DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2017

Health Resources and Services Administration

Justification of Estimates for Appropriations Committees

MESSAGE FROM THE ADMINISTRATOR

I am pleased to present the FY 2017 Congressional Justification for the Health Resources and Services Administration (HRSA). HRSA is the primary Federal agency for improving health and achieving health equity through access to quality services, a skilled workforce and innovative programs. HRSA's programs provide health care to people who are geographically isolated, or economically or medically vulnerable. The FY 2017 Budget provides $10.7 billion, including $4.9 billion in mandatory funding, to invest in and expand programs that will help meet the needs of millions of individuals and families who are medically underserved or face barriers to essential health care.

This past year, the Health Center Program celebrated 50 years of increasing access to comprehensive, high-quality preventive and primary health care to patients regardless of their ability to pay. Today, the program supports more than 1,300 health centers grantees serving nearly 23 million people. In FY 2017, the Health Center Program will continue to play a critical role in the health care system by providing high quality, affordable and comprehensive primary care services in medically underserved communities, even as insurance coverage expands. The Budget provides $5.1 billion for the Health Center Program, including $3.8 billion in mandatory resources. The Budget also proposes to extend mandatory funding for two additional years at $3.6 billion in FY 2018 and FY 2019. Health centers will remain a vital source of primary care for patients who cannot gain access to coverage, as well as insured patients seeking a quality source of care for services not covered by their insurance.

HRSA’s FY 2017 Budget invests resources to increase the number of health care practitioners in areas of the country experiencing shortages. HRSA is requesting $1.3 billion for workforce programs, a total that includes $715.0 million in mandatory funding. The Budget requests strategic investments in the National Health Service Corps, graduate medical education, as well as workforce diversity programs. It includes a new two year investment totaling $100.0 million in new mandatory funding to enhance access to behavioral health services in underserved communities by supporting loan repayment awards to health clinicians, including clinicians with medication assisted treatment training, which combines behavioral therapy and medications to treat substance use disorders. This funding is part of two Administration initiatives to treat opioid use disorders and to improve access to mental health care.

Additionally, the Budget invests in health workforce programs that target a number of other specific disciplines and competencies, including oral health, and geriatric care. By addressing the supply and distribution of certain health professionals, the diversity of the health workforce, and the need for training in contemporary practices focused on more efficient models of care, the Budget works toward helping that all Americans have access to well-qualified health care providers.

The Budget requests $1.3 billion to improve the health of mothers and children. The Budget proposes to extend and expand the Maternal, Infant, and Early Childhood Home Visiting program for $15 billion in new funding over 10 years to expand access for at-risk families to voluntary, evidence-based home visiting services where nurses, social workers, and other

professionals meet with and connect them to assistance to support their children's health, development, and ability to learn.

The Budget request also includes $144.2 million to improve both access to and the quality of health care in rural areas. It will strengthen regional and local partnerships among rural health care providers, expand community-based programs and promote the modernization of the health care infrastructure in rural areas. The Budget provides $10.0 million for an expanded Rural Opioid Overdose Reversal Program to support treatment and intervention of opioid use in rural communities.

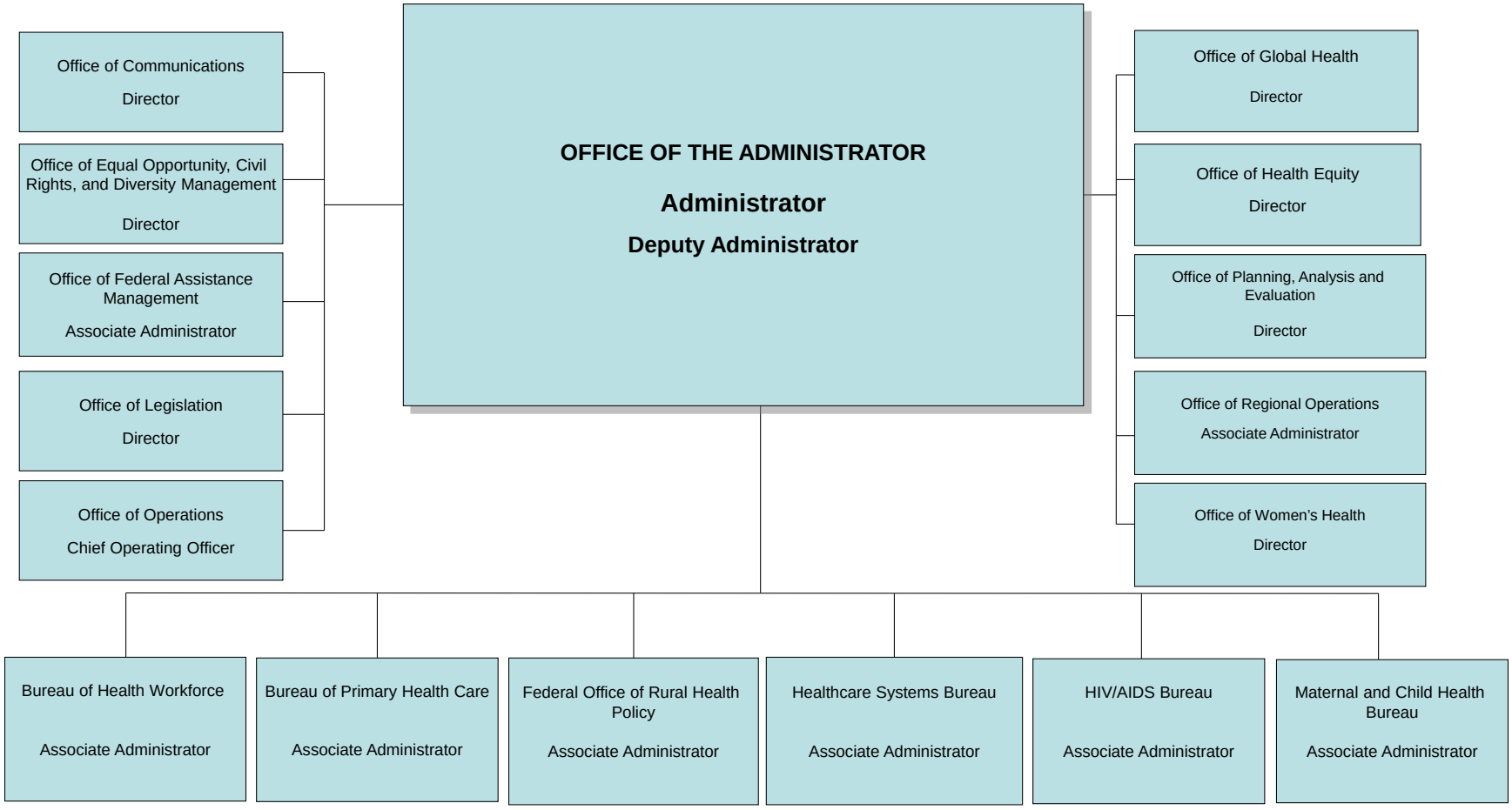
This past year marked the 25th anniversary of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, the legislation that created the Ryan White HIV/AIDS program. Today, the program serves more than 500,000 of those who do not have sufficient health care coverage or financial resources to manage the disease. Over the last 25 years, the program has made great strides moving clients along the HIV care continuum, with 81 percent of program clients retained in care and more than 78 percent of those who are retained in care being virally suppressed. The FY 2017 Budget includes $2.3 billion for the Ryan White program to improve and expand access to care for persons living with HIV/AIDS. This level includes an increase of $9.0 million for a new initiative to support Hepatitis C Treatment in people living with HIV. The goal is to develop evidence-informed models to increase testing for Hepatitis C, build capacity to expand treatment of Hepatitis C, and disseminate effective models of care for patients in need. The Budget request also proposes to consolidate funds from Part D with Part C so resources can be better targeted to points along the care continuum and populations most in need, including women, infants, children, and youth, while reducing duplication of effort and administrative burden among grantees.

Our FY 2017 Budget reflects the Health Resources and Services Administration's commitment to taking important steps toward further improvements in health care access, particularly for underserved populations.

James Macrae
Acting Administrator

Organizational Chart

Health Resources and Services Administration



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Introduction and Mission

The Health Resources and Services Administration (HRSA), an Agency of the U.S. Department of Health and Human Services, is the principal Federal agency charged with increasing access to basic health care for those who are medically underserved. Health care in the United States is among the finest in the world but it is not accessible to everyone. Millions of families still face barriers to quality health care because of their income, lack of insurance, geographic isolation, or language, cultural, or other barriers. The Affordable Care Act provided for substantial expansion of components of the HRSA-supported safety net, including the Health Center Program, the National Health Service Corps, and a variety of health workforce programs, to address these and other access problems. While implementation of health reform and other factors may affect the structure and function of the safety net, assuring an adequate safety net for individuals and families who live outside the economic and medical mainstream remains a key HRSA role.

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

- The millions of Americans who lack health insurance--many of whom are racial and ethnic minorities,
- Over 50 million underserved Americans who live in rural and poor urban neighborhoods where health care providers and services are scarce,
- African American infants who still are 2.4 times as likely as white infants to die before their first birthday,
- The more than 1.2 million people living with HIV infection,
- The more than 120,000 Americans who are waiting for an organ transplant.

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

Overview of Budget Request

The FY 2017 President's program level request is $10.7 billion, including $4.9 billion in mandatory funding, for the Health Resources and Services Administration (HRSA). This is $83.6 million above the FY 2016 Enacted level.

Highlights of the major programs are listed below:

Health Centers and Free Clinics: +$0.9 million; total program $5.1 billion – The Budget continues support of more than 1,300 health centers operating over 9,000 primary care sites. The Budget also proposes $3.6 billion in new mandatory resources in FY 2018 and FY 2019, to extend the current mandatory funding level for two additional years. These resources will help sustain health center funding in future years and ensure that current health centers can continue to provide essential health care services to their patient populations.

Health Workforce: -$300.2 million in discretionary funding; +$345.0 million in mandatory funding; total program $1.3 billion

- *National Health Service Corps (NHSC):+$20.0 million in discretionary; +$50.0 million in mandatory; total program $380.0 million* - All new NHSC funding in FY 2017 will be directed to expand access to behavioral health services. Within this amount, the Budget proposes $25 million in mandatory resources in FY 2017 and FY 2018 as part of a new $1 billion initiative to expand access to treatment to reduce prescription drug abuse and heroin use. This funding will expand the use of medication-assisted treatment (MAT) through investments in NHSC, including enhanced loan repayment to clinicians with MAT training. The Budget also includes $25 million in new mandatory funding in FY 2017 and FY 2018 that is part of the Administration's $500 million initiative to expand access to mental health care. Between FY 2017 and FY 2020, HRSA will devote a total of $2.8 billion for NHSC to expand the number of health care providers in high-need rural and urban communities across the country to 15,000.

- *Health Professions Training for Diversity:* The Budget requests $85.0 million is an increase of $3.1 million. The increase is for Scholarship for Disadvantaged Students (SDS) program. The total SDS program request of $49.0 million will fund approximately 105 grant awards, supporting approximately 3,185 students, an increase of 245 students above the FY 2016 levels. Increased funding will help to meet the demand for scholarship support to disadvantaged students who have unmet financial need in paying for their health professions education.

- *Behavioral Health Workforce Education and Training (BWET):* The Budget requests $56.0 million, an increase of $6.0 million over FY 2016 Enacted. This request will support clinical training for approximately 2,850 additional behavioral health professionals and approximately 2,750 additional paraprofessionals. Prior to FY 2017, these funds were appropriated to the Substance Abuse and Mental Health Services Administration. Having these funds appropriated to HRSA aligns the

Program with the other mental and behavioral health workforce development programs under Title VII of the Public Health Service Act; and streamlines the administration and oversight functions within a single agency. HRSA will continue to leverage SAMHSA's subject matter expertise in formulating new investments in FY 2017.

- *Children's Hospital Graduate Medical Education Program:* The Budget proposes $295.0 million of mandatory resources for each of FYs 2017 through 2021. This program helps eligible hospitals provide graduate training for physicians to provide quality care to children, and enhance their ability to care for low-income patients. Mandatory funding will provide a predictable funding stream for this program.

- *Teaching Health Centers Graduate Medical Education Program*: The Budget includes $60 million in already enacted mandatory funding for residency training in primary care medicine and dentistry in community-based, ambulatory settings. The Budget proposes to extend mandatory funding through FY 2020 for an additional investment of $527 million.

- *Area Health Education Centers (AHEC)*: The Budget does not request funding for the AHEC program. It is anticipated that the AHEC Program grantees may be able to support on-going activities through other funding sources.

- *Public Health/Preventive Medicine:* The Budget requests $4 million below FY 2016 Enacted. The Budget reflects the consolidation of the Integrated Medicine program with the Preventive Medicine Residency program.

Maternal and Child Health: total program $1.3 billion – The FY 2017 Budget proposes to extend and expand the Maternal, Infant, and Early Childhood Home Visiting program $15 billion in new resources over 10 years to improve access for at-risk families to voluntary, evidence-based home visiting services where nurses, social workers, and other professionals meet with families and connect them with assistance that supports and improves their children's health, development, and ability to learn.

HIV/AIDS: +$9.0 million; total program $2.3 billion – The FY 2017 Budget for Ryan White activities includes an increase of $9.0 million for a new initiative to support Hepatitis C Treatment for People Living with HIV. This program will use existing systems to develop evidence-informed models to increase testing for Hepatitis C, build capacity to expand treatment of Hepatitis C, and disseminate effective models of care to patients in need. The total for Ryan White includes $900.3 million for the AIDS Drug Assistance Programs (ADAP) to provide access to life saving HIV related medications and health care services to persons living with HIV in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam and five Pacific jurisdictions. The Budget also proposes to consolidate the Part D Program with the Part C Program. The consolidation expands the focus on women, infants, children and youth across all the funded grantees and will increase points of access for the population and reduces duplication of effort and reporting/administrative burden among currently co-funded grantees to improve medical outcomes. By consolidating the two programs, resources are better targeted to points

along the care continuum to improve patient outcomes. This will result in more funding for direct patient care services.

Healthcare Systems: +$7.0 million in discretionary funding; +$9.0 million in user fees; total programs $119.2 million – The Budget includes an increase of $7.0 million in discretionary funding for the 340B Program as HRSA increases its commitment to program integrity and compliance. The Request would enable full implementation of the statutory obligations for the 340B Program, and enhance oversight of participating manufacturers and covered entities. The Budget proposes a new cost recovery/user fee program as a long term financing strategy to support program activities. The Budget also seeks new rule making authority to ensure adherence to the 340B program's principles, compliance with the law, and the most effective use of this critical safety-net program.

Rural Health: -$5.4 million; total program $144.2 million – The Budget includes an increase of $10.0 million for an expanded Rural Opioid Overdose Reversal program that focuses on prevention, treatment, and intervention of opioid use in rural communities. The Rural Hospital Flexibility Program request is decreased by $15.4 million, as the Small Hospital Improvement Program has become largely duplicative of other programs and resources. This funding level will continue to support 45 Flex grant programs to support critical access hospitals (CAHs) and three grants to support rural veterans. The request allows core activities to be targeted to the area of greatest need with a focus on CAHs, the nation's smallest hospitals.

Program Management: +$3.1 million; total program $157.1 million – This request supports program management activities to effectively and efficiently support HRSA's operations, including increased investments in information technology and cybersecurity.

Family Planning: +$13.5 million; total program $300.0 million – The FY 2017 request will expand family planning services to low income individuals by improving access to family planning centers and preventive services. The request is expected to support family planning services for approximately 4.3 million persons, with approximately 90 percent having family incomes at or below 200 percent of the federal poverty level.

Overview of Performance

This Performance Budget documents the progress HRSA has made and expects to make in meeting the needs of medically underserved individuals, special needs populations, and many other Americans. HRSA and its partners work to achieve the vision of "Healthy Communities, Healthy People." In pursuing that vision, HRSA's strategic goals are to: improve access to quality health care and services, strengthen the health workforce, build healthy communities, and improve health equity. The performance and expectations for HRSA programs are highlighted below, categorized by HRSA goals and HHS strategic objectives to indicate the close alignment of specific programmatic activities and objectives with broader HRSA and Departmental priorities. The examples illustrate ways HRSA helps states, communities and organizations provide essential health care and related services to meet critical needs.

Highlights of Performance Results and Targets

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

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

- In FY 2017, the Health Center program projects that it will serve 27.0 million patients. This is an expected increase of more than 4 million over the 22.9 million persons served in FY 2014.

- HRSA expects to serve 34 million children through the Maternal and Child Health Block Grant (Title V) in FY 2017.

- The Maternal, Infant, and Early Childhood Home Visiting Program made more than 912,000 home visits to families receiving services in FY 2015, exceeding the target of 805,000. In FY 2017 the number of home visits is expected to be 912,000.

- By reaching out to low-income parents to enroll their children in the Children's Health Insurance Program (CHIP) and Medicaid, HRSA improves access to critically important health care. In FY 2017, the number of children receiving Title V services that are enrolled in and have Medicaid and CHIP coverage is expected to be 15 million. In FY 2014, the number was 12.0 million.

- In FY 2017, HRSA's Ryan White HIV Emergency Relief Grants (Part A) and HIV Care Grants to States (Part B) are projected to support, respectively, 1.91 million visits and 1.51 million visits for health-related care (primary medical, dental, mental health, substance abuse, and home health).

- By supporting AIDS Drug Assistance Program (ADAP) services to an anticipated 206,305 persons in FY 2017, HRSA expects to continue its contribution to reducing

AIDS-related mortality through providing drug treatment regimens for low-income, underinsured and uninsured people living with HIV/AIDS.

- The number of organ donors and the number of organs transplanted have increased substantially in recent years. In FY 2017, HRSA's Organ Transplantation program projects that 26,202 deceased donor organs will be transplanted, up from 26,046 in FY 2014.

- To increase the number of patients from racially and ethnically diverse backgrounds able to find a suitably matched unrelated adult donor for their blood stem cell transplants, HRSA's C.W. Bill Young Cell Transplantation program projects that it will have 3.74 million adult volunteer potential donors of minority race and ethnicity listed on the donor registry in FY 2017. More than 3.3 million were listed on the registry in FY 2015.

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

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

- In FY 2015, the National Health Service Corps (NHSC) had a field strength of 9,683 primary care and other clinicians. The NHSC projects that it will support a field strength of nearly 10,200 clinicians in health professional shortage areas in FY 2017.

- In FY 2017, 7,800 health care providers are projected to be deemed eligible for FTCA malpractice coverage through the Free Clinics Medical Malpractice program. The program encourages providers to volunteer their time at sponsoring free clinics.

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

Virtually all HRSA programs help improve health care quality and many do this by focusing on improving the infrastructure of the health care system.

- In FY 2017, 95.7% of Ryan White Program-funded primary care providers are expected to have implemented a quality management program.

- In FY 2017, 94% of Critical Access Hospitals (supported by the Rural Hospital Flexibility Grants program) will report at least one quality-related measure to Hospital Compare. This will be an increase from 88.2% in FY 2013.

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

Performance Management

Achieving a high level of performance is a major priority for HRSA. Performance management is central to the agency's overall management approach and performance-related information is routinely used to improve HRSA's operations and those of its grantees. HRSA's performance management process has two major integrated elements—one that is relatively broad and another that is more specifically focused. Both include setting priorities and goals that are linked to HRSA's Strategic Plan, action planning and execution, and regular monitoring and review with follow-up.

At the first level, priority setting is done each fiscal year in which annual goals, potentially covering a wide range of areas, are defined during the process of establishing performance plans for Senior Staff personnel. At the next level, and complementary to the broader performance management framework, HRSA's Senior Staff must select one or two performance areas and associated metrics within each of four HRSA-specified domains that they will attempt to improve over the succeeding 1-2 years. The domains are: Employee Satisfaction, Customer/Grantee Satisfaction, Timeliness and Quality of Products, and Program Outcomes/Impact. At each level quantitative or qualitative metrics/indicators and targets along with key milestones are stated. Senior Staff, as Goal Leaders, oversee planning and implementation of the major actions that must be accomplished to achieve goals and milestones.

Regular reviews of performance occur between Goal Leaders and the Administrator/Deputy Administrator. For the specified domains-related performance areas, reviews occur two times a year, focusing on progress, obstacles, and possible course corrections, with particular emphasis on root-causes of performance results. For the broader performance management activities, reviews include monthly one-on-one meetings, mid-year and year-end Senior Staff performance reviews, and ad hoc meetings to address emerging issues/problems. These meetings, too, cover progress, successes, challenges, and course-corrections.

These performance management activities promote accountability and transparency, support collaboration in problem solving, and help drive performance improvement at the HRSA-wide level and among its grantees.

All-Purpose Table
Health Resources and Services Administration
(Dollars in Thousands)

Program	FY 2015	FY 2016	FY 2017	
	Final	Enacted	President's Budget	FY 2017 +/- FY 2016
PRIMARY CARE:				
Health Centers:				
Health Centers	1,391,529	1,391,529	1,241,529	-150,000
Health Centers ACA Mandatory	3,509,111	-	-	-
Health Centers Mandatory	-	3,600,000	3,600,000	-
Health Centers Proposed Mandatory	-	-	150,000	+150,000
Health Center Tort Claims	99,893	99,893	99,893	-
Subtotal, Health Centers	***5,000,533***	***5,091,422***	***5,091,422***	**-**
Free Clinics Medical Malpractice	100	100	1,000	+900
Subtotal, Bureau of Primary Health Care (BPHC)	**5,000,633**	**5,091,522**	**5,092,422**	**+900**
Subtotal, Mandatory BPHC (non-add)	*3,509,111*	*3,600,000*	*3,750,000*	*+150,000*
Subtotal, Discretionary BPHC (non add)	*1,491,522*	*1,491,522*	*1,342,422*	*-149,100*
HEALTH WORKFORCE:				
National Health Service Corps (NHSC):				
NHSC	-	-	20,000	+20,000
NHSC ACA Mandatory	287,370	-	-	-
NHSC Mandatory	-	310,000	310,000	-
NHSC Proposed Mandatory	-	-	50,000	+50,000
Subtotal, NHSC	***287,370***	***310,000***	***380,000***	***+70,000***
Loan Repayment/Faculty Fellowships	1,190	1,190	1,190	-
Health Professions Training for Diversity:				
Centers of Excellence	21,711	21,711	21,711	-
Scholarships for Disadvantaged Students	45,970	45,970	49,070	+3,100
Health Careers Opportunity Program	14,189	14,189	14,189	-
Subtotal, Health Professions Training for Diversity	***81,870***	***81,870***	***84,970***	***+3,100***
Health Care Workforce Assessment	4,663	4,663	4,663	-
Primary Care Training and Enhancement	38,924	38,924	38,924	-
Oral Health Training Programs	33,928	35,873	35,873	-
Interdisciplinary, Community-Based Linkages:				
Area Health Education Centers	30,250	30,250	-	-30,250
Geriatric Programs	34,237	38,737	38,737	-
Behavioral Health Workforce Education and Training /1	35,000	50,000	56,000	+6,000

Program	FY 2015	FY 2016	FY 2017	
	Final	Enacted	President's Budget	FY 2017 +/- FY 2016
Mental and Behavioral Health	8,916	9,916	9,916	-
Subtotal, Interdisciplinary, Community-Based Linkages	***108,403***	***128,903***	***104,653***	***-24,250***
Public Health Workforce Development:				
Public Health/Preventive Medicine	21,000	21,000	17,000	-4,000
Nursing Workforce Development:				-
Advanced Nursing Education	63,581	64,581	64,581	-
Nursing Workforce Diversity	15,343	15,343	15,343	-
Nurse Education, Practice and Retention	39,913	39,913	39,913	-
Nurse Faculty Loan Program	26,500	26,500	26,500	-
Comprehensive Geriatric Education	4,500	-	-	-
NURSE Corps Scholarship and Loan Repayment Program	81,785	83,135	83,135	-
Subtotal, Nursing Workforce Development	***231,622***	***229,472***	***229,472***	-
Children's Hospital Graduate Medical Education	265,000	295,000	-	-295,000
Children's Hospital Graduate Medical Education Proposed Mandatory	-	-	295,000	+295,000
Teaching Health Center Graduate Medical Education Mandatory	-	60,000	60,000	-
National Practitioner Data Bank (User Fees)	*18,814*	*21,037*	*21,037*	-
Subtotal, Bureau of Health Workforce (BHW)	**1,092,784**	**1,227,932**	**1,272,782**	**+44,850**
Subtotal, User Fees BHW (non-add)	*18,814*	*21,037*	*21,037*	-
Subtotal, Discretionary BHW (non-add)	*786,600*	*836,895*	*536,745*	*-300,150*
Subtotal, Mandatory BHW (non-add)	*287,370*	*370,000*	*715,000*	*+345,000*
MATERNAL & CHILD HEALTH /2:				
Maternal and Child Health Block Grant	637,000	638,200	638,200	-
Autism and Other Developmental Disorders	47,099	47,099	47,099	-
Sickle Cell Service Demonstrations	4,455	4,455	4,455	-
James T. Walsh Universal Newborn Hearing Screening	17,818	17,818	17,818	-
Emergency Medical Services for Children	20,162	20,162	20,162	-
Healthy Start	102,000	103,500	103,500	-
Heritable Disorders	13,883	13,883	13,883	-
Family-to-Family Health Information Centers Mandatory	5,000	5,000	5,000	-
Maternal, Infant and Early Childhood Home Visiting Program Mandatory	400,000	400,000	400,000	-
Subtotal, Maternal and Child Health Bureau (MCHB)	**1,247,417**	**1,250,117**	**1,250,117**	**-**
Subtotal, Discretionary MCHB (non-add)	*842,417*	*845,117*	*845,117*	-
Subtotal, Mandatory MCHB (non-add)	*405,000*	*405,000*	*405,000*	-

Program	FY 2015	FY 2016	FY 2017	
	Final	Enacted	President's Budget	FY 2017 +/- FY 2016
HIV/AIDS:				
Emergency Relief - Part A	655,220	655,876	655,876	-
Comprehensive Care - Part B	1,315,005	1,315,005	1,315,005	-
AIDS Drug Assistance Program (non-add)	*900,313*	*900,313*	*900,313*	-
Early Intervention - Part C	204,179	205,079	280,167	+75,088
Children, Youth, Women & Families - Part D	73,008	75,088	-	-75,088
AIDS Education and Training Centers - Part F	33,349	33,611	33,611	-
Dental Reimbursement Program Part F	13,020	13,122	13,122	-
Special Program of National Significance (SPNS)	25,000	25,000	-	-25,000
SPNS Evaluation Funds	-	-	*34,000*	*+34,000*
Hepatitis C in People Living with HIV (non-add)	-	-	*9,000*	*+9,000*
Subtotal, HIV/AIDS Bureau	**2,318,781**	**2,322,781**	**2,331,781**	**+9,000**
Subtotal, Evaluation Funds HIV/AIDS (non-add)	-	-	*34,000*	*+34,000*
Subtotal, HIV/AIDS Discretionary (non-add)	*2,318,781*	*2,322,781*	*2,297,781*	*-25,000*
HEALTHCARE SYSTEMS:				
Organ Transplantation	23,549	23,549	23,549	-
National Cord Blood Inventory	11,266	11,266	11,266	-
C.W. Bill Young Cell Transplantation Program	22,109	22,109	22,109	-
Poison Control Centers	18,846	18,846	18,846	-
340B Drug Pricing Program/Office of Pharmacy Affairs	10,238	10,238	26,238	+16,000
340B Drug Pricing Program User Fees (non-add)	-	-	*9,000*	*+9,000*
Hansen's Disease Center	15,206	15,206	15,206	-
Payment to Hawaii	1,857	1,857	1,857	-
National Hansen's Disease Program - Buildings and Facilities	122	122	122	-
Subtotal, Healthcare Systems Bureau (HSB)	**103,193**	**103,193**	**119,193**	**+16,000**
Subtotal, User Fees HSB (non-add)	-	-	9,000	+9,000
Subtotal, Discretionary HSB (non-add)	*103,193*	*103,193*	*110,193*	*+7,000*
RURAL HEALTH:				
Rural Health Policy Development	9,351	9,351	9,351	-
Rural Health Outreach Grants	59,000	63,500	63,500	-
Rural & Community Access to Emergency Devices	4,500	-	-	-
Rural Hospital Flexibility Grants	41,609	41,609	26,200	-15,409
State Offices of Rural Health	9,511	9,511	9,511	-
Radiation Exposure Screening and Education Program	1,834	1,834	1,834	-

Program	FY 2015	FY 2016	FY 2017	
	Final	Enacted	President's Budget	FY 2017 +/- FY 2016
Black Lung	6,766	6,766	6,766	-
Telehealth	14,900	17,000	17,000	-
Rural Opioid Overdose Reversal Grant Program	-	-	10,000	+10,000
Subtotal, Federal Office of Rural Health Policy	**147,471**	**149,571**	**144,162**	**-5,409**
PROGRAM MANAGEMENT	154,000	154,000	157,061	+3,061
FAMILY PLANNING	286,479	286,479	300,000	+13,521
Appropriation Table Match	**6,130,463**	**6,189,558**	**5,733,481**	**-456,077**
Funds Appropriated to Other HRSA Accounts:				
Vaccine Injury Compensation:				
Vaccine Injury Compensation Trust Fund (HRSA Claims)	235,000	237,000	240,000	+3,000
VICTF Direct Operations - HRSA	7,500	7,500	9,200	+1,700
Subtotal, Vaccine Injury Compensation	**242,500**	**244,500**	**249,200**	**+4,700**
Discretionary Program Level:				
HRSA	**6,149,277**	**6,210,595**	**5,797,518**	**-413,077**
Vaccine Direct Operations	7,500	7,500	9,200	+1,700
Total, HRSA Discretionary Program Level	**6,156,777**	**6,218,095**	**5,806,718**	**-411,377**
Mandatory Programs:	**4,201,481**	**4,375,000**	**4,870,000**	**+495,000**
Total, HRSA Program Level	**10,358,258**	**10,593,095**	**10,676,718**	**+83,623**
Less Programs Funded from Other Sources:				
User Fees	*-18,814*	*-21,037*	*-30,037*	*-9,000*
Mandatory Programs	*-4,201,481*	*-4,375,000*	*-4,870,000*	*-495,000*
Evaluation Funds	-	-	*-34,000*	*-34,000*
Total HRSA Discretionary Budget Authority	**6,137,963**	**6,197,058**	**5,742,681**	**-454,377**

/1 FY 2015 and FY 2016 Final funding levels reflect funding for the Behavioral Health Workforce Education and Training program, which were appropriated to SAMHSA. This program is proposed to be transferred to HRSA beginning in FY 2017.

/2 FY 2015 Final funding level does not reflect funding for the Traumatic Brain Injury program of $9.3 million. This program was transferred to the Administration for Community Living beginning in FY 2016.

Budget Exhibits

TAB

Appropriations Language

PRIMARY HEALTH CARE

For carrying out titles II and III of the Public Health Service Act (referred to in this Act as the "PHS Act") with respect to primary health care and the Native Hawaiian Health Care Act of 1988, **[**$1,491,522,000 (in addition to the $3,600,000,000 previously appropriated to the Community Health Center Fund for fiscal year 2016)**]** *$1,342,422,000: Provided*, That no more than **[**$100,000**]***$1,000,000* shall be available until expended for carrying out the provisions of section 224(o) of the PHS Act: *Provided further*, That no more than $99,893,000 shall be available until expended for carrying out the provisions of Public Law 104–73 and for expenses incurred by the Department of Health and Human Services (referred to in this Act as "HHS") pertaining to administrative claims made under such law.[: *Provided further*, That of funds provided for the Health Centers program, as defined by section 330 of the PHS Act, by this Act or any other Act for fiscal year 2016, not less than $200,000,000 shall be obligated in fiscal year 2016 to support new access points, grants to expand medical services, behavioral health, oral health, pharmacy, or vision services, and not less than $150,000,000 shall be obligated in fiscal year 2016 for construction and capital improvement costs: *Provided further*, That the time limitation in section 330(e)(3) of the PHS Act shall not apply in fiscal year 2016.**]**

HEALTH WORKFORCE

For carrying out titles III, VII, and VIII of the PHS Act with respect to the health workforce, section*s* 1128E *and 1921(b)* of the Social Security Act, and the Health Care Quality Improvement Act of 1986, [$786,895,000**]***$536,745,000, Provided, That $20,000,000, to remain available until expended, shall be for the National Health Service Corps Program*: *Provided, further,* That sections 747(c)(2), **[**751(j)(2),**]** *and* 762(k), and the proportional funding amounts in paragraphs (1) through (4) of section 756(e) of the PHS Act shall not apply to funds made

available under this heading:**[***Provided further*, That for any program operating under section 751 of the PHS Act on or before January 1, 2009, the Secretary of Health and Human Services (referred to in this title as the "Secretary") may hereafter waive any of the requirements contained in sections 751(d)(2)(A) and 751(d)(2)(B) of such Act for the full project period of a grant under such section: *Provided further*, That no funds shall be available for section 340G-1 of the PHS Act:**]** *Provided further*, That fees collected for the disclosure of information under section 427(b) of the Health Care Quality Improvement Act of 1986 and sections 1128E(d)(2) and 1921 of the Social Security Act shall be sufficient to recover the full costs of operating the programs authorized by such sections and shall remain available until expended for the National Practitioner Data Bank: *Provided further*, That funds transferred to this account to carry out section 846 and subpart 3 of part D of title III of the PHS Act may be used to make prior year adjustments to awards made under such sections.

MATERNAL AND CHILD HEALTH

For carrying out titles III, XI, XII, and XIX of the PHS Act with respect to maternal and child health, title V of the Social Security Act, and section 712 of the American Jobs Creation Act of 2004, $845,117,000: *Provided*, That notwithstanding sections 502(a)(1) and 502(b)(1) of the Social Security Act, not more than $77,093,000 shall be available for carrying out special projects of regional and national significance pursuant to section 501(a)(2) of such Act and $10,276,000 shall be available for projects described in subparagraphs (A) through (F) of section 501(a)(3) of such Act.

RYAN WHITE HIV/AIDS PROGRAM

For carrying out title XXVI of the PHS Act with respect to the Ryan White HIV/AIDS program, [$2,322,781,000,**]***$2,297,781,000,* of which $1,970,881,000 shall remain available to the Secretary *of Health and Human Services (referred to in this title as the "Secretary")* through

September 30, [2018**]***2019,* for parts A and B of title XXVI of the PHS Act, and of which not less than $900,313,000 shall be for State AIDS Drug Assistance Programs under the authority of section 2616 or 311(c) of such Act: *Provided, That in addition to amounts provided herein, $34,000,000 shall be available under section 241 of the PHS Act to carry out section 2691 of such Act, notwithstanding subsection (a) of such section 2691.*

HEALTH CARE SYSTEMS

For carrying out titles III and XII of the PHS Act with respect to health care systems, and the Stem Cell Therapeutic and Research Act of 2005, **[**$103,193,000,**]***$110,193,000,* of which $122,000 shall be available until expended for facilities renovations at the Gillis W. Long Hansen's Disease Center*: Provided, That the Secretary may collect a fee of 0.1 percent of each purchase of 340B drugs from entities participating in the Drug Pricing Program pursuant to section 340B of the PHS Act to pay for the operating costs of such program: Provided further, That fees pursuant to the 340B Drug Pricing Program shall be collected by the Secretary based on sales data that shall be submitted by drug manufacturers and shall be credited to this account to remain available until expended.*

RURAL HEALTH

For carrying out titles III and IV of the PHS Act with respect to rural health, section 427(a) of the Federal Coal Mine Health and Safety Act of 1969, and sections 711 and 1820 of the Social Security Act, **[**$149,571,000**]***$144,162,000,* of which **[**$41,609,000**]***$26,200,000* from general revenues, notwithstanding section 1820(j) of the Social Security Act, shall be available for carrying out the Medicare rural hospital flexibility grants program: *Provided,* That of the funds made available under this heading for Medicare rural hospital flexibility grants, **[**$14,942,000 shall be available for the Small Rural Hospital Improvement Grant Program for quality improvement and adoption of health information technology and**]** up to $1,000,000 shall be to

carry out section 1820(g)(6) of the Social Security Act, with funds provided for grants under section 1820(g)(6) available for the purchase and implementation of telehealth services, including pilots and demonstrations on the use of electronic health records to coordinate rural veterans care between rural providers and the Department of Veterans Affairs electronic health record system: *Provided further*, That notwithstanding section 338J(k) of the PHS Act, $9,511,000 shall be available for State Offices of Rural Health.

FAMILY PLANNING

For carrying out the program under title X of the PHS Act to provide for voluntary family planning projects, **[**$286,479,000**]***$300,000,000*: *Provided*, That amounts provided to said projects under such title shall not be expended for abortions, that all pregnancy counseling shall be nondirective, and that such amounts shall not be expended for any activity (including the publication or distribution of literature) that in any way tends to promote public support or opposition to any legislative proposal or candidate for public office.

PROGRAM MANAGEMENT

For program support in the Health Resources and Services Administration, **[**$154,000,000**]***$157,061,000*: *Provided*, That funds made available under this heading may be used to supplement program support funding provided under the headings "Primary Health Care", "Health Workforce", "Maternal and Child Health", "Ryan White HIV/AIDS Program", "Health Care Systems", and "Rural Health": *Provided further, That the Administrator may transfer discretionary funds (pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985) which are appropriated for the current fiscal year for HRSA between any of the accounts of HRSA with notification to the Committees on Appropriations of both Houses of Congress at least 15 days in advance of any transfer, but no such account shall be decreased by more than 3 percent by any such transfer.*

GENERAL PROVISIONS

SEC. 223. Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended by adding at the end the following new subsection: "(f) The Secretary may issue regulations with binding and future effect for the program authorized by this section."

Language Analysis

LANGUAGE PROVISION	EXPLANATION
[(in addition to the $3,600,000,000 previously appropriated to the Community Health Center Fund for fiscal year 2016)**]**	Language specific to FY 2016 removed.
[*Provided further*, That of funds provided for the Health Centers program, as defined by section 330 of the PHS Act, by this Act or any other Act for fiscal year 2016, not less than $200,000,000 shall be obligated in fiscal year 2016 to support new access points, grants to expand medical services, behavioral health, oral health, pharmacy, or vision services, and not less than $150,000,000 shall be obligated in fiscal year 2016 for construction and capital improvement costs: *Provided further*, That the time limitation in section 330(e)(3) of the PHS Act shall not apply in fiscal year 2016.]	Language removed that provided allocations specific to FY 2016.
Provided, That $20,000,000, to remain available until expended, shall be for the National Health Service Corps Program:	Language added to provide discretionary funding for National Health Service Corps Program.
Provided, That sections 747(c)(2), **[**751(j)(2),**]** 762(k), and the proportional funding amounts in paragraphs (1) through (4) of section 756(e) of the PHS Act shall not apply to funds made available under this heading: **[***Provided further*, That for any program operating under section 751 of the PHS Act on or before January 1, 2009, the Secretary of Health and Human Services (referred to in this title as the "Secretary") may hereafter waive any of the requirements contained in sections 751(d)(2)(A) and 751(d)(2)(B) of such Act for the full project period of a grant under such section:**]**	Language and citation regarding the Area Health Education Centers is removed because no funding is requested for this program.
Provided further, That no funds shall be available for section 340G-1 of the PHS Act:**]**	Language specific to FY 2016 removed.
Provided, That in addition to amounts provided herein, $34,000,000 shall be available under section 241 of the PHS Act to carry out section 2691 of such Act, notwithstanding subsection (a) of such section	Language added to authorize evaluation funding under section 241 of the PHS Act for the Special Program of National Significance.

LANGUAGE PROVISION	EXPLANATION
2691.	
Provided, That the Secretary may collect a fee of 0.1 percent of each purchase of 340B drugs from entities participating in the Drug Pricing Program pursuant to section 340B of the PHS Act to pay for the operating costs of such program: Provided further, That fees pursuant to the 340B Drug Pricing Program shall be collected by the Secretary based on sales data that shall be submitted by drug manufacturers and shall be credited to this account to remain available until expended.	Language added to authorize the Secretary to collect and spend user fees for the 340B Drug Pricing Program.
[$14,942,000 shall be available for the Small Rural Hospital Improvement Grant Program for quality improvement and adoption of health information technology and**]**	Citation removed as funding is not requested.
Provided further, That the Administrator may transfer discretionary funds (pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985) which are appropriated for the current fiscal year for HRSA between any of the accounts of HRSA with notification to the Committees on Appropriations of both Houses of Congress at least 15 days in advance of any transfer, but no such account shall be decreased by more than 3 percent by any such transfer.	Language added to provide permissive authority to the HRSA administrator to transfer funds between HRSA accounts.
Sec. 223. Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended by adding at the end the following new subsection: "(f) The Secretary may issue regulations with binding and future effect for the program authorized by this section.".	This provision provides the Secretary with express rulemaking authority for the Health Resources and Services Administration's 340B prescription drug program.

Amounts Available for Obligation[1]

	FY 2015 Final	FY 2016 Enacted	FY 2017 Estimate
Discretionary Appropriation:			
Annual	$6,104,784,000	$6,139,558,000	$5,733,481,000
Appropriations Permanently Reduced	-	-	-
Subtotal, adjusted appropriation	**6,104,784,000**	**6,139,558,000**	**5,733,481,000**
Mandatory Appropriation:			
Family to Family Health Information Centers	+5,000,000	+5,000,000	5,000,000
Primary Health Care Access:			
Community Health Center Fund	+3,509,111,000	+3,600,000,000	+3,750,000,000
National Health Service Corps	+287,370,000	+310,000,000	+360,000,000
Subtotal Primary Health Care Access(non-add)	*+3,796,481,000*	*+3,910,000,000*	*+4,110,000,000*
Early Childhood Visitation	+400,000,000	+400,000,000	+400,000,000
Children's Hospital Graduate Medical Education	-	-	+295,000,000
Teaching Health Centers Graduate Medical Education	-	+60,000,000	+60,000,000
Transfer to Other Accounts	-	-5,000,000	-5,000,000
Appropriations Permanently Reduced	-113,519,000	-	-
Subtotal, adjusted budget authority	**+10,419,784,000**	**+10,519,558,000**	**+10,608,481,000**
Offsetting Collections	+18,814,000	+21,037,000	+64,037,000
Subtotal, Spending Authority from offsetting collections	**+18,814,000**	**+21,037,000**	**+64,037,000**
Unobligated balance, start of year	+325,362,000	+422,741,000	+299,000,000
Unobligated balance, end of year	-422,741,000	-299,000,000	-191,000,000
Recovery of prior year obligations	+ 42,253,000	-	-
Unobligated balance, lapsing	+8,718,000	-	-
Total Obligations	**$11,237,672,000**	**$11,262,336,000**	**$10,780,518,000**

[1] Excludes the following amounts for reimbursable activities carried out by this account: FY 2015 - $12,973,000 and 17 FTE; FY 2016 - $13,136,000 and 18 FTE; FY 2017 $10,539,000 and 17 FTE.

Summary of Changes

2016 Enacted	$6,189,558,000
(Obligations)	(-$6,189,558,000)
2017 Estimate	$5,733,481,000
(Obligations)	(-$5,733,481,000)
2016 Mandatory	$4,375,000,000
(Obligations)	(-$4,375,000,000)
2017 Mandatory	$4,870,000,000
(Obligations)	(-$4,870,000,000)
Net Change	**+$38,923,000**
(Obligations)	**+$38,923,000**

	2016 Current		FY 2017	Changes from Base	
	FTE	**Budget Authority**		**FTE**	**Budget Authority**
Increases:					
A. Built in:	2,016			+ 1	
1. January 2017 Civilian Pay Raise		295,034,978			2,581,538
2. January 2017 Military Pay Raise		295,034,978			188,763
3. Civilian Annualization of Jan. 2016		295,034,978			859,595
4. Military Annualization of Jan. 2016		295,034,978			34,559
Subtotal, built-in increases					***3,664,455***
B. Program:					
Discretionary Increases					
Free Clinics Medical Malpractice	-	100,000	1,000,000	-	+900,000
National Health Service Corps	-	-	20,000,000	-	+20,000,000
Scholarships for Disadvantaged Students	5	45,970,000	49,070,000	-	+3,100,000
Behavioral Health Workforce Education and Training	-	50,000,000	56,000,000	-	+6,000,000
Early Intervention - Part C	42	205,079,000	280,167,000	+12	+75,088,000
340B Drug Pricing Program/Office of Pharmacy Affairs	25	10,238,000	17,238,000	-	+7,000,000
Rural Opioid Overdose Reversal Grant Program	-	-	10,000,000	+2	+10,000,000
Program Management	825	154,000,000	157,061,000	-	+3,061,000

	2016 Current		FY 2017	Changes from Base	
	FTE	Budget Authority		FTE	Budget Authority
Family Planning	35	286,479,000	300,000,000	-	+13,521,000
Subtotal Discretionary Program Increases	***932***	***751,866,000***	***890,536,000***	***+14***	***+138,670,000***
Mandatory Increases					
Health Centers	170	3,600,000,000	3,750,000,000	-	+150,000,000
National Health Service Corps	284	310,000,000	360,000,000	-	+50,000,000
Children's Hospital Graduate Medical Education	-	-	295,000,000	+22	+295,000,000
Subtotal Mandatory Program Increases	***454***	***3,910,000,000***	***4,405,000,000***	***+22***	***+495,000,000***
Total Program Increases	**1,386**	**4,661,866,000**	**5,295,536,000**	**+ 36**	**633,670,000**
Decreases:					
A. Built in:					
1. Pay Costs		**-295,034,978**			**-3,664,455**
B. Program:					
Discretionary Decreases					
Health Centers	189	1,391,529,000	1,241,529,000	-	-150,000,000
Area Health Education Centers	4	30,250,000	-	-4	-30,250,000
Public Health/Preventive Medicine	4	21,000,000	17,000,000	-	-4,000,000
Children's Hospitals Graduate Medical Education Program	22	295,000,000	-	-22	-295,000,000
Children, Youth, Women & Families - Part D	12	75,088,000	-	-12	-75,088,000
Special Program of National Significance (SPNS)	1	25,000,000	-	-1	-25,000,000
Rural Hospital Flexibility Grants	3	41,609,000	26,200,000	-	-15,409,000
Subtotal Discretionary Program Decreases	***235***	***1,879,476,000***	***1,284,729,000***	***-39***	***-594,747,000***
Mandatory Decreases	-	-	-	-	-
Total Program Decreases	**235**	**$ 1,879,476,000**	**$ 1,284,729,000**	**-39**	**-$594,747,000**
Net Change Discretionary	**1,167**	**$ 2,631,342,000**	**$ 2,175,265,000**	**-25**	**-$456,077,000**
Net Change Mandatory	**454**	**$ 3,910,000,000**	**$ 4,405,000,000**	**+22**	**+$495,000,000**
Net Change Discretionary and Mandatory	**1,621**	**$ 6,541,342,000**	**$ 6,580,265,000**	**-3**	**+$38,923,000**

Budget Authority by Activity

	FY 2015	FY 2016	FY 2017
	Final	**Enacted**	**President's Budget**
1. PRIMARY CARE:			
Health Centers	1,391,529	1,391,529	1,241,529
Health Centers ACA Mandatory	3,509,111	-	-
Health Centers Mandatory	-	3,600,000	3,600,000
Health Centers Proposed Mandatory	-	-	150,000
Health Center Tort Claims	99,893	99,893	99,893
Subtotal, Health Centers	***5,000,533***	***5,091,422***	***5,091,422***
Free Clinics Medical Malpractice	100	100	1,000
Subtotal, Bureau of Primary Health Care (BPHC)	**5,000,633**	**5,091,522**	**5,092,422**
2. HEALTH WORKFORCE:			
National Health Service Corps (NHSC):			
NHSC	-	-	20,000
NHSC ACA Mandatory	287,370	-	-
NHSC Mandatory	-	310,000	310,000
NHSC Mandatory Proposed	-	-	50,000
Subtotal, NHSC	***287,370***	***310,000***	***380,000***
Loan Repayment/Faculty Fellowships	1,190	1,190	1,190
Health Professions Training for Diversity:			
Centers of Excellence	21,711	21,711	21,711
Scholarships for Disadvantaged Students	45,970	45,970	49,070
Health Careers Opportunity Program	14,189	14,189	14,189
Health Workforce Diversity	-	-	-
Subtotal, Health Professions Training for Diversity	***81,870***	***81,870***	***84,970***
Health Care Workforce Assessment	4,663	4,663	4,663
Primary Care Training and Enhancement	38,924	38,924	38,924
Oral Health Training Programs	33,928	35,873	35,873
Interdisciplinary, Community-Based Linkages:			
Area Health Education Centers	30,250	30,250	-
Geriatric Programs	34,237	38,737	38,737
Behavioral Health Workforce Education and Training	35,000	50,000	56,000
Mental and Behavioral Health	8,916	9,916	9,916
Clinical Training in Interprofessional Practice	-	-	-
Subtotal, Interdisciplinary, Community-Based Linkages	***108,403***	***128,903***	***104,653***
Public Health Workforce Development:			

	FY 2015	FY 2016	FY 2017
	Final	**Enacted**	**President's Budget**
Public Health/Preventive Medicine	21,000	21,000	17,000
Nursing Workforce Development:			
Advanced Nursing Education	63,581	64,581	64,581
Nursing Workforce Diversity	15,343	15,343	15,343
Nurse Education, Practice and Retention	39,913	39,913	39,913
Nurse Faculty Loan Program	26,500	26,500	26,500
Comprehensive Geriatric Education	4,500	-	-
NURSE Corps Scholarship and Loan Repayment Program	81,785	83,135	83,135
Subtotal, Nursing Workforce Development	***231,622***	***229,472***	***229,472***
Children's Hospital Graduate Medical Education	265,000	295,000	-
Children's Hospital Graduate Medical Education Proposed Mandatory	-	-	295,000
Teaching Health Center Graduate Medical Education Mandatory	-	60,000	60,000
Targeted Support for Graduate Medical Education Proposed Mandatory	-	-	-
National Practitioner Data Bank (User Fees)	*18,814*	*21,037*	*21,037*
Subtotal, Bureau of Health Workforce (BHW)	**1,092,784**	**1,227,932**	**1,272,782**
3. MATERNAL & CHILD HEALTH:			
Maternal and Child Health Block Grant	637,000	638,200	638,200
Autism and Other Developmental Disorders	47,099	47,099	47,099
Sickle Cell Service Demonstrations	4,455	4,455	4,455
James T. Walsh Universal Newborn Hearing Screening	17,818	17,818	17,818
Emergency Medical Services for Children	20,162	20,162	20,162
Healthy Start	102,000	103,500	103,500
Heritable Disorders	13,883	13,883	13,883
Family-to-Family Health Information Centers Mandatory	5,000	5,000	5,000
Maternal, Infant and Early Childhood Home Visiting Program Mandatory	400,000	400,000	400,000
Subtotal, Maternal and Child Health Bureau (MCHB)	**1,247,417**	**1,250,117**	**1,250,117**
4. HIV/AIDS:			
Emergency Relief - Part A	655,220	655,876	655,876
Comprehensive Care - Part B	1,315,005	1,315,005	1,315,005
AIDS Drug Assistance Program (non-add)	*900,313*	*900,313*	*900,313*
Early Intervention - Part C	204,179	205,079	280,167
Children, Youth, Women & Families - Part D	73,008	75,088	-
AIDS Education and Training Centers - Part F	33,349	33,611	33,611
Dental Reimbursement Program Part F	13,020	13,122	13,122
Special Program of National Significance (SPNS)	25,000	25,000	-
SPNS Evaluation Funds	-	-	*34,000*

	FY 2015	FY 2016	FY 2017
	Final	**Enacted**	**President's Budget**
Hepatitis C Treatment in People Living with HIV (non-add)	-	-	*9,000*
Subtotal, HIV/AIDS Bureau	**2,318,781**	**2,322,781**	**2,331,781**
5. HEALTHCARE SYSTEMS:			
Organ Transplantation	23,549	23,549	23,549
National Cord Blood Inventory	11,266	11,266	11,266
C.W. Bill Young Cell Transplantation Program	22,109	22,109	22,109
Poison Control Centers	18,846	18,846	18,846
340B Drug Pricing Program/Office of Pharmacy Affairs	10,238	10,238	26,238
340B Drug Pricing Program User Fees (non-add)	-	-	*9,000*
Hansen's Disease Center	15,206	15,206	15,206
Payment to Hawaii	1,857	1,857	1,857
National Hansen's Disease Program - Buildings and Facilities	122	122	122
Subtotal, Healthcare Systems Bureau (HSB)	**103,193**	**103,193**	**119,193**
Subtotal, User Fees HSB (non-add)	-	-	9,000
Subtotal, Discretionary HSB (non-add)	*103,193*	*103,193*	*110,193*
6. RURAL HEALTH:			
Rural Health Policy Development	9,351	9,351	9,351
Rural Health Outreach Grants	59,000	63,500	63,500
Rural & Community Access to Emergency Devices	4,500	-	-
Rural Hospital Flexibility Grants	41,609	41,609	26,200
State Offices of Rural Health	9,511	9,511	9,511
Radiation Exposure Screening and Education Program	1,834	1,834	1,834
Black Lung	6,766	6,766	6,766
Telehealth	14,900	17,000	17,000
Rural Opioid Overdose Reversal Grant Program	-	-	10,000
Subtotal, Federal Office of Rural Health Policy	**147,471**	**149,571**	**144,162**
7. PROGRAM MANAGEMENT	154,000	154,000	157,061
8. FAMILY PLANNING	286,479	286,479	300,000
TOTAL, Discretionary Budget Authority	**6,130,463**	**6,189,558**	**5,733,481**
FTE (excludes Vaccine)	**1,845**	**2,084**	**2,094**

Authorizing Legislation

	FY 2016 Amount Authorized	FY 2016 Final	FY 2017 Amount Authorized	FY 2017 President's Budget
PRIMARY HEALTH CARE:				
Health Centers: Public Health Service (PHS) Act, Section 330, as amended by the Affordable Care Act, P.L. 111-148, Section 5601	Authorized for FY 2016 (and each subsequent year), an amount equal to the previous year's funding adjusted for any increase in the number of patients served and the per-patient costs	1,391,529,000	Authorized for FY 2017 (and each subsequent year), an amount equal to the previous year's funding adjusted for any increase in the number of patients served and the per-patient costs	1,241,529,000
Health Centers (Mandatory): P.L. 111-148, Section 10503; as amended by the Health Care and Education Reconciliation Act, P.L 111-152, Section 2303; as amended by the Medicare Access and CHIP Reauthorization Act, P.L. 114-10, Section 221 (see 42 USC 254b-2)	3,600,000,000	3,600,000,000	3,600,000,000	3,750,000,000
Federal Tort Claims Act Coverage for Health Centers: PHS Act, Section 224, as added by P.L. 102-501 and amended by P.L. 104-73	$10,000,000 per fiscal year is authorized under Section. 224; funding comes from the Health Center line	99,893,000	$10,000,000 per fiscal year is authorized under Section 224; funding comes from the Health Center line	99,893,000
Federal Tort Claims Act Coverage for Free Clinics: PHS Act, Section 224, as added to the PHS Act by P.L. 104-191; as amended by P.L. 111-148, Section 10608	$10,000,000 per fiscal year is authorized	100,000	$10,000,000 per fiscal year is authorized	1,000,000
BUREAU OF HEALTH WORKFORCE:				
National Health Service Corps (NHSC): NHSC: PHS Act, Sections 331-338, as amended by the Health Care Safety Net Act of 2008, P.L. 110-355, Section 3(a)(1) and 3(b)-(d); as amended by the Affordable Care Act, P.L. 111-148, Section 10501(n)(1)-(3)	Authorized for FY 2016 (and subsequent years), based on previous year's funding, subject to adjustment	---	Authorized for FY 2017 (and subsequent years), based on previous year's funding, subject to adjustment	20,000,000
NHSC (Mandatory): Affordable Care Act, P.L. 111-148, Section 10503(b)(2), as amended by the Medicare and CHIP Reauthorization Act, P.L. 114-10, Section 221 (see 42 USC 254b-2)	310,000,000	310,000,000	310,000,000	360,000,000

	FY 2016 Amount Authorized	FY 2016 Final	FY 2017 Amount Authorized	FY 2017 President's Budget
NHSC Scholarship Program: PHS Act, Sections 338A and 338C-H, as amended by P.L. 110-355, Section 3(a)(2); as amended by P.L. 111-148, Sections 5207, 5508(b), 10501(n)(5) NHSC Loan Repayment Program: PHS Act, Sections 338B and 338C-H, as amended by P.L. 110-355, Section 3(a)(2); as amended by P.L. 111-148, Sections 5207, 5508(b), 10501(n)(4) and (n)(5) Students to Service (S2S) Loan Repayment Program: PHS Act, Section 338B and Section 331(i) State Loan Repayment Program (SLRP): PHS Act, Section 338I(a)-(i), as amended by P.L. 107-251, Section 315; as further amended by P.L. 110-355, Section 3(e)	Indefinite Expired		Indefinite Expired	
Loan Repayments and Fellowships Regarding Faculty Positions (Faculty Loan Repayment): PHS Act, Section 738(a) and 740(b), as amended by P.L. 111-148, Sections 5402 and 10501(d)	Expired	1,190,000	Expired	1,190,000
Centers of Excellence: Section 736, PHS Act, as amended by P.L. 111-148, Section 5401	Such Sums as Necessary (SSAN)	21,711,000	SSAN	21,711,000
Scholarships for Disadvantaged Students: PHS Act, Section 737, as amended by P.L. 111-148, Section 5402(b)	Expired	45,970,000	Expired	49,070,000
Health Careers Opportunity Program: PHS Act, Section 739, as amended by P.L. 111-148, Section 5402	Expired	14,189,000	Expired	14,189,000
National Center for Workforce Analysis: PHS Act, Section 761(b), as amended by P.L. 111-148, Section 5103	Expired	4,663,000	Expired	4,663,000
Primary Care Training and Enhancement: PHS Act, Section 747, as amended by P.L. 111-148, Section 5301	Expired	38,924,000	Expired	38,924,000
Oral Health Training Programs (Training in General, Pediatric, and Public Health Dentistry): PHS Act, Section 748, as added by P.L. 111-148, Section 5303	Expired (with provision for carryover funds)	35,873,000	Expired (with provision for carryover funds)	35,873,000
Interdisciplinary, Community-Based Linkages: Area Health Education Centers:	Expired	30,250,000	Expired	--

	FY 2016 Amount Authorized	FY 2016 Final	FY 2017 Amount Authorized	FY 2017 President's Budget
PHS Act, Section 751, as amended by P.L. 111-148, Section 5403				
Behavioral Health Workforce Education and Training: PHS Act, Sections 501, 509, 516, and 520A	Expired	50,000,000	Expired	56,000,000
Education and Training Related to Geriatrics: PHS Act, Section 753, as amended by P.L. 111-148, Section 5305	Expired	38,737,000	Expired	38,737,000
Mental and Behavioral Health Education and Training Grants: PHS Act, Section 756, as added by P.L. 111-148, Section 5306	Expired	9,916,000	Expired	9,916,000
Public Health /Preventive Medicine: PHS Act, Sections 765-768, as amended by P.L. 111-148, Section 10501	Expired	21,000,000	Expired	17,000,000
Nursing Workforce Development: Advanced Education Nursing: PHS Act, Section 811, as amended by P.L. 111-148, Section 5308	Expired	64,581,000	Expired	64,581,000
Nursing Workforce Diversity PHS Act, Section 821, as amended by P.L. 111-148, Sec. 5404	Expired	15,343,000	Expired	15,343,000
Nurse Education, Practice, Quality and Retention : PHS Act, Section 831 and 831A, as amended by P.L. 111-148, Section 5309	Expired	39,913,000	Expired	39,913,000
Nurse Faculty Loan Program: PHS Act, Section 846A, as amended by P.L. 111-148, Section 5311	Expired	26,500,000	Expired	26,500,000
Comprehensive Geriatric Education: PHS Act, Section 865, as re-designated by P.L. 111-148, Section 5310(b)	Expired	0	Expired	0
NURSE Corps (formerly Nursing Education Loan Repayment and Scholarship Programs): PHS Act, Section 846(a), as amended by P.L. 107-205, Section 103; and NURSE Corps Loan Repayment only, as amended by P.L. 111-148, Section 5310	Expired	83,135,000	Expired	83,135,000
Children's Hospitals Graduate Medical Education Program: PHS Act, Section 340E, as amended by P.L. 108-490; and amended by P.L. 109-307; as amended by P.L. 113-98, Section 2	Direct GME: 100,000,000 Indirect Medical Education: 200,000,000	295,000,000	Direct GME: 100,000,000 Indirect Medical Education: 200,000,000	295,000,000

	FY 2016 Amount Authorized	FY 2016 Final	FY 2017 Amount Authorized	FY 2017 President's Budget
Teaching Health Centers Graduate Medical Education Program: PHS Act, Section 340H,, as added by P.L. 111-148, Section 5508, as amended by the Medicare Access and CHIP Reauthorization Act, P.L. 114-10, Section 221	60,000,000 (mandated)	60,000,000	60,000,000 (mandated)	60,000,000
National Practitioner Data Bank: (User Fees) *Title IV, P.L. 99-660, SSA, Section 1921; P.L. 100-508, SSA, Section 1128E* *(also includes: Health Care Integrity and Protection Data Bank (HIPDB), SSA, Section 1128E)*	Indefinite	21.037,000	Indefinite	21,037,000
MATERNAL & CHILD HEALTH:				
Maternal and Child Health Block Grant: Social Security Act, Title V	Indefinite at 850,000,000	638,200,000	Indefinite at 850,000,000	638,200,000
Autism Education, Early Detection and Intervention: PHS Act, Section 399BB, as added by P.L. 109-416, Part R; reauthorized: P.L. 112-32, Section 2; reauthorized: P.L. 113-157, Section 4	Not Specified (sunset 9/30/2019)	47,099,000	Not Specified (sunset 9/30/2019)	47,099,000
Sickle Cell Service Demonstration Grants: As added by the American Jobs Creation Act of 2004, P.L. 108-357, Section 712(c)	Expired	4,455,000	Expired	4,455,000
Universal Newborn Hearing Screening: PHS Act, Section 399M, as amended by P.L. 106-310, Section 702; as amended by P.L. 111-337, Section 2	Expired	17,818,000	Expired	17,818,000
Emergency Medical Services for Children: PHS Act, Section 1910, as amended by P.L. 105-392, Section 415; as amended by P.L. 111-148, Section 5603; as amended by P.L. 113-180, Section 2	20,213,000	20,162,000	20,213,000	20,162,000
Healthy Start: PHS Act, Section 330H(a)-(d), as amended by P.L. 106-310, Section 1501; as amended by P.L. 110-339, Section 2	Expired	103,500,000	Expired	103,500,000
Heritable Disorders: PHS Act, Section 1109-1112 and 1114, as amended by P.L. 106-310, Section 2601; as	11,900,000 (Sections 1109-1112);	13,883,000	11,900,000 (Sections 1109-1112);	13,883,000

	FY 2016 Amount Authorized	FY 2016 Final	FY 2017 Amount Authorized	FY 2017 President's Budget
amended by P.L. 110-204, Section 2; as amended by P.L. 110-237, Section 1; as amended by P.L. 113-240, Section 10 (see PHS Act, Section 1117-authorization levels)	8,000,000 (Section 1113)		8,000,000 (Section 1113)	
Family to Family Health Information Centers: Social Security Act, Section 501(c)(1)(A), as amended by P.L. 109-171, Section 6064; reauthorized: Affordable Care Act, P.L. 111-148, Section 5507, as amended by P.L. 112-240, Section 624; as amended by P.L. 113-67, Section 1203; as amended by P.L. 113-93, Section 207; as amended by the Medicare Access and CHIP Reauthorization Act, P.L. 114-10, Section 216	5,000,000 (mandated)	5,000,000	5,000,000 (mandated)	5,000,000
Maternal, Infant and Early Childhood Visiting Program: Section 511(j), Social Security Act, as added by the Affordable Care Act, P.L. 111-148, Section 2951; as amended by P.L. 113-93, Section 209; as amended by the Medicare Access and CHIP Reauthorization Act, Section 218	400,000,000 (mandated)	400,000,000	400,000,000 (mandated)	400,000,000
HIV/AIDS:[2]				
Emergency Relief - Part A PHS Act, Section. 2601-10, as amended by P.L. 106-345; as amended by P.L. 109-415; as amended by P.L. 111-87	Expired	655,876,000	Expired	655,876,000
Comprehensive Care - Part B: PHS Act, Section. 2611-31, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	1,315,005,000	Expired	1,315,005,000
AIDS Drug Assistance Program (Non-Add) PHS Act, Section. 2611-31 and 2616, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	*Expired*	*900,313,000*	*Expired*	*900,313,000*
Early Intervention – Part C: PHS Act, Section. 2651-67, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	205,079,000	Expired	280,167,000
Coordinated Services and Access to Research for Women, Infants, Children and Youth - Part D: PHS Act, Section 2671, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	75,088,000	Expired	--
Education and Training Centers - Part F: PHS Act, Section 2692(a), as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	33,611,000	Expired	33,611,000

2 The Ryan White Program was authorized through September 30, 2013. However, the program will continue to operate with appropriations. The 2009 reauthorization of the Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87, October 30, 2009) removed the explicit sunset clause. In the absence of the sunset clause, the program will continue to operate without a Congressional reauthorization.

	FY 2016 Amount Authorized	FY 2016 Final	FY 2017 Amount Authorized	FY 2017 President's Budget
Dental Reimbursement Program - Part F: PHS Act, Section 2692(b), as amended by P.L. 106-345, as amended by P.L.109-415, as amended by P.L.111-87	Expired	13,122,000	Expired	13,122,000
Special Projects of National Significance - Part F: PHS Act, Section 2691, as amended by P.L. 104-146, as amended by P.L. 109-415, as amended by P.L. 111-87	Expired	25,000,000	Expired	34,000,000
HEALTHCARE SYSTEMS:				
Organ Transplantation: PHS Act, Sections 371-378, as amended	Expired	23,549,000	Expired	23,549,000
National Cord Blood Inventory: PHS Act, Section 379; as amended by P.L. 109-129, Section 3; as amended by P.L. 111-264; as amended by the Stem Cell Therapeutic and Research Reauthorization Act, P.L. 114-104, Section 3	23,000,000	11,266,000	23,000,000	11,266,000
C.W. Bill Young Cell Transplantation Program: PHS Act, Sections 379-379B, as amended by P.L. 109-129, Section 3; as amended by P.L. 111-264; as amended by the Stem Cell Therapeutic and Research Reauthorization Act, P.L. 114-104, Section 2	30,000,000	22,109,000	30,000,000	22,109,000
Poison Control Centers: PHS Act, Sections 1271-1274, as amended by P.L. 106-174; as amended by P.L. 110-377; as amended by P.L. 113-77	28,600,000	18,846,000	28,600,000	18,846,000
340B Drug Pricing Program: 340B Drug Pricing Program Discretionary: PHS Act, Section 340B, as amended by P.L. 111-148, Section 7101-7103; as amended by P.L. 111-152, Section 2302; as amended by P.L. 111-309, Section 204 *340B Drug Pricing Program/User Fees*	SSAN	10,238,000	SSAN	17,238,000 9,000,000
National Hansen's Disease Program: PHS Act, Section 320, as amended by P.L. 105-78, Section 211	Not Specified	15,206,000	Not Specified	15,206,000
Payment to Hawaii: PHS Act, Section 320(d), as amended by P.L. 105-78, Section 211	Not Specified	1,857,000	Not Specified	1,857,000
National Hansen's Disease - Buildings and Facilities: PHS Act, Section 320 and 321(a)	Not Specified	122,000	Not Specified	122,000
RURAL HEALTH:				
Rural Health Policy Development: Social Security Act, Section 711, and PHS Act, Section 301	Indefinite	9,351,000	Indefinite	9,351,000

	FY 2016 Amount Authorized	FY 2016 Final	FY 2017 Amount Authorized	FY 2017 President's Budget
Rural Health Outreach Network Development and Small Health Care Provider Quality Improvement: PHS Act, Section 330A, as amended by P.L. 107-251, Section 201; as amended by P.L. 110-355, Section 4	Expired	63,500,000	Expired	63,500,000
Rural Hospital Flexibility Grants: SSA, Section 1820(j), as amended by P.L. 105-33, Section 4201(a), and P.L. 108-173, Section 405(f), as amended by, P.L. 110-275, Section 121	Expired	41,609,000	Expired	26,200,000
State Offices of Rural Health: PHS Act, Section 338J, as amended by P.L. 105-392, Section 301	Expired	9,511,000	Expired	9,511,000
Radiogenic Diseases (Radiation Exposure Screening and Education Program): PHS Act, Section 417C, as amended by P.L. 106-245, Section 4, as amended by P.L. 109-482, Sections 103, 104	Indefinite	1,834,000	Indefinite	1,834,000
Black Lung: Federal Mine Safety and Health Act 1977, P.L. 91-173, Section 427(a)	Indefinite	6,766,000	Indefinite	6,766,000
Telehealth: PHS Act, Sec. 330I, as amended by P.L. 107-251, as amended by P.L. 108-163; as amended by P.L. 113-55, Section 103	Expired	17,000,000	Expired	17,000,000
Rural Opioid Overdose Reversal Grant		--		10,000,000
OTHER PROGRAMS:				
Family Planning: Grants: PHS Act Title X	Expired	286,479,000	Expired	300,000,000
Program Management	Indefinite	154,000,000	Indefinite	157,061,000
Vaccine Injury Compensation Program Trust Fund: PHS Act, Title XXI, Subtitle 2, Section. 2110-34	Indefinite	244,500,000	Indefinite	249,200,000
UNFUNDED AUTHORIZATIONS:				
Health Center Demonstration Project for Individualized Wellness Plans PHS Act, Section 330(s), as added to PHS Act by P.L. 111-148, Section 4206	SSAN		SSAN	
School Based Health Centers - Facilities Construction Affordable Care Act, P.L. 111-148, Section 4101(a)	Expired		Expired	
School Based Health Centers - Operations PHS Act, Section 399Z-1, as added by Affordable Care Act, P.L. 111-148, Section 4101(b)	(available until expended)		(available until expended)	

	FY 2016 Amount Authorized	FY 2016 Final	FY 2017 Amount Authorized	FY 2017 President's Budget
Health Information Technology Innovation Initiative PHS Act, Section 330(e)(1)(C), (Grants for Operation of Health Center Networks and Plans), as amended	SSAN		SSAN	
Health Information Technology Planning Grants PHS Act, Section 330(c)(1)(B)-(C), as amended	SSAN		SSAN	
Electronic Health Record Implementation Initiative PHS Act, Section 330(e)(1)(C), as amended	SSAN		SSAN	
Native Hawaiian Health Scholarships: 42 USC 11709, as amended by P.L. 111-148, Section 10221 (incorporating Section 202(a) of title II of Senate Indian Affairs Committee-reported S. 1790)	SSAN (through FY 2019)		SSAN (through FY 2019)	
Health Professions Education in Health Disparities and Cultural Competency PHS Act, Section 741, as amended by P.L. 111-148, Section 5307	Expired		Expired	
Training Opportunities for Direct Care Workers PHS Act, Section 747A, as added by P.L. 111-148, Section 5302	Expired		Expired	
Continuing Education Support for Health Professionals Serving in Underserved Communities PHS Act, Section 752, as amended by P.L. 111-148, Section 5403	SSAN		SSAN	
Geriatric Career Incentive Awards PHS Act, Section 753(e), as amended by P.L. 111-148, Section 5305(a)	Expired		Expired	
Geriatric Academic Career Awards PHS Act, Section 753(c), as amended by P.L. 111-148, Section 5305(b)	Not Specified		Not Specified	
Rural Interdisciplinary Training (Burdick) PHS Act, Section 754	Not Specified		Not Specified	
Grants for Pain Care Education & Training, PHS Act, Section 759, as added by P.L.111-148, Section 4305	(amounts appropriated remain available until expended)		(amounts appropriated remain available until expended)	
Advisory Council on Graduate Medical Education PHS Act, Section 762, as amended by P.L. 111-148, Section 5103	(Amounts otherwise appropriated under this subchapter (V-Health Professions Education) may be utilized by the Secretary to support its		(Amounts otherwise appropriated under this subchapter (V-Health Professions Education) may be utilized by the	

	FY 2016 Amount Authorized	FY 2016 Final	FY 2017 Amount Authorized	FY 2017 President's Budget
	activities; however, subsection (k) states "the Council shall terminate September 30, 2003")		Secretary to support its activities; however, subsection (k) states "the Council shall terminate September 30, 2003")	
Health Professions Education in Health Disparities and Cultural Competency PHS Act, Section 807, as amended by P.L. 111-148, Section 5307	Expired		Expired	
Minority Faculty Fellowship Program PHS Act, Section 738 (authorized appropriation Section 740(b)), as amended by P.L.111-148, Sections 5402, 10501	Expired		Expired	
State Health Care Workforce Development Grants and Implementation Grants 42 U.S.C. 294r, as added by P.L. 111-148, Section 5102	SSAN		SSAN	
Allied Health and Other Disciplines PHS Act, Section 755	Not Specified		Not Specified	
Nurse Managed Health Clinics [Prevention Fund], PHS Act, Section 330A-1, as added by P.L. 111-148, Section 5208	Expired		Expired	
Patient Navigator (Outreach & Chronic Disease Prevention Act of 2005): PHS Act, Section 340A, as amended by P.L. 111-148, Section 3510	SSAN		SSAN	
Teaching Health Centers Development Grants, PHS Act, Section 749A, as added by P.L. 111-148, Section 5508	SSAN		SSAN	
Report on Long Term Effects of Living Organ Donation, PHS Act, Section 371A	Not Specified		Not Specified	
Congenital Disabilities PHS Act, Section 399T	Not Specified		Not Specified	
Pediatric Loan Repayment: PHS Act, Section 775, as added by P.L. 111-148, Section 5203	Expired	--	Expired	--
Clinical Training in Interprofessional Practice: PHS Act, Sections 755, 765, 831	--	--	--	--

	FY 2016 Amount Authorized	FY 2016 Final	FY 2017 Amount Authorized	FY 2017 President's Budget
Rural Access to Emergency Devices: PHS Act, Section 313, and Public Health Improvement Act, P.L. 106-505, Section 413	Expired	--	Expired	--

Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2006				
General Fund Appropriation:				
Base	5,966,144,000	6,443,437,000	7,374,952,000	6,629,661,000
Advance				
Supplementals				3,989,000
Rescissions (Government-Wide)				-66,297,000
Rescission, CMS				-4,509,000
Subtotal	5,966,144,000	6,443,437,000	7,374,952,000	6,562,844,000
FY 2007				
General Fund Appropriation:				
Base	6,308,855,000	7,095,617,000	7,012,559,000	6,390,691,000
Mandatory Authority				3,000,000
Advance				
Supplementals				
Rescissions				
Subtotal	6,308,855,000	7,095,617,000	7,012,559,000	6,393,691,000
FY 2008				
General Fund Appropriation:				
Base	5,795,805,000	7,061,709,000	6,863,679,000	6,978,099,000
Mandatory Authority				9,000,000
Advance				
Supplementals				
Rescissions (L/DHHS/E)				-121,907,000
Transfers				
Subtotal	5,795,805,000	7,061,709,000	6,863,679,000	6,865,192,000
FY 2009				
General Fund Appropriation:				
Base	5,864,511,000	7,081,668,000	6,943,926,000	7,234,436,000
Mandatory Authority				5,000,000
Advance				
Supplementals (P.L. 111-5)				2,500,000,000
Rescission of Unobligated Funds				
Transfers				
Subtotal	5,864,511,000	7,081,668,000	6,943,926,000	9,739,436,000

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2010				
General Fund Appropriation:				
Base	7,126,700,000	7,306,817,000	7,238,799,000	7,473,522,000
Advance				
Supplementals				
Rescissions				
Transfers				9,472,000
Subtotal	7,126,700,000	7,306,817,000	7,238,799,000	7,482,994,000
FY 2011				
General Fund Appropriation:				
Base	7,473,522,000		7,491,063,000	6,274,790,000
Supplementals				
Transfers				
Across-the-board reductions (L/HHS/AG, or Interior)				-12,549,000
American Recovery and Reinvestment Act				73,600,000
Subtotal	7,473,522,000		7,491,063,000	6,335,841,000
FY 2012				
General Fund Appropriation:				
Base	6,801,262,000			6,206,204,000
Advance				
Supplementals				
Rescissions				
Across-the-board reductions (L/HHS/AG, or Interior)				11,730,000
Transfers				11,277,000
Subtotal	6,801,262,000			6,205,751,000
FY 2013				
General Fund Appropriation:				
Base	6,067,862,000			6,194,474,000
Advance				
Supplementals				
Rescissions				-12,389,000
Transfers				-15,807,000
Sequestration				-311,619,000
Subtotal	6,067,862,000			5,854,664,000

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2014				
General Fund Appropriation:				
Base	6,015,039,000		6,309,896,000	6,054,378,000
Advance				
Supplementals				
Rescissions				
Transfers				-15,198,000
Subtotal	6,015,039,000		6,309,896,000	6,039,180,000
FY 2015				
General Fund Appropriation:				
Base	5,292,739,000		6,093,916,000	6,104,784,000
Advance				
Supplementals				
Rescissions				
Transfers				
Subtotal[3]	5,292,739,000		6,093,916,000	6,104,784,000
FY 2016				
General Fund Appropriation:				
Base	6,217,677,000	5,804,254,000	5,987,562,000	6,139,558,000
Advance				
Supplementals				
Rescissions				
Transfers				
Subtotal[4]	6,217,677,000	5,804,254,000	5,987,562,000	6,139,558,000
FY 2017				
General Fund Appropriation:	5,733,481,000			
Base				
Advance				
Supplementals				
Rescissions				
Transfers				
Subtotal	5,733,481,000			

[3] Total includes funding for the Traumatic Brain Injury program, which was transferred to the Administration for Community Living. Total does not include funding for the Behavioral Health Workforce Education and Training program, which is proposed to be transferred to HRSA beginning in FY 2017.
[4] Total does not include funding for the Behavioral Health Workforce Education and Training program, which is proposed to be transferred to HRSA beginning in FY 2017.

Appropriations Not Authorized by Law

	Last Year of Authorization	Last Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2016
School-Based Health Centers (facilities construction) – Affordable Care Act, P.L. 111-148, Section 4101(a)	2013	50,000,000	47,450,000	---
National Health Service Corps: State Loan Repayment Program (SLRP) – Public Health Service (PHS) Act, Section 338I(a)-(i), as amended by P.L. 107-251, Section 315; as amended by P.L. 110-355, Section 3(e)	2012	Such sums as necessary (SSAN)	--	--
National Health Service Corps: NHCS (Field subpart) – PHS Act, Section 338(a)	2012	--	--	--
NURSE Corps (formerly Nursing Education Loan Repayment and Scholarship Programs) PHS Act, Section 846(a), as amended by P.L. 107-205, Section 103; and for NURSE Corps Loan Repayment only—as amended by P.L. 111-148, Section 5310	2007	SSAN	31,055,000	83,135,000
Loan Repayments and Fellowships Regarding Faculty Positions (Faculty Loan Repayment) – PHS Act, Section 738(a) and 740(b), as amended by P.L. 111-148, Sections 5402 and 10501(d)	2014	5,000,000	1,187,000	1,190,000
Pediatric Loan Repayment – PHS Act, Section 775(c)(1) (A) and (B), as added by P.L. 111-148, Section 5203	2014	30,000,000	--	--
Scholarships for Disadvantaged Students – PHS Act, Section 737, as amended by P.L. 111-148, Section 5402(b)	2014	SSAN	44,857,000	45,970,000
Health Careers Opportunity Program – PHS Act, Section 739, as amended by P.L. 111-148, Section 5402	2014	SSAN	14,153,000	14,189,000
National Center for Workforce Analysis – PHS Act, Section 761(b), as amended by P.L. 111-148, Section 5103	2014	7,500,000	4,651,000	4,663,000
Primary Care Training and Enhancement -- PHS Act, Section 747, as amended by P.L. 111-148, Section 5301	2014	SSAN	36,831,000	38,924,000
Oral Health Training Programs (Grants for Innovative Programs for Dental Health) – PHS Act, Section 340G	2012	25,000,000 Total (for FY 2008-12)	31,928,000	35,873,000
Area Health Education Centers PHS Act, Section 751, as amended by P.L. 111-148, Section 5403	2014	125,000,000	30,250,000	30,250,000
Education and Training Relating to Geriatrics – PHS Act, Section 753, as amended by P.L. 111-148, Section 5305 • Geriatric Workforce Development	2014	10,800,000	33,237,000	38,737,000

	Last Year of Authorization	Last Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2016
• Geriatric Career Incentive Awards	2013	10,000,000		
Mental & Behavioral Health Education and Training Grants – PHS Act, Section 756, as added by P.L. 111-148, Section 5306	2013	35,000,000 total (for FY 2010-13)	7,896,000	9,916,000
Nursing Workforce Development • Nurse Retention Grants – PHS Act, Section 831A	2012	SSAN		
Nursing Workforce Development • Nurse Education, Practice, and Quality grants – PHS Act, Section 831, as amended by P.L. 111-148, Section 5309	2014	SSAN	37,913,000	39,913,000
Nursing Workforce Development • Nurse Faculty Loan Program – PHS Act, Section 846A, as amended by P.L. 111-148, Section 5311	2014	SSAN	24,500,000	26,500,000
Nursing Workforce Development • Comprehensive Geriatric Education – PHS Act, Section 865, as re-designated by P.L. 111-148, Section 5310(b)	2014	SSAN	4,350,000	--
Sickle Cell Service Demonstration Grants – American Jobs Creation Act of 2004, P.L. 108-357, Section 712(c)	2009	10,000,000	4,455,000	4,455,000
Healthy Start – PHS Act, Section 330H(a)-(d), as amended by P.L. 106-310, Section 1501; as amended by P.L. 110-339, Section 2	2013	Amount authorized for the preceding FY increased by formula	100,746,000	103,500,000
Emergency Relief - Part A – PHS Act, Section. 2601-10, as amended by P.L. 106-345; as amended by P.L. 109-415; as amended by P.L. 111-87	2013	789,471,000	649,373,000	655,876,000
Comprehensive Care - Part B – PHS Act, Section. 2611-31, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	1,562,169,000	1,314,446,000	1,315,005,000
Early Intervention – Part C – PHS Act, Section. 2651-67, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	285,766,000	205,544,000	205,079,000
Coordinated Services and Access to Research for Women, Infants, Children and Youth - Part D – PHS Act, Section 2671, as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	87,273,000	72,395,000	75,088,000
Special Projects of National Significance - Part F – PHS Act, Section 2691, as amended by P.L. 104-146, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	25,000,000	25,000,000	25,000,000
Education and Training Centers - Part F – PHS Act, Section 2692(a), as amended by P.L. 106-345, as amended by P.L. 109-415, as amended by P.L. 111-87	2013	42,178,000	33,275,000	33,611,000

	Last Year of Authorization	Last Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2016
Dental Reimbursement Program - Part F – PHS Act, Section 2692(b), as amended by P.L. 106-345, as amended by P.L.109-415, as amended by P.L.111-87	2013	15,802,000	12,991,000	13,122,000
Organ Transplantation – PHS Act, Sections 371-378, as amended by P.L. 108-216, P.L. 109-129, P.L. 110-144, P.L. 110-413, and P.L. 113-51	1993 (Sections' 377, 377A, and 377B expired September 30, 2009)	Section 377—5,000,000 Section 377A—SSAN Section 377B—SSAN	2,767,000	23,549,000
Rural Health Outreach Network Development and Small Health Care Provider Quality Improvement – PHS Act, Section 330A, as amended by P.L. 107-251, Section 201; as amended by P.L. 110-355, Section 4	2012	45,000,000	55,553,000	63,500,000
Rural Access to Emergency Devices – PHS Act, Section 313, and Public Health Improvement Act, P.L. 106-505, Section 413	2006	5,000,000	1,485,000	--
Rural Hospital Flexibility Grants – SSA, Section 1820(j), as amended by P.L. 105-33, Section 4201(a), and P.L. 108-173, Section 405(f), as amended by, P.L. 110-275, Section 121	2012	SSAN	41,040,000	41,609,000
State Offices of Rural Health— PHS Act, Section 338J, as amended by P.L. 105-392, Section 301	2002	SSAN	4,000,000	9,511,000
Telehealth – PHS Act, Section 330I, as amended by P.L. 107-251, as amended by P.L. 108-163; as further amended by P.L. 113-55, Section 103	2006	SSAN	6,814,000	17,000,000
Family Planning Grants – PHS Act, Title X	1985	158,400,000	142,500,000	286,479,000

Primary Health Care

TAB

PRIMARY HEALTH CARE

Health Centers

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$1,391,529,000	$1,391,529,000	$1,241,529,000	-$150,000,000
Mandatory Funding	$3,509,111,000	$3,600,000,000	$3,600,000,000	---
Proposed Mandatory	---	---	$150,000,000	+$150,000,000
FTCA Program	$99,893,000	$99,893,000	$99,893,000	---
Total	**$5,000,533,000**	**$5,091,422,000**	**$5,091,422,000**	---
FTE	307	359	359	---

* The FY 2016 and FY 2017 amounts reflect mandatory funding appropriated by Congress in the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114-10).

Authorizing Legislation: Public Health Service Act, Section 330, as amended by Public Law 111-148, Section 5601; Public Law 111-148, Section 10503, as amended by Public Law 114-10, Section 221; Public Health Service Act, Section 224, as added by Public Law 102-501 and amended by Public Law 104-73; Public Law 114-22.

FY 2017 Authorization: FY 2016 authorization level adjusted by the product of -
(i) one plus the average percentage increase in costs incurred per patient served; and
(ii) one plus the average percentage increase in the total number of patients served.

FY 2017 CHC Fund Authorization.....$3,600,000,000

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

Program Description and Accomplishments

For 50 years, health centers have delivered comprehensive, high quality, cost-effective primary health care to patients regardless of their ability to pay. During that time, health centers have become the essential primary care provider for America's most vulnerable populations. Health centers advance the preventive and primary medical/health care home model of coordinated, comprehensive, and patient-centered care, coordinating a wide range of medical, dental, behavioral, and social services. Today, over 1,300 health centers operate over 9,000 service delivery sites that provide care in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin. Nearly half of all health centers serve rural populations. In 2014, these community-based and patient-directed health centers served 22.9 million patients, providing over 90 million patient visits, at an average cost of $721 (including Federal and non-Federal sources of funding). Patient services are supported through Federal Health Center grants, Medicaid, Medicare, Children's Health Insurance Program (CHIP), other third party payments, self-pay collections, other Federal grants, and State/local/other resources.

Health centers serve a diverse patient population:

- People of all ages: Approximately 32 percent of patients in 2014 were children (age 17 and younger); over 7 percent were 65 or older.

- People without and with health insurance: About three in 10 patients were without health insurance in 2014. While the number of uninsured health center patients has increased from 4 million in 2001 to approximately 6.4 million in 2014, the proportion of uninsured health center patients decreased from approximately 35 percent in 2013 to approximately 28 percent in 2014. The Health Center Program will continue to monitor the number of uninsured patients served on an annual basis, as it will continue to provide an understanding of the impact of Affordable Care Act on health center services in the future.

- Special Populations: Some health centers also receive specific funding to focus on certain special populations including agricultural workers, individuals and families experiencing homelessness, those living in public housing, and Native Hawaiians. In 2014 health centers served more than 1.1 million individuals experiencing homelessness, nearly 900,000 agricultural workers and their families, over 400,000 residents of public housing and more than 12,000 Native Hawaiians.

    - Health Care for the Homeless Program: Homelessness continues to be a pervasive problem throughout the United States, affecting rural as well as urban and suburban communities. According to the Department of Housing and Urban Development's 2013 Annual Homeless Assessment Report to Congress, it was estimated that over 1.4 million people were homeless. In 2014, more than 1.1 million persons experiencing homelessness were served by HRSA-funded health centers. In particular, the Health Care for the Homeless Program is a major source of care for homeless persons in the U.S., serving patients that live on the street, in shelters, or in transitional housing. Health Care for the Homeless grantees recognize the complex needs of homeless persons and strive to provide a coordinated, comprehensive approach to health care including substance abuse and mental health services.

    - Migrant Health Centers: In 2014, HRSA-funded health centers served almost 900,000 migratory and seasonal agricultural workers and their families. It is estimated that there are a total of approximately 2.8 million migratory and seasonal agricultural workers in the U.S. (2015 LSC Agricultural Worker Population Estimate Update). The Migrant Health Center Program provides support to health centers to deliver comprehensive, high quality, culturally competent preventive and primary health services to agricultural workers and their families with a particular focus on the occupational health and safety needs of this population.

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

promotion, disease prevention, and primary health care services. Services are provided on the premises of public housing developments or at other locations immediately accessible to residents. In 2014, HRSA-funded health centers served over 400,000 residents of public housing through these grants.

- Native Hawaiians: The Native Hawaiian Health Care Program, funded within the Health Center appropriation, improves the health status of Native Hawaiians by making health education, health promotion, and disease prevention services available through the support of the Native Hawaiian Health Care Systems. Native Hawaiians face cultural, financial, social, and geographic barriers that prevent them from utilizing existing health services. In addition, health services are often unavailable in the community. The Native Hawaiian Health Care Systems use a combination of outreach, referral, and linkage mechanisms to provide or arrange services. Services provided include nutrition programs, screening and control of hypertension and diabetes, immunizations, and basic primary care services. In 2014, Native Hawaiian Health Care Systems provided medical and enabling services to over 12,000 people.

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

Funding decisions are made based on ORC assessments, announced funding preferences and program priorities. For example, various statutory awarding factors are applied, including funding priorities for applications serving a sparsely-populated area; consideration of the rural and urban distribution of awards (no more than 60 percent and no fewer than 40 percent of projected patients come from either rural or urban areas); and a requirement for continued proportionate distribution of funds to the special populations served under the Health Center Program. Additionally, health centers demonstrate performance by increasing access, improving quality of care and health outcomes, and promoting efficiency.

Increasing Access: Health centers continue to serve an increasing number of the Nation's medically underserved. The number of health center patients served in 2014 was 22.9 million; an increase of 9.8 million above the 13.1 million patients served in 2003, and represents a 75 percent increase within that 10-year period. Of the 22.9 million patients served and for those for whom income status is known, 92 percent were at or below 200 percent of the Federal poverty level and approximately 28 percent were uninsured, an increase of approximately 2.4 million uninsured patients since 2004. Success in increasing the number of patients served has been due in large part to the development of new health centers, new satellite sites, and expanded capacity at existing clinics.

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

Results over the past few years demonstrate improved performance as the percentage of pregnant health center patients that began prenatal care in the first trimester grew from 57.8 percent in 2000 to 72.0 percent in 2014, exceeding the target of 65.0 percent. It should also be noted that health centers serve a higher risk prenatal population than seen nationally; making progress on this measure a significant accomplishment.

Appropriate prenatal care management can also have a significant effect on the incidence of low birth weight (LBW), the risk factor most closely associated with neonatal mortality. Monitoring birth weight rates is one way to measure quality of care and health outcomes for health center female patients of childbearing age, a key group served by the Program. This measure is benchmarked to the national rate to demonstrate how health center performance compares to the performance of the nation overall. In 2012, the health center rate was 7.1 percent, a rate that is 11 percent lower than the national rate. In 2013, the health center rate was 7.3 percent, approximately 9 percent lower than the national rate of 8 percent. In 2014, the health center rate was 7.3 percent, and the national rate is not yet reported.

Health center patients, including low-income individuals, racial/ethnic minority groups, and persons who are uninsured, are more likely to suffer from chronic diseases such as hypertension and diabetes. Clinical evidence indicates that access to appropriate care can improve the health status of patients with chronic diseases and thus reduce or eliminate health disparities. The Health Center Program began reporting data from all grantees on the control of hypertension and diabetes via its Uniform Data System in 2008. In 2014, 64 percent of adult health center patients with diagnosed hypertension had blood pressure under adequate control (less than 140/90). Additionally in 2014, 69 percent of adult health center patients with type 1 or 2 diabetes had their most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9 percent).

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

HRSA has also established a Health Center Program Patient Centered Medical Home (PCMH) Initiative. Since FY 2011, data has been collected on the percentage of health centers recognized as a PCMH by national/state accrediting organizations. At the end of FY 2015, 65 percent of health centers were recognized as PCMHs.

