HRSA Profile 1996

HRSA
Health Resources & Services Administration

Profile 1996

HRSA Profile—FY 1996

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List of Acronyms

AAR	Annual Aggregate Reporting
ACCESS	Accelerated Communication Electronic Service System
ACCV	Advisory Committee on Childhood Vaccines
ACF	Administration for Children and Families
ACYF	Administration for Children, Youth, and Families
AETC	AIDS Education and Training Centers
AHEC	Area Health Education Centers
AIDS	Acquired Immune Deficiency Syndrome
ALF	Agricultural Library Forum
AMCHP	Association of Maternal and Child Health Programs
APO	AIDS Program Office
ASTHO	Association of State and Territorial Health Officials
BHPr	Bureau of Health Professions
BHRD	Bureau of Health Resources Development
BPHC	Bureau of Primary Health Care
CARE	Comprehensive AIDS Resources Emergency Act
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CHA	Community Health Advisor
CHC	Community Health Centers
CHOICES	Children's Health Care Options Improved Through Collaborative Efforts and Services
CII	Childhood Immunization Initiative
CISS	Community Integrated Services Systems
C/MHC	Community and Migrant Health Centers
CMO	Chief Medical Officer
COE	Centers of Excellence
COGME	Council on Graduate Medical Education
CQI	Continuous Quality Improvement
CSAP	Center for Substance Abuse Prevention
CSHCN	Children With Special Health Care Needs
CSN	Children's Safety Network
DDA	Division of Disadvantaged Assistance
DFL	Division of Facilities and Loans
DHHS	Department of Health and Human Services
DHS	Division of HIV Services
DN	Division of Nursing
DOT	Division of Transplantation
EMA	Eligible Metropolitan Area
EMS	Emergency Medical Services
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
FY	Fiscal Year
FOH	Federal Occupational Health
FQHC	Federally Qualified Health Center
GAO	Government Accounting Office
GHAA	Group Health Association of America
GMPAT	Grants Management Process Action Team
GPRA	Government Performance and Results Act
GSA	General Services Administration
HBCU	Historically Black Colleges and Universities
HCFA	Health Care Financing Administration
HCH	Health Care for the Homeless
HCOP	Health Careers Opportunity Program
HEAL	Health Education Assistance Loan Program
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development
INS	Immigration and Naturalization Service
IOM	Institute of Medicine
ISN	Integrated Service Network
ITPAT	Information Technology Process Action Team
MCAP	Managed Care Assistance Program
MCH	Maternal and Child Health
MHI	Minority Health Initiative
NACHO	National Association of County Health Officials
NACNEP	National Advisory Council on Nurse Education and Practice
NGA	National Governor's Association
NHSC	National Health Service Corps
NIH	National Institutes of Health
NMDP	National Marrow Donor Program
NPDB	National Practitioner Data Bank
NPR	National Performance Review
OA	Office of the Administrator
OASH	Office of the Assistant Secretary for Health
OC	Office of Communications
OEOCR	Office of Equal Employment and Civil Rights
OIHA	Office of International Health Affairs
OMB	Office of Management and Budget
OMH	Office of Minority Health
OOM	Office of Operations and Management
OPC	Office of Policy Coordination
OPD	Office of Program Development
OPEL	Office of Planning, Evaluation, and Legislation
OPHP	Office of Public Health Practice
OPO	Organ Procurement Organization
OPTN	National Organ Procurement and Transplantation Network
ORHP	Office of Rural Health Policy
OSE	Office of Science and Epidemiology
PCA	Primary Care Association
PCDS	Primary Care Delivery Site
PCO	Primary Care Office
PHPC	Public Housing Primary Care
PHS	Public Health Service
PIC	Partnership for Information and Communication
PLWH	People Living With HIV/AIDS
PSA	Public Service Announcement
REGO II	Reinventing Government Part II
RICHS	Rural Information Center Health Services
SAMHSA	Substance Abuse and Mental Health Services Administration
SHCC	Shriner's Hospitals for Crippled Children
SPNS	Special Projects of National Significance
SPRANS	Special Projects of Regional and National Significance
S/RPCA	State and Regional Primary Care
TAC	Technical Advisory Committee
TAG	Technical Assistance Group
USCLHO	U.S. Conference of Local Health Officers
USDA	U.S. Department of Agriculture
VICP	National Vaccine Injury Compensation Program
WIN	Women's Initiative

Administrator's Message

The programs administered by the Health Resources and Services Administration (HRSA) are designed to improve the health of the Nation by:

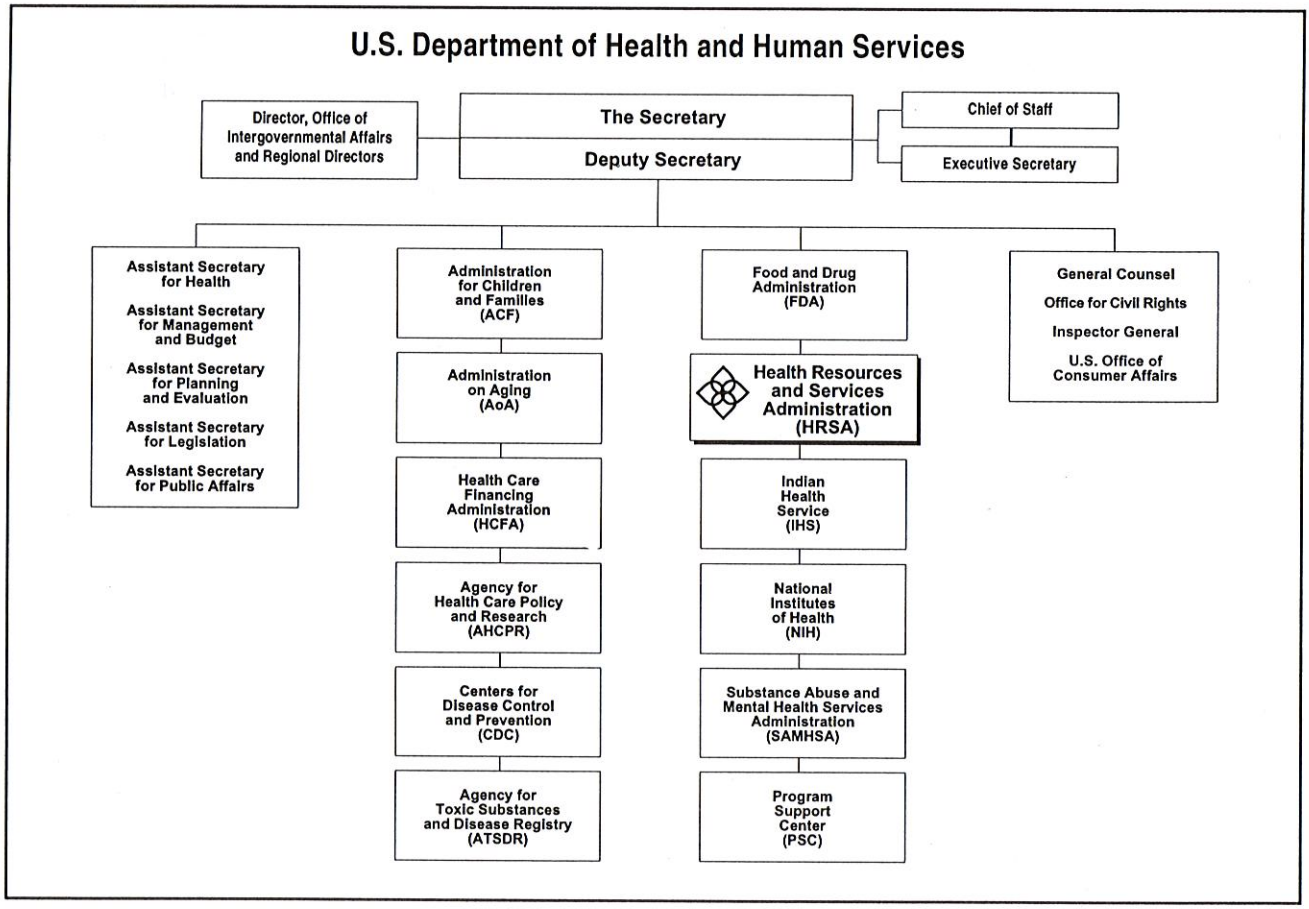
- Assuring that quality health care is available to underserved and vulnerable populations
- Promoting primary care education and practice.

HRSA, in providing national leadership in health care and public health, believes that health care is a right. The diversity of programs supported by HRSA reflects this philosophy and unity of purpose.

This *HRSA Profile* is intended to provide an overview of the Agency and its specific program activities that contribute to the achievement of its mission. As an annual chronicle, the *HRSA Profile* also describes recent program accomplishments and new activities initiated in response to emerging needs. It is important that the *HRSA Profile*, which has served as a major reference document on the Agency, not only outline the major components and activities of the Agency, but also report on the context and changes taking place within the Agency.

The *HRSA Profile* is organized into three sections. The *Program Overview* describes the accomplishments and program activities of the HRSA Office of the Administrator (OA) and each of HRSA's four Bureaus—Bureau of Primary Health Care (BPHC), Bureau of Health Professions (BHPr), Bureau of Health Resources Development (BHRD), and Maternal and Child Health Bureau (MCHB). *Cross-Cutting Activities* describes important areas being supported by multiple programs and Bureaus within HRSA. The *Appendices* provide several reference resources, including information on HRSA legislative authorities, appropriations, and staff names and telephone numbers. As HRSA Administrator, I believe the programs described on the following pages will provide you with a profile of our organization, which is committed to service toward a healthier America for all.

Fiscal year 1995 was not "business as usual" for HRSA. It is undisputed that the past 20 months have seen volatile discussions taking place on assumptions and solutions to government-funded health programs. In this environment, the President, Congress, and public have called upon all



Federal agencies to reassess and even restructure Federal programs to better assure appropriateness of mission and cost-effectiveness of implementation. Reinventing Government Part II ("REGO II"), "downsizing," and "retrenchment of resources" are terms that became part of every agency's vocabulary.

As Administrator of HRSA, I took major steps during FY 1995 to respond to calls for reassessment and reorganization, including a systematic review of the Agency's administrative systems to improve our management and effect greater cost savings; development of a Strategic Plan to succinctly describe the Agency's goals and objectives and specific steps for accomplishing those objectives; and identification of several cross-cutting areas (described in last year's *Profile*), which I believed to be areas that would call upon the strengths of programs in demonstrating HRSA's flexibility and ingenuity in simplifying collaboration and reducing redundancy. I also reemphasized the need for greater innovations in working within retrenched resources to maintain quality and access to care.

As a result of these steps, positive change has taken place. A review of organizational and management structures was initiated and has already resulted in recommendations. A committee known as the Information Technology Process Action Team (ITPAT) was formed to assess and provide recommendations for improving HRSA's use of information technology. Another committee, the Grants Management Process Action Team (GMPAT), was established to evaluate HRSA's grants management process and make recommendations for streamlining and improvement. Recommendations have been presented by both committees to senior staff and myself, based on a continuing quality improvement process. The committees have been authorized to proceed with the recommendations during FY 1996 to develop an implementation plan for the Agency.

HRSA's Strategic Plan was published in January 1995 and is being proactively used to set directions for HRSA and as an instrument for action. For FY 1996, greater effort will be made to look at the programmatic implications of our Strategic Plan, as well as to seek additional guidance from the Department of Health and Human Services (DHHS) and input from the many customers we serve.

After extensive discussions with leadership and line managers within HRSA, I refined and formulated the cross-cutting areas identified in FY 1995 into eight priority areas. Eight Program Priority Committees were established to develop recommendations for consideration by a Steering Committee drawn from HRSA's leaders. In a meeting last fall, each Program Priority Committee made a presentation to the Steering Committee that included recommendations for implementing selected actions. These recommendations are in the process of consideration by the Steering Committee. These program committees demonstrated that by coordination and collaboration, quality initiatives could be started within the framework of existing resources and personnel.

The eight program priority areas are:

Academic-Community Educational Partnerships. To build a culturally competent, diverse, and appropriately educated primary care workforce that responds to community requirements, HRSA can promote large-scale partnerships among academic health centers and community-based service providers, managed care organizations, community hospitals, and rural group practices so that clinical training can take place in community-based sites.

Managed Care. To ensure that vulnerable populations continue to receive care appropriate to their special needs as States increase their utilization of managed care, HRSA can encourage traditional providers of public health services to integrate their services with those of managed care organizations and assist States in monitoring health care access and quality for poor, uninsured, rural, and chronically ill Americans.

State-Based Initiatives. To promote health care services, particularly for underserved populations, as States assume more control over health resources, HRSA can collaborate with State and local agencies to redefine their roles in relation to public health capacity building; offer technical assistance to States for quality assurance and workforce development efforts; and develop innovative methods to promote partnerships with State agencies and enhance State health programming infrastructures.

Community Infrastructure Building. To foster primary care infrastructure building, HRSA can promote the integration of community resources and delivery systems; provide assistance in performing community needs assessments; and disseminate information on replicating successful models for collaborative community efforts and for the training of community health workers.

Telecommunications Technology and Advanced Information Systems. To improve the utility of information systems, HRSA can evaluate potential applications of telemedicine systems and distance-based education for rural providers and clinical training sites; help grantees link their client data with larger data sets; inform communities about Internet access to existing databases; promote the use of management information systems in the field; and help grantees develop technological skills and resources to participate in integrated systems of care.

Border Health. To improve access to care for vulnerable populations in southern border areas, HRSA can continue building health care infrastructures; enhance efforts to

develop an appropriate interdisciplinary health care workforce; and generate innovative methods for recruiting and training community health workers who can address health-related lifestyle and social issues.

Integrated HIV/AIDS Programs. To integrate the broad array of services needed by individuals affected by HIV/AIDS, HRSA can evaluate models of integrated, cost-effective care and disseminate information on successful models; conduct research on integrated service needs, costs, utilization, and access using the newly developed uniform data set for Title I and Title II of the Ryan White Act; and ensure that health care educational curricula include competencies related to HIV/AIDS.

School Health and Adolescents. To bring the school setting into integrated systems of care and to address the growing crisis of adolescent health problems, HRSA can develop school-based and school-linked services that are coordinated with community-based centers; enable children and adolescents to enroll in managed care organizations that provide access to care in school-related settings; and promote access for adolescents to services they are unlikely to find or seek in mainstream settings, such as drug and reproductive health counseling, mental health services, and STD and HIV testing.

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The development and implementation of these priorities will enable HRSA to integrate major policy and program objectives and concerns and more effectively use scarce and precious resources from various legislative authorities.

Some have asked why a Women's Initiative and a Minority Initiative were not included as specific priorities. First, the eight priorities listed above address these significant populations as part of the "underserved and vulnerable" populations already within HRSA's mission. HRSA also believes that these two priorities are overarching and already integral to its goals and that, as a result, each line manager is already held accountable in these two areas. However, HRSA will continue to monitor and review its responsiveness and effectiveness with women's and minority health issues to maximize attention and action throughout the Agency.

These priorities are not to be viewed as another layer of bureaucracy but, rather, as an attempt to facilitate intraorganizational efforts so that HRSA will be an Agency coordinating a variety of activities in support of the communities and States it serves. HRSA commits itself to being an organization working in unity of purpose and diversity of operations to better respond to the health needs of our States, our communities, and our citizens.

This brings us to the future. As the Administrator of HRSA, I continue to be impressed by the diversity of populations we serve, as well as the creativity with which the Agency extends itself to collaborate with a multitude of public and private sectors equally committed to the improvement of public health services. Clearly, it will be the challenge of HRSA to continue to evolve means by which programs can better complement and synergize their activities. To do this, HRSA must and will:

- Serve as a focal point for a new era of innovation in the delivery of health services
- Shepherd a careful transition to ensure that underserved and special populations are included in the design of any reform
- Strengthen its role in developing a body of knowledge related to research in health service delivery, moving from a model of disease management to one of better health supervision and promotion
- Strive to promote decision making and policy formulation based upon professional and scientifically based experiences and community-based responsiveness and relevance
- Because of the retrenched resources of this decade, view itself as a lever for change by wise investment of scarce dollars; by prudent partnerships with foundations, the private sector, and other government agencies; and by maintaining networks of advisors and counselors, representing the grassroots as well as national leadership in health issues.

As it moves toward the 21st century, HRSA enters one of the most challenging eras in assuring the Nation's health. We recognize the challenges before us, but remain convinced that the basic mission and vision of our Agency is valid and purposeful, and will remain intact.

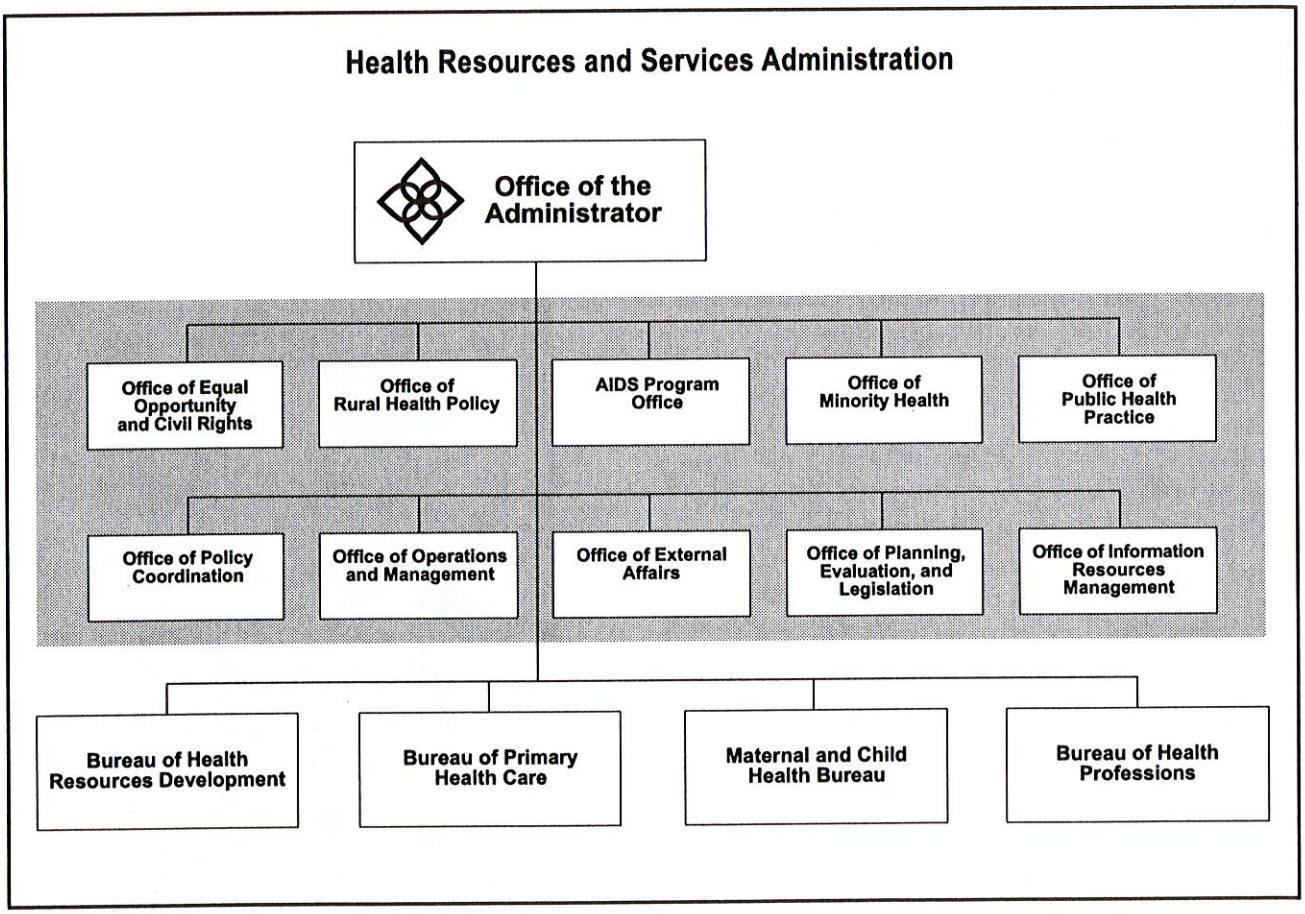
—Ciro V. Sumaya, M.D., M.P.H.T.M.

HRSA Program Overview

HRSA's five major operating components are: Office of the Administrator; Bureau of Primary Health Care; Bureau of Health Professions; Bureau of Health Resources Development; and Maternal and Child Health Bureau. The recent program accomplishments and activities of these components are described in this section.

Office of the Administrator

The Office of the Administrator leads and directs the programs and activities of HRSA, advises the Office of the Secretary for Health and Human Services on policy matters concerning the Agency's programs and activities, and coordinates the Agency's international health activities. The OA is composed of program coordination and administrative offices that support a variety of program activities and provide expertise, advice, and support to the Administrator.



Selected Program Accomplishments

Rural Health

In 1995, the Office of Rural Health Policy (ORHP) announced 26 new Rural Health Services Outreach Grants, bringing the total number of grants awarded under this program to more than 260 in 48 States and territories. A recent survey of the original 100 grantees showed that more than 80 percent were still offering part or all of the services first funded with Outreach Grants.

The six Rural Health Research Centers supported by an ORHP grant program have become the Nation's major source of research into rural health services problems and programs.

HIV/AIDS

With the assistance of the Bureaus, the AIDS Program Office (APO) developed a HRSA Implementation Plan on Zidovudine for reducing perinatal HIV transmission and issued a Program Advisory entitled *Zidovudine Therapy for Reducing Perinatal HIV: Implementation in HRSA-Funded Programs*. The United States Conference of Mayors has been funded to perform an evaluation of HRSA activities to reduce perinatal HIV transmission, which will include case studies in seven geographic areas and a feasibility assessment/evaluation design for data systems.

With the Bureau of Health Professions, the APO also cosponsors a national "warmline" for HIV/AIDS clinical consultation.

