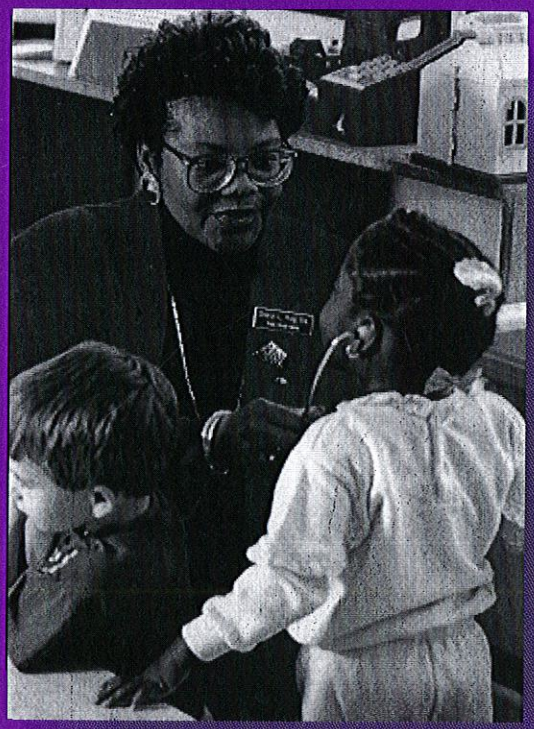
U.S. Department of Health & Human Services

HRSA

Health Resources and Services Administration

ASSURING ACCESS TO ESSENTIAL HEALTH CARE



For more information about the programs of the Health Resources and Services Administration, visit our Web site at **www.hrsa.gov** and click "newsroom" or telephone:

Media Inquiries	**301-443-3376**
General Information	**301-443-3376**
Legislative Information	**301-443-1890**
Grant Information	**888-333-4772**
	888-333-HRSA

Primary Health Care For Underserved People

Primary Care General Information	800-400-2742
HRSA Primary Care Programs	301-594-4100
Community and Migrant Health Centers	301-594-4300
Health Care for the Homeless and Residents of Public Housing	301-594-4420
National Health Service Corps	800-221-9393
Primary Care Training	301-443-1467

Health Care For People Living with HIV/AIDS

Comprehensive AIDS Resources Emergency Act Programs	301-443-6652
HIV/AIDS Clinical Information for Health Care Professionals	800-933-3413
Needlestick Injuries Emergency Information	888-448-4911

Maternal and Child Health

Maternal and Child Health General Information	703-821-8955, ext. 254
HRSA Maternal and Child Health Programs	301-443-0205
Prenatal Care Referrals	800-311-BABY 800-311-2229

Health Professions Training

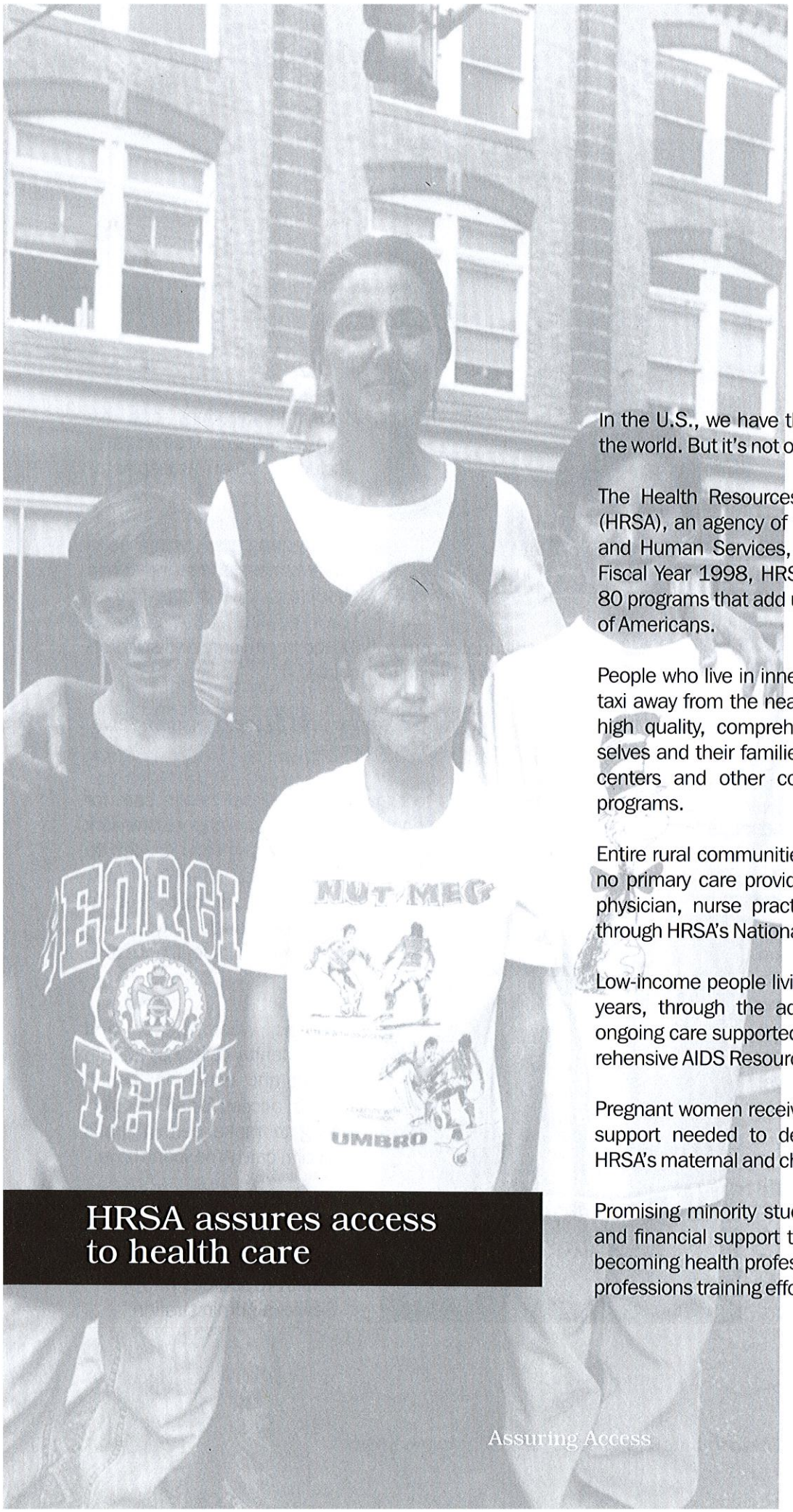
Assistance for Disadvantaged Students	301-443-2100
Scholarships and Loans for Minority and Disadvantaged Students	301-443-1173
Dentistry, Public Health, and Allied Health	301-443-6853
Nursing Education and Practice	301-443-5786
Primary Care Physician Training	301-443-6190
Workforce Data	301-443-6920

Other Health Care Concerns

Hansen's and Black Lung Disease	301-594-4420
Hill-Burton Uncompensated Care	301-443-5656
Managed Care	301-443-1550
Minority Health	301-443-2964
National Practitioner Data Bank	800-767-6732
Organ, Tissue, and Bone Marrow Donation and Transplantation	301-443-7577
Quality of Health Care	301-443-0458
Rural Health	301-443-0835
Vaccine Injury Compensation	800-338-2382
Women's Health	301-443-8695

Field Offices

Boston	617-565-1433
New York	212-264-2771
Philadelphia	215-861-4363
Atlanta	404-562-7980
Dallas	214-767-3872
Kansas City	816-426-5296
Chicago	312-353-6835
Denver	303-844-3203
San Francisco	415-437-8090
Seattle	206-615-2491



HRSA assures access to health care

In the U.S., we have the finest health care system in the world. But it's not open to everyone.

The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is working to change that. In Fiscal Year 1998, HRSA put $3.67 billion to work in 80 programs that add up to access to care for millions of Americans.

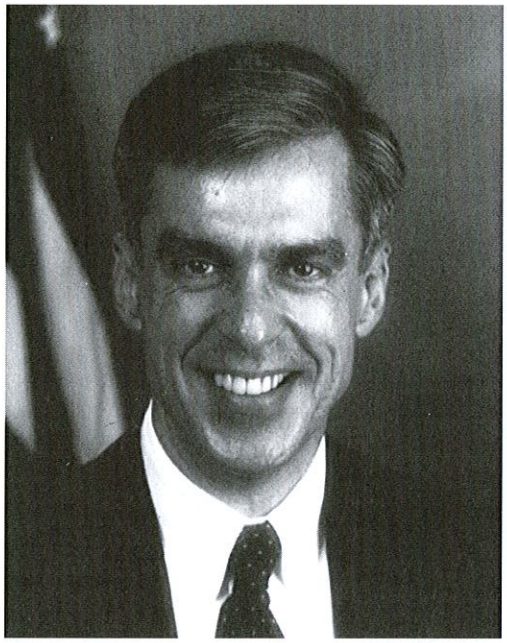
People who live in inner cities—three bus rides and a taxi away from the nearest health care provider—find high quality, comprehensive health care for themselves and their families in HRSA's community health centers and other community-based primary care programs.

Entire rural communities that have lived too long with no primary care provider are able to connect with a physician, nurse practitioner, or physician assistant through HRSA's National Health Service Corps.

Low-income people living with HIV/AIDS gain, literally, years, through the advanced drug treatments and ongoing care supported by HRSA's Ryan White Comprehensive AIDS Resources Emergency (CARE) Act.

Pregnant women receive the prenatal care and social support needed to deliver healthy infants through HRSA's maternal and child health programs.

Promising minority students get the academic boost and financial support they need to realize dreams of becoming health professionals through HRSA's health professions training efforts.



Access to care is the best medicine. With it, we can prevent disease and promote health. We can keep children in school and learning; adults on the job and productive. We have evidence that better health care can even strengthen a weak local economy.