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

Promoting Efficiency: Health centers provide cost effective, quality primary health care services. The Program's efficiency measure focuses on maximizing the number of health center patients served per dollar as well as keeping cost increases below annual national health care cost increases while maintaining access to high quality services. In the analysis of the annual growth in total cost per patient, the full complement of services (e.g., medical, dental, mental health, pharmacy, outreach, translation) that make health centers a "health care home" is captured. In 2012, health center costs grew at a rate of 3.7 percent, equal to the national rate of 3.7 percent. In 2013 the health center rate was 4.8 percent, compared to a national rate of 4.5 percent. In 2014 the health center rate was 4.7 percent and the national rate is not yet known. The recent results trend reflects higher costs realized in the short-term that are associated with managing operations while also implementing significant facility improvements, including major construction and renovation projects.

It is expected that as health center capital improvement projects are completed, the long-term benefits of increased capacity and even greater quality of care will be realized, and cost increases will remain below national comparison data, as has been the case historically. By keeping increases in the cost per individual served at health centers below than national per capita health care cost increases, the Program has served more patients that otherwise would have required additional funding to serve annually, and demonstrates that it delivers its high-quality services at a more cost-effective rate. Success in achieving cost-effectiveness may in part be related to health centers' use of a multi- and interdisciplinary team that treats the "whole patient." This, in turn, is associated with the delivery of high-quality, culturally-competent and comprehensive primary health care services that not only increases access and reduces health disparities, but promotes more effective care for health center patients with chronic conditions.

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

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

- Health centers provide high-quality primary care and do not exhibit the extent of disparities that exist in other US health care settings. (Shi L, Lebrun-Harris L, Parasuraman S, Zhu J, Ngo-Metzger Q "The Quality of Primary Care Experienced by Health Center Patients" Journal of the American Board of Family Medicine, 2013; 26(6): 768-777).

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

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

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

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

Federal Tort Claims Act (FTCA) Program: The Health Center Program administers the FTCA Program, under which participating health centers, their employees and eligible contractors may be deemed to be Federal employees qualified for malpractice coverage under the FTCA. As Federal employees, they are immune from suit for medical malpractice claims while acting within the scope of their employment. The Federal Government assumes responsibility for such claims. In addition, the FTCA Program supports risk mitigation activities, including reviews of risk management plans and sites visits as well as risk management technical assistance and resources to support health centers. In FY 2013, 107 claims were paid totaling $50.6 million, in FY 2014, 103 claims were paid totaling $72.2 million, and in FY 2015, 111 claims were paid totaling $93.8 million.

The Budget supports a legislative proposal to establish legal confidentiality and privilege protections for quality assurance and risk management activities and communications conducted by/with Department of Health and Human Services (HHS) in connection with the FTCA program. Comparable protections have been widely adopted by states and for other federal agencies engaged in patient care, as they support effective quality assurance/risk management programs, promote patient safety, enhance quality of care and mitigate the potential for patient harm and costly claims.

Affordable Care Act

The Affordable Care Act, amended by the Medicare Access and CHIP Reauthorization Act of 2015, appropriated $18.2 billion in mandatory resources over seven years to establish a Community Health Center Fund to provide for expanded and sustained national investment in health centers under Section 330 of the Public Health Service Act. Of this amount, $1.65 billion was appropriated to support major construction and renovation projects at community health centers nationwide and $16.55 billion to support ongoing health center operations, the establishment of new health center sites in medically underserved areas and expand preventive and primary health care services at existing health center sites

Over the last five years, this mandatory funding has supported more than 980 new access points/health center service delivery sites, approximately 2,400 expanded service grants, over 400 grants to expand behavioral health services, over 800 capital development grants, more than 1,700 quality improvement grants targeting the development of PCMH, over 2,200 quality improvement awards for exceptional performance, more than 150 expanded HIV treatment and care grants, outreach and enrollment activities in over 1,200 health centers nationwide, more than 40 health center controlled networks to promote health information technology (HIT) and electronic health record adoption, and ongoing health center operations in over 1,300 health centers nationwide.

In FY 2017, the Health Center program will continue to provide high quality, affordable and comprehensive primary care services in medically underserved communities across the country as insurance coverage expands. Health centers will also remain a vital source of primary care for insured patients seeking a quality source of care, often for services not covered by health insurance.

Funding History

FY	Amount
FY 2013	$1,479,490,000
FY 2013 Mandatory Funding	$1,465,397,000
FY 2014	$1,491,482,000
FY 2014 Mandatory Funding	$2,144,716,000
FY 2015	$1,491,422,000
FY 2015 Mandatory Funding	$3,509,111,000
FY 2016	$1,491,422,000
FY 2016 Mandatory Funding	$3,600,000,000
FY 2017	$1,341,422,000
FY 2017 Mandatory Funding	$3,750,000,000

Budget Request

The FY 2017 request is $5.1 billion, which is the same level as the FY 2016 Enacted Level, and includes $3.75 billion in mandatory funding. This request will provide care to 27.0 million patients in FY 2017, over approximately 4 million more patients than were served in 2014. This funding will support quality improvement and performance management activities at existing

health center organizations, and ensure that current health centers can continue to provide essential health care services to their patient populations.

The Budget requests $7.2 billion in mandatory funding from FY 2018 through FY 2019. Multi-year mandatory funding would provide health centers, which depend on Federal resources to cover daily operational costs, with a stable source of funding with which to manage their operations.

Health Center Fund	FY 2018	FY 2019	Total Funding
Proposed Mandatory Funding	$3.6 billion	$3.6 billion	$7.2 billion

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

Continued funding for the Health Center Program in FY 2017 and beyond will maintain this vital source of primary care for insured and medically underserved patients seeking a quality source of care, often for services not covered by health insurance. After the passage of health insurance reform in Massachusetts, health centers saw a significant increase in newly-insured patients. From 2005 to 2014, the overall number of health center patients increased by more than 260,000 patients (60 percent), even while the overall number of uninsured patients decreased by over 30 percent.

The FY 2017 request supports the Health Center Program's achievement of its ambitious performance targets and continues to enable the provision of access to primary health care services and the improvement of the quality of care in the health care safety net. This request also supports $99.9 million for the Federal Tort Claims Act (FTCA) Program, which is the same level as FY 2016 enacted. The Health Center Program will continue to achieve its goal of providing access to care for underserved and vulnerable populations. Funding also includes costs associated with the grant review and award process, follow up performance reviews, and information technology and other program support costs.

As part of the program's efforts to improve quality of care and health outcomes, the Health Center Program has established ambitious targets for FY 2017 and beyond. For low birth

weight, the Program seeks to be at least 5 percent below the national rate. This is ambitious because health centers continue to serve a higher risk prenatal population than represented nationally in terms of socio-economic, health status and other factors that predispose health center patients to greater risk for LBW and adverse birth outcomes. The FY 2017 target for the program's hypertension measure is that 63 percent of adult patients with diagnosed hypertension will have blood pressure under adequate control. The FY 2017 target for the program's diabetes management measure is 69 percent of adult patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9 percent). These targets will be challenging to achieve because chronic conditions require treatment with lifestyle modifications, usually as the first step, and, if needed, with medication. It is important to have ambitious targets because of the population health centers serve and the importance of good chronic disease management.

The Health Center Program will also continue to promote efficiency and aims to keep cost per patient increases below annual national health care cost increases, as noted in the Center for Medicare and Medicaid Services' (CMS) National Health Expenditure Amounts and Projections. By benchmarking the health center efficiency to national per capita health care cost increases, the measure takes into account changes in the healthcare marketplace while demonstrating the Program's continued ability to deliver services at a more cost-effective rate. The FY 2017 target is to keep the program's cost per patient increase below the 2017 national health care cost increase. To assist in areas of cost-effectiveness, the Program offers technical assistance to grantees to review costs and revenues and develop plans to implement effective cost containment strategies. By restraining increases in the cost per individual served at health centers, the Health Center Program is able to serve a volume of patients that otherwise would have required additional funding to serve, and demonstrates that it delivers its high quality services at a more cost-effective rate.

The FY 2017 Budget Request also supports the Health Center Program's ongoing involvement in an agency-wide effort to improve quality and program integrity in all HRSA-funded programs that deliver direct health care. Another key step the Health Center Program has taken in this area is to establish a core set of clinical performance measures for all health centers. The Program has aligned its required clinical performance measures with the Department's Meaningful Use measures. These measures are also consistent with the overarching goals of Healthy People 2020, and include: immunizations; prenatal care; cancer screenings; cardiovascular disease/hypertension; diabetes; weight assessment and counseling for children and adolescents; adult weight screening and follow up; tobacco use assessment and counseling; asthma treatment; coronary artery disease/cholesterol; ischemic vascular disease/aspirin use; and colorectal cancer screening.

In addition to tracking these core clinical indicators, health center grantees also report their health outcome measures (low birth weight, diabetes, and hypertension) by race/ethnicity in order to demonstrate progress towards eliminating health disparities in health outcomes. To support quality improvement, the Program will continue to facilitate national and State-level technical assistance and training programs that promote quality improvements in health center data and quality reporting, clinical and quality improvement, and implementation of innovative quality activities. The Program continues to promote the integration of HIT into health centers

as part of HRSA's strategy to assure that key safety-net providers are not left behind as this technology advances.

HRSA's efforts to strengthen evidence-building capacity in the Health Center Program include enhancements to the Uniform Data System (UDS) reporting to reflect Affordable Care Act impact. Beginning with 2013 UDS data, patients are reported by both zip code and primary medical insurance status. Data is now reported to show the number of persons living in each zip code, and breaks down that number into four categories: Medicare; Medicaid/S-CHIP/and Other Public Insurance; Private insurance; and Uninsured. All UDS data continues to be aggregated at the health center/organizational level.

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

Funding would allow continued coordination and collaboration with related Federal, State, local, and private programs in order to further leverage and promote efforts to expand and improve health centers. The Health Center Program will continue to work with the CMS and the Office of the National Coordinator for Health Information Technology (ONC) on HIT, and the Centers for Disease Control and Prevention to address HIV prevention and public health initiatives, and the National Institutes of Health on clinical practice issues, among others. In addition, the Health Center Program will continue to coordinate with CMS to jointly review section 1115 Medicaid Demonstration Waivers. The Program will continue to work closely with the Department of Justice on the FTCA Program. Additionally, the proposed Budget supports coordination with programs in the Departments of Housing and Urban Development, Education, and Justice.

Sources of Revenue: ($ in millions)

	FY 2015 Enacted	**FY 2016 Enacted**	**FY 2017 Request Level**
Health Centers:	**$5,000.5**	**$5,091.5**	**$5,091.5**
Other Sources:			
Medicaid	9,250.0	9,870.0	9,870.0
Medicare	1,255.0	1,300.0	1,300.0
CHIP	245.0	255.0	255.0
Other Third	2,000.0	2,100.0	2,100.0
Self Pay Collections	1,100.0	1,100.0	1,100.0
Other Federal Grants	440.0	445.0	445.0
State/Local/Other	3,110.0	3,250.0	3,250.0
TOTAL	**$22,400.5**	**$23,411.5**	**$23,411.5**

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
1.I.A.1: Number of patients served by health centers (Output)	FY 2014: 22.9M Target: 24.3M (Target Not Met)	27.0M	27.0M	Maintain
1.I.A.2.b: Percentage of grantees that provide the following services either on-site or by paid referral: (b) Preventive Dental Care (Output)	FY 2014: 89% Target: 88% (Target Exceeded)	89%	89%	Maintain
1.I.A.2.c: Percentage of grantees that provide the following services either on-site or by paid referral: (c) Mental Health/Substance Abuse (Output)	FY 2014: 79% Target: 70% (Target Exceeded)	75%	75%	Maintain
1.E: Percentage increase in cost per patient served at health centers compared to the national rate (Efficiency)	FY 2014: 4.7% Target: below national rate (Not yet available)	Below national rate	Below national rate	Maintain
1.II.B.2: Rate of births less than 2500 grams (low birth weight) to prenatal Health Center patients compared to the national low birth weight rate (Outcome)	FY 2014: 7.3%, Target: 5% below national rate (Not yet available)	5% below national rate	5% below national rate	Maintain
1.II.B.3: Percentage of adult health center patients with diagnosed hypertension whose blood pressure is under adequate control (less than 140/90) (Outcome)	FY 2014: 64% Target: 63% (Target Exceeded)	63%	63%	Maintain
1.II.B.4: Percentage of adult health center patients with type 1 or 2 diabetes with most recent hemoglobin A1c (HbA1c) under control (less than or equal to 9 percent) (Outcome)	FY 2014: 69% Target: 71% (Target Virtually Met)	69%	69%	Maintain
1.II.B.1: Percentage of pregnant health center patients beginning prenatal care in the first trimester (Output)	FY 2014: 72% Target: 65% (Target Exceeded)	67%	68%	+ 1% point
1.II.A.1: Percentage of Health Center patients who are at or below 200 percent of poverty (Output)	FY 2014: 92% Target: 91% (Target Exceeded)	91%	91%	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
1 II.A.2: Percentage of Health Center patients who are racial/ethnic minorities (Output)	FY 2014: 62% Target: 63% (Target Virtually Met)	62%	62%	Maintain
1.I.A.3: Percentage of health centers with at least one site recognized as a patient centered medical home (Outcome)	FY 2015: 65% Target: 60% (Target Exceeded)	65%	70%	+ 5% points

Grants Awards Table

	FY 2015 Final	FY 2016 Enacted[5]	FY 2017 President's Budget
Number of Awards	1,383	1,383	1,383
Average Award	$3,000,000	$3,000,000	$3,000,000
Range of Awards	$200,000 - $17,500,000	$200,000 - $18,000,000	$200,000 - $18,500,000

[5] Estimates.

Free Clinics Medical Malpractice

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$100,000	$100,000	$1,000,000	$900,000
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Section 224, as amended by Public Law 111-148, Section 10608

FY 2017 Authorization ..... Indefinite

Allocation Method ..... Other

Program Description and Accomplishments

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

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

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

Increasing Access: In FY 2014, 7,637 volunteer health care providers received Federal malpractice insurance through the Free Clinics Medical Malpractice Program, exceeding the Program target. In FY 2012, 192 free clinics operated with FTCA deemed volunteer clinicians; in FY 2013, 227 clinics participated; and in FY 2014, 232 clinics participated. The Free Clinics Medical Malpractice Program also examines the quality of services annually by monitoring the percentage of free clinic health professionals meeting licensing and certification requirements.

Performance continues to meet the target with 100 percent of FTCA deemed clinicians meeting appropriate licensing and credentialing requirements.

Promoting Efficiency: The Free Clinics Medical Malpractice Program is committed to improving overall efficiency by controlling the Federal administrative costs necessary to deem each provider. By restraining these annual administrative costs, the Program is able to provide an increasing number of clinicians with malpractice coverage, thus building the free clinic workforce capacity nationwide and increasing access to care for the vulnerable populations served by these clinics. In FY 2012 the cost was $71 per provider; in FY 2013 the cost was $89 per provider; and in FY 2014 the cost was $61 per provider. In each year, the Program performance target has been exceeded.

To date, there have been no paid claims under the Free Clinics Medical Malpractice Program. The Program Fund has a current balance of approximately $250,000.

Funding History

FY	Amount
FY 2013	$38,000
FY 2014	$40,000
FY 2015	$100,000
FY 2016	$100,000
FY 2017	$1,000,000

Budget Request

The FY 2017 Budget Request is $1.0 million, which is $900,000 more than the FY 2016 Enacted Level. The total request will support the Program's continued achievement of its performance targets addressing its goal of maintaining access and capacity in the health care safety net.

The funding request supports an increase in recent claim activity which could lead to payments from the program fund, and includes costs associated with the application review and approval process, follow up performance reviews, and information technology and other program support costs associated with the development of a web based application and program management system that is replacing a paper based system. The nine claims currently outstanding represent a significant increase over previous Program levels.

Targets for FY 2017 focus on maintaining FY 2016 target levels for the number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage at 7,800 while also maintaining the number of free clinics operating with FTCA deemed volunteer clinicians at 240. The focus on quality will continue to hold the Program to a target of 100 percent for FTCA deemed clinicians meeting appropriate licensing and certification requirements. The Program will also continue to promote efficiency by restraining growth in the annual Federal administrative costs necessary to deem each provider, with a target of $89 administrative cost per provider in FY 2017.

The FY 2017 request will also support the Program's continued coordination and collaboration with related Federal programs in order to further leverage and promote efforts to increase the capacity of the health care safety net. Areas of collaboration include coordination with the Health Center FTCA Program, also administered by HRSA, to share program expertise. In addition, the two programs control costs by sharing a contract to process future claims, and by providing technical support and outreach. The Program will coordinate with non-profit free clinic-related umbrella groups on issues related to program information dissemination and outreach and will continue to collaborate with the Department of Justice (DOJ) and the HHS Office of General Counsel (HHS/OGC) to assist in drafting items including deeming applications and related policies. The Program continues to work with the HHS/OGC to answer legal technical assistance issues raised by free clinics in the Program and clinics interested in joining the Program.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2106
2.I.A.1: Number of volunteer free clinic health care providers deemed eligible for FTCA malpractice coverage (Outcome)	FY 2014: 7,637 Target: 7,200 (Target Exceeded)	7,800	7,800	Maintain
2.1: Patient visits provided by free clinics sponsoring volunteer FTCA deemed clinicians (Outcome)	FY 2014: 502,150 Target: 476,000 (Target Exceeded)	500,000	500,000	Maintain
2.I.A.2: Number of free clinics operating with FTCA deemed volunteer clinicians (Output)	FY 2014: 232 Target: 240 (Target Not Met)	240	240	Maintain
2.I.A.3: Percent of volunteer FTCA deemed clinicians who meet certification and privileging requirements (Output)	FY 2014: 100% Target: 100% (Target Met)	100%	100%	Maintain
2.E: Administrative costs of the program per FTCA covered volunteer (Efficiency)	FY 2014: $61 Target: $89 (Target Exceeded)	$89	$89	Maintain

Health Workforce

TAB

HEALTH WORKFORCE

Summary of Request

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$1,092,784,000	$1,227,932,000	$1,272,782,000	+$44,850,000
FTE	368	444	444	---

The Bureau of Health Workforce (BHW) improves the health of underserved and vulnerable populations by strengthening the health workforce and connecting skilled professionals to communities in need. BHW supports the health care workforce across the entire training continuum – from academic training of nurses, physicians, and other clinicians – and expands the primary care workforce of clinicians who provide health care in underserved and rural communities across the United States. BHW was established in 2014 to help HRSA better respond to the need for a well-trained, well-distributed 21st century health care workforce.

HRSA workforce programs innovatively address the health workforce challenges and needs of the nation through a focus on three priority areas: 1) addressing supply and distribution challenges to ensure access to care for underserved populations across the United States; 2) preparing a diverse health care workforce to ensure culturally competent care for all Americans; and 3) transforming health care delivery to meet the needs of the 21st century by supporting models that drive quality care and achieve improved health outcomes, at a lower cost.

The FY 2017 Budget Request of $1.3 billion is a $45 million increase above the FY 2016 Enacted level. The FY 2017 request includes $310 million in already enacted mandatory funding for the National Health Service Corps in order to ensure that all Americans have access to high-quality clinicians in areas of health professions shortage; as well as a $20 million request for a Mental and Behavioral Health initiative that would target mental and behavioral health clinicians. The Budget also proposes $100 million over two years in new mandatory funding to increase access to behavioral health services through loan repayment to 1,700 clinicians, including clinicians with medication assisted treatment training. This funding is part of two wider Administration initiatives to treat opioid use disorders and to improve access to mental health care. The request includes $60 million in already enacted mandatory funding for the Teaching Health Centers Graduate Medical Education in FY 2017 and a total funding request of $587 million through FY 2020. The proposed extension of THCGME through FY 2020 would assist teaching health centers by providing support for their existing community-based residency programs.

Cross-Cutting Performance Measurement

BHW has tracked and reported on three cross-cutting measures for more than 40 of its programs. The cross-cutting measures focus specifically on the diversity of individuals completing specific

types of health professions training programs;[6] the rate in which individuals participating in specific types of health professions training programs are trained in medically underserved communities;[7] and the rate in which individuals who complete specific types of health professions training programs report being employed in a medically underserved community. Note these measures do not currently include data from the following programs: Faculty Loan Repayment Program, Children's Graduate Medical Education Program and the National Practitioner Data Bank.[8]

During Academic Year (AY) 2014-2015, results showed that 60 percent of graduates and program completers participating in BHW-supported health professions training and loan programs were underrepresented minorities and/or from disadvantaged backgrounds.[9] The FY 2014 target of 46 percent was exceeded, and results showed that some programs had much greater diversity than others. Apart from the diversity programs that were at or near 100 percent and are multidisciplinary, profession-specific programs evidenced greater variability. For example, nursing programs had a rate of 48 percent, oral health programs had a rate of 34 percent, the physician assistant program had a rate of 39 percent, medicine programs (including residency programs) had a rate of 26 percent, and public health and behavioral health programs collectively had a rate of 56 percent. Since these measures encompass underrepresented races/ethnicities, as well as those from disadvantaged backgrounds, a direct comparison using the most recent data for graduates of health professions training programs is not feasible. BHW continues to use its performance measures to further investigate potential factors associated with these profession-specific rates and identify strategies for strengthening program performance in this area.

With regard to the types of settings used to provide training, results showed that 49 percent of individuals participating in BHW-supported health professions training and loan programs received at least a portion of their training in a medically underserved community—just short of the overall performance target of 50 percent. Results showed that nursing programs had a rate of 47 percent; medicine programs (including residency programs) had a rate of 65 percent; oral health programs had a rate of 60 percent; public health and behavioral health programs collectively had a rate of 51 percent; and the physician assistant program had a rate of 63

[6] BHW currently funds more than 40 health professions training and loan programs that have varying types of data reporting requirements based on the program's authorizing legislation. For the purposes of the cross-cutting measures, only programs that are required to report individual-level data are included in the calculation, as this ensures a higher level of accuracy and data quality, as well as consistency in the types of programs that are included in the calculation. Currently, at least 20 of the BHW-funded programs are required to report individual-level data and are included in these calculations. These programs are representative of the health professions and include oral health programs, behavioral health programs, medicine programs, nursing programs, geriatric programs, and physician assistant programs, among others.

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

[8] Programs currently not included in the cross-cutting performance measures will be incorporated and reported in future budget documents as consistent measurement requirements across all programs are being completed.

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

percent. Declines in the rates for both the nursing and behavioral and public health programs this year compared with last year's results were primarily responsible for the overall decline in this measure. Further investigation is needed to better understand factors that are responsible for year-to-year increases or decreases in the rate in which individuals participating in a specific HRSA-supported program are exposed to training in underserved settings.

Results showed that 46 percent of individuals who graduated from or completed specific types of BHW-supported training programs by June 30, 2014[10] reported working in medically underserved communities across the nation one year after graduation/completion. Notably, the physician assistant training program reported a 60 percent rate and the behavioral health programs collectively had a 62 percent rate while oral health programs had a rate of 21 percent. These profession-specific differences observed will continue to be monitored to better understand factors associated with this outcome.

Lastly, the percent of clinical training sites that provide interprofessional training to individuals enrolled in a primary care training program was 19 percent. The results showed that some programs were utilizing interprofessional training sites at a much higher rate than others. For example, pipeline training programs including Area Health Education Centers and HCOP Skills Training had a rate of 4 percent, behavioral health programs collectively had a rate of 44 percent, medicine programs had a rate of 26 percent, and oral health programs had a rate of 26 percent. Notably within the medicine programs, the Teaching Health Centers program had a rate of 55 percent. This first year baseline data on interprofessional training sites will be used to identify strategies for improving program performance in this area.

[10] Measure is based on data reported about graduates and program completers from Academic Year 2013-2014.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [11]	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
6.I.B.1. Percentage of graduates and program completers of Bureau of Health Workforce-supported health professions training programs who are underrepresented minorities and/or from disadvantaged backgrounds.	FY 2014: 60% Target: 46% (Target Exceeded)	46%[12]	46%	Maintain
6.I.C.1. Percentage of trainees in Bureau of Health Workforce-supported health professions training programs who receive training in medically underserved communities.	FY 2014: 49% Target: 50% (Target Not Met)	55%	55%	Maintain
6.I.C.2. Percentage of individuals supported by the Bureau of Health Workforce who completed a primary care training program and are currently employed in underserved areas.[13]	FY 2014: 46% Target: 33% (Target Exceeded)	34%[14]	40%	+6%
6.I.1. Percent of clinical training sites that provide interprofessional training to individuals enrolled in a primary care training program.	FY 2014: 19% (Baseline)	19%	19%	Maintain

[11] Most recent results are for Academic Year 2014-2015 and funded in FY 2014.
[12] The change in target is the result of improved methodology, elimination of duplicate counting and a more accurate estimate of individuals who are serving in underserved areas. HRSA is only using counts from programs that are able to accurately track individuals that are being provided direct financial support from the HRSA program.
[13] Service location data are collected on students who have been out of the HRSA program for one year. The results are from programs that have the ability to produce clinicians with one year post program graduation. Results are from Academic Year 2014-2015 based on graduates from Academic Year 2013-2014.
[14] The change in target is the result of improved methodology, elimination of duplicate counting and a more accurate estimate of individuals who are serving in underserved areas. HRSA is only using counts from programs that are able to accurately track individuals that are being provided direct financial support from the HRSA program.

National Health Service Corps (NHSC)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	---	---	$20,000,000	+$20,000,000
Mandatory	$287,370,000	$310,000,000	$310,000,000	---
Proposed Mandatory	---	---	$50,000,000	$50,000,000
Total	$287,370,000	$310,000,000	$380,000,000	+$70,000,000
FTE	214	284	284	---

Authorizing Legislation: Public Health Service Act, Sections 331-338H, as amended by Public Law 114-10

FY 2017 Authorization .....Expired

FY 2017 Mandatory Authorization.....$310,000,000

Allocation Method ..... Other (Competitive Awards to Individuals)

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

NHSC-approved sites provide care to individuals regardless of ability to pay. Eligible sites include Federally Qualified Health Centers (FQHC) and FQHC Look-Alikes, American Indian and Native Alaska Health Clinics, Rural Health Clinics, Critical Access Hospitals, School-Based Clinics, Mobile Units, Free clinics, Community Mental Health Centers, State or Local Health Departments, and Community Outpatient Facilities, federal facilities such as the Bureau of Prisons, U.S. Immigration and Customs Enforcement, Indian Health Service, and Private Practices. The Affordable Care Act appropriated a total of $1.5 billion in new dedicated funding for the NHSC over five years starting in FY 2011 and allowed for programmatic changes to better support the recruitment and retention of primary care providers to communities in need.

Through the Medicare Access and CHIP Reauthorization Act of 2015, funding was continued for FY 2016 and FY 2017, at $310.0 million per year. Changes to the program also included:

- Raising the maximum allowable annual award for the NHSC Loan Repayment Program (LRP) from $35,000 per year to $50,000.
- Allowing half-time loan repayment contracts.
- Allowing full-time NHSC participants to fulfill a portion of their service commitment through teaching - up to 50 percent of the 40-hour week in a Teaching Health Center, and up to 20 percent in other facilities.

NHSC Scholarship Program

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

NHSC Loan Repayment Program

The NHSC Loan Repayment Program offers fully trained primary care clinicians the opportunity to receive assistance to pay off qualifying educational loans in exchange for service in a HPSA of greatest need. In exchange for an initial two years of service, loan repayers receive up to $50,000 in loan repayment assistance. The loan repayment program recruits clinicians as they complete training and are immediately available for service, as well as seasoned professionals seeking an opportunity to serve the nation's most vulnerable populations.

The NHSC uses an enhanced awarding structure to encourage clinicians to seek placement in high-need HPSAs across the United States. Individuals who are employed in NHSC-approved service sites with HPSA scores of 14 and higher are eligible to receive up to $50,000 for an initial two-year contract. Individuals working in HPSAs of 13 and below are eligible for loan repayment of up to $30,000 for a two-year contract. This policy has allowed the Corps to remain competitive with other loan repayment programs and help communities that have persistent workforce shortages by driving workforce to these high need areas. After the initial service period, NHSC loan repayers with remaining eligible loans may apply for continuation awards in return for additional years of service.

NHSC Students to Service Loan Repayment Program

The NHSC Students to Service (S2S) Loan Repayment Program, which began in FY 2012, provides loan repayment assistance of up to $120,000 to allopathic and osteopathic medical students in their last year of school in return for selecting and completing a primary care residency and working in rural and urban HPSAs of greatest need for three years. This Program

aims to double the number of physicians in the NHSC pipeline; the first cohort of these physicians entered into service in high-need areas in July 2015. After the initial service period, physicians with remaining eligible loans may apply for continuation awards in return for additional years of service.

State Loan Repayment Program

The State Loan Repayment Program is a federal-state partnership grant program that offers a dollar-for-dollar match between the state and the NHSC for loan repayment contracts to clinicians who practice in a HPSA in that state. The program serves as a complement to the NHSC and provides flexibility to states to help meet their unique primary care workforce needs. State grantees have the discretion to focus on one, some, or all of the eligible primary care disciplines eligible with the NHSC and may also include pharmacists and registered nurses. In addition, the State Loan Repayment Program serves as a cost-efficient alternative to the NHSC, as the federal cost-per-clinician in the program is less given the matching requirement. The new grant competition in FY 2014 resulted in an increase in the number of awarded states from 32 to 38.

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

Table 1. NHSC Student Pipeline by Program as of 09/30/15

Programs	**No.**
Scholarship Program	962
Students to Service Program	291
Total	**1,253**

Table 2. NHSC Student Pipeline by Discipline as of 09/30/15

Disciplines	**No.**
Allopathic/Osteopathic Physicians	923
Dentists	185
Nurse Practitioners	31
Physician Assistants	102
Certified Nurse Midwives	12
Total	**1,253**

Table 3. NHSC Field Strength by Program as of 09/30/15

Programs	**No.**
Scholarship Program Clinicians	458
Loan Repayment Program Clinicians	8,062
State Loan Repayment Program Clinicians	1,136
Student to Service Loan Repayment Program	27
Total	**9,683**

Table 4. NHSC Field Strength by Discipline as of 09/30/15

Disciplines	**No.**
Allopathic/Osteopathic Physicians[15]	2,290
Dentists	1,124
Dental Hygienists	237
Nurse Practitioners	1,851
Physician Assistants	1,105
Nurse Midwives	169
Mental and Behavioral Health Professionals	2,872
Other State Loan Repayment Program Clinicians	35
Total	**9,683**

Need: Across the nation, the NHSC clinicians serve patients in communities with limited access to health care. As of September 30, 2015, there were almost 59 million people living in primary care HPSAs, more than 47 million people living in dental HPSAs, and more than 97 million people living in mental health HPSAs. In order for the nation to no longer have these designations, it would take over 7,900 new primary care physicians, 7,100 new dental providers, and over 2,700 behavioral and mental health providers practicing in their respective HPSAs.

As of September 30, 2015, more than 9,600 primary care medical, dental, and mental and behavioral health practitioners were providing service nationwide at NHSC-approved sites in rural, urban, and frontier areas.

In addition, there were more than 10 million people who relied on NHSC providers. These providers work at NHSC-approved sites, all of which must provide care to patients, regardless of their ability to pay. About half of all NHSC-approved sites are HRSA-supported Health Centers, known as FQHCs.

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

[15] Includes psychiatrist.

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

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

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

Program Accomplishments: Over its 42-year history, the NHSC has offered recruitment incentives, in the form of scholarship and loan repayment, to support more than 47,000 health professionals committed to providing care to underserved communities. In 2015, NHSC clinicians working at NHSC service sites provided primary medical, oral, and mental and behavioral health care to more than 10 million underserved people in these communities, known as HPSAs. There are currently approximately 16,000 NHSC-approved sites.

In particular, the NHSC has partnered closely with HRSA-supported Health Centers to help meet their staffing needs. Approximately 50 percent of NHSC clinicians serve in Health Centers around the nation. The NHSC has partnered with the Federal Office of Rural Health Policy to recruit NHSC participants to practice in rural communities. The NHSC also places clinicians in other community-based systems of care that serve underserved populations, targeting HPSAs of greatest need.

In addition to the recruitment of providers, the NHSC also works to retain primary care providers in underserved areas after their service commitment is completed to further leverage the federal investment and to build more integrated and sustainable systems of care. Retention in the Corps is defined as the percentage of NHSC clinicians who remain practicing in underserved areas after successfully completing their service commitment to the Corps. The NHSC does not provide Corps members with any additional financial incentives to remain in these underserved communities when promoting retention and in capturing retention rates. In FY 2012, the NHSC completed a long-term retention study, noting a 55 percent retention rate for clinicians remaining in service to the underserved 10 years after completing their NHSC commitment. This is a 6 percent increase compared to the 2000 rate of 52 percent. Moreover, the NHSC Participant Satisfaction Study fielded in FY 2015 reported a short-term retention (defined as up to two years after service completion) rate of 87 percent.

In FY 2015:

Mandatory Funds*:*

- The Affordable Care Act provided $287.4 million, after sequestration, for the NHSC. These funds were distributed as follows:
  - Field Line -$60.0 million is used to directly support the NHSC Recruitment Line in the form of staffing, acquisition contracts, Primary Care Office cooperative agreements, shortage designation, and other support activities.
  - Scholarships - $44.0 million = 196 new awards and 11 continuations.
  - Loan Repayment - $159.2 million = 2,934 new awards and 1,841 continuations.
  - Students to Service Loan Repayment - $11.5 million = 96 new awards.
  - State Loan Repayment - $12.7 million = 620 new awards.

By the end of FY 2015, the NHSC Field Strength was 9,683, serving the primary care needs of over 10 million patients.

In FY 2016:

Mandatory Funds:

- The Mandatory funding reflects $310.0 million appropriated for NHSC through the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10). These funds are projected to be distributed as follows:
  - Field Line - $70.0 million is used to directly support the NHSC Recruitment Line in the form of staffing, acquisition contracts, Primary Care Office cooperative agreements, shortage designation, and other support activities.
  - Scholarships - $41.0 million = 165 new awards and 16 continuations.
  - Loan Repayment - $172.0 million = 2,654 new awards and 1,732 continuations.
  - Students to Service Loan Repayment - $14.0 million = 117 new awards.
  - State Loan Repayment - $13.0 million = 433 new awards.

By the end of FY 2016, the NHSC Field Strength is projected to be more than 9,153 and serving the primary care needs of 9.6 million patients.

Funding History

FY	Amount
FY 2013	---
FY 2013 Mandatory Funding	$284,700,000
FY 2014	---
FY 2014 Mandatory Funding	$283,040,000
FY 2015	---
FY 2015 Mandatory Funding	$287,370,000
FY 2016	---
FY 2016 Mandatory Funding	$310,000,000
FY 2017 Discretionary	$20,000,000
FY 2017 Mandatory Funding	$310,000,000
FY 2017 Proposed Mandatory Funding	$50,000,000

Budget Request

The FY 2017 Budget Request is $380.0 million, and is $70.0 million above the FY 2016 Enacted level to support an increase for mental and behavioral providers. The Budget will fund 3,671 new and 2,006 continuation loan repayment awards, 146 new and 13 continuation scholarship awards, 500 State Loan Repayment awards and 167 Students to Service Loan Repayment awards. This request is part of a new investment beginning in FY 2017 to bolster the nation's health workforce and to improve the delivery of health care across the country. Between FY 2017 and FY 2020, HRSA will devote a total of $2.86 billion for the NHSC to address health professional shortages in high-need rural and urban communities across the country. Currently, only sites located in the highest of HPSAs are able to fully leverage loan repayment as a significant recruitment tool when competing to hire primary care providers. This $810.0 million annual investment, beginning in FY 2018, would "guarantee" loan repayment to providers at NHSC-approved sites, particularly those between HPSAs such as 8 through 15 — and increase the sites' ability to recruit needed primary care providers while improving the overall distribution of vital providers throughout the country. This would increase the scope and presence of the program in those states and rural communities that are less densely populated and may not have had the benefit of having NHSC providers in recent years.

A new $100 million mandatory investment over two years in mental and behavioral health practitioners through the National Health Service Corps is foundational to two Administration initiatives to treat opioid use disorders and to increase access to mental health services. This $100.0 million investment over two years would support over 1,700 new loan repayment awards for mental and behavioral health clinicians.

Initiative to Increase Treatment for Prescription Drug Abuse and Heroin Use: In 2014, opioids (a class of drugs that include prescription pain relievers and heroin) were involved nearly 29,000 deaths in America. An annual $25 million investment in FY 2017 and FY 2018 ($50 million total) is part of the $1 billion initiative to address this epidemic by helping ensure that all who seek treatment for an opioid use disorder can access it. This $50.0 million investment will increase access to substance use disorder treatment services. These funds would support activities to expand the use of medication assisted treatment through investments in the National Health Service Corps, including enhanced loan repayment awards to clinicians with medication assisted treatment training in FY 2017 and 2018.

Initiative to Increase Access to Mental Health Services: Many areas of the country are experiencing a shortage of mental and behavioral services, especially in rural areas. An annual $25 million investment in FY 2017 and FY 2018 ($50 million total) is part of the $500 million initiative to increase access to mental health services, by investing in enhancing the behavioral health workforce. This includes Psychiatrists, Psychiatric Physician Assistants, Psychiatric Nurse Practitioners, Health Service Psychologists, Licensed Clinical Social Workers, Licensed Professional Counselors, Marriage and Family Therapists, and Psychiatric Nurse Specialists.

NHSC Fund (in millions)	FY 2017	FY 2018	FY 2019	FY 2020	TOTAL
Discretionary	$20	---	---	---	$20
Mandatory	$310	---	---	---	$310
Proposed Mandatory (Treatment for Opioid Use Disorder and Mental Health Initiatives)	$50	$50	---	---	$100
Proposed Annual Mandatory		$810	$810	$810	$2,430
Total	$380	$860	$810	$810	$2,860

This funding addresses ongoing challenges in the American health care system that even as more health professionals are trained, most do not choose to practice in areas where they are most needed. This funding improves the distribution of health care providers into high-need areas. This funding will also address increased demands for health care services from an aging population, including mental and behavioral health services.

Funding in FY 2017 for the NHSC Programs will support efforts to work with Health Centers and other community-based systems of care located in rural, frontier, and urban areas to improve the quality of care provided by reducing gaps in health services and health disparities. As a significant source of highly qualified, culturally competent clinicians for the Health Center Program, rural clinics, and other safety net providers, the NHSC can build on its success in assuring access to health care services for residents of HPSAs, removing barriers to care and improving the overall quality of care to these underserved populations.

The NHSC Program is working with many communities in partnership with state, local, and national organizations to help address their health care needs. Specifically, to address the demand in high-need HPSAs for mental and behavioral health providers, HRSA is also proposing in the FY 2017 budget to create, within the NHSC Loan Repayment Program, a $20.0 million Mental and Behavioral Health expansion that would target mental and other behavioral health clinicians. The proposed set aside would target funding the immediate need for providers on the ground by awarding 351 new Loan Repayment awards to mental and behavioral health clinicians. This would represent a substantial increase in the number of mental and behavioral health clinicians in HPSAs, and will greatly enhance access to these critical services for underserved communities and vulnerable populations. This proposed $20.0 million NHSC Mental and Behavioral Health expansion would also support tribal communities to better meet their mental and behavioral health workforce needs.

In FY 2017:

Discretionary Funds
Mental and Behavioral Health initiative

- $20.0 million for a NHSC Mental and Behavioral Health initiative are projected to be distributed as follows:

- Field Line - $2.0 million to directly support the NHSC Recruitment Line in the form of staffing, acquisition contracts, Primary Care Office cooperative agreements, shortage designation, and other support activities.
- Loan Repayment - $18.0 million = 351 new awards

Mandatory Funds:

- Mandatory funding reflects $310.0 million appropriated for NHSC through the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10). These funds are projected to be distributed as follows:
  - Field Line - $70.0 million to directly support the NHSC Recruitment Line in the form of staffing, acquisition contracts, Primary Care Office cooperative agreements, shortage designation, and other support activities.
  - Scholarships - $38.0 million = 146 new awards and 13 continuations.
  - Loan Repayment - $167.0 million = 2,442 new awards and 2,006 continuations.
  - State Loan Repayment - $15.0 million = 500 new awards.
  - Students to Service Loan Repayment - $20.0 million = 167 new awards.

- Proposed $50.0 million in Mandatory funding for two initiatives to provide treatment for opioid use disorders and increase access to mental health services:
  - Field Line - $5.0 million to directly support the NHSC Recruitment Line in the form of staffing, acquisition contracts, Primary Care Office cooperative agreements, shortage designation, and other support activities.
  - Loan Repayment - $45.0 million = 878 new awards

In FY 2017, mandatory funding will allow for a significant growth in the NHSC Field Strength, which is projected to be over 10,150 and serving the primary care needs of more than 10.7 million patients. This funding would increase the FY 2016 NHSC Field Strength of 9,153 by more than 11 percent, allowing the program to address the anticipated increased demand for access to primary care services in underserved communities and vulnerable populations including the newly insured and aging population. This will also allow the NHSC to explore the feasibility of expanding on a temporary basis the eligible disciplines to include other primary care specialties that are also in high demand. Mandatory funding over FY 2018-FY 2020 will support a field strength of 15,000 providers.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
4.I.C.1: Number of individuals served by NHSC clinicians *(Outcome)*	FY 2015: 10.2 Million Target: 8.9 Million (Target Exceeded)	9.6	10.7	+1.1
4.I.C.2: Field strength of the NHSC through scholarship and loan repayment agreements. *(Outcome)*	FY 2015: 9,683 Target: 8,495 (Target Exceeded)	9,153	10,155	+1,002
4.I.C.4: Percent of NHSC clinicians retained in service to the underserved for at least one year beyond the completion of their NHSC service commitment. *(Outcome)*	FY 2014: 87% Target: 80% (Target Exceeded)	80%	80%	Maintain
4.E.1: Default rate of NHSC Scholarship and Loan Repayment Program participants. *(Efficiency)* (Baseline: FY 2007 = 0.8%)	FY 2015: 0.7% % Target: ≤2.0% (Target Exceeded)	≤ 2.0%	≤2.0%	Maintain
4.I.C.6: Number of NHSC sites *(Outcome)*	FY 2015: 15,979 Target: 14,000 (Target Exceeded)	14,000	14,000	Maintain

Table 6. Loans/Scholarships Table

(whole dollars)	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Loans Repayments	---	---	---
State Loans Repayments	---	---	---
Scholarships	---	---	---
Students to Service Loan Repayment	---	---	---
Mandatory Loans	$159,192,178	$172,000,000	$167,000,000
Mandatory State Loans	$12,730,261	$13,000,000	$15,000,000

(whole dollars)	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Mandatory Scholarships	$44,025,464	$41,000,000	$38,000,000
Mandatory Students to Service Loan Repayment	$11,537,898	$14,000,000	$20,000,000
Discretionary Behavioral Health Expansion Loans	---	---	$18,000,000
Mandatory Mental Health and Opioid Initiatives Loans	---	---	$45,000,000

Table 7. NHSC Awards, by program and funding category

Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017
AWARDS:								
Scholarship	25	5	-	-	-	-	-	-
Scholarship Continuation	5	1	-	-	-	-	-	-
Loan Repayment	1,335	448	-	-	-	-	-	-
Loan Repayment Continuation	701	-	-	-	-	-	-	-
State Loan Repayment	285	-	-	-	-	-	-	-
Students to Service Loan Repayment	-	-	-	-	-	-	-	-
ARRA Scholarship	185	-	-	-	-	-	-	-
ARRA Loan Repayment	2,214	1,053	-	-	-	-	-	-
ARRA State Loan Repayment	161	171	-	-	-	-	-	-
ACA Scholarships	-	248	212	180	190	196	-	-
ACA Scholarship Continuation	-	8	10	16	7	11	-	-
ACA Loan Repayment	-	2,612	2,342	2,106	2,775	2,934	-	-
ACA Loan Repayment Continuation	-	1,305	1,925	2,399	2,105	1,841	-	-
ACA State Loan Repayment	-	223	281	447	464	620	-	-

Table 7. NHSC Awards, by program and funding category

Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017
ACA Students to Service Loan Repayment	-	-	69	78	79	96	-	-
Mandatory Scholarships	-	-	-	-	-	-	165	146
Mandatory Scholarship Continuation	-	-	-	-	-	-	16	13
Mandatory Loan Repayment	-	-	-	-	-	-	2,654	2,442
Mandatory Loan Repayment Continuations	-	-	-	-	-	-	1,732	2,006
Mandatory State Loan Repayment	-	-	-	-	-	-	433	500
Mandatory Students to Service Loan Repayment	-	-	-	-	-	-	117	167
Behavioral Health Expansion Initiative Loan Repayment	-	-	-	-	-	-	-	351
Mental Health and Opioid Initiatives Loan Repayment	-	-	-	-	-	-	-	878
Total Awards	**4,911**	**6,074**	**4,839**	**5,226**	**5,620**	**4,840**	**5,117**	**6,503**

Table 8. NHSC Field Strength, by program and funding category, FYs 2010-2017

Fiscal Year	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
FIELD STRENGTH:								
Scholars	523	495	425	359	249	242	166	122
Loan Repayers	3,201	2,010	754	271	-	-	-	-
State Loan Repayment	581	285	-	-	-	-	-	-
USPHS Commissioned Corps Ready Responders	30	23	17	-	-	-	-	-
Base Field Strength (as of 9/30)	**4,335**	**2,813**	**1,196**	**630**	**249**	**242**	**166**	**122**
American Recovery and Reinvestment Act (ARRA) Loan Repayers	3,032	3,267	1,089	59	-	-	-	-
ARRA State Loan Repayment	161	278	130	106	-	-	-	-
ARRA Scholars	2	4	71	103	77	38	267	240
ARRA Field Strength	**3,195**	**3,549**	**1,290**	**268**	**77**	**38**	**267**	**240**
ACA Scholars	-	-	6	31	133	178	246	263
ACA Loan Repayment	-	3,917	6,791	7,217	7,648	8,062	2,934	-
ACA State Loan Repayment	-	-	625	753	1,135	1,136	1,084	620
ACA Students to Service Loan Repayment	-	-	-	-	-	27	69	147
ACA Field Strength	-	**3,917**	**7,422**	**8,001**	**8,916**	**9,403**	**4,333**	**1,030**
Mandatory Loan Repayment	-	-	-	-	-		4,387	7,102
Mandatory State Loan Repayment	-	-	-	-	-	-	-	433

Table 8. NHSC Field Strength, by program and funding category, FYs 2010-2017

	2010	2011	2012	2013	2014	2015	2016	2017
Mandatory Students to Service Loan Repayment	-	-	-	-	-	-	-	-
Mandatory Field Strength	-	-	-	-	-	-	**4,387**	**7,535**
Behavioral Health Expansion Initiative Loan Repayment	-	-	-	-	-	-	-	351
Behavioral Health Expansion Initiative Field Strength	-	-	-	-	-	-	-	**351**
Mental Health and Opioid Initiatives Loan Repayment	-	-	-	-	-	-	-	878
Mental Health and Opioid Initiatives Field Strength	-	-	-	-	-	-	-	**878**
Total Field Strength	**7,530**	**10,279**	**9,908**	**8,899**	**9,242**	**9,683**	**9,153**	**10,155**

Faculty Loan Repayment Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$1,190,000	$1,190,000	$1,190,000	---
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Sections 738 and 740 as amended by Public law 111-148, Sections 5402 and 10501

FY 2017 Authorization ..... Expired

Allocation Method ..... Other (Competitive Awards to Individuals)

Program Goal and Description: The Faculty Loan Repayment Program (FLRP) is a loan repayment program for health profession graduates from disadvantaged backgrounds who serve as faculty at an eligible health professions college or university for a minimum of two years. In return, the federal government agrees to pay up to $20,000 of the outstanding principal and interest on the individual's health professions education loans for each year of service. The employing institution must also make payments to the faculty member that matches the principal and interest amount paid by HHS for each year in which the recipient serves as a faculty member. The Secretary may waive the institution's matching requirements if the Secretary determines it will impose an undue financial hardship.

Need: The diverse background and experiences of faculty in health professional schools is essential to creating an optimal environment for student learning. The rise of educational debt for health professionals has created barriers for individuals from disadvantaged backgrounds in attaining the education necessary to become faculty, as well as for institutions to recruit and retain diverse faculty members. According to a 2013 University of California study on recent trends of health professional education, existing faculty shortages are recognized as having a direct and adverse impact on the ability to expand programs in some professions, with well qualified students being turned away because there are insufficient numbers of faculty available to teach them.[16] FLRP assists in lessening the financial burden associated with the attainment of advanced education for individuals from disadvantaged background and helps to eliminate recruitment and retention barriers for academic institutions in attracting a cadre of widely experienced faculty members. A sufficient supply and diversity of health professions educators is vital to ensure that the health profession training system is able to prepare the next generation of diverse and culturally competent health care professionals. FLRP increases the recruitment and retention of health professions faculty from disadvantage backgrounds and encourages participants to promote careers in their respective health care fields.

[16] A New Era of Growth: A Closer Look At Recent Trends in Health Professions Education, May 2013 http://www.ucop.edu/uc-health/_files/a-new-era-of-growth_may2013.pdf.

Eligible Entities: Eligible participants are U.S. citizens (either U.S. born or naturalized), U.S. Nationals or Lawful Permanent Residents from a disadvantaged background who have 1) an eligible health professions degree or certificate, 2) an employment commitment for a full-time or part-time faculty position for a minimum of two years from an eligible health professions school, and 3) a written agreement with the school in which the school has agreed to match funds to pay principal and interest due on the applicant's educational loans, unless the school has been granted a full or partial waiver of this requirement.

Program Accomplishments:

In FY 2015:
The FLRP program made 21 new loan repayment awards.

In FY 2016:
The FLRP program is expected to make 20 new loan repayment awards.

Funding History

FY	Amount
FY 2013	$1,177,000
FY 2014	$1,187,000
FY 2015	$1,190,000
FY 2016	$1,190,000
FY 2017	$1,190,000

Budget Request

The FY 2017 Budget Request is $1.2 million, which is equal to the FY 2016 Enacted level. This budget will fund 20 awards to health profession graduates from disadvantaged backgrounds who serve as faculty at an eligible health professions college or university. The availability of pipeline programs and the faculty to support them are imperative to ensuring a sufficient primary care workforce.

Loans Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	21	20	20

Health Professions Training for Diversity

Centers of Excellence

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$21,711,000	$21,711,000	$21,711,000	---
FTE	1	1	1	---

Authorizing Legislation: Public Health Service Act, Section 736, as amended by Public Law 111-148, Section 5401

FY 2017 Authorization .....Such Sums as Necessary

Allocation Method .....Competitive Grant

Program Goal and Description: The Centers of Excellence (COE) Program seeks to increase the supply and competencies of underrepresented minorities (URM) in the health professions workforce by providing grants to health professions schools and other public and nonprofit health or educational entities to serve as innovative resource and education centers for the recruitment, training and retention of underrepresented minority students and faculty. The COE Program is a catalyst to institutionalize the Department's commitment to URM students and to faculty development by providing resources—in the form of educational and training opportunities—that focus in part on diversity in the health professions and minority health issues.

Need: As the U.S. population continues to grow and become more racially, ethnically, and culturally diverse, the need for a diverse workforce has become increasingly important. It has been well documented that increasing racial, ethnic and cultural diversity among health professionals is associated with improved access to care for minority patients and greater patient choice and satisfaction, among many other benefits. Likewise, demand for health care is growing due to an aging population, increased health care spending and the health reforms introduced by the Affordable Care Act. These rapid shifts in population patterns and health care policies require a reconsideration of how minority populations and individuals from disadvantaged backgrounds access and receive quality health care.

The demographic shifts in ethnic and racial diversity over the course of the 21st century will likely have numerous consequences for the health care sector, including an increased demand and need for minority health workers. However, there is a disparity in the representation of minorities in health professions, especially among advanced health professions. For example, the 2010 U.S. census data show the race and ethnicity representation as a percent of the U.S. population as follows: Blacks/African Americans 12.6 percent; Hispanic/Latino 16.3 percent; American Indian and Alaska Native 0.9 percent; Asian 4.9 percent; Native Hawaiian/Other

Pacific Islander 0.2 percent; and White 72.4 percent.[17] In contrast, of the Medical Doctor (MD) degrees conferred in 2013, the distribution was as follows: Black/African American 5.5 percent; Hispanic/Latino 4.8 percent; American Indian/Alaska Native 0.1 percent; Asian 20.1 percent; Native Hawaiian/Other Pacific Islander <0.1 percent; and White 59.3 percent.[18] Of the Doctor of Pharmacy (Pharm.D.) degrees conferred in 2011-12, the distribution was: Black/African American 6.5 percent; Hispanic/Latino 4.2 percent; Native Hawaiian/Other Pacific Islander 1.6 percent; American Indian/Alaska Native 0.5 percent; and White 50 percent.[19] Among dentists, approximately 9 percent of the 181,000 dentists currently practicing in the United States are either Black/African American, Hispanic/Latino, or American Indian/Alaska Native.[20]

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

Designated Health Professions	Targeted Educational Levels	Grantee Activities
• Allopathic medicine • Dentistry • Graduate programs in behavioral or mental health • Osteopathic medicine • Pharmacy	• Undergraduate • Graduate • Faculty development	• Increase outreach to URM students to enlarge the competitive applicant pool. • Develop academic enhancement programs for URM students. • Train, recruit, and retain URM faculty. • Improve information resources, clinical education, cultural competency, and curricula as they relate to minority health issues. • Facilitate opportunities for faculty and student research on minority health issues. • Train students at community-based health facilities serving minority individuals. • Provide stipends and fellowships to URM students and faculty. • Establish a network among the designated Historically Black Colleges and Universities to improve access to and dissemination of best practices for recruitment, retention and training of URM students and faculty.

[17] U.S. Census Bureau. Overview of Race and Hispanic Origin, 2010. 2010 Census Briefs. Issued May, 2011. http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf.
[18] Association of American Medical Colleges, U.S. Medical School Graduates by Race/Ethnicity and Sex, 2012-2014. https://www.aamc.org/download/321536/data/factstable29.pdf.
[19] American Association of Colleges of Pharmacy, 2011-2012 Profile of Pharmacy Students. http://www.aacp.org/resources/research/institutionalresearch/Documents/Fall12_Introduction.pdf.
[20] American Dental Association, 2011. Something to Smile About Careers in the Dental Profession. http://www.ada.org/~/media/ADA/Education%20and%20Careers/Files/minority_dentist_brochure.ashx.

Program Accomplishments: In Academic Year 2014-2015, the COE program supported 189 different training programs and activities designed to prepare individuals to either apply to a health professions training program (academic recruitment) or maintain enrollment in such programs during the academic year (academic retention). Overall, programs and activities supported through the COE program reached approximately 10,500 trainees across the country. Approximately 56 percent of the trainees reached through the COE program were considered underrepresented minorities in the health professions, including 25 percent of trainees who identified as Hispanic, 17 percent who identified as Non-Hispanic Black or African American, 13 percent who identified as Non-Hispanic American Indian or Alaska Native, and approximately 2 percent identified as Non-Hispanic Native Hawaiian or Other Pacific Islander. For each of these racial and ethnic categories, the percentage participating in the COE program is greater than the percent of their representation in the U.S. working-age population as a whole (for example, 25 percent of COE trainees identify as Hispanic, but they only comprise 15.5 percent of the overall U.S. working-age population).[21] In addition, approximately 60 percent of the trainees were from financially and/or educationally disadvantaged backgrounds.

Data were collected about other types of training activities carried out through the COE program. Grantees partnered with 340 healthcare delivery sites, to provide 7,700 clinical training experiences to health professions trainees. Nearly 48 percent of training sites used by COE grantees were situated in primary care settings and approximately 63 percent were located in medically underserved communities. In addition, COE grantees developed or enhanced and implemented more than 130 different curricular activities, most of which were new academic courses and training activities for health professions students, residents and fellows. It is estimated that more than 15,400 trainees were reached through curricular activities supported through the COE program during the academic year.

Finally, with regard to faculty development, results showed that COE grantees supported more than 230 different faculty-focused training programs and activities during the academic year, reaching approximately 3,400 faculty-level trainees. In addition, grantees supported more than 310 collaborative faculty-student research projects related to minority health issues, involving over 490 faculty members and approximately 600 health professions students across Academic Year 2014-2015.

Funding History

FY	Amount
FY 2013	$21,482,000
FY 2014	$21,657,000
FY 2015	$21,711,000
FY 2016	$21,711,000
FY 2017	$21,711,000

[21] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. (2014.) *Sex, race, and ethnic diversity of U.S. health occupations (2010-2012),* Rockville, Maryland.

Budget Request

The FY 2017 Budget Request for the COE program of $21.7 million is equal to the FY 2016 Enacted level. This funding will enable HRSA to continue to support efforts to facilitate faculty and student research on health issues particularly affecting URM groups, strengthen programs to enhance the academic performance of URM students attending the school, and promote faculty development in various areas, including diversity and cultural competency.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result) [22]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
Percent of program participants who completed pre-health professions preparation training and intend to apply to a health professions degree program	---	TBD[23]	TBD	---
Percent of program participants who received academic retention support and maintained enrollment in a health professions degree program	---	TBD[24]	TBD	---
Percent of health professions students participating in research on minority health-related issues	---	TBD[25]	TBD	---
Percent of faculty members participating in research on minority health-related issues	---	TBD[26]	TBD	---
Number of URM students participating in research on minority health issues	FY 2014: 475 Target: 390 (Target Exceeded)	N/A[27]	N/A	---
Number of URM faculty participating in research on minority health issues	FY 2014: 347 Target: 323 (Target Exceeded)	N/A[28]	N/A	---

[22] Most recent results are for Academic Year 2014-2015 and funded in FY 2014.
[23] Baseline for this measure will be set for FY 2015 and available in the FY 2018 Congressional Justification.
[24] Baseline for this measure will be set for FY 2015 and available in the FY 2018 Congressional Justification.
[25] Baseline for this measure will be set for FY 2015 and available in the FY 2018 Congressional Justification.
[26] Baseline for this measure will be set for FY 2015 and available in the FY 2018 Congressional Justification.
[27] Measure is discontinued in FY 2015.
[28] Measure was discontinued in FY 2015.

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	13[29]	13	13
Average Award	$661,287	$891,000	$891,000
Range of Awards	$418,288-$700,000	$860,000-$900,000	$860,000-$900,000

Awards for Designated Historically Black Colleges and Universities

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	4	4	4
Average Award	$3,000,000	$2,900,000	$2,900,000
Range of Awards	$2,339,598 - $3,498,237	$2,300,000 - $3,500,000	$2,300,000 - $3,500,000

[29] For FY 2015 and beyond, the awards to the four designated HBCUs are listed separately in the table below.

Health Professions Training for Diversity

Scholarships for Disadvantaged Students

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$45,970,000	$45,970,000	$49,070,000	+3,100,000
FTE	5	5	5	---

Authorizing Legislation: Public Health Service Act, Sections 737 and 740, as amended by Public Law 111-148, Section 5402(b)

FY 2017 Authorization .....Expired

Allocation Method .....Competitive Grant

Program Goal and Description: The Scholarships for Disadvantaged Students (SDS) Program increases diversity in the health professions and nursing workforce by providing grants to eligible health professions and nursing schools for use in awarding scholarships to students from disadvantaged backgrounds who have financial need, many of whom are underrepresented minorities (URMs). The SDS Program aims to increase: 1) enrollment and retention of URMs, 2) the number of graduates practicing in primary care, and 3) the number of graduates working in medically underserved communities.

Need: Greater diversity among health professionals is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better patient-clinician communication. In addition, evidence suggests that minority health professionals are more likely to serve in areas with a high proportion of uninsured and underrepresented racial and ethnic groups.[30],[31] The SDS Program not only tackles a major barrier for a disadvantaged student's access to a health professions education—high tuition costs—but also strives to connect these students to retention services and activities that support their progression through the health professions educational program.

Eligible Entities: Eligible entities are accredited schools of medicine, osteopathic medicine, dentistry, nursing, pharmacy, podiatric medicine, optometry, veterinary medicine, public health, chiropractic, allied health, and a school offering a graduate program in behavioral and mental health practice or an entity providing programs for the training of physician assistants.

[30] Institute of Medicine. (2004) *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*. Washington, DC: The National Academies Press.

[31] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. (2006). *The rationale for diversity in the health professions: A review of the evidence*. Rockville, MD: U.S. Department of Health and Human Services.

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

Program Accomplishments:
In Academic Year 2014-2015, the SDS Program provided scholarships to 5,285 students from disadvantaged backgrounds, exceeding the program performance target by 80 percent. The majority of students were female (79 percent); between the ages of 20 and 29 (66 percent); and were provided a median scholarship of $7,427. This is a much higher representation of female students than exists in the overall working-age U.S. population, as well as for the many of occupations in the health care sector, where females are already better represented than males.[32] Further analyses showed that 63 percent of students who received an SDS-funded scholarship were considered underrepresented minorities in their prospective professions.

Additionally, 2,091 students who received SDS-funded scholarships successfully graduated from their degree programs by the end of Academic Year 2014-2015. Of these graduates, 57 percent were considered underrepresented minorities in their prospective professions. Upon graduation, 72 percent intended to work or pursue additional training in medically underserved communities, and 48 percent intended to work or pursue additional training in primary care settings. This continues to build upon the FY 2012 program redesign that focused the program on becoming a competitive, primary care grant program.

SDS grantees partnered with over 4,000 clinical sites to provide nearly 35,000 clinical training experiences to students who received SDS-funded scholarships during the academic year. The majority of the clinical training sites were located in medically underserved communities (54 percent) and/or primary care settings (46 percent).

In FY 2016, the SDS Program will build on the program's previous success as the Department makes new funding available. The SDS program will direct funds to health care disciplines that

[32] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. (2014.) *Sex, race, and ethnic diversity of U.S. health occupations (2010-2012),* Rockville, Maryland.

are projected to experience shortages of health professionals in the future including directing funds to awardees that will help meet the demand for behavioral health services.[1] The Department will include funding thresholds for some disciplines to more closely mirror the health professional shortage needs across the country. In addition, the Department will ensure awards are made to grantees across all HHS regions.

Funding History

FY	Amount
FY 2013	$44,497,000
FY 2014	$44,857,000
FY 2015	$45,970,000
FY 2016	$45,970,000
FY 2017	$49,070,000

Budget Request

The FY 2017 Budget Request for the SDS Program of $49.0 million, which is $3.1 million above the FY 2016 Enacted level. This request will fund approximately 105 grant awards, supporting approximately 3,185 students, an increase of 245 students above the FY 2016 levels. Increased funding will help to meet the demand for scholarship support to disadvantaged students who have unmet financial need in paying for their health professions education.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[33]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
Number of disadvantaged students	FY 2014: 5,285 Target: 2,940 (Target Exceeded)	2,940	3,185	+245
Number of URM students	FY 2014: 3,339 Target: 1,820 (Target Exceeded)	1,820	1,970	Maintain
Percent of students who are URMs	FY 2014: 63% Target: 62% (Target Exceeded)	62%	62%	Maintain

[33] Most recent results are for Academic Year 2014-2015, which was funded in FY 2014.

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	99	99	105
Average Award	$431,363	$434,000	$466,000
Range of Awards	$42,840-$650,000	$40,000-$650,000	$40,000-$650,000

Health Professions Training for Diversity

Health Careers Opportunity Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$14,189,000	$14,189,000	$14,189,000	---
FTE	5	5	5	---

Authorizing Legislation: Public Health Service Act, Sections 739 and 740, as amended by Public Law 111-148, Section 5402

FY 2017 Authorization .....Expired

Allocation Method .....Competitive Grant

Program Goal and Description: The goal of the Health Careers Opportunity Program (HCOP) is to provide individuals from disadvantaged backgrounds who desire to pursue a health professions career an opportunity to develop the skills needed to successfully compete for, enter, and graduate from schools of health professions or allied health professions. In FY 2015, the HCOP grant program was redesigned to respond to the evolving health care workforce needs, while continuing efforts to increase the diversity of the health care workforce. The program focuses on specific entry points along a health careers pipeline that begin in the latter years of high school and places increased emphasis on evidence-informed approaches. It expands its recruitment strategies to include non-traditional students and veterans from educationally and economically disadvantaged backgrounds. The program is centered on three key milestones of education: 1) high school completion; 2) acceptance, retention and graduation from college; and 3) acceptance, retention and completion of a health professions program. A rigorous evaluation requirement is incorporated to assess program effectiveness and improve monitoring of outcomes.

The HCOP awardees build on and leverage existing and new partnerships and incorporate key elements such as strengthening and/or establishing public-private partnerships to support the education, training, and community-based placement of health professions students from disadvantaged backgrounds, including racial and ethnic minority students who are underrepresented among health professionals.

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

Program activities and components include:

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

- Establish public-private partnerships by which disadvantaged students gain experiential field placement in the health professions field. In conjunction with academic training, hands-on experience will be attained via a healthcare provider that serves a medically underserved rural or urban community or Health Professional Shortage Area.

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

Need: Greater diversity among health professionals is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better patient-clinician communication. According to U.S. Census Bureau 2010 census projections, "the U.S. population will be considerably older and more racially and ethnically diverse by 2060, when minorities are projected to comprise 57 percent of the population as compared to 37 percent currently." [34] This increase in population diversity will be mirrored in the workforce and in the demand for health care services, underscoring the need to have a diverse and culturally competent health care workforce in place. These rapid shifts in population patterns and social policies require a reconsideration of how minority populations and individuals from disadvantaged backgrounds access and receive quality health care. It has been well-documented that increasing racial, ethnic and cultural diversity among health professionals is associated with improved access to care for minority patients and greater patient choice and satisfaction, among many other benefits.

According to the Bureau of Labor Statistics, employment in the health care industry is projected to increase 29 percent through 2022, compared to an average 11 percent for all other industries. While the need for health care professionals, and particularly professionals who reflect the racial and ethnic diversity of the general population, is growing, there is a significant disparity in the advanced health professions degrees conferred to under-represented minorities. For example, the 2010 U.S. census data show the race and ethnicity representation as a percent of the U.S. population as follows: Blacks/African Americans 12.6 percent; Hispanic/Latino 16.3 percent; American Indian and Alaska Native 0.9 percent; Asian 4.9 percent; Native Hawaiian/Other Pacific Islander 0.2 percent; and White 72.4 percent.[35] In contrast, of the Medical Doctor (MD) degrees conferred in 2013, the distribution was as follows: Black/African American 5.5 percent; Hispanic/Latino 4.8 percent; American Indian/Alaska Native 0.1 percent; Asian 20.1 percent; Native Hawaiian/Other Pacific Islander <0.1 percent; and White 59.3 percent.[36] Of the Doctor of Pharmacy (Pharm.D.) degrees conferred in 2011-12, the distribution was: Black/African

[34] Data are from the Occupational Employment Statistics program, U.S. Department of Labor, Bureau of Labor Statistics.
[35] U.S. Census Bureau. Overview of Race and Hispanic Origin, 2010. 2010 Census Briefs. Issued May, 2011. http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf.
[36] Association of American Medical Colleges, U.S. Medical School Graduates by Race/Ethnicity and Sex, 2012-2014. https://www.aamc.org/download/321536/data/factstable29.pdf.

American 6.5 percent; Hispanic/Latino 4.2 percent; Native Hawaiian/Other Pacific Islander 1.6 percent; American Indian/Alaska Native 0.5 percent; and White 50.0 percent.[37] Among dentists, approximately 9 percent of the 181,000 dentists currently practicing in the United States are Black/African American, Hispanic/Latino, or American Indian/Alaska Native.[38]

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

Program Accomplishments: In Academic Year 2014-2015, the HCOP supported approximately 200 different training programs and activities to promote interest in the health professions among prospective students. In total, HCOP grantees reached more than 12,600 trainees across the country. Results showed that nearly 55 percent of trainees reached through the HCOP were considered underrepresented minorities in the health professions. This included 28 percent of trainees who identified as Hispanic, 22 percent who identified as Non-Hispanic Black or African American, approximately 3 percent who identified as Non-Hispanic American Indian or Alaska Native, and less than 1 percent who identified as Non-Hispanic Native Hawaiian or Other Pacific Islander. Whereas HCOP did not meet the FY 2014 target of 4,435 disadvantaged students participating in structured programs (FY 2014 result is 3,170), the proportion of disadvantaged students participating in structured programs was maintained across both FY 2013 and FY 2014 at 90 percent.

Data were collected on other training-related activities that were required to be carried out by HCOP grantees. Results showed that grantees partnered with over 280 sites to provide more than 6,000 clinical training experiences for HCOP student trainees (e.g., academic institutions, hospitals, and community health centers). Approximately 46 percent of these training sites were situated in primary care settings and approximately 55 percent were located in medically-underserved communities.

In Academic Year 2014-2015, the HCOP for Skills Training and Health Workforce Development of Parprofessionals (i.e., HCOP-Skills program) supported training for a total of 976 certificate students. Results showed that students were primarily female (90 percent), between the ages of 20-29 (44 percent), and enrolled in one of several paraprofessional certificate programs, most commonly training to become community health workers, nursing assistants/aides, and phlebotomy technicians. Further analyses of data showed that approximately 91 percent of students were from financially or educationally disadvantaged backgrounds and 86 percent were considered underrepresented minorities in their prospective professions. A total of 408 students graduated from these certificate-bearing programs by the end of the academic year.

In addition to academic training, HCOP Skills program grantees partnered with a total of 57 sites to provide clinical training experiences for certificate students (e.g., academic institutions, nursing homes, and assisted living facilities). Approximately 67 percent of these training sites

[37] American Association of Colleges of Pharmacy, 2011-2012 Profile of Pharmacy Students. http://www.aacp.org/resources/research/institutionalresearch/Documents/Fall12_Introduction.pdf.
[38] American Dental Association, 2011. Something to Smile About Careers in the Dental Profession. http://www.ada.org/~/media/ADA/Education%20and%20Careers/Files/minority_dentist_brochure.ashx.

were located in medically underserved communities and 35 percent were situated in primary care settings. Training at partnered sites often incorporated interdisciplinary team-based approaches, where more than 140 other students, residents, and fellows were trained on teams with HCOP-Skills trainees.

Finally, grant funds were used to develop and enhance curricula related to health professions and paraprofessions. A total of 17 curricula were newly developed or enhanced, all of which were implemented during the academic year (e.g., trainings, workshops, and academic courses). Approximately 360 students and advanced trainees participated in courses and training activities that were developed or enhanced by grantees of the HCOP Skills Training program.

Funding History

FY	Amount
FY 2013	$14,039,000
FY 2014	$14,153,000
FY 2015	$14,189,000
FY 2016	$14,189,000
FY 2017	$14,189,000

Budget Request

The FY 2017 Budget Request for the HCOP Program is $14.2 million, which is equal to the FY 2016 Enacted level. This request will fund activities for approximately 20 grantees that have developed health career pipeline programs for health professions students and have strong evidence of success in academic performance, retention and graduation. Through these activities, the HCOP will continue to increase the diversity and cultural competence of the health professions workforce.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[39]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
Total number of disadvantaged students in structured programs	FY 2014: 3,170 Target: 4,435 (Target Not Met)	3,500	3,500	Maintain

[39] Most recent results are for Academic Year 2014-2015, which was funded in FY 2014.

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	30	30	20
Average Award	$440,394	$440,394	$630,000
Range of Awards	$151,827-$650,000	$151,827-$650,000	$436,700-$650,000

Health Care Workforce Assessment

The National Center for Health Workforce Analysis

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$4,663,000	$4,663,000	$4,663,000	---
FTE	6	7	7	---

Authorizing Legislation: Public Health Service Act, Sections 761, 792, and 806(f), as amended by Public Law 111-148, Section 5103

FY 2017 Authorization .....Expired

Allocation Method……..……Competitive Grant/Contract

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

- Informing the public on the current state and trends of the U.S. health workforce through timely dissemination of reports and data;
- Building national capacity for health workforce data collection by working with professional associations and others to develop and promote guidelines for data collection and analysis;
- Improving data management, data analysis, modeling and projections to support analysis and decision making as well as evaluation of the effectiveness of workforce programs and policies;
- Building health workforce research capacity;
- Responding to information and data needs by translating data and findings to inform policies and programs; and,
- Analyzing grantee performance data as well as conducting workforce program evaluations.

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

Program Accomplishments:

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

The National Center makes health workforce information available through reports and online databases. Several publications were released during Calendar Year 2015: 1) National and State-Level Projections of Dentists and Dental Hygienists in the U.S., 2012-2025; 2) Sex, Race, and Ethnic Diversity of U.S. Health Occupations (2010-2012); and 3) six factsheets on supply and/or demand of Chiropractors and Podiatrists, Dieticians and Nutritionists, Health Technologists and Technicians, Psychologists, Respiratory Therapists and Healthcare Support OccupationsIn addition, in early 2016, the National Center will release supply and demand projections through 2025 for primary care providers (i.e., physicians, nurse practitioners and physician assistants).

Continuing its work to expand the range of data available through the Area Health Resources Files, the National Center continues to update country, state, and national level data and improve the availability of online comparison and mapping tools for analyzing data.

The National Center has funded a total of seven Health Workforce Research Centers to perform research and data analysis on health workforce issues of national importance. The most recent center funded was a Mental Health Behavioral Center. The Health Workforce Research Center program supports high quality, impartial, policy relevant research on the health workforce to assist decision makers at the federal, state and local levels to better understand health workforce needs. The six funded centers collect, analyze and report health workforce data that answer the question: *What health care workforce is adequate to ensure access to high quality, efficient health care for the U.S. population?*

Funding History

FY	Amount
FY 2013	$2,635,000
FY 2014	$4,651,000
FY 2015	$4,663,000
FY 2016	$4,663,000
FY 2017	$4,663,000

Budget Request

The FY 2017 Budget Request is $4.6 million, which is the same as the FY 2016 Enacted Level. As the nation's health care system continues to change, state- and national-level analysis of health care workforce needs will be critical to making investments in the health workforce. To support these needs, the National Center continues to develop a projections model which allows a more sophisticated modeling of health workforce supply and demand, taking into account changing national demographics, the effects of health reform on demand for health care services, and the impact those changes on the delivery of health care. The National Center's Area Health Resources File continues to expand its focus on specific priority areas for health workforce development such as behavioral and mental health workforce needs, allied health professions,

and oral health workforce. In FY 2017, the National Center plans to support new research on the behavioral and mental health workforce, as well as continuing to support research on allied health occupations, the long term care workforce, the oral health workforce, new ways of using providers such as physicians and nurses, and emerging health care occupations (e.g., community paramedicine, community health workers, etc.)

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

Health Workforce Research Centers Grants Awards Table

	FY 2015 Final[40]	**FY 2016 Enacted**	**FY 2017 President's Budget**
Number of Awards	7	6	6
Average Award	$542,186	$438,000	$438,000
Range of Awards	$362,541-$900,000	$357,000-$500,000	$357,000-$500,000

[40] Note: The FY 2015 awards include an additional $800,000 from the Bureau of Primary Health Care to support the research center awards.

Primary Care Training and Enhancement Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$38,924,000	$38,924,000	$38,924,000	---
FTE	5	5	5	---

Authorizing Legislation: Public Health Service Act, Section 747, as amended by Public Law 111-148, Section 5301

FY 2017 Authorization .....Expired

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

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

- Academic administrative units;
- Interprofessional joint graduate degree programs;
- PA education;
- Physician and PA faculty development;
- Pre-doctoral training; and
- Residency training.

In FY 2015, HRSA streamlined the PCTE Program by combining previously separate funding announcements in order to support projects that propose training across the training continuum (e.g., students, residents, faculty development, and practicing primary care physicians or physician assistants), and across primary care disciplines and professions (e.g., family medicine, general internal medicine, general pediatrics, physician assistants, and other primary care professions).

The PCTE Program focuses on training for transforming health care systems, including enhancing the clinical training experience of trainees in rural areas, and encouraging interprofessional primary care education. In FY 2016, the program will further enhance interprofessional training for practice in transforming health care systems, encouraging expansion of the professions included in the interprofessional education and practice teams. In FY 2016, the Academic Units for PCTE Program was also revisioned to support national academic units to improve clinical teaching and research in primary care. These academic units

will conduct systems-level research, disseminate best practices and create communities of practice to promote the widespread enhancement of primary care training.

Need: Evidence demonstrates that high quality, accessible primary care improves health and reduces costs, with improved satisfaction for both recipients and providers of health care services. However, projections published by HRSA indicate that without changes to how primary care is delivered, the growth in primary care physician supply will not be adequate to meet the demand, with a projected shortage of 20,400 physician FTE by 2020.[41] Geographic maldistribution also contributes to the shortage of primary care providers in many communities. Rural areas have less than half the number of physicians to population compared to urban areas.[42] PAs are valuable primary care team members that are helping to increase the capacity and quality of the health care system. The trends disfavoring primary care practice and working in underserved communities seen in physicians have been mirrored in PAs.

Research demonstrates training in rural and underserved areas increases the likelihood that physicians will practice in these areas[43,44] and training programs can affect the quality of care provided by physicians.[45] The goal of the PCTE Program is to enhance education for primary care providers who will ultimately provide high quality care to underserved communities.

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

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

[41] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis, *"Projecting the Supply and Demand for Primary Care Practitioners Through 2020." 2013.*
[42] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis , Distribution of U.S. Health Care Providers Residing in Rural and Urban Areas. October 2014.
[43] Brooks RG, Walsh M, Mardon RE, Lewis M, Slawson A. The roles of nature and nurture in the recruitment and retention of primary care physicians in rural areas: a review of the literature. Acad Med. 2002; 77(8):790–8.
[44] Morris CG, Johnson B, Kim, S, Chen F. Training Family Physicians in Community Health Centers: A Health Workforce Solution. Health Services Research 2008:40(4):271-6.
[45] Asch DA, Nicholson S, Srinivas S, Herrin J, Epstein AJ. Evaluation Obstetrical Residency Programs Using Patient Outcomes. JAMA 2009:302(12):1277-83.

Designated Health Professions	Targeted Educational Levels	Grantee Activities
	• Academic and community faculty development	residencies. • Primary care academic and community faculty development. • Support development and enhancement of infrastructure in primary care academic administrative units. • Support expansion of training opportunities by funding primary care physician residency positions and physician assistant stipends.

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

In Academic Year 2014-2015, grantees of the PCTE program trained a total of 35,860 physician and PA students, medical residents, fellows, and faculty. Of those trained, 8,785 completed their training program by the end of the academic year. Approximately 22 percent of graduates were underrepresented minorities and/or from disadvantaged backgrounds. Trainees across the PCTE programs had over 1.5 million primary care patient encounters during the academic year. Approximately 59 percent of all physician and PA trainees received at least a portion of their training in medically underserved communities, and 53 percent of physician and PA graduates of PCTE programs currently practice in medically underserved areas. These programmatic accomplishments of producing new primary care providers are particularly important given the continued projected shortage of primary care physicians --a shortage of 20,400 FTEs by 2020-- and 17% increase in demand for primary care PAs by 2020.[46]

Academic Administrative Units in Primary Care Program

The Academic Administrative Units program supports the enhancement of clinical teaching and research in primary care. In Academic Year 2014-2015, grantees of the Academic Administrative Units in Primary Care program trained 8,987 medical students, residents and fellows. Of those trained, 1,962 medical students, residents and fellows completed their degree or training program at the end of the academic year. Approximately 23 percent of the graduates

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

and the program completers were underrepresented minorities and/or from disadvantaged backgrounds. With regard to training sites for this program, 77 percent were located in a primary care setting, 53 percent in a medically underserved community, and/or 25 percent in a rural setting. In addition, 7,580 individuals trained alongside medical students, residents, and fellows while participating in interprofessional team-based care across all training sites affiliated with the program. A total of 7,381 faculty member physicians were trained through the faculty development activities funded by the program, and 60 faculty members completed structured programs. Grantees supported four different types of faculty development activities including grand rounds, professional conferences, continuing education workshops, and academic courses. Most of the faculty physicians training in these programs specialized in either family medicine (17 percent) or geriatrics (54 percent).

Interdisciplinary and Interprofessional Joint Graduate Degree Program

The Interdisciplinary and Interprofessional Joint Graduate Degree program supports the integration of public health and primary care graduate education through the funding of joint degree programs that provide interdisciplinary and interprofessional graduate training in public health and other health professions.

In Academic Year 2014-2015, grantees of the Interdisciplinary and Interprofessional Joint Graduate Degree program trained 4,003 medical students who were dually enrolled in public health degree programs. Of those trained, 1,561 of those students graduated from their degree program at the end of the academic year. Approximately 16 percent of graduates were underrepresented minorities and/or from disadvantaged backgrounds. Training sites for this program were primarily located in a medically underserved community (54 percent), a primary care setting (39 percent), and/or a rural setting (27 percent). In addition, 1,721 individuals trained alongside students while participating in interprofessional team-based care across all training sites affiliated with the program. Grantees of this program developed or enhanced and implemented 82 courses and training activities during the academic year toward the goal of integrating a public health curriculum into the clinical practice model. Lastly, 113 faculty members completed faculty development programs sponsored by grantees, and 543 additional faculty members were trained at professional conferences and workshops.

Physician Assistant Training in Primary Care Program

The Physician Assistant Training in Primary Care program supports physician assistant education programs to enhance primary care education and training for practice in medically underserved areas.

In Academic Year 2014-2015, grantees of the Physician Assistant Training in Primary Care program trained 4,390 physician assistant (PA) students. Of those trained, 1,350 of those students graduated from their degree program at the end of the academic year. About 29 percent of enrollees reported coming from a disadvantaged background, while 13 percent reported coming from a rural background. Approximately 29 percent of graduates were underrepresented minorities and/or from disadvantaged backgrounds. Training sites for this program were primarily located in a medically underserved community (60 percent), a primary care setting (58 percent), and/or a rural setting (19 percent). In addition, 2,025 individuals trained alongside PA

students while participating in interprofessional team-based care across all training sites affiliated with the program. Grantees implemented 135 courses and training activities to PA students during the academic year as part of efforts to integrate primary care curriculum into PA training. Lastly, 364 faculty members were trained through the faculty development activities funded by the program, and 29 faculty members completed structured faculty programs. Grantees supported three different types of faculty development activities, including professional conferences (57 percent), continuing education workshops (39 percent), and academic courses (4 percent).

Physician Faculty Development in Primary Care Program

The Physician Faculty Development in Primary Care program supports projects that prepare physicians who plan to teach in family medicine, general internal medicine, or general pediatrics training programs.

In Academic Year 2014-2015, the Physician Faculty Development in Primary Care program trained 3,406 faculty-level physicians, fellows, and community physicians through a number of structured programs, faculty development activities, and formal coursework. Of those physicians trained, a total of 333 completed the program during the academic year. Of the 43 faculty and fellows who received direct financial support and completed the program, 77 percent intend to practice in a primary care setting and 70 percent intend to practice in a medically underserved community. Analysis of one-year follow-up data on employment location setting for those who completed the program in Academic Year 2013-2014 showed that approximately 37 percent of faculty graduates are now practicing in a primary care setting and/or 21 percent in a medically underserved community. Overall, the program offered 245 faculty development activities during the academic year that included academic courses, clinical rotations, grand rounds, professional conferences, and continuing education workshops. A total of 2,670 faculty-level physicians participated in these training activities with the majority of participants from the primary care disciplines of Family Medicine (53 percent), Pediatrics (16 percent) or Internal Medicine (5 percent). The program also offered 75 structured faculty programs that trained 736 physicians and 160 faculty-level physicians completed. The majority of these physicians were also from Family Medicine (40 percent), Pediatrics (28 percent) or Internal Medicine (12 percent).

Pre-doctoral Training in Primary Care Program

The Pre-doctoral Training in Primary Care program supports projects that support medical schools to enhance primary care education and training for practice in medically underserved areas.

In Academic Year 2014-2015, grantees of the Pre-doctoral Training in Primary Care program trained 13,313 medical students. Of those trained, 3,018 medical students graduated from their degree program at the end of the academic year. Approximately 22 percent of graduates were underrepresented minorities and/or were from disadvantaged backgrounds. Clinical training sites for this program were primarily located in a primary care setting (83 percent), a medically underserved community (58 percent), and/or a rural setting (31 percent). In addition, 4,506 individuals trained alongside medical students while participating in interprofessional team-based care across all training sites affiliated with the program. The program implemented 253

courses and training activities during the academic year to medical students as part of integrating primary care and innovative teaching into the medical school curriculum. Grantees of the program also trained a total of 704 physician faculty members through workshops, professional conferences, and grand rounds.

Residency Training in Primary Care Program

The Residency Training in Primary Care program supports residency training in family medicine, general internal medicine, and general pediatrics to enhance primary care education and training for practice in medically underserved areas.

In Academic Year 2014-2015, grantees of the Residency Training in Primary Care program trained 1,761 primary care residents. Additionally, 561 of those residents completed their residency program at the end of the academic year. Approximately 30 percent of those who completed their programs were underrepresented minorities and/or from disadvantaged backgrounds. Most of the clinical training sites for this program were located in a medically underserved community (70 percent), a primary care setting (58 percent), and/or a rural setting (27 percent). Over 7,500 individuals trained alongside residents while participating in interprofessional team-based care across all training sites affiliated with the program. Grantees of this program developed or enhanced and implemented 341 courses and training activities during the academic year to both medical residents and interprofessional trainees. In terms of faculty development, grantees offered 25 structured faculty development programs during the academic year of which 251 faculty and community physicians completed. Lastly, 125 faculty development activities offered by grantees including professional conferences, workshops, grand rounds, and academic courses provided training to 2,094 primary care faculty and community physicians training to become instructors.

Two additional grant programs - the Primary Care Residency Expansion Program and the Expansion of Physician Assistant Training Program - were funded in 2010 and will continue to increase the number of physician and PA students trained in primary care through 2016. The PCRE and EPAT grantees were funded for limited, five-year project periods which will be completed at the end of Academic Year 2015-2016.

Expansion of Physician Assistant Training Program

The Expansion of Physician Assistant Training (EPAT) Program supported expansion of physician assistant training programs to increase the primary care workforce.

In Academic Year 2014-2015, the Expansion of Physician Assistant Training (EPAT) in Primary Care supported a total of 429 physician assistant students across 12 different types of Physician Assistant programs. Results showed that most students supported were female (73 percent) and between the ages of 20 and 29 (70 percent).Approximately 48 percent of students reported having received clinical training in a medically underserved community, 58 percent in a primary care setting, and 29 percent in a rural setting. In addition, 2,357 individuals trained alongside PA students while participating in interprofessional team-based care across all training sites affiliated with the program. Of the 130 supported students who graduated in Academic Year 2014-2015, 36 percent of students intend to practice in a medically underserved community, 73

percent intend to practice in a primary care setting, and 22 percent intend to practice in a rural setting. Of the Academic Year 2013-2014 graduates whose follow-up employment data were available, most were either practicing in a primary care setting (54 percent), in a medically underserved community (42 percent), or in a rural setting (24 percent).

The EPAT program just fell short of meeting its performance target of producing 332 new physician assistants by the end of Academic Year 2014-2015. The primary reason for this is that performance targets assumed that the physician assistant training programs that were funded were only two academic years in length. As documented by the Physician Assistant Education Association (2013), over 75 percent of physician assistant programs in the US are between 24 and 29 months in length—though the total length in programs can range from 15 to 40 months. At the end of Academic Year 2014-2015, there were 183 physician assistant students in the second year of their program; it is very likely that these students are enrolled in programs that last slightly over 24 months and graduated at the very beginning of Academic Year 2015-2016. It is expected that the program can and will produce 600 new Physician Assistants; however, the cumulative target may not be reached until the beginning of Academic Year 2016-2017 rather than at the end of Academic Year 2015-2016 as previously identified due to the varying length of participating programs.

Primary Care Residency Expansion Program

The Primary Care Residency Expansion program supported the expansions of residency programs in family medicine, general internal medicine, and general pediatrics to increase the primary care workforce.

In Academic Year 2014-2015, the Primary Care Residency Expansion (PCRE) program provided direct financial support to 500 medical residents. Results showed that approximately 62 percent of residents were female and 48 percent were between the ages of 30 and 39 years. Furthermore, 15 percent of residents reported coming from a financially or educationally disadvantaged background and about 17 percent reported coming from a rural background. Most residents reported receiving clinical training in a medically underserved community (84 percent), and nearly all residents (98 percent) reported receiving training in a primary care setting. Over 24,000 individuals trained alongside residents while participating in interprofessional team-based care across all training sites affiliated with the program. Of the 171 residents who completed the program in Academic Year 2014-2015, 71 percent intend to practice in a primary care setting, 41 percent intend to practice in a medically underserved community, and 16 percent intend to practice in a rural setting.

Funding History

FY	Amount
FY 2013	$36,535,000
FY 2014	$36,831,000
FY 2015	$38,924,000
FY 2016	$38,924,000
FY 2017	$38,924,000

Budget Request

The FY 2017 Budget Request is $38.9 million, which is the same as the FY 2016 Enacted level. This request will fund Primary Care Training and Enhancement Program activities that aim to improve the quality of primary care providers, increase the capacity of PA education programs, promote interprofessional practice, enhance medical education through curriculum innovations and improve the distribution and diversity of the health care workforce. Through these activities, the Primary Care Training and Enhancement Program seeks to improve primary care quality and increase the appeal of primary care to students and current practitioners.

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

Outcomes and Outputs Table

The Primary Care Training and Enhancement Program supports primary care workforce growth and diversification, curricular innovations, and development of academic infrastructure. The current outcome measures reflect these objectives. As awards continue to emphasize new and evidence-based education strategies such as interprofessional education and care, community based practice experience, and education responsive to learners' and patients' needs, the evaluation and outcome measures are adjusted accordingly.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[47]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
6.I.C.4.b: Number of primary care physician assistants receiving training through HRSA's Bureau of Health Workforce programs supported with Prevention and Public Health funding: Physician Assistance Expansion (EPAT) (cumulative)	FY 2014: 586[48] Target: 600 (Target Not Met)	N/A	N/A	---
6.I.C.3.a: Number of primary care physicians who complete their education through HRSA's Bureau of Health Workforce programs supported with Prevention and Public Health funding (PCRE) (cumulative)	FY 2014: 327 Target: 332 (Target Not Met)	N/A[49]	N/A	---

[47] Most recent results are for Academic Year 2014-2015 and funded in FY 2014.

[48] Measure is cumulative and captures the training of the four cohorts of physician assistant students funded through the EPAT program with results regarding the training of each cohort applicable for FY 2011, FY 2012, FY 2013, and FY 2014

[49] Measures for the PCRE program will be discontinued in FY 2016, as no new funding for this program is anticipated.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[47]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
6.I.C.3.b: Number of physician assistants who complete their education through HRSA's Bureau of Health Workforce programs supported with Prevention and Public Health funding (EPAT) (cumulative)	FY 2014: 287 Target: 420 (Target Not Met)	N/A[50]	N/A	---
6.I.C.8: Number of Primary Care Patient Encounters	FY 2014: 1,516,049 Target: 180,000 (Target Exceeded)	N/A[51]	N/A	---
Number of physicians completing a Bureau of Health Workforce-funded residency or fellowship	---	TBD[52]	TBD	---
Number of physicians graduating from a Bureau of Health Workforce-funded medical school	---	TBD[53]	TBD	---
Number of physician assistants graduating from a Bureau of Health Workforce-funded program	---	TBD[54]	TBD	---
Number of graduates from a Bureau of Health Workforce-funded joint public health degree program	---	TBD[55]	TBD	---
Percent of physician and physician assistant trainees receiving at least a portion of their clinical training in an underserved area	FY 2014: 59% Target: 52% (Target Exceeded)	55%	55%	Maintain
Percent of physician and physician assistant graduates who practice in medically underserved areas	FY 2014: 53% Target: 35% (Target Exceeded)	38%	38%	Maintain

[50] Measures for the EPAT program will be discontinued in FY 2016, as no new funding for this program is anticipated.
[51] Measure will be discontinued in FY 2016.
[52] Baseline for this measure will be set for FY 2015 and reported in the FY 2018 Congressional Justification.
[53] Baseline for this measure will be set for FY 2015 and reported in the FY 2018 Congressional Justification.
[54] Baseline for this measure will be set for FY 2015 and reported in the FY 2018 Congressional Justification.
[55] Baseline for this measure will be set for FY 2015 and reported in the FY 2018 Congressional Justification.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[47]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
Percent of graduates and program completers who are minority and/or from disadvantaged backgrounds	FY 2014: 23% Target: 35% (Target Not Met)	35%	35%	Maintain
Number of graduates and program completers	FY 2014: 8,785 Target: 3,900 (Target Exceeded)	N/A[56]	N/A	---

Grant Awards Table – Physician Training Grants

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	137	75	75
Average Award	$249,677	$412,000	$412,000
Range of Awards	$77,392-$601,838	$155,000-$750,000	$210,000-$750,000

Grant Awards Table – Physician Assistant Training Grants

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	34	30	30
Average Award	$159,134	$181,000	$181,000
Range of Awards	$90,159-$343,202	$96,000-$500,000	$96,000-$500,000

[56] Measure discontinued in FY 2015.