Minority Health

The Office of Minority Health (OMH) coordinates HRSA activities related to the White House Initiative for Historically Black Colleges and Universities (HBCUs). In FY 1995, HRSA provided $32,532,377 in support of these activities, including grant awards, contracts, and estimated value of administrative infrastructure and recruitment activities. (See also page 9.)

The OMH has lead responsibility for HRSA's activities under the Executive Order establishing the White House Initiative on Educational Excellence for Hispanic Americans. As part of this involvement, a National Association of Hispanic-Serving Health Professions Schools is being established.

Through HRSA's bilingual assistance program, funding has been provided to three national organizations, which awarded grants to 11 local health departments for projects focused on reducing cultural and linguistic barriers to care among Hispanic and Asian/Pacific Islander populations.

Equal Opportunity and Civil Rights

The Office for Equal Opportunity and Civil Rights (OEOCR) worked closely with the Interamerican College of Physicians and Surgeons and the auxiliary to the National Medical Association to provide learning experiences and orientation to HRSA programs for Hispanic and African American high school and college students.

At the request of the OEOCR, the Chief Medical Officer (CMO) served as host for a meeting of high school and college students under the National African American Youth Initiative. Students were aquainted with HRSA and its programs and recruited for careers in science, health, and government.

Policy Coordination

The Office of Policy Coordination (OPC) has successfully implemented the *HRSA Weekly Report* for the Administrator, which includes input from all Bureaus and Offices. The report is captured on HRSA's e-mail system and can be downloaded and printed.

A page-by-page review of the Code of Federal Regulations (CFR) was made by the four HRSA Bureaus, with OPC guidance and oversight, to determine whether Agency regulations now in force can be eliminated or modified if they are outdated or in need of reform. HRSA determined that a total of 83 pages could be removed from the CFR by withdrawing those regulations not currently in use.

Planning, Evaluation, and Legislation

The process of developing the Agency's Strategic Plan began in June 1994 and continued early in 1995. The final version of the HRSA Strategic Plan was released in January 1995.

A Memorandum of Understanding with the American Hospital Association was signed in order to identify and strengthen collaborative arrangements between HRSA and the hospital industry.

The Office of Planning, Evaluation, and Legislation (OPEL) initiated the development of a policy paper on *New Directions for Health Policy*, which stresses the important role HRSA must take as a Federal agency in ensuring the availability of care for underserved populations.

During the past year, the Second National Conference on Primary Care was concluded, and proceedings are being prepared for distribution.

OPEL is collaborating with BPHC on a large-scale personal interview survey of clients in Community Health Centers (CHCs) that will provide data on the amount and kind of primary and preventive care delivered in CHCs, satisfaction with care, health status, behavioral risk factors, and socioeconomic status. (See also page 9.)

Program Activities

An essential part of ensuring the success of program operations is having systems and processes in place to facilitate their conduct. The program coordination and administrative processes initiated within the OA help provide a reliable infrastructure of people and resources to support the needs of HRSA's programs. These processes also ensure that HRSA's vision for the future is formulated and implemented in a meaningful and practical way.

Chief Medical Officer

The Chief Medical Officer provides clinical consultation and assistance to senior Agency officials on clinical and health professional issues and provides policy direction to ensure that standards of care reflect medical health interventions that most effectively deal with the problems of the populations at risk. The CMO represents the Agency on committees, Department task forces, and work groups related to clinical issues; establishes and maintains communications with professional individuals and organizations in DHHS, and with the public and private sectors concerned with clinical care issues affecting HRSA programs; and is responsible for the oversight of the Agency's clinical quality assurance, clinical quality improvement, and risk management activities.

Rural Health

The Office of Rural Health Policy has a Congressional mandate to coordinate rural health activities within DHHS and advise the Secretary on access to health care in rural communities, recruitment and retention of rural health professionals, and the impact of Medicare and Medicaid on small rural hospitals.

ORHP provides matching grants to help establish and support State offices of rural health, which disseminate information, coordinate rural health activities, and provide technical assistance to rural communities in their respective States. This Office also administers the Rural Health Outreach Grant and the Rural Telemedicine Grant programs, funds rural health research centers across the country, and sponsors the Rural Health Information Center Health Service, an information phone line, through the National Agricultural Library of the U.S. Department of Agriculture (USDA). It also staffs the National Advisory Committee on Rural Health, which recommends policy to the Secretary in annual reports.

HIV/AIDS

The AIDS Program Office coordinates all HIV/AIDS-related activities within HRSA and advises the Administrator on policy, clinical, services, and educational issues relating to the administration of HRSA's HIV/AIDS programs. This Office directs the development and implementation of appropriate HRSA policies regarding HIV/AIDS services. The Office also represents HRSA, the Public Health Service (PHS), and DHHS, and coordinates representation with committees and outside groups regarding policy aspects of clinical, educational, and health services related to issues of HIV/AIDS.

Public Health Practice

The Office of Public Health Practice (OPHP) leads the Agency's efforts to strengthen the practice of public health in the Nation by working with State and local governments, private associations, foundations, schools of public health and preventive medicine, and other organizations to focus attention on and promote solutions to problems that may impair the delivery of public health services, especially as they affect comprehensive primary care to disadvantaged populations. This Office also collaborates with other Federal agencies on public health practice issues and develops and supports specialized programs that enhance the practice of public health.

Minority Health

The Office of Minority Health provides Agencywide leadership for programs and activities that address the special health needs of racial/ethnic minorities, with the goal of eliminating disparities while improving health status. Primary needs include improved access to health care and health promotion systems that are affordable, comprehensive, and responsive; consideration of physical, temporal, structural, financial, and linguistic barriers to care; and promotion of culturally competent approaches to enhance the effectiveness of health service delivery.

Equal Opportunity and Civil Rights

The Office of Equal Opportunity and Civil Rights represents HRSA in dealing with Federal agencies and other organizations on matters relating to equal opportunity, civil rights, and affirmative action. OEOCR manages a system of processing, adjudicating, and resolving complaints of employment discrimination for employees and the Commissioned Corps and prepares final Agency decisions. This Office also implements the Americans with Disabilities Act of 1992, Section 504 of the Rehabilitation Act of 1973, Title VI of the Civil Rights Act of 1964, and the Age Discrimination Act of 1975 as they apply to recipients of HRSA funds, and promotes the award of contracts under section 8(a) of the Small Business Act, which pertains to contracts with small businesses owned by minorities and women.

Operations and Management

The Office of Operations and Management (OOM) leads, directs, and coordinates all aspects of HRSA management, including: administrative, financial, personnel, debt, staffing, grants and contracts, procurement, and real and personal property accountability and management. This Office coordinates the implementation of the Freedom of Information Act, oversees the development of annual operating objectives, and coordinates HRSA work plans and appraisals. The OOM's Office of Field Coordination, established in FY 1995, serves as the focal point for field operations within HRSA and is responsible for managing field activities.

Policy Coordination

The Office of Policy Coordination assists and supports the Administrator in his exercise of leadership and direction, and supplies independent expertise, advice, and technical assistance throughout the Agency. The Office coordinates and monitors the implementation of HRSA policy and administrative priorities and coordinates Agency activities with the Office of the Assistant Secretary for Health, other PHS agencies, DHHS, and other government agencies. OPC manages HRSA's correspondence system and oversees HRSA regulations development and implementation processes. The Office also manages HRSA advisory committees.

Planning, Evaluation, and Legislation

The Office of Planning, Evaluation, and Legislation manages the Agency's strategic and program planning, evaluation, health policy formulation, and legislative affairs. OPEL focuses its efforts on health care reform and innovation, data policy, primary care, prevention activities/Healthy People 2000, and managed care issues. OPEL staff work with the Health Care Financing Administration (HCFA) on reimbursement of services and health professions training.

International Health Affairs

The Office of International Health Affairs (OIHA) is HRSA's principal office for coordinating international activities that include bilateral and multilateral health programs with foreign governments, international organizations, and public and private health groups. Principal program areas include: border health (including tuberculosis, outreach and demonstration programs, and health information systems development); Hansen's disease; health manpower development and training; maternal and child health; HIV/AIDS; and nursing education. The OIHA administers the World Health Organization's short-term travel fellowship programs for foreign grantees in the health field by providing technical assistance to the fellows and by scheduling placements in such health areas as the environment, public health administration, health care delivery, and research.

External Affairs

The Office of External Affairs plays the principal role in representing the Agency with leaders and top officials of a variety of public- and private-sector organizations concerning health programs and activities related to health service delivery. It recommends strategies for enlisting external collaboration or support for HRSA programs and maintains relationships with organizations to enhance overall effectiveness of the Agency. It works with the Bureaus and Offices to coordinate messages and initiatives with external groups. It also represents HRSA in intergovernmental activities on the Federal, State, and local levels and addresses issues of policy and program directions. The Office also alerts the Administrator on external events that may have direct impact on HRSA programs.

Within the Office of External Affairs, the Office of Communications (OC) serves as the communications and public affairs office for HRSA, including establishing and maintaining productive relationships with the media. This Office coordinates HRSA communications activities with other DHHS agencies and with regional, State, local, voluntary, and professional public- and private-sector organizations.

The Women's Health Coordinator is the primary HRSA advisor and advocate on women's health issues and works with other government agencies, as well as public and private organizations, to promote opportunities for partnerships to improve health care access and health status for women. A HRSA Women's Health Coordinating Committee, under the Coordinator's leadership, plays a crucial role in shaping the Agency's women's health priorities and developing strategies for improving its response to women's health issues.

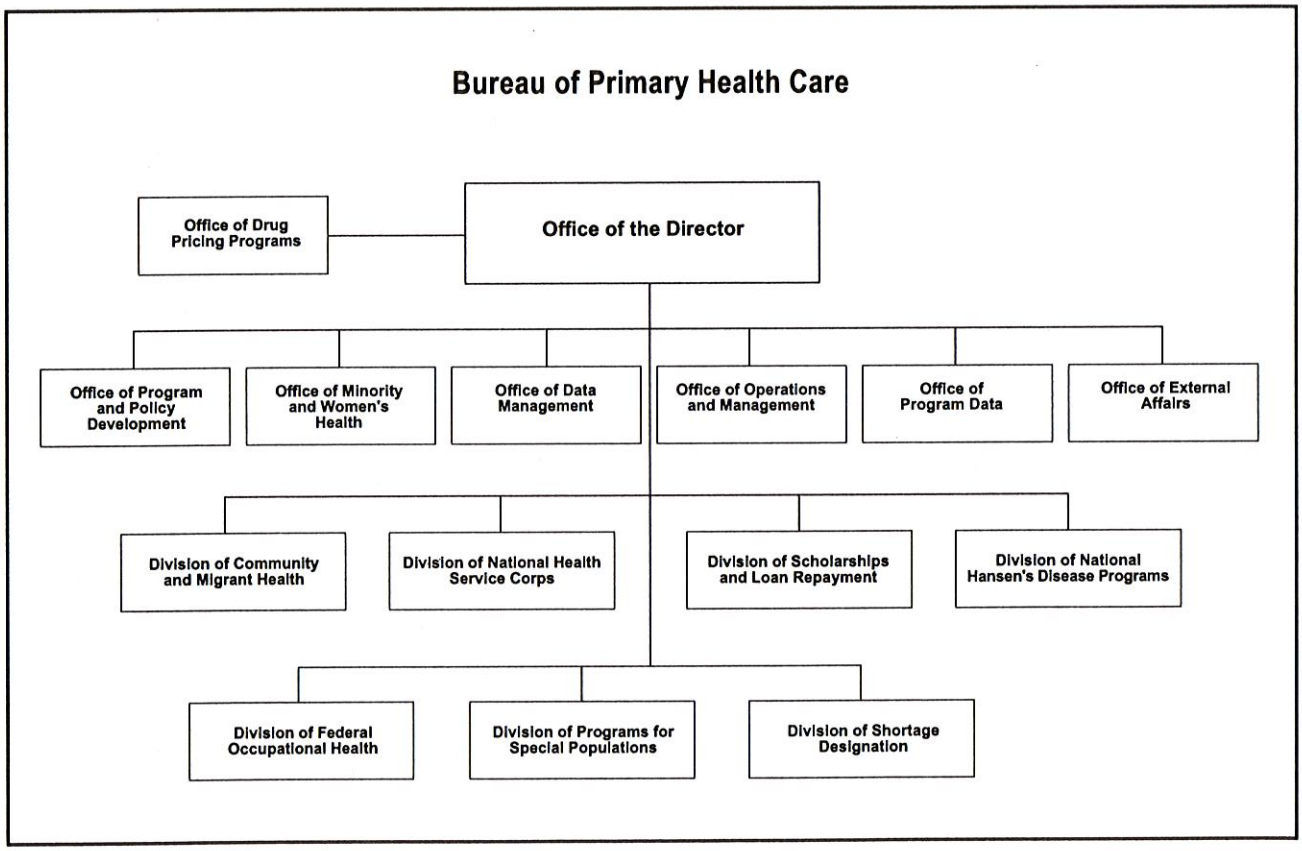
Information Resources Management

The Office of Information Resources Management (OIRM) manages a HRSA-wide data administration program by formulating and administering information resource management policies consistent with policies of the PHS, DHHS, Office of Management and Budget (OMB), General Services Administration (GSA), and Government Accounting Office (GAO). OIRM also establishes system architecture and technical standards for HRSA; builds and maintains the Administrator's Executive Network; and ensures linkage with HRSA, DHHS, and other networks.

Bureau of Primary Health Care

The Bureau of Primary Health Care strives to increase access to comprehensive primary and preventive health care and to improve the health status of underserved and vulnerable populations. In particular, BPHC programs focus on reducing gaps in health status for low-income and minority populations.

BPHC-supported providers and systems of care stress identification of communitywide problems; outreach, education, and preventive services; and reduction of the need for expensive curative care. They focus on community-oriented primary care where public health and personal services intersect to address both population-based and individual health needs. Over the years, BPHC-supported programs and providers have demonstrated their commitment to help communities and the people in the communities take responsibility for their health. Because of their dedication to serving their communities, primary care centers and providers ensure that access to high-quality, cost-effective care is made available to all, regardless of their financial or health status.



Selected Program Accomplishments

Managed Care and Financing

Currently, 157 Community and Migrant Health Centers (C/MHCs) report participating in managed care arrangements, with a total of 566,000 enrollees, a 30 percent increase from the previous year. The number of managed care training sessions increased from 50 in FY 1994 to 120 in FY 1995; the number of managed care contract reviews increased from 50 to 110.

Systems Development

From FY 1989 to FY 1994, the BPHC identified and recommended to HCFA approximately 100 centers for designation as Federally Qualified Health Center (FQHC) Look-Alike organizations that provide health care to approximately 800,000 medically underserved individuals.

In FY 1994, the C/MHC program awarded operation grant funds resulting in the creation of 41 new service delivery sites. The Bureau also awarded funding to 27 school-based clinics as part of the Healthy Schools, Healthy Communities Initiative.

To assist grantees in addressing the challenges of providing care to underserved persons through managed care arrangements, the Bureau initiated the Integrated Service Network (ISN) supplemental grant program during 1993. In FY 1994, $5.7 million were awarded to 29 ISNs.

A *Models That Work* symposium was held in January 1996 to identify groups that deliver quality primary health care to underserved populations in creative and effective ways. The five winning programs will replicate their models in communities across the Nation.

Quality of Care

Staff of the Hansen's Disease Center in Carville, Louisiana, developed a program for the reduction of lower-extremity amputations that could be implemented by community health centers. This program is a self-contained kit of prevention materials with instructions on identifying patients at risk and providing them with the knowledge and ability to prevent ulcers and amputations.

Management Improvement

To ease the paperwork burden on care providers, a new single grant application was developed in 1994 to allow submission of standardized information. This application, which has been distributed to current and potential grantees, can be used for seven grant programs.

The ACCESS (Accelerated Communication Electronic Service System) toll-free bulletin board was established to provide current information on policies, upcoming meetings, legislative actions, and other issues of interest to grantees, program applicants, National Health Service Corps (NHSC) health professionals, loan and scholarship recipients, and the general public. ACCESS users can communicate with each other in a public forum and will soon be able to access some BPHC program databases.

Improved Health Outcomes

In a National Survey of Patient Experiences in Community and Migrant Health Centers, 96 percent of users reported being either satisfied or very satisfied with their care, and 97 percent indicated that they would recommend the centers to family and friends. (See also page 5.)

National Health Service Corps

Today, 3.8 million people who would otherwise lack access are receiving high-quality primary care from more than 2,225 dedicated NHSC professionals. For the 1994-1995 school year, 429 NHSC scholarships were awarded, and 220 were awarded in 1995-1996.

Retention of NHSC providers beyond their service obligations has improved markedly, from 39 percent in 1991 to 53 percent in 1994.

Health Care for the Homeless and Public Housing Primary Care

Administrative tools were developed for use in conducting baseline assessments of 15 Public Housing Primary Care (PHPC) programs. Under the BPHC-HBCU initiative, Clark-Atlanta University and Chicago State University were funded to work with PHPC programs in their communities to pilot the Community Resource Prevention Model developed by the Quality Education for Minorities Network to promote violence prevention activities.

Federal Occupational Health

HRSA's program on Federal Occupational Health (FOH) was chosen as the DHHS candidate for participation in the National Performance Review (NPR) Franchising Group, becoming one of six governmentwide franchising experiments endorsed by the NPR. The FOH was elected because it is an entrepreneurial service program using reimbursements from its client Federal agencies instead of a direct appropriation, and competes with other public- and private-sector occupational health providers for Federal agency occupational health business.

Revenue growth is one measure of customer satisfaction. The FOH revenues were $52 million in FY 1992, $66 million in FY 1993, $77 million in FY 1994, and $81 million in FY 1995; FY 1996 revenues have been projected at $88 million.

The goals of the BPHC include:

- **Building Systems of Primary Health Care**—supporting Community and Migrant Health Centers, Health Care for the Homeless, Primary Care for Residents of Public Housing, HIV Early Intervention, and other programs for populations with special health care needs.
- **Supporting Innovative Service Delivery**—demonstrating new and innovative approaches for delivering health care and related services to those populations at highest risk for poor health outcomes.
- **Recruiting and Retaining Primary Care Providers**—administering the National Health Service Corps programs, including scholarships and loan repayments; developing sites; preparing students for service in underserved areas; and placing and overseeing health professionals in shortage areas.
- **Becoming Partners With States**—collaborating with States through a coordinated strategy, including support in every State via Primary Care Offices and Primary Care Associations that represent community-based providers of care to underserved populations.
- **Identifying Needs**—designating Medically Underserved Areas or Populations and Health Professional Shortage Areas, which are used to determine eligibility for Federal resources and special reimbursement status.
- **Increasing Access**—ensuring a full range of services for medically underserved people by collaborating with Medicare, Medicaid, and other payment sources, as well as with States and localities.

Program Activities

The BPHC has a long history of community empowerment and cultural diversity, offering a unique framework that can be utilized to provide high-quality, community-based, comprehensive, and culturally sensitive health care, as well as to quickly implement special initiatives.

Collectively, at an annual investment of $800 million, BPHC programs support a network of over 700 health delivery organizations and 2,500 sites serving over 9.5 million people. Within these organizations and delivery sites, there are over 4,500 primary care practitioners—1,900 of them National Health Service Corps providers. These programs emphasize prevention, early detection, and timely intervention, and deal with front-line public health crises such as AIDS, substance abuse, teenage pregnancy, violence, infant mortality, and inadequate childhood immunization. They are located in areas where these conditions are exacting the highest toll, helping to stabilize and upgrade otherwise depressed urban and rural areas by generating jobs, assuring the presence of health professionals and facilities, and doing business with local suppliers.

In the wake of new challenges and changing internal and external environments, BPHC is continually rethinking its programs, operations, and planning efforts. Internal strategic planning has led to the formulation of six cross-cutting priority areas—Managed Care and Financing; Systems Development; Quality of Care; Retention and Recruitment; Management and Improvement; and Improved Health Outcomes—that will be used to gauge the ongoing progress in accomplishing its mission and goals.

External factors continue to influence BPHC's program planning and priorities. These programs are the only comprehensive, community-based Federal programs designed to overcome financial, geographic, and cultural/organizational barriers to health care access at the community level. As such, they are an essential part of the Nation's safety net for underserved and vulnerable populations. However, this safety net is increasingly strained by access problems such as financial, geographic, organizational, and cultural barriers. For example, a significant proportion of the U.S. population still cannot afford to pay for care. In just 3 years, the number of persons not covered by public *or* private health insurance jumped from 37 to 41 million. Many of those with private insurance remain underinsured for primary and preventive care. Medicaid, the Federal/State program providing insurance for low-income populations, covers only 33 million people (or 46 percent of those living below 200 percent of the poverty level), and coverage varies from a high of 82 percent in Rhode Island to a low of 25 percent in South Dakota and Utah.

The growth of managed care has not significantly improved access to health care for underserved populations. While participation by private primary care physicians in the Medicaid program has improved in response to the growth in managed care, uninsured low-income persons remain largely unserved by the private sector. Managed care organizations have not resolved concerns regarding access issues and low provider participation, and do not serve the uninsured. Further, private hospitals increasingly transfer uninsured patients to public facilities.

Planning With States and Localities to Increase Access

While the community-based nature of BPHC programs is one strength, States and localities are important partners in building a primary care infrastructure. They contribute

to Federal programs and provide and support primary care. Through the collaborative efforts of BPHC-supported State Primary Care Offices (PCOs) and State Primary Care Associations (PCAs), a Primary Care Access Plan is being developed in each State. These plans identify the areas lacking primary care services. For the first time, it will be possible to identify the location and capacity of all Federal, State, and local programs addressing medical underservice. Further, the plans recommend how needs can be met by drawing on a spectrum of Federal, State, and local resources. For areas recommended as high priority for Federal intervention, BPHC can then target technical assistance to develop a program to meet the community's needs. The solution could be a new health center, a nonfederally-funded NHSC site, provider placement, or expansion of an existing program.

