DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2006

Health Resources and Services Administration

Justification of Estimates for Appropriations Committees

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH RESOURCES AND SERVICES ADMINISTRATION

	FTE	2006 Estimate Amount	Page No.
Letter from the Administrator			2
Health Resources and Services	1,598	$5,966,144,000	3
Health Education Assistance Loans	17	2,916,000	531
Vaccine Injury Compensation Program	25	2,832,000	545

U.S. Department of Health and Human Services

HRSA

Health Resources and Services Administration

MESSAGE FROM THE ADMINISTRATOR

I am pleased to present this FY 2006 Performance Budget for the Health Resources and Services Administration (HRSA). The FY 2006 budget request supports President Bush's plan to make health centers available in every poor county, contains funds to continue implementing his Health Center Growth Initiative, and includes additional assistance for people living with HIV/AIDS.

HRSA's mission is to provide National leadership, program resources and services needed to improve access to high-quality, culturally competent health care. HRSA invests in health care for infants, mothers and children, the underserved, the uninsured, persons with HIV/AIDS, and others with special health care needs. It supports the Nation's health care workforce and the service delivery infrastructure needed to meet the health care needs of vulnerable populations. Additionally, HRSA programs help expand access to organ and bone marrow transplants and prepare hospitals and clinics to respond to bioterrorism and other public health emergencies.

HRSA's FY 2006 budget increases funds for health centers by $303 million. Of those funds, $277 million will complete the President's five-year Growth Initiative and reach its key goals – to establish or expand 1,200 health center sites and serve an additional 6.1 million patients annually by the end of 2006. In 2004, the health center system served an estimated 13.2 million people – about 3 million more than in 2001 – at more than 3,650 service delivery sites, an increase of almost 500 sites since 2001. Health centers provide high-quality preventive and primary health care to its patients, and the President's Initiative has emphasized greater access to dental care throughout the system.

The remaining $26 million in extra FY 2006 funds will be used to develop new health center sites in 40 of the Nation's poorest counties, with plans to place new sites in 25 other high-poverty counties. The FY 2006 budget also targets an additional $10 million above the FY 2005 appropriation to help more people living with HIV/AIDS gain access to life-saving pharmaceuticals through HRSA's AIDS Drug Assistance Program (ADAP).

In FY 2006, HRSA will continue to implement the President's main budgetary priority for the Agency: the expansion of direct health care to Americans who most need it. As a result, funds will be reduced for health professions training programs that do not provide direct care. The budget for certain rural health programs also is reduced, since the new Medicare legislation substantially increases resources to rural providers and hospitals.

HRSA recently revised its Strategic Plan for FY 2005-2010. The plan lays out seven long-range goals for achieving the Agency's mission, with each of the goals supported by strategies and objectives that will serve as HRSA's performance management framework. The budget request presented herein is informed, in part, by results already achieved and by planned targets for the Agency's performance measures. The document clearly shows that HRSA is making significant progress in improving access to care and strengthening the essential health care safety net.

Elizabeth M. Duke
Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Health Resources and Services

FY 2006 Budget	Page No.
Organization Chart	7
Performance Budget Overview:	
Statement of HRSA Mission	8
Discussion of HRSA Strategic Goals	10
Overview of HRSA Performance	12
Overview of HRSA Budget Request	15
PART Summary Table FY 2004 - FY 2006	16
Appropriation Language	19
Explanation of Changes	21
Amounts Available for Obligation	22
Summary of Changes	23
Budget Authority by Activity	25
Budget Authority by Activity (Version including Transfers)	30
Budget Authority by Object	35
Salaries and Expenses	36
Salaries and Expenses by Program Line Item	37
Significant Items in Appropriations Committee Reports:	
FY 2005 House Report 108-636	42
FY 2005 Senate Report 108-345	58
FY 2005 Conference Report 108-792	76
Authorizing Legislation	78
Appropriations History Table	88

FY 2006 Budget | Page No.

Narrative Justification by Activity:

A. Primary Health Care:

1. Health Centers 89
2. Free Clinics Medical Malpractice 111
3. Radiation and Exposure Screening and Education Program 113
4. Healthy Community Access Program 115
5. National Hansen's Disease Program 117
6. National Hansen's Disease Program Buildings and Facilities 120
7. Payment to Hawaii 121
8. Black Lung Clinics 123

B. Health Professions:

1. National Health Service Corps 125
2. Health Professions Training for Diversity 131
3. Training in Primary Care Medicine & Dentistry 141
4. Interdisciplinary, Community-Based Linkages 144
5. Health Professions Workforce Information and Analysis 157
6. Public Health Workforce Development 161
7. Nursing Workforce Development:
   a. Advanced Education Nursing 166
   b. Nursing Workforce Diversity 170
   c. Nurse Education, Practice and Retention Grants 173
   d. Nurse Faculty Loan Program 176
   e. Comprehensive Geriatric Education 178
   f. Loan Repayment and Scholarship Programs 180
8. Bioterrorism Training and Curriculum Development Program 183
9. Children's Hospitals Graduate Medical Education Program 188
10. National Practitioner Data Bank (User Fees) 191
11. Healthcare Integrity and Protection Data Bank (User Fees) 197

C. Maternal and Child Health:

1. Maternal and Child Health Block Grant 202
2. Traumatic Brain Injury 208
3. Healthy Start 211
4. Universal Newborn Hearing Screening 214
5. Emergency Medical Services for Children 216
6. Sickle Cell Service Demonstrations 219

FY 2006 Budget Page No.

D. HIV/AIDS:

1. Ryan White HIV/AIDS Overview 221
2. Emergency Relief - Part A 226
3. Ryan White Comprehensive Care - Part B 229
4. Early Intervention - Part C 233
5. Children, Youth, Women & Families - Part D 236
6. AIDS Education and Training Centers - Part F 238
7. Dental Reimbursement Programs - Part F 240
8. Emergency Funding for HIV/AIDS Drugs 243
9. Telehealth 244

E. Healthcare Systems:

1. Organ Transplantation 247
2. National Cord Blood Stem Cell Bank 255
3. National Bone Marrow Donor Registry 258
4. Poison Control Centers 263
5. National Bioterrorism Hospital Preparedness Program 268
6. Trauma/Emergency Medical Services 275
7. State Planning Grant Program 277
8. Smallpox Vaccine Injury Compensation Program 279

F. Rural Health:

1. Rural Health Activities Program Summary 283
2. Rural Health Policy Development 285
3. Rural Health Care Services Outreach Grants 287
4. Rural Access to Emergency Devices and Public Access Defibrillation Demonstration Projects 289
5. Rural Hospital Flexibility Grants 291
6. Rural Emergency Medical Services Training and Equipment Assistance Grants 293
7. State Offices of Rural Health 295
8. Denali Commission 297

G. Program Management 299

H. Family Planning 302

FY 2006 Budget — Page No.

State and Formula Grant Program Tables:
- Maternal and Child Health Block Grant 305
- Ryan White Comprehensive Care - Part B 307
- National Bioterrorism Hospital Preparedness Program 309

Detail of Full-Time Equivalent Employment (FTE) 311

Budget and Performance Crosswalk 312

Detail of Performance Analysis 315
- Primary Care 319
- Health Professions 340
- Maternal and Child Health 372
- HIV/AIDS 390
- Telehealth 415
- Healthcare Systems 422
- Rural Health 444
- Program Management 455
- Family Planning 460

Full Cost Tables and Summary 465

Changes and Improvements Over Previous Years 478

Links to HHS and HRSA Strategic Plans 479

Partnerships and Coordination 483

Data Verification and Validation 485

Performance Measurement Linkages 502

FY 2004–FY 2005 One-Page PART Summaries 505

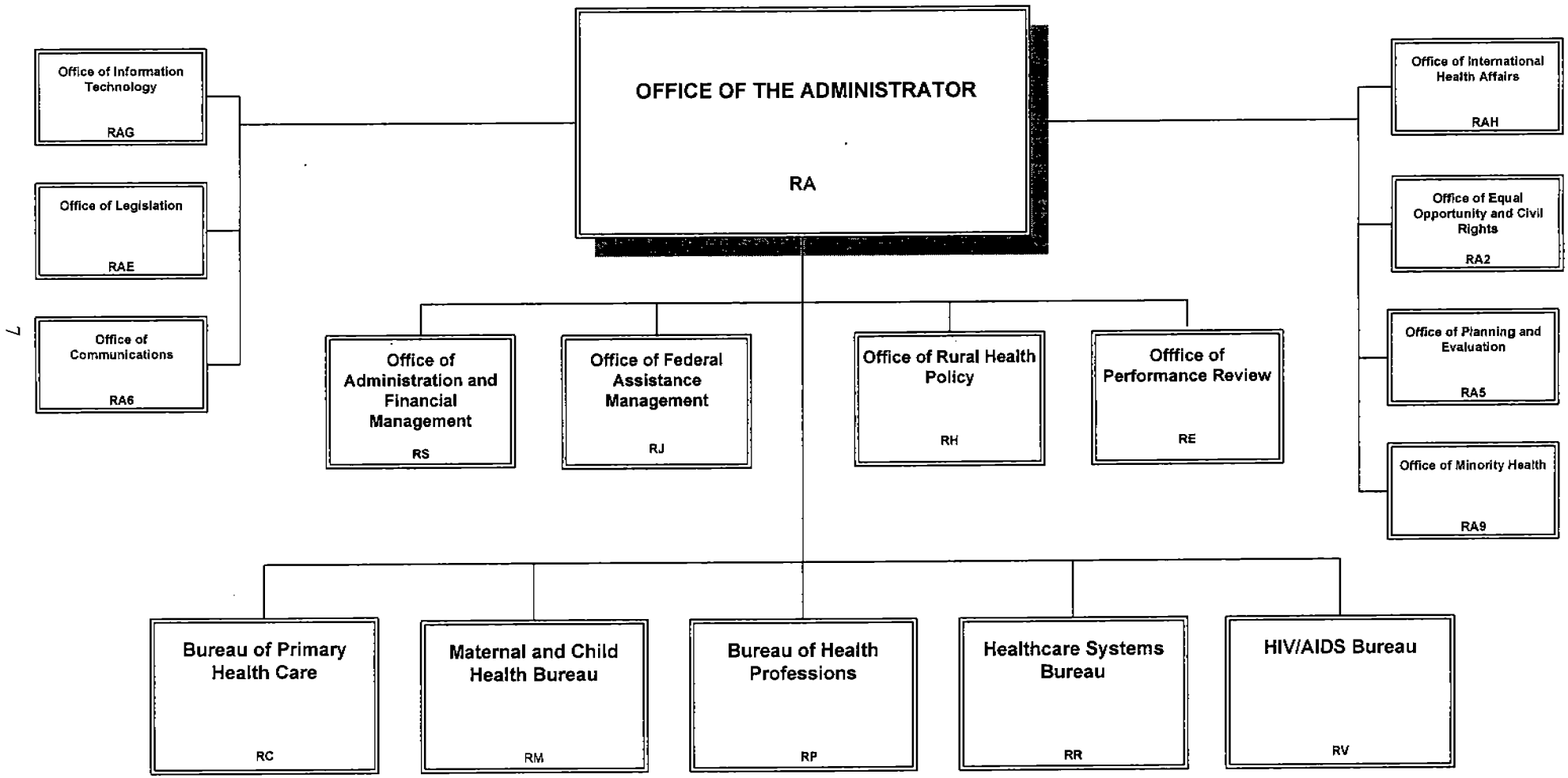
FY 2004–FY 2005 PART Recommendations 515

Summary of Measures 526

Research Coordinating Council 527

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION

ORGANIZATION CHART (HRSA)



AGENCY 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 available to everyone. At a time when the Nation enjoys unprecedented prosperity, millions of families still face barriers to quality health care because of their income, lack of insurance, geographic isolation, or language and cultural differences. A recent Institute of Medicine report concluded that the Nation's health care safety net, while intact for the short term, is endangered over the longer term by shrinking resources (both funding and available practitioners) and expanding responsibility. Assuring a safety net for individuals and families who live outside the economic and medical mainstream is a key HRSA role.

To articulate its purpose and roles and guide future directions, HRSA has revised its Strategic Plan for 2005-2010. The plan identifies the following vision and mission.

Vision

HRSA envisions optimal health for all, supported by a health care system that assures access to comprehensive, culturally competent, quality care.

Mission

HRSA provides national leadership, program resources and services needed to improve access to culturally competent, quality health care.

As the Nation's Access Agency, HRSA focuses on uninsured, underserved and special needs populations. HRSA programs and services target, for example, the following:

- The 44 million Americans who lack health insurance - many of whom are racial and ethnic minorities,
- Over 50 million underserved Americans who live in rural and poor urban neighborhoods where health care services are scarce,
- African American infants who still are 2.4 times as likely as white infants to die before their first birthday,
- 850,000 to 950,000 people living with HIV/AIDS, both in and out of care, and
- Over 87,000 Americans who are waiting for an organ transplant.

Examples of how HRSA accomplishes its mission include:

- Assisting States and communities to identify and address unmet service needs and workforce gaps in the health care system,
- Working with States and communities in developing integrated service systems to help assure access to essential health care,
- Assuring that these systems take into account cultural and linguistic factors, geographic location, and economic circumstances,
- Promoting continuous quality improvement in health services delivery and health professions education,
- Promoting the recruitment, training, and retention of a culturally and linguistically competent and diverse health care workforce,
- Overseeing the Nation's organ transplantation and bone marrow donor systems.

HRSA administers its core services through the work of the five main bureaus and other key offices that are included in this Performance Budget.

STRATEGIC GOALS

HRSA's revised Strategic Plan defines seven long-range goals that support HRSA's mission. Each goal includes several objectives that identify the focus of activities that HRSA will carry out to achieve its mission. HRSA's goals and objectives build upon and are supportive of the goals of the Department of Health and Human Services. Achievement of the HRSA goals and objectives is crucial to the achievement of the goals of the Department particularly, but not exclusively, related to the following Department goals:

Goal 1: Reduce the major threats to the health and well-being of Americans
Goal 2: Enhance the ability of the Nation's health care system to effectively respond to bioterrorism and other public health challenges
Goal 3: Increase the percentage of the Nation's children and adults who have access to health care services, and expand consumer choices
Goal 5: Improve the quality of health care services
Goal 8: Achieve excellence in management practices

The following table presents HRSA's goals and objectives and shows the primary link between HRSA goals and Department goals.

HRSA GOALS AND LINK TO DHHS GOALS	HRSA OBJECTIVES
I. Improve Access to Health Care (Supports DHHS Goal #3)	A. Expand the capacity of the health care safety net B. Promote the development of a culturally diverse and representative health care workforce C. Improve the distribution of health professionals in underserved areas, including in rural and border areas D. Promote access to health insurance and maximize use of available reimbursements for health care services
II. Improve Health Outcomes (Supports DHHS Goals #1, #3)	A. Expand the availability of health care, particularly to underserved, vulnerable, and special needs populations B. Increase the utilization of preventive health care and chronic disease management services, particularly among underserved, vulnerable and special needs populations
III. Improve the Quality of Health Care (Supports DHHS Goal #5)	A. Promote effectiveness of health care services B. Promote patient safety and improve patient protections C. Promote access to, and appropriate use of, health care information D. Promote the implementation of evidence-based methodologies and best practices

IV. Eliminate Health Disparities (Supports DHHS Goals #1, #3)	A. Focus resources and services on diseases and conditions with greatest health disparities B. Promote outreach efforts to reach populations most affected by health disparities C. Promote the integration of cultural competency into HRSA programs, policies and practices
V. Improve the Public Health and Health Care Systems (Supports DHHS Goal #3)	A. Utilize trend data to assist in targeting program resources toward goals B. Increase collaborative efforts to improve the capacity and efficiency of the public health and health care systems C. Accelerate the development and use of an electronic health information infrastructure
VI. Enhance the Ability of the Health Care System to Respond to Public Health Emergencies (Supports DHHS Goal #2)	A. Enhance the ability of hospitals, health centers, emergency medical systems, poison control centers, and health professionals to respond to bioterrorism and other public health threats in a timely and effective manner B. Evaluate capacity of the health care system to plan for and respond to potentially urgent/emergent health care issues
VII. Achieve Excellence in Management (Supports DHHS Goal #8)	A. Foster and lead a high-quality well-trained workforce B. Strategically manage information technology to support programs C. Preserve the financial integrity of HRSA's programs and activities D. Administer a fair, consistent, transparent and efficient grants program E. Identify and capitalize on opportunities for cross-program collaboration

How HRSA Programs and Budget Support HRSA and DHHS Goals

HRSA's programs and budget clearly address HRSA goals and related departmental goals. Virtually all HRSA programs that support, directly or indirectly, care or services to needy populations address the goals to improve access to health care, improve health outcomes, improve the quality of health care, and eliminate health disparities. Examples (not exclusive) include the Health Centers program, the HIV/AIDS program, the National Health Service Corps, the Maternal and Child Health (MCH) block grant, Healthy Start, and the Rural Health Outreach grants program. Through health infrastructure development and coordination and integration of system components, other programs not only address access and quality goals but also support the goal to improve the public health and health care systems. Some examples include the following programs: Health Professions, the MCH block grant, Organ Procurement and Transplantation, National Bone Marrow Donor Registry, Poison Control, and State Offices of Rural Health. The National Bioterrorism Hospital Preparedness program and the Bioterrorism Training and Curriculum Development program are examples of efforts to address the HRSA goal to improve the ability of the health care system to respond to public health emergencies.

For information on the breakout of the budget by HHS strategic goal, please refer to the HHS Budget by Strategic Goal display in the FY 2006 HHS Annual Plan.

OVERVIEW OF PERFORMANCE

This Performance Budget documents the significant progress HRSA has made in meeting the needs of uninsured and underserved individuals, special needs populations, and many other Americans through it efforts to: improve health care, improve health outcomes, improve the quality of care, eliminate health disparities, improve public health and health care systems, and improve the ability of the health care system to respond to public health emergencies. HRSA is pleased to report that HRSA is generally meeting or exceeding its performance targets.

Performance Highlights

A few of the ways HRSA helped states and communities extend essential health care services, and meet other critical needs of their citizens include:

- Investing more than $1.6 billion in FY 2004 in health centers across the country -- centers that serve millions, including migrant workers, homeless people, and residents of public housing. HRSA helped fund 3,651 service delivery sites, including new sites in previously unserved areas. HRSA also supported the expansion of services in many existing sites, particularly in the areas of oral health, mental health, outreach, respite care, and pharmacy services. (Section U.A.1)
- Providing access to care, through Health Centers, to 11 percent of the Nation's uninsured individuals by serving nearly 4.9 million such individuals in 2003, more than one-fourth of whom are children. (Section U.A.1)
- Placing more than 3,600 primary care clinicians in health professional shortage areas through the National Health Service Corps (NHSC). In partnership with state and community organizations, HRSA's Health Centers and NHSC programs deliver high-quality primary care services in more than 4,000 U.S. communities. (Section U.B.1)
- Providing services and treatments to an estimated 570,000 persons each year through the Ryan White CARE Act program administered by HRSA, helping keep the human immunodeficiency virus at bay and enabling persons to live–not just survive. (Section U.D.1)
- Dramatically reducing AIDS-related mortality through new drug treatment regimens for tens of thousands of low-income, underinsured and uninsured people living with HIV/AIDS through the CARE Act's State AIDS Drug Assistance Program, through which more than 86,000 low-income persons received services at least one month of the year. (Section U.D.3)
- Serving, each year, more than 28 million pregnant women, infants and children through at least one of the programs of the Maternal and Child Health Bureau, amounting to 81 percent of all infants, 21 percent of all children and 58 percent of all pregnant women in the United States.
- Reaching out to low-income parents to enroll their children in the State Children's Health Insurance Program and Medicaid, giving their sons and daughters access to critically important health care.
- Helping assure access to a quality health care workforce of professionals in all geographic areas and to all segments of the population through the support of training, recruitment, placement, and retention activities.

- Supporting community-based and local service solutions and public policy initiatives to address the health care problems facing rural America, where twenty percent of the Nation's population lives, yet where only an eighth of doctors practice. For example, HRSA's Rural Outreach Grants served more than 660,000 people in 2003. (Section U.G.1)
- Overseeing the national systems that facilitate the donation and allocation of organs, tissue and bone marrow for persons needing transplants. The number of organ donors has increased and the number of corporate and institutional partners participating in the Secretary's Organ Donation Initiative has grown substantially.
- Helping the Nation's health system and health care providers prepare for bioterrorism and other possible mass casualty events, such as epidemics of rare diseases, through the Bioterrorism Hospital Preparedness program and the Bioterrorism Training and Curriculum Development program.

In these and other ways HRSA has strengthened the Nation's health care safety net and improved Americans' health, health care and quality of life. More detailed information is presented in the section on "Details of Performance Analysis."

Performance Monitoring

HRSA's approach to managing its programs and activities in order to effectively and efficiently serve its constituents includes a strong emphasis on the regular monitoring and use of performance information. As a general management practice, HRSA considers performance results in making decisions on budgetary, programmatic, policy, and administrative issues.

Performance monitoring at HRSA focuses on individual grantees or projects, for example, through the work of HRSA Project Officers and HRSA's Office of Performance Review. Performance planning, monitoring and reporting also occur at the broader Agency program level, including planning and reporting in compliance with the Government Performance and Results Act (GPRA).

HRSA has developed a performance measurement profile for each of its significant program areas as detailed in the section of this Performance Budget on "Details of Performance Analysis." Accordingly, there is, in most cases, a direct linkage between budget line items and corresponding performance profiles. The profiles contain key performance measures related to program goals, information on current and historical performance in reaching program goals, and projections of expected future program performance. These program performance profiles are presented in tables that show the relationship of program goals/measures to the agency-wide goals and objectives detailed in HRSA's Strategic Plan, indicating the close alignment of performance expectations and results with HRSA's mission and priorities. A table later in this document shows how selected HRSA program goals are related to the strategic goals of the Department of Health and Human Services.

Over the past several years, HRSA has been aggressive in refining its overall performance profile by improving some existing measures, developing new outcome measures, eliminating outdated or unnecessary process measures, and adding efficiency measures for all programs. HRSA has

added to its performance profile all measures identified or developed during Program Assessment Rating Tool (PART) reviews.

In monitoring performance, HRSA has a strong outcome focus. Consistent with its mission and objectives as the Nation's Access Agency, HRSA programs produce outcomes that can be categorized as follows:

- Outcomes at the patient/population level related to health status, health behaviors, and specific care received,
- Outcomes at the patient/population level related to persons obtaining access to care,
- Outcomes at the infrastructure level related to the development and distribution of safety-net providers and public health care systems.

Because of HRSA's long-standing emphasis on monitoring outcomes, more than one-half of the measures in HRSA's overall performance profile are outcome measures as defined above. In addition, HRSA continues to monitor selected process and output measures that are also important to gauging the adequacy of program performance.

Overview of HRSA Budget Request

HRSA provides national leadership, program resources and services needed to improve access to culturally competent, quality health care. HRSA's portfolio of programs and initiatives focus on services through health centers, the Ryan White Care Act programs, placements of physicians in underserved areas, the support of the next generation of nurses, and the development of countermeasures and preparation of providers in the event of bioterrorism.

Collectively, these and other programs provide direct services to improve access to care for more than 20 million uninsured or underserved individuals, with a total of 41 million receiving benefits which include infrastructure building services and both direct and enabling population-based services. The HRSA budget provides support for programs that have shown success in providing direct health care and reduces or eliminates funding for programs that have failed to demonstrate results or are similar to other programs.

The FY 2006 President's Budget request for HRSA is $5,966,144,000, a decrease of $836,871,000 below the FY 2005 Enacted Level.

Presidential Priorities

Health Centers Presidential Initiative (+$303 million). The budget will complete the President's commitment to create 1,200 new or expanded health center sites to serve an additional 6.1 million people by 2006. More than 2.4 million additional individuals will receive health care in 2006 through 578 new or expanded sites in rural areas and underserved urban communities. In addition, the President has established a new goal to help every poor county in America in need that lacks a health center and can support one. The request includes $26 million to fund new health center sites in high-poverty counties. In FY 2006, health centers will serve an estimated 16 percent of the Nations population who are at or below 200 percent of the Federal poverty level.

Effects of Proposed Legislation:

The President's Budget request of $5,966,144,000 for HRSA represents current law (including reauthorization) requirements. No proposed law amounts are included.

PROGRAM ASSESSMENT RATING TOOL (PART) SUMMARY

HEALTH RESOURCES AND SERVICES ADMINISTRATION
FY 2004 - 2006

(Dollars in Millions)				
FY 2004 PARTs	**FY 2004 Enacted**	**FY 2005 Appropriation**	**FY 2006 Request**	**Narrative Rating**
1. Health Centers (includes Tort Claims)	$1,617.6	$1,734.3	$2,037.9	Effective
2. Ryan White	$2,044.9	$2,073.3	$2,083.3	Adequate
3. Maternal and Child Health Block Grant	$729.8	$723.9	$723.9	Moderately Effective
4. National Health Service Corps	$169.9	$131.4	$126.8	Moderately Effective
5. Nursing Education Loan Repayment and Scholarship Program	$26.7	$31.5	$31.4	Adequate
6. Health Professions	$409.3	$418.7	$129.2	Ineffective
FY 2005 PARTs				
1. Rural Health Activities	$142.6	$144.7	$29.5	Adequate
2. Children's Hospitals Graduate Medical Education Program	$303.2	$300.7	$200.0	Adequate
3. Bioterrorism Hospital Preparedness Program	$514.9	$491.4	$483.0	Results Not Demonstrated
FY 2006 PARTs				
1. Organ Transplantation	$24.6	$24.4	$23.3	Adequate
2. National Bone Marrow Donor Registry	$22.7	$25.4	$22.9	Moderately Effective
3. Poison Control Centers	$23.7	$23.5	$23.3	Adequate
4. Emergency Medical Services for Children	$19.9	$19.8	0	Results Not Demonstrated
5. Traumatic Brain Injury	$9.4	$9.3	0	Results Not Demonstrated

FY 2004 Narrative:
Health Centers –Rated Effective. Funding increase for this program is requested to achieve the growth goals of this Presidential Initiative, including new and expanded service sites to serve increased numbers of needy individuals. Secretary's Priority Areas: Increasing Access to Health and Long-Term Care Services, Reducing Health Disparities, Preventing Disease/Illness and Expanding Opportunities for Faith-Based and Community Organizations.
Ryan White – Moderate increase for Ryan White activity. All of the increase is for Title II. Increase justified by the Adequate rating for this program. Secretary's FY 2006 Priority Areas: Increasing Access to Health and Long-Term Care Services, Reducing Health Disparities, and Preventing Disease/Illness.
Maternal and Child Health Block Grant – Rated Moderately Effective, the program provides a focus on reducing infant mortality. The overall funding level is maintained, with major funding provided to States in the form of the Block Grant. Secretary's Priority Areas: Increasing Access to Health and Long-Term Care Services, Preventing Disease/Illness, Reducing Health Disparities.
National Health Service Corps – Aimed at providing health professionals in underserved areas. A slight decrease is requested for this program. Secretary's Priority Area: Increase Access to Health and Long-Term Care Services.
Nursing Education Loan Repayment and Scholarship Program – This program is viewed as an important effort to address the nursing shortage in underserved areas. Current funding is basically maintained. Secretary's Priority Area: Increasing Access to Health and Long-Term Care Services.
Health Professions – Most of the funding requested is for Nursing Workforce Development, which continues to be a high priority given increasing shortages in the nursing workforce. Small amounts included for Scholarships for Disadvantaged Students and Workforce Information and Analysis. Secretary's Priority Areas: Increasing Access to Health and Long-Term Care Services, Reducing Health Disparities.

FY 2005 Narrative:
Rural Health –This program area is proposed for a reduction. This reflects in part the recent Medicare legislation that provides extensive resources to rural health care systems. The PART review concluded that there seems to be duplication and redundancy of programs targeted at rural areas across the Department when you include the totality of health and social services programs. Funding remains level for State Offices of Rural Health, because of their coordination efforts on retention and recruitment of rural health professionals. Secretary's Priority Areas: Increasing Access to Health and Long-Term Care Services, Reducing Health Disparities.
Children's Hospitals GME Program – This program is proposed for a reduction in FY 2006. The PART concluded that the program is duplicative of other Federal, state and private efforts, such as Medicaid, private insurers and charitable donations. Secretary's Priority Area: Increasing Access to Health and Long-Term Care Services.
Bioterrorism Hospital Preparedness Program – A slightly reduced level of funding is proposed. Because the program is relatively new, the program is working with States and localities to make sure that performance information is developed and made available to the program. Secretary's Priority Area: Responding to Bioterrorism and Other Public Health Emergencies.

FY 2006 Narrative:

Organ Transplantation - This program focuses on efforts to increase organ donation and transplantation. The budget includes a slight reduction. Secretary's FY 2006 Priority Areas: Increasing Access to Health and Long-Term Care Services and Reducing Health Disparities.

Bone Marrow Donor Registry - This program is designed to provide blood stem cells for transplants from compatible unrelated donors for patients from all racial and ethnic groups. The program maintains and operates the national registry of volunteers willing to donate to people with potentially life threatening diseases. The budget reflects a small reduction. Secretary's FY 2006 Priority Areas: Increasing Access to Health and Long-Term Care Services and Reducing Health Disparities.

Poison Control Centers - This program provides supplemental funding to Poison Control Centers across the country, promotes universal access to PCC services, and encourages the enhancement and improvement of poison education, prevention and treatment. Level funding is proposed. Secretary's Priority Area: Responding to Bioterrorism and Other Public Health Emergencies.

Emergency Medical Services for Children - This program has carried out a program of grants to States or accredited schools of medicine to develop and evaluate improved emergency procedures and protocols for children. For FY 2006, it is proposed that the activities carried out under this program be carried out under the Maternal and Child Health Block grant.

Traumatic Brain Injury - The TBI program was designed to expand State and local capacity to care for individuals with Traumatic Brain Injury and their families. For FY 2006, it is proposed that the activities carried out under this program be carried out under the Maternal and Child Health Block grant.

Health Resources and Services

For carrying out titles II, III, IV, VII, VIII, X, XII, [XIX,][1] and XXVI of the Public Health Service Act, section 427(a) of the Federal Coal Mine Health and Safety Act, title V and sections 1128E[,] and 711[, and 1820][2] of the Social Security Act, the Health Care Quality Improvement Act of 1986, as amended, the Native Hawaiian Health Care Act of 1988, as amended, the Cardiac Arrest Survival Act of 2000, [section 712 of the American Jobs Creation Act of 2004,][3] and the Poison Control Center Enhancement and Awareness Act, as amended, [$6,856,624,000, of which $484,629,000 shall be available for construction and renovation (including equipment) of health care and other facilities and other health-related activities as specified in the statement of the managers on the conference report accompanying this Act, and of which $39,499,000 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 under section 1820 of such Act: *Provided,* That of the funds made available under this heading, $249,000][4] *$5,966,144,000 of which $222,000* shall be available until expended for facilities renovations at the Gillis W. Long Hansen's Disease Center: *Provided [further],* That in addition to fees authorized by section 427(b) of the Health Care Quality Improvement Act of 1986, fees shall be collected for the full disclosure of information under the Act sufficient to recover the full costs of operating the National Practitioner Data Bank, and shall remain available until expended to carry out that Act: *Provided further,* That fees collected for the full disclosure of information under the "Health Care Fraud and Abuse Data Collection Program", authorized by section 1128E(d)(2) of the Social Security Act, shall be sufficient to recover the full costs of operating the program, and shall remain available until expended to carry out that Act: [*Provided further,* That $31,000,000

of the funding provided for community health centers shall be used for base grant adjustments for existing centers: *Provided further,* That no more than $100,000 is available until expended for carrying out the provisions of 42 U.S.C. 233(o) including associated administrative expenses:][5] *Provided further, $26,000,000 of the funding provided for health centers shall be used for high-need counties notwithstanding section 330(s)(2)(B) of the Public Health Service Act,*[6] *Provided further,* That no more than $45,000,000 is available until expended for carrying out the provisions of Public Law 104-73: [*Provided further,* That $9,941,000 is available until expended for the National Cord Blood Stem Cell Bank Program as described in House Report 108-401:][7] *Provided further,* That of the funds made available under this heading, [$288,283,000] *$285,963,000* shall be for the program under title X of the Public Health Service Act to provide for voluntary family planning projects: *Provided further,* 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: *Provided further,* That [$793,872,000] *$797,521,000* shall be for State AIDS Drug Assistance Programs authorized by section 2616 of the Public Health Service Act: *Provided further,* That in addition to amounts provided herein, $25,000,000 shall be available from amounts available under section 241 of the Public Health Service Act to carry out Parts A, B, C, and D of title XXVI of the Public Health Service Act to fund section 2691 Special Projects of National Significance: *Provided further,* That, notwithstanding section 502(a)(1) of the Social Security Act, not to exceed $119,158,000 is available for carrying out special projects of regional and national significance pursuant to section 501(a)(2) of such Act: [*Provided further,* That of the funds provided, $40,000,000 shall

be provided to the Denali Commission as a direct lump payment pursuant to Public Law 106-113, of which $10,000,000 shall be for a psychiatric treatment facility in Bethel, Alaska, $10,000,000 shall be for residential and supportive housing for elders, $2,500,000 shall be for medical and dental equipment for rural clinics, and $5,000,000 shall be for upgrade and construction of shelters for victims of domestic violence and child abuse.][8] *(Department of Health and Human Services Appropriations Act, 2005.)*

Explanation of Changes

1. Citation for Title XIX of the Public Health Service Act is not required, as funding for Emergency Medical Services for Children is not requested in FY 2006.

2. Citation for Section 1820 of the Social Security Act is not required, as funding for the Rural Health Flexibility Grant Program is not requested in FY 2006.

3. Citation is not required, as funding for the Sickle Cell Demonstration program is not requested in FY 2006.

4. Section is deleted to remove FY 2005 Appropriations levels and earmarked funds for individual programs.

5. Section is deleted to remove directive language of FY 2005 Appropriations and the reference to Free Clinics Tort Malpractice program which for which funding is not requested in FY 2006.

6. Proviso is added to direct the specified funds to new Health Centers in high-poverty counties across the country.

7. Section is deleted to remove directive language for the National Cord Blood Stem Cell Bank Program, as funds remain available for this program in FY 2006.

8. Section is deleted to remove directive language for earmarked funds for the Denali Commission.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION
Health Resources and Services

Amounts Available for Obligation 1/

	2004 Actual 2/	2005 Final Appropriation 2/	2006 Estimate 2/
Appropriations:			
Annual	$6,704,704,000	$6,858,624,000	$5,966,144,000
Labor/DHHS/Education Rescission	-	-747,000	-
Across the Board Rescission	-41,276,000	-54,862,000	-
Real Transfer to DHHS/ACF	-70,126,000	-	-
Subtotal, adjusted appropriation	6,593,302,000	6,803,015,000	5,966,144,000
Offsetting Collections:			
Unobligated balance, start of year	+63,846,000	+70,896,000	+45,153,000
Rescission of Unobligated Funds	---	-25,743,000	---
Unobligated balance, end of year	-70,896,000	-45,153,000	-45,153,000
Recovery of prior year obligations	+85,000		
Unobligated balance, lapsing	-8,004,000		
Total new direct obligations	$6,578,333,000	$6,803,015,000	$5,966,144,000

1/ Excludes the following amounts for reimbursable activities carried out by this account: FY 2004 - $167,165,000 and 253 FTE; FY 2005 - $130,000,000 and 314 FTE; FY 2006 -

2/ Excludes funding and FTE from PHSSEF: FY 2004 $542,649,000 and 31 FTE; FY 2005 $518,930,000 and 46 FTE; and FY 2006 $510,500,000 and 48 FTE.

Summary of Changes

2005 Final Conference	
Total estimated budget authority	$6,803,015,000
(Obligations)	(-$6,803,015,000)
2006 Estimate	$5,966,144,000
(Obligations)	(-$5,966,144,000)
Net Change	($836,871,000)
(Obligations)	(-$836,871,000)

	2005 Current Budget Base		Changes from Base	
	FTE	Budget Authority	FTE	Budget Authority
Increases:				
A. Built in:				
1. Annualized cost of 2005 pay raise at 3.5%	1,630	$187,391,000	-	$1,639,671
2. January 2006 pay raise at 2.3%	1,630	$187,391,000	-	3,401,112
3. Within grade increases	1,630	$187,391,000	-	1,873,910
Subtotal, built-in increases			-	+$6,914,693
B. Program:				
1. Health Centers	20	$1,689,671	-	$303,200,000
2. Health Centers Tort Claims	-	44,640,000	-	360,000
3. Nursing Workforce Diversity	-	16,270,000	-	5,000,000
4. Nurse Education, Practice, and Retention	-	36,468,000	-	10,002,000
5. Ryan White Comprehensive Care - Part B	-	1,121,836,000	-	10,000,000
Subtotal, program increases			-	+$328,562,000
Total			-	+$335,476,693

Summary of Changes

Decreases:

A. Built In:				
1. Absorption of Pay Costs	1,630	$187,391,000	-	-$5,928,958
2. One less day of pay	1,630	$187,391,000	-	-$720,735
3. Administrative Costs	-	$501,337,000	-	-$11,478,000
4. IT Reduction	-	-	-	-$1,175,000
B. Program:				
1. Free Clinics Medical Malpractice	2	99,000	-	-99,000
2. Healthy Community Access Program	12	82,993,000	-12	-82,993,000
3. Health Professions Programs (Title VII of PHS Act)	-	299,552,000	-	-288,940,000
4. Advanced Nurse Education	-	58,160,000	-	-14,996,000
5. Children's Hospitals Graduate Medical Education	9	300,730,000	-	-100,730,000
6. Traumatic Brain Injury	-	9,297,000	-	-9,297,000
7. Healthy Start	-	102,543,000	-	-4,796,000
8. Sickle Cell Demonstrations	-	198,000	-	-198,000
9. Emergency Medical Services for Children	-	19,831,000	-	-19,831,000
10. Universal Newborn Hearing Screening	2	9,792,000	-2	-9,792,000
11. Cord Blood Stem Cell Bank	1	9,859,000	-	-9,859,000
12. Trauma/Emergency Medical Services	1	3,419,000	-1	-3,419,000
13. State Planning Grant Program	4	10,910,000	-4	-10,910,000
14. Rural Health Outreach Grants	-	39,278,000	-	-28,186,000
15. Rural and Community Access to Emergency Devices	2	8,927,000	-	-6,914,000
16. Rural Hospital Flexibility Grants	-	39,180,000	-	-39,180,000
17. Rural Emergency Medical Services	1	496,000	-1	-496,000
18. Denali Project	-	39,680,000	-	-39,680,000
19. Health Facilities Construction and Other Misc. Projects	12	482,729,000	-12	-482,729,000
Subtotal, Program Decreases			-32	-$1,153,045,000
Total Decreases			-32	-$1,172,347,693
Net Change			**-32**	**-$836,871,000**

Budget Authority by Activity
(Dollars in thousands)

	FY 2004		FY 2005		FY 2006	
	FTE	Amount	FTE 3/	Amount	FTE 3/	Amount
1. Primary Care:						
Health Centers	20	$ 1,572,895	20	$ 1,689,671	20	$ 1,992,871
Health Center Tort Claims	-	44,734	-	44,640	-	45,000
Total, Health Centers	20	1,617,629	20	1,734,311	20	2,037,871
Free Clinics Medical Malpractice	1	4,821	2	99	2	-
Radiogenic Diseases	2	1,974	2	1,958	2	1,936
Healthy Community Access Program	12	83,425	12	82,993	-	-
Hansen's Disease Center	94	17,413	91	17,251	91	16,066
Payment to Hawaii	-	2,033	-	2,017	-	2,016
Buildings and Facilities	-	249	-	247	-	222
Black Lung	-	5,963	-	5,951	-	5,912
Subtotal, Primary Care	129	1,733,507	127	1,844,827	115	2,064,023
2. Health Professions:						
National Health Service Corps Field	124	45,446	155	45,068	155	40,705
National Health Service Corps Recruitment	-	124,457	-	86,380	-	86,091
Subtotal, National Health Service Corps	124	169,903	155	131,448	155	126,796
Health Professions Training for Diversity:						
Centers of Excellence	-	33,657	-	33,609	-	-
Scholarships for Disadvantaged Students	-	47,510	-	47,129	-	9,831
Loan Repayment/Faculty Fellowships	-	1,313	-	1,302	-	-
Health Careers Opportunity Program	-	36,160	-	35,646	-	-
Subtotal, Health Professions Training for Diversity	-	118,640	-	117,686	-	9,831
Training in Primary Care Medicine and Dentistry	-	81,917	-	88,816	-	-
Interdisciplinary, Community-Based Linkages:						
Area Health Education Centers	-	29,206	-	28,971	-	-
Health Education and Training Centers	-	3,851	-	3,819	-	-
Geriatric Programs	-	31,805	-	31,548	-	-
Quentin N. Burdick Program for Rural Interdisciplinary Training	-	6,125	-	6,076	-	-
Allied Health and Other Disciplines	-	11,674	-	11,753	-	-
Subtotal, Interdisciplinary, Community-Based Linkages	-	82,661	-	82,167	-	-

Budget Authority by Activity
(Dollars in thousands)

	FY 2004		FY 2005		FY 2006	
	FTE	Amount	FTE 3/	Amount	FTE 3/	Amount
Health Professions Workforce Information and Analysis.....	-	722	-	716	-	712
Public Health Workforce Development:						
Public Health/Preventive Medicine; Dental PH Programs.	-	9,170	-	9,097	-	-
Health Administration Programs.....	-	1,078	-	1,070	-	-
Subtotal, Public Health Workforce Development.....	-	10,248	-	10,167	-	-
Nursing Workforce Development:						
Advanced Education Nursing.....	-	58,636	-	58,160	-	42,806
Nursing Workforce Diversity.....	-	16,402	-	16,270	-	21,244
Nurse Education, Practice and Retention.....	-	31,769	-	36,468	-	46,325
Nurse Faculty Loan Program.....	-	4,870	-	4,831	-	4,821
Comprehensive Geriatric Education.....	-	3,478	-	3,450	-	3,426
Loan Repayment and Scholarship Program.....	-	26,736	-	31,482	-	31,369
Subtotal, Nursing Workforce Development.....	-	141,891	-	150,661	-	149,991
Educational Incentive for Curriculum Development & Trng..	4	27,706	5	27,520	5	27,521
Children's Hospitals Graduate Medical Education Program...	8	303,169	9	300,730	9	200,000
Subtotal, Health Professions.....	132	909,151	164	882,391	164	487,330
National Practitioner Data Bank (User Fees).....	23	16,000	24	15,700	24	15,700
Healthcare Integrity and Protection Data Bank (User Fees).....	5	4,000	7	4,000	7	4,000

Budget Authority by Activity
(Dollars in thousands)

	FY 2004		FY 2005		FY 2006	
	FTE	Amount	FTE 3/	Amount	FTE 3/	Amount
3. Maternal & Child Health:						
Maternal and Child Health Block Grant	1	729,817	-	723,928	-	723,928
Traumatic Brain Injury	-	9,375	-	9,297	-	-
Healthy Start	-	97,751	-	102,543	-	97,747
Sickle Cell Service Demonstrations	-	-	-	198	-	-
Universal Newborn Hearing	2	9,873	2	9,792	-	-
Emergency Medical Services for Children	-	19,860	-	19,831	-	-
Subtotal, Maternal and Child Health	3	866,676	2	865,589	-	821,675
4. HIV/AIDS:						
Emergency Relief - Part A	-	615,023	-	610,094	-	610,094
Comprehensive Care - Part B	-	1,085,900	-	1,121,836	-	1,131,836
AIDS Drug Assistance Program (Non-Add)	-	748,872	-	787,521	-	797,521
Early Intervention - Part C	27	197,170	30	195,578	30	195,578
Children, Youth, Women & Families - Part D	-	73,108	-	72,519	-	72,519
Education and Training Centers - Part F	-	35,335	-	35,051	-	35,051
Dental Services Part F	-	13,325	-	13,218	-	13,218
Subtotal, HIV/AIDS	27	2,019,861	30	2,048,296	30	2,058,296
Emergency HIV/AIDS	-	20,000	-	-	-	-
SPNS Evaluation Funding	-	*25,000*	-	*25,000*	-	*25,000*
5. Telehealth	-	3,949	-	3,916	-	3,888
Total, HIV/AIDS Bureau	27	2,043,810	30	2,052,212	30	2,062,184
6. Healthcare Systems:						
Organ Transplantation	-	24,632	-	24,414	-	23,282
Cord Blood Stem Cell Bank	-	9,941	1	9,859	1	-
Bone Marrow Donor Registry	5	22,662	5	25,416	5	22,916
Poison Control Centers	3	23,696	3	23,499	3	23,301
Hospital Preparedness	22	514,943	33	491,410	35	482,979
Trauma/Emergency Medical Services	1	3,449	1	3,419	-	-
State Planning Grant Program	4	14,810	4	10,910	-	-
Subtotal, Healthcare Systems Bureau	13	99,190	14	97,517	9	69,499

Budget Authority by Activity
(Dollars in thousands)

	FY 2004		FY 2005		FY 2006	
	FTE	Amount	FTE 3/	Amount	FTE 3/	Amount
7. Rural Health:						
Rural Health Policy Development	-	8,902	-	8,825	-	8,528
Rural Health Outreach Grants	-	39,601	-	39,278	-	10,767
Rural & Community Access to Emergency Devices	2	10,933	2	8,927	2	1,960
Rural Hospital Flexibility Grants	-	39,499	-	39,180	-	-
Rural EMS	1	497	1	496	-	-
State Offices of Rural Health	-	8,390	-	8,321	-	8,223
Denali Project	-	34,794	-	39,680	-	-
Subtotal, Rural Health	3	142,616	3	144,707	2	29,478
8. Health Facilities Construction and Other Misc. Projects	11	371,536	12	482,729	-	-
9. Program Management	1,186	148,533	1,229	147,080	1,229	145,992
10. Family Planning	46	278,283	49	285,963	49	285,963
HRS Direct Discretionary Level	1,550	6,593,302	1,630	6,803,015	1,598	5,966,144
Program Level:						
HRS	1,550	6,593,302	1,630	6,803,015	1,598	5,966,144
Secretary's Transfer Authority (SPNS)	-	25,000	-	25,000	-	25,000
Subtotal, HRSA Discretionary Program Level	1,550	6,618,302	1,630	6,828,015	1,598	5,991,144

Budget Authority by Activity
(Dollars in thousands)

	FY 2004		FY 2005		FY 2006	
	FTE	Amount	FTE 3/	Amount	FTE 3/	Amount
Budget Authority With Mandatory/User Fee Programs:						
National Practitioner Data Bank (User Fees).....	23	16,000	24	15,700	24	15,700
Healthcare Integrity and Protection Data Bank (User Fees)	5	4,000	7	4,000	7	4,000
Total HRS Program Level.....	1,578	6,638,302	1,661	6,847,715	1,629	6,010,844
Bioterrorism Activities Financed from PHSSEF:						
Educational Incentive for Curriculum Development & Trng	4	27,706	5	27,520	5	27,521
Hospital Preparedness	22	514,943	33	491,410	35	482,979
Smallpox.....	5	-	8	-	8	-
Total Bioterrorism Activities Financed under PHSSEF.....	31	542,649	46	518,930	48	510,500
Total, HRS Program Level	1,609	7,180,951	1,707	7,366,645	1,677	6,521,344
Less the following Non-Discretionary BA Programs:						
National Practitioner Data Bank (User Fees).....	-23	-16,000	-24	-15,700	-24	-15,700
Healthcare Integrity and Protection Data Bank (User Fees)	-5	-4,000	-7	-4,000	-7	-4,000
Secretary's Transfer Authority (SPNS).....	-	-25,000	-	-25,000	-	-25,000
Items financed from PHSSEF (Bioterrorism).	-31	-542,649	-46	-518,930	-48	-510,500
Total Direct HRS Discretionary Budget Authority (0350)	1,550	6,593,302	1,630	6,803,015	1,598	5,966,144

1/ Bioterrorism Programs are funded in the PHSSEF and transferred to HRSA.
2/ The Ryan White AIDS Special Projects of National Significance is funded through the Secretary's Transfer Authority, not from the traditional tap to Ryan White Care Act Parts A, B, C, and D.
3/ FTE levels in FY 2005 and FY 2006 differ from those presented in the Appendix of the Budget of the United States Government to reflect corrected FTE levels.

Budget Authority By Activity
Reflecting Planned Re-allocations and Transfers Related to Influenza,
Health Information Technology and Anthrax Antibiotics
(Dollars in thousands)

	FY 2004 Enacted	FY 2005 Enacted	FY 2005 Revised	FY 2006 Request
1.Primary Care:				
Health Centers	1,572,895	1,689,671	1,689,671	1,992,871
Health Center Tort Claims	44,734	44,640	44,640	45,000
Total, Health Centers	1,617,629	1,734,311	1,734,311	2,037,871
Free Clinics Medical Malpractice	4,821	99	99	-
Radiogenic Diseases	1,974	1,958	1,958	1,936
Healthy Community Access Program	83,425	82,993	82,217	-
Hansen's Disease Center	17,413	17,251	17,251	16,066
Payment to Hawaii	2,033	2,017	2,017	2,016
Buildings and Facilities	249	247	247	222
Black Lung	5,963	5,951	5,951	5,912
Subtotal, Primary Care	1,733,507	1,844,827	1,844,051	2,064,023
2. Health Professions:				
National Health Service Corps Field	45,446	45,068	45,068	40,705
National Health Service Corps Recruitment	124,457	86,380	86,380	86,091
Subtotal, National Health Service Corps	169,903	131,448	131,448	126,796
Health Professions Training for Diversity:				
Centers of Excellence	33,657	33,609	33,085	-
Scholarships for Disadvantaged Students	47,510	47,129	47,129	9,831
Loan Repayment/Faculty Fellowships	1,313	1,302	1,282	-
Health Careers Opportunity Program	36,160	35,646	35,090	-
Subtotal, Health Professions Training for Diversity	118,640	117,686	116,586	9,831
Training in Primary Care Medicine and Dentistry	81,917	88,816	87,986	-

Budget Authority By Activity
Reflecting Planned Re-allocations and Transfers Related to Influenza,
Health Information Technology and Anthrax Antibiotics
(Dollars in thousands)

	FY 2004 Enacted	FY 2005 Enacted	FY 2005 Revised	FY 2006 Request
Interdisciplinary, Community-Based Linkages:				
Area Health Education Centers	29,206	28,971	28,700	-
Health Education and Training Centers	3,851	3,819	3,783	-
Geriatric Programs	31,805	31,548	31,253	-
Quentin N. Burdick Program for Rural Interdisciplinary Training	6,125	6,076	6,020	-
Allied Health and Other Disciplines	11,674	11,753	11,643	-
Subtotal, Interdisciplinary, Community-Based Linkages	82,661	82,167	81,399	-
Health Professions Workforce Information and Analysis	722	716	709	712
Public Health Workforce Development:				
Public Health/Preventive Medicine; Dental PH Programs	9,170	9,097	9,012	-
Health Administration Programs	1,078	1,070	1,060	-
Subtotal, Public Health Workforce Development	10,248	10,167	10,072	-
Nursing Workforce Development:				
Advanced Education Nursing	58,636	58,160	58,160	42,806
Nursing Workforce Diversity	16,402	16,270	16,270	21,244
Nurse Education, Practice and Retention	31,769	36,468	36,468	46,325
Nurse Faculty Loan Program	4,870	4,831	4,831	4,821
Comprehensive Geriatric Education	3,478	3,450	3,450	3,426
Loan Repayment and Scholarship Program	26,736	31,482	31,482	31,369
Subtotal, Nursing Workforce Development	141,891	150,661	150,661	149,991
Educational Incentive for Curriculum Development & Trng	27,706 1/	27,520	27,520	27,521
Children's Hospitals Graduate Medical Education Program	303,169	300,730	297,918	200,000
Subtotal, Health Professions	909,151	882,391	876,779	487,330
National Practitioner Data Bank (User Fees)	16,000	15,700	15,700	15,700
Healthcare Integrity and Protection Data Bank (User Fees)	4,000	4,000	4,000	4,000

Budget Authority By Activity
Reflecting Planned Re-allocations and Transfers Related to Influenza,
Health Information Technology and Anthrax Antibiotics
(Dollars in thousands)

	FY 2004 Enacted	FY 2005 Enacted	FY 2005 Revised	FY 2006 Request
3. Maternal & Child Health:				
Maternal and Child Health Block Grant	729,817	723,928	723,928	723,928
Traumatic Brain Injury	9,375	9,297	9,297	-
Healthy Start	97,751	102,543	101,584	97,747
Sickle Cell Service Demonstrations	-	198	198	-
Universal Newborn Hearing	9,873	9,792	9,700	-
Emergency Medical Services for Children	19,860	19,831	19,831	-
Subtotal, Maternal and Child Health	866,676	865,589	864,538	821,675
4. HIV/AIDS:				
Emergency Relief - Part A	615,023	610,094	610,094	610,094
Comprehensive Care - Part B	1,085,900	1,121,836	1,121,836	1,131,836
AIDS Drug Assistance Program (Non-Add)	748,872	787,521	787,521	797,521
Early Intervention - Part C	197,170	195,578	195,578	195,578
Children, Youth, Women & Families - Part D	73,108	72,519	72,519	72,519
Education and Training Centers - Part F	35,335	35,051	35,051	35,051
Dental Services Part F	13,325	13,218	13,218	13,218
Subtotal, HIV/AIDS	2,019,861	2,048,296	2,048,296	2,058,296
Emergency HIV/AIDS	20,000	-	-	-
SPNS Evaluation Funding	25,000 2/	25,000	25,000	25,000
5. Telehealth	3,949	3,916	3,916	3,888
Total, HIV/AIDS Bureau	2,043,810	2,052,212	2,052,212	2,062,184

Budget Authority By Activity
Reflecting Planned Re-allocations and Transfers Related to Influenza,
Health Information Technology and Anthrax Antibiotics
(Dollars in thousands)

	FY 2004 Enacted		FY 2005 Enacted	FY 2005 Revised	FY 2006 Request
6. Healthcare Systems Bureau:					
Organ Transplantation	24,632		24,414	24,414	23,282
Cord Blood Stem Cell Bank	9,941		9,859	9,859	-
Bone Marrow Donor Registry	22,662		25,416	25,416	22,916
Poison Control Centers	23,696		23,499	23,499	23,301
Hospital Preparedness	514,943	1/	491,410	491,410	482,979
Trauma/Emergency Medical Services	3,449		3,419	3,387	-
State Planning Grant Program	14,810		10,910	10,808	-
Subtotal, Healthcare Systems Bureau	99,190		97,517	97,383	69,499
7. Rural Health:					
Rural Health Policy Development	8,902		8,825	8,825	8,528
Rural Health Outreach Grants	39,601		39,278	38,911	10,767
Rural & Community Access to Emergency Devices	10,933		8,927	8,844	1,960
Rural Hospital Flexibility Grants	39,499		39,180	38,814	-
Rural EMS	497		496	491	-
State Offices of Rural Health	8,390		8,321	8,321	8,223
Denali Project	34,794		39,680	39,309	-
Subtotal, Rural Health	142,616		144,707	143,515	29,478
8. Health Facilities Construction and Other Misc. Projects	371,536		482,729	478,216	-
9. Program Management	148,533		147,080	147,080	145,992
10. Family Planning	278,283		285,963	285,963	285,963
HRS Direct Discretionary Level	6,593,302		6,803,015	6,789,737	5,966,144

Budget Authority By Activity
Reflecting Planned Re-allocations and Transfers Related to Influenza,
Health Information Technology and Anthrax Antibiotics
(Dollars in thousands)

	FY 2004 Enacted		FY 2005 Enacted	FY 2005 Revised	FY 2006 Request
Program Level:					
HRS	6,593,302		6,803,015	6,789,737	5,966,144
Secretary's Transfer Authority (SPNS)	25,000	2/	25,000	25,000	25,000
Subtotal, HRSA Discretionary Program Level	6,618,302		6,828,015	6,814,737	5,991,144
Budget Authority With Mandatory/User Fee Programs:					
National Practitioner Data Bank (User Fees)	16,000		15,700	15,700	15,700
Healthcare Integrity and Protection Data Bank (User Fees)	4,000		4,000	4,000	4,000
Total HRSA Program Level	6,638,302		6,847,715	6,834,437	6,010,844
Bioterrorism Activities Financed from PHSSEF:					
Educational Incentive for Curriculum Development & Trng	27,706	1/	27,520	27,520	27,521
Hospital Preparedness	514,943	1/	491,410	491,410	482,979
Smallpox					
Total Bioterrorism Activities Financed under PHSSEF	542,649	1/	518,930	518,930	510,500
Total, HRS Program Level	7,180,951		7,366,645	7,353,367	6,521,344
Less the following Non-Discretionary BA Programs:					
National Practitioner Data Bank (User Fees)	(16,000)		(15,700)	(15,700)	(15,700)
Healthcare Integrity and Protection Data Bank (User Fees).	(4,000)		(4,000)	(4,000)	(4,000)
Secretary's Transfer Authority (SPNS)	(25,000)		(25,000)	(25,000)	(25,000)
Items financed from PHSSEF (Bioterrorism).	(542,649)		(518,930)	(518,930)	(510,500)
Total Direct HRS Discretionary Budget Authority (0350)	6,593,302		6,803,015	6,789,737	5,966,144

1/ Bioterrorism Programs are funded in the PHSSEF and transferred to HRSA.
2/ The Ryan White AIDS Special Projects of National Significance is funded through the Secretary's Transfer Authority, not from the traditional tap to Ryan White Care Act Parts A, B, C, and D.

Budget Authority by Object

	2005 Appropriation	2006 Estimate	Increase or Decrease
Full-time equivalent employment	1,630	1,598	-32
Ceiling exempt full-time equivalent employment	80	80	-
Full-time equivalent of overtime hours	4	4	-
Average SES salary	$140,152	$145,152	$5,000
Average GS grade	11/09	11/09	-
Average GS salary (excluding benefits)	$57,303	$59,882	$2,579
Average Commissioned salary established by Act of July 1, 1944 (42 USC 207)	$72,681	$76,678	$3,997
Average Commissioned grade	5	5	-
Average salary of ungraded positions	$114,351	$118,431	$4,080
Average salary of wage grade positions	$35,863	$37,142	$1,279
Average grade of wage grade positions	6/5	6/5	-
Personnel compensation:			
Full-time permanent	$102,277,000	$109,847,000	+$7,570,000
Other than full-time permanent	3,244,000	2,507,000	-737,000
Other personnel compensation	2,385,000	1,725,000	-660,000
Special personnel services payments	40,000	0	-40,000
Military personnel	26,433,000	26,593,000	+160,000
Total personnel compensation	134,379,000	140,672,000	+6,293,000
Personnel benefits	25,490,000	23,326,000	-2,164,000
Military personnel benefits	14,434,000	14,694,000	+260,000
Benefits to former personnel	1,035,000	947,000	-88,000
Subtotal Pay Costs	**175,338,000**	**179,639,000**	**+4,301,000**
Travel and transportation of persons	3,013,000	2,666,000	-347,000
Transportation of things	397,000	325,000	72,000
Rent, communication and utilities:			
Rental payments to GSA	13,751,000	13,799,000	+ 48,000
Communication, utilities, and misc. charges	4,449,000	4,000,000	-449,000
Printing and reproduction	1,140,000	1,000,000	-140,000
Other Contractual Services:			
Advisory and assistance services	65,630,000	60,404,000	-5,226,000
Other services	101,263,000	78,116,000	-23,147,000
Purchase of goods and services from government accounts	216,000,000	133,134,000	-82,866,000
Operation and maintenance of facilities	2,136,000	753,000	-1,383,000
Research and development contracts	102,000	102,000	0
Medical care	3,088,000	2,788,000	-300,000
Operation and maintenance of equipment	3,350,000	3,350,000	0
Subsistence and support of persons	231,000	169,000	-62,000
Subtotal Other Contractual Services	391,800,000	278,816,000	-112,984,000
Supplies and materials	1,660,000	1,549,000	-111,000
Equipment	1,486,000	750,000	-736,000
Investments and loans	4,686,000	4,686,000	-
Grants, subsidies, and contributions	6,150,295,000	5,422,914,000	-727,381,000
Insurance claims and indemnities	55,000,000	56,000,000	+ 1,000,000
Interest and dividends	0	0	-
Subtotal Non-Pay Costs	**6,627,677,000**	**5,786,505,000**	**-841,172,000**
Total Budget Authority by Object Class	**$6,803,015,000**	**$5,966,144,000**	**-$836,871,000**

Salaries and Expenses
(Budget Authority)

	2005 Appropriation	2006 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent	$102,277,000	$109,847,000	+$7,570,000
Other than full-time permanent	3,244,000	2,507,000	-737,000
Other personnel compensation	2,385,000	1,725,000	-660,000
Special personnel services payments	40,000	0	-40,000
Military personnel	26,433,000	26,593,000	+160,000
Total personnel compensation	134,379,000	140,672,000	+6,293,000
Personnel benefits	25,490,000	23,326,000	-2,164,000
Military personnel benefits	14,434,000	14,694,000	+260,000
Benefits to former personnel	1,035,000	947,000	-88,000
Subtotal Pay Costs	**175,338,000**	**179,639,000**	**+4,301,000**
Travel and transportation of persons	3,013,000	2,666,000	-347,000
Transportation of things	397,000	325,000	-72,000
Rent, communication and utilities:			
Communication, utilities, and misc. charges	4,449,000	4,000,000	-449,000
Printing and reproduction	1,140,000	1,000,000	-140,000
Other Contractual Services:			
Advisory and assistance services	65,630,000	60,404,000	-5,226,000
Other services	101,263,000	78,116,000	-23,147,000
Purchase of goods and services from government accounts	80,000,000	14,134,000	-65,866,000
Operation and maintenance of facilities	2,135,000	753,000	-1,382,000
Operation and maintenance of equipment	3,088,000	2,788,000	-300,000
Subsistence and support of persons	3,350,000	3,350,000	0
Subtotal Other Contractual Services	231,000	169,000	-62,000
	255,697,000	159,714,000	-95,983,000
Supplies and materials	1,660,000	1,549,000	-111,000
Subtotal Non-Pay Costs	**266,356,000**	**169,254,000**	**-97,102,000**
Total Salaries and Expenses by Object Class	**$441,694,000**	**$348,893,000**	**-$92,801,000**

Salaries and Expenses by Program Line Item

PROGRAM	FY 2004 Adjusted Appropriaton	FTE	FY 2005 Revised Appropriation	FTE	FY 2006 President's Budget	FTE
PRIMARY CARE:						
Health Centers	$1,527,727		1,643,930		1,947,130	
Salaries and Expenses	45,168		45,741		45,741	
Health Centers - Total	**$1,572,895**	**20**	**$1,689,671**	**20**	**$1,992,871**	**20**
Health Centers Tort Claims	$44,734		$44,640		$45,000	
Salaries and Expenses	0		0		0	
Health Centers Tort Claims - Total	**$44,734**		**$44,640**		**$45,000**	
Free Clinics Medical Malpractice	$0		$99		$0	
Salaries and Expenses	294		0			
Free Clinics Medical Malpractice - Total	**$294**	**1**	**$99**	**2**	**$0**	**2**
Radiogenic Diseases	$1,770		$1,742		$1,742	
Salaries and Expenses	204		216		194	
Radiogenic Diseases - Total	**$1,974**	**2**	**$1,958**	**2**	**$1,936**	**2**
Healthy Communities Access Program	$75,440		$74,972		$0	
Salaries and Expenses	7,981		8,021		0	
Healthy Community Access Program - Total	**$83,421**	**12**	**$82,993**	**12**	**$0**	**0**
Hansen's Disease Center	$2,253		$1,944		$1,944	
Salaries and Expenses	15,160		15,307		14,122	
Hansen's Disease Center - Total	**$17,413**	**94**	**$17,251**	**91**	**$16,066**	**91**
Payment to Hawaii	$2,016		$2,000		$2,000	
Salaries and Expenses	17		17		16	
Payment to Hawaii - Total	**$2,033**		**$2,017**		**$2,016**	
Buildings and Facilities	$0		$0		$0	
Salaries and Expenses	249		247		222	
Buildings and Facilities - Total	**$249**		**$247**		**$222**	
Black Lung	$5,759		$5,747		$5,747	
Salaries and Expenses	204		204		165	
Black Lung - Total	**$5,963**		**$5,951**		**$5,912**	
PRIMARY CARE - Subtotal	$1,659,699		$1,775,074		$2,003,563	
Salaries and Expenses	69,277		69,753		60,460	
PRIMARY CARE - Total	**$1,728,976**	**129**	**$1,844,827**	**127**	**$2,064,023**	**115**
HEALTH PROFESSIONS:						
National Health Service Corps Field	$6,414		$2,151		$2,351	
Salaries and Expenses	39,007		42,917		38,354	
National Health Service Corps Field - Total	**$45,421**	**124**	**$45,068**	**155**	**$40,705**	**155**
National Health Service Corps Recruitment	$123,386		$85,311		$85,311	
Salaries and Expenses	1,069		1,069		780	
National Health Service Corps Recruitment -Total	**$124,455**		**$86,380**		**$86,091**	

Salaries and Expenses by Program Line Item

PROGRAM	FY 2004 Adjusted Appropriaton	FTE	FY 2005 Revised Appropriation	FTE	FY 2006 President's Budget	FTE
Health Professions Training for Diversity:						
Centers of Excellence	$32,476		$32,441		$0	
Salaries and Expenses	1,168		1,168		0	
Centers of Excellence - Total	**$33,644**		**$33,609**		**$0**	
Scholarships for Disadvantaged Students	$46,607		$46,234		$9,709	
Salaries and Expenses	895		895		122	
Scholarships for Disadvantaged Students - Total	**$47,502**		**$47,129**		**$9,831**	
Loan Repayment/Faculty Fellowships	$1,302		$1,299		$0	
Salaries and Expenses	3		3		0	
Loan Repayment/Faculty Fellowships - Total	**$1,305**		**$1,302**		**$0**	
Health Careers Opportunity Program	$35,278		$34,775		$0	
Salaries and Expenses	871		871		0	
Health Careers Opportunity Program - Total	**$36,149**		**$35,646**		**$0**	
Training in Primary Care Medicine and Dentistry	$78,242		$85,146		$0	
Salaries and Expenses	3,670		3,670		0	
Training in Primary Care Medicine and Dentistry - Total	**$81,912**		**$88,816**		**$0**	
Interdisciplinary, Community-Based Linkages:						
Area Health Education Centers	$28,513		$28,293		$0	
Salaries and Expenses	678		678		0	
Area Health Education Centers - Total	**$29,191**		**$28,971**		**$0**	
Health Education and Training Centers	$3,683		$3,658		$0	
Salaries and Expenses	161		161		0	
Health Education and Training Centers - Total	**$3,844**		**$3,819**		**$0**	
Geriatric Programs	$29,419		$29,170		$0	
Salaries and Expenses	2,378		2,378		0	
Geriatric Programs - Total	**$31,797**		**$31,548**		**$0**	
Quentin N. Burdick Programs for Rural Interdisciplinary Training	$5,887		$5,843		$0	
Salaries and Expenses	233		233		0	
Quentin N. Burdick Programs for Rural Interdisciplinary Training - Total	**$6,120**		**$6,076**		**$0**	
Allied Health and Other Disciplines	$10,838		$10,918		$0	
Salaries and Expenses	835		835		0	
Allied Health and Other Disciplines - Total	**$11,673**		**$11,753**		**$0**	
Health Professions Workforce Information and Analysis	$695		$689		$689	
Salaries and Expenses	27		27		23	
Health Professions Workforce Information and Analysis - Total	**$722**		**$716**		**$712**	
Public Health Workforce Development:						
Public Health/Preventive Medicine; Dental PH Programs	$8,944		$8,874		$0	
Salaries and Expenses	223		223		0	
Public Health/Preventive Medicine; Dental PH Programs - Total	**$9,167**		**$9,097**		**$0**	
Health Administration Programs	$1,069		$1,066		$0	
Salaries and Expenses	4		4		0	
Health Administration Programs - Total	**$1,073**		**$1,070**		**$0**	

Salaries and Expenses by Program Line Item

PROGRAM	FY 2004 Adjusted Appropriaton	FTE	FY 2005 Revised Appropriation	FTE	FY 2006 President's Budget	FTE
Nursing Workforce Development:						
Advanced Education Development	$56,521		$56,047		$41,051	
Salaries and Expenses	2,113		2,113		1,755	
Advanced Education Development - Total	**$58,634**		**$58,160**		**$42,806**	
Nursing Workforce Diversity	$16,027		$15,895		$20,895	
Salaries and Expenses	375		375		349	
Nursing Workforce Diversity - Total	**$16,402**		**$16,270**		**$21,244**	
Nurse Education, Practice, and Retention	$30,873		$35,573		$45,575	
Salaries and Expenses	895		895		750	
Nurse Education, Practice, and Retention - Total	**$31,768**		**$36,468**		**$46,325**	
Nurse Faculty Loan Program	$4,616		$4,577		$4,577	
Salaries and Expenses	254		254		244	
Nurse Faculty Loan Program - Total	**$4,870**		**$4,831**		**$4,821**	
Comprehensive Geriatric Education	$3,349		$3,323		$3,323	
Salaries and Expenses	127		127		103	
Comprehensive Geriatric Education - Total	**$3,476**		**$3,450**		**$3,426**	
Loan Repayment and Scholarship Program	$24,529		$29,277		$29,277	
Salaries and Expenses	2,205		2,205		2,092	
Loan Repayment and Scholarship Program - Total	**$26,734**		**$31,482**		**$31,369**	
Children's Hospitals Graduate Medical Education Program	$297,656		$295,226		$196,340	
Salaries and Expenses	5,504		5,504		3,660	
Children's Hospitals Graduate Medical Education Program - Total	**$303,160**	**8**	**$300,730**	**9**	**$200,000**	**9**
HEALTH PROFESSIONS - Subtotal	$846,324		$815,786		$439,098	
Salaries and Expenses	62,695		66,605		48,232	
HEALTH PROFESSIONS - Total	**$909,019**	**132**	**$882,391**	**164**	**$487,330**	**164**
MATERNAL AND CHILD HEALTH:						
Maternal and Child Health Block Grant	$706,138		$700,335		$700,335	
Salaries and Expenses	23,664		23,593		23,593	
Maternal and Child Health Block Grant - Total	**$729,802**	**1**	**$723,928**	**0**	**$723,928**	**0**
Traumatic Brain Injury	$8,376		$8,309			
Salaries and Expenses	998		988			
Traumatic Brain Injury - Total	**$9,374**		**$9,297**		**$0**	
Healthy Start	$94,544		$99,337		$94,541	
Salaries and Expenses	3,206		3,206		3,206	
Healthy Start - Total	**$97,750**		**$102,543**		**$97,747**	
Universal Newborn Hearing	$9,098		$9,007		$0	
Salaries and Expenses	770		785		0	
Universal Newborn Hearing - Total	**$9,868**	**2**	**$9,792**	**2**	**$0**	**0**
Emergency Medical Services for Children	$14,312		$14,289			
Salaries and Expenses	5,542		5,542			
Emergency Medical Services for Children - Total	**$19,854**		**$19,831**		**$0**	
Sickle Cell Service Demonstrations	**$0**		**$188**			
Salaries and Expenses	**$0**		**$10**			
Sickle Cell Service Demonstrations- Total	**$0**		**$198**		**$0**	
MATERNAL AND CHILD HEALTH - Subtotal	$832,468		$831,465		$794,876	
Salaries and Expenses	34,180		34,124		26,799	
MATERNAL AND CHILD HEALTH - Total	**$866,648**	**3**	**$865,589**	**2**	**$821,675**	**0**

Salaries and Expenses by Program Line Item

PROGRAM	FY 2004 Adjusted Appropriaton	FTE	FY 2005 Revised Appropriation	FTE	FY 2006 President's Budget	FTE
HIV/AIDS:						
Emergency Relief - Part A	$610,349		$605,438		$605,438	
Salaries and Expenses	4,674		4,656		4,656	
Emergency Relief - Part A - Total	**$615,023**		**$610,094**		**$610,094**	
Comprehensive Care - Part B	$1,078,158		$1,114,051		$1,124,051	
Salaries and Expenses	7,742		7,785		7,785	
Comprehensive Care - Part B - Total	**$1,085,900**		**$1,121,836**		**$1,131,836**	
Early Intervention - Part C	$188,189		$186,110		$186,110	
Salaries and Expenses	8,981		9,468		9,468	
Early Intervention - Part C - Total	**$197,170**	**27**	**$195,578**	**30**	**$195,578**	**30**
HIV/AIDS Drug Purchase	$0		$0			
Salaries and Expenses	20,000		0			
HIV/Drug Purchase - Total	**$20,000**		**$0**	**0**	**$0**	**0**
Children, Youth, Women, and Families - Part D	$71,842		$71,279		$71,279	
Salaries and Expenses	1,266		1,240		1,240	
Children, Youth, Women, and Families - Part D - Total	**$73,108**		**$72,519**		**$72,519**	
Education and Training Centers - Part F	$34,642		$34,358		$34,358	
Salaries and Expenses	693		693		693	
Education and Training Centers - Part F - Total	**$35,335**		**$35,051**		**$35,051**	
Dental Services	$13,080		$12,973		$12,973	
Salaries and Expenses	245		245		245	
Dental Services - Total	**$13,325**		**$13,218**		**$13,218**	
Telehealth	$3,853		$3,858		$3,858	
Salaries and Expenses	58		58		30	
Telehealth - Total	**$3,911**		**$3,916**		**$3,888**	
HIV/AIDS - Subtotal	$2,000,113		$2,028,067		$2,038,067	
Salaries and Expenses	43,659		24,145		24,117	
HIV/AIDS - Total	**$2,043,772**	**27**	**$2,052,212**	**30**	**$2,062,184**	**30**
HEALTHCARE SYSTEMS BUREAU:						
Organ Transplantation	$13,760		$13,557		$13,558	
Salaries and Expenses	10,856		10,856		9,724	
Organ Transplantation - Total	**$24,616**		**$24,413**		**$23,282**	
Cord Blood Stem Cell Bank	$0		$8,811			
Salaries and Expenses	1,042		1,048			
Cord Blood Stem Cell Bank - Total	**$1,042**		**$9,859**	**1**	**$0**	**1**
Bone Marrow Donor Registry	$499		$3,229		$3,229	
Salaries and Expenses	22,155		22,187		19,687	
Bone Marrow Donor Registry - Total	**$22,654**	**5**	**$25,416**	**5**	**$22,916**	**5**
Trauma/Emergency Medical Services	$1,843		$1,813		$0	
Salaries and Expenses	1,598		1,606		0	
Trauma/Emergency Medical Services - Total	**$3,441**	**1**	**$3,419**	**1**	**$0**	**0**
State Planning Grant Program	$13,830		$9,916		$0	
Salaries and Expenses	975		994		0	
State Planning Grant Program - Total	**$14,805**	**4**	**$10,910**	**4**	**$0**	**0**
Poison Control Centers	$19,956		$19,754		$19,754	
Salaries and Expenses	3,722		3,745		3,547	
Poison Control Centers - Total	**$23,678**	**3**	**$23,499**	**3**	**$23,301**	**3**
Healthcare Systems Bureau - Subtotal	$49,888		$57,080		$36,541	
Salaries and Expenses	40,348		40,436		32,958	
Healthcare Systems Bureau Total	**$90,236**	**13**	**$97,516**	**14**	**$69,499**	**9**

Salaries and Expenses by Program Line Item

PROGRAM	FY 2004 Adjusted Appropriaton	FTE	FY 2005 Revised Appropriation	FTE	FY 2006 President's Budget	FTE
RURAL HEALTH:						
Rural Health Policy Development	$6,574		$6,497		$6,497	
Salaries and Expenses	2,328		2,328		2,031	
Rural Health Policy Development - Total	**$8,902**		**$8,825**		**$8,528**	
Rural Health Outreach Grants	$35,114		$34,801		$9,540	
Salaries and Expenses	4,477		4,477		1,227	
Rural Health Outreach Grants - Total	**$39,591**		**$39,278**		**$10,767**	
Rural and Community Access to Emergency Devices	$10,166		$8,160		$1,792	
Salaries and Expenses	767		767		168	
Rural and Community Access to Emergency Devices - Total	**$10,933**	**2**	**$8,927**	**2**	**$1,960**	**2**
Rural Hospital Flexibility Grants	$38,142		$37,828		$0	
Salaries and Expenses	1,352		1,352		0	
Rural Hospital Flexibility Grants - Total	**$39,494**		**$39,180**		**$0**	
Rural EMS	$391		$386		$0	
Salaries and Expenses	106		110		0	
Rural EMS - Total	**$497**	**1**	**$496**	**1**	**$0**	**0**
State Offices of Rural Health	$8,013		$7,949		$7,949	
Salaries and Expenses	372		372		274	
State Offices of Rural Health - Total	**$8,385**		**$8,321**		**$8,223**	
Denali Project	$0		$0			
Salaries and Expenses	34,793		39,680		0	
Denali Project - Total	**$34,793**		**$39,680**		**$0**	
RURAL HEALTH - Subtotal	$98,400		$95,621		$25,778	
Salaries and Expenses	44,195		49,086		3,700	
RURAL HEALTH - Total	**$142,595**	**3**	**$144,707**	**3**	**$29,478**	**2**
Health Facilities Construction and Other Misc. Projects	$360,819		$477,989		$0	
Salaries and Expenses	4,526		4,740		0	
Health Care Facilities Construction and Other Projects - Total	**$365,345**	**11**	**$482,729**	**12**	**$0**	**0**
Program Management	$15,562		$10,647		$9,737	
Salaries and Expenses	132,960		136,433		136,255	
Program Management - Total	**$148,522**	**1,186**	**$147,080**	**1,229**	**$145,992**	**1,229**
Family Planning	$261,730		$269,591		$269,966	
Salaries and Expenses	15,776		16,372		16,372	
Family Planning - Total	**$277,506**	**46**	**$285,963**	**49**	**$286,338**	**49**
HRS Discretionary Budget Authority - Subtotal	$6,125,003		$6,361,320		$5,617,626	
Salaries and Expenses	447,616		441,694		348,893	
HRS Discretionary Budget Authority - Total	**$6,572,619**	**1,550**	**$6,803,014**	**1,630**	**$5,966,519**	**1,598**

HEALTH RESOURCES AND SERVICES ADMINISTRATION

SIGNIFICANT ITEMS IN HOUSE, SENATE AND CONFERENCE APPROPRIATIONS COMMITTEE REPORTS

The following section represents FY 2005 Congressional requirements for reports and significant items derived from House Report 108-636, Senate Report 108-345, and Conference Report 108-792

FY 2005 House Appropriations Committee Report Language (House Report 108-636)

Item 82

School-based health center initiative – The Committee is pleased with the success of the school-based health center initiative, but is concerned that in the last fiscal year only 3 of 43 applications were funded. The Committee expects HRSA to continue to target funds for school-based health centers operated by fully qualified organizations and expresses concern that school-based health centers often experience difficulty completing the complex application process for community health center funding. The Committee requests that HRSA establish a separate application process for school-based health centers that recognizes the distinct patient volume, productivity, scope of service, and staffing requirements that are more appropriate to school-based delivery systems. **(Page 22/23)**

Action taken or to be taken

HRSA will continue to make funding available for the operation and expansion of school-based health centers in FY 2005. Specific program parameters of school-based health centers have been addressed in the application guidance documents for grants administered under the President's Health Centers Initiative. In addition, HRSA supports training provided by the National Assembly on School Based Health Centers which provides training to address the challenges of delivering services to school-based populations. The number of children and their families served by School Based Health Center grantees increased from 45,000 in 1999 to 99,000, in 2003, nearly 100 percent.

Item 83

NHSC assignments – The Committee is pleased by the increasing proportion of NHSC assignees being placed at community, migrant, homeless, and public housing health centers. The Committee encourages HRSA to further expand this effort to ensure that the health center expansion effort has access to a sufficient level of health professionals through the NHSC. **(Page 23)**

Action taken or to be taken

The number of NHSC clinicians serving in health centers continues to increase. In FY 2003, 1,686 NHSC clinicians were serving in health centers, a 43 percent increase over FY 2001. While we understand that recruitment and retention are primarily dependent on local issues, the NHSC strives to support health center efforts to attract NHSC clinicians to serve in health centers

while fulfilling their obligations and to remain in service to the underserved after their obligations have been satisfied. This support includes the following:

- The NHSC stays in touch with our health center and State partners with regular electronic communications to assist them with recruitment and retention activities and to assure an understanding of NHSC policies, requirements and deadlines.
- NHSC scholars who are ready for placement and health center representatives are invited to an annual NHSC conference which includes job fair opportunities to facilitate hiring of NHSC scholars by the health centers.
- The NHSC presents and exhibits at health center conferences at the national, regional, and State level, whenever possible.
- Health centers are encouraged to include a profile with their vacancy announcements for the NHSC Opportunities List on the NHSC web site to provide detailed information designed to attract clinicians to their communities.
- A wealth of resources for communities are available on the web and health centers who post vacancies on the NHSC Opportunities List also receive a Tool Kit from NHSC to guide and improve recruitment and retention activities.

Item 84

Federally qualified health centers – The Committee is concerned that the current HPSA scoring process used by HRSA may disadvantage some health centers located in medically underserved areas of the country. The Committee encourages HRSA to consider using alternative data to score Federally qualified health centers under the automatic designation process. **(Page 24)**

Action taken or to be taken

During the past year, HRSA developed facility HPSA scores for all automatically-designated Health Centers, FQHC look-alikes, RHCs and IHS or tribal sites that are consistent with the HPSA-scoring process already in place for geographic and population group HPSAs, using nationally-available data for the Primary Care Service Areas containing these facilities, and facility-specific data available from information systems (e.g., UDS) on the facilities themselves. The results are available on the web at http://bhpr.hrsa.gov/shortage/autoscore.htm. As a result, all these facilities now have non-zero HPSA scores that can be used for NHSC purposes. If a facility believes that it can improve its score significantly by submitting local data, HRSA has an existing process to accommodate such requests.

Item 85

Treatment for patients with rare diseases – The Committee is concerned that too few clinics and physicians are prepared to treat patients with rare diseases. Therefore, the Committee encourages HRSA to include "treatment of patients with rare diseases" and "training of health professionals to recognize and treat patients with rare diseases" as priority areas in its selection of health professions training grants. **(Page 24)**

Action taken or to be taken

A rare disease (also called an orphan disease) is a disease or condition affecting fewer than 200,000 persons in the United States. An estimated 25 million people in the United States have a

rare disease, including about 10 percent of the overall Medicare population. The geriatric training programs administered by the Bureau of Health Professions (BHPr) train health professionals to respond to the needs of patients who have any one of the more than 6,000 rare diseases known today, including any conditions that result from exposure to agents used in bioterrorism. Consistent treatment of patients with rare diseases is an important goal, and geriatric education and training programs along with needed research can provide an essential component of delivering quality care.

Also, the BHPr training programs in family medicine, internal medicine, pediatrics, physician assistants, pediatric dentistry, general dentistry, geropsychology and podiatry include training students, residents, fellows and faculty members to recognize and address the needs of persons living with rare diseases, although this is not specifically mandated. The Children's Hospital Graduate Medical Education Program funds 60 children's hospitals nationally which provide the majority of training of pediatric residents and subspecialists who care for children living with rare diseases.

Lastly, the training of health professionals to recognize and treat patients with rare diseases can fall under the growing field of genetics. The Division of Nursing has been in the forefront in supporting genetics nursing initiatives and projects under the Advanced Education Nursing Program and the Basic Nurse Education and Practice Program/Nurse Education, Practice and Retention Program.

Item 86

Minority health professions – The Committee encourages HRSA to give priority consideration to awarding grants to those institutions with a historic mission of training minorities in the health professions. The Committee encourages the program to consider applications that are responsive to allied health professions that are experiencing shortages and high vacancy rates, such as laboratory personnel. **(Page 25)**

Action taken or to be taken

There are a total of seven Historically Black Colleges and Universities funded under Section 736(b) of the Public Health Service Act, Centers of Excellence (COE) Program. Schools of allied health are not eligible to apply for COE funding.

The Health Careers Opportunity Program (HCOP) recognizes the role allied health providers play in the quality and accessibility of health care. Currently, HCOP provides $9,810,630 in grant funds to 29 programs to prepare and train allied health professionals, including laboratory personnel. These grantees consist of community colleges and schools of allied health sciences.

In an effort to assure that allied health programs receive fair and equitable access to HCOP resources, the Division of Health Careers Diversity and Development (DHCDD) has consistently involved and retained significant participation of Deans, professors, and administrators from various allied health professions schools, community colleges and community based organizations

in its peer review meetings. During the FY 2004 HCOP Peer Review, 15 reviewers out of 60 total reviewers, or 25 percent were from organizations directly involved with the training of allied health professionals.

Under Section 755 of the Public Health Service Act, Allied Health and other Disciplines, the BHPr will continue to encourage applications for allied health training grants from schools training allied health professionals experiencing shortages, such as medical technologists and related technologist professions. The Department of Labor projects that by the year 2005, there will be four million new jobs that will be added to the health care field. A majority of these new jobs will be for a variety of the 200 plus different allied health professional categories, including medical technologists. In addition, the allied health training grants continue to be responsive to local and State health professions needs.

Item 87

Pediatric dental residency programs – Recruitment and retention of pediatric dental educators is vital to pediatric dental residency programs. While pediatric dentists treat about 30 percent of the children in this country, they train 100 percent of the dentists who treat children. The Committee encourages HRSA to develop innovative programs, such as faculty development initiatives and a faculty loan repayment pilot program.
(Page 26)

Action taken or to be taken

In 2003 there were 283 vacant dental faculty positions in the over 50 U.S. dental schools. Surveys by the American Dental Association and the American Dental Education Association also indicate that as much as 25 percent of currently practicing dentists (and faculty) will retire in coming years. An initiative to include faculty development in the residency training program in general and pediatric dentistry has addressed this crisis.

Item 88

Area health education centers – The program supports two types of projects: (1) basic/core AHEC cooperative agreement projects to plan and implement new and developing programs; and (2) model programs to extend AHEC cooperative agreement projects, with not less than 50 percent of the project costs supported by non-Federal monetary contributions. The Committee encourages AHEC programs to coordinate with the rural health outreach program for the greater effectiveness of both programs. **(Page 26)**

Action taken or to be taken

The HRSA will continue to encourage collaboration between the Office of Rural Health Policy (ORHP) and the Bureau of Health Professions in the preparation of application guidances for new awards. For example: insert language in application guidances to promote collaboration and linkages of programming among AHEC awardees and ORHP Rural Outreach Program awardees; set up meetings of the Federal staff in both programs to discuss the development of joint technical assistance efforts for AHEC and ORHP awardees. This joint effort will help to identify States in which AHEC and ORHP awardee best practices exist, and identify States in which technical assistance could be provided to increase collaboration; encourage joint technical assistance site

visits to ORHP Rural Outreach Program awardees and AHEC awardees which would enhance coordination of outreach to rural populations and AHEC community-based training of health professions students and rural health providers; and, participation-presentations by Federal staff in the annual meeting of awardees of each program to provide a better understanding of specific objectives and mutual goals of both programs.

Item 89

Training of allied health professionals – The Committee continues to encourage HRSA to give priority consideration to projects for schools training allied health professionals experiencing shortages, such as medical technologists and cytotechnologists. The Committee is concerned about high vacancy rates for these laboratory personnel and urges HRSA to redouble efforts to address these shortages. **(Page 27)**

Action taken or to be taken

The Bureau of Health Professions will continue to encourage applications for allied health training grants from schools training allied health professionals experiencing shortages, such as medical technologists and related technologist professions. The Department of Labor projects that by the year 2005, there will be four million new jobs that will be added to the health care field. A majority of these new health care jobs will be for a variety of the 200 plus different allied health professional categories, including the medical technologist category. In addition, the allied health training grants continue to be responsive to local and State health professions needs.

Specifically, 37 percent of all grants awarded under the allied health grant authority since 1990 have been to medical technology, cytotechnology, histotechnology, and clinical laboratory science training programs. This success is due in part to the Bureau staff who provide technical assistance to medical technology programs at the university and community college levels and who provide grant writing workshops at professional association meeting.

Item 90

Geriatric programs - The Committee is concerned that there is an insufficient number of health care providers trained to address the health care needs of the growing older population. With only a small number of new physicians going into the field and those already in the field approaching retirement age, incentives are needed to increase the number of academic geriatricians to competently train health professionals from a variety of disciplines, including geriatric medicine. The Committee believes that to meet the needs of an aging population, HRSA needs to improve the training of all health professionals in geriatrics. **(Page 27/28)**

Action taken or to be taken

The Census Bureau estimates that by the year 2030, one-fifth of our population, or 69 million people, will be more than 65 years old with 8.5 million 85 and older. In the next 50 years, the population over age 85 will increase fivefold, to 19 million. The HRSA has identified geriatrics as an area that has significant implications for the future of health care in this country. The Bureau of Health Professions (BHPr) administers three geriatric programs: Geriatric Education and Training Centers (GECs); Geriatric Training Program for Physicians, Dentists, and Behavioral and Mental Health Professionals; and Geriatric Academic Career Awards (GACA).

The goal of these programs is to improve access to health care for America's elderly by training health professional in geriatrics who may come from a variety of health disciplines.

In FY 2004, the BHPr funded 94 GACAs to support the development of newly trained geriatric physicians as academic geriatricians whose primary focus is teaching geriatrics. Finally, in FY 2004, the Bureau supported thirteen five-year awards to medical schools under the Geriatric Training for Physicians, Dentists, and Behavioral and Mental Health Professionals Program. These institutional training grants provide one-year and two-year fellowships to already trained professionals to focus on additional training in geriatrics.

Item 91

Newborn screening – The Committee is aware of the wide disparity that exists between state newborn screening programs that can result in children suffering irreversible injury or death versus children receiving successful diagnosis and treatment, depending upon whether their state tests for certain disorders. The Committee encourages HRSA to work with States to facilitate the development of educational materials that inform parents and health care providers of the benefits of newborn screening, about which conditions are screened for in their state, and about options to have babies screened for additional conditions that are not covered by their state programs. **(Page 32)**

Action taken or to be taken

MCHB, HRSA worked with parents and the American Academy of Pediatrics, American College of Obstetrics and Gynecology and the American Academy of Family Physicians to develop educational materials for parents and providers, particularly prenatal care providers. These materials are in preparation for pilot testing with the above professional organizations. In addition, MCHB/HRSA sent a letter to State Newborn Screening Program Directors, the State Health Officials and the Maternal and Child Health Directors to encourage the development of educational materials that inform parents about newborn screening and about the option to have additional routine screening tests that the State newborn screening program might not offer, performed on their infant.

Item 92

Advisory Committee – The Committee commends the department on the establishment of the Advisory Committee on Heritable Disorders and Genetic Diseases in Newborns and Children and the appointment by the Secretary of fifteen members. The Committee urges the advisory committee to work promptly in order to provide States with valuable guidance and recommendations regarding newborn screening. **(Page 32)**

Action taken or to be taken

The Advisory Committee on Heritable Disorders and Genetic Diseases in Newborns and Children (the Committee) met June 7-8, 2004 and September 22-23, 2004 and will meet again January 2005. In its first two meeting, the Committee has primarily focused on reviewing newborn screening programs and priority issues for these programs. The Committee also reviewed a draft report to HRSA/MCHB from the American College of Medical Genetics (ACMG) to analyze the scientific literature and gather expert opinion to examine the available information concerning the

scope of newborn screening programs and anticipated future directions, including the delineation of the best evidence for screening specified conditions and develop a set of recommendations based on this best evidence. ACMG presented the report to the Committee and the Committee voted to accept the report and forward it to the Secretary of the Department of Health and Human Services.

Item 93

Newborn screening – It has come to the Committee's attention that NIH has developed a technology to screen newborns for severe combined immune deficiency disease (SCID). The Committee commends the work that the Advisory Committee on Heritable Disorders and Newborn Screening under HRSA is doing in developing a list of recommended diseases to be screened for at birth. Since SCID is a pediatric emergency that can now be detected at birth and successfully treated, and is fatal without immediate diagnosis and treatment, the Committee recommends that the Advisory Committee include SCID newborn screening in its list of recommended newborn screening tests. **(Page 32)**

Action taken or to be taken

The Advisory Committee on Heritable Disorders and Genetic Diseases in Newborns and Children (the Committee) did meet and reviewed a draft report from the American College of Medical Genetics (ACMG) on the evidence for and against screening for specific disorders, including SCID. That report, which the Committee reviewed and adopted, indicated that the current methodology available for screening for SCID was not appropriate for screening newborns in a population-based program. It had not been pilot tested within a research protocol to evaluate its clinical utility and validity and cost-effectiveness within a US population.

Item 94

Hemophilia treatment centers --The Committee continues to recognize the critical role of the national network of hemophilia treatment centers in providing needed comprehensive care for bleeding disorders and urges HRSA to strengthen resources for the centers to ensure continued access to this model disease management network. **(Page 33)**

Action taken or to be taken

MCHB, HRSA also recognizes the critical role of the hemophilia treatment centers in the prevention and treatment of the complications of hemophilia and other clotting disorders. HRSA has spent $5.3 million per year to fund HRSA's National Hemophilia Program. The program works to strengthen these centers. The needs assessment that was conducted during FY 2004 provided information on many areas to strengthen, such as family participation within the governing body of the regional centers. These are being addressed within the grant guidance requirements for this fiscal year.

Item 95

Sudden Infant Death Syndrome (SIDS) – The Committee commends HRSA for its support of the Sudden Infant Death Syndrome (SIDS) program support center and encourages the Maternal and Child Health Bureau to continue its efforts in this area of service. The Committee is pleased

that the SIDS and Other Infant Death Support Center is collaborating with the National Institutes of Health to address the disproportionately high incidence of SIDS among African Americans. **(Page 33)**

Action taken or to be taken

HRSA has supported the National Sudden Infant Death Syndrome Program Support Center (NSIDPSC) for the past seven years with the NSIDPSC continuing to expand its activities. In FY 2005, the NSIDPSC Cooperative Agreement will be competed for another five year project period. In the Center's ongoing effort to reduce the racial disparity in SIDS rates between Blacks and Whites, they are working with the National African American Sorority, Zeta Phi Beta (ZPB). More specifically, the NSIDPSC is working with the ZPB Stork's Nest program training their program staff to teach SIDS risk reduction practices to the Black pregnant women served by the ZPB Stork's Nest program. This effort is being done in collaboration with both the National Institute of Child and Human Development and the National Center for Cultural Competency's SIDS/ID Component. Another ongoing activity of the Center is the implementation of a nurses' education project on SIDS risk reduction and bereavement services with Continuing Education credits available for participants. This effort is designed to improve the quality of these services received in hospitals and community clinics.

Item 96

Treatment centers for thalassemia patients – The Committee restates its long-standing interest in the support that MCHB has provided to comprehensive treatment centers for thalassemia patients under the SPANS program and notes that the current funding is due to expire in FY05. The Committee encourages MCHB to continue this program and to coordinate its activities with relevant voluntary health organizations. **(Page 33)**

Action taken or to be taken

MCHB/HRSA acknowledges the critical role of the three thalassemia centers that MCHB/HRSA funds in providing comprehensive services to patients and families and intends to continue support for the three centers. In FY 2003, the Bureau awarded three year grants to the three centers; these grants will continue in FY 2005. It is the intention of MCHB/HRSA to maintain a close working relationship with the centers and the Cooley's Anemia Foundation.

Item 97

Provider's Partnership program – The Committee recognizes the contributions of the long-standing Provider's Partnership program. The Partnership includes a series of state-level projects initiated to address female psychosocial issues. The morbidity and mortality attributed to these issues such as a woman's depression, tobacco use, substance abuse and domestic violence are becoming increasingly apparent. Obstetrician-gynecologists can play a critical role in addressing these problems within their current practice, however because of their complexity, and the importance of promptly linking at-risk women with appropriate services, responsibility for full psychosocial assessment and treatment cannot fall solely to obstetrician-gynecologists. Partnerships between these women's health care providers and community programs are needed that allow for integration of medical care with psychosocial services. The Committee encourages continued funding of the Provider's Partnership program.

Since 1990, the Maternal and Child Health Bureau has worked in cooperative agreement to run the National Fetal Infant Mortality Review (NFIMR) program. NFIMR provides training and assistance to enhance cooperative partnerships among local community health professionals, public health officers, community advocates and consumers to reduce infant mortality. The goal is to improve local services and resources for women, infants and families, to remove barriers to care, and to ensure culturally appropriate, family friendly services. Such efforts are crucial to understanding and addressing infant health disparities in communities at highest risk. The Committee encourages HRSA to continue to use Healthy Start funds to support the NFIMR project. **(Page 33)**

Action taken or to be taken

MCHB/HRSA is no longer funding the Provider Partnership Program with the American College of Obstetricians and Gynecologists (ACOG). However, when the Federal funding ended last year, ACOG was able to sustain the position of the former project director and she continues many of the activities started under the Federal funding. The focus of activities remains on state-level projects to address psychosocial issues affecting women, with a particular emphasis on postpartum depression and maternal smoking cessation. In addition, in FY 2004 the Safe Motherhood Federal Workgroup, a collaboration with DHHS Office on Women's Health, FDA, CDC, NIH, SAMHSA, and AHRQ convened the National Perinatal Depression Collaborators Meeting with several national organizations attending including ACOG.

At the end of the meeting, the Perinatal Depression Steering Committee was formed to develop and execute a plan that identifies collaborative initiatives for the partnership to be carried out through subcommittees and to facilitate communication and coordination of efforts between stakeholder organizations. This group is headed by the former director of the HRSA/MCHB Provider Partnership at ACOG and will be working with many national organizations also interested in the problem of postpartum depression, including Postpartum Support International, National Perinatal Association, Society for Maternal-Fetal Medicine), Depression and Bipolar Support Alliance, and the American College of Nurse-Midwives.

In addition, the MCHB continues to fund the NFIMR Resource Center. The Resource Center works closely with Healthy Start sites, local health departments, and state MCH to strengthen Fetal and Infant Mortality Review programs nationally. The current cooperative agreement is funded through June 30, 2005 using Healthy Start funds. In FY 2005 there is an open competition to recompete the NFIMR Resource Center. Funds have been reduced from $400,000 to $300,000 for this competition.

Item 98

Dental disease – The Committee encourages ACF's Head Start Bureau and the Maternal and Child Health Bureau to continue and expand their successful interagency agreement to jointly address dental disease, the number one unmet health need of Head Start children. This partnership has brought together Head Start and the dental community at the national, state and local levels to seek solutions to improve access to oral health care for these children through the public and private sectors. **(Page 33)**

Action taken or to be taken

MCHB within HRSA continues to implement and expand the Intra-Agency Agreement with ACF's Head Start Bureau (HSB) addressing Head Start and Early Head Start (HS/EHS) children's access to oral health services, their number one unmet health need. Oral health expertise and leadership to Head Start Regions have been expanded from 4 to 8 regions and it is anticipated that limited expertise will be available to 3 additional Head Start Regional Offices within the next year. Should there be augmentation of the agreement, limited oral health expertise needed for each of Head Start's 12 regions will be provided to work with Federal, State and local stakeholders to build access mechanisms for HS/EHS children.

MCHB and HSB have brought together Head Start programs, public and private dental communities, Medicaid programs, academia and others through Regional and State Oral Health Forums to develop recommendations and strategy plans necessary for implementation in addressing the preventive and clinical oral health needs of HS/EHS children. The statewide problem solving fostered by these forums assists States in developing broad based collaboration between policy makers, the private practice dental community, state health programs, safety net providers, Medicaid/SCHIP and consumers. In those States where partnerships have not been formed, MCHB will continue to encourage collaboration and convene State Head Start Oral Health Forums through a cooperative agreement with the Association of State and Territorial Dental Directors.

To raise public and professional awareness of HS/EHS oral health needs, MCHB will partner with the American Dental Association, American Academy of Pediatric Dentists, American Dental Hygienists Association and other provider organizations that impact on the oral health needs of HS/EHS children. To support Head Start oral health activity at the local level, MCHB will continue to enhance relationships between Head Start State Collaboration Offices and State Dental Programs. The MCHB Oral Health Resource Center will serve as a support system for the Head Start Learning Center to gather, assess, adapt and develop information materials, and identify promising practices to assist Head Start grantees to address their prevention, early intervention and access to dental services needs.

MCHB oral health program has integrated Head Start into its ongoing grant programs to States and communities, academic institutions and provider organizations. These grant programs include Oral Health Integrated Systems Development, State Oral Health Collaborative Systems, and Healthy Tomorrows Partnership for Children.

Item 99

Organ transplantation – The Committee is encouraged by the initial success of the organ donation collaborative project. This project is focused on the Nation's largest hospitals and has adopted the goal of assisting these hospitals achieve organ donation rates of 75% or higher, which will result in at least 6,000 additional organs available for transplantation. The Committee also encourages HRSA to consider adopting a national system of simultaneous referrals of available organs as opposed to the current system of sequential or serial referrals, as this will further guarantee that all available organs are utilized. **(Page 34)**

Action taken or to be taken

The first phase of the Organ Donation Breakthrough Collaborative was completed in September 2004. During this phase, the nation experienced an unprecedented 10.3% increase in the number of organ donors over the same time the previous year. Hospitals participating in the Collaborative demonstrated 14% donation increases. This remarkable donation increase resulted in nearly 600 additional transplants being performed in just the first half of 2004. This is a remarkable accomplishment given that annual transplant increases over the past 10 years have been as small as 33 and only as large as 200-300.

The unprecedented success of this initiative has generated a second phase which includes 189 hospitals (6 international hospitals from Canada) and 52 OPOs (2 international OPOs from Canada). All phase 1 and phase 2 hospitals are now linked via an internet-based knowledge management system which permits rapid dissemination and implementation of effective donation practices.

The Collaborative leadership team is also embarking on an initiative to raise the national average of organs recovered and transplant from each donor from 3.14 to 3.75 by disseminating effective practices utilized by high performing OPOs. When the impact of this new initiative is fully realized, it is estimated that an additional 4,000 organs annually will be made available for transplant.

Improving National System to Speed Placement of Organs. The Department is working with the United Network for Organ Sharing (UNOS), the contractor for the Organ Procurement and Transplantation Network (OPTN) and the organ transplantation and donation community to identify enhancements to the national organ allocation system to speed the placement of organs. To better understand the scope of the issues involved in achieving this objective, UNOS and the Association of Organ Procurement Organizations (AOPO) sponsored a technology summit, involving all interested parties including software vendors, in December 2004 to explore options to leverage computer and communications technology. It is anticipated that the solutions to meeting this objective will be multifaceted and must accommodate the diverse computer and communication capabilities of organ procurement organizations and transplant hospitals and maintain the integrity of the organ placement system. Leveraging technology to improve the efficiency and effectiveness of the transplant system will be a major performance objective in the new contract to operate the OPTN, which will be competed in calendar year 2005. In addition to the activities involving the OPTN, the Division of Transplantation will initiate a new grant program in FY 2005 to provide resources to organ procurement organizations and donor hospitals to establish and improve computer and communication systems to facilitate the work of organ donation coordinators to rapidly place organs and to increase the number of organs placed from each donor.

Item 100

Organ transplantation – The Committee also encourages HRSA to continue to support studies and demonstration projects to increase and maximize organ donation and recovery rates, including living donation. **(Page 34)**

Action taken or to be taken
HRSA will continue to support studies and demonstration projects to better understand what works to increase the number of organ donors and number of organs made available for transplant. HRSA also will continue to use of the *Best Practices Breakthrough Collaborative* process to rapidly identify and replicate effective organ donation practices throughout the organ donation and transplant community. This *Collaborative* process has proven to be a highly cost effective approach to making significant increases in the number of organs made available for transplantation. In addition, HRSA will be initiating a new demonstration grant program to evaluate effective approaches to implementing the new 'reimbursement of travel and subsistence expenses incurred towards living donation' grant authority provided by the Organ Donation and Recovery Improvement Act (PL 108-216).

Item 101
Organ transplantation – The Committee encourages the Division of Transplantation to enhance its partnership with the pulmonary hypertension (PH) community aimed at increasing awareness about the need for increased heart and lung donations. The Committee is aware that the Organ Procurement and Transplantation Network/United Network for Organ Sharing has issued a proposed rule governing the allocation of lungs for transplantation. The Committee encourages OPTN/UNOS to work with the PH community to address its concerns regarding the methodology used to determine transplantation eligibility for PH patients. **(Page 34/35)**

Action taken or to be taken
The Division has and will continue to meet with major medical associations to develop joint approaches for educating the professional medical community about organ donation. The Division will leverage the new authorities provided in the Organ Donation and Recovery Improvement Act, as resources permit, to develop and disseminate educational material and to develop and implement other strategies to strengthen this relationship.

The previous use of waiting time clearly worked to the advantage of patients with slowly-progressive disease who could be placed on the waiting list at a relatively early stage of their disease, and who could then accumulate much waiting time without great risk. This situation led to the disadvantage of patients with a rapidly-progressive disease, who did not have the option of accumulating waiting time. The patient with the highest survival benefit will be harmed most by being denied the organ and, therefore, should be given priority. To address this and other serious deficiencies in the lung allocation system, the OPTN, with the assistance of the Scientific Registry of Transplant Recipients, has developed a methodology that attempts to identify the individuals patients who are most likely to be harmed by a delay in receiving a transplant and to give them priority in the allocation of the organ.

Dr. Tom Egan, chairperson of the OPTN/UNOS Lung Allocation Subcommittee, has reached out to patient advocacy groups to discuss and allay concerns regarding recent revisions to lung allocation policy. Similarly, proactive efforts to identify and include kidney patient advocacy groups in the effort to update the Nation's kidney allocation policies are already underway.

The Division of Transplantation agrees with the need to increase heart and lung donations and accomplishing this will be principle focus of its initiative to raise the national average of organs recovered and transplant from each donor from 3.14 to 3.75 by disseminating effective practices utilized by high performing OPOs. When the impact of this new initiative is fully realized, it is estimated that an additional 4,000 organs annually will be made available for transplant.

Item 102

National Marrow Donor Program (NMDP) – The Committee urges the NMDP to continue innovative, technological, and scientific advances in non-embryonic cell therapies that have the potential to help some of the hundreds of thousands of Americans with leukemia or other life threatening blood diseases. The Committee also strongly encourages the NMDP to continue the enhancement of the Registry through its umbilical cord blood program. In addition, the Committee supports the NMDP's important role in conducting and supporting research to improve the availability, efficiency, safety, and cost of transplants and the effectiveness of Registry operations; maintaining and expanding its medical emergency contingency response capabilities for our nation's national security; and increasing donor and patient outreach programs, especially for minorities and medically underserved population groups. **(Page 35)**

Action taken or to be taken

The Health Resources and Services Administration (HRSA) has been working with the National Marrow Donor Program (NMDP), contractor for the National Bone Marrow Donor Registry (Registry), to ensure that the Registry continues to make progress in increasing the number of adult volunteer donors willing to donate blood stem cells to patients who are diagnoses\d with leukemia or other life threatening blood disorders and who lack a suitably tissue-matched relative. To provide more comparable access to unrelated transplants for patients from minority populations, the Registry remains committed to recruiting donors from every racial and ethnic group, with a focus on minority volunteer donors. In addition, as research has shown the effectiveness of transplants using umbilical cord blood for patients who cannot find a suitably matched adult donor, the Registry has greatly expanded its cord blood program. The Registry currently lists 40,400 cord blood units, which represents about half of the approximately 80,000 units available in the national inventory. The additional funds in the FY 2005 budget will allow the Registry to increase the number of patients receiving life-saving transplants, from both adult volunteers and umbilical cord units.

The Registry will strengthen its efforts to improve donor availability and increase donor and patient outreach programs, especially for minorities and those from medically underserved populations. These efforts will include informing potential donors of the importance of keeping addressed up-to-date and notifying the Registry if they experience a change in health status and/or interest. FY 2005 funds will allow the Registry to continue to support staff devoted to both patient and donor advocacy services. The Office of Donor Advocacy will help donors make an informed decision about the donation process and assist donors in receiving compensation, from their employers, for time spent away from work for the donation process. The Office of Patient Advocacy will continue its special outreach initiatives to identify patients living in zip codes designated as medically underserved and offer one-on-one assistance to attempt to eliminate barriers to transplant. The Registry will continue to offer monetary assistance, known as bridge

funding, for patients awaiting final approval for the transplant from their insurers, so the search for a donor can proceed without delays that could jeopardize the transplant outcome. Donor and patient safety always have been vital concerns of the Registry, addressed among other ways through an active Donor and Patient Safety Monitoring Committee.

The Registry will conduct and support research to improve the availability, efficiency, safety, and cost of transplants and the overall effectiveness of Registry operations. The facilitation of Registry research to improve transplant outcomes has increased substantially over the past three years. Most significantly, in partnership with the Medical College of Wisconsin's International Bone Marrow Transplant Registry (IBMTR, the preeminent research organization in the field), the NMDP created in 2004 a new Center for International Blood and Marrow Transplant Research (CIBMTR). The CIBMTR will strengthen the Registry's ability to facilitate retrospective research and prospective clinical trials aimed at improving transplant outcomes and quality of life for patients who receive blood stem cell transplants. As did the IBMTR, the CIBMTR will apply to traditional funders of research, such as the National Institutes of Health, to carry out its more expensive research.

The CIBMTR also will conduct health services research which will, among other things, examine the cost of, and financial access to, transplants. The Registry's Office of Patient Advocacy has three staff members devoted to payor policy issues, who educate insurers about blood stem cell transplantation, particularly the importance of adequate coverage for a donor search and the differences in cost between an autologous, related and unrelated donor transplants. This education includes roundtable discussions and teleconferences with payors regarding the unique financial barriers facing patients who need an unrelated blood stem cell transplant.

HRSA has worked with the Registry and the Navy to enhance the ability of the Registry to respond to an emergency involving exposure to radiation or certain chemical agents in which some casualties will have temporary or permanent bone marrow failure. Activities included planning for various scenarios, training transplant center and donor center personnel in their roles in an emergency, establishing a core network of eight major transplant centers across the U.S. who will play lead roles in the response to an emergency, and conducting limited drills. The NMDP also has conducted successful pilot tests of very rapid donor selection and donation to be able to meet the short time-frames for transplant that may be required for some casualties, and has incorporated the lessons from these pilots into routine donor searches.

FY 2005 funding will allow for some expansion of the Registry's medical emergency planning. In FY 2005, the Registry will work with the international association of blood stem cell transplant physicians to develop consensus triage and treatment protocols for mass exposures to radiation, and to educate the relevant medical communities about these protocols. In addition, the NMDP will continue to develop relationships with national and stat emergency response organizations to clarify the role of the Registry and its affiliated transplant centers in providing guidance about treatment of casualties, including where they should be taken for treatment. The Registry will continue to develop ways to decrease search times, to better meet the needs of those casualties who may require emergency transplants.

Item 103

Ryan White AIDS programs – The Committee's allocation among the various titles of the Ryan White program reflect the high priority the Committee places on providing resources for the AIDS drug assistance program. . . . The Committee is aware that, for a number of eligible metropolitan areas, the amount of their supplemental grant under title I of the Ryan White CARE Act has fluctuated markedly from year to year, thereby disrupting ongoing programs and services. Accordingly, the Committee directs HRSA to review the processes it uses to evaluate applications and award supplemental grants and to take appropriate steps to reduce such fluctuations and disruptions. **(Page 38)**

Action taken or to be taken

HRSA is aware of the difficulties faced by the fluctuations in the Title I grant awards to Eligible Metropolitan Areas (EMAs). Several factors contribute to this issue: 1) The appropriation levels for Title I over the past 5 years have not changed significantly. 2) At least 50% of the available funding is awarded as a formula grant defined in statute. The proportionate formula uses Estimated Living Cases of AIDS which are calculated by applying survival weights, also defined in statute and revised every two years, to ten years of reported AIDS cases in the EMAs. Amounts from the remaining 50% of the available Title I funding are also used to meet statutory "hold harmless" requirements. 3) The remaining available Title I funds are awarded as supplemental grants and are based on an EMAs demonstrated need as part of the EMAs application. There is variability from year to year and this can affect a specific EMAs supplementary award amount. 4)This award also includes amounts identified in Congressional Appropriation Reports for Minority AIDS Initiatives. These amounts are calculated using the number of non-white AIDS cases in the EMA during the previous two calender years.