Oral Health Training Programs

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$33,928,000	$35,873,000	$35,873,000	---
FTE	3	3	3	

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

FY 2017 Authorizations:
Section 748.....Expired
Section 340G.....Expired

Allocation Method: .....Competitive Grant/Contract

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

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

- Predoctoral Training;
- Postdoctoral Training;
- Dental Faculty Loan Repayment; and
- Faculty Development.

The goal of the Predoctoral Training program is to help better prepare predoctoral dental students, dental hygiene students and dental hygienists to practice in new and emerging models of care. Emphasis will be on training dental hygienists for advanced roles as allowed under state practice acts and models that stress the integration of oral health within the broader health care delivery system.

The goal of the Postdoctoral Training program is to prepare postdoctoral-trained dentists to practice in and lead new and innovative models of oral health care delivery to underserved and vulnerable groups. Emphasis will be on the development and testing of new training and delivery models in clinical training sites and the enhancement of training in dental public health and/or management of oral health at the population health level.

Cross-cutting priorities of the Pre- and Postdoctoral Training programs will be to include innovative approaches to encourage and support individuals from underrepresented minorities, rural or disadvantaged backgrounds, and/or veterans to be successful in oral health professional training programs and to place these oral health professionals in vulnerable, underserved, or rural communities.

The Dental Faculty Loan Repayment Program makes awards to dental training institutions to aid in the recruitment and retention of full-time faculty members within the disciplines of general dentistry, pediatric dentistry and public health dentistry.

State Oral Health Workforce Improvement Program makes awards to states to help them develop and implement innovative programs to address the dental workforce needs of designated Dental Health Professional Shortage Areas (D-HPSAs) in a manner that is appropriate to the states' individual needs.

The State Oral Health Workforce Improvement Program will continue to focus on supporting innovative projects. The program foci include an emphasis on supporting underserved communities by integrating oral and primary care medical delivery systems, and supporting oral health providers who practice in advanced roles specifically designed to improve oral health access.

Need: Oral health is an essential component of overall health. Untreated oral diseases and conditions can have significant impacts on quality of life. Yet, according to a July 2011 study published by the Institute of Medicine (IOM) entitled, *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*,[57] vulnerable and underserved populations face persistent and systemic barriers to accessing oral health care.

The oral health workforce also continues to face shortages. By 2025, increases in the supply of dentists will not meet estimated increases in demand. The dental workforce is expected to grow by only 6 percent, while demand for dental services will grow by 10 percent. However, the supply of dental hygienists in the country is expected to grow and, with changes to the oral health delivery system, dental hygienists could be used to reduce the impact of the projected dentist shortage if they are effectively integrated into the delivery system.[58] Additional challenges to improving access to oral health services include the lack of coordination and integration of oral health, public health, and medical health care systems.

[57] Institute of Medicine and National Research Council. Improving access to oral health care for vulnerable and underserved patients. Washington, DC: The National Academies Press, 2011.
[58] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. National and State-Level Projections of Dentists and Dental Hygienists in the U.S., 2012-2025. Rockville, Maryland: U.S. Department of Health and Human Services, 2015.

Discipline	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Training in General, Pediatric, and Public Health Dentistry Program	$20,970,000	$21,970,000	$21,970,000
State Oral Health Workforce Improvement Grant Program	$12,958,000	$13,903,000	$13,903,000

Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene Program

The Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene Program aims to increase the number of dental students, residents, practicing dentists, dental faculty, dental hygienists, or other approved primary care dental trainees qualified to practice in general, pediatric and dental public health fields and thus increase access to oral health care.

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

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

Program Accomplishments:

In Academic Year 2014-2015, grantees of the Oral Health-sponsored programs trained a total of 2,406 dental and dental hygiene students in pre-doctoral training degree programs, 501 dental residents in advanced primary care dental residency programs, 1,975 dental faculty members in faculty development activities, and provided loan repayments to 34 dentists who have agreed to serve as teaching faculty during the course of their training. This training of 2,406 new dental and dental hygiene students will help to alleviate the existing national shortage of dentists, and projected shortages of dentists at the national level and dental hygienists at the state level expected to occur by 2025.[59] See below for details.

Predoctoral Training

In Academic Year 2014-2015, grantees of the Pre-doctoral Training in General Dentistry, Pediatric Dentistry, and Dental Public Health and Dental Hygiene program trained 2,406 dental and dental hygiene students. Additionally, 748 of those students completed their degree program at the end of the academic year. Of all students trained, approximately 29 percent were either from a disadvantaged background or underrepresented minorities in their prospective professions, whereas 27 percent of graduates were either from a disadvantaged background or underrepresented minorities in their prospective professions. Grantees utilized a total of 272 clinical training sites for this program; 67 percent were located in medically underserved communities, 54 percent in primary care settings, and/or 26 percent in rural areas. During Academic Year 2014-2015, grantees offered 42 courses and training activities that were developed or enhanced to promote primary care dentistry and public health. In addition, 428 individuals trained alongside students while participating in interprofessional team-based care across all training sites affiliated with the program.

Postdoctoral Training

In Academic Year 2014-2015, grantees of the Post-doctoral Training in General, Pediatric and Public Health Dentistry trained 501 dental residents. Of those residents trained, 298 dental residents completed their training program at the end of the academic year. Of all residents trained, approximately 41 percent were underrepresented minorities in their prospective professions or from disadvantaged backgrounds, while 39 percent of residents who completed the program were underrepresented minorities in their prospective professions or from disadvantaged backgrounds. Grantees utilized a total of 283 clinical training sites for this program; 67 percent were located in a medically underserved community, 38 percent in a primary care setting, and 12 percent in a rural setting. During Academic Year 2014-2015, grantees offered 83 courses and training activities that were developed or enhanced to promote primary care dentistry and public health for advanced dental residents. In addition, 3,843 individuals trained alongside residents while participating in interprofessional team-based care across all training sites affiliated with the program.

[59] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. National and State-Level Projections of Dentists and Dental Hygienists in the U.S., 2012-2025. Rockville, Maryland, 2015.
http://bhw.hrsa.gov/healthworkforce/supplydemand/dentistry/nationalstatelevelprojectionsdentists.pdf

Dental Faculty Loan Repayment

In Academic Year 2014-2015, the Dental Faculty Loan Repayment Program provided a median loan repayment of $29,641 to 34 dentists serving as teaching faculty. Females comprised 56 percent of supported faculty and 47 percent of the faculty were between the ages of 40-49. The most commonly represented disciplines were General Dentistry (59 percent) and Pediatric Dentistry (15 percent). With regard to background, 21 percent of teaching faculty members were from financially or educationally disadvantaged backgrounds, 27 percent were from rural backgrounds, and about 15 percent were considered underrepresented minorities in their prospective professions. Faculty funded through the Dental Faculty Loan Repayment program delivered 132 courses during the academic year, with most courses offered in classroom-based settings (55 percent) or as clinical rotations (35 percent). A total of 9,169 students and advanced trainees participated in courses led by DFLP faculty, including dental school students (36 percent), general dentistry residents (44 percent), and pediatric dentistry residents (10 percent).

Faculty Development

In Academic Year 2014-2015, the Faculty Development in General, Pediatric, and Public Health Dentistry and Dental Hygiene program trained a combined total of 1,975 faculty members through faculty development activities and structured programs funded by the grant program. Grantees supported 100 different faculty development activities, including academic continuing education courses (47 percent) and continuing education workshops (32 percent) that focused on a range of oral health topics from addressing the needs of the underserved to treating orofacial pain. Grantees also offered 29 structured faculty development programs, which included 271 program completers during the academic year. Of the 420 faculty members who participated in structured faculty development programs, 44 percent were General Dentists, 23 percent were Public Health Dentists, and 15 percent were Pediatric Dentists. Finally, more than 5,700 dental students, general dentistry residents, and pediatric dentistry residents, were trained in 66 courses and workshops delivered by program faculty who received direct financial support from the grant as instructors.

State Oral Health Workforce Improvement Grant Program

The State Oral Health Workforce Improvement Grant Program aims to enhance dental workforce planning and development, through the support of innovative programs, to meet the individual needs of each state.

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

Designated Health Professions	Targeted Educational Levels / Oral Health Service Development[60]	Grantee Activities
• Oral Health Providers	• Primary and Secondary Education • Pre- and Postdoctoral Programs • Residency Programs • Continuing Education	• Grants and low or no-interest student loans. • The establishment or expansion of dental residency programs. • Expand or establish oral health services and facilities for children with special needs. • Placement and support of dental trainees. • Continuing dental education. • Teledentistry. • Community-based prevention such as water fluoridation and dental sealants. • The development of a state dental officer position or the augmentation of a state dental office. Other activities deemed appropriate by the Secretary.

Program Accomplishments:

In Academic Year 2014-2015, the State Oral Health Workforce Improvement Grant Program continued carrying out a number of community-based prevention activities authorized under statute. Analysis of performance measures showed that grantees established five new oral health facilities for children with unmet needs in dental health profession shortage areas (HPSAs), and expanded eight oral health facilities in dental HPSAs to provide education, prevention, and restoration services to over 6,500 patients. Grantees also supported two tele-dentistry facilities; replaced 11 water fluoridation systems to provide optimally fluoridated water to over 888,000 individuals; provided dental sealants to over 13,000 children; provided topical fluoride to over 31,000 individuals; provided diagnostic or preventive dental services to over 54,000 persons; and oral health education to over 93,300 persons. The program also held 86 promotional events attended by over 3,800 children. Additionally, state grantees hired two new state dental officers, ten new dentists or dental hygienists, one fluoridation expert, two epidemiologists, and eight administrative and other staff members in state dental offices. States also retained 78 positions in state dental offices that had been hired in previous years.

The State Oral Health Workforce Improvement Grant Program provided direct financial support to 151 dental students and six dental residents. Of these 157 students and residents, 55 percent were males and 74 percent were between the ages of 20-29 years old. Approximately 36 percent of students and residents reported coming from a rural background, 22 percent reported coming from a disadvantaged background, and 17 percent comprised an underrepresented minority group.

The State Oral Health Workforce Improvement Grant Program also provided loan repayment to 46 practicing dentists. Of these dentists, 52 percent were female and 57 percent were between the

[60] Varies based on grantee activities.

ages of 30-39 years old. In addition, 61 percent of practicing dentists reported coming from a rural background, 13 percent were from a disadvantaged background, and 11 percent were underrepresented minorities in their prospective professions. All of the dentists were enrolled in the Medicaid program and had 26,424 Medicaid/CHIP patient encounters during the year. Approximately 39 percent of these dentists reported practice settings in dental HPSAs.

Funding History

FY	Amount
FY 2013	$30,681,000
FY 2014	$31,928,000
FY 2015	$33,928,000
FY 2016	$35,873,000
FY 2017	$35,873,000

Budget Request

The FY 2017 Budget Request is $35.9 million, which is the same as the FY 2016 Enacted level. This request will fund continuing and new awards in the Training in General, Pediatric and Public Health Dentistry and State Oral Health Workforce Improvement Grant programs, and will aim to increase access to culturally competent, high-quality, dental health services to rural and other underserved communities by increasing the number, and improving the diversity and distribution of oral health care providers, and improving the training programs for future oral health care providers.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[61]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
Number of students trained	FY 2014: 2,406 Target: 2,200 (Target Exceeded)	1,600[62]	1,600	Maintain
Number of residents trained	FY 2014: 501 Target: 534 (Target Not Met)	311[63]	311	Maintain

[61] Most recent results are for Academic Year 2014-2015 and funded in FY 2014.
[62] Targets changed to reflect programmatic changes.
[63] Targets changed to reflect programmatic changes.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[61]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
Number of faculty trained	FY 2014: 1,975 Target: 190 (Target Exceeded)	1,200[64]	1,200	Maintain
Number of faculty receiving loan repayments	FY 2014: 34 Target: 28 (Target Exceeded)	30	30	Maintain

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

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	46	52	52
Average Award	$416,166	$400,000	$400,000
Range of Awards	$99,070-$748,705	$99,000-$750,000	$99,000-$750,000

Grant Awards Table – State Oral Health Workforce Improvement

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	28	30	30
Average Award	$450,980	$450,000	$450,000
Range of Awards	$284,768-$500,000	$285,000-$500,000	$285,000-$500,000

[64] Targets changed to reflect programmatic changes.

Interdisciplinary, Community-Based Linkages

Area Health Education Centers Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$30,250,000	$30,250,000	---	-$30,250,000
FTE	4	4	---	-4

Authorizing Legislation**:** Public Health Service Act, Section 751, as amended by Public Law 111-148, Section 5403

FY 2017 Authorization .....Expired

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

Program Goal and Description:
The goal of the Area Health Education Centers (AHEC) Program is to enhance access to high quality, culturally competent healthcare in rural and underserved areas through academic-community partnerships. Through these partnerships, AHECs work to provide training and education to further support distribution, diversity, and supply of the primary care health professions workforce.

The AHEC Program supports two types of awards: 1) Infrastructure Development and 2) Point of Service Maintenance and Enhancement. The Infrastructure Development funds are used to plan, develop, and implement AHECs that link the grantee school and at least two other disciplines with local educational and clinical sites. The Point of Service funds are awarded to AHECs that have successfully completed the Infrastructure Development phase in order to improve the capacity and effectiveness of the program through ongoing evaluation.

Need: A growing and aging U.S. population, and to a lesser extent, increased access to insurance coverage through the Affordable Care Act, is expected to increase the demand for primary care services over the next decade.[65] Although the supply of other primary care providers is growing, ensuring an adequate supply of primary care providers for the future remains key to providing high quality healthcare. Ensuring an adequate supply of well-trained, diverse primary care providers is a particular concern for vulnerable and underserved populations, which include approximately 20 percent of Americans who live in rural or inner-city locations designated as health professional shortage areas.[66]

[65] Peterson, S., Liaw, W., Phillips, R., Rabin, D., Meyers, D., & Bazemore, A. (2012). Projecting US Primary Care Physician. Annals of Family Medicine, 10(6), 503-509.
[66] HRSA Bureau of Health Workforce, Designated Health Professional Shortage Areas Statistics, http://ersrs.hrsa.gov/reportserver/Pages/ReportViewer.aspx?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry_HTML&rs:Format=HTML4.0

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

Designated Health Professions	Targeted Educational Levels	Grantee Activities
• Allied health • Community health workers • Dentists • Nurse midwives • Nurse practitioners • Optometrists • Pharmacists • Physicians • Physician assistants • Psychologists • Public health • Other health professions	All education levels are targeted to provide primary care workforce development for the following trainees: • Medical residents • Medical students • Health professions students • CE for primary care providers in underserved areas	• Plan, develop, operate and evaluate AHEC Center(s). • Address health care workforce needs in the service areas coordinating with local workforce investment boards. • Provide clinical rotations in primary care and community-based, interprofessional training. • Disseminate CE courses for health professionals with an emphasis on underserved areas and for health disparity populations. • Facilitate multi-level partnerships between academic institutions, community-based health centers and other organizations to address social determinants of health.

Program Accomplishments: In Academic Year 2014-2015, the AHEC Program supported various types of pre-pipeline, pipeline, and continuing education training activities for thousands of trainees across the country. AHEC grantees implemented over 1,800 unique continuing education courses that were delivered to over 252,000 practicing professionals nationwide, approximately 93,100 of whom were concurrently employed in medically-underserved communities.

AHEC grantees partnered with more than 11,000 sites to provide more than 48,100 clinical training experiences to student trainees (e.g., ambulatory practice sites, hospitals, and physician offices). Approximately 67 percent of these training sites were in primary care settings; 62 percent were located in medically-underserved communities; and 41 percent were set within rural areas. Training at the clinical sites incorporated interdisciplinary team-based approaches, where approximately 2,100 students, residents and/or fellows from a variety of professions and disciplines were trained on teams with AHEC student trainees.

Funding History

FY	Amount
FY 2013	$28,211,000
FY 2014	$30,250,000
FY 2015	$30,250,000
FY 2016	$30,250,000
FY 2017	---

Budget Request

No funding for the AHEC Program is requested in FY 2017, which is $30.2 million below the FY 2016 Enacted level. While the AHEC Program exposes medical students and health professions students to primary care and practice in rural and underserved communities, the FY 2017 President's Budget reflects the prioritization of funding to programs that directly increase the number of primary care providers. It is anticipated that the AHEC Program awardees may be able to support on-going activities through other funding sources.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[67]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
Number of trainees who received continuing education (CE) on topics including Cultural Competence, Women's Health, Diabetes, Hypertension, Obesity, and Health Disparities	FY 2014: 252,259 Target: 215,000 (Target Exceeded)	250,000	N/A[68]	---
Percent of CE trainees who report being currently employed in medically underserved areas	FY 2014: 37% Target: 28% (Target Exceeded)	34%	N/A[69]	---
No. of trainees receiving health career guidance and information from the AHEC Programs	FY 2014: 372,366 Target: 245,000 (Target Exceeded)	325,000	N/A[70]	---

[67] Most recent results are for Academic Year 2014-2015 and funded in FY 2014.
[68] Program was proposed for elimination in FY 2017.
[69] Program was proposed for elimination in FY 2017.
[70] Program was proposed for elimination in FY 2017.

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	52	52	---
Average Award	$544,641	$544,641	---
Range of Awards	$103,550- $1,868,176	$103,550- $1,868176	---

Interdisciplinary, Community-Based Linkages

Geriatric Programs

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$34,237,000	$38,737,000	$38,737,000	---
FTE	7	11	11	---

Authorizing Legislation: Public Health Service Act, Section 753, as amended by Public Law 111-148, Section 5305

FY 2017 Authorization:
Geriatric Education Centers.....Expired
Geriatric Training for Physicians, Dentists, and Behavioral/Mental Health Professionals.....Expired
Geriatric Academic Career Awards.....Expired

Allocation Method..... Cooperative Agreement

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

In FY 2015, HRSA combined the Comprehensive Geriatric Education Program, Geriatrics Education Centers Program, Geriatric Training for Physicians, Dentists, and Behavioral/Mental Health Professionals Program, and the Geriatric Academic Career Awards Program into one competition—the Geriatrics Workforce Enhancement Program. This new program aims to improve health outcomes for older adults by integrating geriatrics with primary care, maximizing patient and family engagement, and transforming the health care system. Special emphasis is on providing the primary care workforce with the knowledge and skills needed to care for older adults and on collaborating with community partners to address gaps in healthcare through individual, system, community and population level changes.

The Geriatrics Workforce Enhancement Program supports training of individuals, including patients, families, caregivers, direct care workers, health professions providers, students, residents, and fellows who will provide healthcare to older adults, and the faculty who train these individuals. Funding may also be used to provide educational programs for patients, family members, and caregivers to afford them with the knowledge and skills for self-management or care delivery of older adults. In addition, funds in the amount of $4 million were available for Alzheimer's disease and related dementia training.

Need: More than 65 million people, 29 percent of the adult U.S. population, provide care for a chronically ill, disabled or an aged family member or friend during any given year and spend an average of 20 hours per week providing care for their loved one.[71] More recent data from the Pew Research Center (2013) indicate that nearly half of all American adults expect to provide care to their older parents at some point in their lives.[72] In addition, the Institute of Medicine identified three shortfalls that the healthcare system will face as the number of older Americans increases: 1) healthcare needs of older adults will be difficult to meet by the current healthcare workforce; 2) there will be severe shortages of geriatric specialists and other providers with geriatric skills; and 3) there will be increased demand for chronic care management skills.[73] Through training provided to the entire provider continuum (students, faculty, providers, direct service workers, and lay and family caregivers) in collaboration with community organizations, improved geriatrics care can become widely available to the ever-increasing cohort of older Americans.

Eligible Entities: Accredited schools of multiple health disciplines, healthcare facilities, and programs leading to certification as a certified nursing assistant.

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

[71] National Alliance for Caregiving in collaboration with AARP (2009). Caregiving in the United States 2009. www.caregiving.org/data/Caregiving_in_the_US_2009_full_report.pdf.
[72] Pew Research Center (2013). The Sandwich Generation: Rising Financial Burdens for Middle-Aged Americans. Pew Social Trends, Washington, D.C.
[73] Institute of Medicine. Retooling for an Aging America: Building the Health Care Workforce. Washington, DC: The National Academies Press, 2008.

Program Accomplishments: This redesigned program began in FY 2015, which combined the Comprehensive Geriatric Education Program, Geriatrics Education Centers Program, Geriatric Training for Physicians, Dentists, and Behavioral/Mental Health Professionals Program, and the Geriatric Academic Career Awards Program into the Geriatrics Workforce Enhancement Program. Program accomplishments are not yet available. Baseline data for the new redesigned program will be set for FY 2015 and reported in the FY 2018 Congressional Justification.

Geriatrics Education Centers Program

The Geriatrics Education Centers Program supported high-quality interprofessional geriatrics education and training to the health professions workforce for both geriatrics specialists and non-specialists.

Eligible Entities: Accredited schools of multiple health disciplines.

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

Program Accomplishments: In Academic Year 2014-2015, the Geriatrics Education Centers (GEC) program supported various types of geriatrics-specific training for health professions students and faculty, as well as for current community-based providers. With regard to the continuing education (CE) of the current workforce, GEC grantees delivered more than 2,800 unique continuing education courses which focused on emerging issues in the field of geriatrics to approximately 150,900 faculty members and current practicing providers. Approximately

one-third of these trainees were participants in the 636 CE courses specifically focused on Alzheimer's disease treatment and education, accounting for 23 percent of all GEC-sponsored CE activities.

In addition to continuing education of the current workforce, GEC grantees provided more than 39,100 clinical training experiences for health professions students and advanced trainees health professions students through partnerships with more than 1,770 healthcare delivery sites (e.g., academic institutions, hospitals, and veteran's affairs hospitals and clinics). Approximately 44 percent of these sites were situated in primary care settings and 32 percent were located in medically-underserved communities. Training at these clinical sites incorporated interdisciplinary team-based approaches, where approximately 5,200 students and advanced trainees from a variety of professions and disciplines were trained on teams with the GEC-supported trainees.

Finally, GEC grantees used funds to support the training of faculty in geriatrics. Results showed that GEC grantees supported more than 2,900 different structured faculty development programs and developmental activities during the academic year, including workshops, conferences, and professional development activities. More than 13,200 faculty members received training on geriatric-related topics as a result of these types of activities.

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

The Geriatrics Training for Physicians, Dentists, and Behavioral and Mental Health Professionals Program provided support to increase the supply of quality, culturally-competent geriatrics faculty and to retrain mid-career faculty in geriatrics.

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

Designated Health Professions	Targeted Educational Levels	Grantee Activities

• Dentistry
• Medicine
• Counseling
  - Marriage & family
  - Professional
  - Substance abuse
• Osteopathic medicine
• Psychology
• Psychiatric nursing
• Psychiatry
• Social work
	• Graduate
	• Post-graduate
	• Faculty
		• Provide intensive one-year mid-career faculty retraining and/or two-year fellowship training in geriatrics.
		• Provide training in and exposure to the physical and mental disabilities of elderly individuals through a variety of service rotations, such as, geriatric consultation services, acute care services, dental services, geriatric behavioral or mental health units, day and home care programs, rehabilitation services, geriatric ambulatory care and comprehensive evaluation units, and community care programs for elderly individuals with developmental disabilities.
		• Apply contemporary educational delivery

Designated Health Professions	Targeted Educational Levels	Grantee Activities
		methods to interprofessional audiences. • Demonstrate application of administrative, clinical, teaching, and research skills as academic and clinical faculty.

Program Accomplishments: In Academic Year 2014-2015, the Geriatric Training for Physicians, Dentists and Behavioral/Mental Health Providers (GTPD) program directly funded 54 fellows specializing primarily in Geriatric Medicine, Dentistry, or Psychiatry. GTPD fellows were primarily female (59 percent), between the ages of 30 and 39 (80 percent), and were either non-Hispanic White (54 percent) or Non-Hispanic Asian (35 percent). Approximately 87 percent of fellows received clinical training in medically-underserved communities and/or a primary care setting (93 percent) during the academic year. Finally, of the 21 fellows who completed their training during Academic Year 2014-2015, 48 percent intended to pursue a full-time faculty appointment at the graduate level.

GTPD grantees partnered with more than 480 healthcare delivery sites (e.g., Veteran's Affairs hospitals and clinics, ambulatory care sites, and academic institutions) to provide approximately 1,150 clinical training experiences to GTPD fellows. Approximately 44 percent of these sites were located in medically-underserved communities. Training at the clinical sites incorporated interdisciplinary team-based approaches, where approximately 1,280 students and advanced trainees from a variety of professions and disciplines were trained on teams with the GTPD-supported fellows.

The GTPD program is multi-purposed in that it not only supports the training of fellows in specific types of geriatric settings, but also requires that each fellow spends at least 25 percent of his or her time teaching health professions students about geriatric-related topics. Program fellows delivered more than 390 courses, workshops and other training activities focused on topics such as oral health, chronic disease management, and geriatric medicine. More than 10,100 trainees were trained as a result of these activities, most commonly medical students, geriatric residents, and psychiatry residents.

Geriatrics Academic Career Awards Program

The Geriatrics Academic Career Awards Program promoted the development of academic clinician educators who provided clinical training in geriatrics, including the interprofessional education teams of health professionals.

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

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

Program Accomplishments: In Academic Year 2014-2015, the Geriatric Academic Career Award (GACA) program funded a total of 52 awardees: 49 faculty members in geriatric medicine, one faculty member in clinical psychology, one faculty member in geriatric psychiatry, and one faculty member in geriatric physical therapy. In total, GACA awardees delivered more than 1,600 different courses, workshops and other types of training activities to more than 63,000 trainees across the health professions—the most common of which included medical school students, residents in internal medicine and residents in geriatrics. These courses training activities focused on topics such as geriatric medicine, transitional care, and mental health in older adults.

In addition to instructing health professions students, residents and fellows, GACA awardees were highly encouraged to engage in professional development and scholarly activities during the academic year as a way of advancing the field of geriatrics. Results obtained showed that GACA awardees conducted presentations about their own research and other related topics at more than 110 conferences at the local, state, or national level and published a total of 65 peer-reviewed publications during the academic year.

Funding History

FY	Amount
FY 2013	$29,011,000
FY 2013 (Prevention Public Health Fund)	$1,847,000
FY 2014	$33,237,000
FY 2015	$34,237,000
FY 2016	$38,737,000
FY 2017	$38,737,000

Budget Request

The FY 2017 Budget Request is $38.7 million, which is the same as the FY 2016 Enacted level, which will provide funding to 44 Geriatrics Workforce Enhancement Program grantees seeking

to improve high quality, interprofessional geriatric education and training, as well as increase geriatrics competencies of primary care providers and other health professionals serving the geriatric community.

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

Outcomes and Outputs Table

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

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[74]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
6.I.C.12: Number of Bureau of Health Workforce-sponsored interprofessional continuing education sessions provided on Alzheimer's disease	FY 2014: 636 (Baseline)	TBD	TBD	---
6.I.C.13: Number of trainees participating in interprofessional continuing education on Alzheimer's disease	FY 2014: 51,726 (Baseline)	TBD	TBD	---
Number of continuing education trainees	FY 2014: 150,926 Target: 79,521 (Target Exceeded)	79,521	100,000	+20,479
Number of Geriatrics Training program Fellows	FY 2014: 54 Target: 45 (Target Exceeded)	N/A[75]	N/A	Maintain
Number of continuing education offerings delivered by grantees	--	TBD[76]	TBD	---
Number of students who received geriatric-focused training in geriatric nursing homes, chronic and acute disease hospitals, ambulatory care centers, and senior centers	--	TBD[77]	TBD	---

[74] Most recent results are for Academic Year 2014-2015 and funded in FY 2014.
[75] Measure discontinued in FY 2015.
[76] Baseline for this measure will be set for FY 2015 and reported in the FY 2018 Congressional Justification.
[77] Baseline for this measure will be set for FY 2015 and reported in the FY 2018 Congressional Justification.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[74]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
Number of faculty members participating in geriatric trainings offered by grantees	--	TBD[78]	TBD	---
Number of individuals trained in new or enhanced curricula relating to the treatment of health problems of elderly individuals	--	TBD[79]	TBD	---
Number of individuals enrolled in geriatric fellowships	--	TBD[80]	TBD	---
Number of advanced education nursing students enrolled in advanced practice adult-gerontology nursing programs	--	TBD[81]	TBD	---
Number of Geriatrics Academic Career Awards Awardees	FY 2014: 52 Target: 68 (Target Not Met)[82]	N/A[83]	N/A	---

Grant Awards Table – Geriatrics Workforce Enhancement Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	44	44	44
Average Award	$811,634	$816,000	$816,000
Range of Awards	$560,614-$850,000	$576,713-$850,000	$557,791-$850,000

[78] Baseline for this measure will be set for FY 2015 and reported in the FY 2018 Congressional Justification.
[79] Baseline for this measure will be set for FY 2015 and reported in the FY 2018 Congressional Justification.
[80] Baseline for this measure will be set for FY 2015 and reported in the FY 2018 Congressional Justification.
[81] Baseline for this measure will be set in FY 2015.
[82] The target was not met because GACA awardees relinquished their grants to take positions, usually promotions, in other institutions.
[83] Measure discontinued in FY 2015.

Interdisciplinary, Community-Based Linkages

Behavioral Health Workforce Education and Training Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$35,000,000	$50,000,000	$56,000,000	+$6,000,000
FTE	1	1	1	---

Authorizing Legislation: Public Health Service Act, Sections 755 and 756

FY 2017 Authorization: .....Expired

Allocation Method:……Grant and Contracts

Program Goal and Description: In FY 2014, SAMHSA and HRSA collaborated to launch the Behavioral Health Workforce Education and Training (BHWET) Program. Began in support of the White House's *Now is the Time* initiative, the BHWET Program is focused on developing and expanding the mental health and substance abuse (jointly referred to as behavioral health) workforce serving children, adolescents, and transitional-age youth at risk for developing or who have developed a recognized behavioral health disorder. Through this program, HRSA will support the training of the behavioral workforce to ensure an adequate supply of professional and allied health paraprofessionals across the country and, in particular, within underserved and rural communities.

The BHWET Program increases the behavioral health workforce including: masters-level social workers, professional counselors, psychologists, marriage and family therapists, psychology doctoral interns, as well as behavioral allied health paraprofessionals. This expanded workforce will increase access to child, adolescent and transitional-age youth services in order to promote early intervention for prevention and mitigation of behavioral health disorders through interprofessional service delivery.

Prior to FY 2017, these funds were appropriated to the Substance Abuse and Mental Health Services Administration as a part of the portfolio under the White House's *Now is the Time Initiative*. However, since its inception HRSA has administered this program, in partnership with SAMHSA. In FY 2017, the Department requests funds be appropriated to HRSA directly for two reasons: (1) to align the BHWET Program with the other mental and behavioral health workforce development programs under Title VII of the Public Health Service Act; and (2) to streamline the administration and oversight functions within a single agency. HRSA will continue to leverage SAMHSA's subject matter expertise in formulating new investments in FY 2017.

Need: The demand for behavioral health services will grow as more individuals are covered under the Affordable Care Act (ACA), and the Mental Health Parity and Addiction Equity Act

(MHPAEA) is fully implemented. For example, between 2012 and 2025, the demand for psychologists is projected to grow by 10 percent as behavioral and mental health is increasingly integrated with primary care.[84]

Eligible Entities: For professional behavioral health workforce need, eligible entities include accredited institutions of higher education or accredited professional training programs that are establishing or expanding internships or other field placement programs in mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse prevention and treatment, marriage and family therapy, school counseling, or professional counseling, with a preference for programs addressing child and adolescent mental health.

For paraprofessional behavioral health workforce needs, accredited community and technical colleges granting state licensure or certification in a behavioral health-related paraprofessional field such as community health worker, outreach worker, social services aide, mental health worker, substance abuse or addictions worker, youth worker, promotora, or peer paraprofessional, with preference for pre-service or in-service training of paraprofessional child and adolescent mental health workers

Program Accomplishments: In Academic Year 2014-2015, the Behavioral Health Workforce Education and Training (BHWET) program for professional and paraprofessional trainees supported more than 2,116 students participating in certificate, internship, and field placement/practicum training programs. Results showed that 40 percent of the students who received support reported coming from a financially or educationally disadvantaged background and 45 percent of students were considered underrepresented minorities in their prospective professions. In addition, one third of BHWET students received training in a primary care setting and approximately 45 percent received training in a medically underserved community. A total of 1,329 students completed their BHWET training programs in Academic Year 2014-2015. Of these program completers, approximately 57 percent intended to become employed or pursue further training toward a career serving at-risk children, adolescents, and transitional-aged youth; 29 percent intended to become employed or pursue further training in a medically-underserved community; and 20 percent intended to become employed or pursue further training in a primary care setting.

BHWET grantees partnered with more than 1,050 sites to provide approximately 1,950 clinical training experiences for BHWET students (e.g., community-based organization, academic institutions, and community mental and/or behavioral health centers). Approximately 55 percent of these training sites were located in medically underserved communities. Training at partnered sites incorporated interdisciplinary team-based approaches, where approximately 1,880 students, residents and/or fellows from a variety of professions and disciplines were trained on teams with BHWET students.

[84] Health Workforce Projections: Psychologists. National Center for Health Workforce Analysis. Health Resources and Services Administration. Rockville, MD. April 2015. http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/projections/index.html.

Finally, BHWET grantees used grant funds to develop, enhance, and implement approximately 270 different curricular activities during the academic year, 70 percent of which were newly created. The majority of these curricula were classroom-based training activities or academic courses for behavioral health students. More than 7,060 students and advanced trainees participated in courses or training activities that were developed or enhanced by BHWET grantees, most commonly graduate students and advanced trainees in clinical social work, and students working toward a paraprofessional certificate in peer counseling.

Funding History

FY	Amount
FY 2013	---
FY 2014	$34,914,000
FY 2015	$35,000,000
FY 2016	$50,000,000
FY 2017	$56,000,000

Budget Request

The FY 2017 Budget Request is $56.0 million, which is $6.0 million above the FY 2016 level. This request will support clinical training for approximately 2,850 additional behavioral health professionals and approximately 2,750 additional paraprofessionals.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[85]	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
Number of students currently receiving training in BHWET degree and certificate programs	FY 2014: 2,116 (Baseline)	5,000	5,600	+600
Number of graduates completing BHWET programs and entering the behavioral health workforce	FY 2014: 1,329 (Baseline)	3,000	3,600	+600

[85] Most recent results are for Academic Year 2014-2015 and funded in FY 2014.

Grant Award Table – Behavioral Health Workforce Education and Training Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	110	110	150
Average Award	$275,616	$402,918	$335,765
Range of Awards	$50,220-$421,855	$50,000-$576,000	$100,000-$480,000

Interdisciplinary, Community-Based Linkages

Mental and Behavioral Health Education and Training Programs

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$8,916,000	$9,916,000	$9,916,000	---
FTE	1	1	1	---

Authorizing Legislation: Public Health Service Act, Section 756

FY 2017 Authorization .....Expired

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

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

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

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

Need: The demand for behavioral health services will grow as more individuals are covered under the Affordable Care Act (ACA), and the Mental Health Parity and Addiction Equity Act (MHPAEA) is fully implemented. For example, between 2012 and 2025, the demand for psychologists is projected to grow by 10 percent as behavioral and mental health is increasingly integrated with primary care.[86]

[86] Health Workforce Projections: Psychologists. National Center for Health Workforce Analysis. Health Resources and Services Administration. Rockville, MD. April 2015. http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/projections/index.html.

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Leadership in Public Health Social Work Education Program	$1,000,000	$1,000,000	$1,000,000
Graduate Psychology Education Program	$7,916,000	$8,916,000	$8,916,000

Leadership in Public Health Social Work Education

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

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

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

Program Accomplishments: In Academic Year 2014-2015, the LPHSWE Program supported a total of 14 graduate-level students. Results showed that the majority of students supported were female (93 percent); between the ages of 20-29 (57 percent); enrolled in dual degree Masters of Social Work (MSW) and Masters of Public Health (MPH) programs focused on public health social work; and received a median award amount of $10,000. Further analyses of data showed that 14 percent of students supported were considered underrepresented minorities in their prospective professions. A total of 4 out of the 14 students supported graduated from their degree programs by the end of the academic year, 100% of whom intended to pursue employment or further training in a medically underserved community.

LPHSWE grantees partnered with a total of 12 sites to provide clinical training experiences for supported students (e.g., community-based organizations, hospitals, and community health centers). Approximately 58 percent of these training sites were located in medically underserved communities and 25 percent were situated in primary care settings. Training at partnered sites incorporated interdisciplinary team-based approaches, where more than 10 other public health social work students and clinical social workers were trained on teams with LPHSWE trainees.

In addition to student support and training, LPHSWE grant funds were also used to develop and enhance curricula. A total of 26 courses and training activities were newly developed or enhanced, 14 of which were implemented during the academic year, and focused on competencies including Leadership and Management as well as Interprofessional Practice. In academic year 2014-2015, approximately 500 students and advanced trainees participated in curricula that were developed or enhanced by LPHSWE grantees.

Graduate Psychology Education Program

The GPE Program aims to increase the supply of trained doctoral-level psychologists prepared to address the behavioral health needs of vulnerable and underserved populations.

Eligible Entities: Eligible entities include accredited doctoral psychology programs within institutions of higher education, and other public or private non-profit entities accredited as doctoral psychology internship programs. Applicants must demonstrate that the training within an accredited graduate program in clinical and/or counseling psychology will occur in collaboration with two or more disciplines other than psychology.

Designated Health Professions	Targeted Educational Levels	Grantee Activities
• Graduate Psychology (doctoral)	• Accredited Graduate Psychology (Doctoral level) Schools and Programs • Accredited internships in public and private nonprofit institutions	• Provide integrated and interprofessional education and clinical training leading to a doctoral degree in psychology. • Increase access to quality behavioral health services to vulnerable, underserved, and needy populations. • Increase the number of prepared psychologists with doctoral degrees serving the medically underserved communities.

Program Accomplishments: In Academic Year 2014-2015, the GPE Program provided stipend support to 179 students participating in practica or pre-degree internships in psychology. This investment is critical when considering that demand for psychologists will rise 10% by 2025, however the supply of psychologists is projected to decline.[87] Results showed that the majority of students who received a stipend were trained in medically-underserved communities (94 percent) and/or a primary care setting (69 percent). In addition, 22 percent of supported students reported coming from a financially- or educationally-disadvantaged background, and approximately 21 percent were considered underrepresented minorities in their prospective professions. Of the 76 students who completed GPE training programs in Academic Year 2014-15, 87 percent intended to become employed or pursue further training in medically-underserved communities and 43 percent intended to become employed or pursue further training in primary care settings. Follow-up employment data were collected from individuals who completed training programs in AY 2013-14. Of the 42 prior year program completers with available employment data, 71 percent entered practice in medically-underserved communities.

GPE grantees partnered with a total of 340 sites to provide more than 1,020 clinical training experiences for psychology graduate students (e.g., hospitals, ambulatory practice sites, and academic institutions). Approximately 81 percent of these training sites were located in medically underserved communities and 47 percent were situated in primary care settings. Training at partnered sites incorporated interdisciplinary team-based approaches, where approximately 1,900 students, residents and/or fellows from a variety of professions and disciplines were trained on teams with GPE graduate students.

In addition to the training and direct support of individual students, GPE grantees used grant funds to support a variety of infrastructure activities. In AY 2014-2015, GPE grantees developed, enhanced, and implemented more than 90 different courses and training activities focused on emerging topics in mental and behavioral health. More than 5,500 graduate students and advanced trainees were reached as a result of these activities which included academic courses and clinical rotations. Finally, GPE grantees supported 40 different types of faculty development activities (e.g., conferences, workshops, professional development activities) which focused on topics ranging from the integration of behavioral health and primary care to evidence-based treatments for PTSD. More than 210 faculty members received training as a result of these activities in Academic Year 2014-15.

Mental and Behavioral Health Education and Training Grants

Program Accomplishments: In Academic Year 2014-2015, the MBHET Program supported 214 graduate-level students participating in either social work practica or pre-degree internships in clinical psychology. Results showed that the majority of students who received stipends were females (80 percent); between the ages of 20 and 29 (64 percent); and received clinical training in a medically underserved community (80 percent). Further analyses revealed that 32 percent of the students who received a stipend reported were from a financial or educational disadvantaged

[87] Health Workforce Projections: Psychologists. National Center for Health Workforce Analysis. Health Resources and Services Administration. Rockville, MD. April 2015
http://bhw.hrsa.gov/healthworkforce/supplydemand/usworkforce/projections/psychologistsapril2015.pdf

background, and 36 percent were considered underrepresented minorities in their prospective professions.

Of the 151 students who completed their MBHET-sponsored training in Academic Year 2014-2015, 120 students intended to pursue further training or enter practice with high need and high demand populations (i.e., in medically underserved communities, primary care settings, and/or rural areas). Employment status will be assessed for these individuals one year after program completion (during Academic Year 2015-2016). Follow-up employment data were also collected from individuals who completed training programs in AY 2013-2014. Of the 87 prior year program completers with available employment data, 71 percent entered practice with high need and high demand populations.

In addition to providing stipends to individual trainees, MBHET grantees partnered with a total of 305 sites to provide more than 480 clinical training experiences for students (e.g., hospitals, community-based organizations, and veteran's affairs hospitals and clinics). Approximately 72 percent of these training sites were located in medically underserved communities, 29 percent were situated in primary care settings, and 27 percent were located in rural areas. Training at partnered sites incorporated interdisciplinary team-based approaches, where approximately 850 students, residents and/or fellows from a variety of professions and disciplines were trained on teams with MBHET students.

Finally, MBHET grantees used grant funds to develop, enhance, and implement more than 180 different curricular activities focused on mental and behavioral health topics. The majority of these activities were new academic courses, clinical rotations, and field placements for behavioral health students. Approximately 4,300 students and mental health professionals participated in curricula that were developed or enhanced by MBHET grantees.

Funding History

FY	Amount
FY 2013	$2,740,000
FY 2014	$7,896,000
FY 2015	$8,916,000
FY 2016	$9,916,000
FY 2017	$9,916,000

Budget Request

The FY 2017 Budget Request is $9.9 million, which is the same as the FY 2016 Enacted level. This funding will continue to support grants in the Graduate Psychology Education Program and the Leadership in Public Health Social Work Education Program.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[88]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
6.I.C.16: Number of students receiving training via clinical internships in Psychology or field placements in Social Work focused on working with high need and high demand populations.	FY 2014: 214 Target: 145 (Target Exceeded)	N/A[89]	N/A	---
6.I.C.17: Number of graduates entering practice with high need and high demand populations	FY 2014: 120 Target: 57 (Target Exceeded)	N/A[90]	N/A	---
6.I.2: Percent of graduates entering practice with high need and high demand populations	FY 2014: 79% Target: 78% (Target Exceeded)	N/A[91]	N/A	---
Number of graduate-level psychology students supported	FY 2014: 179 (Baseline)	170	170	Maintain
Number of interprofessional students trained	FY 2014: 1,917 (Baseline)	1,900	1,900	Maintain
Percent of graduate-level psychology students supported who complete a pre-degree internship in a primary care setting	FY 2014: 63% (Baseline)	60%	60%	Maintain
Percent of grantees who develop or enhance curriculum that integrates behavioral health into primary care	FY 2014: 60% (Baseline)	60%	60%	Maintain
Number of Trainees	FY 2014: 5,512 Target: 875 (Target Exceeded)	N/A[92]	N/A	---
Number Graduates	FY 2014: 76 Target: 105 (Target Not Met)	N/A[93]	N/A	---

[88] Most recent results are for Academic Year 2014-2015, which was funded in FY 2014.
[89] Measures for the MBHET Program will be discontinued in FY 2015 as no new funding for this program is anticipated.
[90] Measure discontinued in FY 2015.
[91] Measure discontinued in FY 2015.
[92] Measure discontinued in FY 2015.
[93] Measure discontinued in FY 2015.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[88]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
Number of Graduates entering practice in MUCs	FY 2014: 66[94] Target: 32 (Target Exceeded)	N/A[95]	N/A	---
Percent of Graduates entering practice in MUCs	FY 2014: 87%[96] Target: 29% (Target Exceeded)	N/A[97]	N/A	---

Grant Award Table – Leadership in Public Health Social Work Education

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	3	3	3
Average Award	$299,914	$300,000	$300,000
Range of Awards	$299,879-$299,971	$275,000-$325,000	$275,000-$325,000

Grant Award Table - Graduate Psychology Education

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	40	46	46
Average Award	$185,482	$168,000	$168,000
Range of Awards	$123,536-$378,992	$128,000-$190,000	$128,000-$190,000

[94] Based on 1-year follow-up data reported for students who completed training requirements in Academic Year 2013-2014. Data available only for 87 out of the 138 graduates reported in the FY 2016 Congressional Justification.
[95] Measure discontinued in FY 2015.
[96] Based on 1-year follow-up data reported for students who completed training requirements in Academic Year 2013-2014. Data available only for 87 out of the 138 graduates reported in the FY 2016 Congressional Justification.
[97] Measure discontinued in FY 2015.63 PERCENT

Public Health Workforce Development

Public Health and Preventive Medicine

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$21,000,000	$21,000,000	$17,000,000	-$4,000,000
FTE	4	4	4	---

Authorizing Legislation: Public Health Service Act, Sections 765 – 768 and 770, as amended by Public Law 111-148, Section 10501

FY 2017 Authorization .....Expired

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

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

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

- Preventive Medicine Residency with Integrative Health Care Training Program - Supports post-graduate physician training by funding the planning, development, operation, or participation in approved residency programs in preventive medicine and public health. Preventive medicine physicians are uniquely trained in both clinical medicine and public health in order to promote and maintain health and well-being and reduce the risks of disease, disability, and death in individuals and populations. In FY 2015, this program incorporated an additional focus on training preventive medicine residents and other primary care professionals in integrative healthcare.

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

Need: Public health professionals are working in a rapidly changing healthcare environment where public health roles and activities are being revised and refined. These forces and events are challenging the skills and abilities of the public health professionals currently employed in tribal, state and local public health agencies. To deliver essential services of high quality, while

continuing to meet community expectations, professionals need to master new information and approaches. With the loss of resources to support public health at the state and local levels, there are fewer staff and resources to carry out many of the core functions.

New and innovative ways to provide training and education are needed to continue to meet core functions with fewer resources. Although much of this is incumbent upon health department leadership to establish a culture of learning where continuing education and training opportunities are encouraged, the Public Health and Preventive Medicine and Integrative Health Care Program plays a pivotal role in training the current and future workforce through pioneering new training content and delivery and through the development and coordination of student placements and collaborative projects. Integrative medicine is in many ways synchronous and complimentary with preventive medicine. More patients are utilizing alternative therapies and this number is expected to grow.[98] Linking integrative medicine and preventive medicine in training can help practitioners provide more comprehensive care, including the integration of complementary therapies or methods with primary care.

Program	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Public Health Training Centers Program	$9,864,000	$9,864,000	$9,864,000
Preventive Medicine Residency with Integrative Health Care Training Program	$11,136,000	$11,136,000	$7,136,000

Public Health Training Centers Program

The PHTC Program aims to strengthen the workforce in state, local, and Tribal health departments to improve the capacity and quality of a broad range of public health personnel to carry out core public health functions by providing education, training and consultation to these public health personnel. There are ten regional PHTCs that have a multi-state service area model with the grantee serving as the "central office" or administrator/coordinator. The grantees have contractual relationships with education and training sites, called Local Performance Sites. The primary target for education and training through the PHTC Program are frontline public health workers and middle managers.

In addition to the ten regional PHTCs, a National Coordinating Center for Public Health Training (NCCPHT) was formed to ensure a shared vision and mission across all regional PHTCs. The NCCPHT provides technical assistance to the regional centers; coordinates the standardization and vetting of course offerings, evaluations and needs assessments nationally; spearheads the replication of evidence-based products; serves as a clearinghouse for public health education and training; finds creative ways to convene regional PHTC grantees on a regular basis; and

[98] Clarke TC, Black LI, Stussman BJ, Barnes PM, Nahin RL. Trends in the Use of Complementary Health Approaches Among Adults: United States, 2002-2012. National Health Statistics Reports. No. 79. Feb. 10, 2015.

improves the collection of data to demonstrate program impact. This Center is jointly funded with CDC.

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

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

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

Program Accomplishments: In Academic Year 2014-2015, grantees of the PHTC program supported various types of training activities for public health students and faculty, as well as for members of the current public health workforce. The majority of the 199 students who participated in PHTC-sponsored field placements were females (78 percent); between the ages of 20-29 (82 percent) and were in first two years of their graduate program (84 percent). Further analyses of data showed that 25 percent of students who participated in field placements coordinated through the PHTC program reported coming from a financial and/or educational disadvantaged background, and 25 percent were considered underrepresented minorities in their prospective health professions

PHTCs partnered with a total of 179 sites to provide more than 280 clinical training experiences to student trainees (e.g., local health departments, academic institutions, and community-based organizations). Approximately 68 percent of these training sites were located in medically-underserved communities. With regard to the continuing education (CE) of the current workforce, PHTC grantees delivered more than 1,700 unique CE courses to over 108,000 trainees during the academic year, approximately 28% of whom were practicing professionals concurrently employed in medically-underserved communities.

PHTC grantees were also required to use funds in support of faculty-student collaboration projects addressing emergent public health issues in communities located within each grantee's geographical service area. Results showed that PHTC grantees supported more than 80 different faculty-student collaboration projects in AY 2014-2015. These projects were primarily focused on community health assessments and development of evidence-based programs for community partners. Approximately 130 faculty members and more than 540 students from a variety of health professions participated in these collaborations.

In addition to undergoing a major programmatic consolidation and redesign in AY 2014-2015, the number of grantee institutions reporting performance data was reduced from 32 to 17, 10 of which were newly consolidated regional public health training centers. PHTCs did not meet the FY 2014 target number of instructional hours offered of 9,320 with a FY 2014 result of 8,726. Whereas the number of CE courses actually increased from the previous year by more than 19 percent (from 2,251 courses in FY 2013 to 2,684 courses in FY 2014), the average duration per course dropped from 4.5 hours to 3.25 hours, resulting in a larger number of shorter duration courses offered in AY 2014-2015. In addition, the target number of students who completed field placements in a state, local, and tribal health departments was not met in FY 2014 (target was 150; FY 2014 result is 24). This target was exceeded by more than 85% in FY 2013, which led to much of the 2014-2015 activity focusing on either closeout of infrastructure-related activities for terminating grants or recruitment of additional graduate student trainees by the newly established regional PHTCs.

Preventive Medicine Residency with Integrative Health Care Training Program

The Preventive Medicine Residency with Integrative Health Care Training Program aims to improve the health of communities by increasing the number and quality of preventive medicine physicians who can address public health needs and advance preventive medicine practices; increase access to integrative medicine; and increase the integration of these two fields (integrative medicine and preventive medicine) into overall primary care training and practice The program provides support for residents in medical training in preventive and integrated medicine, including stipends for residents to defray the costs associated with living expenses, tuition, and fees. Grant funds are used to plan and develop preventive medicine curricula; operate or participate in an accredited residency program in preventive medicine; establish and maintain academic administrative units in preventive medicine; and, improve clinical teaching in preventive medicine. In FY 2015, all new Preventive Medicine Residency with Integrative Health Care Training Program grantees were required to include a training component in integrative medicine.

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

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

Program Accomplishments: In Academic Year 2014-2015, the Preventive Medicine Residency (PMR) grant program supported a total of 54 residents, most of which were completing residencies in either Preventive Medicine/Occupational Medicine or General Preventive Medicine. The majority of residents received clinical or experiential training in a primary care setting (67 percent) and/or a medically underserved community (56 percent). In addition, 17 percent of residents were from a financially or educationally disadvantaged background and approximately 26 percent of residents were considered underrepresented minorities in their prospective professions. Of the 18 residents who completed their residency training programs during the academic year, approximately 67 intended to pursue employment or further training in primary care. Employment status will be assessed for these residents one year after program completion (Academic Year 2015-2016). Follow-up employment data were collected from residents who completed training programs in AY 2013-14. Of the 26 prior year program completers, 35 percent entered practice in medically-underserved communities and 54 percent entered practice in primary care settings.

PMR grantees partnered with more than 160 sites to provide approximately 350 clinical training experiences for PMR residents (e.g., local health departments, state health departments, and community-based organization). Approximately 35 percent of these training sites were located in medically underserved communities and 29 percent were situated in primary care settings. Training at partnered sites incorporated interdisciplinary team-based approaches, where more than 190 students, residents and/or fellows from a variety of professions and disciplines were trained on teams with PMR residents.

In addition to providing stipends and training for individual residents, PMR grantees used funds to support a variety of infrastructure activities. More than 50 unique courses and training activities were developed, enhanced, and implemented during the academic year, providing

training on emerging topics in preventive medicine for more than 590 students and advanced trainees. Finally, PMR grantees supported more than 20 different faculty development programs and activities (e.g., workshops, professional conferences) reaching more than 70 faculty members during the academic year.

Integrative Medicine Program

The Integrative Medicine Program (IMP) in FY 2014 provided 3 years of funding to support a Center for Integrative Medicine in Primary Care (CIMPC). The purpose of the CIMPC is to incorporate evidence-based Integrative Medicine (IM) curricula into existing primary care residency and other health professions training programs. The CIMPC is expected to contribute to the evidence-base for IM, and identify and disseminate promising practices related to the integration of IM into primary care.

Eligible Entities: An eligible applicant for this program shall be: 1) a health professions school, including an accredited school or program of public health, health administration, preventive medicine, or dental public health or a school providing health management programs; 2) an academic health center; 3) a state or local government; 4) any other appropriate public or private non-profit entity; or 5) a consortium of eligible entities.

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

Program Accomplishments: In Academic Year (AY) 2014-2015, the Integrative Medicine Program (IMP) supported the training of 24 residents across residency programs. The majority of residents trained through the program were males (58 percent); between the ages of 30 and 39 (54 percent); and received clinical or experiential training in a primary care setting (75 percent) and/or a medically underserved community (58 percent). Further analyses of data showed that approximately 29 percent of residents supported through the program reported coming from a financially or educationally disadvantaged background and approximately 29 percent of residents were considered underrepresented minorities in their prospective professions. Of the 10 residents who completed their training programs in Academic Year 2014-2015, 60 percent intended to become employed or pursue further training in a medically underserved community and 70 percent intended to become employed or pursue further training in primary care. In addition, 10 AY 2013-14 program completers who contributed follow-up employment data one year after program completion. Of these individuals, 40 percent went on to practice in medically-underserved communities and 40 percent entered practice in primary care settings.

In addition to supporting individual residents, IMP grantees partnered with nearly 50 sites to provide more than 170 clinical training experiences to student trainees. Approximately 55 percent of these training sites were situated in primary care settings and 43 percent were located in medically-underserved communities. Training at the clinical sites incorporated interdisciplinary team-based approaches, where more than 120 students, residents and/or fellows from a variety of professions and disciplines were trained on teams with IMP residents.

A total of 33 curricula were developed or enhanced and implemented during the academic year, reaching more than 400 students and advanced trainees on topics related to integrative and preventive medicine. Finally, the IMP supported 29 different faculty development programs and activities that focused on providing specialized training opportunities on integrative medicine to current preventive medicine faculty. Approximately 270 faculty members received training as a result of these activities.

Funding History

FY	Amount
FY 2013	$7,683,000
FY 2014	$18,131,000
FY 2015	$21,000,000
FY 2016	$21,000,000
FY 2017	$17,000,000

Budget Request

The FY 2017 Budget Request is $17.0 million, which is $4.0 million lower than the FY 2016 Enacted level. The FY 2017 Budget would support the Public Health Training Centers and the Preventive Medicine Residency with Integrative Health Care Training programs. Funding is not explicitly requested for the Integrative Medicine Program since integrative medicine was incorporated into the Preventive Medicine Residency program in FY 2015.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[99]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
6.I.C.9: Number of trainees participating in continuing education sessions delivered by PHTCs	FY 2014: 108,216 Target: 23,000 (Target Exceeded)	23,000[100]	23,000	Maintain
6.I.C.18: Number of instructional hours offered by PHTCs	FY 2014: 8,726 Target: 9,320 (Target Not Met)	9,320	9,320	Maintain
6.I.C.19: Number of PHTC-sponsored public health students that completed field placement practicums in State, Local, and Tribal Health Departments	FY 2014: 24 Target: 150 (Target Not Met)	150	150	Maintain
6.I.C.14: Number of residents enrolled in preventive medicine programs that have incorporated evidence-based integrative medicine principles into the curriculum (including both practical and didactic academic course work)	FY 2014: 24 Target: 61 (Target Not Met)	N/A[101]	N/A	---
6.I.C.15: Number of technical assistance consultations provided by the National Coordinating Center for Integrative Medicine (NccIM)	FY 2014: 1,200 Target: 800 (Target Exceeded)	N/A[102]	N/A	---
Number of residents participating in residencies	FY 2014: 54 Target: 40 (Target Exceeded)	55	55	Maintain
Number of residents completing training	FY 2014: 18 Target: 15 (Target Exceeded)	20	20	Maintain
Number of URM residents completing training	FY 2014: 4 Target: 7	N/A[103]	N/A	---

[99] Most recent results are for Academic Year 2014-2015 and funded in FY 2014.
[100] Targets reduced to reflect programmatic changes and cohort effects.
[101] Program was discontinued in FY 2015. HRSA will report outputs for FY 2013 and 2014.
[102] Program was discontinued in FY 2015. HRSA will report outputs for FY 2013 and 2014.
[103] Measure was discontinued in FY 2015.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[99]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
	(Target Not Met)			
Percent of URM residents completing training	FY 2014: 22% Target: 20% (Target Exceeded)	N/A[104]	N/A	---

Grant Awards Table – Public Health Training Centers Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	11	11	11
Average Award	$872,839	$850,000	$850,000
Range of Awards	$734,366-$1,057,635	$705,000-$1,005,000	$705,000-$1,005,000

Grant Awards Table – Preventive Medicine Residency Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	25	25	25
Average Award	$369,151	$421,000	$270,000
Range of Awards	$147,492-$601,838	$340-$600,000	$200,000-$400,000

[104] Measure was discontinued in FY 2015.

Nursing Workforce Development

Advanced Nursing Education

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$63,581,000	$64,581,000	$64,581,000	---
FTE	6	6	6	---

Authorizing Legislation: Public Health Service Act, Sections 811 and 871, as amended by Public Law 111-148, Section 5308

FY 2017 Authorization .....Expired

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

Program Goal and Description: The Advanced Nursing Education (ANE) Programs provide funding for institutions to support the enhancement of advanced nursing education and practice. ANE grants increase the number of qualified nurses in the primary care workforce by improving nursing education through curriculum and faculty development. Additionally funds can be used for traineeships to increase the number of advanced education nurses, nurse anesthetists or nurse midwives who are trained to practice in primary care, especially for underserved populations or for people who are underrepresented in the health care workforce. The traineeships support all or part of the costs of tuition, books, and fees of the program of advanced nurse education, and the reasonable living expenses of the individual during the traineeship.

In FY 2015 and 2016, HRSA focused on projects that develop academic-practice partnership models for clinical training within the graduate nursing education programs in order to prepare graduate nursing students to provide safe, quality care within the complex practice-based environment of the nation's evolving health care system. Awardees created partnerships between academic institutions and rural or underserved clinical practice sites to improve the quality of clinical sites and preceptors, improve preceptor training and promote students' readiness to practice upon graduation.

Need: HRSA's nursing and primary care projections indicate that the supply of nurses will exceed the demand for nurses at a national level in 2020.[105,106] However, maldistribution of nurses is projected to be a continued problem with some areas of the country having a supply of nurses above the national norm or average, while other areas have a supply that is inadequate to

[105] U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Workforce National Center for Health Workforce Analysis, Future of the Nursing Workforce: National- and State-level Projections, 2012-2025, December 2014.

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

meet the needs of their region. In addition to focusing on better distribution, trends in nursing projections suggest that there is also a need to focus on diversity in the nursing workforce so that it reflects the diversity of the nation.

HRSA's investments will enhance curriculum for advanced practice nurses to ensure they are exposed to training opportunities in underserved areas and are prepared to provide safe, quality care. HRSA will also continue to support the training of nurse educators to ensure an adequate and diverse supply of high quality nurses in underserved communities.

Advanced Nursing Education Grants

The ANE Program support advanced education program development in schools of nursing and seeks to increase the size, quality, and distribution of the advanced practice nurse workforce.

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

Designated Health Professions	Targeted Educational Levels	Grantee Activities
• Nurse practitioners • Clinical nurse specialists • Nurse midwives • Nurse anesthetists • Nurse educators	• Graduate (master's and doctoral)	• Build and enhance advanced nursing education programs.

Program Accomplishments: The Advanced Nursing Education (ANE) grants fund a number of activities, including several traineeships and an expansion program, with the aim of increasing the size of the advanced nursing workforce. In Academic Year 2014-2015, grantees of the ANE program trained 8,735 nursing students and this exceeded the program's performance target of 6,255 by 40 percent. This program also produced a total of 2,148 graduates, thereby exceeding the program performance target of 1,485. In addition, 30 percent of students trained were underrepresented minorities and/or from disadvantaged backgrounds, exceeding the performance target of 24 percent. The majority of ANE students were female (88 percent) and were most commonly between the ages of 30 and 39 (38 percent). Further analysis showed that ANE grantees partnered with over 4,200 healthcare delivery sites to provide clinical and experiential training. Approximately 45 percent of sites used by ANE grantees were located in a medically underserved community, and 46 percent were situated in primary care settings.

In Academic Year 2014-2015, the Advanced Nursing Education Expansion (ANEE) program supported a total of 289 graduate-level nursing students across 30 different types of Nurse Practitioner programs. Results showed that majority of the students supported were female (88 percent); between the ages of 20 and 29 (41 percent); reported being from a financially or educationally disadvantaged background (25 percent) and were underrepresented minorities in their prospective fields (21 percent). In addition, 77 percent received clinical training in primary care settings and 53 percent received training in medically underserved communities during the academic year.

Of the 168 supported students who graduated by the end of the Academic Year 2014-2015, the majority earned a Master's level Nurse Practitioner degree (51 percent). Approximately 17 percent of graduates were considered underrepresented minorities in the field of nursing, and 28 percent reported a financially and/or educationally disadvantaged background. Upon program completion, more than 54 percent of graduates intended to pursue employment or further training in medically underserved communities across the country. Follow-up employment data will be collected from these individuals one year after graduation (in Academic Year 2015-2016). To this end, prior graduates from academic year 2013-2014 were asked to report their employment status one year after graduation. Of the 135 prior graduates who contributed follow-up data, 43 percent were currently employed or pursuing further training in medically underserved communities.

To date, the ANEE program has produced a total of 542 Nurse Practitioners—101 graduates in Academic Year 2011-2012, 148 in Academic Year 2012-2013, 125 in Academic Year 2013-2014, and 168 in Academic Year 2014-2015. While the program was not projected to produce this many Nurse Practitioners by this date, difficulties in recruitment led to grantees distributing funds to first and second year nursing students during the initial year of the program; as a result, 101 second-year nursing students were supported and ultimately graduated from their nursing programs in Academic Year 2011-2012. The funding of these 101 students has caused the program to significantly exceed the number of Nurse Practitioners it was expected to produce by the end of Academic Year 2014-2015 (Target: 430; Actual: 542).

Advanced Education Nursing Traineeship Program

The Advanced Education Nursing Traineeship (AENT) Program aims to increase the number of advanced education nurses trained to practice as primary care nurse practitioners or nurse midwives by supporting tuition, textbooks and reasonable living expenses for traineeships. For FY 2017, HRSA is planning to consolidate AENT into the broader ANE program to leverage both structural elements and nursing traineeships and advance the goals of the ANE legislation.

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

Designated Health Professions	Targeted Educational Levels	Grantee Activities
• Nurse practitioners • Nurse midwives	• Graduate (master's and doctoral)	• Provide education and training for nurses to provide quality primary health care in homes, ambulatory care, and other health care settings. • Provide traineeships for tuition, fees, books/e-books, and reasonable living expenses.

Program Accomplishments: In Academic Year 2014-2015, grantees of the AENT program provided direct financial support to 3,008 advanced nursing students. Approximately 58 percent of supported students were considered underrepresented minorities in their prospective professions or were from financially or educationally disadvantaged backgrounds. The majority

of the students supported were female (90 percent); between the ages of 30 and 39 (37 percent); and received clinical training in medically underserved communities (56 percent) or primary care settings (72 percent) during the academic year.

More than 1,300 of the supported students graduated from their degree programs and entered the workforce. At the time of graduation, 63 percent of graduates intended to pursue employment or further training in medically underserved communities, and 70 percent planned to pursue employment or additional training in primary care settings. Follow-up employment data will be collected on these individuals in Academic Year 2015-2016. Likewise, employment data were collected from prior graduates who completed AENT programs in Academic Year 2013-2014. Of the 612 individuals who provided employment data one year after graduation, 50 percent entered into practice in medically underserved communities, and 71 percent entered into practice in a primary care setting.

Nurse Anesthetist Traineeship Program

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

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

Designated Health Professions	Targeted Educational Levels	Program Activities
• Nurse anesthetists	• Graduate programs in nurse anesthesia (master's and doctoral)	• Supports education of nurse anesthetists to provide quality health care in underserved areas, including Health Professional Shortage Areas (HPSAs). • Provide traineeships for tuition, fees, books/e-books, and reasonable living expenses.

Program Accomplishments: In Academic Year 2014-2015, grantees of the NAT program provided direct financial support to 3,229 nurse anesthetist students. Approximately 30 percent of supported students were considered underrepresented minorities in their prospective professions or were from financially or educationally disadvantaged backgrounds. The majority of the students supported were female (60 percent); between the ages of 20 and 29 (47 percent); and received clinical training in medically underserved communities (64 percent) or primary care settings (37 percent) during the academic year.

More than 1,500 of the supported students graduated from their degree programs and entered the workforce. At the time of graduation, 45 percent of graduates intended to pursue employment or further training in medically underserved communities, and 27 percent planned to pursue employment or further training in a primary care setting. Follow-up employment data will be

collected on these individuals in Academic Year 2015-2016. Correspondingly, employment data were collected from prior graduates who completed NAT programs in Academic Year 2013-2014. Of the 1,212 individuals who provided employment data one year after graduation, 42 percent entered into practice in medically underserved communities, and 26 percent entered into practice in primary care settings.

Funding History

FY	Amount
FY 2013	$59,943,000
FY 2014	$61,089,000
FY 2015	$63,581,000
FY 2016	$64,581,000
FY 2017	$64,581,000

Budget Request

The FY 2017 Budget Request is $64.6 million, which is the same as the FY 2016 Enacted level. This will allow HRSA to continue investing in advanced nurse education and support training for more than 6,255 students through the Advanced Nurse Education grants. The request will also allow HRSA to support nursing traineeships including the Advanced Education Nursing Traineeships and the Nurse Anesthetist Traineeships. The Department working to improve program effectiveness and accountability, by consolidating AENT into the broader ANE program and changing the Nurse Anesthetist Traineeship Program into a competitive grant program.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[107]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
6.I.C.7: Number of Primary Care Nurse Practitioner students supported[108]	FY 2014: 289 Target: 300 (Target Not Met)	N/A[109]	N/A	---

[107] Most recent results are for Academic Year 2014-2015 and funded in FY 2014.
[108] Outputs are based on forward-funded grants.
[109] This measure will be discontinued in FY 2016 as no further funding is anticipated for the ANEE program.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[107]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
6.I.C.3.c: Number of nurse practitioners who complete their education through HRSA's Bureau of Health Workforce programs supported with Prevention and Public Health funding (cumulative)[110]	FY 2014: 542 Target: 430 (Target Exceeded)	N/A[111]	N/A	---
6.I.C.4.c: Number of nurse practitioners receiving training through HRSA's Bureau of Health Workforce programs supported with Prevention and Public Health funding (Cumulative)[112]	FY 2014: 713 Target: 600 (Target Exceeded)	N/A[113]	N/A	---
Number of students trained	FY 2014: 8,735 Target: 6,255 (Target Exceeded)	6,255	7,000	+745
Proportion of students trained who are underrepresented minorities and/or from disadvantaged backgrounds	FY 2014: 30% Target: 24% (Target Exceeded)	24%	27%	+3%
Number of graduates from advanced nursing degree programs	FY 2014: 2,148 Target: 1,485 (Target Exceeded)	1,485	1,800	+315
Number of students supported in AENT program	---	TBD[114]	TBD	---
Number of graduates from AENT program	---	TBD[115]	TBD	---

[110] Outputs are based on forward-funded grants.
[111] This measure will be discontinued in FY 2016 as no further funding is anticipated for the ANEE program.
[112] This measure reflects the number of nurse practitioner and nurse midwife students who received funding through the ANEE program annually.
[113] Measure discontinued in FY 2015 as no further funding was provided for the ANEE program.
[114] Baseline for this measure will be set for FY 2015 and reported in the FY 2018 Congressional Justification.
[115] Baseline for this measure will be set for FY 2015 and reported in the FY 2018 Congressional Justification.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[107]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
Number of students supported in NAT program	---	TBD[116]	TBD	---
Number of graduates from NAT program	---	TBD[117]	TBD	---
Percent of graduates from AENT and NAT programs employed in underserved areas	---	TBD[118]	TBD	---
Number of students supported	FY 2014: 6,237 Target: 3,775 (Target Exceeded)	N/A[119]	N/A	---
Number of graduates supported	FY 2014: 2,884 Target: 2,425 (Target Exceeded)	N/A[120]	N/A	---
Number of graduates practicing in underserved areas	FY 2014: 813 Target: 1,050 (Target Not Met)	N/A[121]	N/A	---
Number of minority or disadvantaged students trained	FY 2014: 1,697 Target: 1,560 (Target Exceeded)	N/A[122]	N/A	---

[116] Baseline for this measure will be set for FY 2015 and reported in the FY 2018 Congressional Justification.
[117] Baseline for this measure will be set for FY 2015 and reported in the FY 2018 Congressional Justification.
[118] Baseline for this measure will be set for FY 2015 and reported in the FY 2018 Congressional Justification.
[119] Measure discontinued in FY 2015.
[120] Measure discontinued in FY 2015.
[121] Measure discontinued in FY 2015.
[122] Measure discontinued in FY 2015.

Grant Awards Table – ANE

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	75	65	65
Average Award	$388,798	$477,000	$477,000
Range of Awards	$157,229-$700,000	$400,000-$700,000	$400,000-$700,000

Grant Awards Table – AENT

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	88	85	85
Average Award	$325,138	$342,000	$342,000
Range of Awards	$98,220-$350,000	$220,000-$440,000	$220,000-$440,000

Grant Awards Table – NAT

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	79	81	81
Average Award	$28,481	$27,439	$27,439
Range of Awards	$2,451-$67,188	$2,800-$69,000	$2,800-$69,000

Nursing Workforce Development

Nursing Workforce Diversity

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$15,343,000	$15,343,000	$15,343,000	---
FTE	1	1	1	---

Authorizing Legislation: Public Health Service Act, Sections 821 and 871, as amended by Public Law 111-148, Section 5404

FY 2017 Authorization .....Expired

Allocation Method .....Competitive Grant/Contract

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

Need: While HRSA's nursing (2025) and primary care projections (2020) generally indicate that the supply of nurses will outpace demand at a national level in 2025 and 2020 respectively, maldistribution of nurses is estimated to be a continued problem. Projections at the national-level mask a distributional imbalance of registered nurses (RNs) at the state-level. Specifically, sixteen states are projected to experience a smaller growth in RN supply relative to their state-specific demand, resulting in a shortage of RNs by 2025. [123, 124] In addition, recent demographic data indicate the nursing workforce is not representative of the racial and ethnic diversity of the nation as a whole. According to the U.S. Census Bureau, individuals from ethnic and racial minority groups accounted for more than one third of the U.S. population (37 percent) in 2012,[125] yet nurses from minority backgrounds represent just 19 percent of the RN workforce.[126]

[123] U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Workforce National Center for Health Workforce Analysis, *Future of the Nursing Workforce: National- and State-level Projections, 2012-2025*, December 2014.
[124] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis, "Projecting the Supply and Demand for Primary Care Practitioners Through 2020." 2013.
[125] U.S. Census Bureau, *Projections Show a Slower Growing, Older, More Diverse Nation a Half Century from Now*, accessed at http://www.census.gov/newsroom/releases/archives/population/cb12-243.html.
[126] Budden,J et. al,(2013) Highlights of the National Workforce Survey of Registered Nurses. Journal of Nursing Regulation 4(2)

The trends in nursing projections suggest that there is a greater need to focus on social determinants to address the distribution and diversity in the nursing workforce. A diverse healthcare workforce with diverse leadership is necessary to help meet the needs of a diverse population and reduce health disparities and inequities. An HHS Office of Minority Health report identified 20 strategies for improving minority health equity, including a recommendation for healthcare professional schools and the healthcare workforce to represent and reflect the diverse communities.[127] A 2013 HRSA report on the nursing workforce shows that only 24 percent of RNs come from racial/ethnic minority groups compared with 30 percent of the working-age population.[128]

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

Designated Health Professions	Targeted Educational Levels	Program Activities
• Registered Nurses (RNs) • Second degree students	• Diploma or Associate Degree RNs • RNs who matriculate into accredited bridge or degree completion program • Baccalaureate degree • Advanced nursing education preparation • PhD Degree, RNs	• Use academic, social and financial supports to support basic preparation and educational advancement of disadvantaged and racial and ethnic minority nurses for leadership positions within the nursing profession and the health care community. • Support academic progression through financial support, advising, mentoring, and enrichment activities. • Support accelerated nursing degree programs and advanced education preparation • Prepare diploma or associate degree RNs to become baccalaureate-prepared RNs.

Program Accomplishments: In Academic Year 2014-2015, the NWD Program continued to emphasize diploma and college-level nursing programs in order to increase the number of nursing graduates eligible to take the licensing exam. The NWD Program trained more than

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

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

4,400 students in degree-bearing nursing programs, exceeding the FY 2014 target of 2,500 by 56 percent. Students were typically female (78%) and under the age of 30 (70%). Approximately 46% of students were underrepresented minorities in their respective fields and nearly 82% were from educationally or financially disadvantaged backgrounds. This is particularly notable when looking at the current makeup of the nursing workforce, where 90.8% of registered nurses are female, and 78.6% are non-Hispanic White.[129] Of the 999 students who graduated during the academic year, 18 percent intended to apply to advanced nursing degree programs.

In addition to providing support to students, NWD grantees also partnered with over 900 different training sites during the academic year to provide more than 22,000 clinical training experiences to NWD trainees across all training programs. Approximately 42 percent of training sites were located in medically underserved communities and 26 percent were in primary care settings.

Funding History

FY	Amount
FY 2013	$14,984,000
FY 2014	$15,641,000
FY 2015	$15,343,000
FY 2016	$15,343,000
FY 2017	$15,343,000

Budget Request

The FY 2017 Budget Request is $15.3 million, which is the same as the FY 2016 Enacted level. This request will fund the education of nursing students to become registered nurses and the preparation of participants for entry into a professional nursing program through pre-entry preparation, retention and stipend/scholarship program activities. In FY 2017, the program will continue to encourage grantees to support diverse students to overcome structural and systematic factors that inhibit health equity in order to enroll, matriculate, and graduate from accredited schools of nursing.

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

[129] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. Sex, Race, and Ethnic Diversity of U.S. Health Occupations (2010-2012), Rockville, Maryland; 2014. Accessed at: http://bhw.hrsa.gov/healthworkforce/supplydemand/usworkforce/diversityushealthoccupations.pdf

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[130]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
Percent of program participants who are underrepresented minorities and/or from disadvantaged backgrounds	---	95%	95%	Maintain
Percent of program participants who completed pre-college preparation training and intend to apply to a nursing degree program	---	TBD[131]	TBD	---
Percent of program participants who received academic retention support and maintained enrollment in a nursing degree program	---	TBD[132]	TBD	---
Percent of underrepresented minority students	FY 2014: 46% Target: 70% (Target Not Met)	N/A[133]	N/A	---
Percent of white disadvantaged students/participants	FY 2014: 39% Target: 35% (Target Exceeded)	N/A[134]	N/A	---
Number of nursing program students	FY 2014: 4,444 Target: 2,500 (Target Exceeded)	N/A[135]	N/A	---
Number of post high school, college, and pre-entry nursing students	FY 2014: 5,481 Target: 300 (Target Exceeded)	N/A[136]	N/A	---

[130] Most recent results are for Academic Year 2014-2015 and funded in FY 2014.
[131] Baseline for this measure will be set for FY 2015 and reported in the FY 2018 Congressional Justification.
[132] Baseline for this measure will be set for FY 2015 and reported in the FY 2018 Congressional Justification.
[133] Measure discontinued in FY 2015.
[134] Measure discontinued in FY 2015.
[135] Measure discontinued in FY 2015.
[136] Measure discontinued in FY 2015.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[130]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
Number of K-12 students/participants	FY 2014: 3,300 Target: 1,500 (Target Exceeded)	N/A[137]	N/A	---
Number of nursing students graduating from nursing programs	FY 2014: 999 Target: 750 (Target Exceeded)	N/A[138]	N/A	---
Number of nursing students expected to receive scholarships	FY 2014: 1,746 Target: 1,000 (Target Exceeded)	N/A[139]	N/A	---

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	44	45	45
Average Award	$322,368	$316,000	$316,000
Range of Awards	$73,646-$353,284	$135,000-$528,000	$135,000-$528,000

[137] Measure discontinued in FY 2015.
[138] Measure discontinued in FY 2015.
[139] Measure discontinued in FY 2015.

Nursing Workforce Development

Nurse Education, Practice, Quality and Retention Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$39,913,000	$39,913,000	$39,913,000	---
FTE	5	5	5	---

Authorizing Legislation: Public Health Service Act, Sections 831, 831A, and 871, as amended by Public Law 111-148, Section 5309

FY 2017 Authorizations
Section 831.....Expired
Section 831A .....Expired

Allocation Method .....Competitive Grant/Contract

Program Goal and Description: The Nurse Education, Practice, Quality and Retention (NEPQR) Program seeks to build and expand nursing educational programs to increase the number of qualified nurses in the healthcare workforce through academic, service, and continuing professional training projects designed to enhance nursing education, improve the quality of patient care, increase nurse retention, and strengthen the nursing workforce. The Program is particularly focused on helping nurses collaborate on and lead interprofessional teams through its work with nurse managed health clinics and by working with schools of nursing and health centers to achieve behavioral health integration into primary care. NEPQR also invests in the Coordinating Center for Interprofessional Education and Collaborative Practice which supports healthcare transformation to collaborative team-based care by addressing the disconnect between health professions education and practice communities. The Center also works to make a difference in the health of people and communities by integrating interprofessional practice and education to enhance patient care, control costs, and improve individual and population health outcomes.

Need: While HRSA's nursing (2025) and primary care projections (2020) generally indicate that the supply of nurses will outpace demand at a national level in 2025 and 2020 respectively.[140, 141] However, the actual distribution of nurses is estimated to continue to be problematic with some

[140] U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Workforce National Center for Health Workforce Analysis, Future of the Nursing Workforce: National- and State-level Projections, 2012-2025, December 2014.
[141] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis, *Projecting the Supply and Demand for Primary Care Practitioners Through 2020." 2013.*.

areas of the country having a supply of nurses well above the national norm or average, while other areas have a supply that is inadequate to meet the needs of their region. This perpetuates the need for more healthcare providers in underserved areas or for underserved populations. HRSA's investments are focused on enhancing curriculum for nurses to ensure they are exposed to training opportunities in underserved areas and are prepared to provide safe, quality care within the complex practice-based environment of the nation's evolving healthcare system. The NEPQR Program specifically addresses the inequitable distribution of the nursing workforce by working with grantees that have a proven track record in underserved areas, rural populations and public health nursing needs.

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

Designated Health Professions	Targeted Educational Levels	Grantee Activities
• Registered nurses • Advanced practice registered nurses	• Baccalaureate education • Advanced nursing education • Continuing professional training	• Develop extended practicums, internships and residency programs. • Offer programs to promote nurse retention. • Develop skills in care enhancements including coordinated care congruent with emerging health care systems. • Increase access to primary care services for rural, underserved and high-risk populations • Increase access to interprofessional clinical training and practice for registered nurses and advanced practice nurses.

Program Accomplishments: The Nurse Education, Practice, Quality and Retention program (NEPQR) program has a variety of legislative goals and purposes that ultimately aim to increase the size, preparation and quality of the nursing workforce. In Academic Year 2014-2015, multiple grants were funded to support several of the program's education, practice, and retention legislative purposes, including the Veterans' Bachelor of Science in Nursing (VBSN) program and the Interprofessional Collaborative Practice (IPCP) program.

The VBSN program is designed to increase enrollment, progression, and graduation of veterans from BSN degree programs. VBSN made awards to 17 schools in Academic Year 2014-2015. A total of 472 veterans were enrolled in BSN degree programs, and 82 graduated with BSN degrees. Further analysis showed that 52 percent of VBSN students were female; 36 percent were between the ages of 30-39 years; 33 percent were underrepresented minorities in the field of nursing; and 24 percent reported coming from a financially and/or educationally disadvantaged background. Approximately 25 percent of veterans received clinical training in a primary care setting, and 29 percent received training in a medically underserved community during the academic year. VBSN grantees developed or enhanced and implemented a total of 21 academic courses as well as trained 730 individuals. Grantees also implemented 10 structured

faculty development programs and 54 faculty development activities including conferences and workshops designed to enhance the teaching of veterans. A total of 1060 faculty were trained as a result.

The IPCP program was designed to create or expand practice environments comprised of nursing and other professional disciplines engaged in collaborative practice innovations. IPCP programs funded more than 13,000 students, of whom 21 percent were underrepresented minorities and 12 percent were from disadvantaged backgrounds. In addition, IPCP grantees partnered with 718 clinical sites to provide interprofessional team-based training to more than 3,200 individuals, 54 percent of whom were nursing students. Approximately 86 percent of the clinical training sites were located in medically underserved communities and 21 percent were in primary care settings.

Funding History

FY	Amount
FY 2013	$37,113,000
FY 2014	$37,913,000
FY 2015	$39,913,000
FY 2016	$39,913,000
FY 2017	$39,913,000

Budget Request

The FY 2017 Budget Request is $39.9 million, which is the same as the FY 2016 Enacted level. This request will enable HRSA to provide nursing educational opportunities, train nurses in team-based, interprofessional clinical practice, including integrating behavioral health into primary care, and provide continuing professional training to the nursing workforce to enhance the quality of patient care. Projects will focus on supporting Bachelor of Science in Nursing (BSN) students receiving extended clinical practice experiences in community-based settings, and on developing and disseminating collaborative practice models that incorporate the full range of healthcare workers in team-based care, particularly integrating behavioral health into primary care. HRSA is also continuing support for the Coordinating Center for Interprofessional Education and Collaborative Practice to enhance the coordination and capacity building for interprofessional practice and education among health professions across the U.S.

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

Outcomes and Outputs Table

The NEPQR Program has several purposes and solicits applications addressing any of its education, practice and retention purposes, one of which is accelerated BSN education projects. The purposes of the NEPQR are broad and flexible, allowing the program to address the emerging needs in nursing workforce development to advance education and practice priorities. As the program adapts to these emerging needs and priorities in the future, new outcome measures will be added as appropriate.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[142]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
Number of trainees participating in interprofessional team-based care	FY 2014: 1,774 (Baseline)	1,700	1,700	Maintain
Number of nurses and nursing students trained in interprofessional team-based care	FY 2014: 3,265 (Baseline)	3,000	3,000	Maintain
Number of veterans enrolled in baccalaureate (BSN) nursing programs	FY 2014: 472 (Baseline)	450	350	-100
Number of veterans who graduate from baccalaureate (BSN) nursing programs	FY 2014: 82 (Baseline)	200	150	-50

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	90	90	90
Average Award	$415,886	$435,000	$435,000
Range of Awards	$131,830-$787,991	$134,000-$788,000	$134,000-$788,000

[142] Most recent results are for Academic Year 2014-2015 and funded in FY 2014.

Nursing Workforce Development

Nurse Faculty Loan Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$26,500,000	$26,500,000	$26,500,000	---
FTE	1	1	1	---

Authorizing Legislation: Public Health Service Act, Section 846A, as amended by Public Law 111-148, Section 5311

FY 2017 Authorization .....Expired

Allocation Method .....Formula[143] Grant

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

Need: HRSA will continue to support the training of nurse educators to ensure an adequate and diverse supply of high quality nurses in rural and underserved communities. Recent demographic data indicates the nursing workforce is not representative of the racial and ethnic diversity of the nation as a whole. According to the U.S. Census Bureau, individuals from ethnic and racial minority groups accounted for more than one third of the U.S. population (37 percent) in 2012,[144] yet nurses from minority backgrounds represent just 19 percent of the registered nurse (RN) workforce.[145] The trends in nursing projections suggest that there is a greater need to focus on diversity in the nursing workforce. Faculty diversity is an essential ingredient in the efforts to diversify the nursing education workforce overall.[146,147] The primary barrier to accepting all qualified students at nursing colleges and universities continues to be an insufficient number of qualified nursing faculty. According to two 2013 studies of nursing

[143] The Department is considering ways to improve program effectiveness and accountability, which may include changing the allocation method from formula to competitive.
[144] U.S. Census Bureau, *Projections Show a Slower Growing, Older, More Diverse Nation a Half Century from Now*, accessed at http://www.census.gov/newsroom/releases/archives/population/cb12-243.html.
[145] National Council of State Boards of Nursing, accessed at https://www.ncsbn.org/JNR0713_05-14.pdf.
[146] American Association of Colleges of Nursing (Nurse Faculty Shortage Fact Sheet (updated December 2013). http://www.aacn.nche.edu/media-relations/fact-sheets/nursing-faculty-shortage.
[147] American Association of Colleges of Nursing. Special Survey on Vacant Faculty Positions for Academic Year 2013-2014. http://www.aacn.nche.edu/leading-initiatives/research-data/vacancy13.pdf.

schools, almost two-thirds of nursing schools could not accept all of their qualified applicants because of faculty shortages, which includes at least 1,358 faculty vacancies across 680 schools.

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

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

Program Accomplishments: In Academic Year 2014-2015, the Nurse Faculty Loan Program (NFLP) supported a total of 2,399 nursing students pursuing graduate level degrees as nurse faculty—exceeding the program's performance target of 2,200. The majority of students (75 percent) who received loans during the academic year were pursuing doctoral-level nursing degrees (e.g., PhD, DNP, DNSc/DNS, or EdD). NFLP loan recipients were primarily females (91 percent); between the ages of 40 and 49 (31 percent); and received a median loan amount of $10,960. Further analyses showed that 20 percent of students who received a loan reported coming from a disadvantaged background, and nearly 25 percent students are considered underrepresented minorities in their prospective professions.

A total of 605 trainees graduated by the end of the 2014-2015 academic year, and 91 percent of these graduates intend to teach nursing. Further analysis showed that of students who graduated in the previous academic year (2013-2014) for whom data were available, 74 percent obtained a full-time faculty appointment.

The number of schools that received new NFLP grant awards in Academic Year 2014-2015 was 93. In order to receive a new NFLP award, schools must meet certain criteria with regard to available fund balances. However, even schools that do not receive new awards may continue giving out loans with the accounts they have already established. Therefore, although 93 schools received a NFLP award this academic year, 94 schools provided NFLP loans to nursing students in Academic Year 2014-2015.

Funding History

FY	Amount
FY 2013	$23,256,000
FY 2014	$24,500,000
FY 2015	$26,500,000
FY 2016	$26,500,000
FY 2017	$26,500,000

Budget Request

The FY 2017 Budget Request is $26.5 million, which is the same as the FY 2016 Enacted level. This request will fund schools of nursing in establishing and operating loan funds that support 2,200 nurses training to become nurse faculty. The program focuses on preparing students to teach, enables both tenure track and non-tenure track faculty to be eligible for loan forgiveness while focusing its efforts on increasing the number of doctoral prepared nurse faculty. The Department is considering ways to improve program effectiveness and accountability, including changing the program into a competitive grant program.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[148]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
Number of graduate-level nursing students who received a loan[149]	FY 2014: 2,399 Target: 2,200 (Target Exceeded)	2,200	2,200	Maintain
Number of loan recipients who graduated from an advanced nursing degree program[150]	FY 2014: 605 Target: 275 (Target Exceeded)	400	400	Maintain
Number of schools receiving NFLP awards	FY 2014: 93 Target: 114 (Target Not Met)	N/A[151]	N/A	---

[148] Most recent results are for Academic Year 2014-2015 and funded in FY 2014.
[149] The wording for this measure has been revised from previous budget documents to better reflect measures collected.
[150] The wording for this measure has been revised from previous budget documents to better reflect measures collected.
[151] Measure discontinued in FY 2015.

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	87	87	87
Average Award	$289,716	$289,716	$289,716
Range of Awards	$11,135-$2,936,106	$11,135-$2,936,100	$11,135-$2,936,100

Nursing Workforce Development

Comprehensive Geriatric Education

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$4,500,000	---[152]	---	---
FTE	1	---	---	---

Authorizing Legislation: Public Health Service Act, Section 865, as amended by Public Law 111-148, Section 5310(b)

FY 2017 Authorization .....Expired

Allocation Method ..... Cooperative Agreement

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

In FY 2015, HRSA combined the Comprehensive Geriatric Education Program, Geriatrics Education Centers program, Geriatric Training for Physicians, Dentists, and Behavioral/Mental Health Professionals program, and the Geriatric Academic Career Awards programs into one competition, the Geriatrics Workforce Enhancement Program, to improve health outcomes for older adults by integrating geriatrics with primary care, maximizing patient and family engagement, and transforming the health care system. Special emphasis is on providing the primary care workforce with the knowledge and skills needed to care for older adults and on collaborating with community partners to address gaps in health care through individual, system, community and population level changes.

The Geriatrics Workforce Enhancement Program supports training of individuals, including patients, families, caregivers, direct care workers, health professions providers, students, residents, fellows who will provide health care to older adults and the faculty who train these individuals. Funding may also be used to provide educational programs for patients, family members, and caregivers to afford them the knowledge and skills for self-management or the care delivery of older adults.[153]

[152] Starting in FY 2016, all of the funding for the Geriatrics Workforce Enhancement Program was included under that program.

[153] Please refer to the Title VII Geriatrics narrative for the Geriatrics Workforce Enhancement Program description, funding, and performance targets.

Need: More than 65 million people, 29 percent of the adult U.S. population, provide care for a chronically ill, disabled or an aged family member or friend during any given year.[154] These individuals spend an average of 20 hours per week providing care for their loved one.[155] More recent data from the Pew Research Center (2013) indicate that nearly half of all American adults expect to provide care to their older parents at some point in their lives.[156] In addition, the Institute of Medicine identified three shortfalls that the health care system will face as the number of older Americans increases: 1) health care needs of older adults will be difficult to meet by the current health care workforce; 2) there will be severe shortages of geriatric specialists and other providers with geriatric skills; and 3) there will be increased demand for chronic care management skills.[157]

Through training provided to the entire provider continuum (students, faculty, providers, direct service workers, and lay and family caregivers) in collaboration with community organizations, improved geriatrics care can become widely available to older Americans.

Comprehensive Geriatric Education Program

The Comprehensive Geriatric Education Program supported the training and education of individuals, particularly nurses and direct service workers, in providing geriatrics care for the elderly.

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

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

[154] National Alliance for Caregiving in collaboration with AARP (2009). Caregiving in the United States 2009. www.caregiving.org/data/Caregiving_in_the_US_2009_full_report.pdf
[155] *Ibid.*
[156] Pew Research Center (2013). The Sandwich Generation: Rising Financial Burdens for Middle-Aged Americans. Pew Social Trends, Washington, D.C.
[157] Institute of Medicine. Retooling for an Aging America: Building the Health Care Workforce. Washington, DC: The National Academies Press, 2008.

Program Accomplishments: In Academic Year 2014-2015, Comprehensive Geriatric Education Program (CGEP) grantees awarded traineeships to a total of 73 students, the majority of whom (69 percent) were studying to become Nurse Practitioners in Adult Gerontology. Approximately 19 percent of supported students were considered underrepresented minorities in their prospective profession and 25 percent were from either educationally or financially disadvantaged backgrounds. The majority of students received clinical training in a primary care setting (55 percent) and/or a medically underserved community (45 percent). Finally, a large proportion of the 56 students who completed their training during Academic Year 2014-2015 intended to pursue employment or further training in either a primary care setting or a medically underserved community (41 and 40 percent, respectively).

