response capability and capacity. Funds may also be used to improve the quality of data uploaded from poison centers to the National Poison Data System (NPDS) in support of national toxicosurveillance activities conducted by the Centers for Disease Control and Prevention (CDC).

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 United States (U.S.) and will be connected to the poison center that services their 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 increased to nearly

84 percent in FY 2014. In FY 2006, only 19 percent of national survey respondents were aware that PCC calls were handled by health care professionals. This increased to 25 percent in FY 2012, the most recent year for which data are available.

For over 50 years, PCCs have been our Nation's primary defense against injury and death from poisonings. Today there is a national network of 55 PCCs that provides cost effective, quality health care advice to the general public and health care providers alike across the entire 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 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. A hallmark of poison center case management is the use of follow up calls to monitor case progress and medical outcomes. Poison centers are not only consulted when children get into household products, but also when seniors and people of all ages take too much medicine or when workers are exposed to harmful substances on the job. Emergency 911 operators refer poison-related calls to PCCs and health care professionals regularly consult PCCs for expert advice on complex cases. PCCs are a critical resource for emergency preparedness and response as well as for other public health emergencies.
The PCP and the American Association of Poison Control Centers (AAPCC) share a critical role in supporting poison centers. As the organization that certifies poison centers, provides professional education to its members, and owns and operates the NPDS, AAPCC enhances the poison center's role as quality public health providers.

According to the AAPCC, in 2012, more than 3.3 million calls were managed by poison control centers, which is an average of more than 9,000 calls per day. On average, poison centers receive a call about an actual exposure every 13.9 seconds. Of the approximate 2.2 million poisonings reported in 2012; 69 percent were managed at the site of exposure, avoiding 1.7 million unnecessary visits to emergency departments and saving money on healthcare costs. While less than 1 percent of exposures occurred in health care facilities, approximately 20 percent of calls were made from a health care facility.[237]

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.[2, 3] Consultation with a poison center can also significantly decrease the patient's length of stay in a hospital and decrease hospital costs.[238,239,240,241] In fact, utilization of poison centers by health care facilities continues to increase, underscoring the increase in the severity of poisonings and the need for toxicological

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[237] Mowry JB, Spyker DA, Cantilena LR Jr, Bailey JE, Ford M. 2012 Annual Report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 30th Annual Report. Clinical Toxicology (2013) 51, 949–1229.
[238] Vassilev ZP, Marcus SM. Impact of a Poison Control Center on the Length of Hospital Stay for patients with Poisoning. J Toxicol Environ Health Part A. 2007; 70(2): 107-110
[239] Zaloshnja, E., Miller, T.R., Jones, P., Litovitz, T.; Coben, J.; Steiner, C.; Sheppard, M. (2006). The potential impact of poison control centers on rural hospitalization rates for poisonings. Pediatrics. 118(5), 2094-2100.
[240] Healthcare Cost and Utilization Project [HCUP] (2007). 2005 National Inpatient Sample. Rockville, MD: Agency for Healthcare Research and Quality, Department of Health and Human Services.
[241] Zaloshnja, E., Miller, T.R., Jones, P., Litovitz, T.; Coben, J.; Steiner, C.; Sheppard, M. The impact of poison control cents on poisoning-related visits to emergency departments, U.S. 2003. Am J Emerg Med. 2008.

expertise in clinical settings.[242] It is estimated that every dollar invested in the poison center system saves $13.39 in medical costs and lost productivity, for a total savings of more than $1.8 billion every year. Of that $1.8 billion, the Federal government saves approximately $662.8 million in medical care savings and reduced productivity.[243]

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 surveillance data. Multiple Federal agencies, including the CDC, Consumer Product Safety Commission, Environmental Protection Agency, Food and Drug Administration, and 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 monitor exposures to e-cigarette devices and liquid nicotine, energy drinks, synthetic cathinones or "bath salts", powdered caffeine, and laundry detergent packets. Additionally, the Office of National Drug Control Policy (ONDCP) and the Department of Justice's Drug Enforcement Administration (DEA) have used PCCs' data to monitor the rise in the abuse of synthetic drugs and inform policy development.

PCCs also provide public and health care provider education. PCCs' health educators actively work to change behaviors to reduce poisonings and promote awareness and utilization of poison center services in their communities. Education efforts, for example, focus on medication safety as a way to reduce unnecessary medication-related emergency room visits, hospitalizations and rehospitalizations. According to the CDC, in 2012, the most recent year for which data are available, unintentional poisoning was the leading cause of unintentional injury deaths. Ninety-one percent of unintentional poisonings were caused by prescription drugs, primarily opioid analgesics. These drugs were implicated in more poisoning deaths than heroin and cocaine combined. Among the actions outlined in the ONDCP's prescription drug abuse prevention plan, Epidemic: Responding to America's Prescription Drug Abuse Crisis, 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. The PCP awards grant funds to the PCCs who are active partners in these efforts. Additionally, the PCCs and the PCP have participated in the National Prescription Drug Take Back events sponsored by the DEA.

PCCs also provide clinical toxicology training to multidisciplinary providers to help them better manage poisoning and overdose cases.

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[242] Bronstein AC, Spyker DA, Cantilena LR Jr, et al. 2011 annual report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 29th annual report. Clin Toxicol (Phila). 2012;50:911-1164.
[243] Value of the Poison Center System: Lewin Group Report for the American Association of Poison Control Centers. 2011.

Funding History

FY	Amount
FY 2012	$18,830,000
FY 2013	$17,657,000
FY 2014	$18,799,000
FY 2015	$18,846,000
FY 2016	$18,846,000

Budget Request

The FY 2016 Budget Request is $18,846,000. The FY 2016 Request is equal to the FY 2015 Enacted level. Funding for the PCP will primarily be used to support the PCCs' infrastructure and core triage and treatment services. PCCs predominantly rely on State and local funding, as Federal funding accounts for less than 10 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 been faced with termination due to State budgetary shortfalls in recent years. Federal funding helps reinforce the nationwide PCC infrastructure, enabling PCCs to sustain their public health and toxico-surveillance efforts.

The following activities will be supported with the requested funding at the FY 2016 Request:

Support and Enhancement Grant Program ($17.346 million): Grant funds will be used to support PCCs' efforts to 1) prevent, and provide treatment recommendations; 2) comply with operational requirements needed to attain or sustain accreditation; and 3) improve and enhance communications and response capability and capacity. Funds will also be used to improve the quality of data uploaded from poison centers to the National Poison Data System (NPDS) in support of national toxicosurveillance activities conducted by the CDC. This request also includes costs associated with processing of grants through HRSA's Electronic Handbooks (EHBs), and conducting 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 Poison Help hotline is a critical public health service that improves the quality of healthcare. The PCP will fund and manage the toll-free number 24 hours a day, every day of the year. Funding will also be used to support translation services for non-English speaking callers.

As legislatively mandated, the Program will continue to fund the nationwide Poison Help campaign to educate the public and health care providers about the national toll-free number and to build upon the existing national public awareness campaign, to highlight the role of PCCs in the public health system with a focus on Medicare and Medicaid beneficiaries. The PCP will continue to promote the hotline among the public and providers as well as engage other Federal grantees including community health centers, 340B Drug Pricing Program participants, geriatric education centers, rural health associations, Ryan White Program grantees, and Head Start programs.

The FY 2016 target is to have 83 percent of all calls made to the PCCs through use of the toll-free number. Additionally, 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.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
25.III.D.3: Increase percent of inbound volume on the toll-free number. (Output)	FY 2013: 85.6% Target: 73.7% (Target Exceeded)	83%	83%	Maintain
25. III.D.4: Percent of national survey respondents who are aware that calls to poison control centers are handled by health care professionals. (Outcome)[244] (FY 2006 Baseline: 19%)	FY 2012: 25% (Target Not in Place)	N/A	25%	N/A
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)[245] (FY 2010 Baseline: 71%)	FY 2012: 69.2% (Target Not in Place)	71%	71%	Maintain

[244] This is a long term measure based on periodic survey data. FY 2016 is the first year for which there is a target. The FY 2016 target is 25 percent.
[245] FY 2013 is the first year for which there is a target. The FY 2013 target is 71 percent.

Grants Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President Budget
Number of Awards	52[246]	52[247]	52[248]
Average Awards	$330,244	$324,376	$333,577
Range of Award	$12,466-$2,001,931	$12,466-$1,980,105	$12,466-$2,038,439
Range of Contracts	$9,342	$9,609-$300,000	$9,884-$300,500

[246] In FY 2014, there were 55 PCCs across the Nation. Fifty-two awards were made under the Support and Enhancement Grant Program, representing all of the poison centers. For grant purposes, HRSA counts the California Poison Control System as a single entity, but it encompasses four California poison centers.
[247] In FY 2015, there are 55 PCCs across the Nation. Fifty-two awards will be made under the Support and Enhancement Grant Program, representing all of the poison centers. For grant purposes, HRSA counts the California Poison Control System as a single entity, but it encompasses four California poison centers.
[248] In FY 2016, we expect that there will be 55 PCCs across the Nation. Fifty-two awards will be made under the Support and Enhancement Grant Program, representing all of the poison 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 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$10,212,000	$10,238,000	$17,238,000	+$7,000,000
USER FEES	---	---	$7,500,000	+$7,500,000
TOTAL	$10,212,000	$10,238,000	$24,738,000	+$14,500,000
FTE	4	11	22	+11

Authorizing Legislation - Public Health Service Act, Section 340B as amended by Sections 7101-7103, P.L. 111-148, as further amended by Section 2302, P.L. 111-152, and as amended by Section 204, P.L. 111-309

FY 2016 Authorization…….…….…..SSAN

Allocation Method……...…….……..….Contract

Program Description and Accomplishments

The 340B Drug Pricing Program (340B Program) was authorized by the Veterans Health Care Act of 1992 and is administered by the Office of Pharmacy Affairs. The 340B Program requires drug manufacturers to provide discounts on outpatient prescription drugs to certain safety net health care providers specified in statute, known as covered entities, including Federally Qualified Health Centers, AIDS Drug Assistance Programs, and certain disproportionate share hospitals. The 340B Program plays an integral role in helping these designated hospitals and clinics to confront the most intractable health problems facing millions of Americans. By allowing eligible entities to purchase drugs for outpatient use at a significant discount, the 340B Program allows these health care providers to stretch scarce federal resources. A 2011 Government Accountability Office (GAO) study found that entities participating in the 340B Program are able to expand the type and volume of care they provide to the most vulnerable patient populations as a result of access to these lower cost medications.

The 340B ceiling price – the maximum amount a drug manufacturer can charge a covered entity for a given drug – is equal to the Average Manufacturer Price (AMP) minus the Unit Rebate Amount (URA), both set by Center for Medicare and Medicaid Services (CMS). Covered entities purchase 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. In FY 2013, covered entities saved an estimated $3.8 billion on their outpatient drug expenditures by participating in the 340B Program. Drug spending under the 340B Program represents approximately two percent of the overall U.S. drug market.

HRSA places the highest priority on the integrity of the 340B Program, and continually works to improve its oversight of the Program. To ensure that both 340B covered entities and participating manufacturers are in compliance with program requirements, HRSA has made a number of

noteworthy changes. All covered entities are required to recertify annually, and attest to compliance with all Program requirements. In FY 2012, HRSA began conducting a systematic approach to auditing covered entities, including risk-based and targeted audits. Through FY 2014, HRSA has completed 244 audits. Depending on the finding, covered entities are working with HRSA to develop a Corrective Action Plan to ensure ongoing compliance. Final results from these audits, including status of corrective action, are available on HRSA's website. Every allegation of non-compliance received is reviewed by HRSA. HRSA uses the results of these program integrity efforts to develop a proactive strategy to promote best practices for complying with Program requirements. The Office of Pharmacy Affairs also expands its compliance oversight and technical assistance to entities through contracts.

The Office of Pharmacy Affairs operates the Prime Vendor Program (PVP), required under Section 340B (a)(8). The PVP facilitates the distribution of drugs to 340B entities, conducts negotiation of pharmaceutical prices below the 340B ceiling price, and provides technical assistance to 340B entities. By the end of FY 2014, the PVP had nearly 7,000 products available to participating entities below the 340B ceiling price, including 3,557 covered outpatient drugs with an estimated average savings of 10 percent below the 340B ceiling price. From 2009 to November 2014, the PVP contracts provided over $279 million in additional sub-ceiling savings for covered entities, enabling them to further expand their pharmacy programs.

HRSA is strongly committed to addressing the issues raised by previous studies by the Office of the Inspector General (OIG) and the GAO. Specifically, the OIG has recommended that HRSA provide covered entities access to ceiling price information and improve oversight of 340B pricing; both activities are underway and will continue to be a top priority in FYs 2015 and 2016, as reflected in this budget request. GAO has recommended that HRSA provide additional clarity around the definition of a patient eligible to receive 340B drugs as well as eligibility of certain hospitals, which will be addressed in guidance to be finalized in FY 2016 and enforced through audits and other oversight activities. Resources to support these activities are also reflected in this request.

Covered Entity Participation

As of October 1, 2014, 12,701 covered entities and 15,571 associated sites participate in the 340B Program, for a total of 28,272 registered sites. Twenty-seven percent of covered entity sites have contract pharmacy arrangements, which results in the registration of approximately 15,600 unique pharmacy locations in the 340B database. P.L. 111-148 expanded the type of entities eligible for participation in the 340B Program to include children's hospitals, critical access hospitals, free standing cancer hospitals, rural referral centers, and sole community hospitals. Since August 2010, the Program has enrolled over 1,174 covered entities and 2,221 newly eligible associated sites, for a total of 3,395 registered sites.

Funding History

FY	Amount
FY 2012	$4,472,000
FY 2013	$4,193,000
FY 2014	$10,212,000
FY 2015	$10,238,000
FY 2016 BA	$17,238,000
FY 2016 User Fees	$7,500,000

Budget Request

The FY 2016 Budget Request is $17,238,000 in budget authority, an increase of $7,000,000 over FY 2015. The Budget also proposes a user fee of $7,500,000 as a long term mechanism to recover costs for operating this program. The request will support full implementation of the statutory obligations for the 340B Program, and enhance oversight of participating manufacturers and covered entities. Using resources efficiently across staff, investments in information technology, and targeted contracts, HRSA will employ this funding to ensure that the 340B Program operates successfully and effectively.

From the inception of the 340B Program in 1992 until 2009, the entire cost of administering the Program, including the development of guidelines and the provision of technical assistance to eligible grantees, has been supported by HRSA program funds. In FY 2009, Congress provided $1,470,000 for 340B in a standalone appropriation. These specific appropriations have grown over the past five years from $2,220,000 to $10,238,000 in FY 2015 to provide a dedicated source of funding to implement this program, particularly as the number of participating entities has expanded to include children's hospitals, critical access hospitals, free standing cancer hospitals, rural referral centers, and sole community hospitals. . Increased funding in FY 2016 is necessary to continue to ensure effective implementation, oversight, and monitoring of the 340B Program. The funding request also supports costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

The areas of focus include:

- Improvement of 340B Public Database - The 340B Program operates the Office of Pharmacy Affairs Information System (OPAIS). OPAIS is a multi-function web-based database system that provides information on covered entities, contract pharmacy arrangements, and participating manufacturers. External stakeholders use the database to verify eligible entities and their associated sites, confirm manufacturer participation, and prevent statutorily prohibited duplicate discounts, among other key program elements. As such, HRSA considers the integrity of the 340B database to be a crucial responsibility that requires ongoing maintenance and development, and will continue to implement a strategic plan to improve the integrity, transparency, and reliability of OPAIS. The Budget provides the resources to ensure that the database continues to meet the needs of external stakeholders.

- Program Guidance - In FY 2016, HRSA will continue to support the development of clear program guidance to provide oversight and maintain the integrity of the 340B Program.

- Covered Entity Eligibility Verification – The 340B Program performs initial eligibility checks of all entities seeking to register with the Program. HRSA also conducts annual recertification of all covered entities, which helps to ensure that covered entities meet all eligibility requirements under the 340B statute. This is a vital program element that requires investments in information systems and highly qualified staff.

- Program Audits of Covered Entities – HRSA plans to continue random and targeted audits of covered entities, as well as publishing audit report summaries and public letters via the HRSA website. With additional funding, more audits of covered entities will be conducted and expand the program's compliance reach while managing program risk. The request provides the funding needed to train and hire staff to conduct on-site audits, write reports, work with entities through the notice and hearing process, and finalize public information to be shared.

- Additional Program Integrity Efforts: HRSA will also continue to dedicate staff to work with entities who self-disclose compliance issues, helping them develop corrective action plans and work with affected manufacturers. HRSA also reviews every allegation received of non-compliance through targeted communication and, if necessary, on-site target audits.

- Technical Assistance for Covered Entities – This Budget support ongoing technical assistance for covered entities to promote best practices in implementation of the 340B Program. HRSA will apply lessons learned from covered entity audits to increase proactive technical assistance and improve overall compliance.

- Program Integrity Efforts for Manufacturers – HRSA will increase the number of audits conducted of manufacturers, as well as publishing audit report summaries and corrective action plans on the HRSA website. In previous years and with limited funding, HRSA had focused only on audits of manufacturers with specific allegations. With additional funding, HRSA will conduct additional audits of manufacturers, adding random audits to its oversight strategy. In addition, HRSA is committed to investigating every allegation received regarding manufacturer compliance. Funding in FY 2016 will support investigation of allegations of overcharges and limited availability of drugs to 340B entities.

- Increased Oversight of 340B Pricing –
    - *Price Verification*: HRSA and CMS have an intra-agency agreement that permits HRSA to compute the 340B ceiling prices using data that manufacturers supplied to CMS. HRSA currently conducts random spot checks of these prices with information submitted voluntarily by a small group of manufacturers. Funds requested in FY 2016 will be used to maintain a system for all manufacturers to

submit 340B price information, allowing regular spot checks of prices and any necessary follow up on pricing errors.
  - *Refunds and Credits*: Funding in FY 2016 will be used to facilitate refunds and credits to entities who were overcharged by participating manufacturers.
  - *Pricing System*: Funding in FY 2016 will be used to continue to implement a system whereby covered entities can access 340B ceiling price information via a secure website.

- Civil Monetary Penalties - HRSA will implement, per statutory authority, civil monetary penalties for manufacturers and covered entities. For manufacturers, HRSA can impose up to a $5,000 penalty to manufacturers for each instance of knowingly and intentionally overcharging a covered entity. HRSA can require covered entities to pay monetary penalties to manufacturers when violations are found to be systematic and egregious.

- Compliance Management Tool – HRSA has made investments in an integrated system of compliance tracking for covered entities and manufacturers, enabling enhanced communication across the Office of Pharmacy Affairs to ensure that all covered entities and manufacturers are in compliance with 340B program requirements. HRSA expects full implementation of this system in FY 2016. Funding in FY 2016 will be used to will support ongoing maintenance and improvements to this system.

- Administrative Dispute Resolution Process - HRSA will continue to 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.