Congress is expected to address reauthorization of the CARE Act this fiscal year and this provides opportunity to review this issue. At the same time, we would hope that the EMAs also assess, and where necessary, restructure, how they are delivering health care to individuals with HIV/AIDS.

Item 104

Community Health Centers – The Committee recognizes the important role community health centers play in terrorism preparedness and response. The Committee is concerned that despite their inclusion in the Department's state plan guidance, community health centers and regional primary care associations have not been fully included in the state and local decision-making process and in the allocation of preparedness resources. The Committee urges the Secretary to examine ways of ensuring that recipients of State and Local Preparedness funds include community health centers and their associated regional organizations are included in both preparedness planning and in resource allocation decisions. **(Page 150)**

Action taken or to be taken

HRSA encourages Health Centers to work with local and State healthcare organizations on the development of integrated emergency response/preparedness plans. Health Centers are required to submit information regarding their efforts in this area in their annual applications. Applicants are asked to address their efforts to coordinate with State and local organizations. Grantees also address their integration into the local/regional emergency plan, along with local, county, or State

disaster response contact information. The Health Center's ability to communicate both internally and externally in a disaster is also addressed.

HRSA encourages Health Centers to gain accreditation by an external accrediting organization. Currently there are 291 HRSA-funded Health Centers that are accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO). All Health Centers accredited by JCAHO must have a formal written emergency preparedness plan that includes components of the above and, in order to maintain accreditation, their plans must be tested annually.

FY 2005 Senate Appropriations Committee Report Language (Senate Report 108-345)

Item 105

Waivers – The Committee urges HRSA to consider waivers for rural or isolated area demonstration projects when calculating requirements such as population density in the State of Hawaii. **(Page 35)**

Action taken or to be taken

HRSA has established a Frontier Workgroup, led by the Office of Rural Health Policy, that is in the process of reviewing rural definitions, as well as considering input from Frontier Education Center, National Rural Health Association, the Western Governors Association, and other organizations.

Item 106

Community Health Centers – The Committee is concerned that Federal community health center funds are often not available to small, remote communities in Alaska, Hawaii and other similar States because the population base is too small. Many of these communities have no health service providers and residents are forced to travel long distances by boat or plane even in emergency situations. The Committee continues to support the administration's effort to double community health center funding to address the growing number of uninsured persons in this country, but, without new approaches to providing health services, many will not benefit from the proposed increases in funding. The Committee recommends that HRSA examine its regulations and applications procedures to ensure they are not unduly burdensome and are appropriately flexible to meet the needs of these communities. The Committee applauds the agency for its initiatives such as the "Alaska Frontier Health Plan" and encourages the agency to continue and expand its efforts with this program. **(Page 36/37)**

Action taken or to be taken

HRSA understands the special challenges that remote locations face in the application process. The FY 2005 application guidance documents have been developed to include a special consideration for sparsely populated areas in the administration of the grant opportunities supported by the President's Health Center Initiative. Health Centers served approximately 64,500 patients in Alaska in 2003, 10 percent of the States' population.

Item 107

Community Health Centers – The Committee strongly urges such collaborations. In addition, the Committee understands that telemedicine technology is often used to maximize resources and collaborative communication, and encourages increased use of these technologies. The Committee applauds HRSA for the continued work that has been done to reexamine regulations and to create an on-line grant application process. **(Page 37)**

Action taken or to be taken

HRSA will continue to encourage applicants to use technologies to maximize resources and take advantage of collaborative communication in the provision of primary health care. HRSA will

also continue to evaluate and improve the online grant application process, and encourage grantees to take advantage of these technologies as well.

Item 108

Community Health Centers – Recognizing that NMHCs are frequently the only source of health care to their patients and that a lack of clinical education sites for nurses is a contributing factor to the nationwide nursing shortage, the Committee encourages HRSA to provide alternative means to secure cost-based reimbursement for NMHCs, by providing that reimbursement or by granting university-based CHCs. In addition, the Committee urges HRSA to research the effectiveness of nurse-managed health centers as a national model to reduce health disparities. **(Page 37)**

Action taken or to be taken

HRSA recognizes that nurse-managed Health Centers are an important element in improving the overall access to care for the Nation's underserved populations. NMHC's are eligible to apply for the New Access Point program and the Federally Qualified Health Center Look-alike program, both of which allow for the receipt of enhanced Medicaid reimbursement and Medicare.

Item 109

Community Health Centers – The Committee appreciates the attention paid by the HRSA Administrator to the special health care needs of Native Hawaiians and the medically underserved, especially to those living on the "neighbor islands" of Hawaii. The diverse, rural and underserved Native Hawaiian populations of the island of Molokai face challenges in obtaining comprehensive primary care and prevention interventions. Drug abuse prevention among youth is particularly difficult to obtain. The Committee urges HRSA to provide technical assistance in the preparation and submission of grants for new community health centers to the community health leaders of Molokai, Lanai, and all other underserved areas of the country. The Committee believes that linking new centers to existing health care programs and facilities is an efficient use of resources. **(Page 37)**

Action taken or to be taken

In FY 2005, HRSA plans to continue to invest resources into the provision of technical assistance to communities interested in expanding access to primary health care services through the development of new or expanded health center sites. It is our intent to continue providing technical assistance through existing relationships with State-based primary care associations to all interested communities, including those in Molokai, Lanai, and the other underserved areas of Hawaii.

Item 110

Community Health Centers – Congress recognized the need to provide mental and behavioral health services to the underserved through the Federal Community Health Centers in the Safety Net Legislation of 2001. The Committee encourages HRSA to expand its efforts to provide mental and behavioral health services by increasing the number of psychologists in Community Health Centers nationwide. **(Page 37/38)**

Action taken or to be taken

HRSA views mental and behavioral health services as integral to the overall provision of primary health care by Health Centers nationwide. The Health Center program recognizes the importance of mental health and substance abuse services by supporting expansion of those services through the President's Health Center Initiative. This support has led to an increase in the percentage of Centers that provide mental health and substance abuse services either on site or by paid referral - from 66 percent in 2001 to 74 percent in 2003.

Item 111

Community Health Centers – An estimated 80 million people have a potentially blinding eye disease, 3 million have low vision, 1.1 million are legally blind, and 200,000 are more severely visually impaired. While it is believed that half of all blindness can be prevented, the number of Americans who suffer vision loss continues to increase. To address this growing problem, the Committee urges the Administrator to strengthen the vision health services at community health centers by establishing partnerships with voluntary health organizations to improve the overall quality of eye care, including comprehensive vision screenings and appropriate follow up care. **(Page 38)**

Action taken or to be taken

HRSA recognizes the importance of comprehensive vision screenings and follow-up care. In 2003, 99 percent of Health Centers provided vision screening either directly or by referral, 96 percent provided optometry services directly or by referral and 97 percent provided dilated eye exams for people with diabetes directly or by referral. In order to strengthen the vision services at Health Centers, HRSA has met with several organizations to explore potential partnerships. HRSA has continued its partnership with the National Association of Community Health Centers (NACHC). Under the cooperative agreement with HRSA, NACHC has partnered with Sight for Students which has resulted in Health Centers having access to free vision screening and glasses for children. NACHC is also exploring partnerships with other organizations concerned with vision services. Recently, HRSA has increased its collaboration with NIH's National Eye Institute particularly in the areas of diabetic retinopathy and vision services for underserved people.

Item 112

School-Based Health Centers – The Committee expects HRSA to continue to target funds for school-based health centers operated by fully qualified organizations and expresses concern that school-based health centers often experience difficulty completing the complex application process for community health center funding. The Committee requests that HRSA establish a separate application process for school-based health centers that recognizes the distinct patient volume, productivity, scope of service, and staffing requirements that are more appropriate to school-based delivery systems. **(Page 38/39)**

Action taken or to be taken

HRSA will continue to make funding available for the operation and expansion of school-based health centers in FY 2005. Specific program parameters of school-based health centers have been addressed in the application guidance documents for grants administered under the President's Health Centers Initiative.

Item 113

Free Clinics Medical Malpractice Coverage – The Committee urges HRSA to create a deeming process as quickly as possible to ensure that health professionals treating patients at free clinics have access to this coverage in a timely manner. HRSA should make every effort to make the deeming process as efficient as possible and to prevent the process from becoming a barrier to use of the program. **(Page 39)**

Action taken or to be taken

HRSA has created a deeming process for the Free Clinics FTCA Medical Malpractice Program. Guidance on the deeming process was published on September 24, 2004, and HRSA has established a designated email account and phone line so that free clinics and eligible health professionals may easily obtain information on the program. The first application was received on December 8, 2004. To date, a total of four applications have been received. Per the relevant authorizing legislation, HRSA will make deeming decisions within 30 days of receipt of a complete application. We fully expect to meet the 30-day deadline for the initial applications.

Item 114

Health Care Access for the Uninsured/Community Access Program – Community Health Centers have the potential to serve as a valuable resource in biomedical and behavioral research aimed at reducing health status disparities among minority and medically underserved populations. The Committee continues to encourage HRSA, through the Community Access Program, to prioritize the establishment of demonstration projects between Community Health Centers and minority health professions schools for the purpose of health status disparities research and data collection. **(Page 40)**

Action taken or to be taken

In October 2002, the Healthy Communities Access Program (HCAP) was authorized. Within this legislation, there was a provision for a "Demonstration Authority" to make awards available to historically black health professions schools for the purposes of 1) developing patient-based research infrastructure at historically black health professions schools which have an affiliation or affiliations with any of the providers identified in the HCAP legislation, 2) establishment of joint and collaborative programs of medical research and data collection between historically black health professions schools and such providers, whose goal is to improve the health status of medically underserved populations; or 3) supporting the research-related costs of patient care, data collection, and academic training resulting from such affiliations.

In FY 2004, a guidance was issued to invite applications for funding under the HCAP Demonstration Program. Five applications were received and four were selected for funding and are currently implementing their activities:

Charles Drew University, Los Angeles, California, $802,305
Morehouse School of Medicine, Atlanta, Georgia, $933,118
Meharry Medical College, Nashville, Tennessee, $782,397
Hampton University, Hampton, Virginia, $706,762

The four "HCAP Demo" grantees are eligible to apply for continuation funding in FY 2005. The continuation guidance will be issued later this month. There will not be a competition for new funds this fiscal year.

Item 115

National Health Service Corps: Field Placements – The Committee is pleased by the increasing percentage of placements of NHSC assignees at Community, Migrant, Homeless, and Public Housing Health Centers. The Committee encourages HRSA to further expand this effort to ensure that the health center expansion effort is sustainable and has access to a sufficient level of health professionals. **(Page 41)**

Action taken or to be taken

The number of NHSC clinicians serving in health centers continues to increase. In FY 2003, 1,686 NHSC clinicians were serving in health centers, a 43 percent increase over FY 2001. While we understand that recruitment and retention are primarily dependent on local issues, the NHSC strives to support health center efforts to attract NHSC clinicians to serve in health centers while fulfilling their obligations and to remain in service to the underserved after their obligations have been satisfied. This support includes the following:

- The NHSC stays in touch with our health center and State partners with regular electronic communications to assist them with recruitment and retention activities and to assure an understanding of NHSC policies, requirements and deadlines.
- NHSC scholars who are ready for placement and health center representatives are invited to an annual NHSC conference which includes job fair opportunities to facilitate hiring of NHSC scholars by the health centers.
- The NHSC presents and exhibits at health center conferences at the national, regional, and State level, whenever possible.
- Health centers are encouraged to include a profile with their vacancy announcements for the NHSC Opportunities List on the NHSC web site to provide detailed information designed to attract clinicians to their communities.
- A wealth of resources for communities are available on the web and health centers who post vacancies on the NHSC Opportunities List also receive a Tool Kit from NHSC to guide and improve recruitment and retention activities.

Item 116

National Health Service Corps: Field Placements – The Committee is concerned by reports that the current HPSA scoring process used by HRSA may be disadvantaging many health centers located in medically underserved areas of the country. The Committee urges HRSA to look into these reports and reconsider requirements that might eliminate health centers from eligibility for the placement of NHSC scholars, Ready Responders, and HHS' J-1 Visa waiver program. **(Page 41)**

Action taken or to be taken

The NHSC is directed by statute to place clinicians in Health Professional Shortage Areas (HPSAs) of greatest need. In addition, the law limits the scholar Opportunities List to not less

than one site per available scholar and not more than two sites per scholar. These requirements result in an Opportunities List for scholars that include sites with the greatest need, many of which are health centers. However, during the last two years loan repayment awards have been made to every complete and eligible applicant for loan repayment, including those who wish to serve in sites with lower HPSA scores. The preponderance of NHSC recruitment funding is reserved for loan repayment to get as many fully trained clinicians into service in underserved areas as soon as possible. This focus on loan repayment has minimized any disadvantage a health center may experience as a result of HPSA scoring.

Item 117

National Health Service Corps: Recruitment – The Committee commends the National Health Service Corps for its focus on ensuring a workforce for integrated, comprehensive health care for the underserved that includes mental and behavioral health services. The Committee urges the NHSC to continue its efforts, increase the number of psychologists in the Loan Repayment Program and begin, for the first time, to support psychology students in the Scholarship Program. **(Page 42)**

Action taken or to be taken

The mental/behavioral health focus of the NHSC has increased in recent years. The NHSC began a series of summits around the country several years ago. These regional meetings were designed to assist States in developing action plans to integrate mental/behavioral health with primary health care services. In FY 2004, the series of summits was completed, allowing every State and territory the opportunity to develop a plan for integration of mental/behavioral health services. In addition, the number of mental/behavioral health clinicians in the NHSC field strength has increased. The most recent data indicate that a total of 645 mental/behavioral health clinicians are serving under the NHSC. This represents nearly 18 percent of the NHSC field strength. In 1998, mental/behavioral health clinicians comprised less than 5 percent of the NHSC field strength. The most recent data indicate that about a third of the mental/behavioral health clinicians currently serving in the NHSC are health service psychologists. The loan repayment program has proven to be a successful method in meeting community need for psychology services because it provides fully trained clinicians to underserved communities as soon as possible.

Item 118

National Health Service Corps: Recruitment – The national nursing shortage is pervasive throughout all of the varied practice, educational and research settings. The United States Public Health Commissioned Corps is a critical aspect of our Nation's public health infrastructure and will be relied upon to respond to a terrorist or bioterrorist event. With the passage of the Nurse Reinvestment Act in 2002, a National Nurse Corps grant program was established. Coupled with the National Health Service Corps, the new National Nurse Corps program may serve as a nurse recruiting pool for the Commissioned Corps. The Committee urges HRSA to establish mechanisms to encourage National Nurse Corps grant recipients to enter the Public Health Service Commissioned Corps. **(Page 42)**

Action taken or to be taken
Both the Nursing Education Loan Repayment Program (NELRP) and the Nursing Scholarship Program (NSP) offer potential recruitment opportunities for the PHS Commissioned Corps.

The NELRP has an excellent opportunity to recruit nurses into the Commissioned Corps since the many recipients of loan repayment agreements are already providing clinical services as registered nurses, whereas the NSP has the majority of its scholars in school. Any efforts to recruit nurses into the Commissioned Corps can be done as an information piece to scholars and loan repayment recipients, and should include the Office of Commissioned Corps Operations, since they are currently recruiting for all disciplines and know the service sites with job openings.

Since inception of the NSP in FY 2002, the Program has provided scholarships to just over 200 exceptionally needy undergraduate nursing students. Currently, 18 former scholars are providing clinical service in health care facilities with critical shortage of nurses. Although scholars are allowed to select service sites from among 11 types of facilities, the program provides information to graduates (three months before graduation) about eligible service sites and encourages them to seek employment opportunities with the Commissioned Corps of the U.S. Public Health Service.

Item 119
Health Careers Opportunity Program – For fiscal year 2005, the Committee encourages HRSA to give priority consideration to awarding grants to those institutions with a historic mission of training minorities in the health professions. **(Page 43)**

Action taken or to be taken
Section 739 of the Public Health Service Act provides a funding preference for applicants that utilize a comprehensive approach. The comprehensive approach incorporates a network of formal partnerships working in a coordinated effort within a specific geographic area. These formal partnerships will address the problems and barriers that prevent disadvantaged students from entering and graduating from the health and allied health professions schools. Applicants receiving this preference will be placed in a more competitive position. In FY 2005, HRSA will provide two specialized Technical Assistance Workshops for Historically Black Colleges and Universities (HBCUs), Hispanic Serving Institutions (HSIs), and Tribal Colleges and Universities (TCUs) across the United States. These workshops are designed to teach minority serving institutions how to meet the comprehensive preference and how to become more competitive for HCOP funding. It will provide a detailed overview of the guidelines for the HCOP, "hands-on" grant writing techniques, and successful HCOP grant recipients will serve as mentors. In FY 2004, 14 HBCUs, 8 Hispanic Serving Health Professions Schools, 6, HSIs, and 2 TCUs were funded for a total of $12 million.

Item 120
Pediatric Rheumatology Study – The Committee commends HRSA for its continuing efforts to address the growing gap between the size of the Nation's aging baby boom population and the number of pulmonary/critical care physicians. The committee understands that HRSA is still developing a report on the healthcare workforce shortage issue, and that the portion of the report that will attempt to identify the causes of, and potential responses to, the critical care workforce

shortage will be informed, in part, by The Critical Care Medicine Crisis: A Call For Federal Action prepared by the American College of Chest Physicians [ACCP] and the members of the Critical Care Workforce Partnership. The Committee continues to encourage HRSA to address the critical care workforce shortage issue and use the pulmonary/critical care specialty as a model for developing and testing policy approaches to address workforce shortage issues. The Committee previously asked HRSA to complete a national study on the status of pediatric rheumatology in the United States. The Committee urges HRSA to conclude its research in this area in partnership with the Arthritis Foundation. As provided in the Children's Health Act of 2000, this study assesses the current pediatric services shortage and identifies strategies for addressing this significant shortage for children with arthritis.
(Page 42/43)

Action taken or to be taken
Incorporation of important new information in this rapidly evolving field of medicine and the expansion of the Critical Care Report to adequately address intensivist practice in the U.S. has caused delays in finishing the Report. We expect to have the final version of the Report by January 30, 2005. The Report must then be internally reviewed and transmitted through appropriate channels prior to public release

Item 121
Allied Health and Other Disciplines – The Committee continues to encourage HRSA to give priority consideration to projects for schools training allied health professionals experiencing shortages, such as medical technologists and cytotechnologists. The Committee is concerned about high vacancy rates for these critical laboratory personnel and urges HRSA to redouble efforts to address these shortages. **(Page 45)**

Action taken or to be taken
The Bureau of Health Professions will continue to encourage applications for allied health training grants from schools training allied health professionals experiencing shortages, such as medical technologists and related technologist professions. The Department of Labor projects that by the year 2005, there will be four million new jobs that will be added to the health care field. A majority of these new health care jobs will be for a variety of the 200 plus different allied health professional categories, including the medical technologist category. In addition, the allied health training grants continue to be responsive to local and State health professions' needs.

Specifically, 37 percent of all grants awarded under the allied health grant authority since 1990 have been to medical technology, cytotechnology, histotechnology, and clinical laboratory science training programs. This success is due in part to the Bureau staff who provide technical assistance to medical technology programs at the university and community college levels and provide grant writing workshops at professional association meeting.

Item 122
Geriatric Education Centers and Training – This program supports grants to health professions schools to establish geriatric education centers and to support geriatric training projects. These centers and geriatric training programs play a vital role in enhancing the skill-base of health care

professionals to care for our Nation's growing elderly population. The Committee is concerned about the shortage of trained geriatricians and urges the agency to give priority to building the workforce necessary to care for the Nation's elderly. **(Page 46)**

Action taken or to be taken

The Census Bureau estimates that by the year 2030, one-fifth of our population, or 69 million people, will be more than 65 years old with 8.5 million 85 and older. In the next 50 years, the population over age 85 will increase fivefold, to 19 million. The HRSA has identified geriatrics as an area that has significant implications for the future of health care in this country. The Bureau of Health Professions (BHPr) administers three geriatric programs: Geriatric Education and Training Centers (GECs); Geriatric Training Program for Physicians, Dentists, and Behavioral and Mental Health Professionals; and Geriatric Academic Career Awards (GACA). The goal of these programs is to improve access to health care for America's elderly by training health professional in geriatrics who may come from a variety of health disciplines.

Item 123

Quentin N. Burdick Program for Rural Health Interdisciplinary Training – This program continues to be an important mechanism for addressing the shortages of health professionals in rural areas. Particularly commendable is the focus on rural health training projects that stimulate interdisciplinary practice and expose students to the unique needs of rural populations. The Committee encourages an emphasis on telemedicine technology to maximize accessibility to resources. The Committee remains concerned about the critical shortage of nurses and this should continue to be addressed at every opportunity. **(Page 46)**

Action taken or to be taken

In FY 2004, the Bureau of Health Professions (BHPr) funded 23 grants (18 continuation grants and 5 new grants) in the Quentin N. Burdick Program for Rural Interdisciplinary Training. All of the Burdick supported educational programs use computers and web-based learning. Three grantees use distance learning methodologies as specific tools of the projects. Eighteen grantees educate and train undergraduate and/or graduate nurses in the rural training programs.

Item 124

Nursing Workforce Development Programs – The Committee recognizes that the current nursing shortage has reached a crisis state across America. The situation only promises to worsen due to a lack of young nurses in the profession, an aging existing workforce, and inadequate availability of nursing faculty to prepare future nurses. The Committee urges HRSA to support programs aimed at increasing nursing faculty and encouraging a diverse population's entry into nursing. **(Page 48)**

Action taken or to be taken

Faculty development initiatives continue to be supported under the Advanced Education Nursing and the Nurse Education, Practice and Retention grant programs; and financial support for students to become faculty is available under the Nurse Faculty Loan Program. Under the Advanced Education Nursing grant program, support for faculty development is available for all projects and has been instrumental in the development of nursing faculty for both the academic and clinical settings over the years. Currently, 18 projects specifically address the preparation of

nursing faculty at the master's level and an additional 14 projects support doctoral preparation. Under the Nurse Education, Practice and Retention grant program, 4 geriatric nursing faculty development projects address the need for faculty to prepare the nursing workforce to care for the growing aging population. Under the Nurse Faculty Loan Program, 69 schools of nursing currently have agreements with HRSA to establish and operate student loan funds in which loans up to $30,000 per year for up to five years to cover the cost of tuition, fees and other reasonable educational expenses are available for nurses enrolled full-time in graduate nursing programs to prepare them as faculty. A loan cancellation provision for up to 85 percent of the loan and interest is available for individuals working as full-time faculty in a school of nursing for four years.

In addition to improving the diversity of the nursing workforce through the Nursing Workforce Diversity Program, the Division of Nursing carries out other activities to promote diversity and cultural competence. It provides grants for the development of continuing education programs and courses to teach nurses about cultural competence and foster theses competencies. The Division also requires that all applicants submitting grants for educational programs address how the projects will recruit students from underrepresented minority and disadvantaged backgrounds, as well as prepare graduates who will provide culturally competent and appropriate care. The applicants are evaluated based on their response through review criteria. As a result, virtually all the programs funded by the Division of Nursing foster diversity and cultural competence.

Item 125

Nursing Workforce Development Programs – The Committee is aware of the Labor Department's partnership with the Council for Adult and Experimental Learning [CAEL] to address the Nation's shortage of nurses. The Committee encourages HRSA to consider extending and expanding these, and other, successful nurse training partnerships. **(Page 48)**

Action taken or to be taken

The HRSA Division of Nursing staff have met with Department of Labor and the Council for Adult and Experimental Learning staff to learn about their activities and programs to address the shortage of nurses. Technical assistance regarding the Title VIII nursing legislation has been provided to key staff of the Council for Adult and Experimental Learning (CAEL). The CAEL Program is expected to submit an application for the current 2005 cycle of the Nursing Education Practice and Retention program which includes a career ladder component. The HRSA and DOL are planning to meet to explore ways in which their respective programs could work together to create an educational continuum to address the nursing shortage.

Item 126

Advanced Education Nursing – With spiraling health care costs and the shortage of professionals, the need to prepare quality, cost effective providers such as nurse practitioners and nurse mid-wives continues to be acute. The Committee understands that Nurse Practitioners have been shown to provide high quality, cost effective care in whatever geographic environment they practice. The Committee believes that it is important to prepare enough of these providers to meet health needs within the current national shortages. The Committee urges HRSA to maximize advanced education traineeships for these two proven critical specialties. **(Page 48)**

Action taken or to be taken

Nurse practitioners and nurse-midwives are very effective primary care providers who have demonstrated their ability to provide quality, affordable, cost-effective primary care services. Traineeship funds are distributed to schools of nursing under a formula based on the number of students and graduates and two statutory funding factors designed to give more funds to schools with graduates working in health professional shortage areas or in settings that will substantially benefit rural or underserved populations, or help meet public health needs in State or local health departments.

Item 127

Nursing Workforce Diversity – The Committee urges the Division of Nursing to develop and increase cultural competence in nursing and to increase the number of underrepresented racial and ethnic minorities in all areas of nursing education and practice to enhance nurses' ability to provide quality health care services to the increasingly diverse community it serves. **(Page 49)**

Action taken or to be taken

In addition to improving the diversity of the nursing workforce through the Nursing Workforce Diversity Program, the Division of Nursing carries out other activities to promote diversity and cultural competence. It provides grants for the development of continuing education programs and courses to teach nurses about cultural competence and fosters these competencies. The Division also requires that all applicants submitting grants for educational programs to address how the projects will recruit students from underrepresented minority and disadvantaged backgrounds, as well as prepare graduates who will provide culturally competent and appropriate care. The applicants are evaluated based on their response through review criteria. As a result, virtually all the programs funded by the Division of Nursing foster diversity and cultural competence.

Item 128

Nursing Workforce Diversity – The Committee recognizes that recent layoffs have disproportionately impacted minority workers, and that nursing recruitment efforts may naturally find emphasis among this population. The Committee believes that increasing the ethnic and cultural competence of nursing and other health professions groups is critical to decreasing the health disparities of this Nation. The Committee encourages HRSA to partner with professional nursing organizations to create diversity leadership programming and training as well as recruiting, retaining and mentoring minority nurses in both the nursing profession and in leadership positions within the profession. These partnerships should focus on the goal of providing more culturally relevant health care so as to decrease the national infant mortality rate. **(Page 49)**

Action taken or to be taken

The Division of Nursing has a long standing relationship with the professional nursing organizations to create diversity leadership programming and training. The Division convened three national minority congresses which included representatives from all nursing professional organizations to get advice and recommendations on how to increase diversity in nursing and requested participants to implement these recommendations in their own settings and

organizations. The National Advisory Council on Nursing Education and Practice focused several meetings on this subject and published an action agenda to increase diversity in nursing and in the area of leadership. The NACNEP publication is one of the most widely circulated publications and used by the nursing organizations to identify and implement strategies to increase diversity. HRSA has also partnered with some of the minority organizations to provide summer internships for health professional students, including nurses in Federal offices. The Division of Nursing has supported a contract to evaluate the highly successful ANA Ethnic Minority Fellowship Program in order to learn the reasons for its success and promote these strategies in future efforts. In addition, the Title VIII legislation provides grants for educational programs to enhance diversity in the workforce, increase the numbers of racial ethnic minorities entering nursing and support the education of nurses to provide culturally competent care.

Item 129

Nurse Faculty Loan Program – The Committee understands that in 2003, nursing programs turned away more than 16,000 potential students due to a lack of faculty, clinical sites, and classroom space. The Committee cites the Bureau of Labor Statistics projected need for 1.1 million new and replacement RNs by the year 2012. With the growing demand for health services and the care provided by an essential nursing workforce, the Committee urges HRSA to focus funding and efforts on resolving the growing shortage of faculty necessary to educate the future nursing workforce. **(Page 49/50)**

Action taken or to be taken

Faculty development initiatives continue to be supported under the Advanced Education Nursing and the Nurse Education, Practice and Retention grant programs; and financial support for students to become faculty is available under the Nurse Faculty Loan Program. Under the Advanced Education Nursing grant program, support for faculty development is available for all projects and has been instrumental in the development of nursing faculty for both the academic and clinical settings over the years. Currently, 18 projects specifically address the preparation of nursing faculty at the master's level and an additional 14 projects support doctoral preparation. Under the Nurse Education, Practice and Retention grant program, 4 geriatric nursing faculty development projects address the need for faculty to prepare the nursing workforce to care for the growing aging population. Under the Nurse Faculty Loan Program, 69 schools of nursing currently have agreements with HRSA to establish and operate student loan funds in which loans up to $30,000 per year for up to five years to cover the cost of tuition, fees and other reasonable educational expenses are available for nurses enrolled full-time in graduate nursing programs to prepare them as faculty. A loan cancellation provision for up to 85 percent of the loan and interest is available for individuals working as full-time faculty in a school of nursing for four years.

Item 130

Maternal and Child Health Block Grant – The Committee is aware of the extreme disparities that exist among State newborn screening programs for metabolic and genetic disorders. Parents and healthcare providers responsible for the care of newborns should be able to provide the best chance at a healthy start on life. For this reason, the Committee strongly urges HRSA to include as a requirement for funding a provision that parents be informed in writing of the availability of additional tests that may not be required under State law. **(Page 52)**

Action taken or to be taken

The newborn screening programs are organized under the auspices of State public health agencies' newborn screening programs. All infants are tested universally for certain genetic conditions such as hemoglobinopathies, metabolic disorders, hearing loss and other congenital conditions. HRSA/MCHB recognizes that physicians and advanced practice nurses are dually charged to ensure appropriate care for newborns, as well as properly educate patients and their families on related health care issues. We are creating model materials for families and for health care professionals to provide information about newborn screening to those with the primary responsibility for prenatal health care, labor and delivery services (obstetricians, family practice physicians and nurse midwives). In addition, HRSA/MCHB sent a letter encouraging all state health officials, maternal and child health directors, and newborn screening program coordinators to facilitate the development of educational materials to inform parents of the newborn screening program and what conditions are screened for in the state. The letter also encouraged the states to facilitate the development of educational materials that inform parents about the option to have their babies screened for additional conditions that could be routinely tested for in the newborn period.

MCHB, HRSA worked with parents and the American Academy of Pediatrics, American College of Obstetrics and Gynecology and the American Academy of Family Physicians to develop educational materials for parents and providers, particularly prenatal care providers. These materials are in preparation for pilot testing with the above professional organizations. In addition, MCHB/HRSA sent a letter to State Newborn Screening Program Directors, the State Health Officials and the Maternal and Child Health Directors to encourage the development of educational materials that inform parents about newborn screening and about the option to have additional routine screening tests that the State newborn screening program might not offer, performed on their infant.

Item 131

Maternal and Child Health Block Grant – The Committee commends the work of the Sudden Infant Death Syndrome Program Support Center, and encourages the Maternal and Child Health Bureau to continue its support of this important center. The Committee is pleased with the collaboration between the NIH and the SIDS and Other Infant Death Program Support Center to address the disproportionately high incidence of SIDS among African Americans. **(Page 53)**

Action taken or to be taken

HRSA has supported the National Sudden Infant Death Syndrome Program Support Center (NSIDPSC) for the past seven years with the NSIDPSC continuing to expand its activities. In FY 2005, the NSIDPSC Cooperative Agreement will be competed for another five year project period. In the Center's ongoing effort to reduce the racial disparity in SIDS rates between Blacks and Whites, they are working with the National African American Sorority, Zeta Phi Beta (ZPB). More specifically, the NSIDPSC is working with the ZPB Stork's Nest program training their program staff to teach SIDS risk reduction practices to the Black pregnant women served by the ZPB Stork's Nest program. This effort is being done in collaboration with both the NICHD and the National Center for Cultural Competency's SIDS/ID Component. Another ongoing activity of the Center is the implementation of a nurses' education project on SIDS risk reduction and

bereavement services with Continuing Education credits available for participants. This effort is designed to improve the quality of these services received in hospitals and community clinics.

Item 132

Maternal and Child Health Block Grant – Chronic Fatigue Syndrome [CFS] patients' most crucial need is for effective, compassionate medical care. Through its demonstration grants program, HRSA has experience in piloting new, efficient ways of delivering health care services to those with emerging illnesses. The Committee encourages HRSA to develop model CFS clinical centers with the goal of delivering effective, multidisciplinary clinical care to persons with CFS. **(Page 53)**

Action taken or to be taken

Funding will not be allocated in FY 2005 to work with grantees to develop model clinical centers for Chronic Fatigue Syndrome.

Item 133

Maternal and Child Health Block Grant – The Committee recognizes the critical role that Maternal and Child Health Centers for Leadership in Pediatric Dentistry Education provide in preparing dentists with dual training in pediatric dentistry and dental public health. . . . The Committee encourages the Maternal and Child Health Bureau to extend this program to all regions. **(Page 53/54)**

Action taken or to be taken

Oral Health continues to be a pressing public health issue. To address this issue the MCHB/HRSA supports three Pediatric Dentistry leadership training programs in three different regions. MCHB was able to expand this program to a 3rd region in the last grant competition in FY 2002. Currently programs are located in Region IV at the University of North Carolina, in Region VII at the University of Iowa and in Region X at the University of Washington.

Item 134

Healthy Start Initiative – The Committee urges HRSA to give preference to current and former grantees with expiring or recently expired project periods. This should include grantees whose grant applications were approved but not funded during fiscal year 2004. **(Page 54)**

Action taken or to be taken

HRSA will provide a preference.

Item 135

Women, Infants, Children, and Youth--Title IV– The Committee expects HRSA to maximize available funds under this part to existing grantees. The Committee is concerned that instructions to HRSA regarding the analysis of data pertaining to administrative costs in title IV have not been followed. The Committee strongly urges HRSA to collaborate with grantees under this title to produce necessary tools for the accurate collection of expense data. Unless HRSA can produce data regarding administrative expenses with a precise definition to ensure accuracy and

comparability, the agency will be unable to impose a limitation on such expenses without harming the ability of grantees to provide services for women, children, youth and families infected with HIV. **(Page 57)**

Action taken or to be taken

HRSA has closely reviewed the data, as well as comments, pertaining to the issue of administrative costs in Title IV to ensure that it will not impede the ability of grantees to continue to provide services for women, children, youth and families infected with HIV. The Department expects to issue a final Notice concerning this issue during the current fiscal year.

Item 136

Organ Donation and Transplantation – The Committee is encouraged by the initial success of Organ Donation Collaborative project and has included funds for its continuation. This project is focused on the Nation's largest hospitals and has adopted the goal of assisting these hospitals achieve organ donation rates of 75 percent or higher, which will result in at least 6,000 additional organs available for transplantation. The Committee also urges the agency to facilitate the adoption of a national system of simultaneous referrals of available **organs as opposed to the** current system of sequential or serial referrals, as this will further guarantee that all available organs are utilized. (Page 58/59)

Action taken or to be taken

The first phase of the Organ Donation Breakthrough Collaborative was completed in September 2004. During this phase, the nation experienced an unprecedented 10.3% increase in the number of organ donors over the same time the previous year. Hospitals participating in the Collaborative demonstrated 14% donation increases. This remarkable donation increase resulted in nearly 600 additional transplants being performed in just the first half of 2004. This is a remarkable accomplishment given that annual transplant increases over the past 10 years have been as small as 33 and only as large as 200-300.

The unprecedented success of this initiative has generated a second phase which includes 189 hospitals (6 international hospitals from Canada) and 52 OPOs (2 international OPOs from Canada). All phase 1 and phase 2 hospitals are now linked via an internet-based knowledge management system which permits rapid dissemination and implementation of effective donation practices.

The Collaborative leadership team is also embarking on an initiative to raise the national average of organs recovered and transplant from each donor from 3.14 to 3.75 by disseminating effective practices utilized by high performing OPOs. When the impact of this new initiative is fully realized, it is estimated that an additional 4,000 organs annually will be made available for transplant.

The Department is working with the United Network for Organ Sharing (UNOS), the contractor for the Organ Procurement and Transplantation Network (OPTN) and the organ transplantation and donation community to identify enhancements to the national organ allocation system to speed the placement of organs. To better understand the scope of the issues involved in achieving

this objective, UNOS and the Association of Organ Procurement Organizations (AOPO) sponsored a technology summit, involving all interested parties including software vendors, in December 2004 to explore options to leverage computer and communications technology. It is anticipated that the solutions to meeting this objective will be multifaceted and must accommodate the diverse computer and communication capabilities of organ procurement organizations and transplant hospitals and maintain the integrity of the organ placement system. Leveraging technology to improve the efficiency and effectiveness of the transplant system will be a major performance objective in the new contract to operate the OPTN, which will be competed in calendar year 2005. In addition to the activities involving the OPTN, the Division of Transplantation will initiate a new grant program in FY 2005 to provide resources to organ procurement organizations and donor hospitals to establish and improve computer and communication systems to facilitate the work of organ donation coordinators to rapidly place organs and to increase the number of organs placed from each donor.

Item 137

Organ Donation and Transplantation – The Committee also urges an increase in grants or contracts to public and non-profit private entities for the purpose of carrying out studies and demonstration projects to increase and maximize organ donation and recovery rates, including living donation. **(Page 59)**

Action taken or to be taken

HRSA will continue to support studies and demonstration projects to better understand what works to increase the number of organ donors and number of organs made available for transplant. HRSA also will continue to use of the *Best Practices Breakthrough Collaborative* process to rapidly identify and replicate effective organ donation practices throughout the organ donation and transplant community. This *Collaborative* process has proven to be a highly cost effective approach to making significant increases in the number of organs made available for transplantation. In addition, HRSA will be initiating a new demonstration grant program to evaluate effective approaches to implementing the new 'reimbursement of travel and subsistence expenses incurred towards living donation' grant authority provided by the Organ Donation and Recovery Improvement Act (PL 108-216).

Item 138

Organ Donation and Transplantation – The Committee commends HRSA for its leadership in promoting increased organ and tissue donations across the nation and encourages the Division of Transplantation to continue its partnership with the pulmonary hypertension community in this important area. Moreover, the Committee is aware that the Organ Procurement and Transplantation Network/United Network for Organ Sharing has issued a proposed rule governing the allocation of lungs for transplantation. The Committee encourages OPTN/UNOS to work with the pulmonary hypertension community to address its concerns regarding the methodology used to determine transplantation eligibility for pulmonary hypertension patients. **(Page 59)**

Action taken or to be taken

The Division has and will continue to meet with major medical associations to develop joint approaches for educating the professional medical community about organ donation. The

Division will leverage the new authorities provided in the Organ Donation and Recovery Improvement Act, as resources permit, to develop and disseminate educational material and to develop and implement other strategies to strengthen this relationship.

The previous use of waiting time clearly worked to the advantage of patients with slowly-progressive disease who could be placed on the waiting list at a relatively early stage of their disease, and who could then accumulate much waiting time without great risk. This situation led to the disadvantage of patients with a rapidly-progressive disease, who did not have the option of accumulating waiting time. The patient with the highest survival benefit will be harmed most by being denied the organ and, therefore, should be given priority. To address this and other serious deficiencies in the lung allocation system, the OPTN, with the assistance of the Scientific Registry of Transplant Recipients, has developed a methodology that attempts to identify the individuals patients who are most likely to be harmed by a delay in receiving a transplant and to give them priority in the allocation of the organ.

Dr. Tom Egan, chairperson of the OPTN/UNOS Lung Allocation Subcommittee, has reached out to patient advocacy groups to discuss and allay concerns regarding recent revisions to lung allocation policy. Similarly, proactive efforts to identify and include kidney patient advocacy groups in the effort to update the Nation's kidney allocation policies are already underway.

The Division of Transplantation agrees with the need to increase heart and lung donations and accomplishing this will be principle focus of its initiative to raise the national average of organs recovered and transplant from each donor from 3.14 to 3.75 by disseminating effective practices utilized by high performing OPOs. When the impact of this new initiative is fully realized, it is estimated that an additional 4,000 organs annually will be made available for transplant.

Item 139

Family Planning – The Committee remains concerned that programs receiving title X funds ought to have access to these resources as quickly as possible. The Committee, therefore, again instructs the Department to distribute to the regional offices all of the funds available for family planning services no later than 60 days following enactment of this bill. **(Page 62)**

Action Taken or to be Taken

The Public Health Service Regional Offices will receive their funding distribution for Title X family planning services within 60 days following enactment of this bill. At least 90 percent of the funds appropriated for Title X activities will be distributed to service grantees for clinical services authorized under section 1001 of the Act. Additionally, any year-end funds will support section 1001 activities.

Item 140

Pharmacy Services – The Committee encourages the Department to begin a study on comprehensive pharmacy services in light of changes in technology, distance and distributive learning models, the aging of the population and the Department's study on the severe pharmacist shortage in order to analyze how they may influence the nature of pharmaceutical education and interventions in healthcare. **(Page 222)**

Action taken or to be taken

Beginning in February 2004, the Bureau began an evaluation of factors in pharmacy school faculty supply and demand leading to faculty shortages and an evaluation of policy options for reducing shortages. The National Center for Health Workforce Analysis completed a Shortage of Pharmacists study four years ago that resulted in the Report, The Pharmacist Workforce: A Study of the Supply and Demand for Pharmacists. Funding has not been made available to update this study because Federal funding has been directed to provide incentives to address two other workforce problems; more effective distribution of practitioners to care for underserved populations and more diverse race/ethnic composition of the health care workforce.

FY 2005 Conference Appropriations Committee Report Language (Conference Report 108-792)

Item 141

Sickle cell disease – The conference agreement includes $200,000 for grants to establish a demonstration program and a National Coordinating Center to develop systemic mechanisms for the prevention and treatment of sickle cell disease as authorized in Section 712 of Public Law 108-357. The Sickle Cell Demonstration Program is designed to improve and expand patient and provider education and the continuity and coordination of service delivery for individuals with sickle cell disease through grants to eligible entities as provided for in the legislation. The conferees encourage HRSA to work with patient and provider organizations to develop these programs and prepare a program plan for fiscal year 2006 within six months of enactment. **(Page 1154)**

Action taken or to be taken

HRSA/MCHB will be working with the Sickle Cell Disease Association of America and professional organizations such as the American Academy of Pediatrics, the American Academy of Family Physicians and the National Association of Community Health Centers to prepare a program plan for FY 2006.

Item 142

Nursing education – The conferees encourage HRSA to provide funding for baccalaureate-prepared registered nurses to obtain advanced nursing education (master's degrees) in psychiatric mental health nursing. The conferees further encourage HRSA to provide funding for post-masters certification training in psychiatric mental health nursing for masters-prepared nurses already trained in other specialties. **(Page 1156)**

Action taken or to be taken

The Division of Nursing through the Advanced Education Nursing Program supports programs to prepare nurses with advanced education in psychiatric mental health nursing. In FY 2004, 20 grants supported masters nurse practitioner programs to prepare nurse practitioners with expertise in psychiatric mental health and six grants supported the preparation of clinical nurse specialists in psych-mental health. Post masters certificate programs in psych-mental health for nurse practitioners and clinical nurse specialists have also been eligible for support since 1998. These programs are often associated with ongoing masters programs such as the one at Catholic University for a post masters certificate in psych-mental health with a focus on children. The Advanced Education Nursing Program initiative "Clinical Experience in Federally Funded Health Centers for Nurse Practitioners and/or Nurse Midwifery Students" funded 11 grants to provide primary care experiences in community based settings. Some of these grants specifically focused on clinical experiences in preventive mental health and/or substance abuse in the community.

Item 143

Mississippi River Delta region – The conferees continue to be concerned about the health care needs of those in the Mississippi River Delta region. The conferees provide $5,200,000 for rural health outreach to continue the ongoing initiative in eight States. These grants provide funding

and technical assistance to help underserved rural communities identify and better address their health care needs and to help small rural hospitals improve their financial and operational performance. The conferees further recommend that HRSA consult with the Delta Regional Authority and the Delta Health Alliance, given their ongoing relationships with communities in the Delta. **(Page 1156/1157)**

Action taken or to be taken

HRSA continues to support activities that address the health needs of those residing in the Mississippi River Delta region. In FY 2005, HRSA will award grants through the Delta States Rural Development Network Grant Program. This grant program supports rural health outreach in the eight States with Delta counties. In addition, the Agency continues to support the Delta Rural Hospital Improvement Program, which works with Delta hospitals to improve their financial, clinical and operational performance. Collaboration with the Delta Regional Authority and the Delta Health Alliance is ongoing.

Authorizing Legislation

	2005 Amount Authorized	2005 Final Appropriation	2006 Amount Authorized	2006 Budget Request
PRIMARY HEALTH CARE:				
Health Centers PHS Act, Section 330, as amended by P.L. 107-251, the Health Care Safety Net Amendments of 2002	SSAN	$1,689,671,000	SSAN	$1,992,871,000
Native Hawaiian Health Care Native Hawaiian Health Care Act of 1988 (P.L. 100-579), as amended by Section 9168 of P.L. 102-396	7/	1/	7/	1/
Health Center Tort Claims (Defense of Certain Malpractice and Negligence Suits) PHS Act, Section 224	1/	$44,640,000	1/	$45,000,000
Guarantee Level of Health Center Loans PHS Act, Section 330(d) / PHS Act, Sections 1601 and 1602	2/	2/	2/	1/
Free Clinic Medical Malpractice PHS Act, Section 224	8/	$99,000	8/	---
Radiogenic Diseases PHS Act, Section 417C(b) amended by P.L. 106-245	SSAN	$1,958,000	SSAN	$1,936,000
Healthy Communities Access Program PHS Act, Section 340, as amended by P.L. 107-251, the Health Care Safety Net Amendments of 2002	SSAN	$82,993,000	SSAN	---
National Hansen's Disease Program PHS Act, Section 320	Indefinite	$17,251,000	Indefinite	$16,066,000
Payment to Hawaii PHS Act, Section 320	Indefinite	$2,017,000	Indefinite	$2,016,000
Buildings and Facilities PHS Act, Section 320 and 321(a)	Indefinite	$247,000	Indefinite	$222,000
Black Lung Federal Mine Safety and Health Act, Section 427(a)	$10,000,000	$5,951,000	$10,000,000	$5,912,000

Authorizing Legislation

	2005 Amount Authorized	2005 Final Appropriation	2006 Amount Authorized	2006 Budget Request
HEALTH PROFESSIONS:				
Health Professions Training for Diversity: Scholarships for Disadvantaged Students PHS Act, Sections 737 and 740(a)	Expired 10/	$47,129,000	Expired 10/	$9,831,000
H. P. Workforce Information and Analysis PHS Act, Section 792	Indefinite	$716,000	Indefinite	$712,000
Education of Health Care Personnel Training PHS Act, Section 319F, as amended by P.L. 107-188, Section 105	Indefinite	($27,520,000) 9/ (non-add)	Indefinite	($27,521,000) (non-add)
Nursing Workforce Development:				
Advanced Education Nursing PHS Act, Section 811	Expired 10/	$58,160,000	Expired 10/	$42,806,000
Nursing Workforce Diversity PHS Act, Sections 821	Expired 10/	$16,270,000	Expired 10/	$21,244,000
Nurse Education, Practice and Retention Grants PHS Act, Sections 831	SSAN	$36,468,000	SSAN	$46,325,000
Nurse Faculty Loan Program PHS Act, Section 846A	SSAN	$4,831,000	SSAN	$4,821,000
Comprehensive Geriatric Education PHS Act, Section 855	SSAN	$3,450,000	SSAN	$3,426,000
Nursing Education Loan Repayment and Scholarship Program PHS Act, Section 846	SSAN	$31,482,000	SSAN	$31,369,000

Authorizing Legislation

	2005 Amount Authorized	2005 Final Appropriation	2006 Amount Authorized	2006 Budget Request
National Health Service Corps Field PHS Act, Sections 331-338	SSAN	$45,068,000	SSAN	$40,705,000
National Health Service Corps Recruitment PHS Act, Section 338A-H	SSAN	$86,380,000	SSAN	$86,091,000
State Loan Repayment PHS Act, Section 338I	SSAN	3/	SSAN	3/
Demonstration Project: Participation of Chiropractic Doctors and Pharmacists in LRP PHS Act, Section 338L, as amended by P.L. 107-251, Section 317	SSAN	3/	SSAN	3/
National Practitioner Data Bank (User Fees) Public Law 100-93, Section 5; Public Law 99-660, Section IV	Indefinite	($15,700,000) (non-add)	Indefinite	($15,700,000) (non-add)
Health Care Fraud and Abuse Data Collection Program (User Fees) Health Insurance Portability and Accountability Act of 1996, Sec. 221, Title II, Public Law 104-191	Indefinite	($4,000,000) (non-add)	Indefinite	($4,000,000) (non-add)
MATERNAL & CHILD HEALTH:				
Maternal and Child Health Block Grant Social Security Act, Title V	$850,000,000	$723,928,000	$850,000,000	$723,928,000
Traumatic Brain Injury Program PHS Act, Sections 1252 and 1253 as amended by the Children's Health Act of 2000 P.L. 106-310, Title XIII, Section 1304	SSAN	$9,297,000	SSAN	---
Healthy Start PHS Act, Section 330H as amended by the Children's Health Act of 2000 P.L. 106-310, Title XV, Section 1501 (a) - (d)	SSAN	$102,543,000	SSAN	$97,747,000
Emergency Medical Services for Children PHS Act, Section 1910	SSAN	$19,831,000	SSAN	---

Authorizing Legislation

	2005 Amount Authorized	2005 Final Appropriation	2006 Amount Authorized	2006 Budget Request
HIV/AIDS:				
Emergency Relief - Part A PHS Act, Sections 2601-07	SSAN	$610,094,000	SSAN	$610,094,000
Comprehensive Care - Part B PHS Act, Sections 2611-2628	SSAN	$1,121,836,000	SSAN	$1,131,836,000
AIDS Drug Assistance Program (Non-Add) PHS Act, Section 2618(b)(2)(H)	SSAN	($787,521,000) (non-add)	SSAN	($797,521,000) (non-add)
Early Intervention - Part C PHS Act, Sections 2651-2655	SSAN	$195,578,000	SSAN	$195,578,000
Coordinated Services and Access to Research for Women, Infants, Children and Youth - Part D PHS Act, Section 2671	SSAN	$72,519,000	SSAN	$72,519,000
Special Projects of National Significance - Part F PHS Act, Section 2691	SSAN	($25,000,000) 4/ (non-add)	SSAN	($25,000,000) (non-add)
Education and Training Centers - Part F II PHS Act, Section 2692(a)	SSAN	$35,051,000	SSAN	$35,051,000
AIDS Dental Services - Part F II PHS Act, Section 2692(b)	SSAN	$13,218,000	SSAN	$13,218,000
Telehealth PHS Act, Section 330I, as amended by P.L. 107-251, the Health Care Safety Net Amendments of 2002	SSAN	$3,916,000	SSAN	$3,888,000

Authorizing Legislation

	2005 Amount Authorized	2005 Final Appropriation	2006 Amount Authorized	2006 Budget Request
HEALTHCARE SYSTEMS				
Organ Transplantation PHS Act, Sections 371-378, as amended by the Organ Donation and Recovery Act.	Expired 5/	$24,414,000	Expired 5/	$23,282,000
Bone Marrow Donor Registry PHS Act, Section 379	SSAN	$25,416,000	SSAN	$22,916,000
National Cord Blood Stem Cell Bank	8/	$9,859,000	8/	---
Hospital Preparedness (Bioterrorism) PHS Act, Sections 319 and 319C-1, as amended by P.L. 107-188, Section 131(a)	Indefinite	($491,410,000) 9/ (non-add)	Indefinite	($457,979,000) (non-add)
Poison Control Centers		$23,499,000		$23,301,000
PHS Act, Section 1271, as amended by P.L. 108-194	$2,000,000		$2,000,000	
PHS Act, Section 1272, as amended by P.L. 108-194	$600,000		$600,000	
PHS Act, Section 1273, as amended by P.L. 108-194	$25,000,000		$27,500,000	
RURAL HEALTH:				
Rural Health Policy Development Social Security Act, Section 711	Indefinite	$8,825,000	Indefinite	$8,528,000
Rural Health Outreach Network Development and Small Health Care Provider Quality Improvement - PHS Act, Section 330A, as amended by P.L. 107-251, the Health Care Safety Net Amendments of 2002	SSAN	$39,278,000	SSAN	$10,767,000
Rural Access to Emergency Devices P.L. 106-505, Section 413	Expired 11/	$8,927,000 14/	Expired 11/	$1,960,000
State Offices of Rural Health PHS Act, Section 338J	Expired 10/	$8,321,000	Expired 10/	$8,223,000
Children's Hospitals Graduate Medical Education Program PHS Act, Section 340E	SSAN	$300,730,000	SSAN	$200,000,000
Program Management PHS Act, Section 301	Indefinite	$147,080,000	Indefinite	$145,992,000

Authorizing Legislation

	2005 Amount Authorized	2005 Final Appropriation	2006 Amount Authorized	2006 Budget Request
Family Planning		$285,963,000		$285,963,000
PHS Act, Section 1001, and	Expired 6/	Expired 6/	Expired 6/	
PHS Act, Section 301	Indefinite	Indefinite	Indefinite	
Unfunded Authorizations:				
Dental HPSAs: Grants for Innovative Programs PHS Act, Section 340G, as amended by P.L. 107-251, the Health Care Safety Net Amendments of 2002	$50,000,000 12/	$0	$50,000,000 12/	---
Coordinated Program to Improve Pediatric Oral Health, Section 320A of the PHS Act, as amended by the Children's Health Act, P.L. 106-310, Section 1603	$10,000,000	$0	$10,000,000	---
Health Professions Training for Diversity:				
Centers of Excellence PHS Act, Section 736	Expired 10/	$33,609,000	Expired 10/	---
Loan Repayments and Fellowships Regarding Faculty Positions PHS Act, Section 738	Expired 10/	$1,302,000	Expired 10/	---
Educational Assistance for Individuals from Disadvantaged Backgrounds PHS Act, Section 739	Expired 10/	$35,646,000	Expired 10/	---
Training in Primary Care Medicine and Dentistry PHS Act, Section 747	Expired 10/	$88,816,000	Expired 10/	---
Interdisciplinary, Community-Based Linkages:				
Area Health Education Centers PHS Act, Section 750, 751, and 757	Expired 10/	$28,971,000	Expired 10/	---
Health Education and Training Centers PHS Act, Sections 750, 752, and 757	Expired 10/	$3,819,000	Expired 10/	---
Education and Training Related to Geriatrics PHS Act, Sections 750, 753, and 757	Expired 10/	$31,548,000	Expired 10/	---

Authorizing Legislation

	2005 Amount Authorized	2005 Final Appropriation	2006 Amount Authorized	2006 Budget Request	
Quentin N. Burdick Program for Rural Interdisciplinary Training PHS Act, Sections 750, 754, 757	Expired 10/	$6,076,000	Expired 10/		---
Allied Health and Other Disciplines PHS Act, Sections 750, 755, and 757	Expired 10/	$11,753,000	Expired 10/		---
Public Health Workforce Development: Public Health/Preventive Medicine; Dental Public Health PHS Act, Sections 766, 767, 768, and 770	Expired 10/	$9,097,000	Expired 10/		---
Health Administration Traineeships and Special Projects PHS Act, Sections 851-PSAs	Expired 10/	$1,070,000	Expired 10/		---
State and Local Public Service Announcements PHS Act, Section 852	SSAN	$0	SSAN		---
Grants for Health Professions Education in Health Disparities and Cultural Compentency PHS Act, Section 741	SSAN	$0	Expired 13/		---
Grants for Health Professions Education (Nursing) PHS Act, Section 807	SSAN	$0	Expired 13/		---
Universal Newborn Hearing PHS Act, Section 399M as amended by the Children's Health Act of 2000, P.L. 106-310, Title VII, Section 702	Expired 10/	$9,792,000	Expired 10/		---
Trauma/EMS PHS Act, Section 1201	Expired 10/	$3,419,000	Expired 10/		---
Screening and Demonstration Programs for Heritable Disorders PHS Act, Secs. 1109 and 1110	SSAN	$0	SSAN		---
Epilepsy, Seizure Disorder PHS Act, Sec. 330E(b), as amended by Sec. 801 of P.L. 106-310	SSAN	$0	SSAN		---

Authorizing Legislation

	2005 Amount Authorized	2005 Final Appropriation	2006 Amount Authorized	2006 Budget Request	
Child Care Safety and Health Grants Programs Children's Health Act, P.L. 106-310, Section 1402	SSAN	$0	SSAN		---
Early Detection and Treatment Re. Childhood Lead Poisoning PHS Act, Section 317O	SSAN	$0	SSAN		---
Rural EMS Training & Equipment Assistance PHS Act, Section 330J amended by P.L. 107-251, the Health Care Safety Net Amendments of 2002	SSAN	$496,000	SSAN		---
Rural Hospital Flexibility Grants Social Security Act, Section 1820(j) as amended by P.L. 108-173	$35,000,000	$39,180,000	$35,000,000		---
Community Access Defibrillation PHS Act, Section 312 as amended by P.L. 107-188	SSAN	$0	SSAN		---
Community Access Defibrillation Demonstration PHS Act, Section 313 as amended by P.L. 107-188	$5,000,000	15/	$5,000,000		---
Denali Project P.L. 105-277, Title III as amended by P.L. 106-113, Title VII	8/	$39,680,000	8/		---
Pediatric Rheumatology PHS Act, Section 763	SSAN	$0	SSAN		---
Grants for Children's Asthma Relief PHS Act, Section 399L	SSAN	$0	SSAN		---
Prevention Research and Programs PHS Act, Section 317K(b) and (c), as amended by P.L. 106-310, Children's Health Act, Section 901	SSAN	$0	SSAN		---
Additional Services for At-Risk Pregnant Women and Infants PHS Act, Section 330H(e), as amended by P.L. 106-310, Children's Health Act,, Section 1501	SSAN	$0	SSAN		---

Authorizing Legislation

	2005 Amount Authorized	2005 Final Appropriation	2006 Amount Authorized	2006 Budget Request
Identification of Intervention that Reduces the Burden and Transmission of Oral, Dental, and Craniofacial Diseases in High Risk Populations; Development of Approaches for Pediatric Oral and Craniofacial Assessment Children's Health Act, P.L. 106-310, Section 1601	SSAN	$0	SSAN	---
Training to Support Education and Training Programs for Physicians and Other Health Professionals and Reports (Lead Poisoning) Children's Health Act, P.L. 106-310, Section 2503	SSAN	$0	SSAN	---
Mental Health Services Delivered via Telehealth PHS Act, Section 330K, amended by P.L. 107-251	SSAN	$0	SSAN	---
Oral Health Promotion & Disease Prevention: School Based Sealant Program PHS Act, Section 317M(c), as amended by P.L. 106-310, Section 1602	SSAN	$0	SSAN	---
Partnerships for Community and Hospital Preparedness PHS Act, Section 319C-2, as amended by Section 131(a), P.L. 107-188	SSAN	$0	SSAN	---
Emergency System for Advance Registration of Health Professions Volunteers PHS Act, Section 319I, as amended by Section 107, P.L. 107-188	SSAN	$0	SSAN	---
Smallpox Emergency Personnel Protection PHS Act, Part C, as amended by P.L. 108-20	SSAN	$0	SSAN	---
Health Facilities Construction and and Other Misc. Projects	8/	$482,729,000	8/	---
State Planning Grant Program PHS Act, Section 301	8/	$10,910,000	8/	---
Telemedicine Incentive Grants PHS Act, Section 330L, as amended by P.L. 108-163	SSAN	$0	SSAN	---
Sickle Cell Service Demonstration Grants PHS Act, Section 301	Indefinite	$198,000	Indefinite	---
Drug Pricing Agreements PHS Act, Section 340B	Indefinite	$0	Indefinite	---
Total, Request Level.....		**$6,803,015,000**		**$5,966,144,000**
Total request level against definite authorizations.....		**$729,879,000**		**$729,840,000**

Authorizing Legislation

	2005 Amount Authorized	2005 Final Appropriation	2006 Amount Authorized	2006 Budget Request

Endnotes:

1/ Included in Health Centers funding.
2/ Carryover available entering FY 2004 equal to $134 million.
3/ Included in National Health Service Corps Funding.
4/ Included in HIV Comprehensive Care Grant Funding.
5/ Legislative authority expired September 30, 1993.
6/ Legislative authority expired September 30, 1985.
7/ Legislative authority expired September 30, 2001.
8/ Authorized by Appropriations Language.
9/ Program funded under the Bioterrorism PHSSEF.
10/ Legislative authority expired September 30, 2002.
11/ Legislative authority expired September 30, 2003.
12/ Amount is authorized over 5 yr fiscal period, end FY 2006.
13/ Legislative authority expires September 30, 2004.
14/ Includes Community Access Defibrillation Demonstration.
15/ Included in Rural Access to AED Devices.

Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1997	3,113,483,000	3,082,190,000	3,210,096,000	3,404,567,000
1998	3,316,479,000	3,616,088,000	3,449,071,000	3,618,137,000 1/
1999	3,773,338,000 3/	3,888,522,000 3/	3,885,900,000 1/	4,108,040,000 1/
2000	4,141,083,000 3/	4,204,395,000 3/	4,365,498,000 1/	4,584,721,000 1/
Government-Wide Rescission	-	-	-	-21,356,000
Mandatory Permanent Indefinite Authority	-	-	-	3,603,000 2/
2001	4,681,337,000 1/	4,734,232,000 3/	4,642,424,000 1/	5,550,876,000 3/
Appropriation Transfer	-	20,000,000	-	20,000,000
Advanced Appropriation	-	30,000,000 4/	-	30,000,000 4/
Government-Wide Rescission	-	-	-	-56,000
Labor/DHHS/Education Rescission	-	-	-	-743,000
Secretary's One Percent Transfer	-	-	-	4,812,000
2002	4,982,593,000	5,691,480,000	5,511,343,000	6,110,551,000
Advanced Appropriation	-	-	30,000,000 5/	-
Labor/DHHS/Education Rescission	-	-	-	-2,591,000
2003	5,381,836,000 6/	5,885,497,000	6,115,654,000 7/	5,926,630,000 8/
Government-Wide Rescission	-	-	-	-42,072,000
2004	5,665,996,000 9/	6,499,987,000 1/	6,175,645,000 1/	6,593,302,000
2005	6,022,833,000	6,305,333,000	6,941,280,000	6,858,624,000
Labor/DHHS/Education Rescission	-	-	-	-747,000
Government-Wide Rescission	-	-	-	-54,862,000
2006	5,966,144,000			

Health Centers

Authorizing Legislation - Section 330 of the Public Health Service Act, as amended and the Native Hawaiian Health Care Improvement Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$1,572,895,000	$1,689,671,000	$1,992,871,000	+$303,200,000
FTCA Claims	$44,734,000	$44,640,000	$45,000,000	+ $360,000
Total	$1,617,629,000	$1,734,311,000	$2,037,871,000	+ $303,560,000
FTE	20	20	20	---

FY 2006 Authorization.....Such Sums As Necessary

Statement of Budget - The FY 2006 request of $2,037,871,000 for Health Centers is an increase of $303,560,000 over the FY 2005 Appropriation.

Program Description

The Health Center program, a major component of America's health care safety net for the Nation's indigent populations for 40 years, is leading a Presidential Initiative to increase health care access over a five year period in the Nation's most needy communities.

The President's Health Centers Initiative

The President's Health Centers Initiative, which began in Fiscal Year (FY) 2002, will significantly affect 1,200 communities with new access points and significantly expanded sites in order to serve another 6.1 million patients by 2006. This expansion complements the President's efforts to increase health insurance coverage in private and public insurance programs, and to help increase access to health care. The President's Health Centers Initiative will broaden the Health Center safety net and increase access to primary health care for the Nation's underserved populations. Due to the current pressures on State budgets and increasing numbers of uninsured and underinsured populations, the Federal Health Center grant is more important now than ever.

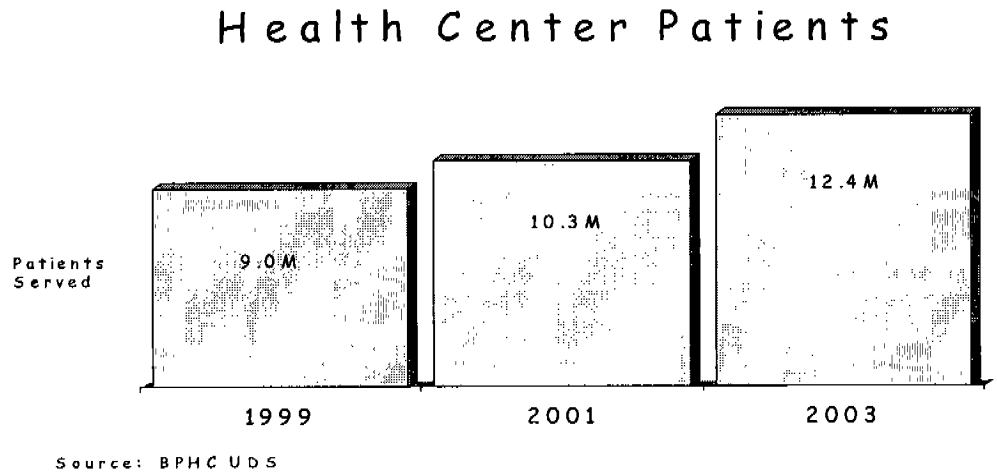
The Health Center Program completed the first three years of the Initiative (FYs 2002, 2003 and 2004) with a strategy that focused on three key elements: 1) Strengthening existing Health Centers; 2) Managing the growth of new Health Centers; and 3) Managing quality improvement in all Health Centers. At the end of FY 2004, this strategy resulted in the creation of 334 new access points (165 new grantees, 169 new satellites), the provision of 285 grants to significantly expand the medical capacity of existing service delivery sites, and the award of more than 300 grants to existing grantee organizations for the expansion of oral health, mental health and substance abuse services.

In 2003, the Uniform Data System indicated that the number of Health Center patients increased by more than one million, the second year this number of patients has been added to the program. When 2004 data are finalized, it is anticipated that there will be an increase of 816,000 Health Center patients over the 2003 level for a total of nearly 3 million additional patients.
FY 2005 funding for the President's Health Centers Initiative is expected to add about 742,000 additional patients.

In their competitive applications for grants funded under the President's Health Centers Initiative, Health Centers estimate the number of additional patients they will be able to serve with the increased support. However, as with any business, the 'ramp-up' process may take more than one year to reach that capacity. Currently, we estimate that Health Centers will achieve 80 percent of their added capacity in the first year and the remaining 20 percent in the second year.

Health Center Program

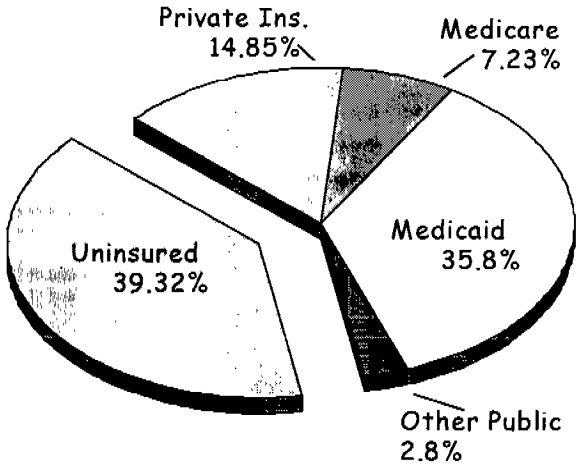
Health Centers, operating at the community level, provide regular access to high quality, family oriented, comprehensive primary and preventive health care, regardless of ability to pay, and improve the health status of underserved populations living in inner city and rural areas. Between 1999 and 2003, the number of Health Center patients increased by about 3.4 million for a total of 12.4 million, an increase of 38 percent.



Health Centers serve clients that are primarily low income and minorities including migrant/seasonal farmworkers; homeless individuals and families; people living in areas with high levels of crime; people living in rural and sparsely populated areas; large numbers of unemployed and impoverished people with chronic diseases, pregnant teens, substance abusers, and many individuals living with HIV/AIDS infection. These clients have difficulty obtaining health services outside of a Health Center and many require translation/interpretation services. Health Center target populations that have lower life expectancy and higher death rates compared to the general population. These patients have less purchasing power, and many are unable to afford even the most basic medical or dental care.

In Calendar Year (CY) 2003, almost 36 percent of Health Center patients were covered by Medicaid, 7.2 percent were covered by Medicare, 17.6 percent were covered by other public or private insurance and over 39 percent were uninsured.

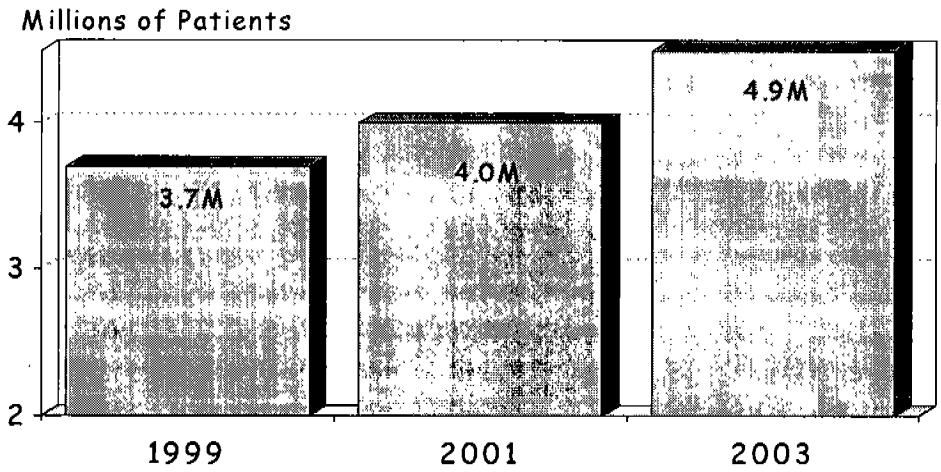
Health Center Patients by Payment Source



Source: BPHC 2003 UDS

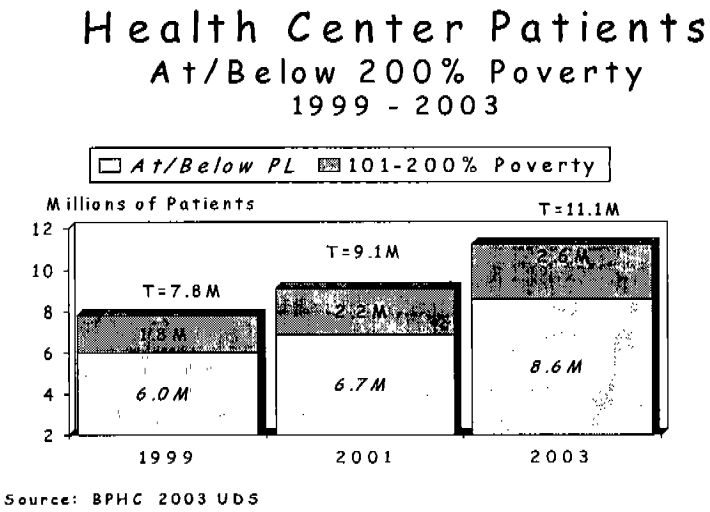
A Health Center commitment to serving the uninsured results in a significant uncompensated care burden. In CY 2003, 4.9 million (39 percent) Health Center patients were uninsured, an increase of 1.2 million uninsured patients or 32 percent from CY 1999.

Health Center Uninsured Patients 1999 - 2003



Source: BPHC 2003 UDS

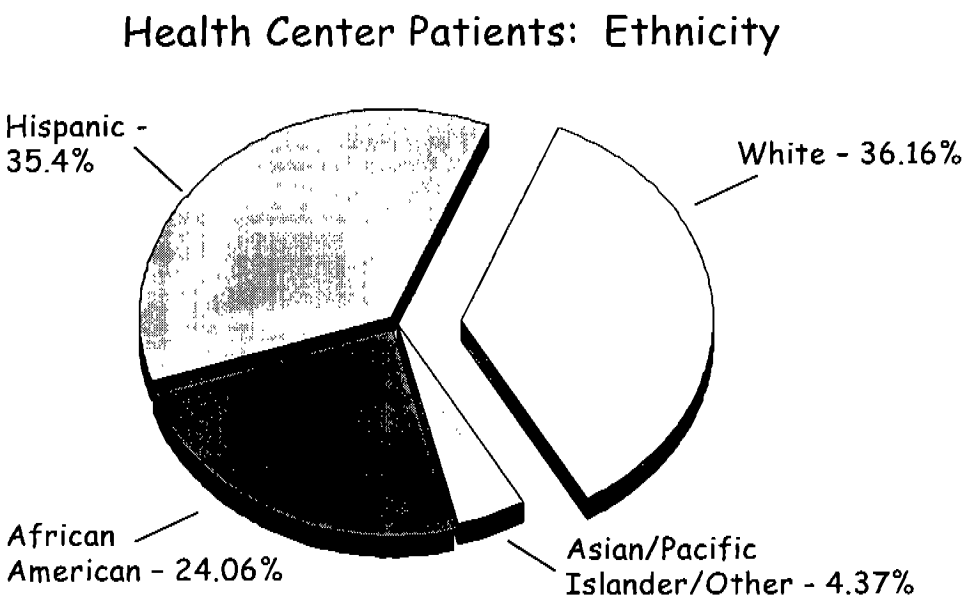
In CY 2003, 11.1 million Health Center patients were at or below 200 percent of poverty, a 43 percent increase over CY 1999.



Source: BPHC 2003 UDS

Health Center patients:

- 64 percent are minorities
- 59 percent are females
- 25 percent are children under age 12
- 46 percent live in rural areas
- more than 678,000 are homeless
- 694,000 are migrant/seasonal farmworkers



Source: BPHC 2003 UDS

Emerging Population Groups That Pose Unique Cultural And Health Care Problems:

Health Centers serve increasingly culturally diverse people, which reflects a significant increase in the U.S. foreign-born population. Center providers have developed creative and successful culturally and linguistically competent practices to serve these diverse population groups. These practices include interpreter services, multi-lingual providers, cultural competence training for staff and targeted outreach programs. Thirty percent of Health Center patients are best served in a language other than English or with sign language. More than 85 percent of Health Centers provide on-site interpretive services which can include patients from five to twenty different cultural groups requiring providers to understand as many as twenty different languages or dialects. In addition to addressing primary care needs, Health Centers provide information and eligibility assistance for associated benefits such as the State Children's Health Insurance Program (SCHIP) and Medicaid for all patients, including those that are non-English speaking. Therefore, translation services and bilingual providers are a critical component of quality health and social services for those who have limited English proficiency.

Health Centers Serving Special Populations

The Health Center program encompasses a number of types of Centers designed to meet the health care needs of specific populations, i.e., migrant and seasonal farmworkers, homeless people, at-risk school children, residents of public housing, and indigenous people of jurisdictions associated with the United States. The Health Center appropriation also includes funds for the Native Hawaiian health care program.

Migrant and Seasonal Farmworkers

The Migrant Health program provides comprehensive, high quality, family-based preventive and primary health services to migrant and seasonal farmworkers (MSFWs) and their families with a culturally sensitive focus. Special outreach and environmental initiatives are offered.

A migrant farmworker is defined as an individual whose principal employment within the last 24 months is in agriculture and who establishes for the purposes of such employment a temporary residence. There are approximately 3-5 million MSFWs in the United States. About 70 percent live below the poverty line with an average income of less than $7,500 per year. About 80 percent are Latinos, with an educational level of less than 6 years of formal schooling. There are also large numbers of Haitian, African American and Asian farmworkers throughout the country. They have limited access to health care while working in one of the most hazardous occupations. They live and work in substandard conditions including low wages, geographic isolation, lack of sanitary facilities, substandard housing, and face barriers of language and culture. They also face the consequences of life on the road including lack of a continuity of needed health services.

For Migrant Health Centers -

- HIV infection has been increasing dramatically among Hispanic men and women in the United States. The infection rate for farm workers may be as much as ten times higher than the national rate.

- a recent survey of agricultural workers in California showed that half of all male workers and two-fifths of females surveyed have never been to a dentist. More than one-third of the males had at least one decayed tooth, and four out of ten females had a broken or missing tooth.

- the same survey also showed that nearly 70 percent of those in the sample lacked any form of health insurance, and only 7 percent were covered by any of the various government-funded programs intended to serve low-income persons.[1]

- farm workers also have high rates of diabetes, cardiovascular disease, asthma and a variety of occupational injuries such as repetitive motion disorders.

- farm workers and their children have a long term risk of cancer and other illnesses given their exposure to harmful pesticides. One study found that 48 percent of migrant children had worked in fields still wet with pesticides. EPA estimates that over 300,000 farm workers suffer acute pesticide poisoning each year.

In CY 2003, primary care services were provided by 125 grantees located in 40 States and Puerto Rico to more than 655,000 migrant and seasonal farm workers including their families. An additional 38,000 migrant/seasonal farm workers were patients at Health Centers that did not receive Migrant Health Center funding.

Homeless Populations

Health Care for the Homeless Centers provide homeless individuals and families with access to high quality, comprehensive preventive, primary care services, including oral health, mental health, and substance abuse services. These health services are provided in settings that promote access to and utilization of services, e.g., in homeless shelters, on the street, and from mobile clinics. Outreach and case management services are included so that health services are accessible. A homeless person is defined as an individual who lacks housing, including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations, and an individual who is a resident in transitional housing. Health Care for the Homeless Centers are the source of care for approximately 25 percent of the estimated 2 million persons who are homeless in the U.S. over the course of a year. There are an estimated 600,000 to 800,000 homeless persons on any given night.

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[1] Suffering in Silence: A Report on the Health of California's Agricultural Workers November 2000.

In CY 2003, Health Care for the Homeless grantees reported that:

- 71 percent of program patients were uninsured
- 59 percent were male; 41 percent were female
- 53 percent were ages 20 to 44; 15 percent were under 20
- 39 percent were African American; 37 percent were White; 20 percent were Hispanic; 2 percent were American Indian/Alaska Native; and 2 percent were Asian/Pacific Islander
- 43 percent lived in homeless shelters; 11 percent lived on the street; the remainder lived in transitional housing, doubled up with friends or family, or had other living arrangements
- for health conditions the largest number of homeless patient medical encounters were for alcohol and drug dependence and other mental disorders. The next largest number of medical encounters were for hypertension and diabetes.
- in addition to being largely uninsured and poor, homeless individuals face the social and medical consequences of life without continuity of shelter, safety, food, and sanitation

In CY 2003, homeless health care services were provided by 159 grantees to approximately 569,000 homeless individuals located in all 50 States, the District of Columbia and the Commonwealth of Puerto Rico. An additional 109,000 homeless individuals were patients at Health Centers that did not receive Homeless Health Center funding.

At-Risk School Children

School-Based Health Centers provide comprehensive primary and preventive health care services, including mental health, oral health, ancillary and enabling services. These services are provided in schools or on school grounds, are family-oriented and tailored to meet the health care needs of youth and adolescents. School-Based Health Centers often serve other family members and residents in the schools' district. The array of provided services is locally determined by school principals, school boards, parents, and providers. No services are provided without fully informed parental consent. School-Based Health Centers support national educational initiatives by making sure that children are healthy and "ready to learn". Most services are structured to address acute medical problems and to manage chronic illnesses that would otherwise cause children to miss days in school or be inattentive in class. Parents do not need to leave work and lose income to take their children in for care. School-Based Health Centers make health care for children accessible, affordable, continuous and preventive.

In CY 2003, the program grantees reported:

- 90 percent of program participants were at or below 200 percent of the poverty level;

- 82 percent were from minority populations;
- 38 percent were enrolled in Medicaid or SCHIP; and
- physical examinations, immunizations, mental disorders, upper respiratory infections, pharyngitis, headaches and asthma are the most frequently reported causes for medical encounters

In CY 2003, 80 School-Based Health Center grantees provided services in 31 States, the District of Columbia, Puerto Rico and the Virgin Islands to nearly 99,000 students in 223 schools.

Residents of Public Housing

Public Housing Primary Care Centers improve the health status of public housing residents by delivering comprehensive, accessible and affordable prevention and primary care services from sites that are in, or adjacent to, public housing developments. Residents of public housing face geographic isolation, and high rates of crime, poverty, and chronic disease. By training and employing residents, providing health education, primary care and enabling services, and prevention programs, these Public Housing Health Centers help overcome this isolation by becoming the hub of the community. They help address uncontrolled chronic disease by being Centers of health and by providing social service improvement activities.

In CY 2003, the program grantees reported:

- 78 percent of public housing primary care users were below 100 percent of poverty;
- 43 percent were enrolled in Medicaid or SCHIP;
- 39 percent were under 20 years of age;
- more than 90 percent of Public Housing Health Center patients were minorities; 45 percent were African American and 41 percent were Hispanic; and
- mental disorders, well child care, hypertension and diabetes are the most frequently reported causes for medical encounters

In CY 2003, 33 Public Housing Health Center grantees provided services to more than 110,000 individuals.

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 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 CY 2003:

- Native Hawaiian Systems provided medical and enabling encounters to more than 3,850 Native Hawaiians.

- The largest number of medical encounters were for heart disease, hypertension and diabetes.

- The Native Hawaiian Health Care Program also supports a health professions scholarship program for Native Hawaiians and administrative costs for Papa Ola Lokahi, an organization that coordinates and assists health care programs provided to Native Hawaiians. In FY 2003, 11 Native Hawaiian scholarships were awarded. More than 150 Native Hawaiian scholarships have been awarded since the beginning of the program.

Health Center Services

In many areas, Health Centers are the only primary care facilities readily available to community residents in underserved or high need areas. They overcome access barriers due to geography, language, culture, poverty, housing status, migration, etc. They provide accessible, affordable, high quality, comprehensive, case managed (coordinated follow up) health care and related services for indigent populations including adult medicine, infectious diseases, OB/GYN, pediatrics, dentistry, pharmacy, mental health and substance abuse treatment programs, school health programs that focus on child and family health issues, disease prevention and health promotion lifestyle programs, night and weekend operation hours, transportation, outreach, translation, and other enabling services.

In CY 2003, Health Centers provided:

- more than 49 million encounters
- more than 220,000 mammograms
- over 1.4 million pap tests
- 2.27 million encounters for immunizations
- nearly 400,000 HIV tests and counseling
- perinatal and delivery care for 332,000 women
- translation services to more than 3.5 million patients

Health Centers Reduce Disparities

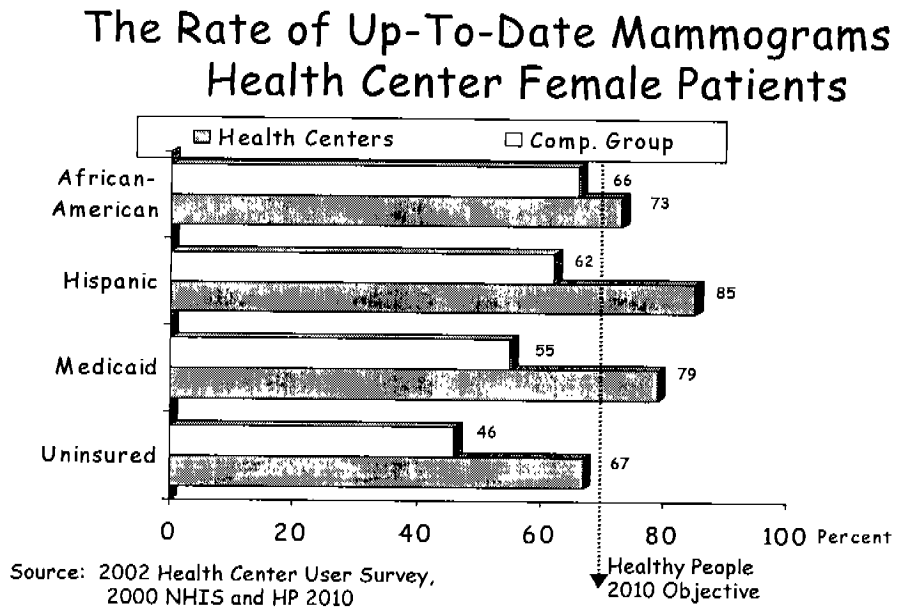
HRSA is committed to implementing strategies that will move toward the elimination of major health disparities among our Nation's vulnerable populations. Health Centers serve low income and minority populations that experience much higher rates of many diseases including diabetes,

cardiovascular disease, asthma, cancer, and HIV/AIDS than the National average. These differences may be aggravated by these same peoples' inability to obtain appropriate pharmaceuticals due to high costs and delays in getting necessary health care treatment unless emergency conditions exist. The result can be poor health outcomes compared to the national population.

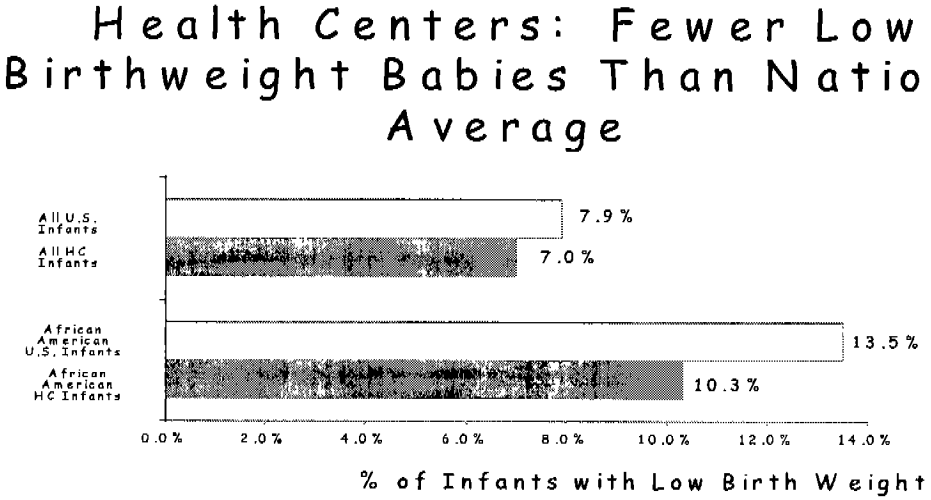
Everyday, Health Centers work to improve health by:

- Reducing disease and morbidity/mortality in targeted clinical areas
- Increasing health care utilization for underserved populations
- Adapting services to meet population needs
- Building and maintaining a diversified health care workforce
- Increasing the cultural competence of their health care workforce
- Enhancing and establishing new partnerships
- Translating clinical knowledge into clinical practice
- Improving the patient office visit
- Enhancing clinical data collection on health outcomes

Because Health Centers offer such high quality services and access to an usual and regular source of primary care which is absolutely essential for improvements in health status, many patients have greater access to preventive services. On a National basis, up-to-date mammography rates for low income African American, Hispanic, Medicaid, and Uninsured women fall far short of the HP 2010 goals of 70 percent. These vulnerable women historically face barriers to access to care. Yet the rates for Health Center women 40 years of age and older from these groups far exceed those of comparable women in the Nation. In three of four cases, Health Center rates even exceed the HP 2010 goal. Health Center women from these groups also record higher rates of up-to-date pap tests and clinical breast exams than comparable National groups of women.



Babies delivered to patients who obtained their prenatal care at Health Centers in 2003, including African American newborns, had better birth weight outcomes than all infants born in the U.S. and all African American infants born in the U.S., respectively.



BPHC UDS 2003, National Vital Statistics Report - November 2004, preliminary 2003 data.

According to data published in recent journal articles[2] and the latest survey and medical claims analysis:

- Health Center patients have lower ambulatory visit costs and lower rates of hospitalizations and associated costs than patients with other types of primary care providers.

- Health Center patients have improved management of chronic diseases compared to the general population:

    - African American and Hispanic hypertensives seen at Health Centers are three times as likely to report blood pressure under control
    - Diabetics receiving care at Health Centers are twice as likely to have glycohemoglobin tests on schedule

Health Centers are providing quality chronic disease management and are taking advantage of opportunities to provide recommended preventive care. Diabetes patients treated at Health Centers were not only more likely to receive secondary preventive services, such as eye and foot exams, but were likely to receive other recommended preventive services than similar patients who obtained care elsewhere.

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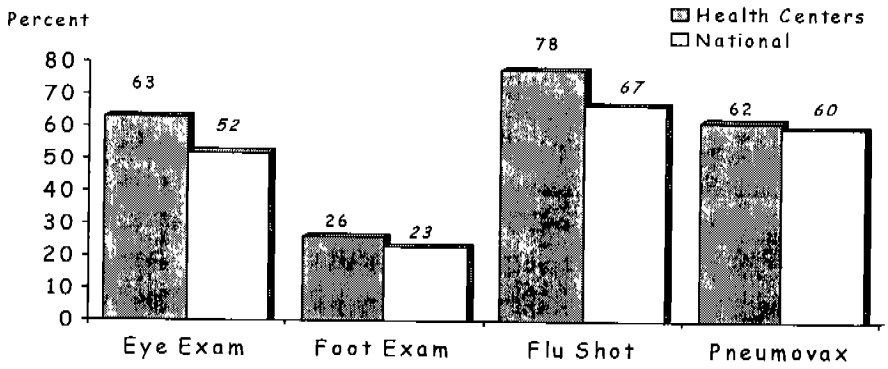
[2] Politzer, et al., Inequality in America: The Contribution of Health Centers in Reducing and Eliminating Disparities in Access to Care, June 2001.

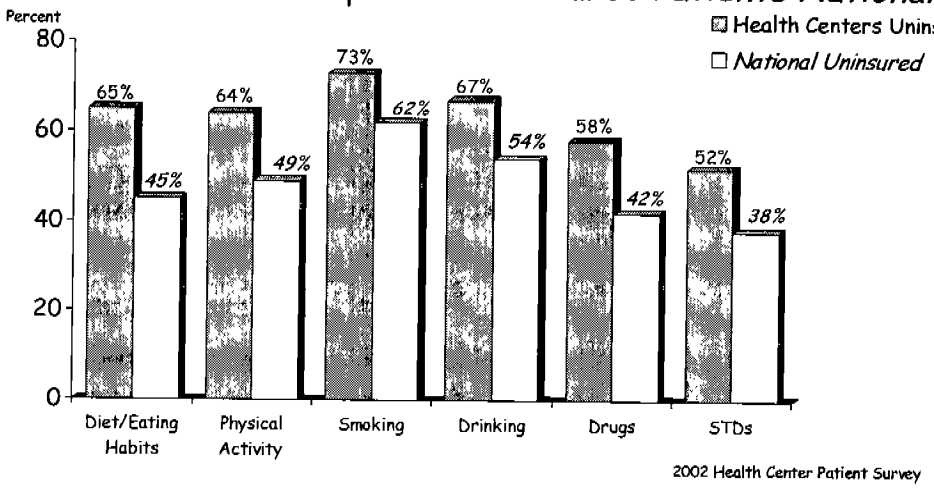
Percent of Health Center Diabetes Patients that Reported Receiving Preventive Services, 2002



Source: 2002 HC User Survey, 2002 NHIS

Health Centers provide increased preventive services to their patients; for example, uninsured patients are more likely to be counseled at Health Centers about dieting and eating habits, physical activity, smoking, drinking, drugs, and STDs than comparable uninsured patients in National samples.

Uninsured Patients Receive Better Disease Prevention Counseling at Health Centers than Comparable *Uninsured Patients Nationally*

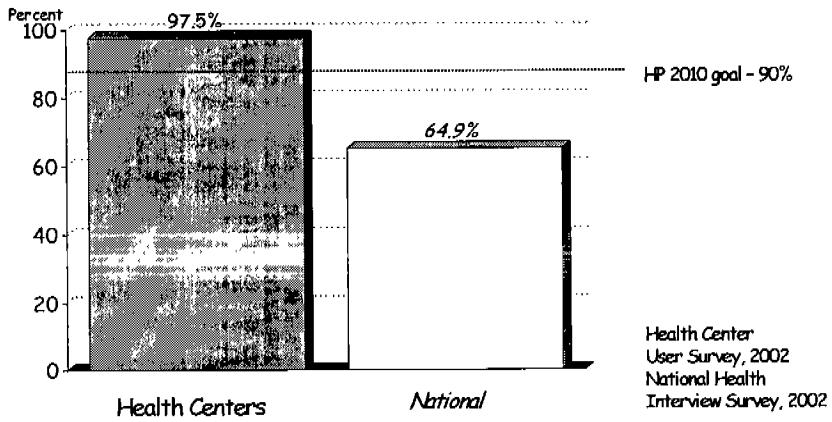


2002 Health Center Patient Survey

Health Centers have a commitment to high quality of primary and preventive care that significantly enhances their patients' long term health status. One of the best measures of effectiveness of care is when patients report that the Center is their regular and usual source of care. In recent surveys of the Nation's and Health Center uninsured - those most likely to have access problems - of those that obtain care at Health Centers, virtually all report that the Center is

their medical home compared to 65 percent who obtained their care elsewhere. It is also important to note that the HP 2010 goal is 90 percent, and Health Centers have exceeded that goal as well.

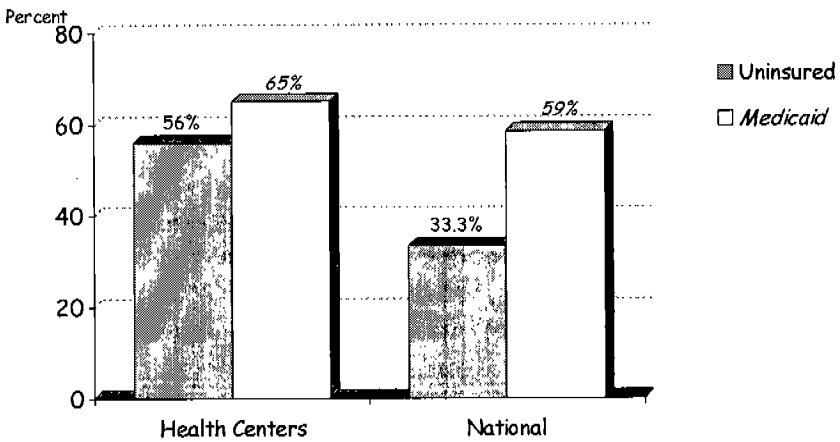
Uninsured Health Center Patients Are More Likely To Have A Regular And Usual Source of Care Than Comparable *Uninsured Patients Nationally*



Also, Health Centers, unlike most other providers, do not select their patients as to whether they carry an insurance card. Health Center uninsured patients visit just as frequently as those who have insurance - unlike many of the Nation's uninsured who are frequently deterred.

Uninsured Patients Face No Access Barriers At Health Centers;

Percent of Patients with 4 or more visits



Sources: Health Center User Survey, 2002
National Health Interview Survey, 2002

Strengthening the Safety Net

HRSA and its Health Center grantees have pursued a host of strategies to strengthen existing safety net providers and to expand effective, quality care to more of the underserved. The strategies for strengthening existing providers are: The Health Disparities Collaboratives, Integrating Delivery Systems, and the enrolling of patients in Medicaid and the State Children's Health Insurance Program.

Health Disparities Collaboratives

Since 1998, the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care has been implementing a series of Health Disparity Collaboratives (HDCs) in Health Centers with the goal of reducing health disparities and overall improved functional and clinical outcomes for Health Center patients.

The Health Disparity Collaboratives are a national effort to achieve strategic system change in the delivery of primary health care. Starting with the Chronic Diseases Care Model, the HDCs focused on the conditions of highest importance to the Health Centers in terms of cost, volume of patient visits, and complexity of care needed. The HDCs have evolved the national Health Center infrastructure to improve the delivery of prevention services, cancer screening and other conditions of an acute nature such as oral health that affect the patient flow at Health Centers.

Currently, the HDCs are in the process of integrating all collaborative activities into a Primary Health Care Collaborative using the experiences gained from the Chronic Disease Collaboratives such as diabetes, depression, asthma, and cardiovascular. Ultimately, the entire effort is a community oriented primary care model for system change for quality improvement.

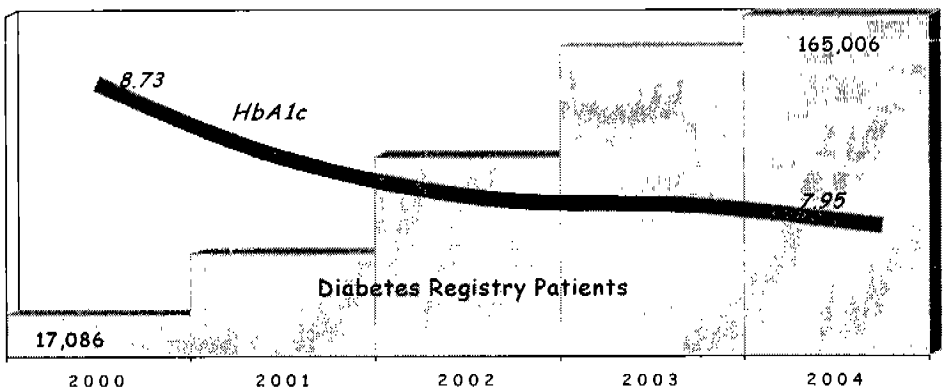
More than 500 Health Centers are participating in the Health Disparities Collaboratives generating documented improvements in diabetes, depression, cardiovascular, cancer, and asthma care for more than 280,000 patients. Health Center teams and senior leadership work with a faculty of experts to achieve excellence in practice with the goals: (1) to increase leadership capacity to implement and spread positive system change; (2) to transform clinical practice through models of care, improvement and learning; (3) to develop infrastructure, expertise and multi-disciplinary leadership to support and drive improved health status; and (4) to build strategic partnerships including the Institute for Healthcare Improvement (IHI), the Centers for Disease Control and Prevention (CDC), the National Cancer Institute, the Environmental Protection Agency (EPA), the National Association of Community Health Centers and the Agency for Healthcare Research and Quality (AHRQ). Additionally, there are collaborative pilots in progress focused on Prevention, Diabetes Prevention, Access, Finance and Redesign, and Perinatal and Patient Safety.

Health Centers participate in year-long intense learning and improvement activities that involve attending three learning sessions and a final congress sharing the improvement tests, changes and documented results accomplished at the health center level. This is followed by continued improvement activities, continual reporting of nationally shared measures and dissemination of the successful changes made to the delivery system. A national and regional/state infrastructure

based in the Primary Care Associations supports the Health Centers quality improvement work. Partnerships formed at the national, State and community levels have resulted in increased access to expertise and resources. Through the partnership with CDC, there are 39 CDC-sponsored State health department diabetes programs trained in the care, improvement and learning models and engaged with health centers that are participating in the Collaboratives.

Two examples of outcomes reported are (1) Average HbA1c levels which have decreased from 8.55 to 7.96 for 165,000 patients with diabetes, (2) For patients with asthma, symptom-free days have increased from 8 to 10.09.

Health Centers Diabetes Collaborative
Increase In The Number of Patients Registered
Decrease In Their Average 3 Month Blood Sugars (HbA1c)
2000 to 2004



Source: Health Disparities Collaboratives Database, January 2005

Research studies in the United States and abroad have found that improved glycemic control benefits people with either type 1 or type 2 diabetes. In general, for every 1 percent reduction in results of A1C blood tests (e.g., from 8 to 7 percent), the risk of developing microvascular diabetic complications (eye, kidney, and nerve disease) is reduced by 40 percent.

Health Disparities Collaboratives, in their focus on the application of evidenced-based care, are a model for more rapid translation of science into practice. An example of this is the translation of the National Institute of Diabetes and Digestive and Kidney Diseases/CDC Diabetes Prevention Program study into a five Health Center pilot collaborative as soon as it was published in the New England Journal of Medicine.

Integrating Delivery Systems

For several years, HRSA has been involved with initiatives to encourage Health Centers to integrate functions with other centers and 'safety net' providers in the community to achieve greater efficiency, improve quality of care, and maintain their competitiveness in the managed care marketplace. The Integrated Services Delivery Initiative (ISDI) provides support for the planning and development of Health Center controlled networks that fall into two categories:

1) practice management networks, which aim to achieve efficiencies and economies of scale through integrating management information systems, financial, administrative, or clinical functions across providers, and 2) managed care networks, whose aim is to maintain and enhance the Health Centers' market share of patients with health care coverage, particularly Medicaid. Those participating have either negotiated contracts with managed care plans or formed their own Health Center-owned managed care plans. Together, these networks serve as catalysts for a comprehensive and integrated service delivery system for under-and uninsured patients in communities.

For the past two years, HRSA has funded Operational networks/plans through legislation (Section 330(e)(1)(C) of the Public Health Service Act) that was implemented in 2003 to allow for support of operational networks and plans that are at least majority controlled or owned by Health Centers receiving assistance under section 330(e).

Operational networks are defined as Center networks that demonstrate an essential, mission-critical function performed for the members at the network level, enabling the member Centers to perform their business and clinical operations more efficiently and effectively.

Operational networks and plans received support under Section 330(c)(1)(B) or (C) of the Public Health Service Act, as amended, to plan and develop practice management or managed care networks that enable the Centers to (1) reduce costs associated with the provision of health care services; (2) improve access to, and availability of, health care services provided to individuals served by the Centers; (3) enhance the quality and coordination of health care services; or (4) improve the health status of communities.

State Children's Health Insurance Program (SCHIP)

Health Centers and Primary Care Associations (PCAs) continue to respond to the opportunity to enroll eligible children in SCHIP and children, pregnant women and the elderly in Medicaid. Health Centers served nearly 254,100 enrolled SCHIP patients in CY 2003.

Health Centers are involved in on site outreach and enrollment activities, and PCAs are effective participants in the design of the programs and outreach strategies, training of eligibility workers and development of policies that promote coverage. Many PCAs have made significant contributions to enrolling children in Medicaid and SCHIP and have worked to increase the number of outstationed Medicaid eligibility workers in Health Centers. HRSA is working closely with CMS to further encourage States to outstation eligibility workers at each Federally Qualified Health Center. PCAs have also used the grant funding to leverage other funding that results in greater coverage. In addition, Health Centers have received grants to allow them to hire outreach workers to assist in the enrollment of homeless and migrant children and their families.

Due to the recent fiscal crisis, many States have imposed SCHIP enrollment caps, increased premiums, and reduced outreach and enrollment which may reduce future increases in SCHIP. Thus far, we have not seen a significant impact on Health Centers. However, we anticipate that these changes may result in an increase in uninsured children being treated at Health Centers

since Centers do not deny care, based on ability to pay. In effect, this could jeopardize the financial viability of Health Centers because Centers will not be compensated for the care that they provide to uninsured children. We will monitor the long-term impact of these changes on Health Centers.

Drug Pricing Program

The 340B drug pricing program was established to reduce outpatient prescription drug costs for a wide variety of safety-net health care providers. Organizations eligible to acquire outpatient drugs at 340B discount prices include Health Center sites, Ryan White grantees and Hemophilia Treatment Centers in HRSA, STD and TB clinics supported by CDC, tribal contractors and urban centers supported by IHS, and family planning grantees managed by OPHS. In addition, disproportionate share hospitals achieve their 340B status by meeting Medicare and Medicaid criteria for serving the poor and carrying out State or local health care service responsibilities.

FQHC Look-Alike Program

An FQHC Look-Alike is a Health Center that is determined by the Health Resources and Services Administration to meet the requirements of the section 330 grant program but does not receive the grant. Once a Health Center is designated an FQHC Look-Alike, it is eligible for the following benefits: cost-based reimbursement under Medicaid and Medicare, participation in the 340(b) Federal Drug Pricing program, and automatic Health Professional Shortage Area (HPSA) designation. The enhanced Medicaid and Medicare reimbursement enables the Health Center to improve access to primary care for underinsured and uninsured patients. By participating in the 340(b) Drug Pricing Program, the Health Center can purchase prescription and non-prescription medications for their outpatients at reduced costs. The HPSA status aids Health Centers in their efforts to recruit and retain health professionals.

Funding levels for the Health Center program during the last five years reflect this effort and are as follows:

	$	FTE
2001	1,168,559,000	20
2002	1,343,175,000	20
2003	1,505,055,000	20
2004	1,617,380,000	20
2005	1,734,311,000	20

Performance Analysis

The Health Center performance measures are designed to track five areas of program activity critical to monitoring improved access to care and performance benchmarks of the President's Health Centers Initiative: population served, infrastructure, preventive services, chronic disease management, productivity and efficiency.

Health Centers continue to serve an increasing number of the nation's underserved. The number of Health Center patients served in 2003 was 12.4 million and the program expects to meet the 13.2 million target in 2004. This increased access beyond the approximately 9 million patients served in1999 represents a near 40 percent increase within a 4-year period. Moreover, it reflects a more than 1 million patient increase 2 years in a row since the inception of the Presidential Initiative. Health Center growth has fallen short of the annual target by less than 1 percent, largely due to the length of time Centers need to establish operations. However, this gap is considerably smaller than last year. Nearly 90 percent of Health Center patients continue to be at or below 200 percent of the Federal poverty level, nearly 65 percent from racial/ethnic minority groups, and nearly 40 percent uninsured.

Success in increasing the number of patients served is contingent upon the development of new Health Centers, new satellite sites, and expanded capacity of existing clinics. As of 2004, the President's Health Centers Initiative, which began in FY 2002, has impacted 619 communities (current and additional capacity to serve about 3 million patients), with new access points (new starts and satellites of existing grantees) and significantly expanded sites (to build capacity including new practices, hours/space). Health Center site expansion has exceeded targeted goals each year of the Presidential Initiative. The 3,651 established sites as of FY 2004 represent a growth of 334 sites since 2001. Moreover, centers experiencing expanded capacity as a result of the Initiative's investment exceeded targets for 2002, 2003, and 2004 at 285 sites. More than 150 additional new or expansion sites are projected by the end of FY 2005 for a total of more than 770 sites that will serve an additional 3.7 million patients after four years of the President's Health Centers Growth Initiative.

Critical to Health Center service and improvement in patient health is the provision of preventive health services including pharmacy, preventive dental, mental health, and substance abuse services. As of CY 2003, a substantial percentage of Centers provided these services, with the numbers keeping pace with or exceeding overall Health Center growth. Recent results from Health Center patient surveys show that appropriate breast and cervical cancer screening exceed those rates for comparable populations served elsewhere, and nearly meet the Healthy People (HP) 2010 goals. African American, Hispanic, uninsured and Medicaid covered Health Center women, those women who traditionally report access disparities, have higher screening rates than their national counterparts.

In addition to providing timely and appropriate preventive services, Health Centers manage patients with debilitating chronic diseases such as diabetes and hypertension. About 71 percent of Health Center diabetics have had at least one glycohemoglobin test annually, the essential test for managing blood glucose levels. Over 90 percent of Health Center patients report their blood pressure under control. Success in managing both hypertension and diabetes patients far exceeds HP 2010 goals, despite the fact that the prevalence and severity of these conditions is higher among Health Center patients than in the overall U.S. population.

Health Center low birth weight rates are lower than national averages for all infants. Moreover, as national rates rose, overall Health Center rates defied national trends, with the Health Center African American low birth weight disparity nearly 40 percent less than observed among all U.S. patients. By measuring and addressing health disparities by race, ethnicity, poverty level, and

geographic location, Health Centers contribute significantly to the national priority of reducing disparities.

Finally, having a regular source of primary health care has been shown to have a significant effect on health status disparities. Health Center uninsured patients are far more likely to have a usual and regular source of care than uninsured patients who obtain care elsewhere. Since Health Center patients are far more likely to be from racial/ethnic minority groups, having a regular and usual source of care contributes to the reduction and elimination of disparities in health status.

Several studies of Medicaid claims for beneficiaries obtaining care at Health Centers compared to elsewhere revealed that the high quality care provided by Health Centers reduces hospitalizations and emergency room use, reduces annual Medicaid costs, and helps prevent more expensive chronic disease and disability among traditionally medically underserved populations. Health Center Medicaid patients are 11 percent less likely to be inappropriately hospitalized and 19 percent less likely to visit the emergency room than Medicaid beneficiaries who had another provider as their usual source of care. Primary, preventive, appropriate care results in efficiencies that are accrued to programs such as Medicaid, with cost reductions of nearly 30 percent compared to beneficiaries who sought care elsewhere.

A PART review of the Health Centers program was conducted during the FY 2004 budget cycle. The program received the highest possible rating of "Effective." Additional performance information is provided in Section U.

Rationale for the Budget Request

The FY 2006 request of $2,037,871,000 for Health Centers is an increase of $303,560,000 over the FY 2005 Appropriation and includes an increase of 360,000 for the Federal Tort Claims Act (FTCA).

In FY 2006, available funding for the Health Center program will support the development of 275 new access points and 303 expanded medical capacity sites, increasing the number of patients served by an estimated 2.4 million for a total of 16.35 million patients.

- $277 Million - FY 2006 is the fifth year of a five year expansion plan to significantly expand the Health Center safety net by increasing the number of access points and people served. Approximately $277 million would fund the development of 275 new access points (new starts administered by new grantee organizations and satellites of existing grantees), 303 expanded existing sites, and serve 2.4 million new patients. New access points will be established through Health Centers targeting the neediest populations and communities by replicating existing models of success. Expanded access points will be targeted in communities where an existing Health Center's ability to provide care falls short of meeting the documented service delivery needs of the uninsured and underserved populations. By significantly expanding the number of existing access points, increased penetration into these populations will be achieved.

- Also included is $26 million for a new initiative to fund Health Centers in poor counties around the Nation. With the FY 2006 requested increase, the current President's Health Center Initiative is on track to establish or expand 1,200 sites and serve an additional 6.1 million patients. However, there is the likelihood that without special attention, some high poverty counties throughout the country may not successfully secure a Health Center site. This new initiative will target approximately 40 high poverty counties without a Health Center site. The goal of the new initiative is to carry the success of the current initiative further to ensure that every poor county that can support one has a Health Center site. Access to primary and preventive health care services is critical, especially in poor communities that are medically underserved.

  The requested level will enable 40 new access points grants in poor counties to be awarded. In addition, the level will fund 25 planning grants to community-based organizations for projects to plan and develop Health Centers in high poverty counties across the country. This support will enable community-based entities to enhance their readiness to implement a health services delivery grant, and in some cases provide an inducement for an organization to address the health care needs of the underserved in a high poverty county where there would otherwise be no expansion activity.

- Federal Tort Claims Act - $45 Million - Within the FY 2006 request is $45 million in no-year funding for payment of FTCA claims reaching settlement and judgment. This level will allow HRSA to pay Health Center FTCA claims during FY 2006.

Program Outputs (PI-1):

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
New Starts	25	43	138
New Satellite Sites	38	47	137
Expanded Sites	66	63	303
Total New/Exp	129	153	578
Service Exp.	45	23	0
Total Sites	3,651	3,741	4,016
Est. Patients Served	13.2M	13.95M	16.35M

Program Outputs (PI-2):

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
High Poverty New Starts	0	0	40
High Poverty Planning Grants	0	0	25

Services to sub-populations included in total service capacity:

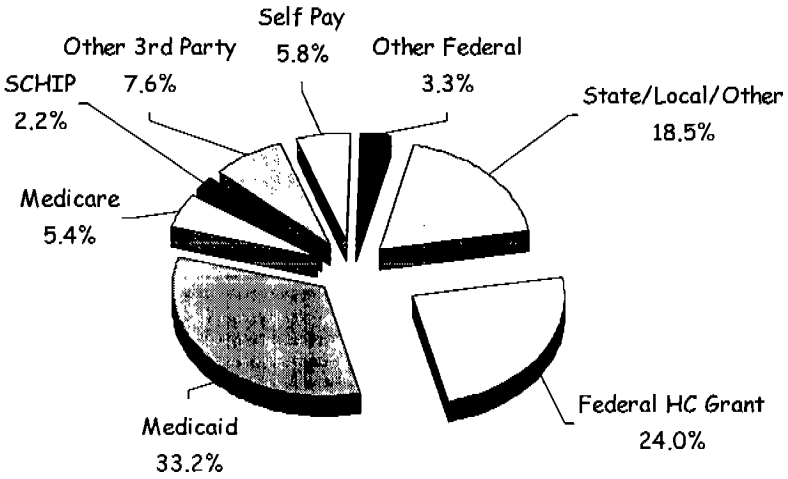
	FY 2004 Estimated	FY 2005 Appropriation	FY 2006 Request
Migrant	715,000	740,000	795,000
Homeless	700,000	725,000	775,000
Public Housing	115,000	120,000	130,000

SOURCES OF REVENUE FOR HEALTH CENTERS
(In millions of dollars)

	FY 2004 Estimate	FY 2005 Appropriation	FY 2006 Request
Health Centers	$1,572.9 1/	$1,689.7 1/	$1,993.0 1/
Other Sources:			
Medicaid	2,180.0	2,345.0	2,765.0
Medicare	355.0	380.0	450.0
SCHIP	145.0	155.0	185.0
Other Third Party	500.0	535.0	630.0
Self Pay Collections	380.0	410.0	480.0
Other Federal Grants	215.0	230.0	275.0
State/Local/Other	1,210.0	1,300.0	1,535.0
TOTAL	$6,557.6	$7,044.7	$8,313.0

1/ Excludes funding for Tort Claims: FY 2004 $44.7 million, FY 2005 - $44.6 million and FY 2006 - $45 million.