CGEP grantees partnered with a total of 210 sites to provide more than 280 clinical training experiences to student trainees (e.g., ambulatory practice sites, hospitals, and physician offices). Approximately 56 percent of these training sites were situated in primary care settings and 36 percent were located in medically-underserved communities. Training at the clinical sites incorporated interdisciplinary team-based approaches, where approximately 270 students, residents and/or fellows from a variety of professions and disciplines were trained on teams with CGEP student trainees.

In addition to the training and support of individual students, CGEP grantees developed, enhanced, and implemented more than 90 different courses and training activities focused on the treatment of health problems among the elderly. More than 5,800 current providers and health professions students, residents, and fellows were reached as a result of these activities. Further, CGEP grantees supported more than 90 different faculty development activities and structured programs, training more than 1,500 faculty members on emerging issues in the field of geriatrics. Finally, with regard to the continuing education (CE) of the current workforce, CGEP grantees offered more than 230 unique courses to approximately 15,100 faculty and practicing professionals from a wide variety of health professions and disciplines. These continuing education activities were primarily focused on geriatric-related topics including advances in geriatric medicine, palliative care, and community-based care.

Funding History

FY	Amount
FY 2013	$4,248,000
FY 2014	$4,350,000
FY 2015	$4,500,000
FY 2016	---
FY 2017	---

Budget Request

The FY 2017 Budget request has been incorporated into the Geriatrics Workforce Enhancement Program narrative.[158] These funding sources will provide $38.7 million in support to 44

[158] See page X for discussion of Title VII Geriatrics programs and GWEP outcomes.

Geriatrics Workforce Enhancement Program grantees who seek to improve high quality, interprofessional geriatric education and training, as well as increase geriatrics competencies of primary care providers and other health professionals serving the geriatric community.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)[159]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
Number of CGEP Grantees	FY 2014: 12 Target: 18 (Target Not Met)	N/A[160]	N/A	---

Grant Awards Table[161]

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	---	---	---
Average Award	---	---	---
Range of Awards	---	---	---

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

Nursing Workforce Development

NURSE Corps

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$81,785,000	$83,135,000	$83,135,000	---
FTE	31	32	32	---

Authorizing Legislation: Public Health Service Act, Section 846

FY 2017 Authorization ..... Expired

Allocation Method .....Other (Competitive Awards to Individuals)

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

The Affordable Care Act amended the NURSE Corps LRP to extend loan repayment to nurse faculty. FY 2010 was the first year NURSE Corps LRP made awards to nurse faculty. These awards assist in the recruitment and retention of nurse faculty at accredited schools of nursing by decreasing economic barriers that may be associated with pursuing a career in academic nursing.

The NURSE Corps Scholarship Program (SP) offers scholarships to individuals who are enrolled or accepted for enrollment in an accredited school of nursing in exchange for a service commitment of at least two years in a Critical Shortage Facility after graduation. Tuition and fees are paid directly to the accredited school of nursing based on an invoice submitted by the scholar's school official. Other reasonable costs reflect an additional annual payment provided directly to each scholar to assist with the cost, as submitted by the academic institution, of books, clinical supplies/instruments, and uniforms.

The NURSE Corps SP awards reduce the financial barrier to nursing education for all levels of professional nursing students and increase the pipeline of nurses who will serve in underserved areas. A funding preference is given to qualified applicants who have the greatest financial need, as determined by the applicants' expected family contribution, and for those enrolled full-time in

a diploma, associate, baccalaureate or graduate nursing degree program, including RN to Bachelors of Science in Nursing (BSN); RN to Master of Science in Nursing-Nurse Practitioner (MSN-NP); and Direct Entry MSN-NP programs.

Need: By 2025, nursing projections show that 16 states will still have shortages in registered nurses.[162] Even in states projected to have sufficient numbers of nurses or where the supply of nurses exceeds demand, there will still be a need for healthcare providers in underserved areas or for underserved populations. The trends in nursing projections also suggest that there is a greater need to focus on distribution and diversity in the RN workforce. The Administration is committed to working with states, academic institutions, professional organization and key stakeholders to address current and anticipated regional shortages of nurses. HRSA will continue to support the training of nurses to ensure an adequate supply of nurses across the country and, in particular, within underserved communities. NURSE Corps is well aligned to meet this need in that program awardees must work in medical facilities located in areas where there are notable shortages of nurses.

Eligible Applicants: Loan Repayment Program: U.S. citizens (either U.S. born or naturalized), U.S. Nationals or Lawful Permanent Residents with a current license to practice as a registered nurse and outstanding qualifying educational loans leading to completion of a diploma or degree in nursing and employed full time (at least 32 hours per week) at a public or private nonprofit Critical Shortage Facility or at an accredited, public or private non-profit school of nursing.

Scholarship Program: U.S. citizens (either U.S. born or naturalized), U.S. Nationals or Lawful Permanent Residents enrolled or accepted for enrollment in an accredited diploma, associate or collegiate (bachelors, master's, doctoral) school of nursing program. Following graduation from the accredited nursing program, service obligations must be completed as a full- or part-time employee in a Critical Shortage Facility located in communities with a notable shortage of health professionals.

Program Accomplishments: The NURSE Corps performance measures gauge these programs' contribution to the HRSA strategic goals of improving access to health care and improving the health care systems through the recruitment and retention of nurses working in Critical Shortage Facilities. Increasing the number of nurses at facilities with a critical shortage of nurses will be a key output. In FY 2015, 55 percent of NURSE Corps LRP participants extended their service contracts to commit to work at a critical shortage facility for an additional year, exceeding the 52 percent target; and in FY 2014, 90 percent of NURSE Corps participants were retained in service at a critical shortage facility for at least one year beyond the completion of their NURSE Corps LRP/SP commitment.

Another measure of program performance is the number of NURSE Corps SP awards that are issued to participants pursuing a baccalaureate degree or advanced practice degree in nursing. In FY 2015, 88 percent of NURSE Corps SP awardees obtained their baccalaureate degree or advanced practice degree, exceeding the 85 percent target.

[162] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis, "Future of the Nursing Workforce: National- and State-level Projections, 2012-2025."December 2014.

In FY 2015:

- NURSE Corps LRP made 590 new loan repayment awards (average award = $67,279) and 319 continuation awards (average award = $23,514).

- NURSE Corps SP made 257 new scholarship awards (average award = $90,539) and 12 continuation awards (average award = $29,458).

In FY 2016:

- NURSE Corps LRP expects to make 674 new loan repayment awards (average award = $60,000) and 309 continuation awards (average award = $25,000).

- NURSE Corps SP expects to make 225 new scholarship awards (average award = $101,748) and 26 continuation awards (average award = $31,702).

Funding History

FY	Amount
FY 2013	$77,957,000
FY 2014	$79,785,000
FY 2015	$81,785,000
FY 2016	$83,135,000
FY 2017	$83,135,000

Budget Request

The FY 2017 Budget Request is $81.8 million, which is equal to the FY 2016 Enacted Budget. This request will fund 240 scholarship (new and continuation) and 997 loan repayment (new and continuation) awards. This request will allow the program to maintain its efforts to address the anticipated demand for access to primary care services in Critical Shortage Facilities resulting from the implementation of the ACA. The funding request also includes costs to directly support the NURSE Corps in the form of staffing and acquisition contracts.

The demand has intensified for nurses prepared in programs that emphasize leadership, patient education, case management, and care across a variety of delivery settings. The National Sample Survey of Nurse Practitioners report[163] indicated that more than a third of the NP workforce is over age 55 and likely to retire soon; however, there is a fair representation of younger NPs entering the workforce. Despite this, there are still projected to be shortages of nurses in 16 states and even variations within states, highlighting the nation's workforce distribution issues rather than production concerns.[164] Further, as the demand for primary healthcare services

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

[164] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis, , "Future of the Nursing Workforce: National- and State-Level Projections, 2012-2025." December2014.

continues to grow as the population ages, NPs play a critical role in offering these services, as evidenced by many states expanding the role of these providers in recent years. The NURSE Corps is a part of the national strategy addressing uneven distribution of healthcare professionals across the nation, particularly in underserved communities.

Funding for the NURSE Corps will continue to address the facilities with a critical shortage of nurses across the U.S. As a measurement of that effort in FY 2017:

- NURSE Corps LRP expects to make 677 new loan repayment awards and 320 continuation awards.
- NURSE Corps SP expects to make 217 new scholarship awards and 23 continuation awards.

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

In FY 2017, the proportion of NURSE Corps LRP participants who request a continuation and commit to work at a critical shortage facility for an additional year is projected to be 52 percent.

Another measure of program performance is the number of NURSE Corps SP awards that are issued to participants pursuing a baccalaureate degree or advanced practice degree in nursing. This measure was initially developed in 2010 when the program only included undergraduate degrees in its first funding preference, resulting in a baccalaureate being the highest attainable degree. In FY 2012, program shifted its focus to also include master's level NPs in the first funding preference. As a result, the program is projecting that the proportion of NURSE Corps SP awardees obtaining their baccalaureate degree or advanced practice degree to be 85 percent in FY 2017. The program has created a new measure to reflect this programmatic shift to account for master's level NPs.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
5.I.C.4: Proportion of NURSE Corps LRP participants who extend their service contracts to commit to work at a critical shortage facility for an additional year. *(Outcome)*	FY 2015: 55% Target: 52% (Target Exceeded)	52%	52%	Maintain

5.I.C.5: Proportion of NURSE Corps LRP/SP participants retained in service at a critical shortage facility for at least one year beyond the completion of their NURSE Corps LRP/SP commitment.	FY 2014: 90% Target: 80% (Target Exceeded)	80%	80%	Maintain
5.I.C.7: Proportion of NURSE Corps SP awardees obtaining their baccalaureate degree or advanced practice degree in nursing. *(Outcome)*	FY 2015: 88%% Target: 85% (Target Exceeded)	85%	85%	Maintain
5.E.1: Default rate of NURSE Corps LRP and SP participants. *(Efficiency)*	FY 2015: LRP: 2% Target: 3% (Target Exceeded) SP: 7.3%.Target: 15% (Target Exceeded)	LRP: 3% SP: 15%	LRP: 3% SP: 15%	Maintain

Table 2. Loans/Scholarships Table

	FY 2015 Final	**FY 2016 President's Budget**	**FY 2017 OMB Higher Level Request**
Loans	$47,205,061	$48,110,375	$48,632,975
Scholarships	$23,622,022	$23,696,155	$23,953,555

Table 3. NURSE Corps Awards, by program, FYs 2010-2017

AWARDS	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Scholarships								
New – RN	458	395	134	148	150	209	140	130
New – NP			99	91	92	48	85	87
--Continuations – RN	18	17	31	20	9	3	16	14
Continuations - NP				1	4	9	10	9
Loan Repayment								
New – RN	842	671	272	161	241	175	303	305
New – NP	112	85	234	292	300	301	236	237
New – NF	185	163	214	127	126	114	135	135
Continuations – RN	115	314	533	470	210	98	139	144
Continuations - NP	20	71	97	12	83	143	108	112
Continuations – NF			102	124	119	78	62	64
Total	**1,750**	**1,716**	**1,716**	**1,446**	**1,334**	**1,178**	**1,234**	**1,237**

*Key: **NP**: Nurse Practitioner; **NF**: Nurse Faculty; **RN**: Registered Nurses*

Table 4. NURSE Corps Field Strength, by program, FYs 2010-2017

FIELD STRENGTH[165]	2010	2011	2012	2013	2014	2015	2016	2017
Scholarship	252	282	475	558	465	396	363	363
Loan Repayment	2112	2443	2592	2,001	1,738	1,634	1,571	1,670
Total	**2,364**	**2,725**	**3,067**	**2,559**	**2,203**	**2,030**	**1,934**	**2,033**

[165] Field Strength for FY 2010 is an estimate. The NURSE Corps did not begin to capture field strength numbers until FY 2011.

Children's Hospitals Graduate Medical Education Payment Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$265,000,000	$295,000,000	---	-$295,000,000
Proposed Mandatory	---	---	$295,000,000	+$295,000,000
FTE	25	22	22	---

Authorizing Legislation: Public Health Service Act, Section 340E

FY 2017 Authorization $300,000,000

Allocation Method ..... Formula Based Payment

Program Goal and Description: The Children's Hospitals Graduate Medical Education (CHGME) Payment Program supports graduate medical education (GME) in freestanding children's teaching hospitals. CHGME helps eligible hospitals maintain GME programs to provide graduate training for physicians to provide quality care to children and enhance their ability to care for low-income patients. It supports the training of residents to care for the pediatric population and enhances the supply of primary care and pediatric medical and surgical subspecialties. In FY 2014, the CHGME program was reauthorized for five years (FY 2014 through 2018) and program eligibility was expanded in some circumstances.

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

Eligible Entities: Freestanding children's teaching hospitals.

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

Program Accomplishments: In FY 2014, 54 children's hospitals received CHGME funding. Based on the most recent year for which performance information was reported, CHGME

grantees reported being responsible for the training of 6,698 full-time equivalent (FTE) residents on and off site.[166] Approximately 43 percent of the FTEs were pediatric residents, 32 percent were pediatric subspecialty residents, and 25 percent were non-pediatric residents such as family practice residents or cardiology residents rotating in children hospitals to learn about care of children in their respective areas of expertise.

Funding History

FY	Amount
FY 2013	$251,166,000
FY 2014	$264,335,000
FY 2015	$265,000,000
FY 2016	$295,000,000
FY 2017 (mandatory)	$295,000,000

Budget Request

The FY 2017 Budget Request is $295.0 million, which is the same as the FY 2016 Enacted level. The CHGME Payment Program was created to address the disparity in Federal GME support between freestanding children's hospitals and other teaching hospitals. The budget request would enable HRSA to continue to support critical graduate medical education for physicians. Mandatory funding will provide stability to children's hospitals receiving CHGME funding to better plan for the needs of the nation's health care workforce focused on providing quality care to children. The FY 2017 funding request also will support a contract that is responsible for verifying that FTEs (residents) are not funded by other federal programs.

The FY 2017 Budget also proposes mandatory funds for the CHGME program through FY 2021 as indicated in the table below.

Projected Funding for FY 2017-FY 2021 (in millions)

	FY 2017	FY 2018	FY 2019	FY 2020 FY	FY 2021
CHGME	$295	$295	$295	$295	$295

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

[166] Each of the children's hospitals report the number of full-time equivalent residents trained during the latest filed (completed) Medicare Cost Report period.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[167]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
7.I.A.1: Maintain the number of FTE residents training in eligible children's teaching hospitals	FY 2014: 6,698 Target: 6,000 (Target Exceeded)	6,300	6,300	Maintain
7.VII.C.1: Percent of hospitals with verified FTE residents counts and caps	FY 2014: 100% Target: 100% (Target Met)	100%	100%	Maintain
7.E: Percent of payments made on time	FY 2014: 100% Target: 100% (Target Met)	100%	100%	Maintain

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	57	58	58
Average Award	$4,385,686	$4,798,000	$4,250,000
Range of Awards	$38,777-$17,785,813	$38,777-$17,785,813	$38,777-$17,785,813

[167] Most recent results are for Academic Year 2014-2015 and funded in FY 2014.

Teaching Health Center Graduate Medical Education Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Mandatory	---	$60,000,000	$60,000,000	---
Total	---	$60,000,000	$60,000,000	---
FTE	4	4	4	---

Authorizing Legislation: Section 340H of the Public Health Service Act, as amended by the Public Law 114-10

FY 2017 Authorization $60,000,000

Allocation Method ..... Formula Based Payment

Program Goal and Description: The Teaching Health Center Graduate Medical Education (THCGME) Program provides funding for residency training in primary care medicine and dentistry in community-based, ambulatory settings. The THCGME Program seeks to not only bolster the primary care workforce through support for new and expanded primary care and dental residency programs, but also improve the distribution of this workforce into needed areas through emphasis on underserved communities and populations. In addition to increasing the number of primary care residents training in these community-based patient care settings, the THCGME Program seeks to increase health care quality and overall access to care. Program funds foster innovation and support curriculum concepts that improve patient continuity, such as the Patient-Centered Medical Home model, Electronic Health Record utilization, population health, telemedicine, and health care leadership.

The THCGME Program was established by the Affordable Care Act and was initially funded at $230 million for the period of FY 2011 through FY 2015. The Medicare Access and CHIP Reauthorization Act of 2015 included $60 million of mandatory funding for each of fiscal years 2016 and 2017.

Interest in the program has grown considerably since its inception. The number of supported programs grew from 11 residency programs in the first year of funding (Academic Year 2011-2012) to 59 programs located in 24 different states across the nation in Academic Year 2015-2016. This growth in the THCGME Program has translated to an increase in resident full time equivalents (FTEs) from 63 in Academic Year 2011-2012 to 690 in Academic Year 2015-2016.

Need: Access to high quality primary care is associated with improved health outcomes and lower costs[168]. There is evidence that physicians who receive training in community and

[168] Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. Milbank Quarterly. 2005; 83(3):457-502.

underserved settings are more likely to practice in similar settings such as health centers[169]. Although health centers receive federal funding to improve access to care, they often have difficulty recruiting and retaining primary care professionals[170]. The THCGME Program is uniquely positioned to meet these recruitment and retention needs by providing funding to support residents training in underserved communities.

Eligible Entities: Community-based ambulatory patient care centers.

Designated Health Professions	Targeted Educational Levels	Grantee Activities
• Family medicine • General dentistry • Geriatrics • Internal medicine • Internal medicine-pediatrics • Obstetrics and gynecology • Pediatrics • Psychiatry • Pediatric dentistry	• Post graduate medical and dental education	• Operate an accredited residency program. • Medical and dental residents will provide patient care services during their training under supervision of program faculty.

Program Accomplishments:

In FY 2011 (Academic Year 2011-2012), 11 Teaching Health Centers began receiving payments and training 63 primary care medical and dental resident FTEs. The program has grown significantly and by FY 2014 (Academic Year 2014-2015) had supported 59 residency programs and more than 550 resident FTEs. These awardees include 36 Federally Qualified Health Centers (FQHCs), two FQHC Look-Alikes, five Area Health Education Centers, two Native American Health Authorities, one Community Mental Health Clinic, two Rural Health Clinics, and 12 additional community-based entities.

The THCGME program awarded 556 resident FTE slots that provided funding to 600 primary care medical residents in Academic Year 2014-2015. Approximately 52 percent of the residents were male and 50 percent were between 30 and 39 years old. In addition to 84 percent of residents receiving training in medically underserved communities, nearly all residents received training in primary care settings (99 percent), accruing a combined total of more than 293,000 contact hours with patients. Given the predicted shortage of primary care physicians, the number of residents in this program training in primary care is noteworthy.[171] Approximately 22 percent

[169] Morris CG and Chen FM. Training Residents in Community Health Centers: Facilitators and Barriers. Annals of Family Medicine 2009; 7:488-94.
[170] Rosenblatt RA, Andrilla CH, Curtin T, Hart LG. Shortages of medical personnel at community health centers: Implications for planned expansion. JAMA 2006; 295:1042-9.
[171] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis, *Projecting the Supply and Demand for Primary Care Practitioners Through 2020." 2013. ."*

of residents reported coming from a financially or educationally disadvantaged background, while 27 percent reported coming from a rural background. The rural aspects and accomplishments of this program—both in terms of training residents in medically underserved communities as well as recruiting residents with rural background-- are particularly important as there are more physicians and surgeons per capita residing in urban as opposed to rural areas.[172] In addition to supporting training of individual residents, THCGME grantees also used funding to develop or enhance curricula on topics related to primary care. Results showed that THCGME programs developed or enhanced and implemented 504 courses and training activities during Academic Year 2014-2015. Approximately 9,400 healthcare trainees (most commonly primary care residents) were trained as a result of these activities.

Of the 98 residents who completed the program in Academic Year 2014-2015, approximately 64 percent reported intentions to practice in a primary care setting, while 34 percent intended to practice in a medically underserved area. This is an important programmatic accomplishment towards increasing the numbers of physicians practicing in primary care, as well as increasing the numbers of those practicing in rural areas, since physicians trained in rural areas tend to practice in rural areas and more physicians graduate from public institutions than from private ones in rural areas, especially in the most rural states.[173] Employment status will be assessed for these individuals one year after program completion (during Academic Year 2015-2016). Employment follow-up employment data were collected from physicians who completed primary care residency programs in AY 2013-2014. Of the 41 prior year program completers with available employment data, most entered practice in a primary care setting (81 percent) and/or in a medically underserved community (44 percent).

Results also showed that THCGME residents continue to serve a number of vulnerable populations including veterans and their families, older adults, and children and adolescents. In addition, 36,335 individuals trained alongside residents while participating in interprofessional team-based care across all training sites affiliated with the THCGME program.

Research has highlighted the curricular and organizational innovations in many of the THCs, enabled by the THCGME's support for community-based training, rather than traditional Medicare GME which is paid only to hospitals.[174] These innovations included quality improvement and patient-centered medical home development.

Funding History

FY	Amount
FY 2013[175]	---
FY 2014	---
FY 2015	---
FY 2016	$60,000,000

[172] http://bhw.hrsa.gov/healthworkforce/supplydemand/nchwafactsheet.pdf
[173] Washko, M. M., Snyder, J. E., & Zangaro, G. (2015). Where Do Physicians Train? Investigating Public And Private Institutional Pipelines. Health Affairs, 34(5), 852-856.
[174] Chen et al. Teaching Health Centers: A new paradigm in graduate medical education. Acad Med 2012; 87(12):1752-6.
[175] THCGME was initially funded at $230 million for the period of FY 2011 through FY 2015.

FY	Amount
FY 2017	$60,000,000

Budget Request

The FY 2017 Budget Request is $60.0 million in already enacted mandatory funding, which is the same as the current appropriation. The funding will maintain the per resident funding level in the prior Academic Year and fund the beginning of Academic Year 2017-2018 through the end of fiscal year 2017.

The FY 2017 Budget also proposes mandatory funds for the THCGME program through FY 2020 as indicated in the table below. The FY 2018 request of $245 million will allow completion of Academic Year 2017-2018 as well as provide full payments for the Academic Year 2018-2019. The FY 2019 and FY 2020 requests of $141 million will provide full support for the corresponding Academic Years up to 876 residents, the currently approved number of residents in THCGME programs. The funding request through FY 2020 is critical for the sustainability of primary care residency programs which require up to 3 to 4 years per resident to complete training.

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

Proposed Mandatory Funding for FY 2018-FY 2020 (in millions)

	FY 2018	FY 2019	FY 2020
THCGME	$245	$141	$141

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[176]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
6.I.C.5: Number of resident positions supported by Teaching Health	FY 2014: 556 Target: 402 (Target Exceeded)	660	760[178]	+100

[176] Most recent results are for Academic Year 2014-2015 and funded in FY 2011.

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)[176]	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
Centers (Cumulative)[177]				

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	59	59	59
Average Award	$1,993,880	$949,153	$949,153
Range of Awards	$195,801-$9,723,034	$81,159-$4,869,565	$81,159-$4,869,565

[178] The increase in the FY 2017 target reflects the natural scale up of new and expanding residency programs that require up to 4 years of training as each class of residents move up or graduate, a new class of residents is recruited.
[177] Measure captures the number of full-time equivalent (FTEs) resident slots supported and not the number of individuals receiving direct financial support through the program. Awardees may use 1 FTE slot to fund two residents at 50 percent time, thus the FTE slot is not a one to one correspondence with number of individuals trained. Number of residents also does not equal the number of graduates as primary care residency programs require one year (Dental and Geriatrics), three years (Family Medicine, Internal Medicine, and Pediatrics), or four years (Ob-Gyn and Psychiatry) of training.

National Practitioner Data Bank

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Discretionary Collections	$18,814,000	$21,037,000	$21,037,000	---
FTE	38	46	46	---

Authorizing Legislation: Section 6403 of the Patient Protection and Affordable Care Act (P.L. 111-148); Title IV of the Health Care Quality Improvement Act of 1986 (P.L. 99-660), as amended; Section 1921 of the Social Security Act (Section 5(b) of P.L. 100-93, the Medicare and Medicaid Patient and Program Protection Act of 1987, as amended); and Section 1128E of the Social Security Act (P.L. 104-191, the Health Insurance Portability and Accountability Act of 1996).

FY 2017 Authorization ..... Indefinite

Allocation Method ..... User Fee Program

Program Goal and Description: The purpose of the National Practitioner Data Bank (NPDB) is to improve health care quality, promote patient safety, and deter fraud and abuse in the health care system by providing information about past adverse actions of practitioners, providers, and suppliers to authorized health care entities and agencies. The NPDB serves as a flagging system intended to prompt a comprehensive review of health care practitioners' licensure activity, medical malpractice payment history and record of clinical privileges. Used in conjunction with information from other sources, the NPDB assists in promoting quality health care.

The NPDB is a web-based electronic reporting and querying system. Reports and queries can be submitted interactively online or via batch electronic file transfer. Credit card and Electronic Funds Transfer (EFT) transactions are securely processed using the U.S. Department of Treasury's Pay.gov service.

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

Program Accomplishments: In FY 2015, the Department updated the National Practitioner Data Bank Guidebook. The Guidebook serves as a seminal policy document for NPDB

stakeholders. Released in April 2015, the refreshed Guidebook incorporates legislative and regulatory changes adopted since its last edition, including the merger of the National Practitioner Data Bank with the Healthcare Integrity and Protection Data Bank. The new Guidebook offers users more and clearer examples of when and how to report and query, more useful tables explaining NPDB policies, and live links to statutes, regulations, and the NPDB website. The NPDB Guidebook provides up-to-date guidance on how the NPDB accomplishes its congressionally-mandated mission to provide information on health care practitioners, entities, providers, and suppliers to authorized queriers.

The Department also accomplished various activities to encourage self-service, reduce help-desk volume, increase efficiency, and lower costs. These activities included 1) streamlining NPDB system modules, 2) revising the Dispute Resolution Process, 3) implementing prepayment options for queriers, 4) streamlining the credit purchasing process, 5) reducing load and fees incurred by Pay.gov, 6) implementing a new self-service web feature to assist NPDB customers in recovering forgotten account credentials, 7) creating a single sign-in widget on the informational website to better facilitate access to the three NPDB web-based user sites, and 8) streamlining the web-based form used by authorized NPDB queriers to provide real-time responses for single-name query transactions.

On June 1, 2015, the Department also launched the redesigned NPDB website, which included modernization of the NPDB website's information architecture, writing style, and branding. The Department over-saw the building of a prototype and usability testing with federal and private healthcare customers to ensure the NPDB website is intuitive to use, and the information is easy to find.

NPDB queriers now receive more accurate information for their hiring, licensing, and credentialing decisions after changes were made to improve the NPDB IT system’s data integrity with point-of-entry data validation, standardization of professional school names, and geocoding.

Finally, the manner by which state licensing bodies attest to their compliance with NPDB reporting requirements has been refined, thereby further enhancing the quantitative and qualitative reporting to the NPDB through rigorous state board compliance activities. While still targeting reports most likely to be disclosed to NPDB queriers, the NPDB State Licensing Board Compliance Framework has been revised, reducing staff effort by 33-50 percent. This increased efficiency has freed staff to begin work to expand compliance monitoring to include other critical targets.

Funding History

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

FY	Amount
FY 2013	$29,747,615
FY 2014	$27,456,000
FY 2015	$18,814,000
FY 2016	$21,037,000
FY 2017	$21,037,000

Budget Request

As mandated by the Health Care Quality Improvement Act, the NPDB does not receive appropriated funds. Instead, the NPDB is financed by the collection of user fees. Annual Appropriations Act language since FY 1993 requires that user fee collections cover the full cost of NPDB operations; therefore, there is no request for appropriation for operating the NPDB. User fees are established at a level to cover all program costs to allow the Data Bank to meet annual and long term program performance goals. Fees are established based on forecasts of query volume to result in adequate, but not excessive, revenues to pay all program costs to meet program performance goals. The NPDB estimate for FY 2017 is 6,706,021 queries on practitioners and organizations, and 106,000 self-queries. Under this estimated scenario, HRSA projects fee collections of $21 million.

Outcomes and Outputs Table

Measure	Year and Most Recent Result /Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
8.III.B.5: Increase the number of practitioners enrolled in Continuous Query (which is a subscription service for Data Bank queries that notifies them of new information on enrolled practitioners within one business day)	FY 2015: 2,069,099 Enrolled Practitioners Target: 1,675,000 Enrolled Practitioners (Target Exceeded)	2,030,000	2,155,000	+125,000
8.III.B.7: Increase annually the number of reports disclosed to health care organizations	FY 2015: 1,257,631 Disclosures Target: 1,285,000 (Target Not Met)	1,260,000	1,265,000	+5,000

Maternal and Child Health

TAB

MATERNAL AND CHILD HEALTH

Maternal and Child Health Block Grant

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$637,000,000	$638,200,000	$638,200,000	---
FTE	34	36	36	---

Authorizing Legislation - Social Security Act, Title V

FY 2017 Authorization $850,000,000

Allocation Methods:

- Direct federal/intramural
- Contract
- Formula grant/cooperative agreement
- Competitive grant/cooperative agreement

Program Description and Accomplishments

The mission of the Maternal and Child Health (MCH) Services Block Grant program (hereafter referred to as 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. The MCH Block Grant program funds, combined with state investments, provide the most significant funding source to help reduce health disparities, improve access to health care, and improve the quality of health care for the MCH populations in 59 states and territories. Specifically, the MCH Block Grant program is mandated to:

- Assure access to quality care, especially for those with low-incomes or limited availability of care;
- Reduce infant mortality;
- Provide and ensure access to comprehensive prenatal and postnatal care to women (especially low-income and at risk pregnant women);
- Increase the number of children who receive regular health assessments and, when indicated, diagnostic and treatment services and appropriate follow-up.
- Provide and ensure access to preventive and primary care services for low income children as well as rehabilitative services for children with special health needs;
- Implement family-centered, community-based, systems of coordinated care for children with special health care needs (CSHCN); and
- Provide toll-free hotlines and assistance with applying for services to pregnant women with infants and children who are eligible for Title XIX (Medicaid).

Through the MCH Block Grant program, HRSA distributes funding to the states, provides oversight by requiring states to report progress annually on key MCH performance/outcome measures and indicators, and offers technical assistance to states to improve performance. Each state is responsible for determining its MCH priorities, based on the findings of a comprehensive Needs Assessment every five years, targeting funds to address the identified priorities and reporting annually on its progress. The State MCH Block Grant program emphasizes accountability in ensuring that states meet the legislative and programmatic requirements while providing appropriate flexibility for each state to address the unique needs of its MCH population. State programs use their federal MCH block grants to support the following types of activities:

- State and local capacity and health care and public health systems building,
- Public education, knowledge development, outreach and program linkage, technical assistance, provider training, evaluation,
- Support for newborn screening and genetic services, lead poison prevention and injury prevention,
- Additional support services for children with special health care needs,
- Health and safety promotion in child care settings, and
- Community capacity building to deliver such enabling services as care coordination, transportation, home visiting, and nutrition counseling.

Specific examples of how States are using their Title V funds to support the above cited activities include:

- Minnesota's Center for Workforce Development provides a wide range of training, services, and resources to build State MCH staff capacity and competencies.
- Puerto Rico is implementing telemedicine technology with the mainland to expand genetic services to remote areas of the island.
- In West Virginia, the Oral Health Program maintains a surveillance system for children and pregnant women to assess progress and assure evidence-based program planning.
- Michigan is working with primary care providers, local health departments and families to assure appropriate follow-up and care for lead-poisoned children statewide.
- Nebraska's Title V program is a significant source of support for the Newborn Screening Program, which provides high quality screening and follow up services.

The MCH Block Grant program also serves as the payer of last resort. In cases where no resources or services are available, states use their MCH block grant to fund direct care services, such as prenatal care, pediatric specialty care, or services for children with special health care needs. The majority of MCH Block Grant program dollars are used by states to fund services often times not covered by public or private health insurance, such as dental services, physical and occupational therapy, and durable medical equipment (e.g., wheelchairs, walkers, and orthotics). In an era of expanding health care coverage under the Patient Protection and Affordable Care Act (ACA), State MCH Block Grant programs assure continuity of care and reduce coverage gaps created by shifts in the insurance eligibility status of individuals.

Program Transformation

In FY 2013, the Maternal and Child Health Bureau (MCHB) initiated efforts to transform the State MCH Block Grant program in order to ensure its continued effectiveness and improve the

program's ability to to respond to current and future needs facing the nation's mothers and children, including children with special health care needs. Another goal of the transformation was to reduce the reporting burden of states and territories while holding states accountable for delineating the specific role played by MCH block grants on improving the health and well-being of state MCH populations. State burden was reduced by realigning and streamlining needs assessments, annual reports, and application processes and improving user friendliness of the Title V Information System (TVIS). State accountability was improved by:

- Requiring separate accounting of federal and state MCH block grant resources to enable states to report specifically on the impact of their federal MCHB block grant resources.
- Distinguishing reimbursable direct services from non-reimbursable primary and preventive services and public health services,
- Using a clear logic model in the selection of state priorities, national and state-specific performance measures, and the State Action Plan, and
- Implementing a new performance measurement framework made up of a limited number of meaningful national and state-specific evidence-based measures. The new performance measurement framework will help states tell a coherent story of how Title V is impacting their MCH populations and enable MCHB to explain how Title V and improves the health and well-being of the nation's MCH populations.

The MCH Block Grant transformation also sought to ensure that states retain flexibility in how they use and report on their MCH block grants. States determine their own needs assessment process, identify their top 7 to10 priorities, and select 8 of the 15 new national performance measures. Further information on the transformation of the State MCH Block Grant program can be found at http://mchb.hrsa.gov/blockgrant/index.html.

Building State MCH Data Reporting Systems

The MCHB continues to work with the State MCH Block Grant programs to expand their MCH data capacity and to provide needed technical support for addressing the performance and programmatic requirements of the MCH Block Grant program. Since 2003, TVIS has provided a Web-based interface for the annual submission of the State MCH Block Grant program Applications and Annual Reports. Integrated with HRSA's grants management system (the HRSA Electronic Handbooks (EHBs)), TVIS makes available to the public, through its web reports, the key financial, program, performance, and health indicator data reported by states.

A new TVIS data entry system was developed for states to use in completing their FY 2016 Application/FY 2014 Annual Reports. The redesigned TVIS aligns the electronic Application/Annual Report preparation/submission process with the new reporting requirements developed as part of the program's transformation process.

Special Projects of Regional and National Significance (SPRANS) and Community Integrated Service Systems (CISS)

In addition to the State MCH Block Grant program, SPRANS and CISS grants also support improved health care of mothers and children. SPRANS projects support national needs/priorities and emerging issues, have regional or national significance, and demonstrate ways to improve state systems of care for mothers and children. These projects support technical

assistance and resources for State MCH Block Grant programs, quality improvement projects to improve health outcomes and systems of care, and projects that improve coordination of services on the local and state levels. Under SPRANS, Congressional appropriations action has set-aside funds specifically in four areas:

1. **Oral Health:** To improve perinatal and infant health;

2. **Epilepsy:** To improve access to quality services and transition care for children and youth with epilepsy in underserved areas;

3. **Sickle Cell:** To improve care coordination for children and families affected by sickle cell disease; and

4. **Fetal Alcohol Syndrome Demonstration:** To decrease the prevalence of alcohol use during pregnancy through provider and consumer education.

As required in the Title V authorizing legislation, SPRANS support research by:

- Driving practice advancement and performance measurement to support the State MCH Block Grant program; training to assure that the practicing and future workforce are meeting the needs of the MCH population;
- Genetic disease testing, counseling, and information development and dissemination programs;
- Screening newborns for sickle cell anemia, and other genetic disorders and follow-up services;
- Supporting hemophilia treatment centers; and
- Maternal and child health improvement projects in the areas of maternal and women's health, child and adolescent health, CSHCN, and state and local implementation and coordination.

CISS projects (through grants, contracts, and other mechanisms) seek to increase the capacity for service delivery at the local level and to foster formation of comprehensive, integrated, community level service systems for mothers and children using one or more of the following 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;
- Improve early childhood system performance measures and sustainability in children's developmental health and family well-being;
- Operate MCH centers under the direction of not-for-profit hospitals;
- Increase MCH projects in rural areas; and
- Provide outpatient and community-based services for CSHCN.

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

MCH Activities	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
State Block Grant Awards	$549,631	$550,831	$550,831
SPRANS	$77,093	$77,093	$77,093
CISS	$10,276	$10,276	$10,276
Total	$637,000	$638,200	$638,200

Table 2. Maternal and Child Health Block Grant SPRANS Set-Aside Grants ($ in thousands)

MCH SPRANS Set-Aside Programs	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
SPRANS	$66,238	$65,013	$65,013
SPRANS - Oral Health	$3,775	$5,000	$5,000
SPRANS – Epilepsy	$3,642	$3,642	$3,642
SPRANS - Sickle Cell	$2,961	$2,961	$2,961
SPRANS - Fetal Alcohol Syndrome Demo	$477	$477	$477
Total SPRANS	$77,093	$77,093	$77,093
CISS	$10,276	$10,276	$10,276

Accomplishments - State MCH Block Grant Program

As a longstanding source of funding for MCH populations, the State MCH Block Grant program supports a wide range of services for millions of children annually. By working to improve access to quality health care and services, the State MCH Block Grant program was able to exceed its FY 2013 target by serving 34.3 million children.

The number of children served by the State MCH Block Grant program fluctuates, with totals ranging between 33.3 million (FY 2009) and 37.4 million (FY 2011).

In recognition of the need for more consistent and accurate data reporting on the number of pregnant women, infants, children, children with special health care needs and others within a state's MCH population who have been reached by a Title V service, reporting requirements have been revised as part of the recent transformation of the State MCH Block Grant program. Since reporting of Title V program participant data began in the 1990s, State MCH programs have seen a shift in the delivery of services from direct, reimbursable health care to population-based preventive screenings and services that are delivered within well-coordinated and comprehensive systems of care. For this reason, a new reporting form was developed to enable states to better capture the "reach" of their Title V programs in serving the MCH population, including the population-based services that may not be individually reimbursed. States began using the new reporting form in developing their Annual Reports.

Of the total number of children who received a State MCH Block Grant program service in FY 2013, 14.9 million children had Medicaid and CHIP coverage. The number of children served by the State MCH Block Grant program with Medicaid/CHIP coverage was slightly less than the program target of 15 million.

Increased coverage under Medicaid and CHIP for children receiving State MCH Block Grant program services assures better access, availability, and continuity of care to a wide range of preventive and acute care services. State reporting on the primary source of insurance coverage

for children served by Title V is linked to the reporting of an unduplicated count of individuals who received reimbursable direct and enabling services. The estimated number of children who are covered by Medicaid or CHIP and who received a direct or enabling Title V service has declined, as states are providing fewer direct services. Despite improved access, State MCH Block Grant continues to play an important role as payer of last resort to address gaps in coverage and services left by Medicaid/CHIP and other third-party payers and great progress has been made on MCH outcomes. The infant mortality rate is down to 5.8 per 1,000, far exceeding the 6.6 per 1,000 target for 2014. The percent of women receiving prenatal care in the first trimester is 76.7 percent in 2014, up from 69 percent in 2006.

Accomplishments - SPRANS Activities in the MCH Block Grant Program

Over the past year, many grants funded under SPRANS have been strengthened by better aligning their goals to support the programmatic transformation of the State MCH Block Grant program. Programs have been redesigned to directly support state grantees by providing evidence-based resources for the development of performance measures, training to ensure states have a knowledgeable workforce, and adequate data to monitor program impact.

A notable example of the accomplishments of a SPRANS set-aside is a Collaborative Improvement and Innovation Network (CoIIN) to reduce infant mortality. The Infant Mortality CoIIN was launched in the U.S. Department of Health and Human Services' (HHS) Region IV and Region VI states in FY 2012 and in Region V in FY 2013. Expansion of the Infant Mortality CoIIN to the remaining HHS regions occurred in FY 2014. In order to support this important project, HRSA has been working collaboratively with the Association of State and Territorial Health Officials, the Association of Maternal and Child Health Programs, CityMatCH, the March of Dimes and other non-federal/federal partners, including the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), and the National Institute for Children's Health Quality.

In FY 2015, the CoIIN moved from a regional to a national approach, and states identified the following six strategic priority topic areas to reduce infant mortality and improve birth outcomes:

1. **SIDS/SUID/Safe Sleep:** To improve safe sleep practices;

2. **Smoking Cessation:** To reduce smoking before, during and/or after pregnancy;

3. **Preconception/Interconception Health:** To promote healthy birth spacing and reduce unintended pregnancy, including a focus on Postpartum Visits (content and frequency), Adolescent Well Visits (content and frequency) and Long Acting Reversible Contraception (LARC);

4. **Prevention of Preterm and Early Term Births:** To reduce early elective deliveries and increase appropriate use of 17 OH progesterone, a drug used to prevent preterm birth;
5. **Risk Appropriate Perinatal Care (Perinatal Regionalization):** To increase the delivery of higher risk infants and mothers at appropriate level facilities; and

6. **Social Determinants of Health:** To incorporate evidence-based policies/programs and place-based strategies to improve social determinants of health and equity in birth outcomes.

States have long been engaged in activities to reduce infant mortality and to address the disparities that exist among racial groups relative to birth outcomes. The CoIIN provides a platform for states to engage in collaborative learning across state lines as 'cyberteams', apply quality improvement methods, and spread policy and program innovation, which in turn accelerates improvement in shared strategies that are impacting to birth outcomes. For example, states shared best practices and lessons learned around non-payment (at the payer level) and hard-stop (at the hospital level) policies for early elective delivery, Medicaid reimbursement and referrals for smoking quit-lines for pregnant women, and even SAS codes to capture real-time data from vital statistics to drive real-time improvements. Key elements of a CoIIN include: 1) reliance on distance-based technology for almost all team activities; 2) expectation of transparency and rapid, on-going communication across all levels of the team with its members being part of the solution; and 3) commitment to sharing and using "real time" data to drive improvement and decision making.

After two years of participation, states in Region IV and Region VI showed about a 12 percent total decline in smoking during pregnancy, translating to approximately 18,000 fewer women smoking in pregnancy since 2011. These states also showed about 29 percent total decline in non-medically indicated early term deliveries, translating to approximately 85,000 early, elective deliveries averted since 2011. The Infant Mortality CoIIN can serve as a successful platform for states to collaborate and share lessons learned/best practices, which collectively drive improvements in pre-/early-term births and low birth weight infants.

Funding History

FY	Amount
FY 2008	$666,155,000[179]
FY 2009	$662,121,000[180]
FY 2010	$660,710,000
FY 2011	$656,319,000
FY 2012	$638,646,000
FY 2013	$604,917,000
FY 2014	$632,409,000
FY 2015	$637,000,000
FY 2016	$638,200,000
FY 2017	$638,200,000

Budget Request

The FY 2017 Budget requests $638.2 million for the MCH Block Grant program, the same as FY 2016 Enacted level. The MCH Block Grant program is the only federal program that focuses

179 Reflects moving $20 million to the Autism and Other Developmental Disorders Program.

180 Reflects moving $6.9 million to the Newborn Screening for Heritable Disorders Program.

solely on improving the health of all mothers, adolescents and children, whether insured or not, through a broad array of public health and community-based programs that are designed and carried out through well-established federal/state partnerships. The Budget Request will support State MCH Block Grant programs serving as a safety net for uninsured and underinsured children, including CSHCN, through capacity and infrastructure building, population-based and enabling services, and the provision of direct healthcare services as a payer of last resort.

MCHB will continue to monitor emerging issues and areas of needed technical assistance in providing technical support to the states. In addition, MCHB will continue to explore promising models and effective strategies that promote improved maternal and child health outcomes.

SPRANS will continue to support oral health, epilepsy, sickle cell, and fetal alcohol, as well as research, training, genetics, hemophilia, and maternal and child health improvement projects in the areas of: collaborative and quality improvement efforts in MCH programs; applied and translational research that has the potential to improve health services and care delivery; MCH workforce training in areas such as pediatric pulmonary centers, behavioral health, nutrition, schools of public health and adolescent health; and a variety of other MCH leadership and improvement efforts. SPRANS and CISS both complement and help ensure the success of the State MCH Block Grant, Medicaid, and CHIP programs, building community capacity to create family-centered, integrated systems of care for mothers and children, including children with special healthcare needs. In addition, the MCH Block Grant program funds the only statutorily required genetic services program. This program funds initiatives to facilitate the adoption of genomic advances into clinical care and public health systems to improve the health of the population.

CISS will continue to fund the Early Childhood Comprehensive Systems Impact and the Early Childhood Comprehensive Systems CoIIN Technical Assistance Center to achieve performance improvements and sustainability for children's developmental health (developmental surveillance, screening, referral and follow-up) for children birth to five aligning with the MCH Block Grant program developmental screening measure and family well-being (maternal depression surveillance, screening, referral and follow-up). CISS will also continue to fund the ACF/HRSA National Center for Early Childhood Health and Wellness and National Center for Early Childhood Quality Assurance which will create resources, provide technical assistance, and promote best practices for building health and wellness and supporting school readiness for the youngest children.

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

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
10.I.A.1: The number of children served by the Maternal and Child Health Block Grant *(Output)*	FY 2013: 34.3M Target: 30M (Target Exceeded)	34M	34M	Maintain
10.I.A.2: Increase the number of children receiving Maternal and Child Health Block Grant services who are enrolled in and have Medicaid and CHIP coverage *(Output)*	FY 2013: 14.9M Target: 15M (Target Not Met)	15M	15M	Maintain

Long Term Objective: Promote outreach efforts to reach populations most affected by health disparities

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
10.IV.B.1: Decrease the ratio of the Black infant mortality rate to the White infant mortality rate *(Output)*	FY 2014: 2.4 to 1[181] Target: 2.1 to 1 (Target Not Met)	2.0 to 1	2.0 to 1	Maintain

[181] Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2014 on CDC WONDER Online Database, released 2015. Data are from the Multiple Cause of Death Files, 1999-2014, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.
Detailed Technical Notes prepared by the National Center for Health Statistics, Centers for Disease Control and Prevention. User Guide to the 2014 Natality Public Use File.

Long Term Objective: Promote effectiveness of healthcare services.

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
10.III.A.1: Reduce the infant mortality rate (Baseline - 2005: 6.9/1,000) *(Outcome)*	FY 2014: 5.8 per 1,000[182] Target: 6.6 per 1,000 (Target Exceeded)	5.8 per 1,000	5.6 per 1,000	-0.2 per 1,000
10.III.A.2: Reduce the incidence of low birth weight births *(Outcome)*	FY 2014:[183] 8.0% Target: 8.1% (Target Exceeded)	7.8%	7.8%	Maintain
10.III.A.3: Increase percent of pregnant women who received prenatal care in the first trimester *(Outcome)* (New Baseline- FY 2006: 69%)[184]	FY 2014: 76.7%[185] Target: 72% (Target Exceeded)	76%[186]	76%	Maintain
10.III.A.4: Increase percent of very low-birth weight babies who are delivered at facilities for high-risk deliveries and neonates *(Outcome)*	FY 2013: 80.9%[187] Target: 77% (Target Exceeded)	80%[188]	82%	+2% point

[182] Murphy SL, Kochanek KD, Xu JQ, Arias E. Mortality in the United States, 2014. NCHS data brief, no 229. Hyattsville, MD: National Center for Health Statistics. 2015.
[183] Detailed Technical Notes prepared by the National Center for Health Statistics, Centers for Disease Control and Prevention. User Guide to the 2014 Natality Public Use File.
[184] A new FY 2006 baseline was established for this measure based on the use of the 2003 Revised U.S. Standard Birth Certificate; baseline included 19 states.
[185] Detailed Technical Notes prepared by the National Center for Health Statistics, Centers for Disease Control and Prevention. User Guide to the 2014 Natality Public Use File; includes 47 states and the District of Columbia.
[186] Beginning with the FY 2016 Application, states will implement a new performance measure framework in the Maternal and Child Health Block Grant program. This framework consists of National Outcome measures, National Performance measures, State-specific Evidence-based or –informed Strategy Measures and State Performance Measures. This measure is National Outcome Measure #1 in the new performance measure framework.
[187] Source: State FY 2016 MCH Block Grant Applications/FY 2014 Annual Reports, To Be Available in the Title V Information System in April 2016, HRSA/MCHB
[188] Beginning with the FY 2016 Application, states will implement a new performance measure framework in the Maternal and Child Health Block Grant program. This framework consists of National Outcome measures, National Performance measures, State-specific Evidence-based or –informed Strategy Measures and State Performance Measures. This measure is National Performance Measure #3 in the new performance measure framework. While the data source will change from state-reported data in the TVIS to linked birth certificate and hospital data on Neonatal Intensive Care Unit (NICU) levels from the American Academy of Pediatrics, the new data will not be available for FY 2016 and FY 2017 reporting. Through FY 2017, states will continue reporting on the previously used National Performance Measure #17 in the TVIS.

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
10.3: Reduce the maternal mortality rate. (deaths/100,000 live births) *(Outcome)*[189]	FY 2007: 12.7 per 100,000[190]	N/A	N/A	N/A

Grant Awards Table – Maternal and Child Health Block Grant

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	59	59	59
Average Award	$9,149,167	$9,159,337	$9,159,337
Range of Awards	$145,747 - $38,936,427	$145,909 - $39,147,524	$145,909 - $39,321,873

State Table

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
	FY 2015 Final[191]	FY 2016 Estimate[192]	FY 2017 Estimate[193]	Difference +/- 2016
Alabama	11,315,300	11,276,093	11,294,665	18,572
Alaska	1,057,421	1,053,258	1,059,975	6,717
Arizona	7,234,630	7,303,265	7,283,634	-19,631
Arkansas	6,896,166	6,905,775	6,903,200	-2,575
California	38,936,427	39,147,524	39,321,873	174,349
Colorado	7,460,860	7,456,536	7,403,302	-53,234
Connecticut	4,613,166	4,629,410	4,631,467	2,057

[189] This is a long-term measure with no annual targets. Wording for this measure has been changed from "Increase maternal survival rate" in order to more accurately reflect data being reported.
[190] Vital statistics compiled by the National Center for Health Statistics, Centers for Disease Control and Prevention. Deaths: Final Data for 2007, Vol. 58, No. 19, May 2010.
[191] Based on ACS 2012 3-year poverty data.
[192] Based on ACS 2013 3-year poverty data.
[193] Based on ACS 2014 3-year poverty data calculated from 1-year poverty data.

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
	FY 2015 Final[191]	FY 2016 Estimate[192]	FY 2017 Estimate[193]	Difference +/- 2016
Delaware	1,961,019	1,960,646	1,965,465	4,819
District of Columbia	6,899,220	6,897,434	6,892,960	-4,474
Florida	19,129,465	19,244,714	19,282,195	37,481
Georgia	16,838,159	16,903,839	16,993,045	89,206
Hawaii	2,176,627	2,171,208	2,157,596	-13,612
Idaho	3,273,054	3,264,072	3,261,071	-3,001
Illinois	21,169,426	21,197,892	21,095,865	-102,027
Indiana	12,201,282	12,224,243	12,174,324	-49,919
Iowa	6,503,197	6,501,721	6,469,314	-32,407
Kansas	4,758,053	4,761,787	4,742,712	-19,075
Kentucky	11,034,716	10,999,903	10,988,522	-11,381
Louisiana	12,066,481	12,077,148	12,084,598	7,450
Maine	3,321,552	3,313,486	3,315,551	2,065
Maryland	11,661,318	11,691,806	11,690,943	-863
Massachusetts	11,009,429	11,053,633	11,059,498	5,865
Michigan	18,938,920	18,891,020	18,777,302	-113,718
Minnesota	9,097,317	9,064,009	9,057,396	-6,613
Mississippi	9,218,562	9,202,426	9,193,974	-8,452
Missouri	12,123,009	12,150,428	12,136,674	-13,754
Montana	2,281,321	2,286,941	2,281,464	-5,477
Nebraska	4,010,626	4,003,137	3,993,946	-9,191
Nevada	2,085,007	2,082,309	2,098,413	16,104
New Hampshire	1,986,075	1,980,782	1,992,667	11,885
New Jersey	11,325,376	11,424,144	11,492,418	68,274
New Mexico	4,075,190	4,075,115	4,074,966	-149
New York	37,703,066	37,817,316	37,875,286	57,970
North Carolina	17,278,043	17,281,079	17,278,293	-2,786
North Dakota	1,734,089	1,728,579	1,727,708	-871
Ohio	22,093,612	22,022,741	21,976,303	-46,438
Oklahoma	6,987,356	6,978,340	6,977,740	-600

CFDA NUMBER/PROGRAM NAME: 93.994/Maternal and Child Health Block Grant				
	FY 2015 Final[191]	**FY 2016 Estimate[192]**	**FY 2017 Estimate[193]**	**Difference +/- 2016**
Oregon	6,260,735	6,246,783	6,235,732	-11,051
Pennsylvania	23,527,801	23,517,894	23,531,854	13,960
Rhode Island	1,632,138	1,639,222	1,628,694	-10,528
South Carolina	11,405,088	11,426,631	11,437,127	10,496
South Dakota	2,141,823	2,150,948	2,150,635	-313
Tennessee	11,697,682	11,714,942	11,752,732	37,790
Texas	34,063,619	34,049,109	33,994,518	-54,591
Utah	6,180,631	6,172,460	6,139,697	-32,763
Vermont	1,649,675	1,643,127	1,648,515	5,388
Virginia	12,072,934	12,106,723	12,156,825	50,102
Washington	8,846,149	8,853,961	8,862,892	8,931
West Virginia	6,056,026	6,061,409	6,064,946	3,537
Wisconsin	10,901,696	10,862,600	10,874,527	11,927
Wyoming	1,213,011	1,212,084	1,196,633	-15,451
SUBTOTAL	**520,103,545**	**520,681,652**	**520,681,652**	**0**
American Samoa	485,820	486,361	486,361	0
Guam	750,323	751,158	751,158	0
Marshalls	226,715	226,967	226,967	0
Micronesia	512,812	513,381	513,381	0
Northern Marianas	458,831	459,341	459,341	0
Palau	145,747	145,909	145,909	0
Puerto Rico	15,643,430	15,660,816	15,660,816	0
Virgin Islands	1,473,657	1,475,295	1,475,295	0
SUBTOTAL	**19,697,335**	**19,719,228**	**19,719,228**	**0**
TOTAL Resources	**539,800,880**	**540,400,880**	**540,400,880**	**0**

Autism and Other Developmental Disabilities

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$47,099,000	$47,099,000	$47,099,000	---
FTE	7	7	7	---

Authorizing Legislation - Public Health Service Act, Section 399BB, reauthorized by Public Law 113-157, Section 4

FY 2017 Authorization ..... Not Specified

Allocation Methods:

- Direct federal/intramural
- Contract
- Competitive grant/cooperative agreement
- Other

Program Description and Accomplishments

In 2014, the Combating Autism Act was reauthorized as the Autism Collaboration, Accountability, Research, Education and Support, or Autism CARES, Act. The goals of the CARES Act are to improve the health and well-being of children and adolescents with autism spectrum disorder (ASD) and other developmental disabilities (DDs) and to advance best practices for the early identification and treatment of autism and related developmental disabilities. MCHB's CARES Act Program addresses areas of particular interest to the families and needs of underserved populations. FY 2016 funding will support 45 Leadership Education in Neurodevelopmental and Related Disabilities (LEND) interdisciplinary training programs, providing services and training to approximately 40 states, with many extending training and services across multiple states; ten Developmental-Behavioral Pediatrics (DBP) training programs; five research networks and eight autism intervention research projects; six state systems grants that provide support to improve the system of health care including early identification and coordination of care; two resource centers; and a national evaluation. All activities continue to be coordinated with the CDC's activities and with priorities of the Interagency Autism Coordinating Committee (IACC).

This Program supports activities to:

- Provide information and education on ASD and other DDs to increase public awareness;
- Promote research and information distribution on the development and validation of reliable screening tools and interventions for autism spectrum disorder and other developmental disabilities;
- Promote early screening of individuals at higher risk for autism spectrum disorder and other developmental disabilities as early as practicable, given evidence-based screening techniques and interventions;

- Increase the number of professionals who are able to confirm or rule out a diagnosis of autism spectrum disorder and other developmental disabilities; and
- Increase the number of professionals able to provide evidence-based interventions for individuals diagnosed with autism spectrum disorder or other developmental disabilities.

Progress Report – Selected Findings

In October 2013, HRSA submitted a detailed account of its progress on its autism activities from 2008-2011 in a report to congress titled *Results of the Combating Autism Act Initiative: HRSA's Efforts to Improve ASD Service Delivery Through Research, Training, and State Implementation Grants Fiscal Year(s) 2008-2011*. A new HRSA study starting with investments from September 30, 2011 to present is currently underway. Findings from this study contributed to the HHS 2013 Report to Congress. Selected findings from the completed evaluation follow. Additional data are also included to provide updates on progress.

Progress Report - Training

To address the shortage of health care professionals qualified to provide screening and diagnostic evaluation for ASD and other DDs, the LEND and DBP programs have expanded the number of professionals in the pipeline to provide these services. In addition, these training programs increased the number of children who received diagnostic evaluations.

From FY 2009-2013, these programs collectively trained over 6,400 pediatricians, developmental-behavioral pediatrics specialists, and other health professionals. They provided more than 3,400 continuing education events (reaching over 306,000) and more than 9,200 outreach trainings (reaching over 285,000) to community pediatricians and other health professionals on early screening, early diagnosis, and early intervention. In all, over 224,000 children received diagnostic evaluations from these programs between FY 2009-2013.

The LEND and DBP programs expanded their training resources and assisted local agencies and practices in building their capacity to provide community-based ASD services. The LEND and DBP programs expanded the number of professionals in the pipeline by:

- Increasing the number of trainees enrolled in their programs. In the 2011-2012 grant year, the LEND and DBP programs collectively trained 3,039 medium-term and 1,474 long-term trainees.[194]
- Increasing the number of trainees that received ASD-focused didactic training. Between the 2009–2010 and 2010-2011 grant years, the number of medium-term trainees enrolled in ASD-focused coursework increased by 8.2 percent and the number of long-term trainees increased by 13.6 percent.
- Providing more clinical training opportunities focused on ASD screening and diagnosis. In the final year of the grant, close to 1,500 medium-term trainees and more than 1,100 long-term trainees had participated in clinical practices covering ASD screening, diagnostic evaluation, and/or intervention.

[194] Medium-term trainees are those who complete between 40 and 299 hours of training during one academic year. Long-term trainees are those who complete more than 300 hours of training.

The LEND and DBP programs also responded to the training needs of practicing pediatricians and other professionals who had limited experience identifying ASD in children. Between fiscal years 2009 and 2011, the LEND and DBP grantees collectively offered more than 1,600 continuing education (CE) events pertaining to ASD screening, diagnostic evaluation, and evidence-based interventions for children with ASD. In fiscal year 2012, the LEND and DBP grantees provided 917 CE events. From fiscal years 2009-2011, these grantees also offered more than 4,000 outreach trainings related to valid and reliable screening and diagnostic tools, and/or evidence-based interventions for ASD and other DDs, with the numbers increasing from year to year. From fiscal years 2009-2013, they provided more than 3,400 continuing education events (reaching over 306,000) and more than 9,200 outreach trainings (reaching over 285,000) to community pediatricians and other health professionals on early screening, early diagnosis, and early intervention.

Progress Report - Research

To improve the health and well-being of children with ASD, the research grantees (both research networks and investigator-initiated autism intervention research projects) conduct studies designed to advance the evidence base on effective interventions, with the long-term goal of improving the health and well-being of children and adolescents with ASD and other DDs. Consistent with HRSA's mission and MCHB strategic priorities, many studies focus on the unique and unaddressed needs of underserved populations by considering ethnic/racial, cultural, linguistic, socioeconomic, literacy and geographic (e.g., rural/urban) diversity of individuals.

The research grantees conducted studies addressing such topics as the efficacy of ASD interventions, early identification of ASD in minority populations, family well-being, and transition. Additionally, they developed consensus-based guidelines and tools to support families and professionals in providing treatment for children with ASD. These tools may, for example, help to quickly assess a child's engagement level on the playground or help parents manage their children's sleep behavior. To date, over one hundred journal articles have been published by the research grantees, thus contributing to the evidence base on the effectiveness of different interventions targeted to diverse populations.

The Autism Intervention Research Network on Physical Health (AIR-P Network) has provided national leadership to strengthen the evidence base for interventions through research, development of clinical practice guidelines, and the dissemination and transfer of findings on interventions, guidelines, tools, and systems management approaches into practice settings and communities in order to promote the implementation of evidence-based practices and improve care. The AIR-P Network has developed three clinical guidelines on insomnia, constipation, and medication choice and has implemented intensive quality improvement efforts to advance the content and process of health care and improve clinical outcomes for individuals with ASD.

In collaboration with all HRSA/MCHB funded autism intervention research programs, the AIR-P Network spearheaded the development of a journal supplement on HRSA autism intervention research findings. The journal supplement was published in *Pediatrics* in November 2012 and covers a rich and diverse compilation of research and practice improvement related to the care and well-being of children and youth with autism and related neurodevelopmental disorders. A

second journal supplement on HRSA autism intervention research findings is expected for publication in early 2016.

The Autism Intervention Research Network on Behavioral Health (AIR-B Network) has established strong partnerships with underserved and under-represented communities and schools in order to provide better behavioral and social outcomes for children with ASD and to equip parents, professionals, educators, and community members with effective interventions that are practical and feasible in real-world settings. The AIR-B Network developed a comprehensive consensus-based guidelines report assessing the scientific evidence on behavioral, educational, and medical interventions and their impact on ASD symptoms, published in November 2012.

The AIR-B Network developed tools to track a child's progress and assess the effectiveness of behavioral ASD interventions over time. These new measures can be used by care providers, parents, and teachers in family and school settings serving diverse populations.

The Developmental-Behavioral Pediatrics Research Network (DBPNet) has established a collaborative scientific and clinical research network to foster research activities to improve care and treatment for children with ASD and other developmental disabilities.[195] DBPNet has developed the national research agenda for DBP research and has completed two studies on Research Training in DBP fellowship programs and the Nature of Referrals to DBP clinicians. The DBPNet has successfully leveraged NIH funding for support of a multi-site protocol on use of family navigators to reduce disparities in timely autism diagnosis and access to early intervention.

The MCH Research Network on Promoting Healthy Weight (HW-RN) among Children with ASD/DD is an interdisciplinary research network that coordinates research activities related to promoting healthy weight among children and youth with ASD/DD. This network, first funded in July 2013, has developed a national research agenda focusing on best practices around preventing overweight and obesity; implemented two intervention programs (a group-based physical activity program using video conferencing and a family based treatment program); conducted secondary data analyses to advance our understanding of risk factors in this vulnerable population; and disseminated a quarterly Research Digest, which is a compilation of the latest publications and innovations in the field for researchers, practitioners, and families.

The Health Care Transitions Research Network (HCT-RN) for Youth and Young Adults with ASD, first funded in September 2014, supports an interdisciplinary, multi-center research forum for scientific collaboration and infrastructure-building, with a focus on research designed to improve health care transitions and promote an optimal transition to adulthood among youth and young adults with ASD, including optimal physical, psychosocial, educational, and vocational outcomes.

The R40 Autism Intervention Research Program focuses on advancing the evidence base on the effectiveness of interventions and improving the research base that will lead to best practices for

[195] Blum, N.J.; DBPNet Steering Committee (2012) The Developmental-Behavioral Pediatrics Research Network: another step in the development of the field**.** 33(1):78-83.

early identification and access to treatment for children and youth with ASD and other DDs and their families. Consistent with HRSA's goal of improving health equity, the program has focused on the needs of underserved populations by considering ethnic/racial, cultural, linguistic, socioeconomic, literacy and geographic (e.g., rural/urban) diversity of individuals. This focus addresses the need for more research on the effectiveness of interventions among these underserved populations for whom disparities in the identification of ASD and other DDs currently exist. Significant R40 research projects have developed and tested: intervention strategies for improving the health care transition for youth with ASD; a culturally compatible parent-to-parent model of support and service coordination for families with a preschool child with ASD; strategies to improve family support and well-being; teleconsultation training for parents to perform Applied Behavior Analysis (ABA) therapy for their rural, underserved children with ASD; and a home-based intervention for rural families to address barriers to accessing early intervention.

Progress Report - State Systems Grants

State systems grants are designed to improve access to comprehensive, coordinated health care and related services for children and youth with ASD and other DDs. The program facilitates improved state systems of services and the implementation of activities focused on improving early and continuous screening, coordination of family-centered services through a medical home, and increasing ASD/DD awareness with parents and professionals. States implemented different approaches in their efforts to improve services. Strategies included: partnering with existing programs, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to promote regular developmental screenings for this underserved population; training primary care practices on medical home concepts and how to develop care coordination plans for children with special health care needs; developing community-based diagnostic teams to decrease wait times for diagnosis and increase capacity; and implementing quality improvement learning collaboratives to increase early screening and decrease age of entry into services. Highlights of state-specific accomplishments are below:

Promoting Access to Family-Centered Medical Homes

- Colorado: From FY 2011 – FY 2014, the grantee trained more than 100 pediatric and family practices in local communities to increase early identification and timely referral within the medical home.
- Connecticut: From FY 2011 – FY 2014, the grantee implemented a continuous quality improvement plan to promote screening, identification and referral within pediatric medical home practices.
- Maine: From FY 2010 – FY 2013, the grantee developed a curriculum on medical homes for families of children with ASD/DD and delivered 17 face-to-face trainings to a total of 130 families over the course of the grant. Training is also available via webinar for families unable to attend in person.
- Maryland: In FY 2013, the grantee developed a "Screening and Beyond" quality improvement learning collaborative for providers, practices and parents to promote and improve access to family-centered medical homes for children with ASD/DD. Results from the Medical Home Index at the conclusion of the year-long learning collaborative indicated a 40 percent increase in pediatric practices regularly applying medical home

knowledge and concepts and a 13 percent increase in applying family-centered care knowledge and concepts.

HRSA has also supported improving access to comprehensive, coordinated health care and related services for children and youth with ASD and other DDs in rural states through the State Autism Spectrum Disorders and Other Developmental Disabilities Programs. During the period of FY 2011 – FY 2014, many of the grantees in the State Autism Spectrum Disorders and Other Developmental Disabilities Program focused activities on the rural, underserved populations in their states. Some key activities include:

- Mississippi: In collaboration with the Mississippi Southeast Rural Health Initiative, the grantee improved access to services by opening a specialty health care clinic within a rural public school for local residents, thereby reducing their long driving times for screening and referral services.
- Ohio: the grantee conducted a pilot project that used telemedicine to deliver Early Intervention services in underserved counties. The pilot provided coordinated care, including virtual communication between providers and their families, home visits, intervention, and coaching to children with ASD and their families who could not otherwise access such specialized services.
- Alaska: the grantee integrated a set of ASD training modules into distance-based associate and bachelor of social work degree programs in order to improve autism training opportunities in rural areas.

Improving Screening Rates

- Maine: From FY 2010 – FY 2013, the grantee trained 208 physicians in the use of the Modified Checklist for Autism in Toddlers (M-CHAT); M-CHAT screening rates among participating providers increased from 56 percent to 82 percent.
- Colorado: From FY 2011 – FY 2014, the grantee saw an 18 percent increase in pediatric practices conducting screenings, as well as a 50 percent increase in M-CHAT use at 18- and 24-month appointments.
- Connecticut: Between 2011 and 2012, the number of HUSKY Health Program enrollees (state's Medicaid program) receiving a developmental screen between the ages of 0-6 years increased by 29 percent to 27,752.
- Maryland: From FY 2013 – FY 2015, M-CHAT use increased from 75 percent to 94 percent for the pediatric practices participating in Maryland's quality improvement collaborative.
- Vermont: The grantee trained 89 of 103 pediatric primary care practices statewide in ASD screening and follow up. The developmental screening rate following the trainings increased from 41.3 percent in 2009 to 79.2 percent in 2013.
- Virginia: Autism and developmental screenings for children seen by 30 months at the 17 practices that received training increased from 50 percent to 73 percent from August 2014 - January 2015.

Additional Program Accomplishments

Reducing Barriers

An early indication of progress toward the goal of reducing barriers to ASD services is evidenced by reported increases in the number of children that received diagnostic evaluations over the course of the grant period. In 2009–2010, the 39 LEND grantees collectively provided diagnostic evaluations to more than 35,000 children. The following year, the number of diagnostic evaluations provided through a LEND program-affiliated clinic exceeded 44,000. From FY 2009-2013, over 224,000 children received diagnostic evaluations from these programs.

Grantees further worked to improve access to ASD services. To enable more families to get the services they need regardless of their ability to pay, the grantees helped advance health insurance and billing improvements. To create more coordinated systems of care for ASD, they mapped existing resources, identified gaps in services, and promoted interdisciplinary collaboration among providers from different disciplines, such as medicine and education.

The LEND and DBP grantees provided Title V and other agencies with technical assistance to expand community-based services for ASD. The research grantees developed and disseminated ASD toolkits and clinical guidelines to support health care providers and families. In addition, the grantees utilized innovative strategies including telehealth and culturally competent family navigators to reduce barriers and improve access to care for underserved rural and racial/ethnic minority communities.

State systems grantees worked at the local, regional, and state levels to improve access to coordinated, comprehensive, timely, and evidence-based screening, diagnostic, and intervention services for ASD and other DDs. By taking a public health approach that includes identifying available resources and gaps in services, building awareness among professionals and the public of the need for early identification and intervention for ASD, and building a more integrated system of services for ASD, the state grantees have achieved significant gains that will continue to spur improvements past their grant periods.

Awareness Building

To promote early screening, diagnostic evaluation, and intervention, grantees engaged various strategies to build awareness of ASD among providers, parents, and the public. A few are highlighted below:

- To raise public awareness, the state grantees developed web sites and web portals for online dissemination of ASD materials. Additionally, grantees distributed screening kits, autism toolkits, as well as print materials and community resource directories for ASD/DDs to medical providers and other professionals. Family-focused materials included resource roadmaps, directories, navigator guides, and autism guidebooks.

- During the grant period, the LEND and DBP training programs developed and/or disseminated close to 2,000 ASD-related educational products to health care practices and providers, educators, and parents.
- The research grantees reached more than 4,000 health professionals through various training events, such as grand rounds presentations and scientific conference presentations. Collectively, they reached more than 6,000 individuals through community outreach sessions.

GAO Review

In 2012, the GAO reviewed HRSA's oversight of the Combating Autism Act programs. On February 27, 2013, the GAO released its report entitled: "Combating Autism Act: HHS Agencies Responded with New and Continuing Activities, Including Oversight." There were no recommendations from the GAO review, and the full report is available here: http://www.gao.gov/products/GAO-13-232.

Funding History

FY	Amount
FY 2013	$44,652,000
FY 2014	$47,099,000
FY 2015	$47,099,000
FY 2016	$47,099,000
FY 2017	$47,099,000

Budget Request

The FY 2017 Budget Request for the Autism and Other Developmental Disabilities program of $47.1 million is the same as the FY 2016 Enacted level. In FY 2017, MCHB will support 45 LEND training programs, ten developmental-behavioral pediatrics training programs, six state systems grants, five autism intervention research networks, two resource centers, and 8 research grants. Grantees will participate in a national program evaluation and all activities will continue to be coordinated with the Interagency Autism Coordinating Committee and, in particular, with the CDC's Learn the Signs Act Early public awareness campaign.

In FY 2017, funds will be used to continue and expand activities initiated in FY 2008 with a focus on improving access, quality, and systems of care for underserved populations, to:

- Provide information, education and coordination;
- Promote research into evidence-based practices for interventions and early identification and the development of reliable screening tools;
- Promote the development, dissemination and implementation of guidelines;
- Promote early screening and intervention;
- Train providers to diagnose and provide care for individuals with ASD and other DD;
- Develop innovative strategies to integrate and enhance existing investments, including translating research findings on interventions, guidelines, tools and systems management approaches to training settings, communities and into practice; and

- Promote life-course considerations, from developmental screening in early childhood to transition to adulthood issues.

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

Grant Awards Table

	FY 2015 Final	**FY 2016 Enacted**	**FY 2017 President's Budget**
LEND	$28,004,199	$28,990,000	$28,990,000
DBP	$1,833,323	$1,948,555	$1,948,555
Research	$9,557,673	$8,402,301	$8,402,301
State Systems	$2,916,786	$2,700,000	$2,700,000
Resource Centers	$941,201	$1,052,141	$1,052,141
Number of Awards	87	76	76
Average Award	$497,163	$540,779	$540,779

Sickle Cell Services Demonstration Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$4,455,000	$4,455,000	$4,455,000	---
FTE	1	2	2	---

Authorizing Legislation - American Jobs Creation Act of 2004, Public Law 108-357, Section 712(c)

FY 2017 Authorization .....Expired (last authorized in FY 2009)

Allocation Methods:

- Competitive cooperative agreement
- Contract

Program Description and Accomplishments

The Sickle Cell Disease Treatment Demonstration Program (SCDTDP) improves care for individuals with sickle cell disease (SCD) by establishing systemic mechanisms to improve prevention and treatment of SCD and its complications. Strategies to improve care include coordinating service delivery; genetic counseling and testing; technical services bundling; health professionals training; and identifying and establishing efforts to expand and coordinate education, treatment, and continuity of care.

In FY 2014, the program was redesigned to support four geographically distributed Sickle Cell Regional Collaboratives for three years to conduct activities that employ a regionalized approach to improve patient outcomes. The cooperative agreement grantees are university medical centers with hematologists who specialize in SCD treatment and management. The grantees are located in Maryland, Ohio, Missouri and California. Each grantee is responsible for developing a sub-award agreement with a state-level partner in each state in the grantee's region. This approach creates regional collaboratives that use collective impact strategies to create partnerships among grantees, SCD centers, and federally qualified health centers (FQHCs). This expands the national reach of the program, allowing it to improve SCD care delivery and data collection on a broader scale. The objectives of the program are to: 1) increase the number of providers that are treating SCD patients in the region; 2) increase the number of providers prescribing disease-modifying therapies, such as hydroxyurea; and 3) increase the number of SCD patients receiving care from providers who possess adequate knowledge for treating SCD.

Grantees are working to:

- Establish four strong regional collaborations and partnerships and provide sub-awards to lead state-level partners from each state in the region;
- Work with regional stakeholders, including medical associations, community-based SCD organizations, and state government partners, to develop a common agenda to increase the number of providers treating SCD patients, the number SCD patients receiving hydroxyurea, and the number of patients receiving care from knowledgeable providers;
- Provide a communication strategy that engages the entire region;
- Implement quality improvement teams to improve SCD care;
- Develop and implement a regional data collection system that will support a national data system; and
- Provide technical assistance throughout the region.

The grantees are expected to work with HRSA Programs relevant to the project's mission such as the National Coordinating Center, the Sickle Cell Disease Newborn Screening Program and the Regional Genetic and Newborn Screening Collaborative, state Medicaid agencies, state Primary Care Associations and Primary Care Offices in the region, and state-level partners, to form partnerships with community-based organizations in their respective states. The Maternal and Child Health Bureau executed a contract to coordinate data collection efforts of the Sickle Cell Regional Collaborative grantees, including creating a database and a data dictionary for the database. The performance of the grantees will be determined by changes in the number of providers treating SCD patients and changes in providers prescribing hydroxyurea in each funded region.

Life expectancy of persons with SCD has increased but affected populations have not benefitted from therapies equally. In 2008, NIH released a report stating that although hydroxyurea is an effective therapy for the management of SCD, only a limited percentage of SCD patients who could benefit from hydroxyurea has access. Barriers to access include: lack of awareness of the benefits of hydroxyurea, limited number of providers willing to prescribe hydroxyurea, lack of clarity of hydroxyurea treatment regimen, and other barriers at both the provider and patient level. The regional approach will allow HRSA and its partners, including other federal agencies, state agencies, medical organizations, and providers, to leverage existing infrastructure to improve access to hydroxyurea, which is the only FDA approved therapy for SCD, and develop infrastructure that will promote the implementation of evidence-based treatments from the National Heart, Lung, and Blood Institute (NHLBI) Clinical Practice Recommendations. In addition, the SCDTDP grantees will collaborate with grantees from the Sickle Cell Disease Newborn Screening Program to ensure SCD patients have access to knowledgeable providers and to increase hydroxyurea use.

HRSA has strengthened its collaborative efforts with other HHS agencies to improve SCD care. HRSA is currently collaborating with NIH, CDC and other HHS partners to develop a national strategy to adapt and institutionalize NIH-developed SCD clinical management guidelines in practice. This strategy will include identifying data elements that can be used across HHS programs.

Funding History

FY	Amount
FY 2013	$4,419,000
FY 2014	$4,455,000
FY 2015	$4,455,000
FY 2016	$4,455,000
FY 2017	$4,455,000

Budget Request

The FY 2017 Budget requests $4.5 million for SCDTDP, the same as the FY 2016 Enacted level. FY 2017 activities will focus on increasing the number of SCD patients who receive quality care in a medical home by increasing the number of providers treating SCD and increasing the number of providers prescribing hydroxyurea. Specifically, the funds will: 1) support four geographically distributed regional projects with nationwide exposure for enhanced access to comprehensive, coordinated, culturally-effective, and family centered high quality services for individuals with sickle cell disease; 2) expand and upgrade data collection efforts and improve capacity to generate evidence of effectiveness through evaluating network activities and outcomes; and 3) focus on increasing the number of knowledgeable providers that are involved with the care of individuals with sickle cell disease.

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

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	4	4	4
Average Award	$849,963	$849,678	$849,678
Range of Awards	$849,850 – $850,000	$840,000 – $860,000	$840,000 – $860,000

James T. Walsh Universal Newborn Hearing Screening

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$17,818,000	$17,818,000	$17,818,000	---
FTE	3	4	4	---

Authorizing Legislation - Public Health Service Act, Section 399M, as amended by Public Law 111-337, Section 2

FY 2017 Authorization .....Expired (last authorized in FY 2015)

Allocation Methods:

- Competitive grant
- Cooperative agreement

Program Description and Accomplishments

The James T. Walsh Universal Newborn Hearing Screening Program (UNHS) began in FY 2000 with the purpose of assisting states to develop newborn hearing screening and early intervention programs. The program supports the Healthy People 2020 objective to increase the proportion of newborns who are screened for hearing loss no later than age one month, receive an audiologic evaluation no later than age three months, and are enrolled in appropriate intervention services no later than age six months. Additionally, programs have adopted quality improvement strategies to decrease the number of infants lost to follow-up/documentation, such as:

- Improving communications with the infant's medical home provider and specialists;
- Scheduling rescreening and/or audiology appointments for the infant at hospital discharge;
- Streamlining the Early Intervention referral process and obtaining a consent for release of information; and
- Improving data tracking systems.

To implement the program, the Maternal and Child Health Bureau (MCHB) awards 59 competitive grants to states and territories and funds one national technical assistance center. In addition to funds to strengthen state screening efforts and reduce loss-to-follow-up/documentation, supplemental funding has been provided since FY 2009 to a total of 10 Leadership Education in Neurodevelopmental and Related Disabilities (LEND) training programs to expand and augment their pediatric audiology training efforts. Collaboration with the Centers for Disease Control and Prevention (CDC), the Administration for Children and Families, and National Institutes of Health's National Institute on Deafness and Other

Communication Disorders is ongoing to coordinate programs and leverage resources at the national and state levels. In FY 2015, MCHB made awards to 59 state and territorial grantees and one national resource center.

The UNHS has been making progress toward the Healthy People 2020 objectives of screening no later than one month of age, performing audiologic evaluations no later than 3 months of age, and providing interventions no later than 6 months of age. Screening for hearing loss prior to hospital discharge improved from 95 percent in 2005 to 97 percent in 2013.[196] The percent of infants who screened positive with appropriate follow-up also improved from 33 percent in 2005 to 65 percent in 2012 and 74 percent in 2013.[196] However, this improvement is not universal, with loss-to-follow-up and/or documentation rates ranging from 2.5 percent to 77 percent among the states and territories. Most states now have legislation mandating hearing screening for newborns, and most U.S. hospitals have implemented newborn hearing screening programs. However, few states and territories have comprehensive data reporting requirements for service providers (audiologists, clinicians, and early intervention providers), which makes accurate and timely monitoring and documentation of follow-up and intervention difficult. The current UNHS program focuses on supporting timely screening and diagnosis and addressing issues related to loss-to-follow-up/documentation so that all children with or suspected to have a hearing loss receive timely diagnostic and early intervention services, including early access to language development supports.

Funding History

FY	Amount
FY 2013	$17,674,000
FY 2014	$17,818,000
FY 2015	$17,818,000
FY 2016	$17,818,000
FY 2017	$17,818,000

Budget Request

The FY 2017 Budget Request for UNHS of $17.8 million is the same as the FY 2016 Enacted level. The FY 2017 Request will support 59 grant awards and one national resource center cooperative agreement to assist the program in achieving the FY 2017 target of screening 98 percent of infants prior to one month of age. Grantee initiatives will include the following:

- Educational outreach efforts that are culturally and linguistically appropriate (e.g. workshops targeted toward nurses and families, family conferences, and social media);
- Utilization of quality improvement methodology to improve linkages within the system;
- Implementation of interoperable databases to improve the tracking of newborns and infants; and

[196] CDC Data (http://www.cdc.gov/ncbddd/hearingloss/ehdi-data2013.html). 2014 and 2015 data have not been validated and are not yet available.

- Partnerships with pertinent entities that submit hearing screening and audiological follow-up data to the programs (i.e. birthing facilities and audiological centers).

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

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
13.1: Increase the percentage of children with non-syndromic hearing loss entering school with developmentally appropriate language skills.[197] *(Outcome)*	FY 2004: 20% estimated (Baseline)	N/A	N/A	N/A
13.2: Increase the percentage of infants with hearing loss enrolled in early intervention before six months of age.[198, 199] (Baseline – FY 2009: 68%) *(Output)*	FY 2013: 67% Target: 65% (Target Exceeded)	72%	72%	Maintain
13.III.A.1: Percentage of infants suspected of having a hearing loss with a confirmed diagnosis by three months of age. *(Output)*	FY 2013: 69% Target: 65% (Target Exceeded)	77%	77%	Maintain
13.III.A.3: Percentage of infants screened for hearing loss prior to one month of age. *(Output)*	FY 2013: 86% Target: 98% (Target Not Met)	98%	98%	Maintain

[197] This long-term measure does not have annual targets.
[198] CDC has been collecting data annually since 2005. Baseline updated to reflect annual data collection. Previously, data were collected by the National Center for Hearing Assessment and Management.
[199] This measure is to be tracked annually in light of new Part C of the Individuals with Disabilities Act (IDEA) regulations which mandate collaboration with Title V programs and newborn hearing screening programs.

Grant Awards Table[200]

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	60 (59 grants and one cooperative agreement)	60 (59 grants and one cooperative agreement)	60 (59 grants and one cooperative agreement)
Average Award	$236,336 (grants) $1,500,000 (cooperative agreement)	$243,187 (grants) $1,200,000 (cooperative agreement)	$243,187 (grants) $1,200,000 (cooperative agreement)
Range of Awards	$21,677-$262,881 (grants) $1,500,000 (cooperative agreement)	$175,000-250,000 (grants) $1,200,000 (cooperative agreement)	$175,000-$250,000 (grants) $1,200,000 (cooperative agreement)

[200] Does not include $700,000 for LEND supplements and $300,000 for medical home capacity building and support for pediatric audiology supplements. Does not include grant offsets.

Emergency Medical Services for Children

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$20,162,000	$20,162,000	$20,162,000	---
FTE	4	4	4	---

Authorizing Legislation – Public Health Service Act, Section 1910, as amended by Public Law 113-180, Section 2

FY 2017 Authorization $20,213,000

Allocation Method ..... Competitive grant/cooperative agreement

Program Description and Accomplishments

The Emergency Medical Services for Children (EMS-C) Program, established in 1984, is the only federal program that focuses specifically on improving the pediatric components of the emergency medical services (EMS) system. The Institute of Medicine (IOM) and other national experts have stated that there are significant gaps across the country in providing quality care to children in emergencies. Pediatric emergency care begins with the 911 call and continues through the delivery of the patient to the appropriate hospital and the return of the child to the community. The mission of the EMS-C Program is to reduce child and youth mortality and morbidity resulting from severe illness or trauma.

The EMS-C Program currently funds 75 grants to support improvements to pediatric emergency care within 49 states, all territories, the Republics of the Marshall Islands and Palau, and the Federated States of Micronesia). By having a presence across the United States, the program aims to reach its goal of ensuring that all children receive optimal emergency care no matter where they live. Each of these entities works to implement the same prehospital and hospital quality performance measures, representing the largest national effort for standardized pediatric emergency care. The program provides state infrastructure support to address the ongoing variability in care due to geographical, jurisdictional and workforce issues as well as evolving best practices.[201] To improve the quality of pediatric emergency care, the EMS-C Program continues to invest in initiatives that promote evidence-based or evidence-informed pediatric emergency care practices.[202]

The EMS-C Program allocates funds through competitive grants and cooperative agreements to state governments and schools of medicine which are divided into five categories: infrastructure,

[201] Health Affairs (Millwood).2013Dec;32(12):2109-15
[202] Schenk, E & Edgerton, E. A Tale of Two Populations: Addressing Pediatric Needs in the Continuum of Emergency Care. *Annals of Emergency Medicine* (2014).

systems of care, research, innovative best-practices, and data support. The types of grants and cooperative agreements include:

- **State Partnership grants** (states, territories and the Freely Associated States) (58 awards) provide infrastructure funding to ensure quality pediatric care in the prehospital and hospital setting as assessed by program performance measures.[203]
- **State Partnership Regionalization of Care (SPROC) demonstration grants** (4 awards) focus on improved access to pediatric emergency care by developing model systems of care to improve pediatric emergency care capacity in rural and tribal communities.
- **Pediatric Emergency Care Applied Research Network (PECARN) grants** (6 awards) conduct meaningful and rigorous multi-institutional studies in the management of acute illness and injury in children across the continuum of emergency medicine.
- **Targeted Issues grants** (5 awards) address cross-cutting issues of pediatric emergency care.
- **EMS-C Innovation and Improvement Center (EIIC) grant** (1 award) supports the implementation of best-practices at the state and local level through quality improvement strategies.
- **EMS-C Data Center grant** (1 award) supports data collection, coordination and analysis for the state partnership performance measures and the research network.

In recent years, the EMS-C investment resulted in the following accomplishments:

- **Improved pediatric readiness of emergency departments**
    - In a joint effort, states, with their EMS-C State Partnership grantees, partnered with the American Academy of Pediatrics, the Emergency Nurses Association, the American College of Emergency Physicians and others to ensure that all emergency departments comply with the joint policy statement "The Care of Children in the Emergency Department" (Pediatrics, 2009). This statement outlines resources necessary to ensure that hospital EDs stand ready to care for children of all ages, from neonates to adolescents. These guidelines are consistent with the recommendations of the Institute of Medicine's report on the future of emergency care in the United States health system and assure all hospital EDs have the appropriate resources (medications, equipment, policies, and education) and staff to provide effective emergency care for children.

    - Over 4,000 emergency departments across the nation have participated in assessing their readiness to care for children, representing approximately 80 percent of the nation's emergency departments. Approximately half of these emergency departments see fewer than 15 pediatric patients a day.
    - Compliance with the policy results in a readiness score of 100 representing the essential foundation to care for children. Determining the weight of the scores throughout the assessment was done by a group of clinical experts with the goal of establishing a standardize minimum for all emergency departments. The nation's readiness score is 69, an improvement of 14 points from 2003 to 2013.[204]

[203] http://www.emscnrc.org/Grantee_Portal/Performance_Measures.aspx
[204] http://www.pediatricreadiness.org/State_Results/National_Results.aspx

- Through a collaborative process, these groups engaged hospital emergency departments to participate in a quality improvement initiative called "The National Pediatric Readiness Project" that supports improving delivery systems at the local level to ensure children receive the right care at the right time.
- Simple system changes such as weighing a child in kilograms rather than pounds to prevent medical errors, ensuring that inter-facility transfer agreements are in place, and that at the local level emergency departments have a physician or nurse champion for pediatric emergency care can greatly improve the care provided to children.[205]

- **Developed the Essential Pediatric Domains and Considerations for Every Hospital's Disaster Plans**
  - Less than half of all U.S. hospitals reported having written disaster plans addressing issues specific to the care of children.
  - Based on these findings, a multidisciplinary workgroup developed the Essential Pediatric Domains and Considerations for Every Hospital's Disaster Preparedness Policies Checklist (the Checklist).[206]
  - The Checklist is being disseminated widely to assure pediatric considerations are included in existing or future disaster plans.
  - The National Advisory Committing on Children and Disasters is reviewing the Checklist as a model tool to improve pediatric readiness in disasters.

- **Worked to develop Regionalized Systems of Care in Tribal and Rural Communities**
  - The SPROC demonstration grantees are working on models to bring urban, rural and tribal communities together to provide seamless care for children.[207]
  - Each grantee (AK, AZ, CA, MT, NM, PA) is exploring avenues to expand healthcare networks within and beyond their state borders by developing and expanding pediatric medical recognition systems to prevent unnecessary transport of children from their community and immediate transfer when medically necessary to a facility with a more advanced level of pediatric care.
    - Arizona is certifying critical access hospitals and small community hospitals to become pediatric ready by ensuring pediatric training, equipment and protocols are available.
    - New Mexico is developing a dynamic virtual pediatric emergency department to provide just in time consultation to rural and tribal emergency departments in the state.
    - Alaska is working to assure everyday pediatric readiness and formally recognized the AK Native Medical Center as a Comprehensive Pediatric Emergency Care facility.
    - California is providing support to assure facilities in the rural north coast are Emergency Department Approved for Pediatrics.
    - Montana's pediatric facility recognition program is assessing the level of readiness of hospitals to care for children at two levels: Pediatric Capable or Pediatric Prepared. Pediatric Capable (typically smaller communities that

[205] Gausche-Hill, M, Ely, M, Schmuhl, P, Telford, R, Remick, K, Edgerton, E, Olson, L. A National Assessment of Pediatric Readiness of Emergency Departments. *JAMA Pediatrics* (2015): 138.
[206] http://www.pediatricreadiness.org/PRP_Resources/Checklist_Essential_Pediatric_Domains.aspx
[207] http://www.emscnrc.org/files/PDF/EMSC_Resources/2012-SPROC-Grant-Recipients.pdf

stabilize and transport severely sick or injured children to larger facilities) or Pediatric Prepared (larger facilities with more resources that can treat children for most conditions).
        - Pennsylvania is expanding access smaller facilities have to a network of pediatric specialists using telemedicine.

- **Targeted Issue Grantees Address Gaps in Prehospital Care for Children.** Grantees are focusing on the following domains to improve care:[208]
    - *Workforce development:* New Hampshire is focusing on developing models for rural pediatric prehospital care education.
    - *Mobile integrated health/community medicine:* Indiana developed a pediatric prehospital asthma interventions entitled "treat the streets" to decrease unnecessary emergency department visits. This project represents one of the first pediatric models for community paramedicine.
    - *Best clinical practices:* New York is conducting a research trial implementing the asthma treatment recommendations in the prehospital setting, taking best practices to the field and evaluating the impact.
    - *Professional development:* Kentucky is addressing the tragedy of a pediatric death in the prehospital setting by developing a mobile application to support EMS providers in providing compassionate care to the family as well as to themselves. This will be applicable to supporting staff and families with all out of hospital deaths.
    - *System evaluation:* Texas developing pediatric evidence-based protocols and then implementing them in the North Eastern Region among six states. This will be the first regional implementation of standardized protocols and an opportunity to measure impact.
    - *EMS Research Infrastructure:* Wisconsin established a pediatric EMS research network consisting of three large EMS agencies to conduct clinical studies. This is the first focused federal investment in pediatric prehospital research.

- **Expanded Pediatric Prehospital Research**
    - The PECARN grantees (AZ, CA, DC, OH, and NY) established an efficient multi-center research network (18 emergency departments and six EMS agencies representing over one million pediatric emergency visits annually) that conducts multiple forms of research: randomized controlled trials and implementation as well as translational research.[209]
    - The network published over 90 multiple peer-reviewed articles that will impact the quality of care provided to children, with 20 publications in 2014. Seminal studies include a randomized controlled trial demonstrated no difference of two medications for the management of pediatric seizures[210] which allows providers to balance the different side effects and cost to optimize care for the child.

[208] http://www.emscnrc.org/Files/PDF/EMSC_Resources/Targeted_Issue_Grants_FY2013.pdf
[209] http://www.pecarn.org/
[210] JAMA. 2014 Apr 23-30;311(16):1652-60

- Multiple studies distinguish clinical factors to aid providers in the use of radiographic imaging in trauma patients, thus decreasing unnecessary radiation exposure or transport to trauma specialty centers.[211,212,213]
- Another study evaluates the integration of a decision support tool into the electronic medical records to provide point of care support in the clinical management of mild traumatic brain injury.[214,215]

- **Expanded Support to the Freely Associated States**
  - The program continues to engage the newer grantees in the Freely Associated States (Republics of Palau and Marshall Islands, and the Federated States of Micronesia). These grantees face challenges of limited infrastructure and technology and geographical isolation.
  - EMS-C aligns with other with other HRSA investments serving these populations to optimally address and overcome these challenges. As a result, these grantees are working to develop formal plans to address the needs of children in the emergency care setting and linking with other grantees of the Pacific Basin to improve access to pediatric care through increased inter-island transport and expanded workforce development.

