DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fiscal Year 2011

Indian Health Service

Justification of Estimates for Appropriations Committees

I am pleased to present the Indian Health Service (IHS) fiscal year (FY) 2011 Congressional Justification and Online Performance Appendix. This budget request provides our most fully integrated and transparent performance budget to date and supports the goals and objectives of the Department of Health and Human Services. Consistent with the Government Performance and Results Act of 1993, this budget justification includes the FY 2011 Annual Performance Plan and the FY 2009 Annual Performance Report with FY 2010 and FY 2011 performance targets provided.

This budget renews and strengthens our partnership with Tribes in the following ways: by aligning the Agency's health funding budget to reflect Tribal priorities, such as diabetes, cancer, behavioral health, and cardiovascular disease; introducing and implementing administrative and operational reforms directed towards more efficient care coordination and funding program requirements; and improving health care quality and access. It is the commitment of IHS staff to achieving these objectives that is the Agency's greatest asset.

For FY 2011, the IHS provides a comprehensive set of performance measures that reflect essential health services with evidence-based linkages to improved health outcomes. The automated monitoring of these performance measures from the local to the national level provides the IHS and our stakeholders with information to assess ongoing progress towards the following Agency-wide goals:

IHS Strategic Goals:

- Build and sustain healthy communities.
- Provide accessible, quality health care.
- Foster collaboration and innovation across the Indian Health System.

Effective administration and oversight of clinical, staff, and financial resources is essential to meeting the health care needs of American Indian and Alaska Native (AI/AN) people. And while the IHS has succeeded in reducing overall mortality for our population by 28 percent over the past 30 years, this progress is offset by a trend of growing disparities in mortality rates between the AI/AN population and our country's population overall during the same period. Our FY 2011 budget request represents the commitment of the IHS and our stakeholders to the Agency's mission by working to meet the health care needs of AI/AN people more efficiently and effectively.

To the best of my knowledge, the performance data reported by IHS for inclusion in the FY 2011 Online Performance Appendix is accurate, complete, and reliable.

/Yvette Roubideaux/
Yvette Roubideaux, M.D., M.P.H.
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2011 Performance Budget Submission to Congress

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

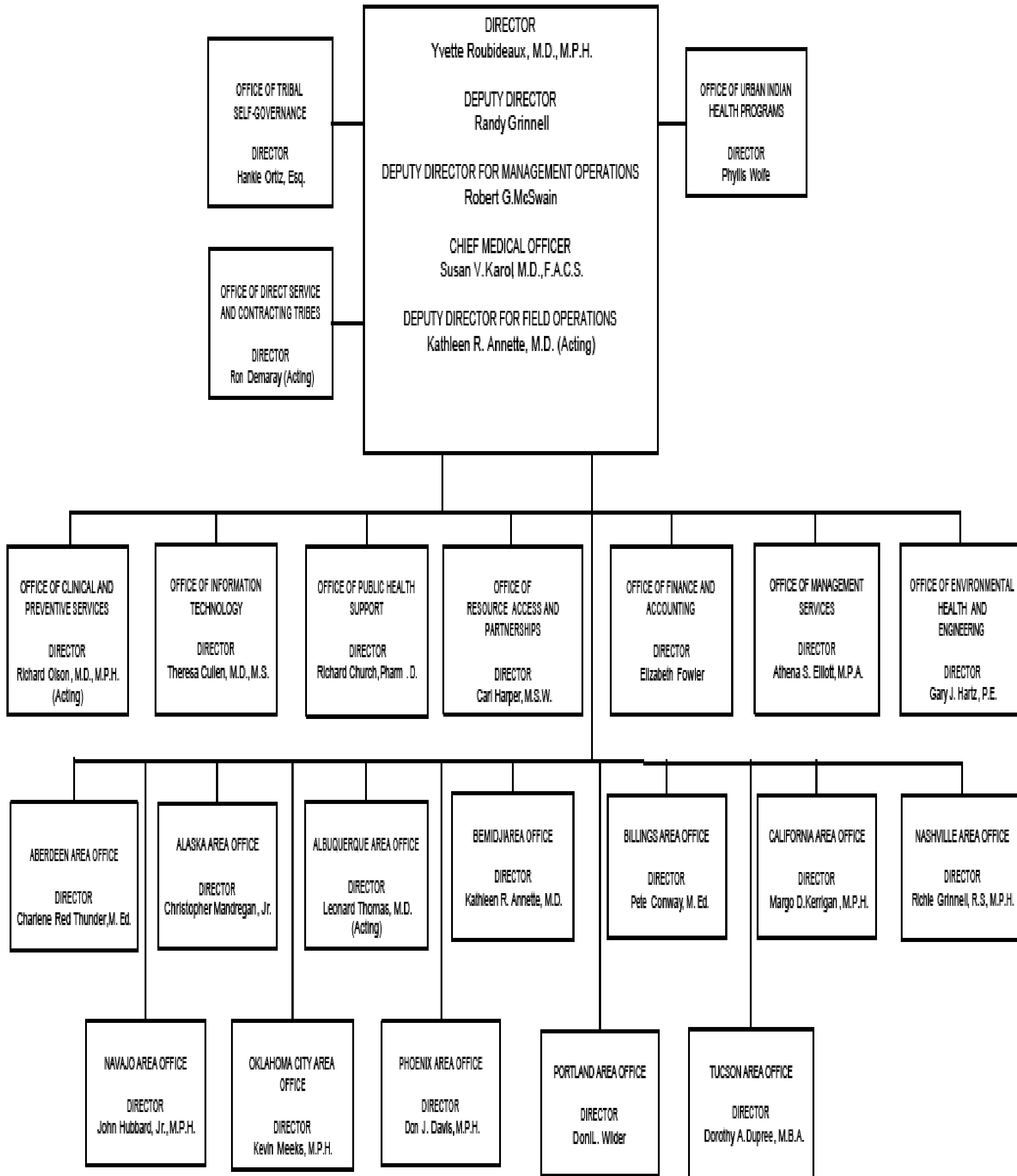
INDIAN HEALTH SERVICE

Approved:

/Yvette Roubideaux/

Yvette Roubideaux

Date: 08/17/2009



EXECUTIVE SUMMARY

Agency Overview

United States Government and Indian Nations

The provision of Federal health services to American Indians and Alaska Natives is based on a special relationship between Indian Tribes and the United States. The Indian Commerce Clause of the United States Constitution, as well as numerous treaties and court decisions, have affirmed this special relationship and the plenary power of Congress to create statutes that benefit Indian people. Principal among these statutes is the Snyder Act of 1921, which provides the basic authority for health services provided by the Federal Government to American Indians and Alaska Natives.

The Indian Health Service and Its Partnership with Tribes

For more than 120 years, Federal trust responsibility for American Indian and Alaska Native health care passed among different government branches. In 1955, this responsibility was officially transferred to the Public Health Service.

In the 1970s, Federal Indian policy was re-evaluated by the Nixon Administration, which adopted a policy of Indian self-determination. This policy promotes Tribal administration of Federal Indian programs, including health care. Self-Determination does not lessen any Federal obligation, but provides an opportunity for Tribes to assume the responsibility of providing health care for their members.

The Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA), as amended, and the Indian Health Care Improvement Act of 1976 (IHCIA), as amended, have provided new opportunities for the IHS and Tribes to deliver care. The IHCIA includes specific authorizations for providing health care services to urban Indian populations, to administer an Indian health professions program, and the ability to collect from Medicare/Medicaid and other third party insurers for services rendered at IHS or Tribal facilities. Under the ISDEAA, many Tribes have assumed the administrative and program direction roles that were previously carried out by the Federal government. Tribes currently administer over one-half of IHS resources through ISDEAA contracts and compacts. The IHS administers the remaining resources and manages those facilities where Tribes have elected not to contract or compact their health programs.

Mission

The mission of the Indian Health Service is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

Overview of Budget Request

The FY 2011 President's Budget request for the Indian Health Service is $4,406,429,000 in discretionary budget authority -- a significant increase of $354,054,000, or 8.7 percent, over the FY 2010 appropriations level. The request includes funds to support activities identified by Tribes as budget priorities including increases to maintain the current level of services provided; expand access to care; increase resources for the Contract Health Services program; fund contract support costs; target two chronic disease health priorities; fund substance abuse treatment programs; and address essential health information technology activities. The budget request includes the following specific funding increases:

CURRENT SERVICES (+$175.6 million)

Federal, Tribal, Urban Pay Costs (+$24.4 million)
The budget request projects a 1.4 percent pay raise for both civilian employees and Commissioned Officers. The $24.4 million requested will fund these pay raises entirely, including commensurate pay raises for Tribal and Urban Indian health program employees.

Population Growth (+$52.5 million)
This request will address the increased service need arising from the growth in the American Indian and Alaska Native population. The population is growing at an average rate of 1.5 percent annually and the $52.5 million requested will provide for the additional services needed for these additional patients eligible for care.

Inflation (+$60.0 million)
This request will address the rising costs of providing health care. The $60.0 million is the calculated need to address a 1.5 percent non-medical inflation rate and a 3.3 percent medical inflation rate.

Staffing and Operating Costs for New Facilities (+$38.8 million)
This request will fund the staffing and operating costs for two newly constructed Health Centers scheduled to open in FY 2011, with potential for two Joint Venture projects to be completed as well. In addition, the request will complete the funding requirements to staff and operate three Joint Venture projects that are scheduled to open in FY 2010. They reflect an investment in the construction of the facilities to expand access to care in locations where existing capacity is most overextended.

PROGRAM INCREASES (+$178.5 million)

Indian Health Care Improvement Fund (+$44 million)
The Indian Health Care Improvement Fund was established by Congress to address funding inequities among Indian health care programs. To diminish health care service backlogs, this program increase will be allocated to IHS and Tribal service sites with

the greatest deficiencies. Funding will allow highly deficient sites to expand health care services and reduce backlogs for primary care.

Health Information Technology Security (+$4 million)

IHS' Health Information Technology (HIT) solution (the Resource and Patient Management System or RPMS) continues to expand to meet additional reporting requirements and provide increased but essential HIT services to patients, providers and communities. This request will address critical health information technology security maintenance and enhancements. Although RPMS is a secure health information system, the recent government mandates to exchange health information increase the security needed to facilitate the external exchanges. In addition, changes in security standards associated with meaningful use will increase security requirements. Additional resources will be employed to provide expert security management of health information. Certification and Accreditation of enhancements to RPMS and continued funding for the Network and Operations Security Center (NOSC) are also planned for FY 2011.

Chronic Diseases (+$2.5 million)

This request will address the prevention of chronic illness in the American Indian and Alaska Native population through new, targeted efforts aimed at reducing their principal risk factors (smoking, obesity, sedentary lifestyle). These cross-cutting approaches add new capability to the Indian health system and offer the opportunity to reduce the risk of and consequences from these debilitating and costly chronic diseases.

Alcohol and Substance Abuse (+$4 million)

This request is for a new competitive IHS grant program to expand access to and improve the quality of treatment for substance abuse treatment services as part of the national drug control strategy. The program will target sites with the greatest need for substance abuse services. The main goal of the grant program will be to enable Indian Health Service, Tribal and Urban facilities to hire additional staff to provide evidence-based and practice-based culturally competent treatment services. The total request for Alcohol and Substance Abuse in FY 2011 is $206 million.

Contract Health Services (+$46 million)

This request will enable the IHS to address the ongoing need for contract health services as evidenced by continued denials of care for the reason of not being within medical priorities. Within this amount, an increase of $5 million will be targeted to the Catastrophic Health Emergency Fund (CHEF) for a total funding level for CHEF of $56 million. The total request for Contract Health Services in FY 2011 is $863 million. This increase will fund approximately 200 additional high cost cases, which will alleviate the effects of high cost cases and enable CHS programs to provide more services at the lower priority levels.

Improve Third Party Collections (+$1 million)
These funds are requested to fund a new grant program to assist urban Indian clinics in improving third party collections.

Contract Support Costs (+$40 million)
The entire requested increase will be applied against existing CSC shortfall associated with ongoing contracts and compacts. The IHS projects that 280 of the total 329 Tribes and Tribal Organizations with P.L. 93-638 contracts and compacts will have CSC shortfalls at the end of FY 2010. The proposed increase will allow continued progress in addressing the CSC needs of tribally operated programs to improve quality of care for AI/ANs. The total request for CSC in FY 2011 is $444 million.

Health Care Facilities Construction (+$37 million over the FY 2010 level)
Funding for construction of new health facilities is increased in this budget request to continue the construction of the replacement hospital at Barrow, Alaska; and continue the construction of the health centers at San Carlos and Kayenta, Arizona. The total request for Health Care Facilities Construction in FY 2011 is $66 million.

AMERICAN RECOVERY AND REINVESTMENT ACT

The Indian Health Service is currently implementing the FY 2009 American Recovery and Reinvestment Act (ARRA) funding for Indian Health Services of $85 million – Health Information Technology, and Indian Health Facilities of $415 million – Health Care Facilities Construction, Maintenance and Improvement of Health Care Facilities, Sanitation Facilities Construction, and Medical Equipment. The obligation of funding will continue through FY 2010 and the final projects will be completed by FY 2013. The IHS is also implementing ARRA projects funded by other Agencies such as the $90 million through two Interagency Agreements with the Environmental Protection Agency for the Safe Drinking Water Act and the Clean Water Act. An exhibit is provided below to show obligations and performance of these programs through FY 2011. These projects are stimulating the economy, investing, and reinvesting in the health information technology and facilities infrastructure to support the Indian Health Delivery System.

EXHIBIT

Summary of Recovery Act Obligations and Performance
(dollars in millions)

ARRA Implementation Plan	FY 2009	FY 2010	FY 2011	FY 2009 – FY 2011
Health Information Technology	$40	$45	-	$85
Health Care Facilities Construction	$133	$94	-	$227
Maintenance & Improvement	$44	$56	-	$100
Sanitation Facilities Construction	$66	$2	-	$68
Equipment	$11	$9	-	$20
Total Obligations	**$294**	**$206**	**$0**	**$500**

Source: Approved Indian Health Services and Indian Health Facilities SF-132.

Selected Performance Measures for Implementation Plans Listed Above

Health Information Technology

Performance Measure	FY 2009 Result	FY 2010 Target	FY 2011 Target
Percentage of all orders that are electronically entered into the Electronic Health Record	N/A	65%	75%

Maintenance & Improvement

Performance Measure	FY 2009 Result	FY 2010 Target	FY 2011 Target
Percentage reduction in the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) through Recovery Act Funding	N/A	6.7%	13.7%

Explanation of Measure: The Backlog of Maintenance and Repair (BEMAR) is an IHS-wide inventory of needed maintenance and repair projects. As maintenance and repair projects are completed the BEMAR deficiency is reduced (improved). As BEMAR is reduced, system-wide capacity for safe and efficient patient care is increased. The percentage reduction measure is the amount the system-wide BEMAR is reduced by completion of Recovery Act projects (numerator) divided by the original system-wide baseline BEMAR (denominator).

Sanitation Facilities Construction

Performance Measure	FY 2009 Result	FY 2010 Target	FY 2011 Target
Number of existing AI/AN homes provided with sanitation facilities funded projects. Cumulative	29,859	30,000	30,050

Note: All funding received in 2009
Data Source: Sanitation Tracking and Reporting System (STARS)

Equipment

Performance Measure	FY 2009 Result	FY 2010 Target	FY 2011 Target
Increased access to diagnostic services with new CT scanners	N/A	N/A	1,300

Explanation of Measure: The number of diagnostic CT diagnostic services will increase at the 2 sites receiving a new CT scanner. This output indicator measures additional services performed due to Recovery Act funding. CT scanners play an important diagnostic role for providers, especially in treating trauma patients. The purchase and installation of CTs at IHS and tribal emergency departments will enhance quality of care and access to care, and will reduce expensive patient transports to other facilities for services.

All Purpose Table
Indian Health Service

(Dollars in Thousands)

Jan 20, 2010

Program	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 Pres. Budget Request
SERVICES				
Hospitals & Health Clinics	1,597,777	85,000	1,754,383	1,893,292
Dental Health	141,936	0	152,634	161,262
Mental Health	67,748	0	72,786	77,076
Alcohol & Substance Abuse	183,769	0	194,409	205,770
Contract Health Services	634,477	0	779,347	862,765
Total, Clinical Services	2,625,707	85,000	2,953,559	3,200,165
Public Health Nursing	59,885	0	64,071	67,571
Health Education	15,723	0	16,682	17,489
Community Health Reps.	57,796	0	61,628	63,991
Immunization AK	1,823	0	1,934	2,009
Total, Preventive Health	135,227	0	144,315	151,060
Urban Health	36,189	0	43,139	45,502
Indian Health Professions	37,500	0	40,743	41,413
Tribal Management	2,586	0	2,586	2,669
Direct Operations	65,345	0	68,720	69,845
Self-Governance	6,004	0	6,066	6,201
Contract Support Costs	282,398	0	398,490	444,332
Total, Other Services	430,022	0	559,744	609,962
TOTAL, SERVICES	3,190,956	85,000	3,657,618	3,961,187
FACILITIES				
Maintenance & Improvement	53,915	100,000	53,915	55,523
Sanitation Facilities Construction	95,857	68,000	95,857	97,710
Health Care Facilities Construction	40,000	227,000	29,234	66,192
Facilities & Environmental Health Support	178,329	0	193,087	202,106
Equipment	22,067	20,000	22,664	23,711
TOTAL, FACILITIES	390,168	415,000	394,757	445,242
TOTAL, BUDGET AUTHORITY	**3,581,124**	**500,000**	**4,052,375**	**4,406,429**
COLLECTIONS				
Medicare	169,364	0	172,024	172,024
Medicaid	550,222	0	562,674	562,674
Subtotal, M / M	*719,586*	*0*	*734,698*	*734,698*
Private Insurance	94,042	0	94,042	94,042
*Total, M / M / PI***	*813,628*	*0*	*828,740*	*828,740*
Quarters	6,288	0	6,288	6,288
Default Recovery Funds*	0	0	0	300
TOTAL, COLLECTIONS	819,916	0	835,028	835,328
Special Diabetes Program for Indians	150,000	0	150,000	150,000
TOTAL, SDPI	150,000	0	150,000	150,000
TOTAL, PROGRAM LEVEL	**4,551,040**	**500,000**	**5,037,403**	**5,391,757**

* New item in FY 2011 and amount is an estimate; see justification in Indian Health Professions narrative.

** Represents estimates of collections from public and private insurers for current and future fiscal years. Estimates are based on actual FY 2008 collections and current reimbursements rates. These estimates may change as a result of actual FY 2009 collections, changes to the types of services covered by insurers, and transition of programs from Federal to tribally-operated.

INDIAN HEALTH SERVICE
FY 2011
Detail of Changes
(Dollars in Thousands)

Jan 8, 2010

Sub Sub Activity	FY 2009 Omnibus	FY 2009 ARRA	FY 2010 Enacted	CURRENT SERVICES: Federal Pay Civ 1.4%	CURRENT SERVICES: Federal Pay CO 1.4%	CURRENT SERVICES: Tribal Pay	CURRENT SERVICES: Inflation Non-Med 1.5% Med 3.3%	CURRENT SERVICES: Population Growth 1.5%	CURRENT SERVICES: Staffing for New Facilities	Curr.Svcs Subtotal	PROGRAM EXPANSION: IHCI Fund	PROGRAM EXPANSION: Health IT Security	PROGRAM EXPANSION: Chronic Diseases	PROGRAM EXPANSION: Alcohol/ Subs Abuse	PROGRAM EXPANSION: CHS/ CHEF	PROGRAM EXPANSION: Improve 3rd Party Collection	PROGRAM EXPANSION: Contract Support Costs	PROGRAM EXPANSION: Health Care Fac. Constr.	Prog. Expans. Subtotal	FY 2011 Budget Request
SERVICES																				
Hospitals & Health Clinics	1,597,777	85,000	1,754,383	5,953	1,135	8,576	17,227	26,278	29,211	88,380	44,000	4,000	2,529	0	0	0	0	0	50,529	1,893,292
Dental Services	141,936	0	152,634	603	280	671	1,454	2,271	3,349	8,628	0	0	0	0	0	0	0	0	0	161,262
Mental Health	67,748	0	72,786	338	37	373	748	1,092	1,702	4,290	0	0	0	0	0	0	0	0	0	77,076
Alcohol & Substance Abuse	183,769	0	194,409	166	11	1,663	2,605	2,916	0	7,361	0	0	0	4,000	0	0	0	0	4,000	205,770
Contract Health Services	634,477	0	779,347	6	0	0	25,722	11,690	0	37,418	0	0	0	0	46,000	0	0	0	46,000	862,765
Total, Clinical Services	2,625,707	85,000	2,953,559	7,066	1,463	11,283	47,756	44,247	34,262	146,077	44,000	4,000	2,529	4,000	46,000	0	0	0	100,529	3,200,165
Public Health Nursing	59,885	0	64,071	318	56	292	559	961	1,314	3,500	0	0	0	0	0	0	0	0	0	67,571
Health Education	15,723	0	16,682	43	0	127	195	250	192	807	0	0	0	0	0	0	0	0	0	17,489
Comm. Health Reps	57,796	0	61,628	3	0	618	818	924	0	2,363	0	0	0	0	0	0	0	0	0	63,991
Immunization AK	1,823	0	1,934	0	0	20	26	29	0	75	0	0	0	0	0	0	0	0	0	2,009
Total, Preventive Health	135,227	0	144,315	364	56	1,057	1,598	2,164	1,506	6,745	0	0	0	0	0	0	0	0	0	151,060
Urban Health	36,189	0	43,139	14	14	266	496	572	0	1,362	0	0	0	0	0	1,000	0	0	1,000	45,502
Indian Health Professions	37,500	0	40,743	20	2	0	648	0	0	670	0	0	0	0	0	0	0	0	0	41,413
Tribal Management	2,586	0	2,586	0	0	0	83	0	0	83	0	0	0	0	0	0	0	0	0	2,669
Direct Operations	65,345	0	68,720	538	84	167	336	0	0	1,125	0	0	0	0	0	0	0	0	0	69,845
Self-Governance	6,004	0	6,066	36	0	0	99	0	0	135	0	0	0	0	0	0	0	0	0	6,201
Contract Support Cost	282,398	0	398,490	0	0	0	5,842	0	0	5,842	0	0	0	0	0	0	40,000	0	40,000	444,332
Total, Other Services	430,022	0	559,744	608	100	433	7,504	572	0	9,217	0	0	0	0	0	1,000	40,000	0	41,000	609,962
Total, Services	3,190,956	85,000	3,657,618	8,038	1,619	12,773	56,858	46,983	35,768	162,039	44,000	4,000	2,529	4,000	46,000	1,000	40,000	0	141,529	3,961,187
FACILITIES																				
Maintenance & Improvement	53,915	100,000	53,915	0	0	0	799	809	0	1,608	0	0	0	0	0	0	0	0	0	55,523
Sanitation Facilities Constr.	95,857	68,000	95,857	60	15	0	340	1,438	0	1,853	0	0	0	0	0	0	0	0	0	97,710
Health Care Fac. Constr.	40,000	227,000	29,234	0	0	0	0	0	0	0	0	0	0	0	0	0	0	36,958	36,958	66,192
Facil. & Envir. Hlth Supp.	178,329	0	193,087	816	387	644	1,273	2,896	3,003	9,019	0	0	0	0	0	0	0	0	0	202,106
Equipment	22,067	20,000	22,664	0	0	0	707	340	0	1,047	0	0	0	0	0	0	0	0	0	23,711
Total, Facilities	390,168	415,000	394,757	876	402	644	3,119	5,483	3,003	13,527	0	0	0	0	0	0	0	36,958	36,958	445,242
TOTAL, IHS	3,581,124	500,000	4,052,375	8,914	2,021	13,417	59,977	52,466	38,771	175,566	44,000	4,000	2,529	4,000	46,000	1,000	40,000	36,958	178,487	4,406,429

Statement of Personnel Resources INDIAN HEALTH SERVICE			
	2009	FY 2010	FY 2011
	Actual	Estimate	President's Budget
Direct:			
Hospitals & Health Clinics	6,284	6,433	6,443
Dental Health	743	748	750
Mental Health	266	268	268
Alcohol & Substance Abuse	179	179	179
Contract Health Services	7	7	7
Total, Clinical Services	7,479	7,635	7,647
Public Health Nursing	258	262	263
Health Education	26	26	26
Community Health Reps	7	7	7
Immunization, AK	0	0	0
Total, Preventive Health	291	295	296
Urban Health	7	7	7
Indian Health Professions	18	18	18
Tribal Management	0	0	0
Direct Operations	327	335	335
Self Governance	13	13	13
Contract Support Costs	0	0	0
Total, SERVICES	8,135	8,303	8,316
Maint. & Improvement	0	0	0
Sanitation Facilities	170	170	170
Hlth Care Facs Construction	0	0	0
Facil. & Envir. Hlth Support	1,032	1,037	1,039
Equipment	0	0	0
Total, FACILITIES	1,202	1,207	1,209
Total, Direct FTE	9,337	9,510	9,525
Reimbursable:			
Buybacks	1,366	1,366	1,366
Medicare	813	813	813
Medicaid	3,376	3,376	3,376
Private Insurance	518	518	518
Quarters	28	28	28
Total, Reimbursable FTE	6,101	6,101	6,101
Trust Funds (Gift)	**23**	**23**	**23**
TOTAL FTE	**15,461**	**15,634**	**15,649**
Total, Civilian FTE	**13,293**	**13,442**	**13,455**
Total, Military FTE	**2,145**	**2,169**	**2,171**

Indian Health Service

Breakdown of Program Level

(Dollars in Thousands)

Jan 27, 2010

Sub Sub Activity	2009 Enacted Budget Authority	2009 Enacted Private Insurance Collections	2009 Enacted Medicare/ Medicaid	2009 Enacted Personnel Quarters	2009 Enacted Total Program Level	2010 Enacted Budget Authority	2010 Enacted Private Insurance Collections	2010 Enacted Medicare/ Medicaid	2010 Enacted Personnel Quarters	2010 Enacted Total Program Level
SERVICES:										
Hospitals & Health Clinics	1,597,777	94,042	719,586 [2]	0	2,411,405	1,754,383	94,042	734,698 [2]	0	2,583,123
Dental Health	141,936	0	0	0	141,936	152,634	0	0	0	152,634
Mental Health	67,748	0	0	0	67,748	72,786	0	0	0	72,786
Alcohol & Substance Abuse	183,769	0	0	0	183,769	194,409	0	0	0	194,409
Contract Health Services	634,477	0	0	0	634,477	779,347	0	0	0	779,347
Total, Clinical Services	2,625,707	94,042	719,586	0	3,439,335	2,953,559	94,042	734,698	0	3,782,299
Public Health Nursing	59,885	0	0	0	59,885	64,071	0	0	0	64,071
Health Education	15,723	0	0	0	15,723	16,682	0	0	0	16,682
Comm. Health Reps.	57,796	0	0	0	57,796	61,628	0	0	0	61,628
Immunization AK	1,823	0	0	0	1,823	1,934	0	0	0	1,934
Total, Preventive Health	135,227	0	0	0	135,227	144,315	0	0	0	144,315
Urban Health	36,189	0	0	0	36,189	43,139	0	0	0	43,139
Indian Health Professions	37,500	0	0	0	37,500	40,743	0	0	0	40,743
Tribal Management	2,586	0	0	0	2,586	2,586	0	0	0	2,586
Direct Operations	65,345	0	0	0	65,345	68,720	0	0	0	68,720
Self-Governance	6,004	0	0	0	6,004	6,066	0	0	0	6,066
Contract Support Costs	282,398	0	0	0	282,398	398,490	0	0	0	398,490
Total, Other Services	430,022	0	0	0	430,022	559,744	0	0	0	559,744
TOTAL, SERVICES	3,190,956	94,042	719,586	0	4,004,584	3,657,618	94,042	734,698	0	4,486,358
FACILITIES:										
Maintenance & Improvement	53,915	0	0	6,288	60,203	53,915	0	0	6,288	60,203
Sanitation Facilities Construction	95,857	0	0	0	95,857	95,857	0	0	0	95,857
Health Care Facs. Constr.	40,000	0	0	0	40,000	29,234	0	0	0	29,234
Facil. & Envir. Health Support	178,329	0	0	0	178,329	193,087	0	0	0	193,087
Equipment	22,067	0	0	0	22,067	22,664	0	0	0	22,664
TOTAL, FACILITIES	390,168	0	0	6,288	396,456	394,757	0	0	6,288	401,045
TOTAL, IHS	3,581,124	94,042	719,586	6,288	4,401,040	4,052,375	94,042	734,698	6,288	4,887,403
Special Diabetes Program for Indians [1]	150,000	0	0	0	150,000	150,000	0	0	0	150,000
GRAND TOTAL	3,731,124	94,042	719,586	6,288	4,551,040	4,202,375	94,042	734,698	6,288	5,037,403

[1] The Special Diabetes Program for Indians is reauthorized for a total of $150,000,000 in FY 2010.

[2] Includes $29,203,000 in Medicaid/Medicare for CMS estimates of tribal collections as well as $138,469,000 for tribal direct collection estimates, which began in FY 2002.

Indian Health Service

Breakdown of Program Level

(Dollars in Thousands)

Jan 27, 2010

Sub Sub Activity	2011 Request Budget Authority	2011 Request Private Insurance Collections	2011 Request Medicare/ Medicaid	2011 Request Personnel Quarters	2011 Request Total Program Level	Increase/Decrease of 2011 Over 2010 Budget Authority	Increase/Decrease Private Insurance Collections	Increase/Decrease Medicare/ Medicaid	Increase/Decrease Personnel Quarters	Increase/Decrease Total Program Level
SERVICES:										
Hospitals & Health Clinics	1,893,292	94,042	734,698 [2/]	0	2,722,032	138,909	0	0	0	138,909
Dental Health	161,262	0	0	0	161,262	8,628	0	0	0	8,628
Mental Health	77,076	0	0	0	77,076	4,290	0	0	0	4,290
Alcohol & Substance Abuse	205,770	0	0	0	205,770	11,361	0	0	0	11,361
Contract Health Services	862,765	0	0	0	862,765	83,418	0	0	0	83,418
Total, Clinical Services	3,200,165	94,042	734,698	0	4,028,905	246,606	0	0	0	246,606
Public Health Nursing	67,571	0	0	0	67,571	3,500	0	0	0	3,500
Health Education	17,489	0	0	0	17,489	807	0	0	0	807
Comm. Health Reps.	63,991	0	0	0	63,991	2,363	0	0	0	2,363
Immunization AK	2,009	0	0	0	2,009	75	0	0	0	75
Total, Preventive Health	151,060	0	0	0	151,060	6,745	0	0	0	6,745
Urban Health	45,502	0	0	0	45,502	2,363	0	0	0	2,363
Indian Health Professions	41,413	0	0	0	41,413	670	0	0	0	670
Tribal Management	2,669	0	0	0	2,669	83	0	0	0	83
Direct Operations	69,845	0	0	0	69,845	1,125	0	0	0	1,125
Self-Governance	6,201	0	0	0	6,201	135	0	0	0	135
Contract Support Costs	444,332	0	0	0	444,332	45,842	0	0	0	45,842
TOTAL, SERVICES	3,961,187	94,042	734,698	0	4,789,927	303,569	0	0	0	303,569
FACILITIES:										
Maintenance & Improvement	55,523	0	0	6,288	61,811	1,608	0	0	0	1,608
Sanitation Facilities Construction	97,710	0	0	0	97,710	1,853	0	0	0	1,853
Health Care Facs. Constr.	66,192	0	0	0	66,192	36,958	0	0	0	36,958
Facil. & Envir. Health Support	202,106	0	0	0	202,106	9,019	0	0	0	9,019
Equipment	23,711	0	0	0	23,711	1,047	0	0	0	1,047
TOTAL, FACILITIES	445,242	0	0	6,288	451,530	50,485	0	0	0	50,485
TOTAL, IHS	4,406,429	94,042	734,698	6,288	5,241,457	354,054	0	0	0	354,054
Default Recovery Funds	0	0	0	0	300	0	0	0	0	0
Special Diabetes Program for Indians [1/]	150,000	0	0	0	150,000	0	0	0	0	0
GRAND TOTAL	4,556,429	94,042	734,698	6,288	5,391,757	354,054	0	0	0	354,054

[1/] The Special Diabetes Program for Indians is reauthorized for a total of $150,000,000 in FY 2011.

[2/] Includes $29,203,000 in Medicaid/Medicare for CMS estimates of tribal collections as well as $132,766,000 for tribal direct collection estimates, which began in FY 2002.

INDIAN HEALTH SERVICE
STAFFING AND OPERATING COSTS FOR NEW / EXPANDED FACILITIES
FY 2011 Requirements*

(Dollars in Thousands)

rev Oct 8, 2009

	Joint Venture Place Holder	Little Axe, OK Absentee Shawnee Health Center Joint Venture		New Town, ND Elbowoods Health Center		Ada, OK Carl Albert Hospital Replacement Joint Venture		Lakeport, CA Lake County Tribal Health Center Joint Venture		Eagle Butte, SD Cheyenne River Health Center		TOTAL	
Opening Date (cal. yr):		Jul 2010		Oct 2010		May 2010		Sept 2010		Sep 2011			
Sub Sub Activity		Pos	Amount	Pos	Amount	Pos	Amount	Pos	Amount	FTE	Amount	FTE/Pos.	Amount
Hospitals & Health Clinics	$9,843	61	$5,522	73	$6,436	38	$4,045	21	$1,948	15	$1,417	208	$29,211
Dental Health		15	1,466	6	614	8	836	2	195	2	238	33	3,349
Mental Health		9	785	0	0	5	564	4	353	0	0	18	1,702
Total, Clinical Services	9,843	85	7,773	79	7,050	51	5,445	27	2,496	17	1,655	259	34,262
Public Health Nursing		4	453	2	230	3	303	2	235	1	93	12	1,314
Health Education		0	0	1	86	1	106	0	0	0	0	2	192
Total, Preventive Health	0	4	453	3	316	4	409	2	235	1	93	14	1,506
Total, Services	9,843	89	8,226	82	7,366	55	5,854	29	2,731	18	1,748	273	35,768
Facilities Support		4	755	3	648	3	678	2	305	2	244	14	2,630
Environmental Health Support		0	0	3	373	0	0	0	0	0	0	3	373
Total, FEHS	0	4	755	6	1,021	3	678	2	305	2	244	17	3,003
Total, Facilities	0	4	755	6	1,021	3	678	2	305	2	244	17	3,003
Grand Total [1]	**$9,843**	**93**	**$8,981**	**88**	**$8,387**	**58**	**$6,532**	**31**	**$3,036**	**20**	**$1,992**	**290**	**$38,771**

[1] Includes utilities

* 2 additional new facilities may come on line for funding in FY 2011

FY 2009 Crosswalk
Budget Authority
Actual Distribution
(Dollars in Thousands)

Sub Activity	Federal Health Administration: Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Administration	Tribal Health Administration: Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Administration	FY 2009 Omnibus
SERVICES																	
Hospitals & Health Clinics	798,234	0	0	0	0	0	0	798,234	799,543	0	0	0	0	0	0	799,543	1,597,777
Dental Health	79,494	0	0	0	0	0	0	79,494	62,442	0	0	0	0	0	0	62,442	141,936
Mental Health	34,132	0	0	0	0	0	0	34,132	33,616	0	0	0	0	0	0	33,616	67,748
Alcohol & Substance Abuse	40,175	0	0	0	0	0	0	40,175	143,594	0	0	0	0	0	0	143,594	183,769
Contract Health Services	294,818	0	0	0	0	0	0	294,818	339,659	0	0	0	0	0	0	339,659	634,477
Subtotal (CS)	1,246,853	0	0	0	0	0	0	1,246,853	1,378,854	0	0	0	0	0	0	1,378,854	2,625,707
Public Health Nursing	0	0	32,578	0	0	0	0	32,578	0	27,307	0	0	0	0	0	27,307	59,885
Health Education	0	0	4,048	0	0	0	0	4,048	0	11,675	0	0	0	0	0	11,675	15,723
Community Health Repr.	0	0	1,035	0	0	0	0	1,035	0	56,761	0	0	0	0	0	56,761	57,796
Immunization AK	0	0	0	0	0	0	0	0	0	1,823	0	0	0	0	0	1,823	1,823
Subtotal (PH)	0	0	37,661	0	0	0	0	37,661	0	97,566	0	0	0	0	0	97,566	135,227
Urban Health Project	0	11,764	0	0	0	0	0	11,764	0	0	24,425	0	0	0	0	24,425	36,189
Indian Health Professions	0	0	0	37,500	0	0	0	37,500	0	0	0	0	0	0	0	0	37,500
Tribal Management	0	0	0	83	0	0	0	83	0	0	0	2,503	0	0	0	2,503	2,586
Direct Operations	0	0	0	0	48,458	0	0	48,458	0	0	0	16,887	0	0	0	16,887	65,345
Self-Governance	0	0	0	0	0	2,921	0	2,921	0	0	0	0	3,083	0	0	3,083	6,004
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	282,398	0	282,398	282,398
Subtotal (OS)	0	11,764	0	37,583	48,458	2,921	0	100,726	0	0	24,425	19,390	3,083	282,398	0	329,296	430,022
Total, Services	1,246,853	11,764	37,661	37,583	48,458	2,921	0	1,385,239	1,378,854	97,566	24,425	19,390	3,083	282,398	0	1,805,717	3,190,956
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	15,795	15,795	0	0	0	0	0	0	38,120	38,120	53,915
Sanitation Facilities Constr.	0	0	0	0	0	0	33,550	33,550	0	0	0	0	0	0	62,307	62,307	95,857
Health Care Facs. Constr.	0	0	0	0	0	0	22,000	22,000	0	0	0	0	0	0	18,000	18,000	40,000
Facs. & Env. Health Sup	0	0	0	0	0	0	125,632	125,632	0	0	0	0	0	0	52,697	52,697	178,329
Equipment	0	0	0	0	0	0	8,568	8,568	0	0	0	0	0	0	13,499	13,499	22,067
Total, Facilities	0	0	0	0	0	0	205,546	205,545	0	0	0	0	0	0	184,623	184,623	390,168
TOTAL, IHS	1,246,853	11,764	37,661	37,583	48,458	2,921	205,546	1,590,784	1,378,854	97,566	24,425	19,390	3,083	282,398	184,623	1,990,340	3,581,124

FY 2010 Crosswalk
Budget Authority
Estimated Distribution
(Dollars in Thousands)

	Federal Health Administration								Tribal Health Administration								
Sub Activity	Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	FY 2010 Approp
SERVICES																	
Hospitals & Health Clinics	881,022	0	0	0	0	0	0	881,022	873,361	0	0	0	0	0	0	873,361	1,754,383
Dental Health	85,722	0	0	0	0	0	0	85,722	66,912	0	0	0	0	0	0	66,912	152,634
Mental Health	36,352	0	0	0	0	0	0	36,352	36,434	0	0	0	0	0	0	36,434	72,786
Alcohol & Substance Abuse	44,931	0	0	0	0	0	0	44,931	149,478	0	0	0	0	0	0	149,478	194,409
Contract Health Services	362,140	0	0	0	0	0	0	362,140	417,207	0	0	0	0	0	0	417,207	779,347
Subtotal (CS)	1,410,167	0	0	0	0	0	0	1,410,167	1,543,392	0	0	0	0	0	0	1,543,392	2,953,559
Public Health Nursing	0	0	34,767	0	0	0	0	34,767	0	29,304	0	0	0	0	0	29,304	64,071
Health Education	0	0	4,511	0	0	0	0	4,511	0	12,171	0	0	0	0	0	12,171	16,682
Community Health Repr.	0	0	2,417	0	0	0	0	2,417	0	59,211	0	0	0	0	0	59,211	61,628
Immunization AK	0	0	32	0	0	0	0	32	0	1,902	0	0	0	0	0	1,902	1,934
Subtotal (PH)	0	0	41,727	0	0	0	0	41,727	0	102,588	0	0	0	0	0	102,588	144,315
Urban Health Project	0	17,715	0	0	0	0	0	17,715	0	0	25,424	0	0	0	0	25,424	43,139
Indian Health Professions	0	0	0	40,743	0	0	0	40,743	0	0	0	0	0	0	0	0	40,743
Tribal Management	0	0	0	83	0	0	0	83	0	0	0	2,503	0	0	0	2,503	2,586
Direct Operations	0	0	0	0	51,820	0	0	51,820	0	0	0	16,900	0	0	0	16,900	68,720
Self-Governance	0	0	0	0	0	2,978	0	2,978	0	0	0	0	3,088	0	0	3,088	6,066
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	398,490	0	398,490	398,490
Subtotal (OS)	0	17,715	0	40,826	51,820	2,978	0	113,339	0	0	25,424	19,403	3,088	398,490	0	446,405	559,744
Total, Services	1,410,167	17,715	41,727	40,826	51,820	2,978	0	1,565,233	1,543,392	102,588	25,424	19,403	3,088	398,490	0	2,092,385	3,657,618
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	15,795	15,795	0	0	0	0	0	0	38,120	38,120	53,915
Sanitation Facilities Constr.	0	0	0	0	0	0	33,550	33,550	0	0	0	0	0	0	62,307	62,307	95,857
Health Care Facs. Constr.	0	0	0	0	0	0	7,234	7,234	0	0	0	0	0	0	22,000	22,000	29,234
Facs. & Env. Health Sup	0	0	0	0	0	0	129,454	129,454	0	0	0	0	0	0	63,633	63,633	193,087
Equipment	0	0	0	0	0	0	8,577	8,577	0	0	0	0	0	0	14,087	14,087	22,664
Total, Facilities	0	0	0	0	0	0	194,610	194,609	0	0	0	0	0	0	200,148	200,148	394,757
TOTAL, IHS	1,410,167	17,715	41,727	40,826	51,820	2,978	194,610	1,759,843	1,543,392	102,588	25,424	19,403	3,088	398,490	200,148	2,292,532	4,052,375

FY 2011 Crosswalk
Budget Authority
Estimated Distribution
(Dollars in Thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								
	Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	FY 2011 Estimate
SERVICES																	
Hospitals & Health Clinics	934,094	0	0	0	0	0	0	934,094	959,198	0	0	0	0	0	0	959,198	1,893,292
Dental Health	88,505	0	0	0	0	0	0	88,505	72,757	0	0	0	0	0	0	72,757	161,262
Mental Health	37,563	0	0	0	0	0	0	37,563	39,513	0	0	0	0	0	0	39,513	77,076
Alcohol & Substance Abuse	47,189	0	0	0	0	0	0	47,189	158,581	0	0	0	0	0	0	158,581	205,770
Contract Health Services	400,905	0	0	0	0	0	0	400,905	461,860	0	0	0	0	0	0	461,860	862,765
Subtotal (CS)	1,508,256	0	0	0	0	0	0	1,508,256	1,691,909	0	0	0	0	0	0	1,691,909	3,200,165
Public Health Nursing	0	0	35,898	0	0	0	0	35,898	0	31,673	0	0	0	0	0	31,673	67,571
Health Education	0	0	4,659	0	0	0	0	4,659	0	12,830	0	0	0	0	0	12,830	17,489
Community Health Repr.	0	0	2,451	0	0	0	0	2,451	0	61,540	0	0	0	0	0	61,540	63,991
Immunization AK	0	0	32	0	0	0	0	32	0	1,977	0	0	0	0	0	1,977	2,009
Subtotal (PH)	0	0	43,039	0	0	0	0	43,039	0	108,021	0	0	0	0	0	108,021	151,060
Urban Health Project	0	18,416	0	0	0	0	0	18,416	0	0	27,086	0	0	0	0	27,086	45,502
Indian Health Professions	0	0	0	41,413	0	0	0	41,413	0	0	0	0	0	0	0	0	41,413
Tribal Management	0	0	0	86	0	0	0	86	0	0	0	2,583	0	0	0	2,583	2,669
Direct Operations	0	0	0	0	52,691	0	0	52,691	0	0	0	17,154	0	0	0	17,154	69,845
Self-Governance	0	0	0	0	0	3,063	0	3,063	0	0	0	0	3,138	0	0	3,138	6,201
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	444,332	0	444,332	444,332
Subtotal (OS)	0	18,416	0	41,499	52,691	3,063	0	115,668	0	0	27,086	19,737	3,138	444,332	0	494,294	609,962
Total, Services	1,508,256	18,416	43,039	41,499	52,691	3,063	0	1,666,963	1,691,909	108,021	27,086	19,737	3,138	444,332	0	2,294,224	3,961,187
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	16,266	16,266	0	0	0	0	0	0	39,257	39,257	55,523
Sanitation Facilities Constr.	0	0	0	0	0	0	34,199	34,199	0	0	0	0	0	0	63,511	63,511	97,710
Health Care Facs. Constr.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	66,192	66,192	66,192
Facs. & Env. Health Sup	0	0	0	0	0	0	134,961	134,961	0	0	0	0	0	0	67,145	67,145	202,106
Equipment	0	0	0	0	0	0	8,983	8,983	0	0	0	0	0	0	14,728	14,728	23,711
Total, Facilities	0	0	0	0	0	0	194,410	194,409	0	0	0	0	0	0	250,833	250,833	445,242
TOTAL, IHS	1,508,256	18,416	43,039	41,499	52,691	3,063	194,410	1,861,372	1,691,909	108,021	27,086	19,737	3,138	444,332	250,833	2,545,056	4,406,429

INDIAN HEALTH SERVICE

Federal Funds

General and Special Funds:

INDIAN HEALTH SERVICES

For expenses necessary to carry out the Act of August 5, 1954 (68 Stat. 674), the Indian Self-Determination Act, the Indian Health Care Improvement Act, and titles II and III of the Public Health Service Act with respect to the Indian Health Service, **[**$3,657,618,000**]** *$3,961,187,000*, together with payments received during the fiscal year pursuant to 42 U.S.C. 238(b) and 238b for services furnished by the Indian Health Service: *Provided*, That funds made available to tribes and tribal organizations through contracts, grant agreements, or any other agreements or compacts authorized by the Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450), shall be deemed to be obligated at the time of the grant or contract award and thereafter shall remain available to the tribe or tribal organization without fiscal year limitation: *Provided further*, That **[**$779,347,000**]** *$862,765,000* for contract medical care, including **[**$48,000,000**]** *$53,000,000* for the Indian Catastrophic Health Emergency Fund, shall remain available until expended: *Provided further*, That **[**$18,251,000 is**]** of the funding provided for **[**Headquarters operations and**]** information technology activities and, notwithstanding any other provision of law, **[**the amount available under this proviso**]** *$4,000,000* shall be allocated at the discretion of the Director of the Indian Health Service:[1] *Provided further*, That of the funds provided, up to **[**$32,000,000**]** *$36,000,000* shall remain available until expended for implementation of the loan repayment program under section 108 of the Indian Health Care Improvement Act: *Provided further*, *That the amounts collected by the Federal Government as authorized by sections 104 and 108 of the Indian Health Care Improvement Act (25 U.S.C. 1613a and 1616a) during the preceding fiscal year for breach of contracts shall be deposited to the Fund authorized by section 108A of the Act (25 U.S.C. 1616a-1) and shall remain available until expended and, notwithstanding section 108A(c) of the Act (25 U.S.C. 1616a-1(c)), funds shall be available to make new awards under the loan repayment and scholarship programs under sections 104 and 108 of the Act (25 U.S.C. 1613a and 1616a):*[2] *Provided further*,

That [$16,391,000] *$16,391,000* is provided for the methamphetamine and suicide prevention and treatment initiative and [$10,000,000] *$10,000,000* is provided for the domestic violence prevention initiative and, notwithstanding any other provision of law, the amounts available under this proviso shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until expended: *Provided further*, *That $4,000,000 is provided for a substance abuse treatment grant program and, notwithstanding any other provision of law, the amounts available under this proviso shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until September 30, 2012:*[3] *Provided further*, That funds provided in this Act may be used for annual contracts and grants that fall within two fiscal years, provided the total obligation is recorded in the year the funds are appropriated: *Provided further*, That the amounts collected by the Secretary of Health and Human Services under the authority of title IV of the Indian Health Care Improvement Act shall remain available until expended for the purpose of achieving compliance with the applicable conditions and requirements of titles XVIII and XIX of the Social Security Act, except for those related to the planning, design, or construction of new facilities: *Provided further*, That funding contained herein for scholarship programs under the Indian Health Care Improvement Act (25 U.S.C. 1613) shall remain available until expended: *Provided further*, That amounts received by tribes and tribal organizations under title IV of the Indian Health Care Improvement Act shall be reported and accounted for and available to the receiving tribes and tribal organizations until expended: *Provided further*, That, notwithstanding any other provision of law, of the amounts provided herein, not to exceed [$398,490,000] *$444,332,000* shall be for payments to tribes and tribal organizations for contract or grant support costs associated with contracts, grants, self-governance compacts, or annual funding agreements between the Indian Health Service and a tribe or tribal organization pursuant to the Indian Self-Determination Act of 1975, as amended, prior to or during fiscal year [2010] *2011*, of which not to exceed [$5,000,000] *$10,000,000* may be used for contract support costs associated with new or expanded self-determination contracts, grants, self-governance compacts, or annual funding agreements: *Provided further*, That the Bureau of Indian Affairs may collect from the Indian Health Service, tribes and tribal organizations operating health facilities

pursuant to Public Law 93-638, such individually identifiable health information relating to disabled children as may be necessary for the purpose of carrying out its functions under the Individuals with Disabilities Education Act (20 U.S.C. 1400, et seq.): *Provided further*, That the Indian Health Care Improvement Fund may be used, as needed, to carry out activities typically funded under the Indian Health Facilities account. (Department of the Interior, Environment, and Related Agencies Appropriations Act, 2010.)

INDIAN HEALTH FACILITIES

For construction, repair, maintenance, improvement, and equipment of health and related auxiliary facilities, including quarters for personnel; preparation of plans, specifications, and drawings; acquisition of sites, purchase and erection of modular buildings, and purchases of trailers; and for provision of domestic and community sanitation facilities for Indians, as authorized by section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), the Indian Self-Determination Act, and the Indian Health Care Improvement Act, and for expenses necessary to carry out such Acts and titles II and III of the Public Health Service Act with respect to environmental health and facilities support activities of the Indian Health Service, **[**$394,757,000**]** *$445,242,000*, to remain available until expended: *Provided*, That notwithstanding any other provision of law, funds appropriated for the planning, design, construction, renovation or expansion of health facilities for the benefit of **[**an**]** *a federally-recognized* [4] Indian tribe or tribes may be used to purchase land on which such facilities will be located: *Provided further*, That not to exceed **[**$500,000**]** *$500,000* shall be used by the Indian Health Service to purchase TRANSAM equipment from the Department of Defense for distribution to the Indian Health Service and tribal facilities: *Provided further*, That none of the funds appropriated to the Indian Health Service may be used for sanitation facilities construction for new homes funded with grants by the housing programs of the United States Department of Housing and Urban Development: *Provided further*, That not to exceed **[**$2,700,000**]** *$2,700,000* from this account and the ``Indian Health Services'' account shall be used by the Indian Health Service to obtain ambulances for the Indian Health Service and tribal facilities in conjunction with an existing interagency agreement between the Indian Health Service

and the General Services Administration: *Provided further*, That not to exceed **[**$500,000**]** *$500,000* shall be placed in a Demolition Fund, to remain available until expended, and be used by the Indian Health Service for the demolition of Federal buildings. (Department of the Interior, Environment, and Related Agencies Appropriations Act, 2010.)

ADMINISTRATIVE PROVISIONS, INDIAN HEALTH SERVICE

Appropriations provided in this Act to the Indian Health Service shall be available for services as authorized by 5 U.S.C. 3109 at rates not to exceed the per diem rate equivalent to the maximum rate payable for senior-level positions under 5 U.S.C. 5376; hire of passenger motor vehicles and aircraft; purchase of medical equipment; purchase of reprints; purchase, renovation and erection of modular buildings and renovation of existing facilities; payments for telephone service in private residences in the field, when authorized under regulations approved by the Secretary; uniforms or allowances therefor as authorized by 5 U.S.C. 5901-5902; and for expenses of attendance at meetings that relate to the functions or activities of the Indian Health Service.

In accordance with the provisions of the Indian Health Care Improvement Act, non-Indian patients may be extended health care at all tribally administered or Indian Health Service facilities, subject to charges, and the proceeds along with funds recovered under the Federal Medical Care Recovery Act (42 U.S.C. 2651-2653) shall be credited to the account of the facility providing the service and shall be available without fiscal year limitation.

Notwithstanding any other law or regulation, funds transferred from the Department of Housing and Urban Development to the Indian Health Service shall be administered under Public Law 86-121, the Indian Sanitation Facilities Act and Public Law 93-638, as amended.

Funds appropriated to the Indian Health Service in this Act, except those used for administrative and program direction purposes, shall not be subject to limitations directed at curtailing Federal travel and transportation.

[None of the funds made available to the Indian Health Service in this Act shall be used for any assessments or charges by the Department of Health and Human Services unless identified in the budget justification and provided in this Act, or approved by the House and Senate Committees on Appropriations through the reprogramming process.][5]

Notwithstanding any other provision of law, funds previously or herein made available to a tribe or tribal organization through a contract, grant, or agreement authorized by title I or title V of the Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450), may be deobligated and reobligated to a self-determination contract under title I, or a self-governance agreement under title V of such Act and thereafter shall remain available to the tribe or tribal organization without fiscal year limitation.

None of the funds made available to the Indian Health Service in this Act shall be used to implement the final rule published in the Federal Register on September 16, 1987, by the Department of Health and Human Services, relating to the eligibility for the health care services of the Indian Health Service until the Indian Health Service has submitted a budget request reflecting the increased costs associated with the proposed final rule, and such request has been included in an appropriations Act and enacted into law.

With respect to functions transferred by the Indian Health Service to tribes or tribal organizations, the Indian Health Service is authorized to provide goods and services to those entities on a reimbursable basis, including payments in advance with subsequent adjustment. The reimbursements received therefrom, along with the funds received from those entities pursuant to the Indian Self-Determination Act, may be credited to the same or subsequent appropriation account from which the funds were originally derived, with such amounts to remain available until expended.

Reimbursements for training, technical assistance, or services provided by the Indian Health Service will contain total costs, including direct, administrative, and overhead associated with the provision of goods, services, or technical assistance.

The appropriation structure for the Indian Health Service may not be altered without advance notification to the House and Senate Committees on Appropriations.
(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2010.)

GENERAL PROVISIONS

Sec. 409. Notwithstanding any other provision of law, amounts appropriated to or otherwise designated in committee reports for the Bureau of Indian Affairs and the Indian Health Service by Public Laws 103-138, 103-332, 104-134, 104-208, 105-83, 105-277, 106-113, 106-291, 107-63, 108-7, 108-108, 108-447, 109-54, 109-289, division B and Continuing Appropriations Resolution, 2007 (division B of Public Law 109-289, as amended by Public Laws 110-5 and 110-28), Public Laws 110-92, 110-116, 110-137, 110-149, 110-161, 110-329, 111-6, 111-8, *and 111-88* [6] for payments for contract support costs associated with self-determination or self-governance contracts, grants, compacts, or annual funding agreements with the Bureau of Indian Affairs or the Indian Health Service as funded by such Acts, are the total amounts available for fiscal years 1994 through **[**2009**]** *2010* for such purposes, except that the Bureau of Indian Affairs, tribes and tribal organizations may use their tribal priority allocations for unmet contract support costs of ongoing contracts, grants, self-governance compacts, or annual funding agreements.