BPHC currently supports 52 cooperative agreements with PCOs and 39 State and Regional Primary Care Associations (S/RPCAs) covering 50 States, the District of Columbia, and Puerto Rico. The State PCOs are units of State government that convene, advocate for, and coordinate primary care activities. The PCOs bring to the table other State organizations, such as the Medicaid Agency, whose programs impact on primary care access of underserved populations.

The PCAs are nonprofit organizations representing Bureau-supported and similar Primary Care Delivery Sites (PCDSs). PCAs facilitate communication among centers and between PCDSs and States, and advocate for primary care at the State and local levels. PCAs facilitate communication between State activities—maternal and child health, State and local health department programs, HIV services—and the PCDSs.

PCOs and PCAs plan for primary care resources; assist PCDSs in working together on State issues; promote the support and involvement of city and county health departments and other State agencies in comprehensive, community-based primary care; provide and arrange for training and technical assistance; and provide and/or arrange for shared services and joint purchasing. PCOs and PCAs are partners with BPHC and are integral to the achievement of all BPHC goals.

Developing Capacity for Managed Care

The venue for health care reform has shifted almost entirely to the States, already very active in the managed care arena. Thus, we can expect additional incentives for managed care and greater flexibility for States, as well as continuing consolidation of the private health sector.

States have a major interest in predictable budgets and Medicaid cost containment. Therefore, some State plans for managed care and health care reform are supportive of programs for the underserved; others offer limited protection for providers of care to those with low income and the underserved. The instrument of choice for implementing Medicaid managed care is the 1115 waiver, which offers broad authority to restructure eligibility and narrow provider choice. Up to 20 States are expected to have 1115 waivers by the end of 1995.

Unfortunately, 1115 waivers do not guarantee that the basic health care needs of the underserved will be met by the State plan. This is because States lack sufficient primary care capacity. Therefore, preparing our programs for managed care and helping them participate in emerging managed care organizations through technical assistance, training, and network development continues to be a high priority.

A Managed Care Assistance Program (MCAP) has been in place for several years. This program is designed to ensure that:

- Federally Qualified Health Centers—including Community and Migrant Health Centers, homeless and public housing programs, and NHSC providers—participate effectively in managed care programs
- State Medicaid agencies include and adequately reimburse FQHCs in managed care programs
- Patients can continue to receive services from BPHC programs and providers under Medicaid managed care.

Drawing upon the expertise of senior executives from the managed care industry, the MCAP is oriented towards enhancing understanding, upgrading staff skills, developing appropriate operational and data management structures, and helping health care providers operate and participate in managed care programs at the local and State levels. It is also designed to encourage and support new collaborative efforts involving FQHCs, private-sector providers, and State and local agencies to give people in underserved areas continued access to quality care and to expand the managed care capacity in underserved areas.

Specifically, the MCAP provides training and technical assistance to BPHC-supported programs to enable them to successfully complete and carry out their mission in the changing health care arena. One hundred twenty-five training sessions had been offered by the end of calendar year 1995, and it is anticipated that all 700 grantees will be offered training. The training sessions provide skill building in managed care techniques (e.g., Medical Management for Managed Care, Negotiating a Managed Care Contract, Marketing, and Network Operations). In addition, through MCAP, one-on-one onsite technical assistance is provided to centers by Health Maintenance

Organization (HMO) executives; self-assessment manuals are developed to assist centers in preparing for managed care; activities are supported to assist centers in developing networks; and close collaboration is maintained with HCFA to review and comment on State Medicaid waiver requests and recommend policy positions and solutions to issues.

Community and Migrant Health Centers

Grant support for C/MHCs is used to fund 627 community-based systems of health care with 1,615 delivery sites. These systems provide access to comprehensive, high-quality, case-managed, family-based primary health care services to populations living in both urban and rural medically underserved areas.

Besides providing primary and preventive health services, C/MHCs case-manage specialty and inpatient care and serve as a link to other health-related services, including substance abuse and mental health. They integrate public health and primary care by offering a full range of enabling services that help people use the system effectively.

Of the approximately 8 million individuals receiving services through C/MHCs, the majority are poor racial/ethnic minorities. Forty-four percent are infants, children, and adolescents, and 30 percent are women of childbearing years. Seventy-eight percent of C/MHC users are either Medicaid recipients or uninsured.

Within the C/MHC program, the Comprehensive Perinatal Care Program and Special Infant Mortality Reduction Initiatives have been designed to improve pregnancy outcomes and the health status of underserved women and infants, including the prevention of infant mortality. In addition, migrant and seasonal farm workers, who are rarely insured through public or private means and face environmental hazards, are singled out for special attention through the Migrant Health Program.

Health Care for the Homeless Program

A total of 132 Health Care for the Homeless (HCH) grantees, located in 48 States, the District of Columbia, and Puerto Rico, are serving approximately 420,000 homeless persons, children, and families annually through more than 500 delivery sites. Services include primary care, substance abuse treatment, case management, and eligibility assistance. These services are delivered through varying models of care, including treatment sites located in areas where homeless people congregate, mobile medical units and medical teams, and shelter-based clinics.

Fifty-two percent of the individuals served by HCH are minorities, and 17 percent are children and adolescents. Ten of the HCH programs are designed specifically to meet the needs of homeless children and children at imminent risk of homelessness.

Public Housing Primary Care Program

The Health Care to Residents of Public Housing Program was developed to improve the health status of residents of public housing by overcoming obstacles to participating in primary care and health promotion. Services offered as part of this program include health screening, health counseling and education, and assistance with entitlement eligibility programs. Outreach, referral, and resident training are included as an integral part of the program to address the needs of the residents.

Currently, there are 22 community-based primary care organizations participating in this program, providing services to approximately 110,000 residents of public housing. Over half of the program's users are children below age one, and 93 percent of the program's users are minorities.

Federally Qualified Health Centers

C/MHC, HCH, and Public Housing grantees are automatically eligible for a cost-based reimbursement rate from Medicare and Medicaid under the Federally Qualified Health Center program. The BPHC also reviews applications from centers seeking to qualify as FQHC "Look-Alikes" because they meet the statutory requirements for these programs but do not receive grant funding. Over 100 organizations have been recommended to HCFA and, as a result, receive the benefits of cost-based reimbursement along with BPHC programs.

National Health Service Corps Programs

The NHSC works with communities and States to address uneven distribution of health care professionals throughout the country. Through the NHSC, primary care physicians, nurse practitioners, certified nurse midwives, physician assistants, dentists, and mental health professionals are recruited and placed in areas designated as Health Professional Shortage Areas (HPSAs) of greatest need. Health professions students receive scholarships and graduates are assisted in repaying their student loans. In return for every year of financial support they receive, graduates are obligated to provide a year of service in inner cities or remote rural areas, with a 2-year minimum obligation.

While a number of States have complementary health care placement programs, the NHSC is often the only source of providers of care for people in communities with high rates of infant mortality, poverty, substance abuse, and other problems. Federal programs and other primary care systems, such as ambulatory primary care clinics of local health departments, rely upon the NHSC to assist in the recruitment of culturally competent, community-responsive primary health care professionals.

The NHSC field strength of 1,930 is reflective of recent increases in program resources after a significant decline in scholarship funding in the 1980s. It includes 345 scholars, 1,122 loan repayers, 337 State loan repayers, and 11 State community scholars. The field strength is 61 percent physicians and 39 percent other disciplines. Approximately 60 percent of NHSC scholars and loan repayers are placed in rural areas, while 40 percent serve in urban areas.

In 1994, 429 NHSC scholarships were awarded, of which 189 were for allopathic physicians, 64 for osteopathic physicians, 43 for nurse practitioners, 124 for physician assistants, and 9 for certified nurse midwives.

The NHSC Loan Repayment program repays up to $35,000 of health professional education loans per year for primary care practitioners who are ready to serve in federally designated HPSAs. In FY 1994, 536 loan repayment awards consisted of 217 allopathic physicians, 75 osteopathic physicians, 91 dentists, 46 nurse practitioners, 88 physician assistants, and 19 certified nurse midwives. During FY 1995, $48 million in NHSC loan repayment funding was awarded to 402 medical, 95 dental, and 189 other health professionals.

State Loan Repayment Program

The State Loan Repayment Program provides support to States to sponsor repayment agreements with primary care practitioners in federally designated shortage areas. During FY 1995, 29 States sponsored 175 new health care professionals through State loan repayment programs. A total of 543 repayment agreements were in force during FY 1995.

The Community Scholarship Program, through Federal-State-local partnerships, awards grants to sponsor scholarships for medical, physician assistant, nurse practitioner, and nurse midwife students committed to returning to serve the sponsoring community located in a health professional shortage area. The program currently has awarded grants to 28 States.

Ryan White Title III(b) Program

The HIV Early Intervention Services Program was designed to increase the capacity and capability of ambulatory care facilities to provide early intervention services as part of a continuum of HIV prevention and care services. The services provided for HIV-infected clients include antiretroviral therapies, prophylaxis for opportunistic infections, and standard and investigational therapies for clinical manifestations of HIV infections/malignancies, as part of ongoing case management and medical and psychosocial care.

Ryan White Title III(b) supports 144 programs which provide mainly primary care services to more than 80,000 clients at nearly 500 service delivery sites. Over 60 percent of these clients represent minorities, 87 percent have family incomes less than 200 percent of the poverty level, and 81 percent are ages 20 to 49. Supportive services offered most frequently to HIV-positive patients include nutritional and mental health counseling and substance abuse counseling and treatment.

Integrated Primary Care and Substance Abuse Treatment Demonstration Program

In FY 1995, the Integrated Primary Care and Substance Abuse Treatment Demonstration Program continued its interagency agreement with the Center for Substance Abuse Treatment within the Substance Abuse and Mental Health Services Administration (SAMHSA). Five programs will provide primary care, HIV services, substance abuse treatment, and mental health care. These organizations are to provide comprehensive health and drug treatment services to injection drug users, their sexual partners, and family members.

Healthy Schools, Healthy Communities

The Healthy Schools, Healthy Communities Initiative was established in 1994. The program funds 27 school-based clinics around the country, in both urban and rural areas. These centers, which have strong community-based support, provide comprehensive onsite primary care services at schools, including diagnosis and treatment of acute and chronic conditions, preventive health services, mental health services, and preventive dental services.

The school-based health centers are located in areas where students are at high risk for poor health, school failure, homelessness, and other consequences of poverty. The 27 centers have the capacity to serve 24,000 children from kindergarten through grade 12, as well as some Head Start children.

Native Hawaiian Health Care Program

Native Hawaiians suffer from the same diseases that are the principal causes of death and illness among other residents of Hawaii and all U.S. citizens, except that they are more acutely affected. The Native Hawaiian Health Care Program seeks to improve the health status of Native Hawaiians through the provision of culturally appropriate and comprehensive health promotion, disease prevention, and primary care services.

In FY 1994, approximately $3.5 million was awarded to five Native Hawaiian Health systems, and to Papa Ola Lokahi, in support of planning, technical assistance, and other activities. These health systems serve approximately 16,000 Native Hawaiians across the Hawaiian Islands.

Pacific Basin Health Initiative

The Pacific Basin Health Initiative was implemented in 1987 to target specific health problems, assist in the development of health systems, increase prevention activities, and provide a coordinated response to the health service and health system needs in the six U.S.-associated Pacific jurisdictions.

Eleven projects were funded in FY 1994, representing a broad range of health care infrastructure development activities, including health education, health professions training, and health planning. Also funded in FY 1994 was a project designed to build capacity for evaluation activities among the Pacific jurisdictions and in health-related projects.

Alzheimer's Demonstration Grant Program

The Alzheimer's Demonstration Grant Program was established to demonstrate the effective identification, utilization, and coordination of appropriate respite care to families and provide supportive services to individuals with Alzheimer's disease or related dementias. Special attention is given to difficult-to-reach and underserved populations.

In FY 1994, approximately $4.9 million was awarded to 13 States, Puerto Rico, and the District of Columbia. Through 147 agencies, direct services were provided to almost 2,000 persons. Another 100,000 persons benefited from Alzheimer's education programs.

National Hansen's Disease Program

The National Hansen's Disease Program cares for 3,000 of the approximately 6,000 people with this condition in the United States. Hansen's Disease is an infectious disease caused by *Mycobacterium leprae* that affects the skin, nerves, and eyes. Without proper treatment, muscle deformity, bone infection, paralysis, and blindness can occur.

HRSA operates the Gillis W. Long Hansen's Disease Center in Carville, LA, and the Regional Ambulatory Care program at 10 clinics throughout the country. The Center also conducts research to reduce tuberculosis transmission through the development and screening of new drugs to treat multiple drug resistant strains of the disease.

Federal Occupational Health Program

As part of the Federal Government's interest in the health of its employees, the Federal Occupational Health program provides a variety of occupational health services and consultation to 107 Federal agencies. These services help Federal managers to increase productivity, decrease health care liability, enhance employee well-being, and improve work environments.

At the close of FY 1994, FOH was providing basic clinical and wellness/fitness services for 257,000 Federal employees; industrial hygiene and environmental services for 850,000 Federal employees; and Employee Assistance Programs for 1.3 million Federal employees. These figures reflect an FOH objective of increasing the number of comprehensive service agreements with the national headquarters of agencies. In 1994, total agreements increased from 4,512 to 4,956.

Drug Pricing Program

Since the passage of the Veterans' Health Care Act of 1992, BPHC has implemented a new program aimed at reducing the cost of outpatient drugs to 13,000 providers, including public hospitals, health centers, health departments, and clinics. Over 500 manufacturers who sell drugs to eligible entities must sign a pricing agreement, which limits the price of drugs to an amount determined by a formula.

The Electronic Data Retrieval System, a national data bank, was established to track the participation and certification of the eligible entities and provide information on pricing calculations and other aspects of the program. Users can download information at low cost, and information is transmitted electronically instead of through mass mailings.

Emergency Response Program

Services are also provided in areas affected by floods, storms, and other natural disasters. To better assess the

needs of programs in the event of a disaster/emergency, an Emergency Response Program has been developed and implemented. The program includes efforts to assess the role played by BPHC programs and providers in the community and the impact of disasters/emergencies on these programs and providers. The *Emergency Response Manual*—consisting of training, a resource database, and a facility/community assessment protocol—serves as the guide for a coordinated Federal response to identified needs.

Immigration Health Services

The Division of Immigration Health Services is the primary focal point for planning, management, policy formation, coordination, direction, and liaison for all health matters pertaining to aliens who are detained by the Immigration and Naturalization Service (INS). Responsibilities include but are not limited to:

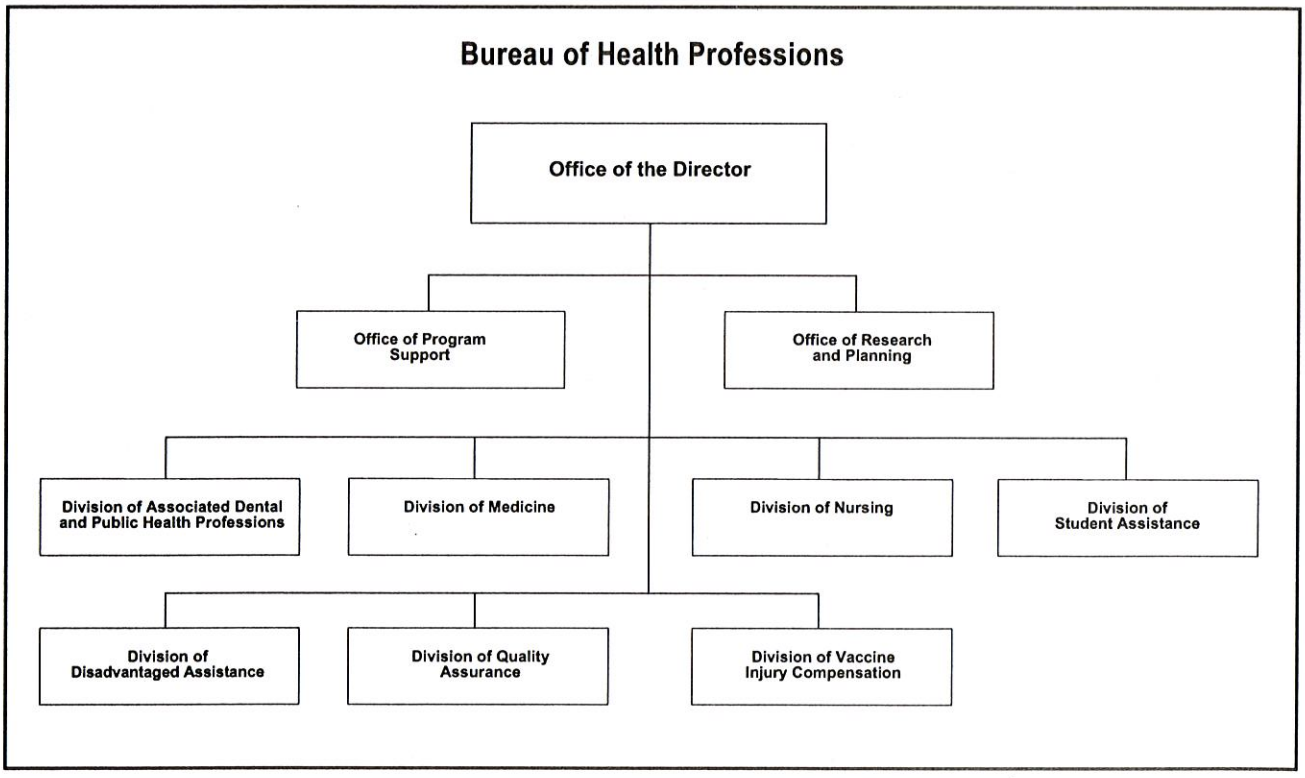
- Development and implementation of policies, procedures, and guidelines relating to the health screening and care of detained aliens
- Direction, coordination, and supervision of the health care operations for aliens at Service Processing Centers, Air Operations, and other public and contract facilities, as required
- Liaison with PHS, the Immigration and Naturalization Service, other Federal agencies, and community and private health agencies regarding health and mental health issues as they relate to detained aliens
- Provision of high-quality, cost-effective health care services to aliens detained in INS-operated facilities
- Provision of medical escort services for detainees being deported or otherwise transported by INS.

Bureau of Health Professions

The Bureau of Health Professions monitors and guides the development of health resources by providing leadership to improve the education, training, distribution, utilization, supply, and quality of the Nation's health personnel.

BHPr has established seven internal strategic directions to achieve the Department's Year 2000 National Health Promotion and Disease Prevention objectives and to guide implementation of the BHPr's programs. These include:

- Promoting primary care education
- Strengthening and expanding public health education and practice
- Expanding the capacity of nursing and allied health professions to meet increasing demands for services
- Increasing the numbers of health care providers from minority/disadvantaged backgrounds
- Promoting educational strategies to recruit and retain health care providers for underserved populations
- Advancing continuous quality improvement in health professions education and practice
- Strengthening health professions data, information systems, and education research.



Selected Program Accomplishments

The BHPr made several changes to streamline the administration of its grant programs, including the use of the Internet and the Bureau's electronic bulletin board to distribute application materials.

In 1996, the Division of Nursing (DN) celebrates 50 years as the key Federal focus for nursing education and practice. Under a contract with the Division of Nursing, the Institute of Medicine (IOM) issued a report that recommended improvements in the skills of nurses to provide leadership in patient management and called for increased use of registered nurses in nursing homes.

In September 1995, the Division of Disadvantaged Assistance (DDA) sponsored a Minority Faculty Development Conference to discuss the underrepresentation of minorities on the faculties of health professions schools and to formulate discipline-specific actions to address this problem.

A National Forum on Geriatric Education and Training, held in the Spring of 1995, brought experts in geriatric education together with service providers, consumers, Federal agencies, and policy makers, resulting in the publication of *A National Agenda for Geriatric Education: White Papers.*

In September 1994, HRSA established the HRSA Community Care Corps, an AmeriCorps program under President Clinton's national service initiative, to provide enabling services to women of childbearing age and their families to increase access to primary care services. In January 1996, the Mental Health Association of Texas and the Centro de Salud Familiar Inc., in El Paso, launched a collaborative effort to replicate HRSA Corps activities to address border health issues—the first collaborative service effort between a State-funded program and a grantee of the Corporation for National Service.

The National Commission on Allied Health was established to conduct a comprehensive review of issues, problems, and potential solutions pertaining to the education, supply, and distribution of allied health personnel throughout the United States. The Commission prepared a 1995 report that examines education, workplace, research, and data issues and makes recommendations regarding the future of allied health.

In June 1995, the National Practitioner Data Bank (NPDB) began operation as an all-electronic system, enabling the data bank to respond to requests more rapidly at lower costs.

The strategy defined by these seven areas is being implemented through a variety of programs supported and operated by BHPr. These programs include: education and training grant programs for institutions such as health professions schools and health professions education and training centers; loan and scholarship programs for individuals, particularly those from disadvantaged backgrounds; loan repayment for disadvantaged faculty; the National Practitioner Data Bank; and the Vaccine Injury Compensation Program (VICP).

Program Activities

Many programs underwent major changes as a result of reauthorization under the Health Professions Education Extension Amendments of 1992, P.L. 102-408. New and expanded areas of emphasis include minority representation, allied health, rural areas, and HIV/AIDS, along with continued strong focus on primary care medicine, nursing, and network programs. Programs were restructured to be responsive to the following national health professions goals:

- Increase the proportion of underrepresented minorities graduating
- Increase the proportion of graduates selecting generalist careers
- Increase the proportion of graduates practicing in underserved areas.

Important themes apparent in the reauthorization include promoting:

- Generalism and primary care in training and education
- Linkages between service and education
- Community-based training and education
- Multidisciplinary training and education
- Targeting of funds to program performance outcomes
- Linkages with health services financing
- Workforce diversity.