HRSA-Supported Performance Outcomes

HRSA measures the performance of the 340B Program by three key metrics. As a drug discount program serving safety net providers, HRSA tracks participation levels of those providers, but also places a high priority on its ability to oversee the compliance of those entities through program audits. HRSA also places emphasis on its ability to oversee the compliance of manufacturers through program audits.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Covered Entity Sites Participating	FY 2014: 28,272 Target: 17,479 (Target Exceeded)	31, 672	33, 572	+1,900

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Covered Entity Audits Conducted	FY 2014: 94 Target: 51 (Target Exceeded)	200	300	+100
Manufacturer Audits Conducted	FY 2014: 0 Target: 1 (Target not met)	1	5	+4

The FY 2016 Budget provides the resources needed to allow the 340B Program to work with covered entities – both those currently participating as well as interested in doing so – to better understand their responsibilities around compliance with statutory requirements. Proactive technical assistance of this nature may result in some sites terminating from the Program and others registering for the Program. HRSA has developed an updated target for FY2015 based on these planned activities, as well as actual participation in FY2014. Overall growth in participating sites is expected to continue, with some deceleration, resulting in an anticipated target of 31, 672 sites. HRSA adjusted the target for FY2016 in a similar manner, resulting in a target of 33,572 sites.

For those covered entities participating in the Program, HRSA will expand its oversight reach even further, compounding the sentinel effect of increased compliance. Data provided by the PVP, who uses audit findings to conduct technical assistance, shows that education based on oversight measures reduces the risk of future compliance issues. Finally, HRSA will conduct audits of manufacturers, which will not only increase compliance, but provide greater insight into the tools and mechanisms used by these companies to comply with 340B statutory requirements and guide future technical assistance.

Contracts Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Contracts	4	2	3
Average Contract	$2,931,444	$4,250,000	$3,333,333
Range of Contracts	$2,436,840- $3,252,874	$3,3000,000- $5,200,000	$1,5000,000- $5,200,000

National Hansen's Disease Program

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$15,168,000	$15,206,000	$15,206,000	---
FTE	58	62	62	---

Authorizing Legislation: Public Health Service Act, Section 320, as amended by Section 211 of the Public Law 105-78

FY 2016 Authorization ..... Indefinite

Allocation Method ..... Contract/Direct Federal/Intramural

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 (U.S.) or Puerto Rico through direct patient care at its facilities in Louisiana; by contracting with 16 regional outpatient clinics under 13 contracts as part of the NHDP's Ambulatory Care Program; and by providing cost free drug regimens, consultations, laboratory services and outpatient referral services as a safety net for private sector physicians (PSP) managing cases of Hansen's Disease. As of FY 2013, there were 3,293 patients cared for through the NHDP's regional outpatient clinics and over 500 cared for by PSPs. The Program is the only dedicated provider of Hansen's Disease treatment services in the U.S. and a crucial source of training and education for health professionals to improve early detection and treatment. The Program provides a national health care infrastructure for diagnosis and treatment of HD, as well as training and education about this disease. The Program also conducts scientific research dedicated to prevention and treatment of Hansen's Disease.

Increasing Quality of Care: Early diagnosis and treatment are the keys to blocking or arresting the trajectory of Hansen's Disease-related disability and deformity. This goal 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 through 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 2013 and 2014, NHDP exceeded its performance target of 150 and trained 259 and 358 physicians, respectively. For FY 2015, NHDP raised the performance target for this measure to 225.

Improving Health Outcomes: Hansen's Disease is a life-long chronic condition, which left untreated and unmanaged usually progresses 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 patients with grades 1 or 2 disability/deformity[249]. The percentage of patients presenting with disability annually fluctuates due to several variables, primarily related to delays in diagnosis. In FY 2010, the disability rate was 47 percent, exceeding the target of 50 percent. In FY 2011and FY 2012, the results were 40 percent and 36 percent, exceeding the target.

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. Performance measures have included 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. The Program has consistently met its research targets. In FY 2011, the Program met its target, developing a "DNA fingerprint" to provide evidence that linked leprosy transmission from armadillos to humans in the Southern U.S. In FY 2012, the Program pursued relevant animal models for human leprosy by defining parameters of nerve dysfunction in armadillos infected with the leprosy bacillus, and in FY 2013 by defining parameters of muscle dysfunction in armadillos.

Promoting Efficiency: The NHDP 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 NHDP 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 annual cost per individual served by the NHDP's outpatient clinic as well as the contracted outpatient Ambulatory Care Program clinics below the national medical inflation rate, the Program can continue to serve more patients that otherwise would have required additional funding. The cost per patient served through NHDP outpatient services has usually been at or below the national medical inflation rate. In FY 2011, the cost per patient served through outpatient services was $1,057, a decrease of 7.4 percent, well below the national inflation rate of 4.13 percent. In FY 2012, the cost per patient served through outpatient services was $1,015, a decrease from the year before of 4.0 percent, below the national inflation rate of 3.43 percent. In FY 2013, the cost per patient served through outpatient services was $942, a decrease of 7 percent, well below the national medical inflation rate of 4.5 percent.

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[249] 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.

Funding History

FY	Amount
FY 2012	$16,045,000
FY 2013	$15,045,000
FY 2014	$15,168,000
FY 2015	$15,206,000
FY 2016	$15,206,000

Budget Request

The FY 2016 Budget Request is $15,206,000. The FY 2016 Request is equal to the FY 2015 Enacted level. The entire FY 2016 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 national promotion effort targeted at physicians whose practice may include individuals with Hansen's Disease (e.g., dermatologists, infectious disease and family practice physicians) is underway, as well as focused efforts to train health care providers in Hansen's Disease where clusters of newly diagnosed cases are appearing. A performance target for FY 2016 Budget Request is to train 225 physicians, improving their knowledge and ability to diagnose and treat Hansen's Disease.

In the area of Hansen's Disease disability/deformity prevention, 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 percent.

The Program's FY 2016 target for its research measure is to pursue a relevant animal model for human leprosy. The Program will also continue to promote efficiency by targeting in FY 2016 cost per patient increases below the national medical inflation rate.

The FY 2016 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 drug clofazimine to over 500 providers nationally. At the request of the FDA, the Program agreed to manage the investigational new drug (IND) application that makes clofazimine available in the U.S. for treatment of leprosy. The NHDP continues its collaboration with the Centers for Disease Control (CDC), to develop Hansen's Disease training and educational material for healthcare providers in the US-Affiliated Pacific Islands (USAPI). Patients who migrate to the United States from these USAPI nations, under the Compact of Free Association, constitute the most rapidly growing subset of Hansen's Disease patients in the United States.

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 by providing additional laboratory, diagnostic, consultation and referral services to private sector physicians.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Table

Measure	Year and Most Recent Result/Target for Recent Result/ (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
3.E.: Maintain increases in the cost per patient served in the outpatient clinics to below the medical inflation rate (Efficiency)	FY 2013: -7.19% Target: Below national medical inflation rate Target: 4.50% (Target Exceeded)	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 2014: 358 Target: 150 (Target Exceeded)	225	225	Maintain
3.II.A.3.: Number of patients provided Hansen's Disease outpatient care through the NHDP (Output)	FY 2013: 3,610 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)	FY 2013: Defined parameters of muscle dysfunction in armadillos infected with the leprosy bacillus Target: Pursue relevant animal model for human leprosy (Target Met)	Pursue relevant animal model for human leprosy	Pursue relevant animal model for human leprosy	Maintain
3.II.A.1.: Percent increases in the level of Hansen's Disease related disability and	FY 2012: 36% Target: 50% (Target Exceeded)	50%	50%	Maintain

Measure	Year and Most Recent Result/Target for Recent Result/ (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
deformity among patients treated and managed by the NHDP (Percentage of patients at Grades 1 and 2)				

Additional Outputs and Outcomes

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
NHDP Resident Population	14	10	10
NHDP Non-Residential Outpatients	177	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	22,000	22,000	22,000

National Hansen's Disease Program by Sub – Activity

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Administration	$ 1,918,000	$ 1,714,000	$1,861,000
Clinical Care	5,000,000	4,934,000	4,711,000
Regional Centers	2,488,000	2,528,000	2,589,000
Research	2,210,000	2,438,000	2,397,000
Facility Operations	2,326,000	2,346,000	2,422,000
Assisted Living Allowance	1,226,000	1,246,000	1,226,000
Total	$15,168,000	$15,206,000	$15,206,000

National Hansen's Disease Program – Buildings and Facilities

	FY 2014 Final	FY 2015 President's Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$122,000	$122,000	$122,000	---
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Sections 320 and 321(a)

FY 2016 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 2012	$127,000
FY 2013	$122,000
FY 2014	$122,000
FY 2015	$122,000
FY 2016	$122,000

Budget Request

The FY 2016 Budget Request is $122,000. The FY 2016 Request is equal to the FY 2015 Enacted level. The total 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.

Outputs and Outcomes Tables

See National Hansen's Disease Program.

Payment to Hawaii

	FY 2014 Final	FY 2015 Enacted	FY 2015 President's Budget	FY 2016 +/- FY 2015
BA	$1,852,000	$1,857,000	$1,857,000	---
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Section 320(d), as amended by Section 211 of Public Law 105-78

FY 2016 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 (HD) 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 2012	$1,960,000
FY 2013	$1,838,000
FY 2014	$1,852,000
FY 2015	$1,857,000
FY 2016	$1,857,000

Budget Request

The FY 2016 Budget Request is $1,857,000. The FY 2016 Request is equal to the FY 2015 Enacted level.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Tables

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Average daily HD Kalaupapa patient load	16	16	16
Total Kalaupapa and Halemohalu patient hospital days	2,603	2,603	2,603
Total Kalaupapa homecare patient days	2,723	2,723	2,723
Total Hawaiian HD Program outpatients	278	278	278
Total outpatient visits	5,826	5,826	5,826

Rural Health Policy

TAB

FEDERAL OFFICE OF RURAL HEALTH POLICY

Summary of the Request

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$141,978,000	$147,471,000	$127,562,000	$-19,909,000
FTE	11	12	9	-3

Established in 1987, the Federal Office of Rural Health Policy (FORHP) serves as a focal point for rural health activities within the Department of Health and Human Services (HHS). The Office is specifically charged with advising on rural policy issues, conducting and overseeing policy-relevant research on rural health issues, and administering grant programs that focus on supporting and enhancing health care delivery in rural communities.

FORHP is charged in Section 711 of the Social Security Act with advising the Secretary on the effects of current policies and proposed statutory, regulatory, administrative, and budgetary changes in the programs established under titles XVIII and XIX (Medicare and Medicaid) on the financial viability of small rural hospitals, the ability of rural areas (and rural hospitals in particular) to attract and retain physicians and other health professionals, and access to (and the quality of) health care in rural areas.

The Office is also charged with overseeing compliance with the requirements of section 1102(b) of the Social Security Act to assess the impact of key regulations affecting a substantial number of small rural hospitals. In addition, FORHP maintains a clearinghouse for collecting and disseminating information on rural health care issues, promising approaches to improving and enhancing health care delivery in rural communities and maintaining research findings relating to rural health care

While located within HRSA, FORHP is statutorily charged with coordinating the activities within the Department that relate to rural health care and providing information to the Secretary and others in the Department with respect to the activities, of other Federal departments and agencies, that relate to rural health care. In addition to its policy role, FORHP also administers a range of grant programs focusing on capacity building and enhancing health care delivery at the community and state levels as well as programs aimed at leveraging the use of health information technology and telehealth to enhance access to and the quality of health care services in rural and underserved areas.

HHS has maintained a significant focus on rural activities for more than 28 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 over 46 million people living in rural America who face ongoing challenges in accessing health care.[250] Rural residents have higher rates of age-adjusted mortality, disability, and chronic disease than their urban counterparts.[251] 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.[252,253] Of the 1,976 rural counties in the United States (U.S.), 1,550 percent are primary care health professional shortage areas (HPSAs).[254]

One of the annual performance measures used to gauge rural health activities is from the Rural Health Care Services Outreach Grant program authority. Programs under this authority provided both direct and indirect services. In FY 2011, 615,849 people received direct services through the FORHP Outreach grants, exceeding the target of 385,000 people. In FY 2012, 747,952 people received direct services, exceeding the target of 390,000. In FY 2013, 703,070 people received direct services, exceeding its target of 395,000.

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. FORHP will improve the coordination of rural health activities within Health Resources and Services Administration (HRSA), across HHS, as well as other Federal Departments by leveraging rural health funds to improve the health of rural populations. Approximately $83.4 million of the total amount requested for the FORHP supports the President's initiative to improve rural health; specifically, $59,000,000 from Rural Health Care Services Outreach; $9,511,000 from the State Offices of Rural Health, and $14,900,000 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, DHHS, and across the Federal Government.

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[250] Calculated using 2010 Census Data and 2013 OMB nonmetropolitan county designations
[251] 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.
[252] Doescher, M., Fordyce, M., Skillman S., WWAMI Rural Health Research Center Presentation: The Aging of the Rural Generalist Workforce. February 2009.
[253] Area Resource File (ARF). 2008. US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Rockville, MD.
[254] WWAMI Rural Health Research Center. Aging of the rural generalist workforce. Seattle, WA: WWAMI Rural Health Research Center, University of Washington; July, 2009.

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. The projects funded under these programs are essentially pilot projects designed to test out new approaches to improving health care delivery in rural communities. These programs are among the only non-categorical grants within HHS, 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 FORHP to focus funding on key emerging needs. For example, in the first couple of years of the "Improving Rural Health Care Initiative", FORHP was able to focus funding on two key areas of need through funding of Network Development grants. The first focus was on health care workforce development in 2010; the second focus was on the adoption of health information technology in 2011. FORHP awarded 20 awards in the Rural Health Workforce Development Program and conducted short-term and long-term evaluations. The program focused on a range of disciplines including mental health, dental, pharmacy, allied health, including primarily physician assistants, nursing and residency programs. Findings show that the average economic impact ratio of the Rural Health Workforce Development Program was 1.59. As such, approximately $19 million was generated from ORHP's $11.9 million investment.

In FY 2011, FORHP awarded 41 health information technology grants to adopt HIT and to reach Meaningful Use (MU) Stages 1 and 2. FORHP is currently evaluating this program as well to understand lessons learned and those findings will be shared broadly to aid other rural providers in their implementation of electronic health records and meeting MU requirements.

In FY 2013, FORHP continued to focus on the "Improving Rural Health Care Initiative", and made 15 awards in the Rural Health Information Technology (HIT) Workforce Program, which focuses on increase the number of qualified HIT professionals in rural areas. 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.

In FY 2015, FORHP will be administering three new pilot programs in further supporting the "Improving Rural Health Care Initiative". These three programs will focus on allied health training, care coordination and benefits counseling.

State Offices of Rural Health Grants

This program provides funding to the State Office of Rural Health (SORH) located in each state to establish and maintain within the state a clearinghouse for collecting and disseminating

information on: rural health issues, research findings related to rural health care; and innovative approaches to delivery of health care in rural areas. The program supports the coordination of activities carried out within the state that relate to rural health care, including providing coordination for the purpose of avoiding duplication of activities. Additionally the program provides technical and other assistance to public and nonprofit private entities regarding participation in federal, state, and nongovernmental programs focused on rural health. Finally, this program supports 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) family medicine residency programs in which the first year of training takes place in urban-based locations and the second and third years of residency occur in rural locations. This program is an established evidence-based approach as research indicates that approximately 70 percent of the RTT graduates stay in rural practice after completing their training. The technical assistance is provided to help RTT programs across the nation expand residency training and ultimately physician practice in rural areas; increase the number of medical students that match to RTT residency programs; and work with rural communities that have an interest in creating new programs. There are currently 37 active programs, which include three programs opened in 2014. This initiative also supports 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. An additional $2,400,000 was used in FY 2014 for the new Evidence-Based Tele-Emergency program to support implementation and evaluation of broad telehealth networks to deliver Emergency Department consultation services via telehealth to rural and community providers without emergency care specialists.

Coordinating Programs for a Targeted Investment

The programs listed above support the initiative. In addition, FORHP will use the existing funds to continue 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 through a Rural Community Health Gateway. These best practices will be disseminated across the Nation as models that can be replicated through the Gateway.

Finally, as part of the initiative, FORHP will work to increase coordination with other agencies that fund programs that benefit rural communities within HRSA, HHS, 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. The FORHP expanded its work with the Department of Veteran Affairs since 2011 on veteran's access to rural health providers through the support of pilot programs that use telehealth and health information exchange to enhance services for rural veterans. In addition, FORHP is working with the VA Office of Rural Health (ORH) on the implementation of the Veteran's Choice Act. This legislation allows rural hospitals and clinics to provide services to Veterans who reside more than 40 miles from a VA facility can and FORHP and the VA ORH are working with rural providers to sign up as VA partners. The FORHP has also worked with the Office of the National Coordinator for Health Information Technology and the U.S. Department of Agriculture to expand access to Health IT capital and expand the use of Blue-Button health information exchange between small rural hospitals and the VA.

Funding History

FY	Amount
FY 2012	$138,172,000
FY 2013	$130,876,000
FY 2014	$141,978,000
FY 2015	$147,471,000
FY 2016	$127,562,000

Budget Request

The FY 2016 Budget Request is $127,562,000. The FY 2016 Request is $19,909,000 below the FY 2015 Enacted level. This request will fund the following rural health activities:

- $59,000,000 for the Rural Health Care Services Outreach, Network, and Quality Improvement Programs. 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. The FORHP expects that 410,000 people will receive direct services in FY 2016.

- $9,351,000 for Rural Health Policy Development. 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 2016 target for these activities is 35 reports.

- $26,200,000 for Rural Hospital Flexibility Grants. This request provides funding for the Rural Hospital Flexibility Program, which provides grants to support a range of activities focusing on CAHs. The activities supported through this funding will continue to support efforts by CAHs to report quality data to Hospital Compare. The FY 2016 target for this activity is 93 percent.

- $9,511,000 for the State Offices of Rural Health Grants. This funding will continue to support key activities for the State Offices of Rural Health (SORH) Program and will support a grant award to each of the 50 states. It is part of HRSA's "Improving Rural Health Initiative" to provide technical and other assistance to rural health providers and helps rural communities recruit and retain health care professionals. The SORH Program anticipates that it will provide 68,960 technical assistance encounters directly to clients in FY 2016. The program also expects 22,858 clients (unduplicated) will receive technical assistance directly from SORHs in FY 2016.

- $1,834,000 for Radiation Exposure Screening and Education Program (RESEP). 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, transporting 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 1,400 individuals in FY 2016.

- $6,766,000 for Black Lung Clinics. 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 12,836 miners in FY 2016.

- $14,900,000 for the Telehealth Grants. The funds will support: (1) TNGP grantees (20 grants); (2) TRCGP grantees (14 grants); (3) Evidence-Based Telehealth Network Grant Program (six grants); and (4) The Licensure Portability Grant Program (two grants). Through these programs, OAT hopes to increase the proportion of diabetic patients enrolled in a telehealth diabetes case management program to 20 percent in FY 2016 (for the FY 2012-2015 cohort). Additionally, OAT anticipates that 320 communities will have access to adult mental health services and 325 communities will have access to pediatric and adolescent mental health services by FY 2016.

The request includes no funding for the Rural and Community Access to Emergency Devices or for the Small Hospital Improvement Program.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
27.1: Reduce the proportion of rural residents of all ages with limitation of activities caused by chronic conditions.[255] (Outcome)	FY 2010: 14.2% Target: 13.9% (Target Not Met)	N/A	N/A	N/A
29.IV.A.3. Increase the number of people receiving direct services through Outreach grants. (Outcome)	FY 2013: 703,070 Target: 395,000 (Target Exceeded)	405,000	410,000	+5,000
27.2: Increase the proportion of critical access hospitals with positive operating margins. [256] (Outcome)	FY 2013: 54.9% Target: 60% (Target Not Met)	N/A	N/A	N/A

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	450	396	357
Average Award	$175,000	$175,000	$175,000
Range of Awards	$75,000-$640,000	$75,000-$640,000	$75,000-$640,000

[255] This is a long-term measure with FY 2013 as a long-term target date. FY 2010 was an earlier long-term target date to be reported in FY 2012.
[256] This is a long-term measure with no annual targets. FY 2013 was a long-term target date.