~~Sec. 419. (a) Notwithstanding any other provision of law and until October 1, 2011, the Indian Health Service may not disburse funds for the provision of health care services pursuant to Public Law 93-638 (25 U.S.C. 450 et seq.) to any Alaska Native village or Alaska Native village corporation that is located within the area served by an Alaska Native regional health entity.~~

~~(b) Nothing in this section shall be construed to prohibit the disbursal of funds to any Alaska Native village or Alaska Native village corporation under any contract or compact entered into prior to May 1, 2006, or to prohibit the renewal of any such agreement.~~

~~(c) For the purpose of this section, Eastern Aleutian Tribes, Inc., the Council of Athabascan Tribal Governments, and the Native Village of Eyak shall be treated as Alaska Native regional health entities to which funds may be disbursed under this section.~~ [7]

Language Analysis

Language Provision	Explanation
SERVICES	
[1] *Provided further*, That [$18,251,000 is] of the funding provided for [Headquarters operations and] information technology activities and, notwithstanding any other provision of law, [the amount available under this proviso] *$4,000,000* shall be allocated at the discretion of the Director of the Indian Health Service:	Language still needed to ensure funds are used for necessary administrative and management functions associated with IHS residual. The IHS residual, i.e., amount of funding identified with those functions which cannot legally be delegated to Indian Tribes, has increased since initial Tribal shares tables were established in the mid-1990s. For example, new mandates for IT security have been issued for Federal government agencies since that time. This language will ensure that the total amount is used for these functions.
[2] *Provided further, That the amounts collected by the Federal Government as authorized by sections 104 and 108 of the Indian Health Care Improvement Act (25 U.S.C. 1613a and 1616a) during the preceding fiscal year for breach of contracts shall be deposited to the Fund authorized by section 108A of the Act (25 U.S.C. 1616a-1) and shall remain available until expended and, notwithstanding section 108A(c) of the Act (25 U.S.C. 1616a-1(c)), funds shall be available to make new awards under the loan repayment and scholarship programs under sections 104 and 108 of the Act (25 U.S.C. 1613a and 1616a):*	Request for appropriations for funds collected from defaulted scholars and loan repayment recipients. Funds will be used to recruit additional professionals to serve Indian communities. Section 108a of the IHCIA authorizes the establishment of the Scholarship and Loan Repayment Recovery Fund and IHS use of these collected funds when appropriated by Congress.
[3] *Provided further, That $4,000,000 is provided for a substance abuse treatment grant program and, notwithstanding any other provision of law, the amounts available under this proviso shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until September 30, 2012:*	For a new competitive IHS grant program to be funded in the Alcohol and Substance Abuse budget line to expand access to and improve the quality of treatment for substance abuse treatment services. Program will target sites with the greatest need for substance abuse services. The main goal of the grant program will be to enable Indian Health Service, Tribal and Urban facilities to hire additional staff to provide evidence-based and practice-based culturally competent treatment

	services. All grant recipients will be required to report on appropriate performance measures, including mandatory reporting of the number of addicted patients that received services. Existing Methamphetamine and Suicide Prevention Initiative (MSPI) distribution methodology developed through tribal consultation will be used for this grant program. The appropriations language will be modeled after the MSPI proviso.
FACILITIES	
[4] *Provided*, That notwithstanding any other provision of law, funds appropriated for the planning, design, construction, renovation or expansion of health facilities for the benefit of **[**an**]** *a federally-recognized* **[4]** Indian tribe or tribes may be used to purchase land on which such facilities will be located:	Added to make language more accurate in clarifying which tribes are eligible for IHS services.
ADMINISTRATIVE PROVISIONS	
[5] ~~None of the funds made available to the Indian Health Service in this Act shall be used for any assessments or charges by the Department of Health and Human Services unless identified in the budget justification and provided in this Act, or approved by the House and Senate Committees on Appropriations through the reprogramming process.~~	Language restricts Department's flexibility in managing overall resources for the Agency.
GENERAL PROVISIONS	
[6] Sec. 409. Notwithstanding any other provision of law, amounts appropriated to or otherwise designated in committee reports for the Bureau of Indian Affairs and the Indian Health Service by Public Laws 103-138, 103-332, 104-134, 104-208, 105-83, 105-277, 106-113, 106-291, 107-63, 108-7, 108-108, 108-447, 109-54, 109-289, division B and Continuing Appropriations Resolution, 2007 (division B of Public Law 109-289, as amended by Public Law 110-5 and 110-28), Public Laws 110-92, 110-116, 110-137, 110-149, 110-161, 110-329, 111-6, 111-8, <u>*and 111-88*</u> [6] for payments for contract support costs associated with self-determination or self-governance contracts, grants, compacts, or annual funding agreements with the Bureau of Indian Affairs or the Indian Health Service as funded	Added to continue provision to limit payments for Contract Support Costs in past years (FY 1994 through 2010) to the funds available in law and accompanying the report language in those years for the Bureau of Indian Affairs and Indian Health Service.

by such Acts, are the total amounts available for fiscal years 1994 through [2009] *2010* for such purposes, except that for the Bureau of Indian Affairs, tribes and tribal organizations may use their tribal priority allocations for unmet contract support costs of ongoing contracts, grants, self-governance compacts or annual funding agreements.	
[7] ~~Sec. 419. (a) Notwithstanding any other provision of law and until October 1, 2011, the Indian Health Service may not disburse funds for the provision of health care services pursuant to Public Law 93-638 (25 U.S.C. 450 et seq.) to any Alaska Native village or Alaska Native village corporation that is located within the area served by an Alaska Native regional health entity.~~ ~~(b) Nothing in this section shall be construed to prohibit the disbursal of funds to any Alaska Native village or Alaska Native village corporation under any contract or compact entered into prior to May 1, 2006, or to prohibit the renewal of any such agreement.~~ ~~(c) For the purpose of this section, Eastern Aleutian Tribes, Inc., the Council of Athabascan Tribal Governments, and the Native Village of Eyak shall be treated as Alaska Native regional health entities to which funds may be disbursed under this section.~~	Language restricts Self-Determination for Tribes.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
SERVICES

Amounts Available for Obligations

	FY 2009	FY 2010	FY 2011
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$3,190,956,000	$3,657,618,000	$3,961,187,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$3,190,956,000	$3,657,618,000	$3,961,187,000
Supplemental, Recovery Act	$85,000,000	$0	$0
Subtotal, adjusted appropriation	$3,275,956,000	$3,657,618,000	$3,961,187,000
Mandatory Appropriation:			
Appropriation	$150,000,000	$150,000,000	$150,000,000
Offsetting Collections:			
Federal sources	$428,000,000	$450,000,000	$500,000,000
Non-federal sources	$189,000,000	$300,000,000	$400,000,000
Subtotal	$617,000,000	$750,000,000	$900,000,000
Unobligated Balance, Start of Year	351,000,000	393,000,000	243,000,000
Unobligated Balance End of Year	393,000,000	243,000,000	142,000,000
Total Obligations	$3,850,956,000	$4,557,618,000	$4,962,187,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FACILITIES

Amounts Available for Obligations

	FY 2009	FY 2010	FY 2011
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$390,168,000	$394,757,000	$445,242,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$390,168,000	$394,757,000	$445,242,000
Supplemental, Recovery Act	$415,000,000	$0	$0
Subtotal, adjusted appropriation	$805,168,000	$394,757,000	$445,242,000
Offsetting Collections:			
Federal sources	$95,000,000	$6,000,000	$6,000,000
Subtotal	$95,000,000	$6,000,000	$6,000,000
Unobligated Balance, Start of Year	307,000,000	347,000,000	353,000,000
Unobligated Balance End of Year	347,000,000	353,000,000	358,000,000
Total Obligations	$860,168,000	$394,757,000	$446,242,000

INDIAN HEALTH SERVICE
SERVICES
Summary of Changes

FY 2010	$3,657,618,000
Total estimated budget authority	3,657,618,000
Less Obligations	(3,657,618,000)
FY 2011 President's Budget	3,961,187,000
Less Obligations	(3,961,187,000)
Net Change	303,569,000
Less Obligations	(303,569,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
2 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	$9,657,000
3 Tribal Pay Cost	--	n/a	--	$12,773,000
4 Within Grade Increase	--	n/a	--	$0
6 Increased Cost of Travel	--	40,084,000	--	$1,129,000
7 Increased Cost of Transportation & Things	--	9,237,000	--	$158,000
8 Increased Cost of Printing	--	499,000	--	$6,000
9 Increased Cost of Rents, Communications, & Utilities	--	29,366,000	--	$616,000
10 Increased Cost of Health Care Provided under Contracts & Grants	--	621,701,000	--	$20,469,000
11 Increased Cost of Supplies	--	130,663,000	--	$3,186,000
12 Increased Cost of Medical or other Equipment	--	11,954,000	--	$185,000
13 Increased Cost of Land & Structure	--	(85,000)	--	$0
14 Increased Cost of Grants	--	2,143,138,000	--	$34,773,000
15 Increased Cost of Insurance / Indemnities	--	1,212,000	--	$3,000
16 Increased Cost of Interest / Dividends	--	87,000	--	$2,000
17 Population Growth	--	n/a	--	$46,983,000
Subtotal, Built-In	--	2,987,856,000	--	129,940,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	18,440,000	273	35,768,000
C. Program Increases	--	314,711,000	--	141,529,000
TOTAL INCREASES	--	3,302,567,000	273	307,237,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(3,668,000)
B. Program Decreases:	--	0	--	0
TOTAL DECREASES	--	0	--	(3,668,000)
NET CHANGE	--	**$3,302,567,000**	--	**$303,569,000**

INDIAN HEALTH SERVICE
Clinical Services
Summary of Changes

FY 2010	
Total estimated budget authority	$2,953,559,000
Less Obligations	(2,953,559,000)
FY 2011 President's Budget	3,200,165,000
Less Obligations	(3,200,165,000)
Net Change	246,606,000
Less Obligations	(246,606,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	$8,529,000
2 Tribal Pay Cost	--	n/a	--	$11,283,000
3 Within Grade Increase	--	n/a	--	$0
4 Increased Cost of Travel	--	37,287,000	--	$1,087,000
6 Increased Cost of Transportation & Things	--	7,755,000	--	$136,000
7 Increased Cost of Printing	--	463,000	--	$6,000
8 Increased Cost of Rents, Communications, & Utilities	--	28,649,000	--	$600,000
9 Increased Cost of Health Care Provided under Contracts & Grants	--	609,228,000	--	$20,106,000
10 Increased Cost of Supplies	--	127,710,000	--	$3,143,000
11 Increased Cost of Medical or other Equipment	--	10,227,000	--	$172,000
12 Increased Cost of Land & Structure	--	(85,000)	--	$0
13 Increased Cost of Grants	--	1,537,970,000	--	$26,169,000
14 Increased Cost of Insurance / Indemnities	--	1,038,000	--	$3,000
15 Increased Cost of Interest / Dividends	--	29,000	--	$2,000
16 Population Growth	--	n/a	--	$44,247,000
Subtotal, Built-In	--	2,360,271,000	--	115,483,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	17,199,000	259	34,262,000
C. Indian Health Care Improvement Fund	--	45,543,000	0	44,000,000
D. New Tribes	--	4,828,000	0	0
E. Chronic Care Initiative	--	2,500,000	0	2,529,000
F. Health Information Technology	--	16,251,000	0	4,000,000
G. Dental Increase	--	1,250,000	0	0
H. Domestice Violence	--	2,500,000	0	0
H. Health Promotion and Disease Prevention	--	800,000	0	0
I. Alcohol/Substance Abuse	--	0	0	4,000,000
J. CHS Increase	--	117,000,000	0	46,000,000
TOTAL INCREASES	--	2,568,142,000	259	250,274,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(3,668,000)
TOTAL DECREASES	--	0	--	(3,668,000)
NET CHANGE	--	**$2,568,142,000**	--	**$246,606,000**

INDIAN HEALTH SERVICE
Hospitals & Health Clinics
Summary of Changes

FY 2010	$1,754,383,000
Total estimated budget authority	1,754,383,000
Less Obligations	(1,754,383,000)
FY 2011 President's Budget	1,893,292,000
Less Obligations	(1,893,292,000)
Net Change	138,909,000
Less Obligations	(138,909,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	7,088,000
2 Tribal Pay Cost	--	n/a	--	8,576,000
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	9,601,000	--	167,000
6 Increased Cost of Transportation & Things	--	6,812,000	--	119,000
7 Increased Cost of Printing	--	451,000	--	6,000
8 Increased Cost of Rents, Communications, & Utilities	--	28,310,000	--	593,000
9 Increased Cost of Health Care Provided under Contracts & Grants	--	187,548,000	--	5,441,000
10 Increased Cost of Supplies	--	110,632,000	--	2,691,000
11 Increased Cost of Medical or other Equipment	--	8,140,000	--	119,000
12 Increased Cost of Land & Structure	--	0	--	0
13 Increased Cost of Grants	--	914,340,000	--	11,757,000
14 Increased Cost of Insurance / Indemnities	--	688,000	--	2,000
15 Increased Cost of Interest / Dividends	--	0	--	0
16 Population Growth	--	n/a	--	26,278,000
Subtotal, Built-In	--	1,266,522,000	--	62,837,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	12,806,000	208	29,211,000
C. New Tribes	--	3,226,000	0	0
D. Indian Health Care Improvement Fund	--	45,543,000	0	44,000,000
E. Chronic Care Initiative	--	2,500,000	0	2,529,000
F. Health IT Telemed	--	16,251,000	0	4,000,000
G. Domestice Violence	--	2,500,000	0	0
H. Health Promotion and Disease Prevention	--	800,000	0	0
TOTAL INCREASES	--	1,350,148,000	208	142,577,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	0	(3,668,000)
TOTAL DECREASES	--	0	0	(3,668,000)
NET CHANGE	--	**$1,350,148,000**	**208**	**$138,909,000**

INDIAN HEALTH SERVICE
Dental Health
Summary of Changes

FY 2010	$152,634,000
Total estimated budget authority	152,634,000
Less Obligations	(152,634,000)
FY 2011 President's Budget	161,262,000
Less Obligations	(161,262,000)
Net Change	8,628,000
Less Obligations	(8,628,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	883,000
2 Tribal Pay Cost	--	n/a	--	671,000
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	1,037,000	--	16,000
6 Increased Cost of Transportation & Things	--	476,000	--	8,000
7 Increased Cost of Printing	--	6,000	--	0
8 Increased Cost of Rents, Communications, & Utilities	--	126,000	--	2,000
9 Increased Cost of Health Care Provided under Contracts & Grants	--	10,289,000	--	367,000
10 Increased Cost of Supplies	--	6,297,000	--	147,000
11 Increased Cost of Medical or other Equipment	--	1,559,000	--	23,000
12 Increased Cost of Land & Structure	--	(85,000)	--	0
13 Increased Cost of Grants	--	69,860,000	--	891,000
14 Increased Cost of Insurance / Indemnities	--	0	--	0
15 Increased Cost of Interest / Dividends	--	0	--	0
16 Population Growth	--	n/a	--	2,271,000
Subtotal, Built-In	--	89,565,000	--	5,279,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	2,624,000	33	3,349,000
C. Dental Increase	--	1,250,000	--	0
D. New Tribes	--	224,000	--	0
TOTAL INCREASES	--	93,663,000	33	8,628,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	0	0
TOTAL DECREASES	--	0	0	0
NET CHANGE	--	**$93,663,000**	**33**	**$8,628,000**

INDIAN HEALTH SERVICE
Mental Health
Summary of Changes

FY 2010				
Total estimated budget authority				72,786,000
Less Obligations				(72,786,000)
FY 2011 President's Budget				77,076,000
Less Obligations				(77,076,000)
Net Change				4,290,000
Less Obligations				(4,290,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	375,000
2 Tribal Pay Cost	--	n/a	--	373,000
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	468,000	--	8,000
6 Increased Cost of Transportation & Things	--	348,000	--	7,000
7 Increased Cost of Printing	--	2,000	--	0
8 Increased Cost of Rents, Communications, & Utilities	--	16,000	--	0
9 Increased Cost of Health Care Provided under Contracts & Grants	--	5,418,000	--	233,000
10 Increased Cost of Supplies	--	1,151,000	--	7,000
11 Increased Cost of Medical or other Equipment	--	316,000	--	3,000
12 Increased Cost of Land & Structure	--	0	--	0
13 Increased Cost of Grants	--	37,378,000	--	489,000
14 Increased Cost of Insurance / Indemnities	--	102,000	--	1,000
15 Increased Cost of Interest / Dividends	--	0	--	0
16 Population Growth	--	n/a	--	1,092,000
Subtotal, Built-In	--	45,199,000	--	2,588,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	1,769,000	18	1,702,000
C. New Tribes	--	106,000	--	0
TOTAL INCREASES	--	47,074,000	18	4,290,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	0	0
TOTAL DECREASES	--	0	0	0
NET CHANGE	--	**$47,074,000**	**18**	**$4,290,000**

INDIAN HEALTH SERVICE

Alcohol & Substance Abuse

Summary of Changes

FY 2010	$194,409,000
Total estimated budget authority	194,409,000
Less Obligations	(194,409,000)
FY 2011 President's Budget	205,770,000
Less Obligations	(205,770,000)
Net Change	11,361,000
Less Obligations	(11,361,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	177,000
2 Tribal Pay Cost	--	n/a	--	1,663,000
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	348,000	--	5,000
6 Increased Cost of Transportation & Things	--	99,000	--	2,000
7 Increased Cost of Printing	--	4,000	--	0
8 Increased Cost of Rents, Communications, & Utilities	--	196,000	--	5,000
9 Increased Cost of Health Care Provided under Contracts & Grants	--	9,224,000	--	331,000
10 Increased Cost of Supplies	--	1,158,000	--	30,000
11 Increased Cost of Medical or other Equipment	--	186,000	--	3,000
12 Increased Cost of Land & Structure	--	0	--	0
13 Increased Cost of Grants	--	168,874,000	--	2,229,000
14 Increased Cost of Insurance / Indemnities	--	13,000	--	0
15 Increased Cost of Interest / Dividends	--	0	--	0
16 Population Growth	--	n/a	--	2,916,000
Subtotal, Built-In	--	180,102,000	0	7,361,000
B. Alcohol/Substance Abuse	--	0	0	4,000,000
C. New Tribes	--	290,000	0	0
TOTAL INCREASES	--	180,392,000	0	11,361,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	0	0
TOTAL DECREASES	--	0	0	0
NET CHANGE	--	**$180,392,000**	**0**	**$11,361,000**

INDIAN HEALTH SERVICE

Contract Health Services

Summary of Changes

FY 2010	$779,347,000
Total estimated budget authority	779,347,000
Less Obligations	(779,347,000)
FY 2011 President's Budget	862,765,000
Less Obligations	(862,765,000)
Net Change	83,418,000
Less Obligations	(83,418,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	6,000
2 Tribal Pay Cost	--	n/a	--	0
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	25,833,000	--	891,000
6 Increased Cost of Transportation & Things	--	20,000	--	0
7 Increased Cost of Printing	--	0	--	0
8 Increased Cost of Rents, Communications, & Utilities	--	1,000	--	0
9 Increased Cost of Health Care Provided under Contracts & Grants	--	396,749,000	--	13,734,000
10 Increased Cost of Supplies	--	8,472,000	--	268,000
11 Increased Cost of Medical or other Equipment	--	26,000	--	24,000
12 Increased Cost of Land & Structure	--	0	--	0
13 Increased Cost of Grants	--	347,518,000	--	10,803,000
14 Increased Cost of Insurance / Indemnities	--	235,000	--	0
15 Increased Cost of Interest / Dividends	--	29,000	--	2,000
16 Population Growth	--	n/a	--	11,690,000
Subtotal, Built-In	--	778,883,000	--	37,418,000
B. CHS Increase	--	117,000,000	--	46,000,000
C. New Tribes	--	982,000	--	0
TOTAL INCREASES	--	896,865,000	--	83,418,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	0
TOTAL DECREASES	--	0	--	0
NET CHANGE	--	**$896,865,000**	--	**$83,418,000**

INDIAN HEALTH SERVICE
Preventive Health
Summary of Changes

FY 2010	$144,315,000
Total estimated budget authority	144,315,000
Less Obligations	(144,315,000)
FY 2011 President's Budget	151,060,000
Less Obligations	(151,060,000)
Net Change	6,745,000
Less Obligations	(6,745,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	$420,000
2 Tribal Pay Cost	--	n/a	--	$1,057,000
3 Within Grade Increase	--	n/a	--	$0
4 Increased Cost of Travel	--	618,000	--	$10,000
6 Increased Cost of Transportation & Things	--	1,109,000	--	$18,000
7 Increased Cost of Printing	--	7,000	--	$0
8 Increased Cost of Rents, Communications, & Utilities	--	231,000	--	$7,000
9 Increased Cost of Health Care Provided under Contracts & Grants	--	3,731,000	--	$107,000
10 Increased Cost of Supplies	--	2,671,000	--	$42,000
11 Increased Cost of Medical or other Equipment	--	948,000	--	$10,000
12 Increased Cost of Land & Structure	--	0	--	$0
13 Increased Cost of Grants	--	106,142,000	--	$1,404,000
14 Increased Cost of Insurance / Indemnities	--	0	--	$0
15 Increased Cost of Interest / Dividends	--	0	--	$0
16 Population Growth	--	n/a	--	$2,164,000
Subtotal, Built-In	--	115,457,000	0	5,239,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	1,241,000	14	1,506,000
C. New Tribes	--	624,000	0	0
TOTAL INCREASES	--	116,698,000	14	6,745,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	0	0
TOTAL DECREASES	--	0	0	0
NET CHANGE	--	**$116,698,000**	**14**	**$6,745,000**

INDIAN HEALTH SERVICE
Public Health Nursing
Summary of Changes

FY 2010	$64,071,000
Total estimated budget authority	64,071,000
Less Obligations	(64,071,000)
FY 2011 President's Budget	67,571,000
Less Obligations	(67,571,000)
Net Change	3,500,000
Less Obligations	(3,500,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	374,000
2 Tribal Pay Cost	--	n/a	--	292,000
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	417,000	--	7,000
6 Increased Cost of Transportation & Things	--	1,017,000	--	17,000
7 Increased Cost of Printing	--	7,000	--	0
8 Increased Cost of Rents, Communications, & Utilities	--	214,000	--	6,000
9 Increased Cost of Health Care Provided under Contracts & Grants	--	2,810,000	--	83,000
10 Increased Cost of Supplies	--	1,916,000	--	25,000
11 Increased Cost of Medical or other Equipment	--	880,000	--	5,000
12 Increased Cost of Land & Structure	--	0	--	0
13 Increased Cost of Grants	--	31,283,000	--	416,000
14 Increased Cost of Insurance / Indemnities	--	0	--	0
15 Increased Cost of Interest / Dividends	--	0	--	0
16 Population Growth	--	n/a	--	961,000
Subtotal, Built-In	--	38,544,000	0	2,186,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	1,183,000	12	1,314,000
C. New Tribes	--	257,000	12	0
TOTAL INCREASES	--	39,984,000	12	3,500,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	0	0
TOTAL DECREASES	--	0	0	0
NET CHANGE	--	**$39,984,000**	**12**	**$3,500,000**

INDIAN HEALTH SERVICE

Health Education

Summary of Changes

FY 2010	$16,682,000
Total estimated budget authority	16,682,000
Less Obligations	(16,682,000)
FY 2011 President's Budget	17,489,000
Less Obligations	(17,489,000)
Net Change	807,000
Less Obligations	(807,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	43,000
2 Tribal Pay Cost	--	n/a	--	127,000
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	158,000	--	2,000
6 Increased Cost of Transportation & Things	--	55,000	--	1,000
7 Increased Cost of Printing	--	0	--	0
8 Increased Cost of Rents, Communications, & Utilities	--	11,000	--	0
9 Increased Cost of Health Care Provided under Contracts & Grants	--	279,000	--	8,000
10 Increased Cost of Supplies	--	747,000	--	14,000
11 Increased Cost of Medical or other Equipment	--	52,000	--	4,000
12 Increased Cost of Land & Structure	--	0	--	0
13 Increased Cost of Grants	--	12,491,000	--	166,000
14 Increased Cost of Insurance / Indemnities	--	0	--	0
15 Increased Cost of Interest / Dividends	--	0	--	0
16 Population Growth	--	n/a	--	250,000
Subtotal, Built-In	--	13,793,000	0	615,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	58,000	2	192,000
C. New Tribes	--	77,000	0	192,000
TOTAL INCREASES	--	13,928,000	2	807,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	0	0
TOTAL DECREASES	--	0	--	0
NET CHANGE	--	**$13,928,000**	--	**$807,000**

INDIAN HEALTH SERVICE

Community Health Representatives

Summary of Changes

FY 2010	$61,628,000
Total estimated budget authority	61,628,000
Less Obligations	(61,628,000)
FY 2011 President's Budget	63,991,000
Less Obligations	(63,991,000)
Net Change	2,363,000
Less Obligations	(2,363,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	3,000
2 Tribal Pay Cost	--	n/a	--	618,000
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	43,000	--	1,000
6 Increased Cost of Transportation & Things	--	37,000	--	0
7 Increased Cost of Printing	--	0	--	0
8 Increased Cost of Rents, Communications, & Utilities	--	6,000	--	1,000
9 Increased Cost of Health Care Provided under Contracts & Grants	--	642,000	--	16,000
10 Increased Cost of Supplies	--	8,000	--	3,000
11 Increased Cost of Medical or other Equipment	--	16,000	--	1,000
12 Increased Cost of Land & Structure	--	0	--	0
13 Increased Cost of Grants	--	60,434,000	--	796,000
14 Increased Cost of Insurance / Indemnities	--	0	--	0
15 Increased Cost of Interest / Dividends	--	0	--	0
16 Population Growth	--	n/a	--	924,000
Subtotal, Built-In	--	61,186,000	0	2,363,000
B. New Tribes	--	290,000	--	0
TOTAL INCREASES	--	61,476,000	0	2,363,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	0
TOTAL DECREASES	--	0	--	0
NET CHANGE	--	**$61,476,000**	--	**$2,363,000**

INDIAN HEALTH SERVICE

Immunization AK

Summary of Changes

FY 2010	$1,934,000
Total estimated budget authority	1,934,000
Less Obligations	(1,934,000)
FY 2011 President's Budget	2,009,000
Less Obligations	(2,009,000)
Net Change	75,000
Less Obligations	(75,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	0
2 Tribal Pay Cost	--	n/a	--	20,000
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	0	--	0
6 Increased Cost of Transportation & Things	--	0	--	0
7 Increased Cost of Printing	--	0	--	0
8 Increased Cost of Rents, Communications, & Utilities	--	0	--	0
9 Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
10 Increased Cost of Supplies	--	0	--	0
11 Increased Cost of Medical or other Equipment	--	0	--	0
12 Increased Cost of Land & Structure	--	0	--	0
13 Increased Cost of Grants	--	1,934,000	--	26,000
14 Increased Cost of Insurance / Indemnities	--	0	--	0
15 Increased Cost of Interest / Dividends	--	0	--	0
16 Population Growth	--	n/a	--	29,000
Subtotal, Built-In	--	1,934,000	0	75,000
TOTAL INCREASES	--	1,934,000	0	75,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	0	0
TOTAL DECREASES	--	0	0	0
NET CHANGE	--	**$1,934,000**	--	**$75,000**

INDIAN HEALTH SERVICE
Other
Summary of Changes

FY 2010	$559,744,000
Total estimated budget authority	559,744,000
Less Obligations	(559,744,000)
FY 2011 President's Budget	609,962,000
Less Obligations	(609,962,000)
Net Change	50,218,000
Less Obligations	(50,218,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	$708,000
2 Tribal Pay Cost	--	n/a	--	$433,000
3 Within Grade Increase	--	n/a	--	$0
4 Increased Cost of Travel	--	2,179,000	--	$32,000
6 Increased Cost of Transportation & Things	--	373,000	--	$4,000
7 Increased Cost of Printing	--	29,000	--	$0
8 Increased Cost of Rents, Communications, & Utilities	--	486,000	--	$9,000
9 Increased Cost of Health Care Provided under Contracts & Grants	--	8,742,000	--	$256,000
10 Increased Cost of Supplies	--	282,000	--	$1,000
11 Increased Cost of Medical or other Equipment	--	779,000	--	$3,000
12 Increased Cost of Land & Structure	--	0	--	$0
13 Increased Cost of Grants	--	499,026,000	--	$7,200,000
14 Increased Cost of Insurance / Indemnities	--	174,000	--	$0
15 Increased Cost of Interest / Dividends	--	58,000	--	$0
16 Population Growth	--	n/a	--	$572,000
Subtotal, Built-In	--	512,128,000	--	9,218,000
B. Urban Increase	--	5,000,000	--	1,000,000
C. Indian Health Professions	--	2,854,000	--	0
D. Direct Operations	--	2,000,000	--	0
E. New Tribes	--	143,000	--	0
F. Contract Support Costs	--	113,418,000	--	40,000,000
TOTAL INCREASES	--	635,543,000	--	50,218,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	0
B. Program Decreases:	--	0	--	0
TOTAL DECREASES	--	0	--	0
NET CHANGE	--	**$635,543,000**	--	**$50,218,000**

INDIAN HEALTH SERVICE
Urban Indian Health
Summary of Changes

FY 2010	$43,139,000
Total estimated budget authority	43,139,000
Less Obligations	(43,139,000)
FY 2011 President's Budget	45,502,000
Less Obligations	(45,502,000)
Net Change	2,363,000
Less Obligations	(2,363,000)

		FY 2010 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	28,000
2	Tribal Pay Cost	--	n/a	--	266,000
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	129,000	--	3,000
6	Increased Cost of Transportation & Things	--	2,000	--	0
7	Increased Cost of Printing	--	0	--	0
8	Increased Cost of Rents, Communications, & Utilities	--	83,000	--	0
9	Increased Cost of Health Care Provided under Contracts & Grants	--	3,277,000	--	48,000
10	Increased Cost of Supplies	--	31,000	--	1,000
11	Increased Cost of Medical or other Equipment	--	15,000	--	1,000
12	Increased Cost of Land & Structure	--	0	--	0
13	Increased Cost of Grants	--	38,323,000	--	444,000
14	Increased Cost of Insurance / Indemnities	--	0	--	0
15	Increased Cost of Interest / Dividends	--	0	--	0
16	Population Growth	--	n/a	--	572,000
	Subtotal, Built-In	--	41,860,000	--	1,363,000
B.	Urban Indian Health Program	--	5,000,000	--	1,000,000
	TOTAL INCREASES	--	46,860,000	--	2,363,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$46,860,000**	--	**$2,363,000**

INDIAN HEALTH SERVICE
Indian Health Professions
Summary of Changes

FY 2010	$40,743,000
Total estimated budget authority	40,743,000
Less Obligations	(40,743,000)
FY 2011 President's Budget	41,413,000
Less Obligations	(41,413,000)
Net Change	670,000
Less Obligations	(670,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	22,000
2 Tribal Pay Cost	--	n/a	--	0
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	43,000	--	0
6 Increased Cost of Transportation & Things	--	1,000	--	0
7 Increased Cost of Printing	--	0	--	0
8 Increased Cost of Rents, Communications, & Utilities	--	0	--	0
9 Increased Cost of Health Care Provided under Contracts & Grants	--	264,000	--	118,000
10 Increased Cost of Supplies	--	9,000	--	0
11 Increased Cost of Medical or other Equipment	--	4,000	--	0
12 Increased Cost of Land & Structure	--	0	--	0
13 Increased Cost of Grants	--	39,009,000	--	530,000
14 Increased Cost of Insurance / Indemnities	--	0	--	0
15 Increased Cost of Interest / Dividends	--	58,000	--	0
16 Population Growth	--	n/a	--	0
Subtotal, Built-In	--	39,388,000	--	670,000
B. Indian Health Professons	--	2,854,000	--	0
TOTAL INCREASES	--	42,242,000	0	670,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	0
TOTAL DECREASES	--	0	--	0
NET CHANGE	--	**$42,242,000**	--	**$670,000**

INDIAN HEALTH SERVICE
Tribal Management
Summary of Changes

FY 2010	$2,586,000
Total estimated budget authority	2,586,000
Less Obligations	(2,586,000)
FY 2011 President's Budget	2,669,000
Less Obligations	(2,669,000)
Net Change	83,000
Less Obligations	(83,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	0
2 Tribal Pay Cost	--	n/a	--	0
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	9,000	--	0
6 Increased Cost of Transportation & Things	--	1,000	--	0
7 Increased Cost of Printing	--	0	--	0
8 Increased Cost of Rents, Communications, & Utilities	--	1,000	--	0
9 Increased Cost of Health Care Provided under Contracts & Grants	--	46,000	--	0
10 Increased Cost of Supplies	--	3,000	--	0
11 Increased Cost of Medical or other Equipment	--	0	--	0
12 Increased Cost of Land & Structure	--	0	--	0
13 Increased Cost of Grants	--	2,499,000	--	83,000
14 Increased Cost of Insurance / Indemnities	--	0	--	0
15 Increased Cost of Interest / Dividends	--	0	--	0
16 Population Growth	--	n/a	--	0
Subtotal, Built-In	--	2,559,000	--	83,000
TOTAL INCREASES	--	2,559,000	--	83,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	0
TOTAL DECREASES	--	0	--	0
NET CHANGE	--	**$2,559,000**	--	**$83,000**

INDIAN HEALTH SERVICE
Direct Operations
Summary of Changes

FY 2010	$68,720,000
Total estimated budget authority	68,720,000
Less Obligations	(68,720,000)
FY 2011 President's Budget	69,845,000
Less Obligations	(69,845,000)
Net Change	1,125,000
Less Obligations	(1,125,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	622,000
2 Tribal Pay Cost	--	n/a	--	167,000
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	1,860,000	--	27,000
6 Increased Cost of Transportation & Things	--	350,000	--	4,000
7 Increased Cost of Printing	--	29,000	--	0
8 Increased Cost of Rents, Communications, & Utilities	--	392,000	--	9,000
9 Increased Cost of Health Care Provided under Contracts & Grants	--	4,483,000	--	77,000
10 Increased Cost of Supplies	--	231,000	--	0
11 Increased Cost of Medical or other Equipment	--	735,000	--	2,000
12 Increased Cost of Land & Structure	--	0	--	0
13 Increased Cost of Grants	--	17,622,000	--	217,000
14 Increased Cost of Insurance / Indemnities	--	174,000	--	0
15 Increased Cost of Interest / Dividends	--	0	--	0
16 Population Growth	--	n/a	--	0
Subtotal, Built-In	--	25,876,000	--	1,125,000
B. Direct Ops	--	2,000,000	--	0
C. New Tribes	--	143,000	--	0
TOTAL INCREASES	--	28,019,000	--	1,125,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	0
TOTAL DECREASES	--	0	--	0
NET CHANGE	--	**$28,019,000**	--	**$1,125,000**

INDIAN HEALTH SERVICE
Self-Governance
Summary of Changes

FY 2010	$6,066,000
Total estimated budget authority	6,066,000
Less Obligations	(6,066,000)
FY 2011 President's Budget	6,201,000
Less Obligations	(6,201,000)
Net Change	135,000
Less Obligations	(135,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	36,000
2 Tribal Pay Cost	--	n/a	--	0
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	138,000	--	2,000
6 Increased Cost of Transportation & Things	--	19,000	--	0
7 Increased Cost of Printing	--	0	--	0
8 Increased Cost of Rents, Communications, & Utilities	--	10,000	--	0
9 Increased Cost of Health Care Provided under Contracts & Grants	--	671,000	--	13,000
10 Increased Cost of Supplies	--	6,000	--	0
11 Increased Cost of Medical or other Equipment	--	25,000	--	0
12 Increased Cost of Land & Structure	--	0	--	0
13 Increased Cost of Grants	--	3,086,000	--	84,000
14 Increased Cost of Insurance / Indemnities	--	0	--	0
15 Increased Cost of Interest / Dividends	--	0	--	0
16 Population Growth	--	n/a	--	0
Subtotal, Built-In	--	3,955,000	--	135,000
TOTAL INCREASES	--	3,955,000	--	135,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	0
TOTAL DECREASES	--	0	--	0
NET CHANGE	--	**$3,955,000**	--	**$135,000**

INDIAN HEALTH SERVICE
Contract Support Costs
Summary of Changes

FY 2010	$398,490,000
Total estimated budget authority	398,490,000
Less Obligations	(398,490,000)
FY 2011 President's Budget	444,332,000
Less Obligations	(444,332,000)
Net Change	45,842,000
Less Obligations	(45,842,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	0
2 Tribal Pay Cost	--	n/a	--	0
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	0	--	0
6 Increased Cost of Transportation & Things	--	0	--	0
7 Increased Cost of Printing	--	0	--	0
8 Increased Cost of Rents, Communications, & Utilities	--	0	--	0
9 Increased Cost of Health Care Provided under Contracts & Grants	--	1,000	--	0
10 Increased Cost of Supplies	--	2,000	--	0
11 Increased Cost of Medical or other Equipment	--	0	--	0
12 Increased Cost of Land & Structure	--	0	--	0
13 Increased Cost of Grants	--	398,487,000	--	5,842,000
14 Increased Cost of Insurance / Indemnities	--	0	--	0
15 Increased Cost of Interest / Dividends	--	0	--	0
16 Increased Cost of Service & Supply Fund	--	0	--	0
17 Population Growth	--	n/a	--	0
Subtotal, Built-In	--	398,490,000	--	5,842,000
B. Contract Support Costs	--	113,418,000	--	40,000,000
TOTAL INCREASES	--	511,908,000	--	45,842,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	0
TOTAL DECREASES	--	0	--	0
NET CHANGE	--	**$511,908,000**	--	**$45,842,000**

INDIAN HEALTH SERVICE
FACILITIES
Summary of Changes

FY 2010	$394,757,000
Total budget authority	394,757,000
Less Obligations	(394,757,000)
FY 2011 President's Budget	445,242,000
Less Obligations	(445,242,000)
Net Change	50,485,000
Less Obligations	(50,485,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilians and CO	--	n/a	--	1,278,000
2 Tribal Pay Cost	--	n/a	--	644,000
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	3,863,000	--	66,000
6 Increased Cost of Transportation & Things	--	2,451,000	--	32,000
7 Increased Cost of Printing	--	97,000	--	0
8 Increased Cost of Rents, Communications, & Utilties	--	20,682,000	--	334,000
9 Increased Cost of Health Care Provided under Contracts & Grants	--	121,801,000	--	588,000
10 Increased Cost of Supplies	--	3,129,000	--	140,000
11 Increased Cost of Medical or other Equipment	--	6,809,000	--	212,000
12 Increased Cost of Land & Structure	--	23,012,000	--	48,000
13 Increased Cost of Grants	--	123,493,000	--	2,136,000
14 Increased Cost of Insurance / Indemnities	--	2,000	--	0
15 Increased Cost of Interest / Dividends	--	0	--	0
16 Increased Cost of Service & Supply Fund	--	0	--	0
17 Population Growth	--	n/a	--	5,483,000
Subtotal, Built-In	--	305,339,000	--	10,961,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	17	3,003,000
C. HCFC Increase	--	0	--	36,958,000
TOTAL INCREASES	--	305,339,000		50,922,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(437,000)
TOTAL DECREASES	--	0	--	(437,000)
NET CHANGE	**--**	**$305,339,000**	**17**	**$50,485,000**

INDIAN HEALTH SERVICE
Maintenance & Improvement
Summary of Changes

FY 2010	$53,915,000
Total budget authority	53,915,000
Less Obligations	(53,915,000)
FY 2011 President's Budget	55,523,000
Less Obligations	(55,523,000)
Net Change	1,608,000
Less Obligations	(1,608,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian CO	--	n/a	--	0
2 Tribal Pay Cost	--	n/a	--	0
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	0	--	0
6 Increased Cost of Transportation & Things	--	0	--	0
7 Increased Cost of Printing	--	0	--	0
8 Increased Cost of Rents, Communications, & Utilties	--	0	--	0
9 Increased Cost of Health Care Provided under Contracts & Grants	--	29,787,000	--	168,000
10 Increased Cost of Supplies	--	7,000	--	75,000
11 Increased Cost of Medical or other Equipment	--	47,000	--	6,000
12 Increased Cost of Land & Structure	--	17,808,000	--	42,000
13 Increased Cost of Grants	--	6,266,000	--	508,000
14 Increased Cost of Insurance / Indemnities	--	0	--	0
15 Increased Cost of Interest / Dividends	--	0	--	0
16 Increased Cost of Service & Supply Fund	--	0	--	0
17 Population Growth	--	0	--	809,000
Subtotal, Built-In	--	53,915,000	--	1,608,000
TOTAL INCREASES	--	53,915,000	--	1,608,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	0
B. Base Funding Reduction	--	0	--	0
TOTAL DECREASES	--	0	--	0
NET CHANGE	**--**	**$53,915,000**	**--**	**$1,608,000**

INDIAN HEALTH SERVICE
Sanitation Facilities Construction
Summary of Changes

FY 2010	$95,857,000
Total budget authority	95,857,000
Less Obligations	(95,857,000)
FY 2011 President's Budget	97,710,000
Less Obligations	(97,710,000)
Net Change	1,853,000
Less Obligations	(1,853,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	75,000
2 Tribal Pay Cost	--	n/a	--	0
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	45,000	--	1,000
6 Increased Cost of Transportation & Things	--	29,000	--	0
7 Increased Cost of Printing	--	0	--	0
8 Increased Cost of Rents, Communications, & Utilties	--	1,000	--	0
9 Increased Cost of Health Care Provided under Contracts & Grants	--	77,699,000	--	221,000
10 Increased Cost of Supplies	--	11,000	--	0
11 Increased Cost of Medical or other Equipment	--	0	--	0
12 Increased Cost of Land & Structure	--	4,818,000	--	0
13 Increased Cost of Grants	--	7,868,000	--	118,000
14 Increased Cost of Insurance / Indemnities	--	0	--	0
15 Increased Cost of Interest / Dividends	--	0	--	0
16 Increased Cost of Service & Supply Fund	--	0	--	0
17 Population Growth	--	0	--	1,438,000
Subtotal, Built-In	--	90,471,000	--	1,853,000
TOTAL INCREASES	--	90,471,000	--	1,853,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	0
B. Base Funding Reduction	--	0	--	0
TOTAL DECREASES	--	0	--	0
NET CHANGE	**--**	**$90,471,000**	**--**	**$1,853,000**

INDIAN HEALTH SERVICE

Health Care Facilities Construction

Summary of Changes

FY 2010	$29,234,000
Total budget authority	29,234,000
Less Obligations	(29,234,000)
FY 2011 President's Budget	66,192,000
Less Obligations	(66,192,000)
Net Change	36,958,000
Less Obligations	(36,958,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	0
2 Tribal Pay Cost	--	n/a	--	0
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	0	--	0
6 Increased Cost of Transportation & Things	--	0	--	0
7 Increased Cost of Printing	--	0	--	0
8 Increased Cost of Rents, Communications, & Utilties	--	0	--	0
9 Increased Cost of Health Care Provided under Contracts & Grants	--	84,000	--	1,000
10 Increased Cost of Supplies	--	0	--	0
11 Increased Cost of Medical or other Equipment	--	18,000	--	0
12 Increased Cost of Land & Structure	--	323,000	--	5,000
13 Increased Cost of Grants	--	28,742,000	--	431,000
14 Increased Cost of Insurance / Indemnities	--	0	--	0
15 Increased Cost of Interest / Dividends	--	0	--	0
16 Increased Cost of Service & Supply Fund	--	0	--	0
17 Population Growth	--	0	--	0
Subtotal, Built-In	--	29,167,000	--	437,000
B. HCFC Increase	--	0	--	36,958,000
TOTAL INCREASES	--	29,167,000	--	37,395,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(437,000)
B. Base Funding Reduction	--	0	--	0
TOTAL DECREASES	--	0	--	(437,000)
NET CHANGE	**--**	**$29,167,000**	**--**	**$36,958,000**

INDIAN HEALTH SERVICE
Facilities & Environmental Health Support
Summary of Changes

FY 2010	$193,087,000
Total budget authority	193,087,000
Less Obligations	(193,087,000)
FY 2011 President's Budget	202,106,000
Less Obligations	(202,106,000)
Net Change	9,019,000
Less Obligations	(9,019,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	1,203,000
2 Tribal Pay Cost	--	n/a	--	644,000
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	3,818,000	--	65,000
6 Increased Cost of Transportation & Things	--	2,331,000	--	32,000
7 Increased Cost of Printing	--	97,000	--	0
8 Increased Cost of Rents, Communications, & Utilties	--	20,644,000	--	333,000
9 Increased Cost of Health Care Provided under Contracts & Grants	--	12,775,000	--	182,000
10 Increased Cost of Supplies	--	2,822,000	--	61,000
11 Increased Cost of Medical or other Equipment	--	1,033,000	--	18,000
12 Increased Cost of Land & Structure	--	61,000	--	1,000
13 Increased Cost of Grants	--	65,539,000	--	581,000
14 Increased Cost of Insurance / Indemnities	--	2,000	--	0
15 Increased Cost of Interest / Dividends	--	0	--	0
16 Increased Cost of Service & Supply Fund	--	0	--	0
17 Population Growth	--	n/a	--	2,896,000
Subtotal, Built-In	--	109,122,000	--	6,016,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	17	3,003,000
TOTAL INCREASES	--	109,122,000	--	9,019,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	0
B. Base Adjustment:	--	0	--	0
TOTAL DECREASES	--	0	--	0
NET CHANGE	**--**	**$109,122,000**	**17**	**$9,019,000**

INDIAN HEALTH SERVICE
Equipment
Summary of Changes

FY 2010	$22,664,000
Total budget authority	22,664,000
Less Obligations	(22,664,000)
FY 2011 President's Budget	23,711,000
Less Obligations	(23,711,000)
Net Change	1,047,000
Less Obligations	(1,047,000)

	FY 2010 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2011 Pay Raise at 1.4% civilian and CO	--	n/a	--	0
2 Tribal Pay Cost	--	n/a	--	0
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	0	--	0
6 Increased Cost of Transportation & Things	--	91,000	--	0
7 Increased Cost of Printing	--	0	--	0
8 Increased Cost of Rents, Communications, & Utilties	--	37,000	--	1,000
9 Increased Cost of Health Care Provided under Contracts & Grants	--	1,456,000	--	16,000
10 Increased Cost of Supplies	--	289,000	--	4,000
11 Increased Cost of Medical or other Equipment	--	5,711,000	--	188,000
12 Increased Cost of Land & Structure	--	2,000	--	0
13 Increased Cost of Grants	--	15,078,000	--	498,000
14 Increased Cost of Insurance / Indemnities	--	0	--	0
15 Increased Cost of Interest / Dividends	--	0	--	0
16 Increased Cost of Service & Supply Fund	--	0	--	0
17 Population Growth	--	0	--	340,000
Subtotal, Built-In	--	22,664,000	--	1,047,000
TOTAL INCREASES	--	22,664,000	--	1,047,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	0
B. Base Funding Reduction	--	0	--	0
TOTAL DECREASES	--	0	--	0
NET CHANGE	**--**	**$22,664,000**	**--**	**$1,047,000**

INDIAN HEALTH SERVICE
Budget Authority by Activity
(Dollars in Thousands)

	2009 Actual		2010 Enacted		2011 Estimate	
	FTE	Amount	FTE	Amount	FTE	Amount
SERVICES:						
Hospitals & Health Clinics	6,284	$1,597,777	6,433	$1,754,383	6,443	$1,893,292
Dental Services	743	141,936	748	152,634	750	161,262
Mental Health	266	67,748	268	72,786	268	77,076
Alcohol & Substance Abuse	179	183,769	179	194,409	179	205,770
Contract Health Services	7	634,477	7	779,347	7	862,765
Total Clinical Services	7,479	2,625,707	7,635	2,953,559	7,647	3,200,165
Public Health Nursing	258	59,885	262	64,071	263	67,571
Health Education	26	15,723	26	16,682	26	17,489
Comm. Health Reps.	7	57,796	7	61,628	7	63,991
Immunization AK	0	1,823	0	1,934	0	2,009
Total Preventive Health	291	135,227	295	144,315	296	151,060
Urban Health	7	36,189	7	43,139	7	45,502
Indian Health Professions	18	37,500	18	40,743	18	41,413
Tribal Management	0	2,586	0	2,586	0	2,669
Direct Operations	327	65,345	335	68,720	335	69,845
Self-Governance	13	6,004	13	6,066	13	6,201
Contract Support Costs	0	282,398	0	398,490	0	444,332
Total Services	8,135	3,190,956	8,303	3,657,618	8,316	3,961,187
FACILITIES:						
Maintenance & Improvement	0	53,915	0	53,915	0	55,523
Sanitation Facilities Constr.	170	95,857	170	95,857	170	97,710
Health Care Facs. Constr.	0	40,000	0	29,234	0	66,192
Facil. & Envir. Health Supp.	1,032	178,329	1,037	193,087	1,039	202,106
Equipment	0	22,067	0	22,664	0	23,711
Total Facilities	1,202	$390,168	1,207	$394,757	1,209	445,242
Total IHS	9,337	$3,581,124	9,510	$4,052,375	9,525	4,406,429

INDIAN HEALTH SERVICE

Authorizing Legislation

(Dollars in Thousands)

Jan 26, 2010

	FY 2010		FY 2011	
	Amount Authorized	Enacted	Amount Authorized	President's Budget
1. Services Appropriation:	3,657,618	3,657,618	3,961,187	3,961,187
25 U.S.C. 13, Act and P.L. 83-568,				
Transfer Act, 42 U.S.C. 2001.				
Snyder Act, Title V,				
P.L. 94-437, Indian Health Care				
Improvement Act (IHCIA), as amended.				
Title I, Indian Health Manpower.				
Indian Self Determination				
and Education Assistance Act,				
P.L. 93-638, as amended,				
Sections 103(b)(2) and 103(e).				
Titles III & V, Self Governance				
Demonstration Program, Indian Self				
Determination Act, as amended.				
P.L. 100-472 Section 106(a)(2) A&B				
P.L. 106-260 Tribal Self Governance				
Amendment of 2000.				
2. Facilities Appropriation:	394,757	394,757	445,242	445,242
Indian Sanitation Facilities Act				
P.L. 86-121, 42 U.S.C. 2004a				
Section 301 of the IHCIA				
P.L. 103-413, P.L. 102-573				
P.L. 98-473, Quarters Return Funds	6,288	6,288	6,288	6,288
3. Public and Private Collections:	828,740	828,740	828,740	828,740
Economy Act				
31 U.S.C. 1535, P.L. 94-437,				
Title V of IHCIA.				
Title I of IHCIA (Default Recovery Funds)	0	0	0	300
4. Special Diabetes Program for Indians:	150,000	150,000	150,000	150,000
111 STAT. 574 (P.L. 105-33)				
114.2763A-525, (P.L. 106-554, Sec. 432)				
123 STAT. 2494 (P.L. 110-275, Sec. 303)				
Unfunded authorizations:	0	0	0	0
Total appropriations:	5,037,403	5,037,403	5,391,457	5,391,757
Total appropriations against Definite authorizations:	5,037,403	5,037,403	5,391,457	5,391,757

INDIAN HEALTH SERVICE
Appropriation History Table
Services

Jan 8, 2010

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2002	$2,387,014,000	$2,390,014,000	$2,388,614,000	$2,389,614,000
Rescission (PL 107-206)	-	-	-	($1,009,000)
2003	$2,513,668,000	$2,508,756,000	$2,466,280,000	$2,492,115,000
Rescission (PL 108-7)	-	-	-	($16,199,000)
2004	$2,502,393,000	$2,556,082,000	$2,546,524,000	$2,561,932,000
Rescission (PL 108-108)	-	-	-	($16,550,000)
Rescission (PL 108-199)	-	-	-	($15,018,000)
2005	$2,612,824,000	$2,627,918,000	$2,633,624,000	$2,632,667,000
Rescission (PL 108-447, Sec. 501)				($15,638,000)
Rescission (PL 108-447, Sec. 122)				($20,936,000)
2006	$2,732,298,000	$2,732,298,000	$2,732,323,000	$2,732,298,000
Rescission (PL 109-54)				($13,006,000)
Rescission (PL 109-148)				($27,192,000)
2007	$2,822,449,000	$2,830,085,000	$2,835,493,000	$2,818,871,000
2008	$2,931,530,000	$3,023,532,000	$2,991,924,000	$3,018,624,000
Rescission (PL 110-161)				($47,091,000)
2009 Omnibus	$2,971,533,000	-	-	$3,190,956,000
2009 ARRA (PL 111-5)	-	-	-	$85,000,000
2010	$3,639,868,000	$3,657,618,000	$3,639,868,000	$3,657,618,000
2011	$3,961,187,000			

INDIAN HEALTH SERVICE
Appropriation History Table
Facilities

Apr 14, 2009

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2002	$319,795,000	$369,795,000	$362,854,000	$369,487,000
2003	$370,475,000	$362,571,000	$391,865,000	$376,190,000
Rescission (PL 108-7)	-	-	-	($2,445,000)
2004	$387,269,000	$392,560,000	$391,188,000	$396,232,000
Rescission (PL 108-108)	-	-	-	($2,560,000)
Rescission (PL 108-199)	-	-	-	($2,322,000)
2005	$354,448,000	$405,453,000	$364,148,000	$394,453,000
Rescission (PL 108-447, Sec. 501)				($2,343,000)
Rescission (PL 108-447, Sec. 122)				($3,137,000)
2006	$315,668,000	$370,774,000	$335,643,000	$358,485,000
Rescission (PL 109-54)				($1,706,000)
Rescission (PL 109-148)				($3,569,000)
2007	$347,287,000	$363,573,000	$357,287,000	$361,226,000
2008	$339,196,000	$360,895,000	$375,475,000	$380,583,000
Rescission (PL 110-161)				($5,937,000)
2009 Omnibus	$353,329,000	-	-	$390,168,000
2009 ARRA (PL 111-5)	-	-	-	$415,000,000
2010	$394,757,000	$394,757,000	$394,757,000	$394,757,000
2011	$445,242,000			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
CLINICAL SERVICES

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$2,625,707	$85,000	$2,953,559	$3,200,165	+$246,606
FTE	7,479	0	7,635	7,647	+12

SUMMARY OF THE BUDGET REQUEST

The FY 2011 budget request for Clinical Services is $3,200,165,000, an increase of $246,606,000 over the FY 2010 President's budget request. This change represents increases of $146,077,000 for pay raises, inflation, population growth and staffing five new/expanded facilities with two Joint Venture construction projects in progress that may come online for funding in FY 2011 and $100,529,000 for program expansion.

The detailed explanation of the request is described in each of the budget narratives that follow.

- $1.893 billion for **Hospitals and Health Clinics**, an increase of $88 million for pay, population growth, and staffing new facilities, and $51 million for program increases to lessen disparities, support health information technology, and combat the impact of chronic diseases in Indian communities. These funds are necessary to support essential personal health services including inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy, etc. In addition, the program includes public/community health initiatives targeting health conditions disproportionately affecting AI/AN such as specialized programs for diabetes, maternal and child health, youth services, communicable diseases including influenza, HIV/AIDS, tuberculosis, and hepatitis, and a continuing emphasis on women's and elders' health.

- $161 million for **Dental Health**, an increase of $9 million for pay, population growth, inflation, and staffing new facilities. These funds are necessary to provide preventive and basic care as over 90 percent of the dental services provided are basic and emergency care. Basic services are prioritized over more complex rehabilitative care such as root canals, crown and bridge, dentures, and surgical extractions. The demand for dental treatment remains high due to the high dental caries rate in the AI/AN children; however, a continuing emphasis on community oral health promotion/disease prevention is essential to long-term improvement of the oral health of AI/AN people.

- $77 million for **Mental Health**, an increase of $4 million for pay, population growth, inflation, and staffing new facilities. These funds are necessary to provide a community-oriented clinical and preventive mental health service program that provides outpatient mental health and related services, crisis triage, case management, prevention programming and outreach services. Mental Health is crucial for the well being of American Indian and Alaska Native individuals and their communities; it is integral to the healing process.

- $206 million for **Alcohol and Substance Abuse**, an increase of $7 million for pay, population growth, and inflation and $4 million for a grant program to support alcohol and other drug dependency treatments and rehabilitation. These funds are necessary to provide preventive and treatment services at both the community and clinic levels. These programs provide alcohol and substance abuse treatment and prevention services within rural and urban communities, with a focus on holistic and culturally-based approaches. The Alcohol and Substance Abuse Program (ASAP) exists as part of an integrated behavioral health team that works collaboratively to reduce the incidence of alcoholism and other drug dependencies in AI/AN communities.

- $863 million for **Contract Health Services**, an increase of $37 million for population growth and inflation, and $41 million to reduce the number of denied and deferred cases and $5 million to fund additional catastrophic cases. These funds are necessary to purchase essential healthcare services not available in IHS/Tribal facilities including inpatient and outpatient care, routine and emergency ambulatory care, transportation, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, physical therapy, etc. The demand for CHS remains high as the cost of medical care increases. The CHS program continues to emphasize adherence to medical priorities, enrolling patients in alternate resources available to them and negotiating discounted rates with medical providers.

The bulk of clinical services funds are provided to 12 Area (regional) Offices which in turn provide resource distribution, program monitoring and evaluation activities, and administrative and technical support to 162 Federal and Tribal service units (local level) for 600 health care facilities providing care to 1.9 million AI/AN primarily in services areas that are rural, isolated and underserved.

Performance Summary Table -- The following table displays annual and long term performance measures that are considered over-arching because all of the programs in this section contribute toward the achievement of targets. Measure 21: Patient Safety is added beginning FY 2010.

Measure	**Most Recent Result**	**FY 2010 Target**	**FY 2011 Target**	**FY 2011 +/- FY 2010**
31: Childhood Weight Control: Proportion of children, ages 2-5 years, with a BMI of 95 percent or higher. IHS – All *(Outcome)*	FY 2009: 25% (No Target Long Term Measure)	24%	N/A	N/A
31: Tribally Operated Health Programs (Outcome)	FY 2009: 24% (No Target Long Term Measure)	24%	N/A	N/A
TOHP-2: Number of designated annual clinical performance goals met. (Outcome)	FY 2009: 16/17 (Target Exceeded)	16/17	16/17	-0
28: Unintentional Injury Rates: Unintentional injury mortality rate in AI/AN population. [1]	FY 2004 94.0 (Target Exceeded)	N/A	N/A	N/A
FAA-3: Unintentional Injury Rates: Unintentional mortality rate in AI/AN population.[2]	FY 2004 90.5 (No Target Long Term Measure)	N/A	N/A	N/A
21: **Patient Safety**: Percent of patient falls in an IHS-funded facility in persons age 65 and older as a result of taking high risk medication.	N/A	Baseline	TBD	N/A
Program Level Funding ($ in millions)	**$2,625.7**	**$2,953.5**	**$3,200.1**	**+$246.6**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

[1] Long Term Measure; reportable in 2016.
[2] Long Term Measure; reportable in 2016.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
HOSPITALS AND HEALTH CLINICS

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$1,597,777	$85,000	$1,754,383	$1,893,292	+$138,909
FTE	6,284	0	6,433	6,443	+10

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization.. IHCIA last authorized in 2000, Snyder and Transfer Acts - Permanent

Allocation Method ....Direct Federal; P.L. 93-638 contracts and compacts with Tribal nations and Tribal consortia; competitive grants; interagency agreements; commercial contracts.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Hospitals and Health Clinics (H&HC) is by far the largest activity within the Indian Health Service (IHS) budget, amounting to nearly one-half of the IHS budget authority. It supports essential personal health services for 1.9 million American Indians and Alaska Natives (AI/AN) including medical and surgical inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy, etc. In addition, the program includes public/community health initiatives targeting health conditions disproportionately affecting AI/AN such as specialized programs for diabetes; maternal and child health; youth services; communicable diseases including influenza, HIV/AIDS, tuberculosis, and hepatitis; a continuing emphasis on women's and elders' health; and a recent focus on planning and organizing regional trauma/emergency medical services delivery systems. The IHS system of care is unique in that personal health care services are integrated with public health services. Collecting, analyzing, and interpreting health information is done through a network of Tribally-operated epidemiology centers in collaboration with a national IHS coordinating center leading to the identification of health conditions as well as promoting interventions. Information technology that supports both personal health services (including the electronic health record and telemedicine) and public health initiatives is primarily funded through the Hospitals and Health Clinics budget.

Approximately one-half of the H&HC budget is transferred under P.L. 93-638 contracts or compacts to Tribal governments or Tribal organizations which provide these individual and community health services for the Federal Government. This is reflected in the outputs table which shows that approximately 58 percent of the outpatient workload and 38 percent of the inpatient workload is performed by Tribally managed hospitals and clinics. Most of the remainder is managed by direct Federal programs providing health care at the local level. A small percentage of the funds (<0.5 percent) is distributed to Tribes via many small competitive

grant programs; examples include eldercare, children and youth, women's health, and health promotion and disease prevention grants.

Although the health status of AI/AN has increased significantly in the past 50 years since the inception of the IHS, the average life expectancy at birth is 74.4 years compared to the U.S. all races life expectancy of 76.9 and the U.S. white of 77.4.[1] The IHS and Tribes primarily serve small, rural populations with mainly primary medical care and community-health services through approximately 700 locations, relying on the private sector for much of the secondary and all of the tertiary medical care needs. A few of our hospitals do provide secondary medical services such as ophthalmology, orthopedics, etc. Of 45 IHS or Tribal hospitals, only one has an average daily census of >45 patients. Nineteen of these 45 hospitals have operating rooms; the majority do not. This speaks to their focus on primary and community based care, not on secondary or tertiary care.

The following are brief descriptions of several specific activities funded through H&HC:

Emergency Services – The IHS' Emergency Services staff office establishes emergency management goals and objectives consistent with those of the Department of Health and Human Services, Department of Homeland Security, and other Federal agencies in addressing mission critical elements, strategic plans, policies, procedures, continuity of operations (COOP), deployment, physical security, and public health infrastructure. IHS is:

(1) building capacity in public health infrastructure and emergency preparedness through linkages among its hospitals and clinics with local, county, Tribal and State agencies and non-governmental organizations throughout the country;
(2) working to assure that the needs of Tribal communities are addressed by States which have received targeted funding for emergency preparedness and response;
(3) working with and expanding the capacity of 91 Tribal and 3 IHS local emergency medical services (EMS) by providing technical assistance to enhance their ability to provide optimum emergency medical access, response and care in Indian Country;
(4) enhancing IHS' ability to deploy staff for national and international emergencies as was done for the response to hurricanes Gustav and Ike, suicide clusters in Tribal communities, wild fires in southern California, and flooding in the Grand Canyon, Northwest, and the Dakotas;
(5) preparing its hospitals and clinics to diagnose and treat victims of a bioterrorism or other mass casualty situations such as pandemic influenza; the IHS pandemic influenza plan was activated for 2 weeks in April and May 2009 in response to the H1N1 outbreak;
(6) measuring the effectiveness of IHS critical infrastructure protection programs though a systematic effort of inspection and review; and
(7) participating in numerous local, regional, and national exercises to test response capabilities and enhance linkages with public safety elements at all levels.

IHS has developed a comprehensive emergency management program that focuses on strengthening an all-hazards response capability in the Agency as well as in AI/AN communities. This program has participated with other Federal Agencies involved in emergency response in Tribal communities to enhance information sharing and provide a common operating picture of Tribal community needs after an emergency to provide an integrated response. A satellite communications system and emergency notification system are maintained to provide backup communications with the 12 Area Offices and provide a quick, reliable method of notification of

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[1] Pappalardo, JG, Freidman, A, et. al. "Life Expectancy Data Years: 1999-2001." Rockville, Maryland: Indian Health Service. 2007.

an emergency. All of these efforts are in support of DHHS' role in enhancing the ability of the Nation's health care system to effectively respond to bioterrorism and other public health challenges.

Alcohol Screening and Brief Intervention – The IHS has initiated a major alcohol intervention (funded through the H&HC budget activity), the Alcohol Screening and Brief Intervention (ASBI) program, to address alcohol abuse and injury prevention, very serious inter-related issues in Indian Country. It is aimed at breaking the alcohol–injury cycle by taking advantage of the "teachable moment" when an injured patient presents at an IHS or Tribal hospital emergency department as a result of possible alcohol or other drug intoxication. The ASBI program is being implemented system-wide in all IHS and Tribal hospitals.

The ASBI is similar to the Screening, Brief Intervention, Referral, and Treatment (SBIRT) program of SAMHSA with which IHS collaborates. We are also working with the American College of Surgeons and level I and II referral trauma centers and their SBIRT programs. In FY 2007, IHS conducted six ASBI train-the-trainer conferences around the country and has trained over 500 physicians, nurses, behavioral and allied health professionals in this intervention methodology. In FY 2008, IHS broadened the scope of the ASBI program to include IHS-Tribal primary care and behavioral health clinics.

An ASBI quality performance measure has been developed and is part of the National Measures (ONM) Report in the RPMS Clinical Reporting System (CRS). This non-GPRA report provides valuable information on how well emergency departments (ED) are screening for hazardous alcohol use in injured individuals, ages 15 – 34, and whether a brief counseling intervention is offered in the ED or ambulatory care settings for those individuals with positive screens. Baseline data in 2008 reveals that 7.5% of the individuals that presented with an ED injury visit received alcohol screening. Additional targeted counseling and education is provided for those individuals that screened positive for hazardous alcohol use. Provider training is being directed toward better documentation using the recommended CPT and patient education codes that comprise the ASBI measure logic.

Trauma Care - The IHS is focusing more attention on trauma care and injury prevention. Combined they bring greater synergy for reducing death and disability and controlling the high costs of traumatic injuries with their many chronic health sequela. Trauma remains the largest cause of death and disability in Indian country for those under age 45 with AI/AN trauma death rates three times higher than U.S. all races rates.