The reauthorization also included a new research authority to study factors affecting selection of careers in primary care, including: educational indebtedness; effectiveness of programs for minority and disadvantaged individuals; and effectiveness of State licensing authorities in protecting the public through investigation of and disciplinary actions against health care providers.

Program initiatives being supported by the BHPr that contribute to achievement of its mission and new and expanded areas of emphasis are highlighted below.

Quality Improvement

The BHPr expanded its focus on promoting continuous quality improvement (CQI) in health professions education through its participation in the Institute of Healthcare Improvement's Interdisciplinary Professional Educational Collaborative, established in 1994. Efforts to date have resulted in:

- A commissioned report, *Interdisciplinary Professional Education in Continuous Improvement of Healthcare—The State of the Art*, to be used by academic institutions, foundations, and government agencies
- Initiation of a series of annual symposiums on quality improvement, including sponsorship of the first symposium, entitled *Building the Knowledge for the Leadership of Improvement of Healthcare*
- Development of two documents—a resource guide for interdisciplinary faculty development in CQI and a strategic plan for the implementation of interdisciplinary faculty development in CQI.

Future plans include sponsoring regional faculty development workshops and an invitational workshop on health industry/academic partnerships to promote improvement of health care outcomes.

BHPr continues to actively pursue a comprehensive grant process improvement strategy through the development of simplified and consolidated program materials as well as the integration of automation technology to reduce administrative burden and improve customer satisfaction.

Council on Graduate Medical Education

The Council on Graduate Medical Education (COGME) reports to the Secretary for Health and Human Services and to the Congress (specifically, the Senate Committee on Labor and Human Resources and the House Committee on Commerce) on matters related to graduate medical education, including the supply and distribution of physicians, shortages or excesses in specialties and subspecialties of medicine, international medical graduates, and financing and types of programs in undergraduate and graduate medical education. In recent years, COGME's reports have focused on increasing the supply of generalist physicians and other important aspects of the physician workforce.

The *Third Report* provided a thorough overview of issues and a number of recommendations on increasing the generalist physician workforce. The *Fourth Report* provided specific recommendations on how to achieve these goals. The *Fifth Report* provided a comprehensive overview and analysis of physician education in women's health and women in the physician workforce. The *Sixth Report* presented findings and recommendations on the impact of managed care on the physician workforce. The *Seventh Report* provided recommendations on DHHS funding of medical education programs under Medicare and the Public Health Service. The *Eighth Report* provided an advanced analysis of physician supply and requirements over the next few decades.

COGME is currently working on the physician workforce in relation to issues of geographic distribution, medical education consortia, minorities in medical education and practice, physician competencies in a managed care world, and international graduate medical education and entry into practice in the United States.

National Advisory Council on Nurse Education and Practice

The National Advisory Council on Nurse Education and Practice (NACNEP) is authorized by the Congress. NACNEP advises the Secretary for Health and Human Services on matters relating to nursing education and practice, the nursing workforce, and the implementation of Congressional legislation.

Joint NACNEP and COGME Councils

The Councils are chartered advisory councils to the Secretary for Health and Human Services and have been a crucial ongoing mechanism for input and advice from both the professions and the public. The first meeting of the Joint NACNEP and COGME Councils and Joint Workgroup on Primary Care Workforce Projections was held during September 1995 and is the first effort of its type undertaken by the Federal Government. BHPr recognized significant activities relating to medicine and nursing and assured that it would maintain a leadership role in increasing interdisciplinary approaches to health workforce planning that build on and complement discipline-specific programs from the Division of Nursing and the Division of Medicine. The Councils also collaborate in examining requirements for primary care practitioners—nurse practitioners, nurse-midwives, physician assistants, and physicians—in providing for primary care needs of the public.

National Commission on Allied Health

The purpose of the National Commission on Allied Health is to provide advice and make recommendations to the Secretary for Health and Human Services, the Committee on Labor and Human Resources of the Senate, and the Committee on Energy and Commerce of the House of Representatives with respect to a comprehensive spectrum of issues, problems, and solutions pertaining to the education, supply, and distribution of allied health personnel throughout the United States. The *Report of the National Commission on Allied Health* was published in October 1995. The Commission also (1) encourages entities providing allied health education to conduct activities to voluntarily achieve the recommendations of the Commission and (2) examines priority research needs within the allied health professions.

Network Programs

BHPr administers education/service multidisciplinary and interdisciplinary network programs. Examples include:

- Area Health Education Centers (AHEC) programs at medical schools/universities that initiate and expand community-based training at underserved sites through community-based Area Health Education Centers
- Health Education and Training Centers that address health professions education and public health education for populations in the United States-Mexico border areas and other severely underserved areas
- National AIDS Education and Training Centers Program (AETC), which provides multidisciplinary training for primary health care providers in the care of HIV-infected individuals and persons with AIDS
- Geriatric Education Centers and affiliated centers representing geriatric education programs in 142 schools of the health professions
- Rural Interdisciplinary Training Programs.

AHEC Program

The AHEC Program is a national network of 41 programs based at medical and health science schools. By legislation they are charged with addressing the maldistribution of health professions in the United States.

There are more than 125 community-based Area Health Education Centers affiliates, involving over 4,000 volunteers who serve as advisory board members, preceptors for health professions students and residents, and other roles that support AHEC programs at the local level. Approximately 80 medical schools and 500 other health professions training institutions have participated.

AHEC programs have collectively coordinated and supported the training of nearly 1.5 million students and residents in medicine, allied health, dentistry, nursing, pharmacy, and other disciplines in underserved areas, as well as contributed to the improved recruitment, distribution, and quality of health professionals. They have also provided hundreds of thousands of continuing education hours to health professionals, and developed information dissemination systems to respond to the needs of practitioners. AHEC programs generate approximately $4 in State and local matching funds for every $1 invested by the Federal Government.

AETC Program

The AETC Program is a network of 15 regional centers (with more than 75 local performance sites) that conduct targeted, multidisciplinary HIV education and training programs for health care providers. The mission of these centers is to increase the number of health care providers who are effectively educated and motivated to counsel, diagnose, treat, and manage individuals with HIV infection and to assist in the prevention of high-risk behaviors which may lead to infection. Goals of the AETC Program are to:

- Provide training to increase the competence and willingness of health care professionals to diagnose, treat, and manage HIV infection and to offer interventions that will prevent HIV infection
- Disseminate state-of-the-art HIV information to providers
- Develop HIV provider materials.

The AETC Program provides training for health care providers in all 50 States, the Virgin Islands, and Puerto Rico. Clinical training of primary care providers—physicians, nurses, dentists, physician assistants, and dental hygienists—is a major focus, but training is also provided for mental health and allied health providers. The majority of resources are concentrated in areas of high HIV prevalence/incidence, but centers also address training needs of providers in suburban and rural areas.

To date, more than 400,000 providers have been trained by the AETC Program. A 1993 study shows that AETC-trained providers are more HIV-competent and more willing to treat persons with HIV than primary care providers in the general population. The toll-free National HIV/AIDS WRX Clinical Telephone Consultation Service—800-933-3413—is especially helpful to providers less experienced with HIV care or those practicing in rural areas. Information dissemination efforts emphasize electronic communication (e.g., AETCNET, Satellite Teleconference Series) and include cosponsoring the quarterly national HIV Clinical Conference Call Series.

Geriatric Education Centers and Initiatives

It has been predicted that, as their share of the population increases, the elderly will be utilizing well over half the Nation's medical care services. Geriatric Education Centers facilitate the training of health professions faculty, students, and practitioners within specific geographical areas. These centers provide a nationwide network offering education and training opportunities for health professionals, including physicians, nurses, dentists, social workers, pharmacists, occupational therapists, physical therapists, optometrists, podiatrists, dieticians, health administrators, clinical psychologists, and other allied and public health personnel. The centers also develop new curricula, training materials, and clinical training sites. There are currently 26 centers involving 17 States.

HRSA also supports Faculty Fellowship Training Programs in Geriatric Medicine, Dentistry, and Psychiatry. In 1994, nine 5-year grants were awarded to provide program and stipend support for 2-year fellowships and 1-year retraining projects for physicians and dentists who plan to teach geriatric medicine, geriatric psychiatry, or geriatric dentistry. Programs supported by these grants emphasize the principles of primary care as demonstrated through continuity of care, ambulatory, preventive, and psychosocial aspects of the practice of geriatric medicine and dentistry.

Nurse Education and Practice

The Nurse Education and Practice Programs administered by the Division of Nursing are unique in their ability to address all seven of the BHPr's strategic directions. The DN provides competent and expert administration in basic and advanced degree nurse education programs, including advanced clinical practice nurses, nurse anesthetists, nurse-midwives, and nurse practitioners. The DN also provides statistical results for interpreting trends and needs of the nursing component of the Nation's health care delivery system, and maintains liaisons with the nursing community and with regional, State, local, and international health interests.

National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program, which became effective October 1, 1988, was created by the National Childhood Vaccine Injury Act of 1986 as a no-fault system through which families of individuals who suffer injury or death as a result of adverse reactions to certain childhood vaccines can be compensated without having to prove negligence on the part of those who made or administered the vaccines. The program was authorized by Congress as a strategy for protecting the Nation's vaccine supply. The Secretary for Health and Human Services is the designated respondent for all petitions under the Act.

The Act distinguishes between those deaths or injuries alleged to be associated with vaccines administered prior to the effective date of the VICP, October 1, 1988, and those deaths or injuries alleged to be associated with vaccines administered on or after the effective date. If an injury occurred prior to the effective date, a petition had to have been filed by January 31, 1991. However, for injuries which occurred on or after the effective date, a petition must be filed within certain periods of time set out in the law.

Each petition is filed and adjudicated by the U.S. Court of Federal Claims. The BHPr's Division of Vaccine Injury Compensation has the delegated responsibility for review of all medical records and recommendations on compensability for each petition. The Secretary is represented by Department of Justice attorneys in all proceedings before the court.

The VICP also provides administrative support to the Advisory Commission on Childhood Vaccines (ACCV), which is composed of nine appointed members—three health professionals, three members of the general public, three attorneys, and four *ex-officio* members. The ACCV, which must meet at least quarterly, advises the Secretary on implementation of the VICP and recommends changes in the Vaccine Injury Table (the Table).

Based on findings of the Institute of Medicine report, *Adverse Effects of Pertussis and Rubella Vaccines,* HRSA, in consultation with the ACCV, has been working with other Department staff to develop recommendations to ensure that the Table reflects the latest scientific information available. On March 10, 1995, based on the IOM report, a modified Table (and the Qualifications and Aids to Interpretation) became effective for all claims filed on or after that date.

Additionally, HRSA, in consultation with the ACCV and other Departmental staff, will be addressing a number of VICP issues, including VICP funding, the processing of claims filed under the VICP, and the addition of new vaccines to the Table.

More than 4,900 petitions for compensation have been filed under the VICP as of October 6, 1995. Through October 6, 1995, awards totaling $589.9 million have been made to individuals who died or suffered injuries associated with administration of a vaccine.

National Practitioner Data Bank

The Health Care Quality Improvement Act of 1986 (Title IV of P.L. 99-660) directs the Secretary to establish a national system to receive and disseminate information on certain adverse actions taken against licensed health practitioners. Final regulations for the Data Bank were published in the *Federal Register* on October 17, 1989. The National Practitioner Data Bank opened on September 1, 1990. A contract to operate the second generation of the NPDB was awarded on July 18, 1994, to Systems Research and Applications Corporation, a private-sector contractor.

The NPDB ensures that incompetent medical and dental practitioners do not compromise health care quality by restricting the ability of incompetent practitioners to move from State to State without disclosure or discovery of their previous poor performance. The NPDB has information on malpractice payments made for the benefit of physicians, dentists, and other licensed health care practitioners; licensure disciplinary actions taken by State medical boards and State boards of dentistry; and professional review actions taken against physicians, dentists, and other licensed health care practitioners by hospitals, other health care entities, and professional societies.

Insurance companies and other entities must report to the NPDB any payment they make on medical malpractice actions or claims. State medical and dental boards must report to the NPDB disciplinary actions taken against physicians and dentists.

Health care entities must report decisions which adversely affect, for more than 30 days, the clinical privileges of the physician or dentist. Professional societies must report adverse actions regarding membership of physicians and dentists. These decisions must have been reached through formal peer review.

Each hospital must query the data bank at the time a physician, dentist, or other health care practitioner applies for clinical privileges or a position on its medical staff, and every 2 years thereafter. Other health care entities may query the data bank when entering into an employment or affiliation agreement with a physician, dentist, or other health care practitioner.

As of June 22, 1995, total queries since the opening of the NPDB numbered over 5.5 million. The total number of reports received during this same period (September 1, 1990 to June 22, 1995) was more than 108,000. Of the more than 108,000 reports, there were in excess of 80,000 separate practitioners who had a single report. Cumulative matches between queries and reports during this same period numbered more than 329,000, and this total contained in excess of 52,000 individual practitioners.

Several electronic enhancements have been implemented since the data bank opened to make the NPDB more efficient, accurate, and secure. Currently, all queries are submitted via electronic methods. In the near future, reports will also be submitted electronically, making the data bank 100 percent automated.

Health Personnel in the United States

BHPr plans, coordinates, and compiles biennially the *Report to the President and Congress on the Status of Health Personnel in the United States.* In addition to providing basic information on health professions, the Report discusses current and emerging health issues and problems that influence the demand for health personnel and their educational preparation. The *Ninth Report* was issued in August 1995.

Curriculum Additions in Health Professions Training Programs

A number of ongoing health professions training grant programs have encouraged curriculum additions to facilitate coverage of HIV infection topics. Among the program activities that have been augmented in this way are the Area Health Education Centers, Physician Assistant Training, Nursing Special Projects for nurse-managed clinics that treat HIV/AIDS patients, and Advanced Nurse Education and Practice.

Organizational components of HRSA responsible for discipline-specific training programs are cooperating with other Federal agencies and professional associations/organizations concerning training efforts. An example is HRSA collaboration with the Centers for Disease Control and Prevention, Veterans Administration, National Institute for Dental Research, and American Association of Dental Schools in developing curriculum guidelines for infection control for dental personnel, and in advocating comprehensive coverage of HIV/AIDS throughout the educational process.

BHPr awarded a contract to the Association of University Programs in Health Administration to update and revise a curriculum entitled, *HIV/AIDS and Health Administration: Managing the Issues*. The curriculum is directed to health administrators at facilities and organizations in rural and small city areas to sensitize them to the increasing problems related to the HIV epidemic. The revised format will be presented over the Adult Learning Satellite Service of the Public Broadcasting System.

Recruitment and Retention of Disadvantaged Individuals and Minorities for the Health Professions

Special strategies are being undertaken to increase the number of minorities in the health professions. Two grant programs—the Health Careers Opportunity Program (HCOP) and the Centers of Excellence (COE) program—serve as the Federal focus for increasing the number of minorities and other individuals from disadvantaged backgrounds in the health and allied health professions. These programs also advance excellence in selected health professions educational institutions that train significant numbers of African, Hispanic, and Native Americans. The program supports recruitment and education designed to expand the academic ability of disadvantaged students during their preprofessional training; facilitates their entry into health and allied health professions schools; and enhances their retention potential in these schools through to graduation.

A particularly successful HCOP is the Postbaccalaureate Program, in which 14 health professions schools have been involved since 1990. This Program focuses on minority/disadvantaged college graduates who either were unsuccessful in gaining admittance into a health professions school or made a late decision to enter. Each participating institution admits a minimum cohort of seven students each year. The selected students are involved in an intensive program for over a year to bolster their math and science skills. Each student is guaranteed admission to the health professions school upon successful completion of this program. As a direct result of the Postbaccalaureate Program, each year more than 100 minority/disadvantaged students who would have been denied admission matriculate as first-year medical students.

BHPr supports COE programs at certain Historically Black Colleges and Universities, Hispanic COE programs, and Native American COE programs at health professions schools that train a significant number of minority students. It also supports other COE programs at health professions schools having enrollments of underrepresented minorities above the national average. The program also supports planning efforts to achieve institutional improvements and initiatives to enhance the academic performance of minority students; increase the number and quality of minority applicants; improve the schools' capacity to train, recruit, and retain minority faculty; improve the information resources and curricula of the school and clinical education with respect to minority health issues; and facilitate faculty and student research on health issues particularly affecting minority groups.

The Nursing Education Opportunities for Individuals From Disadvantaged Backgrounds, administered by BHPr's Division of Nursing, funds grants to eligible applicants for special projects. Projects must increase nursing education opportunities for individuals from disadvantaged backgrounds, including identifying, recruiting, and selecting individuals; facilitating their entry into schools of nursing; providing counseling or other services to retain and graduate students; providing preliminary education; paying stipends; publicizing sources of financial aid; and providing training, information, or advice to faculty to assist them in retaining students from disadvantaged backgrounds enrolled in nursing programs.

Through a cooperative agreement with the Group Health Association of America (GHAA), BHPr is developing a Minority Training Institute to educate minority applicants to become entry-level administrators in health mainte-

nance organizations and other managed care settings. A draft curriculum has been developed and pilot testing has begun. The first class of 14 fellows has entered the 1-year training program, which will combine on-the-job experiences in 11 GHAA member plans in the Washington, DC-Baltimore area with classroom training at the Johns Hopkins School of Public Health. The goal is to place fellows in permanent positions. Eventually, the Institute is expected to become self-sufficient through support from the HMO/managed care community.

Health Education Assistance Loan Program

The Health Education Assistance Loan (HEAL) Program provides market rate interest loans to health professions students. The loans, made by non-Federal lending institutions, are fully insured by the Federal Government. The potential Federal liability as of September 31, 1994, was $3.6 billion. The failure of some borrowers to repay their loans is a continuing concern, however. In FY 1994, $44 million was paid to cover defaults, deaths, bankruptcies, and disabilities.

Congress authorized a $375 million insurance authority for loans to students in FY 1995. Interest rates and compounding terms offered by lenders have become more favorable each fiscal year since 1991, saving borrowers millions of dollars and reducing the Federal liability significantly.

A new initiative, HEAL Refinancing, was started in early FY 1994. As of September 1995, 10,000 borrowers have requested to consolidate $700 million of loan principal. Refinancing offers borrowers an array of benefits, including lower interest rates and alternative repayment options, and should prove to be a significant default reduction tool.

Bureau of Health Resources Development

The Bureau of Health Resources Development identifies health care resource needs through careful assessment of health care systems and support systems to improve access to health care. The BHRD is responsible for resource development to support the provision of services, manpower, and facilities to meet identified needs.

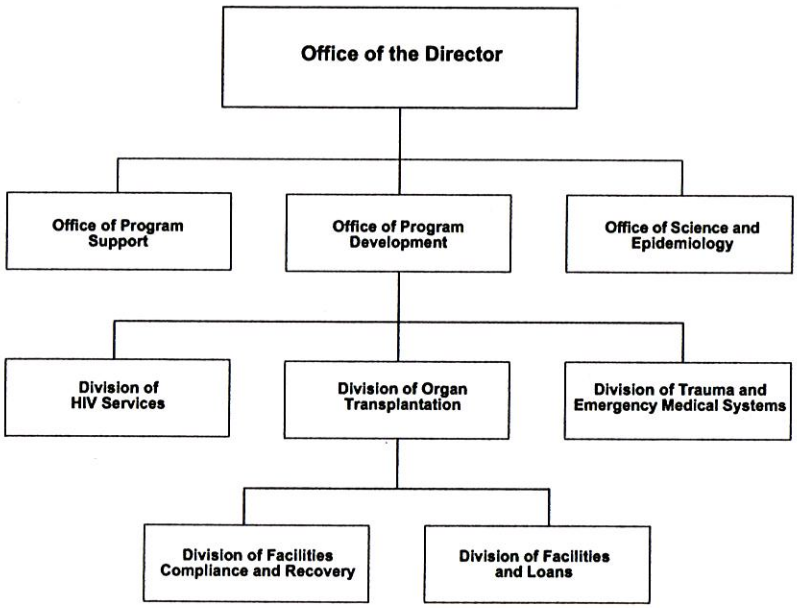
Program Activities

BHRD has three major program areas—Health Facilities, Organ and Bone Marrow Transplantation, and HIV Services—supported by a variety of program initiatives. BHRD also manages trauma and emergency care assistance grants, and its Office of Science and Epidemiology supports program-related research and evaluation to improve the delivery of the Bureau's public health programs. These programs are described below.

Health Facilities

The Division of Facilities Compliance and Recovery manages remaining activities of the Hill-Burton Act, which was passed in 1946 to financially assist construction and modernization of hospitals and other health care facilities. While, for the most part, Hill-Burton is no longer active, it awarded more than $4.6 billion in grants and $1.5 billion in loans to nearly 6,800 hospitals and health care facilities in 4,000 communities across the

Bureau of Health Resources Development



Selected Program Accomplishments

HIV/AIDS

The Division of HIV Services (DHS) provided technical assistance and staff support for the addition of eight new Title I Eligible Metropolitan Areas (EMAs) in FY 1995 and seven potential new Title I grantees for FY 1996, for a total of 49 EMAs.

The Annual Aggregate Reporting (AAR) system for Titles I and II of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was fully implemented. Highlights from the first report include the following data:

	Title I	Title II
Providers	1,310	1,892
Minority Providers	48%	25%
Clients Served	383,870	213,240
Female Clients	27%	25%
African American Clients	35%	28%
Hispanic Clients	22%	21%

A policy on required levels of participation of People Living With HIV/AIDS (PLWH) was disseminated to Title I grantees and planning councils.

In FY 1994, 34 EMAs were provided Title I and supplemental CARE Act grants totaling $320 million, and 54 States and territories were provided CARE Act grants totaling $163 million. In FY 1995, 42 EMAs were provided Title I and supplemental CARE Act grants totaling $349 million, and 54 States and territories were provided CARE Act grants totaling $175 million.