Assuring access to care for underserved Americans is one of the wisest investments we make in the Nation's future—as important as insuring health services, researching medical mysteries, and quelling outbreaks of disease.

Everyone needs access to health care, but more than 40 million Americans have too little because it's too expensive, too distant, or just not capable of meeting their particular needs. Women, children, and racial and ethnic minorities have an especially hard time. The loss of a job—and the insurance that goes with it, the onset of illness, or a move to an underserved area could quickly compromise anyone's ability to get needed health services.

HRSA assures access through a broad range of very different programs. Working in urban neighborhoods, remote regions, and everywhere in-between, HRSA programs meet people's needs for basic primary health care services, like immunization, and for sophisticated treatments, including organ transplantation.

HRSA programs train health care professionals and teach people to take charge of their own health. HRSA supports traditional community-based health care and state-of-the art telehealth technology.

HRSA programs are as diverse as the people we serve, yet they all add up to access.

HRSA works to expand and improve health care for underserved people today and to lay the groundwork for a health care system tomorrow that is open to everyone—one that has minimized infant mortality, eliminated racial disparities in health, and brought down all the many barriers that limit access to care.

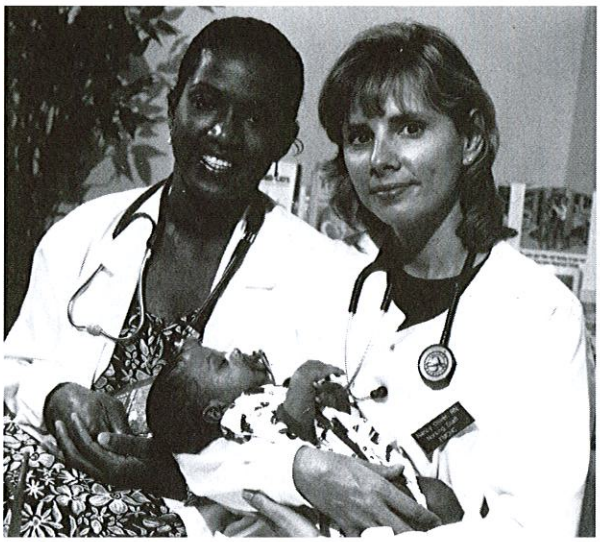
Assuring access to care is as important as insuring health services

Americans want, need, and deserve health care that is both excellent and equitable, health care with access for all. HRSA is working to make certain that's the health care Americans have.

Claude Earl Fox, M.D., M.P.H.
Administrator,
Health Resources and
Services Administration

Assuring Access to Care in Underserved Communities. . .

HRSA's Primary Health Care Programs



An estimated 43 million Americans are medically underserved. That is, they live in inner cities or rural communities where health professionals are in short supply, unavailable, or otherwise inaccessible. Many hard-working families and individuals are also uninsured or underinsured, earning too much money to qualify for Medicaid, but not enough to afford the $6,000 a year that the health insurance industry estimates private insurance for a family of four costs.

Underserved people may be farm workers, laborers, or service workers. They may be insured one month and not the next. Ten million of them are children. About 65 percent of the underserved are African American, Hispanic American, Asian American, American Indian, or other racial/ethnic minority. Addressing health care needs in a way that is respectful of and sensitive to culture is key to building an accessible health care system.

Enhancing the cultural competency of everyone involved in providing health care to underserved people is a high priority throughout HRSA. Cultural competency is a set of complementary behaviors, practices, attitudes, and policies that enable a system, agency, or individuals to effectively work in and serve pluralistic, multiethnic, and linguistically diverse communities.

Cultural competency improves quality of care and is best achieved by working closely with people from the community to be served so that health care services reflect the values, traditions, and customs of clients.

Primary Health Care
FY 1999
$1 billion

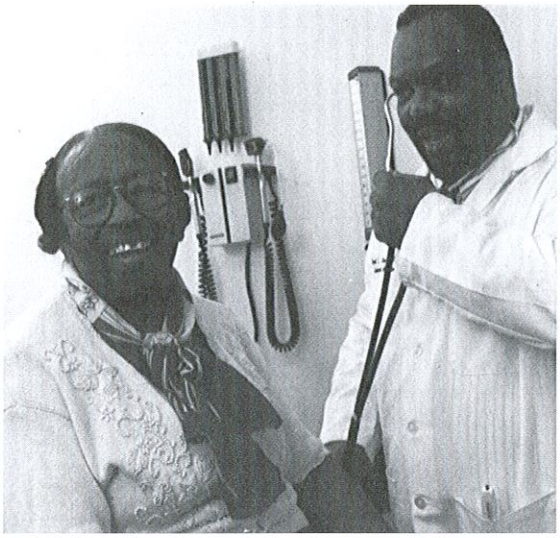
Health Centers **Includes Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Health Care for Residents of Public Housing**	**$925 million**
National Health Service Corps **Includes recruitment, community-based scholarships, and nurse loan repayment**	**$117.7million**
Hansen's Disease Care	**$ 22 million**
Native Hawaiian And Pacific Basin Health Care	**$ 2 million**
Black Lung Clinics	**$ 5 million**

Community and Migrant Health Centers

To vaccinate underserved children, to control their parents' blood pressure, to keep their grandparents' diabetes at bay, HRSA's Bureau of Primary Health Care supports a network of 746 community and migrant health centers, 128 health care programs for homeless people, and 22 primary care programs for residents of public housing. These centers and programs deliver prevention-focused primary care in one of the Nation's 3,200 underserved communities.

In underserved communities, the health center may be the only source of health services and, just as importantly, one place where people know they'll find someone who cares about and for them, their families, and the community itself.

HRSA touches communities like Bayou La Batre, Louisiana, a small fishing village, where HRSA's National Health Service Corps sent Regina Benjamin, M.D., just after she had completed her training in family medicine. The only physician for miles, she came for two years—repayment for a medical school loan. She has stayed with the tiny fishing community for a decade, earning an M.B.A. so



that she could build a fiscally sound practice, making house calls in her white pickup.

All told, 10 million Americans rely on HRSA-supported primary care programs for essential health care.

Although inadequate access to basic health care is a serious national problem, affecting one in six Americans, there is no single solution. In addition to cost, poor, underserved, and uninsured people have many obstacles blocking their access to care. For that reason, HRSA works hand-in-glove with State and local organizations to create health care systems that respond to the specific needs of people in the community they serve.

In Philadelphia, a group of registered nurse practitioners has banded together to form a nurse-run managed health care network that has brought health and hope to two public housing communities. More than half of the residents have received care through the network. Tenant use of the local hospital emergency department, the most expensive, least effective source of primary care, has plummeted, and the percentage of underweight newborns has dropped from 14 to less than 2.

In El Paso, a community health center has become the hub of a wheel whose spokes include education, affordable housing, gang intervention, a food cooperative, and a thrift store. Each month, 350 individuals with no other source of health care are seen and treated. Very nearly all children are immunized. In a single year, the county hospital saves $150,000 on inappropriate use of the emergency room. As a side effect of more appropriate and better health care, neighborhood children's scores in standardized reading tests have jumped by 20 percent.

Health centers are much more than medical clinics. To medically underserved people, they are truly health care havens, offering the range of services needed to stay healthy and productive. Individuals and families who have no health insurance or who are enrolled in Medicaid, but have no other willing providers, constitute nearly 75 percent of health center patients.

Close to half—42 percent—are infants, children, and adolescents. Nearly a third are women of childbearing age.

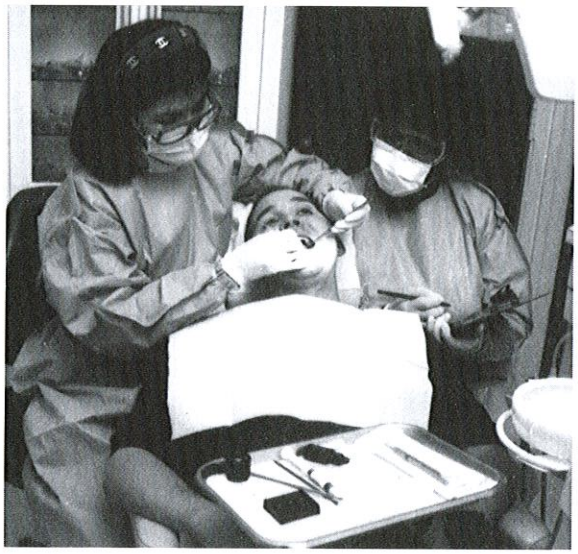
They rely on HRSA health centers for the full range of preventive and primary health care services, including mental health and substance abuse treatment, case management, referrals to and oversight of specialty and inpatient care, and services that help them use health care services most effectively.

Health center patients pay for services on a sliding fee scale. No one is turned away; all are encouraged to return for the regular preventive care that keeps them healthy, productive at work, ready to learn in school, and out of the local emergency room.

Health centers improve the health of underserved individuals and also the well-being of the communities in which they live. They stimulate education and the neighborhood economy. They are a significant force to quell the public health threats of the 90's—violence, child abuse and neglect, substance abuse, and other causes of premature disability and death.

Federal funds account for approximately 60 percent of health centers' operating budgets, 28 percent from HRSA grants and 33 percent from Medicaid reimbursement for services provided. The return on the Federal investment is high. Health centers generate some $3 billion of economic activity each year in the communities they serve.

Underserved communities with active health centers achieve lower infant mortality, fewer hospital admissions, shorter hospital stays, and lower overall Medicaid costs.



Rural community health centers are especially creative in determining how to best provide health services over large, isolated service areas. Telemedicine—allowing doctors to diagnose diseases across the miles—and other technologies on the frontiers of medicine are being pioneered in the Nation's 400-plus rural community health centers and clinics. Many receive service delivery research grants from HRSA's Office of Rural Health Policy.