Health Centers:
Sources of Revenue, FY 2004 est.



Free Clinic Medical Malpractice

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

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$4,821,000	$99,000	$---	- $99,000
FTE	1	2	2	---

FY 2006 Authorization.....$10,000,000

Statement of Budget - No funding is requested for this program in FY 2006. Funds appropriated in FY 2004 and FY 2005, available until expended, are sufficient to support the needs of the program in FY 2006. This represents a reduction of $99,000 from the FY 2005 Appropriated level.

Program Description

Free clinics play a significant role in some communities in meeting the health care needs of the uninsured, particularly at a time when there are indications that physicians may be less likely to provide free care in their offices. They provide a venue for some providers to volunteer their services, although their hours of operation may be limited. Many of these clinics are faith-based. 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 claims under the Federal Tort Claims Act (FTCA) to be made available for free clinic health professionals.

Authorized by Section 224 of the Public Health Service Act, 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 to low-income individuals in medically underserved areas.

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).

- 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.

Qualifying Free Clinics will submit applications to the Department of Health and Human Service to have volunteer providers deemed that they sponsor.

HRSA has created a deeming process for the Free Clinics FTCA Medical Malpractice Program. Guidance on the deeming process was published on September 24, 2004, and HRSA has established a designated email account and phone line so that free clinics and eligible health professionals may easily obtain information on the program. The first application was received on December 8, 2004. To date, a total of four applications have been received. Per the relevant authorizing legislation, HRSA will make deeming decisions within 30 days of receipt of a complete application.

It is estimated that:

- the first claim would be filed in late FY 2005 or FY 2006; and,
- the first settlement/judgment would occur in FY 2007.

Funding levels for the Free Clinic Medical Malpractice program during the last five years reflect this effort and are as follows:

	$	FTE
2001	---	---
2002	---	---
2003	---	---
2004	4,821,000	1
2005	99,000	2

Performance Analysis - Performance measures will be developed in preparation for the PART assessment scheduled for the FY 2008 budget cycle.

Rationale for the Budget - No funding is requested for this program in FY 2006. Funds appropriated in FY 2004 and FY 2005, available until expended, are sufficient to support the needs of the program in FY 2006.

Radiation and Exposure Screening and Education Program (RESEP)

Authorizing Legislation - the Radiation Exposure Compensation Act, section 417C of the Public Health Service Act, as amended.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$1,974,000	$1,958,000	$1,936,000	- $22,000
FTE	2	2	2	---

FY 2006 Authorization.....Such Sums as May Be Necessary.

Statement of Budget - The FY 2006 Budget of $1,936,000 is $22,000 below the FY 2005 Appropriation. This funding will continue support for the program at the FY 2005 Appropriated level.

Program Description

The Radiation and Exposure Compensation Act (RECA) authorizes the establishment of a program of grants to States, local governments, and appropriate healthcare organizations to initiate and support programs for individual cancer screening, appropriate medical referrals, public information development and dissemination, and the facilitation of RECA claim documentation to aid the thousands of individuals adversely affected by the mining, transport and processing of uranium and the testing of nuclear weapons for the Nation's weapons arsenal.

Funding levels for the Radiation and Exposure Screening and Education Program during the last five years reflect this effort and are as follows:

Funding for the RESEP during the past five years has been as follows:

	$	FTE
2001	-	
2002	3,998,000	2
2003	1,987,000	2
2004	1,974,000	2
2005	1,958,000	2

Performance Analysis - Performance measures will be developed in preparation for the PART assessment scheduled for the FY 2008 budget cycle.

Rationale for the Budget Request

The FY 2006 Budget of $1,936,000 includes an administrative cost reduction of $22,000 below the FY 2005 Appropriated level. This funding will continue support for the program at the FY 2005 Appropriated level.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Grantees	6	6	6
Patients	1,200	1,200	1,200

Healthy Communities Access Program

Authorizing Legislation - Section 340 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$83,425,000	$82,993,000	$0	- $82,993,000
FTE	12	12	0	-12

FY 2006 Authorization.....Such Sums As Necessary.

Statement of Budget - The FY 2006 Budget Request does not include funding for the Healthy Communities Access program and reflects a reduction of $82,993,000 below the FY 2005 Appropriation.

Program Description

The Healthy Communities Access Program (HCAP) provides grants to build networks and support provider coordination for uninsured and underinsured individuals. HCAP grantees are public and private non-profit organizations that represent a community-wide consortium of safety net providers who have traditionally provided care to the community's uninsured and underinsured regardless of ability to pay.

Funding levels for the Healthy Communities Access Program during the last five years reflect this effort and are as follows:

	$	FTE
2001	124,988,000	12
2002	104,949,000	12
2003	104,317,000	12
2004	83,425,000	12
2005	82,993,000	12

Performance Analysis - Performance measures will be developed in preparation for the PART assessment scheduled for the FY 2008 budget cycle.

Rationale for the Budget Request

No funding is requested for this program in FY 2006. (Authorizing legislation states that the program sunsets at the end of FY 2006.) The President's Budget has requested additional funding for programs that provide direct health care services such as Health Centers. Only 15 percent of current HCAP program activities supports direct health care services. The budget invests in programs that provide direct access to health care. The budget includes $2.0 billion for

Health Centers, a $304 million increase over the FY 2005 level, to open or expand 618 Health Center sites. The Administration is again proposing policies that will facilitate individuals' purchase of health insurance, including:

- The $74 billion over 10 years for health-insurance tax credits for low-income families that will ultimately help 15 million families purchase affordable health insurance.
- $1 billion in grants over two years for 'Cover The Kids', a new campaign to enroll millions more low-income children in Medicaid and SCHIP.
- $4 billion in grants to States to establish health insurance purchasing pools, through which people who qualify for the tax credit can obtain coverage.
- $28.5 billion over 10 years for tax deductions for premiums for major medical insurance, which will ultimately help 6 million Americans save for their health care costs in tax-free accounts.
- $19.2 billion over 10 years for tax rebates for small businesses that contribute to their employees' HSAs, encouraging more small employers to offer health benefits.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
New Awards	35	32	0
Continuations	51	50	0
4th Year Awards	17	10	0
Demonstrations	4	4	0

National Hansen's Disease Program

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

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$17,413,000	$17,251,000	$16,066,000	- $1,185,000
FTE	94	91	91	---

FY 2006 Authorization.....Indefinite

Statement of Budget - The FY 2006 Budget of $16,066,000 is a reduction of $1,185,000 from the FY 2005 Appropriation.

Program Description

The National Hansen's Disease Program (NHDP) offers heath care to Hansen's Disease (HD) patients at the NHDP Center in Baton Rouge, Louisiana, at other contract supported locations in the Baton Rouge area, and in grant supported outpatient regional clinics. The NHDP also coordinates with local health agencies, Medicare and Medicaid agencies to ensure care for HD patients.

The HD population in the United States is approximately 6,000 of whom about 3,000 are cared for under the NHDP regional care program. In FY 2004, 11 regional HD clinics were located in Arizona, California, Florida, Illinois, Massachusetts, New York, Puerto Rico, Texas and Washington.

At the Baton Rouge, Louisiana hospital facility, there are an average of 11 long term residents receiving nursing home care and about 15 inpatients from around the U.S. receiving short term care. In addition, there are currently about 22 long term residents still residing at the historic Gillis W. Long Center at Carville, Louisiana. About 60 of the former long term residents of the NHDP elected to receive a stipend from the Federal government and live independently.

With the exception of the long term residents who continue to reside at Carville, the NHDP operates from leased space in Baton Rouge. The former Federal property at Carville has been transferred to the State of Louisiana. Space and food service for the remaining long term residents is purchased from the State. The NHDP continues to provide some nursing care for the long term residents at Carville.

Funding levels for National Hansen's Disease Program during the last five years reflect this effort and are as follows:

	$	FTE
2001	17,890,000	133
2002	17,839,000	126
2003	18,024,000	103
2004	17,413,000	94
2005	17,251,000	91

Performance Analysis - The performance measures for Hansen's Disease Activities focus on maintaining the safety-net for outpatient services for persons with this disease. Approximately 6,000 persons in the U.S. have Hansen's Disease. About 3,000 of these persons are cared for through outpatient services throughout the Nation under the Hansen's Disease program. This program has consistently met its targets. See Section U.

Rationale for the Budget Request

The FY 2006 Budget of $16,066,000 reflects an administrative cut of $1,185,000 below the FY 2005 Appropriation.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
ADLP Resident Population	35	35	35
ADLP Non-Residential	15	15	15
Regional Centers (Contracts)	11	11	11
Visits	10,000	10,000	10,000

National Hansen's Disease Program by Sub - Activity

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Administration	$2,050,000	$2,000,000	$1,750,000
Clinical Care	6,313,000	6,363,000	5,800,000
Regional Contracts	1,900,000	2,000,000	2,000,000
Research	2,700,000	2,700,000	2,500,000
Facility Operations	2,450,000	2,238,000	2,153,000
Assisted Living Allowance	2,000,000	1,950,000	1,863,000
Total	$17,413,000	$17,251,000	$16,066,000

National Hansen's Disease Program - Buildings and Facilities

Authorizing Legislation - Section 321 (a) of the Public Health Service Act, as amended.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$249,000	$247,000	$222,000	- $25,000

FY 2006 Authorization.....Indefinite

Statement of Budget - The FY 2006 Budget of $222,000 is a reduction of $25,000 below the FY 2005 Appropriated level and will continue support for the National Hansen's Disease Program - Buildings and Facilities at the FY 2005 Enacted level.

Program Description

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 levels for National Hansen's Disease Program buildings and facilities activity during the last five years reflect this effort and are as follows:

	$
2001	250,000
2002	250,000
2003	248,000
2004	249,000
2005	247,000

Performance Analysis - See the National Hansen's Disease narrative.

Rationale for the Budget Request - The FY 2006 Budget of $222,000 includes an administrative reduction of $25,000 below the FY 2005 Appropriated level and will continue support for the National Hansen's Disease Program - Buildings and Facilities at the FY 2005 Appropriated level.

Payment to Hawaii

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

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$2,033,000	$2,017,000	$2,016,000	- $1,000

FY 2006 Authorization.....Indefinite

Statement of Budget - The FY 2006 Budget of $2,016,000 is $1,000 below the FY 2005 Appropriation, and will continue support for the program at the FY 2005 level.

Program Description

Payments are made to the State of Hawaii for the medical care and treatment in its hospital and clinic facilities at Kalaupapa, Molokai and Honolulu of persons with Hansen's Disease (HD). In FY 2004, the Hansen's Disease program in Hawaii supported an average daily Kalaupapa patient load of 40 persons with a total of 5,802 hospital days, and supported 247 HD outpatients with a total of 6,573 outpatient visits. Expenses above the level of the Federal funds appropriated for the support of medical care are borne by the State of Hawaii.

Funding levels for the Payment to Hawaii program during the last five years reflect this effort and are as follows:

	$
2001	2,045,000
2002	2,044,000
2003	2,032,000
2004	2,033,000
2005	2,017,000

Performance Analysis - See the National Hansen's Disease narrative.

Rationale for the Budget Request

The FY 2006 Budget of $2,016,000 is $1,000 below the FY 2005 Appropriated Level, representing an administrative reduction, and will continue support for the program at the FY 2005 level.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Kalaupapa & Hale Mahalu program	$4,450,605	$4,450,605	$4,450,605
Hawaiian HD Outpatient program	$826,672	$826,672	$826,672
Total Hawaiian HD program	$5,277,277	$5,277,277	$5,277,277
Federal Support	$2,033,000	$2,017,000	$2,016,000
Percent of Cost	38.5%	38.2%	38.2%

Black Lung

Authorizing Legislation - Federal Mine, Health, and Safety Act of 1977, Section 427(a).

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$5,963,000	$5,951,000	$5,912,000	- $39,000

FY 2006 Authorization.....Indefinite

Statement of Budget - The FY 2006 Budget of $5,912,000 is a decrease of $39,000 and will continue support for the Black Lung program at the FY 2005 Appropriated Level.

Program Description

This program provides funds through project grants to public and private entities, including faith-based and community-based organizations, for the purpose of establishing and operating clinics which provide for the outreach and education, diagnosis, treatment, rehabilitation, and benefits counseling of active and retired coal miners and others with occupation-related respiratory and pulmonary impairments. Other patients include steel mill workers, agricultural workers, and others with occupationally-related respiratory and pulmonary disease. As they age, their disease severity progresses, and their need for health care services increases along with the cost of those services.

Funding levels for the Black Lung program during the last five years reflect this effort and are as follows:

	$
2001	6,000,000
2002	5,998,000
2003	5,961,000
2004	5,963,000
2005	5,951,000

Performance Analysis

Black Lung Clinics serve as an essential safety-net for persons who are active and retired coal miners and others with occupation-related respiratory and pulmonary impairments. In FY 2003, the program supported services provided to approximately 17,000 patients. See Section U.

Rationale for the Budget - The FY 2006 Budget of $5,912,000 is a decrease of $39,000 for an administrative reduction and will continue support for the Black Lung program at the FY 2005 Appropriated level.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Number of Grantees	15	15	15
Number of Clinic Sites	43	43	43
Persons Served	17,000	17,000	17,000

National Health Service Corps

Authorizing Legislation - Sections 338A, B, I, and L of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
NHSC Field Budget Authority	$45,446,000	$45,068,000	$40,705,000	- $4,363,000
NHSC Recruitment Budget Authority	124,457,000	86,380,000	86,091,000	-289,000
Total, NHSC	$169,903,000	$131,448,000	$126,796,000	-$4,652,000
FTE (Ceiling)	71	75	75	--
FTE (Ceiling Exempt)	53	80	80	--

FY2006 Authorization.....Such sums as necessary

Statement of Budget

The FY 2006 Request of $126,796,000 is a decrease of $4,652,000 below the FY 2005 Appropriation and supports the program.

Program Description

The National Health Service Corps (NHSC) Program assists Health Professional Shortage Areas (HPSAs) in every State, Territory, and Possession of the United States to meet their primary care, oral, and mental health services needs. Over its 33-year history, the NHSC has offered recruitment incentives, such as scholarship and loan repayment support to more than 25,500 health professionals committed to service to the underserved. NHSC clinicians have expanded access to high quality health services and improved the health of underserved people.

Currently, approximately 50 percent of the NHSC clinicians serve in Health Centers around the Nation. The NHSC will continue to work with Health Centers to help meet their clinician needs. The NHSC also places clinicians in other community-based systems of care that serve underserved populations targeting HPSAs of greatest need.

Access to primary care services continues to be a problem for underserved populations for a variety of reasons which include:

- A disproportionate number of health professionals continue to pursue non-primary care training.
- Geographic misdistribution of all health professionals remains a major problem.
- An aging primary care workforce in many underserved areas moves toward retirement without replacement.
- The national health care workforce for the most part does not reflect the racial and ethnic diversity of the population in communities where the lack of access to services and increased health disparities exist.

The NHSC, in partnership with the Health Center Program and other programs targeting areas and populations in need, is a critical part of the safety net infrastructure that assures access to preventive and primary care for vulnerable people. In many cases, the NHSC is the only source of clinicians to care for people of racial and ethnic diversity in communities where lack of access to health care services and increased health disparities exist.

The NHSC Field Program targets:

- recruitment of health professionals, including underrepresented minority and disadvantaged individuals,
- site development efforts and technical assistance to communities for needs assessment and establishing new services,
- support for sites and communities already being served by NHSC clinicians,
- orientation programs for new clinicians,
- State-based efforts to address health professional shortages and to assist in the recruitment and retention of clinicians to serve in underserved areas through active recruitment and placement assistance,
- the development of clinician mentoring and practice enhancement programs,
- programs to expose health professions students to practices in underserved areas to prepare NHSC scholars and attract other students to practices in these areas, and
- a cadre of Ready Responders, PHS Commissioned Officers who serve in HPSAs and are trained to respond to emergencies throughout the nation.

A portion of these developmental efforts will be focused on oral, mental and behavioral health needs.

The NHSC Recruitment Program awards scholarships to health professions students and loan repayment agreements to fully trained clinicians committed to serving underserved communities.

- The NHSC Scholarship Program awards scholarships to health professions students committed to a career in primary care and service in underserved communities of greatest need. Awards are targeted to individuals who demonstrate characteristics that are significantly related to a probable success in a career of service to the underserved. The

Scholarship Program provides a predictable supply of clinicians who will be available over the next 1 to 8 years, depending on the length of their training programs. Upon completion of training, NHSC scholars become salaried employees of organized systems of care in underserved communities.

- The NHSC Loan Repayment Program offers fully trained clinicians the opportunity to receive assistance to pay off qualifying educational loans in exchange for service in a HPSA of greatest need. This service commitment is for a minimum of 2 years in an underserved community. The loan repayment program attracts 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 combination of these two programs allows flexibility in meeting the future needs (through scholars) and the immediate needs (through loan repayers) of underserved communities.

NHSC Field - FY 2004

- About 300 scholars began service in HPSAs of greatest need.
- Placement of 1,058 loan repayment clinicians to begin immediate service in underserved communities.
- Continued reporting system for NHSC non-grant sites to capture utilization and demographic information on populations served.
- Increased technical assistance to sites to increase the effectiveness, efficiency, and quality of the health care services provided.

NHSC Recruitment - FY 2004

1. AWARDS

- In FY 2003, 189 Scholarships were awarded and 103 Scholarships were continued. There were 1,058 Loan Repayment contracts awarded and 343 amendments processed.

2. PROGRAM

- 24 percent of NHSC Scholars in FY 2003 were racial/ethnic minorities and of the total 146 Scholars, 30 were from disadvantaged backgrounds and/or had exceptional financial need.
- 25 percent of NHSC Loan Repayment participants in FY 2003 were racial/ethnic minorities and of the total 1,204 new loan repayers, 55 came from disadvantaged backgrounds or had exceptional financial need.

- 78.4 percent of NHSC clinicians who fulfilled their service commitment in FY 2003 chose to remain in service to the underserved.

Funding levels for The NHSC Program during the last five years reflect this effort and are as follows:

	$	FTE
2001	125,374,000	176
2002	145,377,000	136
2003	171,089,000	121
2004	169,903,000	124
2005	131,448,000	155

Performance Analysis

The overall goal of the National Health Service Corps, which is a Presidential Initiative, is to reduce access barriers to essential health care by assisting Health Professional Shortage Areas (HPSAs) to meet the needs of their populations for primary, oral and mental health services. The program has been very successful in recruiting dedicated, fully-trained primary care clinicians to serve in federally-funded community health centers, hospital-based practices, health departments, rural health clinics, and other hard-to-fill health provider vacancies.

NHSC field strength has increased steadily in recent years, reaching **over** 4,000 in FY 2004, substantially surpassing the target. However, funding increasing numbers of loan repayment contract amendments is projected to reverse this growth and reduce the NHSC Field Strength. The program's impact goes beyond that indicated by the numbers of providers meeting service obligations each year. For example, a great many providers placed by the NHSC remain in service in high-need areas after their contractual obligations have been completed. From FY 2001 to FY 2003, between 75% and 80% of NHSC clinicians were retained, virtually meeting or exceeding the performance targets for those years. In FY 2001 approximately 4.4 million patients were served by the placement and retention of NHSC clinicians, and the number is projected to increase to 5.34 million patients by FY 2010. Further, NHSC's annual vacancy list also serves as a significant source of employment information for the public and, therefore, each year many needy communities get clinicians through other sources because of the awareness that the NHSC list creates. Clearly, the NHSC program has a broad and long-lasting impact on access to care in the Nation's neediest communities.

The information provided above on NHSC performance is based on a combination of previous GPRA measures and measures developed as part of OMB's assessment of the NHSC program during the FY 2004 budget cycle using the Program Assessment Rating Tool (PART). Additional information on these measures is presented in Section Section U of this performance budget. The strong performance of the NHSC program as noted above and its favorable PART rating were considered in making the FY 2006 request.

Rationale for the Budget

The FY 2006 Budget request of $126,796,000 reflects a Federal administrative cost-savings of $4,652,000 below the FY 2005 Appropriation which includes a $289,000 cost-savings for NHSC Recruitment. The American Jobs Creation Act of 2004 exempts NHSC loan repayments from taxation as income. This change permits HRSA to make approximately 40 percent more awards under the loan repayment program because HRSA no longer will reimburse loan repayment participants for the tax payment. Scholarship awards are also tax exempt.

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

Funding in FY 2006 for the NHSC Field Program will support efforts to work with Health Centers and other community-based systems of care to improve the quality of care provided and reduce the health disparities gap.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Awards			
Scholarships	189	120	121
Scholarship Continuations	103	78	78
Federal Loan Repayments	1,058	553	412
Federal Loan Repayment Amendments	343	918	1,108
State Loan Repayment Program 1/	217	217	217

1/ The State Loan Repayment Program makes grant awards to States who in turn enter into service contracts. The numbers provided reflect the number of contracts entered into by the 34 States participating in the Program in FY 2004.

Table 1. Impact on NHSC Field Strength of FY 2006 Budget Request

Fiscal Year	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
AWARDS:											
Scholarships	265	316	146	189	120	121	121	121	121	121	121
Sch. Cont.	60	89	78	103	78	78	78	78	78	78	78
Fed. LR	286	625	1,204	1,058	553	412	832	898	781	651	677
Fed. LR Amend.	350	254	255	343	918	1,108	507	413	581	767	729
State LR	215	217	217	217	217	217	217	217	217	217	217
FIELD STRENGTH:											
Schol. Obligors	861	892	807	786	814	723	636	628	580	565	508
Loan Repayers	954	1,248	2,161	2,556	2,478	2,031	1,716	2,101	2,215	2,154	2,016
State LR	483	570	557	557	557	557	557	557	557	557	557
CSP	27	28	25	21	19	17	15	13	11	9	9
FED.	39	27	65	65	80	80	80	80	80	80	80
(9/30)	2,364	2,765	3,615	3,985	3,948	3,408	3,004	3,379	3,443	3,365	3,170
Placements:											
Grant	1,182	1,265	1,880	2,072	2,053	1,772	1,562	1,757	1,790	1,750	1,648
Non-Grant	1,182	1,500	1,735	1,913	1,895	1,636	1,442	1,622	1,653	1,615	1,522

Waterfall Assumptions:

1. Funding remains level years FY06 through FY11
2. Funding distribution: 20% Scholarship / 80% Loan Repayment
3. FED. includes Ready Responders

Health Professions Training for Diversity

Centers of Excellence

Authorizing Legislation - Section 736 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$33,657,000	$33,609,000	$---	- $33,609,000

FY 2006 Authorization.....Expired

Statement of Budget

No funding is requested for this program in FY 2006 which is a decrease of $33,609,000 below the FY 2005 Appropriation level.

Program Description

The Centers of Excellence (COE) Program provides support for designated health professions schools. Designated health professions schools, under Section 736 of the Public Health Service Act, include such schools that meet the required general conditions regarding: a) certain Historically Black Colleges and Universities, b) Hispanic individuals, c) Native American individuals, and d) enrollment of underrepresented minorities above the national average for such enrollments of health professions schools. The COE grants and contracts may also be used for other public and nonprofit health or educational entities to assist such designated schools for programs of excellence in health professions education.

Funding levels for the COE Program during the last five years reflect this effort and are as follows:

	$
2001	30,388,000
2002	32,788,000
2003	34,088,000
2004	33,657,000
2005	33,609,000

Performance Analysis

Most of the Health Professions' Title VII and Title VIII programs were reviewed as a unit during the FY 2004 budget cycle using the Program Assessment Rating Tool (PART). This was included in this assessment. These programs, in the aggregate, received a rating of "Ineffective." New

performance measures were established for the Health Professions program overall. These measures are shown in Section U.

Rationale for the Budget Request

No funding is requested for this program in FY 2006 which is a decrease of $33,609,000 below the FY 2005 Appropriation level. Other sources of funding through partnership linkages with private and corporate entities are available to provide support for health professions training. The budget focuses on activities which fund the placement of more doctors, nurses, and other health care professionals in underserved areas. There are regions and pockets of the country that face critical shortages, but 8 of every 10 providers who benefitted from the program's long-term training support in 1999 to 2001 did not practice in shortage areas. The General Accounting Office (GAO) concluded in 1994 that evaluations have not linked the Health Professions programs to changes in supply, distribution, and minority representation of health professionals.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Number of projects	34	34	--
Number of URM students participating in research on minority health issues	1,010	1,010	--
Number of URM faculty	1,850	1,850	--

Health Professions Training for Diversity

Scholarships for Disadvantaged Students

Authorizing Legislation - Section 737 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$47,510,000	$47,129,000	$9,831,000	- $37,298,000

FY 2006 Authorization.....Expired

Statement of Budget

The FY 2006 request of $9,831,000 is a decrease of $37,298,000 below the FY 2005 Appropriation level and supports the program.

Program Description

The Scholarships for Disadvantaged Students (SDS) Program increases diversity in the health professions and nursing workforce by providing funds to eligible health professions and nursing schools for use in awarding scholarships to financially needy students from disadvantaged backgrounds, many of whom are underrepresented minorities (URMs). The health disciplines funded by the SDS Program include allopathic medicine, osteopathic medicine, dentistry, veterinary medicine, optometry, podiatry, pharmacy, chiropractic, behavioral and mental health, public health, nursing, allied health, and physician assistants.

The SDS Program assists eligible students who are pursuing a health professions or nursing education by eliminating or reducing financial barriers that might otherwise prevent these students from enrolling. For each SDS dollar received, the recipient is relieved of the repayment burden associated with loan funds.

The availability of these scholarship funds improves access to health care by reducing the level of debt the students must incur to obtain a health professions or nursing education, thereby facilitating the ability of these students to choose to practice in underserved areas, where salaries are generally lower than in other areas. In addition, as the U.S. population is becoming more racially and ethnically diverse, the training of individuals from disadvantaged backgrounds (including URMs) is essential for meeting the needs of the general population for culturally sensitive and appropriate health care.

Since 1999, SDS funds have been made available only to schools that demonstrate a commitment to enrolling and graduating disadvantaged students. Among schools that meet the eligibility criteria, the distribution of funds is weighted more heavily toward those schools that demonstrate a commitment to training primary care practitioners, URMs, and individuals who practice in medically underserved communities. The school eligibility requirements and funding priorities are designed to direct SDS funds to schools that have a demonstrated commitment to training a health care workforce that will contribute to improved access to health care in our Nation.

Over 13,000 disadvantaged students received scholarship assistance in Academic Year 2003-2004. Of these, more than 6,400 were nursing students and more than 2,000 were pharmacy students.

Of the schools that received SDS awards in FY 2003, 47 percent had a demonstrated commitment to primary care, 71 percent had a demonstrated commitment to enrolling URMs, and 57 percent had a demonstrated commitment to graduating students who practice in medically underserved communities.

Funding levels for the SDS Program during the last five years reflect this effort and are as follows:

	$
2001	44,473,000
2002	46,216,000
2003	47,795,000
2004	47,510,000
2005	47,129,000

Performance Analysis

Most of the Health Professions' Title VII and Title VIII programs were reviewed as a unit during the FY 2004 budget cycle using the Program Assessment Rating Tool (PART). This was included in this assessment. These programs, in the aggregate, received a rating of "Ineffective." New performance measures were established for the Health Professions program overall. These measures are shown in Section U.

Rationale for the Budget Request

The FY 2006 Budget of $9,831,000 reflects a Federal administrative cost-savings of $65,000 below the FY 2005 Appropriation. The total request will facilitate the training of health practitioners from disadvantaged backgrounds, including URMs, helping to increase diversity among health practitioners effecting improved access to health care.

URMs are the fastest growing segment constituting approximately 31 percent of the U.S. population, and the 2000 Census forecasts a marked increase in this percentage in the future. However, they account for only 10 percent of the health professions workforce and 13 percent of

the enrollment in the disciplines eligible for the SDS Program. This disparity is expected to increase during the 21st century.

There is a strong correlation between increased disadvantaged and URM representation within the health professions workforce and improved access to health care. Three times as many minorities live in health professions shortage areas (HPSAs) as compared to the general population. Practitioners who are from disadvantaged backgrounds or are URMs are more likely than other practitioners to locate in HPSAs and to provide care to those who are low-income, disadvantaged, or have special needs.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Number of disadvantaged students	13,022	13,022	2,893
Number of URM students	6,998	6,998	1,555
Percent of URM students	53.7%	53.7%	53.7%

Health Professions Training for Diversity

Faculty Loan Repayment Program/Minority Faculty Fellowship Program:

Authorizing Legislation - Section 738 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$1,313,000	$1,302,000	$---	- $1,302,000

FY 2006 Authorization.....Expired

Statement of Budget

No funding is requested for this program in FY 2006 which is a decrease of $1,302,000 below the FY 2005 Appropriation level.

Program Description

The Faculty Loan Repayment Program (FLRP) and the Minority Faculty Fellowship Program (MFFP) provides loan repayment and fellowships to faculty from disadvantaged backgrounds, many of whom are underrepresented minorities (URMs), at eligible health professions schools or programs. These include allopathic medicine, osteopathic medicine, dentistry, veterinary medicine, optometry, podiatry, pharmacy, nursing, public health, behavioral and mental health, and allied health. In FY 2002, the MFFP funded four grant programs to area medical schools. Recipients must agree to serve as faculty for a minimum of two years.

Funding levels for the FLRP and MFFP Program during the last five years reflect this effort and are as follows:

	$
2001	1,330,000
2002	1,330,000
2003	1,321,000
2004	1,313,000
2005	1,302,000

Performance Analysis

Most of the Health Professions' Title VII and Title VIII programs were reviewed as a unit during the FY 2004 budget cycle using the Program Assessment Rating Tool (PART). This was included

in this assessment. These programs, in the aggregate, received a rating of "Ineffective." New performance measures were established for the Health Professions program overall. These measures are shown in Section U.

Rationale for the Budget Request

No funding is requested for this program in FY 2006 which is a decrease of $1,302,000 below the FY 2005 Appropriation level. It has been a relatively small effort that can be supported in the future by other funding sources, such as States, health professions institutions, and private foundations. NIH will continue to provide support to physicians, nurses, and scientists from disadvantaged backgrounds to conduct clinical research either at NIH or at extramural research institutions. There are regions and pockets of the country that face critical shortages, but 8 of every 10 providers who benefitted from the program's long-term training support in 1999 to 2001 did not practice in shortage areas. The General Accounting Office (GAO) concluded in 1994 that evaluations have not linked the Health Professions programs to changes in supply, distribution, and minority representation of health professionals.

The primary focus of the NIH program is on activities which fund the placement of more doctors, nurses, and other health care professionals in underserved areas.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Number of faculty	44	44	--

Health Professions Training for Diversity

Health Careers Opportunity Program

Authorizing Legislation - Section 739 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$36,160,000	$35,646,000	$---	- $35,646,000

FY 2006 Authorization.....Expired

Statement of Budget

No funding is requested for this program in FY 2006 which is a decrease of $35,646,below the FY 2005 Appropriation level.

Program Description

The Health Careers Opportunity Program (HCOP) provides grants to eligible accredited schools and public and private non-profit health educational entities. HCOP funds may be used for: 1) identifying, recruiting, and selecting individuals from disadvantaged backgrounds for education and training in a health profession; 2) facilitating the entry of such individuals into such a school; 3) providing counseling, mentoring, or other services designed to assist such individuals to complete successfully their education at such a school; 4) providing, for a period prior to the entry of such individuals into the regular course of education of such a school, preliminary education and health research training designed to assist them to complete successfully such regular course of education at such a school, or referring such individuals to institutions providing such preliminary education; 5) publicizing existing sources of financial aid available to students in the education program of such a school or who are undertaken training necessary to quality them to enroll in such a program; 6) paying scholarships, as the Secretary may determine, for such individuals for any period of health professions education at a health professions school; 7) paying such stipends for such individuals for any period of education in student-enhancement programs (other than regular courses), except that such a stipend may not be provided to an individual for more than 12 months; 8) carrying out programs under which such individuals gain experience regarding a career in a field of primary health care through working at facilities of public or private nonprofit community-based providers of primary health services; 9) conducting activities to develop a larger and more competitive applicant pool through partnerships with

institutions of higher education, school districts, and other community-based entities. Funding levels for the HCOP during the last five years reflect this effort and are as follows:

	$
2001	33,044,000
2002	34,611,000
2003	36,153,000
2004	36,160,000
2005	35,646,000

Performance Analysis

Most of the Health Professions' Title VII and Title VIII programs were reviewed as a unit during the FY 2004 budget cycle using the Program Assessment Rating Tool (PART). This was included in this assessment. These programs, in the aggregate, received a rating of "Ineffective." New performance measures were established for the Health Professions program overall. These measures are shown in Section U.

Rationale for the Budget Request

No funding is requested for this program in FY 2006 which is a decrease of $35,646,below the FY 2005 Appropriation level. Other sources of funding through partnership linkages with private and corporate entities are available to provide support for health professions training. Private foundations have put resources into increasing the number of disadvantaged and minority students entering the health professions and other science-disciplines, thus eliminating the need for the Federal Government to fund these activities. There are regions and pockets of the country that face critical shortages, but 8 of every 10 providers who benefitted from the program's long-term training support in 1999 to 2001 did not practice in shortage areas. The General Accounting Office (GAO) concluded in 1994 that evaluations have not linked the Health Professions programs to changes in supply, distribution, and minority representation of health professionals.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Number of minority/disadvantaged students in structured programs:			
Post-secondary	8,120	7,500	--
Secondary education (K-12)	3,891	3,400	--

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Number of matriculants in health and allied health professions schools	1,850	1,500	--
Number of grants	84	80	--

Training in Primary Care Medicine and Dentistry

Authorizing Legislation - Section 747 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$81,917,000	$88,816,000	$---	- $88,816,000

FY 2006 Authorization.....Expired

Statement of Budget

No funding is requested for this program in FY 2006 which is a decrease of $88,816,000 below the FY 2005 Appropriation level.

Program Description

The Training in Primary Care Medicine and Dentistry Program is comprised of four components: (1) Family Medicine (FM) (2) General Internal Medicine (GIM) and General Pediatrics (GP) (3) Physician Assistant (PA) and (4) General and Pediatric Dentistry (GPD).

The Primary Care Medicine, and Dentistry Programs (FM, GIM/GP, PA, and GPD) provide grants to public or nonprofit private hospitals, schools of medicine, osteopathic medicine, dentistry, physician assistants and other public or private nonprofit entities that prepare primary care physicians through predoctoral education, residency training, faculty development, and establishment or substantial expansion of academic administrative units. The program also provides grants to public and private nonprofit schools to plan, develop, and operate or maintain programs for the training of PAs or for individuals who teach in programs of such training. The program provides grants to dental schools, approved residency and advanced education programs in general or pediatric practice of dentistry for planning, development or operations and financial assistance to their residents. Funds are also provided for cooperative agreements and contracts to develop, implement and disseminate innovative curriculum.

Funding levels for the Training in Primary Care Medicine and Dentistry Program during the last five years reflect this effort and are as follows:

	$
2001	91,048,000
2002	93,002,000
2003	92,432,000
2004	81,917,000
2005	88,816,000

Performance Analysis

Most of the Health Professions' Title VII and Title VIII programs were reviewed as a unit during the FY 2004 budget cycle using the Program Assessment Rating Tool (PART). This was included in this assessment. These programs, in the aggregate, received a rating of "Ineffective." New performance measures were established for the Health Professions program overall. These measures are shown in Section U.

Rationale for the Budget Request

No funding is requested for this program in FY 2006 which is a decrease of $88,816,000 below the FY 2005 Appropriation. The number of primary care physicians and physician assistants has grown significantly over the past decade. In addition, salaries and economic incentives for primary care providers have also increased. The General Accounting Office (GAO) reported in 2003 that the U.S. physician population increased by 26 percent, which was twice the rate of growth of the total population, between 1991 and 2001. Many of the Health Professions programs were created in response to an anticipated national shortage of physicians - that shortage does not exist. While geographic disparities persist, growth was seen in historically high-supply metropolitan areas as well as low-supply statewide non-metropolitan areas. There are regions and pockets of the country that face critical shortages, but 8 of every 10 providers who benefitted from the program's long-term training support in 1999 to 2001 did not practice in shortage areas. The General Accounting Office (GAO) concluded in 1994 that evaluations have not linked the Health Professions programs to changes in supply, distribution, and minority representation of health professionals.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Number in clinical training with health care service delivery organizations serving under served areas.			
Residents/Graduates	3,029	3,029	--
Students/Trainees	19,231	19,231	--
Faculty	1,827	1,827	--
Number who enter practice in under served areas.			
Residents/Graduates	483	483	--
Students/Trainees	1,144	1,144	--
Faculty	722	722	--
Number that provide and support primary care.			
Residents/Graduates	1,826	1,826	--
Students/Trainees	23,694	23,694	--
Faculty	3,137	3,137	--
Number of minority/disadvantaged individuals who completed training.			
Residents/Graduates	818	818	--
Students/Trainees	4,476	4,476	--
Faculty	554	554	--
Number of minority/disadvantaged individuals in training.			
Residents/Graduates	856	856	--
Students/Trainees	9,652	9,652	--
Faculty	416	416	--

Interdisciplinary, Community-Based Linkages

Area Health Education Centers:

Authorizing Legislation - Section 751 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$29,206,000	$28,971,000	$---	- $28,971,000

FY 2006 Authorization.....Expired

Statement of the Budget

No funding is requested for this program in FY 2006 which is a decrease of $28,971,000 below the FY 2005 Appropriation level.

Program Description

The AHEC Program provides cooperative agreements to medical and nursing schools to encourage the establishment and maintenance of community based training programs in off-campus rural and underserved areas. Interdisciplinary teams of students, faculty and practitioners are trained in community-based settings such as community/migrant health centers, rural health centers, National Health Service Corps sites, local health departments and other underserved area sites. Emphasis is placed also on enhancing the diversity of the health personnel workforce and improving the practice environment and the quality of care available in underserved areas.

Funding levels for the AHEC Program during the last five years reflect this effort and are as follows:

	$
2001	33,125,000
2002	33,346,000
2003	32,946,000
2004	29,206,000
2005	28,971,000

Performance Analysis

Most of the Health Professions' Title VII and Title VIII programs were reviewed as a unit during the FY 2004 budget cycle using the Program Assessment Rating Tool (PART). This was included in this assessment. These programs, in the aggregate, received a rating of "Ineffective."

New performance measures were established for the Health Professions program overall. These measures are shown in Section U.

Rationale for the Budget Request

No funds are requested for this program in FY 2006 which is a decrease of $28,971,000 below the FY 2005 Appropriation. State and local entities provide significant matching funds (50% Federal and 50% State and Local Matching Funds) to AHEC programs and centers within their individual States. The AHEC Programs have been well received and it is anticipated that they will be supported by state and local resources in the future. The number of primary care physicians and physician assistants has grown significantly over the past decade. In addition, salaries and economic incentives for primary care providers have also increased. The General Accounting Office (GAO) reported in 2003 that the U.S. physician population increased by 26 percent, which was twice the rate of growth of the total population, between 1991 and 2001. Many of the Health Professions programs were created in response to an anticipated national shortage of physicians - that shortage does not exist. While geographic disparities persist, growth was seen in historically high-supply metropolitan areas as well as low-supply statewide non-metropolitan areas. There are regions and pockets of the country that face critical shortages, but 8 of every 10 providers who benefitted from the program's long-term training support in 1999 to 2001 did not practice in shortage areas. The General Accounting Office (GAO) also concluded in 1994 that evaluations have not linked the Health Professions programs to changes in supply, distribution, and minority representation of health professionals.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
No. of medical students trained in community sites in rural/underserved areas	16,000	16,000	--
No. of associated health profession students trained in community sites in rural/underserved areas	14,000	14,000	--
No. of training linkages with community/migrant health centers and other underserved area sites	250	250	--

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
No. of local providers who received continuing education Training on Women's Health, Diabetes, HIV AIDS, Cultural Competence and Bioterrorism Response	300,000	300,000	--
No. of elementary/high school students receiving health career guidance and information from the Kids Into Health Careers in the AHEC Programs	300,000	300,000	--
No. of minority/disadvantaged students participating in a hlth. career trng. and/or academic enhancement experience	24,000	24,000	--
No. of new health professions training sites to be established in underserved areas	20	20	--
No. of health professions students trained at new sites	80	80	--
No. of States with AHEC Programs	46	46	--

Interdisciplinary, Community-Based Linkages

Health Education and Training Centers:

Authorizing Legislation - Section 752 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$3,851,000	$3,819,000	$---	- $3,819,000

FY 2006 Authorization.....Expired

Statement of the Budget

No funding is requested for this program in FY 2006 which is a decrease of $3,819,000 below the FY 2005 Appropriation level.

Program Description

The Health Education and Training Centers (HETC) Program provides grants to HETCs along the U.S.-Mexico Border and in the State of Florida, and in other urban and rural areas. Program emphasis is on health education and population-based approaches; community-based training experiences are provided to health professions students, local providers (including nurses) and community health workers, at sites of severe underservice in order to improve access to health care, and enhance the diversity of students and the cultural competence of the existing health workforce.

Funding levels for the HETC Program during the last five years reflect this effort and are as follows:

	$
2001	4,640,000
2002	4,400,000
2003	4,371,000
2004	3,851,000
2005	3,819,000

Performance Analysis

Most of the Health Professions' Title VII and Title VIII programs were reviewed as a unit during the FY 2004 budget cycle using the Program Assessment Rating Tool (PART). This was included in this assessment. These programs, in the aggregate, received a rating of "Ineffective."

New performance measures were established for the Health Professions program overall. These measures are shown in Section U.

Rationale for the Budget Request

No funds are requested for this program in FY 2006 which is a decrease of $3,819,000 below the FY 2005 Appropriation. The programs have been well-received and it is possible they will be supported by State and local resources and other funding sources in the future. The number of primary care physicians and physician assistants has grown significantly over the past decade. In addition, salaries and economic incentives for primary care providers have also increased. The General Accounting Office (GAO) reported in 2003 that the U.S. physician population increased by 26 percent, which was twice the rate of growth of the total population, between 1991 and 2001. Many of the Health Professions programs were created in response to an anticipated national shortage of physicians - that shortage does not exist. While geographic disparities persist, growth was seen in historically high-supply metropolitan areas as well as low-supply statewide non-metropolitan areas. There are regions and pockets of the country that face critical shortages, but 8 of every 10 providers who benefitted from the program's long-term training support in 1999 to 2001 did not practice in shortage areas. The General Accounting Office (GAO) also concluded in 1994 that evaluations have not linked the Health Professions programs to changes in supply, distribution, and minority representation of health professionals.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
No. of minority/disadvantaged elementary/high school students receiving a health career experience	330	330	--
No. of local residents trained as community health workers	140	140	--
No. of local providers or health professions students receiving a public health training experience at an underserved area site	300	300	--
No. of new health professions training sites to be established in underserved areas	20	20	--
No. of health professions students trained at new sites	80	80	--

Interdisciplinary, Community-Based Linkages

Geriatric Programs

Authorizing Legislation - Section 753 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$31,805,000	$31,548,000	$---	- $31,548,000

FY 2006 Authorization.....Expired

Statement of the Budget

No funding is requested for this program in FY 2006 which is a decrease of $31,548,000 below the FY 2005 Appropriation level.

Program Description

Geriatric programs include three activities: 1) Geriatric Education Centers (GECs); 2) The Geriatric Training Program for Physicians, Dentists, and Behavioral/Mental Health Professionals; and 3) Geriatric Academic Career Awards (GACA).

The Geriatric Training Program for Physicians, Dentists, and Behavioral/Mental Health Professionals provides intensive one and two-year fellowship training in geriatrics to physicians, dentists, and behavioral and mental health professionals who plan to teach geriatric medicine in their respective fields.

Geriatric Academic Career Awards provide five years of support for academic career development to geriatricians who are junior faculty members at medical schools. The awards require and allow the recipients to devote the bulk of their academic careers to teaching geriatrics.

Funding levels for the Geriatric Programs during the last five years reflect this effort and are as follows:

	$
2001	12,410,000
2002	20,400,000
2003	27,818,000
2004	31,805,000
2005	31,548,000

Rationale for the Budget Request

No funds are requested for these programs in FY 2006 which is a decrease of $31,548,000 below the FY 2005 Appropriation. The Geriatric Education and Training Programs are relatively small efforts that can and do secure support from other sources of funding, including the States and other Federal programs such as the Veterans Administration and Centers for Medicaid and Medicare Services. The number of primary care physicians and physician assistants has grown significantly over the past decade. In addition, salaries and economic incentives for primary care providers have also increased. The General Accounting Office (GAO) reported in 2003 that the U.S. physician population increased by 26 percent, which was twice the rate of growth of the total population, between 1991 and 2001. Many of the Health Professions programs were created in response to an anticipated national shortage of physicians - that shortage does not exist. While geographic disparities persist, growth was seen in historically high-supply metropolitan areas as well as low-supply statewide non-metropolitan areas. There are regions and pockets of the country that face critical shortages, but 8 of every 10 providers who benefitted from the program's long-term training support in 1999 to 2001 did not practice in shortage areas. The General Accounting Office (GAO) also concluded in 1994 that evaluations have not linked the Health Professions programs to changes in supply, distribution, and minority representation of health professionals.

Performance Analysis

Most of the Health Professions' Title VII and Title VIII programs were reviewed as a unit during the FY 2004 budget cycle using the Program Assessment Rating Tool (PART). This was included in this assessment. These programs, in the aggregate, received a rating of "Ineffective." New performance measures were established for the Health Professions program overall. These measures are shown in Section U.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Number of health care providers receiving training in geriatrics	61,530	61,530	--
Number of GECs	47	47	--
Number of dollars leveraged from other sources by each dollar of Federal funding	3	3	--

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Number of geriatric fellowship trainees	66	66	--
Number of GACAs	90	90	--

Interdisciplinary, Community-Based Linkages

Quentin N. Burdick Program for Rural Interdisciplinary Training:

Authorizing Legislation - Section 754 of the Public Health Service Act

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$6,125,000	$6,076,000	$---	- $6,076,000

FY 2006 Authorization.....Expired

Statement of the Budget

No funding is requested for this program in FY 2006 which is a decrease of $6,076,000 below the FY 2005 Appropriation level.

Program Description

The goal of the Quentin N. Burdick Program for Rural Interdisciplinary Training is to increase the distribution of health care professionals to rural areas by recruiting, training and retaining teams of interdisciplinary professionals to work in rural underserved areas. The program fumds student stipends and interdisciplinary training projects.

Funding levels for the Quentin N. Burdick Program during the last five years reflect this effort and are as follows:

	$
2001	5,988,000
2002	6,996,000
2003	6,954,000
2004	6,125,000
2005	6,076,000

Performance Analysis

Most of the Health Professions' Title VII and Title VIII programs were reviewed as a unit during the FY 2004 budget cycle using the Program Assessment Rating Tool (PART). This was included in this assessment. These programs, in the aggregate, received a rating of "Ineffective." New performance measures were established for the Health Professions program overall. These measures are shown in Section U.

Rationale for the Budget Request

No funds are requested for this program in FY 2006 which is a decrease of $6,076,000 below the FY 2005 Appropriation. The Quentin N. Burdick Program for Rural Interdisciplinary Training are relatively small training efforts that have secured support from other funding sources, including other Federal programs such as the Administration on Children and Families and private foundations, such as the Robert Wood Johnson Foundation. There are regions and pockets of the country that face critical shortages, but 8 of every 10 providers who benefitted from the program's long-term training support in 1999 to 2001 did not practice in shortage areas. The General Accounting Office (GAO) concluded in 1994 that evaluations have not linked the Health Professions programs to changes in supply, distribution, and minority representation of health professionals.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Number of students and rural health care providers trained in community interdisciplinary rural settings	900	900	--
No. of interdisciplinary rural clinical training sites	35	35	--
Percent of program completers that will work in rural areas	50	50	--

Interdisciplinary, Community-Based Linkages

Allied Health and Other Disciplines:

Authorizing Legislation - Section 755 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$11,674,000	$11,753,000	$---	- $11,753,000

FY 2006 Authorization.....Expired

Statement of the Budget

No funding is requested for this program in FY 2006 which is a decrease of $11,753,000 below the FY 2005 Appropriation level.

Program Description

The Allied Health Projects Grant Program makes grants to eligible entities to assist them in meeting the costs associated with expanding or establishing an allied health professions program. Chiropractic Demonstration Project grants support research in which chiropractors and physicians collaborate to identify and provide effective treatments for spinal and/or lower back conditions. The Podiatric Primary Care Residency Training Program awards grants to eligible entities to plan and implement projects in preventive and primary care training for podiatric physicians residency programs, and may provide financial assistance in the form of traineeships to residents who participate in such projects and who plan to specialize in primary care. In addition to this grant program, HRSA also has cooperative agreements with residency training programs to plan and operate interdisciplinary geriatric podiatric programs.

Funding levels for the Allied Health and Other Disciplines Program during the last five years reflect this effort and are as follows:

	$
2001	8,422,000
2002	9,495,000
2003	11,922,000
2004	11,674,000
2005	11,753,000

Performance Analysis

Most of the Health Professions' Title VII and Title VIII programs were reviewed as a unit during the FY 2004 budget cycle using the Program Assessment Rating Tool (PART). This was included in this assessment. These programs, in the aggregate, received a rating of "Ineffective." New performance measures were established for the Health Professions program overall. These measures are shown in Section U.

Rationale for the Budget Request

No funds are requested for this program in FY 2006 which is a decrease of $11,753,000 below the FY 2005 Appropriation. Many of the community-based interdisciplinary training programs using telemedicine and other distance learning education and training techniques have been institutionalized and will continue to provide training in the future.

The Chiropractic Demonstration Projects and Podiatric Medicine Primary Care Programs are also relatively small efforts that can be supported from other funding sources. There are regions and pockets of the country that face critical shortages, but 8 of every 10 providers who benefitted from the program's long-term training support in 1999 to 2001 did not practice in shortage areas. The General Accounting Office (GAO) concluded in 1994 that evaluations have not linked the Health Professions programs to changes in supply, distribution, and minority representation of health professionals.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Allied Health			
Number of graduates	2,388	2,388	--
Number of URM graduates	972	972	--
Percent of URM graduates	41	41	--
No. of graduates entering practice in MUCs	1,150	1,150	--
Percent of graduates entering practice in MUCs	48	48	--
Chiropractic Demonstration Projects			
Number of awards	3	3	--
No. of chiros. involved in research projects	21	21	--

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Podiatric Primary Care Residency*			
Number of residents/graduates who enter practice in underserved areas.	5	5	–
Number of residents/graduates that provide and support primary care	68	68	--
Number of minority/disadvantaged residents/graduates who completed training	–	–	–
Number of minority/disadvantaged residents/graduates in training	18	18	--

*Data reported for the Podiatric Primary Care Residency training program are FY 2003 expected outcomes projected from FY 2000 actual data, adjusted for budget changes.

Health Professions Workforce Information and Analysis

Authorizing Legislation - Sections 761 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$722,000	$716,000	$712,000	- $4,000

FY 2006 Authorization.....Expired

Statement of the Budget

The FY 2006 Budget request of $712,000 is a decrease of $4,000 below the FY 2005 Appropriation level.

Program Description

The goals of the Health Professions Workforce Information and Analysis program are to: 1) provide health workforce information and analyses to national, State, and local policymakers and researchers on a broad range of issues, such as shortages of registered nurses, shortages of pharmacists, and the distribution of health care workers in underserved areas; 2) conduct Federal-State collaborative efforts directed at assessing the adequacy of the current and future health care workforce from the Federal, State and local perspective; and 3) develop strategies for improving the diversity and distribution of the health workforce.

About 15 cents of every dollar spent in the United States is spent on health care and one out of every 10 jobs is in the health care industry. In spite of the magnitude of expenditures and employment in health care, with the exception of physicians, relatively little is known concerning the health care workforce. For example, while public health is one of the most fundamental Federal, State and local government functions--responsible for addressing health care issues that account for 50 percent of all preventable deaths--there are inadequate data available on the public health workforce to assess public health workforce needs versus supply, distribution, and training needs.

An investment in health workforce information and analysis will result in more efficient allocation of resources and may greatly reduce Federal, State, and private expenditures in health care. For example, better information on the issues affecting the supply and demand for such professions as nurses, pharmacists, and clinical laboratory workers would help identify and describe the causes of reported shortages currently being reported for these professions, and provide potential options for limiting them.

Health policymakers and groups of experts have advocated for a strong Federal Government role in developing information and conducting analyses on health workforce supply, requirements,

and distribution. Two reports include findings from the Institute of Medicine (IOM): Primary Care: America's Health in a New Era, March 1996 and The Nation's Physician Workforce: Options for Balancing Supply and Requirements, February 1996. Many State and local governments have also expressed this need through numerous requests for assistance in analyzing their health workforce supply and requirements.

The Health Professions Workforce Information and Analysis activities are conducted in three ways:

1. In-house research and analysis
2. Cooperative agreements with Regional Centers for Health Workforce Analysis.
3. Contracts

Funding levels for the Health Professions Workforce Information and Analysis Program during the last five years reflect this effort and are as follows:

	$
2001	824,000
2002	824,000
2003	819,000
2004	722,000
2005	716,000

Performance Analysis

In FY 2004, the program produced 21 reports on pressing health workforce issues. Examples of topics covered in recent reports include national and local workforce shortages for nursing aides, home health aides and pharmacists and the implications of changing demographics for physicians and nurses. Additional information is presented in Section U.

Rationale for the Budget Request

The FY 2006 Budget request of $712,000 reflects a Federal administrative cost-savings of $4,000 below the FY 2005 Appropriation. The decrease will allow continued support for evaluation activities and other programs. The total request will continue to support the existing efforts of the National Center.

The Health Professions Workforce Information and Analysis Program will:

- Continue to support one Regional Center for Health Workforce Studies. Working with the appropriate State officials, the Regional Centers would develop methodologies to study local trends in the supply, distribution, requirements and diversity of the health workforce, including physicians, dentists, nurses, allied health and public health

professionals. The Regional Center would then identify areas having localized shortages of these professionals, identify the causes of these shortages, and develop strategies for addressing the problem.

- Conduct important State and national level studies useful to policy makers such as:
  - Conduct research to identify ways to optimize the impact of the National Health Service Corps in order to achieve the best level of service in underserved areas given the finite resources available.
  - Conduct research on the supply, demand, roles, and issues surrounding the use of Community Health Workers, a very large, but generally unrecognized group of health care workers often used as a way of getting services to underserved populations.
  - Publish a report on the issues surrounding the supply and demand for clinical laboratory workers, currently thought to be in short supply.
  - Publish a report on the impact of Title VII health professions training grants on health professionals practicing in medically underserved areas.

Specific focus areas include:

- Inadequate data on the supply, distribution and racial/ethnic makeup of dentists, nurses, optometrists, pharmacists, podiatrists, and physician assistants prevents even a basic understanding of access to care issues and the current balance of supply and demand.
- Major gaps in data regarding the allied health, public health, and alternative and complementary workforce make it difficult to assess the supply and requirements for these health care providers. Data is also needed to assess the degree to which these professions can substitute for physicians and each other.
- Inadequate data and analysis as it relates to the performance of Titles VII and VIII health professions training grant programs prevents program performance improvements and efficient resource utilization.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
No. of Regional Centers for Health Workforce Studies	1	1	1
Health Workforce Database (ARF) Health disciplines & specialties	18	18	18
Health workforce data & analysis reports (State and National) and technical assistance to States	21	74*	24

* 50 of these reports are State Health Workforce Profiles produced every 2-3 years.

Public Health Workforce Development

Public Health, Preventive Medicine, and Dental Public Health Programs:

Authorizing Legislation - Sections 766, 767 and 768 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$9,170,000	$9,097,000	$---	- $9,097,000

FY 2006 Authorization.....Expired

Statement of Budget

No funding is requested for this program in FY 2006 which is a decrease of $9,097,000 below the FY 2005 Appropriation level.

Program Description

The Public Health, Preventive Medicine, and Dental Public Health Programs award grants to eligible entities to support the education and training of the public health workforce to deal with anticipated and new problems, with emphasis on placing public health professionals, preventive medicine specialists, and public health dentists in medically underserved areas, and improving the racial and ethnic diversity in the workforce.

Funding levels for the Public Health, Preventive Medicine, and Dental Public Health Programs during the last five years reflect this effort and are as follows:

	$
2001	9,478,000
2002	10,473,000
2003	10,600,000
2004	9,170,000
2005	9,097,000

Performance Analysis

Most of the Health Professions' Title VII and Title VIII programs were reviewed as a unit during the FY 2004 budget cycle using the Program Assessment Rating Tool (PART). This was included in this assessment. These programs, in the aggregate, received a rating of "Ineffective." New performance measures were established for the Health Professions program overall. These measures are shown in Section U.

Rationale for the Budget Request

No funding is requested for this program in FY 2006 which is a decrease of $9,097,000 below the FY 2005 Appropriation level. Public Health Traineeships, Preventive Medicine Residency Training, and Public Health Training Centers are infrastructure components that support capacity building at the State and local level and can be continued through collaborations between and among State and local health departments, schools of pubic health, residency programs, private foundations, and community-based service providers serving underserved populations.

Dental public health residency programs can be continued through collaborations between and among state and local health departments, schools of public health, schools of dentistry and private foundations. There are regions and pockets of the country that face critical shortages, but 8 of every 10 providers who benefitted from the program's long-term training support in 1999 to 2001 did not practice in shortage areas. The General Accounting Office (GAO) concluded in 1994 that evaluations have not linked the Health Professions programs to changes in supply, distribution, and minority representation of health professionals.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Public Health Traineeships			
No. of students supported with traineeship funds	8,832	8,832	–
No. of grads supported with traineeship funds	–	–	--
No. of URM grads supported with traineeship funds	--	–	--
Percent of URM graduates supported	--	–	--
Average Traineeship	–	--	–
Preventive Medicine Residency Training			
Number of residents receiving residencies	66	66	–
Number of residents completing training	33	33	–
Number of URM residents completing training	12	12	–
Percent of URM residents completing training	35	35	–
Number of residents entering practice in MUCs	12	12	–
Percent of residents entering practice in MUCs	35	35	–
Average cost per resident	$40,000	$40,000	--
Dental Public Health*			
Number of residents/graduates who enter practice in underserved areas.	7	7	–
Number of residents/graduates that provide and support primary care.	13	13	–
Number of minority/disadvantaged residents/graduates who completed training.	4	4	–
Number of minority/disadvantaged residents/graduates in training.	6	6	--
Public Health Training Centers			
Number of Centers	14	14	–
Number of existing public health workers retrained	40,000	40,000	–
No. of existing URM public hlth workers retrained	4,000	4,000	–
% of existing URM public hlth workers retrained	10	10	–
No. of existing public health workers retrained practicing in MUCs	20,000	20,000	–
% existing public hlth workers retrained practicing in MUCs	40 1/	401/	--

1/ Large numbers of existing public health workers in MUCs will be trained using distance learning technologies.

*Data reported for Dental Public Health are FY 2003 expected outputs projected from FY 2000 and FY 2001 actual data, adjusted for budget changes.

Public Health Workforce Development

Health Administration Programs:

Authorizing Legislation - Section 769 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$1,078,000	$1,070,000	$---	- $1,070,000

FY 2006 Authorization.....Expired

Statement of Budget

No funds are being requested for this program in FY 2006 which is a decrease of $1,070,000 below the FY 2005 Appropriation level.

Program Description

The Health Administration Program support trainees, promoting curriculum change and by providing training in underserved locations, including public health agencies and community/migrant health centers.

Funding levels for the Health Administration Programs during the last five years reflect this effort and are as follows:

	$
2001	1,231,000
2002	1,230,000
2003	1,222,000
2004	1,078,000
2005	1,070,000

Performance Analysis

Most of the Health Professions' Title VII and Title VIII programs were reviewed as a unit during the FY 2004 budget cycle using the Program Assessment Rating Tool (PART). This was included in this assessment. These programs, in the aggregate, received a rating of "Ineffective." New performance measures were established for the Health Professions program overall. These measures are shown in Section U.

Rationale for the Budget Request

No funds are being requested for this program in FY 2006 which is a decrease of $1,070,000 below the FY 2005 Appropriation level. The demand for health administration prepared individuals by many private sector health care organizations has increased the numbers of students electing careers in health administration and the Nation's academic training system has responded to meet the increased market demand.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Number of traineeship awards to schools	32	32	--
Total number of students enrolled in schools that receive traineeship awards	NA	NA	
Number of trainees supported with traineeship funds	2,070	2,070	--

Nursing Workforce Development

Advanced Education Nursing

Authorizing Legislation - Section 811 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$58,636,000	$58,160,000	$42,806,000	- $15,354,000

FY 2006 Authorization.....Expired

Statement of the Budget

The FY 2006 Budget request of $42,806,000 is a decrease of $15,354,000 below the FY 2005 Appropriation level.

Program Description

Approximately 10 percent of the nursing workforce is prepared at the master's or doctoral level. The goal of the Advanced Education Nursing authority is to provide grant support for: (1) projects that support advanced nursing education and practice; and (2) traineeships for individuals in advanced education programs. This program prepares registered nurses (RNs) as nurse faculty, nurse practitioners (NPs), clinical nurse specialists (CNSs), nurse midwives (NMWs), nurse anesthetists, nurse administrators, public health nurses and other nurse specialties requiring advanced degrees.

The NP and NMW projects focus on support for graduate-level nurse education in primary care to serve medically underserved populations. Ninety-five percent of funded NP and NMW program graduates work in primary care settings, thereby increasing access to primary health care services. NPs and NMWs are very effective primary care providers who have demonstrated their ability to provide quality, affordable, cost-effective primary care services. Forty-four percent of certified NPs have at least one quarter of their patient population who are Medicaid beneficiaries and 14 percent of certified NPs provide primary care in high poverty areas compared to nine percent of physicians. Ninety percent of visits to certified nurse midwives (CNMs) are for primary, preventive care; only 10 percent relates to labor, birth and newborn care. Seventy percent of women and newborns seen by CNMs are from vulnerable and underserved populations; 20 percent of CNMs provide services in rural areas.

The Nurse Anesthesia projects prepare certified registered nurse anesthetists (CRNAs). Students participate in clinical experiences that increase their interest in practicing in underserved

communities and rural hospitals. Nurse anesthetists provide approximately 65 percent of the 26 million anesthetics given yearly and are the sole providers of anesthesia in more than 70 percent of rural area hospitals. Thirty-four percent of nurse anesthetists practice in communities of less than 50,000.

The other Advanced Education Nursing projects prepare nurses for roles such as nurse faculty, public health nurses, nurse administrators, CNSs and NPs for acute care settings. These programs provide the major support for graduate nursing education programs responding to existing and emerging unmet health care needs, including areas such as geriatrics, patient safety and genetics. Threats to our environment are refocusing how we address public health issues for population based care.

The Traineeship Program provides financial assistance to RN students enrolled in graduate nurse education programs which is essential to increasing the graduation rate from advanced nursing education programs. Due to the high number of full and part-time students and funds available for traineeships, most students receive only partial support.

Data from FY 2001 show that approximately 150 projects enrolled more than 3,500 full and part-time students and graduated over 1,000 nurses with advanced degrees. A breakdown of enrollment shows that 50 percent were enrolled in NP or NMW programs; 43 percent were enrolled in programs to prepare CNSs, public health nurses, nurse educators, nurse administrators and 7 percent were enrolled in nurse anesthetist programs. In addition, nearly 400 schools of nursing received support to provide traineeships to over 8,800 out of more than 37,500 full and part-time graduate nursing students.

Faculty development activities essential for continuing quality educational programs and expanded clinical resources are built into nearly all advanced education nursing programs. Nearly all of the primary care programs include activities related to preparation of preceptors for their clinical teaching.

Funding levels for the Advanced Education Nursing Program during the last five years reflect this effort and are as follows:

	$
2001	59,045,000
2002	60,018,000
2003	50,174,000
2004	58,636,000
2005	58,160,000

Performance Analysis

Most of the Health Professions' Title VII and Title VIII programs were reviewed as a unit during the FY 2004 budget cycle using the Program Assessment Rating Tool (PART). This was

included in this assessment. These programs, in the aggregate, received a rating of "Ineffective." New performance measures were established for the Health Professions program overall. These measures are shown in Section U.

Rationale for the Budget Request

The FY 2006 Budget request of $42,806,000 reflects a Federal administrative cost-savings of $358,000 below the FY 2005 Appropriation and a $15,000,000 cost-savings due to the reallocation of nursing resources based on recommendations made by the Expert Panel under the funding allocation contract carried out by the George Mason University Center for Health Policy Research and Ethics. The panel recommended relative increase in support for basic nursing education. The total request will provide continuation support for programmatic projects and support for traineeships. Funds totaling $9,500,000 out of this request will be used to support approximately 400 formula-driven traineeship grants.

Advanced education nurses are needed to work in all areas, especially with underserved populations. Increased acuity, combined with a shift from hospital-based to community-based care has increased the need for nurses who can address complex clinical issues in all settings.

As tuition and living costs increase, student support has become an essential element in increasing the rate at which nurses complete graduate education. Fiscal pressures on State governments and hospital cost containment measures have reduced student aid. The increased debt burden, combined with a static wage scale has diminished access to educational opportunities. Student enrollment in graduate nursing programs has decreased and more students are enrolled on a part-time basis.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Advanced Education Nursing Program: 1/ Number of students*	3,800	3,800	3,125
Number of minority/disadvantaged students enrolled	836	836	688
% minority/disadvant enrollment	22	22	22
Number of graduates	1,140	1,140	938
Number of graduates practicing in underserved areas	456	456	375
% of graduates practicing in underserved areas	40	40	40
Traineeship Programs: 2/			
Number of students supported*	8,885	8,885	3,900
Number of minority/disadvantaged students enrolled	2,754	2,754	1,302
% minority/disadvantaged enrollment	31	31	31
Number of graduates	2,465	2,465	1,134
Number of graduates practicing in underserved areas	986	986	454
% of grads practicing in underserved areas	40	40	40

*Includes both full-time and part-time students

1/ Advanced Education Nursing Program output targets have been consolidated and include Nurse Practitioner and Nurse Midwifery Programs, Nurse Anesthetist Education Programs and Other Educational Programs.

2/ Traineeship Program targets have been consolidated and include the Nurse Anesthetist Traineeship Program and the Advanced Education Nursing Traineeship Program.

Nursing Workforce Development

Nursing Workforce Diversity

Authorizing Legislation - Section 821 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$16,402,000	$16,270,000	$21,244,000	+ $4,974,000

FY 2006 Authorization.....Expired

Statement of the Budget

The FY 2006 Budget request of $21,244,000 is an increase of $4,974,000 above the FY 2005 Appropriation level.

Program Description

The goal of the Nursing Workforce Diversity Program is to improve the diversity of the nursing workforce to meet the increasing need for culturally sensitive and quality health care. This goal is accomplished by increasing opportunities for individuals from disadvantaged backgrounds to pursue a nursing education. In addition to contributing to the preparation of a racially and ethnically diverse nursing workforce, this program also contributes to the basic preparation of disadvantaged and minority nurses for leadership positions within the nursing profession and the health care community.

Historically, this program has played a significant role in enhancing the retention and graduation rates of minority and disadvantaged students through counseling, tutoring and mentoring services designed to assist students in enrolling and completing nursing education programs. Nursing schools that receive funding for Nursing Workforce Diversity Programs have enrollments in which 38 percent of the students are from minority groups, compared to a national average of 19 percent. All program participants are considered to be disadvantaged and/or are from racial/ethnic minority groups. The program's recruitment and retention activities targeting middle school students and pre-nursing students have been successful in recruiting disadvantaged and minority young people into nursing.

Recent data reveal that projects impact approximately 1,400 pre-nursing and nursing students yearly. In response to the need to increase diversity within the nursing workforce, funded projects have increased their focus on K-12 students. Fiscal Year 2002 data reveal that over 3,500 K-12 students participated in recruitment type activities designed to interest young people in the nursing profession. The FY 2002 data also show that out of more than 3,500 racial/ethnic

minority students/participants in the Nursing Workforce Diversity Program, 48 percent were African American/Black, 16 percent were American Indian/Alaskan Native, 27 percent were Hispanic/Latino, and nine percent were Asian/Pacific Islander.

Funding levels for the Nursing Workforce Diversity Program during the last five years reflect this effort and are as follows:

	$
2001	4,673,000
2002	6,172,000
2003	9,935,000
2004	16,402,000
2005	16,270,000

Performance Analysis

Most of the Health Professions' Title VII and Title VIII programs were reviewed as a unit during the FY 2004 budget cycle using the Program Assessment Rating Tool (PART). This was included in this assessment. These programs, in the aggregate, received a rating of "Ineffective." New performance measures were established for the Health Professions program overall. These measures are shown in Section U.

Rationale for the Budget

The FY 2006 Budget request of $21,244,000 reflects an increase of $5,000,000 offset by a Federal administrative cost-savings of $26,000. The increase will expand the impact of the program by facilitating the recruitment, retention and graduation of disadvantaged and racial/ethnic minority nurses. In 2006, the scholarship authority will continue to assist students enrolled in supported projects to reduce the financial barrier to nursing education.

In addition to support for project grants, an initiative providing small one-year 'seed' grants to schools of nursing to work with junior and senior high school students participating in the Department of Education GEAR-UP Program (Gaining Early Awareness and Readiness for Undergraduate Programs) will be started. The purpose of the initiative is to increase interest in nursing careers. Grantees will establish linkages with community high schools and carry out specific activities to increase awareness of nursing and career opportunities.

Although the minority population in the U.S. account for 31 percent of the total population, only 12.3 percent of the nursing workforce comes from racial/ethnic minority groups. An estimated 500,000 registered nurses from racial/ethnic minority groups would be needed if the nurse population is to reflect the U.S. population as a whole.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Number of minority student/participants*	6,660	6,660	6,910
Percent minority enrollment*	60	60	60
Number of white disadvantaged student/participants	4,440	4,440	4,690
Percent white disadvantaged enrollment	40	40	40
Number of nursing program students	1,950	1,950	2,200
Number of college pre-entry nursing students	1,050	1,050	1,300
Number of K-12 participants	8,050	8,050	8,050
Number of recruitment seed grants	—	–	20
Number of students expected to receive scholarships	470	470**	600**

* Projected number and percent of minority students for FY 2004 and FY 2005 are based on an estimated distribution of at least 60 percent. Yearly shifts in the percent of disadvantaged vs racial/ethnic minority students are based on participant profiles in newly funded projects and the ending of previously funded projects.

** Number of scholarships projected with phasing in the scholarship component in FY 2004.

Nursing Workforce Development

Nurse Education, Practice and Retention Grants

Authorizing Legislation - Section 831 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$31,769,000	$36,468,000	$46,325,000	+ $9,857,000

FY 2006 Authorization.....Such sums as necessary

Statement of the Budget

The FY 2006 Budget request of $46,325,000 is an increase of $9,857,000 above the FY 2005 Appropriation level.

Program Description

The Nurse Education, Practice and Retention Program clusters nine separate program purposes under three priority areas: education, practice and retention. The priorities identified under the education priority area include: (1) expanding enrollment in baccalaureate nursing programs; (2) developing and implementing internships and residency programs; and (3) providing education in new technologies. The priorities identified under the practice priority area include: (1) establishing or expanding nursing practice arrangements; (2) providing care for underserved populations and other high risk groups; (3) continuing education to practice in the emerging health care system; and (4) developing cultural competencies for nurses. The priorities identified under the retention priority area include: (1) promoting advancement for nursing personnel through career ladder programs; and (2) improving the retention of nurses and enhancing patient care directly related to nursing activities.

Funding levels for the Nurse Education, Practice and Retention Grant Program during the last five years reflect this effort and are as follows:

	$
2001	12,790,000
2002	16,283,000
2003	26,825,000
2004	31,769,000
2005	36,468,000

Performance Analysis

Most of the Health Professions' Title VII and Title VIII programs were reviewed as a unit during the FY 2004 budget cycle using the Program Assessment Rating Tool (PART). This was included in this assessment. These programs, in the aggregate, received a rating of "Ineffective." New performance measures were established for the Health Professions program overall. These measures are shown in Section U.

Rationale for the Budget Request

The FY 2006 Budget request of $46,325,000 reflects an increase of $10,002,000 offset by a Federal administrative cost-savings of $145,000 below the FY 2005 Appropriation. Recognizing the need to address the nursing shortage, the increase will be used to support targeted initiatives focusing on faculty development, informatics, baccalaureate education, and three statutory funding preference purposes (developing and implementing internship and residency programs; promoting career advancement for nursing personnel; improving the retention of nurses and enhance patient care that is directly related to nursing activities).

The total request will specifically address enhancing the educational mix and utilization of the nursing workforce by supporting innovative approaches to shape the nursing workforce. Funding facilitates flexibility in meeting local/regional nursing needs as identified in the priorities referenced in the legislation, including enhancing career ladder programs for career advancement in nursing, expanding baccalaureate education, supporting internships and residency programs to facilitate the transition from student to graduate and retention initiatives to keep experienced nurses in the workforce. The addition of retention strategies recognizes the need to address the nursing shortage.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Number of Baccalaureate Projects Targeting Expanded Enrollment*	23	18	18
Number of Primary Care Encounters *	100,000	79,000	79,000
Number of Career Ladder (Mobility) Projects	30	35	40
Number of Career Ladder Participants**	450	525	600
Number of Internship/Residency Projects	20	26	32
Number of Internship/Residency Participants**	210	345	480
Number of Enhanced Patient Care Delivery System Projects	17	20	25

*As the number of projects funded resulting from the funding preference for Internship and Residency Programs, Career Ladder Programs, and Enhancing Patient Care Delivery Systems Programs, the number of projects supported for Expanding Baccalaureate Enrollment and Nurse Practice Arrangements providing primary care encounters decreases.

** Numbers to be adjusted based on FY 2004 year progress reports and grantee monitoring (data reports by program pending). The FY 2004 progress report did not allow full capture of data for these new programs authorized by the Nurse Reinvestment Act of 2002 and funding of these projects in September 2003.

Nursing Workforce Development

Nurse Faculty Loan Program

Authorizing Legislation - Section 846A of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$4,870,000	$4,831,000	$4,821,000	- $10,000

FY 2006 Authorization.....Such sums as necessary

Statement of Budget

The FY 2006 Budget request of $4,821,000 is a decrease of $10,000 below the FY 2005 Appropriation level.

Program Description

The Nurse Faculty Loan Program addresses the problem of a growing shortage of nursing faculty. Both the National League for Nursing and the American Association of Colleges of Nursing have published data on the severity of the shortage and the implications. Potential nursing students are being turned away from nursing schools because faculty are not available. The Nurse Faculty Loan Program will help produce more faculty essential for schools of nursing to expand their capacity to increase enrollments.

The Nurse Faculty Loan Program supports the development of a student loan fund in schools of nursing to increase the number of qualified nursing faculty. Students may receive loans up to $30,000 per year for a maximum of 5 years. The program has a cancellation provision for up to 85 percent of loan for recipients working full-time as nursing faculty for a period of 4 years. Twenty percent of the principal and interest may be canceled for each of the first, second and third year, and 25 percent may be canceled for the fourth year of full-time employment as nursing faculty.

Funding levels for the Nurse Faculty Loan Program during the last five years reflect this effort and are as follows:

	$
2001	---
2002	---
2003	2,980,000
2004	4,870,000
2005	4,831,000

Performance Analysis

Most of the Health Professions' Title VII and Title VIII programs were reviewed as a unit during the FY 2004 budget cycle using the Program Assessment Rating Tool (PART). This was included in this assessment. These programs, in the aggregate, received a rating of "Ineffective." New performance measures were established for the Health Professions program overall. These measures are shown in Section U.

Rationale for the Budget

The FY 2006 Budget request of $4,821,000 reflects a Federal administrative cost-savings of $10,000 below the FY 2005 Appropriation. The total request will continue support for the Nurse Faculty Loan Program which supports student loans of up to $30,000 in participating institutions.

Program Outputs

	FY 2004 Actual	**FY 2005** Appropriation	**FY 2006** Request
Number of Schools Receiving Funds	61	61	61

Nursing Workforce Development

Comprehensive Geriatric Education

Authorizing Legislation - Section 855 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$3,478,000	$3,450,000	$3,426,000	- $24,000

FY 2006 Authorization.....Such sums as necessary

Statement of Budget

The FY 2006 request of $3,426,000 is a decrease of $24,000 below the FY 2005 Appropriation level.

Program Description

The Comprehensive Geriatric Education grants will prepare nursing personnel to care for the aging population, the fastest growing group in today's society. The program supports grants to develop and implement, in coordination with programs under Section 753 (Geriatric Education Programs), programs and initiatives to train and educate individuals providing care for the elderly. Funds are to be used for: (1) providing training to individuals who will provide geriatric care for the elderly; (2) develop and disseminate curricula relating to the treatment of the health care problems of elderly individuals; (3) train faculty members in geriatrics; or (4) provide continuing education to individuals who provide geriatric care. These grants will prepare nurses aides, licensed practical nurses and registered nurses as well as faculty with expertise in the care of the elderly.

The FY 2005 budget will support an estimated 13 one-year 'seed' grants of approximately $50,000 to develop and implement initiatives to train and educate individuals providing geriatric care for the elderly.

Funding levels for the Comprehensive Geriatric Education Program during the last five years reflect this effort and are as follows:

	$
2001	---
2002	---
2003	2,980,000
2004	3,478,000
2005	3,450,000

Performance Analysis

Most of the Health Professions' Title VII and Title VIII programs were reviewed as a unit during the FY 2004 budget cycle using the Program Assessment Rating Tool (PART). This was included in this assessment. These programs, in the aggregate, received a rating of "Ineffective." New performance measures were established for the Health Professions program overall. These measures are shown in Section U.

Rationale for the Budget Request

The FY 2006 Budget request of $3,426,000 reflects a Federal administrative cost-savings of $24,000 below the FY 2005 Appropriation. The decrease is not expected to impact the number of project awards since a new cohort of three year grants is projected.

The total request will be used to continue support for nursing personnel that have the knowledge and skills to care for the unique needs of the elderly. Over the next 25 years, the population over 65 will grow at a rate 5 times that of those under 65, and those over the age of 85 are in the fastest growing segment of the population. This program supports the training of nurses and nursing personnel so that they have the knowledge and skills to care for the unique needs of the elderly.

Program Outputs

	FY 2004 Enacted	**FY 2005** Appropriation	**FY 2006** Request
Number of Geriatric Projects	17	17	17
Number of Geriatric "Seed" Projects	–	13	–

Nursing Workforce Development

Loan Repayment and Scholarship Programs

Authorizing Legislation - Section 846 of the Public Health Service Act, and Section 103 of the Nurse Reinvestment Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$26,736,000	$31,482,000	$31,369,000	- $113,000

FY 2006 Authorization.....Such sums as necessary

Statement of Budget

The FY 2006 request of $31,369,000 is a decrease of $113,000 below the FY 2005 Appropriation level.

Program Description

The Nursing Education Loan Repayment Program (NELRP) focuses on providing service-obligated registered nurses (RNs) for not less than two years at a health care facility with a critical shortage of nurses. The NELRP provides an economic incentive to RNs to start and/or continue practice in health care facilities with a critical shortage of RNs by repaying 100 percent of eligible outstanding educational loans over a three-year period.

The Nurse Scholarship Program reduces the financial barrier to nursing education for all levels of professional nursing students, thus increasing the pipeline. In addition, it will help alleviate staffing shortages in eligible health care facilities with a critical shortage of nurses because scholarship recipients are obligated to fulfill a service commitment payback of at least two years.

Funding levels for the NELRP during the last five years reflect this effort and are as follows:

	$
2001	7,279,000
2002	10,235,000
2003	19,870,000
2004	26,736,000
2005	31,482,000

Performance Analysis

The NELRP program has grown steadily in recent years. In FY 1998, 170 loan repayment contracts were awarded. In FY 2004, that number had grown to 650 new contracts, and 208 contract amendments. One hundred percent of the program's FY 2004 resources were awarded to nurses in critical shortage facilities. Eighty-eight percent of the States benefitted. In FY 2004, 40 percent of former NELRP participants remained employed at a critical shortage facility for at least one year beyond the termination of their NELRP service. Information on these indicators is presented in Section U of this document.

The NELRP program was assessed by OMB during the FY 2004 budget cycle using the Program Assessment Rating Tool (PART) and received a rating of "Adequate." Additional annual performance measures were identified at that time, covering as program participants' extension of their service obligations and retention in service to shortage facilities following completion of contractual obligations. These new measures are also shown in Section U.

Rationale for the Budget Request

The FY 2006 Budget request of $31,369,000 reflects a Federal administrative cost-savings of $113,000 below the FY 2005 Appropriation. The FY 2006 request of $31,369,000 will reduce the number of scholarship awarded. The total request includes $20,000,000 for the NELRP which is estimated to support 850 contract awards for RNs agreeing to work in designated public or nonprofit health facilities.

The NELRP provides an economic incentive to these nurses to start and/or continue practice in health care facilities with a critical shortage of nurses.

The remaining $11,256,000 of the request will be used to provide 272 scholarships to address the need for financial aid to obtain a nursing education. The scholarships will reduce the financial barrier by providing funds for tuition and fees as well as a stipend. A condition of the scholarship is a service commitment payback of at least two years in a facility with a critical shortage of nurses. PART findings were considered when making this request.

There continues to be a serious shortage of nurses at health facilities in certain areas of the United States. The demand has intensified for nurses prepared in programs that emphasize leadership, patient education, case management, and care across a variety of delivery settings.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Number of Contracts	858	850*	850*
Number of Scholarships	118	275	272

* Estimates based on number of expected third year amendments and projected increase loan debt level for new awards.

Bioterrorism Training and Curriculum Development Program

Authorizing Legislation - Section 319F(g) Education of Health Care Personnel; Training Regarding Pediatric Issues of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	($27,706,000)*	($27,520,000)*	($27,521,000)*	(+ $1,000)
FTE	4	5	5	--

FY 2006 Authorization.....Such Sums as May Be Necessary
* Funded in the Public Health and Social Services Emergency Fund (PHSSEF).

Statement of Budget

The FY 2006 Budget of $27,521,000 is an increase of $1,000 above the FY 2005 Appropriation level and supports the program.

Program Description

The purpose of this program is to equip a workforce of health care professionals to address emergency preparedness and response issues. Specifically, the goal of this program is the development of a health care workforce that possesses the knowledge, skills, abilities and core competencies to manage terrorist events and public health emergencies by: (1) recognizing indications of a terrorist event and other public health emergencies; (2) treating patients and communities in a safe and appropriate manner; (3) participating in a coordinated multi-disciplinary response which includes consideration of surge capacity issues; and, (4) rapidly and effectively alerting the public health system of such an event at the community, State, and national level. Bioterrorism is commonly described as occurrences, both deliberate and not, that causes human suffering and injury due to exposure to not only biological but also chemical, nuclear, incendiary or explosive agents and other public health emergencies. The utilization of existing competencies for preparedness training is a new requirement for the program. These competencies will be utilized by the BTCDP awardees to refine existing preparedness curricula and evaluate the trainees on their ability to implement the knowledge gained. There will be an increased emphasis on simulation drills and exercises to test the competencies of trainees and develop strategies for improvement and retraining where deficiencies are identified. Applicants are encouraged to collaborate with DHS sponsored training programs and drills and exercises. In particular, applicants are encouraged to review the DHS 2004 National Response Plan and consider HSPD-5, 8, and 10 as specific areas for collaboration with DHS/OPHEP and CDC.

HRSA will measure awardee performance and incorporation of competencies into curricula development based on annual BHPr/HRSA required reports submitted by BTCDP grantees, documents published by the grantees, and site visits conducted by the project officers. A series of five discipline-specific focus groups/workshops in 2005 will also provide a forum for developing and incorporating core competencies into the curricula and their evaluation. BTCDP grantees and participants from specific disciplines (such as pharmacy, medicine, and nursing will participate in these focus groups/workshops.

The program's objective is to increase the total number of health care providers who are adequately and competently trained to respond to such events. The first goal is to improve the uniformity of the training being offered across the country and to increase the number of trained community health care providers by increasing the number of participants in the continuing education program. A second goal is to integrate the preparedness training into the core curriculum at as many health professions schools across the Nation as possible.

Health care professionals provide a pivotal link to their communities. The Bureau of Labor Statistics identifies more than 6,000,000 individuals employed in health care practitioner and health related technical occupations, providing a large pool of potential trainees.

The practicing health care providers who are targeted for training are drawn from both hospital and community based health care settings including, but not limited to those serving in hospitals, Community Health Centers, Migrant Health Centers, Federally Qualified Health Centers, National Health Service Corps (NHSC) sites and private and group medical practices. The focus of the training program is the full range of local health providers including allied health personnel and emergency medical service personnel, veterinarians as well as food safety experts. The health care providers in the community clearly make up the base of the pyramid of responders utilized by the Department of Homeland Security and are integral to a comprehensive approach to protecting the public. Training and retraining of the Nation's health care workforce is essential to both establishing and maintaining the ability of individual providers to respond to a terrorist event and/or natural disaster. We are training many of the disciplines and professionals who are either not hospital based, or who are not generally thought of as being part of the traditional public health system. We have heard from almost all of our current grantees that they attract many health care providers, such as community based physicians and nurses who will be needed in an emergency event, who traditionally do not consider themselves part of the public health support system.

The Nation's heightened awareness to potential threats of all kinds, from natural occurring disasters to terrorist events, and the belief that it is just a matter of time before a mass casualty event occurs, increases the importance of this program. Effective responses to public health emergencies require close collaboration among all types of health professionals involved in patient care including allied health professionals, medical and dental specialists, mental health providers, pharmacists and other professionals, the public health system, and the emergency response system. To achieve such a collaborative environment it will be necessary to implement models of undergraduate/graduate curricula and continuing education for health professionals that broaden emergency preparedness knowledge and ensure that essential multidisciplinary and

interdisciplinary coordinated responses to emergencies will occur at community, State, regional, and national levels. These multidisciplinary and interdisciplinary models are required to be utilized in each awardee's training programs as outlined in the application materials. This means that the health professions students should not be learning in a vacuum but should learn at an early stage to interact with their colleagues in other health professions which will be required in the real world. The curricula are constantly evolving to meet the needs of preparing each health care discipline for a bioterrorism event or other public health emergency. Relatively few of the 6,000,000 health care providers in the Nation have been trained in preparedness at this time. In addition, once the majority of health care providers are trained, retraining to maintain their skills will be required. In terms of the health professions students, we will be utilizing information gained during the discipline specific focus group workshops to encourage many other health professions schools to utilize/adapt curricula already developed by the FY 2003-2004 awardees. The use of drills to demonstrate the roles and competence of all levels of health care personnel will provide an environment in which the evaluation of the coordination of response systems across agencies can be accomplished. Continuing Education award recipients must collaborate with the Joint Advisory Committee for the CDC and HRSA Cooperative Agreements to ensure that duplication of training efforts does not occur and to coordinate on training provided. In addition, all 32 of the BTCDP awardees attended a joint meeting in September, 2004, to encourage collaboration across these programs and discuss the establishment of common competencies.

In addition, HRSA is working with the Office of Public Health Emergency Preparedness (OPHEP) which is coordinating the DHHS response to Homeland Security Presidential Directive-8 (HPSD-8), entitled National Preparedness. HRSA staff are participating in the DHHS Public Health Emergency Preparedness Training Workgroup focused on the Department's contribution to the Department of Homeland Security task to establish a national training program.

Funding levels for the Bioterrorism Training and Curriculum Development Program during the last five years reflect this effort and are as follows:

	$*	FTE
2001	---	--
2002	---	--
2003	27,818,000	4
2004	27,706,000	4
2005	27,520,000	5

* Funded in the Public Health and Social Services Emergency Fund (PHSSEF).

Performance Analysis

The program started in FY 2003, and actual results from the first grants will be available in FY 2005. Its current measure of performance is the number of health professionals trained through program-supported training activities. Projections based on application data suggest that

the program may have as many as 100,000 health professionals trained by the end of FY 2006, well above the current FY 2006. The program will reevaluate its targets once baseline data become available. (See Section U).

Rationale for the Budget

The FY 2006 Budget request of $27,521,000 reflects a Federal administrative cost-savings of $1,000. The FY 2006 Budget of $27,521,000 will continue support for the Bioterrorism Training and Curriculum Development Program. This level of funding will be used to train approximately 100,000 health professionals and other health care providers annually to assure that a large number of community providers are prepared to respond to an emergency. These professionals will be provided with essential information needed to quickly identify and respond to a terrorist event or other public health emergency.

A competitive cycle in FY 2005 will allow new starts in States with no BTCDP Continuing Education awardees, and will allow existing FY 2004 awardees to be partially funded.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Number of Continuing Education (CE) Projects	19	32	32
Number of Curriculum Development Projects at Health Professions Schools	13	12	12
Health Professionals In Practice-Updates and Continuing Education:			
Health Care Administrators	172	465	485
Allied Health Providers	4,052	6,624	6,901
Nursing	26,004	36,272	37,785
Medicine	14,789	21,897	22,809
Nurse Practitioners	2,737	4,106	4,277
Physician Assistants	1,113	1,694	1,765
Dentists	1,137	1,727	1,799
Pharmacists	2,199	3,714	3,868
Mental Health Providers	2,459	4,392	4,575
Public Health Providers	789	1,186	1,235
EMS	5,401	7,859	8,186
Veterinarians	147	379	394
Other	3,776	5,685	5,921
Total to be Trained	64,775	96,000	100,000

Children's Hospitals Graduate Medical Education Payment Program

Authorizing Legislation - Section 340E of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$303,169,000	$300,730,000	$200,000,000	-$100,730,000
FTE	8	9	9	---

FY 2006 Authorization.....Such sums as necessary

Statement of Budget

The FY 2006 Request of $200,000,000 is a decrease of $100,730,000 below the FY 2005 Appropriation level.

Program Description

The purpose of the Children's Hospitals Graduate Medical Education Payment Program (CHGME PP), authorized by the Healthcare Research and Quality Act of 1999 and amended by The Children's Health Act 2000, is to support graduate medical education (GME) training in freestanding children's teaching hospitals. Payments are made to these hospitals to enhance their financial viability and to help them maintain GME programs in an increasingly competitive health care marketplace.

The CHGME PP addresses the need for funds beyond patient revenues to support the broad teaching mission of freestanding children's teaching hospitals, which includes conducting biomedical research, training health professionals, providing rare and highly specialized clinical services, innovating clinical care, and providing care to the poor and the underserved. Teaching hospitals have higher costs than other hospitals because of the special services they provide.

This is a payment program that supports GME training in freestanding children's teaching hospitals. Payments are determined based on published formulas and methodologies that incorporate the number of residents in training, volume of patient care (number of discharges), hospital capacity (number of available beds), and severity of illness of the children treated at these hospitals (case mix index).

In FY 2001, the CHGME PP supported the training of 4,429 medical residents in 59 freestanding children's teaching hospitals. The financial support for the training of medical residents is based on a three-year rolling average of weighted and unweighted full-time equivalent (FTE) residents, number of discharges, number of available beds, and a case mix index. This support averaged about $58,068 per resident in FY 2001, $72,979 in FY 2002, $73,831 per resident in FY 2003,

and $77,170 in FY 2004. Based on the FY 2005 Appropriation $303 million and the final

number of residents trained in 2004, the average per resident amount is about $77,484. The estimated average payment per resident for FY 2006 will be $51,145.

The CHGME PP has a web site where it publishes information about the program, application materials, time lines, upcoming events, and other communications. Hospitals download the application materials from the web site and complete the application electronically. All electronic communications between the hospitals and program staff are conducted through CHGME PP electronic media. The program plans to enhance and integrate its current use of information technology in its application, reporting, and financial systems to increase productivity and efficiencies for FY 2006 and beyond.

Funding levels for the CHGME Payment Program during the last five years reflect this effort and are as follows:

	$	FTE
2001	234,980,000	13
2002	284,862,000	13
2003	290,102,000	12
2004	303,169,000	8
2005	300,730,000	9

Performance Analysis

The program constantly strives to improve its performance. As of FY 2004, 100 percent of program payments were made on time. The program also verifies 100 percent of resident counts and caps and has developed a methodology, to be pilot tested, for the verification of bed counts, discharges, and case-mix indexes. If useful, feasible and cost-effective, these additional verification steps will be proposed to ensure the accurate allocation of program funds. This program was reviewed by OMB during the FY 2005 budget cycle using the Program Assessment Rating Tool (PART) and was given a rating of "Adequate." More information is provided in Section U.

Rationale for the Budget

The FY 2006 Budget request is $200,000,000. The request will continue substantial Federal GME support to freestanding children's hospitals, enhancing support for the health professions training, basic and clinical research, specialized services, and safety net missions of these hospitals. The total request will support estimated payments of $51,145 per resident at freestanding children's hospital. The CHGME PP estimates that the FY 2006 budget will provide support to approximately 61 freestanding children's hospitals.

This CHGME PP support for training of resident physicians represents an investment in the future of the pediatric workforce, because these hospitals train nearly 30 percent of the Nation's

pediatricians, nearly half of the Nation's pediatric subspecialists, and the majority of selected pediatric specialists. These are the physicians who will care for America's youngest population – its children.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Improve Access to Care Number of FTE residents training **on site** in eligible hospitals funded by the program	4,303	4,303	4,303
Number of FTE residents training **off- site** in eligible hospitals funded by the program	324	324	324
Serving Underserved Population Proportion of hospital's gross revenue from patient care attributed to Medicaid, Medicare, SCHIP and uninsured patients.	Inpatient: 43% Outpatient: 32%	Inpatient: 43% Outpatient: 32%	Inpatient: 43% Outpatient: 32%
Improve Public Health and Health Care Systems Percentage of hospitals funded by the program with negative total margin	25%	25%	25%
Achieve excellence in management Verify 100% of Hospitals' FTE Resident counts and cap	100	100	100
Achieve excellence in management Percent of hospitals with verified bed counts, case mix index, and number of discharges[1]	NA	NA	NA
Efficiency Measure Increase the percentage of payments processed on time	100	100	100

1/ This is a long-term goal for FY 2008 and it is contingent upon the results of cost-benefit studies to be completed in FY 2006.

National Practitioner Data Bank

Authorizing Legislation - Public Health Service Act, Title IV, P.L. 99-660; Health Care Quality Improvement Act of 1986, as amended by P.L. 100-177; Section 5, Medicare and Medicaid Patient Protection Act of 1987 (P.L. 100-93), and Omnibus Budget Reconciliation Act of 1990 (P.L. 100-508).

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

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	($16,000,000)	($15,700,000)	($15,700,000)	---
FTE	23	24	24	---

FY 2006 Authorization.....Indefinite

Statement of Budget

There is no FY 2006 Appropriation request for the National Practitioner Data Bank (NPDB).

Program Description

To help ensure quality health care, the Health Care Quality Improvement Act of 1986 requires the Secretary of Health and Human Services to establish a national system (the National Practitioner Data Bank (NPDB)) for the receipt, storage and dissemination of information on: (1) paid medical malpractice judgments and settlements against all licensed health care practitioners; and (2) sanctions taken by Boards of Medical Examiners, losses of membership in professional societies, and certain professional review actions taken by health care entities against physicians and dentists. Malpractice insurance companies, State licensure boards, and health care entities and professional societies are required to report information to the data bank. As specified in the law, the NPDB makes reported information available to hospitals and other health care entities, State licensing authorities, and professional societies. The existence of the data bank makes it difficult for practitioners to hide this information by moving to another State. Language in appropriations legislation for FY 1993 and all subsequent years requires that user fee collections cover the full cost of NPDB operations. There is no appropriation for the NPDB.

As of September 30, 2003, the NPDB contained 337,781 reports on 202,015 practitioners. Approximately 73% of these reports concerned malpractice payments and approximately 14% concerned licensure actions. Slightly more than 9% were Medicare/Medicaid exclusions. Of the remaining 44,171 reports, approximately 28 % were clinical privileges actions and approximately 71% were exclusion actions. During FY 2003, the NPDB processed 3,233,765 queries from 11,019 registered entities. Querying entities received 440,636 responses from the NPDB which

contained reports on the queried practitioners. Querying entities also received 2,783,989 responses which confirmed that the named practitioner had no malpractice payments, adverse actions, or exclusions since September 1, 1990. An estimated 40,100 licensure, credentialing, or membership decisions were affected by new information provided in responses during FY 2003.

Accomplishments

The NPDB continues to provide critical information to the Nation's hospitals, health plans, and licensing boards for their use in credentialing and licensing practitioners, an important step in ensuring quality health care. This information assures that practitioners with poor practice records or inappropriate behavior cannot move from State to State unnoticed by the appropriate licensing and credentialing authorities.

According to projections based on the 2001 University of Illinois at Chicago and Northwestern University national survey of NPDB users, information supplied by the NPDB changes approximately 39,000 licensing and credentialing decisions annually.

The National Practitioner Data Bank - Healthcare Integrity and Protection Data Bank (NPDB-HIPDB) program was named an Excellence.gov Top Five Award finalist in a ceremony at the Ronald Reagan Building in Washington, D.C., on February 5, 2004. The Top Five Award is the highest honor bestowed by Excellence.gov. The awards are given to Federal organizations for their outstanding information technology (IT) achievements in the public service arena. Excellence.gov was established to recognize the best practices in Federal E-Government applications. It is sponsored by the Industry Advisory Council, the American Council for Technology, and the Federal CIO Council.

Operational Improvements

The NPDB has undergone several technology enhancements in recent years and plans to implement new functionality over the next few years. The NPDB production platform moved to a state-of-the-art Data Center. This move maximizes system availability to users by providing: continuous power, continuous communications, increased protection against fire and other natural disasters, increased physical security, and 24/7 on-site technical support. All paper forms (except for practitioner self-query forms, which must be notarized to ensure practitioner identities) have been eliminated. In addition, the Data Bank migrated from the 10-year old Silicon Graphics Inc. (SGI) hardware platform to a 4th generation SUN Microsystems architecture. Average query response time decreases from just over three hours to less than 2 hours for 99% of submitted queries.

NPDB technical enhancements that are planned for the future include implementation of Section 1921 of the Social Security Act. The current NPDB would expand to include access, by eligible entities, to information received under section 1921.

Research Initiatives for Program Improvement

The NPDB actively assesses the success of the program and identified areas for improvement:

- In early FY 2001, the University of Illinois at Chicago and Northwestern University completed a major national survey on NPDB user satisfaction and the usefulness of NPDB information. The results of this survey, which were generally extremely positive concerning the importance and usefulness of NPDB data to licensing and credentialing decision-making, updated the results of a NPDB user survey conducted in 1994. The results are being used to identify areas in which improvements are needed or in which the usefulness of NPDB data can be improved.

- HRSA conducted an American Customer Satisfaction Index survey of NPDB reporting and querying in FY 2003. Results indicated a very high level of customer satisfaction with the NPDB overall. The results of the survey are being used to identify areas for improvement.

- The Center for Health Policy Studies completed a study of NPDB reporting during FY 2000. This study was designed to improve the act or omission, action, and basis for action codes used by NPDB reporters so the NPDB would receive more complete and more usable information. The NPDB completed implementing recommended improvements in January 2004.

- The NPDB is actively reviewing reports for possible duplicates and other reporting errors such as improperly coded Revision to Action reports and improperly submitted Voids.

The NPDB has also undertaken a number of research efforts aimed specifically at increasing compliance with reporting and querying requirements:

- The NPDB has worked with both the Federation of State Medical Boards (FSMB) and the Public Citizen Health Research Group to compare state licensing information held by these groups to information in the NPDB to ensure completeness of the NPDB and identify any reporting weaknesses. The NPDB provided the results of the comparison to FSMB in
- FY 2003.

- Pricewaterhouse Coopers completed feasibility studies for reporting compliance programs for malpractice payment and clinical privileges reporting during FY 2003. Pricewaterhouse Coopers recommendations were reviewed and several are being implemented.

- The NPDB's Hospital Review project examines non-matches among hospitals between the American Hospital Association (AHA) "Hospital Guide" and the NPDB's registered entities list. In cases where a hospital is listed in the AHA Guide but is not registered with NPDB, a letter is written to the hospital to determine its registration status. Staff then follows up with unregistered hospitals to ensure they register and come into compliance with the statute.

- In the National Association of Insurance Commissioners (NAIC)/NPDB Payment Matching Project, calendar year 2001 and 2002 data on medical malpractice payments on behalf of physicians reported to the NAIC by malpractice payers (insurance companies) was compared to data reported to the NPDB by these companies. In cases where discrepancies were found, a letter was written to the reporting insurer requesting that they reconcile the differences in the payments reported and report any unreported payments to the NPDB.

User fee collections for the NPDB program during the last five years reflect this effort and are as follows:

	$	FTE
2001	13,569,000	22
2002	16,400,000	23
2003	19,500,000*	23
2004	16,000,000*	23
2005	15,700,000*	24

* The estimated decline in revenue is due to query fee reduction and mergers of managed care organizations.

Performance Analysis

The NPDB provides a national data repository on significant adverse professional actions against physicians and dentists, as well as malpractice settlements, and judgments against all licensed healthcare professionals. The Healthcare Integrity and Protection Data Bank operates in conjunction with the NPDB, augmenting it with information on health care related criminal convictions.

The number of queries to these databases provides an indication of the degree to which they are used to inform decisions regarding credentialing, licensing, and extension of clinical privileges to health care providers. Since 1998, the annual volume of queries to the data banks has grown 26%, from 3.1 million in FY 1998, to almost 4 million in FY 2003, with corresponding increases in the number of decisions affected by NPDB or HIPDB data. At the same time, the data banks have been able to increase efficiency tremendously, reducing the amount of time required to process a

query to less than 240 minutes (down from several days in 1990), and reducing user fees at the same time. A customer satisfaction survey completed in FY 2001 by the University of Illinois at Chicago and Northwestern University found that 88% of those interviewed rated the data banks as "useful" or "very useful." The performance of this program was considered in forming the FY 2006 budget request. Detailed performance information is provided in Section U of this document.

Rationale for the Budget

There is no FY 2006 Appropriation request for the National Practitioner Data Bank (NPDB). The NPDB will continue to be operated solely on user fee collections of $15,700,000. The user fee collection estimate is based on 3,600,000 name requests at an average processing fee of $4.25 per request plus self query revenues. Revenues may increase with the implementation of Section 1921 of the Social Security Act (Section 5 of the Medicare and Medicaid Patient and Program Protection Act of 1987) to collect and disclose adverse licensure actions on licensed health professionals not covered by the NPDB.

Currently, the NPDB receives approximately 64,779 queries each week. The level of querying activity is expected to remain relatively steady in FY 2004 as is the number of reports. The estimate of the number of additional queries to the Data Bank generated in FY 2005 is 300,000 but is dependent on the timely publication of Section 1921 rules.

Operational costs of the NPDB include:

1. Contract Data Bank Operations
   - Responding to requests for information and assistance
   - Receiving and encoding information into the data bank
   - Providing information to individuals who query the data bank about themselves
   - Systems enhancements to make the data bank more accessible to users
   - Support for fee collection
   - Maintaining interactive access through the Internet for transmitting reports and requests for information

2. Non-contract Data Bank Operations
   - Oversight of data bank operations and systems security
   - Federal contract management
   - Periodic contract recompetition
   - Development and interpretation of data bank program policy
   - Printing of program informational and marketing materials
   - Management of a system to resolve disputes about the accuracy of data bank information
   - Development of specifications for data bank system enhancements
   - Management of a research capability based on data bank information

- Management of a continuous quality improvement program
- Fee collection

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Reports added to Data Bank	30,000	67,000*	67,000*
Requests for information processed	3,400,000	3,700,000	3,700,000

* This is based on the implementation of Section 1921.

Healthcare Integrity and Protection Data Bank

Authorizing Legislation - Title II, Subtitle C of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191), establishes Section 1128E of the Social Security Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	($4,000,000)	($4,000,000*)	($4,000,000*)	$---
FTE	5	7	7	--

*Estimates include user fees plus supplemental funds from the OIG as necessary.

FY 2006 Authorization.....Indefinite

Statement of Budget

There is no FY 2006 Appropriation request for the Healthcare Integrity and Protection Data Bank.

Program Description

To prevent or reduce fraud and abuse in the medical system and to enhance quality health care, Title II, Subtitle C of the HIPAA of 1996 establishes Section 1128E of the Social Security Act. This section directs the HHS, acting through the Office of Inspector General (OIG), to establish a program to collect, maintain and report on final adverse actions taken against health care providers, suppliers and practitioners. This information is collected from and made available to Government agencies and health plans. This data collection program has been named the Healthcare Integrity and Protection Data Bank (HIPDB).

Through an agreement with the OIG, HRSA is responsible for the development and operation of the HIPDB. Final policy decision making remains with the OIG. The HRSA received allocations from the Health Care Fraud and Abuse Control (HCFAC) account for the development of the HIPDB system, which is modeled after the National Practitioner Data Bank (NPDB). All operating costs are paid by user fees and allocations by the OIG from the HCFAC account. There is no appropriation for the HIPDB.

The HIPDB provides critical information to State and Federal agencies, law enforcement officials, and health plans concerning adverse actions, health care related civil judgments and criminal convictions of health care practitioners, providers and suppliers. This information helps prevent

practitioners, providers, and suppliers with problem backgrounds from moving from State to State unnoticed by licensing and health plan officials, thus improving health care quality. It also helps law enforcement officials in the battle against health care fraud and abuse.

The HIPDB opened for reporting on November 22, 1999. As of September 30, 2003, the HIPDB contained 157,564 reports of health care related civil judgments, criminal convictions, injunctions, licensing and certification actions, exclusions from State and Federal health care programs, and other adjudicated actions involving 92,794 individuals and 2,659 organizations. State licensure actions constituted 74.4% of all HIPDB reports and another 18.7 % concerned exclusion actions. Judgment or conviction reports accounted for 3.5 % of all HIPDB reports. Other actions accounted for the remaining 3.5 %. Individuals were named in 154,186 of these reports and organizations were the subject of 3,378 reports. Of the individuals reported to the HIPDB, 52.9 % were nurses and aides and 20.3 % were physicians. Of the organizations reported to the HIPDB, durable medical equipment suppliers were responsible for 28.6 % of reports, nursing facilities were responsible for 25.1 %, and pharmacies were responsible for 17.6 %.

The HIPDB opened for routine queries on March 6, 2000. By September 30, 2003, the HIPDB had responded to 3,541,884 queries from State and Federal agencies (including law enforcement) and health plans. Health plans were responsible for 71 % of the queries. The HIPDB provides approximately 7,000 free queries for Center for Medicare and Medicaid Services (CMS) and other Federal agencies per week.

During FY 2003, the HIPDB processed 765,520 queries. Queriers received 7,650 responses from the HIPDB which included reports of State licensure actions, exclusions from participation in Medicare or Medicaid, criminal convictions, and non-malpractice civil judgments.

Accomplishments

The National Practitioner Data Bank - Healthcare Integrity and Protection Data Bank (NPDB-HIPDB) program was named an Excellence.gov Top Five Award finalist in a ceremony at the Ronald Reagan Building in Washington, D.C., on February 5, 2004. The Top Five Award is the highest honor bestowed by Excellence.gov. The awards are given to Federal organizations for their outstanding information technology (IT) achievements in the public service arena. Excellence.gov was established to recognize the best practices in Federal E-Government applications. It is sponsored by the Industry Advisory Council, the American Council for Technology, and the Federal CIO Council.

Operational Improvements

The HIPDB has undergone several technology enhancements in recent years and plans to implement new functionality over the next few years. The NPDB-HIPDB production platform moved to a state-of-the-art Data Center. This move maximizes system availability to users by providing: continuous power, continuous communications, increased protection against fire and other natural disasters, increased physical security, and 24/7 on-site technical support. All paper forms (except for practitioner self-query forms, which must be notarized to ensure practitioner identities) have been eliminated. In addition, the Data Banks migrated from the 10-year old Silicon Graphics Inc. (SGI) hardware platform to a 4th generation SUN Microsystems architecture. Average query response time decreases from just over three hours to less than 2 hours for 99 % of submitted queries.

Research Initiatives for Program Improvement

- HRSA conducted an American Customer Satisfaction Index survey of HIPDB reporting and querying during FY 2003. Results showed higher than average levels of user satisfaction with the HIPDB program in comparison to both government and private sector programs. Areas for improvement were also identified and improvements are being made.

- The HIPDB is actively reviewing reports for possible duplicates and other reporting errors such as improperly coded Revision to Action reports and improperly submitted Voids.

- The HIPDB has worked with both the Federation of State Medical Boards (FSMB) and the Public Citizen Health Research Group to compare State Licensing information held by these groups to information in the HIPDB to ensure completeness of the NPDB and identify any reporting weaknesses. The HIPDB provided the results of the comparison to FSMB in FY 2003.

User fee collections for the HIPDB program during the last five years reflect this effort and are as follows:

	$	FTE
2001	4,373,000	9
2002	4,600,000	8
2003	5,600,000	7
2004	4,000,000*	5
2005	4,000,000*	7

*Estimates include user fees plus supplemental funds from the OIG as necessary.

Performance Analysis

The NPDB provides a national data repository on significant adverse professional actions against physicians and dentists, as well as malpractice settlements, and judgments against all licensed healthcare professionals. The Healthcare Integrity and Protection Data Bank operates in conjunction with the NPDB, augmenting it with information on health care related criminal convictions.

The number of queries to these databases provides an indication of the degree to which they are used to inform decisions regarding credentialing, licensing, and extension of clinical privileges to health care providers. Since 1998, the annual volume of queries to the data banks has grown 26%, from 3.1 million in FY 1998, to almost 4 million in FY 2003, with corresponding increases in the number of decisions affected by NPDB or HIPDB data. At the same time, the data banks have been able to increase efficiency tremendously, reducing the amount of time required to process a query to less than 240 minutes (down from several days in 1990), and reducing user fees at the same time. A customer satisfaction survey completed in FY 2001 by the University of Illinois at Chicago and Northwestern University found that 88% of those interviewed rated the data banks as "useful" or "very useful." The performance of this program was considered in forming the FY 2006 budget request. Detailed performance information is provided in Section U of this document.

Rationale for the Budget

There is no FY 2006 Appropriation request for the Healthcare Integrity and Protection Data Bank. Revenues from user fees in FY 2006 may be affected by the planned publication of regulations implementing Section 1921 of the Social Security Act (Section 5 of the Medicare and Medicaid Patient and Program Protection Act of 1987, as amended). These regulations will make some of the data currently available only in the HIPDB available to qualified entities through the National Practitioner Data Bank. It is expected that this may result in a decline in queries to the HIPDB. The HIPDB budget for FY 2005 will be composed of user fee collections plus OIG supplemental income. In FY 2006 user fee collections are expected to total $2,200,000 and an estimated $1,800,000 will be provided by the OIG for continuing operations of the HIPDB and includes non-pay cost increases. Upon implementation of Section 1921, the query volume is expected to decline significantly, and as a result, the user fee revenues will decline and require a larger contribution from the OIG to the HIPDB operations. The collection of user fees began in March 2000, and the processing fee is now $4.25 per request, a reduction of $.75 per request from the FY 2004 Final Conference Action.