Transplantation—Solid Organs and Bone Marrow

In November 1994, authority for the National Bone Marrow Donor Program was redelegated from the National Institutes of Health (NIH) to HRSA, establishing HRSA's responsibility to oversee both solid organ and bone marrow transplantation programs.

The Bureau oversaw, through a contract, the Organ Procurement and Transplantation Network (OPTN), which maintains a national computerized list of more than 40,000 patients waiting for transplants and a 24-hour placement center to match donors with recipients.

Hill-Burton Act Activities

Hill-Burton-obligated facilities delivered approximately $700 million in free or reduced-charge health services to approximately 2 million indigent people; $10 million were distributed through a competitive process under the Title XVI grant program for construction of health facilities; and approximately 18,000 individuals received information from the Hill-Burton Hotline.

A Hill-Burton Demographic Study documented characteristics and medical needs of persons receiving services under this program. Results indicated that the Hill-Burton population was predominantly female (58 percent), usually lived without a spouse (61 percent), had a median age of 32, was more likely to be white (80 percent), had a median household size of 2, generally had no insurance coverage (69 percent), and had a median annual income of $7,200.

Facilities and Loans

A new model to use HHS/HUD/private-sector partnerships to help finance capital needs of primary care clinics and other clinical settings was included in the Secretary's 1997 budget initiatives.

United States. In return for these Federal funds, facilities agreed to allocate a reasonable volume of services to persons unable to pay (the Hill-Burton Uncompensated Services Program)—an obligation that lasts for 20 years after construction is completed. There are now nearly 1,650 obligated facilities; the FY 1995 annual obligation for all facilities is approximately $320 million. Today, more than $33.8 billion in uncompensated services have been provided by these obligated facilities. By the year 2000, it is projected that fewer than 700 facilities will have remaining uncompensated services obligations.

The Division of Facilities and Loans (DFL) oversees the hospital mortgage insurance program managed under a Memorandum of Agreement with the U.S. Department of Housing and Urban Development (HUD) under section 242 of the National Housing Act, enacted in 1968. Since its inception, the HUD 242 Program has provided insurance for 284 hospital mortgage loans totaling $8.2 billion. The portfolio currently is comprised of 106 active insured mortgages totaling nearly $5.5 billion. The additional 178 loans have been paid in full, or otherwise terminated, extinguishing the HUD insurance liability.

Other DFL activities include: (1) monitoring and providing loan management services for 203 remaining loans under the Hill-Burton Hospital Construction Loan Programs with a contingent Federal liability of $343 million, as well as the Section 242 HUD portfolio of loans; and (2) overseeing efforts of the DHHS Office of Engineering Services in supporting construction activities for approximately 20 separate programs, including reviewing the architectural and engineering aspects of Section 242 hospital projects and construction programs for the Department of Education.

Organ and Bone Marrow Transplantation

The Division of Transplantation (DOT) awards and manages the contract for the National Organ Procurement and Transplantation Network, designed to ensure equitable distribution of available organs to patients and transplant centers, and a Scientific Registry of demographic and clinical information on transplant recipients. In FY 1995, $795,000 was available for the OPTN and $1.5 million for the Scientific Registry.

In 1994, DOT assumed oversight of the National Marrow Donor Program (NMDP) headquartered in Minneapolis, Minnesota. The NMDP has the responsibility for conducting the national bone marrow donor search and for compatibility testing of the potential donor. When a closely matched volunteer is identified, the NMDP works closely with the volunteer's donor center in determining whether the donor is healthy and prepared to donate marrow. Transplant centers send NMDP followup data on recipients at 3 months, 6 months, 1 year post-transplant, and every year thereafter. NMDP donor recruitment efforts emphasize recruitment of minority donors; of 1.7 million registered U.S. donors, less than 20 percent represent minorities.

Grants to qualified Organ Procurement Organizations (OPOs) have been awarded since FY 1986 to help improve the effectiveness of organ procurement programs. Several of the grants have been awarded to consolidate programs where multiple OPOs exist, thereby reducing inappropriate competition for donors in large metropolitan areas. Other grant activities have focused on issues such as increasing minority populations' knowledge of organ donation and transplantation, improving responsiveness to the request process, and refining methods of estimating the potential donor pool.

In 1995, the second report on transplant recipient survival rates was published. The nine-volume, 2,700-page report provides survival rates for 252 U.S. hospital transplant centers for transplants performed from 1987 through 1991. The primary purpose of the report is to assist potential transplant recipients in choosing a transplant hospital.

Each February, DOT convenes a national meeting for transplant surgeons and physicians, organ recovery personnel, recipients, and other interested parties to discuss current policies and practices in the field.

HIV Services

The Division of HIV Services plans, develops, implements, and monitors programs that provide health care and support services for people living with HIV disease. DHS is responsible for awarding and monitoring the grant programs established by Title I and Title II of the Ryan White CARE Act of 1990. The purpose of these programs is to provide resources to eligible metropolitan areas with 2,000 or more reported AIDS cases and to States and territories to improve the quality and availability of care for individuals and families with HIV disease.

Under Title I of the CARE Act, EMAs receive formula and supplemental grants to develop comprehensive HIV service delivery systems for individuals and families with HIV. Fifty percent of the available funds are awarded according to a formula based on the number of AIDS cases in the EMA, and 50 percent of the funds are awarded competitively. In FY 1995, $349.4 million was awarded.

Title II of the CARE Act provides for grants to States and territories to improve the quality, availability, and organization of health care and support services for individuals and families with HIV disease. Funds can be used for consortia, home and community-based care, health insurance coverage, and the provision of treatments for individuals with HIV disease. In FY 1995, $174.8 million was awarded.

Trauma Care

The Division of Trauma and Emergency Medical Systems was established as part of BHRD in July 1992 and is responsible for implementing Title XII of the Public Health Service Act. A staff of clinical and prehospital systems professionals provides technical assistance to States and localities on issues such as trauma care planning, data needs assessment tools, protocol development, and quality assurance.

Title XII authorizes grants to State Emergency Medical Services (EMS) agencies for trauma care systems

planning—developing, implementing, and modifying existing State trauma care plans. Planning must involve: standards and requirements for the initial designation and continued evaluation of designated trauma centers and regional trauma care systems; standards and requirements for medically directed triage, transport, and transfer of trauma patients, including children; establishment and collection of data to a central data reporting and analysis system; public education on injury prevention and access to trauma care; and coordination between States. From 1992 to 1994, trauma systems grants were awarded to 41 States and the District of Columbia for development of State trauma system plans. The grants focus on the following areas of study:

- Development of innovative uses of new and current communications technologies
- Developing curricula and training EMS personnel in transport and resuscitation, and management of EMS systems
- Making training for original certification and continuing education more accessible
- Developing protocols and agreements to increase access to prehospital care and equipment
- Evaluating the effectiveness of protocols regarding EMS.

Title XII provides that 10 percent of appropriations be used for grants to public and private nonprofit entities for research and demonstration projects to improve the availability and quality of EMS and trauma care in rural areas. From 1992 to 1994, 14 rural grants were awarded to support efforts such as Rural Preventable Mortality Studies, Rural Trauma Training, and Rural Triage Transport and Documentation Protocols.

A Model Trauma Care System Plan for States has been developed, as mandated, and States are using this model, and other national standards, as a guide in developing their own State plans.

Science and Epidemiology

The Office of Science and Epidemiology (OSE) strives to improve Bureau policies and practices through two distinct approaches:

- Coordinating the development, implementation, and dissemination of evaluation studies
- Administering the Special Projects of National Significance (SPNS) program.

OSE evaluation projects assess key components of service delivery systems, examine the behavior of both service providers and recipients, and evaluate the impact of BHRD programs on service delivery. Current evaluation studies focus on programs funded under the Ryan White CARE Act, the Organ Transplantation Act, the Trauma Care Systems Planning and Development Act, and the Hill-Burton Act.

The objective of the SPNS program is to advance knowledge about the care and treatment of people with HIV/AIDS. Funded competitively under Title II of the Ryan White CARE Act, SPNS grants are awarded to nonprofit organizations for the demonstration and evaluation of innovative and replicable models of HIV care and support services. The SPNS program has targeted several areas, including:

- Access to care through reduction of sociocultural, financial, and transportation barriers encountered by specific populations
- Legal advocacy models
- Reduction of social isolation
- Integration of mental health and primary care services.

In FY 1995, approximately $20 million was awarded to SPNS grantees.

Maternal and Child Health Bureau

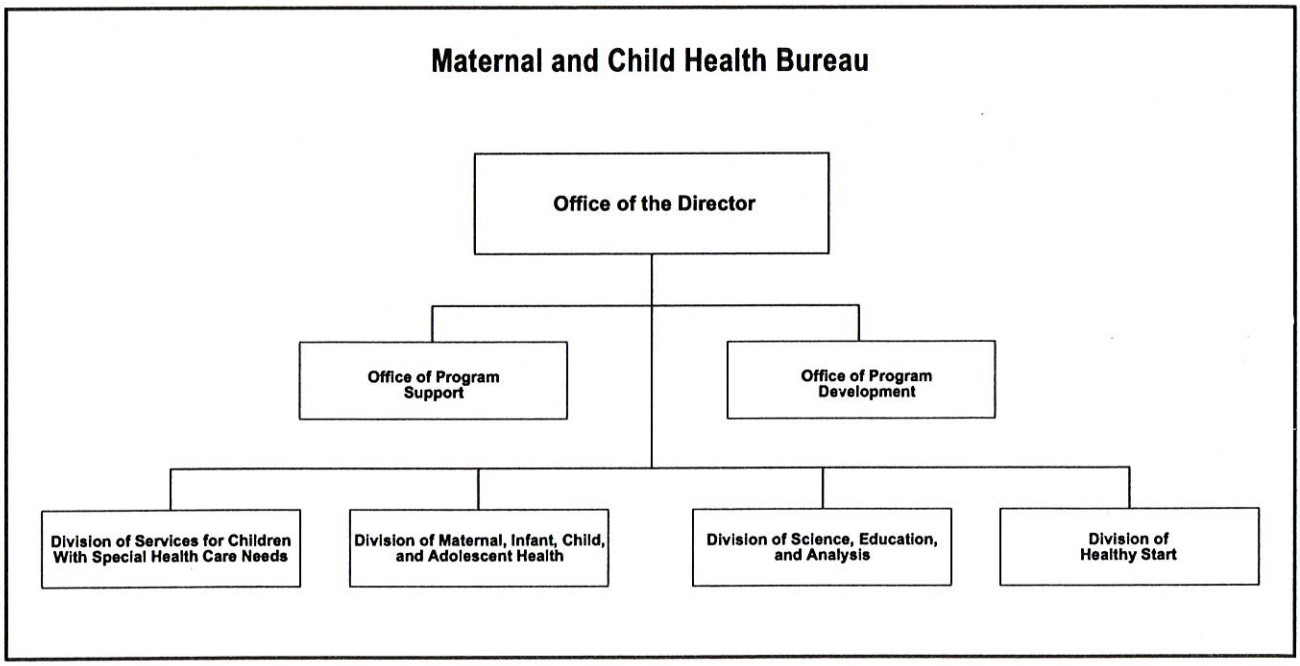
The Maternal and Child Health Bureau traces its origins to the creation of the Children's Bureau in 1912. MCHB is the principal Federal focus for leadership in the planning, implementation, and oversight of national maternal, child, and adolescent health activities. MCHB has four main divisions: Maternal Infant, Child, and Adolescent Health; Services for Children with Special Health Care Needs; Science, Education, and Analysis; and Healthy Start.

Program Activities

MCHB administers a program of block grants to States, as well as two discretionary grant programs: Special Projects of Regional and National Significance (SPRANS) and Community Integrated Services Systems (CISS). Legislative changes in 1989 mandated a number of specific activities to improve the health status of all mothers, children, and adolescents, including implementation of DHHS' "Healthy People 2000" objectives.

The State Block Grants program mandates the development and implementation of the maternal, child, and adolescent health care needs assessments and supports the maternal and child health infrastructure in the Nation. Based on their needs assessments, States must develop and implement plans to enhance the public health infrastructure and build resources to ensure that mothers, children, and adolescents receive quality care with emphasis on the provision and improvement of services to low-income populations who otherwise would have limited access to such services. Infrastructure development is critical in this era of Health Care Reform—HRSA must strive to ensure that the needs of pregnant women, children, and children with special health care needs are not forgotten, even as cost-saving reforms are introduced.

Discretionary grants and contracts are awarded to provide leadership in improving the delivery of maternal and child health care. The SPRANS grant programs support activities in research; training; genetic disease screening, testing, counseling, referral and information dissemination; hemophilia diagnosis and treatment; and demonstration projects aimed at improving health services for



Selected Program Accomplishments

Communications

The second edition of *Health Diary: My Baby, Myself*, mandated by Congress to fill the need for a pregnancy and baby care handbook, was published, and preparations began on a Spanish version of the handbook.

The 60th anniversary of the signing of Title V of the Social Security Act, which authorizes the Maternal and Child Health (MCH) Services Block Grant, was celebrated. In August 1995, banners, posters, and publications and information tables were set up in the Parklawn and Humphrey Buildings to make employees aware of the program.

Program Development

In response to the needs of the States, the required Uniform Title V Application and Annual Report Guidance was simplified, reporting requirements were eliminated, and the guide was reduced to less than 25 percent of its original size.

The Office of Program Development (OPD) organized the review of Medicaid Sections 1115 and 1915(b) waiver requests from the States and served on the PHS Section 1115 Waiver Steering Committee's Monitoring Subgroup, charged with strengthening the role of the PHS as a partner with HCFA in the review, implementation, and monitoring of State Section 1115 health care reform waivers.

State MCH Directors participated in two formal interagency Technical Assistance Groups (TAGs); one with Medicaid State Directors and one with directors of State welfare, child development, and social services programs administered by the Administration for Children and Families.

BPHC and MCHB jointly funded Healthy Schools, Healthy Communities, a community-based school health centers program that provides comprehensive primary care services for youth at high risk for poor health, school failure, and homelessness.

Community Health Advisors (CHAs) fill a critical gap in health care services for underserved communities. Since 1994, the MCHB has served as the lead agency on a Federal Technical Advisory Committee (TAC) on CHAs, composed of representatives from more than 15 offices and agencies. The TAC has secured funding from the Annie E. Casey Foundation to improve the health status of underserved communities by increasing the availability of and reliance on CHAs.

The OPD completed initial work on development of program performance measures required under the Government Performance and Results Act (GPRA).

Science, Education, and Analysis

More than 6,000 new leaders in adolescent health, nursing, nutrition, minority health, and other disciplines were educated, and more than 75 minority youth received education for careers in maternal and child health, health promotion, and disease prevention.

MCHB developed and integrated primary care systems at the community level, securing *Healthier Tomorrows* for more than 74 communities where access to care was limited.

MCHB framed the initial dimensions of the issue of early discharge of newborns and their mothers and established a Public Health Service Special Early Discharge Research Committee. A summit with the presidents of major professional organizations has been convened for late Spring of 1996.

Bright Futures—Guidelines for Health Supervision of Infants, Children, and Families, a collaborative effort between HRSA and the Medicaid Bureau/HCFA, is responding to the health promotion and disease prevention needs of infants, children, adolescents, families, and the professionals who serve them. Many organizations are implementing the *Bright Futures* guidelines.

Services for Children With Special Health Care Needs

The Hemophilia and AIDS Program Branch has participated in the development of the HRSA Program Advisory on ZDV (zidovudine, or AZT) for reducing perinatal HIV transmission. This Program Advisory was disseminated for comment in June 1995.

During FY 1996, more than $10,900,000 in funding for comprehensive hemophilia and HIV education and prevention services was awarded to 26 Hemophilia Treatment Centers grantees and their affiliate centers; there are a total of 145 Hemophilia Treatment Centers throughout the country. The number of active patients served rose from 19,000 to more than 20,000 in FY 1996.

The Children's Health Care Options Improved Through Collaborative Efforts and Services (CHOICES) program is designed to build upon successful collaborative efforts by addressing three major problems created by the lack of functional interagency linkages: access barriers; fragmentation, duplication, gaps, and overlaps in service delivery; and inefficient resource utilization. CHOICES has served as a catalyst to bring together Shriners Hospitals for Crippled Children (SHCC), State Title V Children With Special Health Care Needs (CSHCN) agencies, early intervention programs, and vocational rehabilitation agencies. Major systems changes have occurred within SHCC, and staff across all clinical services have learned about resources available to families and gained an understanding of the value of service coordination.

(Continued)

Selected Program Accomplishments (continued)

The Children's Safety Network (CSN) is a group of organizations working to assist States and others to prevent needless child and adolescent injuries. Currently, six CSN sites are funded. Two sites are designated as core sites, with the responsibility of addressing all aspects of injury and violence prevention; the other four sites are issue-specific, covering rural injury prevention, economics and insurance issues, adolescent violence prevention, and injury data.

HRSA has been intimately involved in the creation of the Administration for Children, Youth and Families (ACYF) Head Start Infant and Toddler Program. The MCHB will be integrally involved at the Federal, State, and local levels in carrying out the health-related responsibilities of this program.

In FY 1995, HRSA, with its partner, the National Highway Traffic Safety Administration, released a 5-year plan to continue to improve emergency medical services for children. Improvements made by this 10-year-old program have been accomplished through demonstration and implementation grants to 41 States.

Healthy Start

The Division of Healthy Start intensified its public information/education efforts in FY 1995 with the expansion from 15 to 22 Healthy Start communities and the development of the third wave of its national public service announcement (PSA) campaign, striving to reduce infant mortality.

mothers, infants, children, adolescents, and children with special health care needs. The CISS program implements State systems-building efforts by making available to any public or private entity direct support for community-level systems building.

MCHB also promotes coordination of activities authorized under Titles V and XIX of the Social Security Act and the dissemination of information to States on preventive services and treatment advances.

Maternal, Infant, Child, and Adolescent Health

The Division of Maternal, Infant, Child, and Adolescent Health serves as the national focus for programs designed to improve the health status of women and children through support of population-based and individual health care activities. The Division has responsibility for supporting core public health functions, including:

- Assessment of health status and problem identification at the local, State, and national levels
- Investigation of specific health problems and health hazards
- Education of the public to promote positive health beliefs, attitudes, and behaviors
- Promotion of community-based, private/public partnerships to identify and implement solutions to maternal and child health problems
- Linkage of women, children, youth, and families to needed population-based, personal health, and other community and family support services
- Evaluation of the effectiveness of health service delivery systems and programs.

Division activities include: the promotion of a national program designed to improve the provision of pediatric emergency medical services; promotion of systems of perinatal care in a managed care environment and health services for children in early childhood development centers and day care settings; and support for appropriate community-directed adolescent health services. It provides technical assistance and consultation programs that address the physical, mental, and oral health and nutritional needs of minority populations. The particular health concerns of adolescents is an important focus of the Division and has resulted in its designation as the Office of Adolescent Health for HRSA.

Services for Children With Special Health Needs

The Division of Services for Children With Special Health Needs plans, develops, implements, directs, monitors, and evaluates national programs to assure access to necessary, comprehensive health services for children with special health care needs and their families. Programs emphasize the development and implementation of family-centered,

comprehensive, coordinated, community-based, and culturally competent systems of care that integrate health education and social services. The Division administers a program of block and discretionary grants that support development of systems of care and services for those with special health needs, including those at risk for or suffering from chronic illness and disabilities, genetic diseases, and HIV infection. It develops policies, guidelines, and standards for the delivery of professional services and effective organization and administration of services of health and health-related programs for the target population.

The Division activities emphasize the development and implementation of community-based services and systems of care designed to improve the health of this special population by conducting national programs of:

- Consultation and technical assistance to State and local agencies and organizations
- Hemophilia diagnosis, treatment, and information services
- Service improvement, development, and implementation
- Government and professional liaison.

The Division also provides a maternal and child health focus for the Bureaus' involvement in international health issues relating to children and families with special health care needs.

Science, Education, and Analysis

The Division of Science, Education, and Analysis has primary responsibility for the development, implementation, review, management, administration, and monitoring of State activities funded through the Federal-State partnership provided for by Title V of the Social Security Act, as amended. It is responsible for all information activities of MCHB and for the Regional/Central Office activities, work plans, and guidance. The Division administers a program of research, professional education and training, and data and analytic efforts to develop new knowledge and skills designed to improve health and prevent disease among mothers, infants, children and adolescents, and children with special health needs.

This Division's activities include the development, coordination, and implementation of technical assistance and consultation to State and local agencies and organizations on research, professional training, and data and information systems, as well as the development and dissemination of health education materials.

A joint venture with the American Academy of Pediatrics supports the Healthy Tomorrow Partnership for Children Program, an initiative to improve access to health care for mothers and children at the community level.

Healthy Start

The Division of Healthy Start has the responsibility for implementing the Healthy Start Initiative, a major national demonstration program to reduce infant mortality in selected U.S. communities with extremely high infant mortality. Division activities focus on assisting community consortia in the development of collaborative community efforts to assure that the appropriate comprehensive package of medical, social, educational, and other supportive services is accessible to pregnant women and infants. Along with these efforts at the community level, the Division assists with bridging the gaps between community needs and available public/private resources and collaborates with State Title V programs in the integration of beneficial services to all families. The lessons learned in the Healthy Start demonstration serve as a model for health care reform and program integration efforts nationwide.

Cross-Cutting Activities

Introduction

As is evident from the *HRSA Program Overview*, the Agency supports a wide diversity of programs aimed at improving the health of the Nation by harnessing and effectively coordinating available resources to promote access to quality health care, improved service delivery, primary care education and practice, and services to underserved and vulnerable populations.

While each Bureau administers programs supporting these principles within the context of their mission statements, there are some program activities that, by their nature, transcend organizational boundaries and must be addressed using a multidisciplinary approach. In responding to critical public health needs, HRSA supports these cross-cutting activities at the Agencywide level. These cross-cutting areas include:

- HIV/AIDS
- Immunization
- Infant Mortality
- Rural Health
- Public Health and Primary Care
- Managed Care
- National and Community Service
- Healthy People 2000 Objectives.