Rural Health Policy Development

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$9,328,000	$9,351,000	$9,351,000	---
FTE	1	1	1	---

Authorizing Legislation - Section 301 of the Public Health Service Act, Section 711 of the Social Security Act.

FY 2016 Authorization ..... Indefinite

Allocation Method ..... Competitive Grant

Program Description and Accomplishments

Rural Health Policy Development activities are key components of the Federal Office of Rural Health Policy (FORHP), including policy analyses, research, information dissemination, and technical assistance. 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 FORHP Rural Health Research Center 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. Research work is funded annually under cooperative agreements to seven research centers. Prior to this Program, efforts to understand and appropriately address the health needs of rural Americans were severely limited by the lack of information about rural populations and impacts of Federal policies and regulations on the rural health care infrastructure and population health. Center products include Policy Briefs and reports published in academic journals and other venues, and are disseminated to Federal and State policy makers.

In addition to the Research Center Program, Rural Health Policy Development Activities include several other cooperative agreement programs. These agreements help to inform FORHP, the Department and the public on a variety of rural health issues ranging from access to health care, quality improvement, workforce challenges, and health care finance.

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 cooperative agreements with the Rural Assistance Center (RAC) and the Rural Health Research Gateway. 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. The Rural Health Research Gateway is a website that provides access to the Research Center Program Policy Briefs and other research products funded by the Office.

In FY 2013, the Rural Health Policy Development efforts of FORHP produced 46 research reports, exceeding the target of 30 reports. This number includes policy briefs and full reports that were released on the Rural Health Research Gateway website as well documents that were published in peer-reviewed journals.

Funding History

FY	Amount
FY 2012	$9,866,000
FY 2013	$9,252,000
FY 2014	$9,328,000
FY 2015	$9,351,000
FY 2016	$9,351,000

Budget Request

The FY 2016 Budget Request is $9,351,000. The FY 2016 Request is equal to the FY 2015 Enacted level. This request will fund will support activities such as the Rural Health Research Center (RHRC) 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 2016 as well as policy brief, manuals and other resources focusing on identifying best practices in rural communities.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
28.V.A.1: Conduct and disseminate policy relevant research on rural health issues. (Outcome)	FY 2013: 46 Target: 35 (Target Exceeded)	35	35	Maintain

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	13	13	13
Average Award	$603,719	$603,719	$603,719
Range of Awards	$120,000-$1,543,618	$120,000-$1,543,618	$120,000-$1,543,618

Rural Health Care Services Outreach, Network and Quality Improvement Grants

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$56,857,000	$59,000,000	$59,000,000	---
FTE	3	3	3	---

Authorizing Legislation - Section 330A of the Public Health Service Act, as amended by Section 201, P.L. 107-251, as amended by Section 4, P.L. 110-355.

FY 2016 Authorization ..... Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Rural Health Care Services Outreach, Network and Quality Improvement Grants are a key part of the Federal Office of Rural Health Policy (FORHP)'s investments in improving rural community health. The purpose of the grants is to improve access to care, coordination of care, integration of services and to focus on quality improvement. All of the grants support collaborative models to deliver basic health care services to rural areas and are uniquely designed to meet rural needs. The grant funding allows rural communities to compete for funding against other rural communities rather than having to also compete against larger metropolitan communities with greater resources.

The Outreach authority 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.

The Outreach authority includes a range of programs designed to improve access to and coordination of health care services in rural communities. Five 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. Grantees are required to demonstrate the impact of their program through outcome-focused measures. Grantees submit baseline data that is tracked throughout the project period, and implement a program that has been adapted from a promising practice or evidence-based model. The programs support innovative models that offer rural communities the tools and resources to enhance health care services and ease in the transition to health care models focusing on improved quality and value.

Sustainability continues to be a priority for the FORHP community-based programs. Each year, different programs within the Outreach authority closes out and, therefore, sustainability is assessed on those respective programs. While there is some variability in sustainability rates from one cohort of grantees to another, it is expected that the vast majority of projects will continue after Federal funding. The most recent cohort of community-based grantees that completed federal funding is the Rural Health Network Development grant program. The FY 2013 results showed that 100 percent of the grantees will sustain either all or some of their programs, exceeding the target of 75 percent.

In addition to sustaining programs beyond the initial Federal investment, FORHP's community-based grants also have an economic benefit. Grantees use the Rural Assistance Center's Economic Impact Analysis tool to assess the economic impact of the Federal investment. The tool translates project impacts into community-wide effects such as the number of jobs created, new spending and the impact of new and expanded services. A recent analysis of 20 Rural Health Network Workforce Development grants, which completed the program in August, 2013 showed that for every HRSA dollar invested, approximately $1.63 in additional revenue was generated in the community for a total of $19.4 million in new local economic activity derived from the original $11.9 million dollars HRSA investment over the 3-year project period.

Since 2008, FORHP has been working with the Center for Medicare and Medicaid Services (CMS) on the Frontier Community Health Integration Program (F-CHIP) demonstration to assess innovative ways to support health care delivery in frontier communities served by low-volume Critical Access Hospitals (CAHs). The Office supported initial information gathering and analysis to inform CMS in its development. The demonstration's Request for Proposal was announced by CMS in FY 2014, and FORHP is funding technical assistance and financial and operational analysis for the hospitals selected to participate. FORHP is also finishing up a pilot grant with some of the eligible hospitals that examines the use of community health workers to better manage chronic diseases. The evaluation for this program is expected to be completed in FY 2015.

FORHP's focus on the rural implications of health care reform and emerging demonstration and innovation activities will continue. FORHP will continue to support frontier and rural demonstrations through the Rural Health Value Program. The purpose of this cooperative agreement is to inform policy makers and rural health care providers about how changes in the health care delivery system may affect them, and to provide technical assistance to rural providers in identifying potential new approaches to health care delivery in their communities. The activity will continue to analyze lessons learned from the Frontier Extended Stay Clinic and F-CHIP Medicare demonstrations while also analyzing the viability of new and emerging care models such as accountable care organizations and patient-centered medical homes for rural communities.

Across the programmatic investments under the Outreach authority, FORHP pulls key lessons learned, findings from evaluations and case studies and makes them available on the Rural Assistance Center's Community Health Gateway so that rural communities from across the country can benefit from the investments in each of the grant programs.

Programs within the Rural Health Care Services Outreach Program authority directly served 615,849 individuals in FY 2011, exceeding its target of 385,000. In FY 2012, 747,952 people received direct services, exceeding the target of 390,000. In FY 2013, 703,070 people received direct services, exceeding its target of 395,000. This slight decrease from FY 2012 to 2013 could be due to the reduced number of awards in FY 2013 for the Quality Program. In FY 2012, there were 56 grantees under the Quality Program and there were only 29 grantees in FY 2013.

The Rural Health Care Services Outreach program legislation, as identified in the President's Budget through the "Improving Rural Health Care Initiative", includes several 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' components of the "Improve Rural Health Initiative.' The program will award 50 continuing grants in FY 2016.

Rural Network Development Grants, which support building regional or local formal network agreements among local hospitals, physician groups, long-term care facilities, public health agencies, and other community organizations 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 54 continuation awards in FY 2016. This program will be geared towards demonstrating the health outcomes made by the network as well as positioning networks to be successful in the current health care landscape.

In FY 2015, the program will also support 15 continuation grants for the Rural Health Information Technology (HIT) Workforce program, which involves increasing the number of qualified HIT professionals in rural communities. This program will create 15 models for other communities to replicate.

The program began training 345 health IT specialist students in its first year through the health IT curriculum developed by the 15 grant awardees through community college and university programs, with a projection of 500 students trained after three years of the pilot program. This program will end in FY 2016 but each grantee will make its training curriculum available publicly on the Department of Labor's Learning Portal so that other rural-serving community and technical colleges can use the material to start their own programs and train additional students.

Network Planning Grants, which began in 2004, promote the planning and development of healthcare networks. The program brings together key parts of a rural health care delivery system, particularly those entities that may not have collaborated in the past under a formal relationship, to 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 approximately 15 new grants in FY 2016.

Small Health Care Provider Quality Improvement Grants, which began in 2006, provides assistance to rural primary care providers with the implementation of quality improvement initiatives. The ultimate goal of the program is to promote the development of an evidence-based culture and delivery of coordinated care in the primary care setting. Additional objectives of the program include: improved health outcomes for patients; enhanced chronic disease management; and better engagement of patients and their caregivers. In FY 2013, FORHP developed a new approach for the program so that it aligns with the current healthcare landscape. Organizations participating in the program are required to utilize an evidence-based quality improvement model, perform tests of change focused on improvement, and use health information technology (HIT) to collect and report data. This program is part of the 'Improving the Quality of Health Care Services in Rural Areas' component of the "Improve Rural Health Care Initiative." The program will award approximately 30 new grants in FY 2016.

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 geographically targeted given the health care disparities across this eight-state region. In FY 2013, FORHP developed a new approach for this program, focused on demonstrating outcomes. The program requires all grantees to support diabetes, cardiovascular disease and/or obesity, and to develop a program based on a promising practice or evidence-based model. The program will award 12 new grants in FY 2016.

FORHP is proposing three new pilot programs in FY 2015 that will continue in FY 2016:

The Rural Network Allied Health Training Program will support the development of formal, mature rural health networks that focus on activities that achieve efficiencies, expand access to, coordinate and improve the quality of essential health care services, and strengthen the rural health care system as a whole. In this project, it is anticipated that this purpose will be achieved through the recruitment, clinical training, and retention of allied health professionals. These formal training programs will target enrolled rural allied health professional students, to include displaced workers and veterans, in completing a rural, community-based clinical training rotation and obtaining eventual employment with a rural health care provider. The program will award 10 continuing grants in FY 2016.

Rural Health Coordination Network Partnership Program will support the development of formal, mature rural health networks that focus on care coordination activities for the following chronic conditions: diabetes, congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). The program will award 8 continuing grants in FY 2016.

Rural Outreach Benefits Counseling Program will expand outreach, education and enrollment efforts to the eligible uninsured, but not enrolled individuals and families, and the newly insured

individuals and families in rural communities. The program will award 10 continuing awards in FY 2016.

Funding History

FY	Amount
FY 2012	$55,553,000
FY 2013	$52,093,000
FY 2014	$56,857,000
FY 2015	$59,000,000
FY 2016	$59,000,000

Budget Request

The FY 2016 Budget Request is $59,000,000. The FY 2016 Request is equal to the FY 2015 Enacted level. This request will continue to support the five key activities for Rural Health Care Services Outreach, Network and Quality Improvement Grants Programs. In FY 2016, the program will support approximately 50 Outreach Services grants, 12 Delta grants, 54 Network Development grants, 30 Quality Improvement grants, 15 Network Planning grants, 10 Allied Heath grants, 8 Care Coordination grants and 10 Benefits Counseling grants. FORHP estimates that 410,000 people will receive direct services in FY 2016.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
29.IV.A.3. Increase the number of people receiving direct services through FORHP Outreach grants. [257] (Outcome)	FY 2013: 703,070 Target: 395,000 (Target Exceeded)	405,000	410,000	+5,000

[257] A new cohort of FORHP Outreach grants is awarded a 3-year project period. During the 1st year of the project period, the number of people receiving direct services through the FORHP Outreach grants tends to be lower due to program start up. The numbers generally increase throughout the project period as outreach efforts are implemented.

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
29.IV.A.4: Percent of Outreach Authority grantees that will continue to offer services after the Federal grant funding ends.[258] (Outcome)	FY 2013: 100% Target: 60% (Target Exceeded)	65%	70%	+5% points

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	291	189	189
Average Award	$199,356	$205,000	$205,000
Range of Awards	$65,780-$300,000	$100,000-$300,000	$100,000-$300,000

[258] The programs under the Outreach program authority have varying 3-year project periods. When sustainability data is captured at the end of a program project period, the result varies based on the program that closes out that particular project period.

Rural Access to Emergency Devices

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$3,356,000	$4,500,000	---	$-4,500,000
FTE	2	2	---	-2

Authorizing Legislation - Public Health Service Act, Section 313, and Section 413, P.L. 106-505 of the Public Health Improvement Act

FY 2016 Authorization – Rural Access to Emergency Devices.....Expired
FY 2016 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.

Since the RAED Program was authorized in FY 2002, approximately $45,000,000 has been invested in rural communities to purchase, place and train providers to use AEDs

Funding History

FY	Amount
FY 2012	$1,100,000
FY 2013	$2,340,000
FY 2014	$3,356,000
FY 2015	$4,500,000
FY 2016	$0

Budget Request

There is no FY 2016 Budget Request for the Rural and Community Access to Emergency Devices program. Activities related to access to emergency medical devices and training in FY 2016 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. Further, the goal of the program to increase public access to emergency medical devices and services has largely been met.

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	21	26	---
Average Award	$128,180	$200,000	---
Range of Awards	$63,000-$200,000	$63,000-$200,000	---

Rural Hospital Flexibility Grants

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$40,507,000	$41,609,000	$26,200,000	$-15,409,000
FTE	2	2	1	-1

Authorizing Legislation - Social Security Act, Section 1820(j), as amended by sec. 4201(a), P.L. 105-33 and Section 405 (f), P.L. 108-173, as amended by Section 121, P.L. 110-275.

FY 2016 Authorization ..... Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Rural Hospital Flexibility activities are a component of the Federal Office of Rural Health Policy (FORHP) and support a range of activities focusing primarily on Critical Access Hospitals (CAHs). There are three grant programs administered under this authority:

- The Medicare Rural Hospital Flexibility Grant Program
- The Small Hospital Improvement Grant Program
- The Rural Veterans Health Access Program

The purpose of the Medicare Rural Hospital Flexibility Grant (Flex) Program is to assist states in working with Critical Access Hospitals (CAHs) on quality reporting and improvement and performance improvement activities as well as helping eligible rural hospitals convert to as CAHs status and enhancing emergency medical services related to CAHs. The ultimate goal of the program is to help CAHs maintain high-quality and economically viable facilities to ensure that residents in rural communities, and particularly Medicare beneficiaries, have access to high quality health care services. States use Flex resources to address identified needs for CAHs within the state and to achieve improved and measurable outcomes in each selected program area. The Flex funding supports a partnership between the States and FORHP to work with the more than 1,300 critical access hospitals in 45 states. The FY 2015 project period guidance reflects the continued push towards funding activities that can provide clear outcomes and demonstrated improvements.

The Flex program has played a key role in ensuring that CAHs are aligned with key quality initiatives across the Medicare program. All prospective payment system hospitals (PPS) are required to submit quality data to the Centers for Medicare and Medicaid Services (CMS) in order to receive a full payment update under Medicare. CAHs are not subject to this requirement but through the Flex program FORHP created the Medicare Beneficiary Quality Improvement Program (MBQIP), for these facilities to submit quality data and use that data to demonstrate

areas of high quality while also identifying areas for improvement. MBQIP is a National Quality Strategy program that began as a voluntary initiative and will become a required activity in FY 2016 to allow for benchmarking and quality improvement initiatives for inpatient, outpatient and patient satisfaction measures.

The second program is the Small Rural Hospital Improvement Program (SHIP). This program provides support to rural hospitals with fewer than 50 beds on software and equipment related to quality and reporting and billing given these facilities often lack administrative capacity or the cash reserved to consistently meet new and emerging requirements. This includes equipment purchase and training for upgrading billing requirements such as the new ICD-10 standards or for software related to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS) patient satisfaction survey. The majority of the over 1,600 hospitals receiving SHIP funds in FY 2013 spent funds to support systems related to quality reporting or training for ICD-10 conversion Overall, the program provides needed investments that directly assists rural hospitals adapt to the changing health care environment.

The third 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 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, which is administered in collaboration with the Veteran's Administration (VA) Office of Rural Health, seeks to enhance care for veterans living in isolated rural areas who receive care both in their home facilities and at more distant VA facilities. The grantees focus on investments in telehealth and health information exchange technology for both access to needed services and continuity of care for veterans in rural communities. Current grantees are located in Alaska, Maine and Montana.

	FY 2014 Final	**FY 2015 Enacted**	**FY 2016 President's Budget**
Rural Hospital Flexibility (Flex) Grant Program	$24,667,000	$24,667,000	$25,200,000
Small Hospital Improvement Program (SHIP)	$14,840,000	$14,942,000	---
Flex Rural Veterans Health Access Program	$1,000,000	$1,000,000	$1,000,000

The Flex performance measures 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 quality in all hospitals. The FY 2006 baseline for this measure is 63.14 percent of CAHs voluntarily 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 from 69 percent in FY 2007 to 79.7 percent in FY 2011 and 87.3 percent in FY 2012.

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 number of individuals trained in EMS leadership and/or trauma courses declined from 2,996 individuals trained in FY 2010 to 2,368 individuals trained in FY 2011. FY 2012 showed an increase in trained EMS leadership to 5,099 personnel trained, exceeding the target. This upward trend is due to increased investment in training programs for that grant year in a couple specific states.

Funding History

FY	Amount
FY 2012	$41,040,000
FY 2013	$38,484,000
FY 2014	$40,507,000
FY 2015	$41,609,000
FY 2016	$26,200,000

Budget Request

The FY 2016 Budget Request is $26,200,000. The FY 2016 Request is $15,409,000 below the FY 2015 Enacted level. This request will continue to support 45 Flex grant programs to support CAHs and three grants to support rural veterans.

The FY 2016 Request allows core activities to be targeted to the area of greatest need with a focus on CAHs, the nation's smallest hospitals. CAHs will continue to receive support through the Flex grant with a focus on enhancing quality and patient outcomes as well as improving financial viability so that these hospitals can continue to ensure access to care for isolated Medicare beneficiaries. The activities supported through this funding will encourage hospitals to report quality data to Hospital Compare (FY 2016 target: 93 percent), engage in patient satisfaction surveys for quality and operational improvement (FY 2016 target: 72 percent), and to invest grant dollars in EMS training and trauma system development (FY 2016 target: 2,995). The program will award 45 grants in FY 2016. Support for the Rural Veterans Health Access Program will allow for continued efforts to increase access for rural veterans to needed services. This program will support three grants in FY 2016.

The Budget eliminates funding for the Small Hospital Improvement Program. The need for Small Hospital Improvement Program grants is lessened by enhanced payments for rural hospitals paid under the Medicare Inpatient Prospective Payment system for inpatient and outpatient services. In addition, over 80 percent of hospitals eligible for funding through the Small Hospital Improvement Program are critical access hospitals and have access to other funding from the Rural Hospital Flexibility Grants program.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
30.V.B.4: Increase the percent of Critical Access Hospitals reporting at least one measure to Hospital Compare. (Outcome)	FY 2012: 87.3% Target: 76% (Target Exceeded)	90%	93%	+3% points
30.V.B.5: Number of individuals trained in emergency medical services leadership and/or trauma courses. (Outcome)	FY 2012: 5,099 Target: 3,615 (Target Exceeded)	2,995	2,995	Maintain
30.V.B.6: Increase the percent of Critical Access Hospitals participating in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.	FY 2012: 49% (Target Not in Place)	70%	72%	+2% points

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	48	48	48
Average Award	$490,000	$550,000	$550,000
Range of Awards	$256,000-$640,000	$300,000-$750,000	$300,000-$750,000

State Offices of Rural Health

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$9,487,000	$9,511,000	$9,511,000	---
FTE	1	1	1	---

Authorizing Legislation - Section 338J of the Public Health Service Act as amended by Section 301, P.L. 105-392.