Migrant health centers serve farm worker families who follow the seasons and harvests around the country. Exposed to pesticides and other environmental hazards in the fields and sometimes to substandard conditions in the camps, farm workers often have no other source of care.

In Monroe, Michigan, migrant health center doctors, nurses, and physician assistants are teaching farm workers to reach out to their neighbors, families, and friends, to provide health education, first aid, and referrals to care. As a result, tuberculosis patients are sticking with their demanding treatment regimen, farm workers' children are being immunized, and adults are equipped with reliable information to prevent the spread of HIV/AIDS.

All HRSA-supported health centers and programs accept Medicaid and Medicare patients, as well as people with no health insurance.

To qualify for community or migrant health center funding, primary care programs must serve communities designated as medically underserved by HRSA. The underserved communities may be geographic regions or specific populations, such as older adults or children.

HRSA's Bureau of Primary Health Care works closely with all health centers and programs to anticipate and respond to the continuously changing needs of underserved communities.

Since 1992, HRSA has reached agreements with more than 500 pharmaceutical manufacturers, who lower the cost of prescription drugs dispensed through community and migrant health centers, as well as clinics, health departments, public hospitals, and other providers.

Primary Health Care for the Homeless and Residents of Public Housing

Exposed to harsh weather and unsanitary surroundings, few Americans are as vulnerable to preventable disease, disability, and death as people who are homeless. For 420,000 children, women, and men in 48 States, the District of Columbia, and Puerto Rico, HRSA's Health Care for the Homeless services are a link to better health.

At 500 sites, doctors and nurses work in storefronts and shelters, and take to the streets in mobile clinics to provide basic medical care, substance abuse treatment, case management, and assistance with social services. A majority (52 percent) of homeless patients are African-American, Hispanic, Asian American, or American Indian; 17 percent are children or juveniles. Ten projects exclusively serve infants, children, and adolescents.

People who live in public housing also have difficulty gaining access to primary care. More than 110,000 residents in 22 public housing sites need not look beyond their own communities. In neighborhood clinics, children are immunized, youngsters receive dental care, adults are screened for disease and counseled on healthy habits. More than half of all public housing health center patients are 1 year old or younger; 93 percent are racial/ethnic minorities.

National Health Service Corps

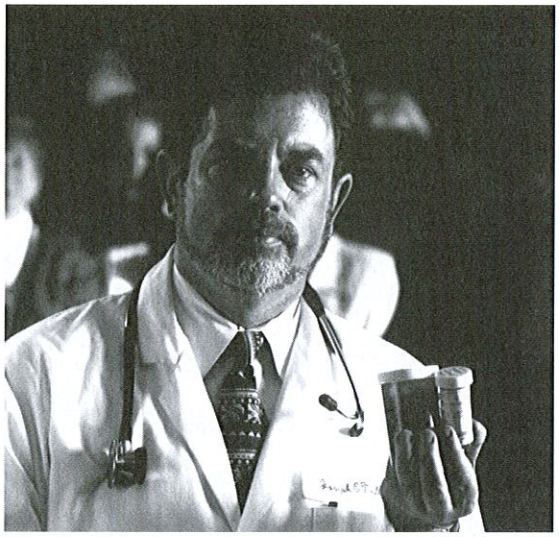
Continuing the great American tradition of service, more than 2,300 National Health Service Corps providers are providing well-baby care, preventive dentistry, and comprehensive primary care where health professionals are scarce. Primary care doctors (61 percent), nurse practitioners, certified nurse midwives, physician assistants, dentists, and mental health professionals work for at least two years in poor urban (40 percent) and isolated rural (60 percent) communities in exchange for scholarships or repayment of their student loans.

Each year, between 50 and 60 percent of National Health Service Corps clinicians choose to stay longer than their obligated year of service for each year of Corps-supported training.

In Fiscal Year 1997, in partnership with 36 States, HRSA, through the State Loan Repayment Program, assisted in the repayment of the student loans of 550 practicing primary health care professionals in exchange for their service within those States' federally designated Health Professional Shortage Areas. In partnership with 13 States and the federally designated shortage areas within them, HRSA, through the Community Scholarship Program, also sponsors scholarships for medical students and physician assistants,' nurse practitioners, and certified nurse-midwives in training in exchange for their commitment to serve the sponsoring community once they have completed their schooling.

Improving Access to Care for People With HIV/AIDS

HRSA's HIV/AIDS Programs



Ryan White Comprehensive AIDS Resources Emergency (CARE) Act programs, administered through HRSA's HIV/AIDS Bureau, provide primary and support services including home health care, case management, substance abuse and mental health treatment, nutrition, housing, and life-sustaining prescription drugs to poor, uninsured, and underinsured people living with HIV/AIDS. Federal spending on CARE Act programs has increased five-fold since 1990, when the law was passed.

Through the CARE Act, an estimated 350,000 people each year have access to services and treatments that keep the human immunodeficiency virus at bay and enable them to live—not just survive. "Not a day goes by that we don't meet people who are alive—raising their children, going to work, reaching out to help others—solely because of the care we provide," said a volunteer physician at a HRSA-supported clinic that provides primary health care to people living with HIV/AIDS.

Help for Communities With High Rates of HIV/AIDS Infection

Early in the AIDS epidemic, it became clear that the virus spread faster in some places than in others. In those areas, health care systems were overwhelmed by the number of people needing treatment for HIV/AIDS. Today, approximately 75 percent of people living with AIDS reside in these hardest-hit areas. Through Title I of the CARE Act, the Federal Government is sharing the burden with these Eligible Metropolitan Areas (EMAs).

HIV/AIDS
FY 1999
$1.4 billion

Emergency Relief to Eligible Metropolitan Areas	**$505**	**million**
Comprehensive Care Grants to States (Includes $285.5 million for AIDS Drug Assistance Programs)	**$738**	**million**
Early Intervention	**$ 94**	**million**
Pediatric HIV/AIDS	**$ 46**	**million**
AIDS Education & Training Centers	**$ 20**	**million**
Dental Services	**$ 7.8**	**million**

In 1997, 49 EMAs in 19 States, the District of Columbia, and Puerto Rico were eligible to receive this assistance. More than half of Title I funds are awarded as formula grants, based on the estimated number of people living with HIV disease in the EMA; the remaining Title I funds are awarded competitively as supplemental grants to EMAs that demonstrate severe need and the ability to use funds cost-effectively. A total of $464.8 million is appropriated under Title I in Fiscal Year 1998.

Because the public heath care system, the extent of Medicaid coverage, and the face of AIDS all differ from place to place, each eligible metropolitan area is required to establish an HIV Health Services Planning Council, charged with assuring that Title I funds are spent in ways that best respond to local needs. Members must include representatives from health care agencies that serve people with HIV and from community-based providers. People from the community who are themselves living with the disease must constitute at least 25 percent of the voting membership.

Although more than half of available Title I funds are awarded to metropolitan areas according to a legislated formula that accounts for the impact of the disease on the community, it is the local council that actually sets priorities and assesses the efficiency and effectiveness of services.

The vast majority of Title I funds go to community-based organizations and agencies that are the

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core of the HIV continuum of care. For people who have HIV/AIDS and nowhere else to turn, these centers provide a health care anchor: a place to go and a professional to see when they are sick; a direct connection to life-sustaining treatments; and a link to services that can keep them well and living in their own homes.

Each metropolitan area is different and so is the portfolio of services supported with CARE Act funds. Typically, however, a poor, uninsured or underinsured person living with HIV/AIDS could expect to find high quality outpatient medical and dental care, mental health counseling, physical therapy, and other needed rehabilitation services. These services are often coordinated by a case manager, who also links patients with home health and hospice care, with housing and transportation, and with other services as they are needed.

HRSA's CARE Act assistance to eligible metropolitan areas is a model for America's overall response to AIDS. It promotes a partnership among governments at all levels, public and private health care providers, community organizations, and, most significantly, people living with HIV/AIDS, who not only receive care through the programs, but also play key roles in directing them.

Support for States

No State has failed to feel the impact of HIV/AIDS. Through Title II of the CARE Act, HRSA makes grants to all 50 States, the District of Columbia, Puerto Rico, and eligible U.S. territories to improve access to health care and support services. These funds support a range of services, help keep health insurance in place, and pay for medications. In Fiscal Year 1998, the States will receive $543 million, including $285.5 million for AIDS Drug Assistance Programs (ADAPs).

States may use a portion of their Title II base awards to fund medications to treat HIV disease, including measures for the prevention and treatment of opportunistic infections. Through State ADAPs, medications are provided to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid, in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam. ADAP funding has increased dramatically in recent years. In Fiscal Year 1996, $52 million in Title II supplemental funds was appropriated specifically for ADAPs (this was in addition to the $53 million that States had already committed from their base Title II awards).

Scientific breakthroughs in treatment have heightened the importance of ADAPs managed by the States through Title II. Both the high cost of the most effective drug therapies and the complexity of the AIDS drug regimen would be insurmountable obstacles for thousands of people living with HIV/AIDS, if not for this shared Federal-State responsibility. In 1997, ADAPs reported serving more than 91,800 low-income persons with HIV.

Title II grants are made according to a formula that considers both the total number of people living with HIV/AIDS in the State and how many of them live outside eligible metropolitan areas that receive funds through Title I. States that for 2 years have had more than 1 percent of the total number of cases of HIV/AIDS in the U.S. must match the Federal funds.

Grants for Early Intervention Services for People with HIV/AIDS

Title III of the CARE Act provides funding to outpatient, primary care service providers for HIV early intervention services that are not otherwise reimbursable. Title III services focus on primary health care and early intervention, including HIV counseling and testing. For those who test positive, the programs act to get patients into primary health care to delay onset of symptoms and provide

"I don't know what I would have done," said Jackie, a 28-year-old HIV-positive Alexandria, Virginia, woman with an energetic HIV-negative daughter. "I already lost one baby. I didn't want to lose another, but I didn't think there was a chance. But she was born healthy and they're working real hard to keep me healthy. I can work. I can take care of my baby. I can have a life."

access to other needed HIV medical care services.