HIV/AIDS

AIDS and the risk of infection with HIV remain among the most compelling public health threats facing the United States. As of June 1995, more than 475,000 Americans had been diagnosed with AIDS (*HIV/AIDS Surveillance Report, 7* [1], Centers for Disease Control and Prevention [CDC], 1995). HIV infection continues to increase in the heterosexual population, particularly among minorities and women. In 1994, AIDS was the third leading cause of death for women aged 25 to 44 years, and the leading cause of death for black women in this age group. Further, the increasing death rate for women affects the care of their children. The estimated 80,000 HIV-infected women of childbearing age alive in 1992 will leave approximately 125,000 to 150,000 children upon their deaths during the 1990s (*MMWR, 45,* [6], CDC, 1996). Profiles on children with HIV indicate that nearly all recent HIV infections occurred perinatally (CDC, 1995).

The observed decade-long upward trend in the proportion of adult/adolescent AIDS cases accounted for by women and by racial/ethnic minorities may be attributable to social, economic, behavioral, and other factors associated with HIV transmission risks; thus, it is important to continue to address these factors through prevention efforts designed to meet the needs of specific communities. HRSA participates in preventive efforts Agencywide, funding four titles of the Ryan White CARE Act that provide individual and support services to people with HIV/AIDS and their families, as well as education and training for health professionals. HRSA also supports initiatives to reduce perinatal HIV transmission.

Ryan White CARE Act—Titles I and II

Titles I and II of the Ryan White CARE Act, administered by HRSA, provide emergency assistance to localities that are disproportionately affected by the HIV epidemic, as well as financial assistance to States or other public or private nonprofit entities for the delivery of essential services to individuals and families with HIV disease. In FY 1995, grants totaling $349.4 million were awarded under Title I and $174.8 million under Title II of the CARE Act.

Title I of the CARE Act creates a program of formula and supplemental competitive grants to help metropolitan areas with 2,000 or more reported AIDS cases meet emergency care needs of low-income HIV patients. Title II of the Ryan White Act provides formula grants to States and territories for operation of HIV service consortia in the localities most affected by the epidemic, provision of home and community-based care, continuation of insurance coverage for persons with HIV infection, and treatments that prolong life and prevent serious deterioration of health. Up to 10 percent of the funds for this program can be used to support Special Projects of National Significance.

HRSA is implementing a reporting system to obtain information on clients and services under Titles I and II of the Ryan White CARE Act. Under this system, service providers and State programs receiving CARE Act funds from State and local grantees will submit Annual Administrative Reports. These reports will contain descriptive information about the organizations providing services, and aggregate information on the numbers and characteristics of clients and the volume of services delivered.

Reducing Perinatal HIV Transmission

HRSA, through each of its Bureaus and HIV programs, has developed an Agencywide Implementation Plan for perinatal HIV reduction activities. HRSA has sponsored the development of consumer and provider educational materials in multiple languages and in multiple media to assist with implementing these activities. HRSA also has developed short- and long-term evaluation studies to assess the impact of Agencywide activities.

In February 1994, results from the AIDS Clinical Trial Group (ACTG) 076 were released. These results demonstrated that a regimen of zidovudine given to pregnant women with HIV infection during pregnancy, labor, and delivery, and to the infants for 6 weeks following delivery, was efficacious in reducing perinatal HIV transmission (from mother-to-child) by two-thirds. In response to these findings and subsequent recommendations made by the PHS, HRSA undertook a number of activities toward the goal of reducing perinatal transmission of HIV in HRSA-funded programs.

HRSA convened two public meetings that included women living with HIV, providers, advocates, policy makers, State and local government and health officials, national organizations and associations, and HRSA grantees to review the findings from ACTG 076, to review subsequent PHS recommendations, and to suggest practical strategies for implementing these recommendations in HRSA programs. HRSA's Administrator sent letters to all HRSA grantees informing them about the findings from ACTG 076, related PHS recommendations, and the ongoing HRSA activities.

HRSA also developed a program advisory, *Zidovudine Therapy for Reducing Perinatal HIV: Implementation in HRSA-Funded Programs,* which, when completed, will be distributed to all HRSA programs. This program advisory is intended to summarize the information available on ZDV for reducing perinatal HIV transmission, current PHS recommendations, and practical strategies and policy changes for implementing these activities in HRSA programs that have been developed through the public process.

HIV/AIDS Technical Assistance Conference Call Series

HRSA develops and conducts technical assistance conference calls with CARE Act grantees to provide a forum for exchanging information and ideas. This collaboration between DHHS/HRSA, grantees, and other HIV/AIDS programs improves the effectiveness of CARE Act programs, assists grantees in better understanding and meeting their program obligations, and strengthens their ability to respond more quickly to the HIV epidemic. To date, more than seven conference calls have been held, covering such topics as quality assurance, AIDS Education and Training Centers, collaboration between CARE Act grantees and CDC HIV prevention programs, and coordination efforts of Title I and II grantees. Future topics will include HIV planning council roles and responsibilities and multijurisdictional issues affecting Ryan White grantees.

Women's Initiative for HIV Care and Reduction of Perinatal HIV Transmission

Two HRSA Bureaus, BHRD and MCHB, collaborated in 1995 to develop the Women's Initiative (WIN) for HIV Care and Reduction of Perinatal HIV Transmission. This was in response to the dramatic results of the AIDS Clinical Trial Group 076, in which perinatal HIV transmission was reduced by two-thirds with the use of ZDV. The 3-year WIN grant program seeks to support innovative HIV health care delivery models that maintain women and their children in care. Major goals are to:

- Provide early identification of women in need
- Provide access to care, including ZDV therapy
- Promote community-based awareness
- Evaluate models of care for possible replication.

WIN is administered through BHRD's SPNS program.

Ryan White Title IV HIV Demonstration Program for Children, Adolescents, and Families

Since 1988, the Pediatric/Family AIDS Demonstration Program has supported projects that stand as a model for and provide a coordinated, comprehensive system of care that is culturally competent, family-centered, and community-based to children, youth, women, and their families with and at risk of HIV infection.

In FY 1994, Congress transferred the Pediatric/Family AIDS Demonstration program to Title IV of the Ryan White CARE Act. Congress funded the program at $22 million, which represents $1.1 million over the FY 1993

level. The program will be permanently authorized in section 2071 of the Public Health Service Act. Title IV authorizes demonstration grants to:

- Support organizations to provide comprehensive services
- Enhance access to organizations that provide comprehensive services
- Enhance access to clinical research trials for children, youth, women, and families with or affected by HIV infection.

As a result of this transfer to Title IV, the focus of the program is further expanded to develop innovative models that link systems of comprehensive primary/community-based medical and social services for the affected population with NIH and other clinical research trials.

The program, referred to as the HIV Demonstration Program for Children, Adolescents, and Families, is now starting its seventh year. It has evolved from primarily focusing on the coordination of services for the management and care of infected children and their families to also addressing the broader prevention, care, and research needs of children, youth, and women affected by HIV/AIDS infection. Currently, there are 44 funded projects in 19 States, the District of Columbia, and Puerto Rico. Over 80 percent of all clients served are African American or Hispanic—groups reported with the highest prevalence of HIV/AIDS.

The Integrated Primary Care and Substance Abuse Treatment Demonstration Program

In FY 1989, HRSA, in conjunction with SAMHSA and the National Institute on Drug Abuse, launched a 3-year, $30 million demonstration program to assess the feasibility of linking primary care and drug abuse treatment to improve the effectiveness of drug treatment and to slow the transmission of HIV. The program was extended in order to continue implementation of program activities. In FY 1995, five of the eight grantees continued to receive funding, and it is expected that in FY 1996, these same grantees will receive continuation funding.

The program provides comprehensive health and drug treatment services to injection drug users, other drug users, their sexual partners, and family members. In 1991, the total caseload exceeded 21,000; an estimated 12,000 clients received substance abuse treatment and over 14,000 clients received primary care services. Forty-three percent of the clients were between 13 and 29 years old, approximately 40 percent were women, and 60 percent were from an ethnic or cultural minority group. Data are currently being analyzed for FY 1994.

Common barriers to successful integration of primary care and substance abuse programs were identified as:

- Deficiencies in provider training
- Lack of provider experience in working with the given population
- Inadequate space in which to provide services
- Lack of needed medical equipment
- Inability of professional staff to ensure that needed treatment is provided.

An evaluation of this program, now under way, will provide further information on the common barriers to successful integration of primary care and substance abuse programs, and identify strategies to overcome them.

HIV and Primary Care

HRSA, through its Title III(b) program, supports a number of HIV initiatives that seek to address significant concerns arising from the HIV epidemic. The Airbridge Initiative is assessing access and continuity of care issues for those clients who may be migrating from Puerto Rico to the greater New York area seeking HIV care. The Gay and Lesbian Adolescents Initiative is identifying the primary care needs of these adolescents and developing strategies for bringing them into and retaining them in care.

Immunization

Vaccines and immunization programs are one of our most effective public health tools. Immunization with vaccines that are available today controls numerous diseases and their complications, including influenza, hepatitis B, meningitis, and childhood vaccine-preventable diseases such as polio, diptheria, tetanus, measles, rubella, pertussis, and mumps. As part of its mission of promoting primary care practices, particularly among underserved and vulnerable populations, HRSA supports a number of immunization-related projects.

Childhood Immunization Initiative

Successful efforts to increase immunization levels in underserved infants and children require three key building blocks:

- National and State-based strategies that assure collaboration and coordination
- An adequate supply of vaccine
- An infrastructure to assure that immunizations are given.

These building blocks are the foundation for HRSA's immunization strategy to increase immunization levels in underserved infants and children through its grant-supported programs. This strategy is being implemented in collaboration with the CDC through the Childhood Immunization Initiative (CII).

The goal of the CII is to increase, by 1996, vaccination levels for 2-year-old children to at least 90 percent for the most critical doses in the recommended childhood immunization schedule. HRSA will support this effort via outreach, tracking, and case management; integrating HRSA programs into the CDC-initiated Immunization Action Plans; developing outcome measures in order to gauge progress; and integrating immunization efforts with delivery of primary care services to underserved children to provide them with a "medical home."

Other Immunization-Related Programs

HRSA supports a number of other immunization-related projects. C/MHCs used a continuous quality improvement approach to develop new clinical reporting requirements for both pediatric and adult immunizations. There are five innovative pilot projects in which State and Regional Primary Care Associations are implementing a group review, audit, and reporting process.

HRSA participated with CDC in formulating Standards for Pediatric Immunization Practice. The standards provide guidance to health care providers on overcoming barriers to immunization and taking advantage of all opportunities to immunize children.

The Primary Care Effectiveness Review, a site visit survey instrument for HRSA-funded health centers, includes a review of medical records to ensure that immunization protocols and practices are consistent with current American Academy of Pediatrics and Advisory Committee on Immunization Practices guidelines and with major issues outlined in the Standards for Pediatric Immunization Practice.

HRSA, through a cooperative agreement with City MatCH, surveyed childhood immunizations in 177 urban health departments nationwide that serve populations greater than 100,000. Ninety-five percent or more of the health departments administer immunizations against eight of the nine major diseases of childhood. To improve immunization levels, health departments are creating more user-friendly delivery systems; expanding immunization outreach and education activities; building and utilizing community partnerships, collaborations, and coalitions; and improving immunization documentation. Results from this survey will be utilized to provide technical assistance and consultation to States on immunizations.

HRSA's Migrant Health Program is working with HCFA on the final stages of a feasibility study on Medicaid reciprocity for migrant farm workers and their families. This approach will reduce one or more financial barriers to the timely immunization of children. HCFA is considering a demonstration phase to implement the recommendations of the study.

HRSA-funded State primary care associations and cooperative agreement agencies collaborate with CDC and the States through the Immunization Action Plans to ensure the participation of HRSA-funded programs in the plans.

HRSA has successfully launched several hepatitis B initiatives in collaboration with other PHS agencies and/or private entities. Currently, HRSA and the New York Children's Health Fund are jointly funding a new Hepatitis Demonstration Project which will target runaway adolescents.

HRSA and CDC are conducting a joint study of preschool immunization rates in the user population of five community health centers. Once baseline information is obtained, assistance is provided in developing and implementing a plan to increase baseline rates and evaluate the impact of interventions.

HRSA is collaborating with the National Service Program, the National Peace Corps Association, and the Congress of Black Churches to increase the number of volunteers working in HRSA-funded programs, including immunization activities.

Through cooperative agreements with the Association of Maternal and Child Health Programs (AMCHP) and City MatCH, HRSA surveyed State maternal and child health programs to identify immunization practices and barriers to delivery of age-appropriate immunizations. A report was published in 1994. The findings and recommendations from the survey serve as the basis for a technical assistance and a consultation plan to assist States to immunize 90 percent of preschool children by their second birthday.

HRSA ensures that the maternal and child health programs of the 59 States and jurisdictions are working towards meeting the goals of having 90 percent of the Nation's 2-year-olds fully immunized. This is being done by monitoring State programs through the Block Grant application review and, working in collaboration with the Interagency Committee on Immunizations as well as using information from the City MatCH and AMCHP studies, providing technical assistance that addresses immunizations as part of its State and community systems development initiative.

Infant Mortality

The infant mortality rate—a standard index of health—is higher in the United States than in many other developed countries. Within the United States, the total infant mortality rate declined for 1993 to its lowest rate ever, and this declining trend appears to be continuing through 1994 (*MMWR, 45* [10], CDC, 1996). However, differences in infant mortality rates persist based on race, socioeconomic status, and access to health care. For example, in 1993, the risk for death during the first year of life for black infants remained 2.4 times greater than for white infants (CDC, 1996). Results of the 1988 National Maternal and Infant Health Survey also indicate that a strong relationship exists between poverty and infant mortality risk.

HRSA supports initiatives for reducing infant mortality as part of its goals of increasing access and availability of health care in underserved areas and supporting education and community-oriented prevention programs.

Healthy Start

The Healthy Start Initiative is a demonstration program funded under section 301 of the Public Health Service Act. The purpose of the Initiative is to identify a broad range of community-driven strategies and interventions that could successfully and significantly reduce infant mortality. The intended goal is to reduce infant mortality by 50 percent in the 15 original Healthy Start communities in 5 years. Healthy Start brings to focus the need to strengthen and enhance community systems of maternal and infant care. The Initiative challenges communities to fully address the medical, behavioral, and psychosocial needs of women and infants. The principles guiding the planning and operation of the program are innovation, community commitment and involvement, increased access, service integration, and personal responsibility.

FY 1991 funding provided opportunities for comprehensive planning activities in 1992. Program implementation and the provision of services began in FY 1993. The Initiative is currently supporting 22 urban and rural communities to implement such strategies and interventions.

The Healthy Start Initiative also features an aggressive national and local public service information and education component to raise awareness of infant mortality and promote prenatal care and other healthy behaviors. An extensive outcome- and process-oriented national evaluation will assess diverse interventions and their effectiveness across distinct populations. In addition, all projects also conduct local evaluations.

Community Integrated Service Systems Development

In response to the need for better-coordinated maternal and child health efforts, HRSA made the development of community-based service systems a top priority. These systems are intended to promote physical, psychological, and social well-being for all pregnant women and children, adolescents, and their families; provide individualized attention for their special health care and related needs; and link health care and services with other needed services and programs, including, but not limited to, early intervention, educational, vocational, and mental health services. The legislation targets areas of high infant mortality.

The Community Integrated Service Systems program makes possible the implementation of systems building at the local level through the use of strategies that can facilitate realization of comprehensive community-based networks of services. CISS funds have been awarded directly to community applicants and States to assist in the development of program and service delivery linkage. CISS' legislation mandates that grantees incorporate one or more of six strategies into their programs: home visiting activities; one-stop shopping; health centers operated by not-for-profit hospitals; services for rural populations; outpatient and community-based service programs for children with special health care needs; and increased provider participation.

Perinatal and Women's Health

HRSA has a long tradition of involvement in perinatal health issues; the first study conducted by the Children's Bureau (MCHB's predecessor agency), back in 1913, looked into prenatal health care and birth outcomes in Johnstown, Pennsylvania. The Johnstown study pinpointed societal deficits that contributed to the poor health of pregnant women and their babies, as well as the necessary health and ancillary services and the medical issues affecting this population.

The Johnstown model has been used many times throughout the century to gather information about gaps in services, barriers to accessing services, and the impact of various interventions. The utility of many of the components of comprehensive prenatal care and the effectiveness of different modes for delivering care have been the subjects for Bureau-supported research and demonstration grants over the years. Home visiting, one-stop shopping, and resource mothers are some of the service delivery innovations first tested by HRSA.

HRSA's strategy for supporting new, innovative projects to improve the health of women and assure healthy birth outcomes is an outgrowth of this early work and is designed to:

- Improve the health care delivery system and access to care
- Improve the content of care and focus on risk reduction
- Improve the capacity of programs to assess needs and effectively respond to them.

Federal Collaborative Initiatives to Improve Infant Mortality

HRSA, through an interagency agreement with the Center for Substance Abuse Prevention (CSAP), is funding demonstration grant programs targeted at community development of comprehensive programs for pregnant substance abusers and their infants. Funded projects are administered by CSAP and address the medical and drug treatment needs of pregnant women through prevention, education, and treatment approaches. Collaboration between multiple agencies on the community level is encouraged.

The National Perinatal Addiction Prevention Program Resource Center is jointly funded by SAMHSA and HRSA. This National Resource Center acts as the country's focal point for policy, research, information/referral, training, service design, technical assistance, and evaluation findings of programs targeting substance-abusing pregnant and postpartum women and their children.

Rural Health

HRSA's Office of Rural Health Policy works within the DHHS and with other Federal agencies, States, national associations, foundations, and private-sector organizations to seek solutions to health care problems in rural communities. It also assists the Secretary in developing rural health finance policy. In particular, the Office advises the Secretary on how the Medicare and Medicaid programs affect access to health care for rural populations. For example, higher Medicare payment updates were recommended for primary care physicians and rural hospitals, along with a more liberal definition of Essential Access Community Hospitals. The Office also examines the rural implications of Federal and State health care reforms.

National Advisory Committee on Rural Health

ORHP administers the National Advisory Committee on Rural Health, which advises the Secretary for Health and Human Services on the priorities and strategies that should be considered when providing and financing health care services in rural areas. The Committee meets three times a year to develop recommendations to the Secretary designed to improve access of rural residents to primary care and hospital care. The Committee's 1994 recommendations focused particularly on the need for supportive and flexible national policies to help States and communities reform the rural delivery system. It also makes recommendations for rural data needs, as well as concerns over rural mental health, rural hospitals, and graduate medical education. The *Seventh Annual Report on Rural Health to the Secretary of Health and Human Services* is available from the Office, as are previous reports. The Committee's eighth report was issued in December 1995.

Rural Health Outreach Grant Program

ORHP administers the Rural Health Outreach Grant program to demonstrate new and innovative models of health care delivery through the integration and coordination of local services. Since 1991, over $100 million has been awarded to almost 300 rural communities in 48 States and 4 territories. For FY 1995, 288 applications were reviewed and grant awards were made for 26 new and 122 continuing projects.

ORHP also implements a matching grant program with States that provides $2.5 million to support the activities of State Offices of Rural Health. Today, there are 50 State offices, each of which serves rural communities by collecting and disseminating information; assisting with the recruitment and retention of health professionals; providing technical assistance to garner Federal, State, and foundation funding; and coordinating rural health interests and activities across the State.

ORHP supports rural health research activities and administers a grant program for Rural Health Research Centers, which collect and analyze information, conduct applied research on rural health care issues, and widely disseminate results. Six centers currently have grants under this program—the State University of New York at Buffalo, the University of Minnesota, the University of North Carolina at Chapel Hill, the University of North Dakota, the University of Southern Maine, and the University of Washington. A full competition of the Rural Health Research Center grant program was conducted in FY 1992. The next competition is anticipated in FY 1996.

Rural Information Center Health Services

Through an interagency agreement with the Department of Agriculture, ORHP supports a national clearinghouse that collects and disseminates rural health information. The Rural Information Center Health Services (RICHS) responds to individual inquiries with customized assistance. RICHS also provides information on Federal grant programs and the status of legislation and has begun to offer a new series of background papers on a variety of rural health issues. RICHS participates in the electronic bulletin board of the Agricultural Library Forum (ALF). Information on how to access ALF directly is available from RICHS through its toll-free number (1-800-633-7701). In addition, ORHP works closely with the Department of Agriculture's Cooperative Extension Service in the development and implementation of their national health initiative, *Decisions for Health*.

Other HRSA Rural Health Activities

ORHP has played a lead role in coordinating telecommunications activities in DHHS. Through June 1992, it managed a Departmental demonstration that established an interactive satellite-based video communication system between Texas Tech University and rural physicians in west Texas. Continuing funding is provided for a major telemedicine demonstration project in West Virginia, called MDTV, which links West Virginia University's Health Sciences Center in Morgantown with a second hub site in Charleston, five small rural hospitals, and two

Veterans Administration hospitals. Three Community Health Centers will be added to the telemedicine network in the next year. MDTV provides 24-hour medical consultations, emergency assistance, and continuing education to the remote sites. Weekly grand rounds are also included in programming. An additional seven telemedicine projects are being funded under the Outreach Grant program. An earlier-funded project in Oregon is continuing using other resources. There, a consortium of community mental health centers in 13 rural counties hooked into an already existing statewide telecommunications network that uses three different modes: satellite, compressed digital transmission, and an electronic data network. The mental health centers can access mental health specialists in Portland and Pendleton for case consultations, admission and discharge interviews, and crisis response. The network is also used to meet the education needs of the rural mental health professionals and paraprofessionals.