FY 2016 Authorization ..... Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

This grant program provides funding to establish and maintain a State Office of Rural Health (SORH) within each state. The primary purpose of a SORH is to assist in strengthening the State's rural health care delivery system. SORHs serve as focal point and clearinghouse for the collection and dissemination of information on rural health issues, research findings, innovative approaches and best-practices pertaining to the delivery of health care in rural areas. As the State's rural institutional framework, SORHs help link rural communities with State and Federal resources in order to help develop long-term solutions to rural health problems. SORHs help form collaborative partnerships and relationships to better coordinate rural health activities, maximize limited resources and avoid duplication of effort and activities. In addition, SORHs identify Federal, State, and nongovernmental programs and funding opportunities, and provide technical assistance to public and nonprofit private entities regarding participation in such rural health programs. Finally, this program supports improving the recruitment and retention of health care providers in rural areas component of the initiative.

Each dollar of Federal support for the program is matched by three State dollars. The SORH Program is part of the "Improving Rural Health Initiative" to strengthen the regional and local partnerships among rural health care providers and improve recruitment and retention of health care professionals in rural areas 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. After an increase from the initial number of encounters of 54,689 in FY 2009 up to a high of 86,140 in FY 2011, numbers have slightly decreased but remained relatively stable at 85,600 in FY 2012 and 82,549 in FY 2013. The FY 2013 target was exceeded. The number of clients receiving technical assistance directly, has varied, up from 25,441 in FY 2011 to 28,496 in FY 2012 and back down

in FY 2013 to 26,574 clients The FY 2013 result did not meet the target, however, grantees received less funding in 2013 due to sequestration.

The third measure reflects the work facilitated by the SORHs through recruitment initiatives in the number of clinician placements. FY 2012 result is 1,619, exceeding the target. This was a decrease from the FY 2011 high of 1,767 placements, but up from FY 2010 of 1,544. Last year efforts were made to improve the collection of information on the clinician placements in rural areas.

Through these efforts, an improved monitoring approach was used to track the number of referrals to vacancies and their resultant placements. The SORHs have been instrumental in helping rural constituents to meet the challenges through sharing information and providing technical assistance around the changing environment that rural health providers face, for example, with the passage of meaningful use requirements.

Funding History

FY	Amount
FY 2012	$10,036,000
FY 2013	$9,411,000
FY 2014	$9,487,000
FY 2015	$9,511,000
FY 2016	$9,511,000

Budget Request

The FY 2016 Budget Request is $9,511,000. The FY 2016 Request is equal to the FY 2015 Enacted level. This request 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. The SORH program anticipates that it will provide 68,960 technical assistance encounters directly to clients in FY 2016. The program also expects that 22,858 clients will receive technical assistance directly from SORHs. Additionally, the program hopes to facilitate 1,260 clinician placements in FY 2016.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
31.V.B.3: Number of technical assistance (TA) encounters provided directly to clients by SORHs. (Outcome)	FY 2013: 82,549 Target: 66,932 (Target Exceeded)	68,277	68,960	+683
31.V.B.4: Number of clients (unduplicated) that received technical assistance directly from SORHs. (Outcome)	FY 2013: 26,574 Target: 31,134 (Target Not Met)	22,632	22,858	+226
31.V.B.5: Number of clinician placements facilitated by the SORHs through their recruitment initiatives. (Outcome)	FY 2012: 1,619 Target: 1,053 (Target Exceeded)	1,260	1,260	Maintain

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
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 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$1,829,000	$1,834,000	$1,834,000	---
FTE	1	1	1	---

Authorizing Legislation - Section 417C of the Public Health Service Act, as amended by Section 4, P.L. 106-245, as further amended by Section 103 and Section 104, P.L. 109-482.

FY 2016 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 maintained the number of users for FY 2010 (1,371) and FY 2011 (1,371), with an increase in users maintained for FY 2012 (1,567) and FY 2013 (1,576). The target was exceeded for both FY 2012 and FY 2013 in part due to the renewed outreach and education efforts targeted for reaching new patient populations previously unaware of available screenings as well as relocated eligible individuals. The additional focus on grantee compliance with uniform screening guidelines in collaboration from program partners with the Department of Justice has also contributed to efforts aimed at more effectively capturing the total number of individuals screened. These shifts within the program became necessary due to the rapidly aging former uranium industry worker population in which potential patients have passed away as well relocated from original mining sites.

The program also measures the average cost of the program per individual. In FY 2012, the average cost of the program per individual screened was $956, which exceeded the target. The total number of individuals screened at RESEP centers each year greatly impacts the results for this measure. These results are somewhat higher than the targets due to the increasing cost of procedures and screenings at these RESEP centers. In FY 2013 the average cost of the program per individual screened was $1,002 which exceeded the target and similarly reflects a correlation with the total number of individuals screened at RESEP clinics for the year.

Funding also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Funding History

FY	Amount
FY 2012	1,664,378
FY 2013	$1,579,599
FY 2014	$1,589,500
FY 2015	$1,834,000
FY 2016	$1,834,000

Budget Request

The FY 2016 Budget Request is $1,834,000. The FY 2016 Request is equal to the FY 2015 Enacted level. This request will continue to support key activities for Radiation Exposure Screening and Education Program. The program will continue to support eight grantees in FY 2016, and the target for the number of individuals screened is 1,400.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
32.1: Percent of RECA successful claimants screened at RESEP centers.) [259] (Outcome)	FY 2013: 15.23% Target: 8.8% (3-year rolling baseline)	N/A	N/A	N/A
32.2: Percent of patients screened at RESEP clinics who file RECA claims that receive RECA benefits. [1] (Outcome)	FY 2013: 84.72% Target: 72% (Target Exceeded)	N/A	N/A	N/A
32.I.A.1: Total number of individuals screened per year. (Output)	FY2013:1,576 Target: 1,450 (Target Exceeded)	1,366	1,400	+34

[259] This is a long-term measure with FY 2013 as a long-term target date.

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
32.E: Average cost of the program per individual screened (Efficiency)	FY 2013: $1,002 Target: $1,397 (Target Exceeded)	$1,093	$1,000	-$93

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	8	8	8
Average Award	$235,827	$235,827	$235,827
Range of Awards	$119,722-$224,852	$180,000-$279,000	$180,000-$279,000

Black Lung

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$6,749,000	$6,766,000	$6,766,000	---
FTE	---	1	1	---

Authorizing Legislation - Federal Mine, Health, and Safety Act of 1977, Section 427(a), P.L. 91-173 as amended by Section 5(6), P.L. 92-303 amended by Section 9, P.L. 95-239, as further amended by CFR Part 55A.

FY 2016 Authorization ..... Indefinite

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Black Lung Program was established in 1980 and provides grants to public and private entities, including community-based organizations, for the purpose of establishing and operating clinics that provide for the outreach and education; screening; diagnosis; treatment; compensation counseling; and rehabilitation, when appropriate, of active, inactive, retired and disabled 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. To assist in the longer-term need faced by those miners with severe disability as a result of Black Lung disease; grantees can also assist miners in preparing the detailed clinical information needed to apply for Federal Black Lung benefits from the U.S. Department of Labor (DoL).

In FY 2013 clinics reported the provision of services to 13,643 miners, which exceeded the target of 12,688 miners. The program also provided 19,346 medical encounters in FY 2013, which was below its target of 27,403. Although several clinics increased outreach efforts and received more referrals from providers and legal representatives, access to qualified medical providers hindered some clinics' abilities to provide necessary services. The number of encounters per million dollars in federal funding in FY 2013 was 10,131 which exceeded the target of 4,372. Data collected from the grantees shows that the cost per encounter with a miner has increased in the last year, suggesting that the clinics are seeing miners with more significant medical issues.

Communities across the country continue to experience an increased need for services related to Black Lung disease. Recent information from the Centers for Disease Control and Prevention's National Institute of Occupational Safety and Health (NIOSH) indicates that the prevalence of coal workers' pneumoconiosis (CWP), also known as black lung disease, is rising. In fact, a

study from 2011 of 2,000 coal miners from Utah to Pennsylvania showed that five times as many miners have CWP than 10 years ago. Many miners are developing severe CWP before 50 years of age, and there is some evidence that this is being manifested as premature mortality. In addition, data from DoL show the number of Federal Black Lung Benefits claims has increased, suggesting that the disease is also leading to increased significant, long-term disability. In FY 2014, HRSA's Black Lung program responded to this evolving need by targeting its resources to areas where the miners reside and with a grantee's projected service levels.

Funding History

FY	Amount
FY 2012	$7,140,000
FY 2013	$6,695,000
FY 2014	$6,749,000
FY 2015	$6,766,000
FY 2016	$6,766,000

Budget Request

The FY 2016 Budget Request is $6,766,000. The FY 2016 Request is equal to the FY 2015 Enacted level. This request will continue to support key activities for the Black Lung Program and the third year of funding for the 15 Black Lung Clinic grantees, which will provide an expanded set of services to include coordinating care to care delivery.

At this level, HRSA will also continue to support the Center of Excellence, which in its third year, will continue to focus on identifying best clinical practices in diagnosing and developing treatment plans for those with CWP and promoting broad adoption of those strategies across the grantees. The Center will be responsible for working closely with stakeholders to strengthen clinical standards across grantees and share relevant information with clinicians and miners. The CoE will also continue to consult with NIOSH and DoL on incorporating emerging research on CWP and coal mining to inform future program investments. By the end of the current project period, all grantees will be incorporating these approaches into their day-to-day activities. At this funding level, the program expects to reach the target of 19,880 medical encounters in FY 2016.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
33.I.A.1: Number of miners served each year. (Output)	FY 2013: 13,643 Target: 12,688 (Target Exceeded)	13,000	12,836	+164
33.I.A.2: Number of medical encounters from Black Lung each year. (Output)	FY 2013: 19,346 Target: 27,403 (Target Not Met)	16,500	19,880	+3,380
33.E: Increase the number of medical encounters per $1 million in federal funding. (Efficiency)	FY 2013: 10,131 Target: 4,372 (Target Exceeded)	9,550	9,550	Maintain

Grant Awards Table

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	15	15	15
Average Awards	$434,165	$434,165	$434,165
Range of Awards	$222,754 - $1,800,000	$222,754- $1,800,000	$222,754 -1,800,000

Telehealth

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$13,865,000	$14,900,000	$14,900,000	---
FTE	1	1	1	---

Authorizing Legislation: Section 330I of the Public Health Service Act; as amended by Public Law 107-251, as further amended by Public Law 108-163.

FY 2016 Authorization ..... Expired

Allocation Method ..... Competitive Grants/Cooperative Agreements and Contracts

Program Description and Accomplishments

The Office for the Advancement of Telehealth (OAT) administers the following grant programs that support telehealth technologies:

- Telehealth Network Grant Program (TNGP), which includes funding projects that demonstrate the use of telehealth networks to improve healthcare services for medically underserved populations in urban, rural, and frontier communities. More specifically, the networks can be used 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.

- Telehealth Resource Center Grant Program (TRCGP), which provides technical assistance to communities wishing to establish or enhance and expand telehealth services.

- Licensure Portability Grant Program (LPGP), which provides support for State professional licensing boards to carry out programs under which licensing boards cooperate to develop and implement State policies that will reduce statutory and regulatory barriers to telemedicine.

As of FY 2012[260], this cohort of TNGP grantees provided a total number of 159 clinical services, across 427 sites in underserved rural communities for a total of 586 sites and services. When added to the FY 2001 baseline of 2,601, TNGP grantees supported 3,187 sites and services in these communities since FY 2005, exceeding the target for FY 2012. As a result, a gradual expansion of sites and/or services is evident across the three year project period (FY 2009-2012), and includes actual results from the new cohort of grantees that began their project periods on September 1, 2012. In FY 2012, 473 communities had access to pediatric mental health services

[260] OAT program's next set of results for FY 2013 will be available in March 2015.

and 518 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 2011 and FY 2012, these results show a relative increase as telehealth projects devote more resources towards mental health services.

In FY 2006, the program began 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 control has been gradually achieved. With new cohorts of telehealth network projects being supported, 23 percent were able to achieve ideal glycemic control compared to a target of 20 percent in FY 2012.

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. In FY 2014, HRSA supported networks in rural underserved communities that are experiencing severe shortages of health care professionals.

In FY 2014, the Telehealth budget was increased by $3,079,000. A portion of these additional funds were utilized to create a new program entitled the Evidence-Based Telehealth Network Grant Program. The purpose of this program is to support implementation and evaluation of broad Telehealth networks to deliver Emergency Department consultation services via Telehealth to rural and community providers without emergency care specialists.

Table 1. Actual Grant Dollars to be awarded for grants

	FY 2014 Final	**FY 2015 Enacted**	**FY 2016 President's Budget**
Telehealth Network Grant Program	$4,909,383	$5,409,383	$5,409,383
Licensure Portability Grant Program	$700,000	$700,000	$700,000
Telehealth Resource Center Grant Program	$5,147,454	$5,153,454	$5,153,454
Contracts	$5,000	$400,000	$400,000
Evidence-Based Telehealth Network Grant Program	$2,000,000	$2,000,000	$2,000,000

Funding History

FY	Amount
FY 2012	$11,502,000
FY 2013	$10,786,000
FY 2014	$13,865,000
FY 2015	$14,900,000
FY 2016	$14,900,000

Budget Request

The FY 2016 Budget Request is $14,900,000. The FY 2016 Request is equal to the FY 2015 Enacted level. This request will support: (1) TNGP grantees (23 grants); (2) TRCGP grantees (14 grants); (3) Evidence-Based Telehealth Network Grant Program (6 grants); and (4) The Licensure Portability Grant Program (2 grants). Through these programs, OAT hopes to increase the proportion of diabetic patients enrolled in a telehealth diabetes case management program to 20 percent in FY 2016 (for the FY 2012-2015 cohort). Additionally, OAT anticipates that 320 communities will have access to adult mental health services and 325 communities will have access to pediatric and adolescent mental health services by FY 2016.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
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 2012: 23% Target: 20% (Target Exceeded)	30%	20%[261]	-10 percentage points
34.1: The percent of TNGP grantees that continue to offer services after the TNGP funding has ended. [262] (Outcome)	FY 2005: 100% (Baseline) Target: N/A (Target Not In Place)	N/A	N/A	N/A

[261] Lower target due to changes in grantee cohort

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
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. [263] (Outcome)	FY 2012: 3,187 Target: 2,556 (Target Exceeded)	2,675	2,700	+25
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 2012: 473 Target: 223 (Target Exceeded)	320	325	+5
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 2012: 518 Target: 188 (Target Exceeded)	315	320	+5
34.E: Expand the number of services and/or sites providing access to health care as a result of the TNGP program per Federal program dollars expended. [264] (Efficiency)	FY 2012: 103 per Million $ Target: 202 per Million $ (Target Not Met)	105 per Million $	106 per Million $	+1 per Million $

[263] 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, future targets may need to be revised if there is evidence of a significant increase in grantees that are providing mental health services.

[264] 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

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	42	45	45
Average Award	$308,921	$308,921	$308,921
Range of Awards	$250,000-$400,000	$250,000-$400,000	$250,000-$400,000

Program Management

TAB

OTHER PROGRAMS

Program Management

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$152,677,000	$154,000,000	$157,061,000	+$3,061,000
FTE	799	799	799	---

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

FY 2016 Authorization……...……Indefinite

Allocation Method……....Other

Program Description and Accomplishments

HRSA's mission is to improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs. To achieve its mission, HRSA requires qualified staff to operate at maximum efficiency. Program Management is the primary means of support for FTEs, business operations and processes, information technology and overhead expenses such as rent, utilities, and miscellaneous charges, for HRSA. Program Management activities support improving HRSA's operations, modernizing its systems and processes and facilitating the implementation of Administration priorities. In addition, Program Management supports agency oversight of a broad variety of program operations funded from other sources, including the National Practitioner Data Bank and the Vaccine Injury Compensation Program.

Improving Processes and Business Operations

HRSA established and continues to improve operational planning processes to foster cross-agency collaboration and avoid potential duplication. In FY 2014, HRSA automated its contracting process to operate in a totally paperless environment, including the receipt of committed funds, the obligation of funds, and the generation and storage of contract documents. HRSA also achieved cost savings by streamlining and enhancing the conference room reservation system in lieu of renting space. Over the past four years, HRSA has reduced travel costs and supported telework participation by increasing the agency-wide utilization of web collaboration tools. Real-time collaboration is accomplished using support ranging from one-on-one for teleworkers to web-based meetings supporting as many as 500 participants. In FY 2014 HRSA's used over 10.1 million virtual meeting minutes, which is about six times greater than the 1.7 million meeting minutes in FY 2011 when data was first collected on this technology.

Finally, HRSA reengineered the National Practitioner Data Bank (NPDB) business processes, including modifying NPDB's IT support contract resulting in an estimated cost savings of $5.7 million over the remaining life of the contract and updated the NPDB server hardware to secure GSA-certified "cloud" technology, saving an additional estimated $900,000 over the next three years.

Investing in the Future

HRSA has taken several steps to ensure that it has a competent, well-trained workforce. In 2010, the agency established the HRSA Learning Institute to help assure that the workforce has the knowledge, skills, and competencies necessary to accomplish the mission. During FY 2014, HRSA developed a standard position description and job analysis template for use by all interested Bureaus and Offices, reducing the time spent in posting similar or identical positions, and benefiting applicants by having multiple selecting officials review and consider them for positions as well as completed training certificates for key positions in the agency including: project officers, grants management specialists, and supervisors. Additionally, over 50 percent of the HRSA's Senior Leadership (SES and GS-15s) are eligible to retire in 2017. To prepare for the pending departures, HRSA has developed a robust leadership development program and is implementing a workforce planning initiative to support managers in conducting workforce analysis and strategically managing our human resources.

Improving Data Transparency and Services

Program Management included 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, while improving program integrity. The EHBs supports HRSA with program administration, grants administration and monitoring, management reporting, and performance measurement and analysis. For FY 2014, HRSA extended the hours for HRSA's grants system help desk, without increasing cost, to improve availability for grantees on the west coast, and developed a single tracking system to document and monitor help desk services; deployed a suite of EHB management dashboards for HRSA Office and Bureau's to improve management and oversight; and made significant performance improvements to decrease the time to key EHBs display screens. These improvements ultimately increased the productivity of HRSA's 433 project officers and HRSA's grantees.

Additionally, HRSA's Data Warehouse serves as the official enterprise repository of HRSA's data and provides and array of visual and interactive tools for searching, accessing, viewing, and displaying the data. These data are used by employees, grantees, health care providers, the public and other audiences interested in HRSA's public health services and information. HRSA has made improvements so that users can quickly access HRSA's investments by Congressional District, county, state, HHS Region, and nationwide. Users can also find a health center in their area or can analyze an address to see if it is in a Health Professional Shortage Area and/or Medically Underserved Area. In 2014, HRSA expanded data capabilities to support smartphones and tablets; improved report features for ease of use and printing; added Affordable Care Act

grants data to fact sheets; and supported the development of a series of widgets, maps, report tools, and charts for senior leadership to enhance program integrity efforts.