In Fiscal Year 1997, 166 primary health care providers in 34 States, the District of Columbia, and Puerto Rico received $69.7 million to bolster and build their HIV early intervention services. In Fiscal Year 1998, $76.3 million is appropriated for these programs. About half of these providers are HRSA-supported community health centers, the others are health care for the homeless programs, hemophilia service providers, family planning programs, local health departments, and other not-for-profit providers. Many of these grantees also receive substantial support from Title I and/or Title II of the CARE Act.

Help for Individuals and Families Living with HIV/AIDS

When the person living with HIV/AIDS is a child, an adolescent, or a woman, the difficulty in gaining access to care is magnified. The everyday difficulties of poverty, inadequate housing, and lack of transportation to and from medical appointments compound the challenge of providing quality care to these special populations.

Through Title IV of the CARE Act, health care programs in at least 26 States, the District of Columbia and Puerto Rico, will be funded with $41 million in Fiscal Year 1998, to provide HIV/AIDS care and treatment to children, women, youth, and families.

In communities where children, youth, and women are at high risk for HIV/AIDS, the funds support comprehensive health care networks. Multiple health and social services are coordinated, often under one roof, and support services, such as transportation and child care, are offered.

Title IV works to develop new ways to effectively link care systems with HIV research conducted by the National Institutes of Health.

Title IV also supports programs that encourage pregnant women to be counseled about HIV and tested as needed. Those who are found to be infected with the virus are educated about medications that have been shown to dramatically lower the risk of perinatal transmission when administered to an HIV-positive woman during pregnancy.

"I don't know what I would have done," said Jackie, a 28-year-old HIV-positive Alexandria, Virginia, woman with an energetic HIV-negative daughter. "I already lost one baby. I didn't want to lose another, but I didn't think there was a chance. But she was born healthy and they're working real hard to keep me healthy. I can work. I can take care of my baby. I can have a life."

Programs to serve people with hemophilia and HIV, models of care for adolescents with or at heightened risk for HIV/AIDS, and national resource centers for women and children also receive support under Title IV.

Developing Models of HIV Care for the Hardest to Reach

HRSA is engaged in identifying new models of care for people with HIV/AIDS through the Special Projects of National Significance (SPNS) Program. This program supports innovation, assessment, dissemination, and replication of programs that increase knowledge and skill in providing HIV/AIDS health and support services to historically underserved and hard-to-reach populations. These

include persons with linguistic barriers; adolescents who lack information and tools to make prudent decisions about sexual activities; individuals whose social/religious traditions inhibit their seeking and/or accessing adequate care; people who are mentally ill; people who are homeless; and previously incarcerated individuals (helping them transition back into society). A strong component of the SPNS-funded models of care is that they can be easily replicated in other health care settings.

In Fiscal Year 1997, 62 projects were funded to explore solutions for a range of HIV care needs, including: the use of managed care to expand access to HIV/AIDS services; the impact of integrated systems of care on meeting the physical, mental, and emotional health needs of children, women, and men with or at risk for HIV/AIDS; and other strategies to improve access and care for people with HIV/AIDS. In 1997, SPNS funded a new initiative to develop HIV service delivery models for Native American communities. The SPNS program received $25 million in Fiscal Year 1998.

Each SPNS grantee is responsible for disseminating information about its program. Through the program, a research and evaluation infrastructure has developed among community-based organizations, further improving the Nation's ability to respond to HIV/AIDS.

Training Health Care Professionals to Care for People with HIV/AIDS

The standard of HIV/AIDS treatment changes so rapidly that there is a continuous need to educate and re-educate physicians, nurses, dentists, and other health care providers. HRSA's network of 15 AIDS Education and Training Centers (AETCs) (Fiscal Year 1998 funding, $17.3 million) works with CARE Act providers, health professions training programs, State and local health departments, and other organizations to train health professionals to test, counsel, diagnose, treat, and manage care for people with HIV/AIDS. On average, 140,000 health care providers receive training through AETCs each year. Since 1991, more than 700,000 providers have received training.

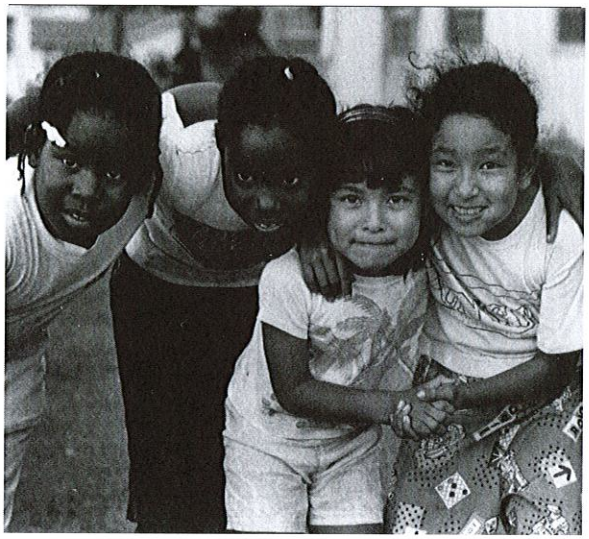
HRSA also supports a telephone consultation service at the Pacific AIDS Education and Training Center at San Francisco General Hospital. Primary health care providers may telephone 1-800-933-3413, Monday through Friday, 10:30 a.m. to 8 p.m. EST, to discuss specific treatment issues and problems with a consulting team that includes physicians, nurse practitioners, and clinical pharmacists. About 4,400 professional consultations are held through this service each year.

Health care providers exposed to blood through needlestick or other job-related incidents may call HRSA's National Clinicians' Post-Exposure hotline, 1-888-448-4911 for advice on prophylaxis for HIV, hepatitis, and other bloodborne pathogens.

To assist dentists in treating people with HIV/AIDS, HRSA reimburses 103 accredited dental schools and postdoctoral dental programs with uncompensated costs incurred in providing oral health care to HIV-positive persons. In Fiscal Year 1998, $7.8 million was appropriated for dental reimbursement.

Expanding Access to Care for Women and Children

HRSA's Maternal and Child Health Programs



The health of American mothers, babies, and children has never been better. More women receive prenatal care—and receive it earlier in their pregnancies. Infant mortality is at an all-time low. Immunization is at an all-time high.

Yet substantial numbers of mothers and children face significant obstacles to adequate health care. One in five children lives in poverty ($16,036 per year or less for a family of four). One in seven has no health insurance. Nearly twice as many American babies die before their first birthdays as babies in Japan, which has the lowest infant mortality rate worldwide (the U.S. ranked 25th among industrialized nations in 1993).

The prospects for good health and well-being are substantially lower for racial and ethnic minority mothers and children than for their white peers. At birth, an African American infant has a life expectancy seven years shorter than the white baby in the adjacent crib.

To assure access to care for all American mothers and children and to give every mother, father, and family the best chance to bring up a happy, healthy child, HRSA in Fiscal Year 1998 will invest more than $800 million in maternal and child health.

Supporting States, Sustaining Systems of Care

For more than 60 years, the Maternal and Child Health Services Block grant, authorized under Title V of the Social Security Act, has supported States in developing health care systems for mothers, children, and families. In Fiscal Year 1998, the block grant will channel $683 million to the 50 States, the District of Columbia, and the U.S. territories. Block grant funds help States meet the most urgent maternal and child health challenges and support Special Projects of Regional and National Significance and Community Integrated Service Systems.

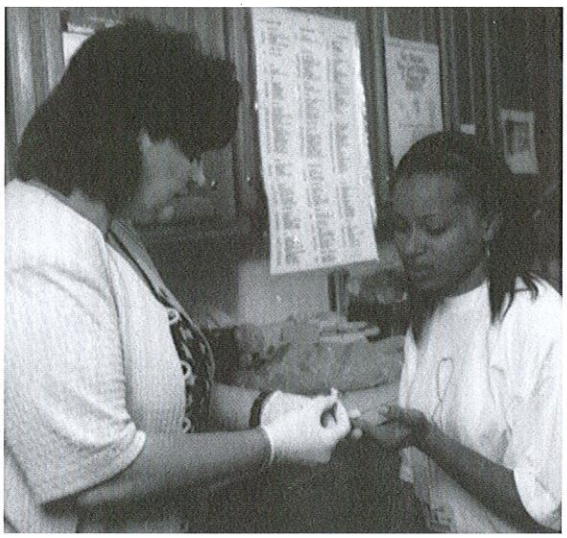
State health departments have great flexibility in allocating block grant monies. Because poor, uninsured, and isolated women and children are at highest risk of falling through gaps in the health care system, systems and services that meet their specific needs have high priority.

To receive the Maternal and Child Health Services Block Grant, each State assesses its own maternal and child health needs, then develops and implements a plan to meet them. Although underserved women, infants, children, and adolescents are the primary beneficiaries, the block grant ultimately protects and promotes the health of all mothers and children. Last year, 4.8 million pregnant women benefitted from outreach and health services supported by the block grant, and approximately 17 million children and families, including children with special health care needs, received appropriate and needed care.

Because poverty itself is a health risk, the Maternal and Child Health Services Block Grant helps States to develop systems of care that mitigate the effects of poverty and promote the health of all mothers and children.

Maternal and Child Health
FY 1999
$870 million

Block Grant to States	**$700**	**million**
Includes Special Projects of Regional and National Significance and Community Integrated Service Systems		
Healthy Start	**$105**	**million**
Emergency Medical Services for Children	**$ 15**	**million**
Abstinence Education	**$ 50**	**million**



Every State uses block grant funds to provide preventive and primary health care to pregnant and postpartum women and to infants, children, and adolescents, as well as specialized health services to children with special health care needs. States also use the funds to support initiatives that address State- and community-specific needs, public health screening, assessment, health education, and disease prevention.