In FY 1994, HRSA awarded a contract to the University of Colorado to examine the role of social workers in health care systems in rural areas and provide information about developing effective interdisciplinary rural health care teams. In FY 1995, two contracts were awarded to examine the roles of health professionals in rural communities. The first contract, awarded to the American Pharmaceutical Association, is exploring aspects of pharmacists' practice in rural communities, including their accessibility as health care providers (geographic and ease of contact). The second contract, awarded to Palmer College of Chiropractics, is to explore the role of chiropractors, who have not been well integrated into health care teams, as members of interdisciplinary teams and health care providers in rural communities.

In FY 1995, HRSA funded 19 projects under its program Grants for Interdisciplinary Training for Health Care for Rural Areas. Ten grants for Health Education and Training Centers for the U.S.-Mexico Border Areas and other urban and rural areas of need were funded.

In FY 1995, there were 33 HRSA-supported AHEC programs, with a majority of the programs addressing rural population needs through AHEC-sponsored health personnel training programs, at approximately 1,149 participating rural training sites.

HRSA, in collaboration with HCFA, administers the Rural Health Medical Education Demonstration Project. The project provides resident physicians with clinical experience in rural areas. Currently, there are eight ongoing projects.

Through an interagency agreement with the Agency for Health Care Policy and Research, the Bureau administered a project at the Arkansas Area Health Education Center to test strategies for disseminating new medical treatment protocols to practicing physicians. This project, which was completed in FY 1994, afforded an opportunity to examine the relevance of the protocols to the needs of rural populations and rural physicians. It also provided some insight into alternative information dissemination strategies. A paper, entitled *Primary Care Physicians' Response to Dissemination of Practice Guidelines*, was accepted for publication by the *Archives of Family Medicine*.

More than 50 percent of the graduates of nursing schools receiving HRSA funding for advanced degree professional nurse traineeships worked in rural and medically underserved communities. HRSA nursing programs also fund nurse anesthetist training, with 76 percent of the funded projects focused on preparing nurse anesthetists to work in rural and medically underserved communities, where 85 percent of all anesthesia for rural areas is administered by nurse anesthetists.

HRSA is required by legislative mandate to ensure that at least 40 percent of its nationwide network of more than 1,700 community health centers and migrant health centers are located in rural areas. In addition, rural areas are among the shortage areas in which HRSA places doctors and other health professionals who participate in the National Health Service Corps.

HRSA provides AIDS-related services to rural areas through Ryan White CARE Act programs. These activities range from an evaluation study to assess the need for rural AIDS services to the establishment of a national AIDS hotline for clinical questions from health professionals throughout the Nation.

Public Health and Primary Care

Improving public health through promotion of primary care education and practice and better access and availability to quality health care are fundamental components of HRSA's mission, supported Agencywide.

Public Health Activities

The Office of Public Health Practice serves as the Agency's focal point on efforts to strengthen the practice of public health in the Nation—as it pertains to the HRSA mission.

OPHP is involved in a wide range of activities that highlight the role of State and local health departments in assuring the health status of their communities, including:

- Addressing issues raised in *The Future of Public Health* (IOM)
- Providing HRSA management with input on programs that impact public health practice
- Working with State and local governments to promote solutions to problems that may impair the delivery of public health services, especially those relating to the establishment of primary care systems
- Developing and coordinating grants, contracts, and agreements for public health practice activities.

OPHP is also the lead HRSA office for activities involving the Joint Council of Official Public Health Organizations. The Joint Council provides the major public health provider organizations with a mechanism to respond to pressing issues.

Other units within HRSA are also directly involved in public health practice activities. The BHPr administers several programs targeted to improving public health education and training. The Public Health Traineeship grant program provides funds to schools for traineeships to individuals pursuing studies in a public health field in which there is a severe shortage of professionals.

The Public Health Special Project grant program supports curriculum development and other projects that further Healthy People 2000 goals in preventive medicine, health promotion and disease prevention, health care in medically underserved areas, and domestic violence. The Public Health Practice Coordinator initiative promotes linkages between schools of public health and the practice community. A five-State pilot study of evolving public health workforce training needs is under way.

The Preventive Medicine and Dental Public Health grant programs support graduate medical education in the specialty of preventive medicine, graduate dental education in the specialty of dental public health, and special initiatives to strengthen development of these disciplines. The Health Administration Traineeships and Special Projects grant program provides traineeships for students and assists in the development or improvement of programs in health administration.

A 5-year initiative to enhance the analytic skills of maternal and child health professionals is under way in maternal and child health training programs in schools of public health. MCHB and the CDC are placing maternal and child health epidemiologists in States to assist the MCH problem solving.

Collaborative Efforts

HRSA continuously monitors the impact of the changing health care environment on PHS programs and evaluates its leadership role and the direction the Agency must take in order to close gaps in the national health care system. Taking a proactive direction, HRSA has increased its focus on identifying timely opportunities for supportive partnerships and new relationships in community-based linkages that will strengthen the public health network. HRSA, with other Federal agencies, is entering into new and innovative relationships with private and nongovernment organizations to support creative health care delivery arrangements and provider training opportunities that will strengthen community-based public health solutions.

A Memorandum of Understanding with the American Hospital Association has been signed in order to identify and strengthen collaborative arrangements between HRSA and the hospital industry. HRSA is currently reviewing potential projects that will result from that agreement.

Close collaboration is taking place with CDC in the area of community-based needs assessment. HRSA is working on a program agenda with CDC on Building Bridges Across Public and Private Sectors Through Collaboration and Partnerships.

Work is under way to identify collaborative opportunities with the Substance Abuse and Mental Health Services Administration.

School Health

Two HRSA Bureaus, MCHB and BPHC, are collaborating on Healthy Schools, Healthy Communities. This initiative will assist States in the development of full-service schools to meet the needs of communities through the provision of comprehensive, culturally competent, and integrated health, psychosocial, and education services for all children, adolescents, and their families. These projects are designed to improve accessibility and increase utilization of comprehensive health and health-related services that are geared to the developmental needs of school-age children.

The projects funded include 10 school health staff development grants to prepare health care providers and education personnel to work effectively in conducting comprehensive school health programs; service demonstration grants to develop community models to provide a comprehensive range of health and health-related services and to build community partnerships to implement the models; and health education/promotion demonstration grants to implement prevention and early intervention programs on such problems as violence, injury, smoking and other drug use, sexual activity, sexually transmitted diseases and HIV/AIDS, and delinquent behavior. The health education/promotion grants are directly linked to the service demonstration grants for school-based health centers and must complement the services of the funded school-based health centers. In FY 1994, $2.5 million were earmarked to launch this school health program.

A new project, Expanded School Health Resources and Training, has been developed to provide up-to-date technical information, materials, and resource assistance to States, school districts, and others regarding development or expansion of health services in the school setting. The project will, in addition, provide information on school health that will assist in policy and program development initiatives to improve the health of school-age children and youth.

Violence Prevention in Schools

As part of its efforts to address violence and related issues, MCHB funded five States to enhance mental health resources and services in schools through systems building and two training and technical assistance centers for mental health resource support nationwide.

BPHC funded three community health centers to improve and increase violence prevention and mental health services in the school-based clinic setting. Each of the three recipients has an established school-based clinic. Through this funding, violence prevention, mental health treatment, and psychosocial support services are being expanded and integrated into the service packages of the three school-based programs. Each center has developed a unique program of mental health services designed to meet the needs of their differing populations and address specific issues related to violence.

Primary Care Initiatives

Access to Primary Care

Over 43 million Americans are without access to primary care because they lack health insurance, live in communities without sufficient health resources, have special needs not met by traditional medical care, or face other barriers such as race, language, or culture. Primary care is a common denominator for all HRSA Bureaus, with some focusing on the development of primary care providers, others on resources, and still others on categorical populations such as mothers and children.

The MCHB, as mandated by Title V of the Social Security Act, provides leadership to the public and private sectors to build an infrastructure for the delivery of primary health care services to all mothers and children in the Nation. A particular responsibility is serving those low-income or isolated populations who otherwise would have limited access to care. There are 59 States (and jurisdictions) that receive funds under the MCH Services Block Grant. Approximately 85 percent of the Block Grant funds are distributed to States under a formula that takes into consideration the percent of the Nation's low-income children residing in each State. The goals of this program include increasing the number of low-income children receiving health assessments and followup diagnostic and treatment services and providing access to comprehensive perinatal care for women and preventive and primary care services for children, including children with special health care needs.

The BPHC has the major responsibility for the delivery of primary care services to targeted medically underserved populations such as low-income minorities, pregnant women, children, the uninsured, immigrants, the homeless, substance abusers, HIV-infected persons, the elderly, and migrant and seasonal farm workers. These services are integrated with those of State and local health departments and organizations within the community served. These programs are designed to complement existing resources, and coalition building with other providers of health and social services is a priority.

Collaborative Efforts

HRSA will continue to work with HCFA to implement significant expansion in the Medicaid and Medicare programs, which offer the programs they fund the possibility of substantially increasing revenues or, alternatively, completely losing their funding base.

To build coalitions and complement existing resources, HRSA has entered into cooperative agreements with public constituent organizations to promote the development of primary care systems in States and local communities. These organizations include the Association of State and Territorial Health Officials (ASTHO), the National Association of County Health Officials (NACHO), the U.S. Conference of Local Health Officers (USCLHO), the National Governors' Association (NGA), and City MatCH.

With support from several HRSA programs, ASTHO maintains a primary care committee that oversees the production of the *ASTHO Access Report*, a monthly newsletter on primary care and maternal and child health, and supports projects and topical reports such as the *1993 Inventory of State Primary Care Cooperative Agreement Activities,* December 1993, and the *ASTHO Multicultural Public Health Capacity Building Pilot Projects Final Report,* February 1994.

In collaboration with the NACHO, linkages are also encouraged between C/MHCs, local health departments, and other providers of primary care services to the underserved. In early FY 1994, a *Model Strategy Workbook* was disseminated, which describes the experience of sites in developing partnerships. A survey of those who received the workbook is currently being conducted to determine if it has had any impact on the development of partnerships. With support from HRSA and the Office of the Assistant Secretary for Health (OASH), NACHO has also completed a bilingual/bicultural health project that will be distributed to local health departments and C/MHCs. The goal of these materials is to assist local communities in recruitment and retention of local providers by providing information on public health functions, clinical improvements mechanisms, and networking opportunities. Finally, another planned NACHO initiative is to develop case studies illustrating the participation of local health departments and C/MHCs in managed care arrangements and integrated service delivery networks.

The USCLHO has developed the Minority Health Initiative (MHI), which is designed to improve the capacity of local communities to address the health needs of their minority populations. In addition, it facilitates information exchange between local health departments and community-based programs.

An NGA Cooperative Agreement has been designed to enhance HRSA's and HCFA's relationships with the various State and local agencies/organizations involved in the delivery of primary care. NGA has conducted forums on the implementation of Medicaid enhancements that greatly affect the provision of primary care—the Federally Qualified Health Center provisions, the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, Medicaid Managed Care programs, and the outstationing of Medicaid eligibility workers.

A collaborative effort with the Administration for Children and Families (ACF) to build comprehensive services of health and child welfare programs at the State and local levels was established in 1994. The home visiting model is an important care component of these projects. In 1994, 43 States, the District of Columbia, and Puerto Rico received 1-year Community Integrated Service Grants from the Bureau to support the development of enhanced health components of the Family Preservation and Family Support Services programs funded by ACF.

In addition, NGA has worked with HRSA Bureaus on a series of policy briefs that discuss the acquisition of cost-based reimbursement by primary care providers and the relationships among case management, C/MHCs, and Medicaid. In FY 1993, NGA policy forums and issue briefs examined the collaborative opportunities available for C/MHCs and State-supported health professions programs to provide community-based primary care training. This year, the NGA is funded to focus on State Medicaid managed care waivers and the role of public-sector providers in the development of these waivers.

Under its Partnership for Information and Communication (PIC) program, the MCHB supports 10 cooperative agreements with various governmental and professional organizations to both facilitate the dissemination of new information and to encourage collaboration among the PIC grantees on issues of common concern, such as activities relevant to health care financing and service delivery strategies and early childhood immunizations programs. The PIC grantees are: Association of Maternal and Child Health Programs, Association of State and Territorial Health Officials, City MatCH and the U.S. Conference of Local Health Officers; Family Voices, Grantmakers in Health; National Association of County and City Health Officials; National Conference of State Legislatures; National Governors' Association; National Healthy Mothers, Healthy Babies Coalition; and the Washington Business Group of Health.

State-Based Activities

State Title V (maternal and child health) programs are located in the departments of health in every State, along with the majority of programs for children with special health care needs. State Title V programs implement their responsibilities by engaging in a range of core public health program functions, including: needs assessment; program planning and development; service delivery, coordination, and financing; standard setting and monitoring; technical assistance, information, and education; and reporting.

The maternal and child health programs support such services as prenatal care, child health services, school health services, and specialized health services and family support for children with actual or suspected developmental disabilities or chronic illnesses. State programs are also developing community-based networks of preventive and primary care that coordinate and integrate public- and private-sector resources and programs for pregnant women, mothers, infants, children, and adolescents.

PCAs and PCOs have wide-ranging activities based on an environmental assessment of needs and resources in the State. The PCO is responsible—with input from the PCA—for development of the State Primary Care Access Plan, which identifies and prioritizes primary care needs in the State. The two State partners, in collaboration with HRSA, seek to develop seamless systems of comprehensive, community-based primary care for the underserved by coordinating all available resources.

Intra-HRSA Linkage Activities

HRSA Bureaus formed various linkage committees and work groups to better support underserved communities. The BPHC/BHPr Linkage Committee was formed in response to an increasing recognition that linkages between community-based primary care delivery sites and health professions educational institutions and programs can provide a stimulus to retain health practitioners in primary care. Since its inception, the Committee has increased collaboration between the two Bureaus in the development and implementation of policies and programs related to service-education linkages, developed new programs and contracts to facilitate these linkages, and increased funds targeted to this activity.

In 1993, with AHEC funding, a contract was awarded to conduct five regional faculty development workshops to bring together the primary care faculties with health center providers. These workshops provided faculty development orientation and training to approximately 250 health providers serving in underserved sites (i.e., community/migrant health centers). Included were physicians, nurse practitioners, and physician assistants who are likely to become preceptors and affiliated faculty for a range of BHPr-sponsored training programs. More than 1,000 copies of the final product, a workbook entitled *Faculty Development Workbook of Primary Care Futures Project*, have been distributed to date.

The MCHB/BPHC Interbureau Workgroup was created to share information about program activities, organizational frameworks, and lessons learned, with the purpose of enhancing the success of programs through collaboration between the two Bureaus. This group has reviewed activities and service programs in both Bureaus. Particular attention has been given to planning requirements that place overlapping demands on States in order to foster more effective collaboration at the service level.

Primary Care Workforce

The health professions education and training programs administered by the BHPr provide assistance to develop and maintain the infrastructure necessary to produce an adequate supply of primary care and public health practitioners to meet the Nation's needs. These programs include a variety of training grant activities that help medical schools and hospitals plan, develop, and operate training programs in family medicine, general internal medicine, and general pediatrics, as well as closely associated health care personnel, such as physician assistants and podiatrists. These programs have emphasized activities to generate and maintain interest in primary medical care at the undergraduate and graduate levels.

Postdoctoral research training in primary medical care is promoted through institutional awards made under the National Research Service Award program. These projects are conducted by institutions that have current and past BHPr-sponsored training activities in family medicine, general internal medicine, and general pediatrics. Similar training experiences are emphasized in the Bureau-administered training programs for advanced general dentistry. The National Institutes of Health Revitalization Act of 1993, Public Law 103-43, doubled the level of this funding. There are currently 10 ongoing projects.

Education and training for nurse practitioners and nurse-midwives is also supported by the Agency. Grants are awarded to eligible institutions to plan, develop, operate, expand, or maintain programs for the education of nurse practitioners and nurse-midwives to work in settings such as the home, ambulatory and long-term care facilities, and other health care institutions. The Nurse Practitioner and

Nurse-Midwifery program has helped develop and expand 60 percent of the current educational programs preparing nurses for primary care delivery, with 95 percent of the nurse practitioner and nurse-midwifery graduates actually working in primary care settings. An annual Nursing Minority Congress convenes over 100 minority nurse national leaders in nurse education and practice. Cosponsors are the National Institute for Nursing Research, National Institutes of Health; Office of Minority Health, DHHS; Office of the Chief Nurse, PHS; Office of the Chief Nurse, Indian Health Service; Office of Minority Affairs, HRSA; Division of Disadvantaged Assistance, BHPr, HRSA; and Psychiatric Nursing Program, National Institute of Mental Health.

In HRSA's Long-Range Plan to Improve Access for Underserved Populations, the National Health Service Corps plays an essential role in meeting long-term expectations to provide health professionals to underserved areas. The plan projects significant increases in loan repayment agreements to support capacity expansion and NHSC scholarships, which will eventually result in significantly higher numbers of providers available for placement in underserved areas. BHPr's part in the long-range plan would provide immediate relief to the most severely underserved areas through strengthening training of primary care physicians and nonphysician providers at service sites. This would expand the pool and improve the quality of primary care providers willing and able to serve the underserved.

An annual Primary Care Fellowship Program is administered by HRSA and the Agency for Health Care Policy and Research. Cosponsors for the fellowship program include CDC, the Indian Health Service, SAMHSA, and HCFA. The purpose is to provide an opportunity for primary care practitioners, academicians, researchers, and administrators to become more effective advocates for improving primary health care. During the intensive 3-week fellowship program in March and June of 1995, 33 participants studied how legislation, research, and health care financing impact primary care policy.

The DHHS Interdepartmental Minority Health Science Careers Coordinating Committee helps to enhance coordination and communication among the various departments and agencies in the executive branch that address the improvement of minority representation in the health science and biomedical professions. Quarterly meetings are held. A *Directory of Minority-Funded Programs* has been disseminated to all committee members and their constituencies.

Various grant programs administered by BHPr have used a funding priority that favorably adjusts the merit review scores of applicants who demonstrate either substantial progress over the past 3 years or a significant experience of 10 or more years in enrolling and graduating trainees from those minority or low-income populations identified as at risk for poor health outcomes. Since this approach rewards both schools with longstanding track records and schools that make short-term progress, the priority encourages both commitment and change.

The Council on Graduate Medical Education has addressed the issue of education and entry of minorities into medicine in many of its reports. Its *Third Report* in 1992 set out a scene of targeted strategies to train more generalist and minority physicians, reduce the number of specialists, and improve the geographic distribution of physicians to support health care reform and cost control strategies. The Council subsequently issued its *Fourth Report* to provide an implementation plan for the *Third Report's* recommendations. COGME's *Seventh Report* also provided recommendations on funding Public Health Service programs, many of which target either directly or indirectly minorities in health professions training.

NHSC programs are promoted by sending literature and making site visits to minority medical schools and other medical schools with large minority populations. Additionally, the National Medical Association, under a contract with HRSA, promotes education for minority health professionals by visiting and providing minority students with information about NHSC scholarship and loan repayment programs. BPHC's Scholarship Program has a special focus for the Secretary's initiative to visit Historically Black Colleges and Universities to explain the scholarship and loan repayment programs and funding preference for scholarships.

To aid needy health professions and nursing students in meeting educational costs, a number of ongoing scholarship and loan programs have been established, including Exceptional Financial Need Scholarships, Financial Assistance to Disadvantaged Health Professions Students, and low-cost health professions and nursing student loans.

Programs that target assistance to individuals from disadvantaged backgrounds in schools that meet specific requirements for the conduct of activities were implemented in FY 1991. These programs include: Loans for Disadvantaged Students, Scholarships for Disadvantaged Students, and a Faculty Loan Repayment Program.

Managed Care

A variety of Managed Care initiatives are under way throughout HRSA, including ongoing participation in health care reform planning at the highest level, collaboration and partnerships with other Federal agencies and nongovernment organizations to coordinate services, and development of proactive initiatives to evaluate the role and effectiveness of managed care in a reformed health care system that will assure access to quality health care services for all populations. Special attention is focused on projects that organize the different reimbursement mechanisms for services, especially Medicaid, to create a seamless, coordinated system of health and social services that responds to the unique needs of each community.

The Nursing Special Projects Program funded for development or expansion more than 50 percent of the currently operating nurse-managed clinics. These clinics provide care to high-risk and vulnerable populations, including the homeless, the frail elderly, persons with HIV/AIDS, school children, and families.

The Office of Planning, Evaluation, and Legislation in the Office of the Administrator has a pivotal coordination and leadership role in initiating and monitoring the Agency's managed care activities. In the changing health care environment, broad strategy efforts work to assure support to the providers of health care to the vulnerable populations and to close the gaps in the health care system with a strong public health network.

Within the context of HRSA's diverse programs, innovative approaches have been crafted to increase the Agency's effectiveness in providing guidance, expertise, and needed technical assistance as the States work with individualized strategies to assure their ability to provide quality services to all populations.

As an example, BHPr has several ongoing efforts to provide managed care training to Bureau staff and to coordinate its managed care projects. An internal managed care work group has been assembled to discuss and coordinate Bureau and Agency managed care projects. The Bureau is sponsoring training sessions for staff on the "ABCs" of managed care, and one Division is holding seminars on timely managed care topics.

A contract has been awarded to Jefferson Medical College to evaluate selected aspects of medical education in managed care settings. The goals of the projects are to identify barriers to the use of managed care organizations for primary care medical education and to develop curricular recommendations and other resources for medical schools, academic institutions, and managed care organizations to better prepare primary care physicians to practice in managed care settings.

Managed Care Priority Committee

The mission of the Managed Care Priority Committee is to ensure that HRSA-funded programs and the underserved populations they serve are active and knowledgeable participants in managed care systems, that managed care providers are aware of and supported in meeting the needs of these underserved populations, and that an appropriately trained primary care workforce exists to provide services in managed care settings.