Creating a Culture of Program Integrity

Program Management also supports program integrity activities and aligns them with performance and strategic planning activities with the intent of reducing programmatic risk and improving performance.

HRSA's Program Integrity Initiative includes:

- An agency-wide workgroup that develops, monitors, and oversees the agency's program integrity activities
- Training for federal staff and grantees
- Hiring program integrity analysts and auditors
- Automated tools and systems for HRSA staff, including a web based funds control and reporting system.

Utilizing feedback received through GAO studies, OIG reports, and issues identified through members of the HRSA Program Integrity Workgroup, HRSA has developed a series of program integrity training, webcasts, and reference materials, including an online program integrity toolkit that provides HRSA staff with a single source of information, resources, templates, policies, procedures, and manuals. Additionally, HRSA collaborated with the HHS Inspector General to provide OIG led grant fraud training to HRSA project officers. HRSA has subjected its mission critical support functions such as time and attendance, property management, research integrity, and more to operational reviews to assess compliance with laws and regulations, and Departmental and HRSA policy. HRSA has established a HRSA-wide governance structure for enterprise-wide business operations and program integrity activities to ensure a customer focused suite of business operation services and functions.

Funding History

FY	Amount
FY 2012	$159,894,000
FY 2013	$151,450,000
FY 2014	$152,677,000
FY 2015	$154,000,000
FY 2016	$157,061,000

Budget Request

The FY 2016 Budget Request for Program Management is $157,061,000, which is $3,061,000 above the 2015 Enacted level.

HRSA is committed to improving quality at a lower cost and improving the effectiveness and efficiency of government operations. HRSA continues to reduce travel costs and support

telework participation by increasing the agency-wide utilization of web collaboration tools, which have led to greater business productivity.

HRSA also continues to enhance its program integrity activities by supporting analytical tools using HRSA's electronic grants system, program data, Office of Federal Assistance Management data sources, HHS sources, and government-wide sources. HRSA currently has multiple data sets that reflect grantee performance, organizational dimensions, financial indicators, and grant compliance, that are not integrated and available for analytical purposes without a lot of manual effort. The data sets often reside in different systems. The goal is that HRSA will be able to identify potential issues in the pre and post-award process and can therefore address the issues before they become audit finding. HRSA plans to focus on a risk-based approach to grantee monitoring using the information and corresponding analysis to help staff spend their time on those grantees that show clear signs of the need for extra attention. HRSA will also continue to provide training for grants management and program staff to support the integration of program integrity with planning and performance. These efforts will enhance the capacity of HRSA grantees to be aware of, and avoid potential financial integrity challenges.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
35.VII.B.1.: Ensure Critical Infrastructure Protection: Security Awareness Training (Output)	FY 2014: 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 and Privacy Awareness training by 100% of HRSA staff. Specialized role-based training for 100% of HRSA staff identified to have significant security and privacy responsibilities	Full participation in Security and Privacy Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security and privacy responsibilities, and participation in Executive Awareness training by 100% of HRSA executive staff	N/A
35.VII.B.2: Ensure Critical Infrastructure Protection:	FY 2014: 100% of HRSA information systems have been Certified and	100% of HRSA information systems will be assessed and authorized to operate	100% of HRSA information systems will be assessed and authorized to operate	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Security Authorization to Operate (Output)	Accredited and granted Authority to Operate. (ATO). (Target Met)	(ATO). In addition all systems will go through continuous monitoring to ensure that critical patches are applied, security controls are implemented and working as intended, and risks are managed and mitigated in a timely manner	(ATO). In addition all systems will go through continuous monitoring to ensure that critical patches are applied, security controls are implemented and working as intended, and risks are managed and mitigated in a timely manner	
35.VII.B.3: Capital Planning and Investment Control (Output)	FY 2014: 1) 100% of major investments received an IT Dashboard Overall Rating of "Green", which indicates an acceptable cost, schedule and Agency CIO Rating; 2) 100% of major Investment Managers are in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM). (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).	Maintain
35.VII.A.3: Strengthen Program Integrity (PI) Activities	FY 2014: (1)Reached staffing of 17 PI analysts (regions and HQ) to increase auditing/site visit capability. (2) HRSA PI	1) Increase staffing to 22 analysts. 2) Operate and maintain PI toolkit and consider further expansion as needed.	1) Maintain FY 2015 PI staffing level 2) Operate and maintain PI toolkit and consider further expansion as needed	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
	Workgroup began to fully deploy two sections of the online PI toolkit. (Target Met)			

FAMILY PLANNING TAB

Family Planning

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
BA	$285,760,000	$ 286,479,000	$300,000,000	$13,521,000
FTE	35	35	35	---

Authorizing Legislation: Title X of the Public Health Service Act
FY 2016 Authorization…….Indefinite
Allocation Method ..... Competitive Grant, Contract, Direct

Program Description and Accomplishments

The Title X Family Planning Program is the only federal grant program dedicated to providing individuals with comprehensive family planning and related preventive health services. Enacted in 1970 as part of the Public Health Service Act, the mission of the Title X Program is to aid individuals and families in determining the number and spacing of children and 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. 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 and evidence-based clinical recommendations, all Title X funded family planning centers provide contraceptive methods, education, 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 unintended pregnancy rates among teens and young adults. According to the most recent data (CY 2013), of the more than 4.5 million individuals served in Title X clinics, approximately 18 percent were under 20 years of age and more than 2.31 million (51 percent) were in their 20's (2013 Family Planning Annual Report (FPAR)). By providing comprehensive family planning and related reproductive and preventive health services (e.g., STD and HIV prevention, education, and screening), unintended pregnancy, infertility and related morbidity have been reduced for these populations.

The Office of Population Affairs (OPA), which administrates the Title X Family Planning Program, in collaboration with CDC, further established itself as a leader in family planning and reproductive health through the release of, "Providing Quality Family Planning Services,

Recommendations of CDC and the U.S. Office of Population Affairs," as a Morbidity and Mortality Weekly Report (MMWR) (April 25, 2014). This document will serve as an evidence-based set of recommendations for Title X family planning grantees, other public family planning and primary care service providers and private providers.

In order to ensure that the Title X family planning program is responsive to the ever-changing needs of clients and is 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. Among the findings from the evaluation, it was noted that the Title X program is extremely resilient and valuable, especially in providing family planning services to its priority population – individuals from low-income families. Historically, 90 percent of the clients served each year in Title X-funded sites have family incomes at or below 200 percent of the federal poverty level. Furthermore, a 2014 Guttmacher Institute publication indicated that for more than half of clients seen in publicly-funded family planning clinics, such as Title X, clients reported that the site was their "usual" or only continuing source of health care and/or health education.

The Title X Program fulfills its mission through awarding competitive grants to public and private nonprofit organizations to support the provision of family planning services, information, and education. According to 2013 FPAR data, services were provided through 95 family planning service grants that supported a nationwide network of 4,168 community-based sites that provided clinical and educational services to more than 4,555,000 persons. Grantees included state and local health departments, hospitals, community health centers, universities, Planned Parenthood centers, and other private nonprofit agencies. There is at least one Title X services grantee in every state, the District of Columbia, and in each of the U.S. territories, including Pacific jurisdictions. 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.

In addition to clinical services, the Title X Family Planning Program also supports three key functions aimed at assisting clinics in responding to clients' needs: (1) training for all levels of family planning agency personnel through a national training program; (2) information dissemination and community-based education and outreach activities; and (3) data collection and research to improve the delivery of family planning services. Each year the program establishes a set of program-wide priorities that provide guidance to grantees in an effort to ensure high-quality, responsive, and appropriate family planning service delivery. In the past several years, the priorities have focused on building the program's capacity to address needs of clients and sustainability of the family planning network. Program priorities have stressed the need to expand access to a broad range of effective and acceptable family planning methods, including Long-Acting Reversible Contraceptives (LARCs) as well as improve the administrative and financial aspects of service providers. An additional emphasis has been put on implementing electronic health record and administrative management systems, increasing the number and types of contracts with health insurance plans and recovering more costs through reimbursements and billing third-party payers.

Broader access to highly effective, but relatively expensive, methods of contraception has been recognized as a key strategy to reducing unplanned pregnancies. At the same time, clinics have

been expected to provide a broader array of primary care services related to preventing unintended pregnancies or achieving healthy pregnancies and positive birth outcomes. As a result, the ability of some providers to address the increasingly complex needs of clients served by Title X family planning centers has created added stress to the program. In response to this and other needs, the National Training Center for Quality Assurance, Quality Improvement and Evaluation began an initiative to improve clinic efficiency in CY 2013. Using innovative strategies, such as distance learning, learning collaborations – cohorts specifically designed to facilitate collaboration with others, and communities of practice – content-directed online groups; participants have begun to implement and document positive changes in how clinical services are delivered – more efficient scheduling, shorter client wait times, and other elements which improve healthcare delivery. The evaluation on these efforts is forthcoming and in response to the findings will assess ways to more broadly expand this initiative.

In 2013, the most recent year for which final data are available, the program accomplished the following: Served over 4,555,000 clients, helping to avert an estimated 870,000 unintended pregnancies, approximately 160,000 of which were among teens. In addition, service sites provided approximately 1.16 million Chlamydia tests for 15–24 year old females, preventing an estimated 1,375 cases of STD-related infertility. Though targets for the number of screenings for Chlamydia infection in females ages 15–24 were not met, the proportion of those screened in this age group increased to approximately 60%. This increase is most likely the result of improved adherence to CDC guidance and other nationally recognized standards of care regarding screening for Chlamydia infection among females in this age group. Additionally, between 2012 and 2013, the number of total clients decreased 4.3 percent, including fewer female clients ages 15 – 24 receiving services, attributing to the lower number of screenings for Chlamydia infection among females among this age group
Policy changes occurring in some states resulted in shifting funds away from some providers of family planning services with large client bases. The decrease in overall clients, specifically female clients, resulted in the number of unintended pregnancies averted also decreasing.

Cervical cancer screenings also declined. While at first glance this may seem problematic, it likely is a positive effect, and reflects adherence to new recommendations from nationally recognized organizations such as the American College of Obstetricians and Gynecologists (ACOG), American Cancer Society (ACS), and US Preventive Services Task Force (USPSTF). These revised standards recommend that screening be initiated later in life and, for most women, performed less frequently. Currently, these organizations recommend that cervical cancer screening begin at age 21, and between ages 21–65, be performed every three years (beginning at age 30, in place of traditional cytology, screening with HPV co-testing may be performed every five years). As providers begin adopting the current screening recommendations, fewer cervical cancer screenings will be performed in all settings, including Title X clinics. FPAR data support this trend, with the latest data indicating that the proportion of women screened for cervical cancer in Title X family planning centers decreased from 52 percent in 2005 to 24 percent in 2013.

The family planning program has historically been able to maintain the increase in the average cost per Title X client at or below the medical care rate of inflation. In 2013, the program continued to perform better than its projected target. In 2013, the program's cost per client

increased at a greater rate than CPI. Despite this increase, the program's five-year average growth rate in its cost per client is approximately 3.3 percent annually – lower than the medical CPI of 3.4 percent over the same period of time. Although some increase in the cost per client is expected and anticipated, the slower average growth (versus the CPI) over the past several years is influenced by many factors, including investments Title X grantees and services sites have made in technology and other infrastructure advancements, such as incorporating electronic health records and implementing strategies to improve their ability to effectively leverage multiple sources of revenue.

Overall, the most significant challenge the program has encountered in recent years is maintaining the number of overall clients. The most significant decline has occurred with female clients, adding further difficulties in meeting performance targets, as targets are dependent on female oriented services. An important asset of the Title X program is its ability to leverage other sources of funding, often the major sources coming from state governments and Medicaid. In recent years, large states have decreased funding for family planning. In the case of Texas, this has resulted in Title X remaining as the only source of public funding for family planning services; consequently, resulting in fewer services sites and a decrease in the number of clients receiving services.

In order to improve overall program performance, the program is increasing the emphasis on financial and program management through providing training and other efforts around billing practices, including billing all appropriate third-party payers, and other cost recovery methods through the Title X National Training Centers as well as in collaboration with CDC, Division of Sexually Transmitted Disease Prevention. In addition, grantees are being urged to implement more efficient administrative systems, such as health information technologies, electronic health records and payment management systems. Another trend, which the program believes will improve program performance, is increased competition and diversity in the types of grantees funded. Increased competition has led to more diversified grantees, leading to improved cost recovery methods and different administrative structures, which, it is anticipated, will ultimately, improve quality and service delivery. To complement these efforts, the program is also focusing on efforts around sustainability and ensuring consistent and continued access to services. Funding has been made available for grantees to invest in health information technology through Title X-only grants, assessments of grantee capacity regarding health IT as well as training and technical assistance in this area have also been made available. Finally, OPA awarded one-year grants in FY 2014 to improve enrollment of Title X clients into insurance in an effort to increase the number and amount of billing opportunities.

Funding History

FY	Amount
FY 2012	$293,870,000
FY 2013	$278,349,000
FY 2014	$285,760,000
FY 2015	$286,479,000
FY 2016	$300,000,000

Budget Request

The FY 2016 President's Budget request of $300,000,000 is $13,521,000 greater than the FY 2015 enacted level. The Budget provides funding for family planning methods and related preventive health services, as well as related training, information, education and research to improve family planning service delivery.

The FY 2016 request is expected to support family planning services for approximately 4,672,000 persons, with approximately 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 1,400 cases of infertility through Chlamydia screening of approximately 1,195,000 females ages 15-24, preventing approximately 425 cases of invasive cervical cancer through cervical cancer screening, and preventing approximately 894,000 unintended pregnancies in FY 2016. The targets for FY 2016 are ambitious and assume that other sources of revenue that contribute to the family planning program at the grantee level; specifically, Medicaid, state and local governments, other federal, state and private grants, and private insurance will remain at historical proportions of the total Title X revenue.

As in the past, approximately 90 percent of the appropriation will be used for clinical family planning services. Those services will continue to include recommended Chlamydia screening, screening for undiagnosed cervical tissue abnormalities and providing a broad range of contraceptive methods and related education and counseling, thereby reducing the number of unintended pregnancies.

OPA views the CDC MMWR, "Providing Quality Family Planning Services, Recommendations of CDC and the U. S. Office of Populations Affairs," as a foundation for the continued advancement of high-quality family planning and healthcare delivery for the future. These evidence-based recommendations reflect a foundation of empirical evidence and information supporting clinical practice and are intended to improve the provision of family planning and reproductive health services regardless of the service setting (i.e., establish family planning and reproductive health recommendations for all clinical providers). These recommendations define family planning as a constellation of services that assist individuals and couples with both preventing unintended pregnancy and assisting with achieving pregnancy leading to healthy birth outcomes. The adoption of these guidelines and standards of care is expected to significantly improve the quality of care provided in Title X services sites and improve the program's performance trends. The program has a detailed implementation plan, which includes informational presentations, training – including tools and guidance for all levels of family planning staff, and monitoring, and evaluation instruments. The systematic release of these documents and materials, including revised programmatic requirements, will improve the quality of family planning, reproductive health, related preventive health services, as well as allow the program to evaluate the impact of the recommendations.

The FY 2016 request will allow the program to provide additional training and support to Title X grantees, sub-recipients and service sites as more individuals gain access to affordable health

care. The program will employ multiple strategies including training of staff and providers, coordination with other federal agencies and data collection reflecting performance and impact. The program is anticipating that additional investment in third party billing, increasing the proportion of clients who have health insurance and better adoption of electronic health records and related health IT systems, will increase revenue and allow the Title X program to reach more of the population in need of family planning services.

Beginning in CY 2015, the program will begin transforming its FPAR data collection system. Currently, FPAR data, representing over 4 million family planning clients, are reported in aggregate at the grantee level. The aggregate nature of the data limits its quality and utility for performance monitoring. OPA is estimating that beginning in CY 2017, all grantees will be requested to submit encounter-level data directly from service sites by leveraging electronic health records (EHR) technology and capabilities to transmit data to an FPAR 2.0 repository. Receipt of encounter-level data at the national level will allow the program to collect de-identified information on client demographics and service utility that will enable OPA to better examine the impact of insurance coverage expansions on the Title X network and enable OPA to establish more rigorous performance metrics that better reflect the quality of services provided, and potentially, the impact on intermediary health outcomes. Collecting encounter level data represents a dramatic shift to the Title X data collection system and will require additional resources to each grantee so their service delivery sites can negotiate with their EHR vendors to collect and report the required FPAR 2.0 data elements. This effort will also require the creation of a centralized data center. In the long term, the investment in this data infrastructure will allow the program to assess the quality of services being provided to clients in real time.

The program is dedicated to improving access to quality family planning, reproductive health and related primary care services through service delivery, training and evidence-based clinical recommendations. In parallel with the implementation of the FPAR 2.0 system, the adoption of EHRs and other electronic administrative systems, and the implementation of the recommendations for providing quality family planning services (MMWR, April 2014), the program, in collaboration with CDC, is in the process of establishing family planning-specific, quality measures for submission to the National Quality Forum for endorsement. These family planning-based and other measures currently under development, are designed to assess the quality and impact of family planning services, within as well as outside of the Title X network.

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 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
36.II.A.1: Total number of unduplicated clients served in Title X service sites. *(Outcome)*	FY 2013: 4,763,797 Target: 4,969,600 (Target not met)	4,307,000	4,672,000	+365,000
36.II.A.2: Maintain the proportion of clients served who are at or below 200% of the Federal poverty level at 90% of total unduplicated family planning users. *(Outcome)*	FY 2013: 90% Target: 90% (Target Met)	90%	90%	Maintain
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 2013: 870,394 Target: 961,300 (Target Not Met)	823,000	892,000	+69,000
36.II.A.4: Increase the proportion of female clients, using a method of contraception, indicating the use of: A: Long Acting Reversible Contraceptive (LARC) as their primary method of contraception.	FY 2013: 8.8% Baseline	A: 9.7%	A: 9.9%	A: +0.2%
36.II.A.4: Increase the proportion of female clients, using a method of contraception, indicating the use of: B: Highly or moderately effective methods of contraception as their primary method of contraception. (Outcome)	FY 2013:70.1% Baseline	B: 77.1%	B: 79.0%	B: +2.3%

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 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
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 2013: 1,164,140 Target: 1,340,300 (Target Not Met)	1,155,500	1,195,000	+39,500
36.II.C.3: Increase the proportion of females ages 15 – 24 attending Title X family planning clinics screened for Chlamydia infection. (Outcome)	FY 2013: 59.8% Baseline: 57.8%	63%	64.4%	+1.4%

Efficiency Measure:

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
36.E: Maintain the actual cost per Title X client below the medical care inflation rate. *(Efficiency)*[265]	FY 2013: $281.87 Target: $292.23 (Target Exceeded)	$291.94	$301.14	+$9.20

[265] Targets are calculated using a four-year average of the Consumer Price Index for Medical inflation.