The block grant represents a true Federal-State partnership: each $4 Federal investment is matched by the States with a $3 contribution or in-kind services. Each State earmarks 30 percent of its grant to care for children with special health care needs, such as cerebral palsy, spina bifida, development delay, and other chronic conditions. In Fiscal Year 1997, the Federal/State partnership contributed more than $1.7 billion to maternal and child health services.

Alabama, through its block grant allotment, cares for some 40,000 childbearing women; 112,000 infants, children, and adolescents; and 30,000 children with special health care needs. Every baby born in the State is screened for life-threatening metabolic disorders. High-risk families learn how to prevent lead poisoning, and their children are screened and referred for services as needed. Babies and children throughout the State are immunized. Communities with high rates of teen pregnancy have resources to address that problem.

California, with substantially different maternal and child health concerns, provides health care to nearly 600,000 women, more than 2 million infants, children, and youth, and almost 130,000 children with special health care needs. All babies with birth defects are tracked, so State epidemiologists can tease out localized or regionalized patterns and discern risks and causes.

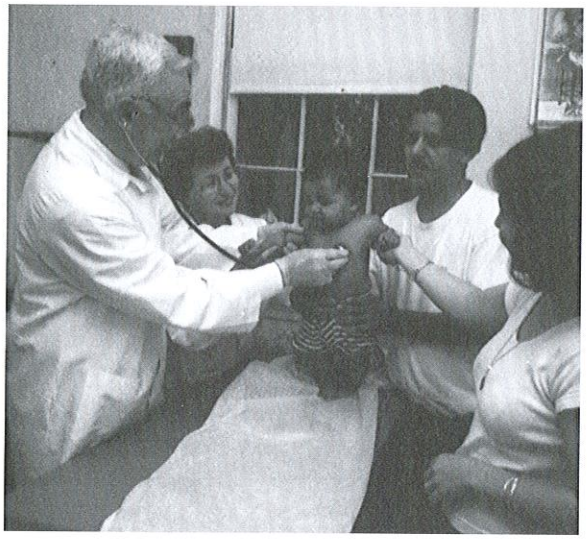
With more than 97 percent of African American Californians born in just 16 communities, California targets block grant funds to reduce infant mortality, premature birth, and low birth weight, which African Americans experience at higher rates than other Americans. The block grant also supports statewide efforts to prevent domestic violence and assist its victims, to reduce teen pregnancy, to prevent Sudden Infant Death Syndrome, and to help women and children enter the State's sophisticated managed health care system.

Exploring New Territory: Special Projects of Regional and National Significance

Scientific breakthroughs—the identification of genetic anomalies, the development of life-saving medications, the refinement of promising therapies—suggest that mothers and children in the U.S. will continue to enjoy better health and live longer, more productive lives. But that can happen only if systems are in place that make these advances in care accessible to all who need them.

HRSA's Special Projects of Regional and National Significance (SPRANS) program, another facet of the Maternal and Child Health Services Block Grant, conducts maternal and child health services research and training, provides genetic services, supports hemophilia diagnostic and treatment centers, and explores innovative strategies to improve the health of mothers and children. In Fiscal Year 1998, some 500 projects will receive a total of $100.5 million.

All SPRANS are carefully evaluated, their strengths and weaknesses identified, and their results assessed. SPRANS have a long history of bridging the gap between the research lab and the front lines of health care. Current projects examine the health consequences of shortened hospital stays for childbirth, interventions to prevent infant jaundice from progressing to bilirubin toxicity, and the effectiveness and importance of home visiting for various infant and child population groups.



To help turn the tide on the most frequent cause of disability and death among U.S. children and adolescents, in Fiscal Year 1998, an additional $3 million in SPRANS funds will go to States for the development of comprehensive and coordinated traumatic brain injury services.

Opening the Door To Health Care For Mothers and Children

Children—particularly children from disadvantaged families—need more than the routine physician visit to become and stay healthy. They need a convenient, reliable source for a range of services, where families are welcomed and encouraged to be involved in their children's care, where comprehensive services are offered and coordinated.

Community Integrated Service Systems grants made through the Maternal and Child Health Services Block Grant help to build health homes for mothers and children. Rooted in the communities they serve, integrated service systems reach out to families in need and provide a constellation of services in ways that accommodate their clients' culture and living circumstances.

In communities with concentrations of families from racial and ethnic minorities prone to hereditary diseases, such as African Americans vulnerable to sickle cell disease, genetic counseling and screening services are emphasized. In Hispanic communities, health care providers are bilingual and/or Spanish translation is available. Providers are trained and systems are organized to be sensitive and responsive to the racial and ethnic culture of clients served.

The Federal-State partnership to insure the Nation's 10 million children with no health insurance, the Children's Health Insurance Program, has shined a spotlight on community-based integrated service systems for children. As States implement the $24 billion over five years effort, HRSA provides guidance, technical assistance and training in developing such systems of care.

In Fiscal Year 1998, HRSA will award a total of $10 million to 131 community-based service systems to expand their capacity to provide integrated services to underserved mothers and children.

Opening Access To Services That Prevent Infant Mortality

Over the past three decades, the U.S. infant mortality rate has steadily decreased. Yet, in 1995, 40,000 babies died before their first birthdays—and African American babies were twice as likely to die as whites.

During the first month of life, premature birth and low birth weight, birth defects, respiratory distress, and problems that originated during pregnancy are the villains. Over the remainder of the first year, the repeat offenders are Sudden Infant Death Syndrome, birth defects, injuries, pneumonia, flu, and homicide.

Since October 1991, HRSA has supported aggressive intervention in the communities with rates at least 1.5 times the national average. Beginning with 15 sites, expanding to 22 in 1994, and growing to include 40 more in 1997, these are the Healthy Start Communities. Early results show that intense local outreach can succeed in enrolling pregnant women in early prenatal care, encouraging fathers to be involved in their children's lives, and keeping infants in routine pediatric care. By training residents of the Healthy Start communities to become outreach workers, projects also create jobs and build community support for infants, children, and families.

Each Healthy Start site creates its own menu of services, but most include outreach to women and families at high

risk for premature birth and premature death, coordination and case-by-case management of services to women and their infants, family education, and services for fathers.

Baltimore Healthy Start has established two neighborhood centers, each with a satellite location, to serve 1,400 women each year. Case managers encourage women to begin receiving prenatal care early in their pregnancies, and also help them receive essential services. These include: supplemental nutrition through the Women, Infants and Children program; health care through Medicaid; financial assistance through Temporary Assistance for Needy Families; and food stamps, high school equivalency classes, and health education.

Healthy Start programs are created and carried out by consortia within the communities they serve. They integrate local services and involve private organizations and individuals in meeting local maternal and child health needs.

HRSA scrutinizes the process and the progress of all the Healthy Start programs and broadly disseminates the Healthy Start model for other communities to adopt and adapt.

Helping Children To Live and Grow Healthfully through Adolescence

HRSA also supports two specialized programs that help children and families successfully weather two storms of childhood and adolescence--injuries and early sexual activity.

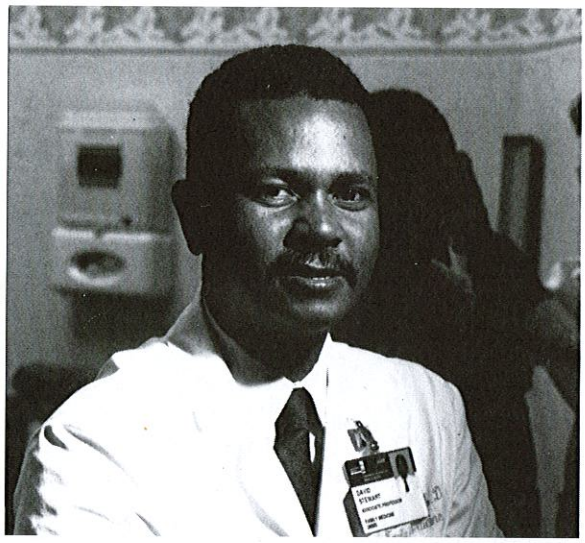
Injury is the number one killer of children and teenagers. Although serious childhood injuries occur frequently, emergency medical service providers are not uniformly trained to treat children and, especially in remote regions, they do not have supplies and emergency medical equipment adapted for pediatric use.

To train and equip emergency medical personnel to care for children—and to educate them to prevent pediatric injury—HRSA supports a nationwide initiative, funded at $13 million in Fiscal Year 1998.

Early sexual activity can cause a cascade of problems, including sexually transmitted disease and adolescent pregnancy. To help teenagers avoid sexual activity and its many complications, HRSA provides grants to States to develop abstinence education programs. In Fiscal Year 1998, the grants total $50 million.

Bolstering Access to Care With Better Balance Among Health Professionals

HRSA's Health Professions Training Programs



A health care workforce that is up to the challenges of the next century—that has the capacity to serve our increasingly diverse population and to deliver quality health care services in underserved areas—is the hinge on which the door to health care access swings.

As the health care system becomes increasingly market-driven, people working at jobs that provide neither health insurance nor salaries sufficient to cover the costs of private coverage can be squeezed out of access to care. Entire communities in inner cities and rural regions find themselves unable to recruit and retain in practice physicians or other primary health care providers. One in six Americans lives where access to essential health care is less than adequate.

African Americans, Hispanics, American Indians, and other racial and ethnic minority groups comprise more than half of the 43 million Americans who live in medically underserved areas, but are severely underrepresented within the health professions. Because minority health care providers are more likely to treat minority patients, any racial or ethnic disparity in the health professions compromises access to health care.