Managed Care for People With HIV/AIDS

The growth of managed care has particular implications for people with chronic conditions, such as HIV disease. These implications are being explored on a number of fronts by HRSA and its Bureaus, including the award in 1994 of grants to five organizations that are testing the feasibility of providing care to persons with HIV under capitated managed care arrangements. The grants were made under the SPNS program. Each of the five projects will be developing and examining models of capitated care delivery within differing environments or for certain discrete services. As part of the SPNS initiative, which requires dissemination of project results, the projects are also developing reports on their findings and experiences that will be made widely available.

The five SPNS capitated care projects are located at the AIDS Healthcare Foundation in Los Angeles, the Johns Hopkins University School of Medicine in Baltimore, the New York State Department of Health's AIDS Institute, the East Boston Neighborhood Health Center, and the Visiting Nurses Association of Los Angeles.

Managed Care Assistance Program

A number of HRSA Bureaus and Offices have become involved in providing assistance to the States as they develop their managed care capacity to service maternal and child health and other vulnerable populations' needs.

As managed care has become embedded in the health field, MCHB has turned a number of its resources to assisting experts responsible for maternal and child health at national, State, and local levels to prepare to play a

central role in assuring that vulnerable populations continue to have access to appropriate primary care and special services under managed care. Expert consultation and technical assistance is provided to States through a national contractor, and a number of grants have been awarded to organizations and agencies involved in coordinating and/or providing care to children with special health care needs. Children with special health care needs are frequently ignored or "carved-out" in State Medicaid-managed care reforms, and new tools and training have been necessary to help find ways to include them in changes that are taking place.

A 2-day training course with invited States as cosponsors has been developed around maternal and child health managed care issues. By the end of FY 1996, over 19 sessions will have been held around the country, reaching individuals working in State and local maternal and child health policy and operations positions from over 45 States. The course, developed in response to State requests for assistance, is designed to enable participants to understand the thinking of managed care organizations and explore the relationship of State and local maternal and child health programs to the world of managed care. The course has provided a grounding for strengthening the care of underserved mothers and children and has led to the emergence of new tools and ideas for refocusing State and local Title V program activities on assuring that the needs of the maternal and child health population continue to be met under managed care.

National and Community Service

On September 21, 1993, President Clinton signed into law the National and Community Service Trust Act, which created the Corporation for National Service. The Corporation's mission is to engage Americans of all ages and backgrounds in community-based service to address the Nation's educational, public safety, environmental, and human—including health—needs. For the 1995-96 program year, more than 25,000 Americans will be engaged in addressing these needs through "AmeriCorps"—the domestic Peace Corps. In exchange for a term of service, AmeriCorps members receive a stipend and an educational benefit.

For the 1995-96 program year, HRSA received a $1.1 million grant from the Corporation for National Service to fund the second year of the HRSA Community Care Corps. The purpose of the program is to engage AmeriCorps members in providing enabling services to community residents so that they may overcome barriers to primary care and related services. Enabling services include home visits, referrals, translation, transportation, and child care.

Teams of AmeriCorps members, composed of health professions students and community residents, are based at existing community-based service sites to provide enabling services. Through this program, communities are able to capitalize on the established infrastructure of both primary care providers and community organizations to offer a cost-effective means of increasing health services and access to them.

Each project is managed by a community-based management team, which includes representatives of community organizations, health service sites, health professions schools, the Public Health Service regional offices, consumers, and AmeriCorps members. Members receive ongoing training in health issues, community awareness, accessing social services, and skills building, as well as participating in a mentoring program.

In the 1995-96 program year, 92 HRSA Corps members will be based at service sites in Chicago, Philadelphia, and Pittsburgh.

Healthy People 2000

The Healthy People 2000 national health objectives represent a strategy for reducing preventable illness, injury, disability, and premature death. The process of reaching agreement on a broad set of national disease prevention and health promotion objectives and the ongoing collaborative process to refine and update implementation planning provide a useful forum for identifying emerging and changing problem areas and special-population issues most likely to be helped by a targeted national effort.

In addition to participation in the DHHS-wide effort to meet the goals and targets of the 22 Priority Area objectives, HRSA remains a co-lead with CDC to provide leadership for strategy development and implementation planning for two major Priority Areas, *Clinical Preventive Services* and *Educational and Community-Based Programs*, and has the lead responsibility for a third Priority Area, *Maternal and Infant Health.*

Cross-Cutting Progress Reviews that cut across the Priority Areas were established to focus on and highlight the culturally related health issues and needs of special population groups. The groups identified for attention include: American Indians/Alaskan Natives; Hispanic Americans; Asian and Pacific Islanders; Black Americans; Adolescents/ Young Adults; People With Disabilities; Women; and People With Low Incomes. The cross-cutting workgroups for each special population effectively broaden the implementation efforts of Healthy People 2000, include a greater representation of Americans in the planning process, and provide assurance of having a more effective impact on improving the health of the Nation.

Clinical Preventive Services

Attainment of the goals and targets of the *Clinical Preventive Services* Priority Area relies substantially on increasing access to, utilization of, and provision of the Clinical Preventive Services recommended by the U.S. Preventive Services Task Force. Other important strategies include patient and provider education on clinical preventive services and adequate reimbursement for providers delivering such services—especially in the emerging managed care setting. These services include immunization, screening for early detection of diseases, and health education and counseling services delivered in a health care setting.

The Intradepartmental Work Group on Clinical Preventive Services for Healthy People 2000 is co-led by HRSA's Office of Planning, Evaluation, and Legislation and CDC's Public Health Practice Program Office. The Work Group serves as the focal point of planning to develop strategies and action steps that bring together Federal agencies in partnership with managed care organizations, national health professions representatives, and other nongovernment and volunteer organizations to encourage support for and implementation of the delivery of preventive services throughout the American health care system.

C/MHCs have a significant impact on their target populations in issues of prevention. C/MHCs have contributed to lower infant mortality rates, reduced hospitalization rates, and fewer hospital days. The BPHC has developed and implemented prevention-oriented clinical performance measures for each of the five life cycles (perinatal, pediatric, adolescent, adult, and geriatric) as part of an overall clinical strategy for C/MHCs. The purpose of these guidelines is to improve the quality of health services and to document the impact of C/MHCs on the health status of underserved people. All of the clinical outcome measures are reflective of the Healthy People 2000 objectives.

Other activities that focus on prevention for the underserved include cooperative agreements with private foundations to foster primary prevention in C/MHCs and support for the Migrant Clinicians Network and the National Association of Community Health Centers to develop prevention materials for C/MHCs.

Educational and Community-Based Programs

The health professions education and training programs build linkages between the public health preventive services agenda and the health professions schools to assure that academic curricula are responsive to and reflective of the changing primary and preventive health care needs of the entire Nation. Programs are funded to provide financial assistance and mentoring opportunities to individuals from disadvantaged backgrounds—as well as from underrepresented, ethnic, and minority groups—to assist their entry into health professions training.

Maternal and Infant Health

The MCHB continues to have lead responsibility for implementing Priority Area 14 of Healthy People 2000, *Maternal and Infant Health*, coordinating the development of implementation plans and tracking mechanisms. A major focus for implementation is through the State MCH programs. The MCH Block Grant requires that State plans and programs be consistent with these and other national objectives for children and adolescents, and requires the States to report annually on progress in meeting major objectives.

Appendices

This section contains three appendices, each of which is organized by Bureau. *Appendix A* lists the legislative authorities (most of which are contained in the Public Health Service Act) for HRSA programs. *Appendix B* lists FY 1995 HRSA appropriations. *Appendix C* lists names and telephone numbers for key HRSA staff.

Appendix A— HRSA Legislative Authorities

PROGRAM	LEGISLATIVE AUTHORITY	AUTHORIZED THROUGH
Bureau of Primary Health Care		
Hansen's Disease Center	Sec. 320, PHS Act	Indefinite
Payment to Hawaii	Sec. 320, PHS Act	Indefinite
Migrant Health	Sec. 329, PHS Act	9/30/94
Community Health Centers	Sec. 330, PHS Act	9/30/94
National Health Service Corps (field)	Sec. 331-338, PHS Act	9/30/94
NHSC Recruitment	Sec. 338A-H, PHS Act	9/30/00
State Loan Repayment	Sec. 338I, PHS Act	9/30/95
Community Scholarships	Sec. 338L, PHS Act	9/30/93
Health Care for the Homeless	Sec. 340, PHS Act	9/30/94
Public Housing Clinics	Sec. 340A, PHS Act	9/30/93
Alzheimer's Demonstration Grants	Sec. 398-398B, PHS Act	9/30/93
Nursing Loan Repayment	Sec. 846, PHS Act	9/30/94
Black Lung Clinics	Sec.427(a),Mine Safety and Health Act of I977	Indefinite
Pacific Basin	Sec. 10, PL 101-527	9/30/93
Native Hawaiians: Health Care, Planning, Training, Research, Scholarships	PL 100-579 as amended	9/30/01
HIV Early Intervention	Sec. 2651-55, PHS Act	9/30/95
Bureau of Health Professions		
HEAL Loans	Sec. 701-20, PHS Act	9/30/95
Loans for Disadvantaged Students	Sec. 721-35, PHS Act	9/30/93
Exceptional Financial Need Scholarships	Sec. 736, PHS Act	9/30/93
Disadvantaged Scholarships	Sec. 737, PHS Act	9/30/93
Faculty Loan Repayment/Fellowships	Sec. 738, PHS Act	9/30/93
Centers for Excellence: Historically Black Centers, Hispanic Centers, Native American Centers, Other Centers	Sec. 739, PHS Act	9/30/93
Disadvantaged Assistance: HCOP Grants, FADHPS Scholarships	Sec. 740, PHS Act	9/30/93
Area Health Education Centers	Sec. 746(i)(1),PHS Act	9/30/95
Health Education and Training Centers (HETC)	Sec. 746(i)(2),PHS Act	9/30/95

PROGRAM	LEGISLATIVE AUTHORITY	AUTHORIZED THROUGH
Family Medicine Training: Family Medicine Residencies, Family Medicine Departments	Sec. 747, PHS Act	9/30/95
Internal Medicine and Pediatrics	Sec. 748, PHS Act	9/30/95
General Dentistry Residencies	Sec. 749, PHS Act	9/30/95
Physician Assistants	Sec. 750, PHS Act	9/30/95
Podiatric Residencies	Sec. 751, PHS Act	9/30/95
Public Health Traineeships	Sec. 761, PHS Act	9/30/95
PH Sp.Proj./Prev. Med. Res.: Public Health Special Projects, Preventive Medicine/Dental Residencies	Sec. 762-765, PHS Act	9/30/95
Allied Health Advanced Training	Sec. 766, PHS Act	9/30/95
Allied Health Special Projects	Sec. 767, PHS Act	9/30/95
Health Administration: Instit./Spec. Proj. Grants, Traineeships	Sec.771, PHS Act	9/30/95
Geriatric Training: Centers, Faculty Training	Sec. 777(a)and(b),PHS Act	9/30/95
Geriatric Optometry	Sec. 777(c), PHS Act	9/30/95
Rural Health Training	Sec. 778, PHS Act	9/30/95
Research Projects	Sec. 781, PHS Act	9/30/95
Chiropractic Demonstrations	Sec. 782, PHS Act	9/30/95
Health Professions Studies	Sec. 792, PHS Act	Indefinite
Nursing Special Projects	Sec. 820, PHS Act	9/30/94
Advanced Nurse Education	Sec. 821, PHS Act	9/30/94
Nurse Practitioners/Midwives	Sec. 822, PHS Act	9/30/94
Nursing Educ. Opportunity	Sec. 827, PHS Act	9/30/94
Nurse Traineeships	Sec. 830, PHS Act	9/30/94
Nurse Anesthetists	Sec. 831, PHS Act	9/30/94
Pacific Basin M.O. Training	Sec. 10, PL 101-527	9/30/93
Vaccine Injury Compensation	Sec. 2110-23 and 2131-34, PHS Act	Indefinite
National Practitioner Data Bank	Title IV, PL 99-660; Sec. 5, PL 100-93	Indefinite
AIDS Education and Training Centers	Sec. 776(a), PHS Act	9/30/95
Maternal and Child Health Bureau		
MCH Block Grant	Title V, Soc. Sec. Act	Indefinite
Healthy Start	Sec. 301, PHS Act	Indefinite
Pediatric HIV Research and Services	Sec. 2671, PHS Act	9/30/95
Pediatric Emergency Medical Services	Sec. 1910, PHS Act	9/30/97
Bureau of Health Resources Development		
Facilities Guarantees and Loans	Titles VI/XVI, PHS Act	Indefinite
Organ/Bone Marrow Transplantation	Secs. 371-379, PHS Act	
Health Teaching Facilities	Former Sec. 726, PHS Act	
Trauma Care	Sec. 1201-32, PHS Act	9/30/96
HIV Emergency Assistance, Part A	Sec. 2601-08, PHS Act	9/30/95
HIV Comprehensive Care, Part B	Sec. 2611-20, PHS Act	9/30/95
Other		
Office of Rural Health Policy	Sec. 711, Soc. Sec. Act	Indefinite
Rural Outreach Grants	Sec. 301, PHS Act	Indefinite
State Rural Health Offices	Sec. 338J, PHS Act	9/30/93
Program Management	Sec. 301, PHS Act	Indefinite

Appendix B—HRSA Appropriations

	FY 1996 Revised Appropriation	FY 1997 President's Budget
Bureau Primary Health Care:		
Consolidated Health Centers Cluster:		
Community Health Centers		
Migrant Health Centers		
Health Care for the Homeless		
Health Services for Residents of Public Housing		
Sub-total Consolidated Health Centers Cluster	$758,132	$757,124
Programs for Special Populations Cluster:		
Black Lung		3,811
Pacific Basin		0
Payment to Hawaii		2,045
Native Hawaiian Health Care		0
State Alzheimer's Disease		3,980
Sub-total Programs for Special Populations Cluster	9,836	7,485
Hansens Disease Center	17,094	16,371
Total BPHC	785,062	780,980
Bureau Health Professions:		
Health Professions Workforce Development Cluster:		
Nat Health Service Corps		37,244
NHSC Recruitment		72,300
State Offices of Rural Health		2,889
Grants to Communities		474
Nursing Loan Repayment		1,962
Health Professions Data Systems		212
Research on Certain Health Professions Issues		0
Sub-total Workforce Development Cluster	115,081	117,205
Enhanced Area Health Education Centers Cluster:		
Area Health Education Centers		23,123
Health Education and Training Centers		3,350
Geriatric Programs		7,933
Rural Health Interdisciplinary Training		3,709
General Dentistry Training		3,381
Allied Health Special Projects		3,424
Podiatric Primary Care Residency Training		605
Chiropractic Demonstration Projects		916
Sub-total Enhanced Area Health Education Centers Cluster	46,441	35,000

	FY 1996 Revised Appropriation	FY 1997 President's Budget
Minority/Disadvantaged Health Professions Cluster:		
Centers of Excellence		22,072
Health Careers Opportunity Program		23,918
Loan Repayment/Faculty Fellowships		947
Scholarships for Disadvantaged Students		16,677
Exceptional Financial Need Scholarships		10,120
Financial Assistance for Disadvantaged H.P. Students		5,999
Loans for Disadvantaged Students.		0
Sub-total Minority/Disadvantaged Health Professions Cluster	79,733	64,085
Primary Care Medicine and Public Health Cluster:		
Family Medicine Programs.		44,002
General Internal Medicine/Pediatrics Training		15,741
Physician Assistant Training.		5,697
Public Health/Preventive Medicine Programs		7,148
Health Admininstration Programs		978
Pacific Basin Medical Officers Training		1,200
Sub-total Primary Care Medicine and Public Health Cluster	74,766	80,000
Nursing Education/Practice Cluster:		
Strengthening Capacity for Basic Nurse Education and Practice		9,436
Nurse Practitioner/Nurse Midwives and Other Advanced Practice Nurses		43,298
Advanced Nurse Education.		(11,134)
Nurse Practitioner/Nurse Midwife Education		(15,460)
Professional Nurse Traineeships		(14,235)
Nurse Anesthetists Training		(2,469)
Increasing Nursing Workforce Diversity		3,453
Sub-total Nursing Education/Practice Cluster	56,187	70,000
National Practitioner Data Bank (User Fees)	(6,000)	(6,000)
Total, BHPr	372,208	366,290
Maternal Child Health Bureau:		
Maternal and Child Health Block Grant	678,204	681,061
Emergency Medical Services for Children	10,755	9,333
Healthy Start.	92,816	74,838
Total, MCHB.	781,775	765,232
Bureau Health Resources Development:		
Health Teaching Facilities	411	297
Organ Transplantation.	2,069	2,296
Health Care Facilities	20,000	2,000
Bone Marrow Donor Registry	15,272	15,332
Total, BHRD.	37,752	19,925

	FY 1996 Revised Appropriation	FY 1997 President's Budget
Program Management	112,058	112,949
RURAL HEALTH:		
Rural Health Research.	9,353	7,884
Rural Health Outreach Grants	27,797	30,254
Total, RURAL HEALTH.	37,150	38,138
Buildings & Facilities	741	828
AIDS:		
Ryan White:		
Emergency Relief - Title I.	391,700	423,943
Comprehensive Care - Title II	260,847	284,954
Early Intervention - Title III.	56,918	64,568
Pediatric Demonstration Grants - Title IV	29,000	34,000
Subtotal, Ryan White.	738,465	807,465
Education and Training Centers.	12,000	16,287
Dental Services	6,937	6,937
Subtotal, AIDS.	757,402	830,689
Subtotal, HRS	2,884,148	2,915,031
Family Planning.	192,592	198,452
Subtotal, Health Resources & Services Administration	3,076,740	3,113,483
Medical Facilities Guarantee & Loan Fund	8,000	7,000
Health Education Assistance Loans:		
HEAL Guarantee Authority	(210,000)	(140,000)
Liquidating Account (non-add)	(0)	(14,481)
Program Account	126	477
HEAL Credit Reform - Direct Operations	2,688	2,695
HEAL - Default Reduction	(1,000)	(1,000)
Subtotal, HEAL.	2,814	3,172
Vaccine - Pre-FY1989 Claims.	110,000	110,000
Vaccine Improvement Trust Fund (HRSA Claims)	56,721	56,721
VICTF Direct Ops - HRSA.	3,000	3,000
Sub-total Vaccine Injury Compensation	169,721	169,721
TOTAL, Health Resources and Services Administration	$3,257,275	$3,293,376

1/ Appropriated to NIH transferred to HRSA.

1/ Line items include a total of $5 million for Health Center Tort Claims as follows: CHCs - $4,100,000; MHCs - $400,000; HCH - $450,000; Public Housing - $50,000.

2/ Includes $3 million for Title I, Ryan White C.A.R.E. Act for program administration.

Appendix C—Key HRSA Staff

Office of the Administrator

Ciro V. Sumaya, M.D., M.P.H.T.M., Administrator 443-2216
John D. Mahoney, Deputy Administrator 443-2194
J. Calvin Adams, Equal Opportunity and Civil Rights 443-5636
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James Corrigan, Grants and Procurement Management 443-1433
George B. Dines, International Health Affairs 443-6152
Kirk Donovan, Financial Management 443-6826
Betty Hambleton, Women's Health Coordinator 443-1530
Ileana Herrell, Ph.D., Minority Health 443-2964
Jeffrey Human, Rural Health Policy 443-0835
James E. Larson, Information Resources Management 443-5036
Douglas S. Lloyd, M.D., Public Health Practice 443-4034
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Thomas Morford, Operations and Management 443-2053
Joseph F. O'Neill, M.D., Associate Administrator for AIDS 443-4588
William Robinson, M.D., Chief Medical Officer 443-0458
Lawrence Sauer, Legislative Office 443-1890
Cherry Tsutsumida, Communications (Acting) 443-2086
Cherry Tsutsumida, M.P.H., External Affairs 443-2033
Alice Wallis, Regulations Officer 443-1960

Bureau of Primary Health Care

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Norris Lewis, M.D., Scholarships and Loan Repayment 594-4370
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Nancy Paquin, Data Management 594-0213
Sonia Leon Reig, External Affairs 594-4100
Patricia Solomon, M.D., Clinical Affairs 594-4110
Donald L. Weaver, M.D., National Health Service Corps 594-4130

Bureau of Health Professions

Vacant, Director 443-5794
Paul M. Schwab, Acting Director 443-5796
Thomas E. Balbier, Vaccine Injury Compensation 443-6593
Thomas C. Croft, Quality Assurance 443-2300
Enrique Fernandez, M.D., Medicine 443-6190
Ciriaco Gonzalez, Ph.D, Disadvantaged Assistance 443-2100

(All numbers are in area code 301 except where noted)

Michael Heningburg, Student Assistance 443-1173
Anthony Hollins, Program Support 443-5798
B. Jerald McClendon, Research and Planning 443-6936
Marla E. Salmon, Sc.D., R.N., Nursing 443-5688
Neil H. Sampson, Dental and Public Health Professions 443-6853

Bureau of Health Resources Development

Vacant, Director 443-1993
William Aspden, Acting Director 443-1993
Dorothy Bailey, Communications 443-6846
Judy Braslow, Organ Transplantation 443-7577
Antonio DeJesus, Program Support 443-2630
Antonio DeJesus, Program Development (Acting) 443-5400
Catherine Flickinger, Information Resources Management 443-6846
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Leonard Krystynak, Facilities and Loans 443-5317
Katherine Marconi, Ph.D., Science and Epidemiology 443-6560
Charlotte G. Pascoe, Facilities Compliance and Recovery 443-5656

Maternal and Child Health Bureau

Audrey Nora, M.D., Director 443-2170
Florence Fiori, Dr.P.H., Deputy Director 443-2170
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Samuel Kessel, M.D., Systems, Education, and Science 443-2340
Eamon Magee, Senior Advisor 443-9657
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Thurma McCann, M.D., Healthy Start 443-0509
Merle McPherson, M.D., Children With Special Health Care Needs 443-2350

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