Assuming a fully functioning HIPDB, an estimated 50,000 additional reports will be added to the database in FY 2004 and 727,000 queries are expected. In FY 2005, 519,000 queries are expected based on the impact of implementing Section 1921, which adds information to the NPDB that was previously only available in the HIPDB.

Operational costs of the HIPDB include:

1. Contract HIPDB Operations

   - Responding to requests for information and assistance
   - Receiving and encoding information into the data bank
   - Providing information to individuals who query the data bank about themselves
   - Systems enhancements to make the data bank more accessible to users
   - Maintaining interactive access through the Internet for transmitting reports and requests for information to the data bank
   - Support for fee collection

2. Non-contract HIPDB Operations

   - Oversight of data bank operations and systems security
   - Federal contract management
   - Periodic contract recompetition
   - Development and interpretation of data bank program policy
   - Printing of program informational and marketing materials
   - Management of a system to resolve disputes about the accuracy of data bank information
   - Development of specifications for data bank system enhancements
   - Management of a research capability based on data bank information
   - Management of a continuous quality improvement program
   - Fee collection

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Reports added to Data Bank	50,000	50,000	50,000
Requests for information processed	727,000	519,000	519,000

Maternal and Child Health Block Grant

Authorizing Legislation - Title V of the Social Security Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$729,817,000	$723,928,000	$723,928,000	---
FTE	1	---	---	---

FY 2006 Authorization $850,000,000

Statement of the Budget

The FY 2006 Budget of $723,928,000 is equal to the FY 2005 Appropriation.

Program Description

The mission of the 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. Specifically the program seeks to: (1) assure access to quality care, especially for those with low-incomes or limited availability of care; (2) reduce infant mortality; (3) provide and ensure access to comprehensive prenatal and postnatal care to women (especially low-income and at risk pregnant women); (4) increase the number of children receiving health assessments and follow-up diagnostic and treatment services; (5) provide and ensure access to preventive and child care services as well as rehabilitative services for certain children; (6) implement family-centered, community-based, systems of coordinated care for children with special health care needs (CSHCN); and (7) provide toll free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Title XIX (Medicaid).

These legislated responsibilities are consistent with the Department's current emphasis on reducing racial/ethnic differences, building capacity and infrastructure for child health, and ensuring quality care. They are also consistent with the President's New Freedom Initiative which states that "the Health and Human Services (HHS) Health Resources and Services Administration, will take the lead in partnership with States, tribes and other organizations, in developing and implementing a plan to achieve appropriate community-based service systems for children and youth with special health care needs and their families." (Reference: Delivering on the Promise: Preliminary Report of Federal Agencies' Actions to Eliminate Barriers and Promote Community Integration. Presented to the President of the United States December 21, 2001.)

Section 502 of the Social Security Act states that of the amounts appropriated up to $600,000,000, 85 percent is for allocation to the States, and 15 percent is for Special Projects of Regional and National Significance (SPRANS) activities. Any amount appropriated in excess of

$600,000,000 is distributed as follows: 12.75 percent is for Community Integrated Service Systems (CISS) activities; of the remaining amount, 85 percent is for allocation to the States, and 15 percent is for SPRANS activities.

The MCH Block Grant is at its core a public health program that reaches across economic lines to improve the health of all mothers and children. Created as a partnership with State MCH programs and with broad State discretion, State Title V programs use appropriated formula grant funds for: capacity and systems building, public information and education, knowledge development, outreach and program linkage, technical assistance, provider training, evaluation, support for newborn screening, and genetic services, lead poisoning and injury prevention, additional support services for children with special health care needs, and promotion of health and safety in child care settings. Special efforts are made to build community capacity to deliver such enabling services as care coordination, transportation, home visiting, and nutrition counseling. Where no services are available, States also use Title V to provide categorical direct care such as prenatal care or services for children with special health care needs.

The accompanying pyramid graphically shows the Title V MCH approach to and resources for providing comprehensive services for mothers and children. It also displays the uniqueness of the MCH Block Grant program that consistently supports services and activities at all levels of the pyramid. Functions related to infrastructure building are at the base of the pyramid and form its foundation.

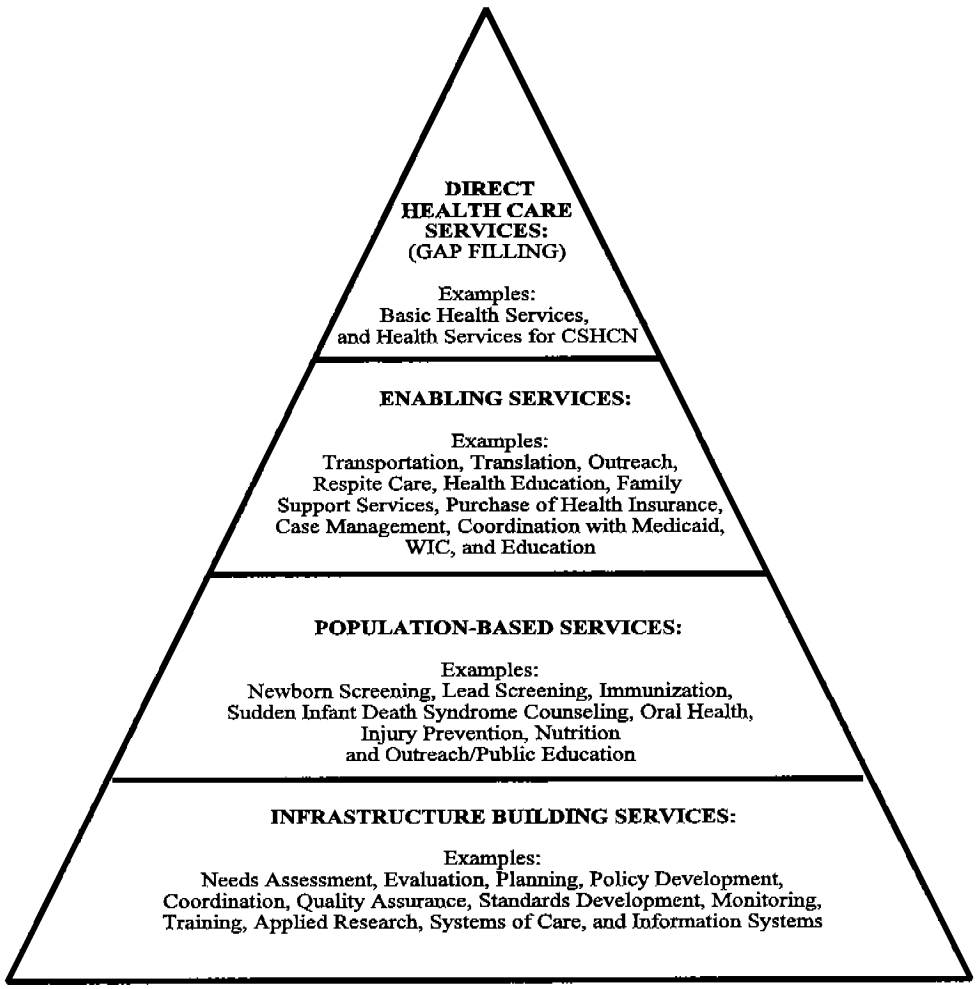
Additional activities that support the improved health care of mothers and children are SPRANS and CISS. SPRANS funds support projects (through grants, contracts, and other mechanisms) in research, training, genetic services and newborn screening and follow-up, hemophilia, and maternal and child health improvement. SPRANS projects must:

- Support national needs and priorities or emerging issues.
- Have regional or national significance.
- 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 six specified strategies:

- Provide maternal and infant home health visiting, health education, and related support services for pregnant women and infants up to one year old.
- Increase participation of obstetricians and pediatricians under Titles V and XIX.
- Integrate MCH service delivery systems.
- Operate MCH centers under the direction of not-for-profit hospitals.
- Increase MCH projects in rural areas.
- Provide outpatient and community-based services for children with special health care needs.

CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



Resources actually expended in FY 2003, including Federal, State and local MCH funds, were distributed along the pyramid as follows: Direct Health Care Services, 57.8%; Enabling Services, 22.0%; Population-Based Services, 10.9%; and Infrastructure Building Services, 9.4%.

Funding levels for the Maternal and Child Health Block Grant Program during the last five years reflect this effort and are as follows:

	$	FTE
2001	709,151,000	2
2002	731,259,000	1
2003	730,710,000	1
2004	729,817,000	1
2005	723,928,000	–

Performance Analysis

The Title V Block grant program provides support to all 59 States and Territories to address three overarching goals: 1) improving access to health care; 2) eliminating health disparities; and 3) improving the quality of health care. In addressing the improvement of access to health care, the program has been able to increase both the number of children served by the States under Title V (to 22.7 million) and the number of pregnant women receiving prenatal care in the first trimester of pregnancy (to 82.2 percent), as well as serving children under Title V who have Medicaid/SCHIP coverage (9.7 million). While the first two numbers are short of the 2003 targets, the increases are nonetheless significant as they occurred in a period of severe financial constraints at the state and local levels. The 9.7 million is a significant increase over the 2002 baseline. In the effort to eliminate health disparities, the steady trend toward reducing infant mortality and the black to white infant mortality rate ratio was reversed in 2002. However, preliminary 2003 data from the National Center for Health Statistics show that the 2002 reversals were temporary and the trend has resumed in the desired direction. On a more positive note, the percent of low birth weight babies born in appropriate facilities has increased to 76 percent, meeting the 2005 goal. While progress in some areas has not been as rapid as desired, the long-term trend has been toward an improvement in access, provision of services and in the reduction of disparities. Many of the factors impacting the health status indicators are not merely resource issues, but are societal in nature, beyond the control of the program. Further information on this program's performance is presented in Section U of this document.

The Title V Block grant was reviewed by OMB for the FY 2004 Budget using the Program Assessment Rating Tool (PART) and received a rating of "Moderately Effective." The performance measures reported above and in Section U incorporate those resulting from the PART review.

In addition, in 2004, the Title V Block Grant program initiated a customer satisfaction survey utilizing the American Customer Satisfaction Index (a standardized methodology used by both public and private sectors). Recipients of the Title V Block grantees' services were surveyed. As a result, the program received a score of 91 out of a possible 100, the second highest score ever recorded for a government program.

Rationale for the Budget

The FY 2006 Budget of $723,928,000 is equal to the FY 2005 Appropriation. In addition to Federal funds to the States, the States are required to match $3 for every $4 in Federal funds for the State Block awards. These funds will enable States to develop and coordinate needed services striving for a seamless, comprehensive system of care for children which will enable HRSA and the States, as well as Medicaid and the State Children's Health Insurance Program (SCHIP) to achieve their goals.

The needs creating the greatest current barriers to the success of MCH's mission are:

- Uninsured Children: In 2003, 8.4 million or 11.4 percent of all children were uninsured (August 2004 Current Population Survey).

- Racial Differences: Differences in health indicators continue to be a major problem across the spectrum of MCH services including infant death, low birth weight, entrance into prenatal care, and general access to care.

- CSHCN who are Unserved or Underserved: These children are most critically in need of multi-disciplinary services. Some of these children are uninsured, while still others are underinsured.

The Title V Federal program 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. State Title V programs support capacity and infrastructure building, population-based and enabling services, as well as direct health care services where no services are available. In these latter roles, Title V programs serve as a safety net for uninsured and underinsured children, including CSHCN. Title V continues to play a valuable, complementary role to SCHIP and Medicaid programs. States will also be able to continue using MCH Block grant funds for newborn hearing screening activities.

SPRANS and CISS funds support innovative discretionary projects in the areas of: applied MCH research; MCH leadership training for neurodevelopmental disabilities, developmental-behavioral pediatrics, pediatric pulmonary centers, pediatric dentistry, nursing, nutrition, schools of public health, adolescent health, and others; expansion of genetics services capacity; hemophilia treatment centers; and a variety of MCH improvement projects (MCHIP) including adolescent health, SIDS, and the "Bright Futures" guidelines for practitioners; medical homes; and child care health and safety. SPRANS and CISS both complement and help ensure the success of State Title V, Medicaid, and SCHIP programs, building community capacity to create family-centered, integrated systems of care for mothers and children, including children with special health care needs.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Grants to States	59	59	59
SPRANS Set-aside:			
Research	28	27	29
Training	149	146	152
Hemophilia	12	12	12
Genetics	23	23	23
MCHIP*	168	164	171
One-time	100	95	0
Sub-total SPRANS	480	467	387
CISS	167	162	182
Total MCH Block Grant	706	688	628

*MCH Improvement Projects

Traumatic Brain Injury

Authorizing Legislation - Sections 1252 and 1253 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$9,375,000	$9,297,000	---	-$9,297,000

FY 2006 Authorization ..... Expired

Statement of the Budget

The FY 2006 Budget does not request funding for the Traumatic Brain Injury Program. This is $9,297,000 below the FY 2005 Appropriation.

Program Description

The Traumatic Brain Injury (TBI) Grant Program funds the development and implementation of statewide systems that ensure access to comprehensive and coordinated TBI services including: pre-hospital care, emergency department care, hospital care, transitional services, rehabilitation, education and employment, and long-term community support.

Through FY 2004, it is anticipated that forty-nine States will have received funding to promote systems and infrastructure development including the four core components (a designated State agency and staff, a statewide action plan, statewide needs and resource assessments, and a State Advisory Board). Thirty-six States will have received funding to implement the State plans from the planning process to improve access to TBI services for consumers and families. In addition, twenty-eight awards will have been made to States for the post demonstration program to continue systems change that began in the implementation phase.

TBI core capacity includes: a statewide action plan, statewide needs assessments, a designated State agency staff, and a State advisory board for TBI systems development to improve services to individuals with TBI and their families.

Funding levels for the Traumatic Brain Injury Program during the last five years reflect this effort and are as follows:

	$
2001	5,000,000
2002	7,496,000
2003	9,438,000
2004	9,375,000
2005	9,297,000

Performance Analysis

In treatment of traumatic brain injury (TBI), rapid, organized treatment is vital not only to saving the lives of victims, but also improving the quality of life for TBI survivors. However, the TBI program was reviewed using the Program Assessment Rating Tool (PART) for the FY 2006 Budget and was given a rating of "Results Not Demonstrated." Further, it was stated that the TBI program demonstrated an inability to develop long-term health outcome measures.

Rationale for the Budget Request

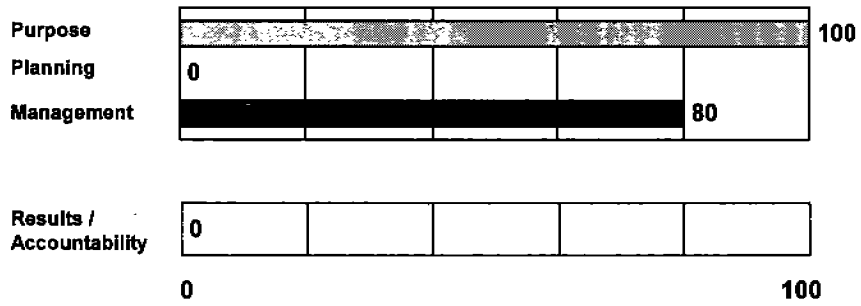
The FY 2006 Budget does not provide funding for this program. If individual States see benefit in continuing this program, they may do so utilizing funds acquired through their MCH Block Grants.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
TBI Awards	38	38	---
TBI Protection and Advocacy	57	57	---

Program: *Traumatic Brain Injury*

Agency: *Department of Health and Human Services*
Bureau: *HRSA*



Key Performance Measures from Latest PART	*Year*	*Target*	*Actual*

Rating: *Results Not Demonstrated*

Program Type: *Competitive Grant*

Program Summary:

The Traumatic Brain Injury (TBI) program provides competitive grants to states to fund coordinated systems for TBI services. States are expected to generate support from local and private sources to sustain TBI projects after the Federal grant period expires.

The assessment found that the program does not have a demonstrated impact on improving the health or wellbeing of individuals with Traumatic Brain Injury. Additional findings include:

- The program has not adopted outcome goals to measure the extent to which the program is improving the health and well-being of individuals with TBI.
- The program has not had an independent evaluation to assess the impact of the state TBI grants.
- Forty-three states have designated a lead TBI agency, conducted a needs and resources assessment of TBI services in the state, and developed a plan to improve TBI services. Seven states have not surveyed their resources or developed a strategic plan to address the health needs of individuals with TBI.

In response to these findings, the Administration proposes to phase-out the TBI program. States can continue key program activities with funds from the Maternal Child Health block grant and state, local, and private resources.

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
9	9	0

Healthy Start

Authorizing Legislation - Section 330H of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$97,751,000	$102,543,000	$97,747,000	$-4,796,000

FY 2006 Authorization ..... Expired

Statement of the Budget

The FY 2006 Budget of $97,747,000 is $4,796,000 less than the FY 2005 Appropriation, and supports non-pay costs.

Program Description

The Children's Health Act of 2000 (P. L. 106-310) amended the Public Health Service Act to provide "such sums as necessary" for continuation and expansion of a distinct Healthy Start program of grants that use community-designed and evidence-supported strategies aimed at reducing infant mortality and improving perinatal outcomes in project areas with high annual rates of infant mortality.

Healthy Start provides grants to communities identified as having both high rates of infant mortality and a community-driven plan that uses a variety of strategies to reduce those disparities in perinatal health care that contribute to the Nation's high infant mortality rate.

The National Evaluation final report (2000) on the first 15 Healthy Start Demonstration sites found that Healthy Start has been successful at enrolling women with high risk of adverse pregnancy outcomes, women who were less likely to receive care in a private office, and were more likely to have less than a high school education, to have lower incomes, and to have more unintended pregnancies compared to other women in the project area.

Subsequent data that include projects which have been funded since the initial phase of Healthy Start are showing additional promising results:

- Low birthweight (LBW) is a major contributor to infant mortality. In 2002, the percent LBW was 7.8, the highest level recorded since the early 1970s. (Source: National Vital Statistics System (NVSS), National Center for Health Statistics, (NCHS), 2003). In 1998, 65 percent of all infant deaths occurred to the 7.6 percent of infants born at low birthweight (Source: NVSS, NCHS, 2000). Low birthweight in the Healthy Start projects averaged 12.1 percent in

1998. By 2002, in contrast to the national trend, these projects had reduced low birthweight to an average 10.5 percent.

- Another risk factor for infant mortality is late entry into prenatal care. For 2001, linked birth and death files indicate that infant mortality rates were higher for infants whose mothers began prenatal care after the first trimester. (Source: NVSS, NCHS, 2003). While nationally 82.8 percent of pregnant women received prenatal care in the first trimester in 1998, first trimester entry into prenatal care for these Healthy Start projects was only 41.8 percent in 1998. By 2002, these projects had increased first trimester entry into prenatal care to 71 percent–an almost 70 percent increase for these projects.

- Community-based projects are funded to reduce disparities in health care in 37 States, the District of Columbia, and Puerto Rico. Each of the vulnerable communities receiving funds has poor perinatal outcomes and/or an infant mortality rate in one or more racial, ethnic or geographically disparate populations that is at least one and a half times the national average.

- Healthy Start projects have made great strides in helping at-risk mothers have healthy babies. The District of Columbia Health Department announced an unprecedented decline in the infant mortality rate in the District of Columbia. The rate dropped by 20.7 percent from 1999 to 2000, reaching its lowest level ever. The District's Health Department Director reported that the District's Healthy Start program achieved a zero infant mortality rate among its clients in 2000.

Funding levels for the Healthy Start Program during the last five years reflect this effort and are as follows:

	$
2001	89,996,000
2002	98,952,000
2003	98,346,000
2004	97,751,000
2005	102,543,000

Performance Analysis

Healthy Start was designed to bring vital prenatal care to the women who need it most. In spite of the economic downturn which has limited services for vulnerable populations in some States, there have been some measurable successes in the Healthy Start program. First, the percentage of program participants receiving prenatal care in the first trimester of pregnancy has significantly increased from 66 percent in 2000 to 72.4 percent in 2003. Therefore, the number of participants who receive late care or no prenatal care has declined. And, perhaps due to this increase in early pregnancy care, a decrease in the number of low birth weight infants among African American participants has also been observed. Additional performance information is provided in Section U.

Rationale for the Budget

The FY 2006 Budget of $97,747,000 is $4,796,000 below the FY 2005 Appropriation, to continue support for the Healthy Start Program for States and communities to strengthen community-based systems that will enhance perinatal care and improve women's and infants' health. Healthy Start clients are often young, poor women who are at high risk of being homeless, uneducated, and unemployed, as well as victims of community and/or family violence. They need to receive special attention and early access to substance abuse treatment, domestic violence reduction, mental health services, parenting assistance, and other critical services.

Funding will permit implementation of a broad range of community-driven approaches including direct outreach from community health workers to women at high risk. Once identified and brought into care, case management can provide linkages with medical and social services and health education. The close connection between these services can assist in reducing significant risk factors such as smoking and alcoholism, while promoting behaviors that can lead to healthy

outcomes for women and their families. These positive relationships and effects which begin 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.

Every Healthy Start program has developed a consortium composed of neighborhood residents, clients, medical and social service providers, and faith and business community representatives. This ensures that not just Healthy Start clients, but the entire community is committed to reduce infant mortality and low birthweight and improve outcomes for women and their infants.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Healthy Start Projects:			
Community	113	96	91
Technical Assistance	1	1	1

Universal Newborn Hearing Screening

Authorizing Legislation - Section 399M of the Public Health Service Act.

	FY 2004 Actual	2005 Appropriation	2006 Request	Increase or Decrease
Current Law BA	$9,873,000	$9,792,000	$0	-$9,792,000
FTE	2	2	0	-2

FY 2006 Authorization ..... Expired

Statement of the Budget

The FY 2006 Budget does not request funding for the Universal Newborn Hearing Screening Program. This is $9,792,000 below the FY 2005 Appropriation.

Program Description

The Universal Newborn Hearing Screening program has supported: (1) physiologic testing of newborn infants prior to their hospital discharge, (2) audiologic evaluation by three months of age, and (3) entry into a program of early intervention by six months of age with linkages to medical home and family to family support.

MCHB has awarded competitive grants to states to implement the program and to one technical assistance center that served those involved in the field. Collaboration with the Centers for Disease Control (CDC) and National Institutes of Health (NIH) has been ongoing in an effort to stimulate the interest of the states and their commitment to implement the program.

Funding levels for the Universal Newborn Hearing Screening Program during the last five years reflect this effort and are as follows:

	$
2001	7,999,000
2002	9,995,000
2003	9,935,000
2004	9,873,000
2005	9,792,000

Performance Analysis

The Universal Newborn Hearing Screening program has been successful in increasing the percentage of newborns screened for hearing loss prior to hospital discharge despite stagnant or

decreased resources. In 2003, almost 90 percent of newborns were screened for hearing loss, surpassing the 2003 and 2004 targets.

Rationale for the Budget Request

No specific funds are requested for this program in FY 2006. Newborn hearing screening activities may be funded by States under the MCH Block grant.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Grant Awards to States	54	54	--
Technical Assistance	1	1	--

Emergency Medical Services for Children

Authorizing Legislation - Section 1910 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$19,860,000	$19,831,000	--	-$19,831,000

FY 2006 Authorization ..... Expired

Statement of the Budget

The FY 2006 Budget does not request funding for the Emergency Medical Services for Children (EMSC) Program. This is $19,831,000 below the FY 2005 Appropriation.

Program Description

The EMSC Program began in 1984 and is designed to ensure state-of-the-art emergency medical care for ill or injured children and adolescents. It covers the entire spectrum of emergency medical care including primary prevention, acute care, and rehabilitation. The EMSC program provides grants to States to improve existing Emergency Medical Services (EMS) systems and to schools of medicine to develop and evaluate improved procedures and protocols for treating children.

The EMSC Program over its lifetime has supported several efforts designed to assist States to have a viable pediatirc component to their State Disaster Response Plans. Response to mass casualty events was included in both the original EMSC 5-year plan (1995-2000) and the second edition (2001-2006).

A specific focus on pediatric components on State Disaster Plans began in early 2001 when a survey of State Plans revealed that most had either non-existent or grossly inadequate pediatric components. In FY 2004, the EMSC Program awarded 9 new State Partnership Grants which focused on (1) integrating issues of EMSC into State public health programs, (2) building capacity for pediatric components of statewide EMS data collection efforts, (3) integrating pediatric performance measures within the EMS system, and (4) incorporating pediatric EMS issues into preparedness for mass casualty disasters and terrorism.

The EMSC Program awarded 47 continuation grants in the State Partnership category. The EMSC Program continued to support the National EMSC Data Analysis Resource Center in order to help EMSC grantees and State EMS Offices develop their own capabilities to collect, analyze, and utilize EMS and other healthcare data to improve the quality of care in State EMS systems. The EMSC Program also supported regional symposia designed to promote interstate exchange of knowledge and collaboration. In addition, the EMSC Program began a national Public Information and Education campaign focused on assisting parents to be better prepared for emergencies.

In addition, the EMSC Program has been concerned with the psychological impact of injury and critical illness, particularly in the emergency environment, since the early 1990's. The program as worked with SAMHSA and, to a lessor extent NIMH, in both service delivery and research related areas. SAMHSA participated in designing the EMSC 5-year plans, and NIMH was one of several NIH institutes which participated in developing an integrated research announcement for emergency medical services for children.

Funding levels for the EMSC program during the last five years reflect this effort and are as follows:

	$
2001	18,985,000
2002	18,984,000
2003	19,373,000
2004	19,860,000
2005	19,831,000

Performance Analysis

The program supports the development of improved emergency procedures and protocols for children. Section U of this document presents additional information on the program's performance. The EMSC program was reviewed using the Program Assessment Rating Tool (PART) for the FY 2006 Budget and was given a score of "Results Not Demonstrated." Further, the EMSC program demonstrated an inability to develop long-term health outcome measures.

Rationale for the Budget Request

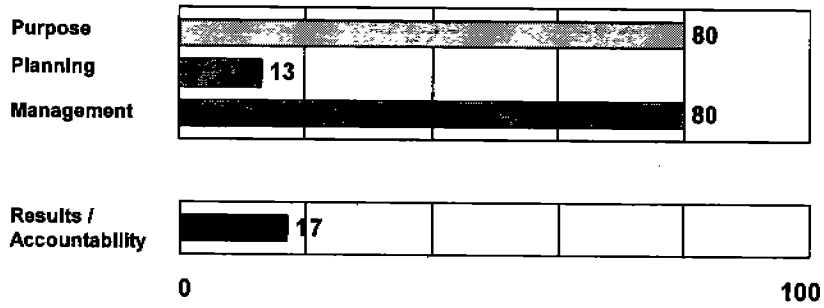
The FY 2006 Budget does not provide funding for this program. If individual States see benefit in continuing this program, they may do so utilizing funds acquired through their MCH Block Grants.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Awards to States	55	55	0
Awards to Medical Schools	23	23	0

Program: *Emergency Medical Services for Children*

Agency: *Department of Health and Human Services*
Bureau: *Health Resources and Services Administration*



Key Performance Measures from Latest PART	*Year*	*Target*	*Actual*

Rating: *Results Not Demonstrated*

Program Type: *Competitive Grant*

Program Summary:

The Emergency Medical Services for Children (EMSC) program provides grants to States or accredited medical schools in States to support programs that expand and improve emergency medical services for children. The program' s ultimate goal is to reduce child and youth morbidity and mortality resulting from severe illness or trauma.

The assessment found that the though the EMSC program possessed a clear purpose and had demonstrated good program management, they provided no long-term performance measures that focused on outcomes or reflected the purpose of the program. As a result, the program was unable to demonstrate any meaningful results. Additionally, the program does not have long-term health outcome measures, nor have any been developed for the FY 2006 PART. Because long-term health outcome measures have not been developed:

- Partners and grantees (i.e. States) cannot commit to, nor work towards, annual and/or long-term goals for the program.
- The program is unable to clarify the impact that funding, policy, or legislative decisions have on its expected performance.
- The program is unable to explain why a particular funding level is the most appropriate.
- There is no way to demonstrate adequate progress by the program in achieving its objectives.

In response to these findings, the Administration will propose eliminating funding of categorical grants for EMSC due to the program' s failure to demonstrate results.

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
20	20	0

Sickle Cell Service Demonstration

Authorizing Legislation - Section 712(c) of the American Jobs Creation Act of 2004.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$--	$198,000	--	-$198,000

FY 2006 Authorization $10,000,000

Statement of the Budget

The FY 2006 Budget does not request funding for the Sickle Cell Service Demonstration Program. This is $198,000 below the FY 2005 Appropriation.

Program Description

The Sickle Cell Service Demonstration Program was created to develop systemic mechanisms for the prevention and treatment of Sickle Cell Disease, including the coordination of service delivery for individuals with Sickle Cell Disease; genetic counseling and testing; bundling of technical services related to prevention and treatment of Sickle Cell Disease; training of health professionals; and identifying and establishing other efforts related to the expansion and coordination of education, treatment, and continuity of care programs for individuals with Sickle Cell Disease.

Funding levels for the Sickle Cell Service Demonstration program during the last five years reflect this effort and are as follows:

	$
2001	--
2002	--
2003	--
2004	--
2005	198,000

Performance Analysis

This program is new and does not yet have any performance to analyze.

Rationale for the Budget Request

The FY 2006 Budget does not provide funding for this program. This is $198,000 below the FY 2005 Appropriation.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Award	---	1	---

Ryan White - HIV/AIDS Overview

Authorizing Legislation - Public Health Service Act, Title XXVI

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Current Law BA	$2,019,861,000	$2,048,296,000	$2,058,296,000	+$10,000,000
PHS Act (SPNS)	$25,000,000	$25,000,000	$25,000,000	-
*Program Total**	*$2,044,861,000*	*$2,073,296,000*	*$2,083,296,000*	*+$10,000,000*
FTE	27	30	30	-

** The amounts include funding for Special Projects of National Significance funded from Department PHS Act evaluation set-asides in FY 2004 and FY 2005 and proposed for FY 2006.*

FY 2006 Authorization.....Expired

Statement of Budget

The FY 2006 Budget of $2,083,296,000 is $10,000,000 above the FY 2005 Appropriation and supports Ryan White Comprehensive AIDS Resources Emergency (CARE) Act program activities.

Program Description

The CARE Act programs of the Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau (HAB) provide the focal point for the Federal response to the primary care and social support needs for persons living with HIV disease in the United States who have no other resources to pay for their care. The CARE Act was enacted in August 1990. It was reauthorized for five years in May 1996, and for an additional five years in October 2000.

After Medicaid and Medicare, the CARE Act is the largest single source of Federal funding for HIV/AIDS health care for low-income, uninsured, and underinsured Americans. Since the CARE Act is the "payer of last resort", the unique statutory mandates in the Act regarding participatory planning help to insure that the CARE Act programs truly meet the needs of persons living with HIV/AIDS. The CARE Act programs demonstrate a comprehensive and aggressive

approach in how government has targeted dollars toward the development of an effective service delivery system by partnering with states, heavily impacted metropolitan areas, community-based providers, and academic institutions.

The Centers for Disease Control and Prevention (CDC) estimates that 850,000 - 950,000 individuals are living with HIV in the U.S., including 180,000-280,000 who do not know they are infected. Additionally it is estimated that 1/3 of those who know their serostatus are not in care. Approximately 42,000 new HIV infections occur in the U.S. every year.

It is estimated that 571,000 individuals received at least one medical care, health, or related support service from a CARE Act provider. Specific HIV health services include medical care, access to lifesaving medications used in the treatment of HIV/AIDS, oral health care, outpatient mental health, outpatient substance abuse treatment, and home health care. Key health-related support services include case management, transportation, food bank, and housing assistance. While ambulatory health care and support services are the primary focus of the legislation, training, technical assistance, and demonstration projects are also funded.

The CARE Act programs (Title XXVI, Parts A-F) include:

Part A (Title I) Emergency Relief Grants to Metropolitan Areas
Part B (Title II) HIV Care Grants to States
Part C (Title III) Early Intervention Services
Part D (Title IV) Children, Youth, Women, and Families
Part F: AIDS Education and Training Centers
Part F: Dental Reimbursements: Community Based Dental Partnerships
Part F: Special Projects of National Significance*
**[Under current statute normally funded by set-asides (not to exceed $25,000,000) from amounts appropriated for Parts A, B, C, and D. For FY 2004 and FY 2005 and proposed for FY 2006, SPNS is funded from Department PHS Act evaluation set-asides.]*

The HIV Emergency Relief Grants, Part A (Title I), provides ambulatory outpatient health and support services to 50 eligible metropolitan areas (EMAs) that are most severely impacted by the HIV epidemic. HIV Care Grants to States, Part B (Title II), provides formula grants to 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam and five U.S. Pacific Territories and Associated Jurisdictions (American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau) for the provision of health care and support services for people living with HIV disease. A separate appropriation "earmark" provides critical funding specifically for the AIDS Drug Assistance Program (ADAP), bringing the benefits of effective and costly anti-retroviral and other pharmaceuticals within reach of persons with HIV who are unable to otherwise afford these therapies. The Part C (Title III) program funds comprehensive primary health care for individuals living with HIV disease who are low-income or medically underserved. Planning grants and capacity building grants support communities and health care entities in their planning efforts to develop high quality HIV primary care for individuals living with HIV disease. Part D (Title IV) programs fund primary care, specialty medical care, psychosocial services, logistical assistance, as well as, outreach and prevention and social

services for women, infants, children, youth, and auxiliary services for their affected family members and links these care systems with HIV research and clinical trials. Part F includes the national network of 11 regional AIDS Education and Training Centers (AETC) and several national resource centers that conduct clinical HIV education and training programs for health care providers. Part F also includes the Dental Reimbursement Program that assists accredited dental schools, post-doctorate dental programs and schools of dental hygiene with non-reimbursed costs incurred in providing oral health treatment to patients with HIV disease. The Community Dental Partnership Program is the newest program where in dental schools and programs partner with community-based dentists to provide oral health care to patients with HIV disease in underserved areas.

While we have seen a significant decline in HIV/AIDS deaths in the last several years, there continue to be key challenges. Most disturbing is the fact that AIDS remains a leading killer in communities of color and the largest increases in HIV/AIDS surveillance reports are in cases among women, youth, racial/ethnic minorities, and injection drug users and their sexual partners. Geographic distribution of cases also points to the continuing need to further develop primary care capacity in underserved urban communities as well as in remote and underserved rural areas of the country that have little or no HIV care infrastructure.

The need to provide treatment to Americans living with HIV/AIDS is a part of the Administration's commitment to continue support of the Ryan White CARE Act and to strengthen that program using the following principles as guidelines:

- Focus Federal resources on life-extending care, such as anti-retroviral drugs, doctor visits, and lab tests.
- Provide greater flexibility to better target Ryan White CARE Act resources to address areas of greatest need.
- Encourage the participation of any provider, including faith-based and community organizations that show results, recognizing the need for State and local planning, and ensuring accountability by measuring progress.

Funding levels, including the comparable SPNS set-aside, for CARE Act programs during the last five years reflect this effort and are as follows:

FY	$	FTE
2001	1,807,609,000	30
2002	1,910,204,000	28
2003	2,017,966,000	30
2004	2,044,861,000	27
2005	2,073,296,000	30

Performance Analysis

Each year, the CARE Act funded programs help an estimated 571,000 individuals living with HIV/AIDS obtain access to life-sustaining care and services. The CARE Act is especially successful in reaching those who need help the most, including minorities, the uninsured and underinsured. Often, when people have to choose between expensive medical treatment and other necessities, health care loses out. The CARE Act funds help to eliminate these difficult decisions.

The performance of CARE Act programs is summarized for each component of the program in the immediately following sections of the Justification. These summaries generally show success, often exceeding the targets, in extending access to HIV/AIDS services for increasing numbers of individuals, addressing disparities by serving proportionately large numbers of racial/ethnic minorities and women, providing life-enhancing medications to tens of thousands of persons monthly, providing continuing education to health providers in treating HIV/AIDS patients, and facilitating affordable dental care needed by persons with HIV/AIDS. In addition to the summaries, details of performance of the various program components are presented in Section U of the Justification.

A Program Assessment Rating Tool (PART) review of the CARE Act Titles I through IV programs was conducted for the FY 2004 period. These CARE Act programs, combined, received a rating of "Adequate." During this process several short-term performance measures were developed to use in assessing performance of these titles overall. They include measures to access reductions in health disparities, improve health outcomes, provision of quality of health care, and improvements in access to health care. The new measures complement and, in some cases, replace component-specific measures in performance budget planning and reporting. FY 2004 data on these new measures, which are shown in Section U, are variously expected in late 2005 and 2006.

Overall:

- In FY 2002, an estimated 571,000 persons received CARE Act services. In comparison with the annual performance figures from FY 2000, an additional 38,000 clients received services through the CARE Act in FY 2002. Data for this measure are reported every two years and data for FY 2004 is expected in late 2006.

- The CARE Act funded programs are serving a significantly higher proportion of women than the target specified in the indicator itself (i.e., five percentage points higher than the representation of women among all AIDS cases in the Nation, as reported by CDC). The percentage of women served by CARE Act programs was 36% in 2003 compared to national CDC AIDS Prevalence data of 21.8 percent..

- In FY 2003, 86,280 persons were served at least one month of the year by ADAP. In comparison with monthly figures from FY 2002, an additional average of 5,102

(unduplicated) clients were receiving anti-retroviral therapies through ADAP in FY 2003. In FY 2003, State ADAP's participation in cost-recovery strategies produced a $92.5 million savings, substantially exceeding the projected target.

Rationale for the Budget

The FY 2006 Budget request of $2,083,296,000 is $10,000,000 above the FY 2005 Appropriation and supports Ryan White Comprehensive AIDS Resources Emergency (CARE) Act program activities. The FY 2006 Budget will provide additional funding flexibility to the State AIDS Drug Assistance Programs to provide life saving drugs to those who are waiting for HIV-related medication. In addition, the FY 2006 budget continues to fund Special Projects of National Significance at $25,000,000 from PHS Act evaluation set-asides.

Ryan White CARE Act, Title I (Part A) Emergency Relief Grants

Authorizing Legislation- Part A, Sections 2601-2607 of the Public Health Service Act

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Current Law BA	$615,023,000	$610,094,000	$610,094,000	--
PHS Act (SPNS)	$7,800,000	$7,626,000	$7,588,000	- $38,000
*Program Total**	*$622,823,000*	*$617,720,000*	*$617,682,000*	*- $38,000*

** The amounts include the proportionate share of funding for Special Projects of National Significance funded from Department PHS Act evaluation set-asides in FY 2004 and FY 2005 and proposed for FY 2006.*

FY 2006 Authorization.....Expired

Statement of Budget

The FY 2006 Budget of $610,094,000 is the same as the FY 2005 Appropriation and supports the program.

Program Description - The Ryan White CARE Act Title I (Part A) program continues to prioritize primary medical care, provision of anti-retroviral therapies, emergency financial assistance, and case management as the areas of greatest need for persons with HIV disease. Title I funds may be used to provide a continuum of care for persons living with HIV disease. The grants fund systems of community-based care comprised of approximately 25 categories of medical, other health and social support services for individuals with HIV/AIDS in EMAs. These services are intended primarily for low income, underserved people living with HIV/AIDS. Fifty percent of the funds available are awarded according to a formula based on the estimated number of living cases of AIDS in the EMA's. The current statute also includes a hold harmless provision which limits a potential loss in an EMA's formula award to a specific percentage of the amount awarded in the previous year (or a "base year" if the hold harmless provision was triggered in an earlier year). The remaining funds, less any hold harmless amounts, are awarded as discretionary supplemental grants based on the demonstration of additional need by the EMA.

An estimated 73 percent of the HIV infected persons who know their HIV status but are not in medical care reside in the Title I Eligible Metropolitan Areas (EMAs). CARE Act Title I funds are targeted to provide services to not only those who know their status and are in care, but to those (some 212,500 to 237,500) who remain unaware of their HIV status and reside in the Title I EMA. A total of 840,421 duplicated clients were served by Title I grantees in 2003. This

includes 316,216 (duplicated) new clients who had a least one visit to a Title I Ryan White CARE Act provider for an eligible service during the reporting period.

Funding levels (current law BA) for Part A (Title I) during the last five years reflect this effort and are as follows:

FY	$
2001	604,169,000
2002	619,381,000
2003*	618,693,000
2004*	615,023,000
2005*	610,094,000

** Excludes comparable amounts for SPNS.*

Performance Analysis

Title I programs have been successful in providing resources to ensure that people with HIV/AIDS receive the comprehensive care that they need in communities struggling to meet the demands for services locally. Title I grants provide essential HIV/AIDS health care and a wide range of support services to those who lack or are only partially covered by health insurance. These grants help our most affected cities provide the high-quality HIV/AIDS care their residents desperately need, without diverting resources from other areas of the budget. Each year, local communities disproportionately affected by the epidemic rely on the Title I grants to continue delivering quality HIV/AIDS care and improving the lives of their citizens. The CARE Act, with this budget, will continue our commitment to fighting HIV/AIDS through providing access to care and treatment for those most in need.

The Title I program has proven successful based on the program's performance measures. The number of visits provided for health-related services demonstrates the effectiveness of the Title I program in delivering primary care and related services for individuals infected with HIV/AIDS by increasing availability of and access to care. In FY 2003, 3.33 million visits were reported by the 51 Title I Eligible Metropolitan Area's (EMAs) grantees. This number exceeded the target of 2.92 million and was 410,000 visits more than the previous year. Additionally, newly developed measures regarding the proportion of women that receive PAP smears and the proportion of clients that receive TB skin tests were reported for the first time in FY 2003. In FY 2003, the program provided PAP smears for 42.6 percent of women served. The program provided 31.5 percent of clients with TB skin testing. Section U provides additional information.

Rationale for the Budget

The FY 2006 Budget request of $610,094,000 is the same as the FY 2005 Appropriation and supports the program. The FY 2006 Budget will support the continuation of services in the fifty-one existing EMAs including:

- Access to a full spectrum of outpatient medical care to poor people with HIV disease who do not currently receive state of the art care.

- Viral load testing for Title I primary care patients.

- Title I participation in pharmaceutical assistance and related primary care services for patients receiving antiretroviral therapy.

- Efforts to improve health outcome disparities of people of color living within the Title I EMAs. (African American, Latinos, American Indians, Alaska Natives, Asian Americans, Native Hawaiians and Pacific Islanders).

- Efforts to sustain the capacity of minority service organizations who reach hard-to-serve populations that are disproportionately represented among those infected with HIV.

Outputs

There are 51 Eligible Metropolitan Areas in FY 2005. No changes are expected or anticipated in FY 2006.

Ryan White CARE Act Title II (Part B) HIV Care

Authorizing Legislation- Part B, Sections 2611-2620 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Current Law BA	$1,085,900,000	$1,121,836,000	$1,131,836,000	+ $10,000,000
State Grants	*$337,028,000*	*$334,315,000*	*$334,315,000*	-
ADAP	*$748,872,000*	*$787,521,000*	*$797,521,000*	*+ $10,000,000*
PHS Act (SPNS)	$13,772,000	$14,023,000	$14,077,000	+ $54,000
*Program Total**	*$1,099,672,000*	*$1,135,859,000*	*$1,145,913,000*	*+ $10,054,000*

** The amounts include the proportionate share of funding for Special Projects of National Significance funded from Department PHS Act evaluation set-asides in FY 2004 and proposed for FY 2005 and FY 2006.*

FY 2006 Authorization.....Expired

Statement of Budget

The FY 2006 Budget of $1,131,836,000 is $10,000,000 above the FY 2005 Appropriation and supports the program.

Program Description

The HIV Care Grants to States, or Title II (Part B) of the Ryan White CARE Act, provide formula grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five U.S. Pacific Territories and Associated Jurisdictions for the provision of more than 25 types of medical and other health and social support services for individuals with HIV including: the provision of home and community-based care, support for State AIDS Drug (Pharmaceutical) Assistance Programs (ADAP), Health Insurance Continuation Programs (HICP) for low-income persons with HIV disease and for State direct services. A State must use a statutorily mandated minimum of its grant funds to provide health and support services to infants, children, women and families with HIV disease. The statute also contains requirements regarding State matching funds and that the CARE Act funds supplement but do not supplant State resources. Title II also provides for supplemental awards to states for Emerging Communities (ECs). These are metropolitan areas with between 500 and 1,999 reported AIDS cases over the most recent five-year period. Twenty-nine communities received these supplemental awards in FY 2004. The number of ECs for FY 2005 is 28. The number of ECs for FY 2006 is unavailable at this time.

The CARE Act emphasizes that such care and support be part of a continuum of care in which efforts to address the needs of individuals with HIV disease and their families are coordinated. Providers funded by the Title II grantees provided services to a total of 650,014 duplicated clients in 2002. These providers reported that 166,061 (duplicated count) new clients had at least one visit for an eligible service during the reporting period. Other funded services also include treatment adherence, services that enhance access, and monitoring of drug treatments, as well as health insurance coverage with prescription drug benefits. Since 1996, a portion of the appropriation for Title II has been "earmarked" to provide grant funds to States to support their ADAP activities. Three percent of the ADAP earmark is reserved for grants to States and Territories with severe need for medication assistance.

In FY 2003, the ADAP's ability to provide medications to underserved populations improved significantly. Specifically:

- The number of State ADAPs with waiting lists varied in 2004 from 8 to 11 States versus 8 to10 State ADAPs with this restriction in FY 2003. The total number of clients on waiting lists decreased from 3,478 in 1998 to an average of 1,242 in 2004.
- The number of ADAPs with 26 or more drugs on their formulary increased from 36 in 1999 to 51 in 2004.
- ADAPs that set financial eligibility above 200 percent Federal Poverty Level (FPL) have increased from 30 in 1998 to 40 in 2004.
- In 2003, 45 State ADAPs required only an HIV positive diagnosis for eligibility versus 43 State ADAPs with this restriction in 1999. Further, only nine State ADAPs require additional medical eligibility criteria (CD4 cell counts) in 2004, versus 10 State ADAPs with this requirement in 1999.

Funding levels (current law BA) for Part B (Title II) during the last five years reflect this effort and are as follows:

FY	$	(ADAP)
2001	910,969,000	(589,000,000)
2002	977,240,000	(639,000,000)
2003*	1,053,393,000	(714,326,000)
2004*	1,085,900,000	(748,872,000)
2005*	1,121,836,000	(787,521,000)

** Excludes comparable amounts for SPNS.*

Performance Analysis

The devastating toll of AIDS in America continues to grow. More than 500,000 people have died since 1981, and between 180,000 - 280,000 of the 850,000 to 950,000 Americans currently living with HIV don't know they are infected. The Title II programs have been successful in helping to ensure that people with AIDS can get the care and services they need to stay healthy longer. Poverty, unfortunately, is also associated closely with HIV/AIDS, but these grants to states help

ensure that people with AIDS can get needed care and services. When insurance runs out, when savings are depleted, or when disability checks are needed to buy groceries instead of prescriptions, patients can turn to the programs funded by the Title II grants to get life-sustaining medical treatment. The Title II ADAP funding underscores the fact that new drug treatments have vastly improved individuals lives.

The Title II program has also been successful based on the program's performance measures as shown in Section U. The number of visits for health-related services demonstrates the effectiveness of the Title II program in delivering primary care and related services for individuals infected with HIV/AIDS by increasing the availability of and accessibility of care. In FY 2003, Title II programs provided 2.32 million visits. The actual performance for FY 2003 exceeded the target for that year by 760,000 visits. Additionally, the number of ADAP clients receiving HIV/AIDS medications through State ADAPs during at least one month of the year provides positive evidence of the ADAPs ability to provide therapeutics to treat HIV disease or prevent the serious deterioration of health arising from HIV disease in eligible individuals. In FY 2003, 86,280 persons were served at least one month of the year by ADAP. In comparison with monthly figures from FY 2002, an additional 5,102 (unduplicated) clients were receiving anti-retroviral therapies through ADAP monthly in FY 2003. The actual FY 2003 performance of 86,280 clients served at least one month per year by ADAP exceeded the FY 2003 target by 1,480 . The Title II programs are serving a significantly higher proportion of women than the target specified in the indicator itself (i.e., five percentage points higher than the representation of women among all AIDS cases in the Nation, as reported by CDC). The percentage of women served by Title II programs was 31.5 percent in 2003 compared to the national CDC AIDS prevalence data of 21.8 percent.

Rationale for the Budget

The FY 2006 Budget request of $1,131,836,000 is $10,000,000 above the FY 2005 Appropriation and supports the program. The FY 2006 Budget request includes $797,521,000 for the ADAP. The increase will be used to provide flexibility to deliver life-saving drugs to those living with HIV/AIDS who are waiting for HIV-related medication. The administration intends to focus these Federal resources on life-extending care, such as anti-retroviral drugs, and to provide greater flexibility to more effectively target CARE Act resources to address areas of greatest need. Additionally, $334,315,000 will be used for basic HIV grants for the provision of services in the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and five Pacific jurisdictions. This amount, for basic HIV grants, also includes $10,000,000 for EC's as required under current statute.

Outputs

There are 59 grantees funded by this activity including the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and five Pacific jurisdictions. Fifty-seven of these entities received ADAP funding in FY 2004. In addition, Title II grant awards included funding for twenty-nine ECs in FY 2004 . In FY 2005 there

will be twenty-eight. Since the number of ECs is based on the actual number of AIDS cases over the most recent five year period, the number for FY 2006 will not be available until mid-CY 2005.

Ryan White CARE Act Title III (Part C) Early Intervention Services

Authorizing Legislation- Part C, Sections 2651-2654 of the Public Health Service Act

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Current Law BA	$197,170,000	$195,578,000	$195,578,000	--
PHS Act (SPNS)	$2,501,000	$2,445,000	$2,433,000	- $12,000
*Program Total **	*$199,671,000*	*$198,023,000*	*$198,011,000*	*- $12,000*
FTE	27	30	30	-

** The amounts include the proportionate share of funding for Special Projects of National Significance funded from Department PHS Act evaluation set-asides in FY 2004 and FY 2005 and proposed for FY 2006.*

FY 2006 Authorization.....Expired

Statement of Budget

The FY 2006 Budget of $195,578,000 is the same as the FY 2005 Appropriation and supports the program.

Program Description

Since its inception, the Ryan White CARE Act Title III (Part C) program has increased access to health care for low income and medically underserved individuals who are infected with HIV or who are at risk for HIV infection by providing early intervention service programs. Title III funds are awarded to community health centers, family planning agencies, comprehensive hemophilia diagnostic and treatment centers, federally qualified health centers under section 1905(1)(2)(B) of the Social Security Act, county and municipal health departments and other nonprofit community-based programs that provide comprehensive primary health care services to populations with or at risk for HIV disease. Currently, 363 Early Intervention Services (EIS) programs provide comprehensive, primary care services to approximately 175,500 people living with HIV/AIDS in 48 States, the District of Columbia, Puerto Rico, and the Virgin Islands.

The programs emphasize early intervention services aimed at preventing and/or reducing HIV-related morbidity as part of the program of comprehensive primary care. Early intervention consists of the medical, educational, and psychosocial services designed to prevent the further spread of HIV, forestall the onset of illness, facilitate access to services, and provide psychosocial support to HIV-infected individuals and their families.

Part C (Title III) programs provide health care for individuals who are infected with or who are at risk for HIV infection. The programs provide comprehensive services including HIV testing, risk

reduction counseling, partner involvement in risk reduction, transmission prevention, appropriate medical evaluation, oral health, nutritional and mental health services, and clinical care (such as CD4 cell monitoring, anti-retroviral therapy, prophylaxis, and treatment of opportunistic infections and other related conditions). Case management, outreach, and eligibility assistance are optional services under this program. Programs are required to deliver primary care services to those with HIV disease and take into account the changing demographics of HIV-infected populations. Programs are also required to demonstrate that the provision of care follows current accepted treatment protocol.

Part C (Title III) also awards grants to provide capacity building for the efforts of organizations to strengthen their infrastructure and enhance their capacity to develop, enhance or expand high quality HIV primary health care services in rural or urban underserved areas and communities of color. These grants may not exceed $150,000 over a three year-period. Additionally, the Title III program provides for two types of planning grant awards to organizations that may not otherwise receive CARE Act funds. These planning grants are designed to help communities plan for the provision of high quality comprehensive HIV primary health care services in rural or urban underserved areas and communities of color where no or limited HIV services exist. They may not exceed $50,000 and are for only one fiscal year.

Funding levels (current law BA) for Part C (Title III) during the last five years reflect this effort and are as follows:

FY	$	FTE
2001	185,879,000	30
2002	193,844,000	28
2003*	198,374,000	30
2004*	197,170,000	27
2005*	195,578,000	30

** Excludes comparable amounts for SPNS.*

Performance Analysis

The Title III program has been successful in providing critical support to the organizations caring for, or planning to care for, some of the most vulnerable populations infected by HIV/AIDS. Early and continuous care can help these individuals live longer, more productive lives. HIV/AIDS continues to grow among traditionally underserved and vulnerable groups and people of color. Women and youth, in particular, remain disproportionately affected by the epidemic. The Title III program provides essential services that many of these people cannot get anywhere else because they are either unable to pay or do not qualify for the services, or because the services themselves are not otherwise available.

The Title III program has proven successful based on the program's primary performance measure as shown in Section U. The number of individuals receiving primary care services through the Early Intervention Services program demonstrates the effectiveness of the Title III program in achieving increased access to care for individuals infected with HIV/AIDS. In FY

2002, the Title III Early Intervention Program served 172,422 clients, exceeding the targeted goal by 19.4 percent, and representing an increase of 9.2 percent in new clients served compared to FY 2001.

Rationale for the Budget

The FY 2006 Budget request of $195,578,000 is the same as the FY 2005 Appropriation and supports the program. The FY 2006 Budget will continue to support existing Title III Early Intervention Services (EIS) Programs and will sustain primary health care and social support services to over 175,500 people living with HIV and AIDS at 363 EIS grantee sites in 48 States, the District of Columbia, Puerto Rico and the U.S. Virgin Islands.

Outputs

Grants	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
EIS	363	363	363
Capacity Development	12	12	12

Ryan White CARE Act Title IV (Part D) Children, Youth, Women, and Families

Authorizing Legislation - Part D, Section 2671 of the Public Health Service Act

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Current Law BA	$73,108,000	$72,519,000	$72,519,000	--
PHS Act (SPNS)	$927,000	$906,000	$902,000	- $4,000
*Program Total**	*$74,035,000*	*$73,425,000*	*$73,421,000*	*- $4,000*

** The amounts include the proportionate share of funding for Special Projects of National Significance funded from Department PHS Act evaluation set-asides in FY 2004 and FY 2005 and proposed for FY 2006.*

FY 2006 Authorization.....Expired

Statement of Budget

The FY 2006 Budget of $72,519,000 is the same as the FY 2005 Appropriation and supports the program.

Program Description

The purpose of the Part D (Title IV) Ryan White CARE Act HIV/AIDS Program for Children, Youth, Women, and Families is to improve and expand primary care and support services in order to increase access to comprehensive, family-centered systems of care. HIV-infected children, youth, women, and affected family members have multiple, complex medical, economic and social service needs which often require more intensive care coordination, intensive case management, child and respite care, and direct service delivery to engage and maintain adolescents and mothers in care. A special focus of the Title IV program is to help identify HIV-positive pregnant women, connect them with care that can improve their health, and prevent perinatal transmission. Assessment and provision of services is delivered at the family level, and usually involves services not only for the infected child(ren) and parent(s), but also for uninfected siblings and caregivers. Services to families may involve coordination of multiple agencies and systems, including managed care organizations, faith-based organizations, social services and foster care agencies.

The program has developed innovative models that link systems of comprehensive community-based medical and social services for the affected population with the National Institutes of Health and other clinical research trials. Funds support innovative and unique

strategies and models to organize, arrange for, and deliver comprehensive services through integration into ongoing systems of care.

Funding levels (current law BA) for Part D (Title IV) during the last five years reflect this effort and are as follows:

FY	$
2001	64,995,000
2002	70,964,000
2003*	73,551,000
2004*	73,108,000
2005*	72,519,000

** Excludes comparable amounts for SPNS.*

Performance Analysis

The AIDS epidemic in America impacts the most vulnerable families more and more each year. The Title IV program has been successful in providing front-line services to many women and children, filling a critical need in the delivery of health care services to persons living with HIV/AIDS. Because women frequently neglect their own health to care for their families, making sure they have access to quality HIV/AIDS care and services is critical. Before women can adequately care for their families, they must care for themselves, and the Title IV programs have shown success in helping bridge this gap.

The Title IV program has proven successful based on the program's performance measures as shown in Section U. The number of female clients receiving comprehensive services demonstrated the effectiveness of the Title IV program by providing HIV-infected children, adolescents, women and families increased access to care. In FY 2003, the program had an approximate 21 percent increase in the number of women receiving comprehensive services as compared to FY 2002. Further, this FY 2003 performance exceeded the performance target by 28.3 percent.

Rationale for the Budget

The FY 2006 Budget request of $72,519,000 is the same as the FY 2005 Appropriation and supports the program. The FY 2006 Budget request will support primary health care and social support services to over 40,000 women, infants, children and youth living with HIV and AIDS and their affected families at grantees situated in 31 States, D.C. and Puerto Rico.

Outputs

There were 91 grant awards including 17 for adolescent programs estimated for FY 2004. The same number of grant awards is estimated for FY 2005 and FY 2006.

Ryan White CARE Act (Part F) AIDS Education and Training Centers

Authorizing Legislation - Part F, Section 2692 (a) of the Public Health Service Act

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Current Law BA	$35,335,000	$35,051,000	$35,051,000	-

FY 2006 Authorization.....Expired

Statement of Budget

The FY 2006 Budget of $35,051,000 is the same as the FY 2005 Appropriation and supports the program.

Program Description

The National AIDS Education and Training Centers (AETC) Program is a network of 11 regional centers (with more than 130 associated sites) that conduct targeted, multi-disciplinary HIV education and training for health care providers. The AETCs serve all 50 States, the District of Columbia, the Virgin Islands, Puerto Rico, Guam, and the five U.S. Pacific Jurisdictions. The AETC Program mission is to increase the number of health care providers who are effectively educated and motivated to counsel, diagnose, treat, and medically manage individuals with HIV infection, and to help prevent high risk behaviors that lead to HIV transmission.

There are four National cross-cutting centers that support and complement the regional AETCs. They are: (1) National Minority AIDS Education Training Center that builds the capacity for HIV care and training among minority health care professionals and health care professionals serving communities of color; (2) the AETC National Resource Center that disseminates training resources and the latest HIV clinical information across the family of AETCs grantees via the internet and other media. It also provides a mechanism for communication of best practices and dissemination of AETC program tools across the AETCs program; (3) the National HIV/AIDS Clinicians' Consultation Center that provides health care providers with timely and appropriate responses to clinical question related to treatment to persons with HIV infection (WarmLine) and/or possible health care worker exposure to HIV and other blood-borne pathogens (PEPline); and (4) the National Evaluation Center which is responsible for program evaluation activities, including assessing the effectiveness of AETCs grantees education, training, and consultation activities.

Emphasis is placed on interactive, hands-on training and clinical consultation to assist providers with complex issues related to the management of highly active anti-retroviral therapy. AETCs collaborate with CARE Act-funded organizations, area health education centers, community-based HIV/AIDS organizations, and medical and health professional organizations.

Since 1991, the AETC program has sponsored more than 700,000 training interactions for providers. Primary care clinicians trained by AETCs have been shown to be more competent with regard to HIV issues and more willing to treat persons living with HIV than other primary care providers.

Funding levels (current law BA) for the AETC program during the last five years reflect this effort and are as follows:

FY	$
2001	31,598,000
2002	35,282,000
2003	35,550,000
2004	35,335,000
2005	35,051,000

Performance Analysis

Given the increasing proportion of AIDS cases among racial and ethnic minorities, the AETC program places emphasis on offering resources that ensure the improvement of clinical education and training for minority providers, which is critical in managing the increasing number of cases in communities of color. The increased proportion of racial/ethnic minority health care providers participating in AETC training intervention programs demonstrates the success of the AETC program in providing training in HIV care to the health care workforce serving medically underserved populations. The actual performance for FY 2003 was 43 percent of which met the target. See Section U.

Rationale for the Budget

The FY 2006 Budget request of $35,051,000 is the same as the FY 2005 Appropriation and supports the program. The FY 2006 Budget request will provide for continued funding of the AETC Program at the current level for health care providers.

Outputs

There currently are eleven Regional centers and four National centers. The 4 National centers focus on minorities, evaluation, resources, and clinical consultation.

Ryan White CARE Act (Part F) Dental Reimbursement Programs

Authorizing Legislation - Part F, Section 2692 (b) of the Public Health Service Act

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Dcrease
Current Law BA	$13,325,000	$13,218,000	$13,218,000	-

FY 2006 Authorization.....Expired

Statement of Budget

The FY 2006 Budget of $13,218,000 is the same as the FY 2005 Appropriation and supports the program.

Program Description - There are two activities supported under this section of the CARE Act. They include Dental Reimbursement and Community-Based Dental Partnership Grants. The HIV/AIDS Dental Reimbursement Program (DRP) supports access to oral health care for individuals with HIV infection, by reimbursing dental education programs for non-reimbursed costs incurred in providing such care. Institutions eligible for reimbursement are dental schools, post-doctoral dental education programs such as hospital-based residencies and dental hygiene education programs that are accredited by the Commission on Dental Accreditation and have documented non-reimbursed costs incurred in providing oral health care to HIV-positive persons. This care includes diagnostic, preventive, oral health education and health promotion, restorative, periodontal, prosthodontic, endodontic, oral surgery, and oral medicine services. By offsetting the costs of non-reimbursed HIV care in dental education institutions, DRP addresses the dual goals of improving access to oral health care and training new generations of dental and dental hygiene students, and dental residents, to manage the oral health care of persons with HIV. Eligible institutions must submit an application annually. Several characteristics make the DRP different from all other CARE Act programs, including these:

- The DRP is a retrospective payment program, not a prospective competitive grant; awards consist of a single one-year lump-sum payment.
- Applicants do not claim funding for indirect or non-service related, program support-type expenses, as can all other CARE Act grant recipients.
- Institutional participation in the DRP is voluntary, and fluctuates from year to year.
- The scope of oral health services available in these institutions is variable The particular focus of any accredited dental education program determines the nature of the service provided.
- The DRP is unique in that it inseparably links health service delivery with the education and training of new generations of providers to be better able to manage the health care of people with HIV; no other CARE Act program does both.

The Community-Based Dental Partnership activity, initiated in FY 2003, funds eligible entities in their efforts to increase access to oral health service delivery and provider training in community settings. Programs funded by the Community-Based Dental Partnership program are collaborative efforts between the eligible entity and community-based dental providers that propose to:

- Provide oral health services for individuals with HIV;
- Establish and manage clinical rotations for students and residents in community-based settings;
- Collaborate and coordinate between the dental education programs and the community-based partners in the delivery or oral health services;
- Collect, manage, and report data that will assess/describe the service delivery and educational components of the funded programs;
- Ensure patient confidentiality and the establishment and review of a system for control of records of HIV positive patients.

Funding levels (current law BA) for the HIV/AIDS Dental Reimbursement program during the last five years reflect this effort and are as follows:

FY	$
2001	9,999,000
2002	13,493,000
2003	13,405,000
2004	13,325,000
2005	13,218,000

Performance Analysis

A weakened immune system can leave people with HIV/AIDS at high risk for serious infections, including those infections that start orally. Regular and vigilant dental care along with good nutrition and other sensible lifestyle habits are essential to maintaining good health. The Dental Reimbursement program has been successful in helping ensure that people with HIV/AIDS receive good oral health services when needed, reducing these risks.

The Dental Reimbursement program has proven to be successful based on the program's performance measure as shown in Section U. The number of persons for whom a portion of their unreimbursed oral health costs were reimbursed demonstrates the effectiveness of the program's contribution to appropriate and quality oral health care services to those HIV infected individuals who are without the financial means to afford them. In 2004, the Dental Reimbursement Program payment awards met 70 percent of the total non-reimbursed costs reported by 63 participating institutions in support of oral health care. For FY 2004 these institutions reported providing care to 30,598 HIV positive individuals, for whom no other funding source was available. The number exceeded the goal by 4,098 individuals. This represents a nearly 9.7 percent increase from FY 2003 in persons for whom a portion/percentage of their unreimbursed oral health costs were reimbursed.

Rationale for the Budget

The FY 2006 Budget request of $13,218,000 is the same as the FY 2005 Appropriation and supports the program. The FY 2006 Budget request will continue to support the reimbursement of applicant institutions, outreach to people with HIV/AIDS who need dental care, and for continued efforts to improve service coordination among reimbursement recipients and other community-based health service providers. Currently, the Dental Reimbursement Program reimburses approximately 70 percent of the costs associated with the more than 30,600 people with oral health needs served by accredited dental schools and other graduate dental education programs.

Outputs

In FY 2004, 64 eligible dental schools and postdoctoral dental education programs received reimbursements under this activity. In addition, 12 community-based dental partnership grants provided training to students and residents enrolled in dental education programs that provide care for people with HIV under the direction of dentists in the community. The same number of reimbursements and grant awards is estimated for FY 2005 and FY 2006.

Emergency Funding for HIV/AIDS Drugs

Authorizing Legislation - Title III, Public Health Service Act

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Current Law BA	$20,000,000	---	---	---

FY 2006 Authorization.....SSAN

Statement of Budget

Emergency Funding for HIV/AIDS Drugs was a special initiative in FY 2004. The Administration is not requesting funds for this activity in FY 2006.

Program Description

Announced in June 2004, this activity provided $20,000,000 to deliver life-saving drugs in ten states who had reported patients living with HIV/AIDS who were waiting for HIV-related medication through the states' AIDS Drug Assistance Programs. The need to provide treatment to Americans living with HIV/AIDS is a part of the Administration's commitment to continue support of the Ryan White CARE Act and to strengthen that program using the following principles as guidelines:

- Focus Federal resources on life-extending care, such as anti-retroviral drugs, doctor visits, and lab tests.
- Provide greater flexibility to better target Ryan White CARE Act resources to address areas of greatest need.
- Encourage the participation of any provider, including faith-based and community organizations that show results, recognizing the need for State and local planning, and ensuring accountability by measuring progress.

In September 2004, HRSA awarded a one year contract for the provision of pharmaceutical services to patients on the AIDS Drug Assistance Program in ten states.

Outputs

As of mid-January 2005, 5,695 prescriptions have been filled for 899 clients under this initiative.

Telehealth

Authorizing Legislation - Section 330I of the Public Health Service Act as amended by the Telehealth Grant Consolidation Act of 2002 (PL 107-251).

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Current Law BA	$3,949,000	$3,916,000	$3,888,000	- $28,000

FY 2006 Authorization.....SSAN

Statement of Budget

The FY 2006 Budget of $3,888,000 is $28,000 less than the FY 2005 Appropriation and supports the program.

Program Description

Telehealth is the use of electronic information and telecommunications technologies to support clinical health care, patient and professional health related education, public health, and health administration. This is in contrast to telemedicine, a subset of telehealth technologies, defined as the use of telecommunications and information technologies to provide or support long-distance clinical care. Telemedicine and telehealth technologies are not things or ends in themselves, but the means to provide services at a distance. Information may be in various forms - audio, video, data, or text.

HRSA envisions these technologies as playing an integral role in facilitating linkages between health care institutions over distance to improve access to quality health care services in this nation and provide educational opportunities for those who would otherwise not have or would have difficulty accessing such opportunities. The Office for the Advancement of Telehealth (OAT) is HRSA's focal point for advancing the effective use of these technologies throughout the Agency. The telehealth program assists underserved urban and rural communities in implementing cost-effective telehealth services that provide health care to people who are isolated from health care, and provides health professions education to the practitioners who serve them. More specifically, the telehealth program: (1) administers telehealth demonstration and evaluation programs; (2) provides technical assistance and promotes knowledge exchange about "best telehealth practices;" (3) assesses telehealth technology investment strategies and provides telehealth technology investment advise to HRSA; (4) works within HRSA and the Department to foster partnerships with other Federal agencies, states, and private sector groups to develop telehealth policy and program initiatives that improve access to quality health services; and (5) coordinates the activities of the Joint Working Group on Telemedicine, a Federal intra-agency group that collaborates to reduce barriers to the effective use of telehealth technologies.

As HRSA's programs have improved and expanded, new priorities have emerged. The concerns for homeland security highlight the need to make greater use of the federal and private investment in the nation's telehealth infrastructure. The rapid rise in health care and health insurance costs in FY 2004 created a greater emphasis on demonstrating the value-added of HRSA's telehealth programs, not only in improving access to care, but in improving the efficiency and quality of the services being offered. Despite the availability of first-rate resources and expertise at a national level, it is local and regional health care providers that must provide the majority of health care services in this nation and be capable of first response to any disaster or terrorist attack. Moreover, it is these providers who serve as the collection and access points for data collection and reporting. Unfortunately, many of these communities lack the specialized expertise and other resources to respond to the challenges of a bio-terrorism threat.

Funding for the Office for the Advancement of Telehealth during the past five years has been as follows:

FY	$
2001	35,976,000
2002*	37,177,000
2003*	26,687,000
2004	3,949,000
2005	3,916,000

** Includes Congressionally mandated projects.*

Performance Analysis

The number of HRSA programs incorporating telehealth technologies in their programs, with special emphasis on frontier areas demonstrates the effectiveness of the program's contribution to improving the public health and health care systems. In 2004, 54 percent of HRSA grantees, which participated in the HRSA Telehealth Inventory (75 percent response rate), were involved in some type of telehealth activity, exceeding the target of 50 percent participation set for 2004. The inventory has allowed HRSA to identify significant barriers and strategies to achieve higher participation in future years.

Rationale for the Budget

The FY 2006 Budget request of $3,888,000 reflects a Federal administrative cost-savings of $28,000 below the FY 2005 Appropriation. The FY 2006 Budget request will provide support for the Telehealth Programs and does not include Congressionally Mandated Projects. The grants awarded will support consortia of health providers that deploy telehealth technologies to: (a) provide access to, coordinate, and improve the quality of health care services; (b) improve the training of health care providers; and (c) improve the quality of health information available to health care providers, patients, and their families.

Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Grant Continuations:			
Telehealth Network Grants.....	15	15	--
Evaluations.....	1	1	1
New Grants/Major Contract Awards			
Telehealth Network Grants.....	0	0	14
Total.....	16	16	15

Organ Transplantation

Authorizing Legislation – Sections 371 - 378 of the Public Health Service Act (P.L. 98-507 and P.L. 108-216), as amended.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$24,632,000	$24,414,000	$23,282,000	- $1,132,000
OPTN	$1,900,000	$1,400,000	$1,900,000	+$500,000
Scientific Registry	$2,215,000	$2,123,440	$2,700,000	+$576,560
Donation Activities	$20,517,000	$20,890,560	$18,682,000	- $2,208,560

FY 2006 Authorization.....Expired*

** For activities other than operation of the Organ Procurement and Transplant Network (OPTN), there is a $2 million cap on funding to support the OPTN.*

Statement of the Budget

The FY 2006 Budget of $23,282,000 is $1,132,000 below the FY 2005 Appropriation, and entirely supports non-pay costs.

Program Description

HRSA's efforts to increase organ donation and transplantation mean the difference between life and death for tens of thousands of Americans and their families each year. Each day, approximately 68 people receive an organ transplant, but another 17 people die because the demand for transplantable organs far exceeds the available supply, and the gap continues to widen. In 2003, there were 25,451 transplants performed, and nearly 84,000 candidates were waiting for an organ at the end of 2003. This represents a gap of 230 percent between the number of transplants that were needed and the number of transplants that were performed due to the shortage of organs. Tragically, nearly 6,500 transplant candidates died while waiting for an organ in 2003. The National Organ Transplant Act, as amended in 1988 and 1990, provided for: the establishment and operation of the Organ Procurement and Transplantation Network (OPTN), which facilitates the matching of donor organs to recipients; the operation of the Scientific Registry of Transplant Recipients (SRTR), which facilitates the ongoing evaluation of the scientific and clinical status of organ transplantation; and grants and contracts to conduct special projects designed to increase the supply of donated organs available for transplantation.

Additional authorities to help increase organ donation were provided in the Organ Donation and Recovery Improvement Act (P.L. 108-216), which was signed into law on April 5, 2004. The major additional authorities provided in this Act include: grants to States to support organ

donation awareness programs; public education and outreach programs designed to increase the number of organ donors, including living donors; the development and dissemination of educational materials to inform health care professionals and other appropriate professionals in issues surrounding organ, tissue, and eye donation; grants to qualified organ procurement organizations and hospitals to establish programs to increase the rate of organ donation; financial assistance to living donors to help defray travel, subsistence and other incidental non-medical expenses; mechanisms to evaluate the long-term effects of living organ donation, and expansion of grant making authority.

Funding levels for Organ Transplantation during the last five years reflect this effort and are as follows:

	$
2001	14,992,000
2002	19,983,000
2003	24,828,000
2004	24,632,000
2005	24,414,000

Performance Analysis

The general purpose of the Organ Transplantation Program is to facilitate transplants for those patients with end-stage organ failure who can benefit from transplantation. The program has performed well in this as indicated by the program's current performance measures related to the growth in numbers of total donors and minority donors, the potential donor conversion rate, and the increased participation in the Secretary's *Workplace Partnership for Life Initiative.*

In FY 2003, there were 13,270 deceased and living donors, an increase of 3.7 percent over the number of donors in FY 2002 which exceeded the target. The conversion rate of eligible donors to actual donors was 50.6 percent in FY 2003, slightly exceeding the target of 50 percent. To reduce health disparities, the program places particular emphasis on recruiting minority donors. The number of living and deceased minority donors was 4,055 in FY 2003, a 10.5 percent increase over FY 2002. This greatly exceeded the target of a four percent annual rate of increase. Tremendous growth has occurred in the number of Workplace Partners enrolled in the Workplace Partnership for Life Initiative. The number of partners increased to 7,827 in FY 2003, exceeding the target of 4,400 by 78 percent. Additional information on the program's performance is provided in Section U.

A Program Assessment Rating Tool (PART) review of the Organ Procurement and Transplantation Program was conducted for the FY 2006 Budget. During this review, the program developed refined and expanded performance measures to better reflect the program's purpose and performance. These measures, which replace previous GPRA measures, focus on goals related to increasing the numbers of donors and transplants and increasing expected life-years gained.

Rationale for the Budget Request

The FY 2006 budget of $23,282,000 reflects an administrative reduction of $1,132,000 below the FY 2005 Appropriation. The following major activities and estimated amounts will be supported:

1. Contract to Operate the OPTN ($1.9 million) HRSA manages a cost-share, cost-reimbursement contract with the United Network for Organ Sharing to operate the OPTN. The OPTN is the unified transplant network authorized by Congress under the National Organ Transplant Act (NOTA) of 1984. The Act called for the network to be operated by a private, nonprofit organization under Federal contract to increase the effectiveness and efficiency of organ sharing and equity in the national system of organ allocation and to increase the supply of donated organs available for transplantation. The contract to operate the OPTN will be re-competed in FY 2005. The projected cost of operating the OPTN in FY 2006 is projected to be $22.5 million. The majority of the costs for the operation of the OPTN are paid through revenues generated by fees authorized by the OPTN final rule to transplant programs to register patients on the national waiting list.

2. Contract to Operate the SRTR ($2.7 million) HRSA manages a cost-reimbursement contract with the University Renal Research and Education Association to operate the SRTR, which provides analytic support to the OPTN to assist its policy-development and evaluation process. In addition, the SRTR provides analytic support to the Advisory Committee on Organ Transplantation. The contract to operate the SRTR will be re-competed in FY 2005.

3. Organ Donation Breakthrough Collaborative ($3.5 million) In FY 2003, the Department announced a new initiative to rapidly increase the number of organ donors in hospitals where the greatest donor potential exists. This initiative, the *Organ Donation Breakthrough Collaborative,* involves a systematic effort to rapidly replicate the proven best practices of hospitals and Organ Procurement Organizations (OPOs) that consistently have high rates of consent for organ donation. The first phase of the Organ Donation Breakthrough Collaborative was completed in September 2004. During this phase, the nation experienced an unprecedented 10.3 percent increase in the number of organ donors over the same time the previous year. Hospitals participating in the Collaborative demonstrated 14 percent donation increases. This remarkable donation increase resulted in nearly 600 additional transplants being performed in just the first half of 2004. The unprecedented success of this initiative has generated a second phase which includes 189 hospitals (six international hospitals from Canada) and 52 OPOs (two international OPOs from Canada). All Phase 1 and Phase 2 hospitals are now linked via an internet-based knowledge management system which permits rapid dissemination and implementation of effective donation practices. The Collaborative leadership team is also embarking on an initiative to raise the national average of organs recovered and transplant from each donor from 3.14 to 3.75 by disseminating effective practices utilized by high performing OPOs. When the impact of this new initiative is fully realized, it is estimated that an additional 4,000 organs annually will be made available for transplant.

4. Social and Behavioral and Clinical Research Grants to Increase Organ Donation ($7.2 million) HRSA currently operates two demonstration grant programs designed to increase knowledge about effective practices to increase the number of organs available for transplantation. The *Social and Behavioral Interventions to Increase Organ and Tissue Donation* grant program funds projects to implement and evaluate social and behavioral studies to increase family consent to donation and/or individual intent to donate. The *Clinical Interventions to Increase Organ Procurement* grant program focuses on clinical activities that start after consent is determined or given at time of death and extend until transplantation. These clinical activities influence whether a potential donor actually progresses to become a donor and the number of organs that may be procured for transplantation.

5. Demonstration Grants for Reimbursement of Travel and Subsistence Expenses Towards Living Organ Donation ($2.0 million) The Organ Donation Recovery and Improvement Act (P.L. 108-216) provides the authority to provide States, organ procurement organizations (OPOs), transplant centers or other public entities for the purpose of providing for the reimbursement of travel and subsistence expenses incurred toward living organ donation. A demonstration grant program will be initiated in FY 2005 to: (1) assist eligible entities in implementing innovative plans to ensure that assistance is provided to individuals who are unlikely to afford the non-medical expenses relating to living organ donation; (2) establish the benefits and risks of reimbursement to donating individuals; (3) assess the impact of the grant program on the incidence of living donation; and (4) determine how the program may be replicated nationwide. The learning gained from this demonstration grant program will be instrumental in the design and implementation of a national system that may be implemented when funding is made available.

6. Grants to Establish Programs Coordinating Organ Donation Activities of Hospitals and Organ Procurement Organizations to Increase the Rate of Organ Donations ($2.0 million) The Organ Donation Recovery and Improvement Act (P.L.108-216) provides the authority to award grants to OPOs and hospitals to establish programs coordinating organ activities. A grant program will be initiated in FY 2005 to provide resources to support activities designed to increase the number of organs that are procured and transplanted from each donor. Activities that will be funded by this program include improvements in information and communications systems and other strategies that improve the coordination of organ donation activities among hospitals and OPOs, including activities that support Department-sponsored best practices collaboratives.

7. Grants to Establish and Enhance the Usefulness of State Donation Registries ($0.5 million) Given the increasing number of States that have enacted 'first person' consent laws, State donor registries offer promising potential to increase the number of individuals that intend to be organ donors that actually become organ donors by recording this consent in automated State registries. The program will be working in FY 2005 with the organ transplantation and donation community, State Health Departments, State Departments of Motor Vehicle Administration, and other stakeholders to identify areas where the Federal government may provide support to increase State donor registry effectiveness. It is anticipated that a small grant program will be initiated in FY 2006 and may be expanded in future years as more resources are made available.

8. Public Education Programs ($2.0 million) The program independently and in collaboration with the organ donation and transplant community and other stakeholders, supports a variety of educational and public outreach efforts to inform the public about the need for organ and tissue donation. Programs are targeted to various segments of the population using various channels including: public service announcements broadcasted via various communication media; printed materials; documentaries; curricula for the classrooms; national organ donation events, and web sites.

9. Professional Education ($1.0 million) The program supports education initiatives and other activities in collaboration with the Organ Procurement and Transplantation Network and with major medical and other professional organizations that are influential in organ and tissue donation including: the American Medical Association, the American Society of Transplant Surgeons, The American Society of Transplantation, The Association of Organ Procurement Organizations, the North American Transplant Coordinators Organization, and the American Bar Association.

10. Advisory Committee on Organ Transplantation and Interagency Activities to Support Donation and Transplantation ($0.482 million) The OPTN final rule authorized 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 program also supports activities with other agencies within the Department related to organ donation and transplant activities including issues related to: long-term donor and recipient outcomes related to living organ donation; xenotransplantation; and organ and tissue safety.

Program Outputs

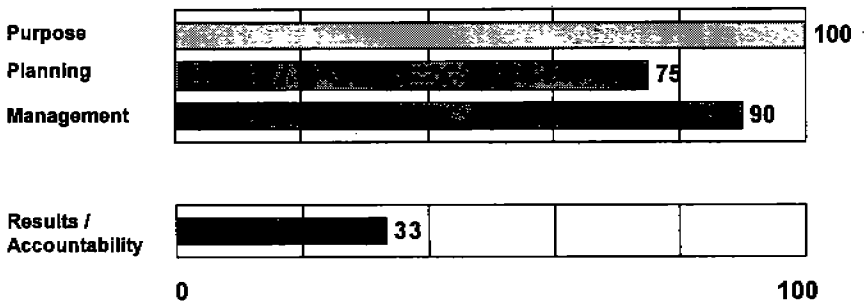
	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Contracts*	33	43	43
Grants**	42	67	70

* Includes two major contracts for the OPTN and SRTR and several small contracts.

** Includes new grants and continuation grants from previous fiscal years – most project periods are three years in length.

Program: *Organ Transplantation*

Agency: *Department of Health and Human Services*
Bureau: *HRSA*



Key Performance Measures from Latest PART	*Year*	*Target*	*Actual*
Annual Measure: Increase the number of organs transplanted each year in accordance with projections until 42,800 organs are transplanted in 2013.	2003		20,392
	2004	21,459	
	2005	23,512	
	2006	25,651	
Annual Measure: Increase the average number of years of life gained in the first 5 years after the transplant for deceased kidney/kidney-pancreas transplanted by 0.003 life-years until the goal of 0.436 life-years gained per transplant is achieved in 2013	2003		0.406
	2004	0.409	
	2005	0.412	
	2006	0.415	
Annual Measure: 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	2003		3,871
	2004	4,257	
	2005	4,641	
	2006	5,048	

Rating: *Adequate*

Program Type: *Competitive Grant*

Program Summary:

The Organ Transplantation program oversees the Organ Procurement and Transplantation Network (OPTN) and the Scientific Registry for Transplant Recipients (SRTR), which are operated under contract with the Health Resources and Services Administration (HRSA). The program also awards grants and directs national initiatives designed to increase the number of donor organs available for transplantation.

The assessment found that the program has not demonstrated sufficient progress towards achieving their goals. Additional findings include

- As of October 2004, there were more than 87,000 individuals on the national organ transplant waiting list maintained by the OPTN. Over the past 10 years, the waiting list has grown at a rate of 10% per year and the number of deceased donors has increased at a rate of only 2.9% per year. Currently, only about 50% of eligible donors consent to donation.
- The program balances the benefits of a system operated by a private organization, the OPTN, with the need for Federal oversight to ensure public accountability for use of the limited number of decreased donor organs.
- The program collects extensive program performance information to manage the grantees' performance. The OPTN and the Scientific Registry of Transplant Recipients (SRTR) are required to analyze and publish hospital-specific data on transplant centers and Organ Procurement Organizations (OPOs). This information is accessible to the public on the internet.

In response to these findings, the Administration will:

1. Improve the organ donation rate by expanding the Organ Donation Breakthrough Collaborative to an additional 150 hospitals.
2. Reduce the variation in organ donation rates by completing an evaluation in July 2005 to study factors that influence the number of organs procured per decreased donor.
3. Work with States to increase the effectiveness of Organ Donation Registries.

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
25	24	23

Health Resources and Services Administration/Health Systems Bureau

Organ Procurement and Transplantion

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Take steps to reduce variation in organ donation consent rates. [OMB response to question 4.5 cited that a May 2003 OIG report found variation in organ donation consent rates among transplant centers at the national level, as well as within geographic regions.]	Ongoing	Y	In April 2003, the Department launched the 'Organ Donation Breakthrough Collaborative' to increase the organ donation consent rates among the nation's hospitals where the greatest number of eligible donors exist. The Collaborative methodology utilizes a structured working relationship between organ procurement organizations and donor hospitals to rapidly implement and refine best organ donation practices to improve the organ donation rate in all hospitals where potential donors occur. From implementation to September 2004, organ donation rates have increased to 14.1% in the 95 hospitals that initally participated in the Collaborative as compared to 8.3% in non-Collaborative hospitals. The Collaborative is being expanded to include an additional 150 hospitals in FY 2005. Evaluation work began in September 2004 on factors and approaches that impact the number of organs that are procured from each donor. This evaluation may lay the ground work for an additional Collaborative.

Next Milestone	Next Milestone Date	Lead Organization	Lead Official
Expand Organ Donation Breakthrough Collaborative to an additional 150 additional hospitals	September 2004	HRSA/SPB/Division of Transplantation	James F. Burdick, M.D.
Complete an evaluation study on factors that influence the number of organs procured per deceased donor and assess whether an additional Collaborative on this issue may be warranted	July 2005	HRSA/SPB/Division of Transplantation	James F. Burdick, M.D.

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Foster ways to improve the effectiveness of State Organ Donation Registies to help increase organ donation. [OMB response to question 4.5 cited a February 2002 OIG report that concluded that State organ donor registries to have a limited impact on increasing donation rates. The OIG recommended that the program foster ways to improve the effectiveness of these registries.]	Ongoing	Y	In November 2001, HSB/DOT sponsored a National Forum on State Registries; the OIG completed its report around the same time. Forum goals included discussion of the potential Federal role in improving registry effectiveness and developing guidelines to assist governments or private organizations in strengthening existing or developing new donor registries. In response to the need to increase the effectiveness of registries, several states have passed laws, known as 'first-person consent laws," that are consistent with the Uniform Anatomical Gift Act to honor an individual's affirmation of consent to donate and ensure that it is recorded in a state registry. In December 2004, an exploratory meeting will be convened with OPO key informants and HSB/DOT to discuss issues related to donor registries: status, activities furthering registry development, and the possible role of the Federal Government. Recommendations are expected by August 2005.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
Assess new authorities provided by the Organ Donation Recovery and Improvement Act (PL 108-216) with respect to activites with States and develop a plan for working with States to increase the effectiveness of State registries.	July 2005	HRSA/SPB/Division of Transplantation	James F. Burdick, M.D.

National Cord Blood Stem Cell Bank

Authorizing Legislation -Authorized by Appropriation Language

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$9,941,000	$9,859,000	---	- $9,859,000
FTE	—	1	1	---

FY 2006 Authorization.....P.L. 108-447, Funds Available Until Expended

Statement of the Budget

The FY 2006 Budget does not request funds for the National Cord Blood Stem Cell Bank. This is a reduction of $9,859,000 below the FY 2005 Appropriation.

Program Description

Blood stem cell transplants offer the possibility of a cure for people with leukemia and many other life-threatening blood disorders. Blood stem originally were obtained from the bone marrow of adult donors for these transplants (thus often referred to as bone marrow transplants; these cell now also may be obtained from the circulating blood of adult donors or collected from the newest source, the umbilical cord and placenta after a normal birth.

Most cord blood transplants have been performed for pediatric recipients, because of the smaller number of stem cells present in cord blood, and the effectiveness of cord blood transplants in pediatric patients is well established. Encouraging results in adult patients have been published recently; this may, especially if confirmed by ongoing studies, stimulate much wider use of cord blood transplants in adult patients over the next few years.

Because it can be used with a less perfect match in tissue type between the donor and recipient than is the case for adult donors, cord blood offers a chance of survival for patients who lack a suitably tissue-matched relative (only about 25 percent of patients have one) and who cannot find an adequately matched unrelated adult donor on the National Bone Marrow Donor Registry (NBMDR). Minority patients, especially African American patients, have a lower probability of finding a perfectly matched unrelated adult donor because of the greater diversity in their tissue types. Consequently, these patients are especially likely to benefit from additional cord blood units. In addition to their use in blood stem cell transplants, stem cells derived from cord blood can be used for clinical and preclinical research into a variety of cellular therapies.

The purpose of this program, which was funded initially through FY 2004 appropriations, is to provide funds to a network of cord blood banks to: (1) build an inventory of the highest quality cord blood units for transplantation, and (2) ensure an integrated system through which physicians and patients are able to locate a suitably matched cord blood unit or adult volunteer

marrow donor via a single, electronic access point. The units will be made available for blood stem cell transplants, and a portion of the units will be made 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.

Funding for the Cord Blood Stem Cell Bank during the last five years has been as follows:

	$	FTE
2001	---	---
2002	---	---
2003	---	---
2004	9,941,000	---
2005	9,859,000	1

Performance Analysis

Performance measures will be developed for this activity in preparation for the PART review process, scheduled for the FY 2008 budget cycle.

Rationale for the Budget

There is no FY 2006 Budget for this program. The program will operate with balances carried forward from FY 2004 and 2005.

Approximately $1 million of the FY 2004 appropriation was to fund a study by the Institute of Medicine (IOM) to recommend an optimal structure for the program and address pertinent issues to maximize the potential of this technology. Regarding the structure of the program, the IOM may recommend direct HRSA funding of individual cord blood banks, HRSA funding of a central registry through which funds would be made available to banks, or some other structure. The study is to be completed by March 31, 2005. HRSA will make the remaining FY 2004 funds and the FY 2005 funds available to implement the program after completion of the IOM study. The current inventory of U.S. public cord blood banks is approximately 80,000 units (with approximately 40,400 of them currently listed on the NBMDR as of December, 2004). Most cord blood banks are experiencing financial difficulty and collecting few if any new units. Federal funding available from the appropriations for FY 2004 and FY 2005 will provide for collection of high quality and racially diverse cord blood units to:

- increase the number of patients finding adequately tissue-matched blood stem cells for transplant,
- facilitate the research needed to determine the best source of blood stem cells for patients with different diseases and characteristics,
- help preserve the existing cord blood bank inventory and infrastructure, and
- increase the number of cord blood units that may be released for research into cellular therapies.

The cost of recruiting a donor, collecting a cord blood unit, performing tissue-typing and infectious disease tests, and putting the unit into storage in a liquid nitrogen freezer currently averages approximately $1,000. At this average cost, approximately 19,000 cord blood units will be collected with FY 2004 and FY 2005 funding (approximately 9,000 units with FY 2004 funds and 10,000 units with FY 2005 funds). This would represent an increase in the national inventory of cord blood units of approximately 24 percent over the current national inventory of 80,000 units. The effect of the new units will be even greater than this large percentage increase suggests, because many of the units in the current inventory are small units collected before the minimum desirable cell dose was known and before today's processing standards were established. Consequently perhaps half of the current inventory consists of units that are too small to be requested for transplant, except for small children, or that have other characteristics that make their use for transplant unlikely for any patient.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Outputs	1 contract (IOM)	contract(s) for 19,000 cord blood units*	---

* Includes cord blood units collected with funds appropriated in FY 2004, which will be made available to cord blood banks in FY 2005 after completion of the IOM report.

National Bone Marrow Donor Registry

Authorizing Legislation - Title III, Section 379 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$22,662,000	$25,416,000	$22,916,000	-$2,500,000
FTE	5	5	5	---

FY 2006 Authorization.....Expired

Statement of the Budget

The FY 2006 Budget of $22,916,000 is $2,500,000 below the FY 2005 Appropriation, and supports pay costs and non-pay costs.

Program Description

Blood stem cell transplants offer the possibility of a cure for people with leukemia and many other life-threatening blood disorders. Blood stem cells for these transplants can be obtained from the bone marrow or circulating blood of volunteer adult donors or collected from the newest source, the umbilical cord and placenta after a normal birth. Each year approximately 38,000 people less than 55 years old are diagnosed with these fatal illnesses, and about 16,000 of them cannot be successfully treated with therapy other than a blood stem cell transplant. When doctors have a patient in need of transplantation, they initially try to locate donors related to the patient. If none are available, as is the case for approximately 70 percent of patients, they use the HRSA-funded National Bone Marrow Donor Registry to search for a suitable unrelated donor. The Registry is operated under contract by the National Marrow Donor Program (NMDP), a Minnesota-based network of donor collection and transplant centers that assists patients in finding HLA-matched unrelated donors. The Registry also facilitates and conducts research into the effectiveness of unrelated marrow transplants, and engages in preparation for the possibility of events in which large numbers of people are exposed to marrow-toxic radiation or chemical agents.

The tissue types of donors must be closely matched with those of their recipients in order for the transplant to be successful. The Registry recruits adult volunteers willing to donate bone marrow (or, in recent years, blood stem cells from the circulating blood), and searches the database of these volunteers to find suitable matches for patients needing transplant. In addition to adult stem cell sources, the Registry lists approximately 40,400 umbilical cord blood units. Research has shown that the blood stem cells in umbilical cord blood are immunologically naive and, therefore, may be used for transplants with a somewhat less perfect tissue type match than adults. Since tissue types are inherited, patients are more likely to find a closely matched donor within their own racial and ethnic groups. However, due to the great diversity in the tissue types of minorities, especially African Americans, the Registry must continue to emphasize recruitment

of adult and umbilical cord blood donors from these populations to increase the likelihood that patients will find a closely matched donor.

The Registry has steadily increased the number of transplants facilitated each year, from 2,205 in FY 2003 to 2,523 in FY 2004. Despite this progress, candidates for unrelated donor transplants still outnumber recipients by approximately 5-1.

Funding for the National Marrow Donor Program during the last five years has been as follows:

	$	FTE
2001	21,958,000	7
2002	21,989,000	6
2003	21,891,000	4
2004	22,662,000	5
2005	25,416,000	5

Performance Analysis

In an effort to increase the likelihood of a patient finding a blood stem cell donor, the Registry has focused its efforts on increasing the donor pool, particularly on adding donors from racial and ethnic minority populations. The number of volunteer potential donors on the Registry has grown by at least seven percent over each of the past three years. In FY 2004, the Registry increased the number of potential donors by 7.2 percent over FY 2003, exceeding the target. The Registry also significantly increased the number of minority potential donors, for whom final figures will be available in April 2005. In FY 2004, the Registry achieved a 2.1 percent reduction in unit cost for its contracted laboratories for Human Leucocyte Antigen (HLA) tissue typing. The cost of tissue typing decreased from $65.00 in FY 2003 to $63.65 in FY 2004.

A Program Assessment Rating Tool (PART) review of the National Bone Marrow Donor Registry program was conducted for the FY 2006 Budget. During this review, the program developed a new set of performance measures that replace previous GPRA measures. The new performance measures focus on long-term goals of increasing the numbers of blood stem cell transplants facilitated by the Registry and increasing patient survival. Short-term measures focus on increasing the numbers of adult stem cell donors, particularly from racial and ethnic minority population groups, and cord blood units listed on the Registry. (See Section U.)

Rationale for the Budget

The FY 2006 Budget request of $22,916,000 reflects a Federal administrative cost-savings of $2,500,000 below the FY 2005 Appropriation. The FY 2006 Budget will continue recruitment of new donors and development of the cord blood program at the levels possible in years prior to FY 2005. The Registry will be able to continue its efforts to recruit and retain minority donors to increase minority Americans' chances of finding a donor among Registry volunteers. The Registry also will work with cord blood banks to increase the number of high quality, racially diverse cord blood units on the Registry.

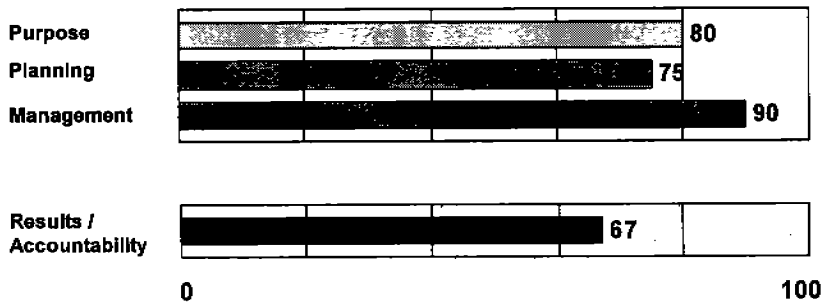
Finally, the NMDP will be able to continue planning exercises to prepare to respond to a radiation or chemical (mustard) emergency that would leave some casualties with temporary or permanent marrow failure, and to facilitate emergency transplants for those casualties who would not otherwise recover marrow function.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Contracts	1	1	1

Program: National Bone Marrow Donor Registry

Agency: *Department of Health and Human Services*
Bureau: *Health Resources and Services Administration*



Key Performance Measures from Latest PART	*Year*	*Target*	*Actual*
Long-term Measure: 95% increase in the number of blood stem cell transplants facilitated by 2010	2003	Baseline	2310
	2010	4500	
Annual Measure: Add 1,000 cord blood stem cell units to the Registry each year between 2006-2010	2003	Baseline	28896
	2006	37500	
	2007	38500	
	2008	39500	
Long-term Measure: Double the number of blood stem cell transplants facilitated for minority patients	2003	Baseline	318
	2010	636	

Rating: Moderately Effective

Program Type: *Competitive Grant*

Program Summary:

The National Bone Marrow Donor Registry (NBMDR) program serves to increase the number of patients with life-threatening disorders (such as Leukemia, or certain immune system and genetic disorders) who are able to obtain transplants from suitably matched, biologically unrelated bone marrow donors. The program facilitates transplants by 1) operating a system to find bone marrow donors and units of umbilical cord blood, and match them with patients needing a transplant, 2) maintaining a scientific registry on recipients of transplants, and 3) ensuring equal access to transplantation across racial/ethnic populations.

The assessment found that:

- The program possesses a clear purpose and serves a specific need as the number of individuals who could benefit from transplant therapy is growing; including an increased percentage of minority recipients who have traditionally had difficulties locating a donor match.
- The program has established ambitious targets and timeframes for its long-term performance measures. The program aims to increase the overall number of blood stem cell transplants facilitated by the NBMDR by 95% between 2003 and 2010 and increase the number of blood cell transplants facilitated by the NBMDR for minorities by 100% between 2003 and 2010.
- To date, the NBMDR program has not tied its budget requests to the accomplishments of its annual and long-term performance goals.
- The NBMDR program has, to a small extent, demonstrated progress toward achieving some of its newly developed long-term goals. The program demonstrated a 10 percent increase in the number of transplants from 2000 to 2001, and a 21 percent increase between 2002 and 2003.
- The NBMDR program has been very successful at increasing recruitment and the number of donors on the Registry. Between 1989 and 1992 nearly 500,000 donors were added. By 2003 the baseline reflected more than 5 million individuals on the Registry.

In response to these findings, the Administration will:

1. Maintain program funding in order to continue the NBMDR program' s efforts to double the number of transplants by 2010, and continue to increase both their recruitment and number of donors on the Registry.
2. Continue to work towards the goal of tying together the program' s budget requests to their annual and long-term performance goals.

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
23	25	23

Health Resources and Services Administration/Healthcare Systems Bureau

National Bone Marrow Donor Registry

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Establish 2010 Target and 2004 Baseline for new Developmental Health Outcome Measure (Increase the rate of patient survival at one year post-transplant) and Monitor Progress toward Target.	Ongoing	Yes	Program staff are continuing to work with the Registry contractor to establish the target and baseline for this measure, by completing a review of data on recent survival rates for the major disease categories.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
Establish 2010 Target and 2004 Baseline	March, 2005	HRSA/SPB/Division of Transplantation	James F. Burdick, M.D.

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Update and Implement a Comprehensive Plan to Increase Transplants, to support the Long-Term PART goal of increasing the annual number of transplants facilitated by the Registry. The major limitation noted during the PART review and during the 2002 GAO review of the program was that the program is underutilized in two respects: many patients who could benefit from the program are referred to the Registry by their physicians very late in the course of their disease or never referred at all, and a substantial number of patients who do search the registry still are not able to find a suitably matched donor. The HRSA contract for the Registry requires the development and periodic updating of a Comprehansive Plan to Increase Transplants. The purposes of this contract deliverable are to estimate the annual need for unrelated donor transplants, to identify and evaluate barriers to transplant, and to provide plans for overcoming those barriers. A plan has been submitted to HRSA for approval and for subsequent implementation. Additional milestones may be specified after approval of the 2004 Plan.	Ongoing	Yes	The 2004 Comprehensive Plan to Increase Transplants has been submitted to HRSA for aproval and for subsequent implementation.
Next Milestones	**Next Milestone Date**	**Lead Organization**	**Lead Official**
Approve the Comprehensive plan to Increase Transplants.	February, 2005	HRSA/SPB/Division of Transplantation	James F. Burdick, M.D.
HRSA presented the PART Goals to Registry Contractor's Board of Directors. The Board of Directors is fully committed to achieving the PART goals for the program, and specifically committed to implementing the Comprehensive Plan to Increase Transplants.	September, 2004	HRSA/SPB/Division of Transplantation	James F. Burdick, M.D.

Poison Control Centers

Authorizing Legislation -- Poison Control Center Enhancement and Awareness Act (106-174) Amendments of 2003 (P.L. 108-194).

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$23,696,000	$23,499,000	$23,301,000	- $198,000
FTE	3	3	3	---

FY 2006 Authorization.....$27,500,000

Statement of the Budget

The FY 2006 Budget of $23,301,000 is $198,000 below the FY 2005 Appropriation, and supports pay costs and non-pay costs.

Program Description

Poisoning is the third most common form of unintentional death in the United States. In any given year there will be between two million and four million poison exposures. Poison Control Centers (PCCs) are an integral and vital part of our Nation's health system which should be available to all Americans, particularly in light of the 2001 terrorist attacks and threats of future bioterrorism. Ready access to poison control services has proven to reduce severity of illness, death, and health care costs.

PCCs provide 24-hour diagnostic and treatment services as well as provide prevention education. PCCs are also part of the continuum of emergency services needed to confront the threat of bioterrorism, since they serve as part of the Nation's surveillance and first response system.

PCC and National Bioterrorism Hospital Preparedness Program (NBHPP) staff collaborate on development of their respective program grant/cooperative agreement guidance and discuss program issues in weekly Division meetings. In addition, while on site visits to awardees, HRSA routinely inquires into collaborations at the State level and reports back their findings to respective program managers. Currently, 43 of 62 PCCs are collaborating on hospital preparedness and bioterrorism activities. Activities include: surveillance, education, and training, surge capacity health care personnel and communication and information technology.

Currently, a national toll-free number, (800) 222-1222, is fully operational in all States, Puerto Rico, and the District of Columbia and connects callers with the PCC serving the geographic area from which calls are placed.

The Poison Control Center Enhancement and Awareness Act (PL. 106-174) was enacted in February 2000 to provide a source of supplemental support to PCCs and was amended and reauthorized in December 2003 (PL. 108-194). The purpose of the Act is to provide assistance for poison prevention and stabilization of PCC funding. Activities have been funded by local and State public and private funds. The majority of the funds are used to support a grant program for the PCCs. Funds also maintain the national toll-free number, continue a media campaign to advertise that number, and support other system enhancements including development of uniform patient management guidelines and improvement of data collection. These and related activities help to ensure universal access to quality poison control services and to introduce necessary improvements to provide comprehensive quality services for the entire population, particularly children who are the most vulnerable to poisonings.

Funding levels for the Poison Control Centers Program during the last five years reflect this effort and are as follows:

	$	FTE
2001	19,995,000	3
2002	21,200,000	3
2003	22,354,000	3
2004	23,696,000	3
2005	23,499,000	3

Performance Analysis

The Poison Control Program provides support to PCCs across the United States, promotes universal access to PCC services, and encourages the enhancement and improvement of poison education, prevention, and treatment. In pursuit of these goals a uniform, evidence-based guideline was developed to assist PCCs. This guideline covered treatment for 35 non-toxic substances. Two uniform guidelines for the treatment of toxic poisoning were also developed and ratified, for a total of three guidelines. The goal for FY 2005 is to develop three additional guidelines. In addition, the number of PCCs meeting certification standards and receiving such certification has increased from 70 percent in 2000 to 84 percent in 2004, attesting to a quality increase in services to the public. The Poison Control Program was reviewed using the Program Assessment Rating Tool (PART) for the FY 2006 Budget and was given a rating of "Adequate." The Program has developed additional performance measures to be tracked in the future as shown in Section U of this document.

Rationale for the Budget Request

The FY 2006 Budget request of $23,301,000 reflects a Federal administrative cost-savings of $198,000 below the FY 2005 Appropriation. The FY 2006 Budget will continue support for the PCC program and will help to stabilize and improve the PCCs, continue cooperative efforts between the Centers for Disease Control and Prevention and HRSA to maintain and publicize the national toll-free number for poison control services. The budget also supports continued development of uniform guidelines for management of poisonings and continued improvements to national data collection, provides technical assistance to PCCs encouraging collaboration and

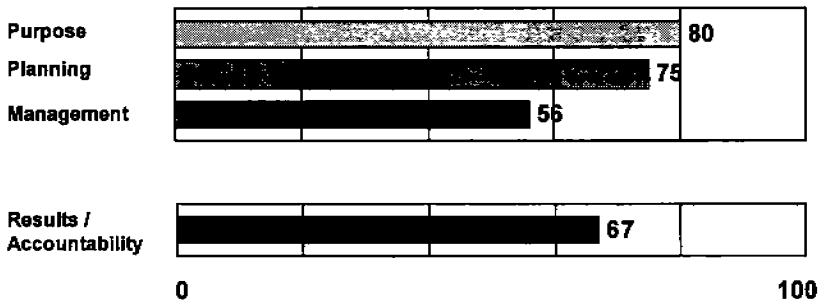
long-range financial stability strategic planning, and facilitates implementation of the Institute of Medicine recommendations.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Grants	69	69	69

Program: Poison Control Centers

Agency: *Department of Health and Human Services*
Bureau: *Health Resources and Services Administration*



Key Performance Measures from Latest PART	*Year*	*Target*	*Actual*
Long-term Measure: Reduce percent of emergency room visits due to poisoning	2001-2002	Baseline	2.05
	2009	1.54	
Annual Measure: Increase percent of inbound volume on the toll-free number	2003	Baseline	36.9%
	2004	40.6%	
	2005	44.6%	
	2006	49.1%	
Annual Measure: Increase the number of PCCs with 24-hour bilingual staff	2004	Baseline	1
	2005	3	
	2006	5	
	2007	7	

Rating: Adequate

Program Type: *Block/Formula Grant*

Program Summary:

The Poison Control Centers (PCC) Program helps to stabilize and improve PCCs and promotes a comprehensive system for the delivery of high quality poison control services nation-wide. Through this program the Secretary awards grants to regional, certified PCCs to help them achieve the financial stability necessary to provide treatment recommendations for poisonings.

The assessment found that the Poison Control Centers Program has a clear purpose and has demonstrated progress toward achieving its long-term goal of reducing emergency room visits due to poisoning (2.47 per 1000 in 1999-2000 to 2.05 per 1000 in 2001-2002). However, the assessment also found that the program has flaws that may limit its effectiveness and efficiency. Additional findings include:

- The program has made considerable progress in addressing its primary purpose: 6 of 7 PCCs that were on the verge of closing at the inception of the program in 2000 have been stabilized through Stabilization Grants, 82 percent of the PCCs now meet certification standards and have been certified (up from 70 percent in 2000).
- The program developed a new long-term goal that is directly linked to improved health outcomes for those possibly exposed to a toxic agent and has established ambitious targets and timeframes for this long-term goal, which is to reduce emergency room visits due to poisoning by 25% by 2009.
- The program does not make clear the impact that funding, policy or legislative decisions have on expected performance. In addition HHS/HRSA has not tied its budget request to the accomplishments of the annual and long-term performance goals.
- The program does not regularly receive timely and credible performance information from key program partners and use it to manage the program.

In response to these findings, the Administration:

1. Will work to establish a performance-based budget that demonstrates the marginal impact of the Administration's funding decisions.

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
24	24	23

Health Resources and Services Administration/Healthcare Systems Bureau

Poison Control Program

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Collect and report grantee perfromance data	09/30/06	Y	New grantee perfromance measures have been devloped and approved.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
Inform grantees and the public of new performance measures through a program strategic plan	06/01/05	HSB	Lori Roche
Report performance measures in 07 budget performance	12/01/05	HSB	Lori Roche

National Bioterrorism Hospital Preparedness Program (NBHPP)

Authorizing Legislation -- Section 319 of the Public Health Service Act.

	FY 2004* Actual	FY 2005* Appropriation	FY 2006* Request	Increase or Decrease
Budget Authority	$514,943,000	$491,410,000	$482,979,000	-$8,431,000
Hospital Preparedness	($507,335,774)	(484,238,335)	($449,979,000)	(-$34,259,335)
Credentialing/ ESAR VHP**	($10,902,891)	($8,832,000)	($8,000,000)	(-$832,000)
Threat Adjustment	—	—	($25,000,000)	(+$25,000,000)
FTE	22	33	35	+2
Hospital Preparedness	(20)	(25)	(25)	(- - -)
Credentialing/ ESAR VHP	(2)	(8)	(8)	(- - -)
Threat Adjustment	- - -	- - -	(2)	(+2)

*Financed under the Public Health and Social Services Emergency Fund.

** Includes $3,295,665 in FY 2004 carryover funds and $1,660,335 in FY 2005 carryover funds.

FY 2006 Authorization.....Such sums as necessary

Statement of the Budget

The FY 2006 Budget of $482,979,000 is $8,431,000 below the FY 2005 Appropriation, and supports pay costs and non-pay costs.

Program Description

Terrorists may threaten or attempt to use biological, chemical, radiological and traditional or improvised explosive weapons against the United States. Local emergency medical services, hospitals, and public health agencies stand directly on the front lines. How the United States responds to such an attack or threat will depend upon (1) the preparedness of local communities, hospitals, outpatient facilities, emergency medical services and health care professionals and (2) the preparedness of States and the Federal Government to augment the capabilities and capacities of the local response mechanisms. The FY 2006 budget for the Department as a whole, as well as the Health Resources and Services Administration (HRSA) specifically, will help to ensure the provision of medical and public health services in the event of a terrorist attack or other public health emergency.

The primary focus of the NBHPP is to improve the capacity of the Nation's hospitals and other supporting healthcare entities to respond to biological, chemical, and radiological terrorist attacks, infectious disease epidemics, mass casualty explosive events and other public health emergencies. The program has enabled State and regional planning among local hospitals, emergency medical services systems, community health centers, poison control centers, and other health care facilities to improve their preparedness and ability to work together to combat and respond to potential terrorist attacks and natural and man-made public health and other medical emergencies. Through coordination efforts at both State and Federal levels, hospital preparedness plans have been linked with State and local public health preparedness planning funded by the Centers for Disease Control and Prevention, and where applicable, the Metropolitan Medical Response Systems funded by the Office of Emergency Preparedness, Department of Homeland Security (DHS). NBHPP has encouraged the use of the Health Alert Network (HAN) to all of their grant awardees and has provided presentations at prior Annual Awardee meetings on HAN. Therefore, all HRSA awardees are familiar with HAN and are connected.

In FY 2004, the NBHPP cooperative agreements were made with 62 entities, including 50 States, the District of Columbia, Puerto Rico, three municipalities (New York City, Chicago, and Los Angeles County), the Commonwealth of the Northern Mariana Islands, the territories of the Virgin Islands, Guam and American Samoa, the Federated States of Micronesia, and the Republics of Palau and the Marshall Islands.

The program has built upon the needs assessments and implementation plans developed by grantees during FY 2002 and updates of these assessments and plans requested during FY 2003 and FY 2004. Proposals were approved and funded in accordance with preparedness priorities developed by the States and other jurisdictions. Specific information on the number of hospitals to be strengthened, the types of upgrades that will be made, and the improvements in hospitals' capacity to respond to public health emergencies, in general, and bioterrorism, in particular, is part of the progress reports submitted by the States and other jurisdictions. To date State assessment data are reported in annual continuation applications and, to some extent, semi-

annual reports. However, the formats used to collect these data do not lend themselves to tracking progress over time. Therefore, NBHPP does not aggregate annual State assessments due to the unique structure of each State's tool instrument. Instead, NBHPP uses the State assessments, semi-annual, and annual progress reports s part of the site visit protocol to review progress and challenges that awardees are experiencing.