Health Professions Training
FY 1999
$301.9 million

Minority & Disadvantaged Student Training — **$92.6 million**
Includes Centers of Excellence, Health Careers Opportunities Program, Loan Repayment Fellowships for Faculty, Scholarships for Disadvantaged Students, Exceptional Financial Need Scholarships, and Financial Assistance for Disadvantaged Health Professions Students

Community-Based Training — **$53.6 million**
Includes AHECs, Health Education and Training Centers, Geriatric Programs, Rural Health Interdisciplinary Training, Allied Health Special Projects, Podiatric Primary Care Residency Training, and Chiropractic Demonstration Projects

Primary Care, Dentistry & Public Health Training — **$89.3 million**
Includes Family Medicine, General Internal Medicine and Pediatrics, Physician Assistant Training, General Dentistry Training, Public Health/Preventive Medicine, and Health Administration Programs

Nursing Education & Practice — **$65.5 million**
Includes Nursing Special Projects, Advanced Nurse Education, Nurse Practitioner/Nurse Midwife Training, Nurse Anesthetist Training, Nurse Disadvantaged Assistance, and Professional Nurse Traineeships

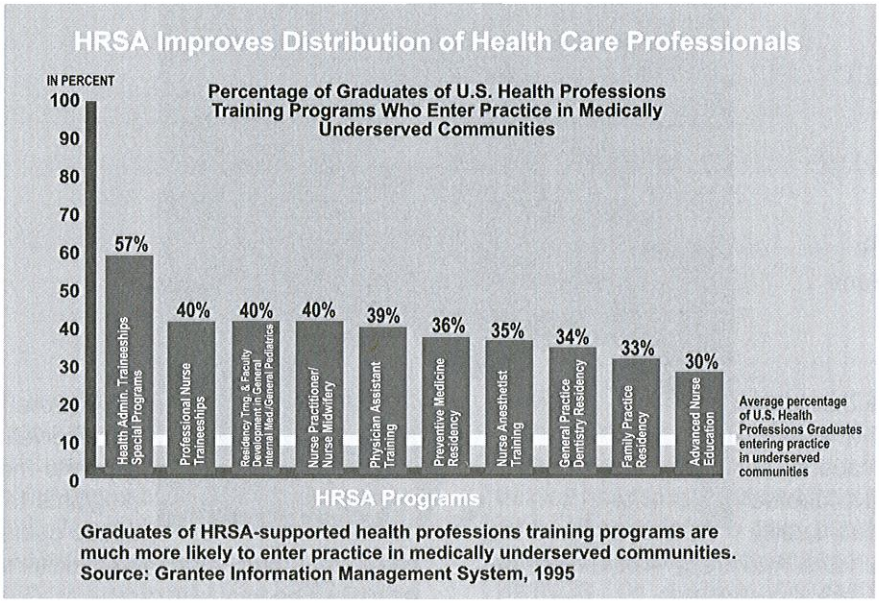
Health Professions Workforce Development — **$ .7 million**
Includes health professions data system and research of certain health professions issues

To improve access to care for underserved Americans, HRSA supports more than 40 distinct programs to increase racial and ethnic diversity within the health professions and improve the distribution of health care providers geographically across the Nation. The Fiscal Year 1998 appropriation for HRSA health professions training programs is $290 million.

Boosting Racial and Ethnic Diversity To Better Serve Diverse People

Health in the U.S. is, to some degree, dependent on racial and ethnic background. African Americans, Hispanics, American Indians, Alaska Natives, Asians, and Pacific Islanders have higher rates of certain diseases, lower rates of successful treatment, and, in some cases, shorter life expectancies. Although many factors contribute to racial and ethnic disparities in health, inadequate access to care is clearly one of the more significant.

Minority health professionals have historically provided more health care for the poor and uninsured and for patients in their own racial and ethnic groups than non-minority providers.



African American physicians are five times as likely to care for African American patients as other physicians; Hispanic physicians treat Hispanic patients at more than twice the rate of other physicians.

But minority health professionals are in short supply, making up less than 10 percent of the health care workforce. African Americans, Hispanics, and American Indians are severely underrepresented at the same time that their numbers within the general population are growing.

The problem is not lack of interest on the part of minority students. Applications to health professions training programs across the country have climbed, but the number of minority students accepted into them has inched downward in recent years. HRSA supports programs that ensure minority students have the skills, the means, and the access they need to successfully enter the health professions.

HRSA supports a range of programs to meet these ends.

- HRSA boosts academic skills of promising students, as early as high school, through the Health Careers Opportunity Program. In Fiscal Year 1997, $25.5 million was granted to 132 programs that enhance the math and science skills of more than 6,000 minority and disadvantaged students.

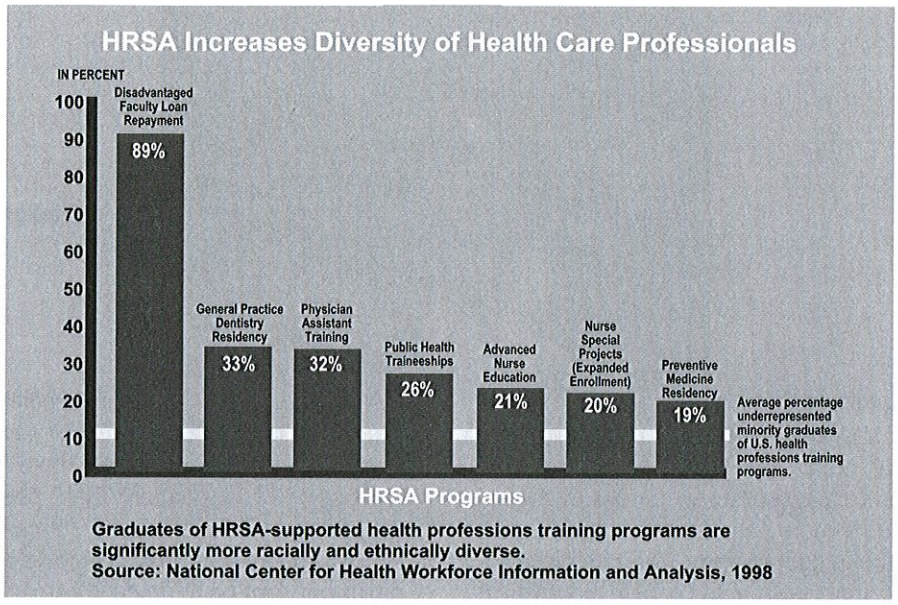
- HRSA provides the financial means for minority and disadvantaged students to enter health professions by making low-cost loans and scholarships to individuals directly and through Historically Black, Tribal, and Asian/Pacific Island Colleges and Universities, and Hispanic Serving Institutions. Some of the scholarships and loans require students to practice primary care in underserved communities after graduation.

- HRSA assures access to health professions training programs tailored to meet the needs of racial and ethnic minorities, supporting schools of medicine, dentistry, pharmacy and other health professions through programs such as Centers of Excellence. These centers have higher than average enrollments of African American, Hispanic, and American Indian students, train minority providers, and conduct research and training on important minority health issues, including the influence of culture on the use of medical services.

  Centers of Excellence students gain clinical experience in minority communities, provide desperately needed care, and learn first-hand the rewards of primary care practice in underserved areas. In Fiscal Year 1997, HRSA made $21.4 million in grants to 22 Centers of Excellence.

- HRSA helps minority and disadvantaged students interested in nursing careers over financial, academic, and cultural obstacles, through Nursing Education Opportunity Programs. In Fiscal Year 1997, HRSA made $3.9 million in grants to 22 programs.

- HRSA nurtures training programs for minority health professions students through Partnerships for Health Professions Education. These schools (seven in Fiscal Year 1997) join forces with local businesses, service providers, schools, service organizations, and others to "grow their own" health professionals. Partnerships identify minority and disadvantaged students in their own communities and support them throughout medical, dental, and pharmacy training. Upon graduation, the newly-minted professionals practice in the home communities.



- HRSA bolsters diversity within the health professions through programs that help training programs recruit and retain minority faculty, develop programs specifically to train providers for service in underserved areas, and conduct research into the health concerns of minority and disadvantaged people.

Putting Health Care Providers Where They Are Needed Most

More than 3,000 communities across the U.S. do not have enough health care providers to meet even their basic needs. Two-thirds of these underserved communities are located in small towns and rural areas. Most of the rest are in poor urban neighborhoods.

HRSA works with health professions schools in these regions to recruit students, train them in community based settings—including community health centers, private physician offices, outpatient clinics, and rural hospitals—and encourage them to root their careers in the underserved areas where they were trained.

HRSA's 36 Area Health Education Centers (AHECs) are the most visible efforts to attract, train, and keep health care professionals in underserved regions. More than two-thirds of the Nation's 143 medical schools are linked to AHECs, through which students receive community based education and training. In Fiscal Year 1997, with $26 million Federal funds and $100 million matching funds from their States, AHECs trained 21,000 students and gave them clinical experience in 500 HRSA community health centers and other community-based settings.

AHECs focus their energies on meeting community, local, and regional health care needs. They reach out to minority and disadvantaged high school and college students within the region and encourage them to consider careers in health care. In Fiscal Year 1997, AHECs introduced 50,000 underrepresented racial and ethnic minority and disadvantaged high school students to health professions training with the expectation that many will become doctors, nurses, and other health care providers.

In the 25 years since the first AHECs were established, they have become a focal point for health care in underserved areas. The AHEC at the Medical University of South Carolina has trained nearly half of the State's practicing family physicians and 12 percent of general internists and pediatricians. At the Southeast Kentucky AHEC, health professions students have worked with elementary schools in nine counties and educated more than 28,000 children on nutrition, personal hygiene, dental care, HIV prevention, and tobacco use. Other AHECs are similarly helping their communities to overcome local health problems.