A trauma care program encompasses injury prevention, emergency medical services (EMS), emergency medicine, surgery, rehabilitation, hospital planning and the regionalization of acute medical care. IHS and Tribal trauma care is dependent for definitive care on distant regional hospitals with advanced critical care capabilities. The strength of the interrelationships developed between IHS and Tribal hospitals with their regional trauma center determines patient outcomes. The goal is to insure optimal trauma care, through transfer agreements with a "first option" regional trauma center. This is being developed in the Southwest in FY 2009**.** These interrelationships are comprehensive and include patient care, patient care information sharing, health professional training, technical assistance, trauma registry, data coordination and problem solving on a regional basis.

The local IHS/Tribal hospital is frequently the closest facility for EMS providers to transport individuals with traumatic injuries. Staffing capacity and capabilities as well as adequate, "state of the art" equipment are essential. The role of diagnostic (e.g., CT scanners, ultrasound) and

surgical and emergency department treatment devices cannot be underestimated. The CT is now the standard of care in trauma and many acute illnesses. Emergency medicine physicians are essential for improving patient care and for emergency department and disaster management. Emergency room nurses are an essential and often underappreciated element in every trauma emergency plan and program.

Programs and activities of public education are important. IHS and Tribes are sponsoring "Trauma Day" local events which include hospital staff, EMS personnel, law enforcement and community leaders. In this setting health care professionals and community leaders brought together can see the obvious connections, commonality of purpose, and the necessity for cooperative efforts. The Trauma Day emphasizes the complementary nature of active health care management with the more subtle passive prevention strategies. These will articulate how Tribes locally and national Indian organizations can impact the trauma problem in Indian Country. The IHS has also established supporting relationships with national trauma, emergency medicine, EMS, and injury control professional organizations. The overall control of the trauma problem in Indian Country will require professional and public recognition of the problem, support and utilization of proven trauma care, injury prevention and mitigating measures.

Domestic Violence Prevention Initiative - Congress appropriated $7.5 million to the IHS in the Omnibus Appropriations Act of 2009, Public Law 111-8, to implement a nationally-coordinated Domestic Violence Prevention Initiative (DVPI). In FY 2010, Congress appropriated an additional $2.5M, for a total of $10M for this initiative. The purpose of the initiative is to support a national effort by the IHS to address domestic violence and sexual assault within AI/AN communities. With these funds, the IHS will further expand its outreach advocacy programs into Native communities, expand the Domestic Violence and Sexual Assault Pilot project, and provide funding for training and the purchase of forensic equipment to support the Sexual Assault Nurse Examiner (SANE) program.

Health Promotion/Disease Prevention – The IHS is increasing access to preventive and curative services (secondary and tertiary prevention) for Indian communities by targeting health programs reflecting community health status to provide the most effective services to the most people. However, these prevention strategies are often difficult to maintain since the impact of the programs is often distant in time and community attention to these efforts may wane in the face of more immediate concerns such as treatment for trauma and for acute and chronic diseases. The IHS recognizes that clinical approaches alone will not reduce the ongoing disparity in health among AI/AN communities.

Since its inception in 2005, the Health Promotion/Disease Prevention Program has focused on promoting primary prevention among AI/AN communities to reduce the leading causes of preventable death such as behaviors related to poor nutrition, physical inactivity, commercial tobacco use, and excessive and underage alcohol consumption. Through integration of the HP/DP program with Behavioral Health and Improving Patient Care programs, the IHS has improved the integration of individual and community health, emphasizing both clinical and community-based prevention efforts.

Accomplishments specific to the HP/DP program include:

- Providing 33 competitive grants to AI/AN communities to enhance and expand prevention efforts focusing on behavioral risk factors that contribute to cancer, obesity, diabetes, and cardiovascular disease.
- Implementing the Healthy Native Communities Fellowship program that has graduated over 200 fellows from across the country. This is an intense year-long program that provides

training, coaching, and mentoring to develop Tribal, IHS, and urban Indian health leaders and staff to be catalysts for implementing positive changes in their local communities.

- Partnering with the National Indian Health Board to promote and expand *Just Move It* physical activity campaign to get 1 million American Indian and Alaska Native people moving. Currently, there are over 29,000 participants from 337 partnering organizations and communities.
- Conducting Community Champion Forums in all 12 IHS Areas. Over 500 individuals have participated in these on-going Forums across the 12 IHS Areas.
- Partnering with Mothers Against Drunk Driving (MADD) to train youth to address underage drinking, revising the Youth in Action manual for the American Indian population, and providing *Protecting You/Protecting Me* training to over 100 individuals in 6 of the 12 IHS Areas.
- Partnering with the University of New Mexico Prevention Research Center to develop the "Across the Life Span Physical Activity Kit" to encourage increased physical activity in schools, worksites, and communities. National training and dissemination was held in May 2009.
- Building local capacity by implementing the Youth Leadership Program to engage youth and their adult mentors to address local issues and coordinating a youth summit in 2 IHS Areas with over 800 participants to expand best and promising strategies.

Additional strategies include:

- Focusing on those traditional practices and values of Indian communities which have a strong role in promoting wellness.
- Promoting and implementing effective programs in schools and communities.
- Engaging youth and strengthening families to make healthy lifestyle choices. The agency is working closely with national youth organizations such as Boys and Girls Clubs of America and United National Indian Tribal Youth, Inc. (UNITY) to promote healthy lifestyles for AI/AN children and youth.
- Engaging professional HP/DP experts through the Prevention Task Force, as well as Federal, Tribal, and community leaders through the Policy Advisory Committee to guide this initiative to eliminate health disparities.

The HP/DP competitive grant program commissioned an evaluation of the 33 Tribal and Urban Indian organizations grantees to assess the effectiveness of the program and determine ways in which the program can be improved. A contractor will be completing the evaluation and anticipates submitting its final report in February 2010. The IHS will use evidence from the evaluation to consider methods to improve the program.

<u>Chronic Disease</u> – The IHS has a long and successful history of addressing public health challenges and acute, infectious diseases. Today, however, increasing chronic disease burdens are challenging the Indian health system. Addressing this challenge is a priority that requires a redesign of the delivery of primary care services to advance reliable and evidence-based care, to better integrate all of the health programs available to patients, and to put them at the center of their care.

One of IHS' initiatives to address chronic disease is the Chronic Care Initiative, now called the Improving Patient Care (IPC) program. Fourteen pilot sites began work in FY 2007 in the IPC and showed improvements in clinical prevention (screening for elevated blood pressure, depression, intimate partner violence, alcohol misuse, tobacco abuse, and obesity); in cancer screening (colorectal, breast, and cervical cancer); in chronic disease treatment (control of blood

pressure), and in patient experience of care (patients who would recommend their healthcare facility to friends and relatives). This work continued in FY 2008; these original 14 sites laid the foundation for changes that will help the Indian health system to make needed improvement in our primary care model.

In FY 2009 the IPC added an additional 24 IHS, Tribal, and Urban Indian health programs and these 38 programs collectively provide services to over 400,000 AI/AN people. The IPC pilot sites work together within a "collaborative," utilizing peer-to-peer learning with faculty guidance that is increasingly provided by natural leaders who have emerged in the early phases of the initiative. The sharing of knowledge and experience within this collaborative structure accelerates learning and improvement. The collaborative uses virtual meeting technology, allowing us to reach larger numbers of professionals in a cost-efficient way and to open the health care improvement process to greater involvement by community members and Tribal leadership.

The changes that the IPC pilot sites are using are conceptually organized by the Care Model which was developed at the MacColl Institute for Healthcare Innovation and tested and implemented widely in the U.S. and abroad. These changes crosswalk closely with published concepts of the "medical home" and rely on the full optimization of the IHS clinical information system. A broad and comprehensive measurement plan guides improvement in the four domains of clinical prevention, care of chronic conditions, patient experience of care, and the cost of care.

In the next few years these health care programs will leverage changes in the delivery of health care and the use of the clinical information system to improve patient self-management skills and to create patient care teams with increased efficiency, effectiveness, and continuity of care. This will provide local sites with the skills and tools to support ongoing health care system improvement. Participating programs will share learning and experience in a collaborative fashion to increase their chances of success and speed of change.

IPC sites report monthly on a core set of performance measures phased in over the first year of participation; trends begin to be evident for the individual sites and for the aggregate after six months of reporting. The IPC evaluation team is providing further analysis of the participating sites and expects to see changes in the outcomes measures 24-48 months after sites begin participation. Outcome and performance measures will be compiled into an Evaluation Report to be published annually in September. As the number of sites joining the IPC in this effort expands, the effect on the majority of H&HC performance measures will increase. Because of the emphasis on clinical screening as well as chronic disease management, the IPC will directly impact most of the H&HC measures such as the 6 diabetes measures, the 3 cancer screening measures, the 3 immunization measures, etc. In addition, new measurements will be developed as appropriate.

Area and regional Tribal staff are being trained to support a significant dissemination effort in FY 2010 and beyond. The work will be made available to an additional 100 IHS, Tribal, and Urban sites over a three year period beginning in FY 2010 and will spread the improvements in primary care proven to be effective by the initial sites.

FUNDING HISTORY

Fiscal Year	Amount	
2006	$1,339,488,000	
2007	$1,411,336,000	
2008	$1,484,016,000	
2009 Recovery Act	$85,000,000*	Health IT, P.L. 111-5
2009 Omnibus	$1,597,777,000	
2010 Enacted	$1,754,383,000	

* see HIT narrative (separate)

BUDGET REQUEST

The FY 2011 budget request for Hospitals and Health Clinics is $1,893,292,000, an increase of $138,909,000 over the FY 2010 Enacted level. Approximately, $934.1 million will be distributed to Federally-administered hospitals and clinics. Approximately $959.2 million to be distributed to Tribally operated hospitals and clinics through P.L. 93-638 compacts and contracts to provide similar services that the IHS would provide if these programs were directly Federally administered.

The increase will provide:

Current Services +$88,380,000

- Pay Costs +$15,664,000 – pay costs increases for Federal and Tribal employees of which about 90% are working at the service unit levels providing health care and related services.
- Inflation +$17,227,000 – to cover the inflationary costs of providing health care services to 1.9 million American Indians and Alaska Natives.
- Population Growth +$26,278,000 – to provide health care services to the additional projected increase in population.
- Staffing/Operating Cost Requirements for New/Expanded Facilities +$29,211,000 – to staff five new/expanded facilities with two Joint Venture construction projects in progress that may come online for funding in FY 2011. Funding these facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address critical health care needs.

Staff for New Facility	Amount	FTE/Tribal Positions
Absentee Shawnee Health Center (JV), Little Axe, OK	$5,522,000	61
Elbowoods Health Center, New Town, ND	$6,436,000	73
Carl Albert Hospital, Replacement (JV), Ada, OK	$4,045,000	38
Lake County Tribal Health Center (JV), Lakeport, CA	$1,948,000	21
Cheyenne River Health Center, Eagle Butte, SD	$1,417,000	15*
Joint Venture (2)	$9,823,000	TBD
Grand Total:	**$29,211,000**	**208**

* Federal FTE

Program Increases +$50,529,000

- **Indian Health Care Improvement Fund +$44,000,000** – The IHCIF methodology compares the current funding of health care delivery sites relative to a benchmark cost for a standard benefits package. The formula allocates funds to sites with the lowest scores.

The benchmark considers site user counts, population health status, prevailing health care costs, and an estimate for Medicare and Medicaid funding. In FY 2010, the IHS, in consultation with Tribes, is evaluating allocation of the Indian Health Care Improvement Fund. The evaluation consists of two complementary parts: (1) a technical work group to evaluate and update data and identify technical improvements to the computations; and (2) a process with Tribal leaders to consider whether the formula itself needs to be changed. Stage one is underway. Statisticians and analysts from IHS and tribal operated programs are assessing measures, data definitions, collection/reporting, and alternative data which may improve accuracy and precision. This stage will be completed in February 2010 in time to allocate FY 2010 IHCIF funding. In stage 2, policy level issues and recommendations to alter the structure of the allocation formula will be considered. Proposed changes to the formula will be subject to full tribal consultation before potential implementation in FY 2011. This budget increase will increase health care in communities with the greatest unmet needs as evidenced by per capita funding, expanded ambulatory services, higher utilization rates, and more persons served.

Health Information Technology +$4,000,000 – The $4,000,000 program increase will be used for health information technology security maintenance and enhancements. Although RPMS is a secure health information system, the recent government mandates to exchange health information increase the security needed to facilitate the external exchanges. In addition, changes in security standards associated with meaningful use will increase security requirements. Additional resources will be employed to provide expert security management of health information. Certification and Accreditation of enhancements to RPMS and continued funding for the Network and Operations Security Center (NOSC) are planned for FY2011. Local, regional, and national support for these essential security enhancements has come from the hospital and health clinics budget.

The establishment of additional Health Information Technology funding within the Hospital and Health Clinics budget ensures sustainability of the ongoing and essential IHS health information technology efforts that are critical to our goal of improving the health status for AI/AN people. Additional details regarding the request are available in the separate HIT narrative.

- **Chronic Diseases +$2,529,000** – The burden of chronic illness remains disproportionately large among AI/AN, contributing to increased rates of disability, a reduction in life expectancy, spiraling costs, and suffering. Tribal leaders have identified diabetes, cancer, heart disease and stroke as national Tribal health priorities. This priority list is consistent with mortality data, which shows that heart disease and cancer are the top two causes of death for AI/AN, [IHS Program Statistics, Trends in Indian Health] and with diabetes prevalence data, which show that AI/AN people suffer from among the highest rates of diabetes in the world [IHS Diabetes Program Fact Sheets]. In addition to the Improved Patient Care and Health Promotion/Disease Prevention programs, the IHS strategy in addressing these needs is to prevent the diseases through new, targeted efforts aimed at reducing their principal risk factors (smoking, obesity, sedentary lifestyle). These cross-cutting approaches add new capability to the Indian health system and offer the opportunity to reduce the risk of and consequences from these debilitating and costly chronic diseases.

  I. Preventing and treating overweight and obesity -- $1,500,000

  - Primary care strategies to address pediatric overweight and obesity to prevent and treat chronic illness in AI/AN communities ($1,250,000): Pilot test and evaluate an

intervention by pediatricians and primary care teams in medical office and school-based health center settings in rural communities to promote early identification and treatment of childhood overweight and obesity through a systematic overweight screening process, in-depth medical assessment, counseling, appropriate follow-up and referral, patient education, and staff training.[2]

1. Up to 25 sites representative of the entire Indian Health System will be selected for participation, including 4 sites currently participating in a pilot project to reduce childhood obesity and overweight with the National Initiative for Children's Health Quality (NICHQ). Sites will be selected that have a high likelihood of success in identifying the set of interventions most likely to result in improvement in reduction of childhood obesity and overweight in AI/AN communities. The lessons learned from these pilot sites will be disseminated to other IHS, Tribal, and Urban Indian health programs.
2. Staff training will also included a telemedicine link between the I/T/U pediatricians and primary care teams with multiple pediatric subspecialists at University of New Mexico for biweekly case reviews and educational programs on topics pertinent to the diagnosis and management of obesity and obesity-related health complications as is currently being done with the 4 pilot project sites.
3. Sites will share expertise, tools, and results with each other throughout the pilot phase.
4. Sites will track and report on both process and outcome measures (see below). Data will be obtained through IHS' Resource and Patient Management System (RPMS) and manually.
5. These funds will support training, local coordination and data reporting at the participating sites, and an evaluation of the effectiveness of the program. If the program is determined to be effective, the evaluation will include an assessment of the cost of system-wide dissemination.

   Outcomes:
   a. Increase the percentage of children age 2 – 18 years that have been screened for overweight with documentation of BMI percentile
   b. Increase the percentage of children age 2 – 18 years with documented diagnosis of overweight/obesity in the active problem list
   c. Increase the percentage of children age 2 – 18 years that are treated and counseled for overweight/obesity
   d. Increase the percentage of children age 2 – 18 years that receive follow-up and referral for more intensive weight management counseling
   e. Long-term: Decrease the rates of pediatric overweight and obesity in participating sites, and develop a refined, multifaceted set of interventions that other sites can employ to reduce rates of childhood overweight and obesity.

- Create a standing body of I/T/U staff, the Indian Health System **Healthy Weight for Life Workgroup**, to facilitate marketing, implementation and evaluation of the Healthy Weight for Life Strategy ($250,000).

[2] Pediatrics Vol. 123June 2009 S253-S316. Web.7 Sep 2009. http://pediatrics.aappublications.org/content/vol123/Supplement_5/

Outcome: Revise and disseminate the "Healthy Weight for Life: A Comprehensive Strategy Across the Lifespan of American Indians and Alaska Natives" to provide individuals, families, schools, worksites, communities, Tribal leaders and organizations, Indian health care delivery system providers, and IHS leadership and staff with guidance for taking action to promote healthy weight across the lifespan. The strategic plan will be a dynamic document that guides the Indian Health Care System in implementing and sustaining multifaceted approaches for individuals, communities, organizations and society that decreases the rates of overweight and obesity across the lifespan in AI/AN people.

II. Reduce smoking rates through provider training, clinic-based cessation programs, and public education -- $1,029,000

American Indians and Alaska Natives have the highest rates of tobacco abuse of any racial or ethnic group in the United States. IHS patient data show rates of tobacco use (over age 5) of between 30% and 45% in areas outside the Southwest, compared to national all-races rates of about 20%. In the Southwest, rates vary from 8% to 20%, but there are published reports of increasing rates among youth. These figures agree closely with published Behavioral Risk Factor Surveillance Survey (BRFSS) data. Rates and geographic distribution of lung cancer and heart disease correspond with these regional differences in tobacco use. Analysis of AI/AN mortality data shows that tobacco abuse is the second largest preventable cause of death for AI/AN people, after diet and exercise (obesity). In 2005, in response to this need, the IHS Tobacco Task Force developed a strategic plan for tobacco control. In the first phase of this plan, the Task Force developed a comprehensive Fieldbook for implementing tobacco control in the IHS primary healthcare setting. A systems-change model was piloted at four sites using these materials, with American Legacy Foundation and CDC/Office on Smoking and Health funding. The Fieldbook, in conjunction with expert consultation and support, will be used as the foundation of a program to ensure that every IHS, Tribal and Urban facility offers evidence-based treatment for tobacco users.

Our strategy will be:

1. Train and certify staff at IHS, Tribal and Urban Indian health facilities to employ evidence-based intervention strategies for every individual currently using tobacco products.
2. Develop and disseminate materials, including on-line educational modules, to educate I/T/U providers in various aspects of the treatment of tobacco dependence.
3. Establish evidence-based tools to integrate tobacco dependence treatment with the Improving Patient Care/Chronic Care program improvement process, using the Fieldbook as well as expert consultation and support.
4. Support enhancements to the health IT applications that will assist in managing cessation patients and collecting rates of tobacco use.
5. Develop and disseminate community health education messages that are appropriate for AI/AN cultures and beliefs.

Outputs and Outcomes:

1. Increase in the number of tobacco users who are treated or counseled (current GPRA performance measure).
2. Decrease in smoking rates as measured by IHS patient records and national BRFSS data (CDC).

3. Long-term: decrease in rates of tobacco-related cancers, heart disease, and chronic lung disease, as measured by cancer and cardiovascular disease registries, and death certificate surveillance.

Hospitals and Health Clinics funding will provide personal health care services for acute, chronic, and emergency conditions as well as clinical preventive services for approximately 1.9 million people; public/community health initiatives targeting health conditions affecting AI/AN; health promotion and disease prevention; emergency preparedness and response; and complex health information technology that supports both personal health services and public health initiatives.

OUTCOMES

Twenty-one performance measures and key program assessment measures are directly related to the H&HC budget; seventeen are reported here and four are included in the Special Diabetes Program for Indians section. These measures include a variety of clinical measures such as prenatal HIV screening, pap smear and mammography screening, domestic violence screening, immunization rates, community-based cardiovascular disease and obesity prevention, depression screening, and reducing tobacco usage. Although the IHS has many more clinical measures, these 17 crosscut many programs and therefore are included in the H&HC line item, but only evaluate the performance of a portion of the clinical care program, as all aspects of primary and some secondary clinical care of individuals, involving thousands of disease states, are provided through the H&HC budget. Each of the approximately 1.9 million individuals cared for in the Indian Health System is unique and requires individual attention and care, so that each individual is a unique "output." Assessing performance data from the most current reported data demonstrates effective H&HC outcomes. In FY 2008, the IHS met or exceeded 15 H&HC performance measures, whereas two were not met, establishment of baseline rates and the TOHP sub-components are not included in this count . Those not met were each only 1 percent under the goal; e.g., the target for controlled blood pressure in diabetic patients was 39 percent but only 38 percent was achieved. Some of these performance measures are very resource intensive. The level of performance measure achievement is similar to that for the past several years.

Two of the 17 performance measures of programs funded through H&HC will be discussed. These are just examples from the performance measures and are not necessarily any more important than the other 17 measures. Most of these relate to direct clinical care and are all important for the agency to meet its mission of elevating the health of Indian people to the highest level.

Diabetes – The agency continues to make significant progress in addressing chronic diseases. A primary focus has been in the treatment and prevention of diabetes and its complications. Diabetes continues to be a growing problem in AI/AN communities. Of particular concern, the incidence of the disease is increasing rapidly in youth and young adults.

Supplemental funding, key Tribal involvement, collaboration with other Federal agencies, and community emphasis all contributed to the IHS meeting or exceeding four of six diabetes performance measures. Ongoing interventions include more effective pharmaceuticals, more aggressive screening for the secondary effects of diabetes, earlier intervention when complications are identified, and emphasizing greater patient compliance with care regimens. The level and quality of services provided to over 100,000 diabetics throughout the IHS are audited annually to improve standardized care and patient outcomes. A wide range of IHS developed performance measures including foot care, eye care, end organ status, and adequacy of

blood sugar control have been incorporated into the National Committee for Quality Assurance/American Diabetes Association national performance diabetes care benchmarks. Six of these are reported as performance indicators. Over two-thirds of Tribal communities have programs in place for community-wide prevention of diabetes, and 83 percent of Tribal communities offer primary prevention programs for children and youth.

Diabetes is the leading cause of end stage renal disease (ESRD) or kidney failure, a serious problem in Indian communities. Early identification of patients at risk through screening for protein in the urine (proteinuria) helps prevent or delay the need for dialysis or renal transplant. Proteinuria is also an independent predictor of cardiovascular disease, the number one killer of AI/AN adults. In conjunction with other diabetes standards of care (blood sugar control and blood pressure control), this performance measure is intended to increase screening of diabetic patients for nephropathy in order to prevent or delay kidney failure by use of angiotensin-converting enzyme (ACE) inhibitors, medications proven to delay or prevent the onset of kidney failure. IHS use of ACE inhibitors has been steadily increasing since 1993. And since 1996 the rate of new cases of kidney failure in AI/AN patients with diabetes has been *decreasing*, while the rates continue to rise in African American and Caucasian diabetic populations. For FY 2007, this measure was changed to require quantitative testing in addition to or instead of the previous qualitative screening method, and a new baseline was established at 40%. The change in the measure was done in order to encourage a better assessment of diabetes related kidney damage. In FY 2008 IHS exceeded the target of 40 percent by an additional 10 percent of patients assessed.

Accreditation/Certification –The Joint Commission (JC), the Accreditation Association for Ambulatory Health Care (AAAHC), and the Centers for Medicare and Medicaid Services (CMS) regularly conduct in-depth quality reviews of IHS and Tribal hospitals and clinics. The average accreditation status levels are consistent with the average levels for all U.S. hospitals. The most frequently cited area for improvement is Life Safety Code Compliance because some IHS facilities are old and cannot be maintained adequately for the current array of services. The average age of IHS facilities is greater than 30 years.

IHS met this performance measure in FY 2008 as four IHS hospitals were evaluated by either the JC or CMS; all remain accredited or certified. The four hospitals surveyed in FY 2008 were Sells, in the Tucson Area, Hopi Health Center, Phoenix Indian Medical Center, and San Carlos in the Phoenix Area. IHS also achieved its goal of 100 percent accreditation of ambulatory facilities. Accreditation contributes both directly and indirectly to improve clinical safety and is essential for maximizing third-party collections. The local IHS multidisciplinary team approach to accreditation and ongoing quality management, with guidance and support from Area staff, has been the mainstay of success. This is one of the most demanding measures to meet, given the growing clinical quality of care assessments that are required as well as issues related to health facilities maintenance and renovation that are critical to accreditation. Measuring accreditation and certification is a very important performance element because these periodic external review processes help monitor that basic policies and procedures, staffing, and patient care outcomes monitoring mechanisms are in place to ensure that consistent high quality patient care is being provided safely. In FY 2010, the IHS expects to maintain 100% accreditation or certification of its facilities.

Federally Administered Activities and Tribally operated programs have also participated in program assessments. Both programs have been successful in performance reporting, utilizing subsets of IHS national performance measures to demonstrate achievement in addressing the major health disparities facing the AI/AN population. For example, IHS recently developed and

released a 40-page guidance document with specific clinical strategies based on childhood obesity prevention and treatment for provider use. IHS is utilizing the most current recommendations to prevent increases in the Childhood Weight Control measure.

OUTCOMES

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
5: Diabetes: Nephropathy Assessment: Proportion of patients with diagnosed diabetes assessed for nephropathy. IHS-All	FY 2009: 50% (Target Exceeded)	54%	55.4%	+ 1.4%
5: Tribally Operated Health Programs	FY 2009: 36% (Target Exceeded)	39%	40.0%	+ 010%
20: Accreditation: Percent of hospitals and outpatient clinics accredited (excluding tribal and urban facilities)	FY 2009: 100% (Target Met)	100%	100%	+ 0%
6: Diabetic Retinopathy: Proportion of patients with diagnosed diabetes who receive an annual retinal examination. IHS-All	FY 2009: 51% (Target Exceeded)	55%	56.4%	+ 1.4%
6: Tribally Operated Health Programs	FY 2009: 48% (Target Exceeded)	51%	52.3%	+ 1.3%
7: Pap Smear Rates: Proportion of eligible women who have had a Pap screen within the previous three years. IHS-All	FY 2009: 59% (Target Met)	60%	61.5%	+ 1.5%
7: Tribally Operated Health Programs	FY 2009: 60% (Target Met)	61%	62.5%	+ 1.5%
8: Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. IHS-All	FY 2009: 45% (Target Met)	47%	49.9%	+ 2.9%
8: Tribally Operated Health Programs	FY 2009: 47% (Target Met)	49%	50.2%	+ 1.2%
9: Colorectal Cancer Screening Rates: Proportion of eligible patients who have had appropriate colorectal cancer screening. IHS-All	FY 2009: 33% (Target Exceeded)	36%	38.8%	+ 2.8%
9: Tribally Operated Health Programs	FY 2009: 36% (Target Exceeded)	39%	40.0%	+ 1.0%
TOHP-4: Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native (AI/AN) populations served by tribal health Programs (Outcome)[1]	2004 64.4	N/A	N/A	N/A
FAA-2: Years of Potential Life Lost (YPLL) in American Indian/Alaska Native population (Outcome) [2]	2004 80.4	N/A	N/A	N/A
24: Combined (4:3:1:3:3:1:4) Childhood Immunization rates[4]: AI/AN children patients aged 19-35 months. In 2010 this measure will add the Varicella vaccine to the basic series that is required. In 2011 Pneumococcal conjugate vaccinations will be added to the childhood immunization series. IHS - All (Outcome)	FY 2009: 79% (Target Exceeded)	80%	82.0%	+ 2.0%
24: Tribally Operated Health Programs	FY 2009: 75% (Target Exceeded)	76%	77.9%	+ 1.9%
FAA-E: Hospital Admissions per 100,000 service population for long term complications of diabetes in federally administered facilities. (Efficiency)	FY 2007: 132.0 (Target Exceeded)	130.7	N/A	-1.0%
FAA-1: Children ages 2-5 years with a BMI at the 95th percentile or higher.	FY 2009: 24.7% (Target Not Met)	24%	N/A	N/A
TOHP-3: Percentage of AI/AN patients with diagnosed diabetes served by tribal health programs that achieve ideal blood sugar control[3]	FY 2009: 34% (No Target Long-term Measure)	N/A	N/A	N/A
16: Domestic (Intimate Partner) Violence	FY 2009: 48%	53%	57.3%	+ 4.3%

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Screening: Proportion of women who are screened for domestic violence at health care facilities. IHS-All	(Target Exceeded)			
16: Tribally Operated Health Programs	FY 2009: 40% (Target Exceeded)	45%	49.3%	+ 4.3%
25: Adult Immunizations: Influenza: Influenza vaccination rates among adult patients aged 65 years and older. IHS-All	FY 2009: 59% (Target Not Met)	60%	61.5%	+ 1.5%
25: Tribally Operated Health Programs	FY 2009: 56% (Target Not Met)	57%	58.4%	+ 1.4%
26: Adult Immunizations: Pneumovax: Pneumococcal vaccination rates among adult patients aged 65 years and older. IHS-All	FY 2009: 82% (Target Met)	83%	85.1%	+ 2.1%
26: Tribally Operated Health Programs	FY 2009: 76% (Target Not Met)	77%	78.9%	+ 1.9%
33: HIV Screening: Proportion of pregnant women screened for HIV	FY 2008: 76% (Target Exceeded)	77%	78.9%	+ 1.9%
FAA-4: Breastfeeding Rates: Proportion of infants 2 months old (45-89 days old) that are exclusively or mostly breastfed.	FY 2009: 33% (Target Exceeded)	33%	31%	-2%
Program Level Funding ($ in millions)	**$1,597.8**	**$1,754.4**	**$1,893.3**	**+138.9**
ARRA Level Funding ($ in millions)	**$85.0**		**$0**	**$0**

[1]Long term measure; reportable in 2015 for FY 2012 with a target of 55.3.
[2]Long term measure; reportable in 2015 for FY 2012 with a target of 62.3
[3]No annual targets; this is a long term measure with a target of 40% in 2014.
[4]Varicella was added to the series of childhood immunizations the agency reports on in FY 2010 and Pneumococcal conjugate vaccine was added for FY 2011. Prior to FY 2010, the agency reported on the 4:3:1:3:3 series of vaccinations.

OUTPUTS

Measure	Most Recent Result (FY 2008)	FY 2010 Target*	FY 2011 Target	FY 2011 +/- FY 2010
Inpatient Admissions - IHS Direct	34,849	35,400	37,400	+2,000
Inpatient Admissions - Tribal Direct	21,809	22,800	24,100	+1,300
Total Admissions	**56,658**	**58,200**	**61,500**	**+3,300**
Outpatient Visits - IHS Direct	4,549,675	5,175,800	5,474,400	+298,600
Outpatient Visits - Tribal Direct	6,162,250	6,489,000	6,863,400	+374,400
Total Outpatient Visits	**10,711,925**	**11,664,800**	**12,337,800**	**+673,000**
Program Level Funding ($ in millions)	**$1,597.8**	**$1,754.4**	**$1,893.3**	**+138.9**
ARRA Level Funding ($ in millions)	**$85.0**		**$0**	**$0**

**FY2010 targets are revised based on actual Inpatient/Outpatient admission data.*

GRANTS AWARDS FUNDED BY HOSPITALS AND HEALTH CLINIC: A small percentage of the funds (<0.5 percent) is distributed to Tribes via many small competitive grant programs; examples include eldercare, children and youth, women's health, and health promotion and disease prevention grants.

	FY 2009	FY 2010	FY 2011
Number of Awards	41	55	55
Average Award	$130,173	$135,455	$135,455
Range of Awards	$24,975 - $1,040,000	$24,975 - $1,040,000	$24,975 - $1,040,000
Total Awards	$5,337,096	$7,450,000	$7,450,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
HOSPITALS AND HEALTH CLINICS
Epidemiology Centers

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$1,597,777	$85,000	$1,754,383	$1,893,292	+$138,909
Epi Ctrs	*$4,609*		*$5,080**	*$5,288*	*+208*
FTE	13	0	13	13	0

*FY 2010 Budget estimated
Note: *Italicized* dollar amounts and FTE are non-add; FY 2009 Enacted updated to reflect the FY 2008 "Actual."

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization... IHCIA last authorized in 2000, Snyder and Transfer Acts - Permanent

Allocation Method ....Cooperative Agreements

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Congress authorized funding of $12,000,000 for the innovative Indian Health Service (IHS) Tribal Epidemiology Center (TEC) program in FY 1996. The intent was to develop public health infrastructure by augmenting existing tribal organizations with expertise in epidemiology and public health through the establishment of Epidemiology Centers.

Epidemiology provides the foundation for all public health activities. Tribal governments and health facilities as well as IHS direct-service sites deliver the majority of public health services such as immunization and cancer prevention and control programs to American Indian and Alaska Native (AI/AN) communities throughout the country. More efficient service delivery and development of effective interventions to improve health requires in-depth knowledge of the causes of illness and mortality among the population and epidemiology provides that knowledge.

Operating from within Tribal organizations, TECs are in a unique position to provide support to local tribal disease surveillance and control programs, and in assessing the effectiveness of public health programs. TECs provide critical support to Tribes who self-govern their health programs. Data generated locally and analyzed by TECs enable Tribes to evaluate Tribal and community-specific health status data so that planning and decision-making can best meet the needs of their Tribal membership. Because these data are used at the local level, immediate feedback is provided to the local data systems which also can lead to improvements in Indian health data overall.

TECs also address national public health goals through work to improve data needed for GPRA reporting and monitoring of the Healthy People 2010 objectives. All TECs monitor the health status of tribes in their region, producing reports annually or biannually for constituent tribes. Following standardization of these reports across all TECs in FY 2012, the IHS National Coordinating Center plans to produce a composite picture of Indian health.

FY 2011 Tribal Epidemiology Centers Allocation (Estimate)			
1	Alaska Native Tribal Health Consortium	Anchorage, AK	$407,000
2	Albuquerque American Indian Health Board	Albuquerque, NM	$407,000
3	Great Lakes Inter-Tribal Council	Lac du Flambeau, WI	$407,000
4	Inter Tribal Council of Arizona	Phoenix, AZ	$407,000
5	Montana/Wyoming Tribal Leaders Council	Billings, MT	$407,000
6	Navajo Nation Division of Health	Window Rock, AZ	$407,000
7	Northern Plains – Aberdeen Area	Rapid City, SD	$407,000
8	Northwest Portland Area Indian Health Board	Portland, OR	$407,000
9	Oklahoma City Area Inter-Tribal Health Board	Oklahoma City, OK	$407,000
10	Seattle Indian Health Board	Seattle, WA	$407,000
11	United South and Eastern Tribes, Inc.	Nashville, TN	$407,000
12	California Rural Indian Health Board - NEW	Sacramento, CA	$407,000
	Administrative and technical support	Albuquerque, NM	$404,000
	TOTAL		**$5,288,000**

FUNDING HISTORY

Approximately 90 percent of the TEC Program budget is distributed through Cooperative Agreements. Funding for each TEC is authorized up to $1,000,000. Initially, four tribal organizations competed and received funding based on recommendations from an objective review panel. These first TECs received funding of up to $155,000 each through cooperative agreements with Tribes and Tribal organizations, such as Indian health boards. In FY 2000, the four original TECs plus two new centers received funding for five years. Three new TECs were added in FY 2005 and in FY 2006, after the most recent competitive 5-year cooperative agreement award process, the IHS TEC program was expanded to include 11 TECs. In FY 2008, one new TEC in California was recognized and funded by the IHS Director's office. All 12 existing TECs now serve a major portion of the AI/AN population in 12 regions comparable to the IHS Administrative Area service population. The IHS Division of Epidemiology and Disease Prevention (DEDP) functions as the national coordinating center and provides technical support and guidance to TECs, utilizing approximately 10 percent of the TEC Program budget. DEDP and TECs collect, analyze, interpret, and disseminate health information in addition to identifying diseases to target for intervention, suggesting strategies for successful interventions and testing the effectiveness of health interventions that have been implemented.

Fiscal Year	Amount
2006 *	*$4,525,802*
2007 *	*$4,549,669*
2008	*$4,548,361*
2009 Recovery Act	*$0*
2009 Omnibus	*$4,609,489*
2010 Enacted	*$5,080,295*

* FY funding amounts were updated to reflect "Actual" *non-add* budget data

BUDGET REQUEST

The FY 2011 budget request for Epidemiology Centers under Hospitals and Health Clinics is $5,288,000. The increase of $208,000 will help fund pay increases and inflation for 12 Cooperative Agreements covering all IHS Areas.

Funding for the TEC Program has steadily increased. Similar to the clinical setting in Indian health, recruitment and retention are tremendous problems for TECs, especially where salary support is dependent on outside grants.

OUTCOMES

Each TEC sets goals and determines outcomes independently as directed by their constituent tribes and health boards. The Program Office tracks the TECs' goals and objectives written in their cooperative agreements. Some of these activities include establishing disease and control programs; and collecting epidemiological data for use in determining health status of tribal communities. The Program Office sets a national outcome for each TEC of developing and disseminating regional health profiles for their constituent tribes and communities.

OUTPUTS TABLE

In the expanding environment of Tribally-operated health programs, epidemiology centers provide additional public health services, such as disease control and prevention programs. Some existing centers provide additional assistance to Tribal participants in such areas as sexually transmitted disease control and HIV and cancer prevention. They also assist Tribes in activities such as conducting behavioral risk factor surveys in order to establish baseline data for successfully evaluating intervention and prevention activities.

The TEC program continues to support tribal communities by providing technical training in public health practice and prevention-oriented research and promoting public health career pathways for tribal members. Efforts to supplement the TEC programs are coordinated with the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) to optimize federal resource utilization, create stronger interagency partnerships, and prevent costly duplication of effort. ***This program continues to promote two HHS Goals: #2 - Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness & #4 – Scientific Research and Development.***

OUTPUTS

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Health Status & Monitoring **Measured by surveys, assessments, reports*	12of 12TECs	12of 12TECs	12 of 12 TECs	0
Provides regional health profiles	12of 12TECs	12of 12TECs	12 of 12 TECs	0
Develop & Implement disease control & prevention programs	12of 12TECs	12of 12TECs	12 of 12 TECs	0
Contribute to national measures, i.e., GPRA/ Healthy People 2010	12of 12TECs	12of 12TECs	12 of 12 TECs	0
Support tribal communities through technical training in public health practice	12of 12TECs	12of 12TECs	12 of 12 TECs	0
Program Level Funding ($ in millions)	**$4.5**	**$5.1**	**$5.3**	**+$.2**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

GRANTS AWARDS

Cooperative Agreements	FY 2009	FY 2010	FY 2011
Number of TEC Awards	12*	12	12
Average Award	$379,030**	$390,769**	$407,000**
Range of Awards	$315,000-$530,000	$300,000-$475,000	TBD
IHS Director's Office Funds	$350,000	$0	$0

* IHS Director's Office Funds - In FY 2009, the Director's Office continued to fund the California TEC until the next competitive funding cycle in FY2011.
** The administrative and technical support for the IHS national coordinating center in Albuquerque is included in average.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
HOSPITALS AND HEALTH CLINICS
Health Information Technology

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$1,597,777	$85,000	$1,754,383	$1,893,292	+$138,909
HIT	*$114,506*	*$85,000*	*$130,757*	*$134,757*	*+4,000*
FTE	511	0	611	611	0

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization... IHCIA last authorized in 2000, Snyder and Transfer Acts - Permanent

Allocation Method ....Direct Federal; Cooperative Agreements, HIT services and products comprise the large majority of allocations to 12 Area Offices within the IHS.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Health Information Technology (HIT) - Health care is information intensive and dependent on technology to assure that appropriate health information is available whenever and wherever the data is needed. Information technology is essential to effective health care delivery and efficient resource management in the IHS. The IHS HIT is based on an architecture that incorporates government and industry standards for the collection, processing and transmission of information. The IHS has a long history of successfully integrating health information technology and health service delivery to improve health outcomes.

The Resource and Patient Management System (RPMS) has been the health information solution for IHS since the mid-1980s. RPMS is an integrated suite of approximately 60 clinical, business, and infrastructure packages that support the delivery of high quality health care services across Indian country. Nationwide there are approximately 170 installations of RPMS that serve up to 400 facilities. Many of these are self-governing Tribal or Urban programs that use RPMS for administrative or workload reporting, provide limited clinical services, or use proprietary systems for clinical care. The full Electronic Health Record (EHR) version of RPMS has been installed on 100 systems and implemented at some 222 hospitals and clinics. All Federal IHS facilities use the RPMS EHR; the majority of Tribal and Urban programs do as well. IHS considers the deployment of the EHR software to be essentially complete, though IHS continues to accept requests for support from self-governing Tribal and Urban programs that are still selecting their HIT solutions. The focus in 2010 and 2011 will be on optimizing EHR utilization for Meaningful Use, especially on inpatient units, as well as extending EHR access to dozens of remote Village Clinics in the Alaskan bush.

Recovery Act funds enable IHS to modernize and extend its electronic health care information tools, improving access, quality, safety and overall health status of American Indian/Alaska Native patients and populations.

Consistent with the intent of ARRA and the HITECH portion of the Act, as well as with its own mission, IHS has identified activities to improve access, quality, safety, and overall health status of American Indian/Alaska Native patients and populations. With ARRA funding, IHS is developing and implementing:

- Meaningful use of a qualified Electronic Health Record –
  - Comprehensive Health Information – Improving capabilities across the RPMS suite, such as clinical care, support services, and practice management, including activities to increase the ease of implementation, support, and usability of the system.
  - Provider Order Entry – Continued improvements to applications that support the communication of orders and consultations, including electronic prescribing, among members of the health care team both on-site and remotely.
  - Clinical Decision Support – Creating and acquiring clinical decision support tools that build additional intelligence into RPMS, supporting quality of care and patient safety.
  - Quality and Performance Reporting – Expanding existing quality and performance reporting capabilities and ensuring that quality and performance data are transparent and accessible to consumers of IHS health care services.
  - Health Information Exchange – Activities to ensure that RPMS meets national interoperability standards and those facilities using RPMS are positioned to participate in exchanges such as the Nationwide Health Information Network.
  - Certification – Ensuring that RPMS receives national certification as a qualified EHR for inpatient use and for behavioral health settings and continued certification as an outpatient EHR solution.
  - Deployment – Intensive support for the deployment of RPMS EHR in all Federal and Tribal inpatient facilities and optimization of implementation in outpatient settings as well.
- Personal Health Record Adoption – Development and collaborations to create truly consumer-oriented tools for management and portability of personal health information.
- Telehealth and Network Infrastructure – Increasing the capability of the IHS technology infrastructure to support a broad range of new telehealth initiatives.

This investment in health information technology within IHS directly benefits the economy through the expenditure of funds in the private sector for goods and services. Planned activities contribute to the revitalization of the American economy because these activities require a significant expansion in the use of IT service companies and support substantial acquisition of hardware from US-based information technology companies.

IHS will continue efforts associated with Recovery Act improvements to information technology activities:

- Ongoing licensing and collaboration for the Personal Health Record.
- Maintenance of the Nationwide Health Information Network (NHIN) gateway mandated by the Office of the National Coordinator for Health Information Technology.
- Maintenance of the new RPMS improvements to ensure meaningful use and certification.
- Increased quality and performance reporting to support transparency and efficiency.
- Compliance with the interoperability standards from the Health Information Technology Standards Panel and standard bodies.

Costs of the IHS IT infrastructure (development, support, licensing, contracts, bandwidth, training of staff, and others) have risen dramatically in the past decade. The RPMS is a leading HIT system in many areas, including wellness, population and public health, chronic care management and electronic clinical quality reporting. The IHS works closely with the Office of the National Coordinator for Health Information Technology, Centers for Medicare and Medicaid Services, Agency for Healthcare Research and Quality, Veterans Health Administration, Department of Defense, and other Federal entities on IT initiatives to ensure that the direction of our HIT system is consistent with other Federal agencies. IHS has routinely shared HIT artifacts (design and requirement documents, clinical quality logic, etc.) with both public and private organizations.

IHS has continued to expand its support for telehealth through the expansion of the telehealth infrastructure, made possible with ARRA funding. Telehealth enables a "best practice" model of specialist health care delivery. Such a model of enhanced access, improved clinical quality, and organizational cost-efficiency is possible through the emerging tools of expert tele-consultation and home monitoring/care coordination. Health information technology has supported telehealth through infrastructure and network support for telemedicine. This support helps ensure that the backbone of the network is adequate for the timely transmission of telehealth needs though increasing use of telehealth will require additional network expansion and enhancements.

The telehealth expansion within IHS specifically targets improved access to care delivery and a comprehensive approach to integrated specialty service delivery. Clinical problems and chronic conditions targeted for enhanced service delivery include diabetes care, cardiovascular care, and behavioral health care. The telehealth program closely integrates its planning, implementation, and evaluation activities with three of the Agency's health initiatives on improving patient care, behavioral health, and health promotion/disease prevention. Specific activities in the telehealth program include:

- Interfaces for teleradiology to ensure secure transmission of images using recognized standards
- Remote network enhancements to support telehealth delivery
- Enhanced teleradiology

These activities will enable telehealth patient visit information, clinical results, billing, and workload requests to be integrated seamlessly into RPMS. The adoption and integration of standardized interfaces will facilitate interoperability of radiology information.

IHS strives to improve its HIT infrastructure to support Presidential, Secretarial and IHS goals and priorities. This infrastructure is fundamental to HIT and health care operations. The current emphasis on health information technology emphasizes the use of a certified electronic health record in a meaningful way. IHS is committed to meeting this charge, recognizing that HIT holds the potential for improved clinical quality and safety and health information interoperability for all citizens.

IHS investments in HIT follow the HHS/IHS Capital Planning and Investment Control (CPIC) processes, the HHS Enterprise Performance Life Cycle (EPLC) process and are documented in the HHS Portfolio Management Tool and the HHS Enterprise Architecture Repository.

The RPMS Program underwent a program assessment in 2003. The assessment cited progress in achieving the majority of long-term performance goals and a clear commitment to provide accurate, timely, and comprehensive information to IHS providers and program managers as

strong attributes of the program. The RPMS program continues to take actions to develop the capability to track how system improvements impact health outcomes, to develop budget requests that are explicitly tied to the accomplishment of annual and long-term performance goals and to analyze alternatives to provide a valid cost accounting link to health outcomes.

The IHS request includes funding to support the President's information technology initiatives and the Departmental enterprise information technology initiatives identified through the HHS planning process.

FUNDING HISTORY

Fiscal Year	Amount *
2006	*$76,192,000*
2007	*$98,243,000*
2008	*$112,006,000*
2009 Recovery Act	*$85,000,000*
2009 Omnibus	*$114,506,000*
2010 Enacted	*$130,757,000*

*This represents the total cost of HIT within IHS. The vast majority is from the Hospital & Health Clinics budget line with a small amount from Direct Operations for federal personnel and travel.

BUDGET REQUEST

The FY 2011 budget request for Information Technology under Hospitals and Health Clinics is $134,757,000, an increase of $4,000,000 over the FY 2010 Enacted level.

<u>Program Increase +$4,000,000</u>

An effective health information technology system including improved infrastructure, an electronic health record, and data warehousing is critical for IHS to deliver quality care and to more efficiently manage and support the health programs. For the past 25 years, the IHS has developed, deployed, and supported a certified and award-winning health information technology system (the Resource and Patient Management System - RPMS) throughout the Indian health care system, in addition to a large integrated wide-area network and national data warehouse.

The $4,000,000 program increase will be used for health information technology security maintenance and enhancements. Although RPMS is a secure health information system, the recent government mandates to exchange health information increase the security needed to facilitate the external exchanges. In addition, changes in security standards associated with meaningful use will increase security requirements. Additional resources will be employed to provide expert security management of health information. Certification and Accreditation of enhancements to RPMS and continued funding for the Network and Operations Security Center (NOSC) are planned for FY2011. Local, regional, and national support for these essential security enhancements has come from the hospital and health clinics budget. This increased funding will facilitate the transition of some of this need throughout IHS to the proposed HIT funding.

The establishment of an identified Health Information Technology funding within the hospital and health clinics budget ensures sustainability of the IHS health information technology efforts. These funds will enable fiscal support for the ongoing implementation, optimization, and utilization of electronic health records and other health information technology.

The budget request of $134,757,000 preserves the ability to support recently acquired HIT so essential to efficient and effective healthcare delivery, ensures an appropriate refresh cycle for infrastructure and health information technology, and continues the innovative development of new capabilities for the information system, all of which remain in the public domain and are re-usable beyond IHS.

OUTCOMES

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
RPMS-E1: Average days in accounts receivable for hospitals. *(Efficiency)*	FY 2010: 65 days (Baseline)	N/A	TBD	TBD	N/A
RPMS-E2: Average days in accounts receivable for small ambulatory clinics. (*Efficiency*)	FY 2010: 64 days (Baseline)	N/A	TBD	TBD	N/A
RPMS-2: Derive all clinical measures from RPMS and integrate with EHR. (Clinical Measures/Areas)	FY 2009: 61/12 (Target Met)	61/12	63/12	65/12	2/12
RPMS-7: Number of patients with clinical images captured or displayed for use in the RPMS Electronic Health Record.	FY 2009: 178,624 (Baseline)	N/A	196,486	216,135	+10%
Program Level Funding ($ in millions)	**$114.5**	**$114.5**	**$130.7**	**$134.7**	**+$4.0**
ARRA Level Funding ($ in millions)	**$0**	**$85.0**	**$0**	**$0**	**$0**

GRANTS AWARDS -- IHS does not use grants for health information technology.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
DENTAL HEALTH

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$141,936	$0	$152,634	$161,262	+$8,628
FTE	743	0	748	750	+2

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization.. IHCIA last authorized in 2000, Snyder and Transfer Acts - Permanent

Allocation Method ....Direct Federal; P.L. 93-638 Self-Determination Contracts, Grants, and Self-Governance Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The purpose of the Dental Program is to raise the oral health status of the American Indian/Alaska Native (AI/AN) population to the highest possible level through the provision of quality preventive and treatment services, at both the community and clinic levels. The Dental Program is oriented toward preventive and basic care and over 90 percent of the dental services provided are basic and emergency care. More complex rehabilitative care (i.e., root canals, crown and bridge, dentures and surgical extractions) are provided where resources allow. The demand for dental treatment remains high due to the high dental caries rate in the AI/AN children; however, a continuing emphasis on community oral health promotion/disease prevention is essential to long-term improvement of the oral health of AI/AN people.

The dental program maintains data and tracking of the three key program objectives – dental sealant, dental access, and topical fluorides. During FY09, the Dental Program exceeded the annual performance goals for all three dental objectives: patients receiving topical fluoride, number of sealants placed, and access to care. While access increased 4%, the number of dental sealants placed increased by 12% and the number of patients receiving topical fluorides increased 19%. These latter two incremental increases are among the largest recorded for dental annual performance objectives. Topical fluorides and dental sealants are proven, widely utilized preventive interventions to reduce tooth decay. One significant challenge the dental program will face is that many adolescents already experience a high prevalence of existing dental sealants from our efforts in previous years, making it increasingly difficult to maintain current high levels of sealant placement production year after year. This high prevalence of sealants represents a significant victory for the IHS Dental Program, as greater numbers of susceptible tooth surfaces have been protected by dental sealants.

In FY 2009, the Division of Oral Health utilized field dental programs in conjunction with the Dental Clinical and Preventive Support Centers to achieve the program performance targets. The

collaborative efforts between the field dental programs and the Dental Clinical and Preventive Support Centers have resulted in an increase in the number of topical fluoride applications, the program meeting the target for dental access, and a decrease in the number of teeth eligible for dental sealants. The Dental Clinical and Preventive Support Centers were designed and implemented in FY 2000 to help augment the dental public health infrastructure necessary to best meet the oral health needs of the AI/AN community. The primary purpose of a Dental Clinical and Preventive Support Center is to provide technical support, training, and assistance in clinical and preventive aspects of dental programs providing care to the AI/AN community.

	Support Center	**States**	**Area**
1	AK Native Tribal Health Consortium	AK	Alaska
2	All Indian Pueblo Council	NM	Albuquerque
3	Intertribal Council of Arizona	AZ, UT, CO	Phoenix/Tucson
4	Northwest Portland Area Indian Health Board	OR, WA, ID	Portland
5	Salish & Kootenai Tribes of Flathead	MT, WY	Billings
6	CA Rural Indian Health Board	CA	California
7	Aberdeen Area Tribal Chairmen's Health Board	ND, SD, NE	Aberdeen
8	Nashville Area Dental Support Center	TN	Nashville

FUNDING HISTORY

Fiscal Year	Amount
2006	$117,731,000
2007	$125,396,000
2008	$133,637,000
2009 Recovery Act	$0
2009 Omnibus	$141,936,000
2010 Enacted	$152,634,000

BUDGET REQUEST

The FY 2011 budget request for Dental Health is $161,262,000, an increase of $8,628,000 over the FY 2010 Enacted level. This increase represents:

Current Services +$8,628,000

- Pay Cost +$1,554,000 for pay increases for Federal and Tribal employees
- Inflation +$1,454,000
- Population Growth +$2,271,000
- Staffing/Operating Costs for New/Expanded Facilities +$3,349,000

Staff for New Facility	Amount	FTE/Tribal Positions
Absentee Shawnee Health Center (JV), Little Axe, OK	$1,466,000	15
Elbowoods Health Center, New Town, ND	$614,000	6
Carl Albert Hospital Replacement (JV), Ada, OK	$836,000	8
Lake County Tribal Health Center (JV), Lakeport, CA	$195,000	2
Cheyenne River Health Center, Eagle Butte, SD	$238,000	2*
TOTAL	**$3,349,000**	**33**

* Federal FTE

OUTCOMES

Measure	Most Recent Results	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
12: **Topical Fluorides:** Number of American Indian and Alaska Native patients receiving at least one topical fluoride application.	FY 2009: 136,794 (Target Exceeded)	136,978	139,033	+2,055
13: **Dental Access:** Percent of patients who receive dental services.	FY 2009: 25% (Target Exceeded)	27%	27.0%	0
14: **Dental Sealants:** Number of sealants placed per year in AI/AN patients.	FY 2009: 257,067 (Target Exceeded)	257,920	261,789	+3,869
Program Level Funding ($ in millions)	**$141.9**	**$152.6**	**$161.2**	**+$8.6**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

OUTPUTS

Measure	Most Recent Results	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Dental Vacancy Rates	26%	26%	26%	0%
Patient Visits	987,502	1,053,300	1,091,400	+38,100
# of Services	3,009,000	3,209,600	3,325,500	+115,900
Program Level Funding ($ in millions)	**$141.9**	**$152.6**	**$161.2**	**+$8.6**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

GRANTS AWARDS – Support Centers

	FY 2009	FY 2010	FY 2011
Number of Awards	4	4	4
Average Award	$249,998	$249,998	$249,998
Range of Awards	$249,996 – 250,000	$249,996 – 250,000	$249,996 – 250,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
MENTAL HEALTH

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$67,748	$0	$72,786	$77,076	+4,290
FTE	266	0	268	268	0

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization.. IHCIA last authorized in 2000, Snyder and Transfer Acts - Permanent

Allocation Method ....Direct Federal; P.L. 93-638 Self-Determination compacts and contracts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

In partnership with American Indians and Alaska Natives (AI/ANs), the purpose of the Mental Health/Social Service (MH/SS) program is to raise their physical, mental, social and spiritual health to the highest possible level. We strive to support AI/AN communities in eliminating behavioral health diseases and conditions by: 1) maximizing positive behavioral health and resiliency in individuals, families, and communities; 2) improving the overall health care of AI/ANs; 3) reducing the prevalence and incidence of behavioral health diseases; 4) supporting the efforts of AI/AN communities toward achieving excellence in holistic behavioral health treatment, rehabilitation, and prevention services for individuals and their families; 5) supporting Tribal and Urban Indian behavioral health treatment and prevention efforts; 6) promoting the capacity for self-determination and self-governance; and 7) supporting AI/AN communities and service providers by actively participating in professional, regulatory, educational, and community organizations at the National, State, Urban, and Tribal levels.

The MH/SS program is a community-oriented clinical and preventive mental health service program that provides primarily outpatient mental health and related services, crisis triage, case management, prevention programming, and outreach services. The MH/SS program provides general executive direction and recruitment of MH/SS program staff to 12 Area Offices (regional) that, in turn, provide resource distribution, program monitoring and evaluation activities, and technical support to 163 service units. These service units consist of IHS, Tribal, and Urban Indian programs whose MH/SS staff are responsible for the delivery of comprehensive mental health care to over 1.9 million AI/ANs. Mental Health is crucial for the well-being of AI/AN communities.

The most common MH/SS program model is an acute, crisis-oriented outpatient service staffed by one or more mental health professionals. Many of the IHS, Tribal, and Urban mental health programs that provide services in times of crises do not have enough staff to operate 24/7. Therefore, when an emergency occurs, the clinics and service units will often have to contract out to non-IHS hospitals and crisis centers. Inpatient services are often purchased from non-IHS hospitals or provided by State or County mental health hospitals. Medical and clinical social work are usually provided by one or more social workers who assist with discharge planning and provide family intervention for child abuse, suicide, domestic violence, parenting skills, and marital counseling.

The MH/SS program model also includes tele-behavioral health technology. Over 50 IHS and Tribal facilities in 8 IHS Areas offer some level of tele-behavioral health services. Another 8 facilities in the remaining 4 IHS Areas are developing tele-behavioral health services or have recently used tele-behavioral health services. A number of Areas as well as individual sites are pursuing cooperative relationships with major academic centers in order to expand access to specialized behavioral health services including Oklahoma Area (University of Oklahoma), Albuquerque Area (University of New Mexico, University of Colorado), Phoenix Area (University of Arizona), and California Area (University of California, Davis), among others.

A number of programs in the Alaska Area rely either solely on or supplement services substantially with tele-health based contacts including the Eastern Aleutian Tribal system, South East Alaska Regional Health Consortium, and Copper River. The central limitation on the expansion of tele-behavioral health services is not the technology but the lack of employees at the remote site to staff service delivery. The expansion of tele-behavioral health cannot be separated from the number of clinical staff available to provide services. As IHS considers transitioning from pilots to larger scale tele-behavioral health efforts, we believe the following approaches show the most promise to maximize services, increase the level of comprehensive clinical care, and to decrease potential suicide lethality in our communities:

1) Develop Urban Tele-Behavioral Health Hubs. Larger urban areas offer a greater potential to recruit, retain, and utilize tele-behavioral health professional staff.
2) Develop shared electronic charting technology. Such tools will permit outlying areas to better utilize a shared treatment plan, maintain up to date clinical information within the treatment team, and create a more comprehensive, less fragmented or “siloed” body of clinical information.
3) Develop specific treatment protocols and guidelines for tele-behavioral health clinical services.

Many IHS, Tribal, and Urban Indian organizations have incorporated traditional healing practices into their behavioral health programs. A variety of traditional healing practices have been utilized in behavioral health programs including prayer, singing, drumming, purification ceremonies (i.e., sweat lodge), smudging, herbs, and the use of tobacco in ceremonies. Tribal programs such as the Navajo Nation Division of Behavioral Health have traditional practitioners who utilize Navajo traditional healing modalities to address substance abuse problems and mental disorders. Urban Indian treatment providers have brought in Native traditional practitioners from different cultural backgrounds and traditions to work with both clients and staff. Many Indian Health Service clinics encourage the use of traditional practitioners.

Over the last 15 years, most of the behavioral health programs have transitioned from IHS to local community control via Tribal contracting and compacting. Half of the Tribes now administer the delivery of mental health programs. Such local programs are community based

and have direct knowledge of their population and what interventions can be effectively implemented. IHS now seeks to support those services with programs and program collaborations to bring resources to the communities themselves.

IHS has developed a suicide surveillance reporting tool to document incidents of suicide in a standardized and systematic fashion. The suicide surveillance tool captures data related to a specific incident of suicide, such as date and location of act, method, contributing factors, and other useful epidemiological information. Local and national reports can be sorted by a number of different variables including the number of suicide events by sex, age, community, tribe, and others. The suicide surveillance measure has evolved from the FY 2004 target of deploying a suicide reporting form into the behavioral health package to integrating the form into the Resource Patient Management System (RPMS) in FY 2005 to setting a baseline level of use in FY 2006. The FY 2009 target for the use of the suicide surveillance form was met and exceeded. The target was to increase the completion of suicidal behavior reporting forms from 1,598, the FY 2008 results to 1,678 in FY 2009. The FY 2009 actual results were 1,687 forms.