During 2003 and 2004, the increased funding and expanded program scope assisted hospitals and supporting healthcare entities with implementation activities to ensure the safety of the healthcare workforce by allowing for the purchase of personal protective equipment (PPE) and/or well-equipped mobile or fixed decontamination facilities and providing the associated training in the proper use and wear of PPE; by purchasing appropriate and adequate pharmaceutical stockpiles and chemical antidotes; by allowing healthcare personnel to attend competency based training sessions in Hospital Emergency Incident Command Structure (HEICS) and allowing for their participation in local drills and exercises. States report that the ability to respond rapidly to the most recent public health outbreaks, specifically Hepatitis A and E.Coli outbreaks, has been directly credited to the ability to improve these crucial systems.

In FY 2003, the awardees merged the CDC and HRSA terrorism planning committees and worked to maximize their funds for the cooperative agreements available through all the agencies funded in DHHS. The NBHPP has enabled State and regional planning among local hospitals, emergency medical services systems, health centers, poison control centers, and other healthcare facilities to improve their preparedness to work together to combat terrorist attacks and other public health emergencies.

The program's focus is now on assisting awardees in implementing their plans to improve surge capacity based on identified needs. Coordination between hospitals and supporting healthcare entities in the enhancement of systems infrastructure is an important strategy that will enable the health system to respond collectively in a seamless interaction of various capabilities. These enhancements include laboratory reporting capability and the increased ability to isolate and decontaminate potentially highly infectious patients.

Credentialling - Emergency System for Advance Registration of Volunteer Health Professionals

The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), a new component of the NBHPP, provides for the development of a national State-based registry of health professional volunteers whose credentials have been verified. The State-based volunteer registry will serve by helping coordinate health personnel surge capacity during a mass casualty or natural disaster. HRSA established a program office within the Division of Healthcare Preparedness staffed with eight personnel to meet the pressing demands of this national initiative. HRSA is working with the awardees (States), professional associations and organizations and other Federal and State emergency management and bioterrorism preparedness programs to develop National ESAR-VHP Technical and Policy Guidelines, Standards and Definitions (Guidelines). The Guidelines provide standards and definitions so that States can share their volunteer health professionals within and across State lines and the Guidelines cover the entire

spectrum of advance registration components to assist the awardees in the successful development of State ESAR-VHPs. The draft Guidelines were developed and circulated for comment in December. The interim Guidelines will be released in the NBHPP 2005 Continuing Program Guidance. Technical assistance to the States (awardees) is planned in a phased approach, continuing through the calendar year 2006.

Coordination activities also include collaboration with the CDC State and local preparedness programs, State emergency management agencies and Department of Homeland Security (DHS) awardees in ensuring that statewide incident management systems are compliant with the National Incident Management System (NIMS). Awardees are required to address the education and training of healthcare professionals involved in terrorism response, which is coordinated with the HRSA Bioterrorism Training and Curriculum Development Program. Awardees must also conduct terrorism preparedness exercises and drills to test the preparedness plans and systems as they are developed.

The NBHPP increase is 181 percent above FY 2003 level. From FY 2003 to a total of $514 million in FY 2004, the number of professional staff increased from 5 project officers serving 59 grantees, to 9 officers serving 62 awardees who provide the highest quality technical assistance and direction to the State grantee bioterrorism coordinators and program directors. Technical assistance is provided in two principal ways. First, the awardees work with their respective project officer on an identified problem or issue. If additional technical assistance is warranted, HRSA initiates a Technical Assistance Request (TAR) for follow-on support. Secondly, the NHBPP program staff can initiate a TAR on topics of general interests to most if not all awardees. Recent examples include studies on syndromic surveillance software applications, isolation and decontamination strategies and finally, international best practices. As well, when certain states need guidance on issues that other states have already dealt with and come to successful resolution those states are out of touch with the state needing guidance.

Improved annual data from the grantees on a State-by-State basis is currently being obtained, and evaluation efforts are being undertaken to formally establish a baseline database. Principle coordination between NBHPP and ESAR VHP occurs at the program director level through the development and implementation of the NBHPP continuation guidance. In December 2004, a pre-conference on ESAR VHP was held immediately prior to the annual NBHPP meeting that included more than 100 participants representing the NBHPP awardees.

Funding levels for the National Bioterrorism Hospital Preparedness Program for the past five years have been as follows:

	$	FTE
2001	---	---
2002	135,000,000	3
2003	514,633,000	15
2004	514,943,000	22
2005	491,410,000	33

Performance Analysis

Since the inception of the program in FY 2002, the National Bioterrorism Hospital Preparedness Program has established and awarded cooperative agreements to 62 jurisdictions. These cooperative agreements have been essential for putting in place healthcare emergency response plans at the local, regional, and State level for the management of mass casualty events that might otherwise overwhelm the healthcare system. Significant progress has been made by awardees in establishing plans, developing partnerships and collaborations, and assessing crucial needs and how to address them. All of the States have designated a Coordinator for Bioterrorism Hospital Preparedness Planning and established planning committees that meet quarterly to provide guidance, direction, and oversight to the State health department in planning for bioterrorism response. Data from semi-annual reports indicate that for FY2004, 89 percent of awardees have developed plans to address surge capacity. All of the jurisdictions have in place, or are finalizing, a system to receive and distribute pharmaceuticals made available from Federal sources, such as antibiotics and smallpox vaccines. States are putting mechanisms in place to address the gaps in communications systems among hospital emergency departments, outpatient facilities, EMS systems, and State and local emergency management, public health and law enforcement agencies, and poison control centers. State plans include such activities as location and staffing needs of alternative care sites and off site triage sites to meet the demands of a mass casualty incident. As well, states are developing MOUs and mutual aid agreements with adjoining interstate regions and where necessary intrastate regions to meet the demand for surge capacity.

State plans also address the necessary components of personnel and supplies needed to staff surge sites, decontamination and isolation aspects of surge capacity and pharmaceuticals and protective equipment needed to insure the safety of first receivers.

In order to close communications gaps, many states are in the process of purchasing and or upgrading existing communications systems in hospitals and other healthcare facilities (i.e. Health Centers) to insure the interoperability with other emergency first responder agencies.

A Program Assessment Rating Tool (PART) review of the program was conducted for the FY 2005 budget. The program received a rating of "Results Not Demonstrated." The assessment indicated that the program had not yet demonstrated results due to its relative newness and the inherent difficulty in measuring preparedness for events that do not regularly occur. New performance measures, focusing on the implementation of various aspects of awardees plans to address surge capacity were developed. These new measures and more information on the program's performance are shown in Section U.

Rationale for the Budget

The FY 2006 budget of $482,979,000 will support an additional $25 million for grants to create a targeted demonstration program for the establishment of a state-of-the-art emergency care capability designed to meet the demands of a terrorist attack or other incident requiring mass casualty care and/or containment of infectious agents, in one or more metropolitan areas. These funds would be awarded competitively based on, among other factors, threat analyses, quality of design and operational plan, and financial sustainability of the project beyond the Federal funding period.

While most hospitals have infection control capability for routine, small scale exposures, and decontamination capability for small numbers of patients, funds requested will assist hospitals and communities in dealing with large-scale epidemics of a rare contagious disease such as smallpox through the ability to isolate larger numbers of patients per facility and regionally as well as the ability to decontaminate larger numbers of potentially infected patients.

Other essential components that are critical in the ability of hospitals and other supporting healthcare entities to be able to detect, respond and treat patients is the availability of proper pharmaceutical stockpiles to include chemical antidotes to treat healthcare personnel and their family members; to insure adequate competency training opportunities and the follow-up drills and exercises that test those competencies; the proper communications equipment that allows for communication between and among hospitals and other emergency first responder agencies.

OPHEP and HRSA are maximizing resource efforts toward healthcare readiness objectives addressed by National Performance Goal (NPG) priority areas. This will require medication and vaccine distribution; isolation and quarantine capacity; personal protective equipment; decontamination facilities; clinical personnel augmentation; training in recognition and treatment of rare diseases and toxic exposures; State-level disaster drills to test the systems developed; and maintenance of a State-level infrastructure to assess needs, plan and implement programs, and develop sustainable, objective plans addressing public health emergencies, including bioterrorist events.

HHS is developing a plan to review the criteria used in funding allocations to States. HRSA will continue to review hospital preparedness plans and associated hospital renovation and equipment expenditures, and will monitor progress to ensure that funds are used in accordance with program objectives. HRSA will continue to promote the creation and exercising of community-level and regional plans whereby hospitals work together with public health authorities and other

healthcare entities and emergency first responder organizations, to deal with mass casualty events. Semi-annual progress reports will be requested from grantees.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
State/Cities/ Territories	62	62	62

Trauma/Emergency Medical Services

Authorizing Legislation -- Section 1232 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$3,449,000	$3,419,000	---	- $3,419,000
FTE	1	1	---	-1

FY 2006 Authorization.....Expired

Statement of the Budget

The FY 2006 Budget does not request funds for the Trauma/Emergency Medical Services Program. This is a reduction of $3,419,000 below the FY 2005 Appropriation.

Program Description

The Trauma-EMS Systems Program, within the authority of Title XII of the Public Health Service Act, provides leadership to facilitate the development of effective, comprehensive and inclusive statewide trauma systems. The Trauma-EMS Systems Program facilitates the development of State/Territorial trauma system infrastructure that coordinates regional systems to administer quality, cost-effective care at the local level. The program promotes prepared trauma systems that can respond to emergency and disaster situations, are coordinated with State emergency management and disaster planning efforts, and function well on a day-to-day basis. The Trauma-EMS Systems Program provides national leadership by performing national system assessments, providing strategic planning for needed initiatives, funding grants to support State infrastructure development, developing best practices and models for State trauma systems planning and evaluation, and coordinating related Federal activities. The program is strategically placed within HRSA's Healthcare Systems Bureau, Division of Healthcare Preparedness.

The 2002 National Assessment of Trauma Systems, EMS Resources, and Disaster Readiness (www.hrsa.gov/trauma) revealed a large variation of trauma system development and much need for improvement across the nation.

Funding levels for the Trauma/EMS Program during the past five years have been as follows:

Year	$	FTE
2001	3,000,000	1
2002	3,499,000	1
2003	3,476,000	1
2004	3,449,000	1
2005	3,419,000	1

Performance Analysis

In fiscal year 2002, HRSA's Trauma-EMS Systems program identified 5 critical infrastructure components necessary to the development of a comprehensive Statewide Trauma System. In order to receive grant funding under this program, the States had to address each of these components and were precluded from implementing other activities until these were accomplished.

Over the last three years, substantial progress has been made in addressing these elements. For instance, 48 states have been successful in establishing a Lead Agency for State trauma Systems, 47 States have identified a specific individual and position within their State government responsible for overseeing Trauma System activites, 47 States have an active Statewide trauma stakeholder group, 44 States have in place a Statewide trauma system plan, and 28 States are currently working on the creation of or enhancement of their State trauma registry. HRSA's new program guidance for FY 2005 will continue to reinforce the importance of maintaining these components and building new capacities within State Trauma Systems including, but not limited to, burn care issues.

Rationale for the Budget Request

There is no FY 2006 Budget for this program. Over the last two years, much work has been directed at expanding beyond just biological hazards to address more of an all-hazards approach to emergency preparedness. Within the HRSA National Hospital Preparedness Program, a critical benchmark was established in FY 2003 (then optional but mandatory in the FY 2004 guidance) for trauma and burn care. HRSA believes that the critical functions in preparing for mass casualty events can and are being addressed within the Hospital Preparedness activities.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Projects	47	50	---

State Planning Grant Program

Authorizing Legislation - Sections 301 of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$14,810,000	$10,910,000	---	-$10,910,000
FTE	4	4	---	- 4

FY 2006 Authorization ..... No authorization proposed

Statement of the Budget

The FY 2006 Budget does not request funds for the State Grant Planning Program. This is a reduction of $10,910,000 below the FY 2005 Appropriation.

Program Description

The State Planning Grant Program supports grants to States to develop designs for providing access to health insurance coverage to all citizens of the State. Funds are being used to conduct insurance coverage surveys. States submit reports to the Secretary that identify characteristics of the uninsured within the State and approaches for providing them with health coverage through an expanded State, Federal and private partnership.

Funding for the State Planning Grant Program during the last five years has been as follows:

	$	FTE
2001	14,996,000	6
2002	15,033,000	3
2003	14,902,000	4
2004	14,810,000	4
2005	10,910,000	4

Performance Analysis

These grants have not have a demonstrable impact on expanding health insurance coverage.

Rationale for the Budget

There is no FY 2006 Budget for this program. Over the course of five years, 46 States, four territories, and the District of Columbia have been funded to analyze and develop plans to cover the uninsured. The FY 2006 Budget expands direct health care services to the uninsured

through Health Centers. The Budget proposes policies that will facilitate individual's purchase of health insurance, including:

- The $74 billion over 10 years for health-insurance tax credits for low-income families that will ultimately help 15 million families purchase affordable health insurance.
- $1 billion in grants over two years for Cover the Kids, a new campaign to enroll millions more low-income children in Medicaid and SCHIP.
- $4 billion in grants to states to establish health insurance purchasing pools, through which people who qualify for the tax credit can obtain coverage.
- $28.5 billion over 10 years for tax deductions for premiums for major medical insurance, which will ultimately help 6 million Americans save for their health care costs in tax-free accounts.
- $19.2 billion over 10 years for tax rebates for small businesses that contribute to their HSAs, encouraging more small employers to offer health benefits.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Grants	35	34	---

Smallpox Vaccine Injury Compensation Program (SVICP)

Authorizing Legislation - Public Law 108-20, the Smallpox Emergency Personnel Protection Act of 2003.

	FY 2004 Actual*	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Claims BA	$263,246	$2,000,000	$2,000,00	---
Admin. BA	$761,095	$1,221,519	$1,279,176	+ $57,657
Total BA	$1,024,341	$3,221,519	$3,279,176	+ $57,657
FTE	5	8	8	---

*This table represents the actual and estimated expenditures against the $42,000,000 appropriated in FY 2003 to the Public Health and Social Services Emergency Fund that the Department has or will annually apportion to HRSA.

FY 2006 Authorization.....Such sums as necessary

The program was authorized and appropriated $42,000,000 in FY 2003 to support the benefits and compensations for an unspecified number of requests. As these are no-year-funds, they are available for claims and administrative operations for the life of the Smallpox Vaccine Injury Compensation Program (SVICP). In FY 2005, $20,000,000 of the amount appropriated was rescinded by the Congress.

Statement of the Budget

The FY 2006 Budget of $3,279,176 is $57,657 above the FY 2005 Appropriation, and supports pay and non-pay costs.

Program Description

In April 2003, Congress passed the Smallpox Emergency Personnel Protection Act of 2003 (the Act) to provide compensation and/or benefits to members of emergency response teams who received a smallpox vaccination and suffered a medical injury from it, resulting in medical expenses, lost employment income, and/or death benefits, all of which are compensable under the Act. In addition, the Act provides similar benefits to individuals who suffer a medical injury from vaccinia contact with a vaccinated response team member. Certain survivors of smallpox vaccine recipients or vaccinia contacts are eligible for death benefits.

Program regulations were published in the Federal Register as interim final regulations in two phases: (1) on August 27, 2003, the *SVICP: Smallpox (Vaccinia) Vaccine Injury Table* listing known and predictable medical injuries from exposure to the smallpox vaccine and

countermeasures; (2) on December 16, 2003, the *SVICP: Administrative Implementation; Interim Rule* covering the policies and procedures by which the Smallpox Vaccine Injury Compensation Program would operate.

In FY 2004, the program's forms and instructions for requesting program benefits were cleared and published. In addition, a SVICP Web page was created and implemented posting the Act, the Secretary of HHS's Declaration Regarding Administration of Smallpox countermeasures, a program overview, the Injury Table and administrative regulations, the Table fact sheet, the Table press release, the program benefit request package consisting of the forms and instructions, the administrative fact sheet, the administrative press release, and frequently asked questions. During FY 2004, the SVICP became operational for program benefits and began processing requests and making benefit payments to individuals.

Funding levels for the Smallpox Vaccine Injury Compensation Program during the last five years reflect this effort and are as follows:

	$	FTE
2001*	---	---
2002*	---	---
2003	42,000,000	1
2004	---	5
2005	-20,000,000	8

*The Law authorizing the Smallpox Vaccine Injury Compensation Program was enacted in 2003.

Performance Analysis

Performance measures will be developed for this activity in preparation for the PART review process, scheduled for the FY 2008 budget cycle.

Rationale for the Budget Request

The FY 2006 Budget of $3,279,176 will support the Smallpox Vaccine Injury Compensation Program. According to the Centers for Disease Control and Prevention (CDC), the injury rate for vaccine recipients is 1-2 deaths per million and 35 injuries per million. More than 38,000 individuals, exclusive of military personnel, received a smallpox vaccination between January 2003 and June 2004. In addition to those who are injured from the smallpox vaccine, there will be request forms submitted by individuals who contracted vaccinia through contact. These individuals may be eligible for program benefits under the Act. The HRSA estimated receiving 75 request packages for program benefits. It was also estimated that 50 of these requesters may be eligible for medical, lost employment income, and/or death benefits. While the program activity has been based on these numbers, it cannot be estimated at this time the total number of individuals who may actually receive a smallpox vaccination as a consequence of the Smallpox Emergency Personnel Protection Act of 2003 or contract vaccinia through contact. However, as of January 2005, the HRSA has received and begun to process 57 request packages from individuals seeking medical, lost employment income and death benefits. During FY 2004, six

of these requests for benefits were approved and payments totaling $263,246 were made to four individuals. These payments ranged from $475 to $131,050. The amounts paid for medical benefits have been less than 10 percent of the actual medical costs incurred by the injured individuals. One death benefit request for $262,100 was made in two payments to the individual's survivors. To date, no payments for lost employment income have been made. Because the program is a secondary payer for requested benefits, it takes considerable time for requesters to collect and for HRSA to obtain the necessary cost information relative to the type of benefits requested, and to calculate the amount, if any, a requester may receive from the Department.

The SVICP staffing of eight FTE in FY 2006 includes the infrastructure to handle the logistics, review, and payment of any volume of request for benefits submitted. This includes the program director, senior advisor, operations manager, medical analyst, legal analyst, senior program analyst, program analyst and program support to review the request forms for eligibility and to handle the medical, lost employment income, and death benefit payments for approved requesters, help-line support, interacting with the public, and responding to internal and external written or oral interrogatories regarding program or request package issues.

The Secretary has issued a Declaration stating that, unless amended, individuals must receive a smallpox vaccination between January 24, 2003, and January 23, 2005. Request packages from vaccine recipients must be submitted within one year of the vaccination. Currently that date is January 23, 2006. Vaccine contacts have two years from the onset of symptoms to submit a request for benefits, which means that there could be request packages submitted to SVICP in FY 2006. Even though the program is a secondary payer to other payers, it may be incumbent upon the program to make payments to requesters prior to them receiving payments from their primary insurance companies. Therefore, there could be strong, continued efforts in FY 2006 to ensure that HHS is recompensed, by either the primary payer (e.g., other Federal departments, State agencies, or insurance companies) for any up-front payments not covered by the Act.

Timely and efficient review of request packages has been a primary objective of the SVICP. The SVICP issued letters to 100 percent of requesters that, based on program criteria, were determined to be eligible. Those individuals are asked to submit all pertinent documentation to support their request for benefits in order for the SVICP to calculate the amount of benefits to which each requester may be entitled. After completing these calculations, HRSA initiates a benefits payment for each approved requester. Since SVICP is a secondary benefits payer, an extensive analysis of financial documentation is required to properly calculate the medical benefits, lost employment income benefits, and/or death benefits that are appropriate for each requester, both current and for the future. HRSA reviews 100 percent of each request package's supporting medical documentation to make program eligibility determinations. HRSA then analyzes each approved requester's supporting legal and financial documentation to calculate whether medical benefits, lost employment income, and/or death benefits are payable to a requester. Each benefit is calculated to determine how much, if any, each approved request for benefit payment will be paid. HRSA processes the benefits payments through the Department's accounting operations which subsequently sends approved payments to the Department of Treasury for payments by electronic funds transfers or other financial payment methods as

appropriate. Future benefit payment annuities will be coordinated with the Department of Justice's methodology that supports the Department's childhood vaccine programs.

In FY 2004, six request packages were approved resulting in payments to four individuals, and ten requests for benefits have been determined to be incomplete. The program estimates that 22 request packages will be finalized in FY 2005, with the remaining 19 request packages finalized in FY 2006.

Program Outputs

	FY 2004 Actual	FY 2005 Estimate	FY 2006 Estimate
Final Determination	6	22	19

Rural Health Activities (Program Summary)

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$142,616,000	$144,707,000	$29,478,000	-$115,229,000

Performance Analysis

Rural health activities, within the Office of Rural Health Policy, encompass several distinct programmatic activities, including Rural Health Policy Development, Rural Health Care Services Outreach Grants, Rural and Community Access to Emergency Devices, Rural Hospital Flexibility Grants, Rural Emergency Medical Services, State Offices of Rural Health, and Denali Projects.

Despite their diversity, these programs share a common overall purpose: to sustain and improve access to quality health care services for rural communities. Because of this shared purpose, these programs were assessed as one unit by OMB using the Program Assessment Rating Tool (PART) for the FY 2005 budget. The program received a rating of adequate. During this review, cross-cutting goals and measures were identified for use in monitoring the overall performance of the programs within the Office of Rural Health Policy. As shown in Section U, these goals and measures focus on two areas as described below.

The first is the health care status of rural Americans. A long-term goal is to contribute to reducing to 13.9 percent by 2010 the proportion of rural residents with limitations of activities caused by chronic conditions. Research conducted by the Centers for Disease Control shows that rural residents are more likely than their urban counterparts to have limitations in the activities of daily living and that rural residents also have higher rates of chronic disease than urban residents.

The Rural Health Care Services Outreach grant program funds a variety of grants focusing on improving access to care and health status and serves as a vehicle for addressing this long-term goal. Therefore, an annual measure associated with this long-term goal relates to increasing the number of people served by these grants. Historically, the Rural Health Care Services Outreach grant program has easily exceeded its short-term target for increasing the number of people served by the Rural Health Care Services Outreach grant program. The number of persons served reached nearly 669,000 in FY 2003, which was in alignment with the level of funding for that year.

The second measurement area focuses on the financial viability of key rural health care providers, thereby maintaining essential points of access to care for rural residents. The long-term measure is increase to 35 percent, by 2010, the proportion of Critical Access Hospitals (CAHs) with positive operating margins. Historically, these hospitals have struggled financially.

The short-term measure is to increase by 0.5 percentage points annually the average operating margin of CAHs, thus tracking annual progress toward the longer-term goal. In FY 1999, only

17 percent of CAHs had positive operating margins. By 2002, this number had increased to 29 percent, indicating, in part, the positive impact of ORHP programs.

Medicare operating margin data is but one measure of a hospital's financial performance and a variety of factors including individual management decisions can influence this measure. Many rural hospitals have seen their Medicare operating margins improve after converting to CAH status due to the cost-based reimbursement they receive from Medicare. Medicare hospital cost report data for FY 2003 and FY 2004 is not yet available to chart progress on this goal.

Rural Health Policy Development

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

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$8,902,000	$8,825,000	$8,528,000	-$374,000

FY 2006 Authorization.....Indefinite

Statement of Budget - The FY 2006 Budget of $8,528,000 is $374,000 below the FY 2005 Appropriation.

Program Description

The primary mission of the Office of Rural Health Policy (ORHP) is to advise the Secretary and other components of the Department of Health and Human Services (DHHS) on rural health issues. To accomplish this mission, ORHP supports a variety of activities, including rural health research and information dissemination and advisory efforts.

ORHP Rural Health Research Centers develop much of the objective information upon which recommendations for improving the delivery of health care services in rural communities is based. In the past, efforts to understand and appropriately address the health needs of rural Americans were severely limited by the lack of information about the rural population and the impact of Federal policies and regulations on the rural health care infrastructure.

The ORHP Rural Health Research Center Grant program is the only Federal research program specifically designed to provide both short and long-term policy relevant studies on rural health issues. Grants were awarded to eight Research Centers in FY 2004. The work of the Centers is published in policy briefs, academic journals, research papers and other venues and is made available to policy makers at both the Federal and State levels.

In addition to the Research Centers, this activity continues support for: (1) the National Advisory Committee on Rural Health and Human Services, which advises the Secretary on rural health and human service programs and policies; (2) dissemination of rural health and human services information by the Rural Assistance Center (the Center responds individually to hundreds of inquiries each month and disseminates information through its web site); (3) small projects that assist the ORHP and HRSA in identifying and clarifying rural health care issues; and activities related to the HHS Rural Initiative.

Funding levels for the Rural Health Policy Development program during the last five years reflect this effort and are as follows:

	$	FTE
2001	13,437,000	--
2002	14,802,000	--
2003	10,630,000	--
2004	8,902,000	--
2005	8,825,000	--

Performance Analysis

The policy activities of the Office of Rural Health Policy continue to meet or exceed performance goals. The performance measure for this activity is the number of rural health research studies completed through the rural health research center grant program. This program is the only research activity within the Department that exclusively focuses on rural health services research analysis.

In FY 2002, the program met its target of producing 24 rural research reports. In FY 2003, the program exceeded its target, producing 21 rural research reports. The program again exceeded its target in FY 2004 by producing 26 reports. These reports help inform the Office's policy role of advising the Department on rural health issues and they ensure that rural concerns are identified and shared within the Department so that policymaking can take into account the unique challenges faced by rural providers and the communities they serve.

Additional performance information is presented in Section U. This program was covered in OMB's combined assessment of HRSA's Rural Health Activities during the FY 2005 budget cycle using the Program Assessment Rating Tool (PART).

Rationale for the Budget Request

The FY 2006 Budget of $8,528,000 will continue support for Rural Health Policy Development which includes an administrative cost reduction of $374,000. This will allow continued operation of key functions for the Office.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Outputs	26	26	26

Rural Health Care Services Outreach Grants

Authorizing Legislation - Section 330A of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$39,601,000	$39,278,000	$10,767,000	-$28,511,000

FY 2006 Authorization.....Indefinite

Statement of Budget - The FY 2006 Budget of $10,767,000 is $28,511,000 below the FY 2005 Appropriation.

Program Description

The Office of Rural Health Policy (ORHP) administers five grant programs under this authority that support collaborative models to deliver basic health care services to the 60 million Americans living in rural areas. The Rural Health Care Services Outreach Grant program increases access to primary health care services for rural Americans. The program supports a wide range of services, including primary medical and dental care, mental health treatment, health promotion and health education services, and hospice care.

The Rural Network Development Grant program helps rural health providers develop community-based, integrated systems of care. Projects build regional or local partnerships among local hospitals, physician groups, long-term care facilities and public health agencies to improve management of scarce health care resources. The program line also includes support for grants to the eight States in the Mississippi Delta for network and rural health infrastructure development.

Beginning in FY 2004, the program also awarded a small number of network planning grants through a new provision that was added to this authority when the program was re-authorized by the Safety Net Amendments of 2002 (P.L.107-251).

Funding levels for Rural Health Care Services Outreach Grants during the last five years reflect this effort and are as follows:

	$	FTE
2001	58,214,000	--
2002	52,098,000	--
2003	57,663,000	--
2004	39,601,000	--
2005	39,278,000	--

Performance Analysis

The Rural Health Outreach program continues to meet performance goals by reaching out to more rural residents each year. The unique aspect of the Outreach program is that it is non-categorical in nature, which allows it to better meet the unique and distinct goals of hundreds of rural communities. This, in turn, helps ensure that access to needed services in rural communities continues to expand where and in ways needed.

The Outreach grant program has served more than 600,000 rural residents since it began in 1993. The program exceeded its FY 2003 goal by 810 persons served. More information on this program's performance is found in Section U of this document. This program was covered in OMB's combined assessment of HRSA's Rural Health Activities during the FY 2005 budget cycle using the Program Assessment Rating Tool (PART).

Rationale for the Budget Request

The FY 2006 Budget of $10,773,000 is a reduction of $28,511,000, including an administrative cost reduction of $325,000. This funding continues a base level of support for the Rural Health Care Services Outreach grant program. The need for this program has decreased in the wake of the approximately $20 billion investment in rural provisions in the Medicare Modernization Act of 2003. The rural provisions in this law will provide support for rural communities by increasing Medicare reimbursement for rural providers. This request will allow for phase-out grants to be awarded to current grantees.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Outputs	162	162	58

Rural Access to Emergency Devices and Public Access Defibrillation Demonstration Projects

Authorizing Legislation - Section 413 of P. L. 106-505 and Sect. 313 of the Public Health Service Act

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$10,933,000	$8,927,000	$1,960,000	- $6,967,000
FTE	2	2	2	---

FY 2006 Authorization - Rural Access to Emergency Devices.....Expired
FY 2006 Authorization - Public Access Defibrillation Demonstration.....$5,000,000

Statement of Budget - The FY 2006 Budget of $1,960,000 is $6,967,000 below the FY 2005 Appropriation.

Program Description

Funding for the Rural AED Grant program was first provided in the FY 2002 appropriation. Community partnerships are eligible to receive funds for the purchase and distribution of AEDs (automatic external defibrillators) and training in their use in the eligible areas of the State. The FY 2003 - 2005 appropriations for the AED program provided funding for additional eligible partnerships for placement of AEDs and training in their use. It is expected that much of the demand for rural AED placement will be met by these appropriations and that the FY 2006 request will be used to address the remaining need for this program.

In FY 2004, additional funding was allocated for the Public Access Defibrillation Demonstration Projects (PADDP). The purpose of the program is to support grants to political subdivisions of States, Indian Tribes and Tribal organizations to develop and implement public access defibrillation projects. The intent of this grant program is to support projects that will increase public access of emergency medical devices and services. There is no request for this program in FY 2006.

Funding levels for the Rural Access to Emergency Devices and Public Access Defibrillation Demonstration Projects during the last five years reflect this effort and are as follows:

	$	FTE
2001	---	--
2002	12,500,000	2
2003	12,419,000	2
2004	10,933,000	2
2005	8,927,000	2

Performance Analysis

This activity was included in the combined PART review of Rural Health Activities conducted for the FY 2005 budget (see earlier Performance Analysis Section on Rural Health Activities). Rural Health Activities received a rating of "Adequate."

Rationale for the Budget Request

The FY 2006 Budget of $1,961,000 is a reduction of $6,967,000 which includes an administrative cost reduction of $53,000. The request will continue base support for the Rural Access to Emergency Devices program. Prior investments in this program have largely met the need and the FY 2006 request will allow targeted investment in the few remaining areas of need. The request includes all pay-related costs associated with this program.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Outputs	47	47	47 grants at 10 % continuation

Rural Hospital Flexibility Grants

Authorizing Legislation - Sec. 1820(j), Title XVIII of the Social Security Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$39,499,000	$39,180,000	---	- $39,180,000

FY 2006 Authorization.....$35,000,000

Statement of Budget - The FY 2006 Budget does not request funds for the Rural Hospital Flexibility Grant Program. This is a reduction of $39,180,000 below the FY 2005 Appropriation.

Program Description

States use Rural Hospital Flexibility (Flex) grants to:

- develop and implement State rural health plans;
- help nearly 1,015 small, financially vulnerable hospitals convert to Critical Access Hospital (CAH) status and receive cost-based payments under Medicare;
- support these hospitals and the communities they serve in developing networks of care;
- integrate CAHs with emergency medical services (EMS) and other sources of care in their communities; and
- improve quality of care in CAHs.

States use the Small Rural Hospital Improvement (SHIP) grants to provide grants of about $10,000 to 1,500 eligible hospitals (hospitals of 50 beds or less located in an rural area) to:

- meet the requirements of the Medicare Prospective Payments System;
- comply with the provisions of the Health Insurance Portability and Accountability Act (HIPAA); and/or
- reduce medical errors and support quality improvement.

Funding levels for Rural Hospital Flexibility Grants during the last five years reflect this effort and are as follows:

	$	FTE
2001	24,966,000	--
2002	39,000,000	--
2003	39,740,000	--
2004	39,499,000	--
2005	39,180,000	--

Performance Analysis

The Rural Hospital Flexibility Grant program performance measures focus on increasing the financial viability of Critical Access Hospitals (CAHs), assisting rural hospitals in conversion to CAH status and increasing network development. The program's primary purpose was to provide support to States to determine if rural hospitals might benefit from conversion to CAH status. To date, more than 1,015 hospitals have been designated as CAHs and the States have had six years to identify those facilities that would benefit most from conversion. The majority of those conversions have taken place. In addition, the reduction in funds will be offset by approximately $20 billion in rural provisions in the Medicare Modernization Act of 2003. The rural provisions in this law will provide support to rural communities by increasing Medicare reimbursement for rural providers. There are also increases in reimbursement and flexibility for CAHs. Consequently, there is no longer a need for this program.

The number of hospitals converting to CAHs has grown rapidly from 657 in FY 2002 to 762 in FY 2003 and 930 in FY 2004, all of which were far beyond the original targets for growth. In addition, CAHs are seeing rapidly improving financial status, thanks in part to the Flex program investment. When this designation first became available, CAHs had an average operating margin of a negative 28 percent. New data show that in FY 2002, the average operating margin for CAHs was reduced to a negative 9.37 percent. This shows that conversion to CAHs has moved these facilities into a much more favorable financial status, which will enable them to continue to serve as key points of access to care for Medicare beneficiaries in rural communities. Additional information is provided in Section U. This program was covered in OMB's combined assessment of HRSA's Rural Health Activities during the FY 2005 budget cycle using the Program Assessment Rating Tool (PART).

Rationale for the Budget Request

There is no FY 2006 Budget for this program. The need for this program has decreased in the wake of the approximately $20 billion investment in rural provisions within the Medicare Modernization Act of 2003 (MMA).

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Outputs	45	45	---

Rural Emergency Medical Services Training and Equipment Assistance Grants

Authorizing Legislation - Section 330J of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$497,000	$496,000	---	- 496,000
FTE	1	1	---	-1

FY 2006 Authorization.....Such sums as necessary

Statement of Budget - The FY 2006 Budget does not request funds for the Rural Emergency Medical Services Training and Equipment Assistance Grants program. This is a reduction of $496,000 below the FY 2005 Appropriation.

Program Description

In FY 2004, the appropriation included $497,000 in funding for the Rural Emergency Medical Training and Equipment Assistance Grant Program (REMSTEP). REMSTEP assists rural and frontier communities in improving emergency medical services. This grant program provides funding for innovative solutions that help address issues such as provider licensure, continuing education, skill retention and expanding scopes of practice to improve emergency medical services (EMS) in rural communities.

Funding levels for Rural Emergency Medical Training and Assistance Grant Program during the last five years reflect this effort and are as follows:

	$	FTE
2001	---	--
2002	---	--
2003	---	--
2004	497,000	1
2005	496,000	1

Performance Analysis

This activity was included in the combined PART review of Rural Health Activities conducted for the FY 2005 budget (see earlier Performance Analysis Section on Rural Health Activities). Rural Health Activities received a rating of "Adequate."

Rationale for the Budget Request

There is no FY 2006 Budget for this program. The need for this program has been offset by increases in Medicare reimbursement for rural emergency medical service providers.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Outputs	---	3	---

State Offices of Rural Health

Authorizing Legislation - Section 338J of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$8,390,000	$8,321,000	$8,223,000	- $98,000

FY 2006 Authorization.....Expired

Statement of Budget - The FY 2006 Budget of $8,223,000 is a reduction of $98,000 below the FY 2005 Appropriation.

Program Description

The Office of Rural Health Policy recognizes that the health care needs of rural communities vary greatly across the country. The Office supports State-level solutions and innovations through State Office of Rural Health grants. The State Office of Rural Health Grant program helps States strengthen rural health care delivery systems by:

- collecting and disseminating health-related information in rural areas;
- providing technical and other assistance to rural health providers, including small rural hospitals; and
- working to help communities recruit and retain health professionals.

Each dollar of Federal support for the program is matched by three State dollars.

Funding levels for the State Offices of Rural Health Program during the last five years reflect this effort and are as follows:

	$	FTE
2001	4,000,000	--
2002	7,996,000	--
2003	8,445,000	--
2004	8,390,000	--
2005	8,321,000	--

Performance Analysis

While covered in OMB's combined assessment of HRSA's Rural Health Activities during the FY 2005 budget cycle using the Program Assessment Rating Tool (PART), the State Offices of Rural Health (SORH) program has developed additional performance measures beginning in 2004. The new measures are more closely aligned with program goals. As funding for this program increased, there was a need to develop more specific program measurement tools to track progress on this program to demonstrate its success.

The first new measure identifies the number of communities receiving technical assistance from State Offices of Rural Health. These Offices play a critical role as an information resource and focal point for rural health activities within their States. One of the primary outcomes of that role is the number of communities they assist to improve access to essential health services.

In FY 2003, the grantees worked with 4,120 communities. The second new measure focuses on recruitment of health professions for rural communities, which is one of the key activities across the 50 State Offices of Rural Health. The measure will determine how many State Offices have an identified focal point for this activity. In FY 2003, 41 of 50 grantees identified a focal point for this activity. More on these measures is presented in Section U.

Rationale for the Budget Request

The FY 2006 Budget of $8,224,000 includes an administrative cost reduction of $98,000, and will continue essential support for the State Offices of Rural Health grant program. The request will be appropriate to continue to meet all needs for this program.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Outputs	50	50	50

Denali Commission

Authorizing Legislation - Section 309 of Public Law 105-277.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$34,794,000	$39,680,000	---	- $39,680,000

FY 2006 Authorization.....Expired

Statement of Budget - The FY 2006 Budget does not request funds for the Denali Commission. This is a reduction of $39,680,000 below the FY 2005 Appropriation.

Program Description

The Denali Commission, an Agency of the Department of Commerce, is modeled on the Appalachian Regional Commission and directed by Federal and State (Alaska) co-chairs. Its core mission is economic development in rural Alaska. The $34,794,000 million appropriated to HRSA for the Commission in FY 2004 was combined with other resources for planning, designing and constructing primary health care facilities in the State. Resources were also used to assist other facilities, such as hospitals and facilities that provide mental health services.

Funding levels for the Denali Commission during the last five years reflect this effort and are as follows:

	$	FTE
2001	10,000,000	--
2002	20,000,000	--
2003	27,321,000	--
2004	34,794,000	--
2005	39,680,000	--

Performance Analysis

This activity was included in the combined PART review of Rural Health Activities conducted for the FY 2005 budget (see earlier Performance Analysis Section on Rural Health Activities). Rural Health Activities received a rating of "Adequate."

Rationale for the Budget Request

There is no 2006 request for this program. The need has largely been met through prior investment.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Funded Projects	27	29	--

Program Management

Authorizing Legislation - Section 301 of the Public Health Service Act

	FY 2004 Enacted	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$148,533,000	$147,020,000	$145,992,000	-$1,088,000
FTE [1]	1,186	1,229	1,229	---

FY 2006 Authorization.....Indefinite

Statement of Budget - The FY 2006 Budget of $145,992,000 is a decrease of $1,088,000 below the FY 2005 Appropriation, and supports the same number of FTE as the FY 2005 Appropriation.

Program Description

HRSA's program management activity improves the agency's capability to operate complex programs funded in FY 2005 at more than $6.8 billion. HRSA must have sufficient numbers of qualified staff to operate at maximum efficiency.

Program management is the primary support mechanism for agency leaders in their quest to assure quality health care to underserved and vulnerable populations and promote primary care education and practice. Program management personnel plan, coordinate, and direct technical assistance and program guidance to clients of all of HRSA's key programs, including:

- Health Centers and other Primary Care programs;
- Health Professions programs;
- Maternal and Child Health programs;
- Ryan White AIDS programs;
- Organ Transplantation and Health Care Facilities programs;
- Rural Health programs; and
- Telehealth.

[1] FTE levels in FY 2005 and FY 2006 are different than those presented in the Appendix of the Budget of the United States Government to reflect corrected FTE levels.

In addition, Program Management supports agency oversight of a broad variety of program operations funded from other sources, which include:

- National Practitioner Data Bank;
- Health Care Integrity and Protection Data Bank
- Vaccine Injury Compensation Program; and
- Immigrant Health.

Performance Analysis - Significant progress has been made in a range of program management activities. The effort to improve the IT infrastructure has involved major efforts at perimeter protection, risk assessment and security awareness training, the costs of which have expanded substantially. The agency has moved forward with its plans for strategic management of human capital. Substantial progress has been made in terms of delayering and streamlining.

During this year, HRSA moved forward with implementation of the revised grants management structure, creating the Office of Federal Assistance Management, which includes two restructured offices: the Office of Financial Policy and Oversight, and the Division of Independent Review which directs HRSA's independent review of applications for grants and cooperative agreements. HRSA has also continued to carry out the HRSA Scholars program, bringing on approximately 50 new Scholars each year as part of a five-year plan to attract a new generation of committed health program professionals.

Rationale for the Budget Request - The FY 2006 Budget of $145,992,000 will support Program Management at the FY 2005 Appropriated level of FTE. The FY 2006 request includes a reduction of $1,175,000 for Information Technology and a reduction of $178,000 in Administrative expenses from the FY 2005 Final Appropriated level.

The Unified Financial Management System (UFMS) is being implemented to replace five legacy accounting systems currently used across the Operating Divisions (OPDIV). The UFMS will integrate the Department's financial management structure and provide HHS leaders with a more timely and coordinated view of critical financial management information. The system will also facilitate shared services among the Agencies and thereby, help management reduce substantially the cost of providing accounting service throughout HHS. Similarly, UFMS, by generating timely, reliable and consistent financial information, will enable the component agencies and program administrators to make more timely and informed decisions regarding their operations. HRSA resources will be used to support these efforts in FY 2006.

The Program Management Office (PMO) and the Program Support Center (PSC) have commenced Operations and Maintenance (O&M) activities for UFMS in FY 04. The PMO and the PSC will provide the O & M activities to support UFMS. The scope of proposed O & M services includes post deployment support and ongoing business and technical operations services. Post-deployment services include supplemental functional support, training, change management and technical help-desk services. On-going business operation services involve core functional support, training, change management and technical help-desk services. On-going business operation services involve core functional support, training and communications,

and help desk services. On-going technical services include the operations and maintenance of the UFMS production and development environments, on-going development support, and backup and disaster recovery services. HRSA resources will be used to support these efforts in FY 2006.

Family Planning

Authorizing Legislation - Title X of the Public Health Service Act.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Budget Authority	$278,283,000	$285,963,000	$285,963,000	---
FTE	46	49	49	---

FY 2006 Authorization.....Expired

Statement of the Budget - The FY 2006 Budget of $285,963,000 is the same as the FY 2005 Appropriated level.

Program Description

The Title X family planning program is administered by the Office of Population Affairs (OPA) within the Office of Public Health and Science (OPHS). The program provides a broad range of effective and acceptable family planning methods and related preventive health services. The Title X program also supports three key functions aimed at assisting clinics in responding to clients' needs: (1) training for family planning clinic personnel through general training programs, as well as training for clinicians through clinical specialty training programs; (2) information dissemination and community-based education and outreach activities; and (3) data collection and research to improve the delivery of family planning services.

Ninety percent of the program funds are used to provide clinical services. Title X service funds are allocated to the ten PHS Regional Offices which, in turn, manage the competitive review process, make grant awards and monitor program performance. Services are provided through 86 service delivery grants that support a nationwide network of more than 4,500 clinics that provide services to approximately 5 million persons each year. Family planning service delivery grants are made to public and private not-for-profit organizations to support the provision of family planning clinical services and information. Services are delivered through a network of community-based clinics that include State and local health departments, hospitals, university health centers, independent clinics, and public and nonprofit agencies. In 2001, nearly 85 percent of U.S. counties, at least one provider of contraceptive services is funded by the Title X family planning program.

The Title X program is designed to provide access to contraceptive services, supplies and information to all who want and need them. By law, priority is given to low-income persons. In addition to contraceptive services and related counseling, Title X-supported clinics provide a number of related preventive health services such as: patient education and counseling; breast and pelvic examinations; cervical cancer screening; STD and HIV prevention education, counseling, testing and referral; and pregnancy diagnosis and counseling. For many clients, Title X clinics provide the only continuing source of health care and/or health education.

Funding levels for the Family Planning Program during the last five years reflect this effort and are as follows:

	$	FTE
2001	253,932,000	49
2002	264,987,000	43
2003	273,350,000	47
2004	278,283,000	46
2005	285,963,000	49

Performance Analysis

The program remains committed to improving family planning service delivery for its target population, increasing utilization of services for underserved populations, providing related preventive health care services, and addressing STD and HIV prevention among Title X clients. In 2003, the most recent year for which complete program data are available, five million patients were seen at 4,531 clinic sites; 90 percent had incomes below 200 percent of the Federal poverty level. Approximately 4 percent of clients receiving services in the Title X service delivery system are male.

Family planning clinics provide a broad range of preventive health services, including breast examinations and Pap tests, to a population that is predominately low-income and who have less access to health care. In 2003, Title X clinics provided 2.852 million Pap tests and 2.771 million clinical breast examinations to family planning clients – approximately six Pap tests and breast exams are performed for every ten female family planning clients. The program also plays a critical role in addressing the prevention of HIV by providing confidential HIV prevention education and counseling, testing on-site or by referral, and referral for care and treatment. In 2003, 526,360 HIV tests were provided to both male and female clients in the Title X family planning services program. The program will continue its HIV integration initiative launched in 2001 to help increase awareness of the disease and its prevention, provide HIV-related services to individuals at increased risk of HIV, and help those individuals who are identified as HIV positive to get care and treatment.

Rationale for the Budget Request

The Title X Family Planning program is requesting $285,963,000, which is the same as the FY 2005 level. This level will enable the program to continue to provide a broad range of clinical family planning and related preventive health care services.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Number of Grants	86	87	87
Clients Served	4,792,000 [3]	4,857,000	5,187,000
Reduce Incidence/Prevalence Disease & Morbidity/Mortality			
Cervical Cancer Screenings	2,955,034	2.9 million	2.9 million
Breast Cancer Screenings	2,863,000	2.8 million	2.8 million
HIV Tests	496,622	500,000	500,000

[3] These data represents the family planning program's performance target. The actual data on the number of clients served, the number of screenings and HIV tests will be available September 2005. There is a one year lag time in collecting the actual data for the current fiscal year.

DEPARTMENT OF HEALTH AND HUMAN SERVICES				
FY 2006 MANDATORY STATE/FORMULA GRANTS				
CFDA NUMBER/PROGRAM NAME: 93.994/MATERNAL and CHILD HEALTH BLOCK GRANTS				
	FY 2004	FY 2005	FY 2006	Difference
STATE/TERRITORY	Actual	Conference	Estimate	+/- 2005
Alabama	$12,415,309	$12,348,388	12,642,291	$293,903
Alaska	$1,180,409	$1,174,208	1,201,440	$27,232
Arizona	$7,842,357	$7,769,858	8,088,259	$318,401
Arkansas	$7,524,664	$7,483,501	7,664,281	$180,780
California	$48,441,501	$47,947,194	50,118,093	$2,170,899
Colorado	$7,603,353	$7,569,141	7,719,395	$150,254
Connecticut	$4,998,766	$4,974,598	5,080,738	$106,140
Delaware	$2,034,791	$2,028,207	2,057,124	$28,917
District of Columbia	$7,170,736	$7,160,786	7,204,482	$43,696
Florida	$20,994,684	$20,818,016	21,593,907	$775,891
Georgia	$17,348,033	$17,245,237	17,696,697	$451,460
Hawaii	$2,392,416	$2,381,011	2,431,101	$50,090
Idaho	$3,387,761	$3,373,170	3,437,253	$64,083
Illinois	$23,027,020	$22,898,485	23,462,987	$564,502
Indiana	$12,318,758	$12,265,926	12,497,954	$232,028
Iowa	$6,760,133	$6,737,839	6,835,749	$97,910
Kansas	$4,963,545	$4,939,926	5,043,655	$103,729
Kentucky	$11,948,246	$11,890,984	12,142,466	$251,482
Louisiana	$14,293,453	$14,203,523	14,598,476	$394,953
Maine	$3,518,418	$3,507,117	3,556,748	$49,631
Maryland	$12,367,885	$12,327,972	12,503,261	$175,289
Massachusetts	$11,968,951	$11,919,050	12,138,207	$219,157
Michigan	$19,903,294	$19,804,006	20,240,058	$436,052
Minnesota	$9,427,666	$9,393,432	9,543,781	$150,349
Mississippi	$10,337,878	$10,279,799	10,534,868	$255,069
Missouri	$13,030,039	$12,967,992	13,240,489	$272,497
Montana	$2,560,004	$2,547,932	2,600,950	$53,018
Nebraska	$4,183,264	$4,167,938	4,235,245	$67,307
Nevada	$1,996,035	$1,976,405	2,062,614	$86,209
New Hampshire	$2,071,712	$2,065,063	2,094,264	$29,201
New Jersey	$12,348,050	$12,283,978	12,565,369	$281,391
New Mexico	$4,723,796	$4,688,570	4,843,277	$154,707
New York	$43,708,310	$43,450,702	44,582,063	$1,131,361
North Carolina	$17,522,028	$17,434,522	17,818,829	$384,307
North Dakota	$1,882,687	$1,876,452	1,903,834	$27,382

STATE/TERRITORY	FY 2004 Actual	FY 2005 Conference	FY 2006 Estimate	Difference +/- 2005
Ohio	$23,310,577	$23,195,606	23,700,537	$504,931
Oklahoma	$7,791,761	$7,743,394	7,955,813	$212,419
Oregon	$6,579,878	$6,545,709	6,695,773	$150,064
Pennsylvania	$25,621,198	$25,502,552	26,023,619	$521,067
Rhode Island	$1,890,246	$1,878,666	1,929,522	$50,856
South Carolina	$11,952,796	$11,900,111	12,131,490	$231,379
South Dakota	$2,357,003	$2,347,448	2,389,412	$41,964
Tennessee	$12,419,315	$12,349,717	12,655,377	$305,660
Texas	$37,908,796	$37,574,044	39,044,210	$1,470,166
Utah	$6,222,721	$6,202,532	6,291,198	$88,666
Vermont	$1,742,951	$1,738,282	1,758,785	$20,503
Virginia	$13,001,114	$12,942,168	13,201,045	$258,877
Washington	$9,613,745	$9,556,668	9,807,340	$250,672
West Virginia	$6,712,857	$6,685,824	6,804,550	$118,726
Wisconsin	$11,261,938	$11,219,694	11,405,224	$185,530
Wyoming	$1,309,374	$1,304,249	1,326,754	$22,505
Subtotal	**$567,892,222**	**$564,587,592**	**$579,100,854**	**$14,513,262**
American Samoa	$530,459	$527,373	$540,929	$13,556
Guam	$819,266	$814,498	$835,436	$20,938
Northern Mariana Islands	$500,990	$498,075	$510,878	$12,803
Puerto Rico	$17,080,795	$16,981,400	$17,417,923	$436,523
Virgin Islands	$1,609,061	$1,599,698	$1,640,820	$41,122
Federated States of Micronesia	$559,930	$556,672	$570,982	$14,310
Marshall Islands	$247,546	$246,106	$252,432	$6,326
Republic of Palau	$159,139	$158,212	$162,279	$4,067
Total States/Territories	**$589,399,408**	**$585,969,626**	**$601,032,533**	**$15,062,907**
TOTAL RESOURCES	**$589,399,408**	**$585,969,626**	**$601,032,533**	**$15,062,907**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION

FY 2006 DISCRETIONARY STATE/FORMULA GRANTS

CFDA NUMBER/PROGRAM NAME: 93.917 HIV CARE FORMULA GRANTS

STATE/TERRITORY	FY 2004 Actual	FY 2005* Appropriation	FY 2006** Estimate	Difference +/- 2005
Alabama	$12,142,447			
Alaska	974,705			
Arizona	11,648,614			
Arkansas	4,933,831			
California	121,425,527			
Colorado	8,420,061			
Connecticut	15,175,723			
Delaware	5,340,795			
District of Columbia	18,323,488			
Florida	111,668,948			
Georgia	36,143,569			
Hawaii	3,298,130			
Idaho	1,019,352			
Illinois	34,870,568			
Indiana	11,402,950			
Iowa	2,067,375			
Kansas	3,061,160			
Kentucky	7,170,005			
Louisiana	22,953,426			
Maine	1,333,909			
Maryland	34,509,971			
Massachusetts	20,190,874			
Michigan	15,455,849			
Minnesota	4,059,707			
Mississippi	9,454,950			
Missouri	10,250,137			
Montana	847,196			
Nebraska	1,887,660			
Nevada	6,456,309			
New Hampshire	1,257,028			
New Jersey	47,641,537			
New Mexico	3,338,463			
New York	169,263,213			
North Carolina	22,655,805			
North Dakota	292,543			

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH RESOURCES AND SERVICES ADMINISTRATION FY 2006 DISCRETIONARY STATE/FORMULA GRANTS CFDA NUMBER/PROGRAM NAME: 93.917 HIV CARE FORMULA GRANTS				
STATE/TERRITORY	**FY 2004 Actual**	**FY 2005* Appropriation**	**FY 2006** Estimate**	**Difference +/- 2005**
Ohio	16,762,266			
Oklahoma	6,343,022			
Oregon	5,902,627			
Pennsylvania	38,316,474			
Rhode Island	3,189,276			
South Carolina	20,705,328			
South Dakota	705,706			
Tennessee	21,178,234			
Texas	76,009,370			
Utah	3,235,191			
Vermont	883,059			
Virginia	22,525,348			
Washington	11,121,586			
West Virginia	2,175,400			
Wisconsin	5,588,912			
Wyoming	360,347			
Subtotal	**$1,015,937,971**			
Indian Tribes	0			
Migrant Programs	0			
American Samoa	52,314			
Guam	145,778			
Marshalls	52,314			
Micronesia	50,000			
Northern Marianas	54,627			
Palau	50,000			
Puerto Rico	33,759,339			
Virgin Islands	1,048,657			
Subtotal	**$35,213,029**			
Total States/Territories* **	**$1,051,151,000**			
Technical Assistance	0			
Other Adjustments ****	$34,749,000			
Subtotal Adjustments	**$34,749,000**			
TOTAL RESOURCES	**$1,085,900,000**	**$1,121,836**	**$1,131,836**	

**Fiscal Year 2005 grant amounts pending award calculations in March 2005*

***Fiscal Year 2006 grant amounts can not be estimated because, under current law, the formula used to determine the grant amount must include the number of AIDS cases in the states as reported to the CDC for the most recent 120 month period. The current "cut-off" date is June 30 preceding the fiscal year for which the grant allocation is awarded.*

**** Total State Grants include or would include amounts for AIDS Drug Assistance Programs as follows:*

FY 2004: $748,872,000 (including 3% setaside for severe need supplemental).

FY 2005: $787,521,000 (including 3% setaside for severe need supplemental).

FY 2006: $797,521,000 (including setaside for severe need supplemental).

*****Includes amount for technical assistance to CARE Act grantees, and program evaluation.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES				
FY 2006 DISCRETIONARY STATE/FORMULA GRANTS				
CFDA NUMBER/PROGRAM NAME: 93.003/HOSPITAL PREPAREDNESS (BIOTERRORISM)				
	FY 2004	FY 2005	FY 2006	Difference
STATE/TERRITORY	Actual	Conference	Estimate	+/- 2005
Alabama	7,762,315			
Alaska	1,958,803			
Arizona	9,030,450			
Arkansas	5,077,591			
California	38,773,726			
Colorado	7,704,930			
Connecticut	6,197,207			
Delaware	2,205,406			
District of Columbia	2,868,302			
Florida	25,775,967			
Georgia	13,719,390			
Hawaii	2,856,721			
Idaho	2,998,297			
Illinois	15,875,995			
Indiana	10,270,929			
Iowa	5,436,624			
Kansas	5,088,830			
Kentucky	7,156,894			
Louisiana	7,764,518			
Maine	2,943,648			
Maryland	9,150,163			
Massachusetts	10,686,180			
Michigan	16,141,386			
Minnesota	8,542,551			
Mississippi	5,327,321			
Missouri	9,530,322			
Montana	2,370,015			
Nebraska	3,602,747			
Nevada	4,174,253			
New Hampshire	2,905,650			
New Jersey	13,878,940			
New Mexico	3,770,553			
New York	18,019,873			
North Carolina	13,417,400			
North Dakota	1,963,221			

STATE/TERRITORY	FY 2004 Actual	FY 2005 Conference	FY 2006 Estimate	Difference +/- 2005
Ohio	18,234,914			
Oklahoma	6,250,131			
Oregon	6,255,978			
Pennsylvania	19,616,940			
Rhode Island	2,603,466			
South Carolina	7,146,769			
South Dakota	2,147,489			
Tennessee	9,699,934			
Texas	33,338,368			
Utah	4,448,125			
Vermont	1,927,552			
Virginia	11,890,053			
Washington	10,069,141			
West Virginia	3,725,218			
Wisconsin	9,180,227			
Wyoming	1,747,144			
Subtotal	**324,929,176**			
American Samoa	601,511			
Guam	738,414			
Northern Mariana Islands	612,902			
Puerto Rico	6,808,171			
Virgin Islands	-			
Federated States of Micronesia	703,671			
Marshall Islands	58,170			
Republic of Palau	528,890			
City of Chicago	5,069,493			
New York City	12,858,383			
Los Angeles County	15,583,364			
Total States/Territories	**$496,791,536**	**$465,000,000**	**$435,000,000**	
TOTAL RESOURCES	**$496,791,536**	**$465,000,000**	**$435,000,000**	

Detail of Full-Time Equivalent (FTE) Employment

HRSA FTE 1/	2004 Actual	2005 Estimate	2006 Estimate	2006 +/- 2005
Direct Program FTE:				
Health Center Loan Guarantee/Tort	20	20	20	-
Healthy Community Access Program	12	12	-	-12
Hansen's Disease Center	94	91	91	-
Radiogenic Diseases	2	2	2	-
National Health Service Corps	71	75	75	-
Children's Hospitals Graduate Medical Education Program	8	9	9	-
Maternal and Child Health Block Grant	1	-	-	-
Universal Newborn Hearing	2	2	-	-2
Poison Control Centers	3	3	3	-
Trauma/Emergency Medical Services	1	1	-	-1
Early Intervention - Part C	27	30	30	-
Health Facilities Construction and Other Directed Projects	11	12	-	-12
Bone Marrow Donor Registry	5	5	5	-
State Planning Grant Program	4	4	-	-4
Rural & Community Access to Emergency Devices	2	2	2	-
Rural EMS	1	1	-	-1
Free Clinics Medical Malpractice	1	2	2	-
Cord Blood Stem Cell Bank	-	1	1	1
Family Planning	46	49	49	-
Subtotal, Program	**311**	**321**	**289**	**-32**
Program Management	**1,186**	**1,229**	**1,229**	**-**
Total, Direct Appropriation	**1,497**	**1,550**	**1,518**	**-32**
Ceiling Exempt:				
National Health Service Corps	53	80	80	-
Total HRSA Direct and Ceiling Exempt	**1,550**	**1,630**	**1,598**	**-32**
Bioterrorism Programs (PHSSEF Approp):				
Hospital Preparedness	22	33	35	2
Educational Incentive for Curriculum Development & Trng	4	5	5	-
Smallpox Vaccine Compensation	5	8	8	-
Total, Bioterrorism Programs	**31**	**46**	**48**	**2**
Total HRSA Direct, Ceiling Exempt, and Bioterrorism Programs	**1,581**	**1,676**	**1,646**	**-30**

Average GS Grade:	
2001	13.3
2002	12.9
2003	12.9
2004	12.9
2005	11.5

1/ FTE levels in FY 2005 and FY 2006 differ from those printed in the Appendix of the Budget of the United States

BUDGET AND PERFORMANCE CROSSWALK
(Dollars in Thousands)

Program Performance Area (PPA)	Budget Activity	FY 2004 Enacted	FY 2005 Appropriation	FY 2006 Request
Health Centers	1. Health Centers	$1,572,895	$1,689,671	$1,992,871
	2. Health Center Tort Claims	44,734	44,640	45,000
	Subtotal	1,617,629	1,734,311	2,037,871
Hansen's Disease Activities	1. Hansen's Disease Center	17,413	17,251	16,066
	2. Payment to Hawaii	2,033	2,017	2,016
	3. Buildings and Facilities	249	247	222
	Subtotal	19,965	19,515	18,304
Black Lung	Black Lung	5,963	5,951	5,912
Other Primary Care*	1. Free Clinics Med. Malpract.	4,821	99	0
*No GPRA/PART measures	2. Radiation Exposure Compensation Act	1,974	1,958	1,936
	3. Healthy Community Access	83,425	82,993	0
	Subtotal	90,220	85,050	1,936
National Health Service Corps.	1. NHSC-Field	45,446	45,068	40,705
	2. NHSC-Recruitment	124,457	86,380	86,091
	Subtotal	169,903	131,448	126,796
Health Professions	1. Centers of Excellence	33,657	33,609	0
	2. Scholarship for Disadvant.	47,510	47,129	9,831
	3. Loan Repay./Fac. Fellow.	1,313	1,302	0
	4. Health Careers Opportunity	36,160	35,646	0
	5. Primary Care Med./Dentistry	81,917	88,816	0
	6. Area Health Educ.Centers	29,206	28,971	0
	7. Health Educ./Train. Centers	3,851	3,819	0
	8. Geriatric Programs	31,805	31,548	0
	9. Quentin N. Burdick Program	6,125	6,076	0
	10. Allied Health and Other	11,674	11,753	0
	11. Workforce Infor./Analysis	722	716	712
	12. PH/Prev. Med./Dental PH	9,170	9,097	0
	13. Health Administration	1,078	1,070	0
	14. Advanced Educ. Nursing	58,636	58,160	42,806
	15. Nursing Workforce Diver.	16,402	16,270	21,244
	16. Nurse Ed., Pract./Retention	31,769	36,468	46,325
	17. Nurse Faculty Loan Prog.	4,870	4,831	4,821
	18. Comp. Geriatric Program	3,478	3,450	3,426
	Subtotal	409,343	418,731	129,165
Workforce Information/Analysis	Workforce Inform./Analysis	722	716	712
Nur. Ed. Loan Repay/Scholarship	Nur. Ed. Loan Repay/Scholar.	26,736	31,482	31,369
BioT Training/Curriculum Dev.	BioT Training/Curriculum Dev.	27,706	27,520	27,521
Children's Hosp. GME Payment	Children's Hosp. GME Pay.	303,169	300,730	200,000
Practitioner Data Banks	1. Nat. Pract. DB(uf)	16,000	15,700	15,700
	2. Healthcare Integrity DB(uf)	4,000	4,000	4,000
	Subtotal	20,000	19,700	19,700
Health Education Assistance Loans (HEAL)	Health Education Assistance Loans (HEAL)	3,353	3,244	2,916

Program Performance Area (PPA)	Budget Activity	FY 2004 Enacted	FY 2005 Appropriation	FY 2006 Request
Maternal/Child Health Blk Grant	Mater./Child Health Blk Grant	729,817	723,928	723,928
Traumatic Brain Injury	Traumatic Brain Injury	9,375	9,297	0
Healthy Start	Healthy Start	97,751	102,543	97,747
Newborn Hearing Screening	Newborn Hearing Screening	9,873	9,792	0
Emergency Med. Serv./Children	Emergency Med. Serv./Children	19,860	19,831	0
Other MCH Programs* *No GPRA/PART Measures	Sickle Cell Service Demonstration	0	198	0
AIDS/HIV-Titles I-IV	1. Part A 2. Part B 3. Part C 4. Part D Subtotal	615,023 1,085,900 197,170 73,108 1,971,201	610,094 1,121,836 195,578 72,519 2,000,027	610,094 1,131,836 195,578 72,519 2,010,027
AIDS/HIV-Part A	AIDS/HIV-Part A	615,023	610,094	610,094
AIDS/HIV-Part B	AIDS/HIV-Part B	1,085,900	1,121,836	1,131,836
AIDS/HIV-Part C	AIDS/HIV-Part C	197,170	195,578	195,578
AIDS/HIV-Part D	AIDS/HIV-Part D	73,108	72,519	72,519
AIDS Educ./Training Program	AIDS Educ./Training Program	35,335	35,051	35,051
AIDS Dental Services Program	AIDS Dental Services Program	13,325	13,218	13,218
Telehealth	Telehealth	3,949	3,916	3,888
Organ Transplantation	Organ Transplantation	24,632	24,413	23,282
National Bone Marrow Program	National Bone Marrow Prog.	22,662	25,416	22,916
Poison Control Program	Poison Control Program	23,696	23,499	23,301
Nat. BioT Hosp. Preparedness	Nat. BioT Hosp. Preparedness	514,943	491,410	482,979
Trauma/Emergency Med. Services	Trauma/Emerg. Med. Services	3,449	3,419	0
Vaccine Injury Compensation	Vaccine Injury Compensation	3,190	3,126	2,828
Other Healthcare Systems Programs* *No GPRA/PART measures	1. Cord Blood Stem Cell Bank 2. State Planning Grant Prog. Subtotal	9,941 14,810 24,751	9,859 10,910 20,769	0 0 0
Rural Health Activities	1. Rural Health Policy Dev. 2. Rural Health Outreach 3. Rural & Comm. AED 4. Rural Hosp. Flexibility 5. Rural EMS 6. State Offices of RH 7. Denali Project Subtotal	8,902 39,601 10,933 39,499 497 8,390 34,794 142,616	8,825 39,278 8,927 39,180 496 8,321 39,680 144,707	8,528 10,767 1,960 0 0 8,223 0 29,478
Rural Health Policy Dev.	Rural Health Policy Dev.	8,902	8,825	8,528
Rural Health Outreach Grants	Rural Health Outreach Grants	39,601	39,278	10,767

Program Performance Area (PPA)	Budget Activity	FY 2004 Enacted	FY 2005 Pres. Budget	FY 2006 Request
Rural Hosp. Flexibility Grants	Rural Hosp. Flexibility Grants	39,499	39,180	0
State Offices of Rural Health	State Offices of Rural Health	8,390	8,321	8,223
Program Management	Program Management	148,533	147,080	145,992
Family Planning	Family Planning	278,283	285,963	285,963
OPDIV TOTAL REQUEST		$7,187,494	$7,373,039	$6,527,092

DETAILS OF PERFORMANCE ANALYSIS
(Section U)

Introduction

This section provides details on HRSA's performance in working toward its mission of providing the national leadership, resources and services necessary to improve access to culturally competent, quality health care, with a particular focus on uninsured, underserved and special needs populations. HRSA is pleased to report, as summarized earlier in the budget narratives and as shown in the following detailed tables and discussion, that HRSA programs are generally meeting or exceeding performance targets.

HRSA's long-range strategies and sub-objectives, which support its mission, provide the organizing framework for this presentation of performance information which complies with the requirements of the Government Performance and Results Act. For each HRSA program activity, performance tables are provided that present performance measures, performance targets, actual performance results, and information on the program's budget. These tables are followed by an analysis of performance for each performance measure.

The goals and measures identified or developed during Program Assessment Rating Tool (PART) reviews are included for all relevant programs. For most of these programs, the PART measures are integrated in the standard performance reporting tables, with a notation in the reference column identifying them as PART measures. For Titles I-IV of the Ryan White CARE Act Program and the Rural Health Program, PART measures are presented in a separate table at the beginning of the relevant program section because these measures are cross-cutting and intended to reflect the combined performance of various program components.

HRSA's program efforts are consistent with and supportive of the strategic goals of the Department of Health and Human Services. The tabular presentations include a crosswalk between the HRSA's outcome measures and the Department's strategic goals. Further, a table is included that shows illustrative examples of how HRSA's performance goals and measures support the Department's strategic goals.

Healthy People 2000/2010 goals and objectives also serve as a foundation for a number of HRSA's performance measures. The performance tables indicate the linkage between HRSA's performance measures and Healthy People objectives.

For performance measures that do not have FY 04 data yet, the performance tables show the month/year in which data are expected. Where there is a delay in reporting data, the most common reasons are: the time it takes for grantees to provide reports of end-of-year progress, the periodicity related to reporting requirements, and the availability of data from non-grantee sources (e.g., vital statistics). Also some performance measures are reported on a multi-year versus yearly basis. Information about data sources and quality is provided, where appropriate, as notes to the performance tables and also in a later section of this document on "Data Verfication and Validation." HRSA, in conjunction with its partners and stakeholders, continues to work on further improving the collection, analysis and reporting of timely and accurate performance data and using these data to inform decision making.

DETAILS OF PERFORMANCE ANALYSIS

CONTENTS

U.A – Primary Care

U.A.1. Health Centers
U.A.2. Hansen's Disease Activities
U.A.3. Black Lung Clinics

U.B – Health Professions

U.B.1. National Health Service Corps (NHSC)
U.B.2. Health Professions and Nursing Education and Training Programs
U.B.3. Workforce Information and Analysis
U.B.4. Nursing Education Loan Repayment and Scholarship Program (NELRP)
U.B.5. Bioterrorism Training and Curriculum Development
U.B.6. Children's Hospitals Graduate Medical Education Payment Program (CHGMEPP)
U.B.7. Practitioner Data Banks (NPDB and HIPDB)
U.B.8. Health Education and Assistance Loans (HEAL) Program

U.C – Maternal and Child Health

U.C.1. Maternal and Child Health Block Grant-Title V
U.C.2. Traumatic Brain Injury
U.C.3. Healthy Start
U.C.4. Universal Newborn Hearing and Screening
U.C.5. Emergency Medical Services for Children

U.D – HIV/AIDS Programs

U.D.1. HIV/AIDS Ryan White CARE Act (Overall—Titles I-IV)
U.D.2. HIV Emergency Relief Grants (Part A)
U.D.3. HIV Care Grants to States (Part B)
U.D.4. HIV Early Intervention Services (Part C)
U.D.5. HIV Children, Youth, Women, Families Grants (Part D)
U.D.6. AIDS Education and Training Centers (Part F)
U.D.7. Dental Reimbursement Program (Part F)

U.E – Telehealth

U.E.1. Telehealth

U.F – Special Programs

U.F.1. Organ Procurement and Transplantation
U.F.2. National Bone Marrow Donor Registry Program
U.F.3. Poison Control
U.F.4. National Bioterrorism Hospital Preparedness Program
U.F.5. Trauma/Emergency Medical Services
U.F.6. Vaccine Injury Compensation Program

U.G – Rural Health

U.G.1. Rural Health Activities (Overall)
U.G.2. Rural Health Policy Development
U.G.3. Rural Health Outreach Grants
U.G.4. Rural Hospital Flexibility Grants
U.G.5. State Offices of Rural Health

U.H – Program Management

U.H.1. Program Management

U.I – Family Planning

U.I.1. Family Planning

U.A PRIMARY HEALTH CARE

Programs included in this section are:

U.A.1. Health Centers
U.A.2. Hansen's Disease Activities
U.A.3. Black Lung Clinics

U.A.1. Program Title: Health Centers

Performance Goals	Targets	Actual Performance	Reference
I. IMPROVE ACCESS TO HEALTH CARE **A. Expand the capacity of the health care safety net** **Long-Term Goal** By 2006, establish an additional 1,200 new or expanded sites and serve 6.1 million more patients. **(Outcome)** **Short-Term Goal** 1. Increase the number of uninsured and underserved persons served by Health Centers. **(Outcome)**	FY 06: 16.4 M FY 05: 14.0 FY 04: 13.2 FY 03: 12.5 FY 02: 11.75 FY 01: 10.5 FY 00: 9.6	FY 04: (8/05) FY 03: 12.4 FY 02: 11.32 FY 01: 10.3 FY 00: 9.6	 **NEW** **FY 03** **DATA** **PART** 3
Short-Term Goal 2. Increase the infrastructure of the Health Center Program to support an increase in utilization, via: a) New Starts	FY 06: 138 FY 05: 43 FY 04: 31 FY 03: 40 FY 02: 43		**PART** 3
b) New Satellite Sites	FY 06: 137 FY 05: 47 FY 04: 30 FY 03: 60 FY 02: 87		3
Total New Sites	FY 06: 275* FY 05: 90 FY 04: 61 FY 03: 100 FY 02: 130	FY 04: 63 FY 03: 100 FY 02: 171	**NEW** **FY 04** **DATA**
Total Sites	FY 06: 4,016* FY 05: 3,741 FY 04: 3,649 FY 03: 3,588 FY 02: 3,447 FY 01: 3,317	FY 04: 3,651 FY 03: 3,588 FY 02: 3,488 FY 01: 3,317	**NEW** **FY 04** **DATA**
c) Expanded Sites	FY 06: 303 FY 05: 63 FY 04: 63 FY 03: 80 FY 02: 130	FY 04: 66 FY 03: 88 FY 02: 131	**NEW** **FY 04** **DATA**
d) Total New or Expanded Sites **(Outcome)**	FY 06: 578* FY 05: 153 FY 04: 124 FY 03: 180 FY 02: 260	FY 04: 129 FY 03: 188 FY 02: 302	**NEW** **FY 04** **DATA**

*Does not include an estimated 40 new access points from the proposed new initiative to assist high-poverty counties without health center sites as described in the Health Center budget narrative.

Performance Goals	Targets	Actual Performance	Reference
3. Increase the percent of grantees that provide the following services either on-site or by paid referral: a) Pharmacy	FY 06: 83% FY 05: 83% FY 04: 83%	FY 04: (8/05) FY 03: 83% FY 02: 83% (baseline)	NEW FY 03 DATA
b) Preventive Dental Care	FY 06: 83% FY05: 83% FY 04: 83%	FY 04: (8/05) FY 03: 83% FY 02: 82% (baseline)	NEW FY 03 DATA
c) Mental Health/Substance Abuse	FY 06: 74% FY 05: 74% FY 04: 74%	FY 04: (8/05) FY 03: 74% FY 02: 71% (baseline)	NEW FY 03 DATA
4. Increase the number of grant applicants that are faith-based or community-based organizations.	FY 06: +5% FY 05: +5%	FY 04: Baseline determined by 3/05 FY 03: Survey implemented	
II. IMPROVE HEALTH OUTCOMES **A. Expand the availability of health care, particularly to underserved, vulnerable, and special needs populations** **Long-Term Goal** By 2006, assure access for the nation's most vulnerable by serving 16% of its estimated population at or below 200% of poverty. **(Outcome)** **Short-Term Goal** 1. Continue to assure access to preventive and primary care for low income individuals (i.e., % of patients at or below 200% of poverty; % of nation's poor served). **(Outcome)**	FY 06: 86% 14.06 M (16%) FY 05: 86% 12.00 M (15%) FY 04: 86% 11.35 M (14%) FY 03: 86% 10.79 M (13%) FY 02: 86% 10.11 FY 01: 86% 9.03 FY 00: 86% 8.26	FY 04: (8/05) FY 03: 90% (11.12M) (12.4%) FY 02: 88% (10.01M) (12%) FY 01: 88% (9.07 M) (11%) FY 00: 87% (8.35 M) (10%)	PART NEW FY 03 DATA
2. Continue to assure access to preventive and primary care for racial/ethnic minorities. **(Outcome)**	FY 06: 65% 10.63 M FY 05: 65% 9.07 M FY 04: 65% 8.58 FY 03: 65% 8.16 FY 02: 65% 7.64 FY 01: 65% 6.83 FY 00: 65% 6.24	FY 04: (8/05) FY 03: 64% (7.92M) FY 02: 64% (7.24 M) FY 01: 64% (6.62 M) FY 00: 64% (6.18 M)	NEW FY 03 DATA 3
3. Continue to assure access to preventive and primary care for uninsured individuals. **(Outcome)**	FY 06: 41% 6.70 M FY 05: 41% 5.72 FY 04: 41% 5.41 FY 03: 41% 5.15 FY 02: 41% 4.82 FY 01: 45% 4.73 FY 00: 43% 4.10	FY 04: (8/05) FY 03:39% (4.87M) FY 02: 39% (4.41 M) FY 01: 39% (4.00 M) FY 00: 40% (3.86 M)	NEW FY 03 DATA 3

Performance Goals	Targets	Actual Performance	Reference
B. Increase the utilization of preventive health care and chronic disease management services, particularly among underserved, vulnerable, and special needs populations. 1. Increase percent of adult diabetic patients with at least one testing of glycohemoglobin annually. **(Outcome)**	FY 06: 71% HP2010: 50% FY 05: 71% FY 04: 75%	FY 04: (8/05) FY 03: 70.9% (124K)* FY 02: 74.8% (47,600) FY 01: 77.2% (29,800) FY 00: 85.6% (19,100) * # patients in registry	**HP - 5** **NEW** **FY 03** **DATA** 1,5
Long-Term Goal By 2006, reduce low birth weight rates in Health Centers to 6.53%, consistent with Healthy People 2010 goal. **(Outcome)** **Short-Term Goal** 2. Decrease percent of births to Health Center prenatal care patients below 2500 grams (LBW). **(Outcome)**	FY 06: 6.53% HP2010: 6% FY 05: 7.05% FY 04: 7.05% FY 03: 6.89% FY 02: 7.01%	FY 04: (8/05) FY 03: 7.05% FY 02: 6.95% FY 01: 7.13% FY 00: 7.14%	**PART** **HP - 16** **NEW** **FY 03** **DATA** 1
3. Increase percent of Health Center women receiving age-appropriate screening for cervical and breast cancer. a) Up-to-date PAP tests **(Outcome)**	FY 06: 90% HP2010: 90% FY 05: D/N/A FY 04: D/N/A FY 03:D/N/A FY 02: 95% HP2000: 85%	FY 04: D/N/A FY 03: D/N/A FY 02: 87.6% FY 99-01: D/N/A FY 95: 88.5%	**HP - 3** 1,5
b) Up-to-date mammograms **(Outcome)**	FY 06: 70% HP2010: 70% FY 05: D/N/A FY 04: D/N/A FY 03: D/N/A FY 02: 75% HP2000: 60%	FY 04: D/N/A FY 03: D/N/A FY 02: 75.7% (age 40+) FY 99-01: D/N/A FY 95: 62.5% (age 50+)	**HP - 3** **NEW** **FY 02** **DATA** 1,5
c) Up-to-date clinical breast exams **(Outcome)**	FY 06: 85% FY 05: D/N/A FY 04: D/N/A FY 03: D/N/A FY 02: 86%	FY 04: D/N/A FY 03: D/N/A FY 02: 80.9% FY 99-01: D/N/A FY 95: 80.5%	1,5

Performance Goals	Targets	Actual Performance	Reference
4. Increase percent of Health Center adults with hypertension who report their blood pressure is under control. **(Outcome)**	FY 06: 90% HP2010: 50% FY 05: D/N/A FY 04: D/N/A FY 03: D/N/A FY 02: 96% HP2000: 50%	FY 04: D/N/A FY 03: D/N/A FY 02: 91% FY 99-01: D/N/A FY 95: 90%	**HP - 12** 1,5
Efficiency Measures 1. Sustain the average cost per individual served at Health Centers. 2. Sustain the annual number of encounters per medical worker.	FY 06: $526 FY 05: $511 FY 04: $496 FY 03: $465 FY 06: 3,475 FY 05: 3,475 FY 04: 3,475 FY 03: 3,475	FY 04: (8/05) FY 03: $492 FY 02: $477 FY 01: $448 FY 04: (8/05) FY 03: 3,521 FY 02: 3,527 FY 01: 3,528	**NEW FY 03 DATA**
Deleted Measure(s) 1. Increase percent of diabetic patients with up-to-date testing of glycohemoglobin – % adults with diabetes tested at recommended intervals. **(Outcome)** 2. Decrease the relative likelihood of Health Center patients hospitalized for potentially avoidable conditions. **(Outcome)**	FY 05: NA FY 04: NA FY 03: 90% FY 02: 90% FY 01: 90% FY 00: 80% FY 06: N/A FY 05: N/A FY 04: N/A FY 03: 10.0 less likely FY 02: 10.0 FY 01: 10.0 FY 00: 10.0 FY 99: 10.0	FY 04: NA FY 03: 34% FY 02: 40% FY 01: 45% FY 00: 40% FY 04: N/A FY 03: TBD FY 02: (9/10) FY 01: (9/08) FY 00: (9/06) FY 99: D/N/A FY 98: 11% less likely than USC* control group (1995) FY 97: 22% less likely than control group (1992) *USC: Usual source of care	**NEW FY 03 DATA** 1,5 1,5

Performance Goals	Targets	Actual Performance	Reference
Total Funding: Health Centers ($ in 000s)	FY 06: $2,037,871 FY 05: $1,734,311 FY 04: $1,617,629 FY 03: $1,505,055 FY 02: $1,343,175	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal\	

D/N/A=data not available

Program Performance Analysis

Long-Term Goal

By 2006, establish an additional 1,200 new or expanded sites and serve 6.1 million more patients.

Goal I.A.1. Increase the number of uninsured and underserved persons served by Health Centers.

(Indicator: Total number of clients served in underserved areas)

Health Centers play an essential role in the Nation's safety net, providing primary care to 20% of the more than 50 million underserved persons in federally designated underserved areas lacking access to primary care providers. For example, a recent OIG report, "Federally Funded Health Centers and Low Income Children's Health Care - Improving SCHIP Enrollment and Adapting to a Managed Care Environment," highlighted the important role of Health Centers in delivering care to children covered by SCHIP and noted that Health Centers can serve as one of the most appropriate agents for enrolling children in SCHIP.

In 2003, according to data retrieved from the Bureau's Uniform Data System (UDS):

1. 890 Health Centers (nearly 3,600 sites) served 12.4 million patients in nearly 50 million encounters at an average cost per user of about $492 dollars.
2. Approximately 40% of patients are under the age of 19, and nearly than 1.3 million of those children are uninsured.
3. HRSA grant dollars represent 24% of Health Centers' revenues.
4. Medicaid revenues have risen from 34% in 2001 to 35% in 2002 and to 36% in 2003. Although the proportion of uninsured patients has remained at 39%, the number of uninsured patients has increased from 3,999,758 in 2001 to 4,405,301 in 2002 to 4,872,045 in 2003.

The 12.4 million patients that were served by the Centers in CY 03 was less than 1% below the target, and it is estimated that the figure will rise in CY 04 to over 13.2 million, exceeding the 04 goal. The CY 03 figure of 12.4 is more than 1 million additional patients served than in CY 02. This was the second year in a row that the program recorded more than a 1 million increase. The program had not ever achieved a 1 million annual increase prior to 2002. New access points established in FY 03 will reach their potential in 2-3 years. Data on the total number of patients served in CY 04 will be available by August, 2005.

Goal I.A.2. Increase the infrastructure of the Health Center Program to support an increase in utilization.

(Indicator: Total number of new or expanded sites)

CY 03 data reveal 12.4 million served at 3,588 sites, meeting the goal for new and expanded sites. In CY 04, the total number of access points reached 3,651, slightly exceeding the goal of 3,649. Together with significant expansion of 66 existing sites, the total increase in infrastructure will ensure access to care for 800,000 more individuals for a total of 13.2 million in CY 04. These figures will rise to 3,741 sites and 14.0 million patients served in 2005. Performance for new and expanded sites will be tracked by UDS, differentiating between new starts and new satellite starts through grant applications.

Goal I.A.3. Increase the percent of grantees that provide pharmacy, preventive dental care, and mental health/substance abuse services either on-site or by paid referral.

Access to pharmacy, oral health, and mental health/substance abuse (MH/SA) services is critical to ensuring overall health and well-being of Health Centers' populations. Inadequate access to pharmacy services often leads to problems with drug interactions, inappropriate doses, and failure to adhere to prescribed therapy. Lack of access to oral health care services is the primary reason for significant disparities in oral health status among vulnerable populations. MH/SA disorders, such as depression and abuse of alcohol are prevalent among underserved populations, and treatment is not accessible in many local communities. These conditions may be prevented or managed through the expansion or improvement of existing primary health care services. Service expansion grants establish pharmacy, oral health, or mental health/substance abuse services at Health Centers without these services, or expand existing services by adding a new service component. A large percentage of these awards fund credentialed positions or contracts with other clinicians (e.g., Community Mental Health Centers) to provide on-site services.

Of the 890 grantees reporting in 2003, 83% reported that they provided pharmacy services either on-site or by paid referral. The figures for dental care and mental health substance abuse services were 83% and 74%, respectively. Overall, the percent of Health Centers providing these services has increased between 2002 and 2003. Pharmacy services remained stable in 2003. Preventive dental care increased 1 percentage point, and mental health/substance abuse services increased 3

percentage points. However, these services fell either 1 or 2 percentage points below their 2003 targets. Forecasts for FY 04 - FY 06 were based on earlier percentage point increases and the expectation that service expansion activities for existing grantees in the President's Health Centers Initiative would be fully funded through 2006, and that new grantees are required to provide these services. Beginning in FY 04, actual resources for service expansions have been reduced (eliminated in 2006). The small number of additional grantees providing these services is not sufficient to increase the overall percentages of health centers providing these services. Thus, FY 04 - 06 forecasts have been reduced and leveled. HRSA uses calendar year UDS figures to track the expansion of these services. CY 04 data are expected in August, 2005.

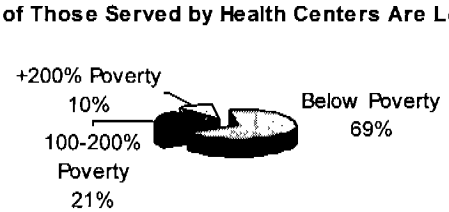
Goal I.A.4. Increase the number of grant applicants that are faith-based or community-based organizations.

To facilitate improved access to care, Health Centers are sponsored by or partner with community-based organizations that build the program's capacity to reach persons in underserved areas. Among the organizations HRSA funds are nonprofit, faith-based and community-based entities. As part of its continuing outreach to smaller, community-based organizations, the Agency continues to partner with organizations that advocate for community development, homelessness, youth, and women to assure a variety of faith/community-based sponsors as applicants for Health Center funding. Enabling services provided by Health Centers are enhanced by these partnerships and/or contracts.

The Agency proposes to measure performance on this measure using a baseline developed from several sources including information gathered in a FY 03 HHS survey of applicants. The FY 05 target will be a 5% increase over the baseline and no additional increase is projected for FY 06.

Long-Term Goal

By 2006, assure access for the nation's most vulnerable by serving 16% of the nation's estimated population at or below 200% of poverty.



Goal II.A.1. Continue to assure access to preventive and primary care for low income individuals.

(Indicator: Percent of Health Center patients at or below 200 percent of poverty; percent of nation's poor served by Health Centers)

To eliminate health disparities, safety-net programs must target access to care for people of low income who are uninsured.

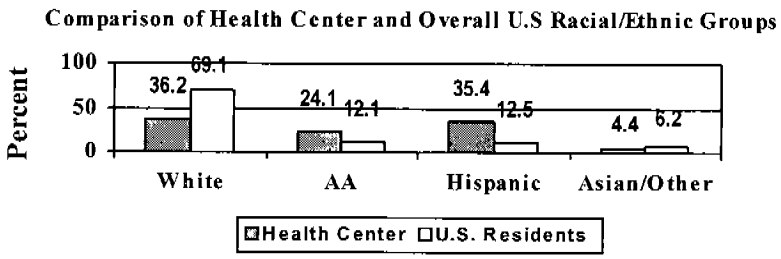
According to estimated UDS Health Center data, 90 percent of patients were at or below 200 percent of the Federal poverty level in CY 03, 4 percentage points above the target, amounting to an estimated 12.4% of the nation's population below 200% of the poverty level. It should be pointed out that 90% of 12.4 million patients served (11.12 million) results in a population at or below 200% of poverty that is more than 3% above the target (10.79 million). The percent of patients at or below 200% of poverty has risen for the eighth year for which UDS data have been collected. Health Centers' serve 12.4% of the Nation's population that is 200% below the poverty level and one quarter by the Nation's population below poverty. With market pressures, it will be a challenge for service delivery sites to continue to serve such a percentage of patients in poverty and maintain a targeted level of 86%. Data on actual performance is based on annual UDS Health Center data for CY 00 - CY 03, with CY 04 UDS data available in August, 2005.

Goal II.A.2. Continue to assure access to preventive and primary care for racial/ethnic minorities.

(Indicator: Proportion of Health Center patients that are underserved minorities)

To eliminate health disparities, safety-net programs must target access to care for people of racial/ethnic minority groups, of low income, and who are uninsured.

According to UDS Health Center data, in CY 03 the population served included 24.1 percent African American (AA), 35.4 percent Hispanic, and 4.4 percent Asian/Other, for a total of 64% - just 1 percentage point below the target. These percentages represent almost twice the percentage of African Americans and three times the percentage of Hispanics reported in the overall U.S. population.

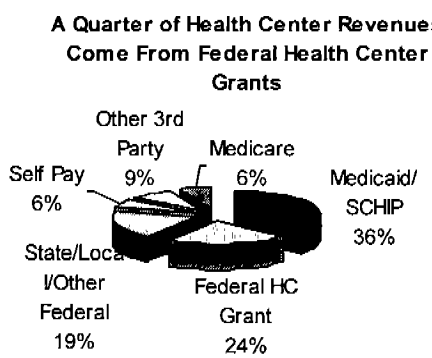


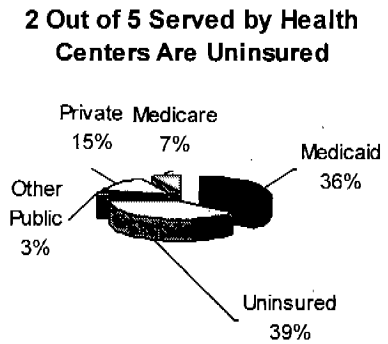
With market pressures it will be a challenge for service delivery sites to continue to serve such a large minority population. It is currently estimated that the targeted percentage of minority patients percentage will hold steady at about 65%. These estimates come from annual UDS Health Center data for CY 00 - 03, with CY 04 UDS data available in August, 2005.

Goal II.A.3. Continue to assure access to preventive and primary care for uninsured individuals. (Indicator: Proportion of Health Center patients that are uninsured)

To eliminate health disparities, safety-net programs must target access to care for people of racial/ethnic minority groups, of low income, and who are uninsured. According to UDS Health Center data, in CY 03 the population served included nearly 4.9 million uninsured, which was 39.3% of the client population served, 2 percentage points below the target.

- More than one quarter or 1.3 million of the uninsured are children.
- In two of five Health Centers, more than 50% of patients are uninsured.
- About 75% of Health Center patients are either uninsured or Medicaid recipients.





Recent research reveals that caseloads of private physicians in the primary care specialties include 4% uninsured and 7% Medicaid for a total of 11% (Source: 2001 National Ambulatory Medical Care Survey), down from the 19% in the previous study (Source: 1998 National Ambulatory Medical Care Survey). Primary care clinics in hospital outpatient departments include 12% uninsured and 38% Medicaid for a total of 50% (Source: Whelan and Forrest, APHA presentation, 1998). Another, more recent report noted that private physicians' charity care averaged:

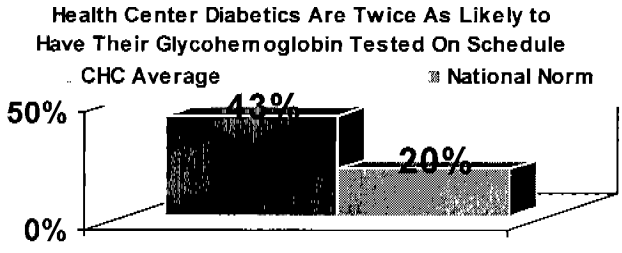
- 10 hours per month for those who did not participate in managed care.
- Less than 5 hours for those with 85% or more revenues attributed to managed care (Source: Cunningham, et al. JAMA, 1999).

With market pressures increasing, Health Center service delivery sites will be challenged to even maintain their role in serving such an uninsured population. Although the uninsured in the nation increased steadily from 1990 -1998, the number first dropped in 1999 to 42.6 (39.3 for new definition), dropped again in 2000 to 38.7 million. However, the FY 01 recession and the events of September 11, 2001 drove the national number back up over 40 million and reached 43.6 million in CY02 and 45 million in CY 03. National data also reveal that 30% of poor and 27% of near-poor patients are uninsured, which would indicate that Health Centers are still serving a greater share of the uninsured at 39% of the patient population as compared to private physicians and hospital outpatient departments. At Health Centers, efforts to increase SCHIP enrollment through outreach have shifted the uninsured to the publicly-insured, as about 40% of Health Center patients are children and one-quarter of them are uninsured. However, evidence suggests that insurance coverage for vulnerable people is largely inadequate for primary care which would effectively shift the insured to the ranks of the underinsured. Even the best medical insurance coverage does not provide reimbursement for the non-medical or enabling services that vulnerable patients need to reduce or eliminate access barriers. The program is committed to continuing to increase the number of uninsured served proportional to Health Center growth. Indeed, the number of uninsured Health Center patients increased by about 150,000 per year between 1998 and 2001, but increased by 400,000 by 2002 and an additional 500,000 by 2003.

Goal II.B.1. Increase percent of adult diabetic patients with at least one testing of glycohemoglobin annually.

Poor people of racial/ethnic minority groups and persons who are uninsured are more likely to suffer from chronic diseases such as hypertension and diabetes. Health Center patients have unusually high rates of these chronic diseases. Clinical evidence indicates that access to appropriate care can improve the health status of patients with chronic diseases and thus reduce or eliminate disparities. Managing the glycohemoglobin levels of diabetics and the blood pressures of hypertensives can have a pronounced effect on their morbidity and mortality.

This measure replaces a previous measure in which the standard was two tests per year. The current measure is less restrictive but more commonly used. Based on information from the Health Disparities Collaboratives Program's diabetes registry, performance in 2000, 2001, 2002 and 2003 was 86.5%, 77.2%, 74.8%, and 70.9% respectively. The FY 04 - FY 06 Health Center targets are 75%, 71%, and 71%, respectively, of patients with at least one testing of



glycohemoglobin annually, well above the HP 2010 goal of 50%. However, this proportion will be a challenge to achieve, given the dramatic increase in the number of persons added to the registry. New diabetics added to the registry will be less likely to have had sufficient time to be tested. Since the inception of the Health Disparities Collaboratives diabetes registry in 2000, registry size increased 56% in 2001, 60% in 2002 and nearly tripled in 2003.

The Diabetes Collaborative holds its diabetic care performance to a higher standard for glycohemoglobin testing using the ADA-recommended criterion of at least two tests per year. According to a Health Center Effectiveness Study conducted in FY 97, 43% of Health Center adults with diabetes had up-to-date glycohemoglobin testing at least twice annually. Based on a literature survey conducted for the Health Center Effectiveness Study, 20 percent of adults with diabetes in mainstream medical practices had their glycohemoglobin tested at ADA-recommended intervals. Health Center patients had ADA-recommended rates that were more than twice the national average even before the Collaboratives Program was established. Collaboratives data suggest that exceeding national rates continues, even with significant growth in the program's diabetes registry. FY 04 data are expected in August, 2005.

Long-Term Goal

By 2006, reduce low birth weights in Health Centers at 6.53%, consistent with Healthy People 2010 goal.

Goal II.B.2. Decrease the percent of births to Health Center patients below 2500 grams (LBW).

Appropriate prenatal care management can have a significant effect on the incidence of low birth weight (LBW). LBW is the risk factor most closely associated with neonatal mortality; thus improvements in infant birth weight can contribute significantly to reductions in infant mortality rates. Rates of LBW among African American infants, along with Puerto Ricans and Asians and Native Americans, are twice the rate of whites. In addition, young mothers, particularly under age 15, are more likely than older women to have LBW infants. These risk factors are reported at a higher rate among Health Center mothers, predisposing Health Center births to higher risk for low birth weight and adverse birth outcomes.

According to UDS Health Center data for CY 03, 7.05% of infants born to mothers who sought their prenatal care at Health Centers were born with LBW. This rate, although above the target of 6.89, is still lower than the national 2002 and 2003 rates of 7.8% and 7.9%, respectively, despite the fact that Health Center mothers and infants are at greater risk of adverse birth outcomes. The Health Center rate continues to follow a steady pattern at about 7%, unlike the increases observed in the national rate.

Healthy People 2010 includes the following objective for infants: Reduce LBW to an incidence of no more than 6 percent of live births. For Health Centers, the long-term target is consistent with that figure, given the greater prevalence of risk factors among Health Center mothers and infants. With expansion it will be a challenge to reduce the Health Center rate below 7% to 6.53%. BPHC will obtain overall LBW rates annually from its UDS. CY 04 LBW data are expected in August, 2005.

Goal II.B.3. Increase the percent of Health Center women receiving age-appropriate screening for cervical and breast cancer.

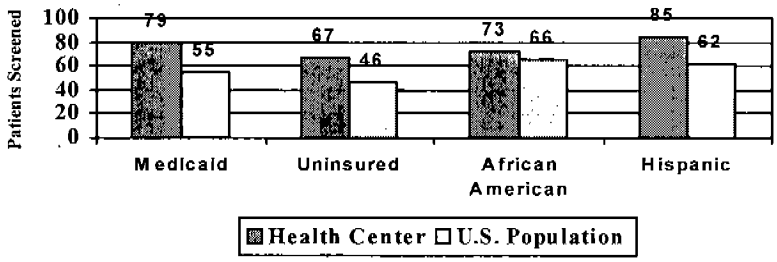
Patients of racial/ethnic minority groups, of low income, and who are uninsured have less access to appropriate screening and preventive services which results in their higher rates of morbidity and mortality. Access to these services can help to eliminate these health status disparities.

Healthy People 2000/2010 include the following national targets for women generally, as tracked by data from the National Health Interview Survey (NHIS):

1. At least 85/90 percent have up-to-date PAP Tests.
2. At least 60/70 percent have up-to-date mammograms.
3. No HP 2010 target for up-to-date clinical breast examinations.

The 2002 Health Center User Survey, comparable to the 2000 National Health Interview Survey showed the following results for Health Center women from the most vulnerable population subgroups who traditionally experience access disparities.

Up-to-Date Mammograms: Health Center Women Age 40 and Over Exceed National Comparison and HP2010 Goal of 70%



Health Center women from the most vulnerable groups reported being up-to-date on these examinations in higher proportions than did low-income women in the general population. Moreover, uninsured Health Center patients are comparable to the nation's patients with insurance. These results demonstrate the Health Center program contribution to reducing national disparities in access to these services. The 2002 pap-test rate (87.6%) is roughly comparable to the 1995 rate (88.5%) despite significant Health Center program growth and still

exceeds the HP 2000 goal (85%). The Health Center pap-test rate does fall short of the HP 2010 goal (90%) and the exceedingly high goal BPHC set for the program (95%). Future targets are lower and comparable to the HP 2010 goal. For mammograms, the 2002 Health Center program rate (75.7%) substantially exceeds the 1995 rate (62.5%), HP 2000 goal (60%), revised HP 2010 goal (70%), and BPHC target (75%) (definition of age-appropriate changed from 50 and over in 1995 to 40 and over in 2002). The clinical breast examination rate (80.9%) is comparable to the 1995 rate (80.5%), yet fell short of the BPHC target (86%) in 2002.

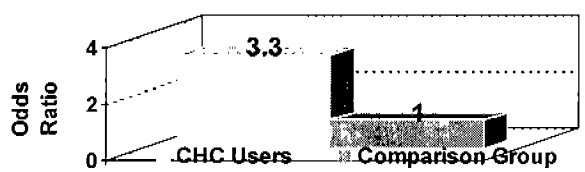
For FY 06, BPHC targets will be 90% for up-to-date Pap tests; 70%, for up-to-date mammograms; and 85% for up-to-date clinical breast exams. The mammography target is set at the HP 2010 rate, although the Health Center rate currently exceeds this rate. It will be difficult to maintain the current Health Center rate during the expansion. Therefore, we have reduced the targets. FY 03, FY 04 and FY 05 data will not be available because BPHC is expanding its current data from the Sentinel Centers Network (SCN) to include this measure, and it will not be available until FY 06. BPHC is moving from reliance on periodic surveys for these meassures and, it is anticipated that future progress on this measure will be monitored and reported annually using SCN data, permitting analyses of patient and provider characteristics (i.e., the type, amount and outcome of care provided by individual providers, adjusted for patient disease burden). The SCN is a representative group of BPHC-supported Health Centers, from which timely relevant information is obtained to guide policy decisions. Core data from participants existing management information systems are extrapolated from hundreds of thousands of patient medical records semi-annually rather than a few thousand every 5 - 7 years as is characteristic of patient surveys. SCN is a rich source of data on Health Center patients and the services they receive. These data provide BPHC and each of the SCN participants with information that cannot be obtained from the sample or aggregate data that are currently collected.

Goal II.B.4. Increase the percent of Health Center adults with hypertension who report their blood pressure is under control.

Hypertension is the most prevalent chronic condition facing Health Center patients. Clinical evidence indicates that controlling blood pressure can reduce morbidity and mortality.

The 1995 Health Center User Survey, comparable to the NHIS, showed that 90% of Health Center patients reported their hypertension under control. The 2002 Survey found an overall comparable rate of 91% for Health Center hypertensives, and comparable rates to 1995 access subgroups men, women and patients from racial/ethnic minority groups.

African American & Hispanic Hypertensives Using Health Centers Are Three Times As Likely To Report Blood Pressure Under Control as NHIS Comparison Group



Healthy People 2010 includes the following objective for adults generally: At least 50 percent of patients with hypertension report that their blood pressure is under control. Not only are BPHC program patients more than three-times as likely to report blood pressure under control as a comparable national group, but the current rate far exceeds the HP 2010 objective. The BPHC program target for FY 06 remains at 90%. With expansion it will be a challenge to maintain current levels. FY03, FY04, and FY 05 data will not be reported because BPHC is expanding its current data from the Sentinel Centers Network (SCN) to include this measure, and it will not be ready until FY 06. BPHC is moving from reliance on periodic surveys for these measures and, it is anticipated that future progress on this measure will be monitored and reported annually using SCN data, permitting analyses of patient and provider characteristics (i.e., the type, amount and outcome of care provided by individual providers, adjusted for patient disease burden). The SCN is a representative group of BPHC- supported Health Centers, from which timely relevant information is obtained to guide policy decisions. Core data from participants' existing management information systems are extrapolated from hundreds of thousands of patient medical records bi-annually rather than a few thousand every 5 - 7 years as is characteristic of patient surveys. SCN is a rich source of data on Health Center patients and the services they receive. These data provide BPHC and each of the SCN participants with information that cannot be obtained from the sample or aggregate data that are currently collected.

Efficiency Measures

1. Sustain the average cost per individual served at Health Centers.

(Indicator: Total revenue divided by total patients)

It is vital that Health Centers maximize the number of patients per dollar and tracking their costs is an appropriate process to assure efficiency. Historically, Health Center cost increases of 5-7% have remained at or below national averages of 9-10%, but the FY 03 cost per patient increased less than 4% over the 02 figure. However, new access points require time to build in efficiencies. It is increasingly difficult to contain costs in a program that is experiencing unprecedented expansion along with serving many of the nation's most vulnerable individuals.

In CY 03, the number of Health Center patients increased by over one million for the second year in a row, compared to past growth that averaged less than 600,000 per year. As such, it will be a significant accomplishment for Health Centers to maintain costs per patient increases at historical levels.

2. Sustain the annual number of encounters per medical worker.

(Indicator: Total number of encounters to physicians, nurse practitioners, physician assistants, and certified nurse midwives divided by their respective FTEs)

It is vital that Health Centers maximize the number of patients and encounters per medical provider and track their productivity. This is an appropriate process to assure that the maximum

number of patients is served and that the Health Centers are operating efficiently. Historically, Health Center productivity has generally remained consistent with national standards for primary care, with only slight declines between 1996 and 2003. Yet, the FY 02 and FY 03 figures show that productivity remained relatively stable from the FY 01 level in the face of significant Health Center expansion. However, it is increasingly difficult to maintain productivity in a program that is experiencing unprecedented expansion along with serving the nation's most vulnerable. New access points require time to build in their productivity gains. As such, it will be a significant accomplishment for Health Centers to sustain only slight productivity declines.

Deleted Measure(s)

1. Increase percent of diabetic patients with up-to-date testing of glycohemoglobin -% adults with diabetes tested at recommended intervals.

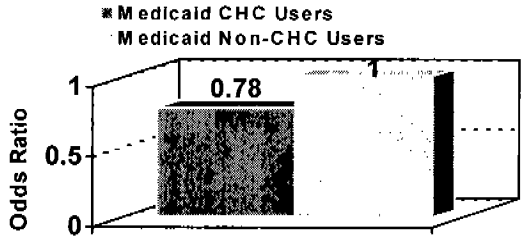
This measure, which requires two tests, was replaced by a measure requiring one annual test as discussed earlier. In the first year, the establishment of a measurement infrastructure under the Diabetes Collaborative enabled 83 Health Centers participating to reach the 60% level in 1999, but short of the ultimate 90% goal. These first Centers raised the rate of diabetics having A1Cs at regular intervals from 20 to 60%, meeting the interim target. In 2000, with more Health Centers newly participating in the collaboratives and a greatly expanded diabetes patient registry, the annual rate dropped, predictably, to 40%, still well above national norms although below target. Similarly, by 2003 with the greatly expanded registry, the rate dropped to 34%. It is anticipated that longevity of Health Centers in the Collaboratives will produce rising rates. Eventually all Health Centers will be part of the Collaboratives.

2. Decrease the relative likelihood of Health Center patients hospitalized for potentially avoidable conditions.

Hospitalization for potentially avoidable conditions, otherwise known as ambulatory care sensitive conditions (ACSC) is widely recognized as a measure of access to primary care. Low rates indicate access to appropriate ambulatory services and serve as a measure of the high quality of care delivered. Lower rates also indicate fewer access barriers that cause patients to postpone or delay needed services or fail to comply with treatment regimens. Reducing the rate of avoidable hospitalizations for patients of racial/ethnic minority groups, of low income, and who are uninsured will help eliminate their health status disparities.

An ongoing evaluation comparing ACSC hospitalizations among Health Center patients and other Medicaid beneficiaries using State Medicaid Research Files (SMRF) data from the National Hospital Discharge Survey for the general population revealed that Health Center Medicaid patients are 22% less likely to be inappropriately hospitalized than Medicaid beneficiaries who use other providers.

Medicaid Health Center Patients Have Significantly Lower Odds of Being Inappropriately Hospitalized For An Ambulatory Care Sensitive Condition



The most recent study attempted to replicate these results, not for all Medicaid beneficiaries, but for those with a regular and usual source of care, making the Health Center comparison more reasonable. Still, Health Center Medicaid beneficiaries are 11% less likely to be inappropriately hospitalized and 19% less likely to seek care from emergency rooms compared to Medicaid beneficiaries who sought regular and usual care from other clinicians.

In 2003, BPHC chose to revise this measure from actual rates to relative rates. Hence, the target was BPHC patients will be 10% less likely to be hospitalized for potentially avoidable conditions than their Medicaid counterparts in the face of expansion.

BPHC has deleted this measure from its annual performance plan. Although BPHC wanted annual estimates, these studies using claims data are often multi-year activities with significant lags in the timeliness of the data and appearable cost of analysis. The 1998 ACSC study used the most recent SMRF Medicaid data from 1995, and the 1997 study used the most recent SMRF data obtained in 1992. Even with the delay in data availability, this measure is worth examining periodically through special studies. ACSC is a well-established measure of quality. Because the data come from a source other than BPHC program data, this measure is important for external validity of program quality performance. BPHC will continue to conduct studies and report on this measure as data become available. The date for reporting FY 03 data will be determined.

U.A.2 Program Title: Hansen's Disease Activities

Performance Goals	Targets	Actual Performance	Reference
I. IMPROVE ACCESS TO HEALTH CARE **A. Expand the capacity of the health care safety net** 1. Continue to provide outpatient care for HD patients through the National Hansen's Disease Program. **(Outcome)**	FY 06: 3,000 patients FY 05: 3,000 FY 04: 3,000 FY 03: 3,000 FY 02: 3,000 FY 01: 3000 FY 00: 3000	FY 04: 3000 patients FY 03: 3000 FY 02: 3000 FY 01: 3000 FY 00: 3000	**NEW FY 04 DATA** 3
Efficiency Measure 1. Maintain increases in the cost per patient served in Hansen's disease outpatient clinics to below the medical inflation rate. **(Developmental)**	FY 06: $660 FY 05: $660	FY 04: $660 FY 03: $628 FY 02: $641 (baseline)	**NEW FY 04 DATA**
Total Funding: Hansen's Disease Activities ($ in 000s)	FY 06: $18,304 FY 05: $19,515 FY 04: $19,695 FY 03: $20,304 FY 02: $20,133	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

Program Performance Analysis

Goal I.A.1. Continue to provide outpatient care for HD patients through the National Hansen's Disease Program.

(Indicator: Number of patients served)

The National Hansen's Disease Program includes a regional outpatient clinic program. The total Hansen's Disease population in the U.S. approximates 6,000 patients of whom about 3,000 are cared for through the National Hansen's Disease Program through outpatient clinics in the area in which they live.

Actual performance for FY 04 met the target.

Efficiency Measure

1. Maintain increases in the cost per patient served in the outpatient clinics to below the medical inflation rate. (Developmental)

(Indicator: Contract clinic costs of the National Hansen's Disease Program divided by the number of patients served by Hansen's disease outpatient clinics)

The National Hansen's Disease program is committed to improving overall efficiency through controlling the cost of care at its outpatient clinics. This was selected as a measurable and trackable indicator. Federal dollars for Hansen's Disease outpatient clinics support 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.

Between FY 00 and FY 02, total outpatient clinic costs averaged approximately $1.85 million dollars and the average cost per patient was approximately $630. Baseline costs established in FY 02 are $641 per patient, based on the 3,000 patients served in outpatient facilities. Outpatient clinic costs dropped to $628 in FY 03 but rose to $660 in FY 04, and are expected to be approximately $660 in FY 05 and FY 06. As the incidence of Hansen's disease remains constant from year to year, the number of patients treated is expected to remain stable. Overall direct costs may rise slightly due to medical cost inflation, but all efforts will be made to increase efficiencies among the contractors to minimize overall cost increases.

U.A.3. Program Title: Black Lung Clinics

Performance Goals	Targets	Actual Performance	Reference
I. IMPROVE ACCESS TO HEALTH CARE **A. Expand the capacity of thehealth care safety net** 1. Serve Black Lung clinic patients with respiratory and pulmonary impairments, including provision of medical and non-medical services. **(Outcome)**	FY 06: 17,000 patients FY 05: 17,000 FY 04: 17,000 FY 03: 17,000 FY 02: 17,000 FY 01: 26,000 FY 00: 35,000 FY 99: 35,000	FY 04: (11/05) FY 03: 20,000 patients FY 02: 16,745 FY 01: 16,357 FY 00: 26,000 FY 99: 35,000	**NEW** **FY 03** **DATA** 3,5
Efficiency Measure 1. Increase the percent of grantees submitting reports electronically. **(Developmental)**	FY 06: 99% FY 05: 66% FY 04: 33	FY 04: (11/05) FY 03: 60% FY 02: 13% (baseline)	**NEW** **FY 03** **DATA**
Total Funding: Black Lung Clinics ($ in 000s)	FY 06: $ 5,912 FY 05: $ 5,951 FY 04: $ 5,963 FY 03: $ 5,961 FY 02: $ 5,998	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

Program Performance Analysis

Goal I.A.1. Serve Black Lung clinic patients with respiratory and pulmonary impairments, including provision of medical and non-medical services.

(Indicator: Number of individuals provided medical and non-medical services)

Actual performance reported between FY 98 and FY 00 for patients served through the Black Lung Program were estimates based on aggregate information provided by grantees. In FY 01, the Black Lung program funded grants to 14 public and private organizations providing specialized diagnosis and treatment services. BPHC learned the number of patients served was overestimated due to definitional inconsistencies among the grantees. As a result, beginning in FY 02, the program utilizes a more reliable data collection instrument to obtain accurate information on the number and type of patients served by the program. Data are collected using the annual grantee report and includes State, private/public entities, faith-based and community-based organizations. In FY 02, the Black Lung program funded grants to 16 grantees serving 16,745 patients. In FY 03 the Black Lung program funded grants to 15 grantees serving 20,000 patients. Data for FY 04 are expected in November, 2005.