HRSA also supports Nursing Special Projects that rely on nurses and nurses-in-training to implement innovative solutions to local and regional health problems. At the University of Maryland School of Nursing, a Wellmobile clinic-on-wheels cares for isolated children and families on the State's Eastern Shore. A clinic established by the Research College of Nursing at Blemheim Elementary School in Kansas City, Missouri screens uninsured children—98 percent of whom are minorities—for illness and teaches families how to improve their health. Nurses from LaSalle University, Temple University, and the University of Pennsylvania, operate a managed care

HRSA supports 20 Rural Interdisciplinary Training programs to ease the severe shortage of primary care providers, dentists, and mental health professionals in rural and remote regions. The shortage persists, in part because rural providers tend to care for more patients and earn less than their urban and suburban counterparts. The interdisciplinary health care teams that HRSA trains enable providers to better serve their patients while simultaneously controlling the cost of care.

Balancing the Workforce To Better Meet Changing Needs

Almost everyone agrees that America needs a better balance between primary and specialty care to meet the needs of our citizens and the requirements of a health care system dominated by managed care. Only about 35 percent of U.S. medical school graduates, however, actually enter the primary care disciplines: family medicine, internal medicine, and general pediatrics.

Public health, with its emphasis on disease prevention and health promotion, is increasingly called on to fill service gaps created by shifts in health care. Yet it is estimated that four in five public health workers have no formal public health training.

Changing demographics and emerging diseases create additional health care challenges that heighten the need for an appropriately trained health care workforce.

HRSA supports a variety of programs that assure health care professionals have the training needed to meet the primary care, public health, and special medical needs of the Nation.

To assure the American people have access to adequate numbers of appropriately-trained primary care and public health providers, HRSA supports the establishment and expansion of family medicine training programs, and faculty development and residency training in family medicine, internal medicine, and general pediatrics.

Almost one-third of all family medicine residents in Fiscal Year 1997 were enrolled in HRSA-supported programs. The graduates were four times more likely to practice in underserved areas than their peers in programs not supported by HRSA. About 75 percent of graduates of HRSA-supported internal medicine and general pediatrics programs went on to practice primary care medicine, twice the rate of other programs, whose graduates tended to pursue specialty training after completing a residency in primary care.

HRSA also supports programs that train other providers of primary health care, including physician assistants, public health and general dentists, and, most notably, advanced practice nurses.

A well-trained nursing workforce has always been essential and changes in the way health care is delivered in the U.S. have only increased the importance of nursing and the system's reliance on nurses to provide diagnostic and treatment services, prevent disease, and educate patients. The primary care provider for underinsured and uninsured individuals and families today is more likely to be a nurse than a physician.

To enhance nursing's contribution to primary health care and public health and to ensure an adequate supply of diverse and appropriately trained nurses to meet the health care needs of underserved people, HRSA supports a variety of programs to recruit, train, and place nurses, including nurse practitioners, certified nurse-midwives, and nurse anesthetists.

In Fiscal Year 1997, HRSA invested $63 million in nurse training and special projects in nursing and contributed to the training of 11,800 nurses.

To train health care providers to meet new and growing needs, HRSA supports AIDS Education and Training Centers (see page 8) and Geriatric Education Centers.

HRSA-supported Geriatric Education Centers train physicians, nurses, social workers, and allied health professionals to anticipate and meet the particular needs of aging people—the fastest-growing age group in the U.S. In Fiscal Year 1997, 27 grants were made, at a total of $5.4 million, which was matched dollar for dollar by States.

Tracking Health Professions Workforce Trends

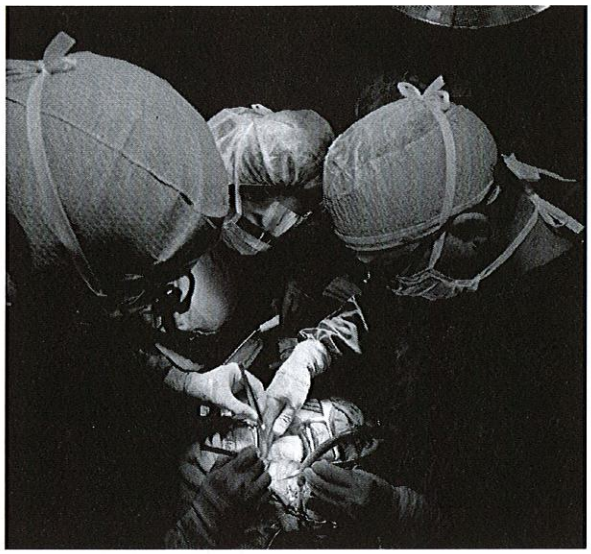
To keep its primary care and public health workforce programs on track, HRSA collects and analyzes data through the National Center for Health Workforce Information and Analysis.

The Center is involved in important surveillance and monitoring activities. It tracks the supply, demand, and distribution of health professionals; maintains the Area Resource File, a massive data base that tracks the location of health care workers; and develops models that predict the future physician supply and requirements.

HRSA assists States in monitoring their own health care workforce needs. HRSA's Integrated Resource Model is a sophisticated forecasting tool that enables States to quantify their primary care provider needs. Additionally, HRSA works in partnership with States to conduct State-focused workforce research and analysis.

HRSA also supports the Council on Graduate Medical Education and the National Advisory Council on Nursing Education and Practice, which study trends in medicine and nursing and advise the Secretary of Health and Human Services and the U.S. Congress on related issues.

Opening Access to Quality and Equality of Care



Organ, Tissue, and Bone Marrow Donation and Transplantation

In the 40 years since surgeons transplanted a kidney from one identical twin to another, organ and tissue transplantation has become routine practice. Last year, more than 20,000 organ transplants were performed—kidneys, hearts, lungs, pancreases, livers, and intestines. Tissue transplants—bone marrow, bone, skin, heart valves—also improved thousands of lives.

Although a single donor can save and enrich the lives of as many as 50 recipients, demand for these precious human resources far outstrips supply. To ensure that access to donated organs is fair, equitable, and efficient, the HRSA Division of Transplantation oversees national organ donation and allocation policies and procedures.

The national Organ Procurement and Transplantation Network, operated by the United Network for Organ Sharing (UNOS) under contract to HRSA, works both against the clock and around the clock to match organs as they become available with patients waiting on the national list—58,000 in the fall of 1998. The Network includes the Nation's 275 transplant centers, 63 regional organ procurement organizations, and 160 laboratories involved in tissue matching.

HRSA also contracts with UNOS to maintain the Scientific Registry of Transplant Recipients, which includes detailed information on all recipients of kidney, heart, liver, heart-lung, and pancreas transplants since October 1, 1987. These data include survival rates, which vary by organ and continue to improve. Five-year survival for kidney recipients is currently better than 80 percent.

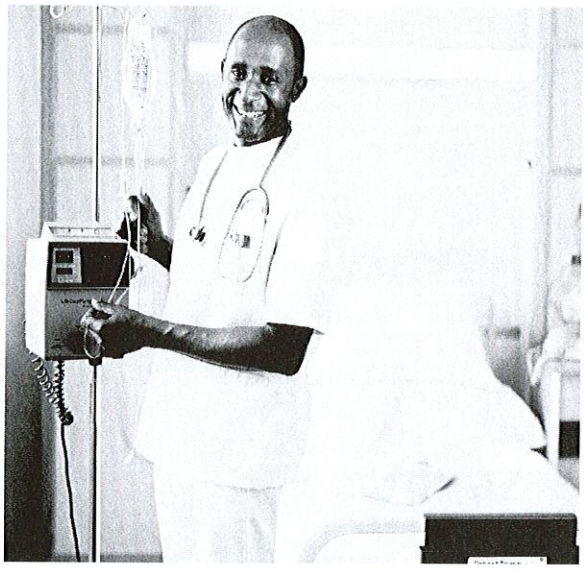
Information on patient outcome and the Nation's 275 transplant centers is published every third year in the national *Report of Center Specific Graft and Patient Survival Rates*. The report helps transplant candidates and their physicians make informed decisions in selecting a transplant center.

To make more organs available for transplant, HRSA conducts national public education campaigns to increase donation, and supports regional organ procurement organizations as they encourage people to make the gift of life. In December 1997, the Department of Health and Human Services launched a National Organ and Tissue Donation Initiative, to work in partnership with medical, legal, business, religious, and service organizations to increase donation.

HRSA also oversees the National Marrow Donor Program, a network of 96 bone marrow donor centers, 114 bone marrow collection centers, 117 transplant centers, 13 donor recruitment groups, and a coordinating center that matches donors with recipients.

FY 1999

Organ, Tissue, and Bone Marrow Donation and Transplantation	**$ 28**	**million**
Health Care Facilities	**$ 65**	**million**
Rural Health Outreach and Telehealth	**$ 75**	**million**
Vaccine Injury Compensation	**$154**	**million**
National Practitioner Data Bank	**$ 12**	**million (user fees)**



The National Marrow Donor Program also studies the effectiveness of bone marrow transplants and related treatments between donors and recipients who are not related to each other.

Because both bone marrow and organ matches can often be better made within the same ethnic group, increasing the number of African American, Hispanic, and Asian American donors is a major focus of both programs.

Health Care Facilities

To assure access to hospitals and other health care facilities, the Federal Government has supported a number of construction grants and loans. HRSA is responsible for monitoring those facilities built under the Hill-Burton Grant and Loan program, which requires recipients to provide a specific amount of free or reduced cost health care to people unable to pay.

Approximately 1,100 facilities were obligated to provide approximately $258 million of free and reduced cost care in Fiscal Year 1998. Over the years, Hill-Burton facilities have provided an estimated $4.5 billion in free and reduced cost services.

HRSA monitors and provides loan management services for 120 remaining Hill-Burton Hospital Construction loans and, on behalf of the U.S. Department of Housing and Urban Development, administers a hospital mortgage insurance program. HRSA also oversees architectural and engineering aspects for 15 other construction programs.