The FY 2009 target was increased based on the FY 2008 performance results; however, targets for this measure are difficult to set, as it is also contingent on broader trends within AI/AN communities. In addition, the suicide surveillance form is currently underutilized by medical and behavioral health providers. To increase the utilization of the suicide surveillance reporting form, IHS will increase and improve awareness of the form and the importance of suicide surveillance activities among providers, facility and Area managers, and administrators. Similarly, RPMS Site Managers and Electronic Health Record (EHR) Clinical Application Coordinators (CAC) must also be aware of the suicide surveillance reporting form component and the appropriate application set-up and exporting processes. The FY 2010 target is to increase to 1,700 forms completed while the FY 2011 target will remain at 1,700 forms completed.

IHS has been assessing the depression screening rate since FY 2006, when a baseline rate of 15 percent was established. In FY 2004 and FY 2005, the measure tracked the number of programs reporting certain behavioral health-related data. In FY 2007, the target for this measure was exceeded by 9 percentage points. In FY 2008, the targets for this measure were met and exceeded. In FY 2008, 35 percent of patients age 18 and older were screened for depression, an increase of 11 percentage points over the FY 2007 rate of 24 percent. This measure has seen significant increases in results from the baseline result of 15 percent in FY 2006. Higher screening rates reflect increasing provider awareness of the importance of universal screening for depression among adults. The FY 2009 target was also met and exceeded at 44 percent. The FY 2010 target is to increase the screening rate to 53 percent and the FY 2011 target is to increase the screening rate to 57.3 percent.

Behavioral Health is an integral part in the treatment and prevention of diseases. Many health conditions are linked to life-long behavior patterns, and therefore can be prevented by a change in lifestyle. By focusing on effective behavioral health techniques and integrating Tribal traditions and customs, we can bring proven behavioral health strategies and specific health promotion and disease prevention programs to AI/AN communities. Significant mental health disparities exist among AI/AN communities. Issues such as substance abuse, domestic violence, forced cultural change, education, poverty, lack of economic opportunity, and isolation can lead to physical and psychological problems.

The objective of the Agency's MH/SS program is to improve the physical, mental, social, and spiritual well-being of AI/AN people by implementing strategies that will integrate and adapt

various types of behavioral health techniques on a Federal, Urban, and Tribal level, by focusing on the following areas:

- ***Suicide Prevention***: Suicides and suicide-related behaviors exact a profound toll on AI/AN communities. Suicides reverberate through close-knit communities and continue to affect survivors many years after the actual incident. Suicide clustering is also a phenomenon known to occur in Indian Country. Most of the suicide prevention programs are at the Tribal and community level. IHS focuses efforts in the areas of emergency preparedness, training, national networking, and educational services. Using the latest information available, the AI/AN suicide rate (17.9) for the three year period (2002-2004) in the IHS service areas is 1.7 times that of U.S. all races rate (10.8) for 2003. Suicide is the second leading cause of death behind unintentional injuries for Indian youth ages 15-24 residing in IHS service areas and is 3.5 times higher than the national average. AI/AN young people ages 15-34 make up 64 percent of all suicides in Indian Country. This information is published in the "Trends in Indian Health, 2002-2003 Edition."
- ***Child/Family Protection***: Child abuse and the cycle of repeat abuse in adulthood are well documented in the literature on American Indians and Alaska Natives. Domestic violence affects all communities, but AI/AN women and children are particularly vulnerable to abuse. In 2003, AI/AN children had the highest rate of victimization; 21.3 children per 1000 *(National Data Analysis System, Child Abuse and Neglect, January 2006)* and 1 in 3 AI/AN women will be physically and/or sexually abused in their lifetime *(Department of Justice, Findings from the National Violence against Women Survey, November 2000).* To help victims of violence, the IHS provides direct services, advocacy, interagency consultation, and collaboration with other federal agencies to provide child/family protection services to AI/AN children and families.
- ***BH Management Information System (MIS)***: The IHS Resource and Patient Management System is a national health information system that effectively captures diagnostic, treatment, outcomes, and referral information regarding significant health issues. To support clinical best practices and disease surveillance, RPMS includes standardized tools for screening as well as clinical decision support tools to facilitate routine and effective screening. Tools exist for depression and domestic violence screening. RPMS output reports and clinical quality performance measurement tools provide information from local facility to national level data on screening results and screening rates. In addition, the Behavioral Health Management Information System is used to share patient care documents and electronic charts across wide geographic areas in real-time (in accordance with the Health Insurance Portability and Accountability Act regulations). Future quality performance measurement activities will focus on health outcomes and response to treatment in addition to rates and patterns of screening. IHS will continue to enhance existing data collection methods and improve the integration and consolidation of behavioral and other health care data. We will also strengthen available technologies such as data marts for comprehensive analysis and reporting to meet the needs of IHS, Tribes, and national programs.

FUNDING HISTORY

Fiscal Year	Amount
2006	$58,455,000
2007	$60,882,000
2008	$63,531,000
2009 Recovery Act	$0
2009 Omnibus	$67,748,000
2010 Enacted	$72,786,000

BUDGET REQUEST

The FY 2011 budget request for Mental Health is $77,076,000, an increase of $4,290,000 over the FY 2010 Enacted level. This increase represents:

Current Services +4,290,000

- Pay Costs +$748,000 for Federal and Tribal pay increases
- Inflation +$748,000 for non-medical inflation of 1.5 percent
- Population Growth +$1,092,000 for population growth at 1.5 percent
- Staffing/Operating Costs for New/Expanded Facilities +$1,702,000

Staffing for New Facilities	Amount	Tribal Positions
Absentee Shawnee Health Center (JV), Little Axe, OK	$785,000	9
Carl Albert Hospital Replacement (JV), Ada, OK	$564,000	5
Lake County Tribal Health Center (JV), Lakeport, CA	$353,000	4
TOTAL	**$1,702,000**	**18**

OUTCOMES

Measure	Most Recent Results	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
29. **Suicide Surveillance:** Increase the incidence of suicidal behavior reporting by health care (or mental health) professionals.	FY 2009: 1,687 (Target Exceeded)	1,700	1,726	+26
18. **Behavioral Health:** Proportion of adults ages 18 and over who are screened for depression. IHS-All	FY 2009: 44% (Target Exceeded)	53%	57.3%	+4.3%
18. Tribally Operated Health Programs	FY 2009: 35% (Target Exceeded)	41%	45.3%	+4.3%
Program Level Funding ($ in millions)	**$67.7**	**$72.8**	**$77.1**	**+$4.3**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

The FY 2011 suicide surveillance target is to increase 1.5% to 1,726 forms completed. The Suicide Reporting Database is beginning to provide a more detailed picture of who is completing or attempting suicide and identifies salient factors contributing to the events. Accurate and timely data captured at the point of care provides important clinical and epidemiological information. Completion of forms should provide more complete information about the incidence of suicidal ideation, attempts and completions, which will provide far more accurate data to national policy makers and will allow interventions to be evaluated for effectiveness in ways not previously possible.

The FY 2011 depression screening target is to increase the screening rate by 4.3 percent over the FY 2010 result to a 57.3 percent screening rate. Depression screening is a lower-cost screening measure with potential high return on investment. Depression screening improves detection, referral, and treatment of mental health needs. Depression is often an underlying component contributing to suicide, accidents, domestic/intimate partner violence, and alcohol and substance abuse. Early identification of depression will contribute to reducing their incidence, as well as allow providers to plan interventions and treatment to improve the mental health and well-being of AI/AN people who experience depression. Tools have been selected to assess depression, monitor response, track such response over time, and are incorporated into the IHS Electronic Health Record. The system is now deployed and in operation in over 250 clinical sites across the country.

GRANT AWARDS

There were no grant awards from Mental Health in FY 2010 or anticipated for FY 2011.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
ALCOHOL AND SUBSTANCE ABUSE

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$183,769	$0	$194,409	$205,770	+$11,361
FTE	179	0	179	179	0

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization.. IHCIA last authorized in 2000, Snyder and Transfer Acts - Permanent

Allocation Method ....Direct Federal; P.L. 93-638 Self-Determination contracts and compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The purpose of the Indian Health Service (IHS) Alcohol and Substance Abuse Program (ASAP) is to raise the behavioral health status of American Indians/Alaska Natives (AI/ANs) to the highest possible level through the provision of preventive and treatment services at both the community and clinic levels. These programs provide alcohol and substance abuse treatment and prevention services within rural and urban communities, with a focus on holistic and culturally-based approaches. The ASAP exists as part of an integrated behavioral health team that works collaboratively to reduce the incidence of alcoholism and other drug dependencies in AI/AN communities.

Significant health disparities among AI/ANs exist across the spectrum of substance abuse problems. The most current IHS health data statistics indicate:

- The age-adjusted[1] alcohol related death rate for AI/ANs is 43.7 (2002-2004) and is over six times the US all races rate of 7.0 (2003)[2].
- The age-adjusted drug related death rate for AI/ANs is 15.0 (2002-2004) and is 1.5 times greater than the US all races rate of 9.9 (2003)[3].

Approximately 5 percent of the employees in IHS-funded ASAP are Federal staff with Tribal and Urban staff comprising 95 percent. The reported certified counselor and professional licensure rates continue at 85 percent. Two ways in which the ASAP measures its ability to raise the behavioral health status of AI/ANs are by ensuring that Youth Regional Treatment Centers

[1] Age-adjusted rate per 100,000 population. Rates have been adjusted to compensate for misreporting of AI/AN race on state death certificates.
[2] US Department of Health and Human Services. Indian Health Service. Trends in Indian Health, 2002-2003 Edition. Washington: Government Printing Office, Released October 2009. ISSN 1095-2896. p.90.
[3] US Department of Health and Human Services. Indian Health Service. Trends in Indian Health, 2002-2003 Edition. Washington: Government Printing Office, Released October 2009. ISSN 1095-2896. p.195.

(YRTC) are licensed and/or accredited and that mothers to-be receive the appropriate screenings for Fetal Alcohol Spectrum Disorders (FASD).

The 12 youth regional treatment centers (YRTCs) provide substance abuse and co-occurring mental health treatment services to AI/ANs. The Nevada Skies Youth Wellness Center, located on the Pyramid Lake Paiute Reservation in Wadsworth, Nevada, opened in May 2009. This facility is a satellite program of Desert Visions Youth Wellness Center in Sacaton, Arizona. Congress authorized the construction of YRTCs in each IHS Area but some Tribes (e.g., Bemidji and Billings) have elected not to construct YRTC's in their Area but to contract for services rather than run their own programs. Currently, there are no plans for either Area to build YRTC. Some IHS areas such as Alaska and Navajo, divide their funds to provide residential services for two programs. There are two YRTCs that are congressionally authorized for the California Area IHS.

Past trending results for this program show consistent achievement of a 100 percent accreditation rate for YRTCs in operation 18 months or longer. In FY 2009, this measure was not met since one facility was not accredited resulting in an accreditation rate of 91 percent. This facility continues to work toward the goal of accreditation by State certification, Joint Commission, or the Commission on Accreditation of Rehabilitation Facilities (CARF) and estimates that accreditation will be obtained by the end of 2010. In FY 2011, the target is to assist all YRTCs in their goal of achieving and maintaining the 100 percent accreditation rate.

In addition to the YRTCs, many of the approximately 300 Tribal and Urban alcohol programs are State-licensed/certified and/or accredited. There are more than a dozen Tribally-operated AI/AN alcohol and substance abuse adult residential treatment centers, including two serving pregnant women and/or women with children.

Alcohol & Substance Abuse - Youth Regional Treatment Centers				
	Name	**Town**	**State**	**IHS Area**
1	Graf-Healing Place	Fairbanks	AK	Alaska
2	Raven's Way	Sitka	AK	Alaska
3	Desert Visions *	Sacaton	AZ	Phoenix
4	Hayool K'aal Hooghan Adult TC	Chinle	AZ	Navajo
5	Unity *	Cherokee	NC	Nashville
6	New Sunrise *	San Fidel	NM	Albuquerque
7	Shiprock Adolescent TC	Shiprock	NM	Navajo
8	Jack Brown	Tahlequah	OK	Oklahoma
9	Wemble Naalam T'at'aksni House	Klamath Falls	OR	Portland
10	Chief Gall *	Mobridge	SD	Aberdeen
11	Healing Lodge of Seven Nations	Spokane	WA	Portland
12	Nevada Skies Youth Wellness Center*	Wadsworth	NV	Phoenix

* Federally operated

The IHS Methamphetamine Prevention Initiative focuses on the reduction, prevention, and treatment of methamphetamine use and abuse among AI/AN populations. Methamphetamine use and abuse is one of the most important health issues for Tribes, according to both formal and informal Tribal consultation.

The IHS Suicide Prevention Initiative is directly related to the Health and Human Services national strategy for suicide prevention, to transform the health care system by supporting community-based approaches to closing the healthcare gap, particularly among racial and ethnic minority populations. Strategies include collaborations and partnerships with consumers and their families, Tribes and Tribal organizations, Urban Indian programs, Federal (e.g., SAMHSA,

NIH, BIA, and others), State, and local agencies, as well as public and private organizations to formulate long term strategic approaches and to share resources to address the issue of suicide in Indian Country more effectively.

In FY 2008, the IHS received $13.782 million to address the Methamphetamine and Suicide Prevention Initiative (MSPI). In the spring of 2008, the IHS National Tribal Advisory Committee on Behavioral Health (NTAC) was formed. This committee is made up of an elected Tribal leader from each of the twelve IHS Areas. In consultation with NTAC, IHS developed a formula to distribute MSPI funds and established criteria for evidence based or practice based models for methamphetamine and suicide reduction programs in Indian Country. In FY 2009, a total of 129 MSPI pilot sites (including two grant programs - Urban and Youth) were awarded. The Urban pilot project expands community level access to effective Urban methamphetamine and/or suicide prevention and treatment programs and the Youth pilot project expands community-level access to effective methamphetamine and suicide prevention programs through Tribal, youth residential, transitional/discharge, and aftercare services.

In FY 2009, there was increased collaboration between IHS and SAMHSA regarding the issues of methamphetamine and suicide prevention in Indian Country. The Garret Lee Smith and Native Aspirations Program, implemented by SAMHSA, complement the efforts of the MSPI. Program officials from both agencies continue to meet regularly to coordinate activities to avoid duplication of effort.

As part of these efforts, expanding access to behavioral health services in a variety of settings remains an important goal. In particular, this includes increasing access to specialty services such as clinical social work, psychiatry and psychology where continued service gaps remain in many locations. IHS has implemented the use of technology in an effort to address this gap in service.

Tele-Behavioral Health (TBH) or tele-videoconferencing is a technical tool that helps address chronic service gaps. In addition to supporting computerized provider order entry and documentation, this technology provides a basic structural support for providing services across large areas without any loss of efficiency. The technology is currently focused on psychiatric support, but it is readily adaptable to provide a variety of clinical and clinical support services from counseling and assessments to clinical supervision to virtual group therapy opportunities.

TBH activities in FY 2009 thus far include the following:

- Tracking Tele-Behavioral Health Clinic code use that currently demonstrates a promising trend of increasing adoption of services;
- Continue establishing a National Tele-Behavioral Health Center of Excellence – site identified and Intra Agency Agreement implemented;
- Promoting the use of Tele-Behavioral Health services at national meetings including the National Office of Information Technology Meeting, National IHS Combined Council Meeting, National IHS/SAMHSA/DOJ Meeting, and through meetings and teleconferences with interested entities including area and service unit programs, Tribal programs, the VA and DOD, state agencies and for-profit/non-for-profit corporations;
- Active participation in planning on use and deployment of Tele-health-specific ARRA funding including development of recommended configurations of videoconferencing equipment, and;
- Continued work on clarifying 42 CFR Part 2 – related regulatory concerns that affect deployment of unified record systems.

Ongoing behavioral health data systems and software development are program priorities for IHS which includes the widely deployed Behavioral Health System v3.0. The Behavioral Health Graphical User Interface (GUI) focuses on the Data Entry module of BHS v3.0 with the goal of facilitating direct provider entry of clinical data, including alcohol screenings. Data collection, management, training, and improvement efforts include expansion of the behavioral health management information system to I/T/U facilities to increase and improve alcohol screenings. Two integrated behavioral health clinical documentation and data platforms have been deployed. There are currently over 340 clinics and Tribal programs reporting to the IHS National Database using one of these platforms. Efforts are underway to integrate these platforms with the IHS Electronic Health Record. This allows access to the development of clinical reminders as well as more sophisticated case and population management tools such as iCare. It will promote interchange of information between primary care and behavioral health settings.

FUNDING HISTORY

Fiscal Year	Amount	Program Increases
2006	$143,198,000	
2007	$148,226,000	
2008	$173,243,000	$13,782,000 – MSPI
2009 Recovery Act	$0	
2009 Omnibus	$183,769,000	$2,609,000 - MSPI
2010 Enacted	$194,409,000	

BUDGET REQUEST

The FY 2011 budget request for Alcohol and Substance Abuse is $205,770,000, an increase of $11,361,000 over the FY 2010 Enacted level. This increase will be used to support:

Current Services +$7,361,000
- Pay Cost +$1,840,000 for pay increases for Federal and Tribal employees
- Inflation +$2,605,000 to fund the costs of providing health care and related services
- Population Growth +$2,916,000 to fund the 1.5% growth

Program Increase +$4,000,000
The $4 million increase is for a new competitive IHS grant program to expand access to and improve the quality of treatment for substance abuse treatment services. The program will target sites with the greatest need for substance abuse services. The main goal of the grant program will be to enable I/T/Us to hire additional staff to provide evidence-based and practice-based culturally competent treatment services. All grant recipients will be required to report on appropriate performance measures, including mandatory reporting of the number of addicted patients that received services. The FY 2011 also request includes $4 million to add qualified and trained behavioral health counselors and other addiction specialists to enhance substance abuse care in Federal, Tribal, and Urban facilities. IHS will collaborate with SAMHA by utilizing agency's technical assistance expertise.

OUTCOMES

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
10. **RTC Improvement/ Accreditation:** Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more)	FY 2009: 91% (Target Not Met)	100%	100%	0

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
11. **Alcohol Screening (FAS Prevention):** Alcohol-use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients. IHS-All	FY 2009: 52% (Target Exceeded)	55%	56.1%	+1.1%
11. Tribally Operated Health Programs	FY 2009: 45% (Target Exceeded)	48%	48.9%	+0.9%
Program Level Funding ($ in millions)	**$183.8**	**$194.4**	**$205.8**	**+$11.4**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

OUTPUTS

Measure	FY 2009	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Outpatient Visits	63,500	66,200	68,500	+2,300
Inpatient Days	3,000	3,200	3,300	100
The proportion of identified meth using patients who enter methamphetamine treatment program	N/A	Baseline	TBD	TBD
Reduce the incidence of suicidal activities (ideation, attempts) in AI/AN communities through prevention, training, surveillance & intervention programs	N/A	Baseline	TBD	TBD
Reduce the incidence of methamphetamine abuse in AI/AN communities through prevention, training, surveillance & intervention programs	N/A	Baseline	TBD	TBD
The proportion of youth (ages 6 – 21) who participate in evidence-based and/or promising practice prevention or intervention programs	N/A	Baseline	TBD	TBD
Establishment of trained suicide crisis response teams	N/A	Baseline	TBD	TBD
Increase Tele-behavioral health encounters	N/A	Baseline	TBD	TBD
Program Level Funding ($ in millions)	**$183.8**	**$194.4**	**$205.8**	**+$11.4**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

GRANT AWARDS: The program anticipates continuation of the MSPI grants for the Urban Programs and Youth Services and awards to improve the quality of treatment for substance abuse treatment services.

	FY 2009	FY 2010	FY 2011*
Number of Awards	15	15	15
Average Award	$100,000	$100,000	$100,000
Range of Awards	$100,000	$100,000	$100,000
Total Awards	$1,500,000	$1,500,000	$1,500,000

*Does not include award estimates for the FY 2011 increase for substance abuse treatment services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
CONTRACT HEALTH SERVICES

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$634,477	$0	$779,347	$862,765	+$83,418
FTE	7	0	7	7	0

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization.. IHCIA last authorized in 2000, Snyder and Transfer Acts - Permanent

Allocation Method ....Direct Federal, '638 Contracts and Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Indian Health Service (IHS) Contract Health Services (CHS) program originated under the Department of Interior, Bureau of Indian Affairs, when authority to enter into health services contracts for American Indian and Alaska Natives (AI/AN) was provided under the Johnson O'Malley Act of 1934. It was transferred 1955 to the Department of Health, Education, and Welfare.

The CHS program supplements and complements direct care and other health care resources available to eligible AI/ANs.

The CHS provides payments to community healthcare providers in situations where:

- There is a designated service area where no IHS or Tribal direct care facility exists;
- The direct care facility does not provide the required health care services;
- The direct care facility has more demand for services than it has capacity to provide; and/or
- The patient is taken to the nearest Emergency Services facility.

The CHS budget supports the purchase of essential healthcare services from community healthcare providers that include, but are not limited to, inpatient and outpatient care, routine and emergency ambulatory care, medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, and physical therapy. Additional services include treatment and services for diabetes, cancer, heart disease, injuries, mental health, domestic violence, maternal and child health, elder care, refractions, ultrasound examinations, dental hygiene, orthopedic services, and transportation.

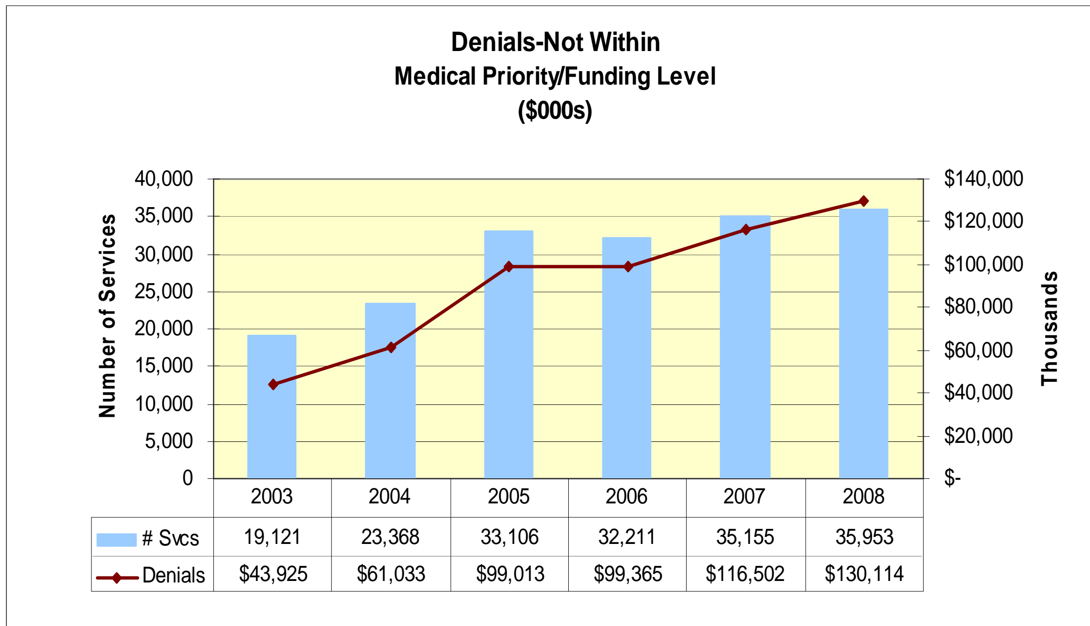
The Tribes operate 50 percent of the CHS budget and do not always report all unmet need data or denied services because of the expense associated with tracking and reporting. For this reason, it

is difficult to measure all unmet services, which vary greatly throughout the country. The data may not reflect the true healthcare needs of Indian country.

This increase will continue to address diabetes, cancer, cardiovascular diseases, and injuries, as well as healthcare disparities, and offset medical inflation and population growth. The CHS program will continue to stretch its resources and strive to meet the needs of AI/AN people.

The rising cost of health care services, transportation, and demand for CHS play a critical role in the number of services that the program can purchase. The IHS' Fiscal Intermediary reports the medical inflation averages 10 percent annually. The 10.7 percent CHS funding increase will allow IHS to cover additional dental services, one-way trips for patient and escort travel, and inpatient and outpatient visits, and will increase access to care to IHS beneficiaries.

The CHS program continues to enforce the CHS eligibility criteria and the IHS medical priority system in order to manage its budget within appropriations. In some instances this may lead to decreased access to prevention and intervention services. The volume of services denied are indicated on the following table:



	2003	2004	2005	2006	2007	2008
# Svcs	19,121	23,368	33,106	32,211	35,155	35,953
Denials	$43,925	$61,033	$99,013	$99,365	$116,502	$130,114

- From 2003 to 2008, CHS denials increased 88 percent from 19,121 to 35,953
- The cost of denials increased 296 percent from $43,924,761 to $130,113,907

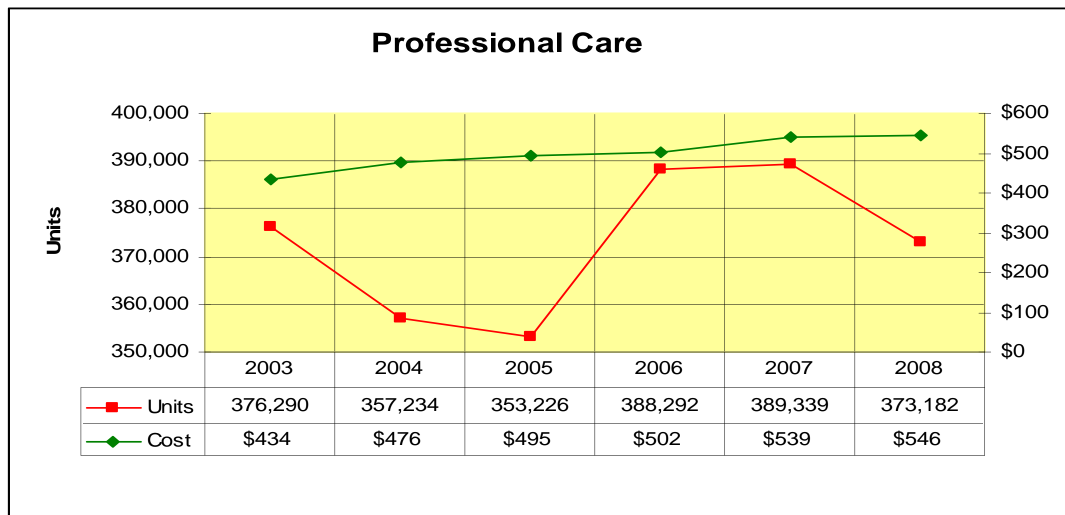
The CHS program includes an Adjudication process for patients and healthcare providers to submit information on denied payments. The IHS estimates that most of the 35,953 denials (not within medical priority) reported will be upheld. The fall out of this is that the patient's credit rating is adversely impacted by non-payment for services. For example, many patients access health care through local community hospital emergency rooms and in other ways. Both patients and community health care providers often believe that IHS does or should provide coverage and/or payments for all AI/ANs that present for services, so it is not uncommon for providers to expect payment from the IHS or Tribal CHS program even in cases where CHS requirements are not met. The IHS anticipates that as additional funding increases the number of denials will decrease.

In FY 2007, the CHS program implemented Section 506 of the Medicare Modernization Act (MMA) that required Medicare participating hospitals to accept Medicare-like rates as payment in full. The MMA Medicare-like rates provision enables IHS, Tribes, and Urban health programs to pay Medicare-like rates for inpatient services and associated costs for hospitals that participate in Medicare programs.

To assist the CHS program in maximizing its annual resources the program contracts with Blue Cross/Blue Shield of New Mexico, as its fiscal intermediary (FI). The FI assists the IHS by ensuring CHS payments are in accordance with its payment policy. In addition, the FI focuses on quality of care and coordinates benefits with other payers to maximize the CHS resources. The FI also calculates payment rates as set forth in negotiated provider contracts.

An important and integral function of the FI is to provide management reports on the provision of services to the AI/AN patient population and services from health care providers from the non-IHS community. These management reports are necessary to ensure the appropriateness of care and the use of CHS funds to enhance the overall effectiveness and management of the CHS program. The FI monitors data, processes payments, provides workload, and financial data in support of the IHS statistical and financial CHS program needs.

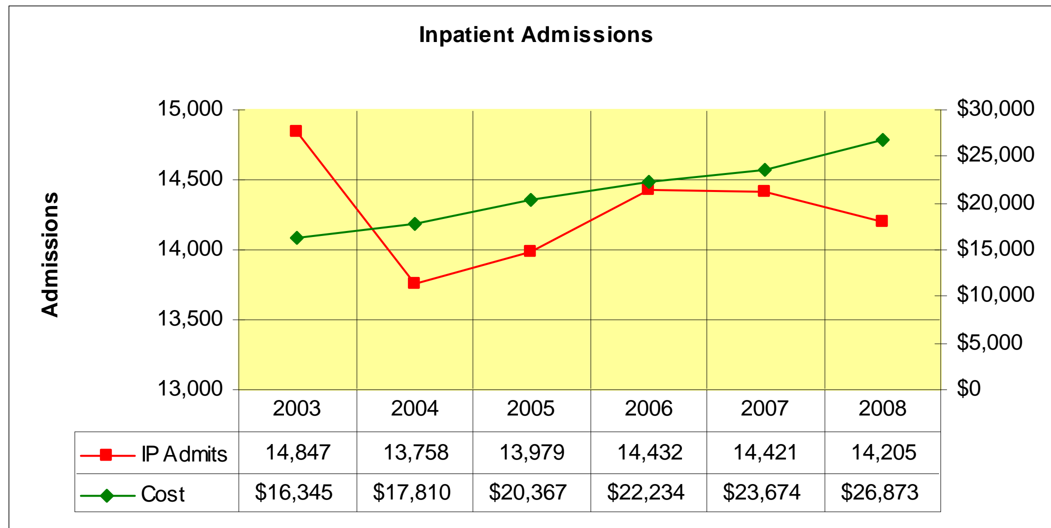
The general trend in the medical industry is that costs continue to increase including the IHS/CHS medical expenditures, while services decrease as demonstrated by the following table.



	2003	2004	2005	2006	2007	2008
Units	376,290	357,234	353,226	388,292	389,339	373,182
Cost	$434	$476	$495	$502	$539	$546

- From 2003 to 2008, CHS purchased professional services* decreased 3,108 or by 1 percent from 376,290 to 373,182 units of service
- Billed costs per visit increased $112 or 25.8 percent from $434 to $546

* Includes Physician, Dental, Eye (dental/vision services continue to decrease), Lab, Radiology and Other Professional Care services such as Ambulance, Cardiography, Pacemaker Analysis, Ventilation, and Physical Therapy etc.



- From 2003 to 2008, inpatient admissions declined by 4 percent from 14,847 to 14,205
- Billed costs per admission increased 64 percent from $16,345 to $26,873

Catastrophic Health Emergency Fund (CHEF) -- The CHEF is administered at the national level and provides funding for high cost cases (after meeting the threshold of $25,000 per case) such as burn victims, motor vehicle accidents, high risk obstetrics, cardiology, etc.

In FY 2008, CHEF funded 1,084 high cost cases for a total cost of $26,578,800. However, 1,096 high cost cases that qualified for CHEF were not covered by the CHEF because the fund was depleted. Once the fund is depleted, the IHS and Tribes pay for these high cost cases from their local CHS budgets. As indicated in the table below the number of high cost cases funded and not funded by CHEF continues to increase annually.

Reported CHEF Cases Funded and Not Funded

	CHEF BUDGET		***High Cost Cases Not Covered by CHEF***	
YEAR	***# Cases***	***Funded***	***# Cases***	***Unfunded***
2003	718	$17,883,000	700	$12,359,000
2004	667	$17,778,206	756	$13,347,720
2005	694	$17,749,935	802	$17,971,608
2006	671	$17,735,176	872	$19,545,288
2007	738	$17,999,680	895	$20,058,448
2008	1,084	$26,578,800	1,096	$27,000,000

Because most IHS and Tribal facilities do not report all of their high costs cases, the number of cases that may qualify for CHEF is most likely much higher. Based on historical trends it is likely some reported cases will not be funded. The table below lists the CHEF cases paid in FY 2008.

CHEF Payments by DIAGNOSIS -- FY 2008

ICD-9-CM CODE	CATASTROPHIC ILLNESS OR EVENT	No.	CHEF AMOUNT	Organ Transplant
390-429.9	Dx-Circulatory,Cerebrovascular,Heart	278	$6,332,133	1 Heart
800-999.9	Injuries & Poisonings	205	$5,486,794	
140-239.9	Neoplasms (Cancer)	150	$ 5,161,514	3 Bone Marrow
520-579.9	Diseases-Digestive System	118	$ 2,775,086	
460-519.9	Diseases-Respiratory System	52	$ 1,311,129	
580-629.9	End Stage Renal/Genital Diseases	61	$ 1,304,060	
710-739.9	Diseases-Musculoskeletal system	74	$ 1,087,966	
780-799.9	Symptoms & ill-defined conditions	37	$ 850,854	
240-279.9	Diabetes, Endocrine, Metabolic Diseases	23	$ 548,478	
630-779.9	Complications-Pregnancy/Premature	17	$ 375,952	
001-139.9	Infectious and Parasitic Diseases	12	$ 357,974	
680-709.9	Diseases-Skin & Subcutaneous Tissue	15	$ 335,452	
320-389.9	Diseases-Nervous System	19	$ 271,596	
290-319.0	Mental Disorders	13	$ 225,384	
280-289.9	Diseases-Blood Forming Organs	5	$ 86,468	
740-759.9	Congenital Anomalies	5	$ 67,960	
	TOTAL	**1,084**	**$26,578,800**	

The CHS program has developed a national performance measure to ensure IHS provides continued access to essential health care services for the AI/AN population. The focus of this measure is to decrease the average number of days from end of service to when a purchase order is generated. The program will use FY 2008 (86 days) as the baseline year with FY 2010 as the actual reporting year. The final reporting date will be October 2010. The FI will base their reporting on fiscal year with quarterly updates.

The FI will provide the data and information to monitor this measure. The FI ensures CHS payments are in accordance with IHS payment policy (payor of last resort) and uses random sampling to provide quality assurance checks on provider claims submitted for payment. IHS will use the quality management report to monitor the days is takes to issue a purchase order.

The CHS program will identify the reasons for the time lag from when the patient received the care to when the purchase order is issued. The program will implement procedures for CHS staff to decrease this time lag. Ultimately, this will improve timely payments to non-IHS healthcare providers. This leads to reduced payment time, which helps maintain current business relationships with non-IHS healthcare providers, and has the potential to generate alternate providers who may not currently do business with IHS because of payment issues (leading to greater patient access to care). Payment improvements will ensure IHS provides continued access to essential health care services.

Furthermore, it supports the following HHS Strategic Goals: 1.2, Increase health care availability and accessibility, and 1.3, Improve health care quality, safety and cost/value.

FUNDING HISTORY

Fiscal Year	Amount
2006	$517,297,000
2007	$543,099,000
2008	$579,334,000
2009 Recovery Act	$0
2009 Omnibus	$634,477,000
2010 Enacted	$779,347,000

BUDGET REQUEST

The FY 2011 budget request for the Contract Health Services program is $862,765,000, an increase of $83,418,000 over the FY 2010 Enacted level. This increase will provide:

Current Services +$37,418,000

Pay Costs +$6,000 - will fund pay increases for six (6) positions for the Pascua Yaqui Tribe in accordance with the FY 2003 Interior Appropriations Conference Report (No.108-10) language. The language states, "The conference agreement also permits funds, provided to new tribes through the contract health services activity to be used for direct medical services in addition to contract care." The Service began funding new tribes from the contract health services account several years ago and it was never the intent of the House and Senate Committee on Appropriations to limit new tribes funding to contract health care only." The FY 2003 language does provide some flexibility to Tribes for funding of positions.

Medical Inflation +$25,722,000 – These funds will address the increased cost of health care, estimated at 3.3 percent.

Population Growth +$11,690,000 - These funds will support the growing AI/AN population; a 1.5 percent growth rate projection based on State births and deaths data.

Program Expansion +$46,000,000

Contract Health Services +$41,000,000 – This increase will allow IHS to cover CHS cases that may otherwise go unfunded. The program estimates that the increase will cover approximately 23 percent of denied cases, based on FY 2008 data. Based on historical information, it is unlikely all CHS cases will be funded.

The increase will enable the CHS program to cover priority I cases, and some priority II. This request will increase the average patient daily load (ADPL) by 22 patients and fund an additional 47,511 outpatient visits (see outputs table). This increase will support the Mammography and Colorectal Cancer Screening Performance Measures. In addition, the estimated number of one-way trips is 68,353 an increase of 3,064 above the 2010 budget. The increase will allow IHS to fund a greater number of trips although the rising costs of both ground and air transportation continues to be a challenge because many AI/ANs live in remote areas of the country.

The estimated number of dental services will be 130,750, an increase of 6,415 above the FY 2010 Enacted budget. The rising cost of health care services, transportation, and demand for CHS play a critical role in the number of services that the program can purchase.

CHEF +$5,000,000 – This increase will fund approximately 200 additional high cost cases. This brings the total funding level for the CHEF to $53 million. More resources for CHEF will alleviate the impact of high cost cases and enable CHS programs to provide more services at the lower priory levels.

The CHS outputs show the relative importance of four major categories provided annually in the following output table. The change in IHS hospital replacements and emphasis on outpatient care has resulted in an increased reliance on CHS resources. Over the past 10 years, the IHS has replaced hospitals with more cost effective comprehensive health care centers requiring the IHS to purchase inpatient, emergency room services and specialized care from outside sources. This trend reflects the transition of the Indian health care delivery from an acute care to a preventive and community-based patient care.

Through the following activities, CHS is working toward providing the highest level of health care to AI/ANs:

- Provide comprehensive support with emphasis on improving the efficiency and effectiveness of CHS programs through managed care initiatives.
- Provide National training and technical assistance for both IHS and Tribal CHS programs.
- Increase partnership with the IHS Business Office to maximize and access all third party resources.
- Promote health education and prevention initiatives.
- Provide comprehensive healthcare services that improve life expectancy and address chronic disease, morbidity and reduces the disparity in health status of AI/ANs as compared to the general U.S. population.
- Negotiate contracts for the best possible rates.
- Adhere to the CHS regulations and the IHS medical priority system.

OUTCOMES

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Average Days between Service End and Purchase Order (PO) Issued	FY 2008: 86 days (Baseline)	82 days	78 days	74 days	-4 days
Program Level Funding ($ in millions)	**$0**	**$634.5**	**$779.3**	**$862.8**	**+$83.4**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**	**$0**

OUTPUTS

Measure	Most Recent Results	FY 2010 Target	FY 2011 Target	FY 2011 +/-FY2010
Gen. Med & Surgery Hospitalization: Average Daily Patient Load	345	401	423	+22
Ambulatory: Out Patient Visits	782,032	909,945	957,456	47,511
Patient Travel: One Way	63,377	65,289	68,353	3,064
Dental Services	103,249	124,335	130,750	6,415
Program Level Funding ($ in millions)	**$634.5**	**$779.3**	**$862.8**	**+$83.4**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

Output calculations based on FI paid data.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551

PREVENTIVE HEALTH

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$135,227	$0	$144,315	$151,060	+$6,745
FTE	291	0	295	296	+1

SUMMARY OF THE BUDGET REQUEST

The FY 2011 budget request for Preventive Health is $151,060,000, an increase of $6,745,000 over the FY 2010 Enacted level. This increase will fund pay increases, population growth, inflation and staffing 5 new and expanded facilities.

- $68 million for **Public Health Nursing**, an increase of $3.5 million for pay, inflation, population growth, and staffing new facilities to support prevention-focused health interventions for individuals, families, and community groups as well as improving health status by early detection through screening and disease management. The Public Health Nursing's health promotion and disease prevention focus is accomplished through primary prevention, secondary prevention, and tertiary prevention focused health interventions towards individuals, families, and community groups as well as improving health status by early detection through screening and disease management. Primary prevention targets healthy populations and activities are aimed at preventing the onset of disease in high risk populations through education, health awareness, and risk reduction. Secondary prevention detects and treats problems in the early stages of illness or disease. These interventions target disease before complications arise and before signs or symptoms appear. Secondary prevention targets populations with common risk factors. Tertiary prevention reduces further complications from a disease or illness and restores the individual to their optimum level of health. Tertiary prevention interventions occur after a disease or illness has developed.

- $17 million for **Health Education**, an increase of $807,000 for pay, inflation, population growth, and staffing new facilities to support the provision of community health, school health, worksite health promotion, and patient education. The Health Education standardizes, coordinates and integrates education issues within the IHS including health literacy for clients, professional education and training, as well as educational materials for staff, patients, families and communities.

- $64 million for **Community Health Representatives (CHRs)**, an increase of $2.4 million for pay, inflation, and population growth, to help bridge the gap between AI/AN individuals and health care resources through outreach by specially trained indigenous community members. CHRs integrate basic medical knowledge about health promotion/disease prevention and local community knowledge.

- $2 million for **Immunization AK**, an increase of $75,000 for Tribal pay, inflation, and population growth, to continue the provision of vaccines for preventable diseases, immunization consultation/education, research, and liver disease treatment and management through direct patient care, surveillance, and education. The Hepatitis B and Haemophilus Immunization Programs (Alaska) budget supports these priorities through direct patient care, surveillance and educating AI/AN patients.

Preventive Health services contribute widely to the performance measures that fall under the auspices of Hospitals & Health Clinics. Public Health Nursing provides community based clinical services which directly contribute to overall performance achievement activities such as immunizations, case management, and patient education. Community Health Representatives are also community based and integral in their contribution to follow up care and patient education. Health education activities permeate the Indian Health System and are integral to many of the screening measures. The Immunization Alaska program plays a key role by tracking immunization rates through specific immunization registries throughout the state of Alaska, and such efforts contribute to the national immunization rates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
PUBLIC HEALTH NURSING

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$59,885	$0	$64,071	$67,571	+$3,500
FTE	258	0	262	263	+1

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization.. IHCIA last authorized in 2000, Snyder and Transfer Acts - Permanent

Allocation Method ....Direct Federal, P.L. 93-638 Contracts, Grants, & Compacts with Tribal nations and Tribal consortia; competitive grants; interagency agreements; commercial contracts.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Indian Health Service (IHS) Public Health Nursing (PHN) is a community health nursing program that focuses on the goal of promoting health and quality of life, and preventing disease and disability in the community that is served. The PHN services were carried out by the Bureau of Indian Affairs in the early 1910 – 1920's then were delegated to the IHS with the Transfer Act in 1955.

The American Indian and Alaska Native (AI/AN) population experiences disproportionate rates of diabetes mellitus, cardiovascular disease, obesity, suicide, and unintentional injuries. The Public Health Nursing program provides health promotion and disease prevention nursing services through community-based primary, secondary and tertiary prevention services that are provided to individuals, families, and community groups. The Public Health Nurses are members of the multidisciplinary health care team. They provide continuity and coordination of healthcare which results in improved outcomes for the AI/AN population. Their work supports high quality, community-based, culturally appropriate care that reduces disparities in access and health outcomes.

Public Health Nursing services include: communicable disease – surveillance and monitoring, immunizations; PHN case management; maternal and child health care – prenatal/postpartum case management and education, newborn/child education, developmental screening, and case management of special needs children; chronic disease care and case management; health education and screenings for at-risk diseases or health concerns, and; school health screenings. Highlighted from recent events is the critical role Public Health Nurses played in the H1N1 influenza outbreak. The PHN expertise in communicable disease policy development, and the provision of assessment, outreach, investigation, surveillance and monitoring interventions, helped to manage the H1N1 influenza outbreak and prevent disease spread in the communities.

PHN programs focus on measurable clinical activities that address health disparities, and activities that support Improving Patient Care (IPC), Health Promotion/Disease Prevention (HP/DP), Behavioral Health. The PHN outcome performance measure supports several elements of the IHS Strategic Plan - Goals 1 and 2: Build and Sustain Healthy Communities and Provide Accessible and Quality Health Care – specifically, providing community-based approaches that address the health gap in the AI/AN population.

Approximately 45 percent (FY 2009) of this budget request supports Tribal compacted and contracted PHN programs. Public Health Nursing program's contributions to the agency and department goals are funded through the distribution of program awards for IHS and Tribal PHN programs. There were 15 grants and program awards issued in FY 2008 and 2009, and that will continue through the FY 2010-2011 cycles. The grants emphasize Departmental and Agency goals of access to health care and disease prevention services. The FY 2008 through FY 2011 grant awards focus on improving health outcomes through primary, secondary and tertiary prevention activities, community assessment and PHN case management services for high risk patients and families. Extending grant potential over a 4-year period will enhance sustainability of services.

In FY 2009, improvements were made in the Public Health Activities Database (PHAD) (formerly titled the CHAPS database), which has the capability of capturing specific public health nursing services at the local level. The PHAD is an Indian Health Performance Evaluation System product. The PHAD allows the PHN programs to track performance related clinical and quality improvement activities.

Overall, the PHN program contributes towards 10 agency performance measures; six are highlighted in the corresponding output table: tobacco screening, domestic violence screening, depression screening, Pap smear follow-up, adult influenza vaccinations, and adult pneumococcal vaccinations. PHN home visit activities prioritize interventions that target the maternal and pediatric population, including: childhood obesity prevention through breastfeeding promotion, screening for early identification of developmental problems, parenting education; elders, and: chronic disease management. Community health individual and group activities include health education and services related to communicable disease prevention; chronic disease prevention; wellness promotion; safety, such as, all-age seatbelt use, bicycle safety, home safety; health risk screenings for diabetes, cholesterol, and hypertension, and; providing school screenings that include immunizations and health assessments.

The performance goals require that the PHN programs focus on:

- Evidence-based *primary, secondary and tertiary prevention interventions*.
  An overview of the prevention interventions are:
  - *Primary prevention interventions* that avert diseases from occurring, such as: immunizations; breastfeeding; health promotion/disease prevention education; building assets in youth, etc.
  - *Secondary prevention* interventions that detect and treat problems in their early stages, such as: health screening of high-risk populations; screening for diabetes and hypertension; fall risk assessments; school health assessments, etc.
  - *Tertiary prevention* interventions that keep existing problems from getting worse, such as: chronic disease care, self-management education, medication management, and care coordination .
  - Community-based PHN services to individuals, families and community groups.

- PHN competitive awards and grants that provide funding to program awardees to increase public health nursing primary, secondary and tertiary prevention interventions that reduce morbidity and mortality in local communities through evidence based practice services.

Major challenges faced by PHN programs:

- The high vacancy rates over the past five years. The vacancy rate in FY 2004 was 9 percent; FY 2005 was 20 percent; FY 2006 was 21 percent; FY 2007 was 22 percent and FY 2008 was at a 22 percent vacancy rate and 4 percent staff turnover; FY 2009 was 18 percent vacancy, a slight improvement
- An increase in individual and family caseloads that have complex or chronic health issues that require more time and intensive PHN services, that impacts overall productivity in terms of PHN outputs.

FUNDING HISTORY

Fiscal Year	Amount
2006	$49,453,000
2007	$52,445,000
2008	$55,939,000
2009 Recovery Act	$0
2009 Omnibus	$59,885,000
2010 Enacted	$64,071,000

BUDGET REQUEST

The FY 2011 budget request for Public Health Nursing is $67,571,000, an increase of $3,500,000 over the FY 2010 Enacted level. The justification for the increase represents $666,000 for pay increases, $559,000 for inflation, $961,000 for population growth and $1,314,000 for staffing for the 5 new/expanded facilities.

The 2011 performance measure is to maintain encounters at the 2010 level. This will be accomplished by improved data collection activities and decreased position vacancies as a result of:

- Improvement in PHN documentation and coding of services through training and the development of standardized PHN documentation templates and embedded codes
- Increased PHN program implementation of electronic health record (EHR) documentation
- Reorganized PHN Internship program to recruit Public Health Nurses for the agency.

Funding for new facilities staffing equates to a total of 11 Tribal positions and 1 Federal FTE, or approximately 5 percent of the total PHN workforce. The impact on performance may not be as significant in FY 2011 given that FTE for new facilities will need time to establish the programs and hire staff. The impact of increasing performance will result in more secondary and tertiary prevention services provided to AI/AN communities, improving early detection and prevention of the complications of chronic disease.

Staffing for New Facilities	Amount	FTE/Tribal Positions
Absentee Shawnee Health Center (JV), Little Axe, OK	$453,000	4
Elbowoods Health Center, New Town, ND	$230,000	2
Carl Albert Hospital, Replacement (JV), Ada, OK	$303,000	3
Lake County Tribal Health Center (JV), Lakeport , CA	$235,000	2
Cheyenne River Health Center, Eagle Butte, SD	$93,000	1*
TOTAL	**$1,314,000**	**12**

* Federal FTE

OUTCOMES

23: **Public Health Nursing:** Total number of public health activities captured by the PHN data system; emphasis on primary, secondary and tertiary prevention activities to individuals, families and community groups.	FY 2009: 428,207 (Target Exceeded)	430,000	436,450	+6,450
Program Level Funding ($ in millions)	**$59.9**	**$64.1**	**$67.6**	**+$3.5**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

OUTPUTS

PHN Vacancy Rates	(2009) 18%	*	*	
Contributes to the following performance measures:				
Tobacco Screening	31,562	33,771	34,109	+338
Domestic Violence Screening	5,820	6,227	6,290	+63
Depression Screening	12,735	13,626	13,763	+137
Pap smear or Follow-up	3,695	3,954	3,993	+39
Adult Influenza Vaccine	51,681	55,299	55,852	+553
Adult Pneumococcal Vaccine	9,204	9,848	9,947	+99
Program Level Funding ($ in millions)	**$59.9**	**$64.1**	**$67.6**	**+$3.5**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

** The vacancy rates are not projected because of unpredictable fluctuations.*

GRANTS AWARDS

	FY 2009	FY 2010	FY 2011
Number of Awards	15	15	15
Average Award	$150,000	$150,000	$150,000
Range of Awards	$150,000	$150,000	$150,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
HEALTH EDUCATION

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$15,723	$0	$16,682	$17,489	+$807
FTE	26	0	26	26	0

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization... IHCIA last authorized in 2000, Snyder and Transfer Acts - Permanent

Allocation Method ....Direct Federal, P.L. 93-638 Self-Determination Contracts and Self-Governance Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Indian Health Service (IHS) Health Education program has been in existence since 1955. The program continues to focus on the importance of educating our American Indian/Alaska Native (AI/AN) clients in a manner that empowers them to make better choices in their lifestyles and how they utilize health services. The 23 IHS and approximately 75 tribal Health Education program staff partner with other IHS disciplines and programs to ensure that the education of our clients continues to occur even at sites without a full-time health educator. The IHS can demonstrate a steady increase in the health and patient education encounters that are being provided to AI/AN clients by all providers within the IHS and by our Tribal partners. This model concept demonstrates not only the collaboration between the IHS Health Education Program and all IHS health disciplines and programs but also demonstrates an IHS-wide focus and commitment to education. As the Health Education Output Table demonstrates, we have maintained a steady increase in the number of AI/AN clients that have participated in an educational encounter. The number of visits in which education was provided has moved from approximately 777,000 visits with education provided in FY 2004 to **2,387,861**, at the end of FY 2009. Clearly this demonstrates the IHS commitment to improve health education access, increased health literacy, increased patient-provider communications, and ultimately better health outcomes.

The Health Education program maintains data tracking of two key program objectives – Tobacco Cessation and Cardiovascular disease (CVD) assessment. During the most recently completed national performance data collection period, the Health Education program contributed to increased performance from the 12 percent FY 2006 baseline to 24 percent in FY 2009 of the proportion of tobacco-using patients that receive tobacco cessation intervention; and increased the proportion of at-risk patients who have a comprehensive assessment for all CVD-related risk factors to 32 percent.

While not a performance indicator, the IHS Health Education maintains IHS-wide statistics on educational encounters. Examples of data available from educational encounters include: 1) the number of clients educated, 2) which providers provided education, 3) where the education took place, 4) what information the patient was provided with, 5) the amount of time spent providing this education, 6) whether the patient understood the education provided, and 7) whether the patient set a behavior goal change. These IHS statistics are currently available from the RPMS system. In partnership with all IHS programs, disciplines and staff, the Health Education Program staff continues to:

(1) Communicate the importance and on-going need for comprehensive clinical and community health education services to AI/AN clients;
(2) Provide these services both as individual one-on-one counseling education sessions and in group encounters in the community;
(3) Standardize, coordinate and integrate education issues within the IHS including health literacy for clients, professional education and training, as well as educational materials for staff, patients, families and communities; and
(4) Assist in transforming the Health Care System to increase access to high quality, effective health care that is predictably safe.

The Health Education Program has identified the following areas of emphasis:

- Continue and strengthen the development of standardized, nationwide patient and health education program through the integration of the IHS Patient Education Protocols into all IHS software packages including the PCC, PCC+ and the Electronic Health Record; with the continued provision of ongoing training to IHS and Tribal staff on the documentation and coding of patient and health education; This effort assists IHS to meet *Healthy People* Objectives to improve consumer access to health information and to improve health communications to our clients.

- Increase a concentrated focus on the area of *Healthy People*: Health Communications:
  - Increase the proportion of AI/ANs with access to health information;
  - Improve the health literacy of AI/ANs with inadequate or marginal literacy skills;
  - Increase the health information contained on www.ihs.gov ensuring that information disclosed is quality-assured and culturally appropriate for AI/AN clients;
  - Improve patient-provider communication skills.

FUNDING HISTORY

Fiscal Year	Amount
2006	$12,429,000
2007	$14,287,000
2008	$14,991,000
2009 Recovery Act	$0
2009 Omnibus	$15,723,000
2010 Enacted	$16,682,000

BUDGET REQUEST

The FY 2011 budget request for the Health Education program is $17,489,000, an increase of $807,000 over FY 2010 Enacted level. This increase would support pay costs of $170,000, inflation of $195,000, population growth of $250,000, staffing for 5 new/expanded facilities and two additional facilities that may come on line for funding in FY 2011 of $192,000.

This funding supports the provision of the existing services to a slightly expanded population of AI/AN people served and supported by new facilities. This funding also supports two key program objectives – Tobacco Cessation and Cardiovascular disease (CVD) assessment. These two performance measures are critical for IHS in terms of impacting health disparities afflicting the AI/AN population, particularly diabetes, cancer, and cardiovascular disease. Health education continues to be an integral part of impacting the rates of these and other chronic diseases, not only in terms of reaching a higher percentage of the population, but in educating each high risk patient about the risks of smoking, or ensuring that such high-risk patients receive the appropriate screening to assist in monitoring the status of ischemic heart disease. IHS anticipates that the CVD assessment will be 33 percent in FY 2010 and to 33.8 percent in FY 2011. Rates for tobacco cessation will be 27 percent for FY 2010 and to 27.7 percent in FY 2011. Similarly, overall increases in Health Education patient encounters for FY 2011 will be increased by 5 percent over the FY 2010 level.

These performance increases represent the IHS Health Education program's commitment to support the Improving Patient Care (IPC) and Health Promotion/Disease Prevention (HP/DP) activities that will be achieved by improving efficiency in delivering and reporting these critical services.

Staffing for New Facility	Amount	Tribal Positions
Carl Albert Hospital Replacement (JV), Ada, OK	$106,000	1
Elbowoods Health Center, New Town, ND	$86,000	1
Total	**$192,000**	**2**

OUTCOMES

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
32: **Tobacco Cessation Intervention:** Proportion of tobacco-using patients that receive tobacco cessation intervention. IHS-All	FY 2009: 24% (Target Exceeded)	27%	27.7%	+0.7%
32: Tribally Operated Health Programs	FY 2009: 19% (Target Exceeded)	22%	22.6%	+0.6%
30: **CVD Comprehensive Assessment**: Proportion of Ischemic Heart Disease patients who have a comprehensive assessment for all CVD-related risk factors. IHS-All	FY 2009: 32% (Target Exceeded)	33%	33.8%	+0.8%
30: Tribally Operated Health Programs	FY 2009: 28% (Target Exceeded)	29%	29.7%	+0.7%
Program Level Funding ($ in millions)	**$15.7**	**$16.7**	**$17.5**	**+$0.8**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

OUTPUTS

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Number of Visits with Health/Patient Education	2,387,861 (baseline)	2,507,254 (+5%)	2,632,617 (+5%)	+125,363
Program Level Funding ($ in millions)	**$15.7**	**$16.7**	**$17.5**	**+$0.8**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
COMMUNITY HEALTH REPRESENTATIVES

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$57,796	$0	$61,628	$63,991	+$2,363
FTE	7	0	7	7	0

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization.. IHCIA last authorized in 2000, Snyder and Transfer Acts - Permanent

Allocation Method .... Direct Federal, P.L. 93-638 Self-Determination Contracts and Self-Governance Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

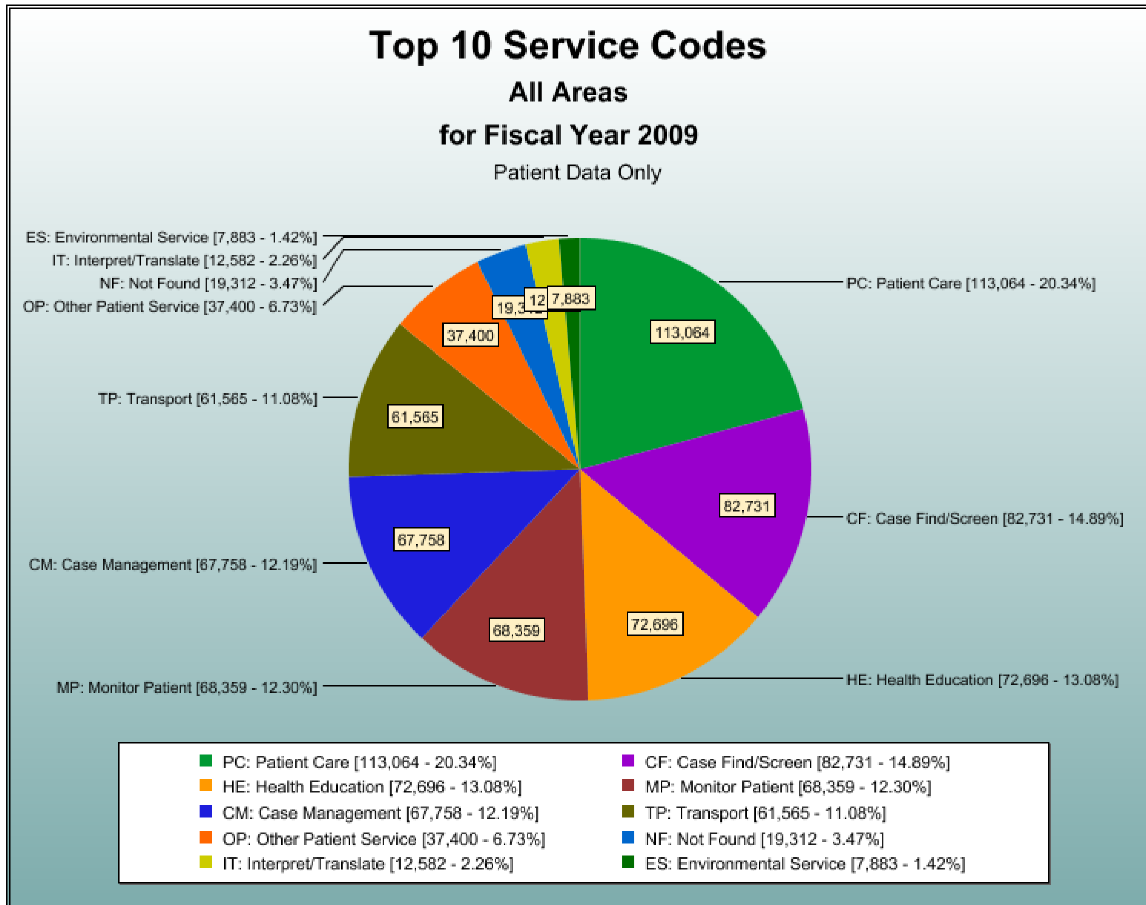
Originally begun by the Office of Economic Opportunity in 1968, the Community Health Representatives (CHR) Program was transferred to the IHS at a time when IHS was looking for ways to support the Tribes in self-determination through the provision of health care. Under the concept of utilizing community members as health para-professionals to expand health services and initiate community change, CHRs serve tribal members and communities as charged by Congress to provide health care, health promotion and disease prevention services to Indian communities (Indian Health Care Improvement Act [IHCIA] as amended, Public Law 100-713, dated November 23, 1988). The IHCIA also mandated the Secretary to provide a quality training program, including continuing education needs for CHRs.

Funds are distributed to the Tribes through Area allocations. All but three of the 264 CHR programs are administered and operated by the Tribes through contracts/compacts under the authority of the Indian Self-Determination and Education Assistance Act (ISDEAA). Headquarters CHR shares are utilized primarily for 1) training, 2) data/software development through the Resource Patient and Management System’s (RPMS) CHR Patient Care Component (PCC) data application and 3) Special Projects in support of training and data software development.