Efficiency Measure

1. Increase the percent of grantees submitting reports electronically. (Developmental)
(Indicator: Number of grantees submitting electronically divided by the total number of grantees)

Under the current system the Black Lung Clinic Program grantees have the option of sending their annual report either by fax or email. Many grantees are smaller organizations and/or located in rural areas and have limited technological access. In following the trend of other DHHS and HRSA programs of electronic reporting, it is the goal to have two-thirds of Black Lung Clinic Program grantees reporting with an electronic version of their annual data by the FY 05 data report. This goal will be accomplished by developing a data collection system that utilizes web technology that will ensure necessary and efficient electronic data reporting for all of the BLCP grantees. As of FY 03, 60% have reported electronically. Data for FY 04 are expected in November, 2005.

U.B HEALTH PROFESSIONS

Programs included in this section are:

U.B.1. National Health Service Corps
U.B.2. Health Professions and Nursing Education and Training Programs
U.B.3. Workforce Information and Analysis
U.B.4. Nursing Education Loan Repayment and Scholarship Programs
U.B.5. Bioterrorism Training and Curriculum Development
U.B.6. Children's Hospitals Graduate Medical Education Payment Program
U.B.7. Practitioner Data Banks (NPDB and HIPDB)
U.B.8. Health Education and Assistance Loans (HEAL) Program

U.B.1. Program Title: National Health Service Corps

Performance Goals	Targets	Actual Performance	Reference
I. IMPROVE ACCESS TO HEALTH CARE **C. Improve the distribution of health professionals in underserved areas, including in rural and border areas** **Long-Term Goal** By 2010, increase by 20% the number of individuals served through the placement and retention of NHSC clinicians. **(Outcome)**	FY 06: 4.94 M FY 05: 4.84 M		 **PART**
Short-Term Goal 1. Increase the number of individuals served through the placement and retention of NHSC clinicians. **(Outcome)**	FY 04: 4.74 M	FY 04: (03/05) FY 01: 4.44 M (baseline)	3,5
2. Increase the field strength of the National Health Service Corps through scholarships and loan repayment agreements. **(Outcome)**	FY 06: 3,408 FY 05: 3,948 FY 04: 3,985 FY 03: 3,170 FY 02: 2,624 FY 01: 2,380 FY 00: 2,697	FY 04: (03/05) FY 03: 3,615 FY 02: 2,765 FY 01: 2,364 FY 00: 2,376	
Long-Term Goal By 2010, increase the number of individuals served in all communities seeking NHSC assistance through NHSC placement, retention, and other sources by 20 percent. **(Outcome)**	FY 06: 1,812[1]	FY 03: 5.94 M (baseline)	**PART** **NEW FY 03 DATA**
Short-Term Goal 3. Increase the number of NHSC-list vacancies filled through all sources.	FY 05: 1,261 FY 04: 1,203 FY 03: 1,145	FY 04: (03/05) FY 03: 3,000 (baseline)	3
4. Increase the percent of NHSC clinicians retained in service to the underserved. **(Outcome)**	FY 06: 79% FY 05: 79% FY 04: 79% FY 03: 78% FY 02: 76% FY 01: 75% FY 00: 74%	FY 04: (03/05) FY 03: 78.4% FY 02: 75.2% FY 01: 80% FY 00: 75.0%	**NEW FY 03 DATA** 3,5
Short-Term Goal 5. Increase the average HPSA score of the sites receiving NHSC clinicians, as a proxy for service to communities of greatest need.	FY 06: 13 FY 05: 12.7 FY 04: 12.1	FY 04: (03/05) FY 01: 11.5 (baseline)	**PART** 3

Performance Goals	Targets	Actual Performance	Reference
Efficiency Measure 1. Increase the percentage of scholars in the match cycle who match with a community prior to the established deadline date.	FY 06: 91% FY 05: 90%	FY 04: 89% (baseline)	
Total Funding: National Health Service Corps ($ in 000s)	FY 06: $126,796 FY 05: $131,448 FY 04: $169,903 FY 03: $171,089 FY 02: $145,377	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

[1] The target is based on the number of new loan repayment (LRP) awards projected, plus the number of scholars finishing school and ready for placement. It is assumed that an equal number of vacancies will be filled through other sources. Because of a shift in the proportion of recruitment line budget to LRP in FY 03, an unusually large number of new LRP awards were made that year, providing a high baseline. As a result, an increase in amendments is expected in FY 05 and FY 06 with a decrease in the number of new awards. While amendments continue to be counted in the field strength, they do not result in filling vacancies.

Program Performance Analysis

Long-Term Goal

By 2010, increase by 20% the number of individuals served through the placement and retention of NHSC clinicians.

Short-Term Goals

Goal I.C.1. Increase the number of individuals served through the placement and retention of NHSC clinicians.

It is estimated that more than 4 million people in underserved areas are receiving care from NHSC clinicians. This number is expected to increase, not only because of increased field strength, but also because each year an increasing number of NHSC clinicians continue to practice in underserved areas following the completion of their service obligations. Retention of NHSC clinicians preserves access to care for the underserved beyond the period of service commitment. The current expansion of Health Center sites and patients will likely place additional reliance on NHSC clinicians.

The FY 01 baseline is 4.44 million. The Long-Term Goal is to gradually increase the number of individuals served to 5.34 million by FY 10. The FY 2005 target is 4.84 million and the target for FY 2006 is 4.94 million.

Goal I.C.2. Increase the field strength of the National Health Services Corps through scholarships and loan repayment agreements.

The NHSC clinicians provide access to care for underserved people. About 50% of NHSC clinicians practice in HRSA grant-supported health centers, and 50% are located in non-HRSA grant supported practices in underserved areas. NHSC clinicians currently meet only 10% of the need for primary care, oral, and mental and behavioral health clinicians in HPSAs.

In FY 03, NHSC field strength reached 3,615, well above the target. FY 04 field strength will be available in March 2005.

Long-Term Goal

By 2010, increase the number of individuals served in all communities seeking NHSC assistance through NHSC placement, retention, and other sources by 20 percent.

Short-Term Goals

Goal I.C.3. Increase the number of NHSC-list vacancies filled through all sources.

Community based primary care sites in underserved communities advertise their health professions vacancies on the NHSC opportunity list. Many of these vacancies are filled by NHSC scholars and loan repayers. However, additional vacancies are filled by volunteers, physicians with a J-1 visa waiver, and other clinicians who may identify the vacancies through the NHSC opportunity list. Filling of vacancies by non-NHSC obligated clinicians is an outcome of the NHSC program which leads to additional people served in underserved areas. The target is based on the number of new loan repayment (LRP) awards projected, plus the number of scholars finishing school and ready for placement. It is assumed that an equal number of vacancies will be filled through other sources. A shift in the budget recruitment line in FY 03 resulted in an unusually large number of new awards in that year. If these awardees seek extensions at the expected rate, the number of new awards in FY06 will decrease. This will not affect overall field strength, but may result in a decrease in the number of new vacancies filled.

Goal I.C.4. Increase the percent of NHSC clinicians retained in service to the underserved. (Indicator: Percent of NHSC clinicians who remain in service to the underserved immediately following completion of their service commitment.)

Retention of NHSC clinicians preserves access to care for the underserved beyond the period of service commitment.

According to FY 03 data, 78.4% of NHSC clinicians report remaining in service to the underserved at an interview conducted after completion of service commitment; this is slightly over the target of 78%. Retention has grown steadily from the mid 50% range in FY 95. A NHSC program evaluation study "Evaluation of the Effectiveness of the National Health Service Corps,"(May 31, 2000) indicates that more than half of NHSC clinicians who completed their service commitments between 1983 and 1997 are currently in service to the underserved. The program plans to measure retention at one year after service obligation and follow cohorts of clinicians over their working lives to assess retention at longer intervals.

Since FY 00, performance has consistently exceeded targets, except in FY 02, when it was slightly under (75.2% actual vs. 76% target). Some year- to- year fluctuation is expected. The target for FY 04 through FY 06 is 79%.

Goal I.C.5. Increase the average HPSA score of sites receiving NHSC clinicians.

The HPSA score is a proxy measure for the degree of need for health professionals in an area. Scores range from 1 to 25, with 25 representing the greatest need. Increasing the average HPSA score of site vacancies filled through NHSC assistance indicates success in targeting vacancies of greatest need.

The FY 01 baseline average HPSA score is 11.5. The long-term goal is to gradually increase the average HPSA score to 14.2 by FY 10. The FY 06 target is 13.

Efficiency Measure

1. Increase the percentage of scholars in the match cycle who match with a community prior to the established deadline date.

NHSC Scholars must serve a period of required service in a HPSA. Scholars who participate in the process of selecting their own service sites typically cost the program less staff time and fewer travel expenses. In addition, a good match increases the likelihood that both sites and scholars will be satisfied with their service, resulting in longer service and a greater likelihood of long-term retention.

Each year, a deadline for placement is established. Scholars who have not found a match by that date must be matched by program staff from vacancies on the NHSC Opportunities List. These forced matches cost the program additional time, and may result in significantly higher travel costs for interviews and site visits. In addition, it increases the likelihood that scholars will need to be transferred prior to completion of service, which further increases costs to the program.

A high percentage of scholars matching prior to the deadline date leads to an increased likelihood of a good match and retention of the scholar in an underserved community following the NHSC obligation. The target for FY 2005 is 90%, and the target for FY 2006 is 91%. The baseline is 89% (FY 04). The FY 05 and FY 06 targets are ambitious, given that the baseline level is already very high, and there will always be some difficult cases.

U.B.2. Program Title: Health Professions and Nursing Education and Training Programs

Performance Goals	Targets	Actual Performance	Reference
I. IMPROVE ACCESS TO HEALTH CARE **B. Promote the development of a diverse and culturally representative health care workforce** **Long-Term Goal** By 2010, increase to 50% the proportion of graduates and program completers of Titles VII and VIII supported programs who are underrepresented minorities and/or from disadvantaged backgrounds. **(Outcome)**		FY 01: 42% (baseline)	HP 2010 1.8 **PART** **NEW FY 01 DATA**
Short-Term Goal 1. Increase the proportion of graduates and program completers of Titles VII and VIII supported programs who are underrepresented minorities and/or from disadvantaged backgrounds. **(Outcome)**	FY 06: 44% FY 05: 43% FY 04: 40%	FY 04: (12/06) FY 01: 42% (baseline)	5
C. Improve the distribution of health professionals in underserved areas, including rural and border areas **Long-Term Goals** By 2010, increase to 96% the proportion of persons who have a specific source of ongoing care. **(Outcome)**		FY 98: 87% (baseline)	HP 2010 1.4 **PART** 3 **PART**
By 2010, increase to 40% the proportion of health professionals trained in Titles VII and VIII supported programs *serving* in medically underserved communities. **(Outcome)**		Baseline: 19%[1]	**NEW BASELINE DATA**
Short-Term Goals 1. Increase the proportion of trainees in Titles VII and VIII supported programs *training* in medically underserved communities. **(Outcome)**	FY 06: 54% FY 05: 53% FY 04: 30%	Baseline: 52%[2] (FY 99–01 average)	3
2. Increase the percentage of health professionals supported by the program who enter practice in underserved areas. **(Outcome)**	FY 06: 21% FY 05: 20% FY 04: 30%	Baseline: 19%[1] (FY 99–01 average)	
Efficiency Measure 1. Decrease the burden hours associated with applying for non-competitive continuation awards, including submission of performance data.	FY 06: 17 FY 05: 17	FY 03: 20 (baseline)	

Performance Goals	Targets	Actual Performance	Reference
Deleted Measure(s)[3] 1. Increase the number of residents/graduates, students/trainees and faculty in clinical training with healthcare service delivery organizations serving underserved areas. **(Outcome)**	FY 02: 41,520 FY 01: 37,790 FY 00: 33,580 FY 99: 31,575	FY 02: 61,610 (est.) FY 01: 57,843 FY 00: 61,531 FY 99: 32,629	**NEW FY 02 DATA**
2. Increase the number of residents/graduates, students/trainees, faculty, and supported students who enter practice in underserved areas. **(Outcome)**	FY 04: 1,443 FY 03: 1,443 FY 02: 5,790 FY 01: 5,565 FY 00: 4,482 FY 99: 4,391	FY 04: (12/06) FY 03: (12/05) FY 02: 11,014 (est.) FY 01: 8,701 FY 00: 6,486 FY 99: 4,336	**NEW FY 02 DATA** 3,5
3. Increase the number of residents/graduates, students/trainees, faculty, and supported students for health professions training programs that provide and support primary care. **(Outcome)**	FY 04: 22,772 FY 03: 4,143 FY 02: 112,441 FY 01: 103,983 FY 00: 68,232 FY 99: 68,350	FY04: (12/06) FY 03: (12/05) FY 02: 340,445 (est.) FY 01: 258,618 FY 00: 255,396 FY 99: 89,295	**NEW FY 02 DATA** 5
4. Increase the number of minority/disadvantaged residents/graduates and faculty that complete training. **(Outcome)**	FY 04: 792 FY 03: 862 FY 02: 14,287 FY 01: 13,186 FY 00: 11,587 FY 99: 10,652	FY04: (12/06) FY 03: (12/05) FY 02: 128,401 (est.) FY 01: 109,289 FY 00: 47,133 FY 99: 10,158	**NEW FY 02 DATA** 5
5. Increase the number of minority/disadvantaged students/trainees, faculty, and supported students in training.	FY 04: 9,207 FY 03: 8,574 FY 02: 21,717 FY 01: 21,286 FY 00: 21,286 FY 99: 21,231	FY04: (12/06) FY 03: (12/05) FY 02: 30,162 (est.) FY 01: 30,813 FY 00: 28,139 FY 99: 20,459	**NEW FY 02 DATA** 5
6. Increase the number of underrepresented minorities serving as faculty. **(Outcome)**	FY 02: 2,226 FY 01: 1,954 FY 00: 334 FY 99: 326	FY 02: 15,049 (est.) FY 01: 8,701 FY 00: 1,494 FY 99: 2,141	**NEW FY 02 DATA** 5
Total Funding: Health Professions and Nursing Training Programs ($ in 000s)	FY 06: $128,453 FY 05: $418,015 FY 04: $408,621 FY 03: $400,516 FY 02: $376,758	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

[1] The data for this measure were obtained from CPMS Table 4. However, not all grantees are required to submit CPMS Table 4, hence the data are incomplete. In addition, since nursing shortages are facility-based rather than geographically-based (unlike physicians, for example), Title VIII nursing programs do not always track whether their graduates enter practice in underserved communities. The Bureau plans to propose an alternative measure once work on the new Strategic Plan has been completed. The baseline estimate is the average of 1999-2001 data. The FY 04 target was set prior to the availability of baseline data. FY 05 and FY 06 targets have been adjusted to reflect the baseline estimate.

[2] These data are only collected by programs in medicine, dentistry, dental public health, and graduate psychology, and thus are not representative of nursing programs. Nursing shortages are facility-based rather than geographically-based (unlike physicians, for example), the Title VIII programs do not use Health Professional Shortage Areas (HPSAs), or Medically Underserved Communities as criteria for distributing funds. The Bureau plans to propose an alternative measure once work on the new Strategic Plan has been completed. The baseline estimate is the average of 1999-2001 data. The FY 04 target was set prior to the availability of baseline data. FY 05 and FY 06 targets have been adjusted to reflect the baseline estimate.

[3] These measures were established prior to the FY 2004 PART Assessment. The targets reflect Title VIII programs only, whereas the actuals reflect the results of both Title VII and Title VIII programs. Results are shown as estimates. Actual results may be higher or lower than the estimates because of limitations of the data system. BHPr is currently performing validity checks on these data.

Program Performance Analysis

Long-Term Goal

By 2010, increase to 50% the proportion of graduates and program completers of Titles VII and VIII supported programs who are underrepresented minorities and/or from disadvantaged backgrounds.

Healthy People 2010 Goal 1.8 calls for increasing the proportion of all degrees awarded to members of underrepresented racial and ethnic groups. For some racial and ethnic groups, access to health care is a problem. Increasing the number of health professionals from certain racial and ethnic groups is an integral part of the solution to improving access to care.

Short-Term Goal

Goal I.B.1. Increase the proportion of graduates and program completers of Titles VII and VIII supported programs who are underrepresented minorities and/or from disadvantaged backgrounds.

One of the key purposes of the Health Professions and Nursing Training Program is to increase the racial/ethnic diversity of the health professional student population. Diversity is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, better patient-provider communication, and better educational experiences for all students in training (IOM 2003).

The baseline estimate of 42% is a partial one based on from data submissions for FY 01. It is necessarily partial because grantees in some States cannot by law collect race/ethnicity data. The 40% FY 04 target was set prior to the availability of baseline data. Estimates vary among programs depending on the purpose of the program. Programs specifically designed to increase minority and disadvantaged representation in the health professional workforce (e.g. Scholarships for Disadvantaged Students) provide 100% of their funds to minority and disadvantaged students. Other programs, such as Training in Primary Care Medicine and Dentistry, do not focus exclusively on minority and disadvantaged students, but provide preferences to institutions enrolling large numbers of these students.

The FY 05 target has been modified to reflect the higher-than-expected baseline estimate. The FY 06 target is 44%. The programs have collected this data since 1999, but data for 2001 are used for the baseline because a change in the way these data were collected starting in 2001 makes the earlier figures non-comparable.

Long- Term Goals

By 2010, increase to 96% the proportion of proportion of persons who have a specific source of ongoing care.

The mission of the Health Professions and Nursing Training Program is to increase access to care, particularly among medically underserved populations. Access to care depends in part on having a specific source of ongoing of care. People with a usual source of healthcare are more likely than those without a usual source of care to receive a variety of preventive healthcare services. This indicator is a proxy measure for improved access to care, and is not limited to specific shortage areas, or specific health professional disciplines. Data for this measure will be obtained from the National Health Interview Survey. The most recent estimate, for 2003, is 88%.

By 2010, increase to 40% the proportion of health professionals trained in Titles VII and VIII supported programs serving in medically underserved communities.

The proportion of health professionals trained in Titles VII and VIII supported programs serving medically underserved communities is a key indicator of the degree to which the program is successful in meeting one of its key objectives: increasing access to care for members of underserved populations. BHPr's Comprehensive Performance Management System and Uniform Progress Report (CPMS/UPR) collects data on overall project performance related to BHPr's strategic goals, objectives, outcomes, and indicators. This measure is comparable to, but longer-term than annual measure I.C.2. The baseline for the long-term measure is 19% (same as for the short-term measure), and the short-term measure provides interim targets for the long-term measure. In the short term, the Bureau does not expect linear increases in the results, given that it takes time to put structural changes in place. However, greater increases are expected in the out years, after new requirements regarding service in underserved communities are put into place.

Short-Term Goals

Goal I.C.1. Increase the proportion of trainees in Title VII and VIII Health Professions- and Nursing Training supported programs *training* in medically underserved communities.

Physicians, dentists, nurses and other health professionals are not distributed evenly throughout the country; rural and inner city areas are especially likely to experience shortages. Locating health professional training opportunities in areas that are underserved is an integral part of the solution to meeting the needs of the underserved. Trainees provide direct services while in training. In addition, studies have shown that health care practitioners have a higher likelihood of locating in underserved areas if they spend part of their training providing healthcare in these areas.

The baseline estimate of 52% was calculated as the average of FY 99 - 01 data. The FY 04 target was set prior to the availability of baseline data. The FY 05 target has been adjusted to reflect the higher-than-expected baseline rate. The Bureau anticipates only modest increases in this rate. Therefore, the FY 05 and FY 06 targets have been set at 53%, and 54%, respectively.

These data are only collected by programs in medicine, dentistry, dental public health, and graduate psychology, and thus are not representative of nursing programs. In addition, since nursing shortages are facility-based rather than geographically-based (unlike physicians, for example), the Title VIII programs do not use Health Professional Shortage Areas (HPSAs), or Medically Underserved Communities as criteria for distributing funds. The Bureau plans to propose an alternative measure when the new Strategic Plan is completed.

Goal I.C.2 Increase the percentage of health professionals supported by the program who enter practice in underserved areas.

A central issue that Titles VII and VIII address is the failure of the market to assure an adequate distribution of physicians, nurses, and other health care providers to all areas of the country, to all types of facilities, and to all population groups, leaving many people without adequate access to health care. Titles VII and VIII are focused on meeting the needs of the underserved, regardless of where they are.

This was a FY 04 PART outcome measure. The FY 04 target of 30% was set prior to the availability of baseline data. The data for this measure were obtained from the Bureau's CPMS/UPR system (Table 4), and the baseline estimate of 19% was calculated as the average of data submitted for FY 99 - 01. FY 05 and FY 06 targets have been adjusted to reflect the baseline estimate. The FY 06 target is 21%.

However, not all grantees are required to submit CPMS Table 4, hence the data are incomplete. In addition, since nursing shortages are facility-based rather than geographically-based (unlike physicians, for example), Title VIII nursing programs do not track whether their graduates enter practice in geographically-defined areas. The Bureau plans to propose an alternative measure when the new Strategic Plan is completed.

This annual measure is tied to the longer term goal of increasing to 40% by 2010 the proportion of health professionals trained in Title VII and VIII supported programs serving in medically underserved communities. As explained in the discussion of that measure, the Bureau is planning to implement changes in requirements regarding service in underserved communities which are expected to lead to greater improvements in results in the out years.

Efficiency Measure

1. Decrease the burden associated with applying for non-competitive continuation awards, including the submission of performance data.

BHPr's Comprehensive Performance Management System and Uniform Progress Report (CPMS/UPR) collects data on overall project performance related to BHPr's strategic goals, objectives, outcomes and indicators, and currently requires approximately 20 hours per grantee. A new web-based CPMS/UPR system with standardized questions, electronic web-based submission and automatic calculations is expected to reduce the burden on grantees. The target for FY 05 and FY 06 is 17 hours per grantee, a decrease of 15% per response.

The baseline estimate of 20 hours per grantee was obtained by surveying a sample of 3 grantees. The FY 06 target is retained at the same level as the FY 05 target, because system-wide changes in forms and processes that are required to further reduce burden typically take several years to fully implement.

Deleted Measure(s)

The following measures were in use prior to the PART review of Titles VII and VIII for the FY 04 budget cycle. These measures have been superceded by the PART measures described above. BHPR will continue to report on these measures up through the last year for which targets have been set. FY 02 results for these measures are shown as estimates and are undergoing review, due to unexpectedly large increases in the reported number of students, trainees and faculty from FY 01 to FY 02.

1. Increase the number of residents/graduates, students/trainees and faculty in clinical training with healthcare service delivery organizations serving underserved areas.

The number of students, trainees, and faculty in clinical training with healthcare service delivery organizations serving underserved populations is an indicator of the extent to which health education programs help meet the needs of the underserved. The FY 02 result is 61,610, which is the combined result for Title VII and Title VIII. FY 02 is the final reporting year for this deleted measure.

2. Increase the number of residents/graduates, students/trainees, faculty, and supported students who enter practice in underserved areas.

The number of residents, graduates, students, trainees, faculty and supported students who enter practice in underserved areas and provide service is an integral part of the solution for providing improved access to care for the underserved. The FY 02 result is 11,014, which is the combined result for Title VII and Title VIII.. FY 04 data will be reported in December, 2006.

3. Increase the number of residents/graduates, students/trainees, faculty, and supported students for health professions training programs that provide and support primary care.

Evidence suggests that primary care providers (defined as those with expertise in family medicine, general internal medicine, and general pediatrics) are more likely to practice in underserved areas compared to other specialists and subspecialists. BHPr programs strongly support training for primary care providers. Data for this measure were obtained from the CPMS/UPR system. Performance exceeded the targets for FY 99, FY 00 and FY 01. The FY 02 result is 340,445, which is the combined result for Title VII and Title VIII. FY 04 performance data will be reported in December, 2006.

4. Increase the number of minority/disadvantaged residents/graduates and faculty that complete training.

Studies have shown that members of minorities and disadvantaged groups are more likely to treat more minority patients than white, non-Hispanic physicians. The FY 02 result is 128,401, which is the combined result for Title VII and Title VIII.. FY 04 data will be reported in December, 2006.

5. Increase the number of minority/disadvantaged students/trainees, faculty and supported students in training.

The goal of a diverse healthcare workforce is dependent, in part, on the number of minority and disadvantaged students/trainees and supported students who are motivated early in their educational career (e.g.,elementary school, high school) to succeed in academically challenging healthcare education programs. Title VII programs place a strong emphasis on increasing minority elementary and high school student interest in health careers, and on alleviating academic and financial barriers that may discourage minority or disadvantaged individuals from applying for, and enrolling in, health provider training programs. The FY 02 result is 30,162, which is the combined result for Title VII and Title VIII.. FY 04 data will be reported in December, 2006.

6. Increase the number of underrepresented minorities serving as faculty.

The effectiveness of the healthcare workforce is dependent on its sensitivity to the cultural differences that affect health. Certain minority groups are underrepresented among the faculty of the institutions that train health professionals. Performance significantly exceeded the targets for FY 00 and FY 01. The FY 02 result is 15,049, which is the combined result for Title VII and Title VIII. FY 02 is the final reporting year for this deleted measure.

U.B.3. Program Title: Health Professions Workforce Information and Analysis

Performance Goals	Targets	Actual Performance	Reference
V. IMPROVE PUBLIC HEALTH AND HEALTHCARE SYSTEMS **A. Utilize trend data to assist in targeting program resources toward goals.** 1. Annually produce results of data collection and analysis activities to inform the market regarding issues relevant to health professions and nursing workforce. (Indicator: number of reports)	FY 06: 25 FY 05: 25 FY 04: 23 FY 03: 23* FY 02: 11 FY 01: 10	FY 04: 21* FY 03: 23 FY 02: 14 FY 01: 10	**REVISED FY 03 AND NEW FY 04 DATA**
Efficiency Measure 1. Reduce processing time for short term information requests. **(Developmental)**	FY 06: 1 day FY 05: 1.2 days	FY 04: 1.3 days FY 03: 2.5 days	**NEW FY 04 DATA**
Total Funding: Workforce Information and Analysis ($ in 000s)	FY 06: $712 FY 05: $716 FY 04: $722 FY 03: $819 FY 02: $824	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

* Revised data. To improve the clarity of this measure, the 50 State Health Workforce Profiles that are produced every 2-4 years have been removed from the measure.

Program Performance Analysis

Goal V.A.1. Annually produce results of data collection and analysis activities conducted to inform the market regarding issues relevant to health professions and nursing workforce. (Indicator: Number of reports produced.)

In addition to developing tools for workforce analysis, the National Center also conducts research on topical or current workforce issues and compiles data and descriptive reports on the health professions. These reports cover a wide range of health workforce issues and topics, including: (1) *Nursing Aides, Home Health Aides, and Related Health Care Occupations*. (2) *Changing Demographics: Implications for Physicians, Nurses and Other Health Care Workers* (3) *The Professional Practice Environment of Dental Hygienists in the Fifty States and the District of Columbia*. The information in these reports is used by a wide range of audiences, including healthcare planners, policy analysts, students, and researchers.

In FY 04, 21 reports were released. Two additional reports were produced, but have not yet been released. The FY 06 target is 25 reports.

Efficiency Measure

1. Reduce processing time for short term information requests.

The National Center receives numerous routine, short-term requests for information. In order to improve efficiency, the Center will begin to track the amount of time it takes to process each information request. The program set a preliminary target of 2 days in FY 05, which (subject to information from the baseline) it believes is achievable while maintaining the quality of the response. As of April 2004, response time for short turnaround information requests (those that do not require in depth research or programming) was 1.3 days. As a result, FY 05 target has been revised to 1.2 days. The FY 06 target is 1 day.

U.B.4. Program Title: Nursing Education Loan Repayment and Scholarship Programs

Performance Goals	Targets	Actual Performance	Reference
I. IMPROVE ACCESS TO HEALTH CARE **C. Improve the distribution of health professionals in underserved areas, including rural and border areas.**			**PART**
Long-Term Goal Increase by 2010 the number of individuals enrolled in professional nursing education programs by 10% over the baseline		2004 (est): 240,500[1] (baseline)	
Short-Term Goal 1. Increase the proportion of nursing scholarship recipients working in a facility with a critical shortage of nurses within 4 months of licensure. **(Outcome)**	FY 06: 85% FY 05: 80% FY 04: 75%	FY 04: 23%[2]	**NEW FY 04 DATA** **5**
Long-Term Goal By 2010, increase to 85% the proportion of NELRP participants working in shortage facilities such as: Disproportionate Share Hospitals for Medicare and Medicaid; Nursing Homes, Public Health Departments (State and local) and Public Health Clinics contained in these Departments. (Outcome)			**PART**
Short-Term Goals 2. Increase the proportion of NELRP participants working in shortage facilities such as: Disproportionate Share Hospitals for Medicare and Medicaid; Nursing Homes, Public Health Departments (State and local) and Public Health Clinics contained in these Departments. **(Outcome)**	FY 06: 90%[3] FY 05: 85%[3] FY 04: 65%[3]	FY 04: 100% FY 03: 100%	**NEW FY 04 DATA** **5**
3. Increase the percent of States in which NELRP contract recipients work.	FY 06: 93% FY 05: 93% FY 04: 85% FY 03: 65% FY 02: 50%	FY 04: 98% FY 03: 88% FY 02: 82%	**NEW FY 04 DATA** **5**

Performance Goals	Targets	Actual Performance	Reference
Long-Term Goal By 2010, increase to 28% the proportion of NELRP participants who remain employed at a critical shortage facility for at least one year beyond the termination of their NELRP service. **(Outcome)**			**PART**
Short-Term Goals 4. Reduce Federal investment per year of direct support by increasing the proportion of program participants who extend their service contracts and commit to work at a critical shortage facility for an additional year. **(Outcome)**	FY 06: 45% FY 05: 40% FY 04: 22%	FY 04: 44% FY 01: 18% (baseline)	3
5. Increase the proportion of NELRP participants who remain employed at a critical shortage facility for at least one year beyond the termination of their NELRP service.	FY 06: 11% FY 05: 11% FY 04: 10%	FY 06: FY 05: FY 04: 40% (preliminary estimate)	**NEW FY 04 DATA** 3
Efficiency Measure 1. Maintain the average length of time it takes the NELRP program to process a request for information and return results to the requestor. **(Developmental)**	FY 06: 4.5 hours FY 05: 4.5 hours	FY 05: (10/05)	
Deleted Measure(s) 1. Award nursing loan repayment contracts.	FY 05: NA FY 04: 600 new contracts FY 03. 700 FY 02: 560 FY 01: 200	FY 04: 650 initial award 208 amendment FY 03: 602 FY 02: 560 FY 01: 443	**NEW FY 04 DATA**
Total Funding: Nursing Loan Repayment and Nursing Scholarship Programs ($ in 000s)	FY 06: $31,369 FY 05: $31,482 FY 04: $26,736 FY 03: $19,870 FY 02: $10,235	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

[1] Students in all pre-licensure R.N. programs in the 2002-2003 academic year.

[2]Target was based on the assumption that all scholars would complete programs and enter service at the same time. As yet, only 23% of the 2003 scholarship recipients have completed programs in FY 04 and entered into service.

[3] The program was able to achieve 100% in FY 03 and FY 04 due to the large number of applicants working in facilities with the most critical shortages. The actual performance greatly exceeded the original targets of 10% and 15% for FY 04 and FY 05 respectively. The FY 05 and FY 06 targets are therefore increased to 85% and 90%, respectively. At this time there is insufficient evidence of a long-term trend to justify adoption of a 100% goal. Achieving the goals depends in part on the number of applications received from applicants employed by the named facility types which is beyond agency control.

[4] See narrative for explanation.

Program Performance Analysis

Long-Term Goals

Increase by 2010 the number of individuals enrolled in professional nursing education programs by 10% over the baseline.

The pool of qualified nurses is shrinking. Under the authority of the Nurse Reinvestment Act, the new Nursing Scholarship Program will work in partnership with other HHS programs to implement efforts to encourage more people to consider nursing careers, motivate them to serve in areas of critical shortage, and inform them of the scholarship and nursing loan repayment options available to them. Since this measure was adopted, there have been some signs of increased interest in nursing careers, but in the short-run, enrollment increases are constrained by a shortage of nursing faculty. Baseline enrollment was estimated at 240,500 in FY 04.

Goal I.C.1. Increase the proportion of nursing scholarship recipients working in a facility with a critical shortage of nurses within 4 months of graduation.

The Nursing Scholarship Program implemented starting in FY 03 will improve BHPr's ability to achieve increased enrollment in nursing programs over the next few years. The program is expected to attract more students into nursing education by providing financial support during the training years.

Data for these performance measures will provide an indication of the degree to which Nursing scholarship resources are being successfully targeted to facilities experiencing the most critical shortages of nurses.

The first nursing scholarship awards were made in September, 2003. Of those, only 23% of awardees have completed their programs and entered service, therefore, the baseline is 23%. We expect this number to increase as the proportion of awardees completing their programs increases. The FY 06 target is 85%.

Long-Term Goal

By 2010, increase to 85% the proportion of NELRP participants working in shortage facilities such as: Disproportionate Share Hospitals for Medicare and Medicaid; nursing homes, public health departments (State and local) and public health clinics contained in these Departments.

Short-Term Goals

Goal I.C.2. Increase the proportion of NELRP participants working in shortage facilities such as: Disproportionate Share Hospitals for Medicare and Medicaid; nursing homes, public health departments (State and local) and public health clinics contained in these departments.

Data for these performance measures will provide an indication of the degree to which NELRP resources are being successfully targeted to facilities experiencing the most critical shortages of nurses. NELRP awardees provide an increase in service hours in facilities providing care to underserved individuals.

Data for these measures will be obtained by monitoring automated data on NELRP contracts. NELRP applicants working in shortage facilities such as: Disproportionate Share Hospitals for Medicare and Medicaid; nursing homes, public health departments (State and local) and public health clinics contained in these departments are in the first preference category for awards.

This was a new PART measure for FY 04, and a preliminary target of 10% was set in the absence of a baseline. In FY 03 the program experienced a sharp increase in the number of applications for loan repayment contracts in general and also for the facility types named above. All available funds for initial awards were expended nurses working in those facility types. In FY 04 all funds were again awarded to nurses employed by those facility types. This result suggests that FY 04 and FY 05 targets should be considerably higher than the 10% and 15% originally set. It would, however, be inappropriate to set them at 100% since there is too little data to reliably predict long term trends and the number of applications received from nurses employed by the various facility types is beyond the program's control. Therefore, the target for FY 04 remains at the previously set 65% level, while the targets for FY 05 and FY 06 are set at 85% and 90%, respectively. The program will continue monitoring trends, and is committed to maximizing the number of program participants serving in facilities with the most critical shortages such as those named in the previous paragraph.

Goal I.C.3. Increase the percent of States in which NELRP contract recipients work. (Indicator: Percent of NELRP contract recipients across the States and Territories)

This was a new indicator starting in FY 02. Until FY 02, information about this program was not widely distributed and contract recipients were limited to a small number of States. Increased funding and marketing strategies in FY 02 resulted in broader distribution of contract awards to RNs working in facilities with the most extreme shortages in more States.

Performance in FY 02 was 82% compared with a target of 50%, and 88% in FY 03, compared with a target of 65%. The target for FY 04 was 85%, but the program achieved 98%. Some fluctuation from year to year is expected because awards are based on financial need and type of facility rather than the State in which the recipient plans to work. The targets for FY 05 and FY 06 have been raised to 93%.

Long-Term Goal

By 2010, increase to 22% the proportion of NELRP participants who remain employed at a critical shortage facility for at least one year beyond the termination of their NELRP service.

Short-Term Goals

Goal I.C.4. Reduce Federal investment per year of direct support by increasing the proportion of program participants who extend their service contracts and commit to work at a critical shortage facility for an additional year. (New Measure)

NELRP is designed to address the maldistribution of registered nurses by creating financial incentives for qualified nurses to work full-time in facilities determined to have a nursing shortage. Initial contracts are for two years of service. This indicator will provide a measure of the degree to which registered nurses participating in NELRP are willing to serve in a critical shortage facility for at least one additional year. NELRP is the only federal program that provides loan repayment for the costs of basic nursing training in exchange for service in shortage facilities. In FY 04 there were 472 participants eligible to extend their contracts; after evaluation 207 (44%) contracts were awarded. The target for FY 05 has been reset for 40% and the FY 06 target to 45% to reflect the program's expectation that performance in those years will be comparable to FY 04.

Goal I.C.5. Increase the proportion of NELRP participants who remain employed at a critical shortage facility for at least one year beyond the termination of their NELRP service.

NELRP is designed to address the maldistribution of registered nurses by creating financial incentives for qualified nurses to work full-time in facility types known to have a nursing shortage.

This indicator will address the issue of retention by providing a measure of the degree to which trained nurses participating in NELRP are willing to serve in a critical shortage facility for at least one additional year beyond the termination of their NELRP service. Data for this PART measure recently began to be submitted for the first time. A preliminary estimate of 40% has been calculated for FY 04, which will be finalized prior to the next performance update. Targets will be revised once the FY 04 data are finalized.

Efficiency Measure

1. Maintain the average length of time it takes the NELRP program to process a request for information and return results to the requestor. (Developmental)

The length of time required to process a request about the Loan Repayment Program is an important dimension of program performance. As awareness of NELRP and its benefits grew among the R.N. community along with the funding, the number of information inquiries and

applications processed has grown dramatically. In FY 04 we hired a contractor to operate a Call Center, maintain detailed statistics on the time required to respond to each inquiry and send monthly reports to the NELRB Chief for monitoring.

There are 3 levels of inquiries. Levels 1 and 2 can generally be handled by Call Center staff using written guidelines provided by the program. Level 3 calls are more complex and are referred to NELRP staff, and may require legal advice and policy decisions. Level 1 and Level 2 calls are currently processed within 170 minutes, on average. Level 3 questions are more unpredictable, and require more time to handle. Four and a half hours is our best estimate of the average processing time the program could achieve in the short run for all inquires, regardless of level. For this reason, a target of 4.5 hours is proposed, and the program will update this measure with actual baseline data in October, 2005.

Deleted Measure(s)

1. Award nursing loan repayment contracts.
(Indicator: Number of loan repayment contracts made)

In FY 99, 202 loan repayment contracts were negotiated. In FY 00, 195 loan repayment contracts were negotiated. In 2001, an additional $5 million was transferred into the program and 434 loan repayment contracts were negotiated.

Performance exceeded or met targets in FY 01 and 02. The number of contracts awarded in FY 03 (602) did not meet the original target of 700. The major reason for this is an increase in the average award amount, due to rising tuition costs, and an increase in the number of masters level nurses applying to the program. In FY 04, the target was 600 initial contracts and the program actually awarded 650. FY 04 is the final reporting year for this deleted measure.

U.B.5. Program Title: Bioterrorism Training and Curriculum Development Program

Performance Goals	Targets	Actual Performance	Reference
VI. ENHANCE THE ABILITY OF THE HEALTH CARE SYSTEM TO RESPOND TO PUBLIC HEALTH EMERGENCIES **A. Enhance the ability of health professionals in community settings, hospitals, health centers, emergency medical systems, poison control centers, and other sites to respond to bioterrorism and other public health threats in a timely and effective manner** 1. Implementation of the HRSA Health Professional Bioterrorism Preparedness training for health professionals in practice, including NHSC members.	FY 06: 100,000 Trainees FY 05: 96,000 FY 04: 64,775 FY 03: 38,000	FY 04: (12/06) FY 03: (10/05)	2
Efficiency Measure 1. Decrease the burden hours associated with applying for non-competitive continuation awards, including submission of performance data.	FY 06: 17 FY 05: 17	FY 04: 19 FY 03: 20 (baseline)	
Deleted Measure(s) 1. Health professional schools will incorporate HRSA Health Professional Bioterrorism Preparedness training into their curriculum.	FY 04: 13* FY 03: 25*	FY 04: (12/06) FY 03: (10/05)	2
Total Funding: Educational Incentives ($ in 000s)	FY 06: $27,521 FY 05: $27,520 FY 04: $27,706 FY 03: $27,818	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

* The FY 03 target of 25 health professional schools implementing the curriculum was established when the expected FY 03 budget was $60 million. Since budget assumptions have changed, the FY 04 target has been reduced accordingly.

Program Performance Analysis

Short-Term Goal

Goal VI.A.1. Implementation of the HRSA Health Professional Bioterrorism Preparedness training for health professionals in practice, including National Health Service Corps (NHSC) members.
(Indicator: Number of Health Professionals by discipline who receive HRSA Health Professional Bioterrorism Preparedness training.) Trainees shall include all health professionals and will include members of the National Health Service Corps (NHSC).

For FY 03 it was projected that the program would train 38,000 persons. This estimate was developed before applications were received. The FY 04 and FY 05 estimates of 64,775 and 96,000 trainees, respectively, are higher as informed by applications. As the training program matures, it is anticipated that 100,000 health professionals will be trained in FY 06. The program does not yet have results to report, because the first grants were awarded in FY 03.

Efficiency Measure

1. Decrease the burden hours associated with applying for non-competitive continuation awards, including submission of performance data.

BHPr has developed a web-based Comprehensive Performance Management System and Uniform Progress Report (CPMS/UPR) system for its Title VII and VIII grantees, and the Bioterrorism program. The UPR is used by Grantees seeking assistance for a second or subsequent budget period within a previously approved project period. The CPMS system collects data on overall project performance related to BHPr's strategic goals, objectives, outcomes and indicators. The new web-based CPMS/UPR system greatly reduces the burden on Grantees in providing the required information.

The estimated average annual burden for FY 05 (expected) is 17 hours per grantee. Previously this burden was an average of 20 hours per grantee. This represents a decreased burden of 15% per response. The reduction target is estimated based on a decrease in duplicate information requested and narrative responses, standardization of questions across forms, and electronic Web-based submission and automatic calculations. The FY 06 target is 17 hours.

Deleted Measure(s)

1. Health professional schools will incorporate HRSA Health Professional Bioterrorism Preparedness training into their curriculum.
(Indicator: Number of health professional schools that have incorporated HRSA Health Professional Bioterrorism Preparedness training into their curriculum)

An essential component for a coordinated response to bioterrorism consists of active collaboration between the public and private health systems as well as within the various disciplines of the healthcare system.

FY 03 was the first year of award under this program. Schools receiving awards in September, 2003 will begin reporting by the end of 2005. The FY 03 target of 25 schools was established using different budget assumptions. In FY 04, budget assumptions changed, and the target was reduced accordingly, and currently reflects the actual number of schools (13) that have received grants. FY 04 data are expected to be available in December 2006. FY 04 will be the final reporting year for this deleted measure.

U.B.6. Program Title: Children's Hospitals Graduate Medical Education Payment Program

Performance Goals	Targets	Actual Performance	Reference
II. IMPROVE ACCESS TO HEALTH CARE **A. Expand the capacity of the health care safety net** 1. Maintain the number of FTE residents in training in eligible children's teaching hospitals.	Total trained on-site: FY 06: 4,450 FY 05: 4,303 FY 04: 4,303 FY 03: 4,429 Total trained off-site FY 06: 378 FY 05: 324 FY 04: 324 FY 03: 236	 FY 04: (7/05) FY 03: 4,450 FY 02: 4,303 FY 01: 4,429 FY 00: 4,549 FY 04: (7/05) FY 03: 378 FY 02: 324 FY 01: 236 FY 00: 271	**NEW** **FY 03** **DATA**
VII. ACHIEVE EXCELLENCE IN MANAGEMENT **C. Preserve the financial integrity of HRSA's programs and activities** **Long-Term Goals** Percent of hospitals with verified FTE resident counts and caps. Percent of hospitals with verified bed counts, case-mix index, and number of discharges. (Measure contingent upon the results of pilot studies to be completed in FY 2006.)	 FY 08: 100% FY 08: 100%		**PART**
Short-Term Goals 1. Percent of hospitals with verified FTE resident counts and caps. 2. Actions to assess the feasibility and cost-effectiveness of verifying all hospitals' bed counts, case-mix indices, and number of discharges.	FY 06: 100% FY 05: 100% FY 04: 100% FY 06: Results of analysis FY 05: Develop methodology	 FY 04: 100% FY 03: 100% FY 04: Methodology report completed. FY 03: The program has completed draft development of methodologies, and is preparing to pilot them.	**PART** **NEW** **FY 04** **DATA**
Efficiency Measure 1. Percent of payments made on time.	FY 06: 100% FY 05: 100%	 FY 04: 100% FY 03: 100%	**NEW** **FY 04** **DATA**

Performance Goals	Targets	Actual Performance	Reference
Deleted Measure(s) 1. Report the percentage of hospitals funded by the program with negative total margins	FY 04: 25% FY 03: 21% FY 02: 26%	FY 04: (7/05) FY 03: 38% FY 02: 25%	**NEW FY 03 DATA**
2. Report the proportion of hospital's gross revenue from patient care attributed to public insurance (Medicaid, Medicare, SCHIP), and uninsured patients.	FY 04: Inpatient: 43% Outpatient: 32% FY 03: Inpatient: 45% Outpatient: 34% FY 02: Inpatient: 48% Outpatient: 41%	FY 04: (7/05) FY 03: Inpatient 46% Outpatient 36% FY 02: Inpatient 43% Outpatient 32%	**NEW FY 03 DATA**
Total Funding: Children's Hospitals Graduate Medical Education ($ in 000s)	FY 06: $200,000 FY 05: $300,730 FY 04: $303,169 FY 03: $290,102 FY 02: $284,862	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

Program Performance Analysis

Goal II.A.1. Maintain the number of FTE residents in training in eligible teaching hospitals.

The healthcare workforce environment requires that sufficient numbers of physicians be appropriately and adequately trained to care for pediatric populations. Freestanding children's hospitals train medical residents and provide significant services to the local, regional and national communities. These services include caring for the Medicaid population, children that are on SCHIP, and the uninsured. A reduction in medical residency training programs would affect the provision of those services, as well as the production of one quarter of the Nation's pediatricians and the majority of pediatric subspecialists.

This performance goal provides an accounting of the number of FTE residents receiving training in and being sponsored by the children's hospitals that are eligible and participating in the CHGME PP. The data captures the number of residents training in hospitals, those rotating through the hospital for training, and those rotating outside the hospitals.

The overall program goal is for the number of residents being trained and being sponsored by children's hospitals participating in the CHGME PP to be maintained (i.e., not to increase). The targets for future years are based on the actual performance data from the baseline. The total number of full-time equivalent (FTE) residents being trained on-site and off-site in FY 03 was reported at 4,828, an increase of 201 FTE residents from the FY 02 reported numbers.

Long-Term Goals

Percent of hospitals with verified FTE resident counts and caps.

Percent of hospitals with verified bed counts, case-mix index, and number of discharges. (This measure is contingent upon the results of pilot studies to be completed in FY 06.)

The long-term goals above and the following short-term goals were set during the FY 05 PART process.

Short-Term Goals

Goal VII.C.1. Percent of hospitals with verified FTE resident counts and caps.

In FY 03, the CHGME PP implemented assessments of all FTE resident counts provided by each of the children's hospitals on their initial application for funds including the caps. In FY 03, the program's target was to assess 100 percent of the hospitals' FTE resident counts used in the determination of CHGME payments. The CHGME PP achieved that target. Also, the CHGME PP as part of its own self-evaluation process developed documentation guidance for use by children's hospitals to assist them with compliance requirements, and to continue promoting consistency, equity and timeliness of the assessments for all children's hospitals in future years. Other assessment process efficiencies are being implemented to reduce both hospital burden and costs associated with these assessments. For FY 05 and FY 06, all of the FTE resident counts claimed by children hospitals for purposes of payment will be assessed prior to the final determination of payments.

VII.C.2. Actions to assess the feasibility and cost-effectiveness of verifying hospitals bed counts, case-mix indices, and number of discharges.

The bed counts, case mix index, and number of discharges affect the determination of IME payments. The objective is to assess whether it is cost-beneficial to conduct a comprehensive assessment of these reported measures.

In FY 04, CHGME PP completed the development of protocols describing proposed assessment methodologies previously targeted for FY 05.

During FY 05 and FY 06, the CHGME PP will pilot the three assessment methodologies using the newly developed protocols as a guide and evaluate the cost-effectiveness of verifying 100% of participating hospitals' bed counts, case-mix indices, and number of discharges.

Efficiency Measure

1. Percent of payments made on time.

The efficiency measure for this program is to make 100 percent of DME and IME payments to children's hospitals on time. The payment process is mandated by law and requires (1) determination of two payments, DME and IME, based on children's hospitals initial application for funds before the beginning of each fiscal year; (2) biweekly payments to start with the beginning of each fiscal year, dependent on availability of funds; and (3) two reconciliation payments, DME and IME, to be disbursed on a biweekly schedule, that are dependent on the Secretary's final determination of the number of residents training at these institutions. For FY 04, 100 percent of DME and IME payments to children's hospitals were made on time. The targets for FY 05 and FY 06 are the same. The CHGME PP is utilizing both efficient management practices and electronic capabilities to generate its payments on time.

Deleted Measure(s)

1. Report percentage of hospitals funded by the program with negative total margins.

In FY 03, 38 percent of children's hospitals reported having negative total margins. This aggregate performance measure, reflecting the children's hospitals financial status, allows the CHGME PP to monitor the financial status of children's hospitals participating in the program.

2. Report the proportion of hospital's gross revenue from patient care attributed to public insurance (Medicaid, Medicare, SCHIP), and uninsured patients.

Children's hospitals have historically provided a significant amount of care to the traditionally underserved populations such as those enrolled in the Medicaid or SCHIP programs, and those who are uninsured. In FY 03, children's hospitals reported that 46 percent of their gross revenue for inpatient care could be attributed to public insurance (Medicare, Medicaid, and SCHIP) and uninsured patients. Similarly, 36 percent of their gross revenue from outpatient care is attributed to public insurance (Medicare, Medicaid, and SCHIP) and the uninsured.

U.B.7. Program Title: National Practitioner Data Bank (NPDB)

Performance Goals	Targets	Actual Performance	Reference
III. IMPROVE THE QUALITY OF HEALTH CARE **B. Promote patient safety and improve patient protections** 1. Increase the use of the NPDB and HIPDB for decision-making (# of decisions affected by NPDB or HIPDB data).	NPDB FY 06: 43,600 FY 05: 40,100 FY 04: 46,800 FY 03: 47,385 FY 02: 39,750 FY 01: 38,000 HIPDB FY 06: 1,000 FY 05: 1,000 FY 04: 1,000 FY 03: 1,200 FY 02: 836	NPDB FY 04: 43,600 FY 03: 40,100 FY 02: 39,100 FY 01: 38,900 HIPDB FY 04: 970 FY 03: 830 FY 02: 920 FY 01: 1,100	**NEW FY 04 DATA**
Efficiency Measure 1. Maintain the length of time it takes the NPDB and HIPDB to process a query and return results to the querier, with a continual increase in the number of reports that the increasing queries must be matched against.	FY 06: < 240 min FY 05: < 240 min FY 04: < 240 min	FY 04: <240 min. FY 03: <240 min FY 90: Several days	**NEW FY 04 DATA**
Total Funding: National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank ($ in 000s) * uf = user fees	FY 06: $15,700 NPDB uf* $ 4,000 HIPDB uf* FY 05: $15,700 NPDB uf* $ 4,000 HIPDB uf* FY 04: $16,000 NPDB uf* $ 4,000 HIPDB uf* FY 03: $19,500 NPDB uf* $ 5,600 HIPDB uf* FY 02: $16,361 NPDB uf* $ 4,576 HIPDB uf*	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

Program Performance Analysis

Goal III.B.1. Increase the use of the NPDB and HIPDB for decision-making.

NPDB provides information on medical malpractice payments, adverse actions or exclusions against physicians, dentists, and in some cases, other health care practitioners to licensing boards, hospitals, health plans, and professional societies for licensing, privileging, and membership decisions. Responses have been shown to affect decision-making in about 9% of cases. HIPDB augments the NPDB by providing information on licensure actions, health care related criminal convictions and civil judgments, for other types of health care providers and suppliers.

Data from our research file indicate that in FY 03 the NPDB provided responses for 3,426,380 queries from entities, of which 478,870 matched responses contained report information. An estimated 43,600 licensure, credentialing, or membership decisions were affected by these match responses during FY 04. The HIPDB affected an estimated 970 decisions in FY 04. A survey by the University of Illinois at Chicago and Northwestern University found that 21% of reports included new information not provided in practitioner applications.

The FY 03 and FY 04 targets are somewhat higher than the actual results for this goal. These targets were based on the assumption that Section 1921 of the Social Security Act, which would expand the NPDB, would be implemented by the beginning of FY 03. However, implementation of Section 1921 has been delayed by the regulatory approval process, and it is now expected in FY 06. FY 05 and FY 06 targets have been adjusted to reflect the number of decisions expected to be affected in the absence of Section 1921. The programs expects the implementation of Section 1921 to greatly increase the number of queries, and the projected number of decisions affected by NPDB data, by making available adverse action data concerning nurses and other types of licensed practitioners (in addition to the physician and dentist data currently available).

Efficiency Measure

1. Maintain the length of time it takes the NPDB and HIPDB to process a query and return results to the querier, with a continual increase in the number of reports that the increasing queries must be matched against.

The length of time it takes the NPDB-HIPDB to process a query and return results to the querier has been reduced dramatically over the last 13 years while the number of reports in the system has continually increased. When the NPDB opened in 1990, it took days and sometimes weeks to process queries. The volume of queries has increased greatly over the years, to about 4.3 million queries a year. The number of reports contained in the NPDB-HIPDB is currently 486,421 (not double counting 59,753 reports which are in both data banks). The system has changed from paper documents to an internet based system containing electronic documents. A query is processed by running the query through the accepted reports in the NPDB-HIPDB database and determining a match. The current average response time is 104 minutes. However, in terms of a performance target for FY 05, the current program standard of <240 minutes is the standard as specified in the program's fixed-price, performance-based contract. The program standard cannot be changed without a contract modification. For FY 05 and FY 06, the program therefore commits to keeping processing time to less than 240 minutes, regardless of any increases in the volume of queries and reports.

U.B.8. Program Title: Health Education Assistance Loans (HEAL)

Performance Goals	Targets	Actual Performance	Reference
VII. ACHIEVE EXCELLENCE IN MANAGEMENT **C. Preserve the financial integrity of HRSA's programs and activities** 1. Conduct an orderly phase-out of the outstanding loan portfolio, resulting in a reduction in the Federal liability associated with the HEAL program.	FY 06: $1,700,000,000 FY 05: $1,900,000,000 FY 04: $2,600,000,000 FY 03: $2,700,000,000 FY 02: $3,300,000,000 FY 01: $3,400,000,000 FY 00: $3,600,000,000	FY 04: $2,028,073,894 FY 03: $2,328,908,027 FY 02: $2,722,255,196 FY 01: $3,174,603,269 FY 00: $3,516,817,133	**NEW FY 04 DATA**
Efficiency Measure 1. Improve claims processing efficiency through implementation of an online processing system (HOPS). **(Developmental)**	FY 06: 08 days FY 05: 09 days	FY 04: (Baseline: 10 days)	**NEW FY 04 DATA**
Deleted Measure 1. Reduce the amount of HEAL claims to be paid from the liquidating account, decreasing the Federal liability associated with the HEAL program.	FY 04: $20,000,000 FY 03: $25,000,000 FY 02: $30,000,000 FY 01: $30,000,000	FY 04: $ 9,151,158 FY 03: $15,303,707	**NEW FY 04 DATA**
Total Funding: HEAL ($ in 000s)	FY 06: $ 2,916* FY 05: $ 3,244* FY 04: $ 3,353* FY 03: $ 3,889* FY 02: $13,791	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

*Direct operations

Program Performance Analysis

Goal VII.C.1. Conduct an orderly phase-out of the outstanding loan portfolio.

The performance targets measure the gradual decrease of the outstanding loan portfolio. The baseline level represents original loan amounts plus accrued interest for the HEAL outstanding loan portfolio. Target estimates reflect the impact of repayments and HEAL default reduction activities on the outstanding loan portfolio.

Actual performance for FY 04 was better than the target due to refinancing of loans and a decrease in requests for claims from the liquidating account. The HEAL program remains committed to proper management and oversight of the $2.0 billion outstanding loan portfolio.

This includes providing the 55,518 HEAL borrowers who have not yet fully repaid their loans with appropriate assistance to facilitate the repayment of their loans, working with lenders and loan holders to minimize defaults, and aggressively pursuing HEAL defaulters.

Efficiency Measure

1. Improve claims processing efficiency through the implementation of an online processing system. (Developmental)
(Indicator: Number of days required to process a claim)

Until recently, HEAL claims were processed by individual claims analysts. The process was labor intensive, and the interpretation of claims information could vary from analyst to analyst. Recently, the HEAL Program instituted an automated method for reviewing claims, based on a new Web-based Oracle database application referred as HOPS (HEAL Online Processing System) to facilitate comprehensive and standardized claims review, based on all applicable laws, regulations, and policies pertaining to lender servicing, due-diligence, litigation, and claim submissions.

The FY 04 baseline is 10 days. The goal is to reduce claim processing time to 9 days in FY 05, and 8 days in FY 06.

Deleted Measure(s)

1. Reduce the amount of HEAL claims to be paid from the liquidating account.

Reducing HEAL claims paid from the liquidating account minimizes Federal liability associated with the HEAL program. The FY 04 Actual Performance for HEAL claims paid exceeded FY 03 targets due to the effectiveness of default reduction initiatives and tight management control. FY 04 is the final reporting year for this deleted measure.

U.C MATERNAL AND CHILD HEALTH

Programs included in this section are:

U.C.1. Maternal and Child Health Block Grant - Title V
U.C.2. Traumatic Brain Injury
U.C.3. Healthy Start
U.C.4. Universal Newborn Hearing Screening and Early Intervention
U.C.5. Emergency Medical Services for Children

U.C.1 Program Title: Maternal and Child Health Block Grant - Title V

Performance Goals	Targets	Actual Performance	Reference
I. IMPROVE ACCESS TO HEALTH CARE **A. Expand the capacity of the health care safety net** 1. Increase the number of children served by Title V. **(Outcome)**	FY 06: 23 M FY 05: 23 M FY 04: 23 M FY 03: 24.5 M FY 02: 24.5 M FY 01: 24 M	FY 04: (12/05) FY 03: 22.7 million FY 02: 22.6 million FY 01: 22.6 million FY 00: 22.8 million FY 99: 23.0 million	**NEW** **FY 03** **DATA** 3
Long-Term Goal By 2008, decrease the number of uninsured children to 8 million. **Short-Term Goal** 2. Increase the number of children receiving Title V services who are enrolled in and have Medicaid and SCHIP coverage. **(Outcome)**	FY 06: 6.2 M FY 05: 6.2 M FY 04: 6.2 M	FY 04: (11/05) FY 03: 9.7 million FY 02: 5.9 million (baseline)	**PART** **NEW** **FY 03** **DATA** 3
3. Increase the percent of infants born to pregnant women who received prenatal care beginning in the first trimester. **(Outcome)**	FY 06: 84% FY 05: 84% FY 04: 84% FY 03: 84% FY 02: 84% FY 01: 90%	FY 04: (11/05) FY 03: 82.2% FY 02: 81.6% FY 01: 81.3% FY 00: 83.2% FY 99: 83.2%	HP-16 **NEW** **FY 03** **DATA** 1,5
IV. ELIMINATE HEALTH DISPARITIES **B. Promote outreach efforts to reach populations most affected by health disparities** 1. Decrease the ratio of the black infant mortality rate to the white infant mortality rate. **(Outcome)**	FY 06: 2.1 to 1 FY 05: 2.1 to 1 FY 04: 2.1 to 1 FY 03: 2.1 to 1 FY 02: 2.1 to 1 FY 01: 2.1 to 1	FY 04: (11/06) FY 03: (11/05) FY 02: 2.48 to 1 FY 01: 2.21 to 1 FY 00: 2.26 to 1 FY 99: 2.3 to 1 FY 98: 2.4 to 1	HP-16 **NEW** **FY 02** **DATA** 1,5

Performance Goals	Targets	Actual Performance	Reference
III. IMPROVE QUALITY OF HEALTH CARE **A. Promote effectiveness of health care services**			**PART**
Long-Term Goal By 2008, reduce infant deaths to 6.5 per 1,000 live births. **(Outcome)**			HP-16
Short-Term Goals 1. Reduce the infant mortality rate. **(Outcome)**	FY 06: 6.7/1000 FY 05: 6.9/1000 FY 04: 6.9/1000 FY 03: 6.9/1000 FY 02: 6.9/1000 FY 01: 6.9/1000 FY 00: 7.0/1000	FY 04: (11/06) FY 03: (11/05) FY 02: 7.0/1000 FY 01: 6.8/1000 FY 00: 6.9/1000 FY 99: 7.1/1000 FY 98: 7.2/1000	1,5 HP-16 **NEW FY 02 DATA**
2. Reduce the incidence of low birth weight births. **(Outcome)**	FY 06: 7.4% FY 05: 7.4% FY 04: 7.5%	FY 04: (11/06) FY 03: (11/05) FY 02: 7.8% FY 01: 7.5% FY 00: 7.6% FY 99: 7.6% FY 98: 7.6%	5
Long-Term Goal By 2008, reduce neonatal deaths to 4.5 per 1,000 live births by improving the quality of prenatal care. **(Outcome)**			**PART** HP - 16
Short-Term Goal 3. Increase percent of low birth weight babies who are delivered at facilities for high-risk deliveries and neonates. **(Outcome)**	FY: 06: 77% FY 05: 76% FY 04: 75%	FY 04: (11/05) FY 03: 76.01% FY 98: 73.0% FY 97: 72.5% (baseline)	**NEW FY 03 DATA** 5

Performance Goals	Targets	Actual Performance	Reference
Long-Term Goal By 2008, increase maternal survival to 8 maternal deaths per 100,000 live births. **(Outcome)** **Short-Term Goal** 4. Reduce illness and complications due to pregnancy. **(Outcome)**	FY 06: 30.0/100 FY 05: 30.0/100 FY 04: 26/100	FY 04: (12/07) FY 03: (12/06) FY 02: (12/05) FY 01: 32.1/100 FY 00: 31.4/100 (baseline)	**PART** **NEW** **FY 01** **DATA** 5
Efficiency Measure 1. Decrease the time of States in applying for Title V Block Grants and in reporting performance data. **(Developmental)**	FY 06: 15% less than baseline FY 05: 12% less than baseline	FY 02: 320 hours for standard applications and 398 hours for application with needs assessment (baseline)	
Deleted Measure(s) 1. Increase the percent of newborns in the State with at least one screening for all of the following: PKU, hypothyroidism, galactasemia, and hemoglobinopathies (e.g. the sickle cell disease). **(Outcome)**	FY 03: 95%	FY 04: NA FY 03: 96% FY 02: 95% FY 01: 95% FY 00: 94%	HP-16 **NEW** **FY 03** **DATA** 1,5
Total Funding: Maternal and Child Health Block Grant ($ in 000s)	FY 06: $723,928 FY 05: $723,928 FY 04: $729,817 FY 03: $730,710 FY 02: $731,259	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

Program Performance Analysis

For some measures, the relationship between budget resources and performance in the MCH Block Grant is relatively straightforward, e.g., increases in the number of children served by Title V. For other measures, the relationship is interdependent with Medicaid and other programs. The attainment of such goals is directly or indirectly tied to the amount of Title V funding at both the national and State levels.

Goal I.A.1. Increase the number of children served by Title V.

The number of children served by Title V is a critical measure of the degree to which the program is successful in reaching and providing services to one of its key target populations. This occurs through provision of direct health care, enabling services, population-based services, and infrastructure building activities. The number of children served by Title V increased steadily from 1997 through 1999. In 2000, there was a temporary slight decrease to 22.8 million from 23.0 million, perhaps reflecting a decrease in State funding, or a shift in the caseload mix, which may have resulted in more covered children receiving costlier services.

In 2003 the numbers increased again from a low of 22.6 million in FY 02 to 22.7 million children served by Title V. Though this is short of the FY 03 target of 24.5 million, the increase is a move in the right direction. Data for FY 04 will be available December, 2005.

Long-Term Goal

By 2008, decrease the number of uninsured children to 8 million.

Access to health insurance coverage increases access to appropriate preventive and acute care, contributing to improved health status of these children along with better school attendance and overall quality of life. The goal is to decrease the number of uninsured children to 8 million by 2008 from 8.4 million in 2000.

Goal I.A.2. Increase the number of children receiving Title V services who are enrolled in and have Medicaid and SCHIP coverage.

This goal is an annual measure for the Long-Term Goal of decreasing the number of children without insurance. Increased coverage under Medicaid and SCHIP for children receiving Title V services would assure continuity of care and receipt of a wide range of services.

The stated target was to increase the number of children receiving Title V services covered by Medicaid and SCHIP to 6.2 million in 2006 from a baseline of 5.9 million in 2002. However, FY 03 data shows the number of children receiving these services at 9.7 million. This jump is due to a change in reporting methods by several large and populous states which previously did not report many recipients due to the use of reimbursement data only. This is a significant number of children in Title V enrolled in Medicaid and SCHIP. Data on the 2004 performance will be available in November, 2005.

Goal I.A.3. Increase the percent of infants born to pregnant women who received prenatal care beginning in the first trimester.

Prenatal care is one of the most important interventions for ensuring the health of pregnant women and their newborn babies. High quality prenatal care begins early in the pregnancy (preferably in the first trimester), and continues throughout the pregnancy, according to accepted standards of periodicity. Accordingly, getting pregnant women into early and regular prenatal care has been a key area of emphasis for the Title V program. The percentage of infants born to pregnant women receiving care beginning in the first trimester of pregnancy is a key indicator of the degree to which the Title V program is successful in reaching its target population.

HRSA is strongly committed to achieving the Healthy People 2010 goal of getting 90% of all pregnant women into prenatal care in the first trimester. However, while the proportion of pregnant women entering prenatal care in the first trimester has increased steadily for all population groups over the last decade (from 75.8% in 1990), progress in recent years has been slow. FY 02 and FY 03 have shown a consistent increase in the number of pregnant women entering prenatal care in the first trimester, with 82.2% recorded in FY 03, closing the gap in order to achieve the FY 06 target of 84%. Data for FY 04 will be available in November, 2005.

The slowing rate of increase in recent years suggests that the easiest improvements may already have been made, and that further gains are likely to be slow. Research has shown that the likelihood of seeking prenatal care is influenced by a variety of financial, social, and psychological factors. Medicaid program expansions have been systematically addressing eligibility and financial barriers. However, social and psychological factors (such as awareness of, and wantedness of, the pregnancy) remain more difficult to address programmatically.

Additional research is needed to identify new strategies for getting pregnant women to begin prenatal care in the first trimester of pregnancy. Accordingly, HRSA's expectations of further increases in the near term are modest.

Goal IV.B.1. Decrease the ratio of the black infant mortality rate to the white infant mortality rate.

Infant mortality is a critical indicator of the health of a population. While the U.S. has made significant progress in reducing the overall infant mortality rate, there is still significant disparity in the rate for selected racial groups. The Black infant mortality rate is more than twice the White rate.

The Black/White Infant Mortality Ratio was 2.48 to 1 in FY 02 (National Vital Statistics Reports), a rate above the performance target for fiscal year 2002. Although infant mortality rates have declined for both Blacks and Whites in recent years, the proportional discrepancy between Blacks and Whites remains largely unchanged. Research has suggested that a higher rate of very low birth weight among Blacks may contribute to, but does not fully explain, racial differences in infant mortality rates. Additional research is needed to identify factors responsible for the black/white infant mortality disparity, and the most effective strategies for addressing it. Accordingly, HRSA's expectations of progress on this measure in the near term remain unchanged. Data for FY 03 are being collected and will be posted by the National Center for Health Statistics when available. Data for FY 04 will be available in November, 2006.

Long-Term Goal

By 2008, reduce infant deaths to 6.5 per 1,000 live births.

Goal III.A.1. Reduce the infant mortality rate.

All countries of the world measure the infant mortality rate as an indicator of general health status. The U.S. has made progress in reducing this rate, but the rate of decline has slowed in the last 10 years and in 2002, has increased, revising, temporarily, a long term trend. Race/ethnicity, maternal age, education, smoking, and number of pregnancies are all factors that contribute to the infant mortality rate.

The overall infant mortality rate increased slightly from 6.8 per 1000 lives births in 2001 to 7.0 per 1000 live births in 2002 (National Vital Statistics Reports). Performance for this goal is slightly short of, the 6.9 per 1000 target for 2002. The target for 2006 is ambitious at 6.7, as infant mortality is a complex problem including my determinants. The relationship between budget resources and performance is very complex in regards to reducing the infant mortality rate. Infant mortality is a significant problem, with many medical, social and economic determinants. Nevertheless, some of its determinants, such as low birth weight, SIDS, respiratory distress, and complications of pregnancy, can be addressed through improved access, newborn screening and other health care services that are directly affected by Title V budget resources.

Infant mortality is also known to be affected by socioeconomic factors, and may actually increase during an economic downturn. Given current technology and childbearing patterns (including increasing numbers of births to women over 40, and increasing rates of multiple births), it may not be possible to reduce overall infant mortality much further in the near term. The Title V program remains one of the best interventions available to increase timely entry into prenatal care and contribute to a reduction in infant mortality. Continued research is needed. Data for FY 03 and FY 04 will be available in November, 2005 and November, 2006, respectively.

Goal III.A.2. Reduce the incidence of low birth weight births.

Low birth weight is associated with short-term morbidity and mortality, as well as long-term disabilities, such as cerebral palsy, autism, mental retardation, vision and hearing impairments, and other developmental disorders. The reduction of the incidence of low birth weight babies would substantially reduce the risk of, and therefore the number of, babies that die in their first year of life, and suffer from long-term disabilities.

The low birth weight (LBW) rate (less than 2,500 grams) increased from 7.5 percent to 7.8 percent in FY 02, the highest level reported in more than three decades. The percent change of LBW is a 15 percent increase since the mid-1980s (from 6.8 percent to 7.8 percent). Recent increases are influenced by the rise in the multiple birth rate, as well as increases in advanced maternal age. Multiples are

much more likely to be born LBW than singletons. In 2002, multiple births accounted for 24 percent of all LBW infants in the United States, compared with 15 percent in 1980. LBW levels were up for the three largest racial/ethnic groups for 2002, i.e., non-Hispanic White births, non-Hispanic black births, and Hispanic births. (Centers for Disease Control and Prevention's National Vital Statistics Reports, Volume 52, Number 10, December 17, 2003)

The target for FY 06, 7.4%, remains an optimistic decrease, when in fact, the percentage of low birth weight infants increased in FY 02 after a slight decrease in FY 01. The reasons for this increase are unclear and warrant investigation. Data for FY 03 and FY 04 will be available in November, 2005 and November 2006, respectively.

Long-Term Goal

By 2008, reduce neonatal deaths to 4.5 per 1,000 live births by improving the quality of prenatal care.

Goal III.A.3. Increase the percent of low birth weight babies delivered at facilities for high-risk deliveries and neonates.

Much research has demonstrated the benefits of delivering high-risk infants in settings that have the technological capacity to care for them. Specifically, research has shown that very low birth weight (VLBW) infants have lower death rates when they are delivered at level III hospitals, which are equipped to care for very small infants.

To ensure that high-risk pregnant women have access to appropriate levels of obstetric care, many States have implemented perinatal regionalization strategies and protocols for the transfer of high-risk women to level III facilities. Evidence, however, indicates that these systems may be eroding as health care networks and financing systems change. The proportion of VLBW infants who are delivered in the level III obstetric hospitals best equipped to provide appropriate neonatal care should be measured to monitor the continuing appropriateness and effectiveness of the level of care delivered to high-risk pregnant women and infants.

Delivering low birth weight babies, who are at higher risk for mortality and morbidity than non-low birth weight babies, at facilities with specialized equipment and personnel capable of the highest standard of care for these babies, significantly assists in reducing their associated mortality. FY 03 data show that the target goal of 76% for FY 05 was met in FY 03. This represents a substantial increase from the baseline of 72.5% in 1997, significantly helping to achieve the long-term goal of reducing neo-natal deaths. Data for FY 04 will be available in November, 2005.

Long-Term Goal

By 2008, increase maternal survival to 8 maternal deaths per 100,000 live births.

Goal III.A.4. Reduce illness and complications due to pregnancy.

Pregnancy and delivery can lead to serious physical and mental health problems for women. Obviously, the reduction of illness and complications due to pregnancy, such as ectopic pregnancy and pelvic inflammatory disease, will substantially reduce the number of women dying as a result or pregnancy and delivery. The goal is to reduce the rate of illness and complications from 31.4 per 100 deliveries in 2000 to 30.0 per 100 deliveries by 2006.

The data from FY 01 show that there has been a slight increase in the rate of illness and complications from 31.4 per 100 to 32.1 per 100. A target of 26.0 per 100 in FY 04 is highly ambitious. The FY 01 statistic is based on the average of the rates of the three most common illnesses found in pregnancy: hypertension, diabetes and anemia. This rate does not include all causes as previous data have, but only the most common three illnesses or conditions that affect pregnancy. Presumably, if other, less common, conditions and illnesses were included the rate would be higher.

Data for FY 02, FY 03, and FY 04 will be available in December, 2005, 2006, and 2007, respectively.

Efficiency Measure

1. Decrease the time of States in applying for Title V Block Grants and in reporting performance data. (Developmental)

MCHB has developed a web-based data collection and reporting system for the Title V Block Grant that combines and simplifies the application and annual report processes. This greatly reduces the burden on States in providing required information. The combined application/annual report will be completed and submitted to MCHB on an annual basis. A State needs assessment will be conducted and reported on at least once every five years.

The estimated average annual burden for FY 06, a year in which a needs assessment portion is not included, is estimated at 272 hours for completion of an application. This represents a decreased burden of 15% for applications/reports. The reduction target is estimated based on a decrease in duplicate data and narrative responses required, standardization of questions across forms, and electronic web-based submission and automatic calculations. An additional factor in the reduction is the increased familiarity of States in using the system.

Deleted Measure(s)

1. Increase the percent of newborns in the State with at least one screening for all of the following: PKU, hypothyroidism, galactasemia, and hemoglobinopathies (e.g. the sickle cell disease).

Newborn screening (NBS) programs began in the early 1960s with the development of a screening test for phenylketonuria (PKU). Since then, all States and some territories of the United States have included NBS as part of their preventive public health system. The mass screening of 4 million infants per year in the United States has been heralded as a successful program that is cost effective and reduces illness, disability, and death associated with inherited conditions. The universal acceptance of newborn screening for specified conditions since 1960 attests to the undeniable benefits that flow from testing and appropriate treatment and intervention.

This measure is being deleted because of the array of screening tests performed by each State varies and is changing constantly. All State programs now include screening for PKU and congenital hypothyroidism. More than 40 programs screen for sickle cell disease, and almost all screen for galactasemia. Others include congenital adrenal hyperplasia, homocystinuria, maple syrup urine disease, biotinidase deficiency, and tyrosinemia. Some disorders are more uniformly screened for than others, and follow-up testing and early initiation of preventive treatment are uneven. Screening for most common disorders are now almost universally available. By 2003, 96% of infants were screened for all 4 conditions, exceeding the target.

U.C.2. Program Title: Traumatic Brain Injury Program

Performance Goals	Targets	Actual Performance	Reference
V. IMPROVE THE PUBLIC HEALTH AND HEALTH CARE SYSTEMS **B. Increase collaborative efforts to improve the capacity and efficiency of the public health and health care systems**			
1. Increase the number of States and Territories that have achieved a minimum TBI core capacity (including State Action Plan, Statewide Needs and Resources Assessment, designated State agency staff, and State Advisory Board)	FY 06: NA* FY 05: 48 FY 04: 47 FY 03: 46 FY 02: 42 FY 01: 35	FY 04: 49 FY 03: 49 FY 02: 45 FY 01: 35	**NEW FY 04 DATA**
2. Increase by 3 per year the number of States/Territories that have begun to implement their TBI plan of action. **(New Measure)**	FY 06: NA*	FY 04: 39 (baseline)	
3. Increase by 6 per year the number of States/Territories that have completed at least 50% of the objectives contained in their TBI plan of action. **(New Measure)**	FY 06: NA*	FY 04: 0 (baseline)	
Efficiency Measure 1. Decrease the application and reporting time burden of grantees by 5% per year for 4 years, thereby collecting more accurate and timely data.	FY 06: NA*	Baseline: TBD	
Total Funding: Traumatic Brain Injury Program ($ in 000s)	FY 06: $0 FY 05: $9,297 FY 04: $9,375 FY 03: $9,438 FY 02: $7,496	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

* Targets have been set, but are not included in this table because the program has no proposed FY 06 budget.

Program Performance Analysis

Goal V.B.1. Increase the number of States and Territories that have achieved minimum TBI core capacity.

The development of systems to address the needs of individuals with TBI is based on the concept that improved outcome from injury can be achieved when critical pre-hospital, hospital and community treatment and support components are organized into a system of care. The number of States and Territories that have achieved a minimum TBI core capacity is an indicator of the degree to which the U.S. has an organized system of care for individuals with TBI. The number of States and Territories with core capacity has increased significantly: from 14 in FY 97, to 49 in FY 04. The FY 05 target of 48 states has been met and exceeded.

While most States and the District of Columbia have achieved minimum TBI core capacity, most of the Territories have not. Increasing TBI core capacity in the Territories will become the focus of the next phase of activities, but progress is likely to be slow. For FY 06, the target would have been 56, all remaining States and Territories.

Goal V.B.2. Increase by 3 per year the number of States/Territories that have begun to implement their TBI plan of action.

When States/Territories begin to implement their TBI action plans, it represents the culmination of the planning process, typically a long and difficult one. An increase of 3 States/Territories per year represents an ambitious goal, given the complexity and difficulty in reaching a consensus among the diverse set of stakeholders on objectives and actions to address the problems of the TBI population.

Goal V.B.3. Increase by 6 per year the number of States/Territories that have completed at least 50% of the objectives contained in their TBI plan of action.

When States/Territories have implemented 50% of their plans' objectives, significant progress has been made in addressing the problems and issues faced by the TBI population. An increase of 6 States/Territories per year represents an ambitious goal, given the level of State as well as Federal resources available, and the complexity and range of needs, as specified in the plans.

Efficiency Measure

1. Decrease the application and reporting time burden of grantees by 5% per year for 4 years, thereby collecting more accurate and timely data.

A new on-line application and reporting system is being implemented in FY 05 and will be fully implemented in FY 06. This system will provide grantees with information from previous years, including budget and service data. This alleviates the grantees from having to supply information that was previously provided. Also, the system prepopulates figures into subsequent forms so that grantees do not have to enter the same data more than once. Reporting is also easier on the on-line system and provides program management with performance data that are far more reliable and valid, with a shorter lag time.

U.C.3. Program Title: Healthy Start

Performance Goals	Targets	Actual Performance	Reference
I. IMPROVE ACCESS TO HEALTH CARE **A. Expand the capacity of the health care safety net** 1. Increase the percentage of women participating in Healthy Start who have a prenatal care visit in the first trimester. **(Outcome)**	FY 06: 75.0% FY 05: 75.0% FY 04: 73.0% FY 03: 71.0% FY 02: 69.0% FY 01: 67.0 %	FY 04: (9/05) FY 03: 72.4% FY 02: 71% FY 01: 66.7% FY 00: 65.8%	**NEW** **FY 03** **DATA**
III. IMPROVE THE QUALITY OF HEALTH CARE **A. Promote the effectiveness of health care services** 1. Decrease the percentage of low birth weight babies born to Healthy Start clients. **(Outcome)**	FY 06: 10.5% FY 05: 10.5% FY 04: 10.5% FY 03: 10.5% FY 02: 10.5% FY 01: 11.4%	FY 04: (9/05) FY 03: 10.5% FY 02: 10.5% FY 01: 10.5% FY 00: 10.78% FY 99: 11.58%	**NEW** **FY 03** **DATA**
Efficiency Measure 1. Increase the number of persons served with constant funding. **(Developmental)**	FY 06: 320,000 FY 05: 300,000	FY 02: 288,806 (baseline)	
Total Funding: Healthy Start ($ in 000s)	FY 06: $ 97,747 FY 05: $102,543 FY 04: $ 97,751 FY 03: $ 98,346 FY 02: $ 98,952	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

Program Performance Analysis

Goal I.A.1. Increase the percentage of pregnant women participating in Healthy Start who have a prenatal care visit in the first trimester.

Early high quality prenatal care is critical to improving pregnancy outcomes. It can help to prevent low birth weight and infant mortality by identifying women who are at particularly high risk and providing counseling and assistance to reduce those risks. It can also help assure that women with complex problems and women with chronic illness or other risks are seen by specialists.

This measure replaces a measure that focused on decreasing the percentage of pregnant women in Healthy Start who received late prenatal care, or no prenatal care at all. This measure more accurately reflects the emphasis of the Healthy Start program.

Healthy Start will continue to focus intensive outreach efforts on enrolling hard-to-reach, high-risk women in prenatal care. The FY 00 result of 65.8% is considered a new program baseline. The program generally aims to increase the percentage beginning prenatal care in the first trimester by 2 percentage points each year. The actual performance for 2003 was 72.4% and exceeded the target. This is considered an accomplishment, given the nature of the program population and the economic conditions. With an emerging resurgence in barriers to early access to prenatal care, e.g., changes in financing of prenatal care at the state level and shortage of providers because of the malpractice situation a slight increase in anticipated for 2004. Data for FY 04 will be available in September, 2005.

Goal III.A.1. Decrease the percentage of low birth weight babies born to Healthy Start clients.

Healthy Start is designed to reduce adverse perinatal outcomes, e.g. low birth weight and infant mortality, by helping communities identify, plan and implement a diverse range of interventions to support and improve perinatal delivery systems in project communities. Low birth weight is associated with an increased risk of infant death. The low birth weight rate has, unfortunately, reduced little among both Blacks and Whites in recent years. The national rate for Healthy Start projects in 1999 was 11.58%. In 2002 this improved to 10.5% and remained there in 2003. This is significant since nationally the percentage of LBW births has increased during the same period. Overall, low birth weight among Blacks was more than double the rate for Whites and Hispanics in 2000.

Actual performance, 10.5% in 2003 (the latest year for which data are available), met the target for that year. Data for FY 04 will be available in September, 2005.

Efficiency Measure

1. Increase the number of persons served with constant funding. (Developmental)

The program proposes to demonstrate its efficiency by serving 20,000 more persons in FY 06 than in FY 05.

U.C.4. Program Title: Universal Newborn Hearing Screening and Early Intervention

Performance Goals	Targets	Actual Performance	Reference
III. IMPROVE QUALITY OF HEALTH CARE **A. Promote effectiveness of health care services** 1. Increase the percent of newborns screened prior to hospital discharge at a constant Federal program expenditure. **(Also Efficiency Measure-Developmental)**	FY 06: NA* FY 05: 90% FY 04: 89% FY 03: 87% FY 02: 85% FY 01: 75%	FY 04: (5/05) FY 03: 89.8% FY 02: 86% FY 01: 69% FY 00: 50% FY 99: 34%	HP-28 3
Total Funding: Universal Newborn Hearing Screening ($ in 000s)	FY 06: $0 FY 05: $9,792 FY 04: $9,873 FY 03: $9,935 FY 02: $9,995	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

* Target has been set, but is not included here because the program has no proposed FY 06 budget.

Program Performance Analysis

Goal III.A.1. Increase the percentage of newborns who have been screened for hearing impairment before hospital discharge at a constant level of funding. (Also Efficiency Measure - Developmental)

Increasing the percentage of newborns who have been screened for hearing impairment before hospital discharge is the first step toward improving the early diagnosis and treatment of infants with hearing impairment. Currently, 38 States have enacted legislative mandates requiring newborn hearing screening for all babies born in those States. States with already enacted legislation account for more than 75 percent of all births in the U.S. annually.

The majority of these States required full implementation by December 2002, but in three States with large birth cohorts, full implementation is not required until 2004. All states are screening the vast majority of infants. In 2001, 69 % of all infants born in the U.S. were screened at birth. In 2003 this percentage rose to 89.8% Data for FY 04 will be available in May, 2005. The target for FY 05 is 90%. There is no target for FY 06.

Efficiency Measure

Same as above.

Increasing the number of newborns screened for hearing impairment while maintaining a consistent level of Federal funding, should that funding continue, would indicate increased program efficiency.

U.C.5. Emergency Medical Services for Children

Performance Goals	Targets	Actual Performance	Reference
V. IMPROVE THE PUBLIC HEALTH AND HEALTH CARE SYSTEMS **B. Increase collaborative efforts to improve the capacity and efficiency of the public health and health care systems**			
1. Increase the number or awardees that demonstrate the operational capacity to provide pediatric emergency care, including all core capacity elements related to: (a) on-line and off-line medical direction for life support providers, (b) essential pediatric equipment and supplies, (c) designation of pediatric specialty care hospitals, and inter-facility transfer agreements. **(New Measure)**	FY 06: NA*	Baseline: TBD	
2. Increase the number of awardees that have adopted requirements for pediatric emergency education for the recertification of paramedics. **(New Measure)**	FY 06: NA*	Baseline: TBD	
Efficiency Measure 1. Decrease the application and reporting time burden of grantees by 5% per year for 4 years, thereby collecting more accurate and timely data.	FY 06: NA*	Baseline: TBD	
Deleted Measure(s) 1. Increase the number of States that require all EMSC-recommended pediatric equipment on Advanced Life Support (ALS) ambulances.	FY 06: NA FY 05: 50 FY 04: 48 FY 03: 25 FY 02: 23 FY 01: 23	 FY 04: 48 FY 03: 47 FY 02: 35 FY 01: 25	HP-1 **NEW** **FY 04 DATA**
Total Funding: Emergency Medical Services for Children ($ in 000s)	FY 06: $0 FY 05: $19,831 FY 04: $19,860 FY 03: $19,373 FY 02: $18,984	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

*Targets have been set, but are not included in this table because the program has no proposed FY 06 budget.

Program Performance Analysis

Goal V.B.1. Increase the number or awardees that demonstrate the operational capacity to provide pediatric emergency care, including all core capacity elements related to: (a) on-line and off-line medical direction for life support providers, (b) essential pediatric equipment and supplies, (c) designation of pediatric specialty care hospitals, and inter-facility transfer agreements.

The EMS System was originally designed to address the needs of adults. The purpose of this program is to increase awareness of the specific needs of children in emergency situations, and increase EMS capacity to address them. The number of States that demonstrate the operational capacity to provide pediatric emergency care provides a critical indicator of the degree to which the appropriate care for children has been integrated into the EMS system.

Goal V.B.2. Increase the number of awardees that have adopted requirements for pediatric emergency education for the recertification of paramedics.

The adoption of guidelines for pediatric emergency care training/education for pre-hospital providers is an integral component of the EMSC Program and helps to ensure the provision of appropriate pediatric emergency care across the continuum of care.

Efficiency Measure

1. Decrease the application and reporting time burden of grantees by 5% per year for 4 years, thereby collecting more accurate and timely data.

A new on-line application and reporting system is being implemented in FY 05 and will be fully implemented in FY 06. This system will provide grantees with information from previous years, including budget and service data. This alleviates the grantees from having to supply information that was previously provided. Also, the system prepopulates figures into subsequent forms so that grantees do not have to enter the same data more than once. Reporting is also easier on the on-line system and provides program management with performance data that are far more reliable and valid, with a shorter lag time. The FY 06 target is a 5% reduction from the baseline that is to be determined.

Deleted Measure(s)

1. Increase the number of States that require all EMSC-recommended pediatric equipment on Advanced Life Support (ALS) ambulances.

FY 04 performance of 48 States met the target. With this level of performance, the target for FY 05 has been set at 50. There is no target for FY 06 for this deleted measure.

U.D HIV/AIDS PROGRAMS

Programs included in this section are:

U.D.1. HIV/AIDS: Ryan White CARE Act (PART and Efficiency Measures)
U.D.2. HIV Emergency Relief Grants (Part A)
U.D.3. HIV Care Grants to States (Part B)
U.D.4. HIV Early Intervention Services (Part C)
U.D.5. HIV Children, Youth, Women, and Their Families Grants (Part D)
U.D.6. AIDS Education and Training Centers (Part F)
U.D.7. Dental Reimbursement and Community Partnership Programs (Part F)

U.D.1. Program Title: HIV/AIDS: Ryan White CARE Act

PART Measures (Titles I-IV) and Efficiency Measure

A PART review for Titles I-IV, as a unit, of the Ryan White CARE Act program was conducted for the FY 04 budget period. During this process, several cross-cutting long-term and annual goals were identified to use in assessing program performance. Because these goals related to the four titles as a whole, they are presented in aggregate below. Also included below is the HIV/AIDS program's efficiency measure.

Performance Goals	Targets	Actual Performance	Reference
I. IMPROVE ACCESS TO HEALTH CARE **A. Expand the Capacity of the Health Care Safety Net** **Long-Term Goal** By 2010, increase the national proportion of people living with HIV receiving primary medical care and treatment to 50 percent (includes all persons who know and those who do not know their serostatus). **(Outcome)**			
Short-Term Goals 1. Increase by 2 percent every second year the number of persons provided services through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act program. **(Outcome)**	FY 06: 2% increase over FY 04 FY 05: NA* FY 04: 2 % increase over FY 02	FY 04: (10/06) FY 03: NA* FY 02: 571,000 persons (est.) FY 00: 533,000 (est.) FY 98: 500,000 (est.)	**NEW FY 02 DATA** 3
2. Increase by 2 percent annually the number of persons who learn their serostatus from Ryan White CARE Act Programs. **(Outcome)**	FY 06: 2% increase over FY 05 FY 05: 2% increase over FY 04 FY 04: 2% increase over FY 03 FY 03: 721,968	FY 04: (2/06) FY 03: 673,291 persons FY 02: 707,812 FY 01: 387,061 FY 00: 352,283	**NEW FY 03 DATA** 3,5

Performance Goals	Targets	Actual Performance	Reference
II. IMPROVE HEALTH OUTCOMES **A. Expand the Availability of Health Care, Particularly to Underserved, Vulnerable, and Special Needs Populations**			
Long-Term Goal By 2010, increase by 10 percent the number of racial/ethnic minorities and by 2.5 percent the number of women served by CARE Act-funded programs. **(Outcome)**			
Short-Term Goals 1. Serve a proportion of racial/ethnic minorities in CARE Act-funded programs that exceeds their representation in national AIDS prevalence data, as reported by the CDC, by a minimum of 5 percentage points annually (e.g., if 15 percent of overall AIDS cases are among racial/ethnic minorities, 20 percent of CARE Act-funded clients will be racial/ethnic minorities). **(Outcome)**	FY 06: 5 percentage points above CDC data FY 05: 5 percentage points above CDC data FY 04: 5 percentage points above CDC data FY 03: 5 percentage points above CDC (63.6%) data FY 02: 5 percentage points above CDC (63.3%) data	FY 04: D/N/A** FY 03: D/N/A** FY 02: D/N/A** FY 00: 69.1% (estimated baseline)	3
2. Serve a proportion of women in CARE Act-funded programs that exceeds their representation in national AIDS prevalence data reported by the CDC, by a minimum of 5 percentage points (e.g., if 15 percent of overall AIDS cases are among women, 20 percent of CARE Act-funded clients will be women). **(Outcome)**	FY 06: 5 percentage points above CDC data FY 05: 5 percentage points above CDC data FY 04: 5 percentage points above CDC data FY 03: 5 percentage points above CDC (21.8%) data FY 02: 5 percentage points above CDC (21.5%) data	FY 04: (10/05) FY 03: 36% FY 02: 34.1% FY 00: 33.3% (estimated baseline)	**NEW FY 03 DATA** 3

Performance Goals	Targets	Actual Performance	Reference
III. IMPROVE THE QUALITY OF HEALTH CARE **A. Promote Effectiveness of Health Care Services** **Long-Term Goal** By 2010, all CARE Act-funded HIV primary medical care providers will have implemented a quality management program and will meet two "core" standards included in the PHS Clinical Practices Guidelines for Treatment of Adults, Adolescents, and Pregnant Women. **Short-Term Goals** 1. Increase by 5 percentage points annually the number of CARE Act-funded primary medical care providers that will have implemented a quality management program. 2. Increase the proportion of new CARE Act HIV-infected clients who are tested for CD4 count and viral load. **(Outcome)**	FY 06: 70% FY 05: 65% FY 04: 60% FY 06: TBD FY 05: TBD	FY 04: (6/05) FY 03: D/N/A** FY 02: 50% (estimated baseline) FY 04: (6/05) (baseline: TBD)	5
IV. ELIMINATE HEALTH DISPARITIES **A. Focus Resources and Services on Diseases and Conditions with the Greatest Health Disparities** **Long-Term Goal** By 2010, reduce deaths due to HIV infection below 3.6 per 100,000 people. **(Outcome)** **Short-Term Goals** 1. Increase the number of AIDS Drug Assistance Program (ADAP) clients receiving HIV/AIDS medications through State ADAPs during at least one month of the year by at least 4 percent. **(Outcome)**	FY 06: 4% over FY 05 FY 05: 4% over FY 04 FY 04: 4% over FY 03 FY 03: 84,331 clients	FY 04: (1/06) FY 03: 86,280 clients FY 02: 81,178 FY 01: 73,784 FY 00: 70,357	**NEW FY 03 DATA** 3
Efficiency Measure 1. Increase by 2 percent annually the amount of savings by State ADAPs participation in cost-savings strategies on medications.	FY 06: 2 percent over FY 05 FY 05: 2 percent over FY 04 FY 04: 2 percent over FY 03 FY 03: 2 percent above baseline or $77.5 million	FY 04: (2/06) FY 03: $92.5M FY 02: $76 million (baseline)	

Total Funding: AIDS: Ryan White CARE Act Program - Titles I - IV ($ in 000s)	FY 06: $2,010,027 FY 05: $2,000,027 FY 04: $1,971,201 FY 03: $1,944,614 FY 02: $1,861,429	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal

* NA = not applicable; data reported every second year
**D/N/A = data not available

Program Performance Analysis

Long-Term Goal

By 2010, increase the national proportion of people living with HIV receiving primary medical care and treatment to 50 percent (includes all persons who know and those who do not know their serostatus).

Goal I.A.1. Increase by 2 percent every second year the number of persons provided services through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act program.

The number of persons provided services through the CARE Act program was selected as a measure of the program goals to improve access to health care for individuals infected with HIV/AIDS by increasing availability of and access to care and services.

In FY 02, an estimated 571,000 persons received CARE Act services. In comparison with the annual performance figures from FY 00, an additional 38,000 clients received services through the CARE Act in FY 02. The unduplicated estimate is based on a model developed in 1999-2000 converting the duplicated number of clients served reduced by a "de-duplication factor."

Actual performance will be reported every second year. FY 04 data is expected in October, 2006.

Goal I.A.2. Increase by 2 percent annually the number of persons who learn their serostatus from Ryan White CARE Act Programs.

The number of individuals who learn their serostatus from a CARE Act program was selected as a measure of achieving the program's goal to improve access to health care for individuals infected with HIV/AIDS by increasing access to services.

In FY 03, the CARE Act provided 673,291 persons confirmation of their serostatus. This represents a decrease of 34,521 persons, a nearly 4.9% decrease compared to FY 02. CARE Act dollars are used for HIV testing only when HIV testing is not otherwise available. The decrease in persons tested using CARE Act funds is due to the $35 million FY 03 CDC initiative called "Advancing HIV Prevention." This new CDC initiative consists of various strategies aimed at

reducing barriers to diagnosis of HIV infection by expanding HIV testing programs outside of traditional medical settings where racial/ethnic minorities and persons who report increased risk for HIV are more likely to be reached. FY 04 data is expected in February, 2006.

Long-Term Goal

By 2010, increase by 10 percent the number of racial/ethnic minorities and by 2.5 percent the number of women served by CARE Act-funded programs.

Goal II.A.1. Serve a proportion of racial/ethnic minorities in CARE Act-funded programs that exceeds their representation in national AIDS prevalence data, as reported by CDC, by a minimum of 5 percentage points (e.g., if 15 percent of overall AIDS cases are among racial/ethnic minorities, 20 percent of CARE Act-funded clients will be racial/ethnic minorities).

Despite the reduction seen in overall AIDS mortality, annual incidence data show that the proportion of AIDS cases among racial/ethnic minorities continues to increase. In addition, benefits provided by new combination drugs (anti-retrovirals/protease inhibitors/HAART) have not uniformly reduced the disparities in incidence of AIDS among racial/ethnic minorities.

CDC reports that forty percent of HIV patients initiate anti-retroviral therapy (ART) late. Latino and African-American patients were significantly more likely to initiate therapy late compared to White patients. The proportion of racial/ethnic minorities served by the CARE Act programs was selected as the a measure of the program's goal to improve health outcomes among individuals infected with HIV/AIDS by increasing utilization for traditionally underserved populations.

The CARE Act Data Report (CADR) is the instrument grantees use to report data on race and ethnicity. Due to the aggregate nature of the CADR data and the way the race/ethnicity questions are currently phrased, the proportion of racial/ethnic minorities served by the CARE Act can not be calculated for 2002-2004. The HIV/AIDS Bureau is in the process of seeking clearance under the Paperwork Reduction Act to change the 2005 CADR data collection questions on race and ethnicity to remedy this problem.

Goal II.A.2. Serve a proportion of women in CARE Act-funded programs that exceeds their representation in national AIDS prevalence data, as reported by CDC, by a minimum of 5 percentage points (e.g., if 15 percent of overall AIDS cases are among women, 20 percent of CARE Act-funded clients will be women).

Despite the reduction seen in overall AIDS mortality, annual incidence data show the proportion of AIDS cases among women continues to increase. In addition, benefits provided by combination drugs (anti-retrovirals/protease inhibitors/HAART) have not uniformly reduced the disparities in incidence of AIDS among women. The proportion of women served by the CARE Act programs was selected as measure of the program's goal to improve health outcomes among individuals infected with HIV/AIDS by increasing utilization for traditionally underserved populations.

The CARE Act funded programs are serving a significantly higher proportion of women than the target specified in the indicator itself (i.e., five percentage points higher than the representation of women among all AIDS cases in the Nation, as reported by CDC). The CARE Act programs exceeded the percentage of women served among all AIDS cases in the U.S. by 14.2 percentage points in 2003, with CDC AIDS Prevalence data reporting 21.8% of persons with AIDS are women and the CARE Act serving 36% women. FY 04 data is expected in October, 2005.

Long-Term Goal

By 2010, all CARE Act-funded HIV primary medical care providers will have implemented a quality management program and will meet two "core" standards included in the PHS Clinical Practices Guidelines for Treatment of Adults, Adolescents, and Pregnant Women.

Goal III.A.1. Increase by 5 percentage points annually the number of CARE Act-funded primary medical care providers that will have implemented a quality management program.

The CARE Act authorization requires implementation of quality management programs at the Federal, grantee, and service provider levels. The intent of such programs is to help providers of clinical care ensure that:

- funded services adhere to established HIV clinical practices and Public Health Service guidelines;
- strategies for improvements to quality medical care include delivery of health-related support services that are vital for achieving appropriate access to care and adherence to treatment; and
- demographic, clinical, and health care utilization information is used to monitor the spectrum of HIV-related illnesses and trends in the local epidemic.

Many grantees already have quality management initiatives in place; for those who do not or who seek to improve their existing programs, technical assistance materials have been developed (see the HAB Web site at www.hab.hrsa.gov/tools/QM/).

For these reasons the number of CARE Act-funded grantees that implement a quality management program was selected as a good measure of the program's goal to improve quality of health care for individuals infected with HIV/AIDS by utilizing quality management programs. As a baseline, HAB estimates that 50% of current CARE Act primary medical care providers for 2002 had implemented a quality management program. This measure was added after the FY 03 data collection efforts were underway. Therefore, FY 04 data is expected in June, 2005.

Goal III.A.2. Increase the proportion of new CARE Act HIV-infected clients who are tested for CD4 count and viral load.

The proportion of new CARE Act HIV-infected clients that are tested for CD4 count and viral load was selected as a good measure of the program goals to improve quality of health care for individuals infected with HIV/AIDS.

This new measure will require additional data from Ryan White providers. The data will include the number of new CARE Act HIV-infected clients who are tested for CD4 and viral load. FY 04 baseline data is expected in June, 2005.

Long-Term Goal

By 2010, reduce deaths due to HIV infection below 3.6 per 100,000 people.

Goal IV.A.1. Increase the number of AIDS Drug Assistance Program (ADAP) clients receiving HIV/AIDS medications through State ADAPs during at least one month of the year by at least 4 percent.

The number of ADAP clients receiving HIV/AIDS medications through State ADAPs during at least one month of the year was selected as a measure of the program's goal to eliminate health disparites among individuals with HIV/AIDS who are underserved by increasing availability and utilization of these medications.

The actual FY 03 performance of 86,280 clients served exceeded the FY 03 target by 1,949 persons served at least one month of the year by ADAP. In comparison with monthly figures from FY 02, an additional average of 5,102 (unduplicated) clients were receiving anti-retroviral therapies through ADAP in FY 03. Many clients are enrolled in ADAP only temporarily while they await acceptance into other insurance programs, like Medicaid. FY 04 data is expected in January, 2006.

Efficiency Measure

1. Increase by 2 percent annually the amount of savings by State ADAPs participation in cost-savings strategies on medications.

Cost-containment strategies are important as more clients are seeking treatment with dramatic increases in the cost of new treatments, and rapidly changing standards of care. This challenges ADAPs to contain costs at the same time they are asked to expand access. As a result, ADAPs have taken a number of steps to stretch dollars. These include changing the system used to purchase/distribute drugs, seeking larger price discounts or rebates on drugs (e.g., through participation in the Section 340B Drug Discount Program), tightening income eligibility criteria, setting caps on ADAP benefits, and/or establishing guidelines for prescribing drugs.

In FY 03, State ADAP's participation in cost-recovery strategies produced a $92.5 million savings, substantially exceeding the projected target. This is based on data submitted by grantees on FY 03 ADAP State Profile. FY 04 data is expected in February, 2006.

U.D.2. Program Title: HIV Emergency Relief Grants (Part A)

Performance Goals	Targets	Actual Performance	Reference
I. IMPROVE ACCESS TO HEALTH CARE **A. Expand the Capacity of the Health Care Safety Net** 1. Increase the number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health) to a level that approximates inclusion of new clients. **(Outcome)**	FY 06: 2.91 M visits FY 05: 2.91 FY 04: 2.91 FY 03: 2.92 FY 02: 2.92 FY 01: 3.05 FY 00: 2.92	 FY 04: (1/06) FY 03: 3.33 M visits FY 02: 3.22 M FY 01: 2.67 FY 00: 2.71	**NEW** **FY 03 DATA** 3
III. IMPROVE THE QUALITY OF HEALTH CARE **A. Promote Effectiveness of Health Care Services** 1. Increase the proportion of women that receive PAP smears. **(Outcome)** 2. Increase the proportion of clients that receive TB skin tests. **(Outcome)**	FY 06: baseline plus 1.5% FY 05: baseline plus 1.5% FY 04: baseline plus 1.5% FY 03: 1% over the baseline FY 06: 1.5% over FY 05 FY 05: 1.5% over FY 04 FY 04: 1.5% over FY 03 FY 03: 1% over the baseline	 FY 04: (10/05) FY 03: 42.6% FY 02: 45.9% (baseline) FY 04: (10/05) FY 03: 31.5% FY 02: 32.5% (baseline)	**NEW** **FY 03 DATA** 5 **NEW** **FY 03 DATA** 5
Deleted Measure(s) 1. Serve a proportion of women and racial/ethnic minorities in Title I-funded programs that exceeds their representation in national AIDS prevalence data, as reported by the CDC, by a minimum five percentage points (e.g., if 15 percent of current overall AIDS cases are among women, 20 percent of Title I-funded clients will be women). **(Outcome)** **(Measure deleted because of similar PART measure)**	Women FY 06: NA FY 05: NA FY 04: NA FY 03: 5 percentage points above CDC (21.8%) data FY 02: 5 percentage points above CDC (21.5%) data Minorities FY 06: NA FY 05: NA FY 04: NA FY 03: 5 percentage points above CDC FY 02: 63.3% plus 5 percentage points is 68.3 percentage points FY 01: 67.7%	 FY 04: NA FY 03: 36.1% FY 02: 33.9% FY 04: NA FY 03: D/N/A* FY 02: D/N/A* FY 01: 72.4%	 **NEW** **FY 03 DATA** 3 3

Performance Goals	Targets	Actual Performance	Reference
Total Funding: AIDS: HIV Emergency Relief Grants (Part A) ($ in 000s)	FY 06: $610,994 FY 05: $610,094 FY 04: $615,023 FY 03: $618,693 FY 02: $619,381	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

*D/N/A = data not available

Program Performance Analysis

Goal I.A1. Increase the number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health) to a level that approximates inclusion of new clients.

The number of visits provided for health-related services was selected as the best measure of the program goals to improve access to health care and related services for individuals infected with HIV/AIDS by increasing availability of and access to care.

In FY 03, 3.33 million visits were reported by 51 Title I Eligible Metropolitan Area (EMA) grantees. This number exceeded the target and was 410,000 visits more than the previous year. Higher numbers of visits may be a result of using the CADR rather than the AAR data. More than 1,500 providers of funded and eligible services provided health care and related supportive services to hundreds of thousands of persons living with HIV/AIDS. FY 04 data is expected in January, 2006.

Goal III.A.1. Increase the proportion of women that receive PAP smears.

Cervical Intraepithelial Neoplasia (CIN) is cellular changes in the cervix, thought to be precursors of cervical cancer and can be detected with PAP smears. Researchers conclude that HIV+ women are three times as likely as HIV negative women to have CIN. Women with HIV are more likely to develop cervical cancer than other women. The possibility increased to 30 times as likely if a women has HIV and HPV, the human papilloma virus.

The proportion of women that receive PAP smears was selected as a measure of the program's goal of improving the quality of health care. In FY 03, the Title I program provided 42.6% of women served with PAP smears. This represents a decrease of 3.3 percentage points compared to FY 02 baseline. The FY 04 target will be 1.5 percent above the FY 03 actual performance number. FY 04 data is expected in October, 2005.

Goal III.A.2. Increase the proportion of clients that receive TB skin tests.

According to the CDC, rates of TB among HIV-infected persons have ranged from 35 - 162 per 1,000 persons (MMWR, Vol. 49, No. RR-6). Between 1985 - 1992, the number of TB cases increased. Latent TB is much more likely to become active TB in someone with HIV. This is because HIV weakens the immune system, which makes it harder for the body to fight off diseases like TB. In people with HIV, TB in the lungs or anywhere else in the body is an AIDS-defining condition. The CDC recommends HIV-infected persons get tested for TB, with a TB Skin Test (TST).

Increasing the proportion of clients that receive TB skin tests was selected as a best measure for the program goal of improving quality of health care among individuals infected with HIV/AIDS by increasing the rate of the TB skin tests. In FY 03, the Title I program provided 31.5% of clients with TB skin tests. This represents a decrease of 1 percentage point compared to FY 02 baseline. The FY 04 target will be 1.5 percent above the baseline. FY 04 data is expected in October, 2005.

Deleted Measure(s)

1. Serve a proportion of women and racial/ethnic minorities in Title I-funded programs that exceeds their representation in national AIDS prevalence data, as reported by the CDC, by a minimum five percentage points (e.g., if 15 percent of current overall AIDS cases are among women, 20 percent of Title I-funded clients will be women).

(Measure deleted after FY 03 because of similar PART measure).

Despite the reduction seen in overall AIDS mortality, annual incidence data show the proportion of AIDS cases among women and minorities continues to increase. In addition, benefits provided by new combination drugs (anti-retrovirals/ protease inhibitors/HAART) have not uniformly reduced the disparities in the incidence of AIDS between genders or among racial/ethnic groups.

CDC reports that forty percent of HIV patients initiate anti-retroviral therapy late. Latino and African-American patients were significantly more likely to initiate therapy late compared to white patients. The proportion of women and racial/ethnic minorities served in Title I programs was selected as the best measure of the program's goal to improve health outcomes among individuals infected with HIV/AIDS by increasing utilization for traditionally underserved populations.

Title I-funded programs have served a significantly higher proportion of women and minorities than the target specified in the indicator itself (i.e., five percentage points higher than the representation of women and racial/ethnic minorities among all AIDS cases in the Nation, as reported by CDC). For FY 03, the Title I-funded programs reported serving 36.1% women (CDC reports 21.8% of AIDS cases are among women in U.S.) which exceeded the percentage of women served among all AIDS cases in the U.S. by 14.3% percentage points in 2003. For FY 01, the Title I-funded programs reported serving 72.4% racial/ethnic minorities served (CDC reports 63.3% racial/ethnic minorities in U.S.) which exceeded the percentage of racial/ethnic minorities served among all AIDS cases in the U.S. by 9.1% percentage points in 2001. The CARE Act Data Report (CADR) is the instrument grantees use to report data on race and ethnicity. Due to the aggregate nature of the CADR data and the way race/ethnicity questions are currently phrased, the proportion of racial/ethnic minorities served by the CARE Act can not be calculated for 2002-2004. The HIV/AIDS Bureau is in the process of seeking clearance under the Paperwork Reduction Act to change the 2005 CADR data collection questions on race and ethnicity to remedy this problem.

U.D.3. Program Title: HIV Care Grants to States (Part B)

Performance Goals	Targets	Actual Performance	Reference
I. IMPROVE ACCESS TO HEALTH CARE **A. Expand the Capacity of the Health Care Safety Net** 1. Increase the number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health) to a level that approximates inclusion of new clients. **(Outcome)**	FY 06: 1.56 M visits FY 05: 1.56 FY 04: 1.55 FY 03: 1.56 FY 02: 1.56 FY 01: 1.45 FY 00: 1.53	FY 04: (1/06) FY 03: 2.32 M visits FY 02: 1.96 FY 01: 1.46 FY 00: 1.42	**NEW** **FY 03 DATA** 3
III. IMPROVE THE QUALITY OF HEALTH CARE **A. Promote Effectiveness of Health Care Services** 1. Increase the number of ADAP clients receiving HIV/AIDS medications through State ADAPs during at least one month of the year. **(Outcome)**	FY 06: 94,966 clients FY 05: 91,314 FY 04: 87,804 FY 03: 84,800 FY 02: 84,800 FY 01: 72,000 FY 00: 71,900	FY 04: (1/06) FY 03: 86,280 clients FY 02: 81,178 FY 01: 73,784 FY 00: 70,357	**NEW** **FY 03 DATA** 3
Deleted Measure(s) 1. Serve a proportion of women and racial/ethnic minorities in Title II-funded programs that exceeds their representation in national AIDS prevalence data, as reported by the CDC, by a minimum of five percentage points (e.g., if 15 percent of current overall AIDS cases are among women, 20 percent of Title II-funded clients will be women). **(Outcome)** **(Measure deleted because of similar PART measure)**	Women FY 06: NA FY 05: NA FY 04: NA FY 03: 5 percentage points above CDC (21.8%) FY 02: 5 percentage points above CDC (21.5%) Minorities FY 06: NA FY 05: NA FY 04: NA FY 03: 5 percentage points above CDC FY 02: 5 percentage points above CDC (63.3%) FY 01: 67.7%	Women FY 03: 31.5% FY 02: 33.8% Minorities FY 03: D/N/A* FY 02: D/N/A* FY 01: 68.3%	**NEW** **FY 03 DATA** 3 3
Total Funding: AIDS: HIV Care Grants to States (Part B) ($ in 000s)	FY 06: $1,131,836 FY 05: $1,121,836 FY 04: $1,085,900 FY 03: $1,053,393 FY 02: $977,240	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

*D/N/A = data not available

Program Performance Analysis

Goal I.A.1. Increase the number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health) to a level that approximates inclusion of new clients.

The number of visits for health-related care (primary medical, dental, mental health, substance abuse, rehabilitative, and home health) was selected as the best measure of the program's goal to increase access to health care and related services for individuals with HIV/AIDS by increasing availability of and access to care.

In FY 03, Title II programs provided 2.32 million visits. The actual performance for FY 03 exceeded the target by 760,000 visits. FY 04 data is expected in January, 2006.

Goal III.A.1. Increase the number of ADAP clients receiving HIV/AIDS medications through State ADAPs during at least one month of the year.