Grant Awards Tables

(whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	95	95	95
Average Award	$ 2,707,200	$2,714,000	$2,842,000
Range of Awards	$75,000 - $19,116,100	$75,000 - $19,116,100	$75,000 - $20,000,000

Supplementary Tables

TAB

Budget Authority by Object Class

(Dollars in Thousands)

PRIMARY HEALTH CARE

OBJECT CLASS	2015 Base	FY 2016 Request	FY 2016 +/- FY 2015
Full-time permanent (11.1)	22,862	23,931	+1,069
Other than full-time permanent (11.3)	566	573	+7
Other personnel compensation (11.5)	279	282	+3
Military personnel (11.7)	1,829	1,852	+23
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**25,536**	**26,638**	**+1,102**
Civilian benefits (12.1)	7,164	7,515	+351
Military benefits (12.2)	1,006	1,018	+12
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**33,706**	**35,171**	**+1,465**
Travel and transportation of persons (21.0)	768	768	-
Transportation of things (22.0)	5	5	-
Rental payments to GSA (23.1)	813	813	-
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	1,719	1,719	-
Printing and reproduction (24.0)	2	2	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	497	497	-
Other services (25.2)	38,247	38,247	-
Purchase of goods and services from government accounts (25.3)	37,083	37,083	-
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	4	4	-
Operation and maintenance of equipment (25.7)	19,009	19,009	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	110	110	-
Subtotal Other Contractual Services	**94,950**	**94,950**	**-**
Equipment (31.0)	458	458	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	1,267,572	1,266,114	-1,458
Insurance Claims and Indemnities (42.0)	91,530	91,523	-7
Total Non-Pay Costs	**$1,457,816**	**$1,456,351**	**-$1,465**
Total Budget Authority by Object Class	**$1,491,522**	**$1,491,522**	**--**

HEALTH WORKFORCE

OBJECT CLASS	2015 Base	FY 2016 Request	FY 2016 +/-FY 2015
Full-time permanent (11.1)	$ 10,116	$ 22,540	+12,424
Other than full-time permanent (11.3)	280	448	+168
Other personnel compensation (11.5)	103	155	+51
Military personnel (11.7)	540	547	+7
Special personnel services payments (11.8)	-	204	+204
Subtotal personnel compensation	**11,039**	**23,894**	**+12,855**
Civilian benefits (12.1)	3,042	7,010	+3,968
Military benefits (12.2)	270	273	+3
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**14,350**	**31,177**	**+16,826**
Travel and transportation of persons (21.0)	175	159	-15
Transportation of things (22.0)	3	3	-
Rental payments to GSA (23.1)	629	600	-29
Rental payments to Others (23.2)	4	4	-
Communication, utilities, and misc. charges (23.3)	1,007	1,007	-1
Printing and reproduction (24.0)	1	1	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	25	25	-
Other services (25.2)	6,719	6,688	-31
Purchase of goods and services from government accounts (25.3)	24,823	23,812	-1,011
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	5,493	5,422	-72
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	74	74	+
Subtotal Other Contractual Services	**37,135**	**36,021**	**-1,114**
Equipment (31.0)	391	339	-52
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	697,906	787,510	+89,604
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**$ 737,250**	**$ 825,643**	**+88,394**
Total Budget Authority by Object Class	**$751,600**	**$ 856,820**	**+105,220**

MATERNAL AND CHILD HEALTH

OBJECT CLASS	2015 Base	FY 2016 Request	FY 2016 +/-FY 2015
Full-time permanent (11.1)	$ 6,097	$ 6,172	+75
Other than full-time permanent (11.3)	178	180	+2
Other personnel compensation (11.5)	80	81	+1
Military personnel (11.7)	450	455	+5
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**6,805**	**6,888**	**+83**
Civilian benefits (12.1)	1,804	1,826	+22
Military benefits (12.2)	221	223	+2
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**8,829**	**8,937**	**+108**
Travel and transportation of persons (21.0)	267	267	-
Transportation of things (22.0)	23	23	-
Rental payments to GSA (23.1)	144	144	-
Rental payments to Others (23.2)	4	4	-
Communication, utilities, and misc. charges (23.3)	211	211	-
Printing and reproduction (24.0)	-	-	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	7,033	7,033	-
Other services (25.2)	1,861	1,861	-
Purchase of goods and services from government accounts (25.3)	13,083	13,083	-
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	4,297	4,297	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	84	84	-
Subtotal Other Contractual Services	**26,358**	**26,358**	**-**
Equipment (31.0)	374	374	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	815,529	815,421	-108
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**$ 842,909**	**$ 842,801**	**-108**
Total Budget Authority by Object Class	**$851,738**	**$ 851,738**	**-**

HIV/AIDS

OBJECT CLASS	2015 Base	FY 2016 Request	FY 2016 +/-FY 2015
Full-time permanent (11.1)	$ 17,095	$ 17,306	+211
Other than full-time permanent (11.3)	278	281	+3
Other personnel compensation (11.5)	286	289	+3
Military personnel (11.7)	1,432	1,448	+16
Special personnel services payments (11.8)	21	22	+
Subtotal personnel compensation	**19,112**	**19,345**	**+233**
Civilian benefits (12.1)	5,091	5,154	+63
Military benefits (12.2)	794	802	+8
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**24,997**	**25,301**	**+304**
Travel and transportation of persons (21.0)	237	231	-6
Transportation of things (22.0)	9	9	-
Rental payments to GSA (23.1)	224	185	-39
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	892	889	-3
Printing and reproduction (24.0)	1	-	-1
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	-	-	-
Other services (25.2)	14,860	13,077	-1,784
Purchase of goods and services from government accounts (25.3)	66,200	63,966	-2,234
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	9,044	8,512	-532
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	62	48	-14
Subtotal Other Contractual Services	**90,167**	**85,603**	**-4,564**
Equipment (31.0)	455	455	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	2,201,800	2,210,108	+8,308
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**$ 2,293,784**	**$ 2,297,480**	**+3,696**
Total Budget Authority by Object Class	**$ 2,318,781**	**$ 2,322,781**	**+4,000**

HEALTHCARE SYSTEMS

OBJECT CLASS	2015 Base	FY 2016 Request	FY 2016 +/- FY 2015
Full-time permanent (11.1)	$ 6,290	$ 6,818	+528
Other than full-time permanent (11.3)	200	202	+2
Other personnel compensation (11.5)	367	371	+4
Military personnel (11.7)	698	707	+9
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**7,556**	**8,097**	**+542**
Civilian benefits (12.1)	2,046	2,222	+176
Military benefits (12.2)	274	276	+3
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**9,876**	**10,596**	**+720**
Travel and transportation of persons (21.0)	212	212	-
Transportation of things (22.0)	75	75	-
Rental payments to GSA (23.1)	920	920	-
Rental payments to Others (23.2)	762	762	-
Communication, utilities, and misc. charges (23.3)	178	178	-
Network use data transmission service (23.8)	8	8	-
Printing and reproduction (24.0)	2	2	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	4,040	4,040	-
Other services (25.2)	49,556	55,962	+6,405
Purchase of goods and services from government accounts (25.3)	4,316	4,308	-8
Operation and maintenance of facilities (25.4)	266	266	-
Research and Development Contracts (25.5)	108	108	-
Medical care (25.6)	2,833	2,833	-
Operation and maintenance of equipment (25.7)	188	188	-
Subsistence and support of persons (25.8)	37	37	-
Discounts and Interest (25.9)	19	19	-
Supplies and materials (26.0)	483	483	-
Subtotal Other Contractual Services	**61,847**	**68,244**	**+6,397**
Equipment (31.0)	778	778	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	28,536	28,419	-117
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**$ 93,317**	**$ 99,598**	**+6,280**
Total Budget Authority by Object Class	**$ 103,193**	**$ 110,193**	**+7,000**

RURAL HEALTH

OBJECT CLASS	2015 Base	FY 2016 Request	FY 2016 +/-FY 2015
Full-time permanent (11.1)	$ 963	$ 649	-314
Other than full-time permanent (11.3)	92	89	-3
Other personnel compensation (11.5)	6	1	-5
Military personnel (11.7)	71	71	-
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**1,133**	**810**	**-323**
Civilian benefits (12.1)	329	237	-92
Military benefits (12.2)	41	41	+
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**1,503**	**1,088**	**-415**
Travel and transportation of persons (21.0)	160	160	-
Transportation of things (22.0)	5	5	-
Rental payments to GSA (23.1)	21	15	-7
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	21	19	-1
Printing and reproduction (24.0)	-	-	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	-	-	-
Other services (25.2)	4,636	4,572	-64
Purchase of goods and services from government accounts (25.3)	3,456	3,366	-90
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	1,380	1,290	-90
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	30	30	-
Subtotal Other Contractual Services	**9,502**	**9,258**	**-244**
Equipment (31.0)	130	116	-14
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	136,130	116,901	-19,229
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**$ 145,968**	**$ 126,474**	**-19,495**
Total Budget Authority by Object Class	**$ 147,471**	**$ 127,562**	**-19,909**

FAMILY PLANNING

OBJECT CLASS	2015 Base	FY 2016 Request	FY 2016 +/-FY 2015
Full-time permanent (11.1)	$ 6,196	$ 6,272	+76
Other than full-time permanent (11.3)	212	215	+2
Other personnel compensation (11.5)	-	-	-
Military personnel (11.7)	829	838	+8
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**7,238**	**7,324**	**+86**
Civilian benefits (12.1)	2,015	2,040	+25
Military benefits (12.2)	364	368	+4
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**9,617**	**9,732**	**+115**
Travel and transportation of persons (21.0)	124	124	-
Transportation of things (22.0)	0	0	-
Rental payments to GSA (23.1)	652	652	-
Rental payments to Others (23.2)	14	14	-
Communication, utilities, and misc. charges (23.3)	31	31	-
Printing and reproduction (24.0)	2	2	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	1,805	1,805	-
Other services (25.2)	531	531	-
Purchase of goods and services from government accounts (25.3)	9,476	9,476	-
Operation and maintenance of facilities (25.4)	61	61	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	-	-	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	4	4	-
Subtotal Other Contractual Services	**11,877**	**11,877**	**-**
Equipment (31.0)	2	2	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	264,173	277,566	+13,393
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**$ 276,875**	**$ 290,268**	**+13,393**
Total Budget Authority by Object Class	**$ 286,492**	**$ 300,000**	**+13,509**

PROGRAM MANAGEMENT

OBJECT CLASS	2015 Base	FY 2016 Request	FY 2016 +/-FY 2015
Full-time permanent (11.1)	$ 74,721	$ 75,640	+919
Other than full-time permanent (11.3)	3,819	3,865	+46
Other personnel compensation (11.5)	1,669	1,690	+21
Military personnel (11.7)	7,193	7,281	+88
Special personnel services payments (11.8)	237	240	+2
Subtotal personnel compensation	**87,639**	**88,716**	**+1,077**
Civilian benefits (12.1)	22,423	22,698	+275
Military benefits (12.2)	3,977	4,026	+49
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**114,039**	**115,440**	**+1,401**
Travel and transportation of persons (21.0)	49	49	+
Transportation of things (22.0)	237	237	-
Rental payments to GSA (23.1)	18,555	19,114	+559
Rental payments to Others (23.2)	3	3	-
Communication, utilities, and misc. charges (23.3)	613	613	-
Commercial Reimbursement (23.6)	155	155	+
Printing and reproduction (24.0)	125	125	+
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	3	3	-
Other services (25.2)	3,683	3,683	-
Purchase of goods and services from government accounts (25.3)	13,230	14,331	+1,101
Operation and maintenance of facilities (25.4)	763	763	-
Research and Development Contracts (25.5)	0	0	-
Medical care (25.6)	0	0	+
Operation and maintenance of equipment (25.7)	2,005	2,005	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	340	340	+
Subtotal Other Contractual Services	**20,025**	**21,126**	**+1,101**
Equipment (31.0)	200	200	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	-	-	-
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**$ 39,961**	**$ 41,622**	**+1,660**
Total Budget Authority by Object Class	**$ 154,000**	**$ 157,061**	**+3,061**

DISCRETIONARY

OBJECT CLASS	2015 Base	FY 2016 Request	FY 2016 +/-FY 2015
Full-time permanent (11.1)	144,340	159,327	+14,987
Other than full-time permanent (11.3)	5,624	5,854	+230
Other personnel compensation (11.5)	2,778	2,857	+79
Military personnel (11.7)	13,043	13,202	+159
Special personnel services payments (11.8)	259	466	+207
Subtotal personnel compensation	**166,044**	**181,706**	**+15,662**
Civilian benefits (12.1)	43,915	48,703	+4,788
Military benefits (12.2)	6,945	7,029	+84
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**216,903**	**237,438**	**+20,535**
Travel and transportation of persons (21.0)	1,992	1,971	-21
Transportation of things (22.0)	357	357	-
Rental payments to GSA (23.1)	21,958	22,442	+484
Rental payments to Others (23.2)	786	786	-
Communication, utilities, and misc. charges (23.3)	4,672	4,667	-5
Commercial Reimbursement (23.6)	155	155	-
Network use data transmission service (23.8)	8	8	-
Printing and reproduction (24.0)	131	131	-1
Other Contractual Services: 25.0	-	0	+
Advisory and assistance services (25.1)	13,403	13,403	-
Other services (25.2)	120,093	124,620	+4,526
Purchase of goods and services from government accounts (25.3)	171,668	169,423	-2,245
Operation and maintenance of facilities (25.4)	1,090	1,090	-
Research and Development Contracts (25.5)	108	108	-
Medical care (25.6)	2,837	2,837	-
Operation and maintenance of equipment (25.7)	41,415	40,722	-693
Subsistence and support of persons (25.8)	37	37	-
Discounts and Interest (25.9)	19	19	-
Supplies and materials (26.0)	1,188	1,174	-14
Subtotal Other Contractual Services	**351,860**	**353,435**	**+1,574**
Equipment (31.0)	2,786	2,720	-66
Sum of 32	-	-	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	5,411,644	5,502,044	+90,400
Insurance Claims and Indemnities (42.0)	91,530	91,523	-7
Total Non-Pay Costs	**$ 5,887,880**	**$ 5,980,239**	**+92,358**
Total Budget Authority by Object Class	**$ 6,104,784**	**$ 6,217,677**	**+112,893**

MANDATORY

OBJECT CLASS	2015 Base	FY 2016 Request	FY 2016 +/- FY 2015
Full-time permanent (11.1)	$ 31,080	$ 30,469	-611
Other than full-time permanent (11.3)	650	582	-68
Other personnel compensation (11.5)	391	348	-43
Military personnel (11.7)	5,593	5,774	+181
Special personnel services payments (11.8)	-	61	+61
Subtotal personnel compensation	**37,715**	**37,234**	**-480**
Civilian benefits (12.1)	9,610	9,598	-12
Military benefits (12.2)	3,314	3,481	+167
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**50,639**	**50,313**	**-325**
Travel and transportation of persons (21.0)	297	291	-6
Transportation of things (22.0)	36	36	-
Rental payments to GSA (23.1)	4,545	4,536	-9
Rental payments to Others (23.2)	16	16	-
Communication, utilities, and misc. charges (23.3)	1,372	1,371	-
GSA Reimbursement Transaction Charge (23.5)	5	5	
Commercial Reimbursement (23.6)	-	-	-
Network use data transmission service (23.8)	-	-	-
Printing and reproduction (24.0)	4	4	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	15,865	15,865	-
Other services (25.2)	13,621	13,621	-
Purchase of goods and services from government accounts (25.3)	79,260	79,243	-17
Operation and maintenance of facilities (25.4)	49	49	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	829	782	-47
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	32	32	-
Subtotal Other Contractual Services	**$ 109,657**	**$ 109,592**	**-65**
Equipment (31.0)	1	1	-
Sum of 32	-	-	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	4,032,410	3,956,465	-75,945
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**$ 4,148,342**	**$ 4,072,317**	**-76,026**
Total Budget Authority by Object Class	**$ 4,198,981**	**$ 4,122,630**	**-76,351**

Salaries and Expenses

(Dollars in Thousands)

DISCRETIONARY

OBJECT CLASS			
	TOTAL	**TOTAL**	**TOTAL**
Full-time permanent (11.1)	144,340	159,327	+14,987
Other than full-time permanent (11.3)	5,624	5,854	+230
Other personnel compensation (11.5)	2,778	2,857	+79
Military personnel (11.7)	13,043	13,202	+159
Special personnel services payments (11.8)	259	466	+207
Subtotal personnel compensation	**166,044**	**181,706**	**+15,662**
Civilian benefits (12.1)	43,915	48,703	+4,788
Military benefits (12.2)	6,945	7,029	+84
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**216,903**	**237,438**	**+20,535**
Travel and transportation of persons (21.0)	1,992	1,971	-21
Transportation of things (22.0)	357	357	-
Rental payments to Others (23.2)	786	786	-
Communication, utilities, and misc. charges (23.3)	4,672	4,667	-5
Printing and reproduction (24.0)	131	131	-1
Other Contractual Services: 25.0	0	0	-
Advisory and assistance services (25.1)	13,403	13,403	-
Other services (25.2)	120,093	124,620	+4,526
Purchase of goods and services from government accounts (25.3)	171,668	169,423	-2,245
Operation and maintenance of facilities (25.4)	1,090	1,090	-
Medical care (25.6)	2,837	2,837	-
Operation and maintenance of equipment (25.7)	41,415	40,722	-693
Subsistence and support of persons (25.8)	37	37	-
Discounts and Interest (25.9)	19	19	-
Supplies and materials (26.0)	1,188	1,174	-14
Subtotal Other Contractual Services	**351,752**	**353,326**	**+1,574**
Total Non-Pay Costs	**359,690**	**361,237**	**+1,548**
Total Budget Authority by Object Class	**576,593**	**598,675**	**+22,082**

Salaries and Expenses
(Dollars in Thousands)

MANDATORY

OBJECT CLASS	2015 Base	FY 2016 Request	FY 2016 +/- FY 2015
Full-time permanent (11.1)	$ 31,080	$ 30,469	-611
Other than full-time permanent (11.3)	650	582	-68
Other personnel compensation (11.5)	391	348	-43
Military personnel (11.7)	5,593	5,774	+181
Special personnel services payments (11.8)	-	61	+61
Subtotal personnel compensation	**37,715**	**37,234**	**-480**
Civilian benefits (12.1)	9,610	9,598	-12
Military benefits (12.2)	3,314	3,481	+167
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**50,639**	**50,313**	**-325**
Travel and transportation of persons (21.0)	297	291	-6
Transportation of things (22.0)	36	36	-
Rental payments to Others (23.2)	16	16	-
Communication, utilities, and misc. charges (23.3)	1,372	1,371	-
Printing and reproduction (24.0)	4	4	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	15,865	15,865	-
Other services (25.2)	13,621	13,621	-
Purchase of goods and services from government accounts (25.3)	79,260	79,243	-17
Operation and maintenance of facilities (25.4)	49	49	-
Operation and maintenance of equipment (25.7)	829	782	-47
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	32	32	-
Subtotal Other Contractual Services	**$ 109,657**	**$ 109,592**	**-65**
Total Non-Pay Costs	**$ 111,381**	**$ 111,310**	**-71**
Total Budget Authority by Object Class	**$ 162,020**	**$ 161,624**	**-396**