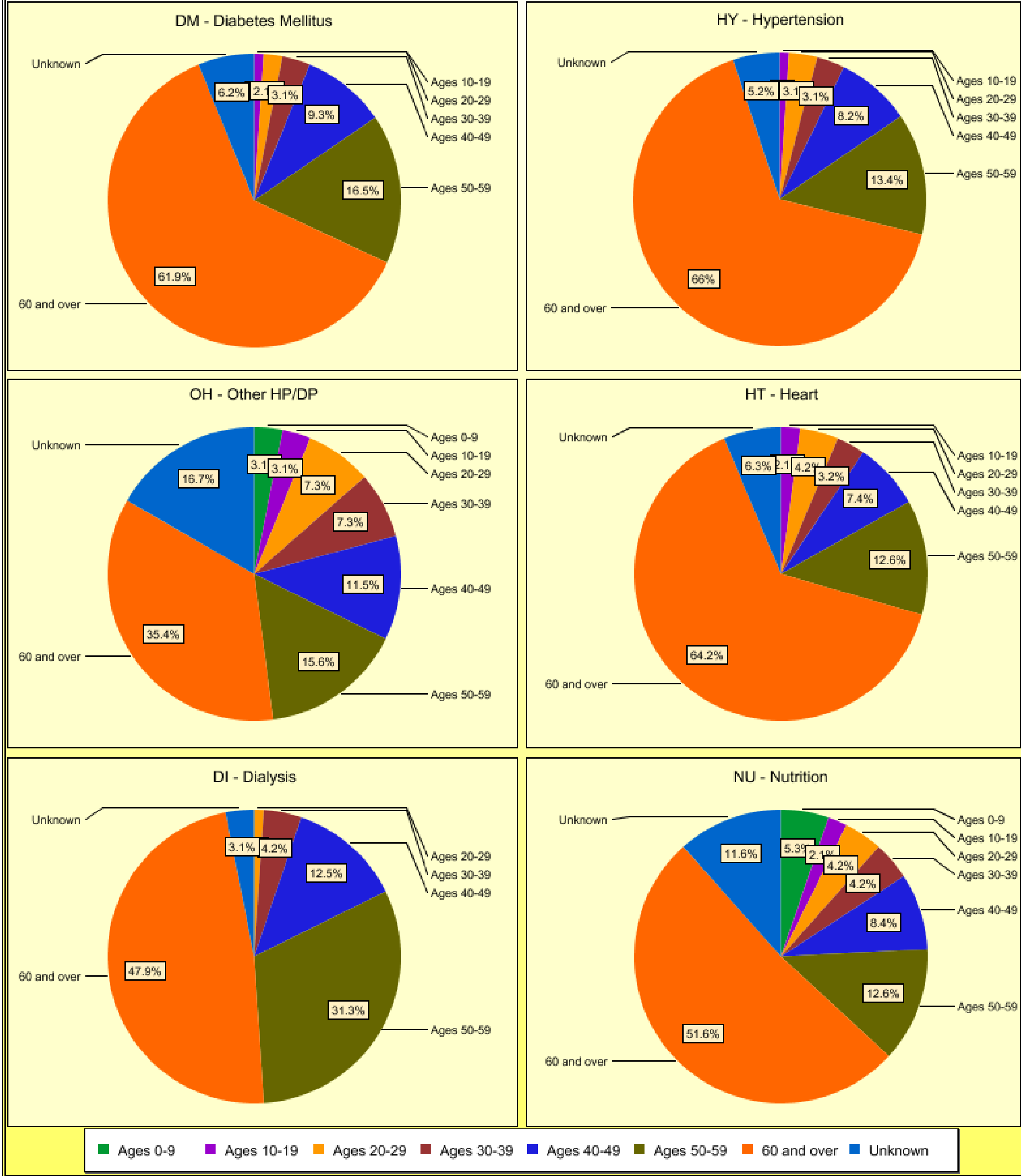
Training is a key tool when providing laypersons with the comprehensive health education needed to perform the wide variety of job responsibilities the various Tribes assign to their CHRs. Training affords CHRs the skills needed to provide 16 categories of services that make a difference in their patients’ lives and which contribute to performance measures under Hospitals and Health Clinics.

For FY 2009, direct ***Patient Care*** (taking vital signs, providing foot care, providing emotional support, providing personal care like bathing, shampooing hair, etc) led in types of services

provided by CHRs at over 20 percent; ***Case Finding/Screening*** nearly 15 percent; ***Health Education*** over 13 percent; ***Monitoring Patients*** over 12 percent; ***Case Management*** over 12 percent; ***Transportation*** at 11 percent; and ***Other Patient Services*** nearly 7 percent (please see following chart):



CHRs provide services to all eligible AI/AN patients as defined by 42 Code of Federal Regulations (CFR), subpart A-G (1986). National CHR Program data shows that for the top 6 health problems for which CHRs provide services, primary beneficiaries in the AI/AN population are elders (please see chart and table below, "Top 6 Health Problem Codes by Age"). "Unknown" typically reflects patients who are not on the specific patient registry at the health facility serving the local population and thus their specific ages are unknown, yet CHRs provide services because they are eligible elsewhere or fall into another eligible category. Percentages combined do not total 100% because these represent only the top 6 health problems for which patients are seen, not for all health problems in the entire population served.


Top 6 Health Problem Codes By Age
for Fiscal Year 2009
All Areas
Patient Data Only
DM - Diabetes Mellitus
HY - Hypertension
OH - Other HP/DP
HT - Heart
DI - Dialysis
NU - Nutrition
Ages 0-9
Ages 10-19
Ages 20-29
Ages 30-39
Ages 40-49
Ages 50-59
60 and over
Unknown

Acquiring data in CHR PCC is challenged by underutilization of the application, under-reporting and access issues to RPMS. Marketing the benefits of the application and focusing on training of CHRs on the proper use, data entry and export of CHR PCC data will support advancing the development and use of health information technology; contribute to statistics which prove program effectiveness; and improve coordination and communication between CHRs and clinicians regarding patient care.

All the charts and data provided here are the results of Tribes using RPMS CHR PCC. The numbers reported will increase as CHR Programs utilizing RPMS CHR PCC are added and as CHR Programs which currently use the software application improve their data entry capability and/or are able to export their files to IHS Headquarters.

A CHR Program performance target is to increase service hours of Chronic Disease services for CVD, Diabetes and Cancer provided by CHRs to support clinical and community-based activities such as the Health Promotion/Disease Prevention, Behavioral Health and Improving Patient Care. These measures impact access to health care services, expand consumer choices and promote healthy behaviors. "High talk, low tech" (the concept that service providers can sometimes utilize human interaction and supportive relationships with much greater effect and intensity than relying on technological resources with patients) pays dividends, as shown in recent studies on services provided by community health workers (CHW, an overall descriptive term reflecting this group of workers) for services like direct patient care and outreach, advocacy, education and screening services that are established as cost effective. For example, Beckham (2004)[1] showed that CHW programs utilized for asthma management reduced total per capita costs from $310 to $129 and Emergency Department (ED) costs from $1,119 per participant to $188. On Diabetes Management, Fedder (2003)[2] showed that Medicaid costs were reduced an average of $2,245 per patient per year by utilizing CHWs.

The health and socio-economic services CHRs provide to their communities support the HHS goal to improve the economic and social well-being of individuals, families and communities and serve to support patient self-management.

Program accomplishments during FY 2009 include:

1) Increased numbers of CHRs trained on use of RPMS CHR PCC;
2) Enhanced collaboration with various disciplines and offices within IHS on projects, including:
   - Diabetes Program to provide outreach, referral and monitoring services (Diabetes is the top health priority identified by tribal leaders for FY 2011;
   - Establishment of a policy workgroup to review and edit *Chapter 16, Community Health Representatives* in the *Indian Health Manual*;
   - Improving Patient Care Program–One example from an IPC pilot site illustrates the value of the clinic and community-based provider connection to benefit patients. At White River Service Unit, which serves the White Mountain Apache Tribe (WMAT), colorectal cancer (CRC) screening rates were vastly improved due to inclusion of the CHRs in the entire process. Clinic staff met with the CHRs regarding CRC and Fecal Occult Blood Test (FOBT) screening. WMAT CHRs encouraged the use of simple English and pictures in the handouts but also advised that the explanation of the testing, rationale, etc. be in Apache as well. As a result, low-level literacy Instructions for FOBT were created which

[1] Beckham, S, Kaahaaina D, Voloch KA et al. A community-based asthma management program: effects on resource utilization and quality of life. Hawaii Medical Journal 2004; 63(4):121-6.

[2] Fedder DO, Chang RJ, Curry S et al. The effectiveness of a community health worker outreach program on healthcare utilization of West Baltimore City Medicaid patient with diabetes, with or without hypertension. Ethn Dis 2003; 13(1):22-7.

were “low-tech” in words and pictures and very simple for patients to understand and follow. Clinic staff partnered with CHRs for the latter to do home follow-up of unreturned tests. These and other changes based on recommendations which came out of their meetings were implemented. White River Service Unit has seen the results in its improved CRC screening measure. More importantly, community members are being screened and educated on risk factors and are understanding the importance of such for their own health;

- Continued support of CHR Work Groups to advise on medications, CHR PCC training and data application enhancements, curriculum, etc.
- In collaboration with IHS Behavioral Health, specialized HIV/AIDS training-of-trainers designed to educate communities, increase awareness and enhance screening efforts

3) Enhanced collaboration within HHS:

- Implementation and incorporation into the CHR Curriculum of a CHR cancer training module through a National Cancer Institute-funded project aimed at involving the CHRs more effectively as part of the care team for cancer prevention, screening, education and tobacco cessation as the community arm of an expanded care team. Additional project work products included “Winds of Hope”, an interactive CD-ROM; and “Talking Tools” - templates to help build communication bridges between Clinic Providers and CHRs which were tested with positive feedback from CHRs and clinic providers to help achieve the goal of improving overall cancer care to patients. Cancer is the second highest health priority identified by tribal leaders for FY 2011;
- Continuation of NIH quarterly mailings of NIH health information focusing on improving the development and dissemination of health information with American Indian and Alaska Native communities.
- A half-day Spring Conference at NIH, sponsored jointly by the IHS HQ CHR Program and the Trans-NIH American Indian/Alaska Native Health Communications and Information Work Group, which focused on the vital role CHRs play in health education and outreach efforts, as well as their importance for building collaborative relationships between tribal communities and researchers.

4) Revision of the CHR curriculum to content which incorporates more certified nurse aide (CNA)-type training. Students pass upon scoring 75% on their written exam, completion of public speaking, presentation of a group project, and upon approval of taking vitals signs. Students felt their knowledge and skills improved. One CHR stated “I felt the learning techniques used by Instructors were very good. I feel that I am much better prepared to meet the needs of my community and I feel that the knowledge I learned I’ll be able to retain.”

IHS and Tribal health facilities depend on CHRs to track down, contact and deliver critical patient health information to patients; educate and encourage them to make and follow up on appointments; and transport them if necessary. CHRs directly impact patient access to and delivery of services. Programmatic activities contribute toward a variety of clinical and national performance measures.

FUNDING HISTORY

Fiscal Year	Amount
2006	$52,946,000
2007	$54,891,000
2008	$54,925,000
2009 Recovery Act	$0
2009 Omnibus	$57,796,000
2010 Enacted	$61,628,000

BUDGET REQUEST

The FY 2011 budget request for Community Health Representatives is $63,991,000, an increase of $2,363,000 over the FY 2010 Enacted level. The increase will provide:

Pay Costs +$621,000 for civilian and tribal pay increases
Inflation +$818,000 to cover the cost of providing health care services
Population Growth + $924,000 to cover the cost of providing health care services to the projected increase in population.

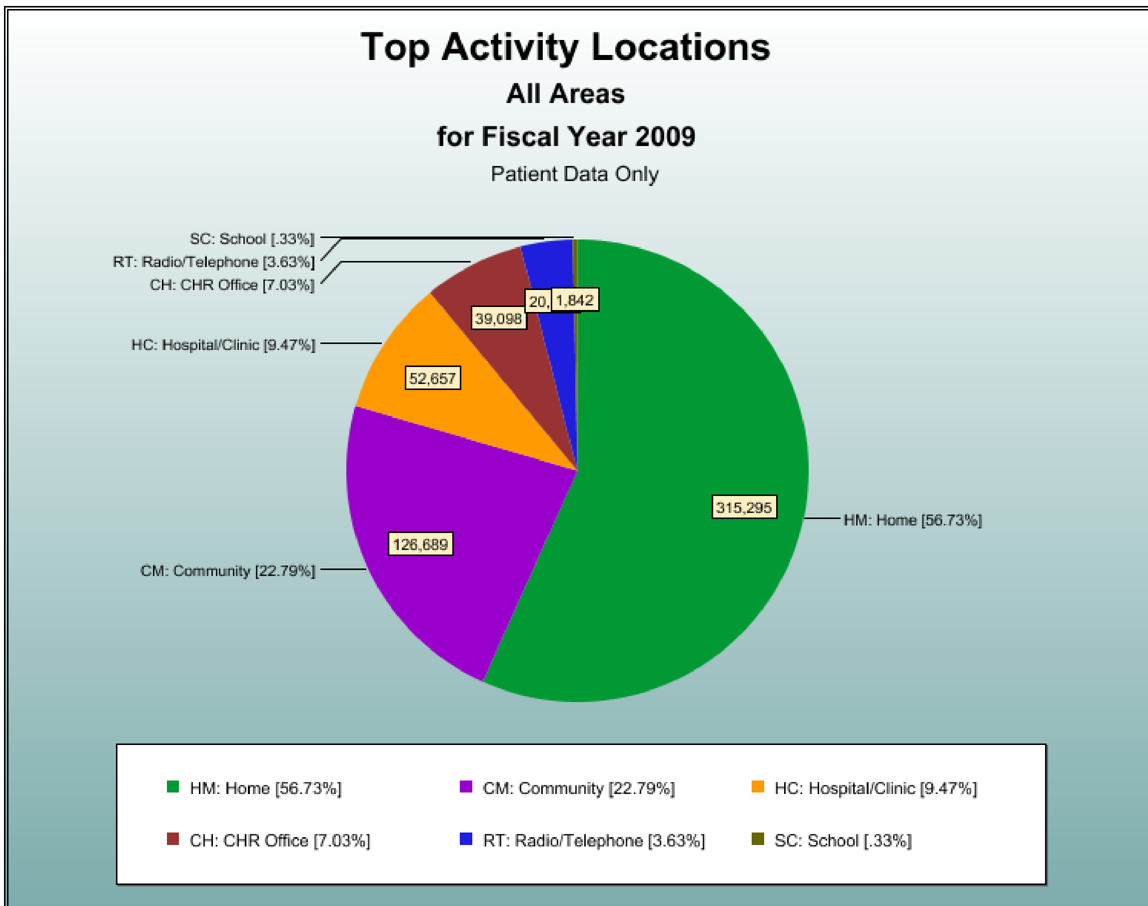
The total funding for Community Health Representatives will provide:

- $62,071,000 (approximately 97%) for '638 Self-Determination contracts and compacts with Tribes for direct health care, health promotion and disease prevention services as identified in tribal funding agreements and scopes of work to 1.9 million AI/AN population throughout 12 Areas in homes and other community-based settings.
- $1,920,000 (approximately 3%) is under direct Federal administration for training, information technology costs, special projects and national education meeting(s); and is subject to tribal shares. These retained funds will also support the following plans in FY 2011, but not limited to:
  - continue efforts to train CHRs nationally on the CHR PCC data application;
  - continue HIT development and data support, specifically to: (a) include limited patient education protocols and codes, (b) require notation of referrals made to and from CHRs to help track access issues and the potential impact of CHR activities, and (c) attempt to integrate continuous quality improvement efforts into data collection and data integrity;
  - enhancement of the national CHR web-based tracking system to improve data reporting to/by the national level;
  - continue encouraging Tribes to send CHRs to training and to utilize the RPMS CHR PCC data application;
  - education on the Model for Improvement and assessment and dissemination of information related to CHR involvement and integration as part of the health care team at Improving Patient Care Program sites which provide patient-centered care across the continuum of settings;
  - exploration of CHR involvement with overall IHS Alcohol Screening Brief Intervention (ASBI) efforts;
  - continue curriculum enhancement and provision of training (as mandated in the Indian Health Care Improvement Act as amended) to as many CHRs as can attend;
  - encourage injury prevention activities including home assessments, child safety seat usage, safe cycling and helmet classes, smoke detectors, and gun locks to reduce the tremendous injury rates among AI/AN persons; and
  - maintain special projects such as certification of CHRs as CHR PCC trainers and consultation with the CHR PCC User Requirements Work Group. The CHR PCC User Requirements Work Group, comprised of CHRs, clinicians and technical experts, will work other important stakeholders in the IHS RPMS to address functionality of the data system to include appropriate patient education components (cancer, diabetes, cardiovascular, etc.), appropriate medical terminology, and tracking of referrals made, along with patient access to and attendance at clinical appointments. Among other responsibilities it will help address deployment and implementation issues for non-federal employees of CHR PCC.

Planned for FY 2011 are increased training efforts to CHRs regarding:

- providing assistance and information to AI/AN veterans concerning their benefits through close collaboration with the VA's Tribal Veteran's Representative (TVR) Program;
- use of evidence-based interventions with patients incorporating an integrated "Five A" model specific to the individual's readiness to quit;
- development and testing of a special CHR module on Diabetes basics and prevention; and
- utilization of the Physical Activity Kit (PAK) developed in partnership with the IHS Health Promotion/Disease Prevention (HP/DP) Program to encourage and motivate patients and communities to an active, healthy lifestyle.

The majority of CHR services are provided to patients in their homes or community settings (see the following chart), which require funds for transportation. Data indicates that services provided in homes increased dramatically over the last year - nearly 55% for FY 2008 compared to 36% in FY 2007 - perhaps reflecting patients' transportation challenges to access health services. Many factors impact the amount and level of services CHRs are able to provide, including but not limited to the relative isolation of many AI/AN living in rural areas and the wide fluctuation of gas prices.



OUTPUTS

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Patient Services in Hours directed to Chronic Diseases (1), (2), (3)	FY 2009: 212,609	151,700	151,700	0
# of contacts (3), (4)	FY 2009: 2,015,963	1,302,500*	1,321,600	+19,100
# of CHRs trained in basic, refresher, and first responder training	FY 2009: 70[7]	70	267	+67
Number of CHRs trained on CHR PCC	FY 2009: 438	640[6]	363[5]	-277
Program Level Funding ($ in millions)	**$57.8**	**$61.6**	**$63.9**	**+$2.4**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

[1, 3]121 of 290 (42% reported in 2009; 55% in 2008; 33% in 2007) CHR Programs assigned Program Codes are reporting with CHR PCC, the only way IHS Headquarters can track CHR data. This number was extrapolated from 42% reporting.
[2]The Program Performance target above represents an effort by the IHS national CHR Program to obtain specific service hours provided in the categories of diabetes, heart, hypertension, nutrition, cancer, other chronic, dialysis, obesity, depression, renal failure, and liver disease related to IHS GPRA indicators and drawn from the CHR PCC software application.
[3]Training conducted on CHR PCC suggests that CHRs routinely under-report the services they provide. Typically they report 2-3 services, but when queried further they identify 5-7 additional services that regularly are unreported (checking homes for hazards as part of injury prevention efforts, providing homemaker services, providing health information on/checking medications, coordinating appointments, interpreting/translating, health education).
[4]Patient contacts are the number of services multiplied by number served
[5] Estimate based only on CHRs trained in regional training throughout the year – no national education conference in FY 2011
[6]Estimate based on inclusion of CHR participants at tentatively scheduled FY 2010 National CHR Education meeting which will be added to the number of CHRs trained throughout the year
[7]Actual number trained was less than target due to unanticipated termination of interagency training agreement
*Revised from previously published estimates due to improved data system capacity

We believe the increased number of patient contacts and services in hours directed to chronic diseases reflects improvement of the data system and data integrity; and that more CHRs are beginning to code accurately the types and number of services they're providing.

With the proposed funding increase for FY 2011, the CHR program will strive to reach the level of services proposed in FY 2010. Key challenges affecting results:

1) Tribes have the option under self-determination to use any data system they deem best supports their needs. RPMS CHR PCC is the only data system by which IHS can furnish data for budget purposes or Program management. If Tribes elect a data source other than RPMS CHR PCC, IHS cannot report the services, activities, trends, or achievements of tribal CHR Programs. Support by tribal leadership for use of CHR PCC is needed.
2) Access to RPMS CHR PCC is challenged by geographic barriers (remoteness) which impact connections to internet via phone or satellite.
3) Access is further complicated by
   a) necessary federal security requirements for Tribal members to request access to RPMS through the Network Operation Security Center (NOSC), to complete the IHS Information Technology Access Control (ITAC) and Rules of Behavior (RoB) forms, and to complete annual security awareness training; and
   b) the need to persuade Chief Executive Officers at the facility level that CHRs should have access to RPMS CHR PCC.

GRANTS AWARDS

No grant awards were made in FY 2008-10; none are anticipated for FY 2011.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551

HEPATITIS B AND HAEMOPHILUS IMMUNIZATION PROGRAMS (ALASKA)

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$1,823	$0	$1,934	$2,009	+$75
FTE	0	0	0	0	0

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization... IHCIA last authorized in 2000, Snyder and Transfer Acts - Permanent

Allocation Method .... Tribal contracts; Tribal Shares; Grants

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Liver Disease and Hepatitis Program (Hepatitis B Program) was initiated in 1983 because of the need to prevent and monitor hepatitis B infection among a large population of Alaska natives with or susceptible to the disease. It continues to provide this service in addition to evaluation of vaccine effectiveness and the medical management of persons with hepatitis and liver disease. The Immunization (Haemophilus Influenza; Hib) Program started in 1989 with a targeted Haemophilus influenzae type b prevention project in the Yukon Kuskokwim Delta and now maintains high vaccine coverage by providing resources, training and coordination to tribal facilities throughout Alaska. These programs are components of the Alaska Native Tribal Health Consortium (ANTHC), based in Anchorage, Alaska.

Hepatitis B Program

According to the report "Regional Differences in Indian Health" released March 2008, liver disease is the 5th leading cause of death in American Indian and Alaska Natives (AI/AN), just behind diabetes. Based on demonstrated high rates of disease, program activities include clinical care of chronic liver disease patients, consultation on immunization and hepatitis issues, regular medical monitoring and clinical care follow-up of hepatitis B carriers, follow-up and new evaluation of hepatitis C infected persons, follow-up of persons with autoimmune liver disease, and follow-up of large cohorts of infants, children and adults vaccinated with hepatitis A and B vaccine to determine duration of immunity and if booster doses will be needed in the future. In addition, the program implemented a clinical protocol to diagnose, evaluate and counsel patients with non-alcoholic fatty liver disease. The program uses sophisticated computer-based applications that integrate laboratory and other clinical data into a series of reports that allows program clinicians to follow a large number of patients with chronic hepatitis and other liver disease. This allows IHS to work closely with Tribal and Alaska Native Regional Corporations to care for these patients, including making at least one visit yearly to all rural Tribal Hospitals and

regional clinics to conduct liver clinics, educate staff and advise public health administrators and Native Health Boards.

The program accomplishments are:

- The Liver Disease and Hepatitis Program follows patients statewide with chronic hepatitis B with the goal of reducing the lifetime risk of death from liver cancer or cirrhosis from 25 percent to <10 percent by early detection and removal of hepatocellular cancer and treatment with antiviral medications. In 2006 and 2007, we screened 60 to 63 percent of AI/AN with chronic hepatitis B or C infection (n = 2251 and 2306, respectively) for liver cancer and for liver aminotransferase levels to detect liver inflammation and potential treatment candidates at least once during the year. Among AI/AN with chronic hepatitis B (n = 1145), 70 (6 percent) patients started antiviral therapy and it is estimated that 200-300 (17-26 percent) may need antiviral therapy in the next 5-10 years.
- The program monitors Alaska Natives statewide with hepatitis C infection for alpha-fetoprotein to detect liver cancer early and perform liver function tests to identify potential treatment candidates. Among AI/AN with chronic hepatitis C (n = 1627) 122 patients, or 8 percent, have been treated with 130 courses of 6 month to 1-year courses of antiviral therapy. With the advent of several new potent and more effective antiviral agents are expected to be licensed in the next 2 years, an estimated 400 to 500, or 25 to 33 percent, patients will need therapy for Hepatitis C in the next 5-10 years.
- The program actively screens for autoimmune hepatitis (AIH), primary biliary cirrhosis (PBC) and nonalcoholic fatty liver disease in the Alaska Native population. AIH and PBC have high mortality rates but treatment, usually life long, can reduce mortality to < 10 percent. The program has determined the prevalence of AIH among AI/AN to be 42.9/100,000 (highest of any ethnic group reported in the world) and PBC among the highest in the world. 131 Alaska Natives with autoimmune liver disease were identified and are followed every 3 months at ANMC or in a field clinic. The program will conduct studies to better understand and monitor the treatment of this disease. Due to the high rates of obesity and type-2 diabetes in Alaska Natives, the program has increased surveillance, screening, counseling and treatment of nonalcoholic fatty liver disease (NAFLD) which appears to be present in over 10 percent of the Alaska Native population. NAFLD can lead to cirrhosis and liver cancer in some patients.
- The program is continuing the largest and longest studies on the immunogenicity, safety and long-term efficacy of hepatitis A and B vaccines in infants, children and adults in the world with 1,050 patients enrolled. The results of many of these studies are published and have made a significant contribution to the literature and to date have had great influence on recommendations that the Advisory Committee on Immunization Practices (ACIP) has made that booster doses are not yet needed for children and adults who received hepatitis A and B vaccine. The 22-year follow-up report of the longest study of the efficacy and immunogenicity of hepatitis B vaccine in children and adults in the world from Alaska Native participants has been accepted for publication in the Journal of Infectious Diseases. Also, the longest study in the world of hepatitis A long-term efficacy and immunogenicity in the world was published in 2008 in the Journal of Infectious Diseases. Results of these studies show that the immunogenicity of hepatitis B vaccine is 92 percent at 22 years and of hepatitis A vaccine is 100 percent at 10 years. Since these vaccines are universally given to all children in the US, these studies are crucial to the US immunization policy for all US citizens, not just AI/AN. Also, IHS conducted a study to define the impact of the hepatitis B vaccine program and found that in children < 20 years of age, the prevalence of chronic hepatitis B infection

fell from 3.2 percent between 1983-1987 to 0.004 percent in 2008 and the incidence of liver cancer in from 3/100,000 from 1984-1988 to 0 cases from 1999-2008.

- The program helped to establish a Molecular Biology Laboratory at the Alaska Native Medical Center, which, to our knowledge, is the only laboratory of this type to be in an IHS facility. Work conducted there has improved our understanding of hepatitis virus genotypes and disease outcomes and allowed us to monitor viral loads. Due to budgetary constraints at the Alaska Native Medical Center, the laboratory closed for one year; we are now in the process of reopening the laboratory.
- The program collaborated with Center for Disease Control (CDC) in Atlanta on a study of the prevalence of chronic liver disease in patients seen at the Alaska Native Medical Center. This study will help to illustrate the overall health impact and help us better address disease disparities. Because of our comprehensive registry of hepatitis B patients, we applied for and were accepted to participate in an NIH sponsored network of 10 university centers in the US who will study the effects of chronic hepatitis B infection and work on innovated ways to diagnose and treat those with chronic HBV.
- International Activities: The program helped to establish a Circumpolar Hepatitis Working Group whose purpose is to exchange information and develop programs to promote hepatitis vaccination and treatment programs for indigenous populations in the Arctic (Alaska, Greenland, Canadian autonomous Tribal Regions and Siberian Indigenous Groups). The ANTHC Liver Disease Program is helping Greenland plan to introduce universal hepatitis B vaccination into the Inuit population and helping Arctic Countries to develop treatment programs for hepatitis B modeled after the Alaska Program. In addition, the ANTHC program is now advising World Health Organization (WHO), the Global Aides Program (GAP) and the Presidents Emergency Program for Aids Recovery (PEPFAR) in establishing vaccination and treatment programs for hepatitis B in underserved countries in Africa and Asia utilizing experience gained from the successful program in Alaska.

Immunization (Hib) Program

The purpose of the Immunization Program is to maximize the prevention of vaccine-preventable disease through advocacy, training, resources, immunization tracking, coordination of vaccine delivery and research on vaccine-preventable disease. We train 13 regional tribal coordinators to track immunizations, recall patients, ensure quality of electronic immunization records and report immunization rates quarterly. We report statewide immunization coverage rates to IHS headquarters.

Since 2007 the Immunization Program has implemented routine rotavirus and human papillomavirus (HPV) vaccination and is currently working with the CDC Arctic Investigation Program and Tribal agencies to promote and monitor the impact of HPV vaccine in Alaska Native females. The program is working with tribal public relations to address parental questions and highlight the importance of vaccines. The program is providing program and technical support to small tribal corporations to achieve accurate immunization records and actively track and recall patients in order to improve immunization rats. The program director is conducting a research protocol with Yukon Kuskokwim (YK) Health Corporation to administer an expanded 13-valent pneumococcal conjugate vaccine to YK Delta infants pre-licensure to address extremely high rates of non-Prevnar® vaccine serotype invasive pneumococcal disease. (The company has applied for FDA licensure for the 13-valent vaccine to replace Prevnar.)

The Liver Disease and Hepatitis Program (Hepatitis B Program) and the Immunization (Haemophilus Influenza) Program both provide consultation on immunization and liver disease

issues to Indian Health Service and Tribal providers throughout the US. Both programs conduct research and publish journal articles in peer-reviewed journals on topics related to vaccine-preventable disease, hepatitis, other liver diseases and health disparities in AI/AN.

The program accomplishments are:

- Met the performance measure target of 78 percent of childhood immunizations in FY 2008 with a FY 2008 level of 83 percent; the 12-31-08 level is 82 percent for 4-3-1-3-3 and 78 percent for 4-3-1-3-3-1 (including varicella).
- Greatly exceeded the performance measure target objective of 76 percent for pneumococcal (Pneumovax) immunization of elders in FY 2008 with 91 percent of elders immunized.
- Alaska Area was below the performance measure target objective of 59 percent for influenza immunization of elders in FY 2008 with an immunization rate of 48 percent.
- Elimination of vaccine-type pneumococcal cases among Alaska Native children <2 years old.
- 96 percent decrease in Hib disease with over 450 cases prevented by vaccine.
- Implemented routine rotavirus immunization in Alaska Native infants.
- Rapid increase in HPV vaccine coverage with 1+HPV doses in Alaska Native girls 13-17 yrs. from 16 percent at the end of 2007 to the 12-31-08 of 64 percent.
- Completed Respiratory Virus Study that demonstrates the association of respiratory syncytial virus, parainfluenza virus or metapneumovirus in the majority of respiratory hospitalizations.
- International collaboration with Australia and New Zealand colleagues to study an improvement for prevention and care of chronic lung disease and bronchiectasis in Alaska Native children.
- During FY2008/2009 published 3 articles in peer-reviewed journals on: Impact of Immunizations in AI/AN children, Otitis Media rates in AI/AN children. Risk factors for Infant Mortality due to Lower Respiratory Tract Infection Death in US children.
- Testing data exchange of vaccine information between tribal facilities and the State Immunization Information System (VacTrAK).

FUNDING HISTORY

Fiscal Year	Amount
2006	$1,621,000
2007	$1,681,000
2008	$1,733,000
2009 Recovery Act	$0
2009 Omnibus	$1,823,000
2010 Enacted	$1,934,000

BUDGET REQUEST

The FY 2011 budget request for the Hepatitis B and Haemophilus Immunization program is $2,009,000, an increase of $75,000 over the FY 2010 Enacted level. The increase will provide pay increases of $20,000 for tribal employees, inflation of $26,000, and population growth of $29,000.

Given the addition of grant funding made available through research studies conducted by the Hepatitis and Immunization Programs, this program can support the current level of services.

Planned activities for FY 2011 include focused clinical and research activities in persons with chronic hepatitis B infection, and the continuance of clinical and research activities in persons with hepatitis C, nonalcoholic fatty liver disease, autoimmune and other liver diseases.

The Immunization program will continue to be involved with the State Immunization Registry (VacTrAK) rollout and will work with our Tribal partners across the state to contribute data. VacTrAK includes a 2-way exchange of immunization data to improve the accuracy and completeness of immunization records and prevent over-vaccination and missed opportunities to vaccinate.

OUTPUTS

Measure	Most Recent Result*	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Hepatitis Program (Targeted/Known Cases = T and Screened = S)				
Hepatitis Patients **Targeted** for Screening	T=2774	T=2872	T=3000	T=+128
Chronic Hepatitis B Patients **Screened**	S=790 T=1148	S=750 T=1138	S=800 T=1175	S=+50 T=+37
Chronic Hepatitis C Patients **Screened**	S=708 T=1239	S=788 T=1314	S=800 T=1350	S=+12 T=+36
Other Liver Disease Patients **Screened****	S=300 T=387	S=300 T=420	S=325 T=450	S=+25 T=+30
Hepatitis A/B vaccinations***	5000	5000	5000	0
Immunization Program				
2011 Objective: Combined (4:3:1:3:3) Immunization Rates for AI/AN Children Aged 19-35 Months	80%	86%	88%	+2%
2011 Objective: Influenza vaccination rates among adult patients aged >65 years	59%	59%	60%	+1%
2011 Objective: Pneumococcal vaccination rates among adult patients aged 65 years and older	88%	88%	90%	+2%
3-27 month old Alaska Native immunization rates reported:	5,200	5,200	5,200	0
19-35 month olds Imm Audited:	3,100	3,100	3,100	0
11-17 year old Imm. audited	12,000	12,000	12,000	0
65+ year old Imm. audited	8,100	8,400	8,400	0
Program Level Funding ($ in millions)	**$1.8**	**$1.9**	**$2.0**	**+$0.1**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

* Data as of 6/1/09
** Other liver disease includes autoimmune hepatitis, primary biliary cirrhosis, nonalcoholic fatty liver disease and hepatitis of unknown etiology.
*** Includes vaccination of patients at high risk (e.g., injection drug users, other liver disease, hepatitis C and/or HIV infection) and scheduled/routine vaccination of infants, children and adults (number based on births, incidence of hepatitis and estimations).
All data reported is available to the Alaska Native Tribal Health Consortium.

GRANTS AWARDS

The program does not award any grants.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
URBAN INDIAN HEALTH

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$36,189	$0	$43,139	$45,502	+$2,363
FTE	7	0	7	7	0

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization.. IHCIA last authorized in 2000, Snyder and Transfer Acts - Permanent

Allocation Method .... Contracts and grants awarded to Urban Indian Health Organizations

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Urban Indian Health Program (UIHP) was established in 1976 to provide affordable and accessible health care for the underserved urban American Indians/Alaska Natives (AI/AN) population. The IHS provides funding through contracts and grants with 34 urban Indian 501(c)(3) non-profit organizations to provide health care services in 41 sites throughout the U.S. Urban Indian Health Organizations (UIHO) define their Title V, P.L. 94-437, as amended, scope of work and services based upon the documented unmet needs of the urban AI/AN community they serve. Each UIHO is governed by a Board of Directors of whom at least 51% are AI/AN.

UIHOs provide primary medical health care and public health case management wrap-around services for approximately 46,000 urban AI/ANs who do not have access to the resources offered on the reservation. Urban Indian primary care clinics and case management programs provide high quality, culturally accessible, affordable and accountable health services including ambulatory health care, health assessment, health promotion, disease education, child abuse prevention, immunizations, and behavioral health services. UIHOs fulfill IHS data reporting requirements including the IHS GPRA report and the Diabetes Non-Clinical Audit report. All UIHOs fulfill the IHS Strategic Plan. Two programs participate in the IHS Improving Patient Care program.

The 34 UIHOs are categorized based upon the level of services they have the capacity to provide.

There are 21 full ambulatory facilities. A full ambulatory UIHO provides direct medical care to the population served for 40 or more hours per week. The range of services varies greatly among the programs that are defined as full ambulatory. Some full ambulatory programs have two or more full time medical doctors, full time pharmacist, provide lab and radiology services, and have on site dental providers. At the opposite end of the spectrum, some full ambulatory programs

have a full time medical provider on site but do not offer dental, pharmacy, lab or radiology services.

Seven of the 21 full ambulatory programs also receive HRSA 330 funding and are designated HRSA 330 Community Health Centers.

1. South Dakota Urban Indian Health, Inc., Pierre, SD
2. Nebraska Urban Indian Health Coalition, Lincoln, NB
3. Denver Indian Health and Family Services, Denver, CO
4. **First Nations Community Health Source, Albuquerque, NM 330**
5. **Indian Health Board of Minneapolis, Minneapolis, MN 330**
6. Gerald L. Ignace Indian Health Center, Inc., Milwaukee, WI
7. American Indian Health & Family Services of SE Michigan, Detroit, MI
8. Indian Health Board of Billings, Inc., Billings, MT
9. Helena Indian Alliance, Helena, MT
10. Native American Health Center, Oakland, CA
11. San Diego American Indian Health Center, San Diego, CA
12. American Indian Health & Services, Santa Barbara, CA
13. **Indian Health Center of Santa Clara Valley, San Jose, CA 330**
14. Sacramento Urban Indian Health Project, Inc., Sacramento, CA
15. Native Americans for Community Action, Flagstaff, AZ
16. Dallas Inter Tribal Center, Dallas, TX
17. **Hunter Health Clinic, Wichita, KS 330**
18. **Native American Community Health Center, Phoenix, AZ 330**
19. **Native American Rehabilitation Assoc. NW, Portland, OR 330**
20. **Seattle Indian Health Board, Seattle, WA 330**
21. Spokane Urban Indian Health, Spokane, WA

There are 7 limited ambulatory programs. A limited ambulatory facility provides direct medical care to the population served for less than 40 hours per week. The range of direct medical care services provided by limited ambulatory programs varies greatly. These programs have medical providers on-site ranging from 32 hours per week to only 4 hours per week. No limited ambulatory program offers dental, pharmacy, lab, or radiology services on site.

1. American Indian Health Services of Chicago, Inc., Chicago, IL
2. North American Indian Alliance, Butte, MT
3. Native American Center, Inc., Great Falls, MT
4. United American Indian Involvement, Los Angeles, CA
5. United American Indian Involvement/Fresno American Indian Health Project, Fresno, CA
6. Nevada Urban Indians, Inc., Reno, Nevada
7. Indian Walk-In Center, Salt Lake City, Utah

There are 6 Information and Referral programs. Information and Referral programs provide behavioral health counseling and education services, health promotion/disease prevention education, and immunization counseling. These programs do not provide direct medical care services. All Information and Referral programs develop and implement a Memorandum of Understanding with their local health clinics to provide culturally relevant competent health care services for urban AI/AN clients referred to the clinic for medical care.

1. Green Bay, WI (advertising for a new contractor)
2. Missoula Indian Center, Missoula, MT
3. United American Indian Involvement, Bakersfield, CA
4. American Indian Community House, New York, NY
5. North American Indian Center of Boston, Jamaica Plains, MA
6. Tucson Indian Center, Tucson, AZ

The target audience or eligibility for UIHP health care services is defined in the authorizing program legislation. An "Urban Indian" eligible for services, as codified in 25 U.S.C. § 1603(c), (f), (g), includes any individual who:

1) Resides in an urban center, which is any community that has a sufficient urban Indian population with unmet health needs to warrant assistance under Title V, as determined by the Secretary of the Department of Health and Human Services ("HHS"); and who
2) Meets one or more of the following criteria:
   a. Irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including:
      i. those tribes, bands, or groups terminated since 1940, and
      ii. those recognized now or in the future by the State in which they reside; or
   b. Is a descendant, in the 1st or 2nd degree, of any such member described in (A); or
   c. Is an Eskimo or Aleut or other Alaska Native; or
   d. Is the descendant of an Indian who was residing in the State of California on June 1, 1852, so long as the descendant is now living in said State; or[1]
   e. Is considered by the Secretary of the Department of the Interior to be an Indian for any purpose; or
   f. Is determined to be an Indian under regulations pertaining to the Urban Indian Health Program that are promulgated by the Secretary of HHS.

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[1]Eligibility of California Indians may be demonstrated by documentation that the individual:
(1) Holds trust interests in public domain, national forest, or Indian reservation allotments; or
(2) Is listed on the plans for distribution of assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), or is the descendant of such an individual.

Urban programs report on the amounts and purposes for which Title V, P.L. 94-437, as amended, funding is used, including: a) the number of eligible Urban Indians for whom services are provided, and b) the number and type of services provided eligible Urban Indians. Information contained in the 2008 Uniform Data System (UDS) report indicated that the Urban Indian health programs served a population that was 55 percent American Indian. The remaining 45 percent included other minority groups, Medicare/Medicaid eligibles, and others with private insurance and individuals who paid on a sliding-fee scale. The actual percent of each non-Indian group is not available because this information is not gathered through the UDS. UIHOs have policies requiring supporting documentation of the eligibility of a particular individual included in their Title V reports which include: Certificate of Degree of Indian Blood (CDIB), BIA Form 4432, Tribal Membership Card, Tribal Correspondence, Birth Certificate(s) (state seal or certified copy) to establish descendants (first or second degree), Family Documents (e.g., family bible), and Self-Certification.

In FY 2008, the UIHOs effectively implemented the IHS Strategic Plan 2007–2011. Twenty programs were provided circuits and routers and connected to Resource and Patient Management System (RPMS). All 20 programs also participated in RPMS training courses and are implementing RPMS throughout their programs. In May, 2008, one UIHO successfully implemented RPMS/Electronic Health Record (EHR). In FY 2009, one program began EHR implementation. Work is underway to implement EHR in one more UIHO in FY 2010.

The 2008 national measure reporting cycle (July 1, 2007 – June 30, 2008) was successful for the Urban Indian programs. Areas of greatest accomplishment included: (1) 100 percent of the urban programs reported performance measures– 34/34, and (2) 5 programs reported through CRS; 25 reported using 100 percent review of the appropriate data source – 25/34 (as opposed to sampling a smaller percentage of records). The goal is to transition to 100% electronic reporting for the UIHOs utilizing RPMS, and once the data is stabilized, advocate for inclusion in IHS national clinical performance measure reporting.

It is estimated that in FY 2011 all output categories listed, the UIHOs will increase encounters by 2 percent. Encounters fall into seven categories:

- Medical services cover medical services either on-site or off-site for the prevention, diagnosis, treatment and rehabilitation of illness or injury. This category also includes obstetrics and gynecology services.
- Ancillary services cover services provided for lab services, imaging services and pharmacy.
- Dental services cover all dental services for the purpose of prevention, assessment or treatment of a dental problem.
- Health Education services cover the provision of a defined program of health education services either performed on-site or off-site for the purpose of health education and disease prevention. Educational programs include obesity prevention, HIV/AIDS, diabetes, cardiovascular disease prevention, and smoking cessation.
- Nutrition services cover a defined set of nutrition services for the purpose of prevention, assessment, or counseling of a nutritional problem.
- Behavioral Health services cover a defined set of behavioral health services either on-site or off-site for the prevention, assessment, counseling, treatment, or rehabilitation of a psychosocial problem including substance abuse.
- Other services cover allied health (audiology, optometry, podiatry, speech therapy), community health (outreach to patients, assistance with other services), and enabling (transportation, medical records, referral for additional health care services).

Urban programs established partnerships with the U.S. Department of Veterans Affairs (VA). All urban programs have active partnerships with their local VA. They have agreements with the local VA that identify joint program initiatives and program services such as alcohol/substance abuse prevention and treatment, HP/DP, and mental health services.

The Office of Urban Indian Health Program received a program assessment review in 2003, and received an Adequate rating. The review cited program management as a strong attribute of the program. As a result of the review, the program has taken the following actions:

- Baselines and targets have been established through the IHS performance measure process for the OUIHP.
- A workgroup was established and produced a comprehensive report addressing the issues from the 2003 review. The report identified specific action items for complying with the review recommendations. The workgroup was disbanded after completion of the report.

The OUHIP will continue to pursue the mission of raising the health status of the urban AI/AN population.

FUNDING HISTORY

Fiscal Year	Amount
2006	$32,744,000
2007	$33,755,000
2008	$34,547,000
2009 Recovery Act	$0
2009 Omnibus	$36,189,000
2010 Enacted	$43,139,000

BUDGET REQUEST

The FY 2011 budget request for the Office of Urban Indian Health Programs is $45,502,000, an increase of $2,363,000 over the FY 2010 Enacted level. The increase will provide:

Current Services +$1,362,000

Pay Costs +$294,000 – to fund pay increases for Federal and Urban grantees' employees
Inflation +$496,000 – to cover the cost of inflation
Population Growth +$572,000 – for population growth at 1.5 percent

The FY 2011 budget request for the OUIHP will be used to provide quality, culturally-competent health care to the urban AI/AN population. Services include medical, dental, behavioral health, health education, immunizations, and many others. The increases for pay costs, medical inflation, and population growth, will allow the program to continue the provision of health services for urban AI/AN.

Program Increase +$1,000,000

The $1,000,000 program increase will be used for competitive grants to assist urban Indian clinics in improving third party collections. The grants will be used for training, on site technical assistance, and off-site technical assistance via conference calls and webinars.
Additional program support will increase revenue and services for the AI/AN populations served.

Measures and targets have been set for the OUIHP for FY 2010.

- The OUIHP Efficiency Measure relates to $Cost per User per Year. The program established a new baseline for this measure for fiscal year 2008, after implementing the Uniform Data System (UDS) in 2009. The new baseline is: $995 per user. New targets are: FY 2009 $1,045; FY 2010 $1,097; FY 2011 $1,152. There is a one-year data lag in reporting using UDS. The formula for cost per user per year uses the total amount funded, from all sources, divided by the total number of users (AI/AN and non AI/AN). With the increases for pay costs, medical inflation and population growth, and use of other leveraged funding sources, these targets should be met.

- A new measure was added in FY 2009 during improvement actions from the UIHP program assessment (UIHP-7): Number of AI/AN served. The UDS is also utilized to obtain this data. The actual number served for FY 2008 was 45,853 AI/AN clients. The FY 2009 target is set at 46,724 AI/AN clients served, with an increase of 2 percent to 47,611 in FY 2010, and an additional 2 percent increase in FY 2011 to 48,515. With the changing economy, these

targets should be met as more urban AI/AN will likely seek health care services from the UIHOs.

- The Diabetes targets for the UIHOs include Ideal Glycemic Control and Controlled Blood Pressure (<130/80). UIHOs did not meet the 2009 Ideal Glycemic Control target of 39 percent, instead achieving a rate of 36 percent. UIHOs will strive to improve performance as the transition to the RPMS system and utilization of the Clinical Reporting System (CRS) application continues for many of these programs. Targets continue to be ambitious in the face of this transition, with FY 2010 at 38% and FY 2011 at 39%. The Blood Pressure Control measure is derived from the Diabetes Audit with a baseline established in FY 2008 of 28%. This result will be maintained through FY 2011.

- Currently 29 programs are online and operating RPMS or implementing RPMS and training. RPMS is used by all 3 program levels (full ambulatory, limited ambulatory, and the outreach and referral programs). The data/information collected through RPMS is dependent on the level of services provided by the individual programs. All components of RPMS are available to the UIHPs, but only the components needed by each facility (tailor made) are loaded and used.

  The OUIHP provides funding for UIHO program health professionals and staff to attend RPMS training including: Patient Information Management Systems (PIMS) training, PCC data entry, patient registration, third party billing, behavioral health, diabetes, i-Care, and site manager training. Eleven IHS Area Offices' Office of Information Technology (OIT) are funded to: (1) procure and install circuits, hardware, and servers to support urban health programs, and (2) support IT personnel including the business office and health information management office costs in support of urban programs.

It is estimated that in all output categories listed in the table below, the UIHOs will increase encounters by 2 percent. This is keeping in line with the measure for the program increasing AI/AN users by 2 percent for FY 2011.

The UIHOs have been very successful in leveraging their IHS funding through the contracts and grants. In addition, many programs are increasing funding by receiving 330 funding from HRSA to become Community Health Centers; working with SAMHSA for funding of behavioral health projects; and the CDC for disease prevention.

The level of services supported by this request is an increase of 5 percent from the previous year. The UIHOs will continue to report on national performance measures, with the future goal of inclusion in IHS-All national performance reporting; implement and utilize RPMS and EHR; and continue to provide quality health services to the urban Indian population.

OUTCOMES

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
UIHP-E: Cost per service user in dollars per year. *(Efficiency)*	FY 2008: $995 (Target Not Met)	$1097	$1152	+$55
UIHP-1: Percent decrease in years of potential life lost. *(Outcome)*[1]	FY 2003: 51.7 (Baseline)	N/A	N/A	N/A
UIHP-2: Percent of AI/AN patients with diagnosed diabetes served by urban health programs that achieve ideal blood sugar control. *(Outcome)*	FY 2009: 36% (Target Not Met)	38%	39%	+1%

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
UIHP-3: Proportion of children, ages 2-5 years, with a BMI of 95 percent or higher. *(Outcome)*[2]	FY 2009: 20%	Baseline	N/A	N/A
UIHP-6: Increase the number of diabetic AI/ANs that achieve ideal blood pressure control. *(Outcome)*[3]	FY 2008: 28% (Baseline)	28%	28%	0%
UIHP-7: Number of AI/ANs served at Urban Indian Clinics. *(Outcome)*	FY 2008: 45,853 (Baseline)	47,611	48,515	+904
Program Level Funding ($ in millions)	**$36.1**	**$43.1**	**$45.5**	**+$2.4**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

[1]*Long-term measure, baseline for 2003 to be reported in 2009 after which a target will be set for 2009*

[2]*Long-term measure, reportable in 2010 and 2013.*

[3]*Baseline set in 2008, result will be available September 2009.*

OUTPUTS

Measure	Most Recent Results*	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Medical Encounters	233,519	242,953	247,812	+4,859
Ancillary Encounters	193,468	201,325	205,351	+4,026
Dental Encounters	53,496	55,657	56,770	+1,113
Health Education Encounters	45,386	47,220	48,164	+944
Nutrition Encounters	85,267	88,711	90,485	+1,774
Behavioral Health Encounters	151,531	157,653	160,806	+3,153
Other Encounters	167,588	174,359	177,846	+3,487
Program Level Funding ($ in millions)	**$36.1**	**$43.1**	**$45.5**	**+2.4**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

*FY 2009 results will be available September 2010.

GRANTS AWARDS TABLES

	FY 2009	FY 2010	FY 2011
Number of Awards	33	33	33
Average Award	$226,983	$226,983	$230,388
Range of Awards	$119,424-$603,311	$119,424-$603,311	$119,424-$603,311

Grant Awards -- Funding for the Urban Indian health programs for FY 2009 came from the FY 2009 appropriations for both the grants and contracts awarded to the programs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
INDIAN HEALTH PROFESSIONS

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$37,500	$0	$40,743	$41,413	+$670
FTE	18	0	18	18	0

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization... IHCIA last authorized in 2000, Snyder and Transfer Acts - Permanent

Allocation Method .... Direct Federal, Grants and Contracts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Congress enacted the Indian Health Care Improvement Act (IHCIA) P.L. 94-437 as amended, which authorizes the Indian Health Service (IHS) Indian Health Professions (IHP) to manage the Scholarship Program, Loan Repayment Program, health professions training related grants, and recruitment and retention activities for IHS. The IHS made their first Scholarship Program awards in 1978 because Congress had not appropriated funds for the IHP program until 1978.

The purpose of the IHP program is:

- To enable American Indians and Alaska Natives to enter the health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs;
- To serve as a catalyst to the development of Indian communities by providing educational opportunities and enabling American Indian and Alaska Native (AI/AN) health care professionals to further Indian self-determination in the delivery of health care;
- To develop and maintain American Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental health field; and
- To assist Indian health programs to recruit and retain qualified health professionals.

Scholarship Program (Sections 103 and 104) – In fiscal year (FY) 1979, the Scholarship Program started with three programs. The Preparatory and Pre-Graduate Scholarship Programs, Section 103, prepare students to enter a health profession training program. The Preparatory Scholarship Program provides financial assistance for AI/AN students (federally or state-recognized) who enroll in compensatory or preparatory courses leading to entry into a health professional school such as nursing, pharmacy and others. The Pre-Graduate Scholarship Program provides financial support for AI/AN students (federally or state-recognized) who enroll in courses leading to a bachelor's degree in specific pre-professional areas such as pre-medicine, pre-dentistry, pre-podiatry, pre-optometry and others as needed by Indian health programs.

The third scholarship program, the Health Professions Scholarship Program, Section 104, provides financial support for AI/AN students (federally recognized only) who are enrolled in health professions or allied health professions programs. Students incur service obligations and payback requirements on acceptance of funding from this program. Graduate students and junior- and senior-level students have priority unless otherwise specified.

In support of Tribal consultation, the IHS receives a recommended priority list from Tribal health programs that assist the Agency in determining discipline priorities. The FY 2009 priorities consisted of 27 health professions, including physicians, nurses, pharmacists and dentists.

The IHS Scholarship Program made 2,536 scholarship awards between FY 2004 and FY 2009 averaging 423 awards per year. In FY 2009, 320 scholarships were awarded for school year 2009-2010. A total of 1,681 new applications were received with 128 new scholarships being funded. An additional 192 continuing scholarship students (students previously receiving the IHS scholarship) were awarded continuing scholarship support.

The cost of health professions education continues to increase. According to Bureau of Labor Statistics data from 2008, tuition and fee costs are expected to increase over 7 percent annually. The average cost per IHS scholar including tuition, fees, monthly stipend and other school related costs was $40,799 in FY 2009.

Eighty-seven percent of the scholarships went to students in the Health Professions Scholarship Program. These students received a total of 252 scholarships (89 new and 163 continuing). Ten percent or 30 scholarships (21 new and 9 continuing) went to students in Health Professions Preparatory Scholarship Program and twelve percent or 38 scholarships (18 new and 20 continuing) went to students in Health Professions Pre-Graduate Program. The following disciplines were awarded during FY 2009 for the 2009-10 school year:

Section 103 Preparatory - 30 students				
Pre-Pharmacy	12		Pre- Medical Technology	1
Pre-Nursing	11		Pre-Occupational Therapy	1
Pre- Clinical Psychology	2		Pre- Social Work	1
Pre- Physical Therapy	2			
Section 103 Pre-Graduate - 38 students				
Pre-Medicine	21		Pre-Optometry	1
Pre-Dentistry	15		Pre-Podiatry	1
Section 104 Professional - 252 students				
Physician (DO and MD)	64		Dental Hygienist	3
Nurse (ADN, BS and MS)	51		Dietitian	3
Pharmacist	41		Occupational Therapist	2
Dentist	24		Chemical Abuse Counseling	1
Physical Therapist	10		Health Care Administration	1
Physician Assistant	9		Health Education	1
Clinical Psychologist	7		Health Records	1
Optometrist	7		Nurse Anesthetist	1
Nurse Practitioner	5		Podiatrist	1
X-Ray Technology	5		Respiratory Therapist	1
Engineer	4		Sanitarian	1
Medical Technology	4		Women's Health Nursing	1
Social Work	4			

In FY 2009, a total of 82 Health Professions Scholarship Program, Section 104, students graduated from their health professions school or completed their training program.

Health Professions (Section 104) Graduating/Completing Training-82 students				
Nurse (ADN, BS and MS)	30		Health Care Administration	2
Physician (DO and MD)	11		Dietitian	1
Pharmacist	8		Health Educator	1
Dentist	8		Medical Technology	1
Clinical/Counseling Psychologists	5		Occupational Therapy	1
Physical Therapist	5		Optometrist	1
Physician Assistant	4		Sanitarian	1
Social Work	3			

Some health professional disciplines including physicians, chemical dependency counselors, clinical psychologists, social workers and dietitians require additional post graduate clinical training before they can become independent licensed practitioners. For other disciplines post graduate training, while not required, is considered to improve clinical skills and knowledge (e.g., pharmacists and optometrists). Individuals in these disciplines may request a deferment of their scholarship service obligation until they complete their post graduate clinical training. Physician deferments are limited to primary care specialty residencies and one fellowship:

Specialties for Deferment	**Deferment Period**
Physician - Emergency Medicine	3 Years
Family Medicine	3 Years
General Pediatrics	3 Years
Obstetrics and Gynecology	4 Years
General Psychiatry	4 Years
Internal Medicine/Pediatrics	4 Years
Internal Medicine/Family Practice	4 Years
Anesthesiology	5 Years
General Surgery	5 Years
Trauma-Critical Care (Fellowship)	2 Years
Chemical Dependency Counselor	2 Years
Clinical Psychologist	2 Years
Social Worker	2 Years
Dietitian	1 Year
Optometrist	1 Year
Pharmacist	1 Year

In FY 2009, there were 74 health professionals on deferment. An additional 22 health professionals on deferment completed their residencies/training.

Health Professions (Section 104) Graduates Deferment Status		
Discipline	In Deferment	Completed Deferment
Physician	60	22
Chemical Dependency Counselor	0	0
Clinical Psychologist	0	0
Social Worker	7	0
Dietitian	7	0
Pharmacist	0	0

The FY 2009 IHS Scholarship Program accomplishments included:

- Utilized print, radio and web media to provide information about the IHS Scholarship Program to high school and college students and their parents;

- Updated design for the scholarship website including: the enhancement of the online scholarship application to include applications for both New and Continuation scholars; addition of Frequently Asked Questions section; addition of links to federal forms (e.g., W-4 form at www.irs.gov); and, updated Area Scholarship Coordinator links. Enhanced monitoring/reporting ability, as well as, tools for statistical analysis of applicant data;
- Provided training to Area Scholarship Coordinators on how to use the electronic application and how to assist scholarship applicants using the new online system;
- Evaluated 1,681 new scholarship application (1,002 electronic and 679 paper applications);
- Worked with the Unified Financial Management System staff and contractor to assure timely payments to students;
- Recorded a three-part IHS Scholarship Orientation Series provided to all current scholars in school and in deferment detailing the requirements for students in school, in deferment and in service; and
- Updated a series of Scholarship Program electronic newsletters. The newsletters included information for past unfunded applicants with assistive information for successful re-application; welcome newsletters for new scholarship students reminding them of communication deadlines and other requirements; and newsletters to students preparing to graduate reminding them about placement/service requirements.

Extern Program (Section 105) **-** The Extern Program is designed to give IHS scholars and other health professions students the opportunity to gain clinical experience with IHS and Tribal health professionals in their chosen discipline. The program also allows students the opportunity to work at sites they may want to apply to for employment after they complete their health professions training. This program is open to scholars and non-scholars. Students are employed up to 120 days annually, with most students working during the summer months. In FY 2009, the Extern Program funded a total of 146 health professions, pre-graduate and preparatory students. A total of 112 (or 76 percent) were health professions students, 5 (or 3 percent) were pre-graduate students and 29 (or 20 percent) were preparatory students. The following health disciplines were funded in FY 2009:

Preparatory – 29 students				
Pre-Nursing	14		Pre-Engineering	1
Pre-Pharmacy	5		Pre-physician Assistant	1
Pre-Dietitian	2		Other	4
Pre-Physical Therapy	2			
Pre-Graduate - 5 students				
Pre-Medicine	4		Pre-Dental	1
Health Professions - 112 students				
Nurse (ADN, BS and MS)	43		Engineer	3
Pharmacist	20		Master Public Health (Epi)	3
Psychologist	6		Medical Technology	3
Health Care Administration	6		X-Ray Technology	3
Dental Hygienist	4		Chemical Abuse Counseling	2
Health Education	4		Sanitarian	2
Physician (DO and MD)	4		Dietitian	1
Physical Therapist	4		Health Records	1
Dentist	3			

Loan Repayment Program (Section 108) – The IHS Loan Repayment Program (LRP) offers health care professionals the opportunity to ease qualified health professions related student loan debts and help Indian health programs meet the staffing needs of high priority sites. Applicants

agree to serve two years at an Indian health program in exchange for up to $20,000 per year in loan repayment funding and up to an additional $4,000 per year to offset the tax liability. Loan repayment recipients with more than $40,000 in loan debt can extend their initial two year contract on an annual basis and receive up to an additional $20,000 per year, plus up to $4,000 for taxes, until their original loan debt is paid. For many health disciplines (e.g., physician, dentist, podiatrist, and optometrist), the average applicant's loan debt exceeds $140,000 (requiring more than 7 years of loan repayment support).