HRSA also awarded and monitored 12 grants at a total of $28 million, for the construction of inpatient, outpatient, research, and bioethics facilities.

Rural Health

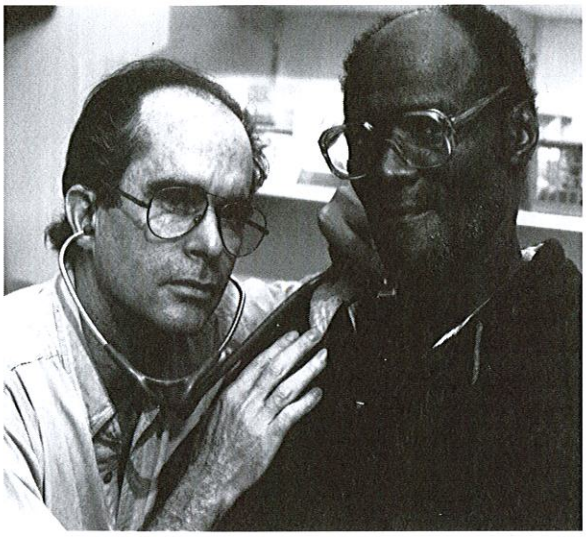
About half of the medically underserved live in rural America. Some are poor and uninsured, but almost all have inadequate access to care for the simple reason that not enough doctors, nurses, dentists, clinics, or hospitals are close enough to meet their routine and urgent care needs.

Rural residents tend to be older and are more likely to be disabled than their suburban and urban counterparts and are susceptible to a constellation of health problems, including occupational injury, exposure to pesticides and other toxins, chronic illness, and depression.

HRSA's rural community health centers and clinics, National Health Service Corps providers placed in rural communities, CARE Act HIV/AIDS programs in rural regions, and rural health professionals training efforts relieve some of the burden of isolation. HRSA programs lighten the load, supporting: 260 rural health outreach programs to take health care into the countryside in 48 States and territories; five rural health research centers—Project HOPE, the University of North Carolina at Chapel Hill, the University of Minnesota, the University of Southern Maine, and the University of Washington; and a matching grant program to establish and maintain State Offices of Rural Health.

Rural communities often lack the critical mass of patients to make the economies of managed care work. How best to adapt managed care to relatively sparse populations and how to link rural health providers by telecommunication technology are at the forefront of HRSA's rural health research.

Rural health outreach is just as innovative: piling all the necessities of prenatal care into a van and delivering physicians and certified nurse midwives to pregnant women so they can deliver healthy babies; working with community elders, who can remember when horses plowed the fields, to set up home-based hospice care; and training paramedics, accustomed to treating trauma, to also prevent accidental injury and illness.



HRSA also supports, in partnership with the U.S. Department of Agriculture, the Rural Information Center Health Service, where professionals, policy makers, and the public can have their questions answered by phoning 1-800-633-7701 or by steering a navigator to http://www.nal.usda. gov.ric/riches.

HRSA maintains a close working relationship with the States through its support of 50 State offices of rural health. These offices provide a focal point within each State for identifying and addressing rural health issues.

National Vaccine Injury Compensation Program

Very rarely, a routine immunization that prevents infectious disease in millions of children inadvertently causes harm. To sustain every child's access to safe and effective vaccines and to compensate and care for those few children and adults who suffer adverse reactions from childhood vaccines, HRSA administers the national no-fault Vaccine Injury Compensation Program (VICP). Physicians from the VICP review the medical records of claimants and make recommendations to attorneys at the Department of Justice as to whether or not specific injuries are eligible for compensation under the Vaccine Injury Table. The Department of Justice represents the VICP before the U.S. Court of Federal Claims, where all claims are adjudicated.

The VICP provides compensation to care for children and adults thought to have been injured by any vaccine recommended by the Centers for Disease Control and Prevention for "routine administration to children." Vaccines covered include diphtheria, tetanus, pertussis (DTP, DTaP, DT, Td or TT), measles, mumps, rubella (MMR or any components), polio (OPV or IPV), hepatitis B, Haemophilus influenzae type b (Hib), and varicella (chicken pox) vaccines.

Now in its 10th year of operation, the VICP has achieved its policy goals of providing expeditious compensation to those injured by rare adverse events, providing liability protection for vaccine manufacturers and administrators, and insuring vaccine market stabilization. The VICP also continues to work with other public and private entities to address national concerns about vaccine risks and benefits, to increase surveillance of vaccine preventable diseases, and to strengthen the national capacity for research and development of safer vaccines.

National Practitioner Data Bank

To assure access to quality health care for all Americans, HRSA oversees the National Practitioner Data Bank, which tracks malpractice and disciplinary actions taken against physicians, dentists, and other health care professionals, then reports that information back to hospitals, health maintenance organizations, and other organizations that employ health care providers.

Before the National Practitioner Data Bank, providers could hide poor practice histories by moving from State to State. Health service providers, professional associations, and State licensing boards, are required by law to report disciplinary actions. Insurers are required to report all malpractice payments.

In turn, hospitals are required to query the Data Bank each time a physician, dentist, or other professional applies for clinical privileges or a medical staff position, and every two years after a professional is hired or granted privileges.

HRSA's National Practitioner Data Bank is the only resource of its kind. Since 1990, it has received nearly 14 million queries from organizations that hire and/or issue credentials to health professionals. The vast majority of the practitioners listed in the Data Bank have only one malprac-

tice claim or disciplinary action against them. More than 6,000 have multiple reports.

Telehealth

To bridge gaps of time and distance that separate individuals and families from needed health care, HRSA promotes telehealth—the use of electronic information and telecommunications technologies to diagnose and treat patients.

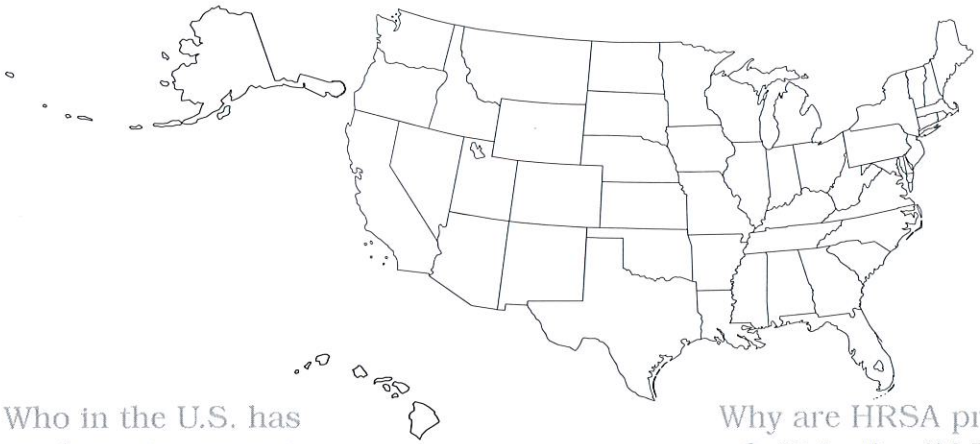
As technology becomes both more widespread and more sophisticated, HRSA expects telehealth to bridge health care gaps in both rural regions and urban areas. HRSA supports 34 telemedicine demonstrations that allow providers and patients to "meet and treat" long distance.

HRSA also uses technology to facilitate knowledge exchange among the Agency's many programs that provide care for underserved people. The Agency develops telehealth policy and programs, provides technical assistance to health care providers, State, and local health officials, and produces public health education tools.

Minority Health

African Americans, Hispanic Americans, Native Americans, and Asian and Pacific Islanders, are beneficiaries of all HRSA programs. They are more likely to be underserved and to suffer the health consequences of disadvantage at the same time that their risk for a number of chronic conditions, such as diabetes and hypertension, is higher than for other Americans.

For these reasons, the HRSA Office of Minority Health works in partnership with historically black colleges and universities and with the National Association of Hispanic-Serving Health Professions Schools, tribal colleges and universities, constituent groups, and others in the public and private sectors to redress the under-representation of minorities in health professions and to address the special health needs of racial and ethnic minorities to eliminate disparities and improve health.



Who in the U.S. has inadequate access to health care?

- 43.2 million Americans live where access to primary health care is inadequate
- 75 million Americans live at or below 200 percent poverty (1996 poverty threshold: $16,036 for a family of four)[1]
- 23 percent of the U.S. population is African American, Hispanic, American Indian, or Alaska Native. About 10 percent of the health professions work force comprises these underrepresented minorities (1996)

How is HRSA helping them?

- 746 community and migrant health centers
- 128 health care programs for the homeless
- 22 health care programs for residents of public housing
- 60 Healthy Start programs to reduce infant mortality
- 40 health professions training programs
- 2,298 National Health Service Corps providers

What support does HRSA give to underserved Americans?

- $1 billion for community/rural health in FY 1998
- $1.1 billion for HIV/AIDS services in FY 1998
- $791 million for maternal/child health in FY 1998
- $290 million for health professions training in FY 1998

Why are HRSA programs needed?

- 39.1 million (16.5 percent) Americans younger than 65 have no health insurance (1995)[1]
- More than 10 million (14 percent) Americans age 15 and younger have no health insurance (1995)[1]
- 30,000 American infants die before their first birthday.
- The U.S. infant mortality rate, 7.2 per 1,000 live births (1996)[2], ranks 25th worldwide (1993)[3]
- 26.5 percent of American children have not recieved the combined series immunizations recommended by the Centers for Disease Control and Prevention (1994)[3]
- Between 650,000 and 900,000 Americans are living with HIV/AIDS (1997)[4]
- 57,947 individuals are on the national list waiting for an organ for transplant (August 1998)

[1]
[2]U.S. Census; Poverty in the U.S., 1996
[3]CDC; Monthly Vital Statistics Report, Vol 46, No. 1
[4]CDC; Health, United States, 1996-1997
CDC; HIV/AIDS Surveillance Report