Detail of Full-Time Equivalent Employment

PROGRAMS	FY 2014			FY 2015			FY 2016		
	Actual Civilian	Actual Military	Actual Total	Est. Civilian	Est. Military	Est. Total	Est. Civilian	Est. Military	Est. Total
Bureau of Primary Health Care:									
Direct:									
Health Centers/Tort	160	25	185	227	25	252	234	25	259
Free Clinics Medical Malpractice	-	-	-	-	-	-	-	-	-
Total, Direct:	**160**	**25**	**185**	**227**	**25**	**252**	**234**	**25**	**259**
Mandatory:									
Community Health Center Fund (ACA)	77	18	95	79	18	97	-	-	-
Community Health Center Fund (proposed)	-	-	-	-	-	-	79	18	97
School-based Health Centers- Facilities (ACA)	9	-	9	8	-	8	-	-	-
Total, Mandatory	**86**	**18**	**104**	**87**	**18**	**105**	**79**	**18**	**97**
Total FTE, BPHC	**246**	**43**	**289**	**314**	**43**	**357**	**313**	**43**	**356**
Health Workforce:									
Direct:									
National Health Service Corps	-	-	-	-	-	-	102	-	102
NURSE Corps Loan Repayment & Scholarship	28	4	32	28	4	32	28	4	32
Centers for Excellence	1	-	1	1	-	1	1	-	1
Scholarships for Disadvantaged Students	4	-	4	4	-	4	4	-	4
Health Careers Opportunity Program	1	-	1	1	-	1	-	-	-
Health Workforce Diversity			-	-	-	-	1	-	1
Health Care Workforce Assessment	4	1	5	6	1	7	6	1	7
Primary Care Training and Enhancement	4	-	4	5	-	5	5	-	5
Oral Health Training	2	-	2	2	-	2	2	-	2
Rural Physician Training Grants	-	-	-	-	-	-	2	-	2
Area Health Education Centers	4	-	4	4	-	4	-	-	-

Geriatric Programs	2	1	3	4	1	5	4	1	5
Mental and Behavioral Health	1	-	1	1	-	1	1	-	1
Clinical Training in Interprofessional Practice			-	-	-	-	2	-	2
Public Health/Preventive Medicine	2	-	2	4	-	4	4	-	4
Advanced Education Nursing Program	5	-	5	6	-	6	6	-	6
Nurse Workforce Diversity	1	-	1	1	-	1	1	-	1
Nurse Education, Practice & Retention	3	-	3	4	-	4	4	-	4
Nurse Faculty Loan Program	1	-	1	1	-	1	1	-	1
Comprehensive Geriatric Education	4	-	4	4	-	4	4	-	4
Children's Hospitals GME Program	22	-	22	22	-	22	22	-	22
HEAL	10	-	10	-	-	-	-	-	-
Total, Direct	**99**	**6**	**105**	**98**	**6**	**104**	**200**	**6**	**206**
Reimbursable:									
National Practitioner Data Bank	43	-	43	46	-	46	46	-	46
Advanced Education Nursing Program			-	-	-	-	-	-	-
Total, Reimbursable:	**43**	**-**	43	**46**	**-**	**46**	**46**	**-**	**46**
Mandatory:									
National Health Service Corps (ACA)	189	**30**	**219**	207	30	237	-	-	-
National Health Service Corps (Proposed ACA)			-	-	-	-	155	30	185
GME Payments for Teaching Health Centers	3	2	5	4	2	6	-	-	-
Targeted Support for GME (Proposed)			-	-	-	-	30	2	32
Total, Mandatory	**192**	**32**	**224**	**211**	**32**	**243**	**185**	**32**	**217**
Total FTE, Health Workforce	**334**	**38**	**372**	**355**	**38**	**393**	**431**	**38**	**469**
Maternal and Child Health Bureau:									
Direct:									
Maternal & Child Health Block Grant	27	4	31	27	4	31	27	4	31
Autism and Other Developmental Disorders	6	1	7	6	1	7	6	1	7
Traumatic Brain Injury	2	-	2	2	-	2	2	-	2
Sickle Cell Service Demonstrations	2	-	2	2	-	2	2	-	2
James T. Walsh Universal Newborn Hearing	4	-	4	4	-	4	4	-	4

Screening									
Emergency Medical Services for Children	4	-	4	4	-	4	4	-	4
Healthy Start	5	-	5	5	-	5	5	-	5
Heritable Disorders	3	-	3	4	-	4	4	-	4
Total, Direct:	**53**	**5**	**58**	**54**	**5**	**59**	**54**	**5**	**59**
Mandatory									
Family to Family Health Info Centers	-	1	1	-	1	1	-	-	-
Home Visiting	18	4	22	18	4	22	-	-	-
Home Visiting (proposed)	-	-	-	-	-	-	18	4	22
Total, Mandatory	**18**	**5**	**23**	**18**	**5**	**23**	**18**	**4**	**22**
Total FTE, MCHB	**71**	**10**	**81**	**72**	**10**	**82**	**72**	**9**	**81**
HIV/AIDS Bureau:									
Direct:									
Ryan White Part A	46	2	48	47	2	49	47	2	49
Ryan White Part B	67	4	71	69	4	73	69	4	73
Ryan White Part C	28	9	37	29	9	38	39	9	48
Ryan White Part D	10		10	10	-	10	-	-	-
Ryan White Part F	4	1	5	4	1	5	4	1	5
Ryan White Part F Dental			-	1	-	1	1	-	1
Total, Direct:	**155**	**16**	**171**	**160**	**16**	**176**	**160**	**16**	**176**
Reimbursable:									
OGAC Global AIDS	13	4	17	13	4	17	12	4	16
Total, Reimbursable	**13**	**4**	**17**	**13**	**4**	**17**	**12**	**4**	**16**
Total FTE, HAB	**168**	**20**	**188**	**173**	**20**	**193**	**172**	**20**	**192**
Healthcare Systems Bureau:									
Direct:									
Organ Transplantation	2	-	2	2	-	2	2	-	2
National Cord Blood Inventory	3	1	4	3	1	4	3	1	4
C.W.Bill Young Cell Transplantation Program	5		5	5	-	5	5	-	5
Poison Control Centers	3		3	3	-	3	3	-	3

340B Drug Pricing Program	2	2	4	9	2	11	13	2	15
Hansen's Disease Center	53	3	56	56	3	59	56	3	59
Covered Countermeasures Compensation	4	2	6	6	2	8	6	2	8
Vaccine	18	1	19	18	1	19	24	1	25
Total, Direct:	**90**	**9**	**99**	**102**	**9**	**111**	**112**	**9**	**121**
Reimbursable:									
340B Drug Pricing Program			-	-	-	-	7	-	7
Hansen's Disease Center	2		2	3	-	3	3	-	3
Total, Reimbursable	**2**	**-**	**2**	**3**	**-**	**3**	**10**	**-**	**10**
Total FTE, HSB	**92**	**9**	**101**	**105**	**9**	**114**	**122**	**9**	**131**
Office of Rural Health Policy:									
Direct:									
Rural Health Policy Development	1		1	1	-	1	1	-	1
Rural Health Outreach Grants	3		3	3	-	3	3	-	3
Rural & Community Access to Emergency Devices	2		2	2	-	2	-	-	-
Rural Hospital Flexibility Grants	2		2	2	-	2	1	-	1
State Offices of Rural Health	1		1	1	-	1	1	-	1
Radiation Exposure Screening & Education Program	-	1	1	-	1	1	-	1	1
Black Lung			-	1	-	1	1	-	1
Telehealth	1		1	1	-	1	1	-	1
Total FTE, ORHP	**10**	**1**	**11**	**11**	**1**	**12**	**8**	**1**	**9**
Family Planning (Direct)*	13	2	15	33	2	35	33	2	35
Program Management (Direct)	729	70	799	729	70	799	729	70	799
Subtotal Direct (non add)	1,309	134	1,443	1,414	134	1,548	1,530	134	1,664
Subtotal Reimbursables (non add)	58	4	62	62	4	66	68	4	72
Subtotal Mandatory (non add)	296	55	351	316	55	371	282	54	336
Total, Ceiling FTE	**1,663**	**193**	**1,856**	**1,792**	**193**	**1,985**	**1,880**	**192**	**2,072**

*Family Planning FY 14 FTE is actually 39, however coding system errors resulted in report of 15 FTE

Average GS Grade

FY 2014	13.7
FY 2015	13.7
FY 2016	13.8

Programs Proposed for Elimination

The following list shows the programs proposed for elimination or consolidation in the FY 2016 Budget Request. Termination of these programs frees up approximately $124.1 million (discretionary) and $2.5 million (mandatory) based on the FY 2014 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 2014 Dollars in Millions
Discretionary	
Health Careers Opportunity Program	$14.2
Area Health Education Centers	$30.3
Ryan White Women, Infants, Children and Youth – Part D	$75.1
Rural & Community Access to Emergency Devices	$4.5
Total Discretionary	**$ 124.1**
Mandatory	
Family to Family Health Information Centers	$ 2.5
Total Mandatory	**$ 2.5**

Program Descriptions

Discretionary:

Health Careers Opportunity Program (-$14.2 million)
Although increasing diversity in the health professions is a high priority, the Budget includes funding directed to building the capacity and training of the primary care workforce.

Area Health Education Centers (-$30.3 million)
Although expanding the dispersal of health professions trainees is a high priority, the Budget includes funding directed to building the capacity and training of the primary care workforce.

Ryan White Children, Youth, Women & Families – Part D (-$75.1 million)
The Budget proposes the merger of the Part C and Part D grant programs. The merger will expand the focus on women, infants, children and youth across all the funded grantees in the Part C program.

Rural & Community Access to Emergency Devices (-$4.5 million)
Activities related to access to emergency medical devices and training 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: (-$2.5 million)
Centers disseminating family based information may work through state and FQHCs to implement medical/health homes without separate Federal MCH funding.

FTE Funded by Mandatory Resources

		FY 2012		FY 2013		FY 2014		FY 2015		FY 2016	
Program	**Section**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**
Community Health Center Fund:	H.R. 3590, Section 10503(b)(1)										
ACA Current Law Mandatory		1,200,000	47	1,500,000	60	2,144,716	95	3,509,111	97	-	-
Proposed Mandatory		-	-	-	-	-	-	-	-	2,700,000	97
Health Centers Construction	H.R. 3590, Section 10503(b)(3)	-	19	-	-	-	-	-	-	-	-
School-Based Health Centers-Facilities	H.R. 3590, Section 4101	50,000	5	47,500	8	-	9	-	8	-	-
National Health Service Corps:	H.R. 3590, Section 10503(b)(2)										
ACA Current Law Mandatory		295,000	248	300,000	229	283,040	219	287,370	237	-	-
Proposed Mandatory		-	-	-	-	-	-			522,630	185
GME Payments Teaching Health Centers	H.R. 3590, Section 5508	-	4	-	6	-	5	-	6	-	
Targeted Support for GME (Proposed)		-	-	-	-	-	-	-	-	400,000	32
Family to Family Health Information Centers:	H.R. 3590, Section 5507										
ACA Current Law Mandatory		5,000	1	-	-	-	-	-	-	-	-
Non-ACA Current Law Mandatory		-	-	5,000	-	5,000	1	2,500	1	-	-
Home Visiting Program:	H.R. 3590, Section 2951										
ACA Current Law Mandatory		350,000	23	379,600	22	-	-	-	-	-	-
Non-ACA Current Law Mandatory		-	-	-	-	371,200	22	-	-	-	-
Proposed Mandatory		-	-	-	-	-	-	400,000	22	500,000	22
Total		**1,900,000**	**347**	**2,232,100**	**325**	**2,803,956**	**351**	**4,198,981**	**371**	**4,122,630**	**336**

Physicians' Comparability Allowance (PCA) Worksheet

Table 1

		FY 2014	FY 2015* (Estimates)	FY 2016 Request
1) Number of Physicians Receiving PCAs		38	42	42
2) Number of Physicians with One-Year PCA Agreements		0	1	1
3) Number of Physicians with Multi-Year PCA Agreements		38	41	41
4) Average Annual PCA Physician Pay (without PCA payment)		$145,843	$146,120	146,120
5) Average Annual PCA Payment		$24,000	$23,000	$23,000
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.	36	40	40

*FY 2014 data will be approved during the FY 2015 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 an extra category is to render advice relating to patient care and community health programs to the HRSA Administrator.

	2014	2015	2016
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 compensated more in the private sector.
Category I - $28,000
Category IV – B - $30,000
Category IV – C - $27,000
Compensation reflects physician longevity and board certification. Physicians are also selecting multi-year contracts, which also reflect compensation for mission specific factors. Compensating at these levels have allowed HRSA to compete with the private sector and to increase retention of HRSA physicians. Most private sector physician salaries exceed the base salary HRSA is able to offer. Hence, PCA provides the mechanism to meet what they are currently making.

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 HRSA did not offer PCA, HRSA would not be able to attract potential candidates or maintain current HRSA medical officers who enhance HRSA mission and goals.

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 three medical officers who retired and one medical officer who resigned that were receiving PCA. HRSA has been able to retain a high rate of our medical officers using this mechanism. Of the remaining medical officers receiving PCA, the

average years of service reflects nine years of service. The years of service range over 20 years.

11) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

N/A

Specific Items

Health Center Loan Guarantee Program

The Health Center Loan Guarantee Program has issued a total of 27 loan guarantees to date, for loans totaling approximately $145 million. Twelve of those guaranteed loans have been released, 14 remain active and one defaulted in 2000.

No loan guarantee applications are currently under review. Remaining Loan Guarantee Program lending authority is approximately $15 million.

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, FCC) 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 2013-2014 and was derived from the 2014 Annual Operating Report.

	Number of Programs	Number of Active Borrowers	Account Balance (FCC)
HPSL	160	34,531	$397,076,983
PCL	112	3,090	$255,659,371
LDS	164	7,303	$134,645,436
NSL	336	43,623	$175,860,216
Total	772	88,547	$963,242,006

New Awards in Academic Year 2013-2014 were as follows:

	Number of New Loans	Amount of New Funds Awarded
HPSL	7,187	$67,485,789
PCL	274	$23,876,560
LDS	1,465	$17,688,837
NSL	10,037	$30,294,750
Total	18,963	$139,345,936

Evaluations of Health Professionals Training Programs

Tracking and monitoring outcomes associated with HRSA's investments in health professions training and education programs remains a top priority for the Bureau of Health Workforce (BHW). In FY 2014, BHW began the implementation of its evaluation framework by conducting a series of multi-year retrospective evaluations of investments made in the Scholarships for Disadvantaged Students program, the Physician Assistant Training in Primary Care program, the Residency Training in Primary Care program, and the Centers of Excellence program. Each of these evaluations capitalized on multiple types and sources of existing data; generated new knowledge regarding the processes and outcomes associated with each investment; informed the development of new Funding Opportunity Announcements; and provided BHW leadership with actionable policy-focused recommendations for strengthening each program's design and related data requirements.

In FY 2015, BHW is incorporating a Rapid Cycle Quality Improvement (RCQI) process into its funding opportunity announcements. The goal of this initiative is to provide grantees with a tool to assess their progress toward meeting the objectives of their grant agreements, and make adjustments where needed. The RCQI is a method that identifies, implements and measures changes made to improve the quality of a process or a system. It consists of systematic and continuous actions that may lead to measurable improvements in training and education programs. The RCQI is used to test changes (initially on a small scale to minimize risk), quickly identify promising innovative ideas, and build confidence that the changes are leading to improvements. The process addresses three fundamental questions: (1) What are we trying to accomplish? (2) How will we know if a change is an improvement? and (3) What changes can we make that will result in improvement?

In FY 2015 and beyond, BHW will continue the implementation of its evaluation framework so as to keep generating new evidence and knowledge regarding HRSA's investments in the training and education of the current and future healthcare workforce. For example, BHW is currently developing a procurement plan for a multi-year prospective joint evaluation of the Nursing Workforce Diversity and the Centers of Excellence programs. This evaluation will aim to identify the evidence and best practices for the recruitment, training and retention of students who are considered underrepresented minorities in the health professions. In addition, BHW will conduct multi-year retrospective evaluations of programs funded in FY 2010 through the Prevention and Public Health Fund so as to determine processes and outcomes associated with these investments over multiple academic years.

The grantees are required to evaluate their progress using the RCQI and provide reports to HRSA at defined intervals throughout the grant lifecycle. HRSA will use the data in these reports to evaluate the degree to which grantees are meeting their grant objectives, and also to identify best practices that can be shared with other institutions to improve their programs., Collectively, BHW's approach to evaluation will enable the agency to provide stakeholders with specific, detailed information about its investments in health professions training and education programs.

Ryan White HIV/AIDS Program

Client Costs for ADAP

FY 2014	FY 2015	FY 2016
$6,181	$6,289	$6,399

The methodology for calculating the cost per client for the ADAP Program is based on a Marginal Cost Estimation Model. This model projects potential cost (total and marginal) to the Federal government through the ADAP earmark based on assumptions concerning growth in number of clients, drug price increases, and program changes impacting cost. A portion of Part B budget funding is “earmarked” for providing access to medications through the State AIDS Drug Assistance Program (ADAP). The services provided by State ADAPs are supported from several sources, with the Federal ADAP earmark representing around 50% of State ADAPs’ support. This budget earmark is the focus of the per client cost estimation.

SIGNIFICANT ITEMS TAB

SIGNIFICANT ITEMS FOR INCLUSION IN L-HHS APPROPRIATIONS COMMITTEE THE FY 2016 CONGRESSIONAL JUSTIFICATION

OMNIBUS - PL 113-235 (December 16, 2014)

1. **National Health Service Corps -** The agreement includes section 223 of this act to modify the rules governing National Health Service Corps (NHSC) to allow every Corps member 60 days to cancel their contract. HRSA is directed to evaluate the establishment of a demonstration project within the NHSC in which optometrists are recognized as primary health services providers for purposes of the Loan Repayment Program. (**Page 9**)

   Action To Be Taken

   In responding to the above directive, evaluate the establishment of a demonstration project within NHSC in which optometrists are recognized as primary health services providers for purposes of Loan Repayment, HRSA will survey the current NHSC sites where NHSC providers work to determine the demand for optometrists. To participate in the NHSC loan repayment program, providers must be employed or have signed an employment contract with a NHSC site located in a Health Professional Shortage Area (HPSA) to be eligible to apply for loan repayment. Therefore, it is essential to determine the demand for optometrist's services in HPSAs to gauge the likelihood of a successful demonstration project.

   It should be noted that if NHSC determines that NHSC sites have a need for optometrists through the Loan Repayment Program, in order to establish a demonstration program, legislative action to grant demonstration authority will be necessary. Currently, NHSC does not have demonstration authority in section 338L of the PHS Act [42 USC 254t].

2. **Autism and Other Developmental Disorders -** the Centers for Disease Control and Prevention recently announced that the highest rate of increased diagnoses for children with autism is from minority and rural communities. HRSA is directed to ensure that competitive funding opportunities are made available to specifically target innovative diagnosis and treatment models, including the use of telehealth networks, to improve the diagnosis and treatment of Autism Spectrum Disorders in minority and rural communities. (**Page 10-11**)

   Action To Be Taken

   HRSA will compete two funding opportunities in FY2015 that address this directive. The MCH Autism Intervention Research Network on Behavioral Health (AIR-B Network) will establish and maintain an interdisciplinary, multicenter research forum for scientific collaboration and infrastructure building, which will provide national leadership in research designed to improve the behavioral, mental, social, and/or cognitive health and wellbeing of children and adolescents with Autism Spectrum Disorder (ASD) and other developmental disabilities. The MCH Autism Intervention Research Network on

Physical Health (AIR-P Network) will establish and maintain an interdisciplinary, multicenter research forum for scientific collaboration and infrastructure building, which will provide national leadership in research designed to improve the physical health and wellbeing of children and adolescents with Autism Spectrum Disorder~~s~~ (ASD) or other developmental disabilities. The AIR-B and AIR-P networks will determine the evidence-based practices for interventions to improve the behavioral and physical health of individuals with ASD and other developmental disabilities, develop guidelines for those interventions, and disseminate information related to such research and guidelines. Network research protocols will focus on addressing disparities in behavioral and physical health interventions and treatment for children and adolescents with ASD, including innovative models that serve vulnerable and underserved populations. Network research will include study populations recruited from diverse backgrounds including racial/ethnic, geographic, and socioeconomic diversity. HRSA is broadening the scope of these funding opportunities to reflect an additional emphasis on innovative diagnosis models, including the use of telehealth networks, to improve the diagnosis and treatment of ASD and other developmental disabilities.