In FY 2009, the LRP had a total of 917 health care professionals who requested loan repayment funding. The LRP made a total of 623 loan repayment awards totalling $23,828,249. There were 426 new two-year contracts and 197 one-year extensions of existing loan repayment contracts. This dollar amount includes the additional $5 million for the LRP added in FY 2008, $4,981,727 from IHS Hospitals and Clinics funding, and additional funding provided by programs and supplemental funding provided by sites (a federally managed hospital or clinic provides funding to the LRP to cover the cost of a loan repayment contract to assure eligible applicants that they will receive loan repayment if the health professional accepts a position at that site).

Not all health care professionals who applied for loan repayment could be funded. A total of 293 health care professionals applying for loan repayment did not receive funding in FY 2009. A total of 181 of these health professionals work in Indian health programs (see Matched Not Awarded column below). Of the 623 LRP awards in FY 2009, 335 went to federal employees (198 to civil service and 137 to Commissioned Corps officers), 284 to tribal employees and 4 employees of urban Indian programs. In FY 2009, the IHS LRP made loan repayment awards to the following disciplines:

Awards by Profession	**Total Awards**	**New Awards**	**Contract Extensions**	**Matched Not Awarded**
Nurses	121	115	6	97
Dental*	116	58	58	1
Pharmacists	97	63	34	25
Physicians	92	53	39	0
PA/APN	65	50	15	34
Behavioral Health	40	28	12	0
Optometrists	25	13	12	5
Podiatrists	16	3	13	0
Rehabilitative Services	15	10	5	4
Other Professions **	39	36	3	15
TOTAL	623	427	196	181

* Includes Dentists and Dental Hygienists

**** Other Professions**	**Total Awards**	**Matched Not Awarded**
X-Ray Technician	10	5
Dietician	9	5
Medical Technician	8	0
Engineer	7	4
Sanitarian	4	1
Respiratory Therapist	1	0
Chiropractor	1	0
TOTAL	40	15

By Pay System	**Awards**
Tribal Employees	284
Civil Service	198
Commissioned Corps	137
Urban Health Employees	4
Total	623

The FY 2009 IHS Loan Repayment Program accomplishments included:

- Developed a new LRP poster for use in high schools and colleges;
- Published a new LRP Application Handbook;
- Completed redesign of the loan repayment website (www.loanrepayment.ihs.gov);
- In preparation for the FY 2009 loan repayment cycle (with applications being accepted starting in October 2008 and loan repayment awards starting January 2009), the LRP updated many materials, including marketing materials and a LRP recruitment packet; and
- Sent each LRP recipient a LRP Recipient Handbook, Policy and Procedure Update and an electronic newsletter to keep them updated about the LRP and the program requirements.

Recruitment and Retention – The IHS continues to support the recruitment and retention efforts and development of health professionals in critical health professional shortage areas.

While most health professionals are recruited to work in full-time positions, some health professionals provided temporary service to IHS facilities through several mechanisms such as direct employment into temporary positions, direct contracting with various facilities, working with contract locum tenens companies, and volunteering their services for various periods of time.

The IHS utilizes recruiters for physicians, nurses, dentists, pharmacists and other health professions. In addition, many health professional staff members assist in recruitment activities by visiting professional schools, attending professional meetings as IHS representatives, and acting as preceptors and mentors for health professions students who come to their facilities as part of their educational training.

In FY 2009, the Health Professions Support Branch (HPSB) accomplishments included:

- Developed a physician multi-resource online recruitment enterprise (MORE) to allow physicians to submit contact information, resumes and other materials directly to recruiters;
- Completed the physician recruitment website;
- Added a pharmacist recruiter and joint IHS and Office of Commissioned Personnel recruiter;
- Updated recruitment and marketing materials;
- Advertise in professional journals and on recruitment websites;
- Work with IHS Human Resources staff and with the Office of Commissioned Corps Operations (OCCO) to identify ways to shorten the time required to hire new health professions staff (in both civil service and Commissioned Corps);
- Attended health career fairs at colleges and high schools; and
- Sent recruitment related direct mailings to student health professionals.

Currently, vacancy rates and total number of vacancies for key health disciplines continue to remain high even when compared to Federally Funded Health Centers.

Profession	Federally Funded Health Centers (2007)[1]	IHS Vacancy Rate (12/2009)	IHS Total Vacancies (12/2009)
Dentist	18.3%	15%	55
Nurse	10.4%	16%	513
Physician	13.3%	25%	280
Optometrist	No Data Available	8%	9
Pharmacist	10.7%	11%	70

1. WWAMI Rural Health Research Center, University of Washington, Nevada Office of Rural Health Recruitment and Retention Symposium, Las Vegas, NV; Jan 10, 2007.

The scholarship and loan repayment programs are unable to provide enough health care professionals to reduce the substantial vacancy rates, but they do continue to have a major impact on meeting the staffing needs of hard to fill sites.

Grant Programs - The IHP administers three grant programs which provide health professions training funding to colleges and universities: the Indians Into Nursing (Section 112); Indians Into Medicine (Section 114); and Indians Into Psychology (Section 217).

The Quentin N. Burdick American Indians into Nursing Program, Section 112, helps to increase the number of nurses, nurse midwives, nurse anesthetists, and nurse practitioners who deliver health care services to Indians.

In FY 2009, grantees:

- Interacted with pre-nursing and nursing Indian students through professional development workshops, health career forums, and other activities; and
- Directly supporting AI/AN nursing students.

The Indians into Medicine (INMED) Program, Section 114, encourages and assists Indian students preparing for a career in healthcare. The outreach goal to tribal communities is to provide greater exposure to careers in healthcare, providing academic support for students through tutoring and career counseling, assisting with financial aid and scholarship applications, and offering summer educational sessions.

In FY 2009, grantees:

- Interacted with Indian students through professional development workshops, health career forums, and other activities;
- Conducted site visits to tribes to identify potential health professions students, worked with health career clubs at Indian schools, and provided workshops in tribal communities to discuss health issues;
- Provided travel grants to high-school and undergraduate students to assist them in attending health profession and Indian health conferences; and
- Hosted a series of other programs that included a Summer Institute to expose students to advanced math and science, a Pathway Program to ease the transition between community college and the university, and MCAT Prep classes.

The American Indians into Psychology (INPSYCH) Program, Section 217, increases psychological services provided to Indian communities. The goal is to outreach to tribal communities in order to provide greater exposure to the field of psychology, providing stipends to undergraduate and graduate students pursuing careers in psychology, and establishing training opportunities for psychology graduate students within tribal communities.

In FY 2009, grantees:

- Supported undergraduate and graduate psychology students;
- Supported students working in tribal mental health facilities; and
- Conducted school visits to identify potential students and provide workshops in tribal communities to discuss health issues.

The projected allocation for the Indian Health Professions (IHP) program in FY 2011 is:

Section	Title	Amount	Expected Outcome
103	Health Professions Preparatory and Pre-Graduate Scholarships	$3,139,560	52 continuing and 20 new contracts
104	Health Professions Scholarship	$12,626,281	190 continuing and 58 new contracts
105	Extern Program	$1,181,932	135 temporary clinical assignments
108	Loan Repayment Program	$20,867,964	540 contract extensions and 121 new contracts.
112	Quentin N. Burdick American Indians Into Nursing Program	$1,713,624	5 grants
114	Indians into Medicine (INMED) Program	$1,126,253	2 grants
217	American Indians Into Psychology Program	$757,386	3 grants
	TOTAL	**$41,413,000**	

FUNDING HISTORY

Fiscal Year	Amount
2006	$31,039,000
2007	$31,375,000
2008	$36,291,000
2009 Recovery Act	$0
2009 Omnibus	$37,500,000
2010 Enacted	$40,743,000

BUDGET REQUEST

The FY 2011 budget request for Indian Health Professions (IHP) is $41,413,000, an increase of $670,000 over the FY 2010 Enacted level. This increase represents $670,000 for pay increases and non-medical inflation. Recruiting needed health care providers is a critical component of the Administration's commitment to expanding access to health care services and improving the health outcomes for AI/ANs. The Scholarship and Loan Repayment Programs are the most effective tools IHS has for recruiting and retaining health care professionals. The increase requested will make a significant investment in reducing provider vacancies and developing a pipeline of qualified candidates to serve in IHS. The ability to hire federal and Tribal staff will reduce the cost of care provided through more expensive locum tenens providers and temporary contractors.

Scholarship Program
In FY 2011, the scholarship budget of $15,765,841 remains the same as the FY 2010 Budget of $15,765,841. Administrative costs are expected to be approximately $750,000 (divided equally between continuing Sections 103 and 104) leaving $15,015,841 available for scholarship awards.

The FY 2011 priority funding includes the current scholarship recipients as well as the Section 104 scholars. The IHS Scholarship Program anticipates funding the Section 103 program at $3,139,560, the same amount as the FY 2010 budget. Available funding for Section 103 scholarship awards will be $2,764,560 (total Section 103 budget of $3,139,560 minus $375,000 in administrative costs) to include 52 continuation awards for Section 103 scholars at a cost of $2,002,000 and 20 new awards at a cost of approximately $762,560 (average cost estimated for a Section 103 award in FY 2011 is expected to be $38,500). The IHS Scholarship Program

anticipates funding the Section 104 program at $12,626,281, the same as the FY 2010 budget. Available funding for Section 104 scholarship awards will be $12,251,281 (total Section 104 budget of $12,626,281 minus $375,000 in administrative costs) to include approximately 190 continuation awards for Section 104 scholars at a cost of $9,405,000 and approximately 58 new awards at a cost of $2,846,281 (average cost estimated for a Section 104 award in FY 2011 is expected to be $49,500).

According to the Bureau of Labor Statistics in 2008, college tuition costs have increased an average of 7.7 percent annually for each of the last 5 years. The increased cost of a college education affects the number of scholarships IHS is able to award**.**

Loan Repayment Program

The FY 2011 LRP budget from IHP funding is $20,867,964, an increase of $670,000 from FY 2010 budget of $20,197,964. The approximate administrative cost of $961,533 leaves approximately $19,906,431 available for extension of current loan repayment contracts and new awards.

IHS anticipates approximately 540 requests for LRP contract extensions in FY 2011 (determined by counting all new FY 2008 two year contracts with more than a $20,000 loan balance and FY 2009 two year contracts with any remaining loan balance). At an anticipated LRP one-year contract cost of $25,023 in FY 2010 and $25,481 in FY 2011, the anticipated 540 contract extension requests will cost approximately $13,759,740. This would leave approximately $6,146,691 for approximately 121 new LRP two-year contract awards (at an average cost for a two-year contract in FY 2011 anticipated to be $50,964).

The above LRP funding and awards does not include the anticipated $4,981,727 in FY 2011 Hospitals and Clinics funding allocated annually for LRP. If this funding continues, it is anticipated that an additional 98 new two year LRP contract will be able to be awarded in FY 2011.

Extern Program

The Extern Program, Section 105, receives $1,181,932 in the FY 2010 budget and remains unchanged in FY 2011. This funding would provide approximately 135 summer externships (at an average cost of approximately $8,762). This budget provides for student externships for scholarship recipients and other health professions students to work at IHS and Tribal sites during non-academic periods.

Quentin N. Burdick American Indians Into Nursing Program

The Indians Into Nursing program, Section 112, receives $1,713,624 in the FY 2010 budget and remains unchanged in FY 2011.

Indians Into Medicine (INMED) Program

The Indians Into Medicine program, Section 114, receives $1,126,253 in the FY 2010 budget and remains unchanged in FY 2011.

American Indians Into Psychology (INPSYCH) Program

The Indians Into Psychology program, Section 217, receives $757,386 in the FY 2010 budget and remains unchanged in FY 2011.

OUTCOMES

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
42: Scholarships: Proportion of Health Professionals Scholarship recipients placed in Indian health settings within 90 days of graduation.	FY 2009: 67% (Target Not Met)	69%	75%	78%	+3%
Program Level Funding ($ in millions)	**$36.3**	**$37.5**	**$40.7**	**$41.413**	**+$0.67**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**	**$0**

The performance goal refers to placement of scholars within 90 days of completion of their health professions degree or training. The IHP works with scholars, discipline chiefs and sites to assist in the placement of available scholarship recipients in Indian health facilities, i.e., hospitals and clinics.

The IHS Scholarship Program's goal is to increase the 90 day placement rate by 3 percent (from 75 percent in FY 2010 to 78 percent in FY 2011) for new scholarship graduates and scholars completing training. While the Scholarship Program did not meet their performance measure in FY 2009 due to delays in licensure by some professionals, especially nurses, program performance continues to improve, as demonstrated by a 47 percent overall increase in the 90-day placement rate from FY 2004 to FY 2009. Increased efficiency in placing health profession scholarship recipients can and will help improve the health care delivery system at Indian health facilities and the workload the health professional contributes towards the accomplishment of clinical and preventive health services.

OUTPUTS

Measure	Most Recent Result (FY 2009)	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Number of Scholarship Awards – Total				
Section 103	30	30	30	0
Section 103P	38	33	42	9
Section 104	252	285	248	(37)
Number of Externs (Section 105)	146	135	135	0
Number of Loan Repayments Awarded – Total (Section 108)b/				
New Awards (2 Year Awards)	196	176	238a/	62
Contract Extensions (1 Year Awards)	427	430	540	110
Continuation Awards (Funded in Previous Fiscal Year)	382	196	176	(20)
Number of Grants Awarded – Total (see Below)	10	10	10	0
Program Level Funding ($ in millions)	**$37.5**	**$40.743**	**$41.413**	**$0.67**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

a/ The $5 million program increase for the Loan Repayment Program in FY 2009 (an increase starting in FY 2008) allowed for approximately 116 new two year awards but will also increase the number of extension awards in FY 2011.
b/ Loan repayment figures do not show data from non-IHP funding ($4,981,727 in H&C funding - 98 new two year awards anticipated in FY 2011).

GRANTS AWARDS

	FY 2008	FY 2009	FY 2010	FY 2011
Indians into Nursing (Section 112)				
Number of Awards	5	5	5	5
Average Award	$350,000	$337,000	$337,000	$337,000
Range of Awards	$264,000-$360,000	$300,000-$350,000	$300,000-$350,000	$300,000-$350,000
Indians Into Medicine (Section 114)				
Number of Awards	2	2	2	2
Average Award	$514,125	$514,125	$514,125	$514,125
Range of Awards	$300,000-$728,250	$300,000-$728,250	$300,000-$728,250	$300,000-$728,250
Indians Into Psychology (Section 217)				
Number of Awards	3	3	3	3
Average Award	$246,000	$247,333	$250,000	$250,000
Range of Awards	$246,000	$246,000-$250,000	$250,000	$250,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
TRIBAL MANAGEMENT GRANT PROGRAM

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$2,586	$0	$2,586	$2,669	+$83
FTE	0	0	0	0	+0

Authorizing Legislation .... 25 U.S.C. 450, Self-Determination and Education Assistance Act, as amended

FY 2011 Authorization..Permanent

Allocation Method .... Discretionary competitive grants to Tribes and Tribal organizations

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Tribal Management grant funds have been made available to tribes since 1976, with the initial passage of the Indian Self-Determination and Education Assistance Act, (ISDEAA) P.L. 93-638 and as amended, August 18, 2000. A Tribal Management Grant (TMG) award provides a Tribe the opportunity to assess, plan, or improve its capacity to assume Programs, Services, Functions and Activities (PSFA) of the IHS if it so chooses.

The TMG Program is a national competitive grant program that awards grants annually to Federally-recognized Tribes and qualified Tribal Organizations. The TMG Program began shortly after passage of P.L. 93-638. Tribes and Tribal Organizations utilize TMG funding to enhance their management capabilities through such projects as conducting health program related feasibility studies; development of Tribal specific health plans; Tribal health program operation evaluation; the development or improvement of Tribal health management structures such as establishing Tribal health boards and improving Tribal financial management systems to assist them in assuming all or part of existing Indian Health Service (IHS) programs, services, functions, or activities. All of these activities improve the management capacity of Tribes to take on additional PSFA provided by the IHS. The IHS distributes the total appropriated amount into two parts – grant awards and program operations.

There are approximately 224 Tribes that are currently Title I contractors and 322 Tribes that are Title V compactors of a total 562 Federally-recognized Tribes. The Title I Tribal contractors include a number of those Tribes directly served by federally-operated health service facilities that have made a decision to contract for funds to operate such IHS programs as alcohol and substance abuse, community health representative, emergency medical service, and other support and ancillary programs. These Title I contractors, many of whom consider themselves as direct service tribes (DST) have chosen not to compact all PSFA of the IHS. Other Title I Tribal contractors continue to pursue additional PSFA as their capacity grows and may eventually transition to Title V compact status. Title I contractors are those tribes that contracted PSFA

under P.L. 93-638 ISDEAA and Title V compactors are those tribes that have compacted PSFA under Title II of P.L. 103-413 Self Governance to redesign and reallocate funds to meet tribal health priorities and needs.

Tribes and Tribal organizations continually work to improve the quality of health care provided to their communities by achieving and maintaining not only Federal standards/regulatory requirements but also applicable health care accreditations. Specific outcomes, as a result, of feasibility studies, evaluation studies and management infrastructure grants are:

- The establishment of Tribal Health Boards which serve as health advisory committees to Tribal Councils;
- Training of Health Boards;
- Through Tribal health board initiatives and recommendations Tribal leaders are prepared to meet their communities' health needs;
- Tribal leaders also ensure compliance through implementation of policy and procedure manuals in key areas such as quality assurance, medical records, and information technology systems.

The TMG program provides an opportunity for Tribes to evaluate Federal programs and plan for the possibility of assuming operational control of a Federal program by contracting under the provisions of the ISDEAA. However, it must be recognized that the award of a self-determination contract or compact in and of itself should not be regarded as a measure of success of the TMG program. The Federal policy of self-determination recognizes the rights of Tribes to make a decision to contract to operate a Federal program or to decide to continue to have the Federal government administer a program on its behalf. This is the hallmark of a TMG award in that it provides a Tribe the opportunity to assess, plan, or improve its capacity to assume PSFA of the IHS if it so chooses. A Tribe then can make informed choices based upon the use of the TMG award to (1) build its capacity to take over PSFA of the IHS or (2) to improve the current capability to administer or manage those PSFA it is currently responsible for and not contract additional PSFA in order to eventually compact.

This grant program is highly competitive and over time has resulted in a greater focus from the TMG program office to provide training sessions to assist Tribes (including previous applicants not selected for funding) to prepare their grant proposals for a more competitive submission and environment.

With the conversion to electronic submission of grant applications on www.grants.gov in 2005, the IHS anticipated that the tribal entities would be submitting fewer applications until knowledge of the electronic application process and experience in electronic submission increased to a comfortable level. The drop in numbers in the output table adequately reflects and captures the higher submission of paper applications in 2004 and 2005. In 2005, paper and electronic applications were accepted. In FY 2006, electronic submission was deemed mandatory by IHS. Training and technical assistance was provided by IHS to meet this need. However, the decrease in submissions is evident in the output table for years FY 2006, 2007 and 2008. It is anticipated that as the comfort level and familiarity increase for electronic submission that the numbers will gradually increase.

The award amounts and number of grants awarded by the TMG program varies annually based on the type of grant applications received and determined fundable. Grants are awarded for single year or multi-year projects dependent upon the number, dollar amounts and type of fundable

applications. New grant awards are awarded each year after the multi-year non-competing continuation award funds are set aside for the previous year's multi-year grants.

FUNDING HISTORY

Fiscal Year	Amount
2006	$2,394,000
2007	$2,438,000
2008	$2,490,000
2009 Recovery Act	$0
2009 Omnibus	$2,586,000
2010 Enacted	$2,586,000

BUDGET REQUEST

The FY 2011 budget request for the Tribal Management Grant Program is $2,669,000, an increase of $83,000 over the FY 2010 Enacted. The increase will cover inflation for multiyear grants and awards (one to two new awards depending on type of grant project selected).

OUTPUTS TABLE

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011+/- FY 2010
Feasibility Studies	4	2	3	+1
Planning Grants	2	2	2	0
Evaluation Studies	1	2	2	0
Management Structure – (Capacity Building and Developmental) Includes Continuations	23	24	25	+1
Program Level Funding ($ in millions)	**$2.6**	**$2.6**	**$2.7**	**+$0.1**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

1/ TMG is not required to submit actual performance targets

The above table consists of the current 4 components of the Tribal Management Grant Program. The Management Structure (capacity-building and developmental) component of the Tribal Management Grant Program varies in the number of awards based on the inclusion of non-competing continuations along with new awards. Management structure allows for the enhancement and development of infrastructure such as management and accounting systems; electronic health records development, conversion, and recordkeeping; and accreditation to meet the standards of either the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the Accreditation Association for Ambulatory Health Care (AAAHC). These grants also assist Tribal organizations in correcting deficiencies in their management and internal control and financial and accounting systems revealed by the single audit act – OMB Circular A-133 Audits of States, Local Governments and Non-Profit Organizations.

GRANTS AWARDS TABLES

	FY 2009	FY 2010	FY 2011
Number of Awards[1]	30	30	32
Average Award	$82,867	$82,867	$84,125
Range of Awards	$25,000 - $149,289	$50,000 - $100,000	$50,000 - $100,000

[1] Includes partial awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
DIRECT OPERATIONS

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011 +/- FY 2010 Appropriation
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	
BA	$65,345	$0	$68,720	$69,845	+$1,125
FTE	327	0	335	335	0

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization... IHCIA last authorized in 2000, Snyder and Transfer Acts - Permanent

Allocation Method ....Direct Federal, P.L. 93-638 Self-Determination Contracts, Grants, and Self-Governance Compacts, Competitive Grants

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Indian Health Service (IHS) Headquarters provides leadership, oversight, and executive direction to 12 regional offices to ensure that comprehensive health care services are provided to American Indians/Alaska Natives (AI/ANs). In addition, Headquarters actively administers the Agency's accomplishment of the HHS goals and activities, while simultaneously maintaining the special Tribal-Federal relationship based in treaty and law.

The Headquarters operations are set forth by statute and administrative requirements by the Department of Health and Human Services (DHHS), the Administration, Congress, and field operations, i.e., 12 Area Offices and 163 Service Units. Headquarters actively works with the DHHS to formulate and implement national health care priorities, goals, and objectives. The IHS Headquarters continues to work with the Department to formulate a budget and necessary legislation. In addition, it responds to congressional inquiries, and interacts with other governmental entities to enhance and support health services for Indian people. The IHS headquarters also formulates policy and distributes resources; provides general program direction and oversight for IHS Areas and Service Units; provides technical expertise to all components of the Indian health system, which includes IHS direct, Tribally operated programs, and urban Indian health programs (I/T/U); maintains national statistics; identifies trends; and projects future needs.

The 12 Area Offices distribute resources, monitor and evaluate the full range of comprehensive health care and community oriented public health programs, and provide technical support to IHS direct and Tribally-operated programs. They ensure the delivery of quality health care through the 163 Service Units and participate in the development and demonstration of alternative means and techniques of health services management and delivery to promote the optimal provision of health services to Indian people through the Indian health system.

The budget funds Headquarters and 12 Area offices operations, and Tribal shares (as indicated by the table below).

	FY 2009 Omnibus	FY 2010 Enacted	FY 2011 Pres. Budget
Headquarters (56.5%)	$36,413,491	$38,826,800	$39,462,425
Title I Contracts (non-add)	*1,960,802*	*2,062,075*	*2,095,833*
Title V Compacts (non-add)	*5,535,116*	*5,820,999*	*5,916,293*
Area Offices (12) (43.5%)	28,931,509	29,893,200	30,382,575
Title I Contracts (non-add)	*832,267*	*875,253*	*889,582*
Title V Compacts (non-add)	*8,459,679*	*8,896,612*	*9,042,256*
BA	**$65,345,000**	**$68,720,000**	**$69,845,000**

The Direct Operations budget supports the leadership and overall management of the IHS to ensure effective support for the IHS mission. This includes oversight of financial, human, facilities, information and support resources and systems. Performance measurement is built into all oversight measures, both in program delivery and administrative support systems.

Leadership and direction also includes specific focus on the HHS Performance Objectives. For FY 2011, IHS activities will continue to focus on performance measures and program assessment performance objectives.

Significant activities include the establishment of performance plans that cascade throughout the agency and provide for performance accountability at all levels of the agency. The Direct Operations budget also supports leadership and oversight for the accomplishment of the performance measures that are included in the IHS FY 2010 Annual Performance Plan. The measures address many of the administrative aspects of providing health care to AI/AN population and comply with the requirements of performance measures and other Departmental goals of achieving equivalent and improved health status for all Americans. In addition, management improvements will be guided by the Department's Performance Objectives and the priorities of the Secretary of Health and Human Services.

Headquarters, through this activity, will continue to develop and expand its crosscutting collaborations and partnerships with other Federal agencies and outside organizations to meet many performance measures and objectives. A FY 2011 performance goal for Direct Operations is to continue the implementation of a human capital strategy to assist managers with succession planning activities. Twenty-seven percent of IHS employees will be eligible for retirement in 2011. Enhancing the IHS workforce's knowledge and skills in areas such as financial management, entrepreneurship and the application of regulations has been identified as critical to meet the IHS' current and future needs to fulfilling the mission of the IHS.

FUNDING HISTORY

Fiscal Year	Amount
2006	$62,194,000
2007	$63,631,000
2008	$63,624,000
2009 Recovery Act	$0
2009 Omnibus	$65,345,000
2010 Enacted	$68,720,000

BUDGET REQUEST

The FY 2011 budget request for Direct Operations is $69,845,000, an increase of $1,125,000 over the FY 2010 Enacted level. The increase will provide:

Current Services +$1,125,000

Pay Costs +$789,000 – will fund pay increases for Federal and Tribal employees.

Inflation +$336,000 – will fund non-medical inflation costs.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
SELF-GOVERNANCE

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$6,004	$0	$6,066	$6,201	+$135
FTE	13	0	13	13	0

Authorizing Legislation .... 25 U.S.C. 450, Self-Determination and Education Assistance Act, as amended

FY 2011 Authorization..Permanent

Allocation Method .... Direct Federal, Cooperative Agreements and Self-Governance Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

In FY 1992, the IHS was instructed by Congress to initiate planning activities with Tribal governments with approved Department of Interior self-governance compacts for the development of a Self-Governance Demonstration Project (SGDP) as authorized by P.L. 100-472. Through enactment of P.L. 102-573, the Indian Health Care Amendments of 1992, authority to fund the Tribal SGDPs was extended to IHS and the Office of Tribal Self-Governance (OTSG) was established. Through enactment of P.L.106-260, the Tribal Self-Governance Amendments of 2000, permanent authority was given to IHS through Title V, Tribal Self-Governance.

Since 1993, the IHS, with Tribal representatives, has developed formula methodologies for identification of tribal shares for all Indian Tribes. Tribal shares are those program and administrative funds that Tribes are eligible to assume and may choose to receive from Headquarters and Area organizational levels of the IHS. Currently, $2.594 billion of the IHS budget is under Tribal Health Administration of which approximately $1.282 billion will be transferred to tribes in support of Tribal Self-Governance with 133 compacts and 154 funding agreements in FY 2011. The remaining balance is used to administer Title I, Urban Health, Contract Support Costs and Tribal Management Grants.

The Self-Governance budget supports a system of care implemented at the local level by Tribal governments through their Compacts and Funding Agreements. The Self-Governance budget further supports accomplishments through:

- Agency performance measure achievement through various Tribal pilot projects throughout the country which are funded through the Self-Governance budget;
- Funding for ambulances to all Indian tribes and tribal organizations;
- Funding to an Indian tribal organization to provide technical assistance, coordination of meeting dates, locations, etc. in development of an annual report to Congress;
- Funding of Interagency Agreement between IHS and U.S. Department of Veterans Affairs to provide support and training to Community Health Representatives, first responders, modular curriculum development/online training, and specialty field training/support for suicide prevention and response.
- Expressing a clear vision of health information technology that conveys the benefits to patients, providers and payers. OTSG continues to provide funding for Government Performance Results Act (GPRA) projects. Specifically, the Alaska and Nashville Area have worked conjointly with the IHS in developing the Clinical Reporting System software application, which is a reporting tool for performance measures as well as other indicators. It is available to all tribes.

Therefore, Self-Governance does not directly control the assessment of these Tribal programs and services. It supports Tribal efforts to pursue their local goals through special programs, advocacy, technical assistance and administrative support.

FUNDING HISTORY

Fiscal Year	Amount
2006	$5,668,000
2007	$5,763,000
2008	$5,836,000
2009 Omnibus	$6,004,000
2009 Recovery	$0
2010 Enacted	$6,066,000

BUDGET REQUEST

The FY 2011 budget request of $6,201,000 is an increase of $135,000 over the FY 2010 Enacted Level of $6,066,000. This increase will provide funds for:

Pay Costs: +$36,000 – to fund the pay increases anticipated in FY 2011 for Federal employees, specifically for the Office of Tribal Self-Governance located within IHS Headquarters.

Inflation: +$99,000 – to cover inflation.

The Self-Governance budget will support the provision of technical assistance to approximately 400 federally recognized Indian tribes and tribal organizations compacted with Indian Health Service (IHS); fund up to 16 Indian Tribes with Planning and Negotiation Cooperative Agreements; continue to fund the performance projects; and address tribal shares funding needs in IHS Areas and Headquarters for any Indian tribe(s) newly entering self-governance**.**

The total funding for Self-Governance will provide:

- $3.0 million (or 48%) will be used for the operating budget of the OTSG: 13 FTEs - payroll costs, travel, supplies, rents/communications and contractual services; reimbursement travel

cost (other than OTSG staff), TDY to the OTSG; planning and negotiation cooperative agreements.

- $3.2 million (or 52%) for a reserve fund: for shortfalls in compact funding in cases where there cannot be a direct transfer of funds from IHS to the Indian tribes to fund self-governance compacts without jeopardizing the support provided by IHS to other Indian tribes. Therefore, the **reserve funds** are used:
  (1) To ensure that funding of tribal shares under Self-Governance compacting does not adversely impact non-Self-Governance Tribes. These funds are provided directly to the Self-Governance Tribes or to Area Offices and/or Headquarters programs and the OTSG so that Self-Governance Tribes may receive their full funding of tribal shares as provided for in P.L. 106-260;
  (2) For Self-Governance costs incurred as the result of special circumstances: severance pays, Reduction In Force (RIF) costs, settlements and assessments costs; assistance with the purchase of ambulances; assistance with incidents caused by natural disasters (e.g., mud slides, etc.);
  (3) To support special projects that enhance Self-Governance Activities: performance projects; development of a curriculum to be used for the training of future Agency Lead Negotiators (ALN) within the IHS; Self-Governance Communication Education project continued agreement; eligibility services project; EMS services; IT project for Electronic Health Records and RPMS at tribal sites; travel/logistics of Advisory committees, workgroups; other trainings; Educational Brochure on Self-Governance.

The Self-Governance budget addresses the following elements of the IHS Strategic Plan: Goal 2, Objective 2.4; Goal 3, Objectives 3.1 – 3.2; and, the OMB Tribally Operated Health Programs (TOHP) program assessment performance measures and follow-up actions.

OUTCOMES

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
TOHP-1: Percentage of TOHP clinical user population included in GPRA data.	FY 2009: 73% (Target Not Met)	78%	78%	0
TOHP-E: Tribally Operated Health Programs: Hospital admissions per 100,000 diabetics per year for long-term complications of diabetes.	FY 2007: 137.1 (Target Exceeded)	135.7	N/A	N/A
Program Level Funding ($ in millions)	**$6.0**	**$6.0**	**$6.2**	**+$0.2**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

OUTPUTS

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Increase Program Training Projects	6	6	6	0
Develop Tribal Health Information Technology Infrastructure Sites/Projects	7 (Target Not Met)	10	10	0
Develop & support IHS Chronic Care initiatives at Tribal site: Screening Projects	1 (Target Not Met)	3	3	0
Third Party Infrastructure Demonstration Project with a Tribe.	New Output Measure	1	1	1
Program Level Funding ($ in millions)	**$6.0**	**$6.0**	**$6.2**	**+$0.2**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
CONTRACT SUPPORT COSTS

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$282,398	$0	$398,490	$444,332	+$45,842
FTE	0	0	0	0	0

Authorizing Legislation .... 25 U.S.C. 450, Self-Determination and Education Assistance Act, as amended

FY 2011 Authorization..Permanent

Allocation Method ....P.L. 93-638 Self-Determination contracts and compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Indian Self-Determination and Education Assistance Act (ISDEAA) allows Tribes to assume operation of Federal programs and to receive not less than the amount of direct program funding that the Secretary would have otherwise provided for the direct operation of the program (specifically, contract support costs were first identified in the 1988 amendments to the ISDEAA). In FY 2010, approximately $2.2 billion of the Agency's appropriation will be under Tribal Health Administration primarily through Title I and V of the ISDEAA. The ISDEAA also provides that contract support costs (CSC) be added to the program amount. The CSC are defined in the ISDEAA as the reasonable costs for activities either not normally provided by the Secretary in direct operation of the program, or were provided by the Secretary in support of the program from resources other than those under contract.

Elements of CSC include:

- Pre-award costs (e.g., consultant and proposal planning services).
- Start-up costs (e.g., purchase of administrative computer hardware and software).
- Direct CSC (e.g., unemployment taxes on direct program salaries).
- Indirect CSC (e.g., pooled costs such as the support of a financial management system).

The IHS CSC policy, in existence since 1992, governs the administration and allocation of CSC, and was developed through extensive consultation and participation of Tribes. The most recent revision of the CSC Policy was in April 2007, and established it as a permanent Chapter within the IHS Manual (Part 6, Chapter 3, TN-2007-05), effective for the fiscal year (FY) 2007 through FY 2010 funding periods.

The revised policy modified the CSC allocation methodology associated with new or expanded awards under the ISDEAA, P.L. 93-638, as amended. Allocations are now made at the average

level of CSC funding paid to all existing P.L. 93-638 awards. The IHS CSC policy conforms to applicable OMB Circular A-87 and A-122 cost principles.

The IHS continues to review the soundness of its allocation policies concerning CSC and to take steps to assure that CSC provided to Tribes is reasonable and does not duplicate other funding provided to Tribes by the IHS under self-determination agreements. The IHS provides specific technical assistance to Tribes on calculating CSC and reviews each Tribal request that is submitted for CSC using a protocol to ensure that the CSC that are approved are consistent throughout the IHS system and not duplicative of other funding provided to Tribes.

Finally, the IHS Tribal Contract Support Cost Workgroup met June 10-11, 2009 in Phoenix, AZ., focusing on IHS CSC policy and resource allocation issues as follows:

- IHS CSC Policy – Allocation methodologies associated with new or expanded awards.
- Allocation of FY 2009 and 2010 CSC appropriations.
- Impact of National Business Center Indirect Cost Rate negotiation changes.
- CSC need associated with American Recovery & Reinvestment Act (ARRA) funds.
- Development of a report on CSC over the past 10 years.

The meeting was attended by approximately 110 Tribal and Federal representatives from throughout Indian country. After a policy review was conducted by workgroup members at this meeting, it was determined that the IHS will extend its existing CSC policy to maintain the current CSC allocation methodologies through FY 2013. A report that discusses Tribal CSC need, resources, and deficiencies will also be issued within the next year. This report will be an update to the 1997 Report to Congress on Contract Support Cost Funding in Indian Self-Determination Contracts and Compacts, which was issued in response to a belief in Congress that the growing contract support cost need should be reviewed. The report found that the growth in CSC need resulted from tribes assuming additional programs under the ISDEAA thus increasing the CSC need to support the additional programs. Based upon recommendations, participants for a smaller workgroup were requested to update the report to reflect what has happened since it was originally published. This smaller workgroup will analyze all previous and current CSC data to determine how best to present the information and education to Tribal contractors and compactors.

This ongoing review of CSC allocation policies and technical assistance ties in directly with HHS Goals and Objectives – FY 2007-2012 (Goal 1: Objective 1.3; Improve health care quality, safety, cost, and value).

Since calendar year 2006, Tribally-operated health programs (TOHPs) continue work to address follow-up recommendations from the findings of the TOHP program assessment. The CSC accounts for 16 percent of the total funding provided to TOHPs, yet, is a key element of cost affecting the overall performance of TOHPs. TOHPs received a rating of adequate on the TOHP program assessment. Generally, this rating describes a program that needs to set more ambitious goals, achieve better results, improve accountability or strengthen its management practices. The TOHP program assessment found that TOHPs maintain or improve the overall health of American Indians and Alaska Natives (AI/AN) each year, as measured by independent evaluations and clinical indicators like screening rates for medical conditions. Most notably, the programs have reduced Years of Productive Life Lost by 11 percent over the past decade. However, performance information is only available for programs that voluntarily report the data. In FY 2008, 73 percent of the population served by TOHPs was reported in performance measures, compared to 76% in FY 2007. By law, the government cannot require Tribal programs

to submit performance data (Indian Self-Determination and Education Assistance Act (ISDEAA) Public Law 93-638, as amended, Section 514). This restriction makes it difficult to identify deficiencies and assist Tribes in improving program performance. Tribes are also not required to inform the IHS of how much funding they receive from other sources, such as Medicare and Medicaid. As a result, it is difficult to determine the relationship between overall funding levels and program performance.

Finally, in continuing to manage CSC funding, and in response to the March, 2005 Supreme Court decision in Cherokee Nation v. Leavitt[1], the IHS has issued additional guidance concerning any new or expanded contracts or compacts being entered into for FY 2007 and subsequent years. This guidance requires that Tribes and the IHS reach agreement concerning the unavailability of Indian Self-Determination (ISD)/CSC funding and the obligation of the IHS to fund CSC pursuant to the appropriations "cap" on CSC. If there is not agreement on the part of the Tribe then the new or expanded program request will likely be declined. These principles need to be adhered to in instances where CSC funding may not be available in order for the IHS to enter into new contracts or compacts under the Indian Self-Determination and Education Assistance Act. If the Tribe and the IHS could not reach agreement, the proposal to contract for the new and expanded programs, services, functions, and activities (PSFA) would be declined.

FUNDING HISTORY

Fiscal Year	Amount
2006	$263,683,000
2007	$269,730,000
2008	$267,398,000
2009 Recovery Act	$0
2009 Omnibus	$282,398,000
2010 Enacted	$398,490,000

BUDGET REQUEST

The FY 2011 budget request for Contract Support Cost is $444,332,000, an increase of $45,842,000 over the FY 2010 Enacted level. The increase will provide:

Current Services

Inflation +$5,842,000 – non-medical inflation cost of 1.5% for ongoing contracts and compacts.

Program Increase +$40,000,000

The entire increase will be applied against the contract support costs shortfall associated with all P.L. 93-638 contracts and compacts that reflect less than full CSC funding at the end of fiscal year 2010. The IHS projects that 280 of the total 329 Tribes and Tribal Organizations with P.L. 93-638 contracts and compacts will have CSC shortfalls at the end of FY 2010. The total CSC shortfall associated with those 280 contracts and compacts is projected to be approximately $109.3 million at the end of FY 2010.

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[1] In ***Cherokee Nation of Oklahoma et. al. v. Leavitt, Secretary of Health and Human Services, et. al***., the Supreme Court ruled that the IHS had received an unrestricted appropriation sufficient to provide plaintiff Tribes full funding of their contract support cost requirements pursuant to their ISDEAA contracts with the Federal Government in fiscal years 1995, 1996, and 1997.

The CSC need associated with program increases included in the FY 2011 budget and the CSC need associated with new or expanded programs assumed by Tribes and Tribal Organizations in FY 2011 is projected to be approximately $50 million. Therefore, the projected CSC level of need funded is not expected to change much between FY 2010 and 2011. The $40 million increase will, however, allow continued progress in addressing the CSC needs of tribally operated programs to improve quality of care for AI/ANs. The IHS Manual, Part 6, "Services to Tribal Governments and Tribal Organizations," Chapter 3, "Contract Support Costs," Section 6-3.3C, specifies how the CSC funds will be distributed. Fifty percent of the FY 2011 increase for CSC will be allocated to those Tribes with the greatest unfunded level of CSC need in such a way as to raise the minimum level of CSC funded to the highest possible level – a bottom up approach. The remaining 50 percent of the FY 2011 CSC increase will then be allocated to all Tribes who have a CSC shortfall in proportion to their overall share of the CSC. As a result of this allocation, the IHS projects that the FY 2011 CSC shortfall will be approximately $114.8 million.

OUTPUTS

Measure	FY 2009	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
The total direct program contracted or compacted by Tribes. [2]	$1,536.0	$1,747.9	$2,133.7	+$386
Program Level Funding ($ in millions)	**$282.3**	**$398.4**	**$444.3**	**$45.8**
ARRA Level Funding ($ in millions)[3]	**$0**	**$0**	**$0**	**$0**

[2] The total number of Tribes/Tribal Organizations contracting or compacting is 329.
[3] The spread of ARRA is unknown.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
PUBLIC AND PRIVATE COLLECTIONS

	FY 2009 Estimate*	FY 2010 Estimate*	FY 2011 Estimate*
Medicare:			
Federal	$128,293,000	$130,953,000	$130,953,000
Tribal [1]	6,986,000	6,986,000	6,986,000
Tribal [2]	34,085,000	34,085,000	34,085,000
Subtotal:	169,364,000	172,024,000	172,024,000
Medicaid:			
Federal	452,824,000	465,276,000	465,276,000
Tribal [1]	22,217,000	22,217,000	22,217,000
Tribal [2]	75,181,000	75,181,000	75,181,000
Subtotal:	550,222,000	562,674,000	562,674,000
Medicare/Medicaid Total:	719,586,000	734,698,000	734,698,000
Private Insurance	94,042,000	94,042,000	94,042,000
TOTAL:	**$813,628,000**	**$828,740,000**	**$828,740,000**
FTE	4,204	4,204	4,204

[1] Represents CMS Tribal collection estimates.

[2] Represents estimates of Tribal collections due to direct billing that began in FY 2002-05.

* Represents estimates of collections from public and private insurers for current and future fiscal years. Estimates are based on actual FY 2008 collections and current reimbursement rates. These estimates may change as a result of actual FY 2009 collections, changes to the types of services covered by insurers, and transition of programs from Federal to tribally-operated.

Authorizing Legislation .... Economy Act of 31 U.S.C. 686 Section 301, P.L. 94-437, and Title IV of Indian Health Care Improvement Act.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The collection of third party revenue is essential to maintaining facility accreditation and standards of health care through the Joint Commission on Accreditation of Healthcare Organizations or the Accreditation Association for Ambulatory Health Care. Public and Private Collections are a significant part of the IHS and Tribal budgets, and support increased access to quality health care services for American Indian and Alaska Natives (AI/AN). Third party revenue represents up to 50 percent of operating budgets at many facilities. IHS has had legislative authority to bill Medicare and Medicaid (M&M) since 1976.

Medicare/Medicaid (M&M) -- The FY 2010 projections do include the 2009 M & M rate increase. The FY 2011 estimates assume continuation of the FY 2010 estimated collections at this time. Completing cost reports to set the CY 2010 M&M rates is a priority.

During FY 2010 and 2011, IHS will continue to place a priority on development of a third party interface with the new Unified Financial Management System. The IHS focus will continue to strengthen business office policies and management practices, including internal controls, patient benefits coordination, provider documentation training, certified procedural coding training and electronic claims processing. Priority efforts include the continued development of modifications to third party billing and accounts receivable software to improve effectiveness and to ensure

system integration with its business processes and compliance with M&M regulations. As part of long term planning goals, the IHS will be investing in its PMS, (Practice Management Software) and evaluating through GSA commercial off the shelf Practice Management Software (PMS) for possible integration into the RPMS PMS.

IHS will continue to work with the Centers for Medicare and Medicaid Services (CMS) and the State Medicaid agencies to improve each program's capability to identify patients who are eligible to enroll in M&M and CHIP programs and in the implementation of new provisions in ARRA and CHIPRA that effect health care delivery, AI/AN exemption of Medicaid and CHIP cost sharing, consulting with the CMS TTAG, (Tribal Technical Advisory Group), and outreach and enrollment grants, etc. IHS will continue to work with the CMS and the Tribes on a number of issues, including third party coverage, claims processing, denials, training, and out stationing State eligibility workers.

The IHS places the highest priority on meeting all accreditation standards for its healthcare facilities. The use of the M&M reimbursements will continue to be used to support and maintain facility accreditation and improve the delivery and access to health care for AI/AN people.

Private Third Party Collection -- The FY 2010 and 2011 private insurance budget estimate is the same as the FY 2009 estimate level. During FY 2010 and 2011, IHS continues work to enhance each health facility's capability to identify patients who have private insurance coverage, improve claims processing, provider documentation and coding that optimizes private insurance billing and collections.

The local Service Units utilize the funds collected to improve services like the purchase of medical supplies and equipment. In addition, the funds will improve local service unit business management practices. The IHS continues to make use of private contractors to pursue collections on outstanding claims from private payers.

OPPS -- IHS will conduct a feasibility study including a proposed project plan component. The focus of the study will include, but not be limited to, an evaluation of the RPMS clinical system billing linkages, evaluation of the capacity IHS Practice Management Software (PMS), and software changes and/or projected costs to purchase and implement IHS-wide a new PMS software. Other key areas to evaluate will include 1) business process changes in Clinical departments, Medical records and business office staffing impacts, 2) Medicare outpatient revenue impacts and cost benefits, 3) necessary clinical and business office staff training, 4) system maintenance and development required by new systems, and 5) equipment and related infrastructure facility requirements.

The following table shows how Medicare, Medicaid and Private Insurance collections are used.

Type of Obligation	FY 2009 Estimate	FY 2010 Estimate	FY 2011 Estimate
Personnel Benefits & Compensation	$338,037,000	$347,678,000	$347,678,000
Travel & Transportation	4,403,000	4,461,000	4,461,000
Transportation of Things	3,999,000	4,080,000	4,080,000
Comm./Util./Rent	12,277,000	12,401,000	12,401,000
Printing & Reproduction	401,000	407,000	407,000
Other Contractual Services	154,653,000	157,212,000	157,212,000
Supplies	108,456,000	110,111,000	110,111,000
Equipment	19,441,000	19,726,000	19,726,000
Land & Structures	25,157,000	25,740,000	25,740,000
Grants	7,966,000	8,079,000	8,079,000
Insurance / Indemnities	253,000	257,000	257,000
Interest/Dividends	116,000	119,000	119,000
Subtotal	$675,159,000	$690,271,000	$690,271,000
Tribal Collections	$138,469,000	$138,469,000	$138,469,000
Total Collections	**$813,628,000**	**$828,740,000**	**$828,740,000**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
SPECIAL DIABETES PROGRAM FOR INDIANS

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$150,000	$0	$150,000	$150,000	0
FTE	0	0	0	0	0

Authorizing Legislation .... 111 Stat. 574, 1997 Balanced Budget Act (P.L. 105-33), Consolidated Appropriation Act 2001 and amendment to Section 330C (c)(2)(c) Public Health Service Act through Senate Bill 2499 (passed the Senate 12/18/07) to extend funding through FY 2009 and the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) Title III Special Diabetes Program for Indians extends funding through FY 2011 .

FY 2011 Authorization...Thru 2011

Allocation Method .... Grants, Interagency agreements, and Contracts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Congress established the initial Special Diabetes Program for Indians (SDPI) through the Balanced Budget Act of 1997. Support for the SDPI was augmented through the Consolidated Appropriations Act of 2001, House Resolution 5738 of 2003, House Resolution 2764 of 2007 and House Resolution 6331 of 2008. As a result, the SDPI now operates with a budget of $150 million per year (through FY 2011).

The IHS Division of Diabetes Treatment and Prevention (DDTP) provides leadership, programmatic, administrative and technical oversight to the SDPI grant program. The mission of the IHS DDTP is to develop, document, and sustain a public health effort to prevent and control diabetes in American Indians and Alaska Natives (AI/ANs). This mission is accomplished by promoting collaborative strategies for the prevention of diabetes and its complications to over 1.6 million AI/ANs through its extensive diabetes network. The diabetes network consists of a national program office; Area Diabetes Consultants in each of the 12 IHS Areas; 19 Model Diabetes programs in 23 different IHS and Tribal sites, and 333 local Community-directed and 66 Demonstration Project IHS, Tribal and Urban Indian SDPI grant programs. The 66 SDPI demonstration grant programs, awarded in FY 2004, are comprised of 30 cardiovascular disease (CVD) risk reduction demonstration projects and 36 diabetes prevention demonstration projects.

This extensive diabetes network supports the SDPI grant programs by providing comprehensive diabetes surveillance, research translation, promotion of quality assurance and improvement activities, technical support, resource and "best practices" information, and develops and distributes American Indian specific diabetes education materials and training. This program also serves as the key IHS contact and source of information for outside organizations and agencies working on diabetes and disparities related to diabetes. Now the most comprehensive rural

system of care for diabetes in the U.S., the IHS combines both clinical and public health approaches to address the problem of diabetes and its complications.

Target Audience -- Congress authorized the initial SDPI appropriation in 1997 in response to alarming trends documenting a disproportionately high rate of type 2 diabetes in AI/AN communities. It came in the wake of increasing public concern about the human and economic costs of diabetes in the U.S. and in particular for the growing disparity in **prevalence** between the AI/AN population and the US general population.

AI/AN communities suffer a disproportionately high rate of type 2 diabetes. The Centers for Disease Control and Prevention (CDC) recently reported that, after adjusting for population age differences, national survey data (2004-2006) for people aged 20 years or older indicate that 6.6 percent of non-Hispanic whites, 7.5 percent of Asian Americans, 10.4 percent of Hispanics, 11.8 percent of non-Hispanic blacks and 16.5 percent of AI/ANs had diagnosed diabetes.

Diabetes is the fourth leading cause of death among AI/ANs, and the diabetes **mortality** rate among AI/ANs is three to four times that of non-AI/ANs. Diabetes is the strongest predictor of heart disease in AI/ANs. Heart disease, the leading cause of AI/AN mortality, appears to be more often fatal among AI/ANs than in other populations. In 2008, 82% of AI/AN adults with diabetes also had diagnosed hypertension. Hypertension in people with diabetes, particularly if it is uncontrolled, significantly increases their likelihood of developing diabetes complications.

In many tribal communities, the complications of diabetes lead to much higher incidence rates of blindness, vascular insufficiency leading to amputation, and kidney failure leading to dialysis than in the general U.S. population. It is estimated that one in every four (24.8 percent) AI/AN elders over age 65 years has coronary heart disease (or one of every five of those aged 55 and older). AI/ANs have the highest rate of premature deaths from heart disease of all races, with 36% of deaths from heart disease classified as premature; the rate is nearly 2.5 that for Whites.

There has been some good news recently. Since 1999, the incidence of kidney failure leading to dialysis has declined 18 percent among AI/AN population with diabetes over age 45 years (a 29 percent decrease was seen in those aged 45-64 years and a 13 percent decrease in those age 65 years and older). This improvement was seen despite the continued rise in diabetes prevalence in the same time period, and was attributed to the reduction in risk factors and improvements in diabetes care practices in Indian communities as shown by our yearly IHS Diabetes Care and Outcomes Audit.

Distribution Method -- In the Balanced Budget Act of 1997, Congress established the SDPI to "establish grants for the prevention and treatment of diabetes" to address the growing problem of diabetes in AI/ANs. The entities eligible to receive these grants included IHS programs, tribes and tribal organizations, and urban Indian organizations.
The IHS distributed this funding to over 300 such entities according to legislative intent through a process that included a formal tribal consultation, development of a formula for distribution of the funds to eligible entities, and a formal grant application and administrative process. These programs were allowed to use this funding to design and carry out interventions that will best address the problem of diabetes in individual communities. Depending on community needs, these programs incorporate a wide range of proven diabetes treatment and prevention strategies, such as patient education, quality diabetes care services, as well as physical activity, nutrition and weight loss activities. $1 million was also set-aside for the CDC Native Diabetes Wellness Program (formerly known as the National Diabetes Prevention Center).

Special Diabetes Program for Indians – Total Yearly Costs 2004-2011

CATEGORY	(Dollars in Millions)
Original Diabetes Grants – now called Community-directed Diabetes Programs (297 Tribal and IHS grants in FY 1998)	$104.8
Administration of Community-directed SDPI grants (Includes administrative funds to IHS Areas, Tribal Leaders Diabetes Committee, Div of Diabetes, Grants Operations, evaluation support contracts, etc.)	4.1
Urban Indian Health Program community-directed diabetes programs (36 grants)	7.5
Demonstration Projects (66 grants)	23.3
Administration of Demonstration Project Diabetes Grants (Includes administrative funds 1) to support the limited dissemination activities, 2) to HQ, 3) to support contracts, etc.)	0.9
Demonstration Project Coordinating Center	3.2
Funds to strengthen the Data Infrastructure of IHS	5.2
Native Diabetes Wellness Center (CDC)	1.0
TOTAL:	**$150.0**

Strategy -- The SDPI has brought Tribes together over these past 12 years, working toward a common purpose and sharing information and lessons learned along the way. The IHS has shown through its public health evaluation activities that these programs have been very successful in improving diabetes care and outcomes, as well as the start of primary prevention efforts, on reservations and in urban clinics.

Tribes and urban Indian organizations have had to make choices about how to best use their local SDPI funding to address the problem of diabetes in AI/AN communities. A study published by the American Diabetes Association in 2007 on the economic burden of diabetes in the U.S., estimated that it costs $11,744 per year to care for one person with diabetes compared with $5,095 per year for persons without diabetes. A recent IHS analysis conducted at one IHS facility, supported by the SDPI, demonstrated that in the Indian health system it costs $7,003 per year to care for an AI/AN person with diabetes compared with $2,205 for a AI/AN person without diabetes, a three-fold difference. Among AI/ANs with diabetes, those who also have CVD cost $12,693 per year, a two-fold increase. Early on in the SDPI program the Indian health care system recognized that it would have to make careful choices about where to invest these funds and knew these choices would best be made locally.

Our evaluation of SDPI and diabetes clinical measures suggests that population-level diabetes-related health is better among our AI/AN patients since the implementation of SDPI. The greatest benefit for AI/AN with diabetes has likely been in the reduction in microvascular complications due to improvement in hyperglycemia, blood pressure control, dyslipidemia, and kidney disease screening and treatment, measures that are reflected in IHS' GPRA measures. Further reducing microvascular and macrovascular complications will require continued efforts to improve glucose, blood pressure and cholesterol values. However, the greatest long-term benefit will most likely be from intensification of the diabetes primary prevention activities now becoming commonplace in AI/AN communities.

Demonstration Projects -- In FY 2004 the IHS, in response to Congressional direction, developed and implemented a SDPI competitive Demonstration Project. The focus of the competitive Demonstration Project is on: 1) primary prevention of type 2 diabetes in those adults at risk for developing diabetes and 2) reduction of cardiovascular risk in AI/AN adults diagnosed with type 2 diabetes. Sixty-six grants were awarded and this 5-year project was launched in November 2004. These Demonstration Projects were not designed to conduct new research. Rather, they were designed to translate findings from scientific studies into the "real world settings" of AI/AN communities and their health care systems.

Preliminary results from these Demonstration Projects (see SDPI Grant Program Evaluation, Bullet #3 below) are promising. When the rigorous evaluation and analysis of the SDPI Demonstration Projects is complete in FY 2010, the IHS will better understand how best to implement the successful interventions in the diverse settings of AI/AN communities. The final analysis and subsequent major reports of findings will be available summer of 2011.

Strengthening the Diabetes Data Infrastructure -- The IHS has used administrative funding from the SDPI to strengthen the diabetes data infrastructure of the Indian health system by improving diabetes surveillance and evaluation capabilities. These funds also support the development and implementation of the IHS Electronic Health Record, the electronic patient and data management system used in many Indian health facilities. As a result of these data infrastructure improvements, the Indian health system has been better able to identify and track American Indians and Alaska Natives with diabetes. This improvement in diabetes surveillance will allow for the measurement of the long-term outcomes of age-specific prevalence of diabetes and of CVD in people with diagnosed diabetes.

Technical assistance, provider networks, clinical monitoring and grant evaluation activities at the Headquarters and Area office levels have also been strengthened. In addition, support for the Area Diabetes consultants, who serve a crucial role in coordinating these functions at the Area level, was made stronger. SDPI funding for the past 12 years has served to build and enhance a much-needed infrastructure within local IHS and Tribal administrations that enables continued development of diabetes programs to address treatment and prevention of diabetes, as well as obesity and other chronic diseases.

Milestones accomplished and challenges faced during current year -- The SDPI provides funding for diabetes treatment and prevention services in 399 Tribal, IHS and urban Indian Health programs. Yearly SDPI grantee assessments are conducted within the yearly SDPI Progress Report. These assessments have shown significant improvements in care and community services provided over time when compared to the baseline SDPI assessment in 1997, as evidenced by:

- Improved Elements of Diabetes Care:
  - 68 percent more grant programs have diabetes teams – health professionals who work together to provide diabetes care.
  - 36 percent more grant programs have diabetes clinics that offer special medical appointments for people with diabetes.
  - 65 percent more grant programs use a diabetes registry to keep track of people with diabetes in their communities.
- Promoting Healthy Lifestyles:
  - 57 percent more grant programs offer nutrition services for adults.
  - 38 percent more grant programs have access to a registered dietitian.
  - 72 percent more grant programs offer community walking and running programs.
  - 53 percent more grant programs have a physical activity specialist.
- Addressing the threat of childhood obesity and diabetes:
  - 76 percent more grant programs have type 2 diabetes prevention programs for youth.
  - 29 percent more grant programs offer nutrition services for children and youth.
  - 69 percent more grant programs have community-based physical activity programs.
  - 52 percent more grant programs have safe environments for physical activity.
- Efforts to Support Behavior Change:
  - 71 percent more grant programs offer organized diabetes education activities.

  - 56 percent more grant programs offer culturally-appropriate diabetes education.
  - 55 percent more grant programs work with social service programs.
  - Greater availability of depression screening and a variety of therapies to help patients cope with stress and depression.
- Weight Management Activities.
  - 65 percent more grant programs offer adult weight management programs.
  - 64 percent more grant programs offer weight management programs for children and youth.

AI/AN communities have used SDPI funds to make quality diabetes practices common place in local health facilities.

- Key Clinical Outcome Measures Have Improved:
  - The mean long-term blood sugar control level (A1C) overall decreased 12 percent from A1C=9.00 percent (1996) to A1C=7.93 percent (2008).
  - The incidence of new cases of kidney failure leading to dialysis among AI/AN has declined 18 percent for the entire adult diabetic population:
    - 29 percent decrease in those aged 45-64 years
    - 13 percent decrease in those aged 65 years and older
  - The mean LDL cholesterol level decreased 19 percent from 118 mg/dl (1996) to 95.3 mg/dl (2008).

Building Programs Based on Best Practices. There are currently 18 IHS Diabetes Best Practice Models – with plans to add 5 more - that focus on successful diabetes prevention, treatment and education practices that have been shown to be successful in AI/AN communities. These Best Practices are based on findings from the latest diabetes scientific research, evidence-based outcomes studies, and the extensive experience of Indian health professionals. The IHS Best Practice models have been used by SDPI applicants to identify strengths in diabetes resources and services in their communities, find gaps in diabetes services or programs, establish program priorities, locate best practice models that could be applied within their own communities, and to begin a work plan to develop their own local best practice models. The current IHS Best Practice models have been updated by Indian health professionals and are available for use by SDPI Community-directed grantees in the FY2010 grant cycle. The new versions will include enhanced accountability measures and strengthened outcomes measures where applicable.

Tribal Consultation. The Tribal Leaders Diabetes Committee, established in 1998, continues to meet several times each year at the direction of the IHS Director to review information on the progress of the SDPI activities and to provide recommendations to the Director of IHS on diabetes-related issues pertinent to AI/AN, as well as to CDC and NIH-NIDDK.

Strengthen IHS Data infrastructure. SDPI funds support the development and implementation of the IHS Electronic Health Record and the IHS Diabetes Management System (a software program that is part of the RPMS system) in all 12 Areas of the IHS and, as a result, the Indian Health system has been better able to identify and track AI/AN with diabetes and improve clinical services.

SDPI Grant Program Evaluation. Several ongoing evaluations are conducted on the SDPI grant programs:

- The CDC's *Framework for Public Health Evaluation*, provides a framework for ongoing program and systems analysis of the SDPI Community-directed grant programs.