Many seminal publications are a direct result of the work of the EMS-C Program and its collaboration with partner organizations. The first evidence-based guidelines (EBGs) for prehospital care were published in a supplementary issue of *Prehospital Emergency Care.*[216] The supplement covered the topics of prehospital analgesia in trauma and air medical transportation of prehospital trauma, using the National Prehospital Evidence-based Guidelines Model Process, with funding provided by NHTSA and EMS-C. Collaboration between NHTSA, EMS-C and the American College of Surgeons led to the publication of evidence-based guidelines on prehospital external hemorrhage control.[217] This publication incorporated the military evidence for hemorrhage control and is now being used in practice for the civilian setting especially in active shooting or explosion settings where immediate hemorrhage control can be lifesaving. Fifteen previous EMS-C Program grantees authored articles that highlighted the advances in the field of pediatric emergency medicine in *Clinical Pediatric Emergency Medicine.*[218] The impact of the program continues to be highlighted in multiple care settings and among different specialties that care for children.

Collaborations

To further achieve system improvements, the EMS-C Program works in collaboration with the Federal Interagency Committee on Emergency Medical Services, a legislated federal entity with representatives from key agencies that intersect with the emergency medical services system.[219]

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[211] Acad Emerg Med. 2014 Jan;21(1):55-64
[212] Ann Emerg Med. 2014 Feb 12
[213] Ann Emerg Med. 2013 Sep;62(3):276-7
[214] J Biomed Inform. 2013 Oct;46(5):905-13
[215] Acad Emerg Med. 2013 Apr;20(4):352-60
[216] Prehospital Emergency Care Jan 2014, Vol. 18, No. Supplement 1;1-51
[217] Prehospital Emergency Care Apr 2014, Vol. 18, No. 2: 163–173
[218] Clinical Pediatric Emergency Medicine.2014 Mar;15(1):1-114
[219] http://www.ems.gov/ficems.htm

The Federal Interagency Committee on Emergency Medical Services ensures collaboration and integration of federal activities within the Department of Health and Human Services, Health Resources and Services Administration, Office of the Assistant Secretary for Preparedness and Response, Centers for Disease Control and Prevention, Indian Health Service, and Centers for Medicare and Medicaid Services, and between the Department of Transportation, Department of Homeland Security, Department of Defense, and Federal Communications Commission. EMS-C brings the only pediatric perspective to this federal group, which sets national agendas and policies for emergency medical services. In addition to Federal Interagency Committee on Emergency Medical Services, EMS-C works with individual federal agencies to ensure the integration of pediatric priorities in the overall Emergency Medical Services system.

A primary federal partner within the Department of Transportation's National Highway Traffic Safety Administration is the Office of Emergency Medical Services. EMS-C collaborates with the Office of Emergency Medical Services on the advancement of standardized and evidence-based prehospital medical protocols, strategies that support regionalization of trauma care, instituting a culture of safety in the EMS setting, and partnering in the implementation of the National EMS Information System. The EMS-C Program's partnership with Office of Emergency Medical Services ensures pediatric relevant issues are integrated into the larger Emergency Medical Services policies, education agendas and guidelines.

The EMS-C Program partnerships with Indian Health Service, the Agency for Health Care Research and Quality, Department of Defense, and the Office of the Assistant Secretary for Preparedness and Response, Hospital Preparedness Program (HPP) have provided opportunities for synergy. Working with the Indian Health Service, EMS-C assures the availability of pediatric-specific training initiatives tailored to the needs of tribal Emergency Medical Services and Indian Health Service medical facility professionals. The collaboration with Indian Health Service also provides opportunities to evaluate health care facilities to ensure they are prepared to care for pediatric patients. The EMS-C Program utilizes the Agency for Healthcare Research and Quality to provide national data on childhood mortality secondary to injury and referral patterns of pediatric patients among various designations of Trauma Centers. The most recent collaboration was with the Department of Defense Uniformed Services University of Health Science (USUHS), School of Medicine and the Hospital Preparedness Program. Collaborations with the USUHS focus on developing a conceptual model of a virtual pediatric trauma center for trauma surgeons and nurses. The military experience abroad has highlighted the gap in pediatric trauma training for nurses and surgeons and is similar to workforce shortages domestically in rural communities. HRSA anticipates a just in time curriculum and virtual access platform will be developed for civilian use, especially in rural communities.

Measuring Impact

The program is demonstrating measurable impact. The EMS-C program annually assesses the percent reduction in pediatric injury mortality for children with severe pediatric injuries presenting to the Emergency Department using the HCUP administrative data. In CY 2012, there was a 16.4% reduction in mortality compared to CY 2011 for children ages 0-15 years with an injury severity score greater than 15 presenting to the Emergency Department. Additionally, in FY 2014, 25 grantees made significant progress in implementing a pediatric medical recognition system, with a subset of 10 grantees having fully developed tiered pediatric medical recognition

systems; and 43 grantees had made significant progress toward assuring the integration of pediatrics in state trauma systems.

The EMS-C Program is developing new prehospital measures to continue the advancement of prehospital care. The performance measures focus on assuring leadership in the coordination of pediatric emergency care, maintaining prehospital pediatric skills, and using data to evaluate use of evidence-based guidelines. These performance measures will be released to grantees in 2016 and baseline data will be collected in 2017. The program will continue to focus on improved impact in the area of the hospital performance measures and pediatric readiness scores.

Funding History

FY	Amount
FY 2013	$20,000,000
FY 2014	$20,162,000
FY 2015	$20,162,000
FY 2016	$20,162,000
FY 2017	$20,162,000

Budget Request

The FY 2017 Budget Request for the EMS-C Program of $20.2 million is the same as the FY 2016 Enacted level. This request supports the program's efforts to achieve its FY 2017 performance targets. The EMS-C Program will continue to support improved access and quality of emergency care of children in the prehospital and hospital setting. The program will continue to focus on approaches to improve access to care in rural and territorial regions. The program will continue to advance the evidence in the prehospital and emergency department setting with the expansion of the PECARN network. In addition, states will incorporate the next phase of prehospital performance measures to ensure the quality of prehospital care, and the program will continue to engage stakeholders in the pediatric readiness project to ensure a solid foundation for all emergency departments to care for children.

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

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
14.1.A: Percent reduction in mortality rate for children with an injury severity score greater than 15. *(Outcome)*[220]	CY 2012: 16.4% decrease [221] Target: 0.5% reduction from prior year (Target Met)	0.5% reduction from prior year	0.5% reduction from prior year	Maintain
14.V.B.4A: Number of awardees that have made significant progress in implementing a pediatric recognition system for hospitals capable of dealing with pediatric medical emergencies. *(Output)*	FY 2014 Result: 25 Target: 26 (Target Not Met)	27	27	Maintain
14.V.B.4B: Number of awardees that have made significant progress in implementing a pediatric recognition system for hospitals capable of dealing with pediatric traumatic emergencies. *(Output)*	FY 2014 Result: 43 Target: 46 (Target Not Met)	44	44	Maintain
14.V.B.5: The percentage of EMS agencies in the state/territory that have a designated individual who coordinates pediatric emergency care. *(Output)(Developmental)*[222]	N/A	N/A	Baseline	N/A
14.V.B.6 The number of awardees that monitor EMS provider skill retention and performance in the use of pediatric equipment.[223] *(Output)(Developmental)*	N/A	N/A	Baseline	N/A

[220] The new data source for this measure is the National Emergency Department Sample. Data is reported from the most currently available pediatric mortality data. Source: Healthcare Cost and Utilization Project, Agency for Healthcare Research and Quality.

[221] The annual percentage change is calculated by the difference in mortality rate from the current year and the previous year divided by the previous year rate. The Mortality Rate for CY 2011 was 5.51 % and the Mortality Rate in CY 2012 was 4.61% among children 0-15 years of age.

[222] This is a developmental measure. Data for 2017 will be available in October of 2018.

[223] This is a developmental measure. Data for 2017 will be available in October of 2018.

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	78	75	76
Average Award	$234,946	$239,865	$236,051
Range of Awards	$85,357- $3,000,000	$130,000 - $3,000,000	$130,000 - $3,000,000

Healthy Start

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$102,000,000	$103,500,000	$103,500,000	---
FTE	7	5	5	---

Authorizing Legislation - Public Health Service Act, Section 330H, as amended by Public Law 110-339, Section 2

FY 2017 Authorization .....Expired (last authorized in FY 2013)

Allocation Method ..... Competitive grant/cooperative agreement

Program Description and Accomplishments

Healthy Start reaches out to pregnant women and new parents, provides them information and support to ensure a healthy pregnancy, and connects them with the health care and other resources they need to nurture their children. The Healthy Start Reauthorization Act of 2007 (P. L. 110-339) amended the Public Health Service Act to continue and expand the Healthy Start program (Healthy Start or HS), which provides grants to support community-designed and evidence-supported strategies that will reduce infant mortality and improve perinatal outcomes in project areas with high annual rates of infant mortality and disparities in other perinatal indicators. HS works to reduce "the disparity in health status between the general population and individuals who are members of racial or ethnic minority groups…" 42 U.S.C. § 254 c-8(e)(2)(B). HS services begin in preconception and follow the woman and child for two years after the end of the pregnancy.

HS aims to reduce disparities in access to and use of health services, to improve the quality of the local health care system, to empower women and their families, and to increase consumer and community participation in health care decisions. HS targets communities with infant mortality rates that are at least 1½ times the U.S. national average, other negative perinatal outcomes (such as low birth weight, preterm delivery, maternal morbidity and mortality), and/or high indicators of poor perinatal outcomes (such as poverty, education, access to care, and other socioeconomic factors), particularly among non-Hispanic Black and other disproportionately affected populations. The FY 2017 budget will support 100 Healthy Start programs in 37 states and communities, and the District of Columbia to deliver uniform, standardized interventions, including risk assessment, health education, medical and psychosocial supports and referrals, by a competent workforce, and support ongoing evaluation at local and national levels.

HS uses the following five strategic approaches to provide individual services and community support to women, infants, and families: 1) improve women's health, 2) promote quality services, 3) strengthen family resilience, 4) achieve collective impact, and 5) increase accountability through quality improvement, performance monitoring, and evaluation. Grantee organizations are expected to increase their roles as leaders and drivers of community change,

accountability, and collective impact. To achieve this, Healthy Start grantees now serve as backbone organizations or hubs responsible for coordinating all available maternal and child health services (federal, state, private, non-profit) in their communities.

The Healthy Start program service delivery model includes the entire family in order to achieve better health outcomes. The program enrolls women and their families at various stages of pregnancy, including pre-conception, inter-conception, and post-conception. Each family enrolling in HS, regardless of the site, receives a standardized, comprehensive assessment that considers health and behavioral health, employment, housing, domestic violence risks, and more. Understanding all aspects of family needs helps provide targeted and appropriate services. Services provided include:

- Health Care Services, including prenatal, postpartum, well-baby, adolescent care, family planning, and women's health;
- Enabling Services, including case management, outreach, home visiting, adolescent pregnancy prevention, childbirth education, parenting skill-building, youth self-esteem building, transportation, translation, child care, breastfeeding and nutrition education, father support, housing assistance, job training, and prison/jail services;
- Public Health Services, including immunization and health education; and
- Provider training

Healthy Start provides community level grants to support three levels of service. The most basic, Level 1, is the Community-Based Healthy Start Program that implements the five HS approaches for the clients it serves. Level 2, the Enhanced Services Healthy Start Program, goes beyond its clients to serve as a leader in the community in achieving program objectives and measuring performance through Fetal and Infant Mortality Reviews, Perinatal Periods of Risk, and/or Maternal Morbidity and Mortality Reviews. Level 3, the Leadership and Mentoring Healthy Start Program, provides mentoring to other HS sites and coordinates, within its community, all of the organizations providing MCH services to ensure continuity and avoid duplication of efforts.

HS works with individual communities to build upon their existing resources to improve the quality of, and access to, healthcare for women and infants at both the service and system levels. These include outreach, health education, case management, home visiting, and the use of prenatal and postnatal care. At the service-level, beginning with direct outreach by HS community health workers to high-risk women, HS projects ensure that mothers and infants have ongoing sources of primary and preventive healthcare and that their basic needs are addressed. Following assessments and screening for perinatal depression and other risk factors, HS case managers link mothers and infants to appropriate services and a medical home and follow them, at a minimum, from entry into prenatal care through two years post-pregnancy. At the system-level, every HS project has a Community Action Network (CAN) consortium comprising neighborhood residents, community key leaders, perinatal care clients or consumers, medical and social service providers, as well as faith-based and business community representatives. Together these key stakeholders identify and address the system-level barriers in their community, including fragmentation in service delivery, lack of culturally appropriate health and social services, and barriers to accessing care.

HS projects collaborate with state and local programs, including but not limited to the Maternal, Infant, and Early Childhood Home Visiting Program (also known as the Federal Home Visiting Program), Women, Infants, and Children (WIC), Early Head Start, Title V Maternal and Child Health Block Grant, Medicaid, Children's Health Insurance Program, and local perinatal systems such as those in community health centers. The connection between these services helps reduce risk factors, such as tobacco and alcohol use, while promoting behaviors that can lead to healthy outcomes for women and their families. By understanding and addressing the importance of a healthy family, healthy home, and healthy community, Healthy Start addresses the needs of the entire family.

Working with grantees directly and through the "Improving Healthy Start Performance Project" (i.e., the Healthy Start EPIC Center – www.healthystartepic.org), HRSA is providing all grantees with extensive technical assistance to strengthen staff skills to implement evidence-based practices in maternal and child health, facilitate grantee-to-grantee sharing of expertise and lessons from the field, enable grantees to conduct ongoing evaluation of activities for effectiveness, and build program capacity to work with community partners to improve health and social service systems for women, infants and families.. This grantee support is further guided by the "Healthy Start Collaborative Innovation Network - COIN" – a team representing the 20 most experienced grantees (18 level 3 funded grantees, one level 1 and one level 2) who meet regularly, review grantees' needs and offer HRSA recommendations on how to provide the most appropriate support to grantees.

Adverse Pregnancy Outcomes in United States

More than 6.7 million women become pregnant each year in the United States. According to data from National Center for Health Statistics, there were 3.99 million live births in 2014.[224] While most women have a safe pregnancy and deliver a healthy infant, that is not the experience for all women. Preterm birth (births at less than 37 completed weeks of gestation) is a key risk factor for infant death. Since the mid-1980s, the percentage of preterm births in the U.S. has been rapidly increasing, reaching a peak of 12.8 percent in 2006.[225] Since then, the preterm delivery rate has decreased, reaching an overall national preterm rate of 11.39 percent in 2013.[225] Although a portion of preterm births over the last decade was due to an increase in multiple births, the percentage of preterm births has also increased among singleton births.
There are significant racial disparities in preterm births and infant death rates in the United States. For example, in 2012 the preterm birth rate for non-Hispanic White infants was 10.29 percent compared to 16.53 percent for non-Hispanic Black infants.[226] Similarly, in 2010 the preterm-related infant mortality rate for non-Hispanic Black infants was 3.1 times higher than that of non-Hispanic White infants.[227]

[224] Hamilton BE, Martin JA, Osterman MJK, et al. Births: Final data for 2014. National Vital statistics reports; vol 64 no 12. Hyattsville, MD: National Center for Health Statistics. 2015.
[225] Martin JA, Hamilton BE, Osterman MKJ. Births in the United States, 2013. NCHS Data Brief #175. Published online December 2014.
[226] Martin JA, Hamilton BE, Osterman MJK, et al. Births: Final data for 2012. National vital statistics reports; vol 62 no 9. Hyattsville, MD: National Center for Health Statistics. 2013.
[227] Mathews TJ, MacDorman MF. Infant mortality statistics from the 2010 period linked birth/infant death data set. National vital statistics reports; vol 62 no 8. Hyattsville, MD: National Center for Health Statistics. 2013.

Despite considerable research efforts to understand and prevent these adverse outcomes, the factors that make some pregnancies more vulnerable than others have not been clearly identified. Emerging research indicates that environmental, biological, and behavioral stressors occurring over the lifespan of the mother – from her earliest life experiences until she delivers her own child – may account for a significant portion of the disparities.

Overall, HS has been successful in improving health outcomes in the nation's populations at highest risk for adverse outcomes (e.g., African Americans, American Indians/Native Americans) in three areas: 1) reduction in infant mortality rates, 2) increasing access to early prenatal care, and 3) addressing barriers to healthcare access.

Reducing Infant Mortality Rates in Healthy Start Project Areas

By design, Healthy Start funds communities with exceptionally high infant mortality rates. Healthy Start communities have been successful in reducing their infant mortality rates so that in 2013, the grantee self-reported infant mortality rate among HS program participants was 5.48 infant deaths per 1,000 live births, which was lower than the national rate of 5.96. In addition, The Center for Health Equity, Gadsden County Federal Health Start has not had an infant death among program participants in the last ten years, and in 2015, the Westside Healthy Start Chicago participant infant mortality rate of 7.60 infant deaths per 1,000 live births was half the overall rate of 14.07 for non-participant individuals living in the same communities. From 2012-2014, the Kansas City Healthy Start program had an average infant mortality rate of 10.5 compared with 2011 baseline of 23.6. Between 2009 and 2014, the Philadelphia Healthy Start project experienced six deaths. This rate of 6.61 per 1,000 live births was comparable to the national average at that time of 6.15 per 1,000 live births. However, in comparison to 2006 baseline data the average infant mortality rate for the W/SW/S Healthy Start project area was 12.67 per 1,000 live births.

A number of other HS grantees reported *no* infant deaths among program participants for the 2010-2012: Crozer-Keystone Health System, PA; Northern Manhattan Perinatal Partnership, Inc., NY; Aunt Martha's Youth Service Center, INC., IL; West Virginia University Research Corp, WV; Portland, OR; Maricopa County Department of Health, AZ; Fresno County Human Services System, Fresno, CA; NC Department of Health and Human Services, NC; Atlanta, GA; and Wichita, KS.

Increasing Access to Early Prenatal Care

The Healthy Start program facilitates access to prenatal care to improve perinatal outcomes. An important risk factor for infant mortality is the adequacy of prenatal care. The population served by the HS projects is, by eligibility criteria definition, disadvantaged and high-risk. Through outreach, health education and care coordination, Healthy Start grantees have played an important role in connecting their clients to services and improving access to, and the use of, prenatal care services for community members. In 2013, 76 percent of Healthy Start participants initiated prenatal care during the first trimester.

From 2007-2012, 90 percent of California Border Healthy Start participants accessed prenatal care in their first trimester compared with baseline of 80 percent. From 2012-2014, an average of 77.6 percent of the Kansas City Healthy Start participants accessed prenatal care in their first trimester compared with 2011 baseline of 74.5 percent. From 2009-2014, 76 percent

of Philadelphia Healthy Start participants accessed prenatal care in their first trimester compared with the 2006 baseline of 51.5 percent.

Addressing Barriers to Healthcare Access

Adverse perinatal outcomes are also linked to limited access to healthcare. Lack of health insurance coverage has not been a major barrier for low-income women to receive care during pregnancy through 60 days following delivery, as most high-risk women served by Healthy Start are eligible for Medicaid. However, many low-income/high-risk women do not enroll in Medicaid and/or do not access any health care services during their pregnancy, thereby missing out on vital available healthcare; that is, accessing vs. eligibility of healthcare has historically been the barrier. To overcome these obstacles and ensure that women access the care they need, HS focuses on helping eligible women and children enroll in Medicaid or in private insurance through their state's health insurance marketplace. In 2014, an estimated 89.2 percent of HS program participants had some form of health insurance.[228] In Des Moines, Iowa, in 2015, 94 percent of Healthy Start participants had health insurance compared with FY 2012-2013 baseline of 78 percent; 90 percent of Healthy Start participants (women, infants and children) had a medical home compared with FY 2012-2013 baseline of 88 percent; and 87 percent of Healthy Start participants received follow up services for perinatal depression compared with FY 2012-2013 baseline of 53 percent.

HS grantees also work to help women and children find health care providers that accept their health insurance. Finally, HS staff members play a critical role in providing case management and care coordination, enabling women to access appropriate prenatal and other essential health care services.

The Healthy Start transformation provides increased opportunities to reduce infant mortality rates. By increasing coordination and integration of maternal and child health services, the Healthy Start program is positioned to deliver community-wide services.

Funding History

FY	Amount
FY 2013	$98,064,000
FY 2014	$100,746,000
FY 2015	$102,000,000
FY 2016	$103,500,000
FY 2017	$103,500,000

Budget Request

The FY 2017 Budget Request for Healthy Start of $103.5 million is the same as the FY 2016 Enacted level. The requested funding will support up to 100 HS sites in 37 states and communities, and the District of Columbia. Approximately 59,040 participants will receive case

[228] The number and percentage are derived from the number participants currently being served, which is 25,098. These figures are based on monthly reports submitted by grantees for the month of February 2015.

managed Healthy Start services, while about 490,960 additional HS community participants will receive outreach and health education services for a total estimate of 550,000 persons served.

HS projects are committed to reducing disparities in perinatal health and infant mortality by transforming their communities, strengthening community-based systems to enhance perinatal care, and improving the health of the women and infants in their communities. HS promotes the uniform implementation of well-defined evidence-supported interventions and the ongoing monitoring of the impact of these interventions on perinatal outcomes and factors that contribute to these outcomes. HS emphasizes strong and ongoing evaluation, increased accountability through monthly program monitoring at both the local and federal levels, and the ability to demonstrate individual and community-wide impact through the use of real time program and client level data and information are required. The Healthy Start program uses five main approaches to achieve its goals:

- **Improving Women's Health:** improving coverage, access to care, health promotion and prevention, and health for women before, during, and after pregnancy.

- **Promoting Quality Services:** promoting the delivery of quality intervention services designed to link families to a medical home; focusing on health promotion and prevention; and advancing service coordination and systems integration, while also supporting the improved access to these services.

- **Strengthening Family Resilience:** supporting the ability of an individual, family, and community to cope with adversity and adapt to challenges or change.

- **Achieving Collective Impact:** maximizing opportunities for community action to address social determinants of health and achieve collective impact. Healthy Start grantees support coordination, integration, and mutually reinforcing activities among health, social services, and other providers and key leaders in the community.

- **Increasing Accountability through Quality Improvement, Performance Monitoring, and Evaluation:** conducting ongoing quality improvement, performance monitoring, and evaluation activities in order to identify best practices, demonstrate implementation of evidence-based practices, and report on results.

Key to achieving these goals is the creation and implementation of two main systems for technical assistance, monitoring and evaluation:

- **Healthy Start Monitoring and Information System (HSMIS):** Collects program data from all grantees on a monthly basis to monitor program activities and identify technical assistance needs. The HSMIS also collects data from clients served by HS to monitor services and health outcomes and enable HRSA and all grantees to better utilize information for ongoing program monitoring, quality improvement, and evaluations at the local and national levels.

- **Supporting Healthy Start Performance Project:** Provides technical assistance to grantees to ensure skilled, well qualified workers at all levels of the program, identify and better define evidence-based effective services and interventions, offer mentoring,

education, and training to staff delivering these interventions and services, and provide shared resources.

The FY 2017 Budget will allow HRSA to continue to build on the successes and lessons learned since the program began in 1991. HS will include activities and components that will support the Administration's priorities of building a ladder of opportunity for all children through the standardized interventions and ongoing monitoring of these activities.

The FY 2017 Budget will also enable HRSA to conduct an objective evaluation of the Healthy Start program to determine the extent to which HS grantees provided services to the highest risk target populations, implemented the program's interventions and strategies as designed, and were able to improve the perinatal outcomes among the population they serve; this will allow HRSA to identify the critical ingredients of HS programs that facilitate success and that should be replicated in other high-risk communities. The Healthy Start Monitoring and Information System will support efforts to further strengthen evaluation, oversight, and accountability activities and efforts.

Funding also includes costs associated with the grant review and award process, follow-up performance reviews, information technology, technical assistance, evaluation, data systems, CoIIN, and other program support costs to support grant activities.

Outcomes and Outputs Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
12.1: The infant mortality rate (IMR) per 1,000 live births among Healthy Start Program clients.[229] *(Outcome)* (Baseline- 2004: 7.65 per 1000 live births)	FY 2013: 5.48 per 1,000 live births	N/A	N/A	N/A
12. III.A.1: Increase annually the percentage of women participating in Healthy Start who have a prenatal care visit in the first trimester. *(Outcome)*	FY 2013: 76% Target: 75% (Target Met)	75%	75%	Maintain
12.III.A.2: Percent of singleton births weighing less than 2,500 grams (low birth weight) *(Outcome)*	FY 2013: 10% Target: 9.6% (Target Not Met)	9.6%	9.6%	Maintain

[229] The next target date for this measure is FY 2020.

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
12.E: Increase the number of persons served by the Healthy Start Program with a (relatively) constant level of funding.(*Efficiency)*	FY 2013: 442,223 Persons Served Target: 547,317 (Target Not Met)	550,000	550,000	Maintain

Grant Awards Table

	FY 2015 Final[230]	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	101 / 12	100	100
Average Award	$916,601 / $122,769	$949,877	$949,877
Range of Awards	$22,064-$2,000,000	$750,000-$2,000,000	$750,000-$2,000,000

[230] New, competing continuation, and non-competing continuation awards / extension with funds awards (partial award extensions to align award cycles)

Heritable Disorders Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$13,883,000	$13,883,000	$13,883,000	---
FTE	4	3	3	---

Authorizing Legislation – Public Health Service Act, Section 1109-1112 and 1114, as amended by Public Law 113-240, Section 10

FY 2017 Authorization……$11,900,000

Allocation Methods:

- Contract
- Competitive grant/cooperative agreement

Program Description and Accomplishments

The programs and activities under the Newborn Screening Saves Lives Reauthorization Act of 2014 are established to enhance, improve or expand the ability of states and local public health agencies to provide screening and follow-up, counseling and health care services to newborns and children having or at risk for heritable disorders. Universal newborn screening provides early identification and follow-up for treatment of infants affected by certain genetic, metabolic, hormonal and/or functional conditions.

Every year over 4 million infants are born in the United States and each infant is screened for certain heritable disorders and medical conditions. Newborn screening saves or improves the lives of more than 12,000 babies in the United States each year. For babies who test positive for one of these conditions, they receive rapid identification, early intervention, and potentially life-saving treatments. Currently, the majority of states are testing for at least 29 of the 32 conditions on the Recommended Uniform Screening Panel (RUSP).

The Heritable Disorders program has six different programs and provides support to the Advisory Committee on Heritable Disorders in Newborns and Children (Committee) and the Interagency Coordinating Committee on Newborn and Child Screening (ICC). The six programs include:

- Implementing Screening for New Conditions added to the RUSP;
- Severe Combined Immunodeficiency (SCID) Implementation Program;
- Improving Timeliness of Newborn Screening Diagnosis Initiative;
- Newborn Screening Data Repository and Technical Assistance Center;
- Regional Genetic and Newborn Screening Service Program; and
- Clearinghouse of Newborn Screening Information.

The Improved Newborn and Child Screening and Follow-up for Heritable Disorders, Section 1109 of the Public Health Service (PHS) Act supports activities that focus on improving newborn screening systems so that state and local public health agencies can provide the appropriate and timely screening, counseling, and/or health care services to newborns and children at risk for or who have congenital, genetic, and metabolic conditions. The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, Section 1111 of the PHS Act, supports the activities of the Advisory Committee. The Clearinghouse of Newborn Screening Information, Section 1112 of the PHS Act, supports the development of a central electronic clearinghouse that contains current educational resources on newborn screening, family support services, and evidence-based guidelines on the diagnosis and treatment of infants and children diagnosed through newborn screening.

Improved Newborn and Child Screening and Follow-Up for Heritable Disorders, Section 1109

SCID is a primary immune deficiency that is characterized by lack of a functioning immune system which, if untreated, leads to death in infancy. In FY 2015, two organizations received grants to support wider implementation, education, and awareness of newborn screening for SCID and related disorders. The purpose of the SCID program is to increase the number of states and/or territories that include screening for SCID as part of their newborn screening program. The program also disseminates national, regional, and state education and training resources for parents, families, and providers.

In FY 2015, a three-year cooperative agreement was awarded under the Improving Timeliness of Newborn Screening Diagnosis initiative to improve the time to diagnosis and treatment for infants undergoing newborn screening who receive a presumptive positive result. Activities include coordinating collaborative learning and quality improvement activities in newborn screening programs using practice-based strategies that improve timeliness. The overall objectives for this initiative are to increase the number of states that meet the Committee's recommendations on timeliness and increase the number of infants receiving timely diagnosis and treatment.

The Newborn Screening Data Repository and Technical Assistance Center was established in FY 2014 as a cooperative agreement to develop a national newborn screening data repository and to provide technical assistance on the implementation of state-based public health newborn screening and other genetics programs, as appropriate. This would be accomplished through resource development, state education and training, policy initiatives, disorder surveillance, evidence-based data collection, evaluation, and collaborative efforts with stakeholders. Activities support the collection of data to increase awareness and understanding of newborn screening, facilitate harmonization of newborn screening activities, and improve the quality of newborn screening and related genetic services across the United States through innovations and advancements in technology.

One of the accomplishments of the Newborn Screening Data Repository and Technical Assistance Center has been establishing a data repository that supports standardization, data-driven quality improvement, evaluation, bi-directional communication, and information sharing. The repository has information from state newborn screening programs across the nation. The

Newborn Screening Data Repository and Technical Assistance Center has also finalized newborn screening case definitions for public health surveillance.

Another initiative that began in FY 2016 was the Implementing Screening for New Conditions added to the RUSP. This initiative supports states with the implementation, education, and awareness of newborn screening for those conditions recently added to the RUSP including Pompe disease. The purpose of this program is to increase the number of states and/or territories that include screening for newly added conditions on the RUSP as part of their newborn screening program. The program will also disseminate national, regional, and state education and training resources for parents, families, and providers.

A new initiative in FY 2017 is the Regional Genetic Networks Program. The goal of this program is to improve access to quality genetic services for underserved populations including the coordination of follow-up and treatment services related to congenital, genetic, and metabolic disorders. The initiative will bring together clinical geneticists, primary care providers, states, and other partners to identify underserved populations not receiving clinical genetic services; establish partnerships with academic institutions, health systems, and state programs to connect genetic services to underserved populations; use innovative health information technology to address gaps in accessing care; provide genetic education and training to primary care providers; and partner with families and health services to improve coordinated care and access to a medical home.

The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, Section 1111

In 2015, the Committee was re-chartered after passage of the Newborn Screening Saves Lives Reauthorization Act of 2014. The ongoing purpose of this Committee is to: 1) provide advice, technical information and systematic evidence-based and peer-reviewed recommendations to the Secretary of Health and Human Services to enhance, expand or improve the ability of the Secretary to reduce the mortality or morbidity from heritable disorders; 2) address the public health impact of newborn screening expansion; 3) periodically update the RUSP, as appropriate, based on a decision-matrix to assess the net benefit of adding a condition to the RUSP and 4) consider ways to ensure that all states attain the capacity to screen for conditions on the RUSP.

In 2015, the Committee reviewed current policies and practices related to the timeliness of newborn screening (NBS) in the United States. Based on their deliberations and findings, the Committee recommends the following practices and timelines for stakeholders such as state NBS programs, birthing facilities and hospitals:

- To achieve the goals of timely diagnosis and treatment of screened conditions and to avoid associated disability, morbidity and mortality, the following timelines should be achieved by NBS systems for the initial newborn screening specimen:
    - Presumptive positive results for time-critical conditions should be communicated immediately to the newborn's healthcare provider but no later than five days of life;
    - Presumptive positive results for all other conditions should be communicated to the newborn's healthcare provider as soon as possible but no later than seven days of life; and

    - All NBS tests should be completed within seven days of life with results reported to the healthcare provider as soon as possible.
- In order to achieve the above goals:
    - Initial NBS specimens should be collected in the appropriate time frame for the newborn's condition but no later than 48 hours after birth; and
    - NBS specimens should be received at the laboratory as soon as possible, ideally within 24 hours of collection.

The Committee also completed evidence-based reviews for Mucopolysaccharidosis Type I (MPS I) and Adrenoleukodystrophy (X-ALD). Based on its findings, the Committee agreed that there was a net benefit for early population screening and recommended the addition of MPS I and X-ALD to the RUSP.

The Clearinghouse of Newborn Screening Information, Section 1112

The Clearinghouse cooperative agreement was re-competed and awarded in FY 2014 in order to maintain a central, online clearinghouse of current newborn screening information and resources such as family support services; follow-up services; and other related materials, resources, and research. The Clearinghouse promotes information sharing and disseminates available authoritative and/or evidence-based guidelines and materials related to diagnosis, counseling, and treatment of conditions detected by newborn screening. It also aims to promote and support communities in their efforts to understand the newborn screening process that is specific to their community, region, and/or state. The intent of the Clearinghouse is to increase awareness, knowledge and understanding of newborn screening for parents, family members, expectant individuals and families, and health professionals.

The Clearinghouse has developed a fully functional website, known as Baby's First Test, which houses current newborn screening resources and facilitates learning, data and resource sharing. The Clearinghouse also created a Spanish version of Baby's First Test. Using social media, the Clearinghouse has created a network of awareness and action. Since the Clearinghouse went live in 2011, it has seen over 500,000 users.

The Interagency Coordinating Committee (ICC) on Newborn and Child Screening, Section 1114

Per statute, the ICC serves to respond to Secretarial requests to assess existing activities and infrastructure in order to make recommendations for programs to collect, analyze, and make data available on the heritable disorders recommended by the Committee and coordinate collaborative efforts for newborn and child screening among all agencies in HHS. The ICC is composed of the Administrator of HRSA, the Director of CDC, the Director of AHRQ, and the Director of NIH. In addition there are other federal liaisons who inform the deliberations of the ICC. The ICC was delegated to HRSA and CDC to serve as co-chairs.

Activities to date include responding to Secretarial requests to provide input regarding recommendations from the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children concerning: newborn screening for critical congenital heart disease, the use and storage of newborn screening residual blood samples, data quality assurance in newborn screening, and newborn screening for Pompe disease and MPS I.

Funding History

FY	Amount
FY 2013	$9,314,000
FY 2014	$11,883,000
FY 2015	$13,883,000
FY 2016	$13,883,000
FY 2017	$13,883,000

Budget Request

The FY 2017 Budget Request for the Heritable Disorders program of $13.8 million is the same as the FY 2016 Enacted level. The Budget Request will support:

- Wider implementation, education, and awareness of newborn screening
- Technical assistance and programmatic support for the state public health programs, particularly as new conditions for newborn screening are considered and implemented throughout the United States through the Newborn Screening Data Repository and Technical Assistance Center.
- A regional infrastructure of public health genomics to improve, expand, strengthen, and evaluate access and quality of a system of genetic services that improve health outcomes for children, youth and adults. The current Regional Genetic and Newborn Screening Services Program is funded at $4.2 million. In FY 2017, the program will be redesigned and transformed to better address current and future needs of patients identified with various genetic conditions.
- The Advisory Committee on Heritable Disorders in Newborns and Children, which will continue to provide evidence-based recommendations as well as technical information to the Secretary regarding heritable disorders and the implementation of newborn screening.
- Ongoing support for the Clearinghouse of Newborn Screening Information, a central repository of current educational and family support and services information, materials, resources and research.
- The ICC, which will continue to undertake relevant activities authorized by the Newborn Screening Saves Lives Reauthorization Act of 2014 to collect and assess information regarding heritable disorders.

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

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Request
Number of Awards	14	14	12
Average Award	$857,352	$848,213	$989,582
Range of Awards	$108,979 - $2,000,000	$300,000 - $2,000,000	$600,000 - $2,000,000

Family-To-Family Health Information Centers

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$5,000,000	$5,000,000	$5,000,000	---
FTE	1	1	1	---

Authorizing Legislation - Social Security Act, Section 501(c)(1)(A) as amended by Public Law 114-10, Section 216

FY 2017 Authorization $5,000,000

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Family-to-Family Health Information Centers (F2F HICs) Program, as reauthorized through the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (P.L. 114-10, Sec. 216), funds family-staffed and family-run centers in the 50 states and the District of Columbia. The F2F HICs provide information, education, technical assistance, and peer support to families of children (including youth) with special health care needs (CSHCN) and health professionals who serve such families. They also assist in ensuring that families and health professionals are partners in decision making at all levels of care and service delivery.

In FYs 2011-2015, the F2F HICs in the 50 states and the District of Columbia received funding to:

- Assist families of CSHCN to make informed choices about healthcare in order to promote good treatment decisions, cost effectiveness, and improved health outcomes;
- Provide information regarding the healthcare needs of and resources available for CSHCN;
- Identify successful health delivery models;
- Develop models for collaboration between families of CSHCN and health professionals, including representatives of healthcare providers, managed care organizations, healthcare purchasers, and appropriate state agencies;
- Provide training and guidance regarding the care of CSHCN;
- Conduct outreach activities to families, health professionals, schools, and other appropriate entities; and
- Enlist families of CSHCN, who have expertise in federal and state public and private healthcare systems, and health professionals to staff these efforts.

Currently, 51 F2F HICs are collecting data on the issues facing families in areas such as service needs, the financing of those services, and communicating the needs of the families of CSHCN with community and state agencies, including Medicaid, Department of Education, and Title V. In addition to serving on state-appointed task forces and committees, F2F HICs are

disseminating information to families and health professionals on new legislation such as the Medicare Access and CHIP Reauthorization Act of 2015 and its impact on their respective states. They help families understand the new provisions and how they affect individual access to coverage. The F2F HICs disseminate information via fact sheets, social media, newsletters and listservs. In addition, they assist HRSA-funded federally qualified health centers (FQHCs), children's hospitals, and pediatric practices across the nation to implement medical/health homes by providing training and educational materials to families and health professionals.

In FY 2015, F2F HICs provided services to 155,950 families, which exceeds the target of 137,000 families. Ninety-eight percent of families served reported they were better able to partner in decision making, exceeding the target of 90 percent. Since its inception, the F2F HICs Program has more than quadrupled the number of families served, and the proportion of families served who reported that F2F HIC assistance helped them be better partners in decision making at any level increased by more than 38 percentage points. Additionally, in FY 2015, F2F HICs trained and provided information, resources, and referrals to approximately 76,000 health professionals who serve CSHCN families within community and state public health agencies, managed care and insurance organizations, medical practices, children's hospitals, universities, FQHCs, and more. FY 2016 data will be collected and reported in the fall of 2016.

There is strong evidence to support the approach adopted by the F2F HICs Program as evidenced by national surveys, a multi-site study, Institute of Medicine reports, the National Quality Forum, the Joint Commission, and the Agency for Healthcare Research and Quality (AHRQ).[231] The research also indicates that family engagement is necessary at all levels of the health and health care system, as it can result in improved health outcomes for CSHCN (e.g., improved transition from pediatric to adult health care systems, fewer unmet health needs, better community-based systems, fewer problems with specialty referrals, lowered out-of-pocket costs, improved physical and behavioral functions, and increased access to preventive health care in a medical home).[232] Principles of family engagement, family/professional partnerships, and patient/family-centered care are integrated into the F2F HICs Program and are identified as national quality indicators.[233] The AHRQ further endorses the need to engage families and help them navigate the health care system, recognize high-quality health care, become informed health care consumers, and develop skills in selecting a hospital, doctor, and health plan (highlighted also as a priority within the National Quality Strategy).[234]

[231] Kenney et al. (2011); Singer et al. (1999); Kuo et al. (2012); IOM (2001); National Priorities Partnership (2008); Joint Commission (2010); AHRQ (2011).
[232] Carman et al. (2013); Ngui (2006); Scal (2005); Baruffi (2005); Smaldone (2005); Young (2005); Fiks et. al. (2012); Fiks et al. (2010); Jassen et al. (2007); Wilson et al. (2010); Smalley et al. (2013).
[233] IOM (2001); National Priorities Partnership (2008).
[234] AHRQ (2015).

Funding History

FY	Amount
FY 2013	$4,745,000
FY 2014	$5,000,000
FY 2015	$5,000,000
FY 2016	$5,000,000
FY 2017	$5,000,000

Budget Request

The FY 2017 Budget for the F2F HICs Program of $5.0 million was appropriated in the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10) and is the same as the FY 2016 level. The entire request is mandatory funding. The funding will be used to support 51 grants to assure that families of CSHCN are able to partner in decision making at all levels by providing information, education, and training regarding the health care needs of and resources available for CSHCN and by providing other enabling support to families and the health professionals serving them. These centers have been key to providing families of CSHCN with health and related information to make informed health insurance choices and the support in accessing health care. No direct health care services are provided.

The funding request also includes costs associated with grant actions that are conducted through the HRSA's Electronic Handbooks, follow-up performance reviews, and program support costs.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
15.III.C.1: Number of families with CSHCN who have been provided information, education and/or training from Family-to-Family Health Information Centers (Output).	FY 2015: 155,950 Target: 137,000 (Target Exceeded)	151,000	166,000	+ 15,000
15.III.C.2: Proportion of families with CSHCN who received services from the Family-to-Family Health Information Centers reporting that they were better able to partner in decision making at any level (Outcome).	FY 2015: 98% Target: 90% (Target Exceeded)	92%	94%	+ 2%

Grant Awards Table[235]

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards[236]	51	51	51
Average Award[237]	$94,316	$95,700	$95,700
Range of Awards	$48,689 - $95,700	$95,700	$95,700

[235] Does not include carryover funding.
[236] The number of actual base awards.
[237] Estimate based on funding appropriated through the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10).

Maternal, Infant, and Early Childhood Home Visiting Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$400,000,000	$400,000,000	$400,000,000	---
FTE	25	29	29	---

Authorizing Legislation - Social Security Act, Section 511(j), as amended by Public Law 114-10, Section 218

FY 2017 Authorization $400,000,000

Allocation Methods:

- Direct federal/intramural
- Contract
- Formula grant/cooperative agreement
- Competitive grant/cooperative agreement

Program Description

The Maternal, Infant, and Early Childhood Home Visiting Program, (MIECHV, hereafter referred to as the Federal Home Visiting Program), administered by the Health Resources and Services Administration (HRSA) in partnership with the Administration for Children and Families (ACF), supports voluntary, evidence-based home visiting services during pregnancy and to parents with young children up to kindergarten entry. Federal Home Visiting Program grants are allocated to and support home visiting programs in all fifty states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, the Northern Mariana Islands, and American Samoa. Additionally, while most of the program funds are allocated to state and territory home visiting grants and general technical assistance, three percent is set aside for awards available to Indian tribes (or a consortium of Indian tribes), tribal organizations, and urban Indian organizations and three percent is set aside for research, evaluation, and corrective action technical assistance to grantees.

Grants to states and territories are administered by the lead state agency designated by the Governor or by statute can be competitively awarded to a nonprofit organization in those states or territories that opted not to participate in the grant program.

Tribal Home Visiting funds are awarded competitively to Indian tribes (or consortia of Indian tribes), tribal organizations, or urban Indian organizations as defined in section 4 of the Indian Health Care Improvement Act.

The Federal Home Visiting Program builds upon decades of scientific research showing that home visits by a nurse, social worker, or early childhood educator during pregnancy and in the first years of life have the potential to improve the lives of children and families by preventing

child abuse and neglect, encouraging positive parenting, improving maternal and child health, and promoting child development and school readiness. Research shows that home visiting provides a positive return on investment to society through savings in public expenditures such as emergency room visits, public benefits, and child protective services, as well as increased tax revenues from parents' earnings.

The Federal Home Visiting Program requires states, territories, and tribal entities to direct their home visiting efforts to at-risk communities. The statute defines at-risk communities as those with concentrations of:

- premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health;
- poverty;
- crime;
- domestic violence;
- high rates of high school drop-outs;
- substance abuse;
- unemployment; or
- child maltreatment.[238]

States, territories, and tribal entities eligible to receive funding through the Federal Home Visiting Program have the flexibility to tailor the program to serve the specific needs of their at-risk communities. In order to meet those needs, the statute required states, territories, and tribal entities to conduct needs assessments to identify eligible at-risk communities, determine priority populations, and choose which approved evidence-based models or promising approaches for home visiting will be used. Following the needs assessments, grantees worked with local implementing agencies to build infrastructure, train a high-quality home visiting workforce, establish data reporting and financial accountability systems, and develop referral networks to enroll families and facilitate service coordination in local communities.

By law, state and territory grantees must spend the majority of their Federal Home Visiting Program funds to implement evidence-based home visiting models, with up to 25 percent of funding available to implement other promising approaches that will undergo rigorous evaluation. Currently five states implement and evaluate a total of six promising approaches.

While there is some variation across the 17 evidence-based home visiting models from which grantees may select (e.g., some programs serve expectant mothers as well as parents with young children while others only serve families after the birth of a child), all models share some common characteristics. In these voluntary programs, trained professionals meet regularly with expectant parents or families with young children in their homes, building strong, positive relationships with families who want and need support. Home visitors evaluate the families' needs and provide services tailored to those needs, such as:

- Teaching parenting skills and modeling effective techniques;

[238] 42 U.S.C. § 711(b)(1)(A).

- Promoting early learning in the home with an emphasis on positive interactions between parents and children and the creation of a language-rich environment that stimulates early language development;
- Providing information and guidance on a wide range of topics including breastfeeding, safe sleep position, injury prevention, and nutrition;
- Conducting screenings and providing referrals to address postpartum depression, substance abuse, and family violence;
- Screening children for developmental delays and facilitating early diagnosis and intervention for autism and other developmental disabilities; and
- Connecting families to other services and resources as appropriate.

The Tribal Home Visiting Program, administered by ACF, is designed to develop and strengthen tribal capacity to support and promote the health and well-being of American Indian and Alaska Native families, expand the evidence base around home visiting in tribal communities, and support and strengthen cooperation and linkages between programs that serve Native children and their families. There is one evidence-based model that has evidence of effectiveness in tribal communities (Family Spirit). Grantees may choose either Family Spirit, or a promising approach (which includes any model that does not have specific evidence of effectiveness in American Indian and Alaska Native populations).

Program Accomplishments

The Federal Home Visiting Program state and territory grantees provided approximately 2.3 million visits from FY 2012 through FY 2015. In FY 2015, states reported serving more than 145,500 parents and children in 825 counties across all 50 states, the District of Columbia, and five territories. This is compared to approximately 115,000 participants in FY 2014, 76,000 in FY 2013, and 34,000 in FY 2012. (See Figures 1 and 2 below)

Figure 1: Growth in the Number of Participants (FY 2012 – FY 2015)

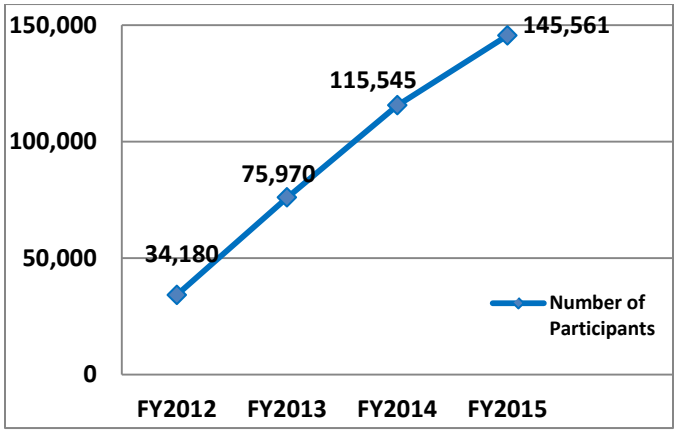
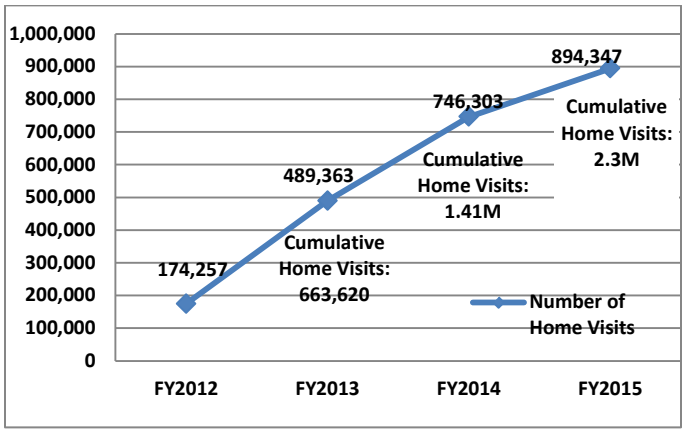


Figure 2: Growth in Number of Home Visits[239] (FY 2012 – FY 2015)



The Federal Home Visiting Program currently serves approximately one-third of the highest risk counties in the country as defined by the following indicators: low birth weight, teen birth rate, percent living in poverty and infant mortality rates.

The Federal Home Visiting Program serves many of the most vulnerable families. In FY 2015:

- 77 percent of participating families had household incomes at or below 100 percent of the federal poverty guidelines ($24,250 for a family of four), and 46 percent were at or below 50 percent of those guidelines;
- 31 percent of adult program participants had less than a high school education, and 33 percent had only a high school degree or equivalent; and
- of newly enrolled households,
  - 22 percent included pregnant teens;
  - 15 percent reported a history of child abuse and maltreatment; and
  - 12 percent reported substance abuse.

In addition, 68 percent of program participants reported belonging to a racial or ethnic minority.

The statute required grantees to report on quantifiable, measurable 3-year benchmarks for demonstrating that the program improves the health and well-being of families participating in the program. The FY 2014 data from the 53 state and territory grantees indicated that the overwhelming majority (83 percent) demonstrated improvement in at least four of the six benchmark areas outlined in the legislation (maternal and newborn health; child injuries, child maltreatment and emergency department visits; school readiness and achievement; crime or domestic violence; family economic self-sufficiency; and service coordination and referrals for other community resources and supports). The nine state and territory grantees that did not demonstrate improvement in at least four benchmarks developed improvement plans and are receiving targeted technical assistance. Three non-profit grantees will be assessed for improvement when they report 3-year benchmark data in FY 2016. The first cohort of Tribal Program awardees also reported their 3-year performance data in 2014 with 77 percent (10 of 13) demonstrating improvement in four of six benchmark areas.

[239] Data represent the number of home visits provided by state and territory grantees (does not include tribal data).

The statute requires that the Federal Home Visiting Program prepare a Report to Congress, which includes information regarding the extent to which eligible entities receiving grants demonstrated improvements in the program's benchmark areas, on any technical assistance provided on benchmark areas, and on recommendations for legislative or administrative action that the Secretary deems appropriate.

The statute also requires an evaluation of the Federal Home Visiting Program. To fulfill this requirement, the Mother and Infant Home Visiting Program Evaluation (MIHOPE) was initiated in 2011. In February 2015, HHS delivered a report to Congress that presented the first findings from the study, including an analysis of the states' needs assessments and baseline characteristics of families, staff, local programs, and models participating in the study. As stated in the report, MIHOPE found that women enrolled in the evaluation face multiple risk factors that can lead to adverse outcomes for themselves and their children. The study also found that local programs' infrastructure is aligned with Federal Home Visiting Program expectations and designed to support quality service delivery for these families. Final reports on program implementation, impacts, and cost effectiveness will be available in 2018.

Grant Information

Since 2011, approximately one-third of the program grant funding was provided via need-based formula, with the balance directed to competitive grants to support the expansion (scale and scope) of home visiting services.

HRSA developed a new formula funding allocation plan for state and territory grantees beginning in FY 2016 with the goals of addressing need, supporting services, rewarding performance, and promoting stability and continuity. The revised funding plan includes formula grants based on two calculations: 1)population need (using 2013 Small Area Income and Poverty Estimate, or SAIPE, data) and 2) the three-year average (FY 2013 – FY 2015) of previous competitive funding awards to promote funding stability and service continuity. The plan also includes additional FY 2016 funds to be awarded through a forthcoming competitive funding announcement.
For FY 2016, $400 million was appropriated for the Program. This mandatory funding will support grants to 53 state and territory grantees, three non-profit organizations, and up to 30 eligible Tribal entities.

Funding History

FY	Amount
FY 2013*	$379,600,000
FY 2014*	$371,200,000
FY 2015**	$400,000,000
FY 2016***	$400,000,000
FY 2017***	$400,000,000

*****The Patient Protection and Affordable Care Act (P.L. 111-148) appropriated $400 million for the Maternal, Infant, and Early Childhood Home Visiting program in FY 2013 and FY 2014, but those amounts were reduced by 5.1 percent and 7.2 percent, respectively, due to sequestration in accordance with the Balanced Budget and Emergency Deficit Control Act, as amended.
** The Protecting Access to Medicare Act of 2014 (P.L. 113-93).
*** The Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10).

Budget Request

The FY 2017 Budget for the Federal Home Visiting Program of $400 million was appropriated by the Medicare Access and CHIP Reauthorization Act of 2015 and is the same as the FY 2016 level. The entire request is mandatory funding. In addition, the FY 2017 request proposes to extend and expand the program by $15 billion in new funding over ten years, which is estimated to serve more than 4.6 million at-risk families and provide over 30 million home visits through FY 2026.

The FY 2017 funding will support and enhance the ability of states, territories, non-profits and Tribal entities to work with local implementing agencies to serve at-risk families. This level of funding will provide:

- Awards to 53 state and territory grantees and three non-profit organizations;
- Up to 30 awards to tribal entities; and
- Support for research, evaluation, and technical assistance for both corrective action and program improvement and enhancement for state, territory, and tribal Federal Home Visiting Program grantees.

The funding will allow HRSA and ACF to continue to support the state, tribal, and locally run evidence-based home visiting services that have been proven to prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness.

Since the inception of the Program, grantees selected or developed their own performance measures for each benchmark construct to give themselves the flexibility to use measures that were meaningful for their specific programs. As such, the performance measures were not uniform across grantees. In FY 2017, the performance measurement system will be re-designed to both streamline and standardize measures, allowing for more effective analysis of grantee performance at the federal level.

The funding for research and evaluation will continue to support activities such as the statutorily required national evaluation, home visiting research, the Home Visiting Evidence of Effectiveness review, and a tribal early childhood research center. Technical assistance to grantees is of vital importance to ensure that home visiting services are provided with quality and fidelity to evidence-based models. The funding supports contracts for technical assistance around performance measurement, implementation, data systems, quality improvement, and research and evaluation; tribal resource centers; and learning and improvement collaboratives to enhance the efficiency and effectiveness of home visiting programs.

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

Outcomes and Outputs Tables[240]

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
37.1: Number of home visits to families receiving services under the Federal Home Visiting program.[241] (*Output*)	State/ Territory/ Tribal: FY 2015: 912,119 Target: 805,000 (Target Exceeded)	State/ Territory/ Tribal: 912,000	State/ Territory/ Tribal: 912,000	State/ Territory/ Tribal: Maintain
37.2: Number and percent of grantees that meet benchmark area data requirements for demonstrating improvement. (*Outcome-Developmental)*	State/Territory: FY 2015: 52 (98%) Tribal: FY 2014: 10 (77%)[242] (Baseline)	State/ Territory: 53 (98%) Tribal: 20 (80%)	State/ Territory: 53 (98%) Tribal: 20 (80%)	State/ Territory: Maintain Tribal: Maintain
37.3: Number of participants served by the Federal Home Visiting Program	State/ Territory: FY 2015: 145,561 Target: 125,000 (Target Exceeded)	State/ Territory/ Tribal: 145,000	State/ Territory/ Tribal: 145,000	State/ Territory/ Tribal: Maintain

Grant Awards Tables

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	107	101	101
Average Award	$3,485,436	$3,683,168	$3,683,168
Range of Awards	$265,000 - $13,201,834	$250,000 - $22,201,618	$250,000 - $22,201,618

[240] In April 2015, the Maternal, Infant, and Early Childhood Home Visiting program was extended for two years at the current funding level of $400 million per year. The FY 2016 President's Budget requested $500 million per year. Performance targets 37.1 and 37.3 for FY 2016 were adjusted to reflect enacted appropriations, which are $100 million less than the request.

[241] A home visit is the service provided by qualified professionals, delivered over time within the home to build relationships with the enrolled caregiver and the index child to achieve improved child and family outcomes. The number of "home visits" demonstrates the level of effort and service utilization for all enrollees and index children participating in the Federal Home Visiting Program.

[242] In FY 2014, 13 Tribal awardees had their 3-year performance assessment. In FY 2016 and 2017, 25 Tribal awardees will have their 3-year performance assessment.

Ryan White HIV/AIDS TAB

RYAN WHITE HIV/AIDS

Ryan White HIV/AIDS Treatment Extension Act of 2009 Overview

	FY 2015 Final*	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$2,318,781,000	$2,322,781,000	$2,297,781,000	-$25,000,000
ADAP (non add)[243]	$900,313,000	$900,313,000	$900,313,000	---
MAI (non add)	$169,077,000	$169,077,000	$169,077,000	---
PHS Evaluation Funds	---	---	$34,000,000	+$34,000,000
Total Funding	$2,318,781,000	$2,322,781,000	$2,331,781,000	+$9,000,000
FTE	189	190	191	+1

*Funding reflects reallocation of funds within the Ryan White program, including reprogramming and use of the Secretary's Transfer Authority.

Authorizing Legislation: Title XXVI of the Public Health Services Act, as amended by Public Law 111-87

FY 2017 Authorization……...…...Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Formula Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

The Ryan White HIV/AIDS Program (RWHAP), the largest Federal program focused exclusively on domestic HIV/AIDS care, provides services that are intended to 1) reduce the use of more costly inpatient care; 2) increase access to care for underserved populations; and 3) improve the quality of life for people living with HIV (PLWH). Recent studies have demonstrated that individuals with HIV on antiretroviral medications who achieve viral load suppression are less likely to transmit HIV to others, reducing new infections. The RWHAP, administered by the HIV/AIDS Bureau (HAB) within HRSA, coordinates with cities, states, and local community-based organizations to deliver a comprehensive system of HIV care, treatment and support. This system of care is critical to ensuring that individuals with HIV are linked and

[243] AIDS Drug Assistance Program (ADAP) Authorizing Legislation: PHS Act, Secs. 2611-31, as amended by P.L. 111-87

retained in care, are able to adhere to medication regimens, and ultimately, remain virally suppressed. This has important implications for both individual health outcomes as well as a significant public health impact on HIV incidence.

The RWHAP provides a system of primary medical care, treatment and supportive services to more than half of the people in the United States who have been diagnosed with HIV. The RWHAP, a payor of last resort, serves low-income PLWH who are uninsured or have some kind of health care coverage. A majority of the clients served by the RWHAP rely on the program for services not typically covered by private health insurers, Medicaid, or Medicare. The RWHAP has developed a robust system of care that provides the services needed to help keep people in care and achieve quality health outcomes like viral suppression. In 2013, the RWHAP served approximately 524,675 low-income PLWH in the United States, 27.8 percent of which were uninsured, and 67.6 percent were living at or below 100 percent of the federal poverty level. According to the Ryan White Services Report (RSR) the majority of clients served in 2013 were racial/ethnic minorities (72.8 percent). Black and Latino populations made up the majority of minority clients served in 2013; 46.8 percent and 22.6 percent respectively.

National HIV/AIDS Strategy: In July 2015, the White House re-released the *National HIV/AIDS Strategy for the United States: Updated to 2020* (NHAS 2020), an update to the first release in 2010. The NHAS has changed the way the American people talk about HIV, prioritize and organize prevention and care services locally, and deliver clinical and non-clinical services that support people living with HIV to remain engaged in health care. In addition, the NHAS 2020 incorporates the scientific advances that could one day bring the United States, and the world, closer to virtually eliminating new HIV infections, effectively supporting all people living with HIV to lead long and healthy lives and eliminating the disparities that persist in some populations. The NHAS 2020 includes 10 quantitative indicators to monitor progress and ensure that the Nation is constantly moving in the right direction to achieve its goals.

The NHAS 2020 has four primary goals:

1) Reducing new HIV infections;

2) Increasing access to care and improving health outcomes for PLWH;

3) Reducing HIV-related health disparities and health inequities; and

4) Achieving a more coordinated national response to the HIV epidemic.

HRSA/HAB is working closely with its recipients to meet all four goals. Reaching these goals requires broad support across federal, state, local, and tribal governments, business, faith-based communities, philanthropy, the scientific and medical communities, educational institutions, PLWH, and others.

Studies have demonstrated that antiretroviral treatment reduces HIV transmission by more than 96 percent. The RWHAP plays a central role in meeting the first NHAS 2020 goal of reducing new HIV infections by ensuring that individuals living with HIV have access to regular care and are started on and adhere to their antiretroviral medications. The RWHAP also plays a critical role in supporting the second NHAS 2020 goal by increasing access to care and improving health outcomes for PLWH by filling gaps in the health care system and reaching underserved and

difficult to reach populations. In 2013, the RWHAP served 56 percent of people in the United States who have been diagnosed with HIV in the United States. Of those receiving care through the RWHAP, 81 percent were retained in care in 2013. HRSA/HAB defines retention in care as having at least 2 outpatient ambulatory medical visits (OAMC) visits 90 days apart and at least one visit prior to Sept 1 of the reporting year.

Through the NHAS 2020, HAB supports the *HIV Care Continuum Initiative*. Within the HIV care continuum, viral suppression is the key goal to improve individual health outcomes and reduce HIV transmission. In 2013, 78.6 percent of clients served by the RWHAP achieved viral suppression, an increase from 69.5 percent seen in 2010. HRSA/HAB measures defines viral suppression as a last viral load result in the last year less than 200 copies/mL, among those with at least one outpatient ambulatory care visit in the reporting year. Individuals receiving HIV care through the RWHAP achieve higher viral suppression, in comparison to the national average of 30 percent. The RWHAP's expert care model and comprehensive services are crucial to retaining and engaging PLWH in care as well as improving the health outcomes of those in care. The RWHAP system of care remains necessary to improve health outcomes such as linkage to, and retention in care, and access to medications that suppress viral load, reducing HIV transmission, and leading to fewer new HIV infections.

The Minority AIDS Initiative (MAI) will continue the RWHAP's efforts to reduce HIV-related health disparities and health inequities, the third goal in NHAS 2020, strengthen organizational capacity, and expand HIV-related services to racial/ethnic minority populations. The MAI funds are used to strengthen primary health care and related services; conduct outreach and education to improve minority access to HIV treatment medications; and for targeted, multidisciplinary education and training programs for health care providers treating minority PLWH.

Ryan White Minority AIDS Initiative (MAI): Within the total amount included for the RWHAP, the FY 2017 Budget requests $169.1 million to address the disproportionate impact of HIV/AIDS on communities of color. RWHAP MAI dollars focus specifically on the elimination of racial and ethnic disparities in the delivery of comprehensive, culturally and linguistically appropriate HIV/AIDS care and treatment in the United States. To achieve this objective, the RWHAP uses MAI funds to conduct the following activities:

- Provide service grants to health care providers who have a history of providing culturally and linguistically appropriate care and services to racial and ethnic minorities;
- Increase the training of health care professionals in order to expand the HIV treatment expertise, resulting in improvements in providing medical care for racial and ethnic minority adults, adolescents, and children with HIV disease; and
- Support education and outreach services to increase the number of eligible racial and ethnic minorities who have access to the ADAP.

Minority AIDS Initiative (MAI) Funding
(Whole dollars)

Program Part	FY 2015	FY 2016	FY 2017
Part A	$54,105,000	$54,105,000	$54,105,000
Part B	$10,145,000	$10,145,000	$10,145,000
Part C	$71,012,000	$71,012,000	$94,683,000 *
Part D	$23,671,000	$23,671,000	N/A
Part F – AETC	$10,144,000	$10,144,000	$10,144,000
Total MAI Funding	$169,077,000	$169,077,000	$169,077,000

* Part C and Part D to be consolidated in FY 2017.

MAI program accomplishments result from the RWHAP developing outcome measures and other indicators that allow for ongoing monitoring of the MAI program's effectiveness. These indicators include:

1. Client-level health outcomes (the MAI client-level health outcomes indicators facilitate improving and stabilizing CD4 counts and reducing viral load);

2. Retention in care;

3. The proportion of health care providers trained in the clinical management of HIV/AIDS who serve primarily uninsured and underinsured minority populations.

Ryan White HIV/AIDS Program Performance: The RWHAP continues to demonstrate excellent performance in improving access to health care, health outcomes, quality of health care, and cost containment. Various strategies are used to achieve the Program's performance goals including:

1. Targeting resources to high-risk, high-need areas;
2. Ensuring availability, access to and excellence of critical HIV-related care and support services and optimizing health outcomes for PLWH;
3. Working to assure patient adherence;
4. Directing outreach and prevention education and testing to populations at disproportionate risk for HIV infection;
5. Tailoring services to populations known to have delayed care-seeking behaviors (e.g., by varying hours, offering care in various sites, offering linguistically and culturally appropriate services); and
6. Collaborating with other programs and providers for referrals to RWHAP service providers.

Improving Access to Health Care: The RWHAP works to improve access to health care by addressing the disparities in access, treatment, and care for populations disproportionately affected by HIV/AIDS including racial/ethnic minorities. The RWHAP provides HIV/AIDS care and treatment services to a significantly higher proportion of HIV-positive racial/ethnic minorities than their representation nationally as reported by the Centers for Disease Control and Prevention (CDC). HRSA has maintained the percentage of racial/ethnic minority clients at a

higher proportion than their representation nationally for the past 5 years. In FY 2013, 72.4 percent of RWHAP clients were HIV-positive racial/ethnic minorities, compared to 68.2 percent of CDC-reported cases among racial/ethnic minorities living with diagnosed HIV infection.[244]

The RWHAP also serves a higher proportion of HIV-positive women relative to the number of HIV cases reported nationally by the CDC and has maintained this higher percentage for the past 5 years. In FY 2013, 27.8 percent of RWHAP clients were HIV-positive women, compared to 24.2 percent of CDC-reported cases among women living with diagnosed HIV infection.[3]

Improving Health Outcomes: From FY 2009 through FY 2013, State ADAP programs served 70,916 additional clients, an increase of 36.5 percent:

- FY 2009: 194,039 clients served through State ADAPs;
- FY 2010: 208,809 clients served through State ADAPs;
- FY 2011: 211,037 clients served through State ADAPs;
- FY 2012: 244,436 clients served through State ADAPs; and
- FY 2013: 264,955 clients served through State ADAPs, exceeding the target by 28,725 clients.

About 55.2 percent of HIV positive people in the United States who are in regular care (defined as two or more medical visits per year) received their medications through RWHAP ADAPs in 2013.

CDC estimates that more than 1.2 million people aged 13 years and older in the United States are living with HIV infection[245], and almost 1 in 8 (12.8 percent) of those infected are unaware of their HIV infection.[246] More than 40,000 new infections occur each year.[247] Beginning in FY 2011, HAB implemented changes for how HIV testing data is reported through the RSR. Prior to 2011, RWHAP-funded providers reported on all HIV testing, regardless of the source of funding for the testing, and approximately 40 percent of HIV testing reported was supported by funds other than RWHAP. In 2011, the RSR requirements changed to collect only tests that were funded by the program, which resulted in a decrease in the number of HIV tests reported relative to previous years. However, the new data provides a more accurate depiction of the impact of RWHAP funding and demonstrates the important strides the RWHAP has made in testing people who do not know their serostatus. The data below reflect the number of individuals tested for HIV infection with positive or negative results:

- FY 2009: 871,696 persons learned their serostatus from the RWHAP;

[244] Table 20a. Persons living with diagnosed HIV infection by race/ethnicity – 2013. CDC HIV Surveillance Report, 2014.
[245] Table 11. Persons living with HIV infection by year. Monitoring Selected National HIV Prevention and Care Objectives by Using HIV Surveillance Data - 2013. CDC HIV Surveillance Supplemental Report, 2015.
[246] Table 9a. Est. HIV prevalence among persons aged >= 13 years and percentages of persons living with undiagnosed HIV infection, 2012.
[247] Table 1a. Diagnoses of HIV infection by year of diagnosis, 2010 – 2014. CDC HIV Surveillance Report, 2014.

- FY 2010: 1,205,257 persons learned their serostatus from the RWHAP;
- FY 2011: 679,531 persons learned their serostatus from RWHAP;
- FY 2012: 657,596 persons learned their serostatus from the RWHAP; and
- FY 2013: 787,663 persons learned their serostatus from the RWHAP, missing the target by 89,862.

Mother-to-child transmission in the U.S. has decreased dramatically since its peak in 1992 due to the implementation of universal testing for HIV for all pregnant women and the use of antiretroviral therapy which significantly reduces the risk of HIV transmission from the mother to her baby. In FY 2013, 95.0 percent of HIV-positive pregnant women served by the RWHAP were prescribed antiretroviral therapy to prevent maternal to child (vertical) transmission of HIV. The percentage of HIV-positive pregnant women in the RWHAP receiving antiretroviral medication has grown 8.0 percent from FY 2009 through FY 2013.

Improving the Quality of Health Care: A major focus of the RWHAP is improving the quality of care that participating clients receive. The Ryan White HIV/AIDS Treatment Modernization Act of 2006 directed recipients to develop, implement, and monitor clinical quality management programs to ensure that service providers adhere to established HIV clinical practices and quality improvement strategies. The Act also required that demographic, clinical, and health care utilization information is used to monitor trends in the spectrum of HIV-related illnesses and the local epidemic. This legislative requirement continues in the Ryan White HIV/AIDS Extension Act of 2009. In FY 2013, 99.2 percent of RWHAP-funded primary care medical providers had implemented a quality management program, exceeding the FY 2013 target, and demonstrating a 4.7 percentage point increase over FY 2009.

The viral load test measures the amount of HIV in the blood and is used to monitor a patient's response to HIV treatment. In FY 2013, 94.0 percent of patients receiving medical care were tested for viral load, exceeding the target of clients receiving viral load testing by 9.7 percentage points.

Cost Containment: Across the RWHAP, recipients are encouraged to maximize resources and leverage efficiencies. One example of this is within Part B, where State ADAPs use a variety of strategies to maximize resources, which result in effective funds management, enabling ADAPs to serve more people. Cost-containment approaches used by ADAPs include: using drug purchasing strategies such as cost recovery through drug rebates and third party billing; directing the negotiation of pharmaceutical pricing; reducing ADAP formularies; capping enrollment; and lowering financial eligibility levels. In 2013, State ADAPs participating in cost-savings strategies on medications saved $896.0 million, missing the FY 2013 target by $93.8 million. From 2009 – 2013 ADAPs participating in cost-savings strategies on medications saved $3.5 billion.

Funding History

FY	Amount[248]
FY 2008	$2,166,792,000
FY 2009	$2,238,421,000
FY 2010	$2,312,179,000
FY 2011	$2,336,665,000
FY 2012	$2,392,178,000
FY 2013	$2,248,638,000
FY 2014	$2,313,024,000
FY 2015	$2,318,781,000
FY 2016	$2,322,781,000
FY 2017	$2,331,781,000

Budget Request

The FY 2017 Budget Request for the RWHAP of $2.3 billion is $9.0 million above the FY 2016 Enacted. These increased resources will support a new initiative, Hepatitis C Treatment in People Living with HIV. The RWHAP has been at the forefront in treating the hepatitis C virus (HCV) among PLWH. However, additional work is needed to expand treatment of HCV among PLWH. The RWHAP demonstrates a comprehensive and data-driven approach in how government has targeted dollars toward the development of a highly effective service delivery system. The FY 2017 Budget Request of $2.3 billion for the RWHAP includes:

Part A: $655.9 million, which provides grants to 24 Eligible Metropolitan Areas (EMAs) and 28 Transitional Grant Areas (TGAs) disproportionately affected by HIV/AIDS;

Part B: $1.315 billion, which provides grants to 59 States and Territories to improve the quality, availability, and organization of HIV/AIDS health care and support services; this includes $900.3 million to provide access to FDA approved, HIV-related medications and insurance assistance through the AIDS Drug Assistance Program (ADAP). The ADAP serves low-income PLWH who have limited or no access to needed medication and is the nation's prescription drug safety net for PLWH;

Part C: $280.2 million, which provides grants directly to approximately 400 recipients to support outpatient HIV early intervention services and ambulatory care services. The request consolidates the Part D Program with the Part C Program to better target resources to points along the care continuum and populations most in need. Savings are expected by recipients and by the Federal government through increased efficiencies and decreased reporting burden, which could result in more resources focused on care;

Part F: $33.6 million for AIDS Education and Training Center (AETC) grants to organizations to support education and training of health care providers through regional centers, local performance sites, and national centers; $13.1 million for the HIV/AIDS Dental Reimbursement Program and the Community-Based Dental Partnership Program, both programs provide training

[248] Includes SPNS.

of the oral health care workforce and access to oral health treatment to patients with HIV disease; and $34.0 million in PHS Evaluation Funds for Special Projects of National Significance (SPNS), which supports the development of innovative models of HIV treatment, in order to quickly respond to emerging needs of clients served by Ryan White HIV/AIDS Program, an increase of $9 million over FY 2016, for Hepatitis C Treatment in People Living with HIV to increase HCV treatment. This project will use existing systems to develop models to increase testing for HCV, build capacity to expand treatment of HCV, and disseminate evidence-informed models of care.

In FY 2017, the RWHAP will continue its central goals of:

1. Ensuring that individuals living with HIV have access to care; and
2. Improving the quality of life of those infected with HIV and those affected by the epidemic.

In FY 2017, HAB will work with recipients to increase their focus on and support of services along the HIV care continuum that are not covered by insurance, but which are critical to ensuring that HIV positive individuals are linked into care and started on antiretroviral medications as early as possible (e.g. case management, transportation services, substance abuse and housing services). This work will ensure that individuals living with HIV are linked into care and begin and adhere to life-saving antiretroviral medications. Achieving this goal is not only crucial to ensuring the health and wellbeing of individuals living with HIV, but to preventing further transmission of the virus and ultimately ending the HIV epidemic.

PLWH who are on the appropriate medications are less infectious, reducing the chance of other Americans becoming infected. The importance of helping PLWH reach viral suppression through antiretroviral medications and other supports has been highlighted by studies demonstrating that antiretroviral treatment reduces HIV transmission by more than 96 percent. The RWHAP will continue to meet this mission until the goal of zero new infections is reached.

The NHAS 2020 targets men who have sex with men, youth (age 13 – 24), and racial/ethnic minorities, specifically black and Hispanic/Latino populations, as groups which are disproportionately impacted by HIV/AIDS. The RWHAP will continue to appropriately target these populations due to their increased risk for HIV. In 2014, an estimated 66.7 percent of all diagnosed infections were attributed to male-to-male sexual contact.[249] At some point in their lifetimes, 1 in 16 black men will be diagnosed with HIV infection, as will 1 in 32 black women.[250] The estimated rate of newly diagnosed HIV infections for black women was 18 times that of white women and almost 5 times that of Hispanic/Latina women.[251] Black and Hispanic/Latina women accounted for 78 percent of the estimated total of all women diagnosed with HIV infection.[252] Additionally, youth aged 13 to 24 accounted for an estimated 22 percent of all new HIV infections in the United States in 2010. The FY 2017 targets for the proportion of racial/ethnic minorities and women served in RWHAP-funded programs are within three

[249] Table 1a. Diagnoses of HIV infection by year of diagnosis, 2010 – 2014. CDC HIV Surveillance Report, 2014.
[250] Table 1. Estimated lifetime risk of HIV diagnosis – 2007. CDC MMWR, Oct. 15, 2010.
[251] Table 3a. Diagnoses of HIV infection by race/ethnicity, 2014. CDC HIV Surveillance Report, 2014.
[252] Table 20a. Persons living with HIV infection by race/ethnicity, year-end 2013. CDC HIV Surveillance Report, 2014.

percentage points of national HIV prevalence data provided to HRSA by CDC. With FY 2017 resources, the RWHAP will also target youth. With youth (ages 13 -24) making up an estimated 22 percent of all new HIV diagnoses in the United States in 2014, appropriate care and treatment services are needed to protect the health of this generation at high risk.

In FY 2017, the number of clients served by ADAPs is predicted to be 206,305 clients. The ADAP performance target reflects adjustments for our current performance and resources, in addition to medical inflation, rising health insurance premiums, reported decreases in state contributions and decreases in drug rebates, and increased costs of laboratory testing associated with antiretroviral use (e.g., resistance, tropism and Human Leukocyte Antigen (HLA) testing for patients). The FY 2017 performance target for persons who learn their serostatus from RWHAPs is 676,003. The Budget will also support the RWHAP's ongoing efforts to improve the quality of health care for PLWH. The FY 2017 performance target for the percentage of RWHAP-funded primary care providers that will have implemented a quality management program is 95.7 percent. The FY 2017 performance targets for HIV positive clients who are tested for viral load is 84.3 percent.

In FY 2017, the RWHAP will continue to coordinate and collaborate with other Federal, State, and local entities as well as national AIDS organizations in order to further leverage and promote efforts to address the unmet care and treatment needs of people living with HIV who are uninsured or underinsured. The HIV/AIDS Bureau's work in collaboration with others has been a key to its success. Federal partners include the Office of the Assistant Secretary for Health (OASH), the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare and Medicaid Services (CMS), Indian Health Service (IHS), the National Institutes of Health (NIH), the Agency for Healthcare Research and Quality (AHRQ), the Department of Housing and Urban Development (HUD), the Department of Veterans Affairs (VA), and the Department of Justice (DOJ) as well as other HRSA-funded programs.

Funding in FY 2017 also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

The funding request supports improved RSR data collection and reporting system for reporting unduplicated, client-level data. The RSR allows the RWHAP and its recipients to track actual numbers of clients served, as well as the services received by each client, and health outcomes. From identifying populations that fell out of care to charting a clients' response to a new treatment regimen, the client-level data provide a picture of what RWHAP providers are doing well and what they can do better, thereby supporting quality improvement efforts. RSR data assists HAB in ensuring the most effective use of its funding in increasing access to treatment and care by measuring health disparities related to quality indicators such as retention and viral suppression. This is supportive of HRSA's agency-wide aim to strengthen its capacity to assess program quality, reach, and impact.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
16.1: Number of racial/ethnic minorities and the number of women served by Ryan White HIV/AIDS-funded programs.[253] *(Long-Term Outcome)*	FY 2005 Baseline: 412,000 racial/ethnic minorities 195,000 women	N/A	N/A	N/A
16.I.A.1: Proportion of persons served by the Ryan White HIV/AIDS Program who are racial/ethnic minorities. *(Outcome)*	FY 2013: 72.4% Target: 68.2% (Target Not Met)	Within 3 percentage points of CDC data[254]	Within 3 percentage points of CDC data	Maintain
16.I.A.2: Proportion of persons served by the Ryan White HIV/AIDS Program who are women. *(Outcome)*	FY 2013: 27.8% Target: 24.2% (Target Not Met)	Within 3 percentage points of CDC data[255]	Within 3 percentage points of CDC data	Maintain
16.III.A.3: Proportion of HIV infected Ryan White HIV/AIDS Program clients that received medical care who were tested for viral load. *(Output)*	FY 2013: 94.0% Target: 84.3% (Target Exceeded)	84.3%	84.3%	Maintain
16.II.A.1: Number of AIDS Drug Assistance Program (ADAP) clients served through State ADAPs annually. *(Output)*	FY 2013: 264,955 Target: 236,230 (Target Exceeded)	212,107	206,305	-5,802[256]

[253] This is a long-term measure without annual targets. FY 2014 is the long-term target year. The FY 2014 target is 422,300/199,875. Next long-term target will be set for FY 2019.

[254] This is a new target set in FY 2015 "Within 3 percentage points of CDC data" and it will be reported using national HIV/AIDS prevalence data provided to HRSA by CDC rather than previous target through FY 2014 of "5 percentage points above CDC data" as reported by national AIDS prevalence data reported in CDC's HIV Surveillance Report. HRSA/HAB will report on this measure using the "5 percentage points above CDC data" as reported by national AIDS prevalence data from CDC's HIV Surveillance Report through FY 2014. The FY 2014 data from HRSA/HAB's RSR will be available in October 2015 and the CDC comparison data from the HIV Surveillance Report may be available around July 2016.

[255] "Within 3 percentage points of CDC data" is a new FY 2015 target and will be reported using national HIV/AIDS prevalence data. Until that time, the target of "5 percentage points above CDC data" as reported by national AIDS prevalence data will be used.

[256] This decrease reflects anticipated medical inflation, notwithstanding an anticipated increase in the number of people served by the RWHAP ADAP.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
16.II.A.2: Number of persons who learn their serostatus from Ryan White HIV/AIDS Programs. *(Output)*	FY 2013: 787,663 Target: 877,525 (Target Not Met but Improved)	676,003	676,003	Maintain
16.II.A.3: Percentage of HIV-positive pregnant women in Ryan White HIV/AIDS Programs who receive antiretroviral medications. *(Output)*	FY 2013: 95.0% Target: 90% (Target Exceeded)	90%	90%	Maintain
16.III.A.1: Percentage of Ryan White HIV/AIDS Program-funded primary medical care providers that will have implemented a quality management program. *(Output)*	FY 2013: 99.2% Target: 95.7% (Target Exceeded)	95.7%	95.7%	Maintain
16.E: Amount of savings by State ADAPs' participation in cost-savings strategies on medications. *(Containing Costs)*	FY 2013: $896.0M Target: $989.8M (Target Not Met)	Sustain prior year results	Sustain prior year results	Maintain

Emergency Relief Grants – Part A

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$655,220,000	$655,876,000	$655,876,000	---
MAI (non add)	$54,105,000	$54,105,000	$54,105,000	---
Total Funding	$655,220,000	$655,876,000	$655,876,000	---
FTE	50	50	50	---

Authorizing Legislation: Public Health Services Act, Section 2601, as amended by Public Law 111-87

FY 2017 Authorization…….……..…….Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Formula Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

Ryan White HIV/AIDS Program (RWHAP) Part A funds provide direct financial assistance to an Eligible Metropolitan Area (EMA) or a Transitional Grant Area (TGA) that has been severely affected by the HIV epidemic. Formula and supplemental grants assist eligible areas in developing or enhancing access to a comprehensive continuum of high quality, community-based care for low-income individuals with HIV. The RWHAP requires EMAs and TGAs, as population centers that experience a high burden of HIV/AIDS, to develop coordinated service delivery systems of care for people living with HIV (PLWH).

Part A of RWHAP prioritizes primary medical care, access to antiretroviral therapies, and other core services in areas of greatest medical need for PLWH. The grants fund systems of care to provide 13 core medical services and additional support services for individuals with HIV/AIDS in 24 EMAs, which are jurisdictions with 2,000 or more AIDS cases over the last five years, and 28 TGAs (jurisdictions with at least 1,000 but fewer than 2,000 AIDS cases over the last five years). Two-thirds of the funds available for EMAs and TGAs are awarded according to a formula based on the number of living cases of HIV/AIDS in the EMAs and TGAs. The remaining funds are awarded as discretionary supplemental grants based on the demonstration of additional need by the eligible EMAs and TGAs, and as Minority AIDS Initiative (MAI) grants. MAI grant awards are determined based on the number of minorities living with HIV and AIDS in a jurisdiction.

In 2013, 75 percent of Part A clients were racial/ethnic minorities and 27.2 percent were women. In 2010, Part A provided 2.63 million visits for health-related care (defined as primary medical, dental, mental health, substance abuse, rehabilitative, and home health), 1.994 million visits in 2011, and 2.28 million visits in 2012. In FY 2013, Part A provided 1.91 million visits for health-related care (defined as primary medical, oral health, mental health, substance abuse, home health, and home and community based services). This did not meet the target due to a change in the data source used for measuring HAB's performance, resulting in a lower number of calculated visits. In the historic data source (RDR), the data were limited to funding source. However, visit data were provided in the aggregate. In the current data source (RSR), the data are filtered at a more precise level resulting in the exclusion of data that may have been included in the historical aggregate data run.

Part A supports a comprehensive continuum of high-quality, community-based care for low-income individuals and families with HIV/AIDS. Eligible service categories include core medical services and support services, as defined by the legislation. Use of RWHAP Part A funds is locally determined, guided by a Planning Council, mandated by statute for EMA recipients and established by the chief elected official of each EMA or TGA. Eligible organizations for sub-recipient contracts under Part A include ambulatory care facilities, community health centers, and a variety of other organizations serving PLWH.

Funding History

FY	Amount
FY 2008	$627,149,000
FY 2009	$663,082,000
FY 2010	$678,074,000
FY 2011	$672,529,000
FY 2012	$666,071,000
FY 2013	$624,262,000
FY 2014	$649,373,000
FY 2015	$655,220,000
FY 2016	$655,876,000
FY 2017	$655,876,000

Budget Request

The FY 2017 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part A of $655.9 million is equal to the FY 2016 Enacted and will support RWHAP activities and services for PLWH in the 24 EMAs and 28 TGAs.

This request addresses ongoing RWHAP implementation during a period of significant change. An estimated 75 percent of all clients served by the RWHAP in 2013 were served in 1 of the 53 metropolitan areas funded under the Part A and roughly 71 percent of all people living with HIV infection reside within these metropolitan areas. RWHAP serves increasingly diverse and challenging (from the perspective of service delivery) populations which are impacted within an ever-changing epidemiologic profile. The clinical paradigm has changed significantly such that ongoing and effective treatment can not only enhance the quality and length of life but can suppress the virus and reduce further infections. Thus, the Part A Program has a significant

public health impact on HIV incidence. These factors provide a new context which will shape the future role of the RWHAP Part A program, one uniquely focused on heavily impacted metropolitan areas that must further develop and sustain a comprehensive system of HIV care to improve health outcomes and address the HIV epidemic.

In FY 2017, Part A recipients will continue to provide services not covered by private or public coverage but which are essential to:

1. Providing quality comprehensive HIV care such as intensive case management and care coordination services, and
2. Linking individuals living with HIV into care, initiating antiretroviral treatment (ART) as early as possible, and retaining them in care.

Supporting interventions that get people linked into care and on medications is critical to prevent the spread of the epidemic as studies have found that treatment reduces HIV transmission by more than 96 percent. Cities in jurisdictions without significant Medicaid expansion will continue to use their RWHAP funds to provide critical primary care services and life-saving medication.

Part A jurisdictions are experienced in data-driven, community-based needs assessment, responsive procurement of a variety of direct medical and supportive services, working with a set of providers to weave together a constellation of services, serving diverse populations and continuing to improve efforts to positively impact the continuum of HIV care. The Part A program will have an even greater role, focused within individual jurisdictions, to address movement along the HIV care continuum for individuals living with HIV and improvements overall at the community or systems level. Part A retains requirements and structures that can address the establishment of an effective HIV continuum of care, set targets, measure and evaluate improvement and consider performance against the care continuum and established HHS measures.

The FY 2017 target for the number of visits funded by Part A of the RWHAP for health-related care (primary medical, dental, mental health, substance abuse, and home health) is 1.91 million visits. Part A funding will also contribute to achieving the FY 2017 targets for the RWHAP's over-arching performance measures, including proportion of racial/ethnic minorities and women served, persons tested for viral load, and providers implementing a quality management program.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
17.I.A.1: Number of visits for health-related care (primary medical; oral health; mental health; substance abuse; home health; and home and community based services). *(Output)*	FY 2013: 1.91 M Target: 2.63 M (Target Not Met)	1.963 M	1.91 M	-53,000

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	53	52	52
Average Award	$11,786,883	$12,013,553	$12,013,553
Range of Awards	$2,097,353-$102,094,291	$2,777,820-$102,094,291	$2,777,820-$102,094,291

Part A – FY 2015 Formula, Supplemental & MAI Grants[257]

Table 1. Eligible Metropolitan Areas

EMAs	Formula	Supplemental	MAI	Total
Atlanta, GA	$14,342,883	$7,236,580	$2,199,314	$23,778,777
Baltimore, MD	10,181,556	5,531,802	1,664,250	17,377,608
Boston, MA	9,045,685	4,616,751	970,982	14,633,418
Chicago, IL	16,552,141	8,606,849	2,337,582	27,496,572
Dallas, TX	10,155,335	4,692,387	1,246,446	16,094,168
Detroit, MI	5,615,198	2,829,536	805,383	9,250,117
Ft. Lauderdale, FL	9,823,388	4,933,999	1,262,309	16,019,696
Houston, TX	13,612,043	6,888,741	2,011,206	22,511,990
Los Angeles, CA	25,597,826	12,792,014	3,320,033	41,709,873
Miami, FL	15,491,586	8,373,652	2,618,619	26,483,857
Nassau-Suffolk, NY	3,385,855	1,817,061	439,563	5,642,479
New Haven, CT	3,443,876	1,859,655	470,217	5,773,748

[257] Awards to EMAs and TGAs include prior year unobligated balances.

EMAs	Formula	Supplemental	MAI	Total
New Orleans, LA	4,628,842	2,308,103	626,706	7,563,651
New York, NY	59,713,012	32,925,911	9,455,368	102,094,291
Newark, NJ	7,647,604	4,011,808	1,299,502	12,958,914
Orlando, FL	5,946,029	2,661,611	749,325	9,356,965
Philadelphia, PA	13,774,948	7,308,601	2,033,071	23,116,620
Phoenix, AZ	5,561,640	2,667,738	493,584	8,722,962
San Diego, CA	7,023,321	3,523,427	672,474	11,219,222
San Francisco, CA	9,905,399	5,235,248	763,902	15,904,549
San Juan, PR	6,666,827	3,425,313	1,279,673	11,371,813
Tampa-St. Petersburg, FL	6,184,807	3,461,915	636,246	10,282,968
Washington, DC-MD-VA-WV	18,891,947	9,446,096	2,927,524	31,265,567
West Palm Beach, FL	4,561,895	2,448,898	674,618	7,685,411
Subtotal EMAs	**$287,753,643**	**$149,603,696**	**$40,957,897**	**$478,315,236**

Table 2. Transitional Grant Areas

TGAs	Formula	Supplemental	MAI	Total
Austin, TX	$2,869,770	$1,315,365	$304,618	$4,489,753
Baton Rouge, LA	2,682,280	1,320,296	431,202	4,433,778
Bergen-Passaic, NJ	2,520,690	1,289,815	350,814	4,161,319
Charlotte-Gastonia, NC-SC	3,771,182	1,863,171	549,427	6,183,780
Cleveland, OH	2,804,458	1,317,999	351,779	4,474,236
Columbus, OH	2,827,542	1,263,172	255,313	4,346,027
Denver, CO	5,067,280	2,469,335	361,318	7,897,933
Fort Worth, TX	2,637,801	1,296,797	312,978	4,247,576
Hartford, CT	2,058,442	1,043,161	276,214	3,377,817
Indianapolis, IN	2,627,666	1,231,581	258,207	4,117,454
Jacksonville, FL	3,619,727	1,715,099	498,192	5,833,018
Jersey City, NJ	3,125,949	1,670,067	472,361	5,268,377
Kansas City, MO	2,763,920	1,312,123	265,495	4,341,538
Las Vegas, NV	3,702,492	1,796,938	377,825	5,877,255
Memphis, TN	4,314,507	2,105,784	706,559	7,126,850
Middlesex-Somerset-Hunterdon, NJ	1,678,396	876,695	222,729	2,777,820
Minneapolis-St. Paul, MN	3,602,836	1,729,569	338,702	5,671,107
Nashville, TN	2,939,585	1,435,768	306,761	4,682,114
Norfolk, VA	3,627,609	1,741,462	530,348	5,899,419

TGAs	Formula	Supplemental	MAI	Total
Oakland, CA	4,290,297	2,130,738	529,169	6,950,204
Orange County, CA	3,851,133	1,895,639	400,548	6,147,320
Ponce, PR	1,219,525	645,667	232,161	2,097,353
Portland, OR	2,583,187	1,265,624	123,476	3,972,287
Riverside-San Bernardino, CA	4,800,966	2,278,932	456,283	7,536,181
Sacramento, CA	2,116,434	999,589	179,748	3,295,771
Saint Louis, MO	3,879,847	1,774,795	450,710	6,105,352
San Antonio, TX	3,091,041	1,458,953	451,567	5,001,561
San Jose, CA	1,876,583	935,034	207,294	3,018,911
Seattle, WA	4,517,198	2,237,012	303,224	7,057,434
Subtotal TGAs	**$91,468,343**	**$44,416,180**	**$10,505,022**	**$146,389,545**
Subtotal EMAs/TGAs	**$379,221,986**	**$194,019,876**	**$51,462,919**	**$624,704,781**

HIV Care Grants to States – Part B

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$1,315,005,000	$1,315,005,000	$1,315,005,000	---
ADAP (non add)	$900,313,000	$900,313,000	$900,313,000	---
MAI (non add)	$10,145,000	$10,145,000	$10,145,000	---
Total Funding	$1,315,005,000	$1,315,005,000	$1,315,005,000	---
FTE	79	79	79	---

Authorizing Legislation: Public Health Service Act, Section 2611, as amended by Public Law 111-87

FY 2017 Authorization……Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Formula Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

Part B, the largest of the Ryan White HIV/AIDS Programs (RWHAP), provides grants to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and five U.S. Pacific Territories or Associated Jurisdictions to provide services for people living with HIV (PLWH), including outpatient ambulatory medical care, HIV-related prescription medications, case management, oral health care, health insurance premium and cost-sharing assistance, mental health and substance abuse services, and support services.