HRSA will commit to further consideration of this directive in future competitions.

3. **Healthy Start** - The Fetal Infant Mortality Review (FIMR) program is an important component of many Healthy Start Initiatives and that providing evidence-based interventions are crucial to improving infant health in high risk communities. HRSA is encouraged to continue to support the FIMR program with Healthy Start funding while educating Healthy Start Programs on the successes of the FIMR. HRSA is also encouraged to assist Healthy Start grantees that did not receive grants in fiscal year 2014 due to changes in the grant process, but were funded in previous years, with transitional funding to help alleviate their shortfalls. (**Page 11**)

Action To Be Taken

HRSA plans to continue to support the Fetal Infant Mortality Review Program and will be working with all Healthy Start grantees to make sure that they work closely with existing FIMR programs in their communities. HRSA will also continue to support the provision of technical assistance to these programs. In communities where there is no FIMR program, HRSA will work with Healthy Start grantees to assist them in establishing a FIMR program in collaboration with their state/local/ or city health departments.

HRSA worked closely with Healthy Start Grantees that did not successfully compete for new grants. In FY 2014 and FY 2015, grantees were offered, and most were provided, additional funding to carry them through the review and selection processes for new awards. Following the award of new grants, existing grantees not receiving a new award were afforded the opportunity to transition their programs by requesting an extension of their project period and the use of unobligated balances of federal funds that they may have not yet expended. This is consistent with HRSA's practice for program close-out for many of its grant programs. HRSA has also offered these grantees access to technical assistance service to assist through the transition process.

4. **Poison Control Centers** - Increased education and outreach services provided by the poison control centers to Medicare and Medicaid beneficiaries could result in substantial savings by the Centers for Medicare and Medicaid Services. The Secretary is directed to continue the discussions with the Nation's poison control centers to develop an action plan to achieve these possible new Medicare and Medicaid cost savings. (**Page 12**)

Action To Be Taken

HRSA has engaged with the American Association of Poison Control Centers (AAPCC) to begin the planning, receive their input, and learn about their efforts with these target populations. HRSA led a webinar on July 16, 2014, with the poison centers' Managing and Medical Directors to discuss how to address increasing poison center awareness among the Medicare population and how best to engage the Medicare population. Topics that were discussed during this webinar included, literature or other research related to poison center awareness and utilization among older adults; existing partnerships that the centers have that HRSA can leverage; best practices; and outreach strategies..

Following are the efforts that HRSA is continuing to engage in towards increasing poison center awareness among the Medicare population:

HRSA plans to award a contract to build upon the existing national public awareness campaign, *Poison Help,* highlighting the role of poison control centers (PCC) in the public health system with a focus on Medicare and Medicaid beneficiaries. The goals of the contract include, increasing public awareness of the national Poison Help toll-free number; educating Medicare and Medicaid beneficiaries about poisoning risk and prevention; and showcasing the role of the national network of PCCs and the services they provide.

HRSA has contracted with the Lewin Group to conduct a retrospective study to determine the value of PCC consultations for Medicare beneficiaries, specifically as it relates to inpatient hospital stays and any cost savings that may be associated with PCC services. This study will examine the number of calls to PCCs by Medicare beneficiaries compared to the number, length of stay and type of hospitalizations of Medicare beneficiaries due to intentional and unintentional poisoning and the cost per call to evaluate if resources devoted to PCCs have an impact on cost savings related to hospitalization rates. The study results will enable HRSA to independently validate savings estimations by the AAPCC; provide Congress with more up-to-date data regarding the value of poison centers; and further substantiate HRSA's efforts to work with the Centers for Medicare & Medicaid Services and the Administration for Community Living to increase awareness and usage of poison control centers.

Additionally, HRSA will continue to partner with the AAPCC in further engaging the Nation's poison control centers to develop an action plan towards achieving these possible new Medicare and Medicaid cost savings.

5. **Oral Health** - There is a significant need for dental providers in rural communities who can provide oral healthcare can education to individuals on the importance of proper oral care and prevention, and concerns remain about the number of unnecessary hospital

emergency room visits for oral health issues. The Office of Rural Health Policy is encouraged to support mobile dentistry programs led by properly licensed dental providers.(**Page 12**)

Action To Be Taken

HRSA/Federal Office of Rural Health Policy (FORHP) agrees that there is a need for dental providers in rural communities who can provide oral healthcare education. FORHP has historically funded oral health projects through the Rural Healthcare Services Outreach (Outreach) and the Rural Health Network Development (Network) Programs. Recognizing the interest, and need, of oral health programs in rural communities, FORHP has developed an evidence base oral health toolkit designed to assist rural communities in the implementation of an oral health program. This toolkit consists of several resources on implementing an oral health program, including planning for sustainability, evaluating oral health programs, and key components needed to successful develop and implement an oral health program. The toolkit can be accessed off of: http://www.raconline.org/communityhealth/oral-health

In FY 2014, FORHP supported 24 oral health programs in the amount of $4,327,584 through the Rural Healthcare Services Outreach, Rural Health Network Development, and Rural Health Network Development Planning Programs. Out of the 24 programs, 3 of the grantees had a mobile dentistry program. The Outreach and Network Planning program are currently competitive and new awards will be made May, 2015. In FY 2015, FORHP is supporting 4 oral health projects in through the Rural Health Network Development program in the total amount of $1,791,855.00. Language was included in the Network Development funding opportunity announcement that required grantees to select a specific topic area, and two were oral health related. Applicants had the option to propose a project around integrating oral health in primary care settings or integrating primary care in oral health settings.

6. **Telehealth -** The Office of the Advancement of Telehealth (OAT) expands high quality medical care to rural communities that do not have adequate access to medical providers including many medical specialties. OAT is directed to use these funds to expand existing telehealth networks and to award new grants under the Telehealth Network Grant Program while also increasing activities that demonstrate the use and success of telehealth networks across the country. OAT is commended for its work to provide greater access, quality, and scope of care to medically underserved populations. OAT is urged to fund sustainable programs with demonstrable accomplishments, placing particular emphasis on programs seeking to aid diverse populations in regions with significant chronic disease burden and evident health disparities such as diabetes. (**Page 13**)

Action To Be Taken

FORHP's OAT has been providing grant funds to support telehealth networks in rural areas for the last twenty years and currently funds 20 Telehealth Network Grant Program (TNGP) grants. These grants: (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, and patients and their families, for decision-making, in rural areas. Approximately 95% of all former grantees continue to have an existing/established telehealth network.

Additionally, in 2014, FORHP created the Evidence-based Tele-Emergency Grant Program (EB TNGP), which supports the implementation and evaluation of broad telehealth networks to deliver 24-hour Emergency Department consultation services via telehealth to rural providers without emergency care specialists. Six EB TNGP grants were awarded along with a contract to evaluate impact on quality of care; appropriateness of use of the technology; changes in patient access; changes in clinical process and outcomes; and impact on the cost of service delivery in terms of efficiency and effectiveness of care.

While FORHP is unable to provide supplemental funds to existing grantees, the Office will hold a competition to meet Congressional intent and anticipates funding approximately three new Telehealth Network Grant Program (TNGP) grants that focus on chronic disease and health disparities in rural areas.

7. **Vaccine Injury Compensation Program** Trust Fund -HHS is directed to implement the Advisory Commission on Childhood Vaccines' recommendations on maternal immunization that were adopted in 2013 as HRSA administers the Vaccine Injury Compensation Program under existing authorities. (**Page 13**)

Action To Be Taken

Given the unique and complex legal and programmatic issues that must be considered, HRSA will continue working with federal partners to determine the most appropriate policy options, including whether the Advisory Commission on Childhood Vaccines' recommendations on maternal immunization could be implemented through administrative action or would require regulatory or legislative changes.

Vaccine Injury Compensation Program

TAB

Vaccine Injury Compensation Program

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Appropriation Language

VACCINE INJURY COMPENSATION PROGRAM TRUST FUND

For payments from the Vaccine Injury Compensation Program Trust Fund (the ‘‘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 $7,500,000 shall be available from the Trust Fund to the Secretary.

Amounts Available for Obligation

	FY 2014 Final	FY 2015 Enacted	FY 2016 Estimate
Discretionary Appropriation:	$ 18,323,000	$21,000,000	$23,000,000
Appropriation previously unavailable	$ 501,000		
Transfer to Other Accounts	-$6,464,000		
Transfer from Other Accounts	$6,443,000		
Subtotal, adjusted Discretionary Appropriation……	**$ 18,803,000**	**$ 21,000,000**	**$ 23,000,000**
Mandatory Appropriation	$ 221,254,000	$230,000,000	$237,000,000
Transfer to Other Accounts	-$228,536,000		
Transfer from Other Accounts	$228,557,000		
Subtotal, adjusted Mandatory Appropriation……	**$221,275,000**	**$230,000,000**	**$237,000,000**
Spending Auth Offsets	2,297,000		
Budgetary Resources Available	**242,375,000**	**251,000,000**	**260,000,000**
Administrative Expenses	18,803,000	21,000,000	23,000,000
Total HRSA Claims	224,000,000	230,000,000	237,000,000
Total New Obligations	**242,803,000**	**251,000,000**	**260,000,000**
Unobligated Balance	1,000,000		

Budget Authority by Activity

	FY 2014 Final	FY 2015 Enacted	FY 2016 Pres. Budget
Trust Fund Obligations: Post-10/1/88 claims	$224,000,000	$230,000,000	$237,000,000
Administrative Expenses: HRSA Direct Operations	$6,464,000	$7,500,000	$7,500,000
Total Obligations	$230,464,000	$237,500,000	$244,500,000

Budget Authority by Object

	FY 2015 Enacted	FY 2016 Estimate	FY 2016 +/- FY 2015
Insurance claims and indemnities	$230,000,000	$237,000,000	+$7,000,000
Salaries & Expenses/Other Services	$7,500,000	$7,500,000	---
Total	$237,500,000	$244,500,000	+$7,000,000

Authorizing Legislation

	FY 2014 Final	FY 2015 Enacted	FY 2016 Pres. Budget
(a) PHS Act, Title XXI, Subtitle 2, Parts A and D:			
Pre-FY 1989 Claims	---	--	---
Post-FY 1989 Claims	SSAN	$230,000,000	$237,000,000
(b) Sec. 6601 (r)d ORBA of 1989 (P.L. 101-239):			
HRSA Operations	$6,464,000	$7,500,000	$7,500,000

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	---	---	---	---
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2013	----	----	----	----
2014	----	----	----	----
2015	----	----	----	----
2016	---	---	---	---

Vaccine Injury Compensation Program

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Claims BA	$234,000,000	$230,000,000	$237,000,000	+$7,000,000
Admin BA	$6,464,000	$7,500,000	$7,500,000	---
Total BA	$240,464,000	$237,500,000	$244,500,000	---
FTE	19	19	25	+6

Authorizing Legislation – Public Health Service Act, Title XXI, Subtitle 2, Parts A and D, Sections 2110-19 and 2131-34.

FY 2016 Authorization ..... Indefinite

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 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 requesting compensation for vaccine injuries or deaths served against the Secretary of HHS (the Secretary), which are filed with the Court;
- Arranges for medical review of each petition and supporting documentation by health care professionals with special expertise in pediatrics and adult medicine, and develops preliminary recommendations that are provided to DOJ, which DOJ incorporates in the

DOJ Rule 4(b) report that is submitted 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 (Table);
- Provides administrative support to the Advisory Commission on Childhood Vaccines (ACCV), composed of nine voting members, including health professionals, attorneys, 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.

The Program has experienced unprecedented growth in total outlays, which consists of compensation awards to petitioners and attorneys' fees and costs payments. As of December 2014, over 3,875 families and individuals have been awarded compensation totaling over $3.06 billion since the Program's inception. FY 2010 through FY 2014 resulted in the largest outlays since the VICP's inception, with over $1.1 billion in compensation awards to more than 1,410 families and individuals. FY 2014 total outlays were over $223.5 million to 365 families, individuals, and attorneys, which is approximately $100 million more than the average amount of outlays from FYs 2005-2012. In FY 2013, 375 families and individuals were awarded compensation totaling over $276.4 million, which was the largest annual outlay in the history of the Program. (Annual outlay totals include payments for attorneys' fees and costs.)

In recent years, the Program also has had a dramatic increase in the number of claims filed. In FY 2013 and 2014, 503 and 632 claims were filed, respectively. However, only an average of 301 claims had been filed annually since FY 2005. As outlined in the tables below, all performance targets were met in FY 2014, despite a significantly increased number of filings, number of compensation awards processed, and amount of compensation paid by the Program. For example, since VICP provides liability protection to vaccine manufacturers and health care providers, one of the performance measures tracks whether petitioners who have been awarded compensation choose to reject the award and file a civil action against a vaccine manufacturer and health care provider. From FY 2010-2014, the target for the percentage of eligible petitioners who were awarded compensation, but opted to reject awards and elected to pursue civil action has been zero percent. The VICP has met this target each of these fiscal years.

The other VICP performance measures, which were established in conjunction with DOJ, are focused on the timely adjudication of vaccine injury claims and payment of compensation. These measures capture the time it takes the Court, DOJ and HRSA to adjudicate claims. The VICP target for the average time to process a claim is 1,300 days. The average claim processing time captures the entire time it takes to process a claim from when a claim is filed with the Court until the Court issues a judgment dismissing the claim or when HRSA authorizes payment of the Court judgment awarding compensation. The FY 2013 and FY 2014 targets of 1,300 days were exceeded with a result of an average of 930 days and 823 days, respectively.

The Court establishes the deadlines for the DOJ to submit Rule 4(b) reports, which include HHS's preliminary medical eligibility recommendation and the DOJ's legal analysis. HHS has

consistently submitted its preliminary input in a timely fashion, supporting the DOJ's ability to exceed its target that 86 percent of cases deemed complete (as certified by petitioner) will be submitted to the Court by the Rule 4(b) report deadline. In FY 2013, 95.2 percent of cases deemed complete were submitted to the Court by the Rule 4(b) report deadline. The FY 2014 result was 91.6 percent.

Processing DOJ settlement proposals quickly and efficiently is a high priority for the VICP. In FY 2013, the average time to process a settlement was 7.2 days, and the FY 2014 result was an average of 4.7 days, both exceeding the 10-day target.

In FY 2012, VICP paid lump sum awards within an average of 3.6 days against the newly established target of 8 days to account for the significant increase in claims. Despite an unprecedented increase in claims and compensation awards, the FY 2013 result was an average of 7.8 days, which exceeded the 8-day target. The FY 2014 lump sum awards were paid in an average 1.5 days, which significantly exceeded the 8-day target as a result of automation and reassignment of staff resources.

The percentage of cases in which settlements were completed by agreement among the parties by DOJ within 15 weeks has remained at 100 percent since FY 2010. The VICP has consistently exceeded the 92 percent target. In meeting and exceeding this target, DOJ attorneys must work closely and effectively with petitioners' counsel, some of whom specialize in vaccine injury litigation, as well as others that have little or no experience before the vaccine court.

Funding History

VICP Awards

FY	Amount
FY 2012	$186,800,263
FY 2013	$277,087,363
FY 2014	$223,729,606
FY 2015	$230,000,000
FY 2016	$237,000,000

Budget Request

The FY 2016 Budget for VICP will support the following:

VICP Claims Awards - The FY 2016 Claims Awards Budget is $237,000,000, an increase of $7,000,000 over the FY 2015 Enacted level. The VICP awards Court-ordered compensation payments to individuals or families of individuals, who have thought to have been injured, or have died, as the result of receiving a covered vaccine(s). For a vaccine to be covered by the VICP, it has to be recommended by the Centers for Disease Control and Prevention (CDC) for routine administration to children and have an excise tax imposed on it. In FY 2016, HRSA estimates that $237,000,000 will be paid out of the Vaccine Injury Compensation Trust Fund (Trust Fund) for Court-ordered awards for alleged vaccine-related injuries or deaths. This

funding is necessary to account for the rise in Court-ordered payments due to the increasing numbers of claims filed annually. The increase in claims filed and adjudicated is primarily the result of the addition of the influenza vaccine to the VICP in 2005. Because the CDC recommended an annual influenza vaccine for many populations other than children, many more people receive the influenza vaccine each year and it now accounts t for approximately 60 percent of claims filed annually.

This Claims Award funding level will ensure adequate funds are available to pay compensation and attorneys' fees and costs awards. These funds would also allow 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 $7,500,000 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), the same level as FY 2015 Enacted. In addition, the VICP will use to funds to continue to provide professional and administrative support to the ACCV, meet specific administrative requirements of the Act, process award payments, maintain necessary records securely, and inform the public of the availability of the VICP.

Claim filings have increased significantly since FY 2006, primarily due to the addition of influenza vaccines in 2005. Between FY 2000-2005, an average of 162 non-autism claims were filed annually. More recently, the numbers have grown more than three-fold with 503 claims filed in FY 2013, and 632 filed in FY 2014. This upward trend has continued with the February 2010 recommendation by CDC of universal use of influenza vaccines for all individuals over the age of six months. For FY 2015, 123 claims have been filed as of December 1, 2014. If this trend continues, it is anticipated that over 700 claims will be filed by the end of FY 2015, which would be the highest number of non-autism claims filed in a fiscal year in the history of the Program.

With these resources, VICP will meet and exceed its FY 2016 performance goals, which include: "Decrease the average time settlements are approved from the date of the receipt of the DOJ settlement proposal" and "Decrease the average time that lump sum only awards are paid from the receipt of all required documentation to make a payment." These measures have FY 2016 targets of ten days and eight days, respectively.

In FYs 2015 and 2016, the Program will use the Administrative funding to continue its work on updating the Table to reflect the best scientific data available. The program will also continue its outreach efforts to better inform the public and healthcare professionals about the VICP through implementation of the VICP Outreach Plan. Because survey data indicate that low income individuals and underrepresented minorities are least likely to be aware of the VICP, the outreach plan emphasizes leveraging other HRSA programs, such as the Health Centers and National Health Service Corps that serve these populations. The plan also includes performance measures to ensure that the components and activities within the strategy are reaching its target audiences and have been implemented successfully.

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
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 2014: 0% Target: 0% (Target Met)	0%	0%	Maintain
26.II.A.2: Average claim processing time.	FY 2014: 823 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 2014: 91.6% 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 settlement proposal.	FY 2014: 4.7 days Target:10 days (Target Exceeded)	10 days	10 days	Maintain
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 2014: 1.5 days Target: 8 days (Target Exceeded)	8 days	7 days	-1 day
26.E: Percentage of cases in which case settlements are completed within 15 weeks.	FY 2014: 100% Target: 92% (Target Exceeded)	92%	92%	Maintain