- In addition, each SDPI Community-directed grant program is required to conduct the annual IHS Diabetes Care and Outcomes Audit. Every two years, as part of its public health approach to diabetes, the IHS Division of Diabetes Treatment and Prevention (DDTP) publishes guidelines to improve the process of diabetes care and the outcomes for patients with diabetes seen in its facilities called the IHS Standards of Care for Diabetes. IHS, tribal and urban clinic facilities are encouraged to maintain diabetes registries of all persons with diabetes. An annual web-based IHS Diabetes Care and Outcomes Audit measuring key variables from the Standards of Care is conducted on patient records from these registries at local facilities to assess performance with the guidelines. Both the Standards and the Audit measures are revised periodically to reflect new scientific findings and our own experience. Trained professional staff perform the yearly audit and a uniform set of definitions is used throughout the Indian health system. Data are collected following standardized protocols using fixed definitions and data collection forms. SDPI Community-directed grant programs are expected to review these audit results and make programmatic determinations and adjustments based on the results.
- To assess the *SDPI* Targeted Demonstration Projects interventions, the IHS is conducting a comprehensive evaluation to answer questions on program effectiveness and outcomes based on solid, statistically accurate, and timely data. Preliminary analyses reveal:
    - Diabetes Prevention Demonstration Project: As of December 31, 2008, 36 programs have recruited 3451 participants with pre-diabetes to receive education to promote weight loss through increased physical activity and reducing fat grams and calories in their diets with a modified version of the 16-session Diabetes Prevention Program Curriculum. Of these participants, 1878 completed both the baseline and follow-up assessments, providing data to assess if whether key clinical characteristics had improved after completing the 16-session Diabetes Prevention Program curriculum. As of December 31, 2008, the average weight loss of participants was 8.6 pounds which represented a 3.9 percent reduction from baseline for the group mean. Both systolic and diastolic blood pressure decreased by 0.7 percent on average and HDL increased by 2.3 percent from baseline (both represent an improvement). Other clinical indicators showed similar improvements. The percent of participants who met the program goal of more than 150 minutes per week of physical activity increased from 23 percent at baseline to 55 percent at follow up.
    - Healthy Heart Demonstration Project: As of December 31, 2008, 30 programs have recruited 3564 participants with diabetes to participate in an intensive, clinic-based case management approach to reduce their risk factors for cardiovascular disease (CVD). Of these participants, 2799 completed baseline and first annual follow-up assessments. The primary outcomes that are assessed at the annual assessment include reduction in blood pressure, changes in HbA1C and lipids, aspirin use, increased physical activity, nutrition, weight loss, and less smoking. As of December 31, 2008, the overall group showed improvements in almost all cardiovascular disease risk factors. For example, the percentage of participants meeting the LDL goal (<100 mg/dl) improved by about 10 percent from baseline (54 percent) to both annual assessments (65 percent and 66 percent for 1st and 2nd annual respectively). The percent of participants who met the goal of >= 150 minutes of physical activity per week also increased significantly from baseline (27 percent) to 1st annual (37 percent) and 2nd annual assessment (45 percent). Additionally, participants reported eating healthy foods more often and unhealthy foods less often at both annual assessments compared to baseline.

Tribal Management of Local Grant Programs. Eighty-one percent of the SDPI Community-directed Diabetes Programs are Tribal programs.

Collaborations and Partnerships. The IHS has developed and built upon collaborations and partnerships with federal and private organizations resulting from the SDPI. These include:

- Joslin Vision Network (JVN) Tele-ophthalmology Project;
- NIDDK/CDC/TLDC/Tribal Colleges collaboration on the Diabetes Education in Tribal Schools project;
- National Indian Health Board (NIHB);
- Tribal Epidemiology Centers;
- National Congress of American Indians (NCAI) and Native American Boys and Girls Clubs;
- Head Start Bureau;
- Committee on Native American Child Health (CONACH);
- American Diabetes Association (ADA);
- Juvenile Diabetes Research Foundation (JDRF);
- American Indian Higher Education Consortium (AIHEC);
- CDC's State Diabetes Control Programs;
- National Diabetes Education Program (NDEP)

Challenges

In its entire history, the IHS had never been faced with creating and managing such a large grant program. In response to this challenge, the IHS DDTP has mobilized an extensive network to undertake one of the most strategic and concerted diabetes treatment and prevention efforts to date and have demonstrated the ability to design, manage and measure a complex, long-term project to address this chronic condition.

Despite the progress made, significant diabetes-related challenges remain in AI/AN communities such as:

- Significant numbers of vacancies for professional health care positions hinder staffing of programs especially in rural areas.
- Finding adequate space to set-up programs and conduct program activities.
- Being located in remote areas making access to clinical services a significant challenge.
- Additional needs for training and technical assistance for:
    - Grant writing and planning.
    - Assessment and planning at the community level.
    - Grant program management and leadership skills.
    - Grant program evaluation – statistics, data analysis and research on program impacts and outcomes.
    - Implementing diabetes prevention strategies that have been proven to work.
    - Implementing prevention of diabetes complications strategies that are known to work.

FUNDING HISTORY

Fiscal Year	Amount
2006	$150,000,000
2007	$150,000,000
2008	$150,000,000
2009 Recovery Act	$0
2009 Omnibus	$150,000,000
2010 Enacted	$150,000,000

BUDGET REQUEST

The FY 2011 baseline budget for Special Diabetes Program for Indian is $150,000,000 to maintain current service levels. Tribal consultation was conducted on the new SDPI extension and, based on the final decisions of the IHS Director and Administration priorities, the activities are being continued and modified appropriately.

OUTCOMES

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Diabetes: A1c Measured[1]: Proportion of patients who have had an A1c test. IHS-All	FY 2009: 80%	N/A	N/A	N/A
Tribally Operated Health Programs	FY 2009: 78%	N/A	N/A	N/A
1: **Diabetes: Poor Glycemic Control**: Proportion of patients with diagnosed diabetes that have poor glycemic control (A1C > 9.5). IHS-All[2,3]	FY 2009: 19/18% (Target Met)	16%	16.0%	0%
1: Tribally Operated Health Programs	FY 2009: 15% (Target Met)	13%	13.0%	%
2: **Diabetes: Ideal Glycemic Control**: Proportion of patients with diagnosed diabetes with ideal glycemic control (A1c <7.0) IHS-All[3]	FY 2009: 36/31% (Target Exceeded)	33%	33.8%	+0.8%
2: Tribally Operated Health Programs	FY 2009: 34% (Target Exceeded)	36%	36.9%	+0.9%
3: **Diabetes: Blood Pressure Control**: Proportion of patients with diagnosed diabetes that have achieved blood pressure control (<130/80). IHS-All[3]	FY 2009: 36/37% (Target Exceeded)	40%	41.0%	+1.0%
3: Tribally Operated Health Programs	FY 2009: 35% (Target Exceeded)	39%	40.0%	+1.0%
4: **Diabetes: Dyslipidemia Assessment:** Proportion of patients with diagnosed diabetes assessed for Dyslipidemia (LDL cholesterol). IHS-All[3]	FY 2009: 74/65% (Target Exceeded)	69%	70.7%	+1.7%
4: Tribally Operated Health Programs	FY 2009: 64% (Target Exceeded)	68%	69.7%	+1.7%
Program Level Funding ($ in millions)	**$150.0**	**$150.0**	**$150.0**	**+$0**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

[1]*There is no measure or goal; this information is provided for context.*
[2]*ForPoor Glycemic Control, a reduction in the rate represents improvement.*
[3]*First figure in results column is Diabetes audit data for which data is not currently available; second is from the Clinical Reporting System.*

OUTPUTS

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Proportion of SDPI yearly grantee assessments completed[1]	94%	90	92	+2
Proportion of SDPI grantees using at least one of the 18 Diabetes Best Practices[2]	82%	100	100	0
Proportion of patients with diagnosed diabetes assessed for DM education# provided [3](yearly audit).	61%	61	64	+3
Program Level Funding ($ in millions)	**$150.0**	**$150.0**	**$150.0**	**$0**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

1 Newly developed target for FY 2010. Target should show steady progress until 100% is reached.
[2] This is a new measure for 2008. Baseline will be established. This assessment will evaluate use of its current 18 formal IHS Diabetes Best Practices. Other programs choose to implement different Diabetes Best Practices. IHS intends to add these additional Best Practices to its formal list of Diabetes Best Practices over time.
[3] Many new programs participated in the audit assessment in 2006 so the expected target was lowered in 2006.

GRANTS

SDPI Community-Directed Grant Programs by State and FY 2009 Annual Funding Amounts in Notices of Award			
State	**State Name**	**Total Number of SDPI Grant Programs**	**Financial Assistance Award FY 2009**
AK	Alaska	25	$8,963,599
AL	Alabama	1	186,868
AZ	Arizona	32	26,359,794
CA	California	45	8,307,826
CO	Colorado	3	728,212
CT	Connecticut	3	283,935
FL	Florida	2	411,650
IA	Iowa	2	518,266
ID	Idaho	4	759,471
IL	Illinois	1	226,282
KS	Kansas	7	695,810
LA	Louisiana	4	307,903
MA	Massachusetts	1	142,066
ME	Maine	5	429,697
MI	Michigan	13	2,172,877
MN	Minnesota	13	3,401,552
MS	Mississippi	2	1,350,679
MT	Montana	19	5,582,611
NC	North Carolina	2	1,143,625
ND	North Dakota	7	2,643,997
NE	Nebraska	4	1,326,504
NM	New Mexico	32	6,938,491
NV	Nevada	19	3,260,720
NY	New York	4	1,159,580
OK	Oklahoma	41	18,387,863
OR	Oregon	15	2,134,513
RI	Rhode Island	1	114,858
SC	South Carolina	1	120,669
SD	South Dakota	14	5,439,117
TN	Tennessee	3	84,609
TX	Texas	4	589,207
UT	Utah	8	1,444,740
WA	Washington	34	3,541,903
WI	Wisconsin	14	2,949,032
WY	Wyoming	4	747,878
	TOTAL	**390 (includes sub-grantees)**	**$112,856,404**

SDPI Grant Demonstration Projects by State and FY 2009 Annual Funding in Notices of Award			
	State	**Total Number of SDPI Demonstration Programs**	**Total FY 2009 Financial Assistance Award**
AK	Alaska	5	$1,767,100
AZ	Arizona	6	2,309,800
CA	California	8	2,740,000
ID	Idaho	1	324,300
KS	Kansas	1	397,100
MI	Missouri	1	324,300
MN	Minnesota	5	1,694,300
MS	Mississippi	1	397,100
MT	Montana	4	1,370,000
ND	North Dakota	1	324,300
NE	Nebraska	1	324,300
NM	New Mexico	7	2,488,500
NY	New York	2	648,600
OK	Oklahoma	7	2,634,100
OR	Oregon	2	794,200
SD	South Dakota	4	1,370,000
UT	Utah	1	397,100
WA	Washington	6	2,018,600
WI	Wisconsin	3	972,900
	Total	**66**	**$23,296,600**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities – 75-0391-0-1-551
FACILITIES

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$390,168	$415,000	$394,757	$445,242	+$50,485
M&I	*$53,915*	*$100,000*	*$53,915*	*$55,523*	*+$1,608*
Sanitation	*$95,857*	*$68,000*	*$95,857*	*$97,710*	*+$1,853*
HCFC	*$40,000*	*$227,000*	*$29,234*	*$66,192*	*+$36,958*
FEHS	*$178,329*	*$0*	*$193,087*	*$202,106*	*+$9,019*
Equipment	*$22,067*	*$20,000*	*$22,664*	*$23,711*	*+$1,047*
Quarters[1]	*$6,288*	*$6,288*	*$6,288*	*$6,288*	*+$0*
FTE	1,202	0	1,207	1,209	+2

[1] Quarters funds are not BA but are rents collected for quarters which are returned to the service unit for maintenance and operation costs. They fall under the Program Authority.

SUMMARY OF THE BUDGET REQUEST

The Indian Health Facilities programs include project, program support, medical equipment, and quarters return activities. Project and program activities include Maintenance and Improvement (M&I), Sanitation Facilities Construction (SFC), and Health Care Facilities Construction (HCFC). The program support activity is Facilities and Environmental Health Support. Medical Equipment and Staff Quarters are also separate activities.

The FY 2011 budget request of $445,242,000 is an increase of $50,485,000 above the FY 2010 enacted level. This increase represents:

Maintenance & Improvement (+$1,608,000) – Specific objectives include:
- Providing routine maintenance and repairs for facilities.
- Achieving compliance with buildings and grounds accreditation standards of the The Joint Commission or other applicable accreditation bodies.
- Providing improvements to facilities for enhanced patient care.
- Ensuring that health care facilities meet building codes and standards.
- Ensuring compliance with executive orders and public laws relative to building requirements, e.g., energy conservation, seismic, environmental, handicapped accessibility, and security.

Sanitation Facilities Construction (+$1,853,000) – Provides for sanitation facilities:
- Projects to serve new or like-new housing, such as Indian homes being constructed or rehabilitated by the BIA-Home Improvement Program (HIP), Tribes, individual homeowners, or other nonprofit organizations.
- Projects to serve existing housing.
- Special projects (studies, training, or other needs related to sanitation facilities construction), and emergency projects.

Health Care Facilities Construction (+$36,958,000) – The request continues the construction of:

- Barrow, Alaska Hospital.
- Kayenta, Arizona Health Center.
- San Carlos, Arizona Health Center.

Facilities and Environmental Health Support (+$9,019,000) – Provides for:

- Personnel who provide facilities and environmental health services throughout the Indian Health Service, and operating costs associated with provision of those services and activities.

Equipment (+$1,047,000) – provides for:

- Routine replacement medical equipment to over 1,600 Federally and Tribally-operated health care facilities.
- New medical equipment in tribally-constructed health care facilities.
- TRANSAM which is surplus Department of Defense medical equipment and ambulance programs.

Quarters (+$0) – rents collected to be used for:

- Operation, management, and general maintenance of quarters, including temporary maintenance personnel services, security guard services.
- Repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (stoves, water heaters, furnaces, etc.).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551
MAINTENANCE AND IMPROVEMENT

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$53,915	$100,000	$53,915	$55,523	+$1,608
FTE	0	0		0	0

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization... IHCIA last authorized in 2000, Snyder and Transfer Acts - Permanent

Allocation Method ....Direct Federal, P.L. 93-638 Self-Determination contracts and Self-Governance compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

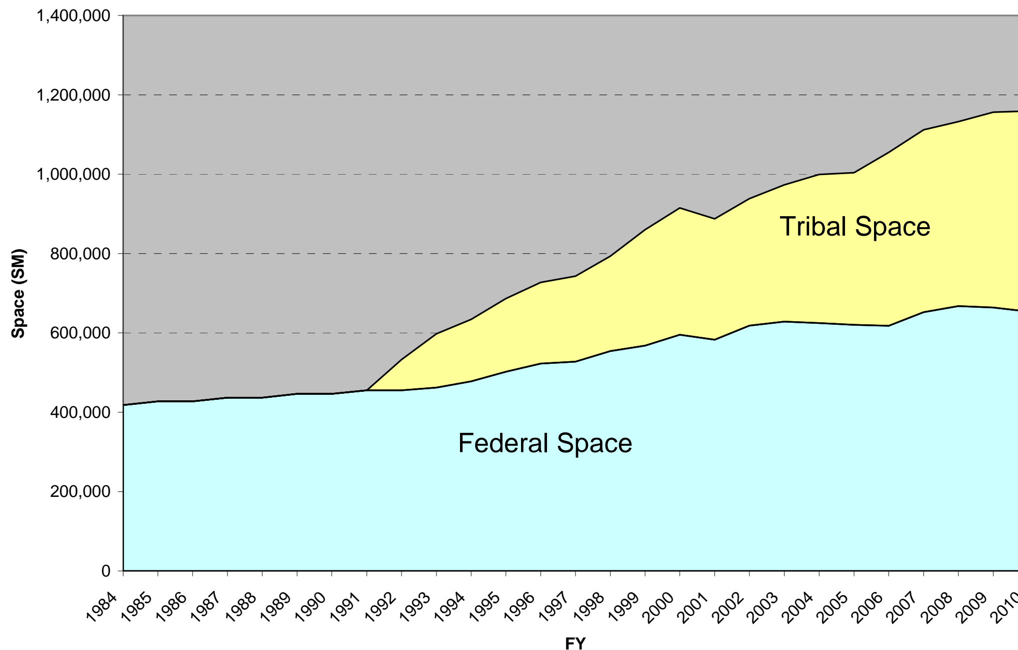
Maintenance and Improvement (M&I) supports the maintenance and improvement of IHS and Tribal health care facilities which are used to deliver and support health care services. The HHS and IHS are committed to sustaining the real property necessary to meet the mission and goals of the IHS. This request also moves towards a strategy of improving the condition of IHS health care facilities to standards set by HHS.

The IHS supports M&I activities in Federal, government-owned buildings and in Tribally-owned space where it is used to provide health care services pursuant to contract or compact arrangements executed under the provisions of the Indian Self Determination and Education Assistance Act (P.L. 93-638). M&I funds are to support and enhance the delivery of health care and preventive health services and to safeguard interests in real property. Maintaining reliable and efficient buildings is increasingly challenging as existing facilities age and additional space is added into the real property inventory.

Annual health care space supported with M&I funds:

FY	Supported Space (Square Meters)
2006	1,054,888
2007	1,112,112
2008	1,132,220
2009	1,156,237
2010	1,156,435

The following graph depicts the increase in Federal and Tribal space supported by the M&I appropriation. Supported space outpaces increases in the M&I appropriation which reduces the ability to meet the specific M&I objectives outlined in the paragraph that follows the graph.



Specific M&I objectives include: (1) providing routine maintenance and repairs for facilities; (2) achieving compliance with buildings and grounds accreditation standards of The Joint Commission (TJC) or other applicable accreditation bodies; (3) providing improvements to facilities for enhanced patient care; (4) ensuring that health care facilities meet building codes and standards; and (5) ensuring compliance with executive orders and public laws relative to building requirements, e.g., energy conservation, seismic, environmental, handicapped accessibility, and security.

The accreditation of facilities demonstrates a high level of quality of services being provided to American Indian and Alaska Native communities. (Detailed status of accreditation of all IHS health facilities is discussed under the Accreditation/Certification section of the Hospitals and Clinics appropriation)

An essential component of these accreditation standards is a viable and proactive maintenance and repair operation with adequate funding levels. Facilities Engineering Program Plans (FEPPs) establish annual M&I workload targets and help determine the most prudent use of available resources. FEPPs are prepared by IHS Area Offices, service units, and Tribal programs to identify, delineate, and plan facilities related activities and projects to be accomplished during the upcoming fiscal year with M&I funds. Funds in the M&I line item account are used primarily to maintain and improve health care facilities and are identified for allocation as routine maintenance and project funds. Staff quarters operation, maintenance, and improvement costs are primarily funded with rent collections called Quarters Return (QR) funds. M&I funds may be used in conjunction with QR funds at locations with few quarters or where QR funds are insufficient to ensure appropriate quarters maintenance.

Status of Facilities

The physical condition of IHS-owned and many Tribally-owned facilities is evaluated through annual general surveys conducted by local facility personnel and IHS Area Office engineers. In addition, comprehensive facility condition surveys are conducted every five years by a team of engineers and architects or other specialists. These surveys, together with routine observations by facilities personnel, identify deficiencies that are included in the Backlog of Essential Maintenance, Alterations, and Repair (BEMAR) database. The identified BEMAR for IHS and reporting Tribal facilities as of October 1, 2009 was $476,732,000. The following table summarizes the BEMAR by category:

BEMAR [1]

Category	Amount
PUBLIC LAW	
Life Safety Compliance	$23,494,000
General Safety	11,085,000
Environmental Compliance [2]	14,316,000
Handicapped Compliance	16,241,000
Energy Conservation	27,138,000
Seismic Mitigation [3]	50,862,000
Sub Total	**$143,136,000**
IMPROVEMENTS	
Patient Care	$92,982,000
Program Deficiencies	29,531,000
Sub Total	**$122,513,000**
MAINTENANCE & REPAIR [4]	
Architectural M&R	$26,227,000
Structural M&R	30,928,000
Mechanical M&R	75,602,000
Electrical M&R	23,014,000
Utilities M&R	12,134,000
Grounds M&R	23,202,000
Painting M&R	6,691,000
Roof M&R	13,285,000
Sub Total	**$211,083,000**
GRAND TOTAL	**$476,732,000**

[1] The M&I allocation will be distributed for routine maintenance and for projects; projects are intended to reduce identified BEMAR deficiencies.

[2] These types of projects include air quality improvement, asbestos remediation, lead-based paint, removal of underground storage tanks and contaminated soil remediation.

[3] The Earthquake Hazard Reduction Program Act required IHS to survey and estimate the cost associated with compliance to seismic construction standards. This survey was completed in the fall of 1998 and added $149,127,000 in seismic deficiencies. Since that time some seismic deficiencies have been corrected as part of larger projects, thus reducing the backlog.

[4] Staff quarters operation, maintenance, and improvement costs are funded through rents collected, called Quarters Return (QR) funds. The M&I funds may be used in conjunction with QR funds at locations where QR funds are insufficient to ensure appropriate quarters maintenance.

M&I Funds Allocation Method

The IHS M&I funds are allocated in four categories: routine maintenance, M&I projects, environmental compliance, and demolition:

Routine Maintenance Funds - Amounts are calculated using the IHS M&I distribution formula, which is based on the modified University of Oklahoma methodology to calculate routine maintenance costs. Routine M&I funds can be used to pay non-personnel costs for the following activities in IHS and Tribally-owned health care facilities: emergency repairs, preventive maintenance activities, maintenance supplies and materials, building service equipment replacement, upkeep activities, training, and local projects. These funds support facilities activities that are generally classified as those needed for 'sustainment' of the existing facilities. In FY 2010, approximately $49 million, identified as M&I routine maintenance, was provided to the IHS Area Offices and Tribes for daily maintenance activities and local projects to maintain the current state of health care facilities. The Building Research Board of the National Academy of Sciences (NAS) (*Committing to the Cost of Ownership - Maintenance and Repair of Public Buildings, 1990*) has determined that approximately two to four percent of current replacement value of supported buildings is required to maintain (i.e., 'sustain') facilities in their current condition. The current IHS investment strategy fully funds sustainment to maintain the facilities in their current condition. It is anticipated that the FY2011 level of funding requested will all go toward meeting the sustainment requirements.

M&I Project Funds - IHS Area Office facilities engineers develop priority lists of larger projects to reduce the BEMAR. Although Tribes with Tribally-owned facilities may take their individual shares of the M&I project pool funds, for those Tribes located in Areas with a Federal facility inventory, M&I project pool funds may be restricted for Federal facilities to ensure that Federal stewardship responsibilities are maintained. Generally M&I projects in this category require levels of expertise, which may not be available at the local facility. Such projects accomplish major repairs and improvements of primary mechanical, electrical, and other building systems as well as public law compliance and program-related alterations. Program-related alteration projects include changes to existing facilities for more efficient utilization, for new patient care equipment, and to accommodate new treatment methodologies. In FY 2010, approximately $1.6 million, identified as M&I project, was provided to the IHS Area Offices and Tribes for projects to reduce the BEMAR deficiencies and to improve healthcare facilities to meet changing healthcare delivery needs. The Healthcare Financial Management Association published the findings of a study that found that in the commercial (non-government) healthcare sector, hospitals spend an average of approximately five percent of a facility's value each year on restoration and modernization. This amount is required to ensure that the backlog of maintenance and repair remains within reasonable levels. It is anticipated that the level of funding requested in FY 2011 will be fully utilized for sustainment.

Under the American Recovery and Reinvestment Act, $100 million was appropriated to the M&I activities, not all of which are BEMAR related. As the result of these funds, the IHS anticipates that BEMAR will be reduced by an estimated $80 million at Federal and tribal facilities. More details are available on Recovery.gov.

Environmental Compliance Funds - The IHS places a high priority on the implementation of the Greening the Government Executive Orders and meeting Federal, State, and local legal/regulatory environmental requirements, including allocating funding to address findings and recommendations from environmental audits to improve energy efficiency and water efficiency, to increase renewable energy usage, to reduce consumption of fossil-fuel generated electricity,

and to implement other energy initiatives. Many IHS and Tribal facilities were constructed before the existence of current environmental laws and regulations. Since IHS is required to comply with current Federal, State, and local environmental regulations, the use of environmental assessments to identify and evaluate potential environmental hazards is important. These assessments form the basis of the IHS facilities environmental remediation activities. The IHS has currently identified approximately $14 million in environmental compliance tasks and included them in the BEMAR database. Tribally-owned health care facilities are scheduled for assessments upon request by a Tribe. In addition to Environmental Compliance, these funds will be used to address some of the $27M in the Energy Conservation BEMAR category for projects that improve the sustainability of IHS assets and have a high return on investment. These funds will be available to both Federal and Tribal facilities on a national basis.

Demolition Funds - The IHS has a number of Federally-owned buildings that are vacant, excess, or obsolete which are no longer needed. The number currently is estimated at over 100 buildings. Many of these buildings are safety and security hazards. Demolition of some of these buildings, in concert with transferring others, reduces hazards and liability. These funds will also be used to fund the cost associated with actions, documentation, testing, etc., required to transfer/dispose of this excess property. These funds may be augmented with Environmental Compliance Funds as available for demolition and disposal to the extent that the proposed action reduces hazards, environmental concerns, or liability to the Indian Health Service.

FUNDING HISTORY

Fiscal Year	Amount
2006	$51,633,011
2007	$54,688,000
2008	$52,889,000
2009 Recovery Act	$100,000,000
2009	$53,915,000
2010 Enacted	$53,915,000

BUDGET REQUEST

The FY 2011 budget request for Maintenance and Improvement is $55,523,000, which is $1,608,000 above the FY 2010 enacted level. This increase represents:

Inflation +$799,000 – will fund non-medical inflation costs.

Population Growth +$809,000 – will fund costs associated with the annual population growth projected to be 1.5%

This level of funding will assist the IHS in meeting the real property asset management requirements and goals as outlined in the Executive Order 13327, *Federal Real Property Asset Management*; Executive Order 13423, *Strengthen Federal Environmental, Energy, and Transportation Management*; Executive Order 13514, *Federal Leadership in Environmental, Energy, and Economic Performance;* and *Energy Independence and Security Act of 2007*; with the end product of improving the condition of existing facilities by eliminating the maintenance and repair backlog, demolition of excess buildings, and thereby raising the Condition Index. The requested funding will also aid in improving the efficiency of IHS and tribal facilities and addressing the most frequently cited area for improvement, which is the physical plant safety and efficiency. The average age of IHS health care facilities is greater than 30 years.

The total funding for M&I may provide:

- Approximately $52.0 million as M&I routine maintenance which is very close to or slightly under the estimated funding needed to sustain the condition of Federal and tribal health care facilities buildings.
- $3 million for environmental compliance projects and $500,000 for demolition projects.

OUTCOMES

Program has no outcomes.

OUTPUTS

Program has no outputs

GRANTS AWARDS

The program has no grants awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551
SANITATION FACILITIES CONSTRUCTION

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$95,857	$68,000	$95,857	$97,710	+$1,853
FTE	170	0	170	170	0

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; 42 U.S.C. 2004a, Indian Sanitation Facilities Act

FY 2011 Authorization..Permanent

Allocation Method ....Direct Federal, P.L. 93-638 Self-Determination Contracts, Memorandum of Agreements, and Self-Governance Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Sanitation Facilities Construction (SFC) is an integral component of the IHS disease prevention activity. The Indian Health Service (IHS) has carried out the program since 1959 using funds appropriated for SFC to provide potable water and waste disposal facilities for AI/AN people. As a result, the rates for infant mortality, the mortality rate for gastroenteritis and other environmentally-related diseases have been dramatically reduced, by about 80 percent since 1973. The IHS physicians and health professionals credit many of these health status improvements to IHS' provision of water supplies, sewage disposal facilities, development of solid waste sites, and provision of technical assistance to Indian water and sewer utility organizations.

The four types of sanitation facilities projects funded through IHS are (1) projects to serve new or like-new housing, such as Indian homes being constructed or rehabilitated by the BIA-Home Improvement Program (HIP), Tribes, individual homeowners, or other nonprofit organizations, (2) projects to serve existing housing, (3) special projects (studies, training, or other needs related to sanitation facilities construction), and (4) emergency projects. Projects that serve new or like-new housing are funded based on a priority classification system. Projects that serve existing housing are annually prioritized with Tribal input in terms of health impact, cost effectiveness and other criteria, then funded in priority order.

Sanitation facilities projects are carried out cooperatively with the tribes who are to be served by the facilities. Tribal involvement has been the keystone of the Sanitation Facilities Program since its inception in FY 1959. Projects start with a Tribal Project Proposal and are funded and implemented through execution of an agreement between the Tribe and IHS. In these agreements the Tribes also agree to assume ownership responsibilities, including operation and maintenance.

SFC projects can be managed by the IHS directly (Direct Service) or they can be managed by Tribes that elect to use Title I or Title V authorization under P.L. 93-638, the Indian Self-

Determination and Education Assistance Act. The overall SFC goals, eligibility criteria, and project funding priorities remain the same, regardless of the delivery methods chosen by a Tribe.

The Indian Health Care Improvement Act (Title III, Section 302(g) 1 and 2 of P.L.94-437) directed the IHS to identify the universe of Indian sanitation facilities needs for existing Indian homes. As of November 2009, the list of all documented projects totaled almost $2.9 billion with those projects considered economically and technically feasible totaling almost $1.5 billion. Typically, it's those projects with exceptionally high capital costs that are considered economically infeasible if their cost per home exceeds an established allowable unit cost per home for a particular geographical area. Technical feasibility relates to operability and sustainability of the proposed system. As of the end of FY 2009, there were about 236,000 or approximately 66% of AI/AN homes in need of sanitation facilities, including nearly 44,000 AI/AN homes without potable water.

The current backlog of projects would provide sanitation facilities to between 95 and 98 percent of all existing Indian homes. Also included in the backlog are projects intended to upgrade existing water supply and waste disposal facilities and projects to improve sanitation facilities operation and maintenance capabilities in Indian country. Maximum health benefits will be realized by addressing existing sanitation needs identified in the backlog and by providing sanitation facilities for new homes when they are constructed.

With completion of all projects approved through FY 2009, approximately 300,000 AI/AN homes will have been provided sanitation facilities since 1960. Experience shows that 60 to 70 percent of the actual construction is performed by Indian Tribes/firms.

The SFC program is a contributing factor in accomplishing the goals of the IHS Strategic Plan including: Goal 1: Build and Sustain Healthy Communities: Objective 1.2) Develop public health infrastructure with Tribes to sustain and support AI/AN communities. SFC projects provide resources for building and sustaining healthy communities through disease prevention; achieving parity in access by attempting to increase the number of AI/AN homes with potable water to 94 percent by 2015; providing compassionate quality health care through the provision of sanitation; and embracing innovation through prevention activities and increased partnerships with other federal agencies, states and tribes. Safe drinking water supplies and adequate waste disposal facilities are essential preconditions for most health promotion and disease prevention efforts, as well as being a major factor in the quality of life of Indian people.

In FY 2009, the IHS provided service to 45,325 AI/AN homes, of which almost 30,000 were served with ARRA funds from the EPA and IHS. This exceeds the combined ARRA and conventional appropriation performance target: to provide sanitation facilities projects to serve 37,500 AI/AN new or like-new and existing homes with water, sewage disposal, and/or solid waste water facilities. The SFC program has exceeded all national performance measures, IHS, Departmental and program assessment performance measures.

In FY 2010, of the $95,857,000 appropriated for sanitation facilities, $47,000,000 will be used to address the backlog of existing homes. This included funding to serve solid waste needs identified on the Sanitation Deficiency System (SDS)[1] (included in the solid waste funding was approximately $500,000 to clean up open dumps evaluated by an interagency task force, the

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[1] The Sanitation Deficiency System (SDS) is an inventory of the sanitation deficiencies of American Indian and Alaska Native communities; those sanitation deficiencies include needed water, sewer, and solid waste facilities for existing American Indian and Alaska Native homes.

members of which included the Bureau of Indian Affairs, the Environmental Protection Agency (EPA), the Department of Agriculture and others). The remainder of the FY 2010 appropriation will be used to provide $47,357,000 for sanitation facilities for new/like-new Indian homes and $1,500,000 for special projects, and emergency projects.

In cooperation with the Office of Management and Budget (OMB) a Common Measure was developed in 2002 with the Rural Utility Service (RUS), the Bureau of Reclamation (BOR), the EPA, and the IHS to allow direct comparisons between rural water programs within the federal government. The Common Measures agreed upon were the number of connections and the population served per million dollars of total project cost. It was recognized that BOR and IHS are direct service programs to a specific population, and EPA and RUS are grant/loan programs that can leverage funding with both of these programs mostly providing strictly upgraded services. SFC has leveraged its project funds yearly gaining up to 100 percent in matching project contributions from other federal (EPA, RUS), state, tribal, and local entities. The IHS compared favorably in the OMB common measure of direct comparisons between federal rural water programs by servicing more than seven times the number of homes per dollar of funding than comparable programs.

An efficiency measure based on the average project duration is evaluating SFC expertise in advancing project discipline. For Sanitation Facilities Construction projects completed during Calendar 2011 and the years thereafter, the average project duration from the execution of the Project Memorandum of Agreement (MOA) to the Construction Completion date as tracked by the Sanitation Facilities Project Data System shall be at 4 years or less. Project duration or the average length of time to complete project construction from the time the project is funded is a measure of actual performance since project schedule is under a project manager's control. This time length has been slowly increasing from 2.5 years in 1993 to over 4 years at the end of 2007. Several factors have contributed to this growth in project duration including increased administrative requirements, more involved environmental reviews, increased complexity of designs and decreases in staff resources. It is expected that the project duration will increase to at least 4.3 years prior to returning to 4 years. Reversing this trend is a protracted undertaking marked by gradual progress due to the sheer number of existing projects already underway, many of which already have durations in excess of four years. All reductions in the length of time a project takes to complete will yield cost savings in both construction inflation costs and project related staffing costs.

Based on the FY 2009 data, 12% of AI/AN homes are without a safe and reliable water supply. A marginal cost analysis for the SFC Program was completed in 2006 for the OMB in conjunction with OMB A-11, Section 221, Budget and Performance Integration. The marginal cost estimates related the level of SFC funding to the percent of AI/AN homes with potable water for a ten year period. According to the marginal cost curves the SFC funding would need to be increased to raise the percent of AI/AN homes that have access to safe drinking water.
The marginal cost analysis for the SFC Program recommendations validated the existing IHS strategic goal and program assessment goal for the SFC Program to increase the number of AI/AN homes with potable water to 94 percent by 2015. The Tribes through tribal consultation, other federal agencies through the Johannesburg MOU, and EPA within their strategic plan are all committed to SFC long term strategic goal.

FUNDING HISTORY

Fiscal Year	Amount
2006	$94,003,000
2007	$94,253,000
2008	$94,253,000
2009 Recovery Act	$68,000,000
2009	$95,857,000
2010 Enacted	$95,857,000

BUDGET REQUEST

The FY 2011 budget request for Sanitation Facilities Construction is $97,710,000 which is $1,853,000 above the FY 2010 enacted level. This increase represents:

Pay Costs +$75,000 – will fund pay increase for staff.

Inflation +$340,000 – will fund non-medical inflation costs.

Population Growth +$1,438,000 – will fund costs associated with the annual population growth projected to be 1.5%.

The budget request for Sanitation Facilities Construction supports essential sanitation facilities including water supply, sewage, and solid waste disposal facilities to American Indian/ Alaska Native (AI/AN) homes and communities. The SFC Program is a preventive health program that yields positive benefits in excess of the program costs.

This level of funding will be allocated as follows, with projects budgeted to include full costs for pre-planning, design, construction costs, and associated overhead:

1) Up to $2,000,000 will be reserved at IHS Headquarters. Of which, $1,000,000 will be used for special projects and for distribution to all Areas as needed to address water supply and waste disposal emergencies caused by natural disasters or other unanticipated situations that require immediate attention to minimize potential threats to public health. Emergency and special funds remaining at the end of the fiscal year may be distributed to the Areas to address the Sanitation Deficiency System (SDS) priority list of needs. The remaining $1,000,000 is for funding special projects in 3 Areas a year to collect homeowner data and other demographic information to strengthen verification mechanisms within the SFC Community Deficiency Profiles (CDP) in an effort to increase transparency, accuracy, and accountability of the CDP data. This data initiative began in 2010 and will be funded over 4 years to collect this data in all twelve IHS Areas. A portion of these funds will be used for improving data collection systems, providing technical assistance and training for users, as well as for covering the costs of a national automated computer aided drafting contract.

2) Up to $50,000,000 of the total FY 2011 SFC appropriation will be reserved to serve new and like-new homes. Some of these funds may also be used for sanitation facilities for the individual homes of the disabled or sick with a physician referral indicating an immediate medical need for adequate sanitation facilities in their home. As needed, amounts to serve new and like-new homes will be established by Headquarters after reviewing Area requests. Priority will be given to projects intended to provide sanitation facilities for the first time to homes in categories B, C, and D (new homes and homes receiving major renovation

bringing the homes up to like new condition) under the BIA Housing Improvement Program (HIP). (NOTE: Homes in BIA/HIP Category A are considered existing homes. Category A homes needing service will be included in the SDS.)

The amount allocated to each Area for projects to serve other new/like-new homes will be used as a basis for determining the Area's pro-rata share of remaining funds for serving such housing.

3) At least $45,500,000 of the SFC appropriation in FY 2011 will be distributed to the Areas for prioritized projects to serve existing homes, based on a formula that considers, among other factors, the cost of facilities to serve existing homes that: (a) have not received sanitation facilities for the first time; or (b) are served by substandard sanitation facilities (water and/or sewer). Another distribution formula element is a weight factor that favors Areas with larger numbers of American Indian and Alaska Native (AI/AN) homes without water supply or sewer facilities, or without both.

4) Up to $5,000,000 will be used for projects to clean up and replace open dumps on Indian lands pursuant to the Indian Lands Open Dump Cleanup Act of 1994.

The IHS appropriated funds will not be used to provide sanitation facilities for new homes funded with grants by the housing programs of the Department of Housing and Urban Development (DHUD). These DHUD housing grant programs for new homes should incorporate funding for the sanitation facilities necessary for the homes.

OUTCOMES

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
(35) SFC-1: Sanitation Improvement: Number of new or like-new and existing AI/AN homes provided with sanitation facilities.	FY 2009: 45,325 (Target Exceeded)	21,811	21,500	-311
(35A) SFC-2: Percent of existing homes served by the program at Deficiency Level 4 or above as defined by 25 USC 1632.	FY 2009: 32% (Target Not Met)	37%	37%	0
SFC-E: Track average project duration from the Project Memorandum of Agreement (MOA) execution to construction completion. *(Efficiency)*	FY 2008: 3.7 years (Target Exceeded)	4.0 years	4.0 years	0
SFC-3: Percentage of AI/AN homes with sanitation facilities[1]	FY 2009: 88%	90%	N/A	N/A
Program Level Funding ($ in millions)	**FY2009: $95.9**	**$95.9**	**$97.7**	**$1.8**
ARRA Level Funding	**FY2009: $67.0**	**$1.0**	**$0**	**$0**

1. Includes approximately 15,370 homes to be served with ARRA funding.
Targets in FY 2009 are revised to reflect funds provided in the Recovery Act.

Outputs - program has no outputs.
Grants Awards - program has no grants awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities – 75-0391-0-1-551

HEALTH CARE FACILITIES CONSTRUCTION

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$40,000	$227,000	$29,234	$66,192	+$36,958
FTE	0	0		0	0

HEALTH CARE FACILITIES CONSTRUCTION PROJECTS

(Dollars in Thousands)

Projects [1]	FY 2009		FY 2010	FY 2011	
	Appropriation	Recovery Act	Appropriation	Budget Request	+/- FY 2010 Pres. Budget
BA	$40,000	$227,000	$29,234	$66,192	$36,958
PIMC System SE ACC Chandler, AZ	4,000				
Barrow, AK, Hosp			15,234	40,192	+24,958
Nome, AK	10,000	/2			
Outpatient Facilities					
Eagle Butte, SD		/2			
Kayenta, AZ HC	12,000		7,000	10,000	+3,000
San Carlos, AZ	14,000		7,000	16,000	+9,000
Youth Regional Treatment Centers (Section 704)					
YRTC Facilities				0	
Joint Venture Construction Program (Section 818e)					
Health Facilities				0	
Small Ambulatory Program (Section 306)					
Small Health Clinics				0	
Dental Facilities Program					
Dental Units				0	

1 *The Inpatient and Outpatient health care facilities, Staff Quarters, and SAP projects are shown in priority order within their subcategory, but they are not prioritized against the other project categories that are listed. For example, the Barrow, AK Inpatient project does not have a higher priority than the Eagle Butte, SD project.*

2 *These projects are reported through Recovery.Gov.*

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization... IHCIA last authorized in 2000,
Snyder and Transfer Acts - Permanent

Allocation Method ....Direct Federal, P.L.93-638 Self-Determination Contracts, and Self-Governance Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Purpose - The IHS Health Care Facilities Construction (HCFC) funds provide optimum availability of functional, modern IHS and tribally operated health care facilities and, where no suitable housing alternative is available, staff housing. The IHS capital improvement program, funded through this budget activity, is authorized to construct health care facilities and staff quarters; renovate/construct Youth Regional Treatment Centers for substance abuse; support tribal construction of facilities under the Joint Venture Construction Program; provide construction funding for Tribal small ambulatory care facilities projects; and provide funding to replace or provide new and replacement dental units.

Pursuant to the Indian Health Care Improvement Act (IHCIA), Public Law (P.L.) 94-437, as amended in 1992, the need for each health care facility and staff quarters construction project is assessed through a periodic application of comprehensive priority system methodologies. The proposals are evaluated objectively and ranked according to need.

To determine the locations where new and replacement facilities are most critically needed, the IHS has developed comprehensive priority system methodologies for health care facilities and staff quarters construction authorities. The IHS Headquarters periodically solicits from the IHS Areas proposals for urgently needed new or replacement health care facilities, essential staff quarters projects, and replacement/new dental units. These proposals are evaluated and ranked. Program justification documents are prepared for those scoring highest. Once justified and approved, projects are placed on the appropriate construction priority list and proposed for funding in the order in which planning documents are approved and progress is achieved.

History - During FY 1990, in consultation with the Tribes, the IHS revised its Health Facilities Construction Priority System (HFCPS) methodology. The HFCPS ranks proposals using factors reflecting the total amount of space needed; age and condition of the existing facility, if any; degree of the isolation of population to be served in the proposed facility; and availability of alternate health care resources. There are three phases to the HFCPS. During FY 1991, Phase I of the methodology was applied to 149 IHS Area-generated proposals for construction of new or replacement health care facilities. Based on the Phase I result, the IHS proceeded with Phase II of the methodology, by submitting the 28 highest ranked proposals to a more detailed analysis. During FY 1992, the IHS consulted with Tribes about incorporating additional flexibility into the HFCPS in order to give consideration to new concepts, such as low acuity beds in health centers, as directed by the Congress in the FY 1992 Conference Report on IHS appropriations. Few Tribes urged the IHS to make changes to the HFCPS. In FY 1993, 23 of the 28 proposals considered in Phase II were advanced to Phase III. IHS Area Offices were asked to develop Program Justification Documents (PJDs) for each of the 23 proposed facilities. In FY 2008, the last of these PJDs were approved, and the projects were placed on the Healthcare Facilities Construction Priority Lists.

The IHS has two processes for reviewing the staff housing needs. Under the Quarters Construction Priority System methodology, the IHS reviews the need for additional quarters units at all existing health care facilities. Phases I and II of this methodology were last applied in 1991. As each Program Justification Document for Staff Quarters (PJDQ) is completed for these projects, the projects are added to the Quarters Construction Priority List. The second process responds to the Department of Health and Human Service office of the Inspector General report of April 17, 1990, regarding needed improvements for planning and construction of IHS staff housing. One of the improvements developed was that the IHS began reviewing the need for quarters at each location where new or replacement health care facilities were being planned, and

incorporating the planning, design, and construction of needed staff quarters as part of the health care facilities construction projects.

The IHS is authorized to construct Youth Regional Treatment Centers (YRTCs) by Section 704 of the IHCIA, P.L. 94-437, as amended.

For the IHS Joint Venture Construction Program (JVCP), the Department of the Interior and Related Agencies Appropriations Act for FY 1991 (P.L. 101-512) authorized and partially funded a “joint venture demonstration program” to equip, supply, operate, and maintain up to three health centers. Under this demonstration, these health centers were to be selected on a competitive basis from those Tribal applicants agreeing to provide an appropriate facility for use as a health center for a minimum of 20 years, under a no cost lease. A subsequent update to the Indian Health Care Improvement Act, P.L. 94-437, incorporated authorization for the Joint Venture Construction Program as a part of Section 818. Beginning in FY 2003, Congressional language directed that staff quarters, if needed, were to be part of the health care facility under the Joint Venture Construction Program. The costs for facility design and construction and staff quarters, if any were to be borne by participating Tribes. The IHS was to be responsible for all costs associated with staffing, initially equipping, and operating the facilities.

The IHS is authorized to provide construction funding to Tribes or Tribal organizations under Section 306 of the IHCIA, P.L. 94-437, as amended. Funding may be awarded only to Tribes operating non-IHS outpatient facilities under the Indian Self-Determination and Education Assistance Act, P.L. 93-638, service contracts. This authorization is administered under the IHS Small Ambulatory Program.

Recent Accomplishments - The efficiency measure for the IHS Health Care Facility Construction program for FY 2009 was to complete construction of one health care facility. This measure was met.

IHS Strategic Objectives, 1 and 2 cannot be realized without replacing small and antiquated facilities with appropriately sized facilities, adequate staffing, and state-of-the-art equipment. Sufficient resources, facilities, and equipment together with a culturally competent, highly skilled work force are fundamental to achieving health care access and health status parity with the U.S. general population. The ability to affect health status in any community involves increasing access to quality healthcare.

FUNDING HISTORY

Fiscal Year	Amount
2006	$37,779,000
2007	$25,664,000
2008	$36,584,000
2009 Recovery Act	$227,000,000
2009	$40,000,000
2010 Enacted	$29,234,000

BUDGET REQUEST

The FY 2011 budget request for Health Care Facility Construction is $66,192,000 which is an increase of $36,958,000 above the FY 2010 enacted level.

Appropriated funds will be allocated as follows:

Barrow Hospital, Barrow, AK: a total request of $40, 192,000-- These funds will be used to continue construction of the Barrow Hospital, which received initial design and construction funding in 2005. The funds will provide for the completion of the building shell including roof, walls, windows and doors, interior build-out including walls/ partitions, ceilings, lighting, and start of purchase and installation of mechanical and electrical equipment. The replacement hospital will provide space to support a modern and adequately staffed health care delivery program, which will improve access to the medical services needed to maintain and promote the health status and overall quality of life for the residents of the Barrow Service Area. The IHS health care services for this region are provided in the Samuel Simmonds Memorial Hospital, which is operated by the Arctic Slope Native Association, Ltd., under a Public Law (P.L.) 93-638 compact, with support services being provided by the Ukpeagvik Inupiat Corporation, under a P.L. 93-638 contract. The IHS also contracts with the North Slope Borough to provide community based services. The proposed new replacement hospital will have health care services for inpatient acute care nursing and labor and delivery (8 beds); endoscopy and outpatient surgery; ambulatory care; emergency and urgent care; ancillary for diagnostic imaging and laboratory; dental; optometry; audiology; physical therapy; community health, including public health nursing, nutrition; health education, alcoholism, and community health representative program; environmental health; and mental health and social services. The proposed 9,326 gross square meters (GSM) replacement hospital will serve a projected user population of 6,142 generating approximately 27,000 primary care provider visits and 40,000 outpatient visits annually. The IHS planned facility includes only IHS supported health care programs.

Kayenta Health Center, Kayenta, AZ: total request of $10,000,000 – These funds will be used to continue construction of the Kayenta Health Center and associated staff quarters, which received initial design funding in FY 2005. The funds will provide for the purchase and erection of structural steel and the completion of the building shell including roof, walls, windows, and doors. The proposed new Kayenta replacement health center will provide space to support a modern and adequately staffed health care delivery program that will improve access to the medical services needed to maintain and promote the health status and overall quality of life for the residents of the service area. The health care programs and services provided at this facility include a level III emergency and urgent care unit with the support of the Tribal emergency medical services (EMS); a 10- bed short stay nursing unit that provides sub-acute care; a three-bed low-risk birthing center, which will allow this health center to function as an IHS alternative rural hospital. Additionally, this health center will have comprehensive ambulatory care, ancillary services, preventive community health services, behavioral health services, service unit administration, and facility support services. The proposed 16,638 gross square meters (GSM) new health center has been planned for a projected user population of 19,253 generating approximately 54,000 primary care provider visits and 107,000 outpatient visits annually. The existing facility will be disposed of in accordance with established regulations and procedures after the replacement health center is operational.

San Carlos Health Center, San Carlos, AZ: a total request of $16,000,000 -- Funds in this request will be used to continue construction of the San Carlos Health Center and associated staff quarters, which received initial design funding in FY 2005. The funds will provide the purchase and erection of structural steel; completion of the building shell including roof, walls, windows, and doors; and partial completion of the site work and utilities for the staff quarters. The existing hospital at San Carlos will be replaced with a modern 16,721 gross square meters (GSM) health center that will have alternative rural hospital capabilities. The replacement facility will be a modern, technologically advanced facility with the required staff to provide an expanded level of

health care services specifically designed to meet the health care needs of the San Carlos Service Unit's projected user population of 12,985 generating approximately 50,000 primary care provider visits and 128,000 outpatient visits annually (projections to 2015 based on actual FY 2008 population figures). The facility will include eight low risk nursing care beds and two birthing beds for a total of ten beds. New services provided by the facility will be a two-bed low risk birthing unit, physical therapy, telemedicine, podiatry, Ultra-sound, ambulatory procedures, CT, and mammography. The staffing for the facility will consist of 354 approved Resource Requirements Methodology Needs Assessment (RRMNA) IHS positions and 70 Tribal employees. The project will also include the construction of 43 new staff housing units.

The FY 2011 HCFC funding level is insufficient to complete any of the three funded projects. At his funding level the projects will be required to be built in phases. Phasing of a project historically has increased costs by 5.75% per year. For these three projects, this could increase costs as much as $23,000,000.

In addition to increases in costs, lower funding levels will change completion schedules. IHS has a goal of 15% of our buildings incorporating the Guiding Principles for High Performance and Sustainable Buildings. Completing these new replacement facilities is an essential part of the plan to meet that goal, and under the current funding levels, it is not likely IHS will meet the 2015 goal for incorporating sustainability into the real property inventory.

OUTCOMES

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
36: Health Care Facility Construction: Number of health care facilities construction projects completed.	FY 2009: 1 (Target Met)	1	1	0
HCFC-E: Health Care Facilities Construction: Percent of health care facilities construction projects completed on time.	FY 2009: 100% (Target Met)	100%	100%	0
Program Level Funding ($ in millions)	**FY 2009: $40.0**	**$29.2**	**$66.2**	**+$37.0**
ARRA Level Funding ($ in millions)	**FY 2009: $138.5**	**$88.5**	**$0**	**$0**

Measure	Most Recent Result All FY 2009	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
HCFC-1: Diabetes: Ideal Glycemic Control: Proportion of patients with diagnosed diabetes with ideal glycemic control.	24/102 (Target Not Met)	26	26.7	+0.7
	45/52 (Target Exceeded)	47	48.2	+1.2
	26/244 (Target Met)	28	28.7	+0.7
	36/37 (Target Not Met)	38	39.0	+1.0
	24/55 (Target Not Met)	26	26.7	+0.7
	31/48 (Target Exceeded)	33	33.8	+0.8

Measure	Most Recent Result All FY 2009	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
	N/A (Exempt)	Exempt	N/A	N/A
	28/37 (Target Exceeded)	30	30.8	+0.8
	28/16 (Target Not Met)	30	30.8	+0.8
HCFC-2: Pap Smear Rates: Proportion of eligible women who have had a Pap screen within the previous three years.	65/53 (Target Exceeded)	66	67.7	+1.7
	38/23 (Target Met)	39	40.0	+1.0
	46/263 (Target Exceeded)	47	48.2	+1.2
	63/4 (Target Exceeded)	64	65.6	+1.6
	61/15 (Target Met)	62	63.6	+1.6
	80/25 (Target Met)	81	83.0	+2.0
	N/A (Exempt)	Exempt	N/A	N/A
	53/11 (Target Not Met)	54	55.4	+1.4
	52/7 (Target Met)	53	54.3	+1.3
HCFC-3: Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years.	54/102 (Target Exceeded)	56	57.9	+1.9
	35/36 (Target Not Met)	37	38.3	+1.3
	35/288 (Target Exceeded)	37	38.3	+1.3
	70/21 (Target Exceeded)	72	74.4	+2.4
	41/36 (Target Exceeded)	43	44.5	+1.5
	74/25 (Target Not Met)	76	78.6	+2.6
	N/A (Exempt)	Exempt	N/A	N/A
	51/19 (Target Exceeded)	53	54.8	+1.8
	52/28 (Target Not Met)	54	55.8	+1.8

Measure	Most Recent Result All FY 2009	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
HCFC-4: Alcohol Screening (FAS Prevention): Alcohol-use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients.	46/40 (Target Exceeded)	49	49.9	+0.9
	69/-1 (Target Not Met)	69	70.3	+1.3
	68/231 (Target Not Met)	71	72.3	+1.3
	73/5 (Target Not Met)	76	77.4	+1.4
	54/10 (Target Exceeded)	57	58.1	+1.1
	79/18 (Target Exceeded)	82	83.6	+1.6
	N/A (Exempt)	Exempt	N/A	N/A
	60/9 (Target Exceeded)	63	64.2	+1.2
	66/-1 (Target Exceeded)	69	70.3	+1.3
HCFC-5: Combined* immunization rates for AI/AN children patients aged 19-35 months[2]: Immunization rates for AI/AN children patients aged 19-35 months.	97 (Target Exceeded)	98	100.0	+2.0
	91 (Target Not Met)	92	94.3	+2.3
	88 (Target Exceeded)	89	91.2	+2.2
	92 (Target Exceeded)	93	95.3	+2.3
	71 (Target Not Met)	72	73.8	+1.8
	85 (Target Not Met)	86	88.2	+2.2
	N/A (Exempt)	Exempt	N/A	N/A
	95 (Target Exceeded)	96	98.4	+2.4
	95 (Target Exceeded)	96	98.4	+2.4
HCFC-6: Influenza vaccination rates among adult patients aged 65 years and older.	67/130 (Target Exceeded)	68	69.7	+1,7
	68/33 (Target	69	70.7	+1.7

Measure	Most Recent Result All FY 2009	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
	Exceeded)			
	60/233 (Target Exceeded)	61	62.5	+1.5
	97/0 (Target Exceeded)	98	100.0	+2.0
	69/25 (Target Not Met)	70	71.8	+1.8
	95/39 (Target Exceeded)	96	98.4	+2.4
	N/A (Exempt)	Exempt	N/A	N/A
	65/24 (Target Exceeded)	66	67.7	+1.7
	52/39 (Target Not Met)	53	54.3	+1.3
HCFC-7: Pneumococcal vaccination rates among adult patients aged 65 years and older.	85/130 (Target Exceeded)	86	88.2	+2.2
	89/33 (Target Exceeded)	90	92.3	+2.3
	88/233 (Target Exceeded)	89	91.2	+2.2
	98/0 (Target Not Met)	99	100.0	+1.0
	86/25 (Target Exceeded)	87	89.2	+2.2
	97/39 (Target Exceeded)	98	100.0	+2.2
	N/A (Exempt)	Exempt	N/A	N/A
	84/24 (Target Exceeded)	85	87.1	+2.1
	86/39 (Target Not Met)	87	89.2	+2.2
HCFC-8: Tobacco Cessation Intervention[2,3]: Proportion of tobacco-using patients that receive tobacco cessation intervention.	5 (Target Exceeded)	8	8.2	+0.2
	37 (Target Exceeded)	40	41.0	+1.0
	26 (Target	29	29.7	+0.7

Measure	Most Recent Result All FY 2009	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
	Exceeded)			
	35 (Target Exceeded)	38	39.0	+1.0
	4 (Target Not Met)	7	7.2	+0.2
	26 (Target Exceeded)	29	29.7	+0.7
	N/A (Exempt)	Exempt	N/A	N/A
	50 (Target Exceeded)	53	54.3	+1.3
	35 (Target Exceeded)	38	39.0	+1.0
HCFC-9: Percent reduction of the YPLL rate within 7 years of opening the new facility. *(Outcome)*	N/A (Jan 2013)	-10% (Fac B) (2014)	-10% (Fac C) (2015)	N/A
HCFC-10: Percent increase in the proportion of diagnosed diabetics demonstrating ideal blood sugar control within 7 years of opening the new facility[1] *(Outcome)*	-14% (Target Not Met)	+10% (Fac B)	+10% (Fac C)	N/A

Measures are reported by facility in ascending order (i.e. Facility A, B, C, D, E, F).
[1]*First figure in results column is performance measure results; second is increased access from baseline.*
[2]*Rate changes prior to 2006 are not comparable due to CRS logic changes; increase in access rates could not be calculated.*
[3]*In FY 2005, this measure tracked the proportion of patients ages 5 and above who are screened for tobacco use. Prior to 2004, measure was Support local level initiatives directed at reducing tobacco usage.*

The group of measures above outlines clinical performance and access to care for eight clinical performance topics and include: diabetes Glycemic control, cancer screening (breast and cervical), Alcohol screening to prevent Fetal Alcohol Syndrome, Tobacco Cessation and immunizations (childhood and adult). Overall trends for these measures show moderate improvement but variations across facilities and across measures were noted. High cost measures such as Glycemic control, cancer screenings, and tobacco cessation can be attributed to the varied results across measures. In addition, increases in access to care (i.e., service population) have been observed for all measures and are not unique to one individual facility. Due to the inflation of the service population, clinical results can have an artificial appearance of declining performance. With that said, over inflation of the denominator (or increase in the service population) can dilute the true performance result (i.e., the overall number of patients being served has increased). All in all, the biggest attribute noted for these performance measures are the vast gains in access to quality healthcare across all topic areas outlined above. The HCFC-10 measure reflects the percent increase in the proportion of diagnosed diabetics demonstrating ideal glycemic control within 7 years of opening a new facility. The FY 2009 target was not met for Facility A, with a result of -14 percent. This result must be reviewed in the context of the increase in the number of active diabetic patients receiving treatment at this facility; there was a 102% increase in diabetic patients between FY 2002 and FY 2009.

OUTPUTS -- Program has no outputs.
GRANTS AWARDS -- Program has no grants awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$178,329	$0	$193,087	$202,106	+$9,019
FS	*$96,038*	*$0*	*$107,518*	*$113,342*	*+$5,824*
EHS	*$67,022*	*$0*	*$69,196*	*$71,824*	*+$2,628*
OEHE	*$15,269*	*$0*	*$16,373*	*$16,940*	*+$567*
FTE	1,032	0	1,037	1,039	+2

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization... IHCIA last authorized in 2000, Snyder and Transfer Acts - Permanent

Allocation Method ....Direct Federal, P.L. 93-638 Self-Determination Contracts, Self-Governance Compacts, and competitive cooperative agreements

SUMMARY OF PROGRAMS

The Indian Health Facilities programs are managed at IHS Headquarters by the Office of Environmental Health and Engineering (OEHE) and throughout the country, more specifically by Area, Field, and Service Unit staff. These programs provide an extensive array of real property, health care facilities and staff quarters construction, maintenance and operation services, as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. The programs both directly and indirectly support all of the IHS facilities performance measures and improved access to quality health services.

The array of services funded under this activity are delivered directly by Federal or Tribal employees or contractors. In addition to staffing costs, funds are used to pay for utilities in IHS health care facilities, certain non-medical supplies and personal property, and biomedical equipment repair.

The OEHE Headquarters staff, and facilities and environmental health-related programs in IHS Area Offices and District Offices, provide support for a diverse range of projects and activities. Area facilities and environmental health personnel include architects, engineers, environmental health officers, real property and staff quarters management specialists, biomedical technicians, facilities planners, injury prevention specialists, institutional environmental health officers, construction inspectors, utility operations consultants, draftspersons, and land surveyors.

This activity has three sub-activities to align program and functions and is summarized below:

- Facilities Support (FS) provides funding for staff, management activities, operation and maintenance of real property and building systems, medical equipment technical support, and planning and construction management support for new and replacement facilities projects.

- Environmental Health Support (EHS) provides funding for management activities and for engineers, environmental health officers, environmental health technicians, engineering aides, injury prevention specialists, and institutional environmental health officers.

- Office of Environmental Health and Engineering (OEHE) provides funding for headquarters management activities and for real property asset management across the IHS facilities and environmental health programs, including technical services and support for capital investments, budget formulation, and long range planning, national policy development and implementation and liaison with the Department, Congress, Tribes, and other Federal agencies.