The number of ADAP clients receiving HIV/AIDS medications through State ADAPs during at least one month of the year was selected as a measure of the program's goal to improve the quality of health care among individuals with HIV/AIDS who are underserved by increasing availability and utilization of these medications.

The ADAP program provides therapeutics to treat HIV disease or prevent the serious deterioration of health arising from HIV disease for eligible individuals. Therapeutics provided by ADAPs include anti-retrovirals, medications for the treatment and prevention of opportunistic infections, and medications to address side effects that may be experienced by individuals on HIV medications. The performance measure for the ADAP includes all therapeutics provided by the program, not just anti-retrovirals.

In FY 03, 86,280 persons were served at least one month of the year by ADAP. In comparison with monthly figures from FY 02, an additional 5,102 (unduplicated) clients were receiving HIV/AIDS medications through ADAP at least one month of the year in FY 03. Many clients are enrolled in ADAP only temporarily while they await acceptance into other insurance programs, like Medicaid. The actual FY 03 performance of 86,280 clients exceeded the FY 03 target by 1,480 served at least one month per year by ADAP. FY 04 data is expected in January, 2006.

Deleted Measure(s)

1. Serve a proportion of women and racial/ethnic minorities in Title II-funded programs that exceeds their representation in national AIDS prevalence data, as reported by the CDC, by a minimum five percentage points (e.g., if 15 percent of current overall AIDS cases are among women, 20 percent of Title II-funded clients will be women).

(Measure Deleted after FY 03 because of similar PART measure).

Despite the reduction seen in overall AIDS mortality, annual incidence data show the proportion of AIDS cases among women and minorities continues to increase. In addition, benefits provided by new combination drugs (anti-retrovirals/protease inhibitors/HAART) have not uniformly reduced disparities in the incidence of AIDS between genders or among racial and ethnic groups. Latino and African-American patients were significantly more likely to initiate therapy late compared to white patients.

The proportion of women and racial/ethnic minorities served in Title II programs was selected as the best measure of the program's goal to improve health outcomes among individuals infected with HIV/AIDS by increasing utilization for traditionally underserved populations.

The Title II-funded programs are serving a significantly higher proportion of women than the target specified in the indicator itself (i.e., five percentage points higher than the representation of women and racial/ethnic minorities among all AIDS cases in the Nation, as reported by CDC). The percentage of women served by Title II programs reported serving 31.5% women (CDC reports 21.8% of AIDS cases are among women in U.S.) in 2002 which is approximately 9.7 percentage points higher than the representation of women among all AIDS cases as reported by the CDC.

The CARE Act Data Report (CADR) is the instrument grantees use to report data on race and ethnicity. Due to the aggregate nature of the CADR data and the way the race/ethnicity questions are currently phrased, the proportion of racial/ethnic minorities served by the CARE Act can not be calculated for 2002-2004. The HIV/AIDS Bureau is in the process of seeking clearance under the Paperwork Reduction Act to change the 2005 CADR data collection questions on race and ethnicity to remedy this problem.

U.D.4. Program Title: HIV Early Intervention Services (Part C)

Performance Goals	Targets	Actual Performance	Reference
II. IMPROVE HEALTH OUTCOMES **A. Expand the Availability of Health Care, Particularly to Underserved, Vulnerable, and Special Needs Populations** 1. Increase the number of people receiving primary care services under Early Intervention Services programs. **(Outcome)**	FY 06: 158,346 clients FY 05: 158,346 FY 04: 158,346 FY 03: 157,803 FY 02: 138,968 FY 01: 117,000 FY 00: 110,398	FY 04: (3/06) FY 03: (3/05) FY 02:172,422 clients FY 01: 157,803 FY 00: 129,654	**NEW FY 02 DATA** 3
IV. ELIMINATE HEALTH DISPARITIES **B. Promote Outreach Efforts to Reach Populations Most Affected by Health Disparities** 1. Increase the number of grant applicants that are Faith-Based and/or Community-Based Organizations.	FY 06: TBD FY 05: baseline plus 5%	FY 04: Baseline, established by 03/05 FY 03: Survey implemented	🏛
Deleted Measure(s) 1. Increase the number of racial and ethnic minorities who are receiving primary care services under Early Intervention Programs. **(Outcome)** **(Measure deleted because of similar PART measure)**	FY 06: NA FY 05: NA FY 04: NA FY 03: 108,095 clients FY 02: 97,277 FY 01: 84,179	FY 04: NA FY 03: D/N/A* FY 02: D/N/A* FY 01: 108,095 clients	3
Total Funding: AIDS: HIV Early Intervention Services (Part C) ($ in 000s)	FY 06: $195,578 FY 05: $195,578 FY 04: $197,170 FY 03: $198,374 FY 02: $193,844	HP: Healthy People PART: OMB Program Assessment Rating Tool 🏛 Presidential Initiative #: DHHS Goal	

*D/N/A = data not available

Program Performance Analysis

Goal II.A.1. Increase the number of people receiving primary care services under Early Intervention Services programs.

The number of individuals receiving primary care services through the Early Intervention Services program was selected as the best measure of achieving the program's goal to improve health outcomes for individuals infected with HIV/AIDS by increasing access to these services.

In FY 02, Title III Early Intervention Program served 172,422 clients, exceeding the targeted goal by 19.5%, and representing an increase of 8.5% in new clients served compared to FY 01. Risk exposure information shows the largest percentage increase in persons with HIV/AIDS served to be among heterosexuals and injection drug users. FY 03 and FY 04 data are expected in March, 2005 and 2006, respectively.

Goal IV.B.1. Increase the number of grant applicants that are faith-based and/or community-based organizations.

The number of grant applicants to the Early Intervention Services Programs that are self-identified as a Faith-Based Organization (FBO) and/or a Community-Based Organization (CBO) was selected as the best measure to assess progress toward eliminating health disparities of communities served by FBOs/CBOs interested in participating in Federally-funded health and human services programs.

The Agency proposes to measure this performance using a baseline developed from several sources including information gathered in a FY 03 HHS survey of applicants, subject to baseline being determined. The FY 05 target is to increase this number by 5%. The FY 04 baseline will be determined by March, 2005.

Deleted Measure(s)

1. Increase the number of racial and ethnic minorities who are receiving primary care services under Early Intervention Programs. (Measure Deleted after FY 03 because of similar PART measure).

Despite the reduction seen in overall AIDS mortality, annual incidence data show the proportion of AIDS cases among women and minorities continues to increase. The number of racial and ethnic minority individuals with HIV/AIDS receiving primary care services through Early

Intervention Services programs was selected as the most appropriate measure to improve health outcomes among individuals infected with HIV, particularly for those who have traditionally been underserved.

In FY 01, the Title III Early Intervention Program provided services to 108,095 racial and ethnic minorities, exceeding the targeted goal by 28.4%. The actual performance in 2001 reflects an increase of 22.9% (20,190 minority clients), compared to FY 00. Slightly more than sixty-eight percent (68.5%) of Title III clients served in 2001 were people of color. The current level of performance reflects significantly increased efforts across all of the Ryan White CARE Act programs to target communities of color. The CARE Act Data Report (CADR) is the instrument grantees use to report data on race and ethnicity. Due to the aggregate nature of the CADR data and the way the race/ethnicity questions are currently phrased, the proportion of racial/ethnic minorities served by the CARE Act can not be calculated for 2002-2004. The HIV/AIDS Bureau is in the process of seeking clearance under the Paperwork Reduction Act to change the 2005 CADR data collection questions on race and ethnicity to remedy this problem.

U.D.5. Program Title: HIV Children, Youth, Women, and Their Families Grants (Part D)

Performance Goals	Targets	Actual Performance	Reference
II. IMPROVE HEALTH OUTCOMES **A. Expand the Availability of Health Care, Particularly to Underserved, Vulnerable, and Special Needs Populations** 1. Increase the number of female clients provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission. **(Outcome)**	FY 06: 32,772 female clients FY 05: 32,772 FY 04: 32,772 FY 03: 32,371 FY 02: 32,371 FY 01: 21,884 FY 00: 14,470	FY 04: (1/06) FY 03: 45,091 female clients FY 02: 37,503 FY 01: 26,983 FY 00: 24,894 FY 99: 18,948 Note: Female clients counted are age 13 and above.	**NEW** **FY 03 DATA** 1,3
Deleted Measure(s) 1. With CDC, decrease by 5 percent annually the number of newly reported AIDS cases in children as a result of perinatal transmission. **(Outcome)**	FY 03: 152 children FY 02: 160 FY 01: 151 FY 00: 161	FY 03: 131 children FY 02: 139 children FY 01: 150 FY 00: 177	**NEW** **FY 03 DATA** **HP** 1,5
Total Funding: HIV Children, Youth, Women and Their Families ($ in 000s)	FY 06: $72,519 FY 05: $72,519 FY 04: $73,108 FY 03: $73,551 FY 02: $70,964	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

Program Performance Analysis

Goal II.A.1. Increase the number of female clients provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission.

The number of female clients receiving comprehensive services, including appropriate services before or during pregnancy to reduce perinatal transmission, was selected as the best way to measure the Title IV program's goal to improve health outcomes for HIV-infected children, adolescents, women and families through increasing utilization of care among this traditionally underserved population.

In FY 03, there was an approximate 21% increase in the number of women receiving comprehensive services, including appropriate services before or during pregnancy to reduce perinatal transmission, through the Title IV program, compared to FY 02. Further, the FY 03 actual performance exceeded the performance target by 28.3%. FY 04 data is expected in January, 2006.

Deleted Measure(s)

1. With CDC, decrease by 5 percent annually the number of newly reported AIDS cases in children as a result of perinatal transmission.

The Title IV program has been in the forefront of many activities to reduce perinatal HIV transmission and to promote healthier outcomes for women with HIV and their children. The number of reported AIDS cases in children as a result of perinatal transmission is no longer considered the best measure of the Title IV program. The Bureau has deleted this measure and FY 03 is the final reporting year. The actual performance number for FY 03 was 131, missing the target by 21 children but keeping relatively steady from FY 02.

There are a number of reasons for expecting perinatal transmissions to remain close to the present number of cases in the United States. Perinatal transmissions come from two groups: women with HIV/AIDS who are receiving anti-retroviral therapy and women with HIV/AIDS who are not receiving anti-retroviral therapy. Among the first group, while anti-retroviral therapy has reduced perinatal transmission of HIV, approximately 8.0% of pregnant women with HIV/AIDS on therapy still give birth to infants who will test positive. There are a number of complex medical factors that are associated with continuing transmission: low CD4 counts, p24 antigenemia, placental membrane inflammation, increased intrapartum exposure to maternal blood, premature rupture of the membrane, premature delivery, maternal viral drug resistance,

and other factors. Women with HIV/AIDS are living longer life spans today and we can expect that the number of pregnancies will increase as the 8.0% transmission rate remains constant.

Among the second group, are women who are not in care, or women who are in care but either not tested or treated. A 1996-1998 study of pregnant women with HIV/AIDS (based on a sample of medical chart reviews in Ryan White CARE Act Title IV clinics), indicates that 12% of the pregnant women who gave birth in 1998 did not receive pre-natal care. HRSA and CDC have undertaken a number of initiatives since this study to increase pre-natal care.

A final reason for not expecting a 5% annual decrease in perinatal transmission is the small number of perinatal HIV transmissions that occurs annually. Fluctuations are common and expected with such small numbers.

U.D.6. Program Title: AIDS Education and Training Centers (Part F)

Performance Goals	Targets	Actual Performance	Reference
V. IMPROVE THE PUBLIC HEALTH AND HEALTH CARE SYSTEMS **B. Increase Collaborative Efforts to Improve the Capacity and Efficiency of the Public Health and Health Care Systems** 1. Increase proportion of racial/ethnic minority health care providers participating in AETC training intervention programs. **(Outcome)**	FY 06: 43% FY 05: 43% FY 04: 43% FY 03: 43% FY 02: 41% FY 01: 40%	FY 04: (3/06) FY 03: 43% FY 02: 45% FY 01: 48% FY 00: 43%	**NEW** **FY 03 DATA** 3
Total Funding: AIDS Education and Training Centers ($ in 000s)	FY 06: $35,051 FY 05: $35,051 FY 04: $35,335 FY 03: $35,550 FY 02: $35,282	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

Program Performance Analysis

Goal V.B.1. Increase proportion of racial/ethnic minority health care providers participating in AETC training intervention programs.

Given the increasing proportion of AIDS cases among racial and ethnic minorities, improving the clinical education and training for minority providers is critical in managing the increasing number of cases in communities of color.

Increase proportion of racial/ethnic minority health care providers participating in AETC training intervention programs was selected as the best method to improve the public health and health care system by providing the education and training in HIV care to the health care workforce serving medically underserved populations. A training intervention is defined as an interaction between a health care provider and an AETC trainer for the purposes of receiving clinical consultation or other types of training related to the provision of HIV/AIDS related health care services. The actual performance for FY 03 was 43% which met the target. FY 04 data is expected in March, 2006.

U.D.7. Program Title: Dental Reimbursement and Community Partnership Programs (Part F)

Performance Goals	Targets	Actual Performance	Reference
I. IMPROVE ACCESS TO HEALTH CARE **D. Promote Access to Health Insurance and Maximize Use of Available Reimbursements for Health Care Services** 1. Increase the number of persons for whom a portion/ percentage of their unreimbursed oral health costs were reimbursed.	FY 06: 26,500 persons FY 05: 26,500 FY 04: 26,500 FY 03: 29,800 FY 02: 29,800 FY 01: 29,800	FY 04: 30,598 persons FY 03: 27,885 FY 02: 26,327 FY 01: 28,396	**NEW** **FY 04 DATA**
Total Funding: AIDS: Dental Services Program ($ in 000s)	FY 06: $13,218 FY 05: $13,218 FY 04: $13,325 FY 03: $13,405 FY 02: $13,493	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

Program Performance Analysis

Goal I.D.1. Increase the number of persons for whom a portion/percentage of their unreimbursed oral health costs were reimbursed.

As the rate of HIV-related mortality slows, the number of people living with HIV who are in need of continuing and regular oral health services continues to grow. The number of persons for whom a portion of their unreimbursed oral health costs were reimbursed was selected as the best measure of the program's goal to improve access to health care for those HIV infected individuals who require oral health services but are without the financial means to afford them.

In 2004, the Dental Reimbursement Program awards met 70% of the total non-reimbursed costs reported by 63 participating institutions in support of oral health care. These institutions reported providing care to 30,598 HIV-positive individuals, for whom no other funded source was available. This number exceeded the goal by 4,098 individuals or 15.5%. This represents a nearly 9.7% increase from FY 03 in persons whom a portion/percentage of their unreimbursed oral health costs were reimbursed. The Community Dental Partnership Program funded 12 partnership programs with the AIDS Dental Services budget to collaborate and coordinate between the dental education programs and the community-based partners in the delivery of oral

health services. Funding for this new program will support oral health service delivery and provider training in community settings. Community-Based Dental Partnership grants are intended for a period of up to three years.

In FY 04, the demographic characteristics of patients who were cared for by institutions participating in the DRP were: 33% women, 50% minority. Therefore, the DRP served a higher proportion of women than the representation of women among all AIDS cases in the nation, as reported by CDC. CDC reports 21.8% of AIDS cases in 2003 were among women and 63.6% of AIDS cases were among racial/ethnic minorities.

U.E TELEHEALTH

The program included in this section is:

U.E.1. Telehealth

U.E.1. Program Title: Telehealth

Performance Goals	Targets	Actual Performance	Reference
III. IMPROVE THE QUALITY OF HEALTH CARE **D. Promote the Implementation of Evidence-Based Methodologies and Best Practices.** 1. Develop improved performance measures for telemedicine grant programs, evaluate rural telemedicine grant program.	FY 06: Publish at least one paper on best practices from OAT grantees' performance reporting. FY 05: Integrate results measures into performance measurement grantee data collection FY 04: Outcomes/results measures of performance pilot tested FY 03: Performance grantee data collection system implemented in OAT. Outcomes/results measures developed FY 02: Expanded data collection system refinement FY 01: Meta analysis completed; Preliminary GPRA data collection instrument incorporated into progress reports.	FY 04: Preliminary outcomes measures developed. First pilot tests for outcomes will be completed in FY05. FY 03: Performance grantee data collection system implemented as part of progress reporting system FY 02: Preliminary measures developed and pilot-tested FY 01: 2000 Data Report Analysis completed; Meta analysis completed; GPRA Telehealth Rep. System design contract awarded; TAP est.	**NEW FY 04 DATA**

Performance Goals	Targets	Actual Performance	References
V. IMPROVE THE PUBLIC HEALTH AND HEALTH CARE SYSTEMS **B. Increase Collaborative Efforts to Improve the Capacity and Efficiency of the Public Health and Health Care System.**	FY 06: Every HRSA grant program uses standard criteria for evaluating their telehealth grants FY 05: N/A*		
1. Incorporate telehealth technologies in every program within HRSA, as appropriate, with a special emphasis on frontier areas.	FY 04: Every HRSA grant program incorporates telehealth technologies in their design, as appropriate.	FY 04: 54% of HRSA grantees have at least one telehealth program. Telehealth Technical Assistance Documents (TADs) completed. TADs published on web in early FY 05.	**NEW FY 04 DATA**
	FY 03: 2 Telehealth Resource Centers funded to assist in deployment of cost effective technologies and common criteria are used to evaluate and monitor all HRSA telehealth programs.	FY 03: Given limited appropriations, Telehealth Resource Centers were not funded. However, a series of telehealth technical assistance documents were under development to assist persons interested in.	
	FY 02: All relevant HRSA grants announcements include language on the inclusion of telehealth technologies in proposals. *N/A - not applicable	FY 02: Announcements now include appropriate language.	

Performance Goals	Targets	Actual Performance	Reference
VI. ENHANCE THE ABILITY OF THE HEALTH CARE SYSTEM TO RESPOND TO PUBLIC HEALTH EMERGENCIES **A. Enhance the ability of hospitals, health centers, emergency medical systems, poison control centers, and health professionals to respond to bioterrorism and other public health threats in a timely and effective manner.** 1. Create a HRSA Telehealth "Network-of-Networks" (NON) to assist in preparing and responding to disasters and terrorist acts.	FY 06: HRSA Telehealth Inventory data integrated into HRSA ongoing data collection syatems FY 05: Every HRSA grantee actively participates in at least one activity of HRSA's Telehealth NON. FY 04: HRSA Telehealth Inventory data integrated into HRSA ongoing data collection systems. FY 03: Web-based HRSA Telehealth Inventory implemented; pilot for National "Network of Networks." FY 02: Web-based HRSA Telehealth Inventory pilot tested.	FY 04: Data collection completed. Approximately 75% of HRSA grantees responded and approximately 54% of those were engaged in some type of telehealth activity. FY 03: Implementation begun FY 02: Web-based system pilot tested	**NEW FY 04 DATA**
Efficiency Measure 1. Increase the proportion of grantees that report electronically. **(Developmental)**	FY 06: 100% FY 05: 95% FY 04: 50 %	FY 04: 51% (est.) FY 03: 0% (baseline)	**NEW FY 04 DATA**
Total Funding: Telehealth ($ in 000s)	FY 06: $ 3,888 FY 05: $ 3,916 FY 04: $ 3,949 FY 03: $26,687 FY 02: $37,177	HP: Healthy People goal PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

Program Performance Analysis

Goal III.D.1. Develop improved performance measures for telemedicine grant programs, evaluate rural telemedicine grant program.

In both FY 00 and FY 01, two evaluation efforts were underway -- a prospective study of encounters in all the rural grantee projects, and a meta-analysis of findings from individual rural telemedicine grant evaluation efforts. The encounter survey was originally to be conducted in FY 99, but based on a review of the draft instrument, it was determined not to go forward with a full survey instrument because of poor results when implementing pilot versions with grantees.

In FY 01, a contract was awarded to Abt Associates to assist OAT in the design of a telemedicine grantee performance measurement system. The output of this initiative was a web-based data

reporting tool to be incorporated into routine progress reports of OAT's grantees, replacing most of the previous charts and data reporting mandated in these reports.

By the end of FY 02, the paper-and-pencil phase of the data reporting system was completed and, starting in FY 03, the web-based automated data reporting system was operational. In FY 03, the web-based tool was incorporated across the telemedicine programs funded by OAT under the Rural Telemedicine and Telehealth Network Grant Programs, allowing critical questions about programs to begin to be answered. Data analysis for FY 03 has been completed. For the first time, these data allowed OAT to evaluate the extent to which the OAT-funded projects were improving the availability of services in rural communities. For example, during the period March 2003 - August 2003, of the more than 200 rural communities served by the grantees reporting, 113 communities had access to behavioral health services that otherwise would not have been available. From these data, routine reports were produced for both HRSA and for individual grantees.

One output of this effort was a recognition that a more specialized system of measurement would be required to measure clinical outcomes related to quality of care and that such a system should be tied to the particular health problem being addressed (e.g., glucose control in diabetic patients as a result of better monitoring and care through telemedicine). In late FY 03, a supplementary effort was begun by a subset of OAT grantees to develop such measures that would serve as a future model for collecting these types of measures across all relevant grantees and programs. In FY 04, measures were developed with an advisory committee. This supplementary performance system will be pilot-tested in FY 05 and is scheduled to be fully implemented in FY 06 for all relevant OAT grantees. Preliminary FY 05 data will be produced from pilot sites and OMB clearance will be sought for full implementation.

Goal V.B.1. Incorporate telehealth technologies in every program within HRSA, as appropriate, with a special emphasis on frontier areas.

In FY 02, HRSA incorporated telehealth technologies in all its programs by requiring all relevant HRSA grant announcements to include language on the inclusion of telehealth technologies. By the end of FY 04, every HRSA grant program was expected to incorporate telehealth technologies in their design based on best practices. OAT, in collaboration with all components of the Agency, was to develop common criteria by which to evaluate telehealth applications for funding and to monitor grantees, which will be based on the lessons learned from OAT grantees and input from other components of HRSA and the Joint Working Group on Telehealth. The target date for achieving this goal has been revised, with the new target date of FY 06. These criteria will be incorporated in all HRSA grant announcements and in the progress performance measurement system for all HRSA by the end of FY 06 .

Greater technical assistance is required to help applicants and grantees take full advantage of telehealth technologies. Initially HRSA hoped to develop regional Telehealth Resource Centers to assist HRSA grantees in this effort. Given that funds to develop and support these centers were not forthcoming, OAT worked with its grantees to develop a series of technical assistance

documents (TADs) to assist grantees in establishing their telehealth programs. The TADs were developed by OAT grantees and based on their real-life experiences in developing 11 telehealth applications – cardiology, dermatology, disease management, electronic medical records for rural health systems, HIV/AIDS, home care, mental health, pharmacy, rehabilitation, school-based health services, and trauma/emergency medical care. The TADs were made available in November 2004 on the Missouri Telehealth Network's website, (http://muhealth.org/~telehealth/geninfo/TAD.html), and through links on the OAT, American Telemedicine Association, and the Telemedicine Information Exchange web-sites.

HRSA has been working with East Carolina University to develop a web-based inventory of all its telehealth programs. Based on the results from the FY 03/FY 04 inventory, 2,488 of the 4,619 grantees reporting (54%) were engaged in some type of telehealth activity.

Goal VI.A.1. Create a HRSA Telehealth "Network-of-Networks" (NON) to assist in preparing and responding to disasters and terrorist acts.

HRSA, through its Office for the Advancement of Telehealth, pioneered the development of the web-based inventory. The Agency saw and continues to see building and expanding its component of a national NON as a means not only to address disasters and terrorist threats, but as an integral part of HRSA's strategy to integrate telehealth services into all of its programs.

In FY 02 and FY 03, OAT collaborated with its grantee, East Carolina University, to develop an easy-to-use, web-based inventory of HRSA programs. In late FY 03, the inventory was implemented HRSA-wide. In FY 04, the first year of data collection was completed. As noted above, the results from the FY 03/FY 04 inventory indicate that approximately 54% of HRSA grantees that responded are involved in some type of telehealth activity. The inventory experienced a response rate of over 75%, with a target of 90% for the second year of data collection, scheduled to end in FY 05. Significant barriers to achieving 100% participation were experienced, including software problems and inaccurate grantee data base, in part attributed to the many changes that grants undergo in a year.

Nonetheless, the project was a major step forward over previous fax-based inventory conducted by OAT for the Agency in FY 98. The web-based inventory allowed grantees to directly enter data onto the web. A data base was automatically generated from the information entered. In FY 05, an archiving and updating capacity will be added to the HRSA Telehealth Inventory, allowing comparisons from year to year. Depending on the progress of HRSA's overall data collection efforts, the Inventory is scheduled to be fully integrated into HRSA's ongoing data collection systems by FY 06. In FY 05, efforts will be made to expand the data collection effort to other agencies through a collaborative venture among agency members of the Joint Working Group on Telehealth, in anticipation of integration into a national NON if such a network evolves. FY 05 data is expected in October, 2005.

Efficiency Measure

1. Increase the proportion of grantees that report electronically. (Developmental)

In FY 03, OAT grantees reported their progress on paper forms. In FY 04, OAT asked its grantees to begin electronic reporting with their first mid-year/mid-project progress report. More than 50% reported electronically, as well as providing paper forms. Failure to report electronically in FY 04 may be due to the start-up nature of many of the grant projects. By FY 05, 95% of grantees will be able to report electronically but, some, perhaps 5%, may experience technical difficulties By FY 06, all OAT grantees will be reporting electronically.

U.F HEALTHCARE SYSTEMS

Programs included in this section are:

U.F.1. Organ Procurement and Transplantation
U.F.2. National Bone Marrow Donor Registry Program
U.F.3. Poison Control Centers
U.F.4. National Bioterrorism Hospital Preparedness Program
U.F.5. Trauma/Emergency Medical Services
U.F.6. National Vaccine Injury Compensation Program

U.F.1. Program Title: Organ Procurement and Transplantation

Performance Goals	Targets	Actual Performance	Reference
II. IMPROVE HEALTH OUTCOMES **A. Expand the availability of health care, particularly to underserved, vulnerable, and special needs populations**			**PART**
<u>Long-Term Goal</u> By 2013, increase the number of deceased donor organs transplanted to 42,800, an increase of 110% over baseline. **(Outcome)**	FY 13: 42,800	FY 03: 20,392 (baseline)	
<u>Short-Term Goals</u> 1. Increase the annual number of organs transplanted in accordance with projections until 42,800 organs are transplanted in 2013. **(Outcome)**	FY 06: 25,651 FY 05: 23,512 FY 04: 21,459	FY 04: (4/05) FY 03: 20,392 (baseline)	
2. Increase the annual number of "non-cardiac death" donors by 333 until the number of 9,251 "non-cardiac death" donors is achieved in 2013. **(Outcome)**	FY 06: 6,920 FY 05: 6,587 FY 04: 6,254	FY 04: (4/05) FY 03: 6,187 (baseline)	
3. Increase the annual number of "cardiac death" donors by 175 until the number of 2,018 "cardiac death" donors is achieved in 2013. **(Outcome)**	FY 06: 793 FY 05: 618 FY 04: 443	FY 04: (4/05) FY 03: 268 (baseline)	
4. Increase the average number of organs transplanted per "non-cardiac death" donor each year by 0.08 until the average of 4.00 is achieved in 2013. **(Outcome)**	FY 06: 3.44 FY 05: 3.36 FY 04: 3.28	FY 04: (4/05) FY 03: 3.20 (baseline)	
5. Increase the average number of organs transplanted per "cardiac death" donor each year by 0.096 until the average of 3.00 is achieved in 2013. **(Outcome)**	FY 06: 2.328 FY 05: 2.232 FY 04: 2.136	FY 04: (4/05) FY 03: 2.04 (baseline)	

Performance Goals	Targets	Actual Performance	Reference
Long-Term Goal By 2013, increase the total expected life-years gained for kidney transplant recipients in the first 5 years after the transplant to 8,543 compared to what would be expected for these recipients had they remained on the waiting list. **(Outcome)**	FY 13: 8,543	FY 03: 3,871 (baseline)	**PART**
Short-Term Goals 6. Increase the average number of life-years gained in the first 5 years after transplantation for deceased kidney/kidney-pancreas transplants by 0.003 life-years until the goal of 0.436 life-years gained per transplant is achieved in 2013. **(Outcome)**	FY 06: 0.415 FY 05: 0.412 FY 04: 0.409	FY 04: (4/05) FY 03: 0.406 (baseline)	
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. **(Outcome)**	FY 06: 5,048 FY 05: 4,641 FY 04: 4,257	FY 04: (4/05) FY 03: 3,871 (baseline)	
Efficiency Measure 1. Decrease the total OPTN operating costs per deceased organ transplanted.	FY 06: $774 FY 05: $789 FY 04: $808	FY 04: (4/05) FY 03: $795 (baseline)	
Deleted Measure(s) 1. Increase the national number of living and deceased donors by 3% per year.	FY 06: NA FY 05: NA FY 04: 13,558	FY 04: (04/05) FY 03: 13,270 (3.7%) FY 02: 12,791 (1.7%) (baseline)	**NEW FY 03 DATA** 1, 5
2. Increase the national number of minority living and deceased donors by 4% per year.	FY 06: NA FY 05: NA FY 04: 3,963	FY 04: (04/05) FY 03: 4,055 (10.5%) FY 02: 3,669 (baseline)	**NEW FY 03 DATA** 1, 5
3. Increase the number of corporate and institutional partners participating in the Secretary's Gift of Life Organ Donation Initiative.	FY 06: NA FY 05: NA FY 04: 6,400 FY 03: 4,400	FY 04: 10,121 FY 03: 7,827 FY 02: 2,400 (baseline)	**NEW FY 03 DATA** 5
4. Increase the conversion rate of eligible deceased donors to actual donors by 4% per year in those 300 donor hospitals with the highest donor potential until a conversion rate of 75% is achieved.	FY 06: NA FY 05: NA FY 04: 54% FY 03: 50%	FY 04: 53.3%) FY 03: 50.6% FY 02: 46 % (baseline)	**NEW FY 03 DATA** 5
5. Increase the national number of living and deceased donors by 6% per year.	FY 03: 14,119	FY 03: 13,270 (5.5%) FY 02: 12,582 (1.7%) (baseline)	**NEW FY 03 DATA** 1,5
6. Increase the national number of minority living and deceased donors by 8% per year.	FY 03: 4,275	FY 03: 4,055 (10.5%) FY 02: 3,669 (baseline)	**NEW FY 03 DATA** 1,5
Total Funding: Organ Procurement and Transplantation ($ in 000s)	FY 06: $23,282 FY 05: $24,413 FY 04: $24,632 FY 03: $24,828 FY 02: $19,983	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

Program Performance Analysis

The Organ Transplantation Program was evaluated for the FY 06 budget by the Office of Management and Budget (OMB) using the Program Assessment Rating Tool (PART). As part of that review, the program developed refined and expanded performance measures that would better reflect the program's purpose and performance. These measures, presented in the table and text replace previous performance measures.

Long-Term Goal

By 2013, increase the number of deceased donor organs transplanted to 42,800, an increase of 110% over baseline.

The intent of this long-term goal is to increase the number of deceased donor organs transplanted overall in FY 13 to 42,800 from the number of overall, deceased donor organs transplanted in FY 03 of 20,392 which is the baseline value for this goal. This represents an increase of 110% over the number of deceased donor organs transplanted in FY 03.

Goal II.A.1. Increase the annual number of organs transplanted in accordance with projections until 42,800 organs are transplanted in 2013.

The intent of this short-term goal is to increase the number of deceased donor organs transplanted on an annual basis so that by FY 13 the long-term goal will be met. For FY 04, FY 05, and FY 06, the goal is to make incremental increases in the overall number of deceased donor organs transplanted. The baseline value for this goal is 20,392 in FY 03.

Goal II.A.2. Increase the annual number of "non-cardiac death" donors by 333 until the number of 9,251 "non-cardiac death" donors is achieved in 2013.

One aspect contributing to the increase in the overall number of deceased donor organs transplanted is the number of "non-cardiac death" donors. The intent of this short-term goal is to increase the number of "non-cardiac death" donors on an annual basis so that by FY 13 the long-term goal will be met. For FY 04, FY 05, and FY 06, the goal is to increase by 333 the number of "non-cardiac death" donors so that by FY 13 9,251 "non-cardiac death" donors will contribute toward a portion of the total number of organs transplanted. The baseline value for this goal is 6,187 in FY 03.

Goal II.A.3. Increase the annual number of "cardiac death" donors by 175 each year until the number 2,018 "cardiac death" donors is achieved in 2013.

Another aspect contributing to the increase in the overall number of deceased donor organs transplanted is the number of "cardiac death" donors. The intent of this short-term goal is to increase the number of "cardiac death" donors on an annual basis so that by FY 13 the long-term goal will be met. For FY 04, FY 05, and FY 06, the goal is to increase by 175 annually the

number of "cardiac death" donors so that by FY 13 2,018 "cardiac death" organ donors will contribute toward a portion of the total number of organs transplanted. The baseline value for this goal is 268 in FY 03.

Goal II.A.4. Increase the average number of organs transplanted per "non-cardiac death" donor each year by 0.08 until the average of 4.00 is achieved in 2013.

Another aspect contributing to increasing the overall number of deceased donor organs transplanted is the average number of organs procured from an organ donor. The intent of this short-term goal is to increase the average number of organs procured from "non-cardiac death" donors on an annual basis so that by FY 13 the long-term goal will be met. For FY 04, FY 05, and FY 06, the annual goal is to increase by 0.08 the average number of organs procured from "non-cardiac death" donors so that by FY 13 an average of 4.00 transplanted organs will be achieved. The baseline value for this goal is 3.20 in FY 03.

Goal II.A.5. Increase the average number of organs transplanted per "cardiac death" donor each year by 0.096 until the average of 3.00 is achieved in 2013.

Another aspect contributing to increasing the overall number of deceased donor organs transplanted (Goal II.A.1) is the average number of organs procured from an organ donor. The intent of this short-term goal is to increase the average number of organs procured from "cardiac death" donors on an annual basis so that by FY 13 the long-term goal will be met. For FY 04, FY 05, and FY 06, the annual goal is to increase by 0.096 the average number of organs procured from "cardiac death" donors so that by FY 13 an average of 3.00 transplanted organs will be achieved. The baseline value for this goal is 2.04 in FY 03.

<u>Long-Term Goal</u>

By 2013, increase the total expected life-years gained for kidney transplant recipients in the first 5 years after the transplant to 8,543 compared to what would be expected for these recipients had they remained on the waiting list.

One way of expressing prognosis of a medical outcome, i.e., life-years gained for the kidney transplant recipient, is to describe 5-year survival. The intent of this long-term goal is to increase, by FY 13, the total number of expected life-years gained for kidney transplant recipients in the first 5 years after a transplant when compared to what would have been expected for this group if they had remained on the waiting list. The baseline value for this goal is 3,871 in FY 03.

Goal II.A.6. Increase the average number of life-years gained in the first 5 years after transplantation for deceased kidney/kidney-pancreas transplants by 0.003 life-years until the goal of 0.436 life-years gained per transplant is achieved in 2013.

The intent of this short-term goal is to increase on an annual basis the average number of life-years gained in the first 5 years following transplantation for deceased kidney or kidney-pancreas transplants by 0.003 life-years until the goal of 0.436 life-years gained per transplant is achieved

by FY 13. For FY 04, FY 05, and FY 06, the goal is to make incremental increases in the average number of life-years gained for the 5 years following organ transplantation. The baseline value for this goal is 0.406 in FY 03.

Goal 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.

The intent of this short-term goal is to increase on an annual basis the total number of life-years gained in the first 5 years following transplantation for deceased kidney or kidney-pancreas transplants to 8,543 total life-years gained compared to the total life-years gained if this group had remained on the waiting list. For FY 04, FY 05, and FY 06, the goal is to make incremental increases in the total number of life-years gained for the 5 years following organ transplantation. The baseline value for this goal is 3,871 in FY 03.

Efficiency Measure

1. Decrease the total OPTN operating costs per deceased organ transplanted.

The intent of this short-term goal is to reduce the total OPTN operating costs associated with organ transplantation per deceased organ transplanted on an annual basis from the baseline amount of $795 in FY 03 to $774 in FY 06, before factoring into the amount the effects of medical inflation.

Deleted Measure(s)

1. Increase the national number of living and deceased donors by 3% per year.

This measure was revised from 6% per year to 3% per year in the FY 05 GPRA report. Under the 6% measure, the target for FY 03 was 14,119. The actual combined number of deceased and living donors for FY 03 was 13,270. If the 3% measure had been applied to the FY 02 baseline number of 12,791, the target for FY 03 would have been 13,174. Under this scenario, the target would have been exceeded. The 13,270 number of deceased and living donors represents a 3.7% increase from the FY 02 actual number reported in the FY 05 GPRA report. This increase is 2 percentage points greater than the 1.7% increase experienced in FY 02. The major component of this increase was the number of deceased donors. After several years of stagnant growth, the number of deceased organ donors increased by 4.3% in FY 03. This is the largest 1-year increase since 1998 when the Center for Medicare and Medicaid Services regulation requiring the reporting of deaths and imminent deaths by hospitals to organ procurement organizations became effective. This is an encouraging sign since the majority of the donation efforts of the Division are targeted toward increasing the number of deceased donors.

The FY 04 target is 13,558. The FY 04 data will be available in April, 2005.

2. Increase the overall national number of minority living and deceased donors by 4% per year.

The target for this measure was revised from 8% per year to 4% per year in the FY 05 GPRA report. Under the 8% measure, the target for FY 03 was 4,275. The actual combined number of minority deceased and living donors for FY 03 was 4,055. This represents a 10.5% increase from the 3,669 number of deceased and living donors reported in FY 02. The number falls below the 4,275 measure established in the FY 04 GPRA report, but exceeds the revised 4% rate of increase established in the FY 05 GPRA report.

The FY 04 target is 3,963. The FY 04 data will be available in April, 2005.

3. Increase by the number of corporate and institutional partners participating in the Secretary's Gift of Life Organ Donation Initiative.

The performance goal for this activity was to enroll 2,400 Workplace Partners for FY 02 and an additional 2,000 partners each additional fiscal year. The target for FY 03 was 4,400. The actual number of Workplace Partners enrolled in FY 03 was 7,827, which is 78% in excess of the FY 03 target. In FY 04 the number reached 10,121, again substantially exceeding the target. This higher than expected performance represents a highly-focused effort involving contractors and the support of the organ procurement community to enroll and support the activities of Workplace Partners. The target for FY 04 was set before the higher FY 03 actual performance was known. While the initial push to enroll partners has exceeded expectations, it is believed that the number of new Workplace Partners enrolled in the coming years will be much fewer because the potential number of organizations that have not already enrolled is much fewer than the original potential. Each additional enrollee will require greater effort.

4. Increase the conversion rate of eligible deceased donors to actual donors by 4% per year in those 300 donor hospitals with the highest donor potential until a conversion rate of 75% is achieved.

This measure is designed to ascertain how efficiently donor potential in the largest 300 hospitals is being converted into actual donors. The 6th element of the Secretary's *Gift of Life Donation Initiative,* the *Organ Donation Breakthrough Collaborative,* was launched by Secretary Thompson in April 2003. The purpose of this project is to increase organ donation rates from the current average of 46% in the 300 hospitals with the highest number of eligible donors to 75%, which is a rate believed to be highly ambitious, but theoretically achievable with enough

resources. Donation increases will be achieved by applying the Institute for Healthcare Improvement's breakthrough collaborative methodology and by implementing organ donation best practices identified in HRSA's "Organ Donation Breakthrough Collaborative: Best Practices Final Report."

The conversion rate is calculated by dividing the number of donors by the number of eligible donors (those deceased individuals that meet specific medical eligibility criteria) multiplied by 100. The performance in FY 04 was 53.3% compared to the target of 54%. Continued improvement toward this target will be dependent on collaborative activities to spread the success of the learning to those hospitals where 90% of the potential eligible donors are found.

5. Increase the national number of living and deceased donors by 6% per year.

This measure was revised from 6% to 3% in the FY 05 GPRA report. The FY 03 target under the 6% goal was 14,119. The actual combined number of deceased and living donors in FY 03 was 13,270. FY 03 is the final reporting year for this deleted measure.

6. Increase the national number of minority living and deceased donors by 8% per year.

This measure was revised from 8% to 4% in the FY 05 GPRA report. The FY 03 target under the 8 % goal was 4,275. The actual combined number of deceased and living donors in FY 03 was 4,055. FY 03 is the final reporting year for this deleted measure.

U.F.2. Program Title: National Bone Marrow Donor Registry Program

Performance Goals	Targets	Actual Performance	Reference
II. IMPROVE HEALTH OUTCOMES **A. Expand the availability of health care, particularly to underserved, vulnerable, and special needs populations** **Long-Term Goal** By 2010, increase by 95% the number of blood stem cell transplants facilitated annually by the Registry. **(Outcome)** **Short-Term Goal** 1. Increase the number of cord blood units listed in the Registry. **(Outcome)**	FY 10: 4,500 FY 06: 37,500 FY 05: 36,500 FY 04: 30,000	FY 03: 2,310 (baseline) FY 04: 35,926 FY 03: 28,896 (baseline)	**PART** **NEW FY 04 DATA**
Long-Term Goal By 2010, increase by 100% the number of blood stem cell transplants facilitated annually by the Registry for minority patients. **(Outcome)** **Short-Term Goal** 2. Increase the number of adult volunteer potential donors of minority race and ethnicity. **(Outcome)**	FY 10: 636 FY 06: 1.71 M FY 05: 1.60 M FY 04: 1.48 M	FY 03: 318 (baseline) FY 04: (4/05) FY 03: 1.37 M (estimated baseline)	**PART**
Long-Term Goal By 2010, increase the rate of patient survival at one year, post transplant. **(Outcome - Developmental)**	FY 10: TBD Target will be established by 4/05.	FY 03:TBD (Baseline) Baseline data will be available 4/05	**PART**
Efficiency Measure 1. Decrease the unit cost of HLA-typing of potential donors by 2% each year.	FY 06: $61.17 FY 05: $62.42 FY 04: $63.70	FY 04: $63.65 FY 03: $65.00 (baseline)	**PART** **NEW FY 04 DATA**

Deleted Measure(s) 1. Increase the national number of unrelated bone marrow donors (national registry of potential donors) by 5% per year. **(Outcome)**	FY 04: 5.30 M donors FY 03: 5.05 M donors FY 02: 4.45 M donors FY 01: 4.24 M donors	FY 04: 5.50 M donors (7.1%) FY 03: 5.13 M donors (6.2%) FY 02: 4.83 M donors (7.3%) FY 01: 4.50 M donors (8.4%) FY 00: 4.15 M donors (10.4%)	**NEW FY 04 DATA**
2. Increase the national number of unrelated minority bone marrow donors (national registry of potential donors) by 8% per year. (Note: Measure #3 below contains higher percent increase targets for a similarly phrased measure for FY 02 and FY 03.) **(Outcome)**	FY 04: 1.49 M donors	FY 04: (4/05) FY 03: 1.37 M donors (est.) (7.9%) FY 02: 1.27 M donors (9.5%) FY 01: 1.16 M donors (11.5%) FY 00: 1.04 M donors (13.0%)	**NEW FY 03 DATA**
3. Increase the national number of unrelated minority bone marrow donors (national registry of potential donors) by 10% per year. **(Outcome)**	FY 03: 1.38 M donors FY 02: 1.26 M donors	FY 03: 1.37 M donors (est.) FY 02: 1.27 M donors	**NEW FY 03 DATA**
Total Funding: National Bone Marrow Donor Registry Program ($ in 000s)	FY 06: $22,916 FY 05: $25,416 FY 04: $22,662 FY 03: $21,891 FY:02 $21,989	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

Program Performance Analysis

Long-Term Goal

By 2010, increase by 95% the number of blood stem cell transplants facilitated annually by the Registry.

The purpose of the program is to increase the number of unrelated blood stem cell transplants facilitated for patients in need. This long-term goal directly reflects the program's purpose.

Goal II.A.1. Increase the number of cord blood units listed in the Registry.

Reaching this goal will increase the number of patients able to find a suitably matched unrelated cord blood unit for their blood stem cell transplant. This will lead to an increase in the number of patients receiving unrelated donor transplants. In FY 03, the Registry listed 28,896 cord blood units. In FY 04, the Registry listed 35,926 cord blood units, a 24.3% increase over FY 03.

Long-Term Goal

By 2010, increase by 100% the number of blood stem cell transplants facilitated annually by the Registry for minority patients.

Reaching this goal will further the statutory aim of ensuring that patients from racially and ethnically diverse backgrounds will have a chance of receiving an unrelated blood stem cell transplant that is comparable to that of non-Hispanic Caucasian patients.

Goal II.A.2. Increase the number of adult volunteer potential donors of minority race and ethnicity.

Reaching this goal will 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 transplant. This will lead to more minority patients receiving unrelated donor transplants. Calculating the exact number of minority donors on the Registry has become difficult since the Registry incorporated the Office of Management and Budget revisions to the Standards for Classification of Federal Data on Race and Ethnicity as of October 1, 2002. Despite the NMDP thoroughly educating its Network members on the change and explaining the importance of capturing racial data from all of the donors recruited to the Registry, many potential Hispanic donors have declined to provide racial data. Thus avoiding double counting of Hispanic donors who also are of minority race is problematic. Discussions are underway to consider how best to report on minority donors. Due to this reporting challenge, information on the actual number of minorities on the Registry in FY 04 is expected to be available in April, 2005.

Long-Term Goal

By 2010, increase the rate of patient survival at one year, post transplant.

The intent of this health outcome measure is to increase the health benefit to patients receiving an unrelated blood stem cell transplant. The program recognizes that it does not have a direct impact on patient care delivery. Nonetheless, the program can influence survival rates in several ways, including improving the degree of tissue-type match between patient and donor by adding adult volunteer potential donors and cord blood units to the Registry, ensuring that the Registry is working with highly competent transplant centers and other organizations, decreasing the time required to identify the best available donor for each patient, and engaging in research to improve transplant outcomes (e.g., by better prevention and treatment of infections and other transplant complications). This new measure is still under development and the target and baseline will be established in April, 2005.

Efficiency Measure

1. Decrease the unit cost of HLA-typing of potential donors by 2% each year.

The cost of Human Leukocyte Antigen (HLA) typing strongly influences the number of volunteer potential donors who can be recruited to join the Registry. Reducing the unit cost of typing makes possible some increase in donor recruitment even without funding increases. In FY 04, the National Marrow Donor Program successfully negotiated a 2.7 percent reduction in cost with its contracted laboratories for Human Leycocyte Antigen (HLA) tissue typing. The cost of tissue typing decreased from $65.00 in FY 03 to $63.65 in FY 04.

Deleted Measure(s)

1. Increase the national number of unrelated bone marrow donors (national registry of potential donors) by 5% per year.

This measure, although valuable and still monitored by the program, was deleted because it focuses on increasing the overall number of volunteer blood stem cell donors. The new PART measure focuses primarily on increasing the number of volunteers who come from racially and/or ethnically diverse backgrounds. The new focus addresses the fact that minority patients generally have a lower likelihood of finding a matched blood stem cell donor on the Registry.

In FY 03, 5.13 million potential unrelated bone marrow donors were on the Registry (an increase of 306,446 or 6.2% over FY 02), which exceeded the goal of 5.05 million. In FY 04, 5.50 million potential unrelated bone marrow donors were on the Registry (an increase of 368,901 or 7.1% over FY 03), which exceeded the target of 5.30 million.

2. Increase the national number of unrelated minority bone marrow donors (national registry of potential donors) by 8% per year.

Despite the current Registry size, minorities still have a more difficult time finding a matched unrelated marrow donor due to their diverse HLA types. This measure is still a major priority for the Registry; however the targets were slightly decreased during the PART process to reflect increases of 6-8% each year. This adjustment was necessary to reflect more intensive education and screening at recruitment in order to increase the retention of donors on the Registry, and because relatively flat funding levels do not permit maintaining the higher percentage increases that were possible in earlier years. In FY 03, it is estimated that 1.37 million potential unrelated minority bone marrow donors were on the Registry, which reflected an increase of 7.9% over FY 02.

Calculating the exact number of non-Hispanic Caucasian donors on the Registry has become difficult since the Registry incorporated the Office of Management and Budget revisions to the Standards for Classification of Federal Data on Race and Ethnicity as of October 1, 2002.

Despite the NMDP thoroughly educating its Network members on the change and explaining the importance of capturing racial data from all of the donors recruited to the Registry, many potential Hispanic donors have declined to provide racial data. Discussions are underway to consider how best to report on minority donors. Due to this reporting challenge, information on the actual number of minorities on the Registry in FY 04 is expected to be available in April, 2005.

3. Increase the national number of unrelated minority bone marrow donors (national registry of potential donors) by 10% per year.

This measure is phrased similarly to the preceding one but contained higher percent increase targets for FY 02 and FY 03. FY 03 is the final reporting year for this deleted measure.

U.F.3. Program Title: Poison Control Centers

Performance Goals	Targets	Actual Performance	Reference
III. IMPROVE THE QUALITY OF HEALTH CARE **D. Promote the implementation of evidence-based methodologies and best practices**			**PART**
Long-Term Goal By 2009, decrease the number of visits to the emergency room by 25 percent. **(Outcome)**		FY 01-02: 2.05 live ER discharges per 1,000 population (baseline)	
Short-Term Goals 1. Develop and ratify uniform and evidence-based guidelines for the treatment of poisoning.	FY 06: 9 FY 05: 6	FY 04: 3*(baseline) FY 03: 2 FY 02: 1 *cumulative	**NEW FY 04 DATA**
2. Increase the number of PCCs with 24-hour bilingual staff.	FY 06: 5 FY 05: 3	FY 04: 1 (baseline)	
3. Increase percent of inbound volume on the toll-free number.	FY 06: 49.1% FY 05: 44.6% FY 04: 40.6%	FY 04: 46.8% FY 03: 36.9% (baseline)	**NEW FY 04 DATA**
Efficiency Measure 1. Decrease the application and reporting time burden of grantees by 5% per year for 4 years, thereby collecting more accurate and timely data.	FY 06: 5% less than baseline	Baseline: TBD	
Deleted Measure(s) 1. Increase the percentage of certified Poison Control Centers at a constant level of federal funding.	FY: 04: 88% FY 03: 82% FY 02: 77% FY 01: 75%	FY 04: 84% FY 03: 82% FY 02: 81% FY 01: 78% FY 00: 70%	**NEW FY 04 DATA**
Total Funding: Poison Control Centers ($ in 000s)	FY 06: $23,301 FY 05: $23,499 FY 04: $23,696 FY 03: $22,354 FY 02: $21,210 FY 01: $19,995	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

Program Performance Analysis

Long-term Goal

By 2009, decrease the number of visits to the emergency room by 25 percent.

Decreasing unneeded emergency room visits for poisoning or suspected poisoning will reduce unnecessary utilization of extremely costly resources, and allow those resources to be better utilized for persons in need of them.

Goal III.D.1. Develop and ratify uniform and evidence-based guidelines for the treatment of poisoning.

Having evidence-based guidelines available for use at the poison control centers will improve uniformity and standard care for acute poisoning-related incidents, thereby improving the quality of care. In FY 02, one guideline covering 35 non-toxic substances was produced. In FY 03, two uniform guidelines for the treatment of toxic poisonings were developed and ratified. The baseline for FY 04 is the cumulative total of guidelines (3) with a goal of developing three additional guidelines in FY 05 and three more in FY 06. There are 10 additional toxic poisoning guidelines under development. Four guidelines are near completion, and six are in the research and review phase. The project is in its final year of a 3-year cooperative agreement with the American Association of Poison Control Centers (AAPCC). However it is anticipated that the project will continue to be funded through FY 06.

Goal III.D.2. Increase the number of PCCs with 24-hour bilingual staff.

According to the American Association of Poison Control Centers, only 1 of 62 Poison Control Centers in the U.S. has 24-hour bilingual staff. In order for the Poison Control Program to ensure universal access and serve a larger population, the goal is to increase the number of PCCs with 24-hour bilingual staff coverage by at least 2 centers per year. This will reduce the number of emergency room visits for non-English speaking populations, by providing understandable advice in a timely manner.

Goal III.D.3. Increase percent of inbound volume on the toll-free number.

Public Law 106-174, the Poison Control Enhancement and Awareness Act, mandated the development of a single, national toll-free number to ensure universal access to poison control services. In 2002, the Poison Control Program, in conjunction with the Centers for Disease Control and Prevention (CDC), initiated a national media campaign to promote the use of 1-800-222-1222. Increasing the use of the national number will not only give callers universal access, but it will also provide individuals the necessary resource to determine the severity of the situation and respond accordingly, which will help to reduce the number of emergency room visits. According to the AAPCC, in 2004, 46.8% of callers and in 2003, 36.9 % of callers utilized this number versus other poison control center telephone numbers. This is a substantial increase from the first year's number of 24.6% (in FY 02). The target is to increase inbound call volume by 10% each year.

Efficiency Measure

1. Decrease the application and reporting time burden of grantees by 5% per year for 4 years, thereby collecting more accurate and timely data.

A new on-line application and reporting system is being implemented in FY 05 and will be fully implemented in FY 06. This system will provide grantees with information from previous years, including budget and service data, eliminating the provision of previously supplied information by the grantees. Also, the system prepopulates figures into subsequent forms so that grantees do not have to enter the same data more than once. Reporting is also easier on the on-line system and provides program management with performance data that are far more reliable and valid, with a shorter lag time. The FY 06 target is a 5% reduction from the baseline that is to be determined.

Deleted Measure(s)

Increasing the percentage of certified centers will increase access to quality services for the U.S. population.

In 2004, 84% of poison control centers were certified. Public Law (P.L.) 108-194, the Poison Control Center Enhancement and Awareness Act Amendments of 2003, reauthorized legislation for (P.L.106-174) and contains a provision which would render poison control centers ineligible for Federal funding beyond FY 05, if certification is not achieved. This provision alleviates the opportunity for uncertified centers to become certified after FY 05.

U.F.4. Program Title: National Bioterrorism Hospital Preparedness Program

Performance Goals	Targets	Actual Performance	Reference
VI. ENHANCE THE ABILITY OF THE HEALTH CARE SYSTEM TO RESPOND TO PUBLIC HEALTH EMERGENCIES **A. Enhance the ability of hospitals, health centers, emergency medical systems, poison control centers, and health professionals to respond to bioterrorism and other public health threats in a timely and effective manner.** 1. Percent of awardees that have developed plans to address surge capacity.	FY 06: 100% FY 05: 100% FY 04: 90%	FY 04: 89% FY 03: 59% (estimated baseline)	**NEW** **FY 04** **DATA**
Long-Term Goal By 2008, 100 percent of hospital regions will have achieved a surge capacity of 500 persons per million in all hospital regions, for response to terrorism and other public health emergencies. **(Outcome)**	FY 06: 85% FY 05: 75%	Baseline: TBD	**PART**
Short-Term Goals 2. Increase the percentage of awardees that have implemented regional plans and met all major milestones established for all of the HRSA priority areas to meet the goal of a surge capacity of 500 persons per million population. **(Outcome)**	FY 06: 85% FY 05: 75%	Baseline: TBD	
3. Increase the percentage of awardees that demonstrate their ability to secure and distribute pharmaceutical resources required in emergency events, including coordinated caches of pharmaceutical caches of metropolitan medical response systems sufficient to treat 500 persons per million population, as certified by HRSA. **(Outcome)**	FY 06: 85% FY 05: 75%	Baseline: TBD	
4. Increase the percentage of awardees that have (1) assessed the existing chemical and radiological response equipment they currently possess, (2) acquired the needed additional equipment as identified in that assessment, and (3) trained hospital and emergency medical service personnel likely to respond/treat 500 persons per million population, chemically or radiologically. **(Outcome)**	FY 06: 85% FY 05: 75%	Baseline: TBD	
5. Increase the percentage of awardees that have successfully demonstrated their ability to evaluate, diagnose, and treat 500 adult and pediatric patients per million population resulting from emergency events, meeting HRSA criteria, as evidenced in reviews of annual drill reports. **(Outcome)**	FY 06: 85% FY05: 75%	Baseline: TBD	

Performance Goals	Targets	Actual Performance	Reference
Efficiency Measure 1. Increase the percent of awardees that file semi-annual reports electronically. **(Developmental)**	FY 06: 100% FY 05: 100%	Baseline: (3/05)	
Total Funding: Hospital Preparedness ($ in 000s)	FY 06: $482,979 FY 05: $491,410 FY 04: $514,943 FY 03: $514,633 FY 02: $135,000	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

Program Performance Analysis

Goal VI.A.1. Percent of awardees that have developed plans to address surge capacity.

Surge capacity remains an issue for many hospitals across the Nation, and is a key to preparedness for biological, chemical, radiological or explosive incidents, as well as other public health emergencies. A mass casualty event resulting from any of these or other scenarios could rapidly overwhelm the health care resources in a region. The development of plans to address surge capacity designed to deal with potential public health emergencies is based on the concept that improved outcomes can be achieved when critical components of preparedness are formalized in a plan and organized into a system of care. The number of awardees that are developing plans for a potential incident involving at least 500 casualties per million in each jurisdiction contributes to an adequate level of preparedness to respond to a mass casualty event. By FY 04, 89% of awardees had developed plans to address surge capacity, one of the key elements to public health emergency preparedness.

Long-Term Goal

By 2008, 100 percent of awardees (States, territories, municipalities) will have achieved a surge capacity of 500 persons per million population for response to terrorism and other public health emergencies.

The purpose of this measure is to demonstrate the improvement in the health care system emergency response system to a mass casualty incident by achieving a surge capacity of 500 persons per million. Surge capacity involves a phased and coordinated approach among local, regional, and State entities to achieve an effective response. The FY 05 target is 75%, and the FY 06 target is 85%.

Goal VI.A.2. Increase the percentage of awardees that have implemented regional plans and met all major milestones established for all of the HRSA priority areas to meet the goal of a surge capacity of 500 persons per million population.

The purpose of this measure is to demonstrate the improvement in the health care emergency response system to a mass casualty incident by establishing regional plans to achieve a surge capacity of 500 persons per million in the HRSA priority areas. This measure ensures a phased and coordinated response to mass casualty events and other public health emergencies from multiple collaborating partners. Regional planning is key in order for States and jurisdictions to coordinate efforts and assets to ensure that a surge in need due to mass casualties does not overwhelm the health care emergency system. The FY 05 target is 75%, and the FY 06 target is 85%.

Goal VI.A.3. Increase the percentage of awardees that demonstrate their ability to secure and distribute pharmaceutical resources required in emergency events, including coordinated caches of pharmaceutical caches of metropolitan medical response systems sufficient to treat 500 persons per million population, as certified by HRSA.

The purpose of this measure is to demonstrate the improvement in the health care emergency response system to a mass casualty incident by establishing a system to secure and distribute pharmaceutical resources that may be required in a health care emergency event. It is important that these pharmaceutical surge plans be regional in nature to avoid potential shortfalls, duplication, or excess resources while ensuring that all medical counter measures, including biologics, therapeutics and devices, could be obtained for response to terrorism and other public health emergencies. The FY 05 target is 75%, and the FY 06 target is 85%.

Goal VI.A.4. Increase the percentage of awardees that have (1) assessed the existing chemical and radiological response equipment they currently possess, (2) acquired the needed additional equipment as identified in that assessment, and (3) trained hospital and emergency medical service personnel likely to respond/treat 500 persons per million population, chemically or radiologically.

The purpose of this measure is to demonstrate the improvement in the health care emergency response system by improving the response capability for a potential chemical or radiologic event. This will be achieved by assessing and obtaining needed equipment, as well as training personnel in the use of the equipment. The FY 05 target is 75%, and the FY 06 target is 80%.

Goal VI.A.5. Increase the percentage of awardees that have successfully demonstrated their ability to evaluate, diagnose, and treat 500 adult and pediatric patients per million population resulting from emergency events, meeting HRSA criteria, as evidenced in reviews of annual drill reports.

The purpose of this measure is to demonstrate the improvement in the health care emergency response system by ensuring that States and regions have demonstrated, through simulated drills and exercises, or through responses to actual public health emergency events, their ability to respond to a mass casualty incident. The FY 05 target is 75%, and the FY 06 target is 85%.

Efficiency Measure

1. Increase the percent of awardees that file semi-annual reports electronically. (Developmental)

The awardees file performance update reports through submission of continuation applications, as well as semi-annual progress reports. By reporting this information electronically, the collection process will be greatly simplified and expedited for program awardees. Compilation of data and review of reports by program staff will be simplified and expedited as well. The project officers use this data and information to manage and monitor programs.

The formal baseline will be established by March 2005. The FY 05 and FY 06 targets are 100%.

U.F.5. Program Title: Trauma/Emergency Medical Services

Performance Goals	Targets	Actual Performance	Reference
IV. IMPROVE THE ABILITY OF THE HEALTH CARE SYSTEM TO RESPOND TO PUBLIC HEALTH EMERGENCIES **C. Accelerate the development and use of an electronic health information infrastructure.** 1. Increase the percent of awardees that submit mid-year reports electronically via new Web site. **(Also Efficiency Measure-Developmental)**	FY 06: NA FY 05: 80% FY 04: 40%	FY 04: (3/05) FY 03: 0% (Baseline)	
Total Funding: Trauma/Emergency Medical Services ($ in 000s)	FY 06: $0 FY 05: $3,419 FY 04: $3,449 FY 03: $3,476 FY 02: $3,499	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

Program Performance Analysis

Goal IV.C.1. Increase the percent of awardees that submit mid-year reports electronically via new Web site. (Also Efficiency Measure - Developmental)

States have very limited personnel to devote to trauma/emergency medical services issues. Applying for grants, while managing projects and outcomes, is time consuming. The Federal Trauma/EMS Systems Program continuously strives to provide creative ways to minimize the workload of the States while increasing Program efficiency. One means of accomplishing this was via the creation of a mechanism whereby State Trauma/EMS Systems Program grantees may electronically submit mid-year performance reports. This action will increase efficiency and lower total expenses. The standardized templates, developed to support this mechanism, will be a more effective way to collect State information.

The Program's grant cycle dictated that the first opportunity to implement the electronic submission of mid-year performance reports will not occur until February, 2005. The FY 04 data are expected by March, 2005.

U.F.6. Program Title: National Vaccine Injury Compensation Program (VICP)

Performance Goals	Targets	Actual Performance	Reference
II. IMPROVE HEALTH OUTCOMES **A. Expand availability of health care resources to underserved, vulnerable, and special needs populations** 1. Process payment of annuities within 60 calendar days of receipt of the Department of Justice (DOJ) final clearance letter. **(Efficiency Measure)**	FY 06: 99% FY 05: 99% FY 04: 99% FY 03: 98% FY 02: 95%	FY 04: 100% FY 03: 100% FY 02: 100% FY 01: 96.3% FY 00: 100%	**NEW FY 04 DATA**
2. Process payment of lump sum awards within 30 calendar days of receipt of the DOJ final clearance letter. **(Efficiency Measure)**	FY 06: 99% FY 05: 99% FY 04: 99% FY 03: 98% FY 02: 93%	FY 04: 99.2% FY 03: 100% FY 02: 96.8% FY 01: 96.2% FY 00: 96.7%	**NEW FY 04 DATA**
Administrative Funding: National Vaccine Injury Compensation Program (VICP) ($ in 000s)	FY 06: $2,832* FY 05: $3,151* FY 04: $3,190* FY 03: $2,972*	HP: Healthy People goal PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

*Direct operations

Program Performance Analysis

Goal II.A.1. Process payment of annuity premiums within 60 calendar days of receipt of the Department of Justice (DOJ) clearance letter. (Efficiency Measure)

Annuity premiums are paid in a exceptionally timely, efficient manner. In FY 04, 100% of payments were made within 60 days of receipt of the clearance letter. Because of this efficiency, annuity brokers no longer include rate lock-in quotes with their proposals, as they do with other agencies, because of a system and process that can take advantage of 24-hour rate quotes. The FY 05 and 06 targets are 99% of all contract premiums will be paid within 60 days of the DOJ clearance letter.

Goal II.A.2. Process payment of lump sum awards within 30 calendar days of receipt of the DOJ clearance letter. (Efficiency Measure)

Lump sum awards are paid in an exceptionally timely, efficient manner. In FY 04, 99.2% of payments were made within 30 days of receipt of the clearance letter, meeting the FY 04 target. The FY 05 and 06 targets are 99% of all lump sum awards will be paid within 30 days of the DOJ clearance letter.

U.G RURAL HEALTH

Programs included in this section are:

U.G.1. Rural Health Activities (PART Measures and Efficiency Measure)
U.G.2. Rural Health Policy Development
U.G.3. Rural Health Outreach and Network Development Grants
U.G.4. Rural Hospital Flexibility Grants
U.G.5. State Offices of Rural Health

U.G.1. Program Title: Rural Health Activities

PART Measures and Efficiency Measure

A PART review of the programs of the Office of Rural Health Policy (ORHP), as a unit, was conducted for the FY 05 budget. During this process, the following long-term and short-term (annual) goals and measures were identified to use in assessing ORHP's performance. Also shown in the table below is an efficiency measure for the ORHP.

Performance Goals	Targets	Actual Performance	Reference
IV. ELIMINATE HEALTH DISPARITIES **A. Focus resources and services on diseases and conditions with the greatest health disparities** **Long-Term Goal** By 2010, reduce to 13.9% the proportion of rural residents of all ages with limitation of activities caused by chronic conditions. **(Outcome)**	FY 06: 689,276* FY 05: 682,253 FY 04: 675,498	FY 00: 14.6% (baseline)	
Short-Term Goal 1. Increase by 1% annually the number of people served through Outreach Grants. **(Outcome)**		FY 04: (9/05) FY 03: 668,810 FY 02: 673,700 (baseline)	**NEW FY 03 DATA**
V. IMPROVE THE PUBLIC HEALTH AND HEALTH CARE SYSTEMS **B. Increase collaborative efforts to improve the capacity and efficiency of public health and health care systems** **Long-Term Goal** By 2010, increase to 35% the proportion of critical access hospitals with positive operating margins. **(Outcome)**		FY 99: 17 % (baseline)	
Short-Term Goal 1. Increase by 0.5 percentage point annually the average operating margin of critical access hospitals. **(Outcome)**	FY 06: NA FY 05: 0.5 percentage point over FY 04	FY 04: (10/05) FY 99: -14.05 % (baseline)	
Efficiency Measure 1. Increase the proportion of grantees who are applying and reporting on progress electronically. **(Developmental)**	FY 06: 15% FY 05: 15%	FY 03: 0% (baseline)	
Total Funding: Office of Rural Health Policy ($ in 000s)	FY 06: $ 29,478 FY 05: $144,707 FY 04: $142,616 FY 03: $156,218 FY 02: $114,881	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

* Target reflects estimate at time of PART assessment.

Program Performance Analysis

Long-Term Goal

By 2010, reduce to 13.9% the proportion of rural residents of all ages with limitation of activities caused by chronic conditions.

This PART measure was chosen because rural residents experience greater limitation of activity caused by chronic conditions than urban residents. A reduction of activity limitation is an indicator of improvement of health status and wellness. According to the Centers for Disease Control and Prevention, (CDC), the proportion of rural residents of all ages with limitation of activities caused by chronic conditions in FY 00 was 14.6%. By 2010, the goal is to reduce this proportion to 13.9%.

Short-Term Goal

Goal IV.A.1. Increase by 1% annually the number of people served through Outreach Grants.

The Outreach grant program is an effective way to provide services to rural communities to improve health and wellness. According to the Outreach Grants Reporting System, the Outreach grant program served 673,700 rural residents in FY 02 and 668,810 in FY 03. This slight decrease is attributable to making fewer grant awards in FY 03 due to a high number of non-competing continuation awards.

Long-Term Goal

By 2010, increase to 35% the proportion of critical access hospitals with positive operating margins.

This measure is used to monitor efforts to increase the financial viability of small rural hospitals. According to the Flex Tracking Project, 17% of Critical Access Hospitals (CAHs) were operating with positive operating margins in FY 99. Preliminary analysis of Medicare cost-report data for CAHs shows that progress toward this goal is being made. In FY 02, the number of CAHs with positive operating margins had increased to 29%. As these facilities become more economically viable, they will be more likely to survive long term and therefore continue serving as a key access point for health care in rural communities.

Goal V.B.1. Increase by 0.5 percentage point annually the average operating margin of critical access hospitals.

This measure is important because an increase in the average operating margin of CAHs will contribute to these hospitals' financial viability. CAHs serve as key access points for Medicare beneficiaries in rural areas and also act as the focal point for expanded health care services in rural communities by helping to attract physicians and other health care personnel. Therefore, the focus on operating margin helps determine the long-term viability of CAHs to continue to play that access role. Medicare cost reports show that CAHs had a -14.05% average operating margin in 1999. Since that time, the Congress has passed three pieces of legislation that have included provisions increasing administrative flexibility for CAHs. It is expected that these changes in the law will help address some of the financial challenges and barriers facing CAHs. Early analysis of Medicare cost report data shows positive progress toward this goal. In 2002, the average operating margin for CAHs was -9.37%. In future years as more CAHs file and close their cost reports, there will be an opportunity to more fully measure progress toward this goal. For FY 06, the program related to measure V.B.1 is not proposed for funding.

Efficiency Measure

1. Increase the proportion of grantees who are applying and reporting on progress electronically. (Developmental)

Currently, none of the ORHP grantees are applying for grants electronically or submitting their progress reports electronically. In keeping with the Department's emphasis in moving to electronic submission, the ORHP intends to increase to 15% in FY 06 the number of grantees who either apply electronically for grants or who submit their progress reports electronically. This number reflects a realistic and aggressive goal given the widely varying levels of electronic submission capability among the grantees, many of whom are small grass-roots and community-based organizations. The efficiency measure targets reflect a slower than expected number of applicants taking advantage of the opportunity to apply for grants electronically.

U.G.2. Program Title: Rural Health Policy Development

Performance Goals	Targets	Actual Performance	Reference
V. IMPROVE THE PUBLIC HEALTH AND HEALTH CARE SYSTEMS **A.Utilize trend data to assist in targeting program resources toward goals.** 1. Conduct and disseminate policy relevant research on rural health issues.	FY 06: 30 research reports FY 05: 26 FY 04: 25 FY 03: 20 FY 02: 24 FY 01: 18 FY 00: 25	FY 04: 26 FY 03: 21 FY 02: 24 FY 01: 19 FY 00: 27	**NEW FY 04 DATA**
Total Funding: Rural Health Policy Development ($ in 000s)	FY 06: $ 8,528 FY 05: $ 8,825 FY 04: $ 8,902 FY 03: $10,630 FY 02: $14,802	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

Program Performance Analysis

Goal V.A.1. Conduct and disseminate policy relevant research on rural health issues.

Twenty-one projects were completed in FY 03. The program produced 26 research projects in FY 04, one more than the target amount. The target for FY 05 is 26 reports completed with 30 reports expected for 2006. The increase is due to a new program that funds single-year research awards and an expansion in the number of research centers funded from six to eight in FY 05.

The twenty-six FY 04 reports completed assess the sustainability of small rural hospitals, including their low volume, and assuring quality through improving patient safety and reducing medical errors. Other reports inform the policy discussion on improving the health of rural citizens by ensuring access to health promotion programs, rural health clinics, and mental health care.

For FY 05 and FY 06, there will be an emphasis on policy research concerning the impact of proposed restructuring of Medicare, of physician reimbursement on recruitment and retention, and changes in managed care for Medicaid. These changes are expected to have a significant impact on the health of rural citizens and the financial health of rural providers, especially hospitals. Through the policy research, ORHP expects to predict the impact of the payment reforms on rural citizens, their hospitals and communities and, most importantly, to identify options for changes to lessen any negative effects.

U.G.3. Program Title: Rural Health Outreach and Network Development Grants

Performance Goals	Targets	Actual Performance	Reference
IV. ELIMINATE HEALTH DISPARITIES **A. Focus resources and services on diseases and conditions with the greatest health disparities** 1. Increase by 1% annually the number of people served through Outreach grants. **(Outcome)**	FY 06: 689,276* FY 05: 682,253	FY 04: (9/05) FY03: 668,810 FY 02: 673,700 (baseline)	**NEW FY 03 DATA** 3
Deleted Measure(s) 1. Outreach Program: Develop and operate collaborative models of health care services in rural areas that will serve underserved populations. **(Outcome)**	FY 06: NA FY 05: NA FY 04: 650,000 FY 03: 668,000 numbers represent number of persons served per year	FY 04: (9/05) FY 03: 668,810	1,3,5
Total Funding: Rural Health Outreach Grants ($ in 000s)	FY 06: $10,767 FY 05: $39,278 FY 04: $39,601 FY 03: $57,663 FY 02: $52,098	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

* Target reflects estimate at time of PART assessment.

Program Performance Analysis

Target populations for this program include rural minorities, the elderly, pregnant women, children and adolescents, migrant and seasonal farm workers, rural Americans with special needs and rural underserved populations. We estimate that close to 2.9 million rural Americans have been served by the program since its inception in FY 91. Outreach and Network awards have been made in 48 states, four Territories, and the District of Columbia. For the Outreach program, an independent evaluation suggests that more than 80 percent of grantees continue operating five years after funding.

Goal IV.A.1. Increase by 1% annually the number of people served through Outreach grants. (Also PART Measure)

The Outreach grant program is an effective way to provide services to rural communities to improve health and wellness. According to the Outreach Grants Reporting System, the Outreach grant program served 673,700 rural residents in FY 02 and 668,810 in FY 03. This slight decrease is attributable to making several fewer grant awards in FY 03 due to a high-number of non-competing continuation awards. The program expects to have data showing the number of rural residents served in FY 04 available in September of FY 05. This is a PART measure that replaces the deleted measure.

Deleted Measure(s)

1. Outreach Program: Develop and operate collaborative models of health care services in rural areas that will serve underserved persons.
(Indicator: Number of persons served)

Information submitted by grantees provides an estimated number of people served by the grant. The number can be quite large in the case of projects that involve the use of media presentations or distance learning technologies. Other projects are providing very specialized services to a small population (e.g., pregnant women within a rural community). In FY 03, the program exceeded its target by serving 668,810, slightly above the target amount of 668,000.

U.G.4. Program Title: Rural Hospital Flexibility Grants

Performance Goals	Targets	Actual Performance	Reference
V. IMPROVE THE PUBLIC HEALTH AND HEALTH CARE SYSTEMS **B. Increase collaborative efforts to improve the capacity and efficiency of public health and health care systems** 1. Increase by 0.5 percentage point annually the average operating margin of critical access hospitals. **(Also PART Measure)** **(Outcome)**	FY 06: NA FY 05: 0.5 percentage point over FY 04	FY 99: - 14.5% (baseline)	3
2. Appropriate rural facilities will be assisted in converting to Critical Access Hospital (CAH) status to help stabilize their financial status. **(Outcome)**	FY 06: NA FY 05: 1,025 FY 04: 785 FY 03: 660 FY 02: 240 FY 01: 222	 FY 04: 930 FY 03: 762 FY 02: 657 FY 01: 500	**NEW** **FY 04** **DATA** 3
3. Facilities and communities will be assisted in the development of networks.	FY 06: NA FY 05: 1,200 FY 04: 1175 FY 03: 400 FY 02: 320 FY 01: 304	 FY 04: 1181 FY 03: 1121 FY 02: 385 FY 01: 378	**NEW** **FY 04** **DATA**
Total Funding: Rural Hospital Flexibility Grants ($ in 000s)	FY 06: $0 FY 05: $39,180 FY 04: $39,499 FY 03: $39,740 FY 02: $39,985	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

Program Performance Analysis

Goal V.B.1. Increase by 0.5 percentage point annually the average operating margin of critical access hospitals. (Also PART Measure)

This measure is important because an increase in the average operating margin of CAHs will contribute to these hospitals' financial viability. These facilities play a key role in ensuring access to care for Medicare beneficiaries in rural areas. Their ability to continue to play that role is directly tied to their financial viability. Therefore, the financial health of these CAHs often is a proxy for their ability to continue to serve as a key access point for health care services. The Flex Evaluation Project reported a -14.5% average operating margin in 1999. Since that time, the Congress has passed three pieces of legislation that have included provisions increasing administrative flexibility for CAHs. It is expected that these changes in the law will help address some of the financial challenges and barriers facing CAHs. Early analysis of Medicare cost report data shows progress toward this goal. In 2002, the average operating margin for CAHs

was -9.37%. Cost report data for FY 03 and FY 04 are not yet available. The program does not have a FY 06 target since this program is not proposed for funding.

Goal V.B.2. Appropriate rural facilities will be assisted in converting to Critical Access Hospital (CAH) status to help stabilize their financial status.

Conversion of appropriate rural facilities to CAH status will help sustain the rural health care infrastructure to provide access to high quality care for rural Medicare beneficiaries. This is a core component of the Flex program. Meeting statutory requirements for certification and Conditions of Participation for CAHs enables the facility to be reimbursed on the basis of reasonable cost. This demonstrably improves financial performance of these most vulnerable facilities, thereby sustaining access.

In FY 02, the number of conversions climbed to 657, significantly above the target, and the trend continued to 762 in FY 03. By FY 04, the number of facilities converted to CAH-status had increased to 930. Conversion-related activities continued to be a major emphasis of the program during FY 04. As the program has matured, additional emphasis has been placed on quality and performance improvement, improving existing CAH operations, and development of community-level collaborative relationships (including EMS) which strengthen rural healthcare. Consequently, we expect the potential growth in the number of conversions to slow in the coming years with the total universe of conversions expected to peak at just over 1,000. A FY 06 target was set. However, this target is no longer applicable because the program is not proposed for funding.

Goal V.B.3. Facilities and communities will be assisted in the development of networks.

Building relationships between CAHs and other providers, both within the community and beyond the rural community for those services it is not appropriate to provide locally, is a critical component of infrastructure and systems development to sustain viable delivery capability in rural communities. Network development is promoted to reduce duplication, reduce overhead costs, improve services and improve quality of care. In FY 01, ORHP exceeded its target goal of 304 by assisting 378 facilities/communities. In FY 02, this measure exceeded expectations as grantees continued to work with the initial group of developing networks while adding seven more (Target - 320, Actual - 385). In FY 03, the figure was 1121 (target 400); this represents a markedly increased emphasis by State grantees, resulting in part from increased Federal program emphasis on collaboration and development of quality improvement networks. In FY 04, that figure increased to 1,181. The FY 05 target is 1,200. As the total number of CAHs reaches it's expected peak at just over 1,000, the program emphasis will move to network development and the number of facilities and communities assisted in network development is expected to grow more rapidly. An FY 06 target was set. However, this target is no longer applicable because the program is not proposed for funding.

U.G.5. Program Title: State Offices of Rural Health

Performance Goals	Targets	Actual Performance	Reference
V. IMPROVE THE PUBLIC HEALTH AND HEALTH CARE SYSTEMS **B. Increase collaborative efforts to iprove the capacity and efficiency of the public health and health care systems**			
1. Increase the number of communities receiving technical assistance from a State Office of Rural Health.	FY 06: 4,450 FY 05: 4,400	FY 03: 4,120 (baseline)	**NEW FY 03 DATA**
2. Increase the number of States that have an identified focal point for rural recruitment with a national source of applications.	FY 06: 43 FY 05: 42	FY 03: 41 (baseline)	
Total Funding: State Offices of Rural Health ($ in 000s)	FY 06: $8,223 FY 05: $8,321 FY 04: $8,390 FY 03: $8,445 FY 02: $7,996	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

Program Performance Analysis

Goal V.B.1. Increase the number of communities receiving technical assistance from a State Office of Rural Health.

This measure is important because rural communities and providers are often isolated and have unique technical assistance needs. By providing this technical assistance, a State Office of Rural Health (SORH) is equipping rural communities with the tools and resources needed to coordinate rural health at the local level. The SORH enables a community to create localized solutions to problems which in turn strengthens the rural health delivery system one community at a time. This goal is one of the programs' core functions. The program established a baseline of 4,120 communities in FY 03. Future targets will be somewhat conservative and reflect the joint funding of this program with State governments. The States match the funding three to one and it takes time to create changes within this activity. Given that, the target for FY 05 is 4,400. The target for FY 06 is 4,450.

Goal V.B.2. Increase the number of States that have an identified focal point for rural recruitment with a national source of applicants.

This measure was chosen because rural residents experience greater challenges in recruitment of health professionals. With at least 20 percent of the population living in rural areas and less than 11 percent of the nation's physicians practicing in nonmetropolitan areas, the goal of fostering rural recruitment activities is a key component to many activities of the State Offices. Workforce shortages hamper attempts to address other pressing health care problems in rural America. Many State Offices meet this goal by participating in a national rural recruitment program, such as the National Rural Recruitment and Retention Network (3RNET). The program established a baseline with FY 03 data that indicated 41 States having identified a focal point for rural recruitment. Future targets will be somewhat conservative and reflect the joint funding of this program with State governments. The States match the funding three to one and it takes time to create changes within this activity. Given that, the target for FY 05 is 42 while the target for FY 06 is 43.

U.H PROGRAM MANAGEMENT

The program included in this section is:

U.H.1. Program Management

U.H.1. Program Title: Program Management

Performance Goals	Targets	Actual Performance	Reference
VII. ACHIEVE EXCELLENCE IN MANAGEMENT **B. Strategically manage information technology to support programs** 1. Information Technology Management: Ensure Critical Infrastructure Protection.			
A. Perimeter Protection	FY 06: Complete the redesign of the security monitoring/network auditing/incident detection capability to ensure compatibility to the modified IT infrastructure. FY 05: Establish a comprehensive operational security services capability by incorporating security monitoring/incident detection, event reaction/incident response, and security intelligence. FY 04: Identification of all HRSA network components (and their functionality), appropriate placement of sensors and network software on each component, and establishment of an auditing/monitoring process for these components.	FY 04: Implemented encrypted incident response reporting and updated security alert/event tracking software. FY 03: Trained, equipped and implemented a HRSA incident response team, installed security alert/event tracking software, and implemented host based intrusion prevention systems on 12 highly sensitive systems. FY 02: HRSA has completed the installation of network intrusion software that will provide baseline metrics for the number and percentage of network intrusions.	
B. Risk Assessment	FY 06: Complete C&A for two (2) new HRSA systems and complete annual re-certification efforts on ten (10) HRSA mission critical/essential systems. FY 05: Maintain certification and accreditation for 100% of HRSA's mission-critical and mission-essential systems. Ensure security plans are in place for 70% of all systems on the HRSA General Support System. FY 04: Certification and Accreditation (C&A) for 100% of HRSA's mission-critical and mission-essential systems.	FY 04: Performed annual self-assessments and re-certified ten (10) mission critical/essential systems. FY 03: Completed C&A for six (6) HRSA mission-critical/essential systems. FY 02: C&A activities for two (2) Mission-critical systems were completed; official accreditation signature occurred in FY 03.	

Performance Goals	Targets	Actual Performance	Reference
C. Security Awareness Training	FY 06: Develop and deploy a training module for Information System Security Officers (ISSOs) and successfully complete annual security awareness training for 95% of HRSA staff. FY 05: Successful completion of Security Awareness Training by 80% of HRSA staff. Successful completion of specialized security training by 100% of HRSA staff assigned specific security duties. FY 04: 70% of HRSA staff will successfully complete security awareness training.	FY 04: Developed and implemented new awareness training module and trained 84% of HRSA staff. FY 03: Deployed a web-based security awareness tool in July, 2003 and trained approximately 1,320 staff (90%) by the end of fiscal year. FY 02: HRSA Security Awareness Program was initiated in October, 2002 and will report performance in FY 03.	
A. Foster and lead a high-quality, well-trained workforce 1. Strategic Management of Human Capital Initiative: As part of a management review, HRSA will implement a Delayering Management and Streamlining Organizational Plan.	FY 06: Continue with implementation of streamlining efforts. FY 05: Continue with implementation of next stage of streamlining plans. FY 04: Continue with implementation of next stage of streamlining plans. FY 03: Budget/Financial Management Office and Grants Management Office consolidated FY 02: Legislative Office and Communications Office consolidated	FY 04: Broad-ranging organizational package published in Federal Register. FY 03: Consolidation of Grants Management functions and Budget functions. FY 02: Legislative Office consolidated at the HRSA OA level. Communications Office consolidated at the HRSA OA level.	
2. Strategic Management of Human Capital Initiative: Implement the HRSA Scholars Program.	FY 06: NA FY 05: 40 FY 04: 50 FY 03: 30 FY 02: 50 FY 01: 48	FY 01: N/A FY 04: 41 scholars FY03: 43 FY 02: 53 FY 01: 48	
Total Funding: Program Management ($ in 000s)	FY 06: $145,992 FY 05: $147,080 FY 04: $148,533 FY 03: $157,357 FY 02: $149,037 FY 01: $145,601 FY 00: $124,761 FY 99: $118,712	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

Program Performance Analysis

Goal VII.B.1. Information Technology Management: Ensure Critical Infrastructure Protection.

HRSA continues to administer a diligent Critical Infrastructure Protection (CIP) program that includes, among other efforts, a strong emphasis on perimeter protection, incident response, risk assessment, and security awareness training. Legislation such as the Federal Information Security Management Act (FISMA) imposes significant computer security requirements including periodic assessments of security risks to information systems and data supporting its critical operations.

HRSA will monitor the performance of the CIP and Information Systems Security Program through the following measures:

A. **Perimeter Protection:** HRSA will protect the perimeter and network boundaries by implementing the appropriate network intrusion infrastructure to detect and mitigate improper network violations. In FY 04, HRSA implemented encrypted incident response reporting and updated security alert/event tracking software. FY 06 Goal: HRSA will complete the redesign of the security monitoring/network auditing/incident detection capability to ensure compatibility to the modified IT infrastructure..

B. **Risk Assessment:** As defined by OMB Circular A-130 and integral to the IT security program, HRSA will broaden risk assessment efforts for Agency information systems and networks. In FY 04, HRSA performed annual self-assessments and re-certified ten (10) mission critical/essential systems. FY 06 Goal: HRSA will complete Certification and Accreditation for two (2) new HRSA systems and complete annual re-certification efforts on ten (10) HRSA mission critical/essential systems.

C. **Security Awareness Training:** In addition to security education and outreach efforts, HRSA will expand the security awareness training program for Agency employees, and other program staff with unique information security responsibilities. In FY 04, HRSA developed and implemented new awareness training module and trained 84% of HRSA staff. FY 06 Goal: HRSA will develop and deploy a training module for Information System Security Officers (ISSOs) and successfully complete annual security awareness training for 95% of HRSA staff.

Goal VII.A.1. Strategic Management of Human Capital Initiative: As part of a management review, HRSA will implement a Delayering Management and Streamlining Organizational Plan.

HRSA continues to focus its efforts to consolidate and re-deploy staff to more effectively support the President's Management Agenda and accomplish the mission and goals of the Department and HRSA. By the end of December 2001, HRSA had accomplished the following: 1) Created a Citizen-Centered Agency; 2) Realigned Health Professions Programs into one Bureau and created a mission centered Primary Care Bureau; 3) Streamlined the Office of the Administrator; 4) Consolidated Information Technology (IT) functions; and 5) Consolidated Legislative and Public Affairs staff within HRSA, with appropriate reporting relationships to OS.

During FY 02 and FY 03, HRSA accomplished the following restructuring efforts:
1) Completed the restructuring of its financial management functions. These functions were formerly performed by the Office of Management and Program Support and HRSA's four Bureaus. They have all been consolidated; and 2) Completed a reorganization plan that was announced in the Federal Register on January 7, 2003, which restructured the grants function within HRSA. During FY 2004, a substantial Agency restructuring package was published in the Federal Register on September 21, 2004. This eliminated a variety of levels, created an Office of Federal Assistance Management which consolidated the grants activity within HRSA, and realigned administrative and financial management activities in the Office of Administration and Financial Management.

Goal VII.A.2. Strategic Management of Human Capital Initiative: Implement the HRSA Scholars Program.

To assist in accomplishing the President's Strategic Management of Human Capital Initiative, HRSA has developed the HRSA Scholars Program. This program will increase career development opportunities and develop a new approach to hiring staff-experienced professionals and young graduates. It has components for workforce planning, outreach and recruitment, hiring, recruiting incentives, training, developing and mentoring, and evaluation. This approach focuses on bringing in honor students at the GS-5, 7 and 9 levels.

During FY 01, the HRSA Scholars Program was developed and implemented. Forty-eight Scholars were hired. In FY 02 and FY 03 the numbers of scholars were 53 and 43, respectively.

For FY 04, 41 HRSA Scholars were brought on board. This initiative is a five-year initiative (FY 01- FY 05) and, therefore, no FY 06 targets have been set.

The HRSA Scholars Program served as a model for the HHS Emerging Leaders Program. Additionally, HRSA is a full participant in the HHS Emerging Leaders Program. Of the first class of 65, HRSA took 5 positions. This represents about 7.7% of the total HHS class, although HRSA represents only 3.2% of the HHS workforce.

U.I FAMILY PLANNING

Programs included in this section are:

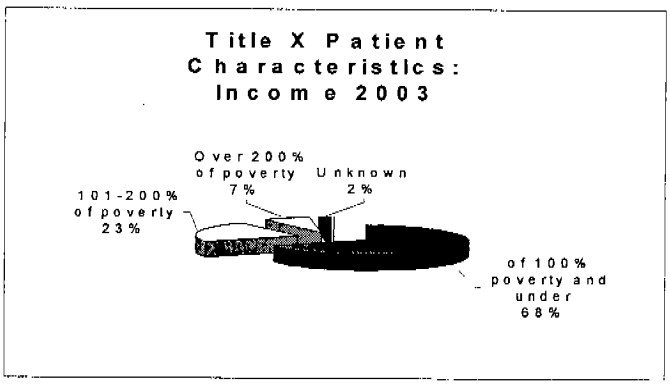
U.I.1. Family Planning

U.I.1. Program Title: Family Planning

Performance Goals	Targets	Actual Performance	Reference
II. Improve Health Outcomes **A: Expand the availability of health care, particularly to underserved, vulnerable and special needs populations** 1. Continue to assure that priority is given to providing family planning services to persons from low-income families. **(Outcome)**	**Unduplicated Users** FY 06: 90% 5.187 million FY 05: 90% 4.857 million FY 04: 90% 4.792 million FY 03: 90% 4.792 million FY 02: 90% 4.792 million FY 01: 4.792	 FY 04: (11/05) FY 03: 91% 5.012 million FY 02: 90% 4.974 FY 01: 89% 4.857	**NEW FY 03 DATA** 3
B: Increase the utilization of preventive health care and chronic disease management services, particularly among underserved, vulnerable and special needs populations 1. Ensure women receive screening for cervical and breast cancer. (a) # of Pap Tests provided **(Outcome)** (b) # of Breast exams provided **(Outcome)**	 FY 06: 2.955 million pap tests FY 05: 2.955 million FY 04: 2.955 million FY 03: 3.0 million FY 02: 3.0 million FY 06: 2.8 million breast exams FY 05: 2.8 million FY 04: 2.8 million FY 03: 2.8 million FY 02: 2.8 million	 FY 04: (11/05) FY 03: 2.852 million FY 02: 2.955 million FY 01: 3.047 million FY 04: (11/05) FY 03: 2.771 million FY 02: 2.863 million FY 01: 2.853 million	**NEW FY 03 DATA** 1,5
2. Assure access to HIV tests performed on-site in family planning clinics. **(Outcome)**	FY 06: 500,000 FY 05: 500,000 FY 04: 399,000 FY 03: 383,360 FY 02: 383,360	 FY 04: (11/05) FY 03: 526,360 FY 02: 493,622 FY 01: 601,259	**NEW FY 03 DATA** 3,5
Efficiency Measure 1. Increase the proportion of family planning annual reports (FPAR) that are submitted electronically. **(Developmental)**	FY 06: 100% FY 05: 100%	 FY 04: Baseline to be established 11/05	
Total Funding: Family Planning ($ in 000s)	FY 06: $285,963 FY 05: $285,963 FY 04: $278,283 FY 03: $273,350 FY 02: $264,987	HP: Healthy People PART: OMB Program Assessment Rating Tool Presidential Initiative #: DHHS Goal	

Program Performance Analysis

II.A.1. Continue to assure that priority is given to providing family planning services to persons from low-income families.
(Indicator: Total number of clients served and proportion of clients with incomes at or below 200 percent of the Federal poverty level)



Title X clinics play a key role in providing family planning and related preventive health services to individuals who can least afford such services - low-income persons, many of whom have no insurance or lack insurance coverage for family planning and related reproductive health care services. The fundamental purpose of the Title X program is to provide family planning education and services to all persons who desire them, and assure access by giving priority to low-income persons. Services are provided without regard to an individual's ability to pay, and if the person's income is below the poverty level, the services are free of charge.

In 2003, the most recent year for which program data are available, 5.012 million patients were seen at 4,531 clinic sites; 91 percent had incomes below 200 percent of the Federal poverty level. This represents one percent more clients served in 2003 than were served in 2002, an increase of over 37,000 users, and the highest level ever reported. Of these, 95 percent were women and 5 percent were men. The increase in the number of clients served builds upon the additional clients seen in the previous two reporting periods. Between 2000 and 2001, the program served an additional 300,000 users; and between 2001 and 2002, the program served an additional 100,000 users. The small increase in overall users between 2002 and 2003 suggests a leveling off in client numbers, following the more substantial gains experienced between 2000-2001 (7%) and 2001-2002 (2%).

Goal II.B.1. Ensure that women receive screening for cervical and breast cancer.
(Indicator: Total number of Pap tests and breast exams provided in Title X family planning clinics)

Family planning clinics provide a broad range of preventive health services, including breast examinations and Pap tests, to a population that is predominately low-income and who have less access to appropriate health screening and preventive services. Breast and cervical cancer screening are crucial to reducing future morbidity and mortality, particularly among poor, minority and uninsured women. Early detection with Pap tests can prevent a significant

percentage of potential invasive cervical cancers. Access to these services can help eliminate disparities. Although all sexually active women are at risk for cervical cancer, the disease is more common among women of low socioeconomic status, those with a history of multiple partners or early onset of sexual intercourse and smokers.

In 2003, Title X clinics provided 2.852 million Pap tests and 2.771 million clinical breast examinations to family planning clients. The numbers for these selected services in 2003 represent fluctuations from those reported in 2002 -- Pap tests decreased by 3 percent or 102,596 fewer Pap tests and clinical breast exams declined by 3 percent or 91,363 fewer breast exams. The ratio of reported tests to total female users is .60 for Pap test and .58 for clinical breast exams, indicating that approximately 6 Pap tests and breast exams are performed for every 10 female family planning users. These ratios have gradually declined over the past eight years, from about 7 Pap test or breast exams per female user in 1995 to about 6 now.

It is important to note that the trend for the number of Pap tests will most likely continue to decline as a reflection of revised recommendations issued by professional organizations which establish national standards of care. Specifically, these organizations recommend that cervical cancer screening be initiated within three years after the onset of sexual intercourse. Also, the screening interval may be lengthened, depending on the type of technology used (liquid-based vs. conventional Pap) and client history. Because of these factors, it is likely that the number of Pap tests per year will decline below the set targets.

Goal II.B.2. Assure access to HIV testing performed on-site in family planning clinics. (Indicator: The total number of HIV tests provided in Title X family planning clinics)

Title X family planning clinics play a critical role in addressing the prevention of HIV by providing confidential HIV prevention education and counseling, testing on-site or by referral, referral for care and treatment. Title X clinics provide services to a population that matches the demographics of the population of women most at risk for HIV - primarily young, low-income, and minority. These clients are sexually active and therefore at risk for STD and HIV infection. Since Title X clinics serve clients who may be at increased risk for HIV infection, ensuring access to HIV testing is an essential service.

In 2003, 526,360 HIV tests were provided to both male and female users in the Title X family planning services grant program. The number of HIV tests increased by 7% or 32,738 more HIV tests compared to those reported in 2002. HIV tests reported for male users in 2003 represents 14 percent of all HIV tests provided, indicating a higher ratio of HIV tests per male user compared to female users. The ratio of HIV tests to total users is .11 or about one test for every ten users, a ratio that has increased slightly between 2003 and 2002. Regionally, the ratios for HIV test to users range from a low of .03 in Regions V and VIII to a high of .15 in Region II. (Several grantees report that these tests are often provided but not funded with Title X monies and thus not reported on the FPAR.) In addition to monitoring the number of HIV tests provided on-site to clients, the program is examining improved methods for monitoring the proportion of HIV tests that are positive and for making certain that HIV positive clients receive appropriate referral. HIV services in family planning clinics are an important intervention for reaching

people with prevention counseling and an opportunity to link infected individuals with needed care and treatment services.

In FY 01, for the first time, the family planning program dedicated a total of $5 million ($3 million from the Secretary's Minority AIDS Initiative Discretionary Fund and $2 million in Title X funds) to implement an initiative directed at enhancing and extending HIV prevention, counseling, testing and referral services in selected family planning clinics primarily in communities with high rates of HIV, and in areas where racial and ethnic minorities are underserved or disproportionately impacted by HIV. Thirty-four supplemental awards were made to Title X family planning grantees to provide enhanced HIV-related services to clients at risk. In FY 04, the program made available, on a competitive basis, $9 million ($6 million from the Secretary's Minority AIDS Initiative Discretionary Fund and $3 million in Title X funds) for the continuation of this effort. This will help increase awareness of the disease and its prevention, provide HIV-related services to individuals at increased risk of HIV, and help those individuals who are identified as HIV positive to get care and treatment. A total of 63 projects were funded in all ten Public Health Service regions – 34 are new projects and 29 are competitive continuations of previously funded HIV integration projects.

Efficiency Measure

Increase the proportion of family planning annual reports (FPAR) that are submitted electronically. (Developmental)
(Indicator: Percentage of all Title X service grantee that submit FPAR electronically)

The family planning annual report is intended to provide a comprehensive view of the family planning service activities within the scope of the grantee's Title X-funded project. Grantees report the total, unduplicated number of users, encounters and other outputs from activities that are within the scope of the grantee's approved project. Consistent with the Department's E-government initiative, beginning in FY 03, the FPAR can be submitted electronically or in hard copy. The two options for electronic submission include the new OPA eGrants System, which will be encouraged, or as an electronic file attached to an e-mail message.

Full Cost of HRSA Programs
FY 2004 - FY 2006
(Dollars in Thousands)

	FY 2004 Full Cost	FY 2005 Full Cost	FY 2006 Full Cost
PRIMARY CARE:			
Health Centers	1,664,674	1,782,970	2,097,424
Black Lung Clinics	6,136	6,118	6,085
National Hansen's Disease Center	17,413	17,251	16,066
Free Clinics Medical Malpractice	4,961	102	-
Radiogenic Diseases	2,031	2,013	1,993
Healthy Communities Access Program	85,851	85,322	-
Buildings and Facilities	256	254	228
Payment to Hawaii	2,092	2,074	2,075
Subtotal, Primary Care	**1,783,415**	**1,896,104**	**2,123,871**
HEALTH PROFESSIONS:			
Health Professions Training for Diversity	122,090	120,988	10,118
Training in Primary Care Medicine and Dentistry	84,299	91,308	-
Interdisciplinary Community Based Linkages	85,065	84,472	-
Public Health Workforce Development	10,546	10,452	-
Nursing Workforce Development (No LRP/Schol)	118,504	122,523	122,089
Childrens Hospitals Graduate Medical Education P	303,169	300,730	200,000
National Health Service Corps	169,903	131,448	126,796
Nursing Education Loan Repayment and Scholarsh	27,514	32,365	32,286
Bioterrorism Training and Curriculum Developmer	27,706	27,520	27,521
Workforce Information and Analysis	743	736	733
HEAL Direct Operations	3,353	3,244	2,916
National Practitioners Data Bank	16,000	15,700	15,700
Healthcare Integrity and Protection Data Bank	4,000	4,000	4,000
Subtotal, Health Professions	**972,892**	**945,486**	**542,159**
MATERNAL AND CHILD HEALTH:			
Maternal and Child Health Block Grant	751,042	744,239	745,084
Universal Newborn Hearing Screening	10,160	10,067	-
Traumatic Brain Injury	9,648	9,558	-
Healthy Start	100,594	105,420	100,603
Emergency Medical Services for Children	20,438	20,387	-
Sickle Cell Service Demonstrations	-	204	-
Subtotal, Maternal and Child Health	**891,881**	**889,875**	**845,687**

Full Cost of HRSA Programs
FY 2004 - FY 2006
(Dollars in Thousands)

	FY 2004 Full Cost	FY 2005 Full Cost	FY 2006 Full Cost
HIV/AIDS :			
HIV Emergency Relief Grants (Part A)	632,909	627,211	627,923
HIV Care Grants to States (Part B)	1,117,481	1,153,311	1,164,912
HIV Early Intervention Services (Part C)	197,170	195,578	195,578
HIV Children, Youth, Women & Families (Part D)	75,234	74,554	74,638
AIDS Education and Training Centers (Part F)	36,363	36,034	36,075
AIDS Emergency Drugs (FY 2004 only)	20,582	-	-
AIDS Dental Services (Part F)	13,713	13,589	13,604
Subtotal, HIV/AIDS Programs	2,093,451	**2,100,277**	**2,112,730**
HEALTHCARE SYSTEMS:			
Organ Transplantation	25,348	25,099	23,962
Bone Marrow Donor Registry	23,321	26,129	23,586
Poison Control Centers	24,385	24,158	23,982
Hospital Preparedness (Bioterrorism)	514,943	491,410	482,979
Trauma/Emergency Medical Services	3,549	3,515	-
VICP Direct Operations	3,190	3,126	2,828
All Other Healthcare Systems	25,471	21,352	-
Subtotal, Healthcare Systems	620,208	**594,789**	**557,337**
RURAL HEALTH:			
Rural Health Outreach	40,753	40,380	11,082
Rural Health Policy Development	9,161	9,073	8,777
Rural Hospital Flexibility Grants	40,648	40,279	-
State Offices of Rural Health	8,634	8,554	8,463
Rural and Community AED	11,251	9,177	2,017
Rural EMS	511	510	-
Denali Project	35,806	40,793	-
Subtotal Rural Health Programs	**146,764**	**148,766**	**30,339**
Telehealth	4,064	4,026	4,002
Health Facilities Construction and Other Projects	371,536	482,729	-
Family Planning	278,283	285,963	285,963
Program Management	-	-	-
TOTAL PROGRAM LEVEL	**6,790,958**	**6,865,286**	**6,502,088**

Total to prorate Prog Mgmt against:
FY 2004 = 5,107,295
FY 2005 = 5,242,235
FY 2006 = 4,995,749

Distribution of Program Management
FY 2004
(Dollars in Thousands)

	Performance/ Program Activity	Allocation of Program Management	Full Cost
PRIMARY CARE:			
Health Centers	1,617,629	47,045	1,664,674
Black Lung Clinics	5,963	173	6,136
National Hansen's Disease Center	17,413	0	17,413
Free Clinics Medical Malpractice	4,821	140	4,961
Radiogenic Diseases	1,974	57	2,031
Healthy Communities Access Program	83,425	2,426	85,851
Buildings and Facilities	249	7	256
Payment to Hawaii	2,033	59	2,092
Subtotal, Primary Care	1,733,507	49,908	1,783,415
HEALTH PROFESSIONS:			
Health Professions Training for Diversity	118,640	3,450	122,090
Training in Primary Care Medicine and Dentistry	81,917	2,382	84,299
Interdisciplinary Community Based Linkages	82,661	2,404	85,065
Public Health Workforce Development	10,248	298	10,546
Nursing Workforce Development (No LRP/Schol	115,155	3,349	118,504
Childrens Hospitals Graduate Medical Education	303,169	0	303,169
National Health Service Corps	169,903	0	169,903
Nursing Education Loan Repayment and Scholars	26,736	778	27,514
Bioterrorism Training and Curriculum Developm	27,706	0	27,706
Workforce Information and Analysis	722	21	743
HEAL Direct Operations	3,353	0	3,353
National Practitioners Data Bank	16,000	0	16,000
Healthcare Integrity and Protection Data Bank	4,000	0	4,000
Subtotal, Health Professions	909,151	12,682	972,892
MATERNAL AND CHILD HEALTH:			
Maternal and Child Health Block Grant	729,817	21,225	751,042
Universal Newborn Hearing Screening	9,873	287	10,160
Traumatic Brain Injury	9,375	273	9,648
Healthy Start	97,751	2,843	100,594
Emergency Medical Services for Children	19,860	578	20,438
Sickle Cell Service Demonstrations	0	0	0
Subtotal, Maternal and Child Health	866,676	25,205	891,881

Distribution of Program Management
FY 2004
(Dollars in Thousands)

	Performance/ Program Activity	Allocation of Program Management	Full Cost
HIV/AIDS :			
HIV Emergency Relief Grants (Part A)	615,023	17,886	632,909
HIV Care Grants to States (Part B)	1,085,900	31,581	1,117,481
HIV Early Intervention Services (Part C)	197,170	0	197,170
HIV Children, Youth, Women & Families (Part D	73,108	2,126	75,234
AIDS Education and Training Centers (Part F)	35,335	1,028	36,363
AIDS Emergency Drugs (FY 2004 only)	20,000	582	20,582
AIDS Dental Services (Part F)	13,325	388	13,713
Subtotal, HIV/AIDS Programs	2,039,861	53,590	2,093,451
HEALTHCARE SYSTEMS:			
Organ Transplantation	24,632	716	25,348
Bone Marrow Donor Registry	22,662	659	23,321
Poison Control Centers	23,696	689	24,385
Hospital Preparedness (Bioterrorism)	514,943	0	514,943
Trauma/Emergency Medical Services	3,449	100	3,549
VICP Direct Operations	3,190	0	3,190
All Other Healthcare Systems	24,751	720	25,471
Subtotal, Healthcare Systems	99,190	2,885	620,208
RURAL HEALTH:			
Rural Health Outreach	39,601	1,152	40,753
Rural Health Policy Development	8,902	259	9,161
Rural Hospital Flexibility Grants	39,499	1,149	40,648
State Offices of Rural Health	8,390	244	8,634
Rural and Community AED	10,933	318	11,251
Rural EMS	497	14	511
Denali Project	34,794	1,012	35,806
Subtotal Rural Health Programs	142,616	4,148	146,764
Telehealth	3,949	115	4,064
Health Facilities Construction and Other Projects	371,536	0	371,536
Family Planning	278,283	0	278,283
Program Management	148,533	0	0
Total Discretionary Level	6,593,302	148,533	6,790,958
Total to prorate Program Mgmt against	5,107,295		

Distribution of Program Management
FY 2005
(Dollars in Thousands)

	Performance/ Program Activity	Allocation of Program Management	Full Cost
PRIMARY CARE:			
Health Centers	1,734,311	48,659	1,782,970
Black Lung Clinics	5,951	167	6,118
National Hansen's Disease Center	17,251	0	17,251
Free Clinics Medical Malpractice	99	3	102
Radiogenic Diseases	1,958	55	2,013
Healthy Communities Access Program	82,993	2,329	85,322
Buildings and Facilities	247	7	254
Payment to Hawaii	2,017	57	2,074
Subtotal, Primary Care	1,844,827	51,276	1,896,103
HEALTH PROFESSIONS:			
Health Professions Training for Diversity	117,686	3,302	120,988
Training in Primary Care Medicine and Dentistry	88,816	2,492	91,308
Interdisciplinary Community Based Linkages	82,167	2,305	84,472
Public Health Workforce Development	10,167	285	10,452
Nursing Workforce Development (No LRP/Scho	119,179	3,344	122,523
Childrens Hospitals Graduate Medical Education	300,730	0	300,730
National Health Service Corps	131,448	0	131,448
Nursing Education Loan Repayment and Scholar	31,482	883	32,365
Bioterrorism Training and Curriculum Developm	27,520	0	27,520
Workforce Information and Analysis	716	20	736
HEAL Direct Operations	3,244	0	3,244
National Practitioners Data Bank	15,700	0	15,700
Healthcare Integrity and Protection Data Bank	4,000	0	4,000
Subtotal, Health Professions	882,391	12,632	945,487
MATERNAL AND CHILD HEALTH:			
Maternal and Child Health Block Grant	723,928	20,311	744,239
Universal Newborn Hearing	9,792	275	10,067
Traumatic Brain Injury	9,297	261	9,558
Healthy Start	102,543	2,877	105,420
Emergency Medical Services for Children	19,831	556	20,387
Sickle Cell Service Demonstrations	198	6	204
Subtotal, Maternal and Child Health	865,589	24,286	889,875

Distribution of Program Management
FY 2005
(Dollars in Thousands)

	Performance/ Program Activity	Allocation of Program Management	Full Cost
HIV/AIDS :			
HIV Emergency Relief Grants (Part A)	610,094	17,117	627,211
HIV Care Grants to States (Part B)	1,121,836	31,475	1,153,311
HIV Early Intervention Services (Part C)	195,578	0	195,578
HIV Children, Youth, Women & Families (Part I	72,519	2,035	74,554
AIDS Education and Training Centers (Part F)	35,051	983	36,034
AIDS Emergency Drugs (FY 2004 only)	0	0	0
AIDS Dental Services (Part F)	13,218	371	13,589
Subtotal, HIV/AIDS Programs	2,048,296	51,981	2,100,277
HEALTHCARE SYSTEMS:			
Organ Transplantation	24,414	685	25,099
Bone Marrow Donor Registry	25,416	713	26,129
Poison Control Centers	23,499	659	24,158
Hospital Preparedness (Bioterrorism)	491,410	0	491,410
Trauma/Emergency Medical Services	3,419	96	3,515
VICP Direct Operations	3,126	0	3,126
All Other Healthcare Systems	20,769	583	21,352
Subtotal, Healthcare Systems	97,517	2,736	594,789
RURAL HEALTH:			
Rural Health Outreach	39,278	1,102	40,380
Rural Health Policy Development	8,825	248	9,073
Rural Hospital Flexibility Grants	39,180	1,099	40,279
State Offices of Rural Health	8,321	233	8,554
Rural and Community AED	8,927	250	9,177
Rural EMS	496	14	510
Denali Project	39,680	1,113	40,793
Subtotal Rural Health Programs	144,707	4,060	148,767
Telehealth	3,916	110	4,026
Health Facilities Construction and Other Projects	482,729	0	482,729
Family Planning	285,963	0	285,963
Program Management	147,080	0	0
Total Discretionary Level	6,803,015	147,080	6,865,286
Total to prorate Prog Mgmt against	5,242,236		

Distribution of Program Management
FY 2006
(Dollars in Thousands)

	Performance/ Program Activity	Allocation of Program Management	Full Cost
PRIMARY CARE:			
Health Centers	2,037,871	59,553	2,097,424
Black Lung Clinics	5,912	173	6,085
National Hansen's Disease Center	16,066	0	16,066
Free Clinics Medical Malpractice	0	0	0
Radiogenic Diseases	1,936	57	1,993
Healthy Communities Access Program	0	0	0
Buildings and Facilities	222	6	228
Payment to Hawaii	2,016	59	2,075
Subtotal, Primary Care	2,064,023	59,848	2,123,871
HEALTH PROFESSIONS:			
Health Professions Training for Diversity	9,831	287	10,118
Training in Primary Care Medicine and Dentistry	0	0	0
Interdisciplinary Community Based Linkages	0	0	0
Public Health Workforce Development	0	0	0
Nursing Workforce Development (No LRP/Scho	118,622	3,467	122,089
Childrens Hospitals Graduate Medical Education	200,000	0	200,000
National Health Service Corps	126,796	0	126,796
Nursing Education Loan Repayment and Scholar	31,369	917	32,286
Bioterrorism Training and Curriculum Developm	27,521	0	27,521
Workforce Information and Analysis	712	21	733
HEAL Direct Operations	2,916	0	2,916
National Practitioners Data Bank	15,700	0	15,700
Healthcare Integrity and Protection Data Bank	4,000	0	4,000
Subtotal, Health Professions	487,330	4,691	542,158
MATERNAL AND CHILD HEALTH:			
Maternal and Child Health Block Grant	723,928	21,156	745,084
Universal Newborn Hearing Screening	0	0	0
Traumatic Brain Injury	0	0	0
Healthy Start	97,747	2,856	100,603
Emergency Medical Services for Children	0	0	0
Sickle Cell Service Demonstrations	0	0	0
Subtotal, Maternal and Child Health	821,675	24,012	845,687

Distribution of Program Management
FY 2006
(Dollars in Thousands)

	Performance/ Program Activity	Allocation of Program Management	Full Cost
HIV/AIDS :			
HIV Emergency Relief Grants (Part A)	610,094	17,829	627,923
HIV Care Grants to States (Part B)	1,131,836	33,076	1,164,912
HIV Early Intervention Services (Part C)	195,578	0	195,578
HIV Children, Youth, Women & Families (Part]	72,519	2,119	74,638
AIDS Education and Training Centers (Part F)	35,051	1,024	36,075
AIDS Emergency Drugs (FY 2004 only)	0	0	0
AIDS Dental Services (Part F)	13,218	386	13,604
Subtotal, HIV/AIDS Programs	2,058,296	54,435	2,112,731
HEALTHCARE SYSTEMS:			
Organ Transplantation	23,282	680	23,962
Bone Marrow Donor Registry	22,916	670	23,586
Poison Control Centers	23,301	681	23,982
Hospital Preparedness (Bioterrorism)	482,979	0	482,979
Trauma/Emergency Medical Services	0	0	0
VICP Direct Operations	2,828	0	2,828
All Other Healthcare Systems	0	0	0
Subtotal, Healthcare Systems	69,499	2,031	557,337
RURAL HEALTH:			
Rural Health Outreach	10,767	315	11,082
Rural Health Policy Development	8,528	249	8,777
Rural Hospital Flexibility Grants	0	0	0
State Offices of Rural Health	8,223	240	8,463
Rural and Community AED	1,960	57	2,017
Rural EMS	0	0	0
Denali Project	0	0	0
Subtotal Rural Health Programs	29,478	861	30,339
Telehealth	3,888	114	4,002
Health Facilities Construction and Other Projects	0	0	0
Family Planning	285,963	0	285,963
Program Management	145,992	0	0
Total Discretionary Level	5,966,144	145,992	6,502,088
Total to prorate Prog Mgmt against	4,995,749		

SUMMARY OF FULL COST*
($ in Millions)

Performance Program Area	FY2004	FY 2005	FY2006
Health Centers[1]	$1,664,674.0	$1,782,970.0	$2,097,424.0
Expand Quality Services Incorporates: I.A.1., I.A.2., II.B.1., II.B.2., II.B.3, II.B.4.	66,587.0	71,318.8	314,613.6
Strengthen Quality Services Incorporates: II.A.1., II.A.2., II.A.3., II.B.1., II.B.2., II.B.3., II.B.4.	1,548,146.8	1,658,162.1	1,740,861.9
National Hansen's Disease Program Activities[2]	17,413.0	17,251.0	16,066.0
I.A.1.	0.0	0.0	0.0
Black Lung Clinics	6,136.0	6,118.0	6,085.0
I.A.1.	6,136.0	6,118.0	6,085.0
National Health Service Corps	169,903.0	131,448.0	126,796.0
I.C.1. Incorporates: I.C.4.	35,679.6	27,604.1	26,627.2
I.C.2. Incorporates: I.A.3., I.C.5.	134,223.4	103,843.9	100,168.8
Health Professions and Nursing Training Programs[3]	420,504.0	429,743.0	132,207.0
I.C.1.	168,201.6	171,897.2	52,882.8
(Deleted Measure #3)	42,050.4	0.0	39,662.1
I.C.2.	126,151.2	128,922.9	26,441.4
I.B.1. Incorporates Deleted Measure #4	84,100.8	85,948.6	118,986.3
Workforce Information and Analysis	743.0	736.0	733.0
V.A.1.	743.0	736.0	733.0
Nursing Education Loan Repayment/Scholarship Program	27,514.0	32,365.0	32,286.0
I.C.1. Incorporates Deleted Measure #1	6,878.5	8,091.3	8,071.5
I.C.2. Incorporates: I.C.3, I.C.4, I.C.5, and Deleted Measure #1	20,635.5	24,273.8	24,214.5
Bioterrorism Training and Curriculum Development[4]	27,706.0	27,520.0	27,521.0
VI.A.1.	23,550.1	23,392.0	23,392.9
Deleted Measure #1	4,155.9	0.0	0.0
Children's Hospitals Graduate Medical Education Payment Program	303,169.0	300,730.0	200,000.0
II.A.1.	294,073.9	300,730.0	194,000.0
Efficiency Measure #1	3,031.7	NA	2,000.0
VII.C.1.	3,031.7	NA	2,000.0
VII.C.2.	3,031.7	NA	2,000.0
Practitioner Data Banks (NPDB and HIPDB)	20,000.0	19,700.0	19,700.0
III.B.1.	20,000.0	19,700.0	19,700.0
Health Education & Assistance Loans (HEAL)	3,353.0	3,244.0	2,916.0
VII.C.1.	3,353.0	3,244.0	2,916.0
Maternal and Child Health Block Grant-Title V[5]	751,042.0	744,239.0	745,084.0
Increase Utilization Incorporates: I.A.1., I.A.2., I.A.3	337,968.9	334,907.6	335,287.8
Reduce Infant Mortality Incorporates: IV.B.1., III.A.1., III.A.2., III.A.3.	112,656.3	111,635.9	111,762.6
Increase Maternal Survival Incorporates: III.A.4.	112,656.3	111,635.9	111,762.6

Performance Program Area	FY 2004	FY 2005	FY 2006
Traumatic Brain Injury	9,648.0	9,558.0	0.0
V.B.1., V.B.2., V.B.3.	9,648.0	9,558.0	0.0
Healthy Start	100,594.0	105,420.0	100,603.0
I.A.1.	50,297.0	52,710.0	50,301.5
III.A.1.	50,297.0	52,710.0	50,301.5
Universal Newborn Hearing and Screening	10,160.0	10,067.0	0.0
III.A.1.	10,160.0	10,067.0	0.0
Emergency Medical Services for Children[6]	20,438.0	20,387.0	0.0
V.B.1.	NA	3,058.1	0.0
V.B.2.	NA	2,038.7	0.0
Deleted Measure #1	4,087.6	NA	NA
HIV/AIDS Titles I-IV[7]	2,022,794.0	2,050,654.0	2,063,051.0
I.A.1. Incorporates: I.A.2., II.A.1., II.A.2., III.A.1., III.A.2., IV.A.1.	1,759,830.8	1,784,069.0	1,794,854.4
HIV Emergency Relief Grants (Part A)[8]	632,909.0	627,211.0	627,923.0
I.A.1. Incorporates: III.A.1., III.A.2.	360,758.1	357,510.3	357,916.1
HIV Care Grants to States (Part B)[9]	1,117,481.0	1,153,311.0	1,164,912.0
III.B.1. Incorporates: I.A.1.	726,362.7	749,652.2	757,192.8
HIV Early Intervention Services (Part C)[10]	197,170.0	195,578.0	195,578.0
II.A.1. Incorporates: IV.B.1.	167,594.5	166,241.3	166,241.3
HIV Pediatric Grants (Part D)[11]	75,234.0	74,554.0	74,638.0
II.A.1.	66,205.9	65,607.5	65,681.4
AIDS Education and Training Centers (Part F)[12]	36,363.0	36,034.0	36,075.0
V.B.1.	16,363.4	16,215.3	16,233.8
Dental Service Program (Part F)	13,713.0	13,589.0	13,604.0
I.D.1.	13,713.0	13,589.0	13,604.0
Telehealth[13]	4,064.0	4,026.0	4,002.0
III.D.1.	101.6	100.7	100.1
V.B.1.	203.2	201.3	200.1
VI.A.1.	203.2	201.3	200.1
Organ Procurement and Transplantation Program	25,348.0	25,099.0	23,962.0
II.A.1. Incorporates: II.A.2., II.A.3., II.A.4., II.A.5., II.A.6., II.A.7.	25,348.0	25,099.0	23,962.0
National Bone Marrow Donor Program[14]	23,321.0	26,129.0	23,586.0
II.A.1.	4,804.1	5,382.6	4,858.7
II.A.2.	17,304.2	19,387.7	17,500.8
Poison Control Centers[15]	24,385.0	24,158.0	23,982.0
III.D.1	NA	2,415.8	2,398.2
III.D.2.	NA	1,207.9	1,199.1
III.D.3.	NA	2,415.8	2,398.2
Deleted Measure #1	2,438.5	NA	NA
National Bioterrorism Hospital Preparedness Program[16]	514,943.0	491,410.0	482,979.0
VI.A.1.	102,988.6	0.0	0.0
VI.A.2., VI.A.3., VI.A.4., VI.A.5.	NA	98,282.0	96,595.8
Trauma/Emergency Medical Services[17]	3,549.0	3,515.0	0.0
Vaccine Injury Compensation Program[18]	3,190.0	3,126.0	2,828.0
II.A.1. and II.A.2.	638.0	625.2	565.6
Rural Health Activities[19]	146,764.0	148,766.0	30,339.0
IV.A.1.	64,576.2	65,457.0	13,349.2
V.B.1.	27,885.2	NA	NA

Performance Program Area	FY 2004	FY 2005	FY 2006
Rural Health Policy Development[20]	9,161.0	9,073.0	8,777.0
V.A.1.	3,664.4	3,629.2	3,510.8
Rural Health Outreach[21]	40,753.0	40,380.0	11,082.0
IV.A.1.	24,451.8	24,228.0	6,649.2
Rural Hospital Flexibility Grants[22]	40,648.0	40,279.0	0.0
V.B.1.	16,259.2	16,111.6	0.0
V.B.2.	8,129.6	8,055.8	0.0
V.B.3.	8,129.6	0.0	0.0
State Offices of Rural Health[23]	8,634.0	8,554.0	8,463.0
V.B.1.	3,453.6	3,421.6	3,385.2
V.B.2.	2,590.2	2,566.2	2,538.9
Family Planning[24]	278,283.0	285,963.0	285,963.0
II.A.1. Incorporates: II.B.1., II.B.2.	250,454.7	257,366.7	257,366.7
Total Full Cost**	$6,479.0	$6,865.3	6,502.1

* Full cost data for the measures under each performance program area are shown as non-adds. The sum of full costs of performance measures may not equal the full cost of the performance program area, to the extent the program has elements for which there are no current measures.
** Equals the total program level.