Part B includes the AIDS Drug Assistance Program (ADAP), which supports the provision of HIV medications and related services, including health insurance premium and cost-sharing assistance. Seventy-five percent of Part B funds must be used to support 13 core medical services. Part B funds are distributed through base and supplemental grants, ADAP base and ADAP supplemental grants, Emerging Communities (ECs) grants, and Minority AIDS Initiative grants. The base awards are distributed by a formula based on a state or territory's living HIV/AIDS cases weighted for cases outside of Part A-funded jurisdictions. The ECs are metropolitan areas that do not qualify as EMAs or TGAs but have 500-999 cumulative reported AIDS cases over the last five years. States apply on behalf of the ECs for funding through the Part B base grant application. Part B Supplemental grants are available through a competitive process to eligible states with demonstrated need.

Congress designates a portion of the Part B appropriation to support the ADAPs. The ADAPs provide FDA-approved prescription medications for PLWH who have limited or no prescription drug coverage or who need assistance with insurance premiums and cost-sharing to afford HIV medications. The ADAP funds are distributed by a formula based on living HIV/AIDS cases; ADAP Supplemental funds are a five percent set aside for states with severe need. ADAP funds also may be used to purchase health insurance for eligible clients or to pay for services that enhance access, adherence, and monitoring of drug treatments. Individual ADAPs operate in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, the Republic of Palau, and the Republic of the Marshall Islands.

About 55.2 percent of HIV positive people in the United States who are in regular care (defined as two or more medical visits per year) received their medications through RWHAP ADAPs in 2013. Overall, the demand for ADAP services has increased over the past few years, from 211,037 clients in FY 2011, to 244,436 clients in FY 2012 and 264,955 clients in FY 2013. In the period of FY 2009 – FY 2013, the RWHAP ADAP programs experienced a growth of 36.5 percent or 70,916 additional ADAP clients. In FY 2013, 64.4 percent of the 264,955 clients served by ADAPs were people of color. Nationally, more than 77.7 percent of ADAP clients had incomes at or below 200 percent of the federal poverty level.

Increased demand for Part B services in recent years has led a number of States to implement cost-containment measures for their Part B ADAPs. Cost-containment measures include: reducing ADAP formularies, capping enrollment, lowering financial eligibility levels, and implementing waiting lists for people to enroll in their ADAP. In addition, states implemented cost-savings strategies such as recovering costs when another payor was primary, coordinating benefits with Medicare Part D, and improving drug purchasing models. In particular, State ADAPs reported savings by participating in manufacturer rebate programs and recovering costs through insurance reimbursement of $896.0 million in 2013.

Since FY 2010, HHS has taken several actions to address the ADAP crisis:

- In FY 2010, HHS used emergency authority to redistribute and transfer $25 million to provide direct assistance to help State ADAP programs eliminate their waiting lists and to address cost containment measures;
- The FY 2011 appropriation provided an increase of $50 million for State ADAPs, including $40 million in emergency relief funding;
- In FY 2012, $75 million in emergency funding was provided for ADAPs, including $35 million in redirected funding announced by President Obama on World AIDS Day and $40 million in continuation emergency funding first appropriated in FY 2011;
- In FY 2013, HHS redirected an additional $35 million above the FY 2013 appropriations for State ADAPs, bringing the total for ADAP emergency relief funding to $75 million;
- In FY 2014, HHS leveraged $73 million from the ADAP appropriation to support emergency relief efforts to help State ADAP programs eliminate their waiting lists and to address cost containment measures; and

- In FY 2015, HHS leveraged $75 million from the ADAP appropriation to support emergency relief efforts to help State ADAP programs eliminate their waiting lists and to address cost containment measures.

As a result of the increased investments in ADAP and the increased technical assistance activities for cost-containment measures, the program was able to serve 264,955 clients with HIV-related medications in FY 2013 and thousands more were provided with insurance coverage. ADAP waiting lists decreased from a peak of 9,310 in September, 2011, to zero in August, 2015 because of these directed efforts. In FY 2016 and FY 2017, HRSA will continue the use of ADAP Emergency Relief Funds through 311 authority in order to distribute resources based on demonstrated need to avoid or mitigate ADAP waiting lists as PLWH will need ongoing ADAP assistance for medications in order to increase their access and adherence to antiretroviral medications and achieve viral load suppression.

The RWHAP Part B Programs have been successful in helping to ensure that PLWH have access to the care and treatment services they need to live longer, healthier lives. Recent studies have demonstrated that individuals with HIV on antiretroviral medications who achieve viral load suppression are less likely to transmit HIV to others. The RWHAP provides the care and treatment services that support the achievement of viral suppression and therefore, has a significant public health impact on HIV incidence as well. These efforts demonstrate the central role of the RWHAP in meeting the NHAS 2020 goals by ensuring that individuals living with HIV have access to regular care, are started on, and adhere to their antiretroviral medications.

In 2013, 69.1 percent of Part B clients were racial/ethnic minorities, and 28 percent were women. The number of visits for health-related services demonstrates the scope of the Part B Program in delivering primary care and related services for PLWH by increasing the availability and accessibility of care. In FY 2010, Part B provided 2.20 million visits for health-related care (defined as primary medical; oral health; mental health; substance abuse; home health; and home and community based services); 1.086 million visits in FY 2011; and 2.04 million visits in FY 2012. In FY 2013, the Part B Program provided 1.49 million visits for health-related care. This did not meet the FY 2013 target due to the change in the data source used for measuring HAB's performance, resulting in a lower number of calculated visits. In the current data source (RSR), the data are filtered at a more precise level resulting in the exclusion of data that may have been included in the historical run given the way the analysis was done with aggregate data or data combined from several elements. The change in the data source from RDR to RSR resulted in a lower number of calculated visits which is attributed to using client-level data (RSR) and how the data analysis is done.

Funding History

FY	Amount	ADAP (Non-Add)
FY 2008	$1,195,248,000	($794,376,000)[258]
FY 2009	$1,223,791,000	($815,000,000)
FY 2010	$1,276,791,000	($858,000,000)
FY 2011	$1,308,141,000	($885,000,000)
FY 2012	$1,360,827,000	($933,299,000)
FY 2013	$1,287,535,000	($886,313,000)
FY 2014	$1,314,446,000	($900,313,000)
FY 2015	$1,315,005,000	($900,313,000)
FY 2016	$1,315,005,000	($900,313,000)
FY 2017	$1,315,005,000	($900,313,000)

Budget Request

The FY 2017 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part B of $1.3 billion is equal to the FY 2016 Enacted level. The Request includes $900.3 million for ADAPs to provide access to life saving HIV related medications and health care services to people living with HIV (PLWH) in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam and five Pacific jurisdictions. The 311 authority will be utilized to implement the Emergency Relief Fund to minimize ADAP waiting lists.

Research shows that treatment reduces HIV transmission by 96 percent, highlighting the importance of ensuring that all individuals living with HIV have access to care and are prescribed antiretroviral therapy (ART). By keeping PLWH in care and on medications, the RWHAP plays a critical role in preventing the spread of the HIV epidemic, as PLWH who are on antiretroviral therapy and virally suppressed are much less likely to transmit the infection.

The impact of the first Affordable Care Act health care coverage enrollment period varied greatly between the RWHAP ADAP programs, particularly between states that expanded Medicaid and those that did not. HRSA reviewed data provided by the National Alliance of State and Territorial AIDS Directors (NASTAD) which included the total number of clients by state in June 2013 and June 2014. Between June 2013 and June 2014, many Medicaid expansion states had a decrease in the number of RWHAP clients served, with an overall 13 percent decrease in the number of clients served. In contrast, most states that have not expanded Medicaid saw an increase in the number of ADAP clients between June 2013 and June 2014; with an average 7 percent increase in the number of clients served and many states growing rapidly (over 10 percent per year). Factoring in the variability in client increases and decreases in RWHAP ADAPs in both states expanding Medicaid and not expanding Medicaid, HRSA projects that the RWHAP could continue to see 5 percent to 10 percent growth per year in the number of clients through FY 2017.

Demand for ADAP services continues to be high, with HRSA anticipating that the RWHAP will continue to see steady growth in the number of clients through FY 2017. An important

[258] FY 2008 actual expenditure was $813,858,028 due to the hold harmless provision. For FY 2008, the statute requires that the grant not be less than 100 percent of the FY 2007 total grant.

contributing factor to the demand for services for ADAP continues to be access to HIV medications and high cost-sharing requirements for these medications. Challenges with insurance eligibility and coverage of medications has left many PLWH without the ability to cover the costs of their needed antiretroviral medications or without access to clinically appropriate medications. The RWHAP will continue to provide access to life-saving medications and related services for PLWH.

In FY 2017, RWHAP Part B/ADAP recipients will continue to work directly with uninsured individuals living with HIV to enroll them in private health insurance or expanded Medicaid, as available. ADAP will continue to support HIV medications not on health coverage plan formularies and the cost-sharing required by health coverage plans. RWHAP ADAP resources will also support:

- The continued increase in RWHAP growth as more PLWH are diagnosed, linked to care, and retained in care;
- The continued increase in RWHAP growth as more people entering the health care system with coverage who require assistance with insurance premiums and cost-sharing, and;
- The continued need for ADAP for clients who are unable to transition to new health care coverage options due to the lack of Medicaid expansion or other barriers.

The FY 2017 ADAP clients served performance target is 206,305. The FY 2017 Part B performance target for number of visits for health-related care (primary medical; oral health; mental health; substance abuse; home health; and home and community based services) is 1.51 million visits.

Part B/ADAP funding will also contribute to achieving the FY 2017 targets for the RWHAP's over-arching performance measures, including proportion of racial/ethnic minorities and women served, persons receiving a viral load test, and providers implementing a quality management program.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
18.I.A.1: Number of visits for health-related care (primary medical; oral health; mental health; substance abuse; home health; and home and community based services). *(Output)*	FY 2013: 1.49 M Target: 2.27 M (Target Not Met)	1.80 M	1.51 M	-290,000

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	59	59	59
Average Award	$19,522,330	$21,511,441	$21,511,441
Range of Awards	$41,049-$146,242,711	$50,000-$163,000,000	$50,000-$163,000,000

Part B – FY 2015 State Table[259]

State/ Territory	Base	Part B Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
Alabama	$7,976,597	$1,019,000	$10,803,548	$323,086	$154,760	$20,276,991
Alaska	500,000	70,000	1,186,878	0	0	1,756,878
American Samoa	50,000	0	1,641	0	0	51,641
Arizona	3,882,141	0	10,827,122	0	110,405	14,819,668
Arkansas	3,123,030	0	5,232,707	0	46,750	8,402,487
California	32,257,238	10,000,000	105,060,020	163,159	1,227,573	148,707,990
Colorado	3,426,475	0	9,576,324	0	77,452	13,080,251
Connecticut	2,850,915	0	8,886,087	0	132,458	11,869,460
Delaware	2,097,349	0	2,631,273	205,352	41,460	4,975,434
District of Columbia	3,910,268	0	12,946,258	0	236,965	17,093,491
F. States Micronesia	47,110	0	0	0	0	47,110

[259] Awards include prior year unobligated balances.

State/ Territory	Base	Part B Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
Florida	30,387,962	4,000,000	94,631,997	489,052	1,327,506	130,836,517
Georgia	12,473,753	6,106,950	51,843,217	161,543	557,798	71,143,261
Guam	200,000	0	65,659	0	0	265,659
Hawaii	1,605,394	0	2,014,081	0	21,195	3,640,670
Idaho	581,579	0	1,432,012	0	0	2,013,591
Illinois	9,429,494	0	36,025,197	0	442,514	45,897,205
Indiana	3,449,383	0	10,256,998	0	0	13,706,381
Iowa	1,363,342	0	1,976,612	0	0	3,339,954
Kansas	1,128,220	0	2,504,880	0	0	3,633,100
Kentucky	3,927,131	0	4,926,866	266,090	45,856	9,165,943
Louisiana	6,211,426	0	23,990,723	0	260,930	30,463,079
Maine	809,893	0	1,016,069	0	0	1,825,962
Marshall Islands	41,049	0	0	0	0	41,049
Maryland	6,821,069	0	25,372,991	0	470,464	32,664,524
Massachusetts	4,696,962	0	14,171,054	0	185,891	19,053,907
Michigan	4,898,741	0	12,591,701	0	184,372	17,674,814
Minnesota	1,983,134	650,000	5,990,537	0	64,049	8,687,720
Mississippi	5,766,528	1,247,460	7,444,057	279,276	129,509	14,866,830
Missouri	3,494,623	0	9,866,043	0	0	13,360,666
Montana	500,000	0	445,912	0	0	945,912
N. Marianas	50,000	0	1,641	0	0	51,641
Nebraska	1,244,278	270,834	1,686,036	0	0	3,201,148
Nevada	2,053,241	0	6,135,807	0	0	8,189,048
New Hampshire	500,000	0	943,844	0	0	1,443,844
New Jersey	10,444,434	892,370	35,426,184	0	518,089	47,281,077
New Mexico	1,824,549	0	2,289,027	0	0	4,113,576
New York	35,945,402	23,761,212	107,791,915	634,602	1,870,792	170,003,923
North Carolina	11,362,100	3,500,000	25,200,594	297,650	368,672	40,729,016
North Dakota	500,000	0	229,683	0	0	729,683
Ohio	6,771,868	0	15,872,174	309,390	183,443	23,136,875
Oklahoma	3,565,362	0	4,473,000	224,748	0	8,263,110
Oregon	1,699,373	215,349	4,588,724	0	0	6,503,446
Pennsylvania	10,816,632	0	27,514,285	268,217	415,905	39,015,039
Puerto Rico	5,685,385	1,923,247	29,555,636	0	335,683	37,499,951

State/ Territory	Base	Part B Suppl.	ADAP Total	Emerging Communities	MAI	Grand Total
Republic of Palau	50,000	0	3,283	0	0	53,283
Rhode Island	1,436,612	0	2,159,607	182,129	21,034	3,799,382
South Carolina	9,983,125	2,000,000	12,754,206	551,406	213,090	25,501,827
South Dakota	500,000	0	389,849	0	0	889,849
Tennessee	5,284,566	2,639,542	21,550,662	0	196,524	29,671,294
Texas	22,040,540	2,400,000	79,798,506	0	945,270	105,184,316
Utah	1,682,589	392,816	3,117,239	0	0	5,192,644
Vermont	500,000	0	372,613	0	0	872,613
Virgin Islands	500,000	0	994,334	0	9,972	1,504,306
Virginia	7,134,573	0	28,143,465	386,631	274,583	35,939,252
Washington	3,568,711	0	9,653,473	0	73,431	13,295,615
West Virginia	1,009,421	0	1,384,578	0	0	2,393,999
Wisconsin	3,582,250	341,500	4,518,961	257,669	53,737	8,754,117
Wyoming	500,000	0	225,702	0	0	725,702
Total	**$310,125,817**	**$61,430,280**	**$900,493,492**	**$5,000,000**	**$11,198,132**	**$1,288,247,721**

Early Intervention Services – Part C

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$204,179,000	$205,079,000	$280,167,000	+$75,088,000
MAI (non add)	$71,012,000	$71,012,000	$94,683,000	+$23,671,000
Total Funding	$204,179,000	$205,079,000	$280,167,000	+$75,088,000
FTE	42	42	54	+12

Authorizing Legislation: Public Health Service Act, Section 2651, as amended by Public Law 111-87

FY 2017 Authorization……..……..…….…...Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

Part C of the Ryan White HIV/AIDS Program (RWHAP) provides grants directly to community and faith-based primary health clinics and public health providers in 49 states, Puerto Rico, the District of Columbia, and the U.S. Virgin Islands. Part C Programs are the primary means for targeting HIV medical services to underserved and uninsured people living with HIV (PLWH) in specific geographic communities, including rural and frontier communities. Part C Programs target the most vulnerable populations, including people of color, men who have sex with men (MSM), women, infants, children and youth as well as low-income populations. Part C Programs have the cultural competency and expertise to provide care to these underserved and vulnerable populations. In 2013, 71 percent of those served by Part C clinics were racial/ethnic minorities and 28.1 percent were female. Part C provided 976,619 Outpatient Ambulatory Medical Care visits and performed 592,006 HIV tests in 2013.

The number of persons receiving primary care services under Part C Early Intervention Services programs was 273,157 in FY 2010; 256,347 in FY 2011; and 288,347 clients in FY 2012. In FY 2013, 292,653 clients were served by the Part C Early Intervention Services program, exceeding the target of 265,325 by 27,328.

As part of a $15 million initiative named *Increasing Access to HIV Care and Treatment (IAHCT)*, HRSA grant recipients identified, engaged and linked HIV positive clients into primary care through 271 RWHAP Part C funded clinical sites. In FY 2013, 18,777 clients were enrolled or re-engaged with this funding, which exceeded the initial goal of 7,500 people. The Part C Program engaged clients along the HIV care continuum by linking those who tested

positive to care as soon as they received their diagnosis, enrolled patients in care who were aware of their positive diagnosis but were not yet in care, and re-engaged those who had fallen out of care.

In FY 2015, the Part C Program increased its emphasis on care for all populations, including women, infants, children and youth. HRSA continues to support models of care that target points along the HIV care continuum to improve patient outcomes.

Funding History

FY	Amount
FY 2008	$198,754,000
FY 2009	$201,877,000
FY 2010	$206,383,000
FY 2011	$205,564,000
FY 2012[260]	$215,086,000
FY 2013	$194,444,000
FY 2014	$205,544,000
FY 2015	$204,179,000
FY 2016	$205,079,000
FY 2017	$280,167,000

Budget Request

The FY 2017 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part C of $280.2 million is $75.1 million above the FY 2016 Enacted. The Request proposes to consolidate the Part D Program with the Part C Program to expand the focus on women, infants, children and youth across all the funded recipients, in an effort to increase access for all genders and populations across the country that need HIV care and treatment services. The consolidation will also reduce duplication of effort and reporting/administrative burden among currently co-funded recipients to improve medical outcomes.

In 2014, approximately 67 percent of Part D Programs funded by the RWHAP were dually funded by Part C. HIV positive clients served under Part D are eligible for services under the consolidated program, and the merged program emphasizes care across all vulnerable populations, genders and ages. By consolidating the two programs, resources are better targeted to points along the care continuum to improve patient outcomes. This should result in more funding for direct patient care services. The Part C Program will provide 1.46 million visits for health-related care (primary medical; oral health; mental health; and substance abuse) in FY 2017. Part C funding will also contribute to achieving the FY 2017 targets for the RWHAP's over-arching performance measures including: proportion of racial/ethnic minorities and women served, persons learning of their serostatus from RWHAP, persons tested for viral load, and providers implementing a quality management program.

[260] Reflects Ryan White BA only (does not include $5.089 million in Health Center Program BA for Part C recipients in FY 2012).

In FY 2017, many Part C recipients will continue to see the benefits of health care coverage expansions that allow uninsured individuals living with HIV to enroll in private health insurance or expanded Medicaid. The Part C Program supports health care services that may not be fully covered by public or private health care coverage but are considered essential to reducing the burden of HIV/AIDS and are a crucial part of the care network that links and retains individuals into care. The Part C Program allows for flexibility that may be needed by recipients depending on local factors. In states and cities where the number of insured RWHAP clients increases, Part C recipients will continue to provide services along the HIV care continuum that are not covered by private or public health care coverage but which are critical to providing quality comprehensive HIV care. Such critical health care services include intensive case management and care coordination services, linking and retaining individuals living with HIV into care and starting and adhering to ART regimens as early as possible. The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result/ (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
19.II.A.2: Number of visits for health-related care (primary medical; oral health; mental health; and substance abuse). *(Output)*	FY 2013: 1.68 M (Target Not Set)	1.45 M	1.46 M	+ 0.01 M
Retired Measure[261] 19.II.A.1: Number of people receiving primary care services under Early Intervention Services programs. *(Output)*	FY 2013: 292,653 Target: 265,325 (Target Exceeded)	N/A	N/A	N/A

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	347	347	387
Average Award	$527,472	$527,472	$645,994
Range of Awards	$95,000-$1,578,446	$95,000-$1,578,446	$95,000-$1,578,446

[261] This measure will be retired given the Part C and Part D consolidation. HRSA/HAB will report on this measure through FY 2015. The FY 2015 data will be available in May 2017.

Women, Infants, Children and Youth – Part D

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$73,008,000	$75,088,000	---	-$75,088,000
MAI (non add)	$23,671,000	$23,671,000	---	-$23,671,000
Total Funding	$73,008,000	$75,088,000	---	-$75,088,000
FTE	12	12	---	-12

Authorizing Legislation: Public Health Service Act, Section 2671, as amended by Public Law 111-87

FY 2017 Authorization……..……Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

The Part D Program focuses on providing access to coordinated, family-centered primary medical care and support services for HIV-positive women, infants, children, and youth (WICY) and their affected family members. It also funds support services, such as case management and childcare that help clients obtain and stay in needed care. Eligible organizations are public or private nonprofit entities that directly provide or arrange via contract or MOU for primary care for HIV-positive women, infants, children, and youth. Part D recipients include community based organizations, hospitals, and State and local governments. Currently, there are 115 WICY programs located in 40 states, the District of Columbia, and Puerto Rico.

Funding History

FY	Amount
FY 2008	$73,690,000
FY 2009	$76,845,000
FY 2010	$77,621,000
FY 2011	$77,313,000
FY 2012	$77,167,000
FY 2013	$72,361,000
FY 2014	$72,395,000
FY 2015	$73,008,000
FY 2016	$75,088,000
FY 2017	---

Budget Request

The FY 2017 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part D proposes to consolidate the Part D Program with the Part C Program and does not request separate funding for the Part D Program. The FY 2017 Budget Request is $75.1 million below the FY 2016 Enacted level. The consolidation will expand the focus on women, infants, children and youth across all the funded recipients, increase points of access for these populations and reduce duplication of effort and reporting/administrative burden among co-funded recipients. In 2014, approximately 67 percent of Part D Programs funded by the RWHAP were dually funded by Part C. Under the proposed consolidation, current Part D Programs will be eligible to apply for grant funding under the Part C Program requirements. These programs will be able to provide services to HIV positive clients with supplemental expansion funds. The consolidated C/D Program will be focus on improving outcomes along the HIV care continuum focusing on specific sub-populations (e.g. youth and women) that are served.

Outcomes and Outputs Table

Retired Measure[262]	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
20.II.A.1 Number of female clients[263] provided comprehensive services, including appropriate services before or during pregnancy, to reduce perinatal transmission. *(Output)*	FY 2013: 60,777 Target: 49,802 (Target Exceeded)	N/A	N/A	N/A

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	115	115	---
Average Award	$581,322	$598,713	---
Range of Awards	$94,829-$2,143,182	$94,829-$2,143,182	---

[262] This measure will be retired given the Part C and Part D consolidation. HRSA/HAB will report on this measure through FY 2015. The FY 2015 data will be available in May 2017.
[263] Female clients counted are age 13 and above.

AIDS Education and Training Programs – Part F

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$33,349,000	$33,611,000	$33,611,000	---
MAI (non add)	$10,144,000	$10,144,000	$10,144,000	---
Total Funding	$33,349,000	$33,611,000	$33,611,000	---
FTE	5	5	5	---

Authorizing Legislation: Public Health Service Act, Sec. 2692(a), as amended by Public Law 111-87.

FY 2017 Authorization……...….Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

The mission of the AIDS Education and Training Centers (AETC) program of the Ryan White HIV/AIDS Program (RWHAP) is to increase the number of health care providers who are effectively educated and motivated to counsel, diagnose, treat and medically manage people with HIV disease, and to help prevent high-risk behaviors that lead to HIV transmission. This mission is obtained through implementation of multidisciplinary education and training programs for health care providers in the prevention and treatment of HIV/AIDS. Overall the AETC program is charged with increasing the knowledge, skills and education of providers and organizations to be able to provide quality care and increase access to care. The AETC network offers specialized clinical education and consultation on HIV/AIDS transmission, treatment, and prevention to front-line health care workers, including physicians, nurses, physician assistants, dentists and pharmacists. AETCs currently train providers through a variety of training modalities, including didactics, clinical preceptorships, self-study, clinical consultation, communities of practice and distance-based technologies.

The AETCs support the National HIV/AIDS Strategy Updated to 2020 (NHAS 2020): by providing training, education, and technical assistance to strengthen the delivery of services and quality of care along the HIV care continuum. Health care providers who are well-trained to provide high quality HIV care are needed to ensure system capacity for the increases of PLWH in care that are occurring due to improved survival and increased numbers of patients linked and

retained in care. The management of HIV/AIDS care and treatment, consistent with established guidelines and reflecting current research, is the central focus of training. This is increasingly important as the HIV epidemic expands in the United States with improved testing rates and prolonged survival. In addition, the number of trained HIV care professionals is projected to decrease as many of those who have worked in the epidemic since its inception reach retirement age. Training an expanded cadre of culturally competent, high quality providers will be vital to meet the NHAS 2020 goals of increasing access to quality HIV/AIDS care and treatment and improving health outcomes for PLWH particularly in the context of expanded healthcare coverage.

The AETCs target training to providers who serve minority populations, the homeless, rural communities, incarcerated persons, federally qualified community and migrant health centers, and RWHAP sites. AETC-trained providers are more competent with regard to HIV care and more willing to treat PLWH than other primary care providers. The AETCs provide education in a variety of formats including skills building workshops, hands-on preceptorships and mini-residencies, on-site training, tele-education and technical assistance. Clinical faculty also provides timely clinical consultation in person or via the telephone or internet. Based in leading training institutions across the country, the AETCs use nationally recognized faculty, opinion leaders and HIV researchers in the development, implementation, and evaluation of the education, training and technical assistance offered.

In 2012-2013, the proportion of racial/ethnic minority health care providers participating in AETC training intervention programs was 45.3 percent. During 2012-2013, AETCs conducted 15,678 training events. The most common type or modality of training was individual clinical consultation at 30 percent across the time period.

Funding History

FY	Amount
FY 2008	$34,094,000
FY 2009	$34,397,000
FY 2010	$34,745,000
FY 2011	$34,607,000
FY 2012	$34,542,000
FY 2013	$32,390,000
FY 2014	$33,275,000
FY 2015	$33,349,000
FY 2016	$33,611,000
FY 2017	$33,611,000

Budget Request

The FY 2017 Budget Request for the Ryan White HIV/AIDS Program (RWHAP) Part F-AETC of $33.6 million is equal to the FY 2016 Enacted level. The Request will support targeted, multidisciplinary education and training programs for novice and experienced health care providers treating people living with HIV (PLWH). Funding will support the training of additional health care providers to deliver high quality HIV/AIDS care and treatment services in

primary care settings that have not typically provided services to PLWH. HRSA will continue to prioritize interactive training and technical assistance that result in health system strengthening and transformation.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
21.V.B.1: Proportion of AETC training intervention participants that are racial/ethnic minorities. *(Output)*	FY 2013: 45.3% Target: 43% (Target Exceeded)	43%	43%	Maintain

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	16	16	16
Average Award	$1,900,000	$1,900,000	$1,900,000
Range of Awards	$202,000-$4,500,000	$202,000-$4,500,000	$202,000-$4,500,000

Dental Reimbursement Program – Part F

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$13,020,000	$13,122,000	$13,122,000	---
FTE	1	1	1	---

Authorizing Legislation: Public Health Service Act, Section 2692(b) as amended by Public Law 111-87

FY 2017 Authorization…….…….…..Expired

Allocation Method:

- Competitive Grants
- Formula Grants
- Contracts

Program Description and Accomplishments

The Part F Dental funding supports two programs: the HIV/AIDS Dental Reimbursement Program (DRP) and the Community-Based Dental Partnership Program (CBDPP).

Dental Reimbursement Program

The HIV/AIDS Dental Reimbursement Program provides access to oral health care for people living with HIV (PLWH) by reimbursing dental education programs for the non-reimbursed costs they incur providing such care. By offsetting the costs of non-reimbursed HIV care in accredited dental education institutions, the Dental Reimbursement Program improves access to oral health care for PLWH and trains dental and dental hygiene students and dental residents to provide oral health care services to PLWH. The care provided through the program includes a full range of diagnostic, preventive, and treatment services, including oral surgery, as well as oral health education and health promotion.

Dental schools, post-doctoral dental education programs, and dental hygiene education programs accredited by the Commission on Dental Accreditation that have documented non-reimbursed costs for providing oral health care to PLWH are eligible to apply for reimbursement. Funds are then distributed to eligible organizations taking into account the number of people served and the cost of providing care.

In FY 2014, the DRP awards met 26.9 percent of the total non-reimbursed costs reported by 56 participating institutions in support of oral health care. These institutions reported providing care

to 39,138 HIV-positive individuals, for whom no other funded source was available. This number exceeded the goal by 5,822 individuals or 17.5 percent. This represents a 5.2 percent increase from FY 2011 for persons whom a portion/percentage of their unreimbursed oral health costs was reimbursed. In FY 2014, the demographic characteristics of patients who were cared for by institutions participating in the DRP were 54.8 percent minority and 30.7 percent women.

Community Based Dental Partnership Program

The CBDPP supports collaborations between dental education programs and community-based partners to deliver oral health services in community settings while training students and residents enrolled in accredited dental educations programs. In FY 2014, CBDPP funded 12 partnership grants to collaborate and coordinate between the dental education programs and the community-based partners in the delivery of oral health services.

Programs	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Dental Reimbursement Program	$8,741,754	$8,741,754	$8,741,754
Community-Based Dental Partnership Program	$3,538,515	$3,538,515	$3,538,515

Funding History

FY	Amount
FY 2008	$12,857,000
FY 2009	$13,429,000
FY 2010	$13,565,000
FY 2011	$13,511,000
FY 2012	$13,485,000
FY 2013	$12,646,000
FY 2014	$12,991,000
FY 2015	$13,020,000
FY 2016	$13,122,000
FY 2017	$13,122,000

Budget Request

The FY 2017 Budget Request for the Ryan White HIV/AIDS Part F-Dental Service Program of $13.1 million is equal to the FY 2016 Enacted and will support oral health care for people with HIV. This Request supports the reimbursement of applicant institutions through the Dental Reimbursement Program and funding of the Community-Based Dental Partnership Program. The FY 2017 target for the number of persons for whom a portion of their unreimbursed oral health costs will be reimbursed is 39,138.

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

Outcomes and Outputs Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
22. I.D.1: Number of persons for whom a portion/ percentage of their unreimbursed oral health costs were reimbursed. *(Output)*	FY 2014: 39,138 Target: 33,316 (Target Exceeded)	39,810	39,138	-672

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	69	69	69
Average Award	$178,875	$178,875	$178,875
Range of Awards	$404-$1,005,549	$404-$1,005,549	$404-$1,005,549

Special Projects of National Significance – Part F

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$25,000,000	$25,000,000	---	-$25,000,000
PHS Evaluation Funds	---	---	$34,000,000	+$34,000,000
Total Funding	$25,000,000	$25,000,000	$34,000,000	+$9,000,000
FTE	---	1	2	+1

Authorizing Legislation: Public Health Service Act, Section 2691, as amended by Public Law111-87

FY 2017 Authorization……..……..…..Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

The Special Projects of National Significance (SPNS) Program supports the development and evaluation of innovative models of HIV care to quickly respond to the emerging needs of clients served by the Ryan White HIV/AIDS Program (RWHAP). SPNS evaluates the effectiveness of the models' design, implementation, utilization, cost, and health related outcomes, while promoting the dissemination and replication of successful models. Through these special projects, SPNS recipients implement a variety of promising interventions gathering evidence-informed practices and lessons learned to improve treatment outcomes and avert new HIV infections for those living with HIV/AIDS. SPNS initiatives continue to address the emerging needs of the most disenfranchised populations living with HIV including men who have sex with men, racial/ethnic minority women and men, intravenous drug users, transgender women, and other population groups.

In July 2015, the Office of National AIDS Policy (ONAP) released the National HIV/AIDS Strategy: Updated to 2020 (NHAS 2020), integrating the recommendations of the HIV Care Continuum Working Group, and the recommendations of the Working Group on the Intersection of HIV/AIDS, Violence Against Women and Girls, and Gender-related Health Disparities, to inform the Nation's response to domestic HIV epidemic. The SPNS Program aligns with NHAS 2020 goals, to increase access to care, improve health outcomes of people living with HIV (PLWH), and reduce HIV-related health disparities. The NHAS 2020 directs Federal agencies to

prioritize the HIV care continuum by accelerating efforts to increase HIV testing, services, and treatment, and improve patient access for HIV positive individuals.

The SPNS program provides opportunities for the development, implementation, and assessment of system, community, and individual-level innovations designed to meet the goals of NHAS 2020, as well as the demands of a changing health care system in the delivery of HIV care as healthcare coverage expands. Through its demonstration projects, SPNS models contribute to the advancement of public health knowledge toward the elimination of HIV in the United States by promoting models that focus on expanding linkage to HIV medical care, improve lifelong retention in HIV medical care, delivery of ART, and ultimately achieve HIV viral load suppression among PLWH.

The list of SPNS initiatives continuing into FY 2016 include: 1) System-level Workforce Capacity Building for Integrating HIV Primary Care in Community Health Care Settings; 2) Health Information Technology (HIT) Capacity Building for Monitoring and Improving Health Outcomes along the HIV care continuum; 3) Culturally Appropriate Interventions of Outreach, Access and Retention among Latino(a) Populations; 4) Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations; 5) Enhancing Engagement and Retention in Quality HIV Care for Transgender Women of Color; and 6) Systems Linkages and Access to Care Initiative. New initiatives for FY 2015 include: 1) Use of Social Media to Improve Engagement, Retention, and Health Outcomes along the HIV care continuum and 2) Dissemination of Evidence-Informed Interventions to Improve Health Outcomes along the HIV care continuum.

As of 2014, of the current SPNS recipients: 13 percent are community-based organizations, 28 percent are state or county departments of health, 21 percent are community health centers, 25 percent are academic-based clinics and evaluation and technical assistance centers, and 13 percent are AIDS service organizations.

Funding History

FY	Amount
FY 2008	$25,000,000
FY 2009	$25,000,000
FY 2010	$25,000,000
FY 2011	$25,000,000
FY 2012	$25,000,000
FY 2013	$25,000,000
FY 2014	$25,000,000
FY 2015	$25,000,000
FY 2016	$25,000,000
FY 2017	$34,000,000

Budget Request

The FY 2017 Budget Request for the SPNS Program of $34.0 million, an increase of $9.0 million over FY 2016 Enacted, to support Hepatitis C Treatment in People Living with HIV.

Hepatitis C virus (HCV) affects approximately 3.2 million people in the U.S., making it the most common chronic blood borne infection.[264] Approximately 50 percent of those infected are not aware of their infection.[265] Over time, chronic HCV can lead to liver failure, liver cancer and death. Among those with HIV, approximately one quarter is co-infected with HCV. People with HCV/ HIV co-infection have higher liver-related morbidity and mortality, even when their HIV infection is well-controlled.[17] Chronic hepatitis C infection can be cured, and treating HCV leads to better health outcomes and is cost-effective.[266] Several highly effective medications are available to treat and cure hepatitis C in people living with HIV (PLWH) with minimal side effects. Unlike previous treatments, the newer medications have been shown to be equally effective in curing HCV in those individuals that are co-infected with HIV.[267] These new medications represent the culmination of major breakthroughs in drug development.

Despite advances in treatment, only a small percentage of HCV-infected patients have received treatment.[268] The high cost of these newer treatments, which has limited access to treatment, has been at the forefront of discussions regarding why HCV treatment is not being more widely prescribed. Other barriers such as a lack of physicians trained and willing to treat HCV and health care systems that do not support treatment and follow-up of HCV also contribute. Poor patient uptake and poor patient adherence of HCV treatment is low in mono-infected patients, and is even lower among HCV/ HIV co-infected patients.

The Ryan White HIV/AIDS Program (RWHAP)[269] has been at the forefront of HCV treatment among PLWH. However, given the changes in the health care environment and advances in treatment, additional work is needed to expand treatment of HCV among PLWH. The $9.0 million will be distributed among four RWHAP Part A and four Part B recipients as competitive grants. Each of the implementation sites will receive between $800,000 and $1.5 million, depending on epidemiology and demonstrated need to expand and provide treatment of HCV to PLWH.

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[264] CDC. *HIV and Viral Hepatitis.* 2014

[265] Denniston MM, Klevens RM, McQuillan GM, Jiles RB. Awareness of infection, knowledge of hepatitis C, and medical follow-up among individuals testing positive for hepatitis C: National Health and Nutrition Examination Survey 2001-2008. *Hepatology (Baltimore, Md.).* 2012;55(6):1652-1661

[266] Rein DB, Wittenborn JS, Smith BD, Liffmann DK, Ward JW. The Cost-effectiveness, Health Benefits, and Financial Costs of New Antiviral Treatments for Hepatitis C Virus. Clinical infectious diseases : an official publication of the Infectious Diseases Society of America. 2015.

[267] HHS. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. 2015; http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf, 2015.

[268] Grebely J, Oser M, Taylor LE, Dore GJ. Breaking down the barriers to hepatitis C virus (HCV) treatment among individuals with HCV/HIV coinfection: action required at the system, provider, and patient levels. *The Journal of infectious diseases.* 2013;207 Suppl 1:S19-25

[269] Ryan White HIV/AIDS Program is authorized by Title XXVI of the Public Health Service Act (P.L. 111-87, 111th Congress), Ryan White HIV/AIDS Treatment Extension Act of 2009.

Recipients will be selected based on demonstrating that they can reach populations that are at high risk for HCV infection, such as by age cohort (e.g., persons born between 1945-1965), and high risk behaviors such as injection drug use. Recipients will also need to have infrastructure established that can be scaled up for HCV testing and treatment activities quickly. The implementation sites will represent areas of high burden of HIV/HCV co-infection. Demonstrated successes from the project have a high probability of being generalizable to treatment strategies for mono-infected persons with HCV, since the health departments will develop local systems to treat hepatitis C using multiple resources.

Knowledge of prevention and treatment for the public health issue of HCV will be increased through education of providers on the hepatitis guidelines and the quality of health care will improve. By getting infected individuals appropriate treatment earlier in infection, health outcomes will improve as health care costs associated with HCV infection decrease. It can also be extrapolated from HIV care that treatment of HCV also prevents new HCV infections, which in turn decreases the overall public health burden. This project has the potential to increase the number of HIV/HCV co-infected patients who are successfully treated for HCV by 5 percent in one year, but with sustained implementation of the models, could increase to 25 percent over the subsequent 5 to 10 years.

An Evaluation and Technical Assistance Center will also be funded to educate providers nationally on HCV, including appropriate screening, care, and treatment of HCV infection among PLWH who are co-infected with HCV.

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

Grant Awards Table

	FY 2015 Final	**FY 2016 Enacted**	**FY 2017 President's Budget**
Number of Awards	64	64	71
Average Award	$376,834	$376,732	$461,789
Range of Awards	$271,754-$3,050,000	$279,488-$3,050,000	$280,127-$3,050,000

Healthcare Systems TAB

HEALTHCARE SYSTEMS

Organ Transplantation

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$23,549,000	$23,549,000	$23,549,000	---
FTE	1	2	2	---

Authorizing Legislation: Public Health Service Act, Sections 371-378, as amended by Public Law 113-51

FY 2017 Authorization……..…..…..…..…...……..…..... Expired

Allocation Method:
- Contracts
- Competitive Grants/Co-operative Agreements
- Other (Interagency Support)

Program Description and Accomplishments

The National Organ Transplant Act of 1984 (NOTA), as amended, provides the authorities for the Organ Transplantation Program (Program). The primary purpose of the Program is to extend and enhance the lives of individuals with end-stage organ failure for whom an organ transplant is the most appropriate therapeutic treatment. The Program oversees a national system, the Organ Procurement and Transplantation Network (OPTN), to allocate and distribute donor organs to individuals waiting for an organ transplant. The allocation of organs is guided by policies developed by the OPTN with analytic support from the Scientific Registry of Transplant Recipients (SRTR). In addition to the efficient and effective allocation of donor organs through the OPTN, the Program also supports efforts to increase the supply of deceased donor organs made available for transplantation and to ensure the safety of living organ donation.

The Program goals are summarized by two overarching measures: (1) increase the annual number of deceased donor organs transplanted; and (2) increase the total number of expected life-years gained in the first five years after the transplant for all kidney and kidney/pancreas transplant recipients (from deceased donors) compared to life years expected had they remained on the waiting lists.

In 2014 (the most recent year for which full-year data are available), 26,046 deceased donor organs were transplanted, which is a 2.40 percent increase over 2013 and a 27.73 percent increase over the baseline of 20,392 deceased donor organs transplanted in 2003. In 2013,

25,435 deceased donor organs were transplanted, a 3.58 percent increase over 2012. In 2012, 24,557 deceased donor organs were transplanted, a 1.67 percent decrease from 2011.

The overall increase in the number of transplanted organs from deceased donors is largely attributed to the improvements in the conversion rate. The conversion rate describes the number of deceased donor organs made available for transplantation by converting the number of "eligible deaths" into actual donors. An "eligible death" is defined as an individual, age 70 years or younger, who meets the criteria for neurological death, whose heart continues to beat, and who has not been diagnosed with exclusionary medical conditions published by the OPTN. The baseline conversion rate in 2003 was 52 percent. For the last three years, the conversion rate has been as follows: 2012 - 72.60 percent; 2013 - 71.0 percent; and 2014 - 72.60 percent. The 2014 result represents a 39.62 percent improvement from the 2003 baseline.

Increases in conversion rates can be attributed to a variety of factors including the adoption of best practices at Organ Procurement Organizations (OPOs) and donor hospitals as a result of activities of the Donation and Transplantation Community of Practice (DTCP). Knowledge-sharing and performance improvement activities advance action on individual donor designation, family support and consent, donor management, and organizational cultures that support effective donation processes. Increases in the conversion rate also reflect an effective collaboration between the Program and the organ donation and transplant community, and is especially noteworthy because the number of eligible deaths has been declining in recent years. In 2014, there were slightly more than 9,000 eligible deaths compared to 2012 when there were greater than 12,000. The number of eligible deaths in 2002 was in excess of 12,000. This decrease is attributable to declining numbers of brain deaths due to prevention, decreased severity, and improved management of brain injuries from head trauma. Many of these same factors have also led to a leveling-off of the previous gains achieved in conversion rates. In FY 2014, the conversion rate of 72.6 percent far exceeded the FY 2003 baseline of approximately 50 percent but fell slightly short of the target set for the year (73.25 percent). Specific factors include the shifting focus, over time, of the transplant community towards other efforts as well as the fact that the natural peak of the conversion rate may have been reached. Since 2010 the conversion rates achieved have ranged within a marginal window of 71 percent - 72.6 percent, which reflects a 1.6 percent fluctuating range over five years. Conversion rates will continue to be monitored over the next couple of years to more fully assess any potential next steps.

Increasing "life-years-gained" is a long term goal and depends on achieving incremental targets annually per transplant. In FY 2012, the average number of life-years gained per transplant was 0.320, and the total expected life-years gained from all kidney and kidney/pancreas transplants performed was 3,709 years compared to a target of 6,928 years. In FY 2013, the average number of life years gained per transplant was 0.300, and the total life-years gained were 3,518 years compared to a target of 4,367 years. In FY 2014, the average number of life years gained per transplant was 0.280, and the total life-years gained were 3,466 years compared to a target of 4,433 years. The continuing decrease in the average and total life-years gained by transplant recipients is attributable to an increase in life-years gained prior to transplants from improvements in dialysis management and clinical care of patients on the waitlist. However, despite the downward trend of life-years gained after transplant in recent years, the number of

life-years gained per year post transplant still exceeds the number of life-years gained had transplant recipients remained on the waiting list.

In addition to supporting the OPTN and the SRTR, the Program supports public education and outreach initiatives to 1) increase donor registrations, 2) enhance public awareness of the need for organs, 3) encourage family discussion about organ donation, and 4) improve public trust in the organ transplant system. Research identifies target audiences such as adults over 50, parents, teens, and Spanish-speaking Hispanics. Communication channels include print, radio, television, Internet (organdonor.gov), and social media platforms. The Program also partners with stakeholders including hospitals, faith leaders, and post-secondary institutions.

Funding History

FY	Amount
FY 2013	$23,301,000
FY 2014	$23,490,000
FY 2015	$23,549,000
FY 2016	$23,549,000
FY 2017	$23,549,000

Budget Request

The FY 2017 Budget Request for Organ Transplantation program of $23.5 million is equal to FY 2016 Enacted level. The FY 2017 Budget Request will continue support for the Organ Transplantation Program in achieving the FY 2017 performance targets: (1) Transplant 26,202 deceased donor organs and (2) achieve 4,644 expected life-years gained for the five year post-transplant period for kidney and kidney/pancreas transplants performed.

The following activities will be supported with the requested funding:

Contract Allocation – $13.069 million

Contract to operate the OPTN — The OPTN is a critical system that facilitates matching donor organs to individuals needing an organ transplant. Given the great demand for and limited supply of organs, policies developed by the OPTN are under continual review and refinement to achieve the best outcomes for patients, attain the maximum benefit for the maximum number of waitlist candidates, make the best use of donor organs, and be consistent with the policy development requirements of the OPTN final rule (42 CFR §121). The costs of operation of the OPTN are funded with appropriated funds and revenues generated by patient registration fees collected by the contractor under authority of 42 CFR §121.5(c).

Contract to operate the SRTR — The SRTR provides analytic support to the OPTN in the development of organ allocation policies and program performance evaluation. Additionally, the SRTR provides analytic support to HHS, including the Advisory Committee on Organ Transplantation. To make information about the performance of transplant programs and organ procurement organizations more widely available to the public the SRTR publishes, on the Internet, transplant program risk-adjusted patient and graft outcomes and organ procurement

organization risk-adjusted organs transplanted per donor. The SRTR also publishes online a comprehensive Annual Data Report that includes most current ten years of data on waitlist, transplant, and deceased donor organ donation.

Contract(s) to Support Public and Professional Education Activities — The Program, independently and in collaboration with the organ donation and transplant community and other stakeholders, supports a variety of public and professional education and outreach efforts designed to increase organ donation. Projects to educate the general public and specific segments of the population use communication options appropriate to the message and audience including public service announcements broadcast via electronic media, virtual meetings, webinars, printed materials, documentaries, educational programs for the classrooms, national organ donation events, and websites.

Grants including Cooperative Agreement(s) – $8.890 million

Grants to Support Projects to Increase Organ Donation — Through a competitive process, the Program awards grants to public and non-profit private entities to test new and replicate effective approaches for increasing organ donation, promote public awareness about organ donation, and support improvements and upgrades to state-specific donor registries.

Cooperative Agreement to Provide Support for Reimbursement of Travel and Subsistence Expenses toward Living Organ Donation — This cooperative agreement provides reimbursement of travel and subsistence expenses to living organ donors who are not able to receive such support: 1) under any state compensation program, insurance policy, or under any Federal or state health benefits program; 2) by an entity that provides health services on a prepaid basis; or 3) by the recipient of the organ.

Advisory Committee, Interagency Agreements and Other Internal Support Allocation – $1.590 million

Advisory Committee on Organ Transplantation and Interagency Activities to Support Donation and Transplantation — The OPTN final rule (42 CFR §121.12) authorizes the creation of an Advisory Committee on Organ Transplantation (ACOT) to provide recommendations to the Secretary on issues related to organ donation and transplantation. The Program supports the activities of the ACOT including the logistics for periodic meetings and analytic requirements. These funds also support interagency activities in support of the Program's mission.

Other Program Related Activities

The funding request also includes costs associated with the grant review and award process, follow-up performance reviews, information technology and other program support costs. For example, the HRSA Electronic Handbooks support the Organ Transplantation Program with program administration, grants administration and monitoring, management reporting, and grantee performance measurement and analysis. The funding also includes IT investment costs to support the strategic and performance outcomes of the Program and contributes to its success by providing a mechanism for sharing data and conducting business in a more efficient manner.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
23.II.A.1: Increase the annual number of deceased donor organs transplanted.	FY 2014: 26,046 Target: 25,014 (Target Exceeded)	25,796	26,202	+406
23.II.A.7: Increase the total number of expected life-years gained in the first 5 years after the transplant for all deceased kidney and kidney/pancreas transplant recipients compared to what would be expected for these patients had they remained on the waiting list.	FY 2014: 3,466 Target: 4,433 (Target Not Met)	4,572	4,644	+72
23.II.A.8: Increase the annual conversion rate of eligible donors.	FY 2014: 72.60% Target: 73.25% (Target Not Met)	73.75%	74.00%	+0.25% points

Grants Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	15	15	15
Average Award	$470,250	$536,486	$511,354
Range of Awards	$138,194-$2,581,509	$247,891-$3,200,000	$225,000-$3,500,000

National Cord Blood Inventory

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$11,266,000	$11,266,000	$11,266,000	---
FTE	4	4	4	---

Authorizing Legislation: Public Health Service Act, Section 379, as amended by Public Law 111-264

FY 2017 Authorization…….....Expired

Allocation Method…….…….....……Contract

Program Description

The National Cord Blood Inventory (NCBI) Program, established through the Stem Cell Therapeutic and Research Act of 2005 and reauthorized by the Stem Cell Therapeutic and Research Reauthorization Act of 2010, is charged with building a genetically and ethnically diverse inventory of at least 150,000 new units of high-quality umbilical cord blood for transplantation. These cord blood units (CBUs), as well as other units in the inventories of participating cord blood banks, are made available to physicians and patients for blood stem cell transplants through the C.W. Bill Young Cell Transplantation Program (Program), which is authorized by the same law. Cord blood banks participating in the NCBI Program also make cord blood units available for preclinical and clinical research focusing on cord blood stem cell biology and the use of cord blood stem cells for human transplantation and cellular therapies.

Blood stem cell transplantation is potentially a curative therapy for many individuals with leukemia and other life-threatening blood and genetic disorders. Each year, nearly 18,000 people in the U.S. are diagnosed with illnesses for which blood stem cell transplantation from a matched donor is their best treatment option. Often, the first-choice donor is a sibling, but only 30 percent of people have a fully tissue-matched brother or sister. For the other 70 percent, or approximately 12,600 people, a search for a matched unrelated adult donor or a matched umbilical cord blood unit must be performed.

The tissue types of blood stem cell donors must be closely matched with those of their recipients in order for the transplant to be successful. Since tissue types are inherited, patients are more likely to find a closely matched donor within their own racial and ethnic group. However, due to the high rate of diversity in the tissue types of racial and ethnic minorities, especially African-Americans, racial and ethnic minorities are less likely to find a suitably matched adult marrow donor on the Registry of the Program. Because umbilical cord blood can be used with a less than

perfect match in tissue type between donor and recipient than is the case for adult marrow donors, umbilical cord blood offers a chance of survival for patients who lack a suitably tissue-matched relative and who cannot find an adequately matched unrelated adult donor through the Program. Minority patients, especially African-American patients, are especially likely to benefit from additional CBUs. For these reasons, the Health Resources and Services Administration's (HRSA's) policy for the NCBI continues to emphasize increasing the number of CBUs collected from minority donors.

The NCBI provides funds through competitive contracts for the collection and storage of qualified CBUs by a network of cord blood banks in the U.S. The NCBI program selects cord blood banks based on assessment of technical merit, overall quality, ability to collect from diverse populations, geographic dispersion of storage sites, evaluation of past performance, and evaluation of proposed costs. Additionally, HRSA continues to place particular emphasis on the demonstrated ability of cord blood banks to collect and bank significant numbers of CBUs from African-American donors.

Program Accomplishments

Currently, 13 cord blood banks hold NCBI contracts. As of September 30, 2015, 79,276 NCBI CBUs were available through the Program (Table 1). A cumulative total of 99,154 units of cord blood will be collected with all funds awarded during the period FY 2007 – FY 2016. HRSA estimates that approximately 5,500 additional units will be collected with funds awarded in FY 2017, making a total of 104,654 cord blood units collected with all funds awarded during the period of FY 2007 – 2017.

The availability of umbilical cord blood has significantly increased access to blood stem cell transplantation, particularly for those patients who would not otherwise have a well-matched adult donor. Since 2007, 4,367 (44 percent) NCBI CBUs have been selected for transplantation, compared to 9,980 total cord blood transplants (NCBI and non-NCBI), during the same time period (Table 2). This is evidenced by the fact that cord blood has accounted for about one half of the growth in blood stem cell transplants over the life of the NCBI Program. Furthermore, the presence of the NCBI further increases access to transplantation compared to non-NCBI CBUs, because NCBI CBUs are more genetically diverse and contain higher cell counts. The higher cell counts reflect more blood stem cells infused into a transplant patient and can be used with larger patients and assist with improving outcomes. The NCBI units released for transplantation had cell counts well above the levels generally available prior to implementation of the NCBI Program.

It should be noted that the number of NCBU cord blood units released for transplants fell below the target set for FY2015 but there was one key mitigating factor – the increasing use of alternative therapies. In particular, haploidentical transplants (use of blood stem cells from a donor who is biologically related to the recipient-patient) have been on the rise. Despite this recent trend, NCBI units remain a key in servicing a diverse population. As the inventory continues to grow, the diverse units comprising the NCBI will continue to serve an increasing number of patients. Of the cord blood units collected with funds awarded from FY 2007 - FY 2015, over 60 percent are from racial and ethnic minorities. Trends in cord blood

transplantations will continue to be monitored and assessed over the next couple of years and future targets may need to be adjusted accordingly depending on the results.

In addition to directly growing the NCBI inventory, the support provided to NCBI-contracted banks has played an important role in stimulating the collection and banking of many other (non-NCBI) units. These CBUs may not meet the minimum cell content threshold established for the NCBI, but may be a suitable source of blood stem cells for smaller patients where an acceptable cell dose can still be achieved using smaller units. Additionally, NCBI banks have provided to researchers more than 53,025 non-NCBI units, for a wide variety of research purposes.

Table 1. Cord Blood Collections

Fiscal Year	Cumulative Units Made Available[270]
2007	2,017
2008	11,870
2009	22,920
2010	34,744
2011	43,340
2012	53,609
2013	63,960
2014	74,650
2015	79,276

Table 2. Cord Blood Units Released for Transplantation

Fiscal Year	NCBI Units Released for Transplantation	Total Cord Blood Units (NCBI and Non-NCBI) released for Transplantation through the C.W. Bill Young Cell Transplantation Program
2007	4	648
2008	104	898
2009	458	1056
2010	530	1153
2011	690	1180
2012	714	1191
2013	714	1102
2014	544	1359
2015	609	1393
Total	4,367	9,980

[270] Due to the lag between when cord blood units are collected and when they have been fully tested and qualified for listing on the public registry, all of the units collected with funds from a given fiscal year will not be made available on the registry during that same fiscal year.

Funding History

FY	Amount
FY 2013	$11,147,000
FY 2014	$11,266,380
FY 2015	$11,266,000
FY 2016	$11,266,000
FY 2017	$11,266,000

Budget Request

The FY 2017 Budget Request for the National Cord Blood Inventory program of $11.3 million is equal to FY 2016 Enacted level. This funding will be used to support progress toward the statutory goal of building a genetically diverse inventory of at least 150,000 new units of high-quality cord blood for transplantation and will, as a result, increase the number of patients in all population groups who are able to obtain life-saving transplants. Cell dose and degree of match between patient and cord blood unit are both strongly associated with transplant outcomes. Therefore, a larger inventory of publicly available CBUs will contribute to improved patient survival after transplant because a growing inventory of high cell count CBUs will allow better tissue matches between patients and CBUs.

Funding at the requested level is estimated to support the collection and banking of approximately 5,500 additional CBUs assuming an average price to HRSA of $1,611 per cord blood unit. The average price is expected to increase by approximately $200 per cord blood unit in FY 2017. The price increase for NCBI CBUs, which are obtained through contracts, is anticipated due to: 1) additional expenses associated with obtaining and maintaining biologics license applications (BLA) from the Food and Drug Administration; and 2) cord blood banks not financially positioned to offer the government the same significant discounts as provided previously. However, HRSA will continue to seek substantial discounts for each cord blood unit through competitive negotiations.

With the addition of the CBUs added in FY 2017, approximately 81,500 NCBI units will be available for patients searching for an appropriately matched cord blood unit through the C.W. Bill Young Cell Transplantation Program.

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

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
The cumulative number of minority cord blood units available through the C.W. Bill Young Cell Transplantation Program (NCBI & non-NCBI	FY 2015: 136,477 Target: 89,300 (Target Exceeded)	86,720	90,020	+3,300
The size of the National Cord Blood Inventory (cumulative # of units banked and available through the C.W. Bill Young Cell Transplantation Program)	FY 2015: 79,276 Target: 70,500 (Target Exceeded)	76,000	81,500	+5,500
The annual number of NCBI cord blood units released for transplant	FY 2015: 609 Target: 750 (Target Not Met)	700	700	Maintained

Contracts Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Contracts	7	8	13
Average Contract	$1,486,331	$1,289,842	$793,749
Range of Contracts	$269,000-$4,108255	$269,000-$2,609,600	$260,000-1,870,000

C.W Bill Young Cell Transplantation Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$22,109,000	$22,109,000	$22,109,000	---
FTE	8	8	8	---

Authorizing Legislation: Public Health Service Act, Sections 379-379B, as amended by Public Law 111-264

FY 2017 Authorization……..Expired

Allocation Method……..……..……Contract

Program Description

The primary goal of the C.W. Bill Young Cell Transplantation Program (Program) is to increase the number of transplants for recipients suitably matched to biologically unrelated donors of bone marrow[271] and umbilical cord blood. The Program works toward this goal by: (1) providing a national system for recruiting potential bone marrow donors; (2) tissue typing potential donors; (3) coordinating the procurement of bone marrow and umbilical cord blood units for transplantation; (4) offering patient and donor advocacy services; (5) providing for public and professional education; and (6) collecting, analyzing, and reporting data on transplant outcomes.

Blood stem cell transplantation, which includes bone marrow and cord blood, is a potentially curative therapy for many individuals with leukemia and other life-threatening blood and genetic disorders. Each year nearly 18,000 people in the U.S. are diagnosed with life-threatening illnesses where blood stem cell transplantation from a matched donor is the best treatment option. Often, the ideal donor is a suitably-matched family member, but only 30 percent of people have a fully-matched relative. The other 70 percent, or approximately 12,600 people, often search for a matched unrelated adult donor or umbilical cord blood unit.

Per authorizing legislation renewed on October 8, 2010 (The Stem Cell Therapeutic and Research Reauthorization Act of 2010, P.L. 111-264), the C.W. Bill Young Cell Transplantation Program is the successor to the National Bone Marrow Donor Registry. While the scope of activities required of the Program is similar to that of its predecessor, the Program has expanded responsibility for collecting, analyzing, and reporting data on transplant outcomes, to include all

[271] Public Health Service Act, Sections 379-379B, as amended by P.L. 111-264 states that the term 'bone marrow' means the cells found in the adult bone marrow and peripheral blood.

allogeneic (from a genetically similar, but not identical, donor) blood stem cell transplants as well as other therapeutic uses of blood stem cells. The Program is operated through four major contracts that require close coordination and oversight. The authorizing legislation also requires an Advisory Council to provide recommendations to the Secretary of Health and Human Services and to the Health Resources and Services Administration (HRSA) on activities related to the Program. The major components of the Program are:

1. A Cord Blood Coordinating Center responsible for facilitating transplants with blood stem cells from umbilical cord blood units (including HRSA-funded National Cord Blood Inventory units) and providing expectant mothers with information on options regarding the use of umbilical cord blood;
2. A Bone Marrow Coordinating Center responsible for recruiting adult potential donors of blood stem cells, especially from underrepresented ethnic and racial minority populations, and for facilitating transplants with cells from adult donors;
3. A combined Office of Patient Advocacy and Single Point of Access to assist patients and their families from diagnosis through survivorship, and to enable physicians to search for and obtain a suitable blood stem cell product through a single point of electronic access; and
4. A Stem Cell Therapeutic Outcomes Database for collecting outcomes data on related and unrelated donor blood stem cell transplants and implementing an approach to collecting data on emerging therapeutic uses of donated blood stem cells.

Contracts for all components of the Program are awarded through a competitive process. In FY 2017, the Program components will be re-competed and funding will be provided to support ongoing contract activities.

Performance measures are incorporated into the contracts and monitored quarterly to ensure that the Program meets its long-term goals to: (1) increase the number of blood stem cell transplants facilitated annually; (2) increase the number of transplants facilitated annually for minority patients; (3) increase the number of domestic transplants facilitated annually; and (4) increase one-year post-transplant patient survival. The Program's long-term goals are supported by two annual measures: (1) increase in the number of adult volunteer potential donors of minority race and ethnicity on the Program's registry; and (2) decrease the per unit cost for human leukocyte antigen (HLA) tissue typing needed to match patients and donors. Additional performance standards are developed and monitored under each contract.

Program Accomplishments

The purpose of the Program is to increase the number of unrelated blood stem cell transplants facilitated for patients in need. The Program exceeded all three of its FY 2013 long-term goals and the new long-term goals established for FY 2017 are to: (1) facilitate 6,960 transplants (a 10.8 percent over the number of transplants facilitated in FY 2013); (2) facilitate 1,150 minority transplants (a 15.9 percent increase over the number of minority transplants facilitated is FY 2013); and (3) sustain the rate of patient survival at one-year post-transplant at the goal established in FY 2010 (i.e., 69 percent). The Program is facilitating transplants for older and higher risk patients; therefore, it is unlikely that the survival rates will continue to increase at the previous pace.

The Program continues to serve a diverse patient population, with umbilical cord blood playing a vital role in expanding access to transplant for minority patients. Increasing the number of blood stem cell transplants facilitated for patients from racially and ethnically diverse backgrounds addresses the statutory aim of ensuring comparable access to transplantation for patients from all populations. Adding to the pool of potential adult volunteer blood stem cell donors also helps accomplish this goal. As of the end of FY 2015, more than 13.6 million potential adult volunteer donors were listed on the Program's registry. More than 3.35 million (26 percent) of these 13.6 million adult donors listed self-identify as belonging to a racial/ethnic minority group. This exceeded the FY 2015 goal of 3.26 million by 2.76 percent.

The cost of tissue typing strongly influences the number of potential volunteer donors who can be recruited to the Program's registry. Reductions in the cost of typing make it possible to recruit more donors for a given level of funding. The FY 2017 cost for each donor's tissue typing will remain at $58.00, the same level negotiated and achieved in FY 2015. The cost of tissue typing increased from $40.81 in FY 2014 to $58.00 in FY 2015 as a result of the advancement in typing technology, from an allele-based, high-resolution method, to a DNA-based, sequencing platform. Also, more genetic markers are being examined to assist physicians in conducting donor searches on behalf of patients. This change in tissue typing technology, will likely result in more rapid matching between potential donors and searching patients, thus allowing patients to more rapidly move toward transplantation.. Though the goal addressing typing costs does not predict increases, the cost may rise if it is determined that the level of tissue typing specificity needs to increase (due to technological advances), which could result in more expedited matching between potential donors and searching patients.

Funding History

FY	Amount
FY 2013	$21,877,000
FY 2014	$22,054,000
FY 2015	$22,109,000
FY 2016	$22,109,000
FY2017	$22,109,000

Budget Request

The FY 2017 Budget Request for the C.W Bill Young Cell Transplantation program of $22.1 million is equal to FY 2016 Enacted level. This funding will be used to support the Program's performance target of having 3,740,000 adult volunteers from racially/ethnically diverse minority population groups listed on the Program's registry. These funds also will support the major Program components (Cord Blood Coordinating Center, Bone Marrow Coordinating Center, Office of Patient Advocacy, Single Point of Access, and Stem Cell Therapeutic Outcomes Database). The majority of funds will be used to recruit and tissue-type new donors. The Program will also continue: (1) collecting comprehensive outcomes data on both related and unrelated-donor blood stem cell transplants; (2) assessing quality of life for transplant recipients; (3) working with foreign transplant centers to obtain data on U.S. stem cell products provided to

them for transplant; and (4) collecting data on emerging therapies using cells derived from bone marrow and umbilical cord blood.

Importantly, FY 2017 funding will allow the Program to continue the critical planning it has been involved in with the Department of Health and Human Services to respond to a national radiation or chemical emergency that could leave some casualties with temporary or permanent marrow failure, and to facilitate emergency transplants for those casualties who would not otherwise recover marrow function.

The funding request also includes costs associated with information technology and other program support costs.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
24.II.A.2: The number of adult volunteer potential donors of blood stem cells from minority race and ethnic groups. (Outcomes)	FY 2015: 3.35M Target: 3.26M (Target Exceeded)	3.49M	3.74M	+0.24M
24.1: The number of blood stem cell transplants facilitated by the Program[272](Outcome)	FY 2013: 6,283 Target: 5,513 (Target Exceeded)	N/A	6,960	N/A
24.2: The number of blood stem cell transplants facilitated for minority patients by the Program.[273] (Outcome)	FY 2013: 992 Target: 845 (Target Exceeded)	N/A	1,150	N/A
24.3: The rate of patient survival at one year, post- transplant.[274] (Outcome)	FY 2013: 71% Target: 69% (Target Exceeded)	N/A	69%	N/A
24.4: The number of blood stem cell transplants facilitated for domestic patients by the Program. [275]	FY 2013: (baseline) 3,918	N/A	5,135	N/A

[272] This is a long-term measure. After FY 2013, the next year for which long-term targets are set is FY 2017. The FY 2017 target has been established at 6,960.
[273] This is a long-term measure. After FY 2013, the next year for which long-term targets are set is FY 2017. The FY 2017 target has been established at 1,150.
[274] This is a long-term measure. After FY 2013, the next first year for which long-term targets are set is FY 2017. The FY 2017 target remains 69%.
[275] This is a new long-term measure. The first year for which long-term targets are set is FY 2017. The FY 2017 target is 5,135.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
(Outcome)				
24.E: The unit cost of human leukocyte antigen (HLA) typing of potential donors. (Efficiency)	FY 2014: $40.81 Target: $40.81 (Target Met)	$58.00	$58.00	$0

Contracts Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	5	5	5
Average Award	$3,964,000	$3,964,000	$3,933,000
Range of Awards	$42,000-$13,195,000	$42,000-$13,195,000	$35,000-$13,437,000

Poison Control Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$18,846,000	$18,846,000	$18,846,000	---
FTE	3	3	3	---

Authorizing Legislation: Public Health Service Act, Sections 1271-1274, as amended by Public Law 113-77

FY 2017 Authorization ..... National Toll-Free Number - $700,000

FY 2017 Authorization .....Nationwide Media Campaign - $800,000

FY 2017 Authorization .....Poison Control Center Grant Program – $28,600,000

Allocation Method:

- Contracts
- Competitive Grants/Co-operative Agreements

Program Description and Accomplishments

The Poison Control Program (PCP) is authorized through Public Law 113-77, the Poison Center Network Act. The Program is legislatively mandated to fund poison centers; establish and maintain a single, national toll-free number (800-222-1222) to ensure universal access to poison center services and connect callers to the poison center serving their area; and implement a nationwide media campaign to educate the public and health care providers about poison prevention, poison center services, and the 800 number.

The grant program supports poison control centers' (PCCs) efforts to 1) prevent and provide treatment recommendations for poisonings; 2) comply with operational requirements needed to sustain accreditation and or achieve accreditation; and 3) improve and enhance communications and response capability and capacity. Funds may also be used to improve the quality of data uploaded from poison centers to the National Poison Data System (NPDS) in support of national toxicosurveillance activities conducted by the Centers for Disease Control and Prevention (CDC).

The Poison Help Line, 800-222-1222, was established in 2001 to ensure universal access to PCC services. Individuals can call from anywhere in the United States (U.S.) and will be connected to the poison center that services their area. The PCP maintains the number and provides translation services in over 150 languages. Services are also provided for the hearing impaired.

Through the nationwide Poison Help media campaign, the PCP has been working to educate the public about the 800 number and increase awareness of poison center services. In FY 2014, 84 percent of the calls coming into the toll-free number were completed calls. The remaining 16 percent of the calls were terminated by the caller before it could be answered by a PCC. In FY 2012, 25 percent of national survey respondents were aware that PCC calls were handled by health care professionals, a 6 percent increase over the previous survey, which is fielded every five years.

For over 50 years, PCCs have been our Nation's primary defense against injury and death from poisonings. Today there is a national network of 55 PCCs that provides cost effective, quality health care advice to the general public and health care providers alike across the entire U.S. including American Samoa, the District of Columbia, the Federated States of Micronesia, Guam, Puerto Rico, and the U.S. Virgin Islands. Twenty-four hours a day, seven days a week, health care providers and other specially trained poison experts provide poisoning triage and treatment recommendations at no cost to the caller. A hallmark of poison center case management is the use of follow up calls to monitor case progress and medical outcomes. Poison centers are not only consulted when children get into household products, but also when seniors and people of all ages take too much medicine or when workers are exposed to harmful substances on the job. Emergency 911 operators refer poison-related calls to PCCs and health care professionals regularly consult PCCs for expert advice on complex cases. PCCs are a critical resource for emergency preparedness and response as well as for other public health emergencies.

According to the American Association of Poison Control Centers (AAPCC), in 2014 2.9 million calls were managed by poison control centers, which is an average of 8,000 calls per day. Of the approximate 2.2 million poisonings reported in 2014, 68 percent were managed at the site of exposure, avoiding unnecessary visits to emergency departments and saving money on healthcare costs. While less than 1 percent of exposures occurred in health care facilities, approximately 21 percent of calls were made from a health care facility.[276]

Multiple studies have demonstrated that accurate assessment and triage of poison exposures by poison centers save dollars by reducing severity of illness and death, and eliminating or reducing the expense of unnecessary trips to an emergency department.[276] [277] Consultation with a poison center can also significantly decrease the patient's length of stay in a hospital and decrease hospital costs.[277,278,279,280] In fact, utilization of poison centers by health care facilities continues to increase, underscoring the increase in the severity of poisonings and the need for toxicological

[276] Mowry JB, Spyker DA, Cantilena JR, McMillan N, Ford M. 2014 Annual Report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 32nd Annual Report. Clinical Toxicology (2015) 53:10, 962-1147.

[277] Vassilev ZP, Marcus SM. Impact of a Poison Control Center on the Length of Hospital Stay for patients with Poisoning. J Toxicol Environ Health Part A. 2007; 70(2): 107-110

[278] Zaloshnja, E., Miller, T.R., Jones, P., Litovitz, T.; Coben, J.; Steiner, C.; Sheppard, M. (2006). The potential impact of poison control centers on rural hospitalization rates for poisonings. Pediatrics. 118(5), 2094-2100.

[279] Healthcare Cost and Utilization Project [HCUP] (2007). 2005 National Inpatient Sample. Rockville, MD: Agency for Healthcare Research and Quality, Department of Health and Human Services.

[280] Zaloshnja, E., Miller, T.R., Jones, P., Litovitz, T.; Coben, J.; Steiner, C.; Sheppard, M. The impact of poison control cents on poisoning-related visits to emergency departments, U.S. 2003. Am J Emerg Med. 2008.

expertise in clinical settings.[281] It is estimated that every dollar invested in the poison center system saves $13.39 in medical costs and lost productivity, for a total savings of more than $1.8 billion every year. Of that $1.8 billion, the Federal Government saves approximately $662.8 million in medical care savings and reduced productivity.[282]

In addition to providing the public and health care providers with treatment advice on poisonings, a second critical function of the PCCs is the collection of poison exposure and surveillance data. Multiple Federal agencies, including the CDC, Consumer Product Safety Commission, Environmental Protection Agency, Food and Drug Administration, and Substance Abuse and Mental Health Services Administration, use these data for public health surveillance, including timely identification, characterization, or ongoing tracking of outbreaks and other public health threats. In addition, many State health departments collaborate directly with poison centers within their jurisdictions. For example, States and Federal agencies used data from PCCs to monitor exposures to e-cigarette devices and liquid nicotine, energy drinks, synthetic cathinones or "bath salts", powdered caffeine, and laundry detergent packets.

According to the CDC, in 2013, the most recent year for which data are available, unintentional poisoning was the leading cause of unintentional injury deaths. Ninety-one percent of unintentional poisonings were caused by prescription drugs, primarily opioid analgesics. The rate for drug poisoning deaths involving opioid analgesics nearly quadrupled over a 14-year period. In March 2015, HHS announced an evidenced-based effort to focus on prescribing practices and treatment to reduce prescription opioid and heroin use disorders. PCCs play a critical role in combatting opioid drug-related abuse and misuse from helping to define and trace the problem within a local and national context to responding to calls from healthcare providers seeking treatment advice for substance abuse patients. PCCs also provide public and health care provider education. PCCs' health educators actively work to change behaviors to reduce poisonings and promote awareness and utilization of poison center services in their communities. Education efforts, for example, include partnering with health departments, departments of education, and other state agencies, etc.; promoting safe prescription medication use and storage messaging at health fairs and community events; and collaborating to develop media campaigns focused on preventing injuries. Additionally, PCCs participate in the National Prescription Drug Take Back events sponsored by the Drug Enforcement Agency to provide a safe, convenient, and responsible means of disposing of prescription drugs, while also educating the general public about the potential for abuse of medications.

[281] Bronstein AC, Spyker DA, Cantilena LR Jr, et al. 2011 annual report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 29th annual report. Clin Toxicol (Phila). 2012;50:911-1164.

[282] Value of the Poison Center System: Lewin Group Report for the American Association of Poison Control Centers. 2011.

Funding History

FY	Amount
FY 2013	$17,657,000
FY 2014	$18,799,000
FY 2015	$18,846,000
FY 2016	$18,846,000
FY 2017	$18,846,000

Budget Request

The FY 2017 Budget Request for the Poison Control Program is $18.8 million, which is equal to the FY 2016 Enacted level. Funding for the PCP will primarily be used to support the PCCs' infrastructure and core triage and treatment services. PCCs predominantly rely on State and local funding, as Federal funding accounts for approximately 10 percent of total funding for the PCCs. While PCCs have innovatively secured funding from a variety of local sources, including philanthropic organizations, their financial stability is tenuous. Many State funded poison control centers have been faced with termination due to State budgetary shortfalls in recent years. Federal funding helps reinforce the nationwide PCC infrastructure, enabling PCCs to sustain their public health and toxicosurveillance efforts.

The following activities will be supported with the requested funding at the FY 2017 Request:

Poison Center Network Grant Program: Grant funds will be used to support PCCs' efforts to 1) prevent poisonings and provide treatment recommendations; 2) comply with operational requirements needed to attain or sustain accreditation; and 3) improve and enhance communications and response capability and capacity. Funds will also be used to improve the quality of data uploaded from poison centers to the National Poison Data System (NPDS) in support of national toxicosurveillance activities conducted by the CDC. This request also includes costs associated with processing of grants through HRSA's Electronic Handbooks (EHBs), and conducting follow-up performance reviews.

National Toll-Free Hotline Services and Promotion of Number and Services: Ensuring access to PCCs through the national toll-free Poison Help hotline is a critical public health service. The PCP will fund and manage the toll-free number 24 hours a day, every day of the year. Funding will also be used to support translation services for non-English speaking callers.

Nationwide Media Campaign: As legislatively mandated, the Program will continue to educate the public and health care providers about the national toll-free number and to build upon the existing national public awareness campaign, to highlight the role of PCCs in the public health system with a focus on Medicare and Medicaid beneficiaries. In FY 2015, the PCP awarded a contract to build upon the existing national public awareness campaign, Poison Help, . The goals of the contract include, increasing public awareness of the national Poison Help toll-free number; educating Medicare and Medicaid beneficiaries about poisoning risk and prevention; and showcasing the role of the national network of PCCs and the services they provide. The PCP will also continue to promote the hotline among the public and providers as well as engage other

Federal partners including community health centers, 340B Drug Pricing Program participants, geriatric education centers, rural health associations, Ryan White Program providers, and Head Start programs.

The FY 2017 target is to maintain the percent of inbound call volume on the toll-free number at 83 percent. Additionally, the PCP aims to maintain the 68 percent of human poison exposure calls made to PCCs that are managed outside of a health care facility, as reported by the AAPCC. This will be a challenge because the U.S. is in the grip of an epidemic of prescription drug and heroin overdoses, which is increasing emergency room visits.

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

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
25.III.D.3: Percent of inbound volume on the toll-free number. (Output)	FY 2014: 83.7% Target: 73.7% (Target Exceeded)	83%	83%	Maintain
25. III.D.4: Percent of national survey respondents who are aware that calls to poison control centers are handled by health care professionals. (Outcome)[283] (FY 2006 Baseline: 19%)	FY 2012: 25% (Target Not in Place)	25%	N/A	N/A
25. III.D.5: Percent of human poison exposure calls made to PCCs that were managed by poison centers outside of a healthcare facility. (Output)	FY 2014: 68.1% Target: 71% (Target Not Met)	71%	71%	Maintain

[283] This is a long term measure based on periodic survey data (data are reported every 5 years). FY 2016 is the first year for which there is a target. The next year for which targets are reported will be 2021.

Grants Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	52[284]	52[285]	52[286]
Average Awards	$324,376	$333,577	$323,762
Range of Award	$12,466-$1,980,105	$12,466-$2,038,439	$12,466-$1,974,902
Range of Contracts	$9,609-$300,000	$9,884-$300,500	$10,168-$320,443

[284] In FY 2015, there were 55 PCCs across the Nation. Fifty-two awards were made under the Poison Center Network Grant Program, representing all of the poison centers. For grant purposes, HRSA counts the California Poison Control System as a single entity, but it encompasses four California poison centers.

[285] In FY 2016, there are 55 PCCs across the Nation. Fifty-two awards will be made under the Poison Center Network Grant Program, representing all of the poison centers. For grant purposes, HRSA counts the California Poison Control System as a single entity, but it encompasses four California poison centers.

[286] In FY 2017, we expect that there will be 55 PCCs across the Nation. Fifty-two awards will be made under the Poison Center Network Grant Program, representing all of the poison centers. For grant purposes, HRSA counts the California Poison Control System as a single entity, but it encompasses four California poison centers.

Office of Pharmacy Affairs/340B Drug Pricing Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$10,238,000	$10,238,000	$17,238,000	+$7,000,000
USER FEES	---	---	$9,000,000	+$9,000,000
TOTAL	$10,238,000	$10,238,000	$26,238,000	+$16,000,000
FTE	25	25	25	---

Authorizing Legislation: Public Health Service Act, Section 340B, as amended by Public Law 111-309, Section 204

FY 2017 Authorization…….…….…….…….....SSAN

Allocation Method……...…….……..….Contract

Program Description and Accomplishments

Section 602 of Public Law 102-585, the "Veterans Health Care Act of 1992," enacted section 340B of the Public Health Service Act (PHSA), "Limitation on Prices of Drugs Purchased by Covered Entities" and is administered by the Office of Pharmacy Affairs. The 340B Program requires drug manufacturers to provide discounts on outpatient prescription drugs to certain safety net health care providers specified in statute, known as covered entities, including Federally Qualified Health Centers, AIDS Drug Assistance Programs, and certain disproportionate share hospitals. The 340B Program can help these designated hospitals and clinics provide more care to additional patients. A 2011 Government Accountability Office (GAO) study found that entities participating in the 340B Program are able to expand the type and volume of care they provide to the most vulnerable patient populations as a result of access to these lower cost medications.

The 340B ceiling price – the maximum amount a drug manufacturer can charge a covered entity for a given drug – is equal to the Average Manufacturer Price (AMP) minus the Unit Rebate Amount, both set by the Centers for Medicare and Medicaid Services (CMS). Covered entities purchase 340B drugs that are at least 23.1 percent below AMP for brand name drugs; 13 percent below AMP for generic drugs; and 17.1 percent below AMP for clotting factor and pediatric drugs. In 2014 covered entities saved an estimated $4.5 billion on their outpatient drug expenditures by participating in the 340B Program. Overall, drug spending under the 340B Program represents approximately two percent of the total U.S. drug market.

HRSA places a high priority on the integrity of the 340B Program, and continually works to improve its oversight of the Program. HRSA conducts the following activities to ensure both covered entities and manufacturers are in compliance with program requirements:

- Performance of initial eligibility checks of all entities seeking to register with the Program.
- Annual recertification of all covered entities including an attestation to compliance with all Program requirements.
- Audits of covered entities to assure compliance within the Program. Since FY 2012, HRSA has completed 444 covered entity audits which included review of 5,324 offsite outpatient facilities and 11,268 contract pharmacies. Final results from these audits, including status of corrective action, are available on HRSA's website.
- Reviews every allegation received of non-compliance through targeted communication and, if necessary, on-site audits.
- Audits of manufacturers, with the first audit occurring in FY 2015.
- Contracts to expand compliance oversight and technical assistance to entities
- Assistance to covered entities who self-disclose compliance issues, including the development of corrective action plans and work with affected manufacturers.
- Supports an integrated system of compliance tracking for covered entities and manufacturers, enabling enhanced communication across the Office of Pharmacy Affairs to ensure that all covered entities and manufacturers are in compliance with 340B program requirements. HRSA expects full implementation of this system in FY 2016, with FY 2017 funding supporting ongoing maintenance and improvements

HRSA uses the results of these program integrity efforts to develop and refine a proactive strategy to promote best practices for complying with Program requirements.

The Office of Pharmacy Affairs operates the Prime Vendor Program (PVP), required under Section 340B (a) (8) of the Public Health Service Act. The PVP facilitates the distribution of drugs to 340B entities, conducts negotiation of pharmaceutical prices below the 340B ceiling price, and provides technical assistance to 340B stakeholders. By the end of FY 2014, the PVP had nearly 7,000 products available to participating entities below the 340B ceiling price, including 3,557 covered outpatient drugs with an estimated average savings of 10 percent below the 340B ceiling price. From 2009 to November 2014, the PVP contracts provided over $279 million in additional sub-ceiling savings for covered entities, enabling them to further expand their pharmacy programs.

HRSA continues to strengthen the program, including implementation of recommendations made by the Office of the Inspector General (OIG) and GAO. For example, OIG recommended that HRSA provide covered entities access to ceiling price information and improve oversight of 340B pricing. The following activities are either underway or planned as priorities in FY 2016 and FY 2017:

- Price Verification – Compute the 340B ceiling prices using data that manufacturers supplied to CMS, based on a HRSA-CMS inter-agency agreement. Conduct random spot checks of these prices with information submitted voluntarily by a small group of manufacturers.
- Price Submission – Maintain a secure system for all manufacturers to submit 340B price information, allowing regular spot checks of prices and any necessary follow up on pricing errors.

- Refunds and Credits – Facilitate refunds and credits to entities who were overcharged by participating manufacturers.
- Pricing System – Continue to develop a system whereby covered entities can access 340B ceiling price information via a secure website. Implementation is expected during calendar year 2016.

In addition, GAO recommended that HRSA clarify the definition of a patient eligible to receive 340B drugs, as well as eligibility of certain hospitals. HRSA continues to move forward on the goal of providing more clear policy for all stakeholders through regulations and guidance. The following activities were initiated in FY 2015 and will continue to be priorities in FY 2016 and FY 2017:

- Program Guidance – HRSA will continue to support the development of program guidance to strengthen oversight and maintain the integrity of the 340B Program. The 340B Program Omnibus Guidance was published in August 2015 and the public comment period closed October 27, 2015. HRSA is currently in the process of reviewing over 1,200 comments received to assess impact and determine next steps.

- Civil Monetary Penalties – HRSA plans to implement, per statutory authority, civil monetary penalties for manufacturers and covered entities. For manufacturers, HRSA can impose up to a $5,000 penalty to manufacturers for each instance of knowingly and intentionally overcharging a covered entity. HRSA can require covered entities to pay monetary penalties to manufacturers when violations are found to be systematic and egregious. The Civil Monetary Penalty regulation was published in June 2015 and the public comment period closed in August 2015. HRSA is currently in the process of reviewing the comments received to assess impact and determine next steps.

- Administrative Dispute Resolution Process – HRSA will continue to implement an administrative process for the resolution of claims by covered entities that they have been overcharged for drugs purchased and claims by manufacturers of violations, including appropriate procedures for the provision of remedies and enforcement of such process through mechanisms and sanctions. HRSA is drafting the regulation which will govern the Administrative Dispute Resolution process. Publication of a Notice of Proposed Rulemaking for public comment is anticipated in calendar year 2016.

Covered Entity Participation

As of October 1, 2015, 11,848 covered entities and 20,223 associated sites participate in the 340B Program, for a total 32,071 registered sites. Twenty-seven percent of covered entity sites have contract pharmacy arrangements, which result in the registration of approximately 15,600 unique pharmacy locations in the 340B database.

Funding History

FY	Amount
FY 2013	$4,193,000
FY 2014	$10,212,000
FY 2015	$10,238,000
FY 2016 BA	$10,238,000
FY 2017 BA	$17,238,000
FY 2017 User Fees	$9,000,000

Budget Request

The FY 2017 Budget Request for the 340B Program includes $17.2 million in budget authority, an increase of $7 million to the FY 2016 Enacted level. In addition, this request proposes a user fee equal to 0.1 percent of the total 340B drug purchases paid by a participating covered entity as a long-term mechanism to recover costs for operating the program, which would generate an estimated $9 million per year.

Funding will support implementation of the statutory obligations for the 340B Program, enhanced oversight of participating manufacturers and covered entities, increased efficiencies using information technology, and overall successful operation of the program. The $7 million increase will support the following activities:

- Improvement of 340B Public Database – The Office of Pharmacy Affairs Information System (OPAIS) is a multi-function web-based database system that provides information on covered entities, contract pharmacy arrangements, and participating manufacturers. External stakeholders use the database to verify eligible entities and their associated sites, confirm manufacturer participation, and prevent statutorily prohibited duplicate discounts. Integrity of the 340B database requires ongoing maintenance and development. This requested increase provides additional resources to improve further the integrity, transparency, security, and reliability of the OPAIS and ensure that the database continues to meet the needs of external stakeholders.

- Program Audits of Covered Entities – HRSA plans to continue random and targeted audits of covered entities, as well as publish audit report summaries and public letters via the HRSA website to expand the program's compliance reach while managing program risk. The FY 2017 request provides the funding needed to hire and train staff to conduct an additional 100 on-site covered entity audits, write reports, and work with entities through the notice and hearing process, and finalize public information to be shared.

- Compliance Management Tool – HRSA plans to implement the base functions of the system in FY 2016 and provide ongoing maintenance. This request provides for improvements to the system as HRSA's program integrity efforts are expanded.

- User Fee System – HRSA would develop a multi-functional web-based User Fee System that would provide for the calculation and collection of the user fee and a reporting

requirement of manufacturer sales data from which the fee would be calculated. The system would also support the verification of payments by the covered entities. FY 2017 funding will be utilized to develop the system used to calculate and verify the fees collected. HRSA would need to establish this system to collect and obligate the user fees.

Finally, the FY 2017 Budget includes a general provision to provide clear regulatory authority for the 340B program. Under current law, there are only three areas where HRSA has explicit regulatory authority in the 340B Program: the calculation of 340B ceiling prices, the imposition of manufacturer civil monetary penalties, and the implementation of a dispute resolution process. HRSA lacks explicit regulatory authority for all other provisions in the statute, including for example, the definition of a patient, the utilization of contract pharmacies, and hospital charity care requirements. Clear legislative authority to conduct rulemaking for all provisions in the 340B statute would be most effective in facilitating HRSA's oversight over, and management of, the 340B Program. In addition, regulatory authority would allow HRSA to provide greater clarity and specificity for its program requirements which would enable us to respond to some key GAO findings, such as clarifying hospital eligibility requirements and the definition of a 340B patient (See: *GAO 11-836 Drug Pricing: Manufacturer Discounts in the 340B Program Shows Benefits, but Federal Oversight Needs Improvements*). Because regulations are binding and enforceable, regulations would allow HRSA to be more specific about 340B Program requirements and provide necessary clarity for stakeholders. The funding request also includes costs associated with contract award process, follow-up reviews, and information technology and other program support costs.

HRSA-Supported Performance Outcomes

HRSA measures the performance of the 340B Program by three key metrics. As a drug discount program serving safety net providers, HRSA tracks participation levels of eligible providers, and ensure quality through oversight and audits of covered entities and manufacturers.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
Covered Entity Sites Participating	FY 2015: 32,071 Target: 31,672 (Target Exceeded)	33,572	34,579	+1,007
Covered Entity Audits Conducted	FY 2015: 200 Target: 200 (Target Met)	200	300	+100
Manufacturer Audits Conducted	FY 2015: 1 Target: 1 (Target Met)	5	5	Maintain

The FY 2017 request provides the resources needed to allow the 340B Program to work with covered entities – both those currently participating as well as interested in doing so – to better understand their responsibilities around compliance with statutory requirements. Proactive technical assistance of this nature may result in some sites terminating from the Program and others registering for the Program.

For those covered entities participating in the Program, HRSA will continue to expand its oversight activities, producing a sentinel effect of increased compliance. Data provided by the PVP shows that education based on oversight measures reduces the risk of future compliance issues. Finally, HRSA will conduct additional audits of manufacturers, which should not only increase compliance, but provide greater insight into the tools and mechanisms used by these companies to comply with 340B statutory requirements and guide future technical assistance.

Contracts Awards Table

	FY 2015 Final	**FY 2016 Enacted**	**FY 2017 President's Budget**
Number of Contracts	2	3	4
Average Contract	$4,250,000	$3,333,333	$3,500,000
Range of Contracts	$3,300,000 - $5,200,000	$1,500,000-$5,200,000	$1,600,000 -$5,400,000

National Hansen's Disease Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$15,206,000	$15,206,000	$15,206,000	---
FTE	58	59	59	---

Authorizing Legislation: Public Health Service Act, Section 320, as amended by Public Law 105-78, Section 211

FY 2017 Authorization ..... Indefinite

Allocation Method:

- Direct Federal/Intramural
- Contract

Program Description and Accomplishments

The National Hansen's Disease Program (NHDP) has been providing medical care, training, education, and research for Hansen's Disease (HD, leprosy) and related conditions as authorized since 1921. Medical care includes providing direct patient care (diagnosis, treatment and rehabilitation), cost free HD drug regimens, consultations, laboratory services and outpatient referral services to any patient living in the United States (U.S.) or its territories. The Program strengthens the safety net infrastructure for patients with this rare disease by providing critical training and education to healthcare providers to detect and diagnose HD early. The Program also consults with non-NHDP providers caring for HD patients; provides facilities throughout the country that can address long-term resident, short-term referral, and outpatient needs; and advances the science through a laboratory dedicated to Hansen's Disease.

Increasing Quality of Care: Early diagnosis and treatment are the keys to blocking or arresting the trajectory of Hansen's Disease-related disability and deformity. This goal is best achieved if there are enough health care providers in the U.S. with knowledge of the disease and access to the support provided by the NHDP through its function as an outpatient clinic, and training, education, and referral center. Increasing knowledge about Hansen's Disease in the U.S. medical/healthcare community is expected to lead to earlier diagnosis and intervention, resulting in a decrease in Hansen's Disease-related disabilities. For FY 2014, NHDP trained 358 physicians, exceeding the target. In FY 2015, NHDP revised this measure to include all healthcare providers in order to reflect more accurately the range of disciplines trained. In FY 2015 the number healthcare providers who have received training from NHDP totaled 448.

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

Through its focus on early diagnosis and treatment, the NHDP monitors its impact on improving health outcomes for Hansen's Disease patients through the prevention of increases in the percentage of patients with grades 1 or 2 disability/deformity[287]. The percentage of patients presenting with disability annually fluctuates due to several variables, including migration, immigration, stigma of the disease and primarily related to delays in diagnosis. In FY 2013, the disability rate was 25 percent, exceeding the target of maintaining disability below 50 percent.

The Program is also working to improve health outcomes through research. The Program has advanced scientific knowledge through breakthroughs in genomic and molecular biology including the development of six protective biological response modifiers (BRMs) and six white blood cell subtype markers (CMs) that are important in host resistance to Hansen's Disease. These markers and other progress will aid in the study of defective nerve function in infected armadillos, which will ultimately permit development of a full animal model for human Hansen's Disease. The Program has developed a "DNA fingerprint" to provide evidence that linked leprosy transmission from armadillos to humans in the Southern U.S.; defined parameters of nerve and muscle dysfunction in armadillos infected with the leprosy bacillus; and in 2014 the program developed methods to monitor neuropathy due to leprosy in the armadillo.