Notes:

Estimation methodology provided on the page following the footnotes.

[1] The Health Centers program's overarching goals are to expand and to strengthen primary care services for underserved populations. Providing quality care is integral to both goals. Federal appropriations to HRSA constitute approximately 25% of total Health Centers' operating costs. The remainder of full cost is attributable to FTCA funding.

[2] The remainder of funds is attributable to inpatient/outpatient services in Baton Rouge, laboratory research, the rehabilitation program, training of medical professionals, payments to Hawaii, and building and facilities costs.

[3] For FY 05 and FY 06, the remainder of full cost is accounted for by the activities related to the deleted #3 measure, activities which will continue although the measure is to be deleted.

[4] For FY 05 and FY 06, the remainder of full cost is accounted for by the activities related to deleted measure #1, activities which will continue although the measure is to be deleted.

[5] The table does not equal the total full cost because the Block Grant provides a variety of services for mothers and children. These measures only represent a portion of all the services provided.
These are estimates based on program knowledge and data provided by States/jurisdictions. The MCH Block grant allows the flexibility to serve populations based on their individual needs. Therefore we estimate 25% of their funds go to State specific activities not captured in the above categories.

[6] The remainder of full cost is taken up by other activities, including provision of technical assistance to States for EMSC data collection, analysis and data linkage, development of model systems (i.e., model of pediatric component for State disaster plans), linkage to research, enhancing pediatric patient safety, and development of clinical practice guidelines.

[7] The remainder of CARE Act funds are awarded for Part F, State and Local Administration and Planning, Technical Assistance, and Evaluation.

[8] The remainder of Title I funds are awarded for the provision of services for non-racial/ethnic minorities.

[9] The remainder Title II funds are awarded for the States and Territories in developing and/or enhancing access to a comprehensive continuum of high quality, community based care for low-income individuals and families living with HIV. Program components eligible for funding include: HIV Care Consortia, Home and Community-Based Care, Health-Insurance Programs, Provision of Treatments and State Direct Services.

[10] The remainder of Title III funds are awarded for other services including case management and eligibility assistance, outreach, social work, prevention education and harm reduction and other Title II-eligible optional services.

[11] The remainder of Title IV funds are awarded for the provision of services for men. As Title IV projects provide family-centered care, support services are provided to male care givers of infected women, and to male infants, children and youth.

[12] The remainder of AETC funds are provided for the provision of AETC training intervention programs for non-racial/ethnic minorities.

[13] The remainder of Telehealth funds are awarded for both the provision of grants to develop telehealth network projects in rural areas, in medically underserved areas, in frontier communities, and for medically underserved populations and for the provision of grants to develop a telemedicine network comprised of a multi-specialty entity that provides 24-hour-a-day access to a range of specialty care.

[14] Approximately 95% of the available budget supports the established performance goals as outlined in the table above. An additional 5 % is spent to support activities such as: managing patient searches for donors, assisting patients in dealing with financial and other barriers to transplant, conducting research to improve transplant outcomes, developing ways to complete donor searches more quickly, and ensuring that the Registry network of transplant centers, donor centers and other organizations comply with all applicable Federal requirements and with Registry policies.

[15] While these measures are extremely important in improving the provision of care, the vast bulk of program resources are directed toward maintaining the current poison control centers as accredited, effective entities.

[16] The remaining 80% of full cost for FY 04 is accounted for by the activities associated with PART measures that become effective in FY 05.

[17] No distribution by measures is done because the sole current measure for this program is an efficieney measure. Additional measures will be developed when this program undergoes PART review, tentatively scheduled for the FY 08 budget.

[18] Approximately 20% of the available budget supports the established GPRA performance goals outlined in the table above. This is based upon the salaries and benefits of staff that perform work, both full-time and part-time, in the authorization and discharge of compensation payments. The remaining 80% of the budget provides for operations in program management, policy development and implementation, outreach and communication, case review and medical analysis, the Expert Witness Program (EWP), as well as in support of the statutorily-required quarterly meetings of the Advisory Commission on Childhood Vaccines. Note: Congress appropriates such sums as may be necessary.

[19] Generally, the remainder of Rural Health activities full cost is attributed to other program activities in Policy, State Offices of Rural Health and Rural Access to Emergency Devices. For FY 05 and FY 06, the program related to measure V.B.1 is not proposed for funding.

[20] The performance measure focuses solely on the Rural Health Research Center Grant program, which receives approximately 40 percent of the funds allocated under this funding. The remainder of the funding supports the other policy related activities of the Office that are explained in narrative.

[21] This program includes both the Rural Health Outreach and the Rural Health Network Development grant programs, which are funded under the same line. A larger portion (approximately 60%) of resources is devoted to the Outreach program.

[22] The performance measures focus on the activities supported by the Rural Hospital Flexibility Program (Flex). Distributions do not add to 100% because the performance measures do not take into account the portion of this funding that supports the Small Hospital Improvement Program.

[23] The performance measures focus on the activities supported by the State Office of Rural Health Program, which are only partially supported by Federal funding as all grantees must match that funding on a 3:1 basis. The remaining funding is attributed to other program activities within the scope of the program authority as explained earlier in the program narrative.

[24] Ninety percent of the program's appropriation is devoted to clinical service delivery. Conference report language accompanying the Title X annual appropriation legislation states, "The Committee intends that at least 90 percent of funds appropriated for Title X activities be for clinical services authorized under section 1001 of the Act."

The other 10 percent of the program appropriation is used for administrative support, as well as to support three key functions aimed at assisting clinics in responding to clients' needs: (1) training for family planning clinic personnel through general training programs, as well as training for clinicians; (2) information dissemination and community-based education and outreach activities; and (3) data collection and research to improve the delivery of family planning services. It is important to note that this cost estimate represents only the Federal appropriation of the program. Various other sources of revenue (e.g., Medicaid reimbursements, State and local funds, patient fees, other Federal grant programs) supplement appropriated family planning grant funds to support the full cost of client care. Title X funding comprises approximately one-fourth of the operating budgets of family planning clinics.

Methodology - Estimated Full Cost

The table above provides estimates for FY 2004-2006 of the full cost of each HRSA performance program area. The full cost was estimated by adding program management cost to the program levels from the APT (except in the cases when the latter includes program management cost). The program management cost was allocated, where appropriate, across programs based on the proportion of total program level cost represented by each program.

The table also includes information on the full cost of each program area by performance measures. These distributions are based on professional judgments, supported to the extent possible by financial and other statistical data. In many cases, performance measures are aggregated in the distributions of cost because of the interdependence of the activities and goals represented by the measures.

The cost distributions by performance measures are presented for "active" measures in a given year, excluding (except in special cases) efficiency measures. That is, measures that are to be deleted are included only for the applicable year(s) before their deletion; new measures are included beginning with the first year in which performance data are expected. When the cost distributions by performance measure do not add to total cost for a given program area, explanatory notes are provided.

CHANGES AND IMPROVEMENTS OVER PREVIOUS YEAR

Budget Performance Integration

The major change in this FY 06 Performance Plan/04 Report is its full integration with HRSA's budget request. This entailed more than just physically going from two volumes to one volume. Rather, it involved the blending of HRSA's budget request with information on how past performance supports the request and how expected future performance also informed the budget request. This was done with respect to traditional GPRA measures as well as PART measures and ratings. Examples of this integration are evident in a revised introductory section that presents overview performance and budget information in a more unified fashion, the new "Performance Analysis" summaries that are part of each program's budget narrative, the inclusion of PART information throughout the document, the inclusion of full cost by performance measures, and linkages in the budget narratives to detailed performance information.

Linkage to Strategic Plans

HRSA is revising its Strategic Plan. Each performance measure for all HRSA programs reported herein were categorized according to the newly revised seven Strategic Goals and the newly revised sub-strategies or objectives, showing the close alignment of performance results and expectations with organizational mission and priorities (see Exhibit U). In addition, Exhibit X has been updated to include additional measures to show the linkages between HRSA performance measures and the HHS Strategic Plan.

Review of Performance Goals

HRSA has continued to review its performance goals to determine opportunities for improvement. The Agency has deleted a number of output and other outdated goals, revised some goals for more precision, and added outcome goals. These additions include, but are not limited to, those goals identified during the FY 06 PART review process.

Detailed Performance Tables and Analysis

HRSA also improved the reporting of performance by refining its detailed performance tables. One such change was the separation of current measures from the deleted measures on which the Agency still needs to report. This gives a clearer picture than that given in the past on a program's performance measurement profile. Other changes include a reduction in old historical data and refinements in the measure-by-measure discussions, making for a more succinct presentation of performance.

LINKS TO HHS AND OPDIV STRATEGIC PLANS

The Department has updated its Strategic Plan for the period FY 04-09. HRSA participated in the effort to refine the overall HHS goals and objectives. HRSA has linked its performance goals with the goals and objectives in the Department's Strategic Plan as shown in the section on HRSA's Strategic Goals. For each of the eight HHS goals, HRSA provides examples of program activities and performance goals in the matrix that follows.

HRSA has updated its Strategic Plan for FY 05-10. Links of performance goals to HRSA's Strategic Plan goals and objectives are indicated in the performance tables found in Exhibit U.

Illustration of HRSA Performance Goals that Support HHS Strategic Objectives

HHS Strategic Objective	HRSA Activity	HRSA Performance Goals
Goal 1: Reduce the major threats to the health and well-being of Americans		
1.1: Reduce behavioral and other factors that contribute to the development of chronic diseases	Primary Care: Health Centers	Performance goals aimed at reducing disparities, such as those focused on appropriate screening for cancer and control of hypertension, include efforts aimed at health education and health promotion for the target population.
1.2: Reduce the incidence of sexually transmitted diseases and unintended pregnancies	Family Planning	Increase the number of uninsured persons served by Family Planning clinics.
	HIV/AIDS: HIV Pediatric Grants	Increase the number of enrolled female clients provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission.
1.5: Reduce tobacco use, especially among youth	Primary Care: Health Centers	Performance goals aimed at reducing disparities, such as those focused on appropriate screening for cancer and control of hypertension, include efforts aimed at health education and health promotion for the target population.
1.6: Reduce the incidence and consequences of injuries and violence	Maternal and Child Health: Emergency Medical Services for Children	Increase the number of States that require all EMSC-recommended pediatric equipment on Advanced Life Support Ambulances.
Goal 2: Enhance the ability of the Nation's health care system to effectively respond to bioterrorism and other public health challenges		
2.1: Build the capacity of the health care system to respond to public health threats in a more timely and effective manner, especially bioterrorism threats	Office of Special Programs: Hospital Preparedness	Increase the percent of States that have developed plans to address surge capacity.
Goal 3: Increase the percentage of the Nation's children and adults who have access to health care services and expand consumer choices		
3.1: Encourage the development of new, affordable health insurance options	Maternal and Child Health Block Grant	Increase the percent of Children with Special Health Care Needs in the State program with a source of insurance for primary and specialty care.
	Maternal and Child Health Block Grant	Increase the number of children receiving Title V services who are enrolled in and have Medicaid and SCHIP coverage.
3.2: Strengthen and expand the health care safety net	Primary Care: Health Centers	Increase the number of uninsured and underserved persons served by Health Centers.
	Primary Care: Health Centers	Assure access to preventive and primary care for low income individuals, including an increase in the percent of the nation's poor served.
	Primary Care: Health Centers	Assure access to preventive and primary care for minority individuals.

HHS Strategic Objective	HRSA Activity	HRSA Performance Goals
	Health Professions	Increase the field strength of the National Health Service Corps through scholarships and loan repayment agreements.
	Health Professions and Nursing Training Programs	Increase the proportion of graduates and program completers who are underrepresented minorities and/or from disadvantaged backgrounds.
	Health Professions and Nursing Training Programs	Increase the number of residents/graduates, students/trainees, faculty, and supported students who enter practice in underserved areas.
	Rural Health: Rural Health Outreach	Increase the number of persons served by Outreach Grants.
	HIV/AIDS: HIV Early Intervention Services	Increase the number of people receiving primary care services under Ryan White Early Intervention Services programs.
3.4: Eliminate racial and ethnic health disparities	Primary Care: Health Centers	Increase proportion of Health Center adults with hypertension who report their blood pressure is under control.
3.5: Expand access to health care services for targeted populations with special health care needs	HIV/AIDS: HIV Emergency Relief Grants (Part A)	Increase the number of visits for health-related care to a level that takes account of new clients in the program.
	HIV/AIDS: HIV Care Grants to States (Part B)	Increase the number of visits for health-related care to a level that takes account of new clients in the program.
	HIV/AIDS: HIV Care Grants to States (Part B)	Increase the number of ADAP clients receiving HIV/AIDS medications through State ADAPs during at least one month of the year.
	Maternal and Child Health Block Grant	Increase the percent of Children with Special Health Care Needs in the State program with a source of insurance for primary and specialty care.
Goal 4: Enhance the capacity and productivity of the Nation's health science research enterprise		
4.4: Improve the coordination, communication, and application of health research results	Rural Health: Rural Health Policy Development	Rural Health Research Grant Program: To conduct and disseminate policy relevant research studies in each of ORHP's rural research centers.
Goal 5: Improve the quality of health care services		
5.2: Increase the appropriate use of effective health care services by medical providers	Health Professions and Nursing Training Programs	Promote a health care workforce with a mix of the competencies and skills needed to improve access to cost-effective quality care.
	HIV/AIDS	Increase the percent of CARE Act-funded primary care providers that will have implemented a quality management program.
	Primary Care: Health Centers	Decrease the proportion of health center users who are hospitalized for potentially avoidable conditions (i.e., conditions sensitive to ambulatory care interventions).
5.3: Increase consumer and patient use of health care quality information	Special Programs: Organ Procurement and Transplantation	Increase the number of minority organ donors nationally.

HHS Strategic Objective	HRSA Activity	HRSA Performance Goals
Goal 6: Improve the economic and social well-being of individuals, families, and communities, especially those most in need		
6.2: Increase the proportion of older Americans who stay active and healthy	Health Professions and Nurse Training Programs	Promote a health care workforce with a mix of the competencies and skills needed to improve access to cost-effective quality care.
Goal 8: Achieve excellence in management practices		
8.2: Improve the strategic management of human capital	Program Management	Implement the HRSA Scholars program.

PARTNERSHIPS AND COORDINATION

A major source of HRSA's strength is its many linkages and partnerships with other Federal agencies, States, and national and local organizations. Achievement of its mission is dependent on effective partnerships and HRSA continuously seeks new and renewed relationships with external entities to leverage resources, create synergy, and extend capacity to address the health and health system issues and problems confronting the communities we serve. In its revised Strategic Plan, HRSA identifies as a core value underpinning the development and management of its programs the creation of useful, effective forms of collaborations with partners in regulation, research, service delivery, and management.

Among the linkage and partnership arrangements that have been formed with external partners are following:

- Federal partners such as ACF, CDC, SAMHSA, CMS, VA, DOJ, HUD, AHRQ, AND IHS. Examples include:
  - HRSA's and CDC's partnership efforts focus on a variety of disease prevention and health promotion activities, including immunization efforts, and improved data collection and analysis.
  - HRSA and CDC have worked closely with the Office of Public Health Preparedness to implement new programs to improve preparedness for bioterrorism and other mass casualty events.
  - HRSA and CDC collaborate on a great number of HIV/AIDS issues, including prevention, intervention, and continuity of care issues, as well as service delivery research,
  - HRSA and AHRQ partner on various research efforts such as studies of the health care safety net and HIV/AIDS services.
  - HRSA collaborates with SAMHSA to integrate behavioral health/substance abuse screening, early intervention, referral, and follow-up into primary health care settings funded through HRSA grants, and to identify service linkage and integration opportunities.
  - HRSA and DOJ partner in work related to Vaccine Injury Compensation.

- State and local government partnerships through such programs as the Maternal and Child Health Block Grant, Ryan White Care Act Programs, State Offices of Rural Health, and National Bioterrorism Hospital Preparedness.

- National associations and organizations linkages, such as with those representing State and local public health agencies, groups of primary health care providers, adults and children with special health care needs, and health professions associations.

- Work with academic institutions, such as the variety of partners working on health professions training, workforce analysis, and health services research and evaluation.

- Links with foundations, such as the Robert Wood Johnson Foundation, the Kellogg Foundation and the Kaiser Family Foundation.

- Linkages with business groups such the thousands of businesses involved in helping educate employees and members about the urgent need for organ donation.

DATA VERIFICATION AND VALIDATION

General

There are numerous concerns about the availability and cost of data to measure performance and results. Data systems often have been initiated to measure the results of individual programs, usually as a legislated requirement. Many programs target the same populations within and outside of HRSA, so there is the potential for individual programs trying to obtain different information, in different formats and at different times, from the same source, thereby increasing the reporting burden at the grantee level.

Because HRSA programs are generally carried out by grantees at the State and local level, who often use subgrantees or contractors to perform the work, the system is not structured to produce a routine flow of data on grantee performance and outputs. HRSA is working to establish useful and efficient systems for gathering performance and accountability information. Another data issue is the competing need to collect essential performance measurement information while, at the same time, attempting to meet the requirements of the Paperwork Reduction Act which aims to reduce the reporting burden associated with participation in Federal programs. These competing needs at times are difficult to resolve. This variety of data issues will continue to be addressed as we proceed with the development of our performance measurement strategy.

It is clear that additional effort is needed to move toward increased use of common, structured, and standardized data strategies to carry out an effective system of performance measurement. A good deal of work has already been initiated in this area.

Primary Care
(Bureau of Primary Health Care)

A. General Description of the Sources/Systems

To prepare for implementation of GPRA, several years ago BPHC initiated a three-part data collection and evaluation strategy. First, a Uniform Data System (UDS) was developed and implemented to collect aggregate administrative, demographic, financial, and utilization data annually from each organization receiving support.

Second, surveys of a representative sample of health center users and provider visits were developed in collaboration with the National Center for Health Statistics. These surveys provide in-depth information on individuals and the care they receive, based on and comparable to the National Health Interview Survey (NHIS) and the National Hospital Ambulatory Medical Care Survey (NHAMCS).

Third, BPHC reoriented its portfolio of other evaluation efforts, shifting from a descriptive case-study approach to the use of previously validated secondary data sources that enable a comparison of users and similar populations of non-users, and systematic sampling of organizations and users. Notable among these efforts are studies of Health Center Effectiveness that use claims data from CMS's State Medicaid Research Files (SMRF), on-site reviews of content of care, and Hospitalizations for Ambulatory Care Sensitive Conditions, which also uses the SMRF files to examine potentially avoidable hospitalizations.

Future progress on clinical measures will be monitored and reported bi-annually using Sentinel Centers Network (SCN) data, permitting analyses of patient and provider characteristics (i.e., the type, amount and outcome of care provided by individual providers, adjusted for patient disease burden). The SCN is a representative group of BPHC-supported Health Centers, from which timely relevant information is obtained to guide policy decisions. Core data from participants' existing management information systems are extrapolated from hundreds of thousands of patient medical records bi-annually rather than a few thousand every 5 - 7 years as is characteristic of patient surveys. SCN is a rich source of data on Health Center patients and the services they receive. These data provide BPHC and each of the SCN participants with information that cannot be obtained from the sample or aggregate data that are currently collected.

B. Data Quality

The UDS, which combined five previously separate reporting formats, is in its ninth year of operation for more than 900 health center grantees. It is validated through edit checks and onsite reviews conducted during each organization's project period. It is used to supply information for the access performance goals. UDS modifications are made annually based on feedback from focus groups comprised of UDS customers. In addition, grantees were given the option to transmit UDS data for FY 99 electronically, with mandatory electronic transmission for FY 00. More than 20% of grantees provided such data for FY 99, and nearly all grantees transmitted electronically in FY 00 and 01. Continued electronic transmission has resulted in nearly 100% reporting in 2002 and 2003.

C. Performance Information on Data Sources

Mandatory electronic UDS data submission addresses the reliability and validity concerns expressed in a recent GAO report. FY 00 UDS data were available in November 2001, with 2001 UDS data available in August 2002, with even more rapid turnarounds in June for 2002 and 2003 as the efficiency of electronic transmission improved.

The national surveys are the source of most Healthy People 2000 and 2010 objectives, which can be used as targets for BPHC performance goals for disparity reduction. BPHC has linked several of the health center program performance measures to HP 2010 targets. Information from the Health Center User and Visit Surveys fielded in FY 95 were used for baselines; BPHC repeated

these surveys for FY 02 encounters and anticipates at approximate five-seven year intervals thereafter to provide longitudinal comparisons for GPRA.

Chronic disease can be complicated and costly to treat. In order to address the increasing chronic disease burden on our patients and increase the quality of care they received for these conditions, BPHC launched our Health Disparities Collaboratives. Health Centers and their patients are increasingly participating in the Collaboratives, especially in the last two years. The Collaboratives started with 1,685 patients in March of 1999 and have grown to 252,891 patients by June 2004. The diabetes registry has increased from 15,045 in July 2000 to 135,164 patients by June 2004. The original reported HbA1c performance at 60% dropped with the expansion of the diabetes collaborative to new centers and new diabetics, but performance was still well above national norms. In addition, health centers have also seen improvement in the control of hypertension among patients in the collaboratives. Depression patients have also shown improvement. In September 2003, 10% of patients with depression in the registry had a 50% reduction in their depression risk score. In July of 2004, twice as many patients (22%) had a 50% reduction in their score. These results too were accomplished even as the number of patients in the registry increased.

In FY 00, BPHC launched a data gathering infrastructure that will assure that performance measures are obtained annually. In FY 01 and FY 02, it began to develop teams of data collectors at sentinel sites to obtain outcome data on an annual reporting basis. Ultimately, BPHC will work to develop the data and tracking infrastructures within service delivery sites (Disease/Care Collaborative: Diabetes, Depression and Asthma, Hypertension) to assure prompt annual reporting on the performance measures and obtain health status outcome measures. These activities are designed to move health centers to a paperless, high technology network of management information systems.

D. Data Limitations

For performance reporting of the health center population from racial/ethnic minority groups and for reporting of patients by income, health centers are unable to obtain such information for some of their patients. To report the number of patients in these categories from the "known" categories would uniformly produce underestimations because even though not reported, those patients do have a race/ethnicity and income. BPHC used statistical convention to distribute the "unknown" category across the "known" categories, assuming that the "unknown" have the same distribution. Preliminary tests of UDS data reveal that this is a reasonable assumption.

As with the surveys, information from special studies of previously validated data sources will be used for performance goals related to disparity reduction, although some additional work is needed to develop appropriate targets and baselines.

However, limitations of Health Center management information systems have either postponed BPHC's ability to report results as anticipated or in such cases as diabetic record extraction, have precluded BPHC reporting of annual dilated eye examinations.

HIV/AIDS Data Collection Efforts
(HIV/AIDS Bureau)

A. General Description of the Sources/System

HRSA's HIV/AIDS Bureau (HAB) requires one annual data report from all its grantees and contracted service providers. The Ryan White CARE Act Data Report (CADR) is completed by all Ryan White CARE Act Title I, II, III, and IV-funded grantees and service providers. The completed reports provide HAB with aggregate data for the previous calendar year on the characteristics of service providers, the characteristics of clients served, the types of services offered, HIV counseling and testing services provided to clients, and other medical information on the clients served.

HAB's Division of Science and Policy (DSP), Epidemiology and Data Branch (EDB) also collects client-level data from a select group of five Title I and II grantees that have agreed to participate in demonstration projects for the purpose of collecting such data. This project will be expanded to include Title III grantees and possibly Title IV grantees in the future.

Although, the majority of data for the Ryan White CARE Act program performance measures are obtained from the CADR the following are additional data sources used:

- ADAP Monthly report and State Profile,
- Periodic estimation by HAB of total clients in care,
- Client Demonstration Project Data,
- Grant Applications,
- Grantees' Needs Assessment, and
- CDC *HIV/AIDS Surveillance Reports*.

The periodic estimation of the number of persons served by the CARE Act is based on the duplicated number of clients served reduced by a "de-duplication factor" that was modeled in 1999-2000.

B. Quality

In order to ensure data quality, HAB conducts a single round of data verification for all 2003 CARE Act Data Report (CADR) submissions. Reports detailing items in need of correction and instructions for submitting revised data will be mailed to grantees. Grantees will have two weeks to consult with their providers and submit corrections to HAB's data contractor.

C. Performance Information of Data Sources

The CADR provides comprehensive CARE Act program data for state and local governments. When making funding decisions, HIV planning bodies will find the CADR data helpful in their effort to target CARE Act funds to groups most affected by HIV/AIDS. CARE Act data can also be used to respond to special funding requests from potential non-governmental funding organizations and groups. Organizations currently serving populations with HIV/AIDS can use the CADR data to enhance grant applications. This data can be useful for state/local-level planning, documenting programmatic accomplishments, and describing a program. CADR data may be used to create tables, graphs, charts, maps for reports, brochures, grant applications (along with other data, where possible), policy briefs, journal publications, and training documents. The data contained in the CADR provide basic information that can be helpful as Grantees plan and implement changes in their CARE Act service systems to better address the needs of communities serving people living with HIV/AIDS. CADR data can be used to describe the socio-demographic characteristics of the clients to determine if the vulnerable and underserved populations most affected by the epidemic in a given service area are being served. These data also can be used to describe the types and volume of services provided.

D. Data Limitations

Data reported as part of the CARE Act Data Report system are aggregate level data as such, the data cannot be cross-tabulated during data analysis. CADR data are primarily descriptive and have limited use in drawing conclusions about quality of services, the impact of service utilization on individual health status, or the effectiveness of services provided with CARE Act funding. One limitation of this type of data is the type of questions that can be answered using these data. For example, data from this system will provide the number of clients served by each grantee using CARE Act funding; however, it is not possible to determine the exact number or combination of services received by each individual client. A second limitation is the system contains duplicated data for clients. CADR data as collected and reported by individual providers are generally unduplicated. However, since an individual client may receive services from more than one provider, there is no way of knowing that the counts of individuals served by one provider are not also included in the counts of individuals reported by another provider in the same grantee service area.

These limitations have been addressed, first, by giving grantees the option to participate in a client-level reporting system that can address questions concerning the relationships across variables for individual clients. Secondly, CARE Act grantees whom already collect or are willing to collect client-level data and submit it to HAB can compete for HAB funding to do so. HAB also funds special evaluation projects to examine significant CARE Act service issues.

Maternal and Child Health Bureau (MCHB)

A. General Description of the Sources/Systems

This section describes data sources and systems for the following Maternal and Child Health Bureau Programs, including the Maternal and Child Health Block Grant, and other MCH programs, including the Special Projects of Regional and National Significance (SPRANS), Community Integrated Services Systems (CISS), Traumatic Brain Injury, Healthy Start, Universal Newborn Hearing Screening and Early Intervention, and the Emergency Medical Services for Children.

Maternal and Child Health Bureau (MCHB) Block Grant

In late 1997, the Maternal and Child Health Bureau (MCHB) completed an extensive collaborative effort with the States to re-engineer and streamline the Maternal and Child Health (MCH) Block Grant Annual Report. In this effort, MCHB and the States introduced performance measurement into the Title V Block Grant program. The annual report is submitted online by each State and contains 18 national performance measures, 6 national outcome measures, and 7 to10 State-specific performance measures, and 1 State-specific outcome measure.

Each State sets target values for each of the measures for a five-year period and reports online annually on actual performance into a relational data base. The data, submitted each July, report achievements for the prior fiscal year, and set goals for the subsequent fiscal year. This information is available to the public through the Title V Information System (TVIS) at www.mchdata.net.

Other MCH Grant Programs

The Maternal and Child Health Bureau has taken the same approach used for the MCHB Title V Block Grant System to develop a Discretionary Grant Information System for its other grant programs, including MCHB Title V Discretionary Grants (SPRANS and CISS), Healthy Start, Emergency Medical Services for Children, Traumatic Brain Injury, Universal Newborn Hearing Screening and Early Intervention, and others. New performance measures have been approved and are currently being phased in for use in the new online reporting system. Performance data through this mechanism will be received beginning in FY 06.

B. Data Quality

States submit data on their Title V programs through the on-line Title V Information System (TVIS). The TVIS provides pre-formatted and interactive data entry that helps assure standardized data across States, and greatly simplifies the data entry process. All calculations (ratios, rates, percentages, as well as totals) are done automatically, tables are interlocked where data overlap, and historical data are preserved so that only the annual data for the year in question need to be newly entered. Required data must be entered before the TVIS will accept the report, and the system performs immediate checks for many common errors (out of range values, alpha entries in numeric fields. inverted ratios, etc.). Values which exceed statutory allowable limits trigger electronic flags, open notation fields, and/or prompt for a justification or waiver request. State data submitted electronically through the TVIS is stored in a relational data base allowing retrieval of data quickly and easily.

The data for the discretionary grants (the Discretionary Grants Information System -DGIS) is constructed exactly as is the TVIS, with the same requirements and restrictions. Grantees will report through the on-line system, greatly improving data comparability, and standardization, similar to the TVIS. It is expected that the quality of the data will greatly improve in a very short time.

TVIS and DGIS are components of an enterprise-wide information management system in which performance measure data are electronically submitted, validated and aggregated. These performance data serve as the basis for informing management decisions and program priorities. TVIS and DGIS are not application portals, which is Grants.gov.

Great care has been taken in the development of new performance measures to ensure that they are valid indicators for the specific concerns of each program. Detailed definition sheets were developed for each measure which address, among other things, the significance and relevance of the measure. State-developed measures must meet similar requirements. All of the standard measures relate to the overall objectives of each program.

C. Performance Information on Data Sources

The TVIS represents the first automated data set containing performance data on MCH programs in all 59 States and Jurisdictions. MCHB began entering State data from the Title V programs into the TVIS in 1997. Reporting has improved steadily since the first year, and MCH data on the TVIS is improving and becoming more complete. The variations in data collection and data sources used by different states are known, and clearly documented.

Some data, especially vital statistics data, come from CDC and are not duplicated in the TVIS.

DGIS, now being implemented, is the first automated data set containing performance data on the approximately 800 MCH programs supported by discretionary grant funds. MCHB will begin entering State data in the DGIS in FY 05. It is expected that reporting will greatly improve and data will be far more available and reliable.

D. Data Limitations

As noted above, not all States and community-based grantees are able to report all required items for the same uniform time periods, and for each year. MCHB has launched an initiative to improve States' ability to collect, tabulate, edit, analyze, disseminate, and use data. This effort is being closely coordinated with the State MCH Directors, and other program grantees to assure their data needs are met. In addition, technical assistance is being provided to discretionary grantees to assure accurate reporting of performance measure data.

Health Professions - Comprehensive Performance Management System (CPMS) (Bureau of Health Professions)

A. General Description of the Source/System

The Bureau of Health Professions (BHPr) has developed a systematic approach to collecting and measuring performance data on the Bureau's Titles VII and VIII health professions and nursing education programs. The Comprehensive Performance Management System (CPMS) collects data on grantee performance related to the BHPr's strategic goals, objectives, outcomes and indicators. Grantees are required to report data on trainees, graduates and program completers trained in Primary Care, Allied Health and other Health Professions disciplines. The CPMS's purpose is to incorporate accountability and measurable outcomes into BHPr's programs, and to develop a framework that encourages quality improvement in its programs and projects. At the core of the Comprehensive Performance Management System (CPMS) are cross-cutting output/outcome indicators that measure activities common to most programs and measure the aggregate effects of grantee achievements in support of the BHPR's goals. The indicators are, in turn, associated with goals established by HRSA. The Bureau collaborates with representatives from health professions associations and leaders in health professions schools to ensure that it is using the appropriate outcome indicators that will tell as complete a story as possible.

BHPr has enhanced its CPMS data collection instrument to make it more efficient and user friendly for the grantee. The new system allows each grantee to enter its data and submit the report directly to BHPr staff via the web. This has allowed the Bureau to significantly improve response rates, timeliness and quality of the data it collects from grantees.

BHPr's GPRA plan was recently revised to reflect new annual goals for selected programs identified during program reviews (PART) conducted in the summer of 2002. BHPr is also in the process of revising its Strategic Plan, which may also include new strategic goals and objectives. To plan for the data collection requirements associated with these goals, a

performance measurement workgroup has been working to review BHPr's data needs, identify needed data elements, and recommend data collection and analysis procedures to ensure consistent tabulation and reporting across all programs. The performance measurement workgroup's deliberations will have implications for the current reporting system. Plans to implement changes will be discussed in future reports.

B. Data Quality

As indicated above, the BHPr has worked for several years to develop, test and refine the CPMS, the data collection instruments and the editing standards and methods to be used during data input. BHPr used these methods to process the grantee reports for FY 99 which were submitted during the first and second quarters of FY 00. BHPr modified the tables and procedures based on lessons learned in the FY 98 data collection activity. BHPr developed extensive business rules for validation and correction of submitted data and extensive federal quality assurance has provided assurance that data entry for the FY 99 data was at least 98% accurate. BHPr used these same methods to collect and assess the quality of the FY 00 data.

The CPMS data, collected from all grantees as a condition for continuation of the grant, are enumerative. BHPr uses counts, sums and other basic descriptive statistics to analyze and report the data.

C. Performance Information on Data Sources

The baseline data, going back to FY 98, is composed of data collected from grantees prior to beginning the CPMS. Those performance data sources were compiled from program records, grantee applications and progress reports.

D. Data Limitations

BHPr initiated the CPMS in response to the need to improve data availability, quality and timeliness. It is recognized that the quality of CPMS can be no better than the quality of data submitted by grantees. As part of implementing Public Law 105-392, BHPR defined data requirements to be addressed in competitive grant applications.

To emphasize the importance of high quality data, BHPr also is requiring organizations which submit applications for competitive grants beginning in FY 00 to describe the methods and systems that will be used to accurately collect and submit CPMS and other performance data. Grantees with deficient systems are required to present a corrective action plan for getting them to an acceptable level.

Actual results for the "Deleted Measures" in Section U increased dramatically in some cases between FY 01 and FY 02. These results are shown as estimates pending a review to determine the validity of these data.

Healthcare Systems Bureau

1. Organ Procurement and Transplantation

A. General Description of the Source/System

With the exclusion of the Workplace Partnership measure, the data used to assess the performance measures are obtained from the Organ Procurement and Transplantation Network (OPTN) data system. The OPTN data collection system collects information from transplant centers, organ procurement organizations and histocompatibility laboratories on all organ transplants that involve the use of deceased donor organs. These data are provided on a continual basis through an Internet-based data reporting system developed by the contractor for the OPTN, the United Network for Organ Sharing (UNOS).

The data for reporting the number of Workplace Partners is obtained from a database that is maintained by a contractor with responsibility for enrolling Workplace Partners. This is a rather simple data collection system that involves recording the name, address and contact information about the Workplace Partner.

B. Data Quality

The OPTN data collection system employs a variety of data checks at every point along the data collection and reporting continuum. Data entry screens include a variety of data element checks and cross checks that must be satisfied before the data is accepted by the system. The contractor for the OPTN conducts additional data quality checks and follows-up with the transplant programs, organ procurement organizations and histocompatibility laboratories to resolve discrepancies in the data. An additional level of data quality review is performed by the contractor for the Scientific Registry of Transplant Recipients (SRTR). The SRTR contractor receives an updated snapshot of the OPTN data system every month. The SRTR conducts additional data quality checks of the OPTN data and uses external data sources to verify that the number of deaths reported pre- and post-transplant are accurate. The OPTN and SRTR contractors work collaboratively on projects to continually improve the quality of the data.

C. Performance Information on Data Sources

Data obtained from the OPTN data system meet all of the requirements of the Program for assessing program performance as compared to the established program performance measures. The OPTN data collection system contains historical transplant data from 1986, when the first

contract for the OPTN was awarded. UNOS, the contractor for the OPTN since its inception, has made continual improvements to the scope and quality of the data collected. Rigorous safeguards are taken to assure that the system is operational 24 hours/day, 365 days/year. The system has a certified security and continuity of operation plan. The Workplace Partnership database is backed-up daily.

D. Data Limitations

The data for the number of deceased and living organ donors, and the conversion rate for eligible donors are obtained from the OPTN data collection system. These data are updated on a real-time basis by organ procurement organizations, transplant programs, and histocompatability laboratories. For organ donation data, there is typically a 3-month lag between the reporting of data and when data are made available to the government and other users. Data for calendar year activity are typically available in the April following the end of the calendar year for which data are being reported. Other than the 3-month lag, these data are sufficient for assessing program performance against the GPRA measures. Data from the Workplace Partner database are available on a real-time basis.

2. National Bone Marrow Donor Program

A. General Description of the Source/System

The data that are used to report on program performance measures are obtained from the National Marrow Donor Program, the HRSA contractor for the National Bone Marrow Donor Registry. The NMDP uses its Search, Tracking and Registry (STAR) system to collect donor information, to manage and facilitate all patient searches, and to track detailed post-transplant clinical status. The STAR system is used to communicate electronically with all of the necessary NMDP Network members needed to facilitate unrelated transplants, including: transplant centers, donor centers, apheresis centers, collection centers, cord blood banks, contract laboratories, repositories, and cooperative registries.

The STAR system was implemented in 1992, and has undergone many changes with regard to technology, data collection processes and data content. It is used to manage data for more than 5 million donors and 30,000 cord blood units, and has been used to facilitate more than 18,000 transplants.

B. Data Quality

The data system for reporting performance measures is validated through edit checks during the contracting period. Each month, the Project Officer receives monthly reports and statistical highlights indicating the number of donors added to the Registry by race/ethnicity. The highlights also indicate the number of transplants performed by stem cell source (marrow, peripheral or umbilical cord), race/ethnicity and disease category. The data for the reported

performance measures are gathered from the statistical highlights. The NMDP staff conducts site visits of their member centers and validate data (e.g. reviewing patient records) to assure accuracy.

The contract with the National Marrow Donor Program also contains performance measures, which examine some of the same measures outlined in this performance report/plan. The NMDP submits quarterly reports against the performance measures and summarizes activities in place to meet the established goals. The quarterly progress reports are discussed in detail during Project Officer meetings and other venues.

C. Performance Information on Data Sources

Historically, data collected for the National Bone Marrow Donor Registry are at least 98% complete and timely. These data are critical to the ongoing operation of the National Bone Marrow Donor Registry and to the facilitation of unrelated blood stem cell transplants. Safeguards are taken to assure that the system maintains its integrity and is operational.

D. Data Limitations

Calculating the exact number of minority donors on the Registry has become increasingly difficult since the Registry incorporated the Office of Management and Budget revisions to the Standards for Classification of Federal Data on Race and Ethnicity as of October 1, 2002. Despite the NMDP thoroughly educating its Network members on the change and explaining the importance of capturing racial data from all of the donors recruited to the Registry, many potential Hispanic donors have declined to provide racial data. Thus avoiding double counting of Hispanic donors who also are of minority race is problematic. Discussions are underway with the contractor to consider how best to report on minority donors.

3. National Bioterrorism Hospital Preparedness Program

A. General Description of the Source/System

The National Bioterrorism Hospital Preparedness Program (NBHPP) has recently initiated a three-part data collection and evaluation strategy. First, NBHPP requires all of its awardees to submit semi-annual progress reports. These are used primarily for project management; however, they will also be used to determine progress made on program performance measures as they are reported by all awardees based on standard topic areas, which coordinate with the performance measures in the performance budget. Second, NBHPP has requested performance data be submitted by each awardee annually in the continuation application. This data will be reported with approximately one data submission per critical benchmark area, which will also lend itself to performance measure reporting for the performance budget and longitudinal

monitoring. Third, NBHPP has commissioned a hospital assessment survey to be conducted. This survey will assess hospital readiness at the hospital level. HRSA-funded hospitals will be asked questions regarding their preparedness in a number of critical areas, which will also lend themselves to informing performance budget reporting.

B. Data Quality

All three of the data sources are based upon self-reported data by either the awardee or hospital officials. This is an efficient and timely method of collecting data; however, there is no built in quality check. The hospital assessment survey will be an online survey, which will improve data collection, timeliness of data and data use, and ease of aggregation and computation.

An extensive amount of care and attention was used in developing requirements for the annual reporting requested in the continuation applications from the program awardees. Extensive comments were solicited from program partners, program staff, and awardees to ensure adequate buy-in to the information requested, as well as ensuring the information was being requested in an appropriate fashion for ease and uniformity of reporting.

C. Performance Information on Data Sources

Data from the three different data sources will be used to report on the NBHPP performance. All three sources are new and will begin to yield data in 2005.

D. Data Limitations

Data from the semi-annual report will be qualitative, and will require more intensive evaluation to extract information across awardees. The quality of the data depends to some extent on the skills of the data extractor. Data from the hospital assessment survey will be reported to the NBHPP in aggregate form for each state, and the information from individual hospitals will be hidden from the NBHPP.

4. National Vaccine Injury Compensation Program

A. General Description of the Source/System

The National Vaccine Injury Compensation Program (VICP) maintains a highly-controlled internal data system, which contains detailed case-specific data values for the over 10,265 claims filed (as of May 13, 2004). This data system includes payment information, as well as legal, epidemiological, medical, diagnostic information, and is used for often highly complex cross-linking data analysis.

B. Data Quality

This data source has met the VICP expectation by providing valid and reliable information for performance measurement purposes. Information contained in this data system have been reviewed and validated by the Office of the Inspector General (OIG), the General Accounting Office (GAO), the Congressional Budget Office, and Agency and Departmental independent actuarial contractors. In January 2001, the database conversion initiative referenced above was completed, which included a comprehensive data quality and integrity review, eliminating redundancies and finalizing a complete integration of all data tables.

C. Performance Information on Data Sources

There are limitations regarding some of the data in the data system, but not with the payment data. Some of the data are derived from claims and documentation filed by petitioners without verification by the VICP. Hardcopy Court decisions, judgments, and payment information is entered immediately as it becomes available into the database, and can be confirmed and validated for performance measures.

D. Data Limitations

Anyone can file a claim alleging a vaccine-related injury or death. Sometimes, these allegations have no merit and are eventually dismissed by the Court. Thus, no valid scientific conclusions can be drawn from the data on injuries related to specific vaccines. Additionally, the Access data system is highly complex, and usually requires a data contractor, or an individual with extensive training and experience, to run queries and/or produce reports that go beyond simple status reports or basic analysis.

Rural Health - Office of Rural Health Policy

1. Rural Health Outreach

A. General Description of the Source/System

The Rural Health Outreach Grant program is designed to support new and innovative models of health care in rural areas that lack essential health services. A major goal of the program is to promote collaboration among health care providers in rural areas through the creation of consortia among local providers.

To date, the data collected by the Office of Rural Health Policy on the Outreach program grantees includes the primary focus of the project (e.g. case management, consumer health education, emergency care, etc.), an estimate of the time spent on the service; the percent of the population groups served, a numeric estimate of the population mix (e.g. adults, children, elderly,

etc.), and information on project participants as well as other data. In FY 99 the Office revised the data collection form slightly for clarity and also added two questions, 1) to determine if the project serves an MUA or HPSA, and 2) to find out if the grantee is replicating a previously successful project. These efforts will provide short-term information on the program.

The grant period for the Outreach grants is three years, making long-range studies not possible. There has been little systematic information available about the near term effectiveness of alternative models of service delivery of consortia arrangements and their longer term sustainability. Over the past several years the Office has been developing a simple instrument that grantees would use to report on the numbers and demographics of the populations they serve. While long-term studies are not possible given the 3-year duration of grants, a 2002 study by the University of Minnesota found that 80 percent of grantees continued their projects beyond the Federal funding period.

2. Data Systems, Flex

A. General Description of the Source/System

The Medicare Rural Hospital Flexibility Program (Flex), managed by the Federal Office of Rural Health Policy (ORHP) is authorized at a level of $35 million per year to provide grants to States (47 grantees). These grants support the development of State rural health plans, facilitating conversion of appropriate small rural hospitals to Critical Access status, development of rural health networks, strengthening rural EMS operations, and improving the quality of care in rural facilities.

Data on the effectiveness of this program are obtained from two principal sources. First, an annual status report is required of grantees in which they report their accomplishments in applying grant dollars to promote the goals of the Flex program in their state. Second, and much more elaborate, ORHP has contracted with the Univ. of Minnesota to collaboratively track the progress of Flex. Both quantitative and qualitative measures are studied, and the global impact of the program on health care in rural America is assessed.

The second annual report has been completed and data-gathering for the third is well under way. Current quantitative data are maintained by the University of North Carolina.

B. Data Quality

Data are collected through telephone interviews, e-mail, survey instruments and site visits. They are organized and managed by the collecting research center and presented in easily usable form. Data are maintained on the Web. Since there is a finite universe of grantees, potential CAHs, and communities to support, the degree of completeness and accuracy of data is relatively

straightforward to ascertain. Some data can be cross-checked with CMS; the Flex Technical Assistance Center maintains data from all grantees which serves as a cross-check for many elements; often, verification is done directly with the source.

Additionally, visibility of the data on the Web site provides the continual opportunity to verify accuracy by knowledgeable users of the data.

C. Performance Information on Data Sources

The data collection project spans the life of this program, which was initiated in 1999. All parties endeavor to continuously improve the collection and quality of data, though no major revisions of the process have been deemed necessary or appropriate. The Tracking Team (research center representatives and ORHP) annually determines the scope of work for the tracking project to maintain program relevance of data collected and reported.

Data on networks, community development efforts, and quality improvement projects are being expanded; the same is true of the global impacts on rural health care by the program.

D. Data Limitations

Since the data are largely self-reported by grantees and small facilities, they are subject to minor inaccuracies from the source and to incomplete reporting. These limitations appear to be minor and are continuously addressed through the mechanisms described above in section B on data quality.

Family Planning

Family Planning Annual Report

All service grantees receiving funding under the Title X services program are required to submit annual data on the number of family planning users by selected demographic characteristics, contraceptive method adopted or used at the time of last visit, number of Pap tests, breast exams and STD tests, staffing profiles, and funding sources. The FPAR has been revised to capture more detailed information about services delivered. Data collection using the revised FPAR is scheduled to begin in January, 2005. The revised FPAR consists of 14 tables in which grantees report data on user demographic characteristics, user social and economic characteristics, primary contraceptive use, utilization of family planning and related health services, utilization of health personnel, and the composition of project revenues. The new data elements in the revised FPAR include information on:

- user health insurance coverage status,
- number of users with limited English proficiency (LEP),

- contraceptive use among male family planning users,

- number of abnormal Pap results and number of women referred for followup on the basis of their clinical breast exam,

- Chlamydia testing data by age and gender, and

The responsibility for the collection and tabulation of annual service data from Title X grantees rests with the Office of Population Affairs, which is responsible for the administration of the program. Reports are submitted annually on a calendar year basis (January 1 - December 31) to the regional offices. Grantee reports are tabulated and an annual report is prepared summarizing the regional and national data. The annual report describes the methodology used both in collection and tabulation of grantee reports, as well as the definitions provided by OPA to the grantees for use in completing data requests. Also included in the report are lengthy notes that provide detailed information regarding any discrepancies between the OPA requested data and what individual grantees were able to provide. All data inconsistencies and their resolution are noted in an appendix to the report. These are included for two reasons: (1) to explain how adjustments were made to the data, and how discrepancies affect the analysis and (2) to identify the problems grantees have in collecting and reporting data, in hope of improving the process.

PERFORMANCE MEASUREMENT LINKAGES

Budget

In the FY 06 HRSA budget, performance measurement is linked with every significant program element for which funding is requested. As required by statute, the HRSA budget proposals incorporate performance measures that attempt to gauge and identify the outcomes and benefits to be achieved by the implementation of the program increments. It is expected that the inclusion of performance measurements in annual funding requests will enable the Congress and Executive Branch policy-makers to assess the value and success of HRSA's programs in the context of national priorities and benefits to the American people.

Human Resources

One of the President's Government-wide reforms is delayering mangement levels to streamline organizations. To enhance the administration and operation of HRSA, HRSA has undertaken a Management Review which has assisted in the development and implementation of a Delayering Management and Streamlining Organizational Plan. This plan is improving government functions and efficiencies in operations.

Delayering Management and Streamlining Organizational Plan

The initial recommendations in HRSA's Delayering Management and Streamlining Organizational Plan are currently being implemented. Results are as follows:

- Created a citizen-centered Agency.
- Realigned Health Professions Programs into one Bureau and created a mission centered Primary Care Bureau. This consolidation is a citizen-centered effort that puts the full spectrum of HRSA's health professions' recruitment, training, loans, scholarship, and placement into one Bureau.
- Streamlined the Office of the Administrator (OA). This action makes the OA smaller and enables management to stay focused on streamlining, reducing the time it takes to make decisions and take actions, improve business processes, and reshape the composition of HRSA's workforce. This also places vital crosscutting efforts close to the Bureaus that provide services directly to the Nation.
- Consolidation of Legislative and Public Affairs staff within HRSA, with appropriate reporting relationships to OS.
- Completed an Agency Reorganization Plan that was announced in the Federal Register on January 7, 2003 which focused on grants management activities.

- During FY 04, a substantial Agency restructuring package was published in the Federal Register on September 21, 2004. This eliminated a variety of levels, created an Office of Federal Assistance Management which consolidated the grants activity within HRSA, and realigned administrative and financial management activities in the Office of Administration and Financial Management.
- Budget/Financial Management staff: HRSA completed the restructuring of its budget functions, including formulation, execution and resources analysis.
- Office of Performance Review: The Office of Performance Review replaces the Office of Field Operations. The mission is to enhance the performance of HRSA-supported programs within the States and communities.
- The Office of Human Resources Development is currently being consolidated across the Department.

Strategic Workforce Planning

By FY 06, 37 percent of HRSA's civilian workforce and 49 percent of HRSA's Commissioned Corps workforce will be eligible to retire. In response, the HRSA Scholars Program (HSP) was launched. The program targets entry-level positions in the GS-5-7, and 9 grade levels. It has components for workforce planning, outreach and recruitment, hiring, recruiting incentives, training, developing and mentoring, and evaluation. Additionally, HRSA is a full participant in the HHS Emerging Leaders Program.

Cost Accounting

HRSA produces financial statements for each of its six major GPRA program areas: Primary Care, Health Professions, Maternal and Child Health, HIV/AIDS, Healthcare Systems Bureau and Rural Health. In addition, a statement is produced for the Family Planning program, which is financially under HRSA but is located in another organization. The statements report financial position and the net cost of operations and are based on accounting records maintained for HRSA by the Program Support Center.

Cost accounting is an important tool for decision-makers in assessing the value and potential of budget increments and program initiatives.

Information Technology

A significant management priority is to strengthen the use of information technology and improve the data systems of the agency. HRSA has made great progress in improving its information technology, investing in workforce training and automating functions that support the core mission of the agency. A high priority will be given to Critical Infrastructure Protection (CIP) to meet the goal of a reliable, interconnected and secure information system as mandated by Federal directives.

Additional priority will be given to electronic commerce, moving toward the goal of providing electronic transactions for all government business, procurement, and the range of dealing with grantees including applications, meeting reporting requirements, and improved data systems.

Program Evaluation

The purposes of the Health Resources and Services Administration (HRSA) evaluation program are to enhance strategic and performance planning and reporting, strengthen budget and legislative development, and improve programs and policies. HRSA's evaluation priorities are to (1) develop and support performance measurement, (2) evaluate program effectiveness and impact, (3) assess and monitor program implementation, and (4) conduct crosscutting policy analysis and environmental assessments. Evaluations are funded by a combination of evaluation set-aside and program funds.

Performance measurement includes technical assistance and training to strengthen the agency's capacity to respond to the requirements of the Government Performance and Results Act (GPRA), and continuing enhancement of HRSA's ability to monitor program performance over time.

FY 2004 AND FY 2005 ONE-PAGE PART SUMMARIES

FY 2004

Health Centers Program
Maternal and Child Health Block Grant Program
Ryan White CARE Act Program (Titles I-IV combined)
National Health Service Corps Program
Health Professions Program (Most of Titles VII and VIII combined)
Nursing Education Loan Repayment and Scholarship Program

FY 2005

Rural Health Activities (All programs)
National Bioterrorism Hospital Preparedness Program
Children's Hospitals Graduate Medical Education Payment Program

Program: *Health Centers*

Agency: *Department of Health and Human Services*

Bureau: *Health Resources and Services Administration*

Rating: *Effective*

Program Type: *Competitive Grant*

Last Assessed: *2 years ago*

Key Performance Measures from Latest PART	Year	Target	Actual
Long-term Measure: Rate of low weight births among health center patients (New measure)	1999		7.37%
	2000		7.14%
	2001		7.13%
	2006	6.53%	
Annual Measure: Number in millions of those served by health centers who are below 200% of poverty and the national percentage of all people below 200% of poverty served by the program (New measure)	2001		9.1/11%
	2004	11.8/14%	
	2005	12.0/15%	
	2006	14.1/16%	
Long-term Measure: Number of new and expanded health center sites and millions of additional people served	2002	260/1.3	302/1.04
	2005	772/3.7	
	2006	1,350/6.1	

Recommended Follow-up Actions	Status
Proposes an additional $150 million above the 2003 Budget for the President's health center initiative to expand and create 1,200 health center sites and increase the service capacity by 6.1 million patients by 2006.	Completed
Proposes an additional $20 million increase to pay health center malpractice claims, a legislative proposal to cap non-economic awards, and a proposal for the HHS Inspector General to improve oversight of health center malpractice coverage.	Action taken, but not completed

Update on Follow-up Actions:

Program continues to struggle to estimate liabilities to the government that arise from malpractice coverage extended to health center employees under the Federal Tort Claims Act.

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
1,617	1,734	2,038

Program: *Maternal and Child Health Block Grant (MCHBG)*

Agency: *Department of Health and Human Services*

Bureau: *Health Resources and Services Administration*

Rating: *Moderately Effective*

Program Type: *Block/Formula Grant*

Last Assessed: *2 years ago*

Key Performance Measures from Latest PART	Year	Target	Actual
Long-term Measure: National rate of maternal deaths per 100,000 live births	1980		9.4
	1999		8.3
	2008	8	
Long-term Measure: National rate of infant deaths per 1,000 live births	2000		6.9
	-		
	2006	6.7	
	2008	6.5	
Annual Measure: National rate of illness and complications due to pregnancy per 100 deliveries	1998		31.2
	1999		31.4
	2004	26	

Recommended Follow-up Actions	Status
Propose an increase of $19 million above the 2003 Budget to support the program's strong performance and to ensure continued efforts to improve the health of all mothers and children.	Completed

Update on Follow-up Actions:

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
730	724	724

Program: *Ryan White*

Agency: *Department of Health and Human Services*

Bureau: *Health Resources and Services Administration*

Rating: *Adequate*

Program Type: *Block/Formula Grant*

Last Assessed: *2 years ago*

Key Performance Measures from Latest PART	Year	Target	Actual
Long-term Measure: National rate of deaths per 100,000 people due to HIV infection	1994		15.4
	1999		5.4
	2010	3.6	
Long-term Measure: National proportion of people living with HIV receiving primary medical care and treatment	2000		33%
	2010	50%	
Annual Measure: Number of persons who learn their serostatus from Ryan White CARE Act-funded programs	2000		352,283
	2004	2% increase	
	2005	2% increase	
	2006	2% increase	

Recommended Follow-up Actions	Status
Increase funding for the Ryan White AIDS Drug Assistance Program, +$100 million, so that the program can purchase drug treatments for an additional 9,200 persons.	Completed
Develop recommendations and legislative strategies in preparation for the 2005 reauthorization, to find more meaningful ways of allocating drug treatment funding and standardizing eligibility across states.	Action taken, but not completed

Update on Follow-up Actions:

HRSA's efforts to develop recommendations and legislative strategies in preparation for the 2005 reauthorization have been ongoing, and important steps towards completing this objective have been taken.

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
2,045	2,073	2,083

Program: *National Health Service Corps*

Agency: *Department of Health and Human Services*

Bureau: *Health Resources and Services Administration*

Rating: *Moderately Effective*

Program Type: *Competitive Grant*

Last Assessed: *2 years ago*

Key Performance Measures from Latest PART	Year	Target	Actual
Long-term Measure: Patients served through the placement and retention of NHSC clinicians.	2005	4.84 M	
	2006	4.94 M	
	2010	5.33 M	
Long-term Measure: Patients served through NHSC placements and retention, as well as other sources (Communities with a compelling need for providers that do not receive a NHSC clinician may more easily recruit a provider from another source as a result of increased exposure from the program.	2010	7.08 M	
Annual Measure: Average Health Professional Shortage Area (HPSA) score of areas receiving NHSC clinicians (HPSA scores gauge provider shortages and whether the program targets communities well.(New measure)	2004	12.1	
	2005	12.7	
	2006	13.0	

Recommended Follow-up Actions	Status
The Administration proposes $23 million above the 2003 Budget, a 12% increase above 2003 and 46% increase above 2002, to place more doctors and other clinicians in areas facing a shortage of health providers.	Completed
The Administration will serve areas of greatest need by better targeting NHSC placements and taking into account foreign physicians who serve in areas with a shortage of health providers through visa waivers.	Action taken, but not completed
The Administration will support more underrepresented minorities and other students and health professionals from disadvantaged backgrounds through the program by enhancing recruitment efforts.	Action taken, but not completed

Update on Follow-up Actions:

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
170	131	127

Program: *Health Professions*

Agency: *Department of Health and Human Services*

Bureau: *Health Resources and Services Administration*

Rating: *Ineffective*

Program Type: *Competitive Grant*

Last Assessed: *2 years ago*

Key Performance Measures from Latest PART	Year	Target	Actual
Long-term Measure: Proportion of persons who have a specific source of reliable, continuing healthcare (New measure)	2001		86%
	2010	96%	
Long-term Measure: Proportion of health professionals completing funded programs that are serving in medically underserved communities (These communities have too few primary care physicians, higher infant mortality rates, lower family incomes and often an older population.) (New measure)	2010	40%	
Annual Measure: Proportion of health professionals completing Health Professions funded programs who are underrepresented minorities and/or from disadvantaged backgrounds (New measure)	2004	40%	
	2005	43%	
	2006	44%	

Recommended Follow-up Actions	Status
Proposes to continue the phase-out of most health professions grants consistent with the 2003 Budget and direct resources to activities that are more capable of placing health care providers in medically underserved communities.	Completed
Proposes to redirect $34 million from advanced education nursing to basic nursing activities, including $12 million to the Nursing Education Loan Repayment program for loan repayment awards and newly authorized scholarships to increase the supply of practicing nurses.	Completed

Update on Follow-up Actions:

FY 2004 Enacted level was $409 million, $327 million above the FY 2004 President's Budget.

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
409	416	129

Program: *Nursing Education Loan Repayment and Scholarship*

Agency: *Department of Health and Human Services*

Bureau: *Health Resources and Services Administration*

Rating: *Adequate*

Program Type: *Competitive Grant*

Last Assessed: *2 years ago*

Key Performance Measures from Latest PART	Year	Target	Actual
Long-term Measure: Number of individuals enrolled nationwide in nurse education and training programs compared with 2004 (Increasing enrollment in these programs can help prevent or reduce a shortage of nurses in the health care system.	2010	+10%	
Annual Measure: Percentage of program participants that serve in nursing homes, hospitals that provide care to a disproportionate number of low-income patients under Medicare and Medicaid, and public health departments and clinics compared with 2003.	2004	65%	
	2005	75%	
	2006	85%	
Annual Measure: Percentage of participants who remain employed at the health facility for at least a year after completing their federal service contract.	2004	+10%	

Recommended Follow-up Actions	Status
Proposes an increase of $12 million above the 2003 President's Budget for loan repayment awards and newly authorized scholarships by redirecting resources from advanced nursing education activities that do not increase the supply of practicing nurses.	Completed
Will maximize the impact of the program by targeting providers to nursing homes, hospitals that serve a disproportionate number of low-income patients under Medicare and Medicaid, and other priority health facilities.	Action taken, but not completed
Will conduct an evaluation of the program's impact, develop outcome measures, and begin to track performance against newly adopted benchmarks by developing a baseline and refining performance targets.	Action taken, but not completed

Update on Follow-up Actions:

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
27	31	31

Program: *Rural Health Activities*

Agency: *Department of Health and Human Services*

Bureau: *Health Resources and Services Administration*

Rating: *Adequate*

Program Type: *Competitive Grant*

Last Assessed: *1 year ago*

Key Performance Measures from Latest PART	Year	Target	Actual
Long-term Measure: Percentage of critical access hospitals with positive operating margins	1999	Baseline	17%
	2010	35%	
Long-term Measure: Proportion of rural residents of all ages with limitation of activity caused by chronic conditions	2000	Baseline	14.6%
	2010	13.9%	
Annual Measure: Number of people served by outreach grants	2002	-	673,700
	2005	682,253	
	2006	689,075	
	2007	695,966	

Recommended Follow-up Actions	Status
The Administration will continue to monitor progress toward data gathering for the newly developed long-term and annual performance goals.	Action taken, but not completed

Update on Follow-up Actions:

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
147	147	33

Program: *Hospital Preparedness Grants*

Agency: *Department of Health and Human Services*

Bureau: *Health Resources and Services Administration*

Rating: *Results Not Demonstrated*

Program Type: *Block/Formula Grant*

Last Assessed: *1 year ago*

Key Performance Measures from Latest PART	Year	Target	Actual
Long-term Measure: Percentage of hospital regions that have achieved a surge capacity of 500 persons per million in all hospital regions, for response to terrorism and other public health emergencies.	2005	75%	
	2006	85%	
	2007	95%	
	2008	100%	
Annual Measure: Percentage of awardees that have implemented regional plans and meet all major milestones established for all of the HRSA priority areas to meet the goal of a surge capacity of 500 persons per million population.	2005	75%	
	2006	85%	
	2007	95%	
	2008	100%	
Annual Measure: Percentage of awardees that will demonstrate their ability to secure and distribute pharmaceutical resources required in emergency events, including coordinated caches of pharmaceuticals from metropolitan medical response systems, sufficient to treat 500 persons per million population, as certified to by HRSA.	2005	75%	
	2006	85%	
	2007	95%	
	2008	100%	

Recommended Follow-up Actions	Status
The Administration will work with State and local representatives to ensure that performance information will be available to determine when acceptable preparedness has been demonstrated, and to target assistance for those regions that are not adequately prepared.	Action taken, but not completed
The Administration has established outcome oriented goals and targets for surge capacity and preparedness.	Action taken, but not completed

Update on Follow-up Actions:

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
515	491	483

Program: *Children's Hospitals Graduate Medical Education Payment*

Agency: *Department of Health and Human Services*

Bureau: *Health Resources and Services Administration*

Rating: *Adequate*

Program Type: *Block/Formula Grant*

Last Assessed: *1 year ago*

Key Performance Measures from Latest PART	Year	Target	Actual
Long-term Measure: Percent of hospitals with verified bed counts, case-mix index, and number of discharges. This measure is contingent upon the results of pilot studies to be completed in FY2006.	2008	100%	
Annual Measure: Percent of payments made on time	2003	100%	100%
	2004	100%	100%
	2005	100%	
	2006	100%	
Annual Measure: Percent of hospitals with verified FTE resident counts and caps	2003	100%	100%
	2004	100%	100%
	2005	100%	
	2006	100%	

Recommended Follow-up Actions	Status
Contingent upon the results of pilot studies, will verify 100% of hospitals' reported data on bed counts, case-mix index, and number of discharges by FY 2008.	Action taken, but not completed
The program is required by statute to pay hospitals on a bi-weekly basis. The Administration will examine whether the program can improve efficiency by paying hospitals on a quarterly basis.	Action taken, but not completed

Update on Follow-up Actions:

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
303	298	200

FY 2004 AND FY 2005 PART RECOMMENDATIONS

FY 2004

Health Centers Program
Maternal and Child Health Block Grant Program
Ryan White CARE Act Program (Titles I-IV combined)
National Health Service Corps Program
Health Professions Program (Most of Titles VII and VIII combined)
Nursing Education Loan Repayment and Scholarship Program

FY 2005

Rural Health Activities (All programs)
National Bioterrorism Hospital Preparedness Program
Children's Hospitals Graduate Medical Education Payment Program

Health Resources and Services Administration
Health Centers Program, Bureau of Primary Care

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Program has struggled to project liabilities to the government that arise from malpractice coverage for health center employees under the Federal Tort Claims Act (FTCA). FTCA should have a means to estimate future obligations.	Completed		Completed. The Princeton Insurance Company, a HRSA contractor, engaged an actuarial firm to estimate ultimate loss projections and annual payouts for the Health Center program for FY 2003, 2004 and 2005. The HRSA/BPHC expects to repeat the actuarial study on a regular basis to meet the need of projecting loosses for the FTCA program.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
NA		BPHC Division of Clinical Quality	Suzanne Feetham, Amy Taylor, Felicia Collins

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Efforts to increase collaboration with other programs	Ongoing	Y	HRSA collaborated with CMS in developing regulations for the Medicare Modernization Act of 2003 regarding 340B drug pricing. SAMHSA/HRSA are identifying linkages/integration mechanisms to increase access of primary care patients to mental health/substance abuse services and mental health consumers/recovering persons to primary care. SAMHSA was instrumental in developing Depression Collaborative and continues their involvement. HRSA/SAMHSA are exploring feasibility of adding substance abuse outcomes to core measures of a comprehensive primary care Collaborative.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
NA			

Health Resources and Services Administration

Title V Maternal and Child Health Block Grant

		Lead Organization Maternal and Child Health Bureau	**Lead Official** Peter van Dyck
Recommendation	**Completion Date**	**On Track? (Y/N)**	**Comments on Status**
Carry out evaluation of the Block Grant program.	09/30/04	Y	Completed

Health Resources and Services Administration/HIV/AIDS Bureau

Ryan White Comprehensive AID Resource Emergency (CARE) Act (Titles 1-IV)

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
The program's performance plan should include efficiency measures and targets that address issues that are directly linked to the mission of the program.	Completed	Y	Current Status: Completed. The program developed the following efficiency measure: "Increase by 2% annually the amount of savings by State ADAPs' participation in cost-savings strategies on medications." This measure is included in the program's plan/report on performance measures.

Next Milestone	Next Milestone Date	Lead Organization	Lead Official
None	N/A	HIV/AIDS Bureau	Deborah Parham Hopson

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
The program needs to implement mechanisms to identify problems or make corrective fixes prior to the mismanagement of resources in those instances when grantees or sub-grantees don't use their funds according to statute.	Ongoing	Y	Current Status: HAB has identified problems and is making corrective fixes to assure grantees use funds appropriately through improved grantee monitoring, additional resources, and enhanced compliance activities. The program implemented an evaulation effort entitled "Improving the Monitoring of Ryan White CARE Act Title 1 and Title II Sub-Grantee Performance," with a resultant consensus document indentifying TA areas, including **fiscal accountability**. A 2nd consultation with grantees was held at the RWCA All Titles Meeting August 23-26 and resulted in an evaluation to obtain feedback from grantees on selected workshops offered at the conference. The evaluation was part of the follow-up to implementation of HAB's Training and Technical Assistance Response Plan to assist grantees improve the monitoring of subgrantee performance. A 3rd consultation is planned in Spring 2005 with a core group of grantees that met in the beginning of the project to evaluate the effectiveness of technical assistance provided and recommmendations for future needs.

Next Milestone	Next Milestone Date	Lead Organization	Lead Official
1.3rd Consultation Meeting with core group pf grantees to evaluate effectiveness of TA & provide recommendations	Spring 2005	HIV/AIDS Bureau	Deborah Parham Hopson
2. Development of web-based ADAP Quarterly Report	January 2005-Completed	HIV/AIDS Bureau	
3. Set-aside evaluation study: -- Implement Response Plan	Ongoing through September 2005	HIV/AIDS Bureau	
4. Enhanced monitorning of contracts, fiscal reports, project reports and site visit repors by HAB	Ongoing	HIV/AIDS Bureau, HRSA, OPR & other Federal oversight officials	

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Develop recommendations and legislative strategies in preparation for the 2005 reauthorization to find more meaningful ways of allocating drug treatment funding and standardizing eligibility across states.	Ongoing	Y	Current Status: A consultation on Maintaining and Improving Access to HIV-Related Drug Therapies was conducted on January 24, 2003. The meeting was structured to identify a range of options that HRSA's HIV/AIDS Bureau (HAB) could consider in addressing the difficulties in assuring access to HIV-related drug therapies. A discussion paper for grantees on ethical considerations in establishment of ADAP waiting lists was identified as a short-term activity at the consultation meeting. A long-term activity was identified as a Policy Study and reauthorization activities. HAB commissioned a Policy Study conducted by the George Washington University on the "AIDS Drug Assistance Program: Assessing the Use and Distribution of Scarce Resources," completed in August 2004. Study findings and themes identified by HAB for reauthorization will be incorporated into activities that will help address allocation of drug treatment funding and standardizing eligibility across states. As a result of the National partners meeting, the ADAP Ethics discussion paper will be used as an internal document in developing TA activities for grantees that have ADAP waiting lists or at risk for having a waiting list. HRSA/HAB continues its participation with the OS Reauthorization Work Group to develop policy and legislative recommendations for the upcoming 2005 RWCA Reauthorization.

Next Milestone	Next Milestone Date	Lead Organization	Lead Official
1. Internal Review of Monograph on "AIDS Drug Assistance Program: Assessing the Use and Distirbution of Scarce Resources"	1st Quarter CY 2005	HIV/AIDS Bureau	Deborah Parham Hopson
2. Policy meeting to review TA, training and programmatic enhancments from report findings	2nd Quarter CY 2005	HIV/AIDS Bureau	
3. Provision of staff assistance to the OS in preparation for 2005 Reauthoriation	Ongoing	HIV/AIDS Bureau	

Health Resources and Services Administration/Bureau of Health Professions
National Health Service Corps

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Provide outcome information for newly adopted measures.	Completed, 9/02	Y	Completed. Baseline data provided in the Performance Plan.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
N/A		BHPR	Dr. Donald Weaver

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Improve efficiency through greater flexibility in the allocation of funds between scholarships and loans.	Completed, 10/03	Y	Completed. Program allocated a larger proportion of funds to loan category.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
N/A		BHPR	Dr. Donald Weaver

Health Resources and Services Administration/Bureau of Health Professions
Health Professions and Nursing Education & Training Programs

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Clarify the purpose of the program	10/01/05	Y	Draft Strategic Plan is available.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
All Grantee meeting planned for Spring 2005	06/30/05	BHPR	CAPT Kerry Nesseler

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Develop common goals, outcome measures, and reporting. Use performance data to improve outcomes.	10/01/05	Y	A draft measure set has been completed. The measure set will be refined and data requirements identified over the next few months.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
Finalize common performance measures;	03/30/05	BHPR	Dr. Janet Schiller
Identify data requirements.	06/30/05	BHPR	Dr. Janet Schiller

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Increase activities to support and promote basic nursing.	Completed, 9/03		Completed. By adding new program components such carrer ladder component.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
N/A			Dr. Denise Geolot

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Develop baseline data for Long Term Goals #2 and #3	12/30/04	Y	Completed.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
N/A			

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Status of comprehensive, independent evaluations	03/30/05	Y	Descriptive evaluation of Title VII underway
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
Descriptive evaluation of Title VII ongoing.	03/30/05	BHPR	Director, National Center for Workforce Analysis

Health Resources and Services Administration/Bureau of Health Professions
Nursing Education Loan Repayment Program

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Target resources to critical shortage facilities.	Completed, 9/03	Y	Completed. A "preference" for applicants from critical shortage areas was added to award criteria.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
N/A		BHPR	Dr. Denise Geolot

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Conduct evaluations	03/30/08	Y	Phase 1 evaluation report in clearance
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
Clear Phase 1 evaluation report; submit to Congress	2/1/05	BHPR	Dr. Denise Geolot
Work on Phase 2 report	3/30/06		Dr. Denise Geolot

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Improve measurement of key outcomes.	Completed, 1/03	Y	Completed. See PART and other measures in Performance Plan.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
N/A	NA	BHPR	Dr. Denise Geolot

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Provide baseline data for Long-Term Goals #1, #2, #3	Completed, 8/04	Y	Completed. See Performance Plan
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
N/A	NA	BHPR	Dr. Denise Geolot

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Efforts to make performance data available to the public.	03/30/05	Y	Evaluation report to be put on web still in clearance
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
Place FY 03 Evaluation Report on Web	03/30/05	BHPR	Dr. Denise Geolot
Place HRSA FY 04 Performance Report on Web	06/30/05	BHPR	Dr. Denise Geolot

Health Resources and Services Administration
Rural Health Activities

Recommendation I	Completion Date	On Track? (Y/N)	Comments on Status
Continue to monitor progress towards data gathered for newly developed long-term and annual performance goals.	Ongoing	Y	A plan is being developed to enhance our data collection and reporting activities on a regular basis.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
1. Regularly document and report interim data on long-term and annual performance goals and other related measures for the program.	Ongoing	ORHP	Tom Morris

Recommendation II	Completion Date	On Track? (Y/N)	Comments on Status
Articulate overarching program long-term goals and annual program performance measures and other related goals to all partners, grantees, contractors and other entities to achieve a unified commitment towards the goals.	Dec. 05	Y	An office plan has been developed for sharing the program information and the process is in place to begin meeting the first milestone. A comprehensive program strategic planning process is underway. ORHP has communicated its long-term goals and annual performance measures and other related goals on all of its program listserves. In addition, ORHP has posted its long-term goals and annual performance measures on its website.
Next Milestones	**Next Milestone Date**	**Lead Organization**	**Lead Official**
1. Finalize a program strategic plan that incorporates program long-term goals and annual program performance measures and other related goals and post the plan on the program listserves and website.	May, 05		**Jennifer Riggle**
2. Include relevant program goals in all RFP's, contracts, cooperative agreements and grant guidances.	May, 05		

Health Resources and Services Adminstration/Healthcare Systems Bureau/Heath Systems Bureau

Bioterrorism Hospital Preparedness Program

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Program will work with State and local representatives to ensure that performance information will be available to determine when acceptable preparedness has been demonstrated, and to target assistance for those regions that are not adequately prepared.	Completed	Yes	Completed. Program has worked with States and local representatives to establish three mechanisms to collect and share performance information, including semi-annual progress reports, annual continuation applications, and a hospital preparedness assessment survey
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
N/A			

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
The program is effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly.	TBD	--	An assessment will be made on whether to recommend revising the funding formula once the FY05 funding level is received
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
An assessment will be made on whether to recommend revising the funding formula based on the FY05 funding level	04/01/05	DHCEP/NBHPP	Rick Smith

Health Resources and Services Administration/Bureau of Health Professions
Children's Hospitals Graduate Medical Education Payment Program

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
100 percent assessment of full-time equivalent (FTE) resident counts including the "cap"	Completed	Y	CHGME PP completed this assessment in FY 2003 and will complete the FY 2004 FTE assessment for the FY 04 children's hospitals applications in 06/30/04
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
The program will continue to conduct the assessment of the FTE resident counts on a yearly basis	Ongoing	BHPR	Dr. Ayah E. Johnson

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Assess the feasibility of verifying all data provided by hospitals that affect payments: bed counts, case mix index, and number of discharges.	09/30/07	Y	Assessment methodology developed.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
Bed count pilot study	09/30/05	BHPR	
Contract for pilot study on discharges, case mix	03/30/05		Dr. Ayah E. Johnson
Complete pilot on bed counts	09/30/05		
Complete pilot on discharges, case mix	09/30/06		
Cost-benefit analysis of bed counts, discharges, case mix	09/30/07		

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Examine whether program efficiency can be increased by making payments quarterly rather than biweekly.	09/30/05	Y	Completed Analysis. No changes in payments schedule because statutory requirements is for 26 biweekly payments.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
Propose legislative change depending on key parties.	06/30/05	BHPR	Dr. Ayah E. Johnson

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Status of comprehensive, independent evaluations	TBD	Y	Not previously identified as a recommendation.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
Not previously identified as a recommendation. Issue is currently under consideration.	TBD	BHPR	Dr. Ayah E. Johnson

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Efforts to make performance data available to the public.	03/30/05	Y	Performance data is available to the public through the publication of the GPRA report
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
Place performance measures on program web site	03/30/05	BHPR	Dr. Ayah E. Johnson
FY 04 Performance Report on HRSA web site	3/30/05		

MEASURES AND RESULTS SUMMARY TABLE

Year	Total Measures in Plan*	Outcome Measures	Output Measures	Efficiency Measures	Results Reported	Target Met	Target Not Met
2002	65	48	14	3	61	42	19
2003	76	50	19	7	64	41	23
2004	109	69	26	14	33	23	10
2005	119	67**	28	24	NA	NA	NA
2006	119	70**	26	23	NA	NA	NA

* Measures with targets for specified year. For years prior to 2006, the number of measures differs from the number originally shown in that year's plan because of subsequent additions, deletions and consolidations of measures.

** The addition of FY 05 and FY 06 PART output measures and new efficiency measures bring the relative proportion of outcome measures down somewhat as compared to previous years.

Research Coordination Council:

Coordination of Planned FY 2006 RD & E Activities

The Health Resources and Services Administration (HRSA) coordinates its RD & E activities in consultation with other DHHS agencies, collaborates on research and evaluation projects, and jointly funds surveys. Through participation on the Research Coordination Council (RCC), HRSA assures that its research, demonstration and evaluation activities align with the Secretary's and President's priority research themes. Traditionally, HRSA's research and evaluation activities have been coordinated with those of other DHHS agencies through agency membership on HRSA's research agenda setting and review committees and a number of jointly funded research activities. However, HRSA's participation in the RCC has helped to identify additional areas of joint interest and opportunities for collaboration. Some of these activities pre-date the FY 2006 budget submission, but others are new initiatives anticipated for FY 2006 and beyond. These activities address recommendations made by the Research Coordinating Council's workgroups and are summarized below with specific examples from HRSA's Bureaus and the Office of Rural Health Policy (ORHP).

- The Research Coordinating Council recommended, in general, that all DHHS agencies be encouraged to continue and expand research collaborations with IHS. The Ryan White HAB SPNS program collaborates with the Indian Health Service, AHRQ, the CDC, and NIMH on research projects related to integrated HIV care for Native Americans, information technology to improve HIV care, and prevention initiatives in primary care. The IHS is involved in research priority setting with the ORHP's Rural Health Research Centers, and is involved with the Maternal and Child Health Bureau (MCHB) in establishing a partnership to address the health risk behaviors and health status of Native American youth. In addition, ORHP's new Rural Research Grant program will provide individual researchers with up to $150,000 to conduct policy oriented rural health services research on topics which also address the health care needs of special populations, including American Indians and Alaska Natives. In addition, IHS is working with the HIV/AIDS Bureau (HAB) to develop guidance for grant applications focused on the provision of integrated HIV services to Native American and Alaskan Native populations in primary care settings.

- Representatives of NIH participate in the review of grant applications and in monitoring individual grant program results in the Organ Donation and Transplantation Program.

- The Health Workgroup recommended that DHHS devote more resources to strategies for eliminating health disparities. HRSA's HIV/AIDS Bureau (HAB) is now working with the Office of HIV/AIDS Policy and the Office of Minority Health to apply the RARE (Rapid Assessment and Response Evaluation) methodology to community-based planning efforts for the elimination of disparities in HIV care.

- The Health Workgroup also called for better coordination between the rural health and the health disparities communities within DHHS. The ORHP invites representatives of AHRQ, ASPE, the CDC, CMS, IHS, NIMH, and SAMHA to participate in biannual meetings of its Rural Health Research Center Directors to ensure that their research interests are reflected in the centers' research projects. Currently, the Rural Health Research Center (RHRC) program and the Rural Research Grant program are the only health services research programs dedicated entirely to producing policy relevant research on health care in rural areas.

- The Health Workgroup recommended better coordination of Agencies' efforts to attract underrepresented minorities to the health care and health research fields. MCHB, in cooperation with the Office of Minority Health, is working to implement a plan developed by the Expert Panel on Minority Researchers to increase minority researchers in the field of maternal and child health.

- The Special Programs Bureau Bioterrorism Hospital Preparedness Program provided funds to AHRQ to carry out a research solicitation related to the priority elements of the Hospital Preparedness Program. There remains a close interaction between the two agencies in this area.

- The Science Workgroup recommended continued collaboration on clinical prevention efforts. HAB is collaborating with the CDC and NIMH to develop models of care that address primary prevention of HIV/AIDS and secondary re-infection for use in clinical primary care settings. HAB also is working with the Office of Family Planning to develop demonstrations for getting women at risk of HIV into care early.

- HRSA also coordinates with other agencies in conducting surveys, provides briefings on its research findings, and partners on secondary analyses of survey data.

HRSA will continue to work with the RCC to ensure coordination of RD&E efforts as we move into FY 2006 and beyond. Provided below is a table which reflects the FY 2006 Budget Request by priority area:

Research Coordination Council
(Dollars in Thousands)

Research Priority	FY 2005	FY 2006
I. Working Toward Independence	--	--
II. Rallying the Armies of Compassion	800	2,315
III. No Child Left Behind	744	--
IV. Promoting Active Aging and Improving Long-Term Care	--	--
V. Protecting and Empowering Specific Populations	--	--
VI. Helping the Uninsured and Increasing Access to Health Insurance	6,625	6,000
VII. Realizing the Possibilities of 21st Century Health Care	19,900	21,381
VIII. Ensuring Our Homeland is Prepared to Respond to Health Emergencies	1,000	1,000
IX. Understanding Health Differences and Disparities - Closing the Gaps	22,973	19,670
X. Preventing Disease, Illness, and Injury	6,015	8,742
XI. Agency - specific Priorities	2,720	2,700
Total RD&E	$60,777	$61,808

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Health Education Assistance Loans

FY 2006 Budget	Page No.
Appropriation Language	532
Amounts Available for Obligation	533
Summary of Changes	535
Budget Authority by Activity	535
Budget Authority by Object	535
Salaries and Expenses	537
Authorizing Legislation	538
Appropriation History Tables	539
Justification:	
A. General Statement	541
B. Health Education Assistance Loan Program	542

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Health Education Assistance Loan Program

Such sums as may be necessary to carry out the purpose of the program, as authorized by title VII of the Public Health Service Act, as amended. For administrative expenses to carry out the guaranteed loan program, including section 709 of the Public Health Service Act [3,270,000] *$2,916,000.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Liquidating Account (SLIA)

Amounts Available for Obligation

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Estimate
Appropriation	$4,000,000	$4,000,000	$4,000,000
Collections:			
Repayments/Recoveries	21,350,000	14,000,000	14,000,000
Total available	25,350,000	24,000,00	24,000,000
Total claims	-15,062,000	-18,000,000	-18,000,000
Sweep-up to Treasury	10,288,000	---	---

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

HEAL Program and Financing Accounts

Amounts Available for Obligation

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Estimate
Balance, start of year	$249,176,000	$205,667,000	$133,215,000
Appropriation	3,353,000	3,244,000	2,916,000
Collections:			
Subsidy	26,413,000	---	---
Upward Re-estimate	808,000	6,732,000	---
Downward Re-estimate	-37,720,000	-39,897,000	---
Interest	-9,960,000	-14,319,000	-14,319,000
Repayments/Recoveries	5,232,000	3,752,000	4,283,000
Total collections	-15,227,000	-43,732,000	-10,036,000
Total available	237,302,000	165,179,000	126,095,000
Claims:			
Death and disability	-371,000	-377,000	-372,000
Defaults	-27,911,000	-28,343,000	-27,960,000
Total claims	-28,282,000	-28,720,000	-28,332,000
Administrative Expenses	-3,353,000	-3,244,000	-2,916,000
Ending balance	$205,667,000	$133,215,000	$94,847,000

SUMMARY OF CHANGES

Discretionary Appropriation:

Decrease:	FTE	Budget Authority
2005 HEAL Program Account	17	$3,244,000
2006 HEAL Program Account	17	2,916,000
Total Change	–	-$328,000

Budget Authority by Activity
(Dollars in thousands)

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Estimate
Liquidating Account SLIA	$4,000,000	$4,000,000	$4,000,000
HEAL Program Account:			
Administrative Expenses	$3,353,000	$3,244,000	$2,916,000

Budget Authority by Object
Liquidating Account (SLIA)

Object Class (42.0)	FY 2005 Appropriation	FY 2006 Estimate	Increase or Decrease
Investments and loans	$4,000,000	$4,000,000	—

Budget Authority by Object
Program Account

	FY 2005 Appropriation	FY 2006 Estimate	Increase or Decrease
Full-time equivalent employment 1/	17	17	---
Average GS Grade	13.7	13.7	---
Average GS Salary	$90,865	$90,865	---

1/ Includes 7 FTEs for the Office of HEAL Default Reduction.

Personnel compensation:			
Full-time permanent	$1,496,000	1,575,000	+79,000
Other than full-time perm	48,000	51,000	+3,000
Other personnel comp	27,000	28,000	+1,000
Total personnel comp	1,571,000	1,654,000	+83,000
Personnel benefits	309,000	325,000	+16,000
Subtotal Pay Costs	1,880,000	1,979,000	+99,000
Travel			
Transportation of things	600	600	---
Rental payments to Others	426,000	426,000	---
Communications, utilities, and miscellaneous charges	88,000	88,000	---
Printing	500	500	---
Other Contractual Services:			
Other services	199,000	100,000	-99,000
Purchase of goods and services from other Government accounts	619,000	291,000	-328,000
Operation and Maintenance of Equipment	8,000	8,000	---
Subtotal Other Contractual Services	1,341,000	914,000	-427,000
Supplies and materials	2,000	2,000	---
Equipment	21,000	21,000	---
Subtotal Non-Pay Cost	1,364,000	937,000	-427,000
Total Budget Authority	3,244,000	2,916,000	-328,000

Salaries and Expenses
Program Account

	FY 2005 Appropriation	FY 2006 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$1,496,000	1,575,000	+79,000
Other than full-time perm (11.3)	48,000	51,000	+3,000
Other personnel comp (11.5)	27,000	28,000	+1,000
Total personnel comp (11.9)	1,571,000	1,654,000	+83,000
Personnel benefits	309,000	325,000	+16,000
Subtotal Pay Costs	1,880,000	1,979,000	+99,000
Travel (21.0)	---	—	---
Transportation of things (22.0)	600	600	---
Rental payments to Others (23.2)	426,000	426,000	—
Communications, utilities, and miscellaneous charges (23.3)	88,000	88,000	---
Printing (24.0)	500	500	---
Other Contractual Services:			
Other services (25.2)	199,000	100,000	-99,000
Purchase of goods and services from other Government accounts (25.3)	619,000	291,000	-328,000
Operation and Maintenance of Equipment (25.7)	8,000	8,000	—
Subtotal Other Contractual Services	1,341,000	914,000	-427,000
Supplies and materials (26.0)	2,000	2,000	---
Subtotal Non-Pay Cost	1,343,000	916,000	-427,000
Total Current Law Salaries and Expenses	3,223,000	2,895,000	-328,000

Authorizing Legislation

	FY 2006 Amount Authorized	FY 2005 Appropriation	FY 2006 Amount Authorized	FY 2006 Budget Request
Health Education Assistance Loans and Student Loan Insurance Account:				
Appropriation:				
Liquidating Account (SLIA):				
PHS Act, Sec 710	1/	4,000,000	1/	4,000,000
Program Account:				
PHS Act, Secs. 709, 720*	SSAN*	3,244,000	SSAN*	2,916,000
Borrowing authority (SLIA):				
PHS Act, Sec 710(b)	2/	---	2/	---

*Such sums as may be necessary.

1/ Sec 710(a)(2) states "Except as provided in subparagraph (B), all amounts received by the Secretary as premium charges for insurance and as receipts, earnings, or proceeds derived from any claim or other assets acquired by the Secretary in connection with his operations under this subpart, and any other moneys, property, or assets derived by the Secretary from the operations of the Secretary in connection with this section, shall be deposited in the Account."

2/ Sec 710(b) states "If at any time, the moneys in the Account are insufficient to make payments in connection with the collection or default of any loan insured by the Secretary under this subpart, the Secretary of the Treasury may lend the Account such amounts as may be necessary to make the payments involved, subject to the Federal Credit Reform Act of 1990."

APPROPRIATION HISTORY

SLIA Liquidating Account

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1996	42,000,000	42,000,000	42,000,000	13,000,000
1997	14,481,000	14,481,000	14,481,000	37,608,000
1998	29,566,000	29,566,000	29,566,000	29,566,000
1999	37,000,000	37,000,000	37,000,000	37,000,000
2000	31,500,000	31,500,000	31,500,000	31,500,000
2001	10,000,000	10,000,000	10,000,000	10,000,000
2002	10,000,000	10,000,000	10,000,000	10,000,000
2003	7,000,000	7,000,000	7,000,000	7,000,000
2004	4,000,000	4,000,000	4,000,000	4,000,000
2005	4,000,000	4,000,000	4,000,000	4,000,000
2006	4,000,000			

APPROPRIATION HISTORY
HEAL Program Account

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1996	20,966,000	16,188,000	16,188,000	2,814,000
1997	3,172,000	3,165,000	3,165,000	3,165,000
1998	3,708,000	3,708,000	3,708,000	3,695,000
1999	3,688,000	3,688,000	3,688,000	3,688,000
2000	3,688,000	3,688,000	3,688,000	3,688,000
Rescission	---	---	---	-1,000
2001	3,679,000	3,679,000	3,679,000	3,679,000
Rescission	---	---	---	-7,000
2002	3,792,000	3,792,000	3,792,000	3,792,000
Rescission	---	---	---	-1,000
2003	3,914,000	3,914,000	3,914,000	3,914,000
Rescission	—	—	—	-25,000
2004	3,389,000	3,389,000	3,389,000	3,389,000
Rescission	—	—	—	-36,000
2005	3,270,000	3,270,000	3,270,000	3,270,000
Rescission	—	—	—	-26,000
2006	2,916,000			

General Statement

Health Education Assistance Loans (HEAL)

To assist in training students in various health fields, the HEAL program was authorized to provide insured loans for students enrolled in schools of allopathic and osteopathic medicine, dentistry, veterinary medicine, optometry, podiatry, public health, pharmacy, chiropractic, and graduate programs in health administration, clinical psychology and allied health.

Eligible student borrowers obtain loans, to be used for tuition and other reasonable educational and living expenses, from participating commercial lenders, educational institutions, State agencies, insurance companies and pension funds. The repayment of principal and interest is guaranteed by the Federal Government if the borrower becomes permanently disabled, dies, or defaults on the repayments.

Student Loan Insurance Account (SLIA)

The SLIA provides repayments to the lenders on defaulted HEAL loans, and for claims due to the death or disability of student borrowers. Deposits to the fund are derived from insurance premiums charged to the borrowers when the loans are made, repayments of defaulted claims, and if necessary, from borrowing authority and/or appropriations.

Health Education Assistance Loans
Authorizing legislation - Public Health Service Act, Title VII, Sections 701-720.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Liquidating Account Budget Authority	$4,000,000	$4,000,000	$4,000,000	$---
Administrative Expenses	$3,353,000	$3,244,000	2,916,000	-328,000
Total	$7,353,000	$7,244,000	$6,916,000	-$328,000
FTE (Ceiling)	11	10	10	--
FTE (Ceiling Exempt)	6	7	7	--

FY 2006 Authorization .....Expired except for Administrative Expenses and Office of Health Education Assistance Loans (HEAL) Default Reduction. The Liquidating Account is such sums as may be necessary.

Statement of Budget

The FY 2006 Budget of $2,916,000 is a decrease of $328,000 below the FY 2005 Appropriation and supports the program.

Program Description

The Health Education Assistance Loan (HEAL) Program has provided $4 billion to help 156,000 students of diverse socio-economic backgrounds pay for their health professions education. Although authority to make new HEAL loans expired September 30, 1998, the program has an outstanding loan portfolio of $2.3 billion which will not be fully repaid for at least the next 25 years.

As the original HEAL loan term extends at least 25 years, administrative funds are required to properly service active accounts, project future claims, and to carry out default reduction activities which can save taxpayers millions of dollars. As a result of aggressive program efforts, nearly 35,600 borrowers have refinanced more than $2.1 billion in HEAL loans, with substantially lower interest rates and improved terms. Timely payment of claims will avoid excess interest payments to lenders and aid in recovery of overdue accounts. Refinancing of existing HEAL loans ended in FY 2004.

The HEAL Program maintains and updates quarterly a list of defaulted HEAL borrowers on the World Wide Web (www.defaulteddocs.dhhs.gov). These borrowers have defaulted on the

repayment of their HEAL loans and are excluded, as practitioners, from participating in Medicare/Medicaid. The program makes available additional information with respect to these borrowers to relevant Federal and State agencies and legislators, school associations, professional and specialty associations, State licensing boards, hospitals with which such borrowers may be associated, and other relevant organizations. Millions of dollars have been received from defaulters as a result of the activities associated with publicizing their names.

The HEAL Program continues to maintain oversight for an outstanding portfolio that includes 61,848 borrowers with loans worth $2.3 billion. In FY 2003, the default rate for the HEAL Program increased slightly from 3.0 to 3.1 percent. In addition, the program refinanced nearly $78.9 million in HEAL loans, resulting in reduced loan costs for nearly 1,300 borrowers and a reduction in the Federal liability associated with these loans.

The HEAL staff have continued to maintain essential operational activities associated with a loan guarantee program of this magnitude, such as the processing of lender claims and borrower requests for forbearance and disability. Default reduction activities have also continued, including providing technical assistance to States regarding licensing sanctions, and maintaining and updating the HEAL defaulter web site, which currently includes approximately 1,500 health professionals who owe the Federal Government approximately $160.6 million on their defaulted HEAL loans.

Funding levels for the HEAL Program during the last five years reflect this effort and are as follows:

	Direct Operations		Liquidating Account
	$	FTE	$
2001	3,672,000	28	10,000,000
2002	3,791,000	22	10,000,000
2003	3,889,000	19	7,000,000
2004	3,353,000	17	4,000,000
2005	3,244,000	17	4,000,000

Performance Analysis

The HEAL program was created to provide last dollar financial support to students attending schools of allopathic medicine, osteopathic medicine, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, health administration, clinical psychology, and chiropractic. Authority to make new HEAL loans expired in FY 1998. The program is currently working on phasing out an outstanding loan portfolio of approximately $2.3 billion. For the last 4 years, the program has routinely met or exceeded its targets for phasing out the outstanding loan portfolio, through initiatives to help borrowers manage their indebtedness, and through partnerships with lenders and loan holders. More information on this program's performance is presented in Section U of this document. The program's performance informed decisions concerning the FY 2006 budget request.

Rationale for the Budget Request

The FY 2006 Budget request of $2,916,000 reflects a Federal administrative cost-savings of $328,000 below the FY 2005 Appropriation. The FY 2006 Budget includes $4,000,000 for the Liquidating Account to handle claims (defaults, death and disabilities) that will come due in FY 2005 for loans guaranteed before FY 1992.

Program Outputs

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Liquidating Account:	$4,000,000	$4,000,000	$4,000,000
Inflows to Account	$20,000,000	$20,000,000	$20,000,000
Outflows from Account	$24,000,000	$24,000,000	$24,000,000
Number of Borrower Claims Paid from Accounts	277	277	277

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Vaccine Injury Compensation Program

FY 2006 Budget	Page No.
Appropriation Language	546
Amounts Available for Obligation	547
Budget Authority by Activity	548
Budget Authority by Object	548
Salaries and Expenses	548
Authorizing Legislation	549
Appropriation History Table	550
Justification:	
A. Vaccine Injury Compensation Program	551

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Vaccine Injury Compensation Program

For payments from the Vaccine Injury Compensation Program 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 Public Health Service Act, to remain available until expended: Provided, That for necessary administrative expenses, not to exceed [$3,176,000] *$2,832,000* shall be available from the Trust Fund to the Secretary of the Department of Health and Human Services.

Vaccine Injury Compensation Program

Amounts Available for Obligation

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Unobligated Balance, Start of Year.....	$1,901,000,000	$2,020,811,000	$2,169,679,000
Receipts.....	142,500,000	170,000,000	188,000,000
Interest Income.....	55,204,000	60,000,000	62,000,000
Total, Receipts/Collections.....	197,704,000	230,000,000	250,000,000
Total Balance/Net Collections.....	2,098,704,000	2,250,811,000	2,419,679,000
Claims Appropriation (Obligations).....	66,796,000	68,132,000	70,884,000
Total Admin.DOJ/Claims Ct/HRSA....	11,097,000	13,000,000	13,000,000
Total New Obligations.....	77,893,000	81,132,000	83,884,000
Unobligated Balance, End of Year.....	$2,020,811,000	$2,169,679,000	$2,335,795,000

Budget Authority by Activity

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request
Trust Fund Obligations:			
Post-10/1/88 claims.....	$66,796,000	$68,132,000	$70,884,000
Administrative Expenses:			
HRSA Direct Operations.....	3,190,000	3,150,000	2,832,000
Total Obligations.....	$69,986,000	$71,282,000	$73,716,000

Budget Authority by Object

	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Insurance claims and indemnities	$68,132,000	$70,884,000	---
Other services..(25.2).....	3,150,000	2,832,000	-$318,000
Total.....	$71,282,000	$73,716,000	-$318,000

Salaries and Expenses
(Budget Authority)

	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Other Services (25.2).....	$3,150,000	$2,832,000	-$318,000

Authorizing Legislation

	FY 2005 Amount Authorized	FY 2005 Appropriation	FY 2006 Amount Authorized	FY 2006 Request
Vaccine Injury Compensation Program:				
(a) PHS Act, Title XXI, Subtitle 2, Parts A and D:				
Pre-FY 1989 Claims.....	$110,000,000	---	$110,000,000	---
Post-FY 1989 Claims.....	Indefinite	$ 68,132,000	Indefinite	$70,884,000
(b) Sec. 6601(r)d OBRA of 1989 (P.L. 101-239):				
HRSA Operations.....	Indefinite	$ 3,150,000	Indefinite	$ 2,832,000

Appropriation History Table

Vaccine Injury Compensation Program

(Pre-1988 Claims Appropriation)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1995	110,000,000	110,000,000	110,000,000	110,000,000
1996	110,000,000	110,000,000	110,000,000	110,000,000
1997	110,000,000	110,000,000	110,000,000	110,000,000
1998	---	---	---	---
1999	---	---	100,000,000	100,000,000
2000	---	---	---	---
2001	---	---	---	---
2002	---	---	---	---
2003	---	---	---	---
2004	---	---	---	---
2005	---	---	---	---
2006	---	---	---	---

National Vaccine Injury Compensation Program

Authorizing Legislation - Title XXI, Subtitle 2, Parts A and D, of the Public Health Service Act as amended, and related legislation; Sections 4131 and 9510 of the Internal Revenue Code as amended.

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Request	Increase or Decrease
Claims BA	$66,796,000	$68,132,000	$70,884,000	+ $2,752,000
Admin. BA	$3,190,000	$3,150,000	$2,832,000	- $298,000
Total BA	$69,986,000	$71,282,000	$73,716,000	+ $2,454,000
FTE	17	25	25	0

FY 2006 Authorization.....Such sums as necessary

Statement of the Budget

The FY 2006 Budget of $73,716,000 is $2,454,000 above the FY 2005 Appropriation, of which $2,832,000 supports administrative costs of operating the program.

Program Description

The National Childhood Vaccine Injury Act of 1986 (the Act) established the VICP to equitably and expeditiously compensate individuals or the families of individuals who have been injured by childhood vaccines. The VICP also serves to stabilize the vaccine environment by substantially reducing the threat of liability for vaccine companies, physicians, and other health care professionals who administer vaccines.

HRSA has been delegated the authority to administer Parts A and D of Subtitle 2. Consistent with this delegation, HRSA:

- informs the public of the availability of the VICP;
- receives petitions for compensation served on the Secretary of HHS (the Secretary);
- arranges for medical review of each petition and supporting documentation by physicians with special expertise in pediatrics, and develops recommendations to the Court regarding the eligibility of the petitioners for compensation;
- publishes notices of each petition received in the Federal Register;
- promulgates regulations to modify the Vaccine Injury Table;

- provides administrative support to the Advisory Commission on Childhood Vaccines (ACCV), composed of nine voting members, including health professionals, attorneys, and parents of children who have suffered a vaccine-related injury or death, and specified HHS agency heads (or their designees); and
- processes award payments to petitioners and attorneys for judgments entered by the Court.

Funding for the VICP during the last five years has been as follows:

	$	FTE
2001	80,595,000	24
2002	62,802,000	21
2003	102,972,000	20
2004	69,986,000	17
2005	71,258,000	25

Performance Analysis

The VICP has implemented several highly successful financial management initiatives that have proven to be pivotal in successfully fulfilling its mission. One initiative is the establishment of specific payment time-line standards and performance measures, such as the goal to pay annuity premiums within 60 days of the U.S. Department of Justice (DOJ) clearance letter, and lump sum awards to petitioners within 30 days of receiving final clearance documentation.

These ongoing efforts to improve financial management of the compensation payment process have continued to result in substantial measurable results. In FY 2004, VICP performance exceeded its target goal of 99 percent by funding 100 percent of annuity contracts within 60 days of the DOJ clearance. Additionally, the VICP paid FY 2004 "lump sum only" awards within 30 days 99.8 percent of the time, exceeding the 99 percent performance standard. (See Exhibit U.)

Rationale for the Budget

The FY 2006 budget of $73,712,000 is $2,454,000 above the FY 2005 Appropriation. The request will fund the following:

VICP Awards

The VICP awards payments to individuals, or the families of individuals, who have been injured, or have died as the result of a vaccine(s) recommended by the Centers for Disease Control and Prevention for routine administration to children. In FY 2006, HRSA estimates that $70,884,363 will be paid out of the Vaccine Injury Compensation Trust Fund (the Trust Fund) for payment of awards due to vaccine-related injuries or deaths.

Administrative Expenses

HRSA is anticipating using $2,832,000 from the Trust Fund for administrative expenses to cover costs borne by the internal medical review of claims, external medical review of claims by outside consultants (including, where warranted, expert testimony to the Court), professional and administrative support to the ACCV, meeting specific administrative requirements of the Act, processing award payments, and maintaining necessary records.

Health Education
Assistance Loans

Vaccine Injury
Compensation Program

Health Education
Assistance Loans

Vaccine Injury
Compensation Program