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

By restraining increases in the annual cost per individual served by the NHDP's outpatient clinic as well as the contracted outpatient Ambulatory Care Program clinics below the national medical inflation rate, the Program can continue to serve more patients that otherwise would have required additional funding. Increases in the cost per patient served through NHDP outpatient services has usually been at or below the national medical inflation rate. For FY 2014, the cost per patient served through outpatient services represented a slight increase of 3.50 percent, however, is still below the national medical inflation rate of 3.84 percent.

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

Funding History

FY	Amount
FY 2013	$15,045,000
FY 2014	$15,168,000
FY 2015	$15,206,000
FY 2016	$15,206,000
FY 2017	$15,206,000

Budget Request

The FY 2017 Budget Request for National Hansen's Disease Program is $15.2 million, which is equal to the FY 2016 Enacted level. The Program will continue its goals in the area of increasing quality of care and improving health outcomes for Hansen's Disease patients.

The FY 2017 Budget Request will support the Program's achievement of its performance targets, including training 550 healthcare providers.

In the area of Hansen's Disease disability/deformity prevention, both the Program's existing case management efforts, as well as its activities to train more private sector physicians and healthcare workers to recognize Hansen's Disease and initiate treatment earlier, will help prevent further increases in the level of disability/deformity among Hansen's patients, maintaining the Grade 1 and Grade 2 levels of deformity to less than or equal to 50 percent.

The FY 2017 funding will support the Program's continued coordination and collaboration with related Federal, State, local, and private programs to further leverage and promote efforts to improve quality of care, health outcomes, and research related to Hansen's Disease.

Areas of collaboration include a partnership with the Food and Drug Administration (FDA) Drug Shortage Program to distribute the drug clofazimine to over 500 providers nationally. At the request of the FDA, the Program agreed to manage the investigational new drug (IND) application that makes clofazimine available in the U.S. for treatment of leprosy. The NHDP continues its collaboration with the Centers for Disease Control and Prevention, to develop Hansen's Disease training and educational material for healthcare providers in the US-Affiliated Pacific Islands (USAPI). Patients who migrate to the United States from these USAPI nations, under the Compact of Free Association, constitute the most rapidly growing subset of Hansen's Disease patients in the United States.

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

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

Outputs and Outcomes Table

Measure	Year and Most Recent Result/Target for Recent Result/ (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/- FY 2016 Target
3.E.: Maintain the increase in the cost per outpatient served below the medical inflation rate.	FY 2014: 3.50% Target: Below national medical inflation rate Target: 3.84 % (Target Met)	Maintain below national medical inflation rate	Maintain below national medical inflation rate	Maintain
3.II.A.4.: Number of healthcare providers who have received training from NHDP.	FY 2015: 448 (Target was not in place)	550	550	Maintain
3.II.A.1.: Percentage of patients at Grade 1 or 2 disability.	FY 2013: 25% Target: 50% (Target Exceeded)	Less than or equal to 50%	Less than or equal to 50%	Maintain

Additional Outputs and Outcomes

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
NHDP Resident Population	10	10	10
NHDP Non-Residential Outpatients	177	177	177
Ambulatory Care Program (ACP) Clinics	16	17	17
ACP Clinic Patients (Outpatients)	3,000	3,000	3,000
ACP Clinic Patient Visits	16,000	16,000	16,000
NHDP Non-Residential Outpatient Visits	22,000	22,000	22,000

National Hansen's Disease Program by Sub – Activity

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Administration	$ 1,860,000	$1,998,000	$1,998,000
Clinical Care	$4,539,000	$4,355,000	$4,359,000
Regional Centers	$2,514,000	$2,654,000	$2,654,000
Research	$2,621,000	$2,524,000	$2,524,000
Facility Operations	$2,544,000	$2,680,000	$2,680,000
Assisted Living Allowance	$1,128,000	$995,000	$991,000
Total	**$15,206,000**	**$15,206,000**	**$15,206,000**

National Hansen's Disease Program – Buildings and Facilities

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$122,000	$122,000	$122,000	---
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Sections 320 and 321(a)

FY 2017 Authorization ..... Indefinite

Allocation Method
- Direct Federal

Program Description and Accomplishments

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

Funding History

FY	Amount
FY 2013	$122,000
FY 2014	$122,000
FY 2015	$122,000
FY 2016	$122,000
FY 2017	$122,000

Budget Request

The FY 2017 Budget Request is $122,000, which is equal to the FY 2016 Enacted level. The total request is required for continued renovation and repair work on patient areas, to complete minor renovation work on the Carville museum, and to continue regular renovation and repair work on clinic areas and offices.

Payment to Hawaii

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$1,857,000	$1,857,000	$1,857,000	---
FTE	---	---	---	---

Authorizing Legislation: Public Health Service Act, Section 320(d), as amended by Public Law 105-78, Section 211

FY 2017 Authorization ..... Indefinite

Allocation Method

- Direct Federal

Program Description and Accomplishments

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

Funding History

FY	Amount
FY 2013	$1,838,000
FY 2014	$1,852,000
FY 2015	$1,857,000
FY 2016	$1,857,000
FY 2017	$1,857,000

Budget Request

The FY 2017 Budget Request is $1.9 million, which is equal to the FY 2016 Enacted level.

In addition to the payment made to the State of Hawaii for the medical care and treatment of person with HD, the funding request also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs.

Outputs and Outcomes Tables

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Average daily HD Kalaupapa patient load	16	16	16
Total Kalaupapa and Hale Mohalu patient hospital days	2,603	2,603	2,296
Total Kalaupapa homecare patient days	2,723	2,723	2,944
Total Hawaiian HD Program outpatients	278	278	289
Total outpatient visits	5,826	5,826	6,721

Rural Health Policy

TAB

FEDERAL OFFICE OF RURAL HEALTH POLICY

Summary of the Request

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$147,471,000	$149,571,000	$ 144,162,000	-$5,409,000
FTE	14	13	15	+2

Established in 1987, the Federal Office of Rural Health Policy (FORHP) serves as a focal point for rural health activities within the Department of Health and Human Services (HHS). FORHP is specifically charged with advising on rural policy issues, conducting and overseeing policy-relevant research on rural health issues, and administering grant programs that focus on supporting and enhancing health care delivery in rural communities.

FORHP is charged in Section 711 of the Social Security Act with advising "the Secretary on the effects of current policies and proposed statutory, regulatory, administrative, and budgetary changes in the programs established under titles XVIII and XIX [Medicare and Medicaid] on the financial viability of small rural hospitals, the ability of rural areas (and rural hospitals in particular) to attract and retain physicians and other health professionals, and access to (and the quality of) health care in rural areas." FORHP is also charged with overseeing compliance with the requirements of section 1102(b) of the Social Security Act to assess the impact of key regulations affecting a substantial number of small rural hospitals. In addition, FORHP maintains clearinghouses for collecting and disseminating information on rural health care issues, promising approaches to improving and enhancing health care delivery in rural communities, and policy-relevant research findings addressing rural health care delivery.

In addition to its policy role, FORHP administers a range of grant programs focusing on capacity building and enhancing health care delivery at the community and state levels as well as programs aimed at leveraging the use of health information technology and telehealth to enhance access to and the quality of health care services in rural and underserved areas.

HHS has maintained a significant focus on rural activities for more than 28 years. Historically, rural communities have struggled with issues related to access to care, recruitment and retention of health care providers and maintaining the economic viability of hospitals and other health care providers in isolated rural communities.

There are over 46 million people living in rural America who face ongoing challenges in accessing health care.[288] Rural residents have higher rates of age-adjusted mortality, disability,

[288] Calculated using 2010 Census Data and 2013 OMB nonmetropolitan county designations.

and chronic disease than their urban counterparts.[289] Rural areas also continue to suffer from a shortage of a broad range of health care providers for their communities' health care needs and face workforce shortages at a greater rate than their urban counterparts.[290,291] Sixty percent of all designated primary medical health are located in rural areas[292]

Improving Rural Health Care Initiative

The goal for the President's Improving Rural Health Care Initiative is to build healthier rural populations and communities through evidence-based practices, to improve the access and to improve the quality of health care in rural areas. To achieve this goal, the initiative focuses on five activities:

- Strengthening rural health care infrastructure;
- Improving the recruitment and retention of health care providers in rural areas;
- Building an evidence base for programs that improve rural community health;
- Providing direct health care services; and
- Improving the coordination of rural health activities within HRSA, HHS, and across the Federal Government.

Approximately $90.0 million of the total amount requested for FORHP supports the President's initiative to improve rural health; specifically, $63.5 million for Rural Health Care Services Outreach, $9.5 million for the State Offices of Rural Health, and $17.0 million for Telehealth.

Rural Health Care Services Outreach, Network, and Quality Improvement

The Rural Health Outreach authority includes a range of programs designed to improve access to care, coordination of care, and integration of services, and to focus on quality improvement in health care for rural communities. All of the grants support collaborative models to deliver basic health care services to rural areas and are uniquely designed to meet rural needs. The grant funding allows rural communities to compete for funding against other rural communities rather than have to also compete against larger metropolitan communities with greater resources.

These programs are among the only non-categorical grants within HHS, which allows grantees to determine the best way to meet local need. This flexibility in funding reflects the unique nature of health care challenges in rural communities and the need to allow communities to determine the best approach to addressing local health concerns. The broad non-categorical nature of the

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[289] Meit, M., Knudson,, A., Gilbert, T, et al. (October 2014). The 2014 Update of the Rural-Urban Chartbook. Retrieved from https://ruralhealth.und.edu/projects/health-reform-policy-research-center/pdf/2014-rural-urban-chartbook-update.pdf.

[290] Doescher, M., Fordyce, M., Skillman S., WWAMI Rural Health Research Center Presentation: The Aging of the Rural Generalist Workforce. February 2009.

[291] Area Health Resource File (ARF). 2008. US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Rockville, MD.

292 Health Resources and Services Administration. (2014). Designated Health Professional Shortage Areas Statistics. Rockville, MD.

programs also allows FORHP to focus funding on key emerging needs. For example, in the first couple of years of the Improving Rural Health Care Initiative, FORHP was able to focus funding on two key areas of need through funding of Network Development grants. The first focus was on health care workforce development in 2010; the second focus was on the adoption of health information technology in 2011. FORHP awarded 20 awards in the Rural Health Workforce Development Program and conducted short-term and long-term evaluations. The program focused on a range of disciplines including physicians and physician assistants as well as mental health, dental, pharmacy, and allied health. Findings show that the average economic impact ratio of the Rural Health Workforce Development Program was $1.59 for every HRSA dollar invested. As such, approximately $19.0 million was generated from FORHP's $11.9 million investment. In addition, FORHP awarded 41 health information technology grants in 2011 to adopt HIT and to reach Meaningful Use (MU) Stages 1 and 2 and findings show that 88 percent of the grantees met meaningful use stage 1 and 2. The average economic impact ratio was $0.92 for every HRSA dollar invested.

In FY 2013, FORHP continued to focus on the Improving Rural Health Care Initiative and made 15 awards in the Rural Health Information Technology (HIT) Workforce Program to increase the number of qualified HIT professionals in rural areas. To date, 380 students are enrolled and receive training. This program helps to improve access to and the quality of health care in rural areas by supporting three of the initiative's five components: strengthening rural health care infrastructure, providing direct health care service, and improving the recruitment and retention of health care providers in rural areas.

In FY 2015, FORHP administered three new pilot programs to further support the Improving Rural Health Care Initiative. These three programs focus on allied health training, care coordination and benefits counseling. The Rural Allied Health Program, developed as a result of the Job-Driven Training Initiative, supports 10 grants that will focus on the recruitment and retention of allied health professionals. The Rural Health Care Coordination Network Partnership Program supports eight grantees and focuses on the delivery of coordinated care. The Rural Outreach Benefits Counseling Program supports 10 grants to focus on outreach, education and enrollment efforts for the uninsured and newly insured.

State Offices of Rural Health Grants

State Offices of Rural Health grants provide funding to the State Office of Rural Health (SORH) located in each state to establish and maintain within the state a clearinghouse for collecting and disseminating information on: rural health issues, research findings related to rural health care, and innovative approaches to delivery of health care in rural areas. The program supports the coordination of activities carried out within the state that relate to rural health care. SORHs also build coalitions to leverage available resources to better meet the rural health needs in rural communities through sharing information and working collaboratively with a wide variety of stakeholders. Additionally, the program provides technical and other assistance to public and nonprofit private entities regarding participation in federal, state, and nongovernmental programs focused on rural health. Finally, this program supports improving the recruitment and retention of health care providers in rural areas component of the initiative.

Telehealth Grants

The Telehealth program expands the use of telecommunications technologies within rural areas that can link rural health providers and patients with specialists to increase access to, and the quality of, healthcare provided to rural populations. These grants support the Improving Rural Health Care Initiative by strengthening rural health care infrastructure. FORHP awarded $1.3 million in FY 2015 for the new Rural Child Poverty Telehealth Network Grant Program (RCP-TNGP). The purpose of this program is to demonstrate how telehealth networks can improve access to, coordination of, and the quality of health care services for children living in impoverished rural areas and in particular how such networks can be enhanced through the integration of social and human service organizations. Additionally, $750,000 was awarded to support a Telehealth-Focused Rural Health Research Center, through a cooperative agreement, to increase the amount of publicly available, clinically informed, and policy relevant telehealth related research.

Coordinating Programs for a Targeted Investment

The telehealth grant programs also support the Improving Rural Health Care Initiative. In addition, FORHP will continue to conduct program evaluations and build an evidence base for new ways to improve health care in rural communities. Evaluations will focus on measuring:

- The program impact on the health status of rural residents with chronic conditions;
- The return on investment for rural grantees and communities; and
- The economic impact of the Federal investment in rural communities.

FORHP will also identify successful models, lessons learned, and common challenges faced by rural grantees through a Rural Community Health Gateway. These best practices are being disseminated across the nation as models that can be replicated through the Gateway.

Finally, as part of the Improving Rural Health Care Initiative, FORHP will work to increase coordination with other agencies that fund programs that benefit rural communities within HRSA, HHS, and across the Federal Government. This will include increasing rural participation in health professional training and service programs in Title VII and VIII of the Public Health Service Act as well as the National Health Service Corps. Since 2011, FORHP has expanded its work with the Department of Veteran Affairs on veteran's access to rural health providers through the support of pilot programs that use telehealth and health information exchange to enhance services for rural veterans. In addition, FORHP is working with the VA Office of Rural Health (ORH) on the implementation of the Veteran's Choice Act. This legislation allows rural hospitals and clinics to provide services to Veterans who reside more than 40 miles from a VA facility. FORHP and the VA are working with rural providers to sign up as VA partners. FORHP has also worked with the Office of the National Coordinator for Health Information Technology (ONC) and the U.S. Department of Agriculture to expand access to Health IT capital and expand the use of Blue-Button health information exchange between small rural hospitals and the VA. FORHP has also continued to work with the Department of Labor (DOL) on the Black Lung Clinics program, and the DOL and Department of Justice (DOJ)

on the Radiation Exposure Screening and Education (RESEP) program for eligible miners to receive compensation.

Affordable Care Act

The Affordable Care Act (ACA) presents opportunities to provide comprehensive care and services to individuals who otherwise cannot afford or gain access to care by extending health insurance coverage and improving coordinated care. The ACA is increasing access to insurance coverage for rural Americans. To support these efforts, FORHP invested $1.3 million in FY 2014 to supplement 52 outreach grantees to conduct ACA outreach and enrollment activities. Grantees reported helping more than 9,000 people signed up for health insurance. FORHP continued this effort in FY 2015 by supplementing 57 grantees, and through April 2015, over 5,500 people have been enrolled. In FY 2015, FORHP developed a Rural Outreach Benefits Counseling Grant Program focused on expanding health insurance outreach, education, and enrollment efforts to eligible uninsured individuals and families and newly insured individuals and families in rural communities. This program made 10 awards in FY 2015.

The FY 2017 request supports the need for rural-specific programs, research, and grants to provide help to rural communities focus on innovative ways to enhance services in rural communities and emphasize quality improvement in rural hospitals and clinics.

Funding History

FY	Amount
FY 2013	$130,876,000
FY 2014	$141,978,000
FY 2015	$147,471,000
FY 2016	$149,571,000
FY 2017	$144,162,000

Budget Request

The FY 2017 Budget Request for the Federal Office of Rural Health Policy program of $144.2 million is $5.4 million below the FY 2016 Enacted level. This Request will continue to support the President's Improving Rural Health Care Initiative. FORHP's FY 2017 Budget includes the following programs:

- $63.5 million for the Rural Health Care Services Outreach, Network, and Quality Improvement Programs. The Request will continue to support key activities for Rural Health Care Services Outreach, Network, and Quality Improvement Grants Programs. One of the goals of the Improving Rural Health Care Initiative is to help existing rural entities improve the coordination of health services in rural communities and strengthen the rural health care systems as a whole. FORHP expects that 415,000 people will receive direct services in FY 2017.

- $9.4 million for Rural Health Policy Development. Funding will support activities including the Rural Health Research Center cooperative agreement grant program, as

well as policy analysis, technical assistance, and information dissemination activities on a range of rural health issues. The FY 2017 target for these policy-research activities is 39 reports.

- $26.2 million for the Rural Hospital Flexibility Program, which provides grants to support a range of activities focusing on critical access hospitals (CAHs) through the Rural Hospital Flexibility Grants and the Flex Rural Veterans Health Access Program Grants. The request continues support for the Flex Rural Veterans Access Program to increase access for rural veterans to needed services. The activities under this funding will continue to support efforts by CAHs to report quality data to Hospital Compare. The FY 2017 target is for 94 percent of CAHs reporting quality data to Hospital Compare.

- $9.5 million for the State Offices of Rural Health Grants. This funding will continue to support key activities for the SORH Program and will support a grant award to each of the 50 states. It is part of the President's Improving Rural Health Initiative to provide technical and other assistance to rural health providers and help rural communities recruit and retain health care professionals. The SORH Program anticipates that it will provide 82,549 technical assistance encounters directly to clients in FY 2017. The program also expects 26,574 clients (unduplicated) will receive technical assistance directly from SORHs in FY 2017.

- $1.8 million for Radiation Exposure Screening and Education Program. The purpose of this program is to provide grants to States, local governments, and appropriate health care organizations to support programs for individual cancer screening for individuals adversely affected by the mining, transporting and processing of uranium and the testing of nuclear weapons for the Nation's weapons arsenal. The RESEP grantees also help clients with appropriate medical referrals, engage in public information development and dissemination, and facilitate claims documentation to aid individuals who may wish to apply for support under the Radiation Exposure Compensation Act. This program expects to screen 1,400 individuals in FY 2017.

- $6.7 million for the Black Lung Clinics Program. The purpose of this program is to commit funds through project grants for establishing clinics that provide for the outreach and education, diagnosis, treatment, rehabilitation, and benefits counseling of active and retired coal miners and other with occupation-related respiratory and pulmonary impairments. This program expects to serve 13,800 miners in FY 2017.

- $17.0 million for the Telehealth Grants. The funds will support the Telehealth Network Grant Program, Telehealth Resource Centers, the Evidence-Based Telehealth Network Grant Program, the Licensure Portability Grant Program, the Rural Child Poverty Telehealth Network Grant Program, and a Telehealth-focused Rural Health Research Center. Through these programs, OAT hopes to increase the proportion of diabetic patients enrolled in a telehealth diabetes case management program to 25 percent in FY 2017 (for the FY 2016-2019 cohort). Additionally, OAT anticipates that 320 communities will have access to adult mental health services and 330 communities will have access to pediatric and adolescent mental health services by FY 2017.

- $10.0 million for the Rural Opioid Overdose Reversal Grant Program (ROOR). The purpose of this program is to provide funding to rural communities to focus on prevention, treatment, and intervention of opioid misuse. Grantees will implement innovative strategies for care coordination and communication by a team of qualified health care providers in support of the following goals: 1) providing education and prevention services; 2) training licensed healthcare professionals to recognize the signs of opioid overdose and learn the appropriate way to administer naloxone; 3) providing appropriate transport to a hospital or clinic for continued care after administration; 4) referring those with a drug dependency to an appropriate substance abuse treatment centers where care coordination is provided by a team of providers; and 5) purchasing naloxone and opioid overdose reversal devices; . ROOR aims to demonstrate improved and measurable health outcomes, including, but not limited to, reducing opioid overdose morbidity and mortality in rural areas.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
27.1: The proportion of rural residents of all ages with limitation of activities caused by chronic conditions.[293] (Outcome)	FY 2010: 14.2% Target: 13.9% (Target Not Met)	N/A	N/A	N/A
29.IV.A.3: Number of unique individuals who received direct services through FORHP Outreach grants.[294] (Outcome)	FY 2014: 820,176 Target: 400,000 (Target Exceeded)	410,000 [295]	415,000 [295]	+5,000
27.2: Increase the proportion of critical access hospitals with positive operating margins. (Outcome)	FY 2013: 54.9% Target: 60% (Target Not Met)	N/A	N/A	N/A

[293] This is a long-term measure with FY 2013 as a long-term target date. FY 2010 was an earlier long-term target date.
[294] This measure was revised from "number of people receiving direct services through FORHP grants" to this to ensure that each encounter is counted once and not multiple times.
[295] A new cohort of FORHP Outreach grants is awarded a 3-year project period. During the 1st year of the project period, the number of people receiving direct services through the FORHP Outreach grants tends to be lower due to program start up. The numbers generally increase throughout the project period as outreach efforts are implemented.

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	442	434	370
Average Award	$328,608	$338,185	$329,729
Range of Awards	$18,000-$1,548,632	$18,000-$1,548,632	$74,187-$1,548,632

Rural Health Policy Development

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$9,351,000	$9,351,000	$9,351,000	$---
FTE	1	1	1	---

Authorizing Legislation: Public Health Service Act, Section 301 and Social Security Act, Section 711

FY 2017 Authorization ..... Indefinite

Allocation Method ..... Competitive Grant

Program Description and Accomplishments

Rural Health Policy Development activities are a key component of the Federal Office of Rural Health Policy (FORHP) and support a range of activities including policy analysis, research, and information dissemination. The Office is charged in its authorizing language to advise the Secretary on how Departmental policies affect rural communities and to conduct research to inform its policy analysis activities. The Office is also charged with supporting information dissemination and the operation of a clearinghouse on national rural health initiatives.

The FORHP Rural Health Research Center Program is a major component of Rural Health Policy Development activities. It is the only Federal research program specifically designed to provide both short- and long-term policy relevant studies on rural health issues. Awards are currently made to seven research centers annually. In the past, efforts to understand and appropriately address the health needs of rural Americans were severely limited by the lack of information about the rural population and the impact of Federal policies and regulations on the rural health care infrastructure, and health services research that has addressed rural has not often been policy-relevant. 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, Rural Health Policy Development Activities support six additional cooperative agreements that focus on data and trend analysis of new and ongoing policy issues, and dissemination of FORHP-funded grantee research products. In keeping with the Office's statutory mandate, the Office supports a cooperative agreement with the Rural Health Information Hub (formerly named the Rural Assistance Center). The Rural Health Information Hub (RHI Hub) is a clearinghouse for anyone in need of rural health policy and program information. The RHI Hub responds individually to hundreds of inquiries each month by both phone and e-mail and disseminates information through its web site and various reports and information guides on a range of key rural health issues. The Office also uses a cooperative

agreement mechanism to disseminate the various research products produced by its research programs. Together, these research and dissemination agreements are used to support data and analysis needs across the Department. In FY 2014, the Rural Health Policy Development efforts of FORHP produced 57 research reports, exceeding the target of 35 reports. This number includes policy briefs and full reports that were released on the Rural Health Research Gateway website as well documents that were published in peer-reviewed journals.

Finally, major components of Rural Health Policy Development serve the Office's advisory functions. The Office staffs the National Advisory Committee on Rural Health and Human Services (NACRHHS), which provides an external public voice on key rural policy issues. NACRHHS advises the Secretary on rural health and human service programs and policies, and produces policy briefs and recommendations on emerging rural policy issues for the Secretary. The Office also participates on the White House Rural Council.

Funding History

FY	Amount
FY 2013	$9,252,000
FY 2014	$9,328,000
FY 2015	$9,351,000
FY 2016	$9,351,000
FY 2017	$9,351,000

Budget Request

The FY 2017 Budget Request for Rural Health Policy Development program of $9.4 million is equal to the FY 2016 Enacted level. This request will support research activities including the Rural Health Research Center grant program, as well as other research and general technical assistance and information dissemination related the Office's policy work. The Research Center and rapid response programs will support the production of 39 Policy Briefs and reports in FY 2017. Policy briefs and reports are a way for the rural health research centers to disseminate information to providers and decision-makers at the Federal, State and local levels regarding the challenges in rural communities and how those communities are impacted by current and proposed policies.

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

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
28.V.A.1: Conduct and disseminate policy relevant research on rural health issues. (Outcome)	FY 2014: 57 Target: 35 (Target Exceeded)	35	39	+4

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	13	13	13
Average Award	$656,662	$656,662	$656,662
Range of Awards	$120,000-$1,548,632	$120,000-$1,548,632	$120,000-$1,548,632

Rural Health Care Services Outreach, Network and Quality Improvement Grants

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$59,000,000	$63,500,000	$63,500,000	$---
FTE	5	5	5	---

Authorizing Legislation: Public Health Service Act, Section 330A, as amended by Public Law 110-355, Section 4

FY 2017 Authorization ..... Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Rural Health Care Services Outreach, Network and Quality Improvement Grants are a key part of investments by the Federal Office of Rural Health Policy (FORHP) in improving rural community health. The purpose of the grants is to improve access to care, coordination of care, and integration of services, and to focus on quality improvement. All grants support collaborative models to deliver basic health care services to rural areas and are uniquely designed to meet rural needs. The grants allow rural communities to compete for funding against other rural communities rather than having to also compete against larger metropolitan communities with greater resources. The Outreach authority programs are among the only non-categorical grants within HHS and allow the grantees to determine the best way to meet local need. This flexibility in funding reflects the unique nature of health care challenges in rural communities and need to allow communities to determine the best approach to addressing need. Each of the programs focus on making the initial investment in a rural area with the expectation that the community will continue to provide the services at the conclusion on the grant funding.

The Outreach authority includes a range of programs designed to improve access to and coordination of health care services in rural communities. Five of these programs are part of the President's Improving Rural Health Care Initiative to strengthen the regional and local partnerships among rural health care providers, improve recruitment and retention of health care professionals in rural areas, and provide direct health care services. Grantees are required to demonstrate the impact of their program through outcome-focused measures. Grantees submit baseline data that is tracked throughout the project period and implement a program that has been adapted from a promising practice or evidence-based model. The programs support innovative models that offer rural communities the tools and resources to enhance health care services and ease the transition to health care models focusing on improved quality and value.

Sustainability continues to be a priority for the community-based programs. Each year, different programs within the Outreach authority close out and, therefore, sustainability is assessed on those respective programs. While there is some variability in sustainability rates from one cohort of grantees to another, it is expected that the vast majority of projects will continue after Federal funding. The most recent cohort of community-based grantees that completed Federal funding is the Rural Health Care Services Outreach grant program. The FY 2014 results showed that 100 percent of the grantees continued to sustain either all or some of their programs exceeding the target of 60 percent.

In addition to sustaining programs beyond the initial Federal investment, FORHP's community-based grants also have an economic benefit. Grantees use the RHI Hub's Economic Impact Analysis tool to assess the economic impact of the Federal investment. The tool translates project impacts into community-wide effects such as the number of jobs created, new spending and the impact of new and expanded services. A recent analysis of 20 Rural Health Network Workforce Development grants that completed the program in August 2013, showed that for every HRSA dollar invested, approximately $1.63 in additional revenue was generated in the community for a total of $19.4 million in new local economic activity derived from the original $11.9 million HRSA investment over the 3-year period.

The Rural Health Network Workforce Development Program is one of the pilot programs that FORHP has administered as part of the Improving Rural Health Care Initiative. Findings show that the average economic impact ratio of the Rural Health Workforce Development Program was $1.59 for every HRSA dollar invested. As such, approximately $19 million was generated from FORHP's $11.9 million investment. In FY 2011, FORHP awarded 41 health information technology grants to adopt Health Information Technology (HIT) and to reach Meaningful Use (MU) Stages 1 and 2, and findings show that 88 percent of the grantees met meaningful use stage 1 and 2. In addition, the average economic impact ratio was $0.92 for every HRSA dollar invested. In FY 2013, FORHP continued to focus on the Improving Rural Health Care Initiative and made 15 awards in the Rural HIT Workforce Program, which focuses on increasing the number of qualified HIT professionals in rural areas. To date, 380 students are enrolled in the program. These programs help to improve access to and the quality of health care in rural areas by supporting three of the initiative's five components: strengthening rural health care infrastructure, providing direct health care service, and improving the recruitment and retention of health care providers in rural areas.

In FY 2015, FORHP funded three pilot programs in further support of the Improving Rural Health Care Initiative. These three programs focus on allied health training, care coordination and benefits counseling. The Rural Allied Health Program, developed as a result of the Job-Driven Training Initiative, focuses on the recruitment and retention of allied health professionals. FORHP made 10 awards. The Rural Health Care Coordination Network Partnership Program, developed as a result of the White House Rural Council Public-Private Partnership, focuses on the delivery of coordinated care, and made 8 awards. The Rural Outreach Benefits Counseling Program, which focuses on outreach, education and enrollment efforts for the uninsured and newly insured, made 10 awards.

FORHP is working with the Centers for Medicare & Medicaid Services (CMS) on the Frontier Community Health Integration Program (F-CHIP). In this demonstration, the Office supported initial information gathering and analysis to inform CMS in its development. CMS is reviewing demonstration applications, and FORHP is funding technical assistance for the hospitals selected to participate. FORHP is also finishing up a pilot grant with some of the eligible hospitals that examines the use of community health workers to better manage chronic diseases. Clients reported that the program had a positive impact on their overall quality of life and reduced the cost of care for some clients. There was a statistically significant decline in both hospitalizations and 30-day readmissions for clients participating in intervention for at least a full year.

FORHP's focus on the rural implications of health care reform, emerging demonstration and innovation activities, and Delivery System Reform will continue. FORHP continues to support the Rural Health Value (RHV) Cooperative Agreement. This grant informs rural health care providers and systems and FORHP grantees about how changes in the health care delivery system may affect them, and provides technical assistance to rural providers in identifying potential new approaches to health care delivery in their communities. As part of this work, RHV continues to analyze lessons learned from the Frontier Extended Stay Clinics and F-CHIP Medicare waiver demonstrations, while also analyzing the viability of new and emerging care models such as accountable care organizations and patient-centered medical homes for rural communities, as well as payment models such as value-based purchasing and works with rural health care providers and systems to understand how these models might affect them.

Across the programmatic investments under the Outreach authority, FORHP pulls key lessons learned, as well as findings from evaluations and case studies, and makes them available on the RHI Hub's Community Health Gateway so that rural communities from across the country can benefit from the investments in each of the grant programs.

The Rural Health Care Services Outreach program legislation includes five key programs:

- Rural Health Care Services Outreach Grants focus on improving access to care in rural communities through the work of community coalitions and partnerships. These grants often focus on disease prevention and health promotion but can also support expansion of services such as primary care, mental and behavioral health, and oral health care services. This program is part of the 'Providing direct health care services' and 'Building an evidence base for programs that improve rural community health' components of the "Improve Rural Health Initiative." In FY 2015, grantees were required to submit baseline data, which will be tracked throughout the project period, and also develop their program based on a promising practice or evidence-based model. The program will award 60 continuing grants in FY 2017.

  In FY 2015, the Rural Outreach Benefits Counseling Program, a pilot program, awarded 10 grants. The program focuses on expanding a range of health insurance outreach, education and enrollment efforts to eligible uninsured individuals and families and newly insured individuals and families in rural communities. This program is part of the 'Providing direct health care services' component of the Improving Rural Health Care Initiative. The program will award 10 continuing grants in FY 2017.

- Rural Network Development Grants support building regional or local partnerships among local hospitals, physician groups, long-term care facilities, and public health agencies to improve management of scarce health care resources. This program is part of the 'Strengthening Rural Health Care Infrastructure' component of the "Improve Rural Health Initiative." The program expects to make up to 30 new awards in FY 2017, which will be geared towards demonstrating the health outcomes made by the network as well as positioning networks to be successful in the current health care landscape. Grantees under this program are likely to focus on population based health and quality improvement initiatives such as care coordination and medical homes.

  In FY 2014, the program made 15 awards for the Rural Health Information Technology (HIT) Workforce pilot program, which involves increasing the number of qualified HIT professionals in rural communities. This program will end in FY 2016.

  In FY 2015, the program made eight new awards to the Rural Health Care Coordination Network Partnership Program that will support the development of formal, mature rural health networks that focus on care coordination activities for one or more of the following chronic conditions: diabetes, congestive heart failure, and chronic obstructive pulmonary disease. The main goal of care coordination is to meet patients' needs and preferences in the delivery of high-quality, high-value health care. The program will award eight continuing grants in FY 2017.

  The program also made 10 new awards to the Rural Network Allied Health Training Program, a pilot program that will support integrated rural health networks that partner with local community colleges and other accredited educational institutions (such as vocational and technical colleges) to develop formal clinical training programs. These formal training programs will target enrolled rural allied health professional students, to include displaced workers and veterans, in completing a rural, community-based clinical training rotation and obtaining eventual employment with a rural health care provider. The program will award 10 continuing grants in FY 2017.

- Network Planning Grants, which began in FY 2004, bring together key parts of a rural health care delivery system (hospitals, clinics, public health, etc.) so they can work together to address local health care challenges. Network Planning is part of the 'Strengthening Rural Health Care Infrastructure' component of the "Improve Rural Health Initiative." The program will award up to 15 new grants in FY 2017.

- Small Health Care Provider Quality Improvement Grants, which began in FY 2006, help to improve patient care and chronic disease outcomes by assisting rural primary care providers with the implementation of quality improvement activities. Specifically, program objectives include developing more coordinated delivery of care, enhanced chronic disease management, and improved health outcomes for patients. An additional goal of the program is to prepare rural health care providers for quality reporting and pay-for-performance programs. In FY 2016, FORHP is developing a new approach for the program so that it aligns with delivery system reform (DSR). This program is part of the

Improving Rural Health Care Initiative. The program expects to make 21 continuing awards in FY 2017.

- The Delta States Network Grant Program, which began in 2001, provides network development grants to the eight states in the Mississippi Delta for network and rural health infrastructure development. In addition, the program supports chronic disease management, oral health services, and recruitment and retention efforts. Unlike the programs mentioned above, this program is geographically targeted given the health care disparities across this eight-state region. In FY 2013, FORHP developed a new approach for this program, focused on demonstrating outcomes. The program requires all grantees to support diabetes, cardiovascular disease, and obesity, and to develop a program based on a promising practice or evidence-based model. The program will award 12 continuing grants in FY 2017.

Funding History

FY	Amount
FY 2013	$52,093,000
FY 2014	$56,857,000
FY 2015	$59,000,000
FY 2016	$63,500,000
FY 2017	$63,500,000

Budget Request

The FY 2017 Budget Request for the Rural Health Care Services Outreach Network and Quality Improvement Grants program of $63.5 million is equal to the FY 2016 enacted level. In FY 2017, the program will continue support for approximately 60 Outreach Services grants, 12 Delta grants, up to 30 Network Development grants, 21 Quality Improvement grants, and up to 15 Network Planning grants, 10 Rural Network Allied Health Training Program grants, 8 Rural Health Care Coordination Network Partnership Program grants, and 10 Rural Outreach Benefits Counseling Program grants. FORHP expects that 415,000 people will receive direct services in FY 2017.

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

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
29.IV.A.3. Number of unique individuals who received direct services through FORHP Outreach grants.[296] (Outcome)	FY:2014: 820,176 Target: 400,000 (Target Exceeded)[297]	410,000	415,000	+5,000
29.IV.A.4: Percent of Outreach Authority grantees that will continue to offer services after the Federal grant funding ends.[298] (Outcome)	FY 2014:100% Target: 60% (Target Exceeded)	70%	75%	+5%

Note: The Rural Hospital Transitions Network Program is a new component of the Rural Health Outreach Health Services line. Performance measures for this program are under development.

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	221	214	166
Average Award	$220,105	$200,125	$245,030
Range of Awards	$74,954-$525,000	$74,541-$945,000	$74,187-$945,000

[296] This measure was revised from "number of people receiving direct services through FORHP grants" to this to ensure that each encounter is counted once and not multiple times.
[297] A new cohort of FORHP Outreach grants is awarded a 3-year project period. During the 1st year of the project period, the number of people receiving direct services through the FORHP Outreach grants tends to be lower due to program start up. The numbers generally increase throughout the project period as outreach efforts are implemented.
[298] The programs under the Outreach program authority have varying 3-year project periods. When sustainability data is captured at the end of a program project period, the result varies based on the program that closes out that particular project period.

Rural Access to Emergency Devices

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$4,500,000	---	---	---
FTE	1	---	---	---

Authorizing Legislation: Public Health Service Act, Section 313, and Public Health Improvement Act, Section 413, Public Law 106-505. The new Rural Opioid Overdose Reversal program was funded through the RAED program line, and used the Federal Office of Rural Health Policy's legislation (Section 711(b) of the Social Security Act (U.S.C. 912(b); Public Law 113-235)

FY 2017 Authorization – Rural Access to Emergency Devices.....Expired
FY 2017 Authorization – Public Access Defibrillation Demonstration.....Expired

Allocation Method .....Competitive Grants

Program Description and Accomplishments

The Rural Access to Emergency Devices (RAED) Grant Program began in 2002 and provided funds to community partnerships which then purchased and distributed automatic external defibrillators (AEDs) to be placed in rural communities. The grants also provided training in the use of AEDs by emergency first responders.

In FY 2015, the appropriation included funding for a grant program focusing on opioid overdoses. The Rural Opioid Overdose Reversal Grant Program provides funding to rural community partnerships for the purchase of devices used to reverse the effects of opioid overdoses. The grant program also provided training on the use the devices.

Since the RAED Program was authorized in FY 2002, approximately $45,000,000 has been invested in rural communities to purchase, place, and train providers to use AEDs. In FY 2014, grantees purchased 166 AEDs that were used 38 times. Additionally, grantees conducted 100 training meetings in which 646 first-responders and 2,660 laypersons were trained to recognize sudden cardiac arrest, perform CPR and use an AED.

Funding History

FY	Amount
FY 2013	$2,340,000
FY 2014	$3,356,000
FY 2015	$4,500,000
FY 2016	$---
FY 2017	$---

Budget Request

There is no FY 2017 Budget Request for the Rural and Community Access to Emergency Devices program. The discontinuation of funding for this program reflects that the demand for these devices has been largely met. To the extent there is ongoing need for activities related to access to emergency devices, rural communities may apply for other FORHP grant funding, including the Rural Health Outreach Services Grant Programs. Activities related to access to emergency medical devices and training in FY 2017 may be addressed through other funding sources available to grantees, such as the Rural Outreach and Rural Network Development programs. Rural residents could use both of these program authorities to support projects that include the purchase of AEDs and training in their use. Funding for the Rural Opioid Overdose Reversal Program is being requested as a separate activity in FY 2017.

Grant Awards Table

	FY 2015 Final	**FY 2016 Enacted**	**FY 2017 President's Budget**
Number of Awards	30	---	---
Average Award	119,387	---	---
Range of Awards	$50,930-$200,000	---	---

Rural Hospital Flexibility Grants

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$41,609,000	$41,609,000	$26,200,000	-$15,409,000
FTE	3	3	3	---

Authorizing Legislation: Social Security Act, Section 1820(j), as amended by Public Law 105-33, Section 4201(a), and Public Law 108-173, Section 405 (f), as amended by Section 121, Public Law 110-275

FY 2017 Authorization .....Expired

Allocation Method .....Competitive Grants

Program Description and Accomplishments

The Rural Hospital Flexibility activities are a component of the Federal Office of Rural Health Policy (FORHP) and support a range of activities focusing primarily on Critical Access Hospitals (CAHs). There are three grant programs administered under this authority:

- The Medicare Rural Hospital Flexibility Grant Program
- The Small Hospital Improvement Grant Program
- The Rural Veterans Health Access Program

The purpose of the Medicare Rural Hospital Flexibility Grant (Flex) Program is to assist states in working with CAHs on quality reporting and improvement and performance improvement activities as well as helping eligible rural hospitals convert to CAH status and enhancing emergency medical services related to CAHs. The ultimate goal of the program is to help CAHs maintain high-quality and economically viable facilities to ensure that residents in rural communities, and particularly Medicare beneficiaries, have access to high quality health care services. States use Flex resources to address identified needs for CAHs within the state and to achieve improved and measurable outcomes in each selected program area. The Flex funding supports a partnership between the states and FORHP to work with the more than 1,300 critical access hospitals in 45 states. The FY 2015 project period guidance reflects the continued push towards funding activities that can provide clear outcomes and demonstrated improvements.

The Flex program has played a key role in ensuring that CAHs are aligned with key quality initiatives across the Medicare program. All prospective payment system hospitals (PPS) are required to submit quality data to the Centers for Medicare & Medicaid Services (CMS) in order to receive a full payment update under Medicare. CAHs are not subject to this requirement but through the Flex program FORHP created the Medicare Beneficiary Quality Improvement Project (MBQIP), for these facilities to submit quality data and use that data to demonstrate areas

of high quality while also identifying areas for improvement. MBQIP is a National Quality Strategy program that began as a voluntary initiative and became a required activity in FY 2015 to allow for benchmarking and quality improvement initiatives for inpatient, outpatient, and patient satisfaction measures. This initiative helps to ensure that participating CAHs are aligned with broader quality reporting requirements for all hospitals. In 2013, the most recent year for which data is available, 88 percent of CAHs reported on at least one quality measure, exceeding the target of 78 percent.

The second program is the Small Rural Hospital Improvement Program (SHIP). This program provides support to rural hospitals with fewer than 50 beds on software and equipment related to quality, reporting, and billing, given these facilities often lack administrative capacity or the cash reserved to consistently meet new and emerging requirements. Funding for this program is distributed by making awards to 47 states with eligible hospitals. The support provided includes equipment purchase and training for upgrading billing requirements, such as the new ICD-10 standards, or for software related to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient satisfaction survey. The majority of the more than 1,600 hospitals funded by SHIP in FY 2013 supported systems related to quality reporting or training for ICD-10 conversion.

The third program is the Flex Rural Veterans Health Access Program that began in FY 2010. This three-year program provides grants to three states with high percentage of veterans compared to the total population and focuses on increasing the delivery of mental health services or other health care services deemed necessary to meet the needs of veterans of Operation Iraqi Freedom and Operation Enduring Freedom living in rural areas. The program, which is administered in collaboration with the Veteran's Administration (VA) Office of Rural Health, seeks to enhance care for veterans living in isolated rural areas who receive care both in their home facilities and at more distant VA facilities. The grantees focus on investments in telehealth and health information exchange technology for both access to needed services and continuity of care for veterans in rural communities. Current grantees are located in Alaska, Maine and Montana.

	FY 2015 Final	**FY 2016 Enacted**	**FY 2017 President's Budget**
Rural Hospital Flexibility (Flex) Grant Program	$25,667,000	$25,667,000	$25,200,000
Small Hospital Improvement Program (SHIP)	$14,942,000	14,942,000	---
Flex Rural Veterans Health Access Program	$1,000,000	$1,000,000	$1,000,000

The Flex performance measures reflect efforts to increase CAH participation in reporting at least one measure to CMS's Hospital Compare. The data posted on the Hospital Compare Website is a key part of the Department's ongoing efforts to increase transparency in the health care system by measuring quality in all hospitals. The FY 2006 baseline for this measure is 63.14 percent of CAHs voluntarily reporting at least one measure to Hospital Compare. Since FY 2006, there has

been a steady progression each year of CAHs reporting at least one measure, with an increase from 69 percent in FY 2007 to 88.2 percent in FY 2013. As patient satisfaction metrics have become an important component to measuring the value of health care, we have encouraged CAHs to voluntarily report to the HCAHPS and have increased from the baseline in FY 2010 of 38 percent reporting to 59 percent reporting in FY 2013, exceeding the target.

Emergency Medical Services (EMS) are also an important part of the Flex Program and help to support quality and viability of rural communities across the continuum of care. The number of individuals trained in EMS leadership and/or trauma courses increased from 2,368 individuals trained in FY 2011 to 5,099 in FY 2012 due to increased investment in a few specific states. FY 2013 dropped to 3,396, exceeding the target, but lower than FY 2012 as the focus on the program is more on quality and financial and operational improvements.

Funding History

FY	Amount
FY 2013	$38,484,000
FY 2014	$40,507,000
FY 2015	$41,609,000
FY 2016	$41,609,000
FY 2017	$26,200,000

Budget Request

The FY 2017 Budget Request for Rural Health Flexibility Grant program of $26.2 million is $15.409 million below the FY 2016 Enacted level. This request will continue to support 45 Flex grant programs to support CAHs and three grants to support rural veterans. The FY 2017 Request allows core activities to be targeted to the area of greatest need with a focus on CAHs, the nation's smallest hospitals. The FY 2017 Request allows CAHs to continue to receive support through the Flex grant with a focus on enhancing quality and patient outcomes as well as improving financial viability so that these hospitals can continue to ensure access to care for isolated Medicare beneficiaries. The activities supported through this funding will encourage hospitals to report quality data to Hospital Compare (FY 2017 target: 94 percent), engage in patient satisfaction surveys for quality and operational improvement (FY 2017 target: 74 percent), and to invest grant dollars in EMS training and trauma system development (FY 2017 target: 2,995). Support for the Rural Veterans Health Access Program will allow for continued efforts to increase access for rural veterans to needed services.

The FY 2017 Budget Request eliminates funding for the Small Hospital Improvement Program, as over 80 percent of hospitals eligible for funding through the SHIP are CAHs and have access to other funding from the Rural Hospital Flexibility Grants program. HRSA will continue to work with the hospitals on technical assistance as needed to ensure they are aware of other resources available.

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

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
30.V.B.4: Increase the percent of Critical Access Hospitals reporting at least one measure to Hospital Compare. (Outcome)	FY 2013: 88.2% Target: 78% (Target Exceeded)	93%	94%	+1% point
30.V.B.5: Number of individuals trained in emergency medical services leadership and/or trauma courses. (Outcome)	FY 2013: 3,396 Target: 2,995 (Target Exceeded)	2,995	2,995	Maintain
30.V.B.6: Increase the percent of Critical Access Hospitals participating in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey	FY 2013: 59% Target: 50% (Target Exceeded)	72%	74%	+2% points

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	95	94	48
Average Award	$550,000	$550,000	$550,000
Range of Awards	$18,000-$750,000	$18,000-$750,000	$300,000-$750,000

State Offices of Rural Health

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$9,511,000	$9,511,000	$9,511,000	---
FTE	1	1	1	---

Authorizing Legislation: Section 338J of the Public Health Service Act, as amended by Public Law 105-392, Section 301

FY 2017 Authorization .....Expired

Allocation Method .....Competitive Grants

Program Description and Accomplishments

This grant program provides funding to establish and maintain a State Office of Rural Health (SORH) within each state. The primary purpose of a SORH is to assist in strengthening the State's rural health care delivery system, and each dollar of Federal support for the program is matched by three state dollars. SORHs serve as focal point and clearinghouse for the collection and dissemination of information on rural health issues, research findings, innovative approaches and best-practices pertaining to the delivery of health care in rural areas. As the State's rural institutional framework, SORHs help link rural communities with State and Federal resources in order to help develop long-term solutions to rural health problems. SORHs help form collaborative partnerships and relationships to better coordinate rural health activities, maximize limited resources and avoid duplication of effort and activities. In addition, SORHs identify Federal, State, and nongovernmental programs and funding opportunities, and provide technical assistance to public and nonprofit private entities regarding participation in such rural health programs. Technical assistance is central to the SORH role. Two of the SORH measures focus on the number of technical assistance encounters provided directly to clients by SORHs, as well as the number of clients (unduplicated) that receive technical assistance directly from SORHs. Although the FY 2014 result exceeded the target of 67,601 encounters, the total number of encounters has been decreasing. The number of clients served in FY 2014 was 22,057, which missed the target of 22,408.

For both the technical assistance encounters and number of clients, the decline this year is in part due to several states strengthening their data collection methodology to ensure it was in line with the instructions and not duplicating technical assistance encounters. FORHP will be providing additional support and guidance to states around instructions and measures and will move this measure to more of a maintenance -of-effort indicator.

The third measure reflects the work facilitated by the SORHs through recruitment initiatives in the number of clinician placements. FY 2013 result is 1,718, which exceeded the target. The

SORHs have been instrumental in helping rural constituents to meet the challenges through sharing information and providing technical assistance around the changing environment that rural health providers face, for example, with the passage of meaningful use requirements.

Funding History

FY	Amount
FY 2013	$9,411,000
FY 2014	$9,487,000
FY 2015	$9,511,000
FY 2016	$9,511,000
FY 2017	$9,511,000

Budget Request

The FY 2017 Budget Request for the State Office of Rural Health program of $9.5 million is equal to the FY 2016 Enacted level. This request will continue to support key activities for the State Offices of Rural Health Program and will support a grant award to each of the 50 states. The SORH program anticipates that it will provide 82,549 technical assistance encounters directly to clients in FY 2017. The program also expects that 26,574 clients will receive technical assistance directly from SORHs. Additionally, the program hopes to facilitate 1,260 clinician placements in FY 2017.

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

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
31.V.B.3: Number of technical assistance (TA) encounters provided directly to clients by SORHs. (Outcome)	FY 2014: 76,035 Target: 67,601 (Target Exceeded)	68,960	82,549	+13,589
31.V.B.4: Number of clients (unduplicated) that received technical assistance directly from SORHs. (Outcome)	FY 2014: 22,057 Target: 22,408 (Target Not Met)	22,858	26,574	+3,716

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
31.V.B.5: Number of clinician placements facilitated by the SORHs through their recruitment initiatives. (Outcome)	FY 2013: 1,718 Target: 1,260 (Target Exceeded)	1,260	1,260	Maintain

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	50	50	50
Average Award	$170,462	$172,000	$172,000
Range of Awards	$152,627-$171,598	$150,000-$172,000	$150,000-$172,000

Radiation Exposure Screening and Education Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$1,834,000	$1,834,000	$1,834,000	---
FTE	1	1	1	---

Authorizing Legislation: Public Health Service Act, Section 417C, as amended by Public Law 109-482, Sections 103 and 104

FY 2017 Authorization ..... Indefinite

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Radiation Exposure Screening and Education Program (RESEP), which began in 2002, provides grants to States, local governments, and appropriate health care organizations to support programs for cancer screening for individuals adversely affected by the mining, transport and processing of uranium and the testing of nuclear weapons for the Nation's weapons arsenal. The RESEP grantees also help clients with appropriate medical referrals, engage in public information development and dissemination, and facilitate claims documentation to aid individuals who may wish to apply for support under the Radiation Exposure Compensation Act.

The program measures the total number of individuals screened at RESEP centers each year. Although the number of users was stable for a couple of years – FY 2012 (1,567) and FY 2013 (1,576) – it dropped in FY 2014 (1,025). This reduction was due to start-up challenges encountered by a new RESEP clinic funded during this cycle. It is expected that screenings will increase in future years.

The program also measures the average cost of the program per individual. The total number of individuals screened at RESEP centers each year greatly impacts the results for this measure. In FY 2012, the average cost of the program per individual screened was $956, which exceeded the target. In FY 2013, the average cost of the program per individual screened was $1,002. These results are somewhat higher than the targets due to the increasing cost of procedures and screenings at these RESEP centers. For FY 2014, the average cost of the program per individual screened was $1,308, also exceeding the target due to increasing cost of procedures and screenings correlating with the contributing factors to lower volume of total individuals screened at RESEP clinics for the year.

Funding History

FY	Amount
FY 2013	$1,579,599
FY 2014	$1,589,500
FY 2015	$1,834,000
FY 2016	$1,834,000
FY 2017	$1,834,000

Budget Request

The FY 2017 Budget Request for the Radiation Exposure Screening and Education program of $1.8 million is equal to the FY 2016 Enacted level. This request will continue to support key activities for Radiation Exposure Screening and Education Program such as: implementing cancer screening programs; developing education programs; disseminating information on radiogenic diseases and the importance of early detection, screening eligible individuals for cancer and other radiogenic diseases, providing appropriate referrals for medical treatment, and facilitating documentation of Radiation Exposure Compensation Act (RECA) claims. The program will be competitive in FY 2017.

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

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
32.1: Percent of RECA successful claimants screened at RESEP centers.[299] (Outcome)	FY 2013: 15.23 % Target: 8.8% (3-year rolling baseline)	N/A	N/A	N/A
32.2: Percent of patients screened at RESEP clinics who file RECA claims that receive RECA benefits.[300] (Outcome)	FY 2013: 84.72% Target: 72% (Target Exceeded)	N/A	N/A	N/A

[299] This is a long-term measure with FY 2013 as a long-term target date. The next long-term date is FY 2018.
[300] This is a long-term measure with FY 2013 as a long-term target date. The next long-term date is FY 2018.

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
32.I.A.1: Total number of individuals screened per year. (Output)	FY2014: 1,205 Target: 1,400 (Target not met)	1,200	1,200	Maintain
32.E: Average cost of the program per individual screened (Efficiency)	FY 2014: $1,308 Target: $1,251(Target not met)	$1,300	$1,300	---

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	8	8	8
Average Award	$206,637	$206,637	$206,637
Range of Awards	$127,696-$232,776	$180,000-$279,000	$180,000-$279,000

Black Lung

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$6,766,000	$6,766,000	$6,766,000	---
FTE	1	1	1	---

Authorizing Legislation: Federal Mine, Health, and Safety Act of 1977, Public Law 91-173, Section 427(a), as amended by Public Law 95-239, Section 9

FY 2017 Authorization ..... Indefinite

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

The Black Lung Clinics Program (BLCP) was established in 1980 and provides grant funds to eligible public and private entities, including community-based organizations, for the purpose of establishing and operating clinics that provide for the outreach, education, diagnosis, treatment, and rehabilitation of active, inactive, disabled, and retired coal miners. As persons with respiratory and pulmonary disease age, their disease severity progresses and their need for health care services increase along with the cost of those services. To assist in the longer term need faced by those miners with severe disability as a result of black lung disease, grantees can also assist coal miners and their families in preparing the detailed information needed to apply for the Federal Black Lung benefits from the Department of Labor (DOL).

The ability to provide support to miners is a key program measure. In FY 2013, the program supported services to 13,713 miners, which exceeded the target of 12,688. In FY 2014, the program provided general services and information to 11,843 miners, which fell below the target of 12,840 miners.

An equally important measure is the number of miners who had a medical encounter. The program supported 16,958 medical encounters with patients with black lung in FY 2014, which fell below the target of 18,129 medical encounters. Finally, in FY 2014, the number of medical encounters per $1 million in federal funding was 7,664, which fell below the target of 10,374.

Several factors may have played a role in contributing to these gaps. First, HRSA implemented a new approach in FY 2014 to more effectively respond to the growing prevalence and incidence of black lung across the country. This resulted in funding a new grantee that is still in the early stages of building its capacity to screen, diagnose, and treat miners in its state's service area. Another factor could be staff turnover which remains an issue at many of the black lung clinics and there continue to be shortages in the number of clinicians able to perform exams related to the new DOL standards for x-rays, pulmonary testing, and medical documentation.

Funding History

FY	Amount
FY 2013	$6,695,000
FY 2014	$6,749,000
FY 2015	$6,766,000
FY 2016	$6,766,000
FY 2017	$6,766,000

Budget Request

The FY 2017 Budget Request for the Black Lung program of $6.7 million is equal to the FY 2016 Enacted level. This request will continue to support key activities of the Black Lung Program. The program expects to fund up to 16 awards in FY 2017.

According to a 2011 report developed by the National Institute for Occupational Safety and Health, the prevalence of coal worker's pneumoconiosis (CWP) is rising nationally. The overall CWP prevalence among coal miners declined from 11.2 percent in 1970 to 2.0 percent in 1999, however, since 2000, the prevalence of CWP has increased to 3.3%. This data led to HRSA implementing a new approach for the FY 2014 grant cycle to ensure that program funding levels and resources were effectively coordinated with other Federal efforts and addressed the growing needs of the target population. HRSA also funded a Black Lung Center of Excellence (BLCE) through a cooperative agreement to ensure more consistency across programs. While some grantees and applicants are clinically focused, others are more geared towards outreach, education, and counseling. The BLCE will bring more scientific rigor and consistency to the BLCP by providing technical assistance to individual grantees and helping expand the medical and public health knowledge base around black lung disease.

Outputs and Outcomes Tables

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
33.I.A.1: Number of miners served each year. (Output)	FY 2014: 11,843 Target: 12,840 (Target Not Met)	12,836	13,800	+964

Measure	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
33.I.A.2: Number of medical encounters from Black Lung each year. (Output)	FY 2014: 16,958 Target: 18,129 (Target Not Met)	19,880	20,000	+120
33.E: Increase the number of medical encounters per $1 million in federal funding. (Efficiency)	FY 2014: 7,664 Target: 10,374 (Target Not Met)	9,550	N/A[301]	N/A

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	16	16	16
Average Award	$416,869	$416,869	$416,869
Range of Awards	$150,000-627,015	$150,000-$627,015	$150,000-$627,015

[301] For FY 2017, this measure will be revised to account for only HRSA funding instead of Federal funding. Therefore, a target is not applicable for FY 2017.

Telehealth

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$14,900,000	$17,000,000	$17,000,000	$---
FTE	1	1	1	---

Authorizing Legislation: Public Health Service Act, Section 330I

FY 2017 Authorization .....Expired

Allocation Method:

- Competitive Grants/Cooperative Agreements
- Contracts

Program Description and Accomplishments

The Office for the Advancement of Telehealth (OAT) administers the following grant programs that support telehealth technologies:

- Telehealth Network Grant Program (TNGP), which includes funding projects that demonstrate the use of telehealth networks to improve healthcare services for medically underserved populations in urban, rural, and frontier communities. More specifically, the networks can be used to: (a) expand access to, coordinate, and improve the quality of health care services; (b) improve and expand the training of health care providers; and/or (c) expand and improve the quality of health information available to health care providers, patients, and their families. With each grant cycle, HRSA funds a unique cohort of TNGP grantees. HRSA currently funds two ongoing cohorts of TNGP grantees. The Evidence-Based Tele-Emergency Network Grant Program supports implementation and evaluation of broad telehealth networks to deliver Emergency Department consultation services via telehealth to rural and community providers without emergency care specialists. The Rural Child Poverty Telehealth Network Grant Program (RCP- TNGP), which demonstrates how telehealth networks can expand access to, coordinate and improve the quality of health care services for children living in impoverished rural areas, and in particular how such networks can be enhanced through the integration of social and human service organizations. In FY 2016, the focus of the competitive TNGP is on telehealth services delivered to rural communities through school-based health centers and clinics.

- Telehealth Resource Center Grant Program (TRC), which provides technical assistance to communities wishing to establish or enhance and expand telehealth services.

- Licensure Portability Grant Program (LPGP), which provides support for State professional licensing boards to carry out programs under which licensing boards cooperate to develop and implement State policies that will reduce statutory and regulatory barriers to telemedicine.

- Telehealth Focused Rural Health Research Center, which provides funding to increase the amount of publically available, high quality, impartial, clinically-informed, and policy-relevant telehealth related research.

As of FY 2013,[302] this cohort of TNGP grantees provided a total number of 92 clinical services, across 231 sites in underserved rural communities for a total of 323 sites and services. When added to the FY 2001 baseline of 2,601, TNGP grantees supported 2,924 sites and services in these communities since FY 2005, exceeding the target for FY 2013. As a result, a gradual expansion of sites and/or services is evident across the three year project period (FY 2012-2015) and includes actual results from the new cohort of grantees that began their project periods on September 1, 2012. In FY 2013, 377 communities had access to pediatric mental health services, and 422 communities had access to adult mental health services for which they otherwise would not have had access in the absence of the TNGP grants.

The program continues to collect data on a measure to assess the program's impact on clinical outcomes in diabetic patients served by the grantees of the TNGP program, targeting control of hemoglobin A1c levels in patients. As a result, ideal glycemic control has been gradually achieved. With new cohorts of telehealth network projects being supported, 32 percent were able to achieve ideal glycemic control compared to a target of 21 percent in FY 2013.

The OAT Programs are an integral component of the President's Improving Rural Health Care Initiative to expand the use of telecommunications technologies that increase the access to and quality of health care provided to rural populations. The Telehealth programs strengthen partnerships among rural health care providers, recruit and retain rural health care professionals, and modernize the health care infrastructure in rural areas. In FY 2015, HRSA supported networks in rural underserved communities that are experiencing severe shortages of health care professionals.

In FY 2015, the Telehealth budget was increased, and $1,300,000 was allocated to create a new program entitled the Rural Child Poverty Telehealth Network Grant Program (RCP- TNGP), which supports the White House Rural Council's effort to address child poverty. The purpose of this program is to demonstrate how telehealth networks that include social and human service organizations can expand access to, as well as coordinate and improve the quality of, health care services for children living in impoverished rural areas. Additionally, $750,000 was allocated to create a Telehealth-Focused Rural Health Research Center, which will assist rural health providers and decision-makers at the Federal, state and local levels by contributing to the policy-relevant evidence base of telehealth services. In FY 2016, the Telehealth budget was increased by $2,100,000 and the funding was allocated to fund additional TNGP grantees.

[302] OAT program's next set of results for FY 2013 will be available in early 2016.

Table 1. Planned Dollars to Award for Grants

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Telehealth Network Grant Program	$ 4,932,292	$6,300,000	$6,300,000
Licensure Portability Grant Program	$500,000	$500,000	$500,000
Telehealth Resource Center Grant Program	$4,499,875	$4,550,000	$4,550,000
Rural Child Poverty Telehealth Network Grant Program	$1,300,000	$1,300,000	$1,300,000
Telehealth-Focused Rural Health Research Center	$750,000	$750,000	$750,000
Evidence-Based Telehealth Network Grant Program	$2,385,567	$2,400,000	$2,400,000

Funding History

FY	Amount
FY 2013	$10,786,000
FY 2014	$13,865,000
FY 2015	$14,900,000
FY 2016	$17,000,000
FY 2017	$17,000,000

Budget Request

The FY 2017 Budget Request for the Telehealth program of $17.0 million is equal to the FY 2016 Enacted level. This request will support up to 21 TNGP grantees, 14 TRCGP grantees; six Evidence-Based Telehealth Network Grant Program grantees; two Licensure Portability Grant Program grantees; four Rural Child Poverty Telehealth Network Grant Program grantees, and one grant for the Telehealth-focused Rural Health Research Center. Through these programs, OAT hopes to increase the proportion of diabetic patients enrolled in a telehealth diabetes case management program to 25 percent in FY 2017. Additionally, OAT anticipates that 320 communities will have access to adult mental health services and 330 communities will have access to pediatric and adolescent mental health services by FY 2017.

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

Outputs and Outcomes Tables

Measure[303]	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
34.II.A.1: Increase the proportion of diabetic patients enrolled in a telehealth diabetes case management program with ideal glycemic control (defined as hemoglobin A1c at or below 7%). (Outcome)	FY 2013: 32% Target: 21% (Target Exceeded)	20%	25%	+5% points
34.1: The percent of TNGP grantees that continue to offer services after the TNGP funding has ended. [304](Outcome)	FY 2005: 100% (Baseline) Target: N/A (Target Not In Place)	N/A	N/A	N/A
34.III.D.2: Expand the number of telehealth services (e.g., dermatology, cardiology) and the number of sites where services are available as a result of the TNGP program. (Outcome)	FY 2013: 2,924 Target: 2,565 (Target Exceeded)	2,700	2,725	+25
34.III.D.1: Increase the number of communities that have access to pediatric and adolescent mental health services where access did not exist in the community prior to the TNGP grant. (Outcome)	FY 2013: 377 Target: 239 (Target Exceeded)	325	330	+5
34.III.D.1.1: Increase the number of communities that have access to adult mental health services where access did not exist in	FY 2013: 422 Target: 202	320	320	+5

[303] This is a demonstration program, every three years each cohort of TNGP grantees "graduates" from its three-year grant while a new cohort of grantees commences a new three-year cycle of grant-supported Telehealth activities. The data is calculated as a cumulative number. However, with each new cohort, the distribution of these services is uncertain. Therefore, the targets may need to be revised if there is evidence of a significant increase in grantees that are providing mental health services.

[304] This is a long-term measure for FY 2013. FY 2013 data will be available in FY 2016.

Measure[303]	Year and Most Recent Result / Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
the community prior to the TNGP grant. (Outcome)	(Target Exceeded)			
34.E: Expand the number of services and/or sites providing access to health care as a result of the TNGP program per Federal program dollars expended.[305] (Efficiency)	FY 2013: 65 per Million $ Target: 203 per Million $ (Target Not Met)	106 per Million $	106 per Million $	Maintain

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	47	47	47
Average Award	$289,755	$328,866	$328,866
Range of Awards	$250,000-$750,000	$250,000-$750,000	$250,000-$750,000

[305] This measure provides the number of sites and services made available to people who otherwise would not have access to them per million dollars of program funds spent. Every three years a new cohort of grantee commences with a new three-year cycle of grant supported activities, gradually expanding sites and services per dollar invested. With each new cohort, there is a start-up period where services are being put in place but are not yet implemented.

Rural Opioid Overdose Reversal Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	---	---	$10,000,000	$10,000,000
FTE	---	---	2	2

Authorizing Legislation: Section 711(b) of the Social Security Act (U.S.C. 912(b), as amended

FY 2017 Authorization Indefinite

Allocation Method ..... Competitive Grants

Program Description and Accomplishments

Opioid overdoses are an increasing problem throughout the United States. The Centers for Disease Control and Prevention (CDC) reports that every day in the United States 120 people die as a result of drug overdose, and 51.8 percent of those overdoses are related to pharmaceuticals. Of that 51.8 percent, 71.3 percent involved opioid pain relievers. People in rural communities are especially vulnerable and more likely to overdose on prescription painkillers than people in cities, according to the CDC. In response to the nation-wide problem, on June 19, 2014, the Office of National Drug Control Policy convened the White House Summit on the Opioid Epidemic. In FY 2015, Congress appropriated funds to HRSA's Rural Access to Emergency Devices (RAED) program line to specifically focus on opioid overdose reversal in rural communities. The FY 2017 Budget Request proposes to establish a defined appropriation specifically to enhance these opioid overdose activities.

The purpose of the initial Rural Opioid Overdose Reversal Program, competed in FY 2015, is to reverse the incidences of morbidity and mortality related to opioid overdoses in rural communities through the purchase and placement of emergency devices used to rapidly reverse the effects of opioid overdoses and training of licensed healthcare professionals and emergency responders on their use. Community partnerships are an important component of this program and can be comprised of local emergency responders as well as other local non-profit and for-profit entities involved in the prevention and treatment of opioid overdoses. In addition, care coordination is essential to efforts in reducing incidences of morbidity and mortality related to opioid overdoses. As a result, these funds would support innovative approaches that involve broad community partnerships and emphasize the use of a medical model, which may include physician use of buprenorphine and Naloxone, through the referral of individuals to appropriate substance abuse treatment centers where care coordination and communication would be facilitated by a team of qualified healthcare providers.

Funding History

FY	Amount
FY 2013	$---
FY 2014	$---
FY 2015	$---
FY 2016	$---
FY 2017	$10,000,000

Budget Request

The FY 2017 Budget Request for the Rural Opioid Overdose Reversal Program is $10.0 million. In FY 2015, $1.8 million was invested in a program of more limited scope at HRSA. Community partnerships, including local emergency responders, schools, police, and fire departments, among other non-profit entities working on this issue, will be eligible to receive funding. The funds will help to increase the availability of naloxone in rural and frontier communities, including the Delta, Border and Appalachia regions; train appropriate healthcare providers working in rural communities; and refer patients to the appropriate treatment center in rural areas. The overall goal of the program is to reduce the morbidity and mortality rates in rural communities associated with opioid overdose. This request is part of a Department-wide and nationwide effort focused on prevention, treatment and intervention of opioid use.

The development of this program will involve cross-cutting collaboration across other Federal agencies, including the Substance Abuse and Mental Health Administration, working to address this epidemic to ensure that there is no duplication of efforts. There will be a coordinated and aligned effort among the agencies to share lessons learned and establish community and state partnerships.

The requested amount would fund additional rural partnerships to accomplish the following goals:

1. Train licensed healthcare professionals to recognize the signs of opioid overdose and learn the appropriate way to administer naloxone;
2. Provide appropriate transport to a hospital or clinic for continued care after administration;
3. Refer those with a drug dependency to an appropriate substance abuse treatment centers where care coordination is provided by a team of providers; and
4. Provide education and prevention services; and
5. Purchase naloxone and opioid overdose reversal devices.

It is expected that grantees will implement innovative approaches involving broad community partnerships, including the referral of individuals to appropriate substance abuse treatment centers where care coordination and communication is facilitated by a team of qualified health care providers. Grantees will also be required to demonstrate improved and measurable health outcomes, including but not limited to, reducing opioid overdose morbidity and mortality in rural areas.

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

Outputs and Outcomes

Performance measures are under consideration, possibly including indicators such as reducing opioid overdose morbidity and mortality in rural areas.

Grant Awards Table

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	---	---	30
Average Award	---	---	$272,000
Range of Awards	---	---	$245,000-$300,000

Program Management TAB

Program Management

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$154,000,000	$154,000,000	$157,061,000	+$3,061,000
FTE	747	825	829	+4

Authorizing Legislation: Public Health Service Act, Section 301

FY 2017 Authorization……...……Indefinite

Allocation Method……....Other

HRSA's mission is to improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs. To achieve its mission, HRSA requires qualified staff to operate at maximum efficiency. One of HRSA's goals is to strengthen program management and operations by improving program customer satisfaction, increasing employee engagement, and implementing organizational improvements and innovative projects. Program Management is the primary means of support for FTEs, business operations and processes, information technology and overhead expenses such as rent, utilities, and miscellaneous charges, for HRSA. In addition, Program Management supports agency oversight of a broad variety of program operations funded from other sources, including the National Practitioner Data Bank and the Vaccine Injury Compensation Program.

Improving Processes and Business Operations

HRSA established and continues to improve operational planning processes to foster cross-agency collaboration and avoid potential duplication. In FY 2014, HRSA automated its contracting process to operate in a totally paperless environment, including the receipt of committed funds, the obligation of funds, and the generation and storage of contract documents. Over the past five years, HRSA has reduced travel costs and supported telework participation by increasing the agency-wide utilization of web collaboration tools. Real-time collaboration is accomplished using automated tools that support a full range of requirements from one-on-one for teleworkers to web-based meetings supporting as many as 500 participants. In FY 2014 HRSA's used over 10.1 million virtual meeting minutes, which is about six times greater than the 1.7 million meeting minutes in FY 2011 when data was first collected on this technology.

HRSA also reengineered the National Practitioner Data Bank (NPDB) business processes, including modifying NPDB's IT support contract resulting in an estimated cost savings of $5.7 million over the remaining life of the contract and updated the NPDB server hardware to secure GSA-certified "cloud" technology, saving an additional estimated $900,000 over the next three years.

Investing in the Future

HRSA has taken several steps to ensure that it has a competent, well-trained workforce. In 2010, the agency established the HRSA Learning Institute to help assure that the workforce has the knowledge, skills, and competencies necessary to accomplish the mission. During FY 2014, HRSA developed a standard position description and job analysis template for use by all interested Bureaus and Offices, reducing the time spent in posting similar or identical positions, and benefiting applicants by having multiple selecting officials review and consider them for positions as well as completed training certificates for key positions in the agency including: project officers, grants management specialists, and supervisors. Additionally, over 50 percent of the HRSA's Senior Leadership (SES and GS-15s) are eligible to retire in 2017. To prepare for the pending departures, HRSA has developed a robust leadership development program and is implementing a workforce planning initiative to support managers in conducting workforce analysis and strategically managing our human resources.

Improving Data Transparency and Services

Program Management includes IT funding for the continued development, operations and maintenance of enterprise functionality of the HRSA Electronic Handbooks (EHBs). The EHBs is an IT Investment that supports the strategic and performance outcomes of the HRSA Programs and contributes to their success by providing a mechanism for sharing data and conducting business in a more efficient manner, while improving program integrity. The EHBs supports HRSA with program administration, grants administration and monitoring, management reporting, and performance measurement and analysis. For FY 2014, HRSA extended the hours for HRSA's grants system help desk, without increasing cost, to improve availability for grantees on the west coast, and developed a single tracking system to document and monitor help desk services; deployed a suite of EHB management dashboards for HRSA Office and Bureau's to improve management and oversight; and made significant performance improvements to decrease the time to key EHBs display screens. These improvements ultimately increased the productivity of HRSA's project officers and HRSA's grantees.

Additionally, HRSA's Data Warehouse serves as the official enterprise repository of HRSA's data and provides and array of visual and interactive tools for searching, accessing, viewing, and displaying the data. These data are used by employees, grantees, health care providers, the public and other audiences interested in HRSA's public health services and information. HRSA has made improvements so that users can quickly access HRSA's investments by Congressional District, county, state, HHS Region, and nationwide. Users can also find a health center in their area or can analyze an address to see if it is in a Health Professional Shortage Area and/or Medically Underserved Area. In 2014, HRSA expanded data capabilities to support smartphones and tablets; improved report features for ease of use and printing; added grants data to fact sheets; and supported the development of a series of widgets, maps, report tools, and charts for senior leadership to enhance program integrity efforts.

Creating a Culture of Program Integrity

Program Management also supports program integrity activities and aligns them with performance and strategic planning activities with the intent of reducing programmatic risk and improving performance.

HRSA's Program Integrity Initiative includes:

- An agency-wide workgroup that develops, monitors, and oversees the agency's program integrity activities
- Training for federal staff and grantees
- Hiring program integrity analysts and auditors
- Automated tools and systems for HRSA staff, including a web based funds control and reporting system.

Utilizing feedback received through GAO studies, OIG reports, and issues identified through members of the HRSA Program Integrity Workgroup, HRSA has developed a series of program integrity training, webcasts, and reference materials, including an online program integrity toolkit that provides HRSA staff with a single source of information, resources, templates, policies, procedures, and manuals. Additionally, HRSA collaborated with the HHS Inspector General to provide OIG led grant fraud training to HRSA project officers. HRSA has subjected its mission critical support functions such as time and attendance, property management, research integrity, FOIA, and more to operational reviews to assess compliance with laws and regulations, and Departmental and HRSA policy. HRSA has established a HRSA-wide governance structure for enterprise-wide business operations and program integrity activities to ensure a customer focused suite of business operation services and functions. HRSA is currently evolving its Program Integrity Initiative to focus on Enterprise Risk Management (ERM) and the development of a risk-aware organizational culture.

Funding History

FY	Amount
FY 2013	$151,450,000
FY 2014	$152,677,000
FY 2015	$154,000,000
FY 2016	$154,000,000
FY 2017	$157,061,000

Budget Request

The FY 2017 Budget requests $157.0 million, which is $3.0 million above the FY 2016 Enacted. This funding level supports program management activities to effectively and efficiently support HRSA's operations, including increased investments in information technology and cybersecurity

HRSA is committed to improving quality at a lower cost and improving the effectiveness and efficiency of government operations. HRSA continues to reduce travel costs and support

telework participation by increasing the agency-wide utilization of web collaboration tools, which have led to greater business productivity.

HRSA also continues to enhance its program integrity activities by supporting analytical tools using HRSA's electronic grants system, program data, Office of Federal Assistance Management data sources, HHS sources, and government-wide sources. The goal is that HRSA will be able to identify potential issues in the pre and post-award process and can therefore address the issues before they become an audit finding. HRSA plans to focus on a risk-based approach to grantee monitoring using the information and corresponding analysis to help staff spend their time on those grantees that show clear signs of the need for extra attention. HRSA will also continue to provide training for grants management and program staff to support the integration of program integrity with planning and performance. These efforts will enhance the capacity of HRSA grantees to be aware of, and avoid potential financial integrity challenges.

IT Investments

Significant progress has been made in a range of program management activities. Some highlights include:

- Improve cybersecurity efforts through the implementation of state of the art security tools and robust reporting. These integrated tools not only improve and secure the Information Technology infrastructure, but will also reduce the number of physical servers as part of the ongoing virtualization and consolidation initiative.

- Continue implementation of the Enterprise Architecture, Capital Planning and Investment Control (CPIC) and Enterprise Performance Life Cycle (EPLC) processes.

- Support the Federal Information Technology Shared Services Strategy by consuming more than 35 shared services offered by other HHS Operating Divisions. Shared services enables HRSA to drive down operating costs in support and commodity areas, improve return on investment and eliminate waste and duplication.

- Continue development, operations and maintenance of the Electronic Handbooks (EHBs). This IT Investment supports the strategic and performance outcomes of the HRSA Programs, the EHBs supports HRSA with program administration, grants administration and monitoring, management reporting, and performance measurement and analysis.

- Release of a new Data Warehouse responsive site redesign that has already increased mobile and tablet device usage by 20%. The Data Warehouse is the official repository for current enterprise HRSA data and promotes maximum operating efficiency through centralization, reconciliation, and standardization of data across HRSA's various transactional business systems. The Data Warehouse also promotes "Open Data" by providing HRSA and the general public with a single source of HRSA programmatic information, related health resources, demographic, and statistical data for analyzing and

reporting on HRSA activities with easily accessible, readily-available charts, maps, reports, data portal, dashboards, tools, downloadable files and data feeds.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
35.VII.B.1.: Ensure Critical Infrastructure Protection: Security Awareness Training (Output)	FY 2015: Full participation in Security Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security responsibilities and participation in Executive Awareness training by 100% of HRSA executive staff (Target Met)	Full participation in Security and Privacy Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security and privacy responsibilities, and participation in Executive Awareness training by 100% of HRSA executive staff	Full participation in Security and Privacy Awareness training by 100% of HRSA staff, specialized security training for 100% of HRSA staff identified to have significant security and privacy responsibilities, and participation in Executive Awareness training by 100% of HRSA executive staff	Maintain
35.VII.B.2: Ensure Critical Infrastructure Protection: Security Authorization to Operate (Output)	FY 2015: 100% of HRSA information systems have been Certified and Accredited and granted Authority to Operate. (ATO). (Target Met)	100% of HRSA information systems will be assessed and authorized to operate (ATO). In addition all systems will go through continuous monitoring to ensure that critical patches are applied, security controls are implemented and working as intended, and risks are managed and mitigated in a timely manner	100% of HRSA information systems will be assessed and authorized to operate (ATO). In addition all systems will go through continuous monitoring to ensure that critical patches are applied, security controls are implemented and working as intended, and risks are managed and mitigated in a timely manner	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
35.VII.B.2a: Ensure Critical Infrastructure Protection: Security HSPD-12 Privilege and Non-Privilege	New Measure	Privacy - 95% of HRSA staff (federal and contractor) accessing the HRSA network with Privileged accounts must use PIV cards or other 2-factor authentication.	Privacy - 95% of HRSA staff (federal and contractor) accessing the HRSA network with Privileged accounts must use PIV cards or other 2-factor authentication.	Maintain
35.VII.B.2b: Ensure Critical Infrastructure Protection: Security Cyber Sprint	New Measure	Cyber Sprint - Remediation of critical findings from cyber hygiene scanning within 30 Days	Cyber Sprint - Remediation of critical findings from cyber hygiene scanning within 30 Days	Maintain
35.VII.B.2c: Ensure Critical Infrastructure Protection: Security Privacy Impact Assessment (PIA) Or Privacy Threshold Assessment (PTA)	New Measure	Identify 85% of systems that require a PIA or a Privacy Threshold Assessment (PTA)	Identify 85% of systems that require a PIA or a Privacy Threshold Assessment (PTA)	Maintain
35.VII.B.2d: Ensure Critical Infrastructure Protection: Security Phishing	New Measure	5 Phishing Campaigns completed	5 Phishing Campaigns completed	Maintain
35.VII.B.3: Capital Planning and Investment Control (Output)	FY 2015: 1) 100% of major investments received an IT Dashboard Overall Rating of "Green",	1) 100% of major investments will receive an IT Dashboard Overall Rating of "Green", which	1) 100% of major investments will receive an IT Dashboard Overall Rating of "Green", which indicates an	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
	which indicates an acceptable cost, schedule and Agency CIO Rating; 2) 100% of major Investment Managers are in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM). (Target Met)	indicates an acceptable cost, schedule and Agency CIO Rating; 2) 100% of major Investment Managers will be in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM).	acceptable cost, schedule and Agency CIO Rating; 2) 100% of major Investment Managers will be in compliance with the Federal Acquisition Certification for Program/Project Management (FAC P/PM).	
35.VII.B.4: Enterprise Architecture	New Measure	Enterprise Architecture: 90% of IT investments reported to OMB with mapping to at least one HHS segment and domain.	Enterprise Architecture: 90% of IT investments reported to OMB with mapping to at least one HHS segment and domain.	Maintain
35.VII.A.3: Strengthen Program Integrity (PI) Activities	FY 2015: 1) Maintained PI staffing levels 2) PI online toolkit maintained (Target Met)	1) Maintain FY 2015 PI staffing level 2) Operate and maintain PI toolkit and consider further expansion as needed	1) Maintain FY 2016 PI staffing level 2) Implement the HHS Enterprise Risk Management effort at HRSA	N/A

Family Planning TAB

Family Planning

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
BA	$286,479,000	$286,479,000	$300,000,000	+$13,521,000
FTE	18[306]	35	35	---

Authorizing Legislation ..... Title X of the Public Health Service Act

FY 2017 Authorization ..... Indefinite

Allocation Method ..... Direct Federal, Contract, Competitive Grant

Program Description and Accomplishments

The Title X Family Planning Program is the only federal grant program dedicated to providing individuals with comprehensive family planning and related preventive health services. Enacted in 1970 as part of the Public Health Service Act, the mission of the Title X Program is to aid individuals and families in determining the number and spacing of children and to provide access to contraceptive services, supplies, and information to all who want and need them. By law, priority is given to persons from low-income families.

The public health value of family planning services is well documented. Cited by the Centers for Disease Control and Prevention (CDC) as one of the greatest public health achievements of the 20th century[307], family planning services have been used by millions of individuals in the United States and around the world. The Title X Family Planning Program is committed to the delivery of high-quality family planning and reproductive health services to all women and men who want them. Guided by nationally recognized standards of care and evidence-based clinical recommendations, all Title X funded family planning centers provide contraceptive methods, education and counseling, as well as other services that aid in achieving healthy pregnancies and related preventive health services to their clients.

The Title X Program has greatly contributed to decreasing unintended pregnancy among women and families, as well as significantly reducing unintended pregnancy rates among teens and young adults. According to the most recent data (CY 2014), of the more than 4.1 million individuals served in Title X clinics, approximately 18 percent were under 20 years of age and more than 2.1 million (50 percent) were in their 20s (2014 Family Planning Annual Report (FPAR)). By providing comprehensive family planning and related reproductive and preventive health services (e.g., STD and HIV prevention, education, and screening), unintended pregnancy, infertility and related morbidity have been reduced for these populations. In addition, the Office

[306] Due to coding error, FTE is reporting lower than actual 35 FTE
[307] http://www.cdc.gov/about/history/tengpha.htm

of Population Affairs (OPA), which administers the Title X Family Planning Program, in collaboration with CDC, further established itself as a leader in family planning and reproductive health through the release of, "Providing Quality Family Planning Services, Recommendations of CDC and the U.S. Office of Population Affairs," as a Morbidity and Mortality Weekly Report (MMWR) (April 25, 2014). This document serves as an evidence-based set of recommendations for Title X family planning grantees, other public family planning and primary care service providers, and private providers.

In order to ensure that the Title X family planning program is responsive to the ever-changing needs of clients and is adhering to the letter and spirit of the statute, OPA commissioned a two-year independent evaluation by the Institute of Medicine (IOM), completed in May 2009. Among the findings from the evaluation, it was noted that the Title X program is extremely resilient and valuable, especially in providing family planning services to its priority population – individuals from low-income families. Historically, approximately 90 percent of the clients served each year in Title X-funded sites have family incomes at or below 200 percent of the federal poverty level. Furthermore, a 2014 Guttmacher Institute publication indicated that for more than half of clients seen in publicly-funded family planning clinics, such as Title X, clients reported that the site was their "usual" or only continuing source of health care and/or health education.

The Title X Program fulfills its mission through awarding competitive grants to public and private nonprofit organizations to support the provision of family planning services, information, and education. According to 2014 FPAR data, services were provided through 94 family planning service grants that supported a nationwide network of 4,127 community-based sites that provided clinical and educational services to more than 4,129,000 persons. Grantees included state and local health departments, hospitals, community health centers, universities, Planned Parenthood centers, and other private nonprofit agencies. There is at least one Title X services grantee in every state, the District of Columbia, and in each of the U.S. territories, including Pacific jurisdictions. Title X family planning program regulations require that projects provide a broad range of effective and acceptable family planning methods and related preventive health services.

In addition to clinical services, the Title X Family Planning program also supports three key functions aimed at assisting clinics in responding to clients' needs: (1) training for all levels of family planning agency personnel through a national training program; (2) information dissemination and community-based education and outreach activities; and (3) data collection and research to improve the delivery of family planning services. Each year the program establishes a set of program-wide priorities that provide guidance to grantees in an effort to ensure high-quality, responsive and appropriate family planning service delivery. In the past several years, the priorities have focused on building the program's capacity to address the broader reproductive health needs of clients as well as sustaining the family planning network. Program priorities have stressed the need to expand access to a broad range of effective and acceptable family planning methods, including Long-Acting Reversible Contraceptives (LARCs) as well as to improve the administrative and financial practices of service providers. An additional emphasis has been placed on implementing electronic health record and administrative

management systems, increasing the number and types of contracts with health insurance plans and recovering more costs through reimbursements and billing third-party payers.

Broader access to highly effective, but relatively expensive, methods of contraception has been recognized as a key strategy to reducing unplanned pregnancies. At the same time, clinics have been expected to provide a broader array of primary care services related to preventing unintended pregnancies or achieving healthy pregnancies that result in positive birth outcomes. As a result, the ability of some providers to address the increasingly complex needs of clients served by Title X family planning centers has created added stress to the program. In response to this and other needs, the National Training Center for Quality Assurance, Quality Improvement and Evaluation began an initiative to improve clinic efficiency in CY 2013. Using innovative strategies, such as distance learning, learning collaborations –(cohorts specifically designed to facilitate collaboration with others), and communities of practice (content-directed online groups), participants have begun to implement and document positive changes in how clinical services are delivered – more efficient scheduling, shorter client wait times, and other elements which improve healthcare delivery. The evaluation on these efforts is forthcoming and in response to the findings OPA will assess ways to more broadly expand this initiative.

In 2014, the most recent year for which final data are available, the program accomplished the following: Provided services to over 4,129,000 clients, helping to avert over 941,000 unintended pregnancies, approximately 171,800 of which were among teens. In addition, service sites provided approximately 1.0 million Chlamydia tests for 15–24 year old females, preventing an estimated 1,176 cases of STD-related infertility. Targets for the number of screenings for Chlamydia infection in females ages 15–24 were not met, and though the proportion of those screened in this age group was approximately 58%, this is a decrease of two percentage points from 2013. Additionally, between 2013 and 2014, the number of total clients decreased 9.4 percent; including an 11.2 percent drop in the number of female clients ages 15 – 24 receiving services, contributing to the lower number of screenings for Chlamydia infection among females among this age group.

Overall, the most significant challenge the program has encountered in recent years is maintaining the number of overall clients. The most significant decline has occurred with female clients, adding further difficulties in meeting performance targets, as targets are dependent on female- oriented services. OPA consistently assesses how to maintain and increase services to individuals, and will continue its analysis of strategies and approaches that better direct technical assistance and resources to areas which have more individuals who are in need of Title X services but do not currently have access to them.

There are many factors that may be contributing to the decrease in the number of clients. Two of the primary factors include increases in the unit cost per service provided to clients and increases in resources dedicated to improving project infrastructure. Infrastructure costs that are high up-front investments but are also necessary for long-term sustainability include, but are not limited to, purchasing and updating electronic health record and electronic billing systems, entering into and updating contracts with insurance carriers and implementing systems to enable the ability to bill and maximize reimbursement from public and private insurance providers and related third party payors, and updating other related health IT systems. Additionally, since Title X family

planning projects consist of multiple sources of funding, changes in any one or more may have a significant impact in the capacity of these projects. For example, decreases in state and local sources of revenue and changes in reimbursement rates impact the ability to maintain capacity and provide services to more individuals in need of Title X family planning services.

Additionally, factors noted by Title X grantees as contributing to a decline in number of clients served include: 1) more clients are using highly effective, long-acting contraceptive methods (LARCs) that do not require annual visits; 2) current recommendations for cervical cancer screenings do not recommend yearly screenings; and 3) some clients that have gained insurance may be seeking care from providers outside of the Title X network.

Title X providers continue to invest in health infrastructure improvements as a necessity in the quickly-changing healthcare environment. Investments in IT such as Electronic Health Records are resource intensive in both money and provider time, however are vital in order to monitor patient care, achieve high-quality healthcare services and setup systems to bill third party insurance and maximize reimbursement. Further, in alignment with recommendations for providing quality family planning services, clients are receiving more effective contraceptive methods which are more costly. As a result of these and other market forces, costs are increasing and more resources are being dedicated per visit, therefore affecting the overall number of clients served annually.

Cervical cancer screenings also declined, and though it appears counterintuitive, it likely is a positive effect, and a reflection of adherence to current, evidence based recommendations from nationally recognized organizations such as the American College of Obstetricians and Gynecologists (ACOG), American Cancer Society (ACS), and US Preventive Services Task Force (USPSTF). These revised standards recommend that screening be initiated later in life and, for most women, performed less frequently. Currently, these organizations recommend that cervical cancer screening begin at age 21, and between ages 21–65, be performed every three years (beginning at age 30, in place of traditional cytology, screening with HPV co-testing may be performed every five years). As providers begin adopting the current screening recommendations, fewer cervical cancer screenings will be performed in all settings, including Title X clinics. FPAR data support this trend, with the latest data indicating that the proportion of women screened for cervical cancer in Title X family planning centers decreased from 52 percent in 2005 to 21 percent in 2014.

The family planning program has historically been able to maintain the increase in the average cost per Title X client at or below the medical care rate of inflation. In 2013, the program continued to perform better than its projected target. In 2014, the program's cost per client increased at a greater rate than CPI. The significant decrease in the number of clients combined with the increases in costs are the two major drivers in the escalation of the program's cost per client during this reporting year. Though overall costs are increasing, the program's grantees and service sites are increasing the average reimbursement from third-party payers, contributing to greater overall revenue per client. Although some increase in the cost per client is expected, the program has begun emphasizing the need for grantees to identify areas or populations where there is a need for publicly-supported family planning services that is not being met, as well as an assessment of grantee infrastructure capacity, further analysis of program performance trends,

and examining how similar public health care services programs are responding to changes in the healthcare delivery environment. The program will continue to use this and other strategies to extend the reach of the program while improving quality and the efficient use of financial, personnel, and other resources.

OPA is increasing the emphasis on financial and program management through providing training and other efforts around billing practices, including billing all appropriate third-party payers, and other cost recovery methods through the Title X National Training Centers as well as in collaboration with CDC, Division of Sexually Transmitted Disease Prevention. In addition, grantees are being urged to implement more efficient administrative systems, such as health information technologies, electronic health records and payment management systems. Another trend, which the program believes will improve program performance, is increased competition and diversity in the types of grantees funded. Increased competition has led to more diversified grantees, leading to improved cost recovery methods and different administrative structures, which, it is anticipated, will ultimately, improve quality and service delivery. To complement these efforts, the program is also focusing on efforts around sustainability and ensuring consistent and continued access to services. Funding has been made available for grantees to invest in health information technology through Title X-only grants, and assessments of grantee capacity regarding health IT as well as training and technical assistance in this area have also been made available. Finally, OPA awarded one-year grants in FY 2014 and 2015 to improve enrollment of Title X clients into insurance in an effort to increase the number and amount of billing opportunities for Title X providers.

Funding History

FY	Amount
FY 2013	$278,349,000
FY 2014	$285,760,000
FY 2015	$286,479,000
FY 2016	$286,479,000
FY 2017	$300,000,000

Budget Request

The FY 2017 Budget Request for Family Planning of $300 million is $13.521 million more than the FY 2016 Enacted Level. The FY 2017 request provides funding for family planning methods and related preventive health services, as well as related training, information, education and research to improve family planning service delivery.

The FY 2017 request is expected to support family planning services for approximately 4,259,000 persons, with approximately 90 percent having family incomes at or below 200 percent of the federal poverty level. These services include the provision of family planning methods, education, counseling, and related preventive health services. The performance of the program is reflected in the outcome measures which have been modified to better reflect clinical practice recommendations as well as better assess changing program priorities and national trends. These outcomes include preventing approximately 1,278 cases of infertility through

Chlamydia screening of approximately 1,032,500 females ages 15-24, preventing approximately 385 cases of invasive cervical cancer through cervical cancer screening, and preventing approximately 977,400 unintended pregnancies in FY 2017. The targets for FY 2017 are preliminary and assume that other sources of revenue that contribute to the family planning program at the grantee level; specifically, that Medicaid, state and local governments, other federal, state and private grants, and private insurance will remain at historical proportions of the total Title X revenue. In addition, the program's targets also take into consideration continuing shifts toward increasing Medicaid expansions and availability of the health insurance marketplace through ACA.

As in the past, approximately 90 percent of the appropriation will be used for clinical family planning services. Those services will continue to include recommended Chlamydia screening, screening for undiagnosed cervical tissue abnormalities and providing a broad range of contraceptive methods and related education and counseling, thereby reducing the number of unintended pregnancies.

OPA views the CDC MMWR, "Providing Quality Family Planning Services, Recommendations of CDC and the U. S. Office of Populations Affairs," as a foundation for the continued advancement of high-quality family planning and healthcare delivery for the future. These evidence-based recommendations reflect a foundation of empirical evidence and information supporting clinical practice and are intended to improve the provision of family planning and reproductive health services regardless of the service setting (i.e., establish family planning and reproductive health recommendations for all clinical providers). These recommendations define family planning as a constellation of services that assist individuals and couples with both preventing unintended pregnancy and assisting with achieving pregnancy leading to healthy birth outcomes. The adoption of these guidelines and standards of care is expected to significantly improve the quality of care provided in Title X services sites and improve the program's performance trends. The program is in the process of implementing a detailed implementation plan, which includes informational presentations, training – including tools and guidance for all levels of family planning staff, and monitoring, and evaluation instruments. The systematic release of these documents and materials, including revised programmatic requirements, will improve the quality of family planning, reproductive health, related preventive health services, as well as allow the program to evaluate the impact of the recommendations.

The FY 2017 request will allow the program to focus on developing and forming a Family Planning Delivery System Improvement Center that will use evidence based principles to support the delivery of quality family planning services within a sustainable system of care. The Center's efforts will benefit Title X, and also other primary care providers. This will assure long term provision of quality family planning services in the U.S.

OPA will also employ additional strategies to improve the long term sustainability of Title X providers including training of staff and providers, coordination with other federal agencies, and data collection reflecting performance and impact. The program anticipates that additional investments in third party billing, increasing the proportion of clients who have health insurance and better adoption of electronic health records and related health IT systems, will increase revenue and allow the Title X program to reach more of the population in need of family

planning services. These improvements will continue to allow the leveraging of the Title X grant funding to a greater extent than in previous years.

In CY 2015, the program began transforming its FPAR data collection system to become interoperable with Electronic Health Records (EHR) systems. Currently, FPAR data, representing over 4 million family planning clients, are reported in aggregate at the grantee level on an annual basis. The aggregate nature of the data limits its quality and utility for performance monitoring. OPA is estimating that beginning in CY 2018, all grantees will be requested to submit encounter-level data directly from service sites by leveraging electronic health records (EHR) technology and secure data exchange capabilities to transmit data to an FPAR 2.0 repository. Receipt of encounter-level data at the national level will allow the program to collect de-identified information on client demographics and service utility that will enable OPA to track more rigorous performance metrics that better reflect the quality of services provided, and potentially, the impact on intermediary health outcomes. OPA also plans to give segments of the data back to providers and grantees in the field to use for quality improvement initiatives. Collecting encounter level data represents a dramatic shift to the Title X data collection system and will require additional resources to each grantee so their service delivery sites can negotiate with their EHR vendors to collect and report the required FPAR 2.0 data elements. This effort will also require the creation of a centralized data center. In the long term, the investment in this data infrastructure will allow the program to assess the quality of services being provided to clients.

The program is dedicated to improving access to quality family planning, reproductive health and related primary care services through service delivery, training and evidence-based clinical recommendations. In parallel with the implementation of the FPAR 2.0 system, the adoption of EHRs and other electronic administrative systems, and the implementation of the recommendations for providing quality family planning services (MMWR, April 2014), the program, in collaboration with CDC, is in the process of establishing family planning-specific, quality measures for submission to the National Quality Forum for endorsement. These family planning-based and other measures currently under development, are designed to assess the quality and impact of family planning services, within as well as outside of the Title X network.

The HHS budget adheres to OMB's initiative-level target, allowing for priority investments and the continuation of key policies from the FY 2017 President's Budget.

Outputs and Outcomes Tables

Long Term Objective: Increase the number of unintended pregnancies averted by providing Title X family planning services, with priority for services to low-income individuals.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
36.II.A.1: Total number of unduplicated clients served in Title X service sites. *(Outcome)*	FY 2014: 4,129,283 Target: 4,461,000 (Target Not Met)	4,672,000	4,259,000	-413,000
36.II.A.2: Maintain the proportion of clients served who are at or below 200% of the Federal poverty level at 90% of total unduplicated family planning users. *(Outcome)*	FY 2014: 91.8 Target: 90% (Target Exceeded)	90%	90%	Maintain
36.II.A.3: Increase the number of unintended pregnancies averted by providing Title X family planning services, with priority for services to low-income individuals. *(Outcome)*	FY 2014: 941,156 Target: 858,000 (Target Exceeded)	1,080,000[308]	977,400	-102,600
36.II.A.4: Increase the proportion of female clients, using a method of contraception, indicating the use of: A: Long Acting Reversible Contraceptive (LARC) as their primary method of contraception.	FY 2014: 13.17% FY 2012 Baseline: 8.8%	9.9%	11%	+1.1% point
36.II.A.4: Increase the proportion of female clients, using a method of contraception, indicating the use of: B: Highly or moderately effective methods of contraception as their primary method of contraception. (Outcome)	FY 2014: 74.32% Baseline: 70.1%	79.0%	80.0%	+1% point

[308] The FY 2016 target was updated based on a 2013 revised analysis of contraceptive effectiveness, usage, and method mix among public-sector family planning services, which resulted in an overall expected increase.

Long Term Objective: Reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15 – 24.

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
36.II.B.1: Reduce infertility among women attending Title X family planning clinics by identifying Chlamydia infection through screening of females ages 15-24. *(Outcome)*	FY 2014: 996,379 Target: 1,196,600 (Target Not Met)	1,195,000	1,032,500	-162,500
36.II.C.3: Increase the proportion of females ages 15 – 24 attending Title X family planning clinics screened for Chlamydia infection. *(Outcome)*	FY 2014: 57.86% Baseline	64.4%	64.4%	Maintain

Efficiency Measure:

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
36.E: Maintain the actual cost per Title X client below the medical care inflation rate. *(Efficiency)*	FY 2014: $301.24 Target: $283.85 (Target Not Met)	$301.14	$328.21	+$27.07

Grant Awards Tables

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	89	92	92
Average Award	2,897,000	$2,803,000	$2,935,000
Range of Awards	$75,000 - $19,116,100	$75,000 - $20,000,000	$78,500 - $20,940,000

Supplementary Tables

TAB

Budget Authority by Object Class

(Dollars in Thousands)

DISCRETIONARY			
OBJECT CLASS	**2016 Base**	**FY 2017 Request**	**FY 2017 +/- FY 2016**
Full-time permanent (11.1)	145,985	145,528	-457
Other than full-time permanent (11.3)	5,758	5,824	+66
Other personnel compensation (11.5)	2,301	2,301	-
Military personnel (11.7)	12,804	13,197	+393
Special personnel services payments (11.8)	118	119	+1
Subtotal personnel compensation	***166,966***	***166,969***	***+3***
Civilian benefits (12.1)	46,514	46,404	-110
Military benefits (12.2)	6,833	7,048	+215
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**220,313**	**220,421**	**+108**
Travel and transportation of persons (21.0)	2,332	2,264	-68
Transportation of things (22.0)	163	163	-
Rental payments to GSA (23.1)	18,069	17,868	-201
Rental payments to Others (23.2)	739	739	-
Communication, utilities, and misc. charges (23.3)	4,781	4,603	-178
Commercial Reimbursement (23.6)	126	126	-
Network use data transmission service (23.8)	10	10	-
Printing and reproduction (24.0)	129	129	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	10,144	10,144	-
Other services (25.2)	159,282	181,758	+22,476
Purchase of goods and services from government accounts (25.3)	165,844	157,184	-8,660
Operation and maintenance of facilities (25.4)	1,031	1,031	-
Research and Development Contracts (25.5)	91	91	-
Medical care (25.6)	2,833	2,833	-
Operation and maintenance of equipment (25.7)	10,568	10,160	-408
Subsistence and support of persons (25.8)	40	40	-
Discounts and Interest (25.9)	301	301	-
Supplies and materials (26.0)	1,279	1,265	-14
Subtotal Other Contractual Services	***351,414***	***364,808***	***+13,394***
Equipment (31.0)	21,480	18,891	-2,589
Grants, subsidies, and contributions (41.0)	5,480,142	5,013,631	-466,511
Insurance Claims and Indemnities (42.0)	89,859	89,827	-32
Total Non-Pay Costs	**5,969,245**	**5,513,059**	**-456,185**
Total Budget Authority by Object Class	**6,189,558**	**5,733,481**	**-456,077**

PRIMARY HEALTH CARE			
OBJECT CLASS	**2016 Base**	**FY 2017 Request**	**FY 2017 +/- FY 2016**
Full-time permanent (11.1)	14,012	14,195	+183
Other than full-time permanent (11.3)	665	674	+9
Other personnel compensation (11.5)	127	128	+1
Military personnel (11.7)	1,760	1,783	+23
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	***16,564***	***16,780***	***+216***
Civilian benefits (12.1)	4,630	4,691	+61
Military benefits (12.2)	781	791	+10
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**21,975**	**22,262**	**+287**
Travel and transportation of persons (21.0)	686	686	-
Transportation of things (22.0)	7	7	-
Rental payments to GSA (23.1)	2,347	2,347	-
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	789	789	-
Commercial Reimbursement (23.6)	-	-	-
Network use data transmission service (23.8)	-	-	-
Printing and reproduction (24.0)	-	-	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	-	-	-
Other services (25.2)	65,016	65,916	+900
Purchase of goods and services from government accounts (25.3)	46,869	46,869	-
Operation and maintenance of facilities (25.4)			-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	3,849	3,849	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	101	101	-
Subtotal Other Contractual Services	***115,835***	***116,735***	***+900***
Equipment (31.0)	4,814	4,814	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	1,255,224	1,104,969	-150,255
Insurance Claims and Indemnities (42.0)	89,845	89,813	-32
Total Non-Pay Costs	**1,469,547**	**1,320,160**	**-149,387**
Total Budget Authority by Object Class	**1,491,522**	**1,342,422**	**-149,100**

HEALTH WORKFORCE			
OBJECT CLASS	**2016 Base**	**FY 2017 Request**	**FY 2017 +/- FY 2016**
Full-time permanent (11.1)	10,127	7,779	-2,348
Other than full-time permanent (11.3)	255	250	-5
Other personnel compensation (11.5)	111	83	-28
Military personnel (11.7)	719	671	-48
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**11,212**	**8,783**	**-2,429**
Civilian benefits (12.1)	3,163	2,448	-715
Military benefits (12.2)	372	342	-30
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**14,747**	**11,573**	**-3,174**
Travel and transportation of persons (21.0)	150	132	-18
Transportation of things (22.0)	22	22	-
Rental payments to GSA (23.1)	1,032	802	-229
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	1,272	1,207	-66
Commercial Reimbursement (23.6)	-	-	-
Network use data transmission service (23.8)	-	-	-
Printing and reproduction (24.0)	-	-	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	-	-	-
Other services (25.2)	10,360	28,265	+17,905
Purchase of goods and services from government accounts (25.3)	21,518	13,534	-7,984
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	545	245	-300
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	1	1	-
Subtotal Other Contractual Services	**32,424**	**42,045**	**+9,621**
Equipment (31.0)	4,629	2,560	-2,069
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	782,619	478,404	-304,215
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**822,148**	**525,172**	**-296,976**
Total Budget Authority by Object Class	**836,895**	**536,745**	**-300,150**

MATERNAL AND CHILD HEALTH			
OBJECT CLASS	**2016 Base**	**FY 2017 Request**	**FY 2017 +/- FY 2016**
Full-time permanent (11.1)	6,587	6,672	+85
Other than full-time permanent (11.3)	219	222	+3
Other personnel compensation (11.5)	101	102	+1
Military personnel (11.7)	337	341	+4
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	***7,244***	***7,337***	***+93***
Civilian benefits (12.1)	2,198	2,226	+28
Military benefits (12.2)	162	164	+2
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**9,604**	**9,727**	**+123**
Travel and transportation of persons (21.0)	333	333	-
Transportation of things (22.0)	16	16	-
Rental payments to GSA (23.1)	264	264	-
Rental payments to Others (23.2)	2	2	-
Communication, utilities, and misc. charges (23.3)	448	448	-
Commercial Reimbursement (23.6)	-	-	-
Network use data transmission service (23.8)	-	-	-
Printing and reproduction (24.0)	27	27	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	6,826	6,826	-
Other services (25.2)	3,089	3,089	-
Purchase of goods and services from government accounts (25.3)	11,460	11,460	-
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	588	588	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	300	300	-
Supplies and materials (26.0)	15	15	-
Subtotal Other Contractual Services	***22,278***	***22,278***	**-**
Equipment (31.0)	1,371	1,371	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	810,774	810,651	-123
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**835,513**	**835,390**	**-123**
Total Budget Authority by Object Class	**845,117**	**845,117**	**-**

HIV/AIDS			
OBJECT CLASS	**2016 Base**	**FY 2017 Request**	**FY 2017 +/- FY 2016**
Full-time permanent (11.1)	18,769	18,913	+144
Other than full-time permanent (11.3)	467	473	+6
Other personnel compensation (11.5)	278	281	+3
Military personnel (11.7)	1,626	1,931	+305
Special personnel services payments (11.8)	44	45	+1
Subtotal personnel compensation	***21,184***	***21,643***	***+459***
Civilian benefits (12.1)	5,879	5,922	+43
Military benefits (12.2)	915	1,088	+173
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**27,978**	**28,653**	**+675**
Travel and transportation of persons (21.0)	289	239	-50
Transportation of things (22.0)	-	-	-
Rental payments to GSA (23.1)	1,211	1,111	-100
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	875	763	-112
Commercial Reimbursement (23.6)	-	-	-
Network use data transmission service (23.8)	-	-	-
Printing and reproduction (24.0)	1	1	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	-	-	-
Other services (25.2)	20,733	17,493	-3,240
Purchase of goods and services from government accounts (25.3)	59,771	57,741	-2,030
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	2,951	2,844	-107
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	42	28	**-14**
Subtotal Other Contractual Services	***83,497***	***78,106***	***-5,391***
Equipment (31.0)	6,182	5,655	-527
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	2,202,740	2,183,245	-19,495
Insurance Claims and Indemnities (42.0)	8	8	-
Total Non-Pay Costs	**2,294,803**	**2,269,128**	**-25,675**
Total Budget Authority by Object Class	**2,322,781**	**2,297,781**	**-25,000**

HEALTHCARE SYSTEMS			
OBJECT CLASS	**2016 Base**	**FY 2017 Request**	**FY 2017 +/- FY 2016**
Full-time permanent (11.1)	8,045	8,150	+105
Other than full-time permanent (11.3)	292	295	+3
Other personnel compensation (11.5)	295	300	+5
Military personnel (11.7)	1,181	1,196	+15
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	***9,813***	***9,941***	***+128***
Civilian benefits (12.1)	2,639	2,673	+34
Military benefits (12.2)	509	516	+7
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**12,961**	**13,130**	**+169**
Travel and transportation of persons (21.0)	481	481	-
Transportation of things (22.0)	60	60	-
Rental payments to GSA (23.1)	1,164	1,164	-
Rental payments to Others (23.2)	737	737	-
Communication, utilities, and misc. charges (23.3)	416	416	-
Commercial Reimbursement (23.6)	-	-	-
Network use data transmission service (23.8)	10	10	-
Printing and reproduction (24.0)	-	-	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	463	463	-
Other services (25.2)	50,372	57,282	+6,910
Purchase of goods and services from government accounts (25.3)	3,746	3,746	-
Operation and maintenance of facilities (25.4)	140	140	-
Research and Development Contracts (25.5)	91	91	-
Medical care (25.6)	2,832	2,832	-
Operation and maintenance of equipment (25.7)	291	291	-
Subsistence and support of persons (25.8)	40	40	-
Discounts and Interest (25.9)	1	1	-
Supplies and materials (26.0)	731	731	-
Subtotal Other Contractual Services	***58,707***	***65,617***	***+6,910***
Equipment (31.0)	1,633	1,640	+7
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	27,024	26,938	-86
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**90,232**	**97,063**	**+6,831**
Total Budget Authority by Object Class	**103,193**	**110,193**	**+7,000**

RURAL HEALTH POLICY			
OBJECT CLASS	**2016 Base**	**FY 2017 Request**	**FY 2017 +/- FY 2016**
Full-time permanent (11.1)	851	1,087	+236
Other than full-time permanent (11.3)	58	59	+1
Other personnel compensation (11.5)	9	9	-
Military personnel (11.7)	56	57	+1
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	***974***	***1,212***	***+238***
Civilian benefits (12.1)	281	360	+79
Military benefits (12.2)	38	38	-
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**1,293**	**1,610**	**+317**
Travel and transportation of persons (21.0)	161	161	-
Transportation of things (22.0)	5	5	-
Rental payments to GSA (23.1)	24	24	-
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	135	135	-
Commercial Reimbursement (23.6)	-	-	-
Network use data transmission service (23.8)	-	-	-
Printing and reproduction (24.0)	-	-	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	-	-	-
Other services (25.2)	6,564	6,564	-
Purchase of goods and services from government accounts (25.3)	2,532	2,532	-
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	50	50	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	3	3	-
Subtotal Other Contractual Services	***9,149***	***9,149***	**-**
Equipment (31.0)	220	220	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	138,584	132,858	-5,726
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**148,278**	**142,552**	**-5,726**
Total Budget Authority by Object Class	**149,571**	**144,162**	**-5,409**

PROGRAM MANAGEMENT			
OBJECT CLASS	**2016 Base**	**FY 2017 Request**	**FY 2017 +/- FY 2016**
Full-time permanent (11.1)	81,018	82,072	+1,054
Other than full-time permanent (11.3)	3,538	3,584	+46
Other personnel compensation (11.5)	1,344	1,362	+18
Military personnel (11.7)	6,220	6,300	+80
Special personnel services payments (11.8)	74	75	+1
Subtotal personnel compensation	***92,194***	***93,393***	***+1,199***
Civilian benefits (12.1)	25,571	25,903	+332
Military benefits (12.2)	3,613	3,660	+47
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**121,378**	**122,956**	**+1,578**
Travel and transportation of persons (21.0)	67	67	-
Transportation of things (22.0)	44	44	-
Rental payments to GSA (23.1)	11,523	11,651	+128
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	818	818	-
Commercial Reimbursement (23.6)	126	126	-
Network use data transmission service (23.8)	-	-	-
Printing and reproduction (24.0)	100	100	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	2	2	-
Other services (25.2)	3,142	3,142	-
Purchase of goods and services from government accounts (25.3)	10,471	11,826	+1,355
Operation and maintenance of facilities (25.4)	856	856	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	2,293	2,293	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	380	380	-
Subtotal Other Contractual Services	***17,144***	***18,499***	***+1,355***
Equipment (31.0)	2,628	2,628	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	172	172	-
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**32,622**	**34,105**	**+1,483**
Total Budget Authority by Object Class	**154,000**	**157,061**	**+3,061**

FAMILY PLANNING			
OBJECT CLASS	**2016 Base**	**FY 2017 Request**	**FY 2017 +/- FY 2016**
Full-time permanent (11.1)	6,576	6,661	+85
Other than full-time permanent (11.3)	263	267	+4
Other personnel compensation (11.5)	35	36	+1
Military personnel (11.7)	905	917	+12
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	***7,779***	***7,881***	***+102***
Civilian benefits (12.1)	2,153	2,181	+28
Military benefits (12.2)	443	449	+6
Benefits to former personnel (13.1)		-	-
Total Pay Costs	**10,375**	**10,511**	**+136**
Travel and transportation of persons (21.0)	165	165	-
Transportation of things (22.0)	9	9	-
Rental payments to GSA (23.1)	506	506	-
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	27	27	-
Commercial Reimbursement (23.6)	-	-	-
Network use data transmission service (23.8)	-	-	-
Printing and reproduction (24.0)	-	-	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	2,854	2,854	-
Other services (25.2)	7	7	-
Purchase of goods and services from government accounts (25.3)	9,476	9,476	-
Operation and maintenance of facilities (25.4)	35	35	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	-	-	-
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	6	6	-
Subtotal Other Contractual Services	***12,378***	***12,378***	-
Equipment (31.0)	4	4	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	263,015	276,400	**+13,385**
Insurance Claims and Indemnities (42.0)			-
Total Non-Pay Costs	**276,104**	**289,489**	**+13,385**
Total Budget Authority by Object Class	**286,479**	**300,000**	**+13,521**

MANDATORY			
OBJECT CLASS	**2016 Base**	**FY 2017 Request**	**FY 2017 +/- FY 2016**
Full-time permanent (11.1)	47,762	50,566	+2,804
Other than full-time permanent (11.3)	975	996	+21
Other personnel compensation (11.5)	541	570	+29
Military personnel (11.7)	6,279	6,418	+139
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	***55,557***	***58,550***	***+2,993***
Civilian benefits (12.1)	15,493	16,370	+877
Military benefits (12.2)	3,674	3,756	+82
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**74,724**	**78,676**	**+3,952**
Travel and transportation of persons (21.0)	348	350	+2
Transportation of things (22.0)	51	51	-
Rental payments to GSA (23.1)	5,008	5,209	+201
Rental payments to Others (23.2)	18	18	-
Communication, utilities, and misc. charges (23.3)	1,632	1,632	-
GSA Reimbursement Transaction Charge (23.5)	5	5	-
Commercial Reimbursement (23.6)	-	-	-
Network use data transmission service (23.8)	-	-	-
Printing and reproduction (24.0)	3	3	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	15,865	15,865	-
Other services (25.2)	19,366	71,230	+51,864
Purchase of goods and services from government accounts (25.3)	110,968	118,127	+7,159
Operation and maintenance of facilities (25.4)	-	-	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	760	1,060	+300
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	38	38	-
Subtotal Other Contractual Services	***146,997***	***206,320***	***+59,323***
Equipment (31.0)	128	2,022	+1,894
Grants, subsidies, and contributions (41.0)	4,146,086	4,575,714	+429,628
Insurance Claims and Indemnities (42.0)	-	-	-
Total Non-Pay Costs	**4,300,276**	**4,791,324**	**+491,048**
Total Budget Authority by Object Class	**4,375,000**	**4,870,000**	**+495,000**

Salaries and Expenses

(Dollars in Thousands)

DISCRETIONARY			
OBJECT CLASS	**2016 Base**	**FY 2017 Request**	**FY 2017 +/- FY 2016**
Full-time permanent (11.1)	145,985	145,528	-457
Other than full-time permanent (11.3)	5,758	5,824	+66
Other personnel compensation (11.5)	2,301	2,301	-
Military personnel (11.7)	12,804	13,197	+393
Special personnel services payments (11.8)	118	119	+1
Subtotal personnel compensation	***166,966***	***166,969***	***+3***
Civilian benefits (12.1)	46,514	46,404	-110
Military benefits (12.2)	6,833	7,048	+215
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**220,313**	**220,421**	**+108**
Travel and transportation of persons (21.0)	2,332	2,264	-68
Transportation of things (22.0)	163	163	-
Rental payments to Others (23.2)	739	739	-
Communication, utilities, and misc. charges (23.3)	4,781	4,603	-178
Commercial Reimbursement (23.6)	126	126	-
Network use data transmission service (23.8)	10	10	-
Printing and reproduction (24.0)	129	129	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	10,144	10,144	-
Other services (25.2)	159,282	181,758	+22,476
Purchase of goods and services from government accounts (25.3)	165,844	157,184	-8,660
Operation and maintenance of facilities (25.4)	1,031	1,031	-
Medical care (25.6)	2,833	2,833	-
Operation and maintenance of equipment (25.7)	10,568	10,160	-408
Subsistence and support of persons (25.8)	40	40	-
Discounts and Interest (25.9)	301	301	-
Supplies and materials (26.0)	1,279	1,265	-14
Subtotal Other Contractual Services	***351,323***	***364,717***	***+13,394***
Total Non-Pay Costs	**359,603**	**372,751**	**+13,148**
Total Budget Authority by Object Class	**579,916**	**593,173**	**+13,256**

Salaries and Expenses

(Dollars in Thousands)

MANDATORY			
OBJECT CLASS	**2016 Base**	**FY 2017 Request**	**FY 2017 +/- FY 2016**
Full-time permanent (11.1)	47,762	50,566	+2,804
Other than full-time permanent (11.3)	975	996	+21
Other personnel compensation (11.5)	541	570	+29
Military personnel (11.7)	6,279	6,418	+139
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	***55,557***	***58,550***	***+2,993***
Civilian benefits (12.1)	15,493	16,370	+877
Military benefits (12.2)	3,674	3,756	+82
Benefits to former personnel (13.1)	-	-	-
Total Pay Costs	**74,724**	**78,676**	**+3,952**
Travel and transportation of persons (21.0)	348	350	+2
Transportation of things (22.0)	51	51	-
Rental payments to Others (23.2)	18	18	-
Communication, utilities, and misc. charges (23.3)	1,632	1,632	-
GSA Reimbursement Transaction Charge (23.5)	5	5	-
Commercial Reimbursement (23.6)	-	-	-
Network use data transmission service (23.8)	-	-	-
Printing and reproduction (24.0)	3	3	-
Other Contractual Services: 25.0	-	-	-
Advisory and assistance services (25.1)	15,865	15,865	-
Other services (25.2)	19,366	71,230	+51,864
Purchase of goods and services from government accounts (25.3)	110,968	118,127	+7,159
Operation and maintenance of facilities (25.4)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	760	1,060	+300
Subsistence and support of persons (25.8)	-	-	-
Discounts and Interest (25.9)	-	-	-
Supplies and materials (26.0)	38	38	-
Subtotal Other Contractual Services	***146,997***	***206,320***	***+59,323***
Total Non-Pay Costs	**149,054**	**208,379**	**+59,325**
Total Budget Authority by Object Class	**223,778**	**287,055**	**+63,277**

Detail of Full-Time Equivalent Employment

Programs	FY 2015			FY 2016			FY 2017		
	Actual Civilian	Actual Military	Actual Total	Actual Civilian	Actual Military	Est. Total	Actual Civilian	Actual Military	Est. Total
Bureau of Primary Health Care:									
Direct:									
Health Centers/Tort	156	22	178	167	22	189	167	22	189
Free Clinics Medical Malpractice	-	-	-	-	-	-	-	-	-
Total, Direct:	**156**	**22**	**178**	**167**	**22**	**189**	**167**	**22**	**189**
Mandatory:									
Health Centers	99	23	122	146	24	170	146	24	170
School-based Health Centers- Facilities (ACA)	6	1	7	-	-	-	-	-	-
Total, Mandatory	**105**	**24**	**129**	**146**	**24**	**170**	**146**	**24**	**170**
Total FTE, BPHC	**261**	**46**	**307**	**313**	**46**	**359**	**313**	**46**	**359**
Health Workforce:									
Direct:									
NURSE Corps Loan Repayment & Scholarship	8	3	31	29	3	32	29	3	32
Centers for Excellence	1	-	1	1	-	1	1	-	1
Scholarships for Disadvantaged Students	5	-	5	5	-	5	5	-	5
Health Careers Opportunity Program	4	1	5	4	1	5	4	1	5
Health Care Workforce Assessment	5	1	6	6	1	7	6	1	7
Primary Care Training and Enhancement	5	-	5	5	-	5	5	-	5
Oral Health Training	2	1	3	2	1	3	2	1	3
Area Health Education Centers	4	-	4	4	-	4	-	-	-
Geriatric Programs	6	1	7	10	1	11	10	1	11
Behavioral Health Workforce Education and Training	1	-	1	1	-	1	1	-	1
Mental and Behavioral Health	1	-	1	1	-	1	1	-	1
Public Health/Preventive Medicine	4	-	4	4	-	4	4	-	4
Advanced Education Nursing Program	6	-	6	6	-	6	6	-	6
Nurse Workforce Diversity	1	-	1	1	-	1	1	-	1
Nurse Education, Practice & Retention	4	1	5	4	1	5	4	1	5
Nurse Faculty Loan Program	1	-	1	1	-	1	1	-	1
Comprehensive Geriatric Education	1	-	1	-	-	-	-	-	-
Children's Hospitals GME Program	24	1	25	21	1	22	-	-	-

Programs	FY 2015			FY 2016			FY 2017		
	Actual Civilian	Actual Military	Actual Total	Actual Civilian	Actual Military	Est. Total	Actual Civilian	Actual Military	Est. Total
Total, Direct	**103**	**9**	**112**	**105**	**9**	**114**	**80**	**8**	**88**
Reimbursable:									
National Practitioner Data Bank	38	-	38	46	-	46	46	-	46
Total, Reimbursable:	**38**	**-**	**38**	**46**	**-**	**46**	**46**	**-**	**46**
Mandatory:									
National Health Service Corps	185	29	214	255	29	284	255	29	284
Children's Hospitals GME Program	-	-	-	-	-	-	21	1	22
Teaching Health Center Graduate Medical Education	3	1	4	3	1	4	3	1	4
Total, Mandatory	**188**	**30**	**218**	**258**	**30**	**288**	**279**	**31**	**310**
Total FTE, Health Workforce	**329**	**39**	**368**	**409**	**39**	**448**	**405**	**39**	**444**
Maternal and Child Health Bureau:									
Direct:									
Maternal & Child Health Block Grant	32	2	34	34	2	36	34	2	36
Autism and Other Developmental Disorders	6	1	7	6	1	7	6	1	7
Sickle Cell Service Demonstrations	1	-	1	2	-	2	2	-	2
James T. Walsh Universal Newborn Hearing Screening	3	-	3	4	-	4	4	-	4
Emergency Medical Services for Children	4	-	4	4	-	4	4	-	4
Healthy Start	6	1	7	4	1	5	4	1	5
Heritable Disorders	4	-	4	3	-	3	3	-	3
Total, Direct:	**56**	**4**	**60**	**57**	**4**	**61**	**57**	**4**	**61**
Mandatory									
Family to Family Health Info Centers	-	1	1	-	1	1	-	1	1
Home Visiting	20	5	25	24	5	29	24	5	29
Total, Mandatory	**20**	**6**	**26**	**24**	**6**	**30**	**24**	**6**	**30**
Total FTE, MCHB	**76**	**10**	**86**	**81**	**10**	**91**	**81**	**10**	**91**
HIV/AIDS Bureau:									
Direct:									
Ryan White Part A	47	3	50	47	3	50	47	3	50
Ryan White Part B	73	6	79	73	6	79	73	6	79

Programs	FY 2015			FY 2016			FY 2017		
	Actual Civilian	Actual Military	Actual Total	Actual Civilian	Actual Military	Est. Total	Actual Civilian	Actual Military	Est. Total
Ryan White Part C	35	7	42	35	7	42	44	10	54
Ryan White Part D	9	3	12	9	3	12	-	-	-
Ryan White Part F	4	1	5	4	1	5	4	1	5
Ryan White Part F Dental	1	-	1	1	-	1	1	-	1
Special Project of National Significance (SPNS)	-	-	-	1	-	1	-	-	-
Total, Direct:	**169**	**20**	**189**	**170**	**20**	**190**	**169**	**20**	**189**
Reimbursable:									
OGAC Global AIDS	11	3	14	11	3	14	11	3	14
Special Project of National Significance (SPNS)	-	-	-	-	-	-	2	-	2
Total, Reimbursable	**11**	**3**	**14**	**11**	**3**	**14**	**13**	**3**	**16**
Total FTE, HAB	**180**	**23**	**203**	**181**	**23**	**204**	**182**	**23**	**205**
Healthcare Systems Bureau:									
Direct:									
Organ Transplantation	1	-	1	2	-	2	2	-	2
National Cord Blood Inventory	3	1	4	3	1	4	3	1	4
C.W.Bill Young Cell Transplantation Program	8	-	8	8	-	8	8	-	8
Poison Control Centers	3	-	3	3	-	3	3	-	3
340B Drug Pricing Program/Office of Pharmacy Affairs	19	6	25	19	6	25	19	6	25
Hansen's Disease Center	53	3	56	53	3	56	53	3	56
Covered Countermeasures Compensation	5	1	6	7	1	8	7	1	8
Vaccine	16	2	18	23	2	25	23	2	25
Total, Direct:	**108**	**13**	**121**	**118**	**13**	**131**	**118**	**13**	**131**
Reimbursable:									
340B Drug Pricing Program/Office of Pharmacy Affairs	-	-	-	-	-	-	7	-	7
Hansen's Disease Center	2	-	2	3	-	3	3	-	3
Total, Reimbursable	**2**	**-**	**2**	**3**	**-**	**3**	**10**	**-**	**10**
Total FTE, HSB	**110**	**13**	**123**	**121**	**13**	**134**	**128**	**13**	**141**
Federal Office of Rural Health Policy:									
Direct:									
Rural Health Policy Development	1	-	1	1	-	1	1	-	1
Rural Health Outreach Grants	4	1	5	4	1	5	4	1	5

Programs	FY 2015			FY 2016			FY 2017		
	Actual Civilian	Actual Military	Actual Total	Actual Civilian	Actual Military	Est. Total	Actual Civilian	Actual Military	Est. Total
Rural & Community Access to Emergency Devices	1	-	1	-	-	-	-	-	-
Rural Hospital Flexibility Grants	3	-	3	3	-	3	3	-	3
State Offices of Rural Health	1	-	1	1	-	1	1	-	1
Radiation Exposure Screening & Education Program	1	-	1	1	-	1	1	-	1
Black Lung	1	-	1	1	-	1	1	-	1
Telehealth	1	-	1	1	-	1	1	-	1
Rural Opioid Overdose Reversal Grant Program	-	-	-	-	-	-	2	-	2
Total FTE, FORHP	**13**	**1**	**14**	**12**	**1**	**13**	**14**	**1**	**15**
Family Planning (Direct)*	12	3	15	32	3	35	32	3	35
Program Management (Direct)	687	60	747	765	60	825	769	60	829
Subtotal Direct (non add)	1304	132	1436	1426	132	1558	1406	131	1537
Subtotal Reimbursable (non add)	51	3	54	60	3	63	69	3	72
Subtotal Mandatory (non add)	313	60	373	428	60	488	449	61	510
Total, Ceiling FTE	**1,668**	**195**	**1,863**	**1,914**	**195**	**2,109**	**1,924**	**195**	**2,119**

*Due to a coding error, FTE is reporting lower than the actual 35 FTE

Average GS Grade

FY 2105	**12.8**
FY 2016	**12.8**
FY 2017	**12.9**

Programs Proposed for Elimination

The following list shows the programs proposed for elimination or consolidation in the FY 2017 Budget Request. Termination of these programs frees up approximately $103.3 million (discretionary) based on the FY 2015 levels for priority health programs that have demonstrated a record of success or that hold significant promise for increasing accountability and improving health outcomes. Following each program is a brief summary and the rationale for its elimination.

Program	FY 2015 Dollars in Millions
Discretionary	
Area Health Education Centers	$ 30.3
Ryan White Women, Infants, Children and Youth – Part D	$73.0
Total Discretionary	**$ 103.3**

Program Descriptions

Discretionary

Area Health Education Centers (-$30.3 million)
Although expanding the dispersal of health professions trainees is a high priority, the Budget includes funding directed to building the capacity and training of the primary care workforce.

Ryan White Children, Youth, Women & Families – Part D (-$73.0 million)
The Budget proposes the merger of the Part C and Part D grant programs. The merger will expand the focus on women, infants, children and youth across all the funded grantees in the Part C program.

FTE Funded by Mandatory Resources

		FY 2013		FY 2014		FY 2015		FY 2016		FY 2017	
Program	**Section**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**	**Total Funding**	**FTE**
Community Health Center Fund:											
ACA Current Law Mandatory	H.R. 3590, Section 10503(b)(1)	1,500,000	60	2,144,716	95	3,509,111	122	-	-	-	-
Non-ACA Current Law Mandatory		-	-	-	-	-	-	3,600,000	170	3,600,000	170
Proposed Mandatory										150,000	
School-Based Health Centers-Facilities	H.R. 3590, Section 4101	47,500	8	-	9	-	7	-	-	-	-
National Health Service Corps:											
ACA Current Law Mandatory	H.R. 3590, Section 10503(b)(2)	300,000	229	283,040	219	287,370	214	-	-	-	-
Non-ACA Current Law Mandatory		-	-	-	-	-	-	310,000	284	310,000	284
Proposed Mandatory		-	-	-	-	-	-	-	-	50,000	-
GME Payments Teaching Health Centers:	H.R. 3590, Section 5508										
ACA Current Law Mandatory		-	6	-	5	-	4	-	-	-	-
Non-ACA Current Law Mandatory		-	-	-	-	-	-	60,000	4	60,000	4
Family to Family Health Information Centers:											
Non-ACA Current Law Mandatory	H.R. 3590, Section 5507	5,000	-	5,000	1	5,000	1	5,000	1	5,000	1
Home Visiting Program:											
ACA Current Law Mandatory	H.R. 3590, Section 2951	379,600	22	-	-	-	-	-	-	-	-
Non-ACA Current Law Mandatory		-	-	371,200	22	400,000	25	400,000	29	400,000	29
Total		**2,232,100**	**325**	**2,803,956**	**351**	**4,201,481**	**373**	**4,375,000**	**488**	**4,575,000**	**488**

Physicians' Comparability Allowance (PCA) Worksheet

		FY2015	FY 2016* Estimate	FY 2017 Request
1) Number of Physicians Receiving PCAs		39	42	42
2) Number of Physicians with One-Year PCA Agreements		2	0	0
3) Number of Physicians with Multi-Year PCA Agreements		37	42	42
4) Average Annual PCA Physician Pay (without PCA payment)		$146,858	$147,422	$147,422
5) Average Annual PCA Payment		$21,875	$22,000	$22,000
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	2	2	2
	Category II Research Position	0	0	0
	Category III Occupational Health	0	0	0
	Category IV-A Disability Evaluation	0	0	0
	Category IV-B Health and Medical Admin.	37	40	40

*FY 2015 data will be approved during the FY 2016 Budget cycle.

7) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

n/a

8) Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

For each category, the amount of PCA given is to retain highly qualified medical officers that could potentially be compensated more in the private sector.
Category I - $28,000
Category IV – B - $30,000

Compensation reflects physician longevity and board certification. Physicians are also selecting multi-year contracts, which also reflect compensation for mission specific factors. Compensating at these levels has allowed HRSA to compete with the private sector and to increase retention of HRSA physicians. Most private sector physician salaries exceed the base salary HRSA is able to offer. Hence, PCA provides the mechanism to get close to what they are currently receiving.

9) Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist).

PCA is used to recruit and retain highly qualified medical officers. It is difficult to compete with private industry salaries. If HRSA did not offer PCA, HRSA would not be able to attract potential candidates or maintain current HRSA medical officers who enhance HRSA mission and goals. In FY15, we had two offers rejected.

10) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

HRSA had two Medical Officers that resigned that were receiving PCA. Using this mechanism has benefitted HRSA with a 95% retention rate for Medical Officers. With the use of PCA, HRSA was able to recruit (8) Medical Officers. However, two offers with PCA were rejected because they were limited to $14,000 PCA agreement due to them having less than 24 months of Federal service.

11) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

N/A

Specific Items

Health Professions Loan Program

HRSA is responsible for the administration of the following revolving loan programs: Health Professions Student Loan (HPSL) Program, the Nursing Student Loan (NSL) Program, Loans for Disadvantaged Students (LDS), and the Primary Care Loans (PCL). These programs were initially financed through appropriations to the revolving loan funds. Appropriations ceased in 1984.

Currently, these programs are financed through revolving accounts (Federal Capital Contribution (FCC)) and do not receive annual appropriations. Through these revolving fund accounts, the HPSL, PCL, LDS, and NSL programs award funds to institutions that in turn provide loans to individual students. As borrowers pay back loans the program's revolving account gets replenished, and the collected funds are then used to make new loans in the following academic year. If the program's revolving account has excess funds that will not be used to provide new loans, these excess funds are returned to HRSA. Funds returned to HRSA are then awarded to programs that are in need of additional funds. Therefore, the funding awarded each year fluctuates and is dependent upon the amount of loans repaid into the revolving account. The HPSL, PCL, LDS, and NSL programs aim to expand high-quality educational opportunities to those students, including racial and ethnic minorities and disadvantaged students, who otherwise could not afford a health professions education. Please see the table labeled, *Matrix of Health Professional Campus-Based Program* below.

HPSL and PCL

The HPSL program received Federal appropriations from 1965 through 1979. The PCL program was authorized in 1993 and established using allopathic and osteopathic funds from the HPSL revolving funds.

In the nearly 50 years that the programs have been in existence, the total cumulative Federal investment of $59.3 million has grown to provide more than $2.9 billion in loans to approximately 400,00 students. Please see *Health Professional Student Loan and Primary Care Loan Programs* graphic below.

NSL

The NSL program received Federal appropriations from 1967 through 1978. In the nearly 50 years that the programs have been in existence, the total cumulative Federal investment of $17.7 million has grown to provide more than $831 billion in loans to more than 300,000 students. Please see *Nursing Student Loan Programs* graphic below.

LDS

The LDS program received Federal appropriations from 1991 through 1995. Since the program began, the total cumulative Federal investment of more than $41 million has grown to provide more than $238 million in loans to more than 22,000 students.

The information below reflects preliminary data for Academic Year 2014-2015 and was derived from the 2015 (FY 2014) Annual Operating Report.

Program	Number of Programs	Number of Active Borrowers (H367)	Account Balance (FCC)
HPSL	162	34,353	$405,831,597
PCL	109	2,966	$251,721,912
LDS	169	7,541	$149,818,689
NSL	337	43,501	$182,345,335
Total	**777**	**88,361**	**$989,717,534**

New Awards in Academic Year 2014-2015 were as follows:

Program	Number of New Loans (H2/P2)	Amount of New Funds Awarded (H164)
HPSL	7,466	64,383,784
PCL	367	22,472,153
LDS	1,636	21,387,852
NSL	10,554	30,667,676
Total	**20,023**	**138,911,465**

Matrix of Health Professional Campus-Based Program

Program	Type	Eligible Disciplines						Student Eligibility and Requirements			School Requirements			Financial Support and Requirements								
		Medicine (MD/DO)	Nursing	Dentistry	Pharmacy	Other[309]	Allied Health	DAB[310]	EFN[311]	Service Obligation	Match ($^1/_9$)	Revolving Fund	Other[312]	Covered Expenses[313]	Interest Rate	Grace Period	Deferment: Advanced Training[314]	Deferment: Other Activity[315]	Deferment: Peace Corps (3yrs)	Deferment: Uniform Service (3yrs)	Repay Period[316]
HPSL	Loan			✓	✓	✓			✓		✓	✓		COA	5%	12m	✓ (no limit)	✓ (2yrs)	✓	✓	10-25yrs
PCL	Loan	✓							✓	Practice primary care for 10yrs; or until loan repaid	✓	✓		COA (yrs 1-2) COA+ (yrs 3-4)	5%	12m	✓ (4yrs)		✓	✓	10-25yrs
NFL	Loan		✓							Serve as full-time nurse faculty for 4yrs; 85% of loan canceled	✓	✓		COA *Cap = $35,000/yr for maximum of 5yrs*	3%	9m	✓ (3yrs)	✓ (3yrs)		✓	10yrs
NSL	Loan		✓						✓		✓	✓		$3,300/yr $5,200/yr (last 2yrs) *Cap = $17,000*	5%	9m	✓ (10yrs)		✓	✓	10yrs
LDS	Loan	✓		✓	✓	✓		✓	✓		✓	✓	✓	COA (yrs 1-2) COA+ (yrs 3-4)	5%	12m	✓ (no limit)	✓ (2yrs)	✓	✓	10-25yrs
SDS	Scholar	✓	✓	✓	✓	✓	✓	✓	✓				✓	At least 50% tuition *Cap = $15,000/yr*							

[309] **Other Eligible Disciplines –** Includes Optometry, Podiatry, and Veterinary medicine. For SDS, also includes Chiropractic, Behavioral and Mental Health, Public Health, and Physician Assistants.

[310] **DAB (Disadvantaged Background)** – *"Student comes from an environment that has inhibited him or her from obtaining the knowledge, skill, and abilities required to enroll in and graduate from a health professions or nursing school."*

[311] **EFN (Exceptional Financial Need)** – *"Student comes from a family with an annual income below a level based on low-income thresholds according to family size."* For PCL and SDS, parental income is not included in calculating need for independent students.

[312] **Other School Requirements** – For LDS, schools must (1) recruit/retain DAB students and minority faculty; (2) give students experience providing clinical services to DAB/minority populations; and (3) assist students obtain health professions degree through mentoring. For SDS, schools must have recruitment and retention programs for DAB students.

[313] **COA (Cost of Attendance)** – *"The sum of tuition and fees, room and board, books and supplies, and other expenses including personal expenses and transportation."* For LDS, covered expenses are COA less expected family contribution. For PCL and LDS, 3rd and 4th year medical students may receive larger awards.

[314] **Advanced Training** – Includes eligible internships, residencies, and related activities (e.g., doctoral program for NFL). For PCL, borrower must complete primary care residency within 4 years of graduation.

[315] **Other Activities** – Includes eligible training fellowships and related educational activities (e.g., post-doctoral program for NFL).

[316] **Repay Period –** For NFL, 85% of the loan is cancelled in exchange for the student completing a 4-year service obligation upon graduation. Repayment of the remaining 15% of loan is postponed during the service obligation. If student fails to meet obligation, loan will accrue at prevailing market rate.

Evaluations of Health Professionals Training Programs

Tracking and monitoring outcomes associated with HRSA's investments in health professions training and education programs remains a top priority for the Bureau of Health Workforce (BHW). In FY 2015, BHW continued implementation of its evaluation framework by conducting a series of multi-year retrospective evaluations of investments made in its health workforce programs including the Predoctoral Dental Training, Postdoctoral Dental Training, Expansion of Physician Assistant Training, and Primary Care Residency Expansion. Each of these evaluations capitalized on multiple types and sources of existing data; generated new knowledge regarding the processes and outcomes associated with each investment; informed the development of new funding opportunity announcements; and provided BHW leadership with actionable policy-focused recommendations for strengthening each program's design and related data requirements.

In FY 2016 and beyond, BHW will continue the implementation of its evaluation framework so as to keep generating new evidence and knowledge regarding HRSA's investments in the training and education of the current and future healthcare workforce. For example, BHW is currently implementing a procurement for a multi-year prospective joint evaluation of the Nursing Workforce Diversity and the Centers of Excellence programs. This evaluation aims to identify the evidence and best practices for the recruitment, training and retention of students who are considered underrepresented minorities in the health professions. In addition, BHW will conduct multi-year retrospective evaluations of its behavioral health programs and complete evaluations of programs funded through the Prevention and Public Health Fund so as to determine processes and outcomes associated with these investments over multiple academic years.

In FY 2015, BHW began to incorporate a Rapid Cycle Quality Improvement (RCQI) process into its funding opportunity announcements and will continue this initiative in FY 2016. The goal of this initiative is to provide grantees with a tool to assess their progress toward meeting the objectives of their grant agreements, and make adjustments where needed. The RCQI is a method that identifies, implements and measures changes made to improve the quality of a process or a system. It consists of systematic and continuous actions that may lead to measurable improvements in training and education programs. The RCQI is used to test changes (initially on a small scale to minimize risk), quickly identify promising innovative ideas, and build confidence that the changes are leading to improvements. The process addresses three fundamental questions: (1) What are we trying to accomplish? (2) What changes can we make that will result in improvement? and (3) How will we know if a change is an improvement?

The grantees are required to evaluate their progress using the RCQI and provide reports to BHW at defined intervals throughout the grant lifecycle. BHW will use the data in these reports to evaluate the degree to which grantees are meeting their grant objectives, and also to identify best practices that can be shared with other institutions to improve their programs. Collectively, BHW's approach to evaluation will enable the agency to provide stakeholders with specific, detailed information about its investments in health professions training and education programs.

SIGNIFICANT ITEMS

TAB

SIGNIFICANT ITEMS FOR INCLUSION IN L-HHS APPROPRIATIONS COMMITTEE THE FY 2017 CONGRESSIONAL JUSTIFICATION

OMNIBUS PL 114-113 (December 18, 2015)

1. **Oral Health Training –** Health Resources and Services Administration (HRSA) is directed to publish a new funding opportunity and then award grants in fiscal year 2016 from the funding provided. (**Page 7)**

   Action To Be Taken

   In FY 2016, HRSA plans to make funds available for the Dental Faculty Loan Repayment program, which provides grants to dental training institutions to develop and manage loan repayment programs to selected dental faculty. The Funding Opportunity Announcement (FOA) will provide a funding priority for qualified applicants (1) that have a record of training individuals who are from a rural or disadvantaged background or are underrepresented minorities; and (2) that propose teaching programs targeting vulnerable populations and the risk-based clinical disease management of all populations, which are two of eight legislative funding priorities for the program.

HOUSE REPORT 114-195 (July 10, 2015)

1. **Perinatal transmission of Hepatitis B. —** The Committee is pleased that progress is being made to develop and implement a strategic plan to reduce the rate of perinatal transmission of hepatitis B. The Committee has urged HRSA to expand efforts to eliminate perinatal transmission of Hepatitis B for the past three fiscal years and little progress has been made. The Committee expects HRSA to test intervention strategies followed by the adoption of best practices protocols in HRSA funded health care settings as soon as feasible in fiscal year 2016. **(Page 27)**

   Action To Be Taken

   HRSA will continue to support the identification and promotion of best practices to prevent perinatal transmission of Hepatitis B among the nation's vulnerable populations. These efforts will include collaboration with the Centers for Disease Control and Prevention (CDC) viral Hepatitis program.

2. **Area Health Education Centers (AHEC)** - The Committee requests HRSA provide an update on the AHEC program's impact to increase the primary healthcare workforce and the AHEC program's nationwide activities in the fiscal year 2017 CJ. (**Page 30)**

Action To Be Taken

In Academic Year 2014-2015, the AHEC program supported various types of pre-pipeline, pipeline, and continuing education training activities for thousands of trainees across the country. AHEC grantees implemented over 1,800 unique continuing education courses that were delivered to over 252,000 practicing professionals nationwide, approximately 93,100 of whom were concurrently employed in medically-underserved communities.

AHEC grantees partnered with more than 11,000 sites to provide more than 48,100 clinical training experiences to student trainees (e.g., ambulatory practice sites, hospitals, and physician offices). Approximately 67 percent of these training sites were in primary care settings; 62 percent were located in medically-underserved communities; and 41 percent were set within rural areas. Training at the clinical sites incorporated interdisciplinary team-based approaches, where approximately 2,100 students, residents and/or fellows from a variety of professions and disciplines were trained on teams with AHEC student trainees.

3. **Transfer from Planned Home Birth to Hospital –** The Committee is aware that CDC data shows the rates for out of hospital births in the United States have been slowly but steadily increasing since 2004, and that because of this trend, collaboration within an integrated maternity care system is essential for optimal mother-baby outcomes. The Committee believes that all women and families planning a home or birth center birth have a right to respectful, safe, and seamless consultation, referral, transport and transfer of care when necessary. Therefore the Committee directs HRSA to develop a strategy for facilitating ongoing inter-professional dialogue and cooperation, and encouraging universal adoption of the Best Practice Guidelines for Transfer from Planned Home Birth to Hospital, in order to achieve optimal mother-baby outcomes in all settings and with all providers, and to report back to this Committee with an update on its progress. (**Page 33)**

Action To Be Taken

HRSA is aware that the rates for out of hospital births have been increasing. HRSA will work closely with its partners, including national organizations of professionals serving pregnant women, to develop a strategy for facilitating ongoing inter-professional dialogue and cooperation in order to encourage and support universal adoption of the Best Practice Guidelines for Transfer from Planned Home Birth to Hospital.

SENATE REPORT 114-74 (June 25, 2015)

1. **Bureau of Primary Health Care** - The Committee urges HRSA to prioritize fiscal year 2016 grant awards to include the establishment of new school-based health center delivery sites, and to report to the Committee in the fiscal year 2017 CJ how many organizations applied for funding for new delivery sites in School-Based Health Centers and how many were funded. (**Page 40)**

Action To Be Taken

New access point competitive funding opportunities include school-based locations as eligible service delivery sites. In fiscal year 2015, the Health Center Program received 28 applications to support new access points in schools, of which 22 were awarded funds.

2. **Tuberculosis [TB]. --** Cases of TB continue to be reported in every State in the United States, and CDC has identified drug resistant TB as a serious antibiotic resistant threat to the nation. The Committee urges HRSA to strengthen coordination between Community Health Centers and State and local tuberculosis control programs to ensure appropriate identification, treatment, and prevention of TB among vulnerable populations. (**Page 40)**

Action To Be Taken

HRSA will continue to strengthen its partnership with CDC and promote coordination between health centers and State and local disease control programs to ensure appropriate identification, treatment and prevention of diseases impacting vulnerable populations, including tuberculosis.

3. **National Health Service Corps [NHSC] –** The Committee recognizes the importance of the Corps scholarship and loan-repayment programs for serving medically underserved communities and populations with health professional shortages and/or high unmet needs for health services. The Committee notes with concern that the criteria and methodology for designating a Health Professional Shortage Areas [HPSA] has not been significantly updated in more than 20 years. The HPSA methodology is outdated and therefore may not be reliably identifying areas with primary care shortages or help target Federal resources to areas experiencing the greatest shortages. The ability to accurately identify areas experiencing shortages of health workers is essential to the Secretary's ability to use scarce resources as efficiently as possible. Therefore, the Committee encourages the Secretary to prioritize updating the HPSA designation and scoring methodology based on stakeholder recommendations made by the Negotiated Rulemaking Committee in 2011. The Committee encourages HRSA to consider utilizing all authorized priority categories when granting awards, including prioritizing applicants willing to continue to serve in a HPSA area after the period of obligated service, as authorized by 42 U.S.C. 254l–1(d)(2)(B) and 42 U.S.C. 254l(d)(2)(B) and additional flexibility available to the Secretary to ensure the Corps scholarship and loan-repayment programs serve the underserved communities in every State, to the extent appropriate under the law. **(Page 41)**

Action To Be Taken

The Affordable Care Act required the formation of a Negotiated Rulemaking Committee on primary care shortage designation, which was established in 2010 and met 14 times over the following 13 months. It was unable to reach a consensus during their deliberations, and therefore could not present a proposed regulation for the Department's review. The Committee submitted a report to the Secretary in that included recommendations, as well as minority reports from members who did not concur with the recommendations. HHS has been carefully considering these reports as well as stakeholder input and the views of other federal partners. In addition, HRSA has been working to modernize shortage designation through a thorough review of our business processes and the development of the Shortage Designation Management

System (SDMS), a new online system for submission and review of shortage designation applications. While SDMS does not change the methodology for determining shortage designation eligibility, it does eliminate manual processes, reduce the burden on States to identify and source data by using validated national data sets, and provide transparency through defined business rules that follow shortage designation policy.

As authorized by 42 U.S.C. 254l–1(d)(2)(B) and 42 U.S.C. 254l(d)(2)(B), the NHSC reviews and awards applicants based on all statutory funding preferences, including HPSA score, disadvantaged background and characteristics likely to remain in a HPSA. The program has been very successful in recruiting clinicians willing to continue to serve the underserved after fulfillment of the period of obligated service. A recent study completed in FY 2014 showed 86 percent of those who had fulfilled their NHSC commitment remained in service to the underserved in the short term, defined as up to 2 years after their NHSC commitment ended.[317] An evaluation conducted in FY 2012 showed that 55 percent of NHSC clinicians continue to practice in underserved areas 10 years after completing their NHSC service commitment.[318] This reaffirmed findings from an earlier study in FY 2000 which showed the majority of NHSC clinicians remained committed to service to the underserved in both the short and long term.[319] NHSC participants serve the underserved communities in every State. The current FY 2015 NHSC Field Strength of 9,683 is distributed in all 50 states and the District of Columbia, ranging from 32 in Vermont to 704 in New York.

4. **National Health Service Corps –** The Committee recognizes that the Secretary retains the authority to include additional disciplines in the Corps. As such, the Committee urges the Secretary to include pharmacists — individuals recognized as part of the primary care team in medical home demonstration programs — as eligible recipients of scholarships and loan repayments through the program. **(Page 42)**

Action To Be Taken

For the NHSC, there is no necessity to specify additional specialties in the NHSC legislation, as both the NHSC LRP and NHSC Scholarship Program (SP) have the authority to assure the provision of primary care services by recruiting "…if needed by the Corps, an adequate supply of other health professionals" [338B(a)(2) and 338A(a)(2)]. Specialized care, however, has not historically been considered within the realm of primary care or the purview of the NHSC, as it is more narrowly-focused and less comprehensive than primary care services.

In the past, decisions to expand NHSC disciplines have been made in concert with the stakeholder community and NHSC service delivery sites in particular. In FY 2012, in response to community demand, NHSC expanded eligibility for the NHSC State Loan Repayment Program (SLRP) to pharmacists. The SLRP provides cost-sharing grants to states and territories to assist them in operating their own state educational loan repayment program for primary care

[317] FY 2014 National Health Service Corps Customer Satisfaction Survey.
[318] "Evaluating Retention in BCRS Programs" Final Report. March 30, 2012. Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.
[319] "Evaluation of the Effectiveness of the National Health Service Corps" Final Report. May 31, 2000. Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill and Mathematica Policy Research, Inc.

providers working in HPSAs within their state. Currently, there are eight states (AK, CO, ID, MT, NV, VA, WA, and WV) that have incorporated pharmacists into their loan repayment program. HRSA administers a yearly NHSC satisfaction survey to its current members and alumni. The NHSC Site Satisfaction Survey from 2015 found that while important, pharmacists were not identified as top recruiting priorities for NHSC-eligible sites.

Furthermore, broadening of the discipline mix by creating preferences for certain populations or types of providers could dilute the NHSC's focus of providing primary care services to underserved and vulnerable populations at current resource levels. This could result in the redirecting of resources away from already-identified needs for primary care services by underserved communities and vulnerable populations. NHSC is already an oversubscribed program with only the current eligible provider types. For example, in FY 2015 NHSC's Loan Repayment Program received 6,355 eligible new applications, but was only able to fund 2,934 new awards. As a result, NHSC is not able to meet the current recruitment needs of our sites. Expanding eligible provider types will only exacerbate this issue.

5. **Primary Care Training and Enhancement -** The Committee provides $36,831,000 for Primary Care Training and Enhancement programs, which support the expansion of training in internal medicine, family medicine, pediatrics, and physician assistance. Funds may be used for developing training programs or providing direct financial assistance to students and residents. The Committee directs HRSA to prioritize programs that support underserved communities and applicants from disadvantaged background in any new grant competition in fiscal year 2016. (**Page 43)**

Action To Be Taken

The PCTE FY 2016 Funding Opportunity Announcement (FOA) includes funding preferences that are established in the authorizing statute. These preferences are awarded to applicant institutions that have a high rate for placing graduates in practice settings having the principal focus of serving residents of medically underserved communities and are awarded to institutions that have achieved a significant increase in the rate of placing graduates in such settings. In addition, the FY 2016 PCTE FOA takes into account applicants ability to: describe the national, regional and or local needs for the project, describe the needs of the community where the program will take place, provide information regarding the diversity of the population served and the diversity of the workforce involved in the delivery of services.

6. **Training in Oral Health Care -** The Committee directs HRSA to prioritize programs that support underserved communities and applicants from disadvantaged background in any new grant competition. Further, the Committee encourages HRSA to focus on training programs that target vulnerable populations in risk-based clinical disease management of all populations. The Committee urges HRSA to work with Centers for Medicare and Medicaid Services (CMS) on the evaluation and support of additional models for expanding access to oral healthcare. Such models should include emergency room diversion programs and efforts under State law to deploy and evaluate new provider types. (**Page 43)**

Action To Be Taken

The FY 2016 State Oral Health Workforce FOA supports States in developing and implementing innovative programs to address the oral health workforce needs of designated Dental HPSAs. This includes integrating oral and primary care medical delivery systems for underserved communities, supporting programs for oral health providers practicing in advanced roles specifically designed to improve oral health access in underserved communities, and community-based prevention service programs for underserved populations consistent with risk-based clinical disease management. HRSA, including its National Center for Workforce Analysis, will begin a dialogue with the CMSon the evaluation and support of additional models for expanding access to oral healthcare including emergency room diversion programs and efforts under State law to deploy and evaluate new provider types.

HRSA will work to prioritize funding to support funding to underserved communities and applicants from disadvantaged background in other funding opportunity announcements it plans for FY 2016, including the Dental Faculty Loan Repayment program, which provides grants to dental training institutions to develop and manage loan repayment programs to selected dental faculty.

7. **Area Health Education Centers** - The Committee requests HRSA provide an update on the AHEC program's impact to increase the primary healthcare workforce and the AHEC program's nationwide activities in the fiscal year 2017 CJ. (**Page 44)**

Action To Be Taken

In Academic Year 2014-2015, the AHEC program supported various types of pre-pipeline, pipeline, and continuing education training activities for thousands of trainees across the country. AHEC grantees implemented over 1,800 unique continuing education courses that were delivered to over 252,000 practicing professionals nationwide, approximately 93,100 of whom were concurrently employed in medically-underserved communities.

AHEC grantees partnered with more than 11,000 sites to provide more than 48,100 clinical training experiences to student trainees (e.g., ambulatory practice sites, hospitals, and physician offices). Approximately 67 percent of these training sites were in primary care settings; 62 percent were located in medically-underserved communities; and 41 percent were set within rural areas. Training at the clinical sites incorporated interdisciplinary team-based approaches, where approximately 2,100 students, residents and/or fellows from a variety of professions and disciplines were trained on teams with AHEC student trainees.

8. **Mental and Behavioral Health** - The Committee supports HRSA for its collaboration with SAMHSA to integrate primary care and behavioral health. HRSA should include an update on this initiative in the fiscal year 2017 CJ. (**Page 45)**

Action To Be Taken

HRSA and SAMHSA collaborate to support several efforts that seek to integrate primary care and behavioral health care. These efforts include the Behavioral Health Workforce Education and Training (BHWET) Program for professionals and paraprofessionals, which aims to expand the substance abuse and mental health workforce focused on children, adolescents, and

transitional-age youth. Initially funded in FY 2014 for a 3-year period, the BHWET Program for professionals supports pre-degree clinical internships and field placements of master's-level social workers, psychologists, professional counselors, psychiatric-mental health nurse practitioners, and marriage and family therapists; and, doctoral-level psychologists. The BHWET Program for paraprofessionals trains students in community and technical colleges, who seek to obtain a certificate in a paraprofessional behavioral health field, including community health workers, outreach workers, social services aides, mental health workers, substance abuse/addictions workers, youth workers, promotoras, and peer counselors. A total of 110 awardees trained the first student cohort in FY 2015.

In addition, HRSA, in collaboration with SAMHSA, funded a Health Workforce Research Center focused on behavioral health, which has three overall tasks: 1) develop a standardized method for data collection for the behavioral health workforce to improve consistency, comparability, validity and reliability of data across occupations and worker settings; 2) develop a comprehensive profile of the size and composition of the national behavioral health workforce including: occupation, practice setting, education/training, demographics, service provision, distribution, ability to serve vulnerable/underserved populations, and participation in team-based care; and 3) provide a comprehensive assessment of the legal and administrative authorities formally granted to behavioral health professionals through state scopes of practice, determine whether scopes of practice align with current professional responsibilities, and make recommendations for modifications to standardize practice across professions. The Center was established in FY 2015 and is beginning to work on projects for FY 2016.

In FY 2016, HRSA released a new competition for the Nurse Education, Practice, Quality and Retention- Interprofessional Collaborative Practice Program: Behavioral Health Integration program. This program will make available approximately $8 million to fund an estimated 16 cooperative agreements. Grantees will integrate evidence-based, interprofessional, team-based models of behavioral health services into routine nurse-led primary care in vulnerable and/or underserved/rural populations.

Finally, the SAMHSA/HRSA Center for Integrated Health Solutions was jointly established in FY 2010 to: *"promote the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in behavioral health or primary care provider settings."* The SAMHSA/HRSA Center for Integrated Health Solutions provides technical assistance (TA) through webinars, development of issue briefs, topic specific learning communities, and telephone TA to the range of HRSA and SAMHSA grantees interested in integrating care. With a combined national audience of behavioral health and primary care providers, as well as a focus on the health care safety net, the Center's mailing list reaches over 55,000 individuals on a monthly basis with information on topics such as:

- Screening, Brief Intervention, and Referral to Treatment (SBIRT);
- Care Coordination;
- Clinical Workflow;
- Integrated Care Teams;
- Referral to Specialty Treatment;
- Behavioral Health Self-Management;

- Patient and Family Engagement;
- Confidentiality; and
- Financing and Billing.

9. **Children's Health and Development -** There is increased evidence that experiences in early childhood have long-term health consequences over the course of one's life. These experiences are critical in all areas of children's educational, social, and physical development, and economic well-being. Children living in States with persistently high child poverty rates experience more negative health outcomes than their peers in other States. Therefore, the Committee directs HRSA to fund studies focused on systemic change that would positively affect the policy of child-health-related institutions and systems in States with the highest levels of childhood poverty. Recipient programs should consider inter- and intra-cultural dynamics to yield best practices for areas across the Nation with diverse populations, persistent poverty and child health outcomes in need of improvement. The Committee intends that this effort will provide a model for other States to utilize in improving child health and development outcomes. (**Page 47)**

Action To Be Taken

The Maternal, Infant, and Early Childhood Home Visiting Program (also known as the Federal Home Visiting Program) will fund activities and research to advance understanding of statewide systems change to positively affect child health outcomes in states with high poverty, as well as promote development of best practices that can be adopted in other states. Although these activities are national in scope and implemented in every state, the aim is to develop and promote best practices that can be applied to all states, and particularly those with the highest rates of child poverty.

1. HRSA supports the Home Visiting Applied Research Collaborative (HARC), which is responsible for developing a national home visiting research agenda and a research infrastructure to inform policy and practice. Two HARC-affiliated studies will address statewide systems:

    - One study, entitled “Stakeholder-driven research to strengthen coordination as a core element of home visiting (HV) to improve family functioning and health”, aims to strengthen early childhood systems coordination capacity and practice at the state and local levels as a core element of home visiting. Upon completion, the project work plan includes activities to promote stakeholders’ use of study results to strengthen coordination capacity and practice as a means to improve family health and functioning. (Anticipated completion – April 2018)

    - A second project, on developing a methodology for a multi-state evaluation of home visiting’s role within community systems of care, will design a study that can be implemented across states to generate a comprehensive understanding of the role home visiting currently plays in local and state systems of care across the country. The project will include development of protocols and metrics for assessing the results of systems coordination. (Anticipated Proposal Development – March 2016; study to follow)

2. The Federal Home Visiting Program invests in the Mother and Infant Home Visiting Program Evaluation (MIHOPE) and MIHOPE-Strong Start (SS) impact studies, national studies of home visiting which are some of the largest studies of home visiting ever conducted, and which will examine impacts of home visiting on key outcomes of health, development and well-being for children and families in poverty.

3. The Program also invests in the Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN) as the first ever national learning collaborative focused on data-driven and time-limited learning and evaluative activities using rapid testing to show improvement in practices and improved results for families.

In addition, HRSA will release a funding opportunity announcement in 2016 for the Early Childhood Comprehensive Systems (ECCS) Impact grants to fund state and local teams to participate in a quality improvement collaborative to advance their statewide early childhood systems with the aim of improving age-appropriate developmental skills among communities' three year old children. These grants include collaboration with MIECHV communities. HRSA is also funding an ECCS Collaborative Improvement and Innovation Network Technical Assistance Center (ECCS CoIIN TAC). The ECCS CoIIN TAC will provide intensive, targeted technical assistance to the ECCS Impact grant recipients, Rural Integration Models for Parents and Children to Thrive (Rural IMPACT) communities, Promise Zones, and other grantees working on systemic change that would positively affect the policy of child-health-related institutions and systems.

Lastly, HRSA is currently funding the Rural IMPACT Demonstrations, through which intensive technical expertise is being provided to ten high-poverty rural and tribal communities to deliver integrated health, education, and other support services for high-risk children and their parents with the goal of reducing child poverty.

10. **Maternal and Child Health Bureau** - The Committee is concerned that the Autism and Other Developmental Disorders program's State System Grants are not of a sufficient size to accomplish their objectives to improve access to comprehensive, coordinated healthcare and related services for children and youth with autism spectrum disorder [ASD] and other developmental disabilities. Many rural States need significant assistance with diagnosis of ASD and building networks to provide access to properly trained health providers. The Committee requests that HRSA report in the fiscal year 2017 CJ on which rural States have received such grants and what scale of improvement they were able to achieve. (**Page 48)**

Action To Be Taken

In FY 2016, HRSA will compete a funding opportunity to address needs and challenges of children and youth with ASD and other developmental disabilities (DDs). The State Autism Spectrum Disorders and Other Developmental Disabilities Program will fund up to six grants to improve early diagnosis, referral, access and coordination of care for children and youth with ASD and other DDs, particularly for those residing in rural and underserved communities. These grants will be larger than in the past to better enable grantees to use evidence-based/evidence-informed innovative strategies, including those related to the use of health information technology and the promotion of family engagement, to build the necessary system of services for children and youth with ASD. At a minimum, the awardees will be required to apply twenty-five percent of their funding to rural, medically underserved populations. The innovative strategies include: 1) telehealth and/or telemedicine including mental health, 2) family navigators, and 3) shared resources such as community health teams, innovator agents, and regional extension centers.

HRSA has also supported several rural states through the State Autism Spectrum Disorders and Other Developmental Disabilities Programs as highlighted below.

- During the period of FY 2011 – FY 2014, many of the grantees in the State Autism Spectrum Disorders and Other Developmental Disabilities Program focused activities on the rural, underserved populations in their states. Some key activities include:
    - Mississippi: In collaboration with the Mississippi Southeast Rural Health Initiative, the grantee improved access to services by opening a specialty health care clinic within a rural public school for local residents, thereby reducing their long driving times for screening and referral services.
    - Ohio: the grantee conducted a pilot project that used telemedicine to deliver Early Intervention services in underserved counties. The pilot provided coordinated care, including virtual communication between providers and their families, home visits, intervention, and coaching to children with ASD and their families who could not otherwise access such specialized services.
    - Alaska: the grantee integrated a set of ASD training modules into distance-based associate and bachelor of social work degree programs in order to improve autism training opportunities in rural areas.

11. Necrotizing Enterocolitis [NEC] - HRSA shall identify best practices and successful interventions for the prevention of NEC, particularly in premature infants. The Committee directs HRSA to prioritize prevention of NEC when awarding grants through the Healthy Start Initiative program. (**Page 49)**

Action To Be Taken

HRSA will identify best practices and interventions for the prevention of NEC through Healthy Start. HRSA completed a new round of grant funding in FY 2015; therefore, the next round of open competition funding will not occur until FY 2019. Given the importance of this issue, HRSA will require current grantees to make NEC a priority wherever programmatically appropriate. Furthermore, HRSA will direct the Healthy Start Supporting Performance Project

technical assistance center to gather guidelines, current research, and best practice findings related to NEC and to disseminate this information and support to grantees.

12. **Poison Control Centers** - The Committee directs the Secretary to continue the discussions with the Nation's poison control centers to develop an action plan to achieve these possible new Medicare and Medicaid cost savings. (**Page 52)**

Action To Be Taken

HRSA awarded a contract to build upon the existing national public awareness campaign, *Poison Help,* highlighting the role of poison control centers (PCC) in the public health system with a focus on Medicare and Medicaid beneficiaries. The goals of the contract include, increasing public awareness of the national Poison Help toll-free number; educating Medicare and Medicaid beneficiaries about poisoning risk and prevention; and emphasizing the role of the national network of PCCs and the services they provide.

HRSA contracted with the Lewin Group to conduct a retrospective study to determine the value of PCC consultations for Medicare beneficiaries, specifically as it relates to inpatient hospital stays and any cost savings that may be associated with PCC services. This study will examine the number of calls to PCCs by Medicare beneficiaries compared to the number, length of stay and type of hospitalizations of Medicare beneficiaries due to intentional and unintentional poisoning and the cost per call to evaluate if resources devoted to PCCs have an impact on cost savings related to hospitalization rates. The study results will enable HRSA to independently validate savings estimations by the American Association of Poison Control Centers (AAPCC); provide Congress with current data regarding the value of poison centers; and substantiate HRSA's efforts to work with the Centers for Medicare and Medicaid Services and the Administration for Community Living to increase awareness and usage of poison control centers.

13. **Federal Office of Rural Health Policy [FORHP]** – The Committee encourages HRSA to suppose energy reliability and power generation capacity for health and dialysis facilities in rural areas of the United States. **(Page 53)**

Action To Be Taken

The Rural Health Care Services Outreach Grants (Section 330A of the Public Health Service Act) provide grants to rural public or rural nonprofit private entities for expanded delivery of health care services in rural areas. While HRSA's rural health funding is statutorily focused on health programs rather than physical infrastructure, HRSA will explore how increasing dialysis access in rural areas could potentially be addressed under this program, provided that this need can be demonstrated by potential applicants.

14. **Federal Office of Rural Health Policy** - The Committee encourages HRSA to partner with the Delta Regional Authority [DRA] on the awarding in and administration of grants under the Delta States network grant program and, to the extent possible, ensure that such awards are in accordance with DRA's strategic plan. (**Page 53)**

Action To Be Taken

HRSA continues to collaborate with the DRA on the Delta States Network Program. During the FY 2013 competitive cycle, HRSA and DRA collaborated in the Delta States funding opportunity announcement (FOA) allowing applicants to apply for both the Delta States Program and the Healthy Workforce Challenge Program, which was developed by DRA. This collaboration provided applicants an opportunity to maximize the resources and investments made in the Delta region.

In addition, in FY 2016 HRSA will compete the Delta States Program. The FOA aligns closely with DRA's "Promoting a Healthy Delta" initiative and its focus on improving chronic disease management. HRSA will continue to collaborate with DRA as the new grants are awarded and projects are implemented.

15. **Federal Office of Rural Health Policy** - The Committee is deeply concerned about the changes HRSA made to the Black Lung Clinic Grants Program in fiscal year 2014, including the adoption of a three-tiered funding system and an overall per-applicant cap. These changes to the program have unnecessarily increased the administration burden on applicants and may result in reductions in funding for States and communities most in-need of the essential healthcare services provided by this program. The Secretary is directed to evaluate funding levels for applicants based on the needs of populations those applicants will serve and the ability of those applicants to provide healthcare services to miners with respiratory illnesses, with preference given to State agency applications over other applicants in that State, without regard to the funding tiers and overall per-applicant funding cap established by the Secretary in FY 2014. (**Page 54)**

Action To Be Taken

The program will be competitive in FY 2017 and HRSA will take into account the concerns of the Committee.

16. **Federal Office of Rural Health Policy** - The Committee directs the Office for the Advancement of Telehealth (OAT) to use these funds to expand existing telehealth networks and to award new grants under the Telehealth Network Gant Program while also increasing activities that demonstrate the use and success of telehealth network across the country. (**Page 55)**

Action To Be Taken

FORHP will use the appropriated funds to support a combination of new and existing telehealth networks and to support ongoing research related to the impact of telehealth on rural and underserved populations. HRSA will compete the Telehealth Network Grant Program in FY 2016.

17. **Federal Office of Rural Health Policy** - The Committee directs OAT to fund sustainable programs with demonstrable accomplishments, placing particular emphasis on programs seeking to aid diverse populations in regions with significant chronic disease burden and evident health disparities. (**Page 55)**

Action To Be Taken

FORHP will continue to fund grant programs that have a specific focus on chronic disease. For example, the Telehealth Network Grant Program (TNGP) has tracked diabetes outcomes since 2004. In addition to diabetes, asthma and obesity will be emphasized in the upcoming TNGP funding opportunity announcement. The TNGP guidance targets communities with significant chronic disease burden and evident health disparities by requiring applicants to quantify the needs in their communities.

FORHP will continue to evaluate program sustainability by measuring the percentage of grantees that continue to offer telehealth services after funding has ended.

18. **Federal Office of Rural Health Policy** - The Committee encourages OAT to strongly consider a pilot program on telemedicine efforts to expand access to key health services in schools in high poverty areas. (**Page 55)**

Action To Be Taken

FORHP supports the Rural Child Poverty Telehealth Network Grant Program that focuses specifically on serving children living in high poverty rural areas via telehealth. In FY 2015, four three-year grants were awarded to telehealth networks to coordinate and improve the quality of health care services for children living in impoverished rural areas. This grant program supports networks which include social and human service organizations, some located in or adjacent to schools, to help address social determinants of health.

Additionally, FORHP supports the Telehealth Network Grant Program. In the FY 2016 competitive cycle, the funding opportunity announcement encourages telehealth networks that deliver services through school-based health centers/clinics, particularly those serving high-poverty populations.

19. **Federal Office of Rural Health Policy** – Accordingly, the Committee strongly encourages the inclusion and expansion of telestroke initiative in the Telehealth Network Grant Program to improve patient care in rural, urban, and suburban settings. (**Page 55)**

Action To Be Taken

FORHP supports the Evidence-Based Tele-emergency Network Grant Program that focuses specifically on tele-emergency services, including stroke. The purpose of this program is to support the implementation and evaluation of broad telehealth networks to deliver Emergency Department consultation services via telehealth to rural and community providers without emergency care specialists. In FY 2015, six three-year grants were awarded to develop and

deliver clinical Tele-Emergency services, including telestroke, that enhance access to health care services for rural residents.

20. FAMILY PLANNING - The Committee directs HRSA to ensure that any pregnancy options counseling funded under this title includes adoption counseling and is provided by counselors who have knowledge and experience in adoption practices. (**Page 55)**

Action To Be Taken

Title X Family Planning service grants issued under section 1001 of the Public Health Service Act must follow the regulations that apply to those grants (42 CFR Part 59, Subpart A, 59.5 (a)(5).

Pregnancy testing and counseling is a required service under Title X, and staff that provide pregnancy test counseling are knowledgeable about all pregnancy options and are trained to provide the neutral, factual information and nondirective counseling that is required under the regulations, including information and counseling about adoption. Pregnant clients that request in-depth counseling and/or referrals for a specific pregnancy option such as adoption are provided with an appropriate referral where they can obtain the additional information and/or service.

In the past, Title X training grantees and providers received specific training on adoption through Spaulding for Children, the National Infant Adoption Awareness Training Program (the grant to Spaulding was funded by the Administration for Children and Families (ACF) - that grant ended in 2012.

Vaccine Injury Compensation TAB

Vaccine Injury Compensation Program

Table of Contents

FY 2017 Budget

Appropriation Language

VACCINE INJURY COMPENSATION PROGRAM TRUST FUND

For payments from the Vaccine Injury Compensation Program Trust Fund (the ‘‘Trust Fund’’), such sums as may be necessary for claims associated with vaccine-related injury or death with respect to vaccines administered after September 30, 1988, pursuant to subtitle 2 of title XXI of the PHS Act, to remain available until expended: *Provided*, That for necessary administrative expenses, not to exceed **[$7,500,000]** $9,200,000 shall be available from the Trust Fund to the Secretary.

Amounts Available for Obligation

(Amounts in Dollars)

	FY 2015 Final	FY 2016 Enacted	FY 2017 Estimate
Discretionary Appropriation:	18,543,000	24,608,000	24,608,000
Transfer to Other Accounts	-7,496,000		
Transfer from Other Accounts	7,496,000		
Subtotal, adjusted Discretionary Appropriation……	**18,543,000**	**24,608,000**	**24,608,000**
Mandatory Appropriation	220,696,000	237,000,000	240,000,000
Transfer to Other Accounts	-225,909,000		
Transfer from Other Accounts	225,909,000		
Subtotal, adjusted Mandatory Appropriation……	**220,696,000**	**237,000,000**	**240,000,000**
Spending Auth Offsets	2,528,000		
Budgetary Resources Available	**241,767,000**	**261,608,000**	**264,608,000**
Administrative Expenses	18,543,000	24,608,000	24,608,000
Total HRSA Claims	225,909,000	237,000,000	240,000,000
Total New Obligations	**244,452,000**	**261,608,000**	**264,608,000**

Budget Authority by Activity

	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Budget
Trust Fund Obligations: Post-10/1/88 claims	235,000,000	237,000,000	240,000,000
Administrative Expenses: HRSA Direct Operations	7,500,000	7,500,000	9,200,000
Total Obligations	242,500,000	244,500,000	249,200,000

Budget Authority by Object

	FY 2016 Enacted	FY 2017 Estimate	FY 2017 +/- FY 2016
Insurance Claims and Indemnities	237,000,000	240,000,000	+3,000,000
Salaries and Expenses/Other Services	7,500,000	9,200,000	+1,700,000
Total	244,500,000	249,200,000	+4,700,000

Authorizing Legislation

	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Budget
(a) PHS Act, Title XXI, Subtitle 2, Parts A and D:			
Pre-FY 1989 Claims	---	--	---
Post-FY 1989 Claims	235,000,000	237,000,000	240,000,000
(b) Sec. 6601 (r)d ORBA of 1989 (P.L. 101-239):			
HRSA Operations	7,500,000	7,500,000	9,200,000

Appropriation History Table

(Pre-1988 Claims Appropriation)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1996	110,000,000	110,000,000	110,000,000	110,000,000
1997	110,000,000	110,000,000	110,000,000	110,000,000
1998	---	---	---	---
1999	---	---	100,000,000	100,000,000
2000	---	---	---	---
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2014	---	---	---	---
2015	---	---	---	---
2016	---	---	---	---
2017	---	---	---	---

Vaccine Injury Compensation Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Claims BA	$235,000,000	$237,000,000	$240,000,000	+$3,000,000
Admin BA	$7,500,000	$7,500,000	$9,200,000	+$1,700,000
Total BA	$242,500,000	$244,500,000	$249,200,000	+$4,700,000
FTE	18	25	25	---

Authorizing Legislation – Public Health Service Act, Title XXI, Subtitle 2, Parts A and D, Sections 2110-19 and 2131-34

FY 2017 Authorization ....Indefinite

Allocation Method ..... Other

Program Description and Accomplishments

The National Childhood Vaccine Injury Act of 1986 (the Act) established the National Vaccine Injury Compensation Program (VICP) to compensate individuals, or families of individuals, who have been injured by childhood vaccines, and to serve as a viable alternative to the traditional tort system. The Health Resources and Services Administration (HRSA) administers VICP in conjunction with the Department of Justice (DOJ) and the U.S. Court of Federal Claims (Court). HRSA has been delegated the authority to administer Parts A and D of Subtitle 2. Consistent with this delegation, HRSA:

- Receives petitions requesting compensation for vaccine injuries or deaths served against the Secretary of HHS (the Secretary), which are filed with the Court;
- Arranges for medical review of each petition and supporting documentation by health care professionals with special expertise in pediatrics and adult medicine, and develops preliminary recommendations that are provided to DOJ, which DOJ incorporates in the DOJ Rule 4(b) report that is submitted to the Court regarding the eligibility of petitioners for compensation;
- Publishes notices in the Federal Register listing each petition received;
- Promulgates regulations to modify the Vaccine Injury Table (Table);
- Provides administrative support to the Advisory Commission on Childhood Vaccines (ACCV), composed of nine voting members, including health professionals, attorneys, parents of children

who have suffered a vaccine-related injury or death, and specified HHS agency heads (or their designees);
- Informs the public of the availability of the Program; and
- Processes award payments to petitioners and their attorneys for judgments entered by the Court.

Since FY 2013, VICP has experienced growth in total outlays, which consists of compensation awards to petitioners and attorneys' fees and costs payments. In FY 2013, 375 families and individuals were awarded compensation totaling over $277.0 million, which was the largest annual outlay in the history of the Program. FY 2014 annual outlays were over $223.7 million to 365 families, individuals, and attorneys which is approximately $100 million more than the average amount of $123 million in annual outlays from FYs 2005-2012. In FY 2015, 508 families and individuals were awarded compensation totaling over $ 225.9 million.

In FY 2016, HRSA estimates that $237 million will be paid out of the Vaccine Injury Compensation Trust Fund (Trust Fund) for Court-ordered compensation for alleged vaccine-related injuries or deaths. The FY 2017 Request is necessary to account for the rise in Court-ordered compensation due to the increasing numbers of claims filed annually. The increase in claims filed and adjudicated is primarily the result of the addition of the influenza vaccine to the VICP in 2005. Because the CDC recommends an annual influenza vaccine for adults in addition to children, many more people receive the influenza vaccine each year and it now accounts for approximately 60 percent of claims filed annually.

In recent years, the Program also has had a dramatic increase in the number of claims filed. In FY 2014 and FY 2015, 633 and 804 claims were filed, respectively. In FY 1999-2005, an average of 162 non-autism claims were filed annually. The increase in claims is largely related to the coverage of the seasonal influenza vaccine (which was added in FY 2005) resulting in an average of 320 non-autism claims filed annually from FY 2006-2013.

The increased number of claims filed has resulted in the need for more HRSA MOs to review claims. The 804 claims filed in FY 2015 is the highest number of non-autism claims filed in a fiscal year in the history of the Program. Over the last five years, the number of claims filed has steadily increased primarily due to the increase in the number of influenza claims. More recently, the numbers have risen from 503 claims filed in FY 2013 to 633 claims filed in FY 2014 compared to 325 filed in FY 2006 and 410 in FY 2007.

In FY 2015, the VICP assigned 804 cases to its 10 HRSA MOs, approximately 80 cases per MO. By comparison, between FY 2000 and FY 2005, no more than 40-50 cases per year were reviewed per each MO. In addition to the significant increase in caseload, MOs conducted reviews of over 6,000 supplemental records that were submitted in FY 2015 for claims filed in previous years.

Additionally, the increased number of claims filed has resulted in the need for more medical experts to review claims and testify before the Court. HRSA contracts with medical experts to perform these tasks. In FY 2015, over 5,422 medical expert hours were used. In FY 2017, the Program expects about 6,300 medical expert hours will be used.

On July 1, 2014, the Court created a "Special Processing Unit" (SPU), which has expanded its capacity to process the increasing number of claims filed by hiring and assigning attorneys to handle certain

categories of claims. While the SPU has increased the Court's capacity to resolve claims, HHS's capacity to conduct medical reviews of claims has not increased. Cases placed in the SPU track have Court-ordered deadlines that are much shorter than other claims, putting an even greater burden on the MOs to review claims quickly.

Approximately 70 percent of claims filed are placed by the Court into the SPU. Increased funding is necessary to hire additional full-time MOs, as well as medical experts to defend the increase in number of claims filed., Settling cases that should be defended sends inconsistent and confusing messages to the court and petitioners. A high rate of settlements gives the appearance that vaccines are causing harm, thereby jeopardizing the Secretary's efforts to encourage vaccination and communicate safety of licensed vaccines. Settling these cases also threatens the integrity of the Vaccine Injury Trust Fund balance, and creates a legal precedent that violates the medical and scientific integrity of the Program.

To date, HRSA MOs were able accommodate the increased workload resulting from the rise in the number claims filed. Doing so permitted the Program to meet and exceed its goals. However, due to the ongoing increase in the number of claims filed, the same level of effort made in the past by the MOs cannot be sustained over the long term. This increased workload puts quality and timeliness of medical reviews at risk and additional funds are needed to allow VICP to hire additional medical reviewers in order to continue to meet and/or exceed program goals.

As outlined in the tables below, all performance targets were met or exceeded in FY 2015. Since the VICP provides liability protection to vaccine manufacturers and health care providers, one of the performance measures tracks whether petitioners who have been awarded compensation choose to reject the award and file a civil action against a vaccine manufacturer and health care provider. In FY 2014 and FY 2015, the target for the percentage of eligible petitioners, who were awarded compensation, but opted to reject awards and elected to pursue civil action, has been zero percent. The VICP has met this target each of these fiscal years.

The other VICP performance measures are focused on the payment of lump sum only awards and the processing of negotiated settlements. In FY 2014, the average time to process a settlement was 4.7 days, and the FY 2015 result was an average of 4.9 days, both exceeding the 10-day target. In FY 2014, VICP paid lump sum awards within an average of 1.5 days against the target of 8.0 days to account for the significant increase in claims. The FY 2015 lump sum awards were paid in an average 2.2 days, which exceeded the 8-day target as a result of automation and reassignment of staff resources. Between FY 2014 and FY 2015, there was a 39 percent increase in petitioner awards which accounts for the slightly longer average time in FY 2015. Also, the new measures regarding the funding of court-ordered annuities and the completion of medical reports were added.

Funding History - VICP Awards

FY	Amount
FY 2013	$277,087,363
FY 2014	$223,729,606
FY 2015	$225,908,764
FY 2016	$237,000,000
FY 2017	$240,000,000

Budget Request

The FY 2017 Budget for VICP will support the following:

VICP Claims Compensation - The FY 2017 Budget Request to compensate claims for the VICP is $240 million. The FY 2017 Request is $3 million above the FY 2016 Enacted level. The VICP provides Court-ordered compensation to individuals or families of individuals, who are thought to have been injured, or have died, as the result of receiving a covered vaccine(s). For a vaccine to be covered by the VICP, it has to be recommended by the Centers for Disease Control and Prevention (CDC) for routine administration to children and have an excise tax imposed on it.

The FY 2017 Request will ensure adequate funds are available to compensate petitioners and pay their attorneys' fees and costs. These funds will also allow the VICP to continue to meet its zero percent target for the percentage of eligible claimants who opt to reject awards and elect to pursue civil action.

Administrative Expenses - The FY 2017 Budget Request to pay the administrative expenses for the VICP is $9.2 million. The FY 2017 Request is $1.7 million above the FY 2016 Enacted level. This request will fund administrative expenses to cover costs associated with the internal medical review of claims by HRSA MOs and external medical review of claims by outside consultants (including, where warranted, expert testimony to the Court) as a result of the significant increase in filed claims. In addition, the VICP will use the funds to continue to provide professional and administrative support to the ACCV, meet specific administrative requirements of the Act, process compensation awards, maintain necessary records securely, and inform the public of the availability of the VICP.

In FY 2017, the Program will also use the administrative funding to continue its work on updating the Table to reflect the best scientific data available. Updating the Table by adding vaccine injuries to it will allow claims alleging those injuries and that meet the Table criteria to be compensated more expeditiously since it is presumed that the vaccine caused the injury if no other cause for the injury is found.

The Program will continue its outreach efforts to better inform the public and health care professionals about the VICP through implementation of the VICP Outreach Plan. Because survey data indicate that low income individuals and underrepresented minorities are least likely to be aware of the VICP, the outreach plan emphasizes leveraging other HRSA programs, such as the Health Centers and National Health Service Corps that serve these populations. The plan also includes performance measures to ensure that the components and activities within the strategy are reaching its target audiences and have been implemented successfully.

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

Outputs and Outcomes Tables

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
26.II.A.1: Percentage of cases in which judgment awarding compensation is rejected and an election to pursue a civil action is filed.	FY 2015: 0% Target: 0% (Target Met)	0%	0%	Maintain
26.II.A.4: Average time settlements are approved from the date of receipt of the DOJ settlement proposal.	FY 2015: 4.9 days Target: 10 days (Target Exceeded)	10 days	10 days	Maintain
26.II.A.5: Average time that lump sum only awards are paid from the receipt of all required documentation to make a payment.	FY 2015: 2.2 days Target: 8 days (Target Exceeded)	7 days	7 days	Maintain
26.II.A.6: Percentage of cases in which court-ordered annuities are funded within the carrier's established underwriting deadline.	New Measure Implemented for FY 2016 (Baseline: 100%)	98%	98%	Maintain
26.II.A.7: Percentage of medical reports that are completed within 90 days of receipt of complete medical records. (Developmental)	Developmental Measure for FY 2016 (Implemented on 10/01/2015)	TBD	TBD	N/A