FUNDING HISTORY

Fiscal Year	Amount
2006	$150,709,000
2007	$165,272,000
2008	$169,638,000
2009 Recovery Act	$0
2009	$178,329,000
2010 Enacted	$193,087,000

BUDGET REQUEST

The FY 2011 budget request for Facilities and Environmental Health Support is $202,106,000 which is $9,019,000 over the FY 2010 enacted level. This increase represents:

Pay Costs +$1,847,000 - will fund pay increases for Federal and Tribal employees.

Inflation +$1,273,000 - will fund non-medical inflation costs.

Population Growth +$2,896,000 - will fund costs associated with the annual population growth projected to be 1.5%.

Staffing for New Facilities +$3,003,000 - to fund staffing and operations, including utilities, at 5 new and replacement facilities. Operating cost is based on a percentage of the total new staffing cost for all sub-sub-activities within a healthcare facility.

Staff for New Facilities	Amount	FTE/Tribal Positions
Absentee Shawnee Health Center (JV), Little Axe, OK	$755,000	4
Elbowoods Health Center, New Town, ND*	$1,021,000	6
Carl Albert Hospital, Replacement (JV), Ada, OK	$678,000	3
Lake County Tribal Health Center (JV), Lakeport, CA	$305,000	2
Cheyenne River Health Center, Eagle Butte, SD	$244,000	2**
Grand Total:	**$3,003,000**	**17**

* Environmental Health Support - $373,000 and 3 positions
**Federal FTE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551
FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT
FACILITIES SUPPORT

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$96,038	$0	$107,518	$113,342	+$5,824
FTE	569	0	574	576	+2

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization... IHCIA last authorized in 2000, Snyder and Transfer Acts - Permanent

Allocation Method ....Direct Federal, P.L. 93-638 Self-Determination Contracts, Self-Governance Compacts, and competitive cooperative agreements

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The personnel paid from this account operate and maintain health care facilities and staff quarters. Staff functions supported by this sub-activity include management, operation and maintenance of real property and building systems, medical equipment technical support, and planning and construction management for new and replacement facilities projects. In addition, this sub-activity provides funding for related Area and service unit operating costs, such as utilities, building operation supplies, facilities-related personal property, and biomedical equipment repair and maintenance. Lease costs however are funded from the IHS Services appropriation.

The IHS is committed to ensuring that health care is provided in functional and safe structures. Because many IHS facilities are located in isolated and remote environments far from urban centers, the IHS also builds and maintains residential quarters (housing) at some locations to house non-local health care personnel.

The IHS owns approximately 944,000 square meters of facilities (buildings and structures) and 740 hectares of Federal and trust land. The nature of space varies from sophisticated medical centers to residential units and utility plants. Facilities range in age from less than one year to more than 156 years. The average age of our health care facilities is greater than 30 years.

In addition to Federally-owned space, the IHS manages direct-leased and GSA-assigned space. The table below shows the space occupied by IHS and Tribal Health Care Programs.

Space Occupied by IHS and Tribal Health Care Programs - FY 2009				
Type of Facility	Federally Owned	Direct Federal Lease	GSA Assigned	Tribal *
Hospitals and Health Centers	472,000 M2	89,000 M2	0 M2	288,000 M2
Staff Quarters	323,000 M2	0 M2	0 M2	0 M2
Other	149,000 M2	17,000 M2	61,000 M2	313,000 M2
Total	**944,000 M2**	**106,000 M2**	**61,000 M2**	**601,000 M2**

(FY 2009 end of year)

* Tribal Space listed for Hospitals and Health Centers includes all eligible supported space at locations where direct medical services are provided under P.L. 93-638 contracts in non-IHS owned buildings. Staffing and operation costs (including lease costs) for health care services are funded from the IHS Services appropriation.

Four principal staff functions are funded at the Area and Service unit levels through the Facilities Support sub-activity.

- **Facilities Engineering** -- Area and Service unit facilities engineers and staff are responsible for ensuring that IHS building systems are operated properly, facilities and grounds are maintained adequately, utilities are managed appropriately, environmental compliance requirements are met, and buildings are safe. The need for maintenance and improvement projects is determined at the Area level and identified in Area Facilities Engineering Plans.

- **Clinical Engineering --** The IHS has highly sophisticated medical equipment in its inventory. Skilled and specialized personnel are employed to maintain and service that equipment because the lives of patients and level of patient care depend on accurate calibration and safe operation. Clinical engineers and technicians perform this critically important function. Larger IHS facilities have clinical engineering personnel on-site, but most IHS and Tribal facilities depend on Area, district, or service unit-based clinical engineers and technicians who travel to several facility locations to repair and maintain biomedical equipment.

- **Realty Management** -- Area Realty Management Officers provide technical and management assistance for realty activities associated with direct-leased, GSA-assigned, and IHS-owned (and to some degree Tribally-owned) space. The program includes facility and land acquisitions and disposals, licensing/easement processing, use-permit issuance, quarters management and rent-setting activities, lease administration, and budget functions. The program also helps Tribes and Tribal organizations acquire, administer, and/or manage excess Federally-owned and Tribally-leased real property.

- **Facilities Planning and Construction** -- Some IHS Areas have facilities planning and construction-monitoring components that assist in the planning and construction management of new and replacement health care facility and staff quarters projects. The need for new and replacement facilities is determined by applying the IHS Health Facilities Construction and Quarters Construction Priority System methodologies. Area staffs develop initial proposals for new and replacement facilities, prepare Program Justification Documents, Program of Requirements Documents, and Project Summary Documents for projects. While construction is underway, Area facilities management staff may be supplemented with construction management personnel to oversee Federal interests in the construction of new and replacement facilities.

  In addition, the functions of these facility and realty positions support new real property asset management requirements as required by Executive Order 13327, *"Real Property Asset Management*"; Executive Order 13423, *Strengthen Federal Environmental, Energy, and*

Transportation Management; Executive Order 13514, *Federal Leadership in Environmental, Energy, and Economic Performance*; *Energy Independence and Security Act of 2007*; and HHS Program Management objectives. These management actions are to ensure management accountability, to ensure the efficient and economic use, to recognize the importance, and to respond to the current condition of Federal real property.

The IHS places a high priority on the implementation of the Greening the Government Executive Orders and meeting Federal, State, and local legal/regulatory environmental requirements, including allocating funding to address findings and recommendations from environmental audits. The costs associated with implementation of these requirements compete against other Facilities Support requirements within the existing budget levels. Starting in FY 2004, a national effort was initiated to execute a new cycle of environmental assessments with emphasis on direct building and grounds related deficiencies with sufficient data to initiate projects to address pending environmental deficiencies. The IHS is setting aside Maintenance and Improvement funds in the amounts of approximately $3 million for environmental compliance projects, and $500,000 for demolition projects.

In conjunction with improved management practices, energy conservation measures, and projects, IHS reduced the energy related utility consumption for IHS managed facilities from 2,190,000 British Thermal Unit per Square Meter (BTU/SM) in 2003 to 2,008,000 BTU/SM in 2009 which is a 8.1 percent reduction. These efforts help stem the growth in utilities costs, which is occurring primarily due to space increases and inflation. IHS will continue all of these functions in FY 2010 and FY 2011. However, this will only partially address the overall impact of expected increases in energy cost. During the period FY 2003 through FY 2009, total utility costs have increased 50 percent from $15.5 million to $23.4 million and total utility costs per Gross Square Meters increased 49 percent from $25/GSM to $38/GSM. The IHS continues to aggressively investigate options to reduce energy costs through energy-savings performance contracts, utility energy-efficiency service contracts, and other contractual platforms for achieving conservation goals.

FY	Cost	BTU/SM	Cost/GSM
2004	14,800,000	2,150,000	$ 25
2005	18,500,000	1,930,000	$ 30
2006	21,800,000	1,797,000	$ 33
2007	21,900,000	1,923,000	$ 35
2008	24,300,000	1,964,000	$ 39
2009	23,400,000	2,008,000	$38

BUDGET REQUEST

The FY 2011 budget request for Facilities Support is $113,342,000. It is an increase of $5,824,000 above the FY 2010 enacted level. This increase represents:

Pay Costs +$940,000 - will fund pay increases for Federal and Tribal employees.

Inflation +$691,000 - will fund non-medical inflation costs.

Population Growth +$1,563,000 - will fund costs associated with the annual population growth projected to be 1.5%.

Staffing for New Facilities +$2,630,000 - to fund staffing and operations, including utilities, at new and replacement facilities. Operating cost is based on a percentage of the total new staffing cost for all sub-sub-activities within a healthcare facility.

OUTCOMES

Program has no outcomes.

OUTPUTS

Program has no outputs.

GRANTS AWARDS

Program has no grants awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551
FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT
ENVIRONMENTAL HEALTH SUPPORT

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$67,022	$0	$69,196	$71,824	+$2,628
FTE	388	0	388	388	0

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization..IHCIA last authorized in 2000, Snyder and Transfer Acts - Permanent

Allocation Method ....Direct Federal, P.L. 93-638 Self-Determination Contracts, Self-Governance Compacts, and competitive cooperative agreements

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The program provides funding for IHS Area, District and Service Unit management activities and environmental health staffs which include engineers, environmental health officers, environmental health technicians, engineering aides, injury prevention specialists, and institutional environmental health officers. American Indians and Alaska Natives face hazards in their environment that contribute to their health status, including: communities in remote/isolated locations where residents are exposed to severe climatic conditions, hazardous geography, and extreme isolation; increased exposure to disease carrying insects and rodents; limited availability of housing and extensive use of sub-standard housing; insanitary methods of sewage and garbage disposal; and unsafe water supply.

Division of Sanitation Facilities Construction (SFC) staff manages and provides professional engineering services to construct over 400 sanitation projects annually at a total cost of over $190 million[1]. The annual project funding the program manages includes contributions from Tribes, States, and other Federal Agencies. These services include management of staff, pre-planning, consultation with Tribes, coordination with other Federal, State and local governmental entities, identifying supplemental funding outside of IHS, developing local policies and guidelines with Tribal consultation, developing agreements with Tribes and others for each project, providing project design, project construction, assuring environmental and historical preservation procedures are followed, assisting Tribes where the Tribes provide construction management, and providing technical assistance to Tribes with operation and maintenance of constructed facilities. In accordance with the Indian Health Care Improvement Act (Title III, Section 302(g) 1 and 2 of P.L. 94-437) the SFC staff annually updates its inventory of sanitation facilities deficiencies for existing Indian occupied homes. This is accomplished through extensive consultation with

[1] Does not include approximately 150 projects with at total cost of approximately $160 million funded under the American Recovery and Reinvestment Act.

Tribes. The SFC staff also develops and updates an inventory of all open dump sites on Indian lands as required under the Indian Lands Open Dump Cleanup Act (P.L. 103-399). Both of these inventories are widely used by other governmental agencies in their evaluation and funding of sanitation projects. Consistent with the 1994 Congressional set aside for "… tribal training on the operation and maintenance of sanitation facilities," $1,000,000 of these support funds are used to provide for continued operation and maintenance training. The SFC staff provides technical assistance, training and guidance to Indian families and communities regarding the operation and maintenance of essential water supply and sewage disposal facilities.

To accomplish its goals, the **Division of Environmental Health Services (DEHS)** is a consultative public health advisor to Tribes. The DEHS staff lead the assessment and identification of environmental hazards and risk factors facing Tribal groups and partner with Tribal groups in the development of sound public health strategies to prevent or mitigate environmental hazards. Strategies employed by DEHS staff include: maintaining surveillance of disease and injury incidence in communities; investigation of disease and injury incidents; identifying environmental hazards in community facilities and institutions such as food service establishments, Head Start Centers, community water supply systems, and health care facilities; and providing training, technical assistance and project funding to develop the capacity of Tribal governments to address their environmental health issues. The DEHS is administered through the following three program emphasis areas:

- **General Environmental Health** staffs are the lead environmental health professionals providing environmental health services to Tribes on issues of water quality, waste disposal, hazardous materials management, food sanitation, community injury prevention, institutional environmental health, vector control, occupational safety and health, and other environmental health issues.

  Staff and Tribal partners use the Web-based Environmental Health Reporting System (WebEHRS) to collect community and facility environmental health data.
  The WebEHRS data is used for surveillance of environmental factors, monitoring community environmental health conditions, and addressing community public health priorities. Data provided by WebEHRS is used by environmental health staff to monitor workload and prioritize environmental health conditions in communities with Tribal governments. Expansion of the capacity of WebEHRS to track activities, projects, and priorities for Tribal and federal environmental health programs has been a performance measure for the IHS.

- **Injury Prevention Program** staff lead in developing public health strategies to reduce the burden of injury experienced by AI/ANs. AI/ANs die from injuries at a rate 2 to 4 times the U.S. All Races rate. Treatment of injuries (hospitalizations and ambulatory cases) cost an estimated $350,000,000 per year in direct health care costs to IHS, Tribes, and Contract care facilities. The IHS Injury Prevention Program has developed effective strategies and initiatives to reduce the burden of injury experienced by AI/AN, including: surveillance of community-based injuries; development of targeted prevention programs based on surveillance data; developing community coalitions to address their injury issues; developing the capacity of community coalition members through injury prevention practitioners training; funding competitively awarded cooperative agreement to develop Tribal injury prevention infrastructure; and evaluation program initiatives. In FY 2009, 22 of the 31 Tribal projects to develop Tribal infrastructure are continuing best practices as community-based IHS Tribal Injury Prevention Cooperative Agreements. Four percent of the 562 federally recognized tribes are currently funded through this program. The program awards consisted of 22 five-year programs and 8 three-year projects. In FY 2008 and 2009, the 8 three-year

projects were completed. Projects ranged from distribution and installation of child safety seats to bullying prevention in schools and elderly fall prevention at home. The IHS is currently assessing the results of these projects. There were no new awards in FY 2006 – FY 2009. The next award cycle is expected to be announced in FY 2010 after the 22 five-year programs have been completed.

Environmental Health staffs monitor environmental health conditions in 710 Head Start programs across the country. In conjunction with other Federal partners, the IHS Injury Prevention program currently funds 36 of the Head Start programs through the Sleep Safe program to address fire and burn injuries. Additionally 16 of the Head Start programs are funded through the Ride Safe program to address motor vehicle injuries.

Implementing effective injury prevention strategies can result in enormous financial and societal savings. Societal costs include indirect costs such as pain and suffering, value of lifetime earnings lost, or value of goods and services not produced because of injury-related illness, disability or death. There is an expected 45 percent reduction in risk of death in a motor vehicle crash when lap/shoulder belts are worn. The average lifetime medical costs for a victim with a traumatic brain injury is $6.8 million and first-year expenses for the care of a spinal cord injury victim range from $200,000 to $700,000, according to Spinal Cord Injury Rehab, a collaborative research project among six spinal cord injury rehabilitation facilities and a research organization.

- The **Institutional Environmental Health** (IEH) program is comprised of staff with specialized skills to quantify, evaluate, and respond to unique environmental and safety hazards found in health care, educational, childcare, correctional, and industrial facilities.

  The IEH program staffs are knowledgeable of and provide support in the following disciplines: infection control, industrial hygiene, radiation protection, hazardous materials and waste, safety management, ergonomics, fire/life safety, emergency management, public health preparedness, security, and environmental compliance. Also, IEH program staffs perform evaluations and management system reviews of IHS and Tribal health care facilities seeking accreditation and/or certification. Maintaining accreditation ensures that IHS continues to have access to third party funding.

  The IEH program utilizes a web-based occupational health incident reporting system called "WebCident" in IHS healthcare facilities. WebCident is used to report injuries, illnesses, hazardous conditions, security, and property-related incidents experienced by visitors, patients, and others, as appropriate. WebCident is used to prepare required Occupational Safety and Health Administration logs, identify, document and track hazardous conditions, and report trends to assist with the development of targeted prevention strategies. DEHS continues to support the expansion of WebCident to all IHS and Tribal health care facilities and refine the program from feedback provided by users. Data developed through WebCident will be used to reduce occupational injuries/illnesses and associated workers' compensation claims, and reduce/eliminate hazards to employees, patients, visitors, and others.

TRIBAL HEALTH PROGRAMS

The IHS Area, District and Service unit environmental health personnel also train Tribal employees to provide environmental health services, under contract with IHS wherever a Tribe desires, provided that funds are available and other considerations make such arrangement

practicable. As a result of training provided by IHS, Tribal environmental health personnel are better prepared to provide higher levels of service to the Indian people and to support the provision of direct patient care services. For example, some Tribes have chosen to contract for the provision of the full range of environmental health services as typically provided by the IHS direct delivery program.

Area, District and Service unit environmental health personnel work with Tribes/Tribal organizations to encourage maximum participation in planning health services delivery programs. Also, they provide technical assistance to the Tribal officials who carry out administrative/management responsibilities associated with operation of Federally supported programs. Their support of self-determination for Tribal organizations will continue. However, the extent to which there is participation in the self-determination process depends on, and is determined by, the individual Tribes/Tribal organizations.

BUDGET REQUEST

The FY 2011 budget request for Environmental Health Support is $71,824,000. It is an increase of $2,628,000 above the FY 2010 enacted level. This increase represents:

Pay Costs +$706,000 - will fund pay increases for Federal and Tribal employees.

Inflation +$477,000 - will fund non-medical inflation costs.

Population Growth +$1,072,000 - will fund costs associated with the annual population growth projected to be 1.5%.

Staffing for New Facilities +$373,000 - to fund staffing and operations, including utilities, at new and replacement facilities. Operating cost is based on a percentage of the total new staffing cost for all sub-sub-activities within a healthcare facility.

The request funds the costs of personnel who accomplish environmental health services, injury prevention activities, and sanitation facilities construction activities, at the IHS Area, District, and Service unit levels and pays operating costs associated with provision of those services and activities.

OUTCOMES

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
27: Injury Intervention: Occupant protection restraint use	FY 2009: At least 1 intervention/11 Areas (Target Met)	New surveys based on FY 2009 Intervention	Discontinued	N/A
34: Environmental Surveillance: Identification and control of environmental health risk factors[1]	FY 2009: 3 interventions/11 Areas (Target Met)	New surveys based on FY 2009 Interventions	Discontinued	N/A
Program Level Funding ($ in millions)*	**FY 2009: $67.0**	**$69.2**	**$71.8**	**+$2.6**

[1] Prior to FY 2008 this measure tracked the number of environmental health programs with an automated web-based environmental health surveillance data collection system

** This funding level supports these outcome measures plus all of the activities under the environmental health support activity.*

OUTPUTS

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Injury Intervention: Occupant protection restraint use	FY 2009: At least 1 intervention/11 Areas (Target Met)	N/A	Seatbelt use (Baseline)	N/A
Environmental Surveillance: Identification and control of environmental health risk factors[1]	FY 2009: 3 interventions/11 Areas (Target Met)	N/A	Foodborne illness (Baseline)	N/A
Program Level Funding ($ in millions)*	**FY 2009: $67.0**	**$69.2**	**$71.8**	**+$2.6**

Past trends for the Injury Intervention measure have shown positive outcomes in meeting set targets. The FY 2007 target was to implement three community injury prevention projects and report them using an automated tracking system, and the target was met. The FY 2008 target was for each Area to conduct a seat belt observation survey in 1 site to get a baseline usage rate for that site. The target was met. All 11 Areas conducted seat belt usage surveys to get baseline rates. In FY 2009, the measure was 1 pilot project in 11 Areas (implementing a comprehensive intervention designed to increase restraint use) per Area. The FY 2010 target is to conduct more seatbelt usage surveys so we can compare the new rates to the 2008 baseline rates. If our comprehensive interventions were successful, we expect to see improvement in the rates. In FY 2011 the target is to establish baseline seatbelt use rates in the communities served by the IHS Injury Prevention Cooperative Agreement Sites that are focusing on seatbelt usage. These Cooperative Agreement sites are new and will be awarded at the end of 2010. In FY 2011 this measure will be re-categorized as a program level measure, but continued to be reported annually to demonstrate program activities.

Past trends for the Environmental Surveillance measure have shown an increase in the number of environmental health programs with automated web-based environmental health surveillance data collect system (WebEHRS). The FY 2007 target of 29 was met and a result of 32 was achieved. Because this system is now in wide use, the FY 2008 target was to set a baseline rate for identifying and addressing environmental risk factors in communities in 11 of the Areas. This target was exceeded. Twelve Areas identified baseline risk factors. The FY 2009 target is for each of Area to implement at least three interventions to address one of the environmental risk factors identified in FY 2008. In FY 2010 the target is to calculate rates for our risk factors so we can compare the new rates to the 2008 baseline rates. If our three interventions were successful, we expect to see improvement in the rates. The Area Environmental Health programs independently selected risk factors that were specific to their environmental health priorities. Many Areas, but not all Areas, selected some type of food safety-related risk factor to address in FY 2009. Examples of risks that some Areas have selected to address include: reducing the repeat of critical food safety violations in schools; increasing the number of schools implementing the USDA Food Safety Program; and reducing the prevalence of children with asthma on one reservation. Each Area will determine the reduction (or increase) their program wants to achieve, given their current capacity. Given the high number of food safety related risk factors identified in FY 2008, the FY 2011 target will focus specifically on this high priority risk factor. The FY 2011 target is to identify a baseline rate of out of compliance risk factors in food safety surveys and implement interventions for improvement. This target covers food service

establishments surveyed by IHS staff. In FY 2011 this measure will be re-categorized as a program level measure, but continued to be reported annually to demonstrate program activities.

GRANTS AWARDS

Program has no grants awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551
FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT
OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING SUPPORT

(Dollars in Thousands)

	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Appropriation	FY 2011 Pres. Budget Request	FY 2011 +/- FY 2010 Appropriation
BA	$15,269	$0	$16,373	$16,940	+$567
FTE	75	0	75	75	0

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization.. IHCIA last authorized in 2000, Snyder and Transfer Acts - Permanent

Allocation Method ....Direct Federal, P.L. 93-638 Self-Determination Contracts, Self-Governance Compacts, and competitive cooperative agreements

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Office of Environmental Health and Engineering Support activity provides funds for management activities, personnel, contracts, contractors, and operating costs for the Office of Environmental Health and Engineering (OEHE) Headquarters. Headquarters personnel have management responsibility for IHS facilities and environmental health programs, provide direct technical services and support to Area personnel, and perform critical management functions. Headquarters management activities includes national policy development and implementation, budget formulation, project review and approval, congressional report preparation, quality assurance (internal control reviews, Federal Managers Financial Integrity Act activities and other oversight), technical assistance (consultation and training), long range planning, meetings (with the Department of Health and Human Services, Members of Congress and their representatives, Tribes, and other Federal agencies), and recruitment and retention. Typical direct support functions performed by OEHE personnel who serve as project officers for health care facilities construction projects are: reviewing and/or writing technical justification documents, participating in design reviews and site surveys, conducting onsite inspections, and monitoring project funding status, etc.

In addition, these positions support new real property asset management requirements as required by Executive Order 13327, Real Property Asset Management; and HHS Program Management objectives. These actions are to ensure management accountability and to ensure the efficient and economic use of Federal real property, while recognizing the importance of these assets and responding to their current condition.

In FY 2009, OEHE Support funded personnel and developed and utilized data systems to distribute resources to Area offices for facilities and environmental health activities. Also, technical guidance, information, and training were provided throughout the IHS system in support of the Facilities Appropriation. Some of the activities and accomplishments include approval of

Program Justification Documents and Program of Requirements, review and announcement of Joint Venture and Small Ambulatory projects, and awarding contracts for health care facilities construction.

OEHE continued to coordinate between a centralized approach to facilities management and infrastructure outside of the IHS to the geographical challenges of the Indian Health System. The coordination effort of a decentralized management structure throughout the IHS is complex. Health care delivery decisions are made locally and infrastructure needs are community based to ensure inappropriate decisions are not made from a distance which may adversely affect Indian communities.

BUDGET REQUEST

The FY 2011 budget request for Office of Environmental Health and Engineering Support is $16,940,000, which is an increase of $567,000 above the FY2010 enacted level. This increase represents:

Pay Costs +$201,000 - will fund pay increases for Federal and Tribal employees.

Inflation +$105,000 - will fund non-medical inflation costs.

Population Growth +$261,000 - will fund costs associated with the annual population growth projected to be 1.5%.

OEHE collects and reports facility data for the IHS to HHS. This information is consolidated at the HHS level for all Operating Divisions of HHS and reported to the Office of Management and Budget. OEHE continues to coordinate the requirements of HHS and the mission of the IHS. Targets and measurements are documented in the HHS Real Property Asset Management Plan.

OUTCOMES

Program has no outcomes.

OUTPUTS

Program has no outputs.

GRANTS AWARDS

Program has no grants awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551
EQUIPMENT

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$22,067	$20,000	$22,664	$23,711	+$1,047
FTE	0	0		0	0

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2011 Authorization.. IHCIA last authorized in 2000, Snyder and Transfer Acts - Permanent

Allocation Method ....Direct Federal, P.L. 93-638 Self Determination contracts and Self-Governance compacts for replacement medical equipment that is formula based; Equipment funds for tribally-constructed health care facilities are competitively allocated; and TRANSAM and ambulance purchase programs are Federally managed.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

This sub-activity supports maintenance, replacement, and the purchase of new biomedical equipment at IHS and Tribal health care facilities.

The IHS and Tribal health programs manage laboratory, x-ray, and biomedical equipment valued at approximately $320 million. Accurate clinical diagnosis and effective therapeutic procedures depend in large part on health care providers using modern and effective medical equipment to assure the best possible health outcomes. The average life expectancy for today’s medical device is approximately six years depending on the intensity of use, maintenance, and technical advances. In FY 2010, the medical equipment program distributed over $16.6 million to IHS and tribal health programs to purchase new medical equipment, including replacement of existing equipment used in diagnosing and treatment of illnesses. Allocation of medical equipment funds is formula based. The remaining equipment funds are allocated for new medical equipment in tribally-constructed health care facilities ($5 million) and for the TRANSAM and ambulance programs ($1 million).

Annual health care space supported with replacement medical equipment funds:

FY	Supported Space (Square Meters)
2006	1,098,403
2007	1,155,452
2008	1,174,901
2009	1,199,346
2010	1,202,267

This budget activity also funds equipment for replacement clinics built by Tribes using other funding sources. These equipment funds are competitively allocated where tribes and tribal organizations are invited to apply for these equipment funds during the annual application period.

Tribally-constructed health care facilities supported annually with equipment funds:

FY	Project Awards
2004	49
2005	31
2006	27
2007	32
2008	19
2009	15

Using these funds, 15 awards - see table below - were made to tribal organizations that funded and constructed clinics or clinic additions. Tribes plan on spending in excess of $74 million in construction projects using non-IHS funding sources to access these equipment funds. As a result, approximately 71,000 individual patients will be treated with updated medical equipment in these tribally-funded construction projects.

Bristol Bay Dental Clinic	Sokaogon Chippewa HC	Narragansett Health Clinic
Nunapitchuk Health Clinic Project	Polson Health Center	Grand Ronde Dental Clinic
Ouzinkie Health Clinic	Toiyabe Dialysis Unit	Lummi Nation Dental Clinic
Tyonek Health Clinic	Shingle Springs Health Center	Makah Tribal Health Clinic
Zia Pueblo Health Center	Yuki Trails Clinic	Bad River Clinic

The program funds are also used to acquire new and like-new excess medical equipment from the Department of Defense (DoD) or other sources through the TRANSAM (i.e., Transfer of DoD Excess Medical and Other Supplies to Native Americans or TRANSAM) program and to procure ambulances for IHS and tribal emergency medical services programs.

Such program activities support IHS strategic goal 2: providing accessible, quality health care.

FUNDING HISTORY

Fiscal Year	Amount
2006	$20,947,214
2007	$21,619,214
2008	$21,282,000
2009 Recovery Act	$20,000,000
2009	$22,067,000
2010 Enacted	$22,664,000

BUDGET REQUEST

The FY 2011 budget request for Equipment is $23,711,000, which is an increase of $1,047,000 above the FY 2010 enacted level. This increase represents:

Inflation +$707,000 – will fund medical/non-medical inflation costs.

Population Growth +$340,000 – will fund costs associated with the annual population growth projected to be 1.5%.

Budget by Program Activity:

- Approximately $17.7 million for routine replacement medical equipment to over 1,600 Federally and Tribally-operated health care facilities.
- Approximately $5 million for new medical equipment in tribally-constructed health care facilities.
- Approximately $1 million for the TRANSAM and ambulance programs.

Under the American Recovery and Reinvestment Act, $20 million was appropriated for Equipment activities. Medical equipment at many IHS and Tribal health care sites is out of date or inadequate, especially at sites with high volumes of patients. Recovery Act funds ($8.75 million) are being used to mitigate some of the most pressing needs. Recovery Act funds ($5 million) also are being used to replace approximately 62 ambulances at IHS and tribal emergency medical services programs. Many of the existing ambulances are beyond their useful life and need replacement. Ambulances beyond their useful life have higher costs to maintain, lower availability, and lower reliability for emergency transport. Conversely, newer units have lower maintenance costs, higher availability, and better reliability for meeting communities' most urgent needs. The remaining Recovery Act funds ($6.25 million) are being used to procure Computed Tomography (CT) Scanners that will improve diagnostic capability.

OUTCOMES - Program has no outcomes.

OUTPUTS - Program has no outputs.

AWARDS GRANTS - Program has no awards grants.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551
PERSONNEL QUARTERS/QUARTERS RETURN FUNDS

(Dollars in Thousands)

	FY 2009		FY 2010	FY 2011	FY 2011
	Appropriation	Recovery Act	Appropriation	Pres. Budget Request	+/- FY 2010 Appropriation
BA	$6,288	$0	$6,288	$6,288	+$0
FTE	0	0	0	0	0

Authorizing Legislation .... Public Law 98-473, as amended

FY 2011 Authorization.. Indefinite

Allocation Method .... Quarters Return (QR) funds are collected from tenants of quarters that are operated by direct Federal and P.L. 93-638 Self Determination contract and Self-Governance compact programs. These funds are distributed and used at the locality in which they are collected.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Quarters Return funds will support the operation, management, and general maintenance of personnel quarters at IHS health care facilities.

Staff quarters' operation, maintenance, and improvement costs are funded with Quarters Return (QR) funds. QR funds are collected from tenants of quarters. These funds will be used for the operation, management, and general maintenance of quarters, including maintenance personnel services, security guard services, repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (stoves, water heaters, furnaces, etc.). In certain situations, M&I funds may be used, in conjunction with QR funds, to ensure adequate quarters maintenance; e.g., locations with few quarters where QR funds are not enough to pay for all required maintenance costs.

FUNDING HISTORY

Fiscal Year	**Amount**
2006	$ 6,288,000
2007	$ 6,288,000
2008	$ 6,288,000
2009 Recovery Act	$0
2009	$ 6,288,000
2010	$6,288,000

BUDGET REQUEST

The FY 2011 budget estimate for Quarters is $6,288,000, which is the same as the 2010 enacted level. Rental rates are established in accordance with OMB A-45.

OUTCOMES -- Program has no outcomes.
OUTPUTS -- Program has no outputs.
AWARDS -- Program has no awards grants.

FY 2011 BUDGET SUBMISSION
INDIAN HEALTH SERVICE
OBJECT CLASSIFICATION
(Dollars in Thousands)

Object Class	FY 2010 Appropriation	FY 2011 Estimate	FY 10 +/- FY 2011
DIRECT OBLIGATIONS			
Personnel Compensation:			
Full-Time Permanent(11.0)……	404,865	412,361	7,496
Other than Full-Time Permanent(11.3)……	25,267	25,717	450
Other Personnel Comp.(11.5)……	53,714	54,689	975
Military Personnel Comp (11.7)……	96,112	98,058	1,946
Special Personal Services Payments (11.8)……	254	254	0
Subtotal, Personnel Compensation……	580,212	591,079	10,867
Civilian Personnel Benefits(12.1)……	131,934	134,371	2,437
Military Personnel Benefits (12.2)	43,145	44,009	864
Benefits to Former Personnel(13.0)……	5,770	5,780	10
Subtotal, Pay Costs……	**761,061**	**775,239**	**14,178**
Travel(21.0)……	44,471	46,916	2,445
Transportation of Things(22.0)……	11,542	12,388	846
Rental Payments to GSA(23.1)……	12,492	13,812	1,320
Rental Payments to Others(23.2)……	1,714	1,856	142
Communications, Utilities and Miscellaneous Charges(23.3……	37,822	40,330	2,508
Printing and Reproduction(24.0)……	527	568	41
Other Contractual Services:			
Advisory and Assistance Services(25.1)……	9,774	10,536	762
Other Services(25.2)……	159,087	177,499	18,412
Purchases from Govt. Accts.(25.3)……	66,556	72,027	5,471
Operation and Maintenance of Facilities(25.4)..	7,437	7,985	548
Research and Development Contracts(25.5)……	7	7	0
Medical Care(25.6)……	408,338	522,194	113,856
Operation and Maintenance of Equipment(25.7)	7,904	8,449	545
Subsistence and Support of Persons(25.8)……	65,431	66,585	1,154
Subtotal, Other Contractual Current……	**724,534**	**865,282**	**140,748**
Supplies and Materials(26.0)……	140,034	153,145	13,111
Equipment (31.0)……	19,327	20,613	1,286
Land & Structures (32.0)……	7,949	8,680	731
Investments & Loans (33.0)……	0	0	0
Grants, Subsidies, & Contributions (41.0)……	2,289,586	2,466,677	177,091
Insurance Claims & Indemnities (42.0)……	1,223	1,126	(97)
Interest & Dividends (43.0)……	93	97	4
Subtotal Non-Pay Costs……	**3,291,314**	**3,631,490**	**340,176**
Total, Direct Obligations……	**4,052,375**	**4,406,729**	**354,354**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
Salaries and Expenses
(Budget Authority - Dollars in Thousands)

Object Class	FY 2010 Appropriation	FY 2011 Estimate	Increase or Decrease
Personnel Compensation:			
Full-Time Permanent (11.0)	404,865	412,361	7,496
Other than Full-Time Permanent (11.3)	25,267	25,717	450
Other Personnel Comp. (11.5)	53,714	54,689	975
Military Personnel Comp. (11.7)	96,112	98,058	1,946
Special Personnel Services Payments (11.8)	254	241	(13)
Subtotal, Personnel Compensation	580,212	591,066	10,854
Civilian Personnel Benefits (12.1)	131,934	134,371	2,437
Millitary Personnel Benefits (12.2)	43,145	44,009	864
Benefits to Former Personnel (13.0)	5,770	5,780	10
Total, Pay Costs	**761,061**	**775,226**	**14,165**
Travel (21.0)	18,638	19,843	1,205
Transportation of Things (22.0)	11,542	12,388	846
Rental Payments to Others (23.2)	1,714	1,856	142
Communications, Utilities & Misc. Charges (23.3)	37,822	40,330	2,508
Printing and Reproduction (24.0)	527	568	41
Other Contractual Services:			
Advisory and Assistance Services (25.1)	9,774	10,536	762
Other Services (25.2)	159,087	177,499	18,412
Purchases from Govt. Accts. (25.3)	66,556	72,027	5,471
Operation and Maintenance of Facilities (25.4)	7,437	7,985	548
Operation and Maintenance of Equipment (25.7)	7,904	8,449	545
Subsistance and Support of Persons (25.8)	65,431	66,585	1,154
Subtotal, Other Contractual	316,189	343,081	26,892
Supplies and Materials (26.0)	140,034	153,145	13,111
Total, Non-Pay Costs	**526,466**	**571,211**	**44,745**
Total Salaries & Expenses	1,287,527	1,346,437	58,910
Direct FTE	9,510	9,525	15

INDIAN HEALTH SERVICE
Detail of Full-Time Equivalents (FTE)

	FY 2009 Actual	FY 2010 Estimate	FY 2011 Estimate
Headquarters			
Sub-Total, Headquarters	433	438	439
Area Offices			
Aberdeen Area Office	1,890	1,909	1,908
Alaska Area Office	579	584	584
Albuquerque Area Office	1,017	1,027	1,026
Bemidji Area Office	480	485	485
Billings Area Office	908	917	916
California Area Office	91	91	91
Nashville Area Office	175	177	177
Navajo Area Office	4,619	4,664	4,662
Oklahoma City Area Office	1,591	1,607	1,606
Phoenix Area Office	2,649	2,675	2,673
Portland Area Office	554	560	559
Tucson Area Office	451	455	455
Sub-Total, Area Offices	15,005	15,173	15,187
Trust Funds (Gift)	23	23	23
TOTAL FTES	15,461	15,634	15,649

Average GS Grade

2007............................	8.2
2008............................	8.2
2009............................	8.2

INDIAN HEALTH SERVICE
DETAIL OF PERMANENT POSITIONS

(Dollars in Thousands)

	2009 Actual	2010 Estimate	2011 Estimate
Total - ES's......................	18	18	18
Total - ES Salaries......................	$3,479	$3,548	$3,619
GS/GM-15.....................................	426	426	426
GS/GM-14.....................................	382	382	382
GS/GM-13.....................................	399	405	406
GS-12...	910	923	925
GS-11...	1,290	1,308	1,311
GS-10...	588	596	598
GS-9...	1,298	1,316	1,319
GS-8...	285	289	290
GS-7...	1,061	1,076	1,079
GS-6...	1,290	1,308	1,311
GS-5...	2,136	2,166	2,171
GS-4...	1,216	1,233	1,236
GS-3...	227	230	231
GS-2...	51	52	52
GS-1...	1	1	1
Subtotal..	11,560	11,709	11,738
Total - GS Salaries.........................	$445,448	$468,267	$477,731
Assistant Surgeon General CO-08..	1	1	1
Assistant Surgeon General CO-07..	7	7	7
Director Grade CO-06....................	498	505	506
Senior Grade CO-05.......................	551	559	560
Full Grade CO-04...........................	567	575	576
Senior Assistant Grade CO-03.......	392	392	392
Assistant Grade CO-02..................	104	104	104
Junior Grade CO-01.......................	35	35	35
Subtotal..	2,155	2,179	2,181
Total - CO Salaries	$256,000	$254,000	$258,000
Ungraded.......................................	1,328	1,346	1,350
Total - Ungraded Salaries	$33,528	$35,246	$35,958
Trust Funds (Gift)	23	23	23
Average ES level............................	ES-02		
Average ES salary..........................	$193		
Average GS grade...........................	8.2		
Average GS salary..........................	$38,533		

Indian Health Service

Programs Proposed for Elimination or Consolidation

The Indian Health Service has no programs slated for elimination, reduction, or consolidation in FY 2011 budget plan.

INDIAN HEALTH SERVICE

Summary of Reimbursements, Assessments, and Purchases

FY 2008

Jan 27, 2010

Type of Funding		Object Class 11.1 & 12.1	21.0	22.0	23.2 & 23.3	24.0	25.3	26.0	31.0	FY 2008 Actual	FY 2009 Estimate	FY 2010 Estimate	FY 2011 Estimate
	Reimbursement for Services Purchased within HHS												
SSF	Service & Supply Fund				100,360		21,252,935			21,353,295	23,114,174	23,258,616	20,755,000
SSF	HHS Consolidated Acquisition System (HCAS) Operations and Maintenance						5,147,246			5,147,246	3,547,242	3,875,268	3,953,000
SSF	Unified Financial Management System (UFMS) Operations and Maintenance						4,485,812			4,485,812	4,552,000	4,937,116	5,036,000
SSF	UFMS Assessment/Analysis for 12.0 Upgrade						0			0	257,000	858,000	1,543,000
	Subtotal SSF	0	0	0	100,360	0	30,885,993	0	0	30,986,353	31,470,416	32,929,000	31,287,000
OS TAP	Audit Resolution						64,688			64,688	85,774	54,000	60,000
OS TAP	Information Technology Service Center *(Under SSF as of FY 09)*						3,274,622			3,274,622	0	0	0
OS TAP	Web Communications						1,447,173			1,447,173	1,693,159	2,097,000	2,224,000
OS TAP	Small Business Center						177,208			177,208	177,000	177,000	187,000
OS TAP	Tracking Accountability Government Grants System						89,000			89,000	77,000	95,000	99,000
OS TAP	Departmental Contract Information System						188,140			188,140	192,000	242,000	249,000
OS TAP	Acquisition Integration Modernization						259,006			259,006	259,000	259,000	259,000
OS TAP	High Performing Organizations and Competitive Sourcing Reporting						39,162			39,162	39,000	53,000	53,000
OS TAP	Commissioned Corps Force Management						7,775,320			7,775,320	8,189,635	8,332,000	8,285,000
OS TAP	HSPD-12											1,669,000	2,264,000
OS TAP	OGC Claims											379,000	391,000
	Subtotal Non-PSC	0	0	0	0	0	13,314,319	0	0	13,314,319	10,712,568	13,357,000	14,071,000
JFA	Office of General Counsel	896,637	72,191	27		1,167	664,031	2,001	31,177	1,667,231	1,341,409	989,237	996,393
JFA	HSPD-12 Implementation						345,694			345,694	331,068	1,669,000	2,264,000
JFA	HCAS						1,043,656			1,043,656	1,718,379	0	0
JFA	HHS Enterprise						1,152,000			1,152,000	878,547	761,899	2,071,495
JFA	IT Access for the Disabled						46,426			46,426	71,359	43,002	0
JFA	Regional Health Administrators						577,407			577,407	562,511	388,899	308,010
JFA	Motor Vehicle Management Information System						8,000			8,000	8,000	8,000	8,000
JFA	Secretarial Protective Operations Staff						0			0	65,000	0	0
JFA	(Environmental) Compliance and Process Tracking System						0			0	11,000	0	0
JFA	Health Services Research Library						525,000			525,000	535,000	572,000	580,008
JFA	Office of Global Health Affairs						13,404			13,404	13,404	13,404	13,592
JFA	Media Monitoring and Analysis						0			0	58,694	58,694	61,379
	Subtotal JFA Assessments	896,637	72,191	27	0	1,167	4,375,618	2,001	31,177	5,378,818	5,594,371	4,504,135	6,302,877
	Government-wide Administrative Functions												
JFA	Tri-Council (CFOC, CIOC, PEC)						35,561			35,561	59,774	60,969	61,823
JFA	Federal Employment Services						86,774			86,774	68,845	70,222	71,205
JFA	President's Council on Bioethics						18,454			18,454	17,480	9,227	18,454
	Subtotal, GAF	$0	$0	$0	$0	$0	$140,789	$0	$0	140,789	146,099	140,418	151,482
	Grand Total	896,637	72,191	27	100,360	1,167	48,716,719	2,001	31,177	49,820,279	47,923,454	50,930,553	51,812,359

Object Class Description:
11.1 & 12.1 -- Salaries & Benefits
21.0 -- Travel
22.0 -- Transportation of Things
23.2. & 23.3-- Rental Payments, Communications, Utilities
24.0 -- Printing & Reproduction
25.3 -- Purchases of goods and servics from Gov't Accounts
26.0 -- Supplies & Materials
31.0 -- Equipment

FY 2011 HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

INDIAN HEALTH SERVICE Allocation Statement:

The **IHS** will use **$2,171,495** of its **FY 2011** budget to support Department-wide enterprise information technology and government-wide E-Government initiatives. Operating Divisions help to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process, and the government-wide E-Government initiatives. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Of the amount specified above, **$193,656.83** is allocated to developmental government-wide E-Government initiatives for **FY 2011**. This amount supports these government-wide E-Government initiatives as follows:

FY 2011 Developmental E-Gov Initiatives*	
Line of Business - Human Resources	$29,491.23
Line of Business - Grants Management	$2,236.44
Line of Business - Financial	$18,063.16
Line of Business - Budget Formulation and Execution	$12,000.00
Disaster Assistance Improvement Plan	$31,866.00
Federal Health Architecture	$100,000.00
FY 2011 Developmental E-Gov Initiatives Total	**$193,656.83**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Prospective benefits from these initiatives are:

Lines of Business-Human Resources Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital. HHS has been selected as a Center of Excellence and will be leveraging its HR investments to provide services to other Federal agencies.

Lines of Business-Grants Management: Supports end-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and, post-award closeout actions. The Administration for Children and Families (ACF), is a GMLOB consortia lead, which has allowed ACF to take on customers external to HHS. These additional agency users have allowed HHS to reduce overhead costs for internal HHS users. Additionally, NIH is an internally HHS-designated Center of Excellence. This effort has allowed HHS agencies using the NIH system to reduce grants management costs. Both efforts have

allowed HHS to achieve economies of scale and efficiencies, as well as streamlining and standardization of grants processes, thus reducing overall HHS costs for grants management systems and processes.

Lines of Business –Financial Management: Supports efficient and improved business performance while ensuring integrity in accountability, financial controls and mission effectiveness by enhancing process improvements; achieving cost savings; standardizing business processes and data models; promoting seamless data exchanges between Federal agencies; and, strengthening internal controls.

Lines of Business-Budget Formulation and Execution: Allows sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

Disaster Assistance Improvement Plan (DAIP): The DAIP, managed by Department of Homeland Security, assists agencies with active disaster assistance programs such as HHS to reduce the burden on other federal agencies which routinely provide logistical help and other critical management or organizational support during disasters.

Lines of Business-Federal Health Architecture: Creates a consistent Federal framework that improves coordination and collaboration on national Health Information Technology (HIT) Solutions; improves efficiency, standardization, reliability and availability to improve the exchange of comprehensive health information solutions, including health care delivery; and, to provide appropriate patient access to improved health data. HHS works closely with federal partners, state, local and tribal governments, including clients, consultants, collaborators and stakeholders who benefit directly from common vocabularies and technology standards through increased information sharing, increased efficiency, decreased technical support burdens and decreased costs.

In addition, **$574,216.27** is allocated to ongoing government-wide E-Government initiatives for **FY 2011**. This amount supports these government-wide E-Government initiatives as follows:

FY 2011 Ongoing E-Gov Initiatives*	
Grants.Gov	$72,420.28
Integrated Acquisition Environment	$455,168.62
GovBenefits	$46,627.37
FY 2011 Ongoing E-Gov Initiatives Total	**$574,216.27**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Department of Health & Human Services
Indian Health Service

Number of Service Units and Facilities
Operated by IHS and Tribes, October 1, 2009

Type of Facility	TOTAL	IHS Total	TRIBAL Total	Title I [a]	Title V [b]	Other [c]
Service Units	**162**	60	102			
Hospitals	**45**	29	16	2	14	0
Ambulatory	**600**	**91**	509	195	308	6
Health Centers	296	59	237	119	118	0
School Health Centers	17	4	13	11	2	0
Health Stations	121	28	93	57	36	0
Alaska Village Clinics	166	0	166	8	152	6

[a] Operated under P.L. 93-638, Self Determination Contracts

[b] Operated under P.L. 106-260, Tribal Self-Governance Amendment of 2000

[c] Operated by a local government, not a tribe, for some Alaska Native villages through a standard procurement contract

Indian Health Service
Summary of Inpatient Admissions and Outpatient Visits
Federal and Tribal
FY 2008 Data

Direct Care Admissions

	IHS	Tribal	TOTAL
TOTAL	**32,923**	**21,204**	**54,127**
Aberdeen	4,515		4,515
Alaska		11,788	11,788
Albuquerque	1,719		1,719
Bemidji	461		461
Billings	2,127		2,127
California			*
Nashville		1,207	1,207
Navajo	13,363	3,152	16,515
Oklahoma	4,540	4,495	9,035
Phoenix	5,572	562	6,134
Portland			*
Tucson	626		626

* No direct inpatient facilities in FY 2008

Direct Care Outpatient Visits

	IHS	Tribal	TOTAL
TOTAL	**4,813,024**	**6,034,216**	**10,847,240**
Aberdeen	749,608	98,336	847,944
Alaska	**	1,441,928	1,441,928
Albuquerque	461,688	71,961	533,649
Bemidji	255,001	618,070	873,071
Billings	485,387	118,080	603,467
California	**	487,381	487,381
Nashville	8,891	391,373	400,264
Navajo	1,047,161	332,165	1,379,326
Oklahoma	692,303	1,541,765	2,234,068
Phoenix	730,831	365,125	1,095,956
Portland	254,722	508,855	763,577
Tucson	127,432	59,177	186,609

** No IHS facilities in FY 2008

INDIAN HEALTH SERVICE
Immunization Expenditures

	FY 2009 Estimate	FY 2010 Estimate	FY 2011 Estimate	Increase or Decrease
Infants and Children	$12,527,528	$12,903,354	$13,329,165	+$425,811
Adults 65+	$1,734,588	$1,786,625	$1,845,584	+$58,959
HPV vaccine Female 19-26 years))	$8,823,797	$9,088,511	$9,388,432	+$299,921
Adult 19 – 64 years influenza			$3,210,800	$3,210,800
Monitoring	$103,800	$106,914	$110,442	+$3,528
Total:	$23,189,713	$23,885,404	$27,884,423	+$3,999,018

1/ The immunization estimates do not include the Hepatitis B and Haemophilus Immunization program (Alaska) budget line item

The Indian Health Service (IHS) patient care data system does not calculate itemized costs for the treatment of various conditions. Therefore, an indirect method was used for calculating immunization costs based on an estimated patient population and the amount of staff time for required immunizations, as well as the immunization costs not available through the Vaccines for Children program.

Immunization costs were categorized by age groups; infants and children (3 to 27 months of age), and adults≥65 years of age. In addition costs for two specific vaccines – HPV and influenza - were included for two age groups, as well as an estimate of monitoring costs.

By combining these two groups, an estimate of $10,540,043 was calculated for the IHS immunization expenditures in FY 2004 with inflation costs added into the equation. Since then, costs have been iterated using inflation rates and the addition of new expenses, such as the introduction of a new vaccine:

FY 2008 Estimated Costs = FY 2007 cost times 4.2 percent
FY 2009 Estimated Costs = FY 2008 cost times 3.8 percent
FY 2010 Estimated Costs = FY 2009 cost times 3.0 percent
FY 2011 Estimated Costs = FY 2010 cost times 3.3 percent

For FY 2011, $3,210,800 was added for adult (19 – 64 year old) flu vaccination. The total cost does not include inflation, which may affect future estimated costs. The methodology was calculated based on the following assumptions:

1. 50% coverage of the 19 – 64 year old population (~ 401,349)
2. Cost of a dose of influenza vaccine at $8.00.

Overall, the estimated costs for these immunizations are affected by:

1. Individuals outside these target groups are regular recipients of immunizations (e.g., HBg and influenza immunization for health care workers and those at specific risk for other vaccine-preventable diseases), however, there is not a methodology to estimate the size of these groups.
2. There is not a methodology to estimate indirect costs or administrative overhead associated with the administration of immunizations, or operation of the immunization program.

DEPARTMENT OF HEALTH AND HUMAN SERVICE
Indian Health Service
Drug Control Budget
FY 2011

RESOURCE SUMMARY

	Budget Authority (in Millions)		
	2009 Enacted	2010 Enacted	2011 Estimate
Drug Resources by Function			
Prevention	18.139	18.771	19.208
Treatment	73.379	77.246	83.921
Total Drug Resources by Function	**$91.518**	**$96.017**	**$103.130**
Drug Resources by Decision Unit			
Alcohol and Substance Abuse	87.162	91.661	98.774
Urban Indian Health Program	4.356	4.356	4.356
Total Drug Resources by Decision Unit	**$91.518**	**$96.017**	**$103.130**

Drug Resources Personnel Summary			
Total FTEs (direct only)	168	171	174
Drug Resources as a Percent of Budget			
Agency Budget	$ 4,551.040	$ 5,037.403	$5,391.757
Drug Resources Percentage	2.01%	1.91%	1.91%

MISSION

The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. IHS supports substance abuse treatment and prevention services as part of this mission.

Methodology

The Indian Health Service (IHS) includes the appropriation for Alcohol and Substance Abuse (excluding the amount designated as Adult Alcohol Treatment) and the portion of Urban Indian Health Program (UIHP) funds for National Institute on Alcohol Abuse and Alcoholism programs transferred to the IHS under the UIHP budget.

BUDGET

In FY 2011, IHS requests $103.1 million for its drug control activities. This is $7.113 million above the FY 2010 Enacted level.

Alcohol and Substance Abuse
Total FY 2011 Request: $205.7 million
The FY 2011 request includes an increase in funding for Alcohol and Substance Abuse for a new competitive grant program to expand access to and improve the quality of treatment for substance abuse treatment services. The program will target sites with the greatest need for substance abuse services. The main goal of the grant program will be to enable I/T/Us to hire additional staff to provide evidence-based and practice-based culturally competent treatment services. All grant recipients will be required to report on appropriate performance measures, including mandatory reporting of the number of addicted patients that received services.

FY 2011 Program Changes

In FY 2011, IHS will continue to serve American Indian and Alaska Natives impacted by methamphetamine abuse through its Youth Regional Treatment Centers and other federal and Tribally-operated substance abuse treatment and prevention programs. IHS, through the Methamphetamine and Suicide Prevention Initiative (MSPI), provides Area allocations funding for pilot projects and federal grant awards -114 Area Tribal awardees, 11 Urban grantees, 3 Tribal Youth grantees, and one federally-operated Youth Regional Treatment Center (YRTC) program award to establish evidence based or practice based methamphetamine and suicide prevention and intervention pilot projects. The award and grant recipients will participate on regular conference calls on methamphetamine and suicide prevention initiative. The goal of the group conference calls is to share evidence based and promising practices in methamphetamine and suicide prevention programs in American Indian/Alaska Native communities. In addition, an annual meeting on methamphetamine and suicide interventions will be held to share evidence-based and practice-based models.

Urban Indian Health Program- Alcohol and Substance Abuse Title V Grants
Total FY 2011 Request: $45.5 million
The FY 2011 budget estimate includes funds for the Urban Indian Health Program, a portion of which is provided in the form of federal grants to 34 urban Indian 501(c)3 non-profit organizations to carry out alcohol and substance abuse prevention and treatment activities in the communities served. All urban programs have active partnerships with their local Veteran's Health Administration programs and several have identified joint program alcohol and substance abuse initiatives.

The FY 2011 Budget includes funding for the Urban Indian Health Program. In FY 2011, IHS will continue to serve urban American Indians and Alaskan Natives impacted by alcohol and substance abuse through the Title V grant program, Alcohol and Substance Abuse Prevention and Treatment. Substance abuse prevention and education programs services address alcohol/drugs, suicide, self-esteem, injury control, domestic violence, and sexual abuse.

Performance

Introduction

This section on the FY 2009 performance of the drug control portion of the IHS Alcohol and Substance Abuse Program is based on agency GPRA documents. The IHS Alcohol and Substance Abuse Program undertakes anti-drug abuse activities to raise community awareness and target high-risk groups in addition to educating staff on issues and skills related to substance abuse. In 2007, IHS' Tribally-Operated Health Program (TOHPs) including its drug control activities, were assessed in FY 2005 and received an assessment rating of "Adequate."

IHS Alcohol and Substance Abuse Program		
Selected Measures of Performance	**FY 2009 Target**	**FY 2009 Achieved**
Alcohol-use screening among appropriate female patients	47%	52%
Accreditation rate for Youth Regional Treatment Centers*	100%	91%

* In operation 18 months or more.

Discussion

The measures reported in the table indicate results from both Tribally-Operated Health Programs and Federally-Administered Health Programs. Currently, Tribally-Operated Health Programs have 17 measures, including alcohol- and health- related performance indicators.

The percent of appropriate female patients screened for alcohol-use (Fetal Alcohol Syndrome prevention) at Federally-operated facilities increased from 47% in FY 2008 to 52% in FY 2009, which is 5% over our target of 47%.

The accreditation measure – 'Accreditation rate for Youth Regional Treatment Centers' – was not met in FY 2009. The FY 2010 and FY 2011 performance target will remain 100% and the agency is confident that the target will be met.

IHS also conducts the Comprehensive Update in Substance Abuse and Dependence course. This course is provided twice a year to IHS/Tribal/Urban primary care providers to enhance professional skills in addiction prevention, intervention and treatment. The program includes a section on prevention, recognition, and treatment of opioid dependence. Safe prescribing activities have become a high priority for IHS. Activities include the development of a lending library (video and slide materials) designed to improve provider in-service capability and community presentations. Approximately 50 primary care providers receive this training each year.

Indian Health Service

Indian Self Determination

Indian Health Service Philosophy -- The Indian Health Service (IHS) has implemented the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 93-638, as amended, in the spirit by which the Congress recognized the special legal relationship and the obligation of the United States to American Indian and Alaska Native peoples. In keeping with the concept of tribal sovereignty, IHS policy implements the ISDEAA and maximizes opportunities for tribes to exercise their right to manage and operate IHS health programs, or portions thereof, under Title I and Title V, as well as those tribes who choose their health services to be provided directly by the IHS. The IHS recognizes that tribal decisions to contract/compact or not to contract/compact are equal expressions of self-determination.

Title I Contracts and Title V Self-Governance Compacts -- The IHS contracts/compacts with tribes and tribal organizations (T/TO) pursuant to the authority provided under Title I and Title V of the ISDEAA, as amended. This Act allows T/TO to enter into contracts/compacts with the Government to plan, conduct, and administer programs that are authorized under Section 102 of the Act. The IHS has been contracting with T/TO pursuant to the authority of P.L. 93-638 since its passage in 1975. Today, the IHS currently administers self-determination contracts under Title I and compacts authorized under Title V valued at more than $2.2 billion. The IHS currently administers contracts and Annual Funding Agreements (AFA) with 238 tribes or tribal organizations pursuant to Title I of the ISDEAA. The IHS currently administers compacts and Funding Agreements authorized under Title V of the ISEAA who meet certain criteria. To date, 75 Title V compacts and 97 Funding Agreements have been negotiated with 330 Tribes.

IHS and Tribally-Operated Service Unit and Medical Facilities -- The total dollars administered under ISDEAA contracts and compacts have nearly doubled in recent years and the scope of services managed and provided by tribal programs has also expanded greatly. Tribes have historically assumed control of community services first and then expanded into medical care. For example, the Community Health Representatives program and community-based components of the alcohol programs have been almost 100 percent tribally operated. The number of Tribally operated hospitals has now started to rise, and over 31 percent of the hospitals funded by IHS are managed by tribes. This trend is expanding their scope and is also reflected in the increasing number of ambulatory medical facilities now managed by tribes.

Self-Determination Implementation: Contract Support Cost Funding -- Because the rate of T/TO entering into self-determination contracts and compacts has been steadily increasing, the demand for contract support cost (CSC) funding to support T/TO in their contracting/compacting has also increased. The CSC funding is authorized pursuant to Section 106(a)(2) of the ISDEAA. This funding has been used by T/TO to develop strong, stable tribal governments capacity to professionally manage their contracts/ compacts and the corresponding services to their communities. Additionally, through the funding of CSC, the IHS has helped in the development of T/TO who are maturing and now achieving greater levels of self-sufficiency in health care operations and administration.

The primary growth in CSC since 2003 can be attributed to the need to maintain the current level of services as annual program increases are included in ongoing contracts and compacts. Additional increased needs for CSC is attributed to the increased contracting and compacting of new or expanded programs, services, functions, or activities by T/TO under both Title I and V of the ISDEAA. The Agency has taken steps to ensure that funding provided is allowable, allocable,

reasonable, and necessary and has recently adopted standards for the review and approval of CSC. This has proven beneficial in maintaining consistency in the determination of tribal CSC requirements. The T/TO support an appropriate share of administrative streamlining. The IHS has provided administrative shares of its budget to T/TO associated with their contracting and compacting activities since 1995.

Indian Health Service
Self Governance Funded Compacts FY 2009

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	Total
Alabama	**$3,544,000**	**$219,000**	**$125,000**	**$684,000**	**$4,572,000**
Poarch Band of Creek Indians	$3,544,000	$219,000	$125,000	$684,000	$4,572,000
Alaska	**$383,873,000**	**$29,984,000**	**$24,359,000**	**$63,831,000**	**$502,047,000**
Alaska Native Tribal Health Consortium	$99,254,000	$20,097,000	$4,177,000	$5,153,000	$128,681,000
Aleutian Pribilof Islands Association, Inc.	$3,168,000	$771,000	$332,000	$521,000	$4,792,000
Arctic Slope Native Association	$7,830,000	$67,000	$989,000	$2,337,000	$11,223,000
Bristol Bay Area Health Corporation	$21,336,000	$844,000	$1,818,000	$5,393,000	$29,391,000
Chugachmiut	$4,056,000	$104,000	$223,000	$1,158,000	$5,541,000
Copper River Native Association	$2,078,000	$33,000	$165,000	$482,000	$2,758,000
Council of Athabascan Tribal Governments	$1,867,000	$101,000	$67,000	$843,000	$2,878,000
Eastern Aleutian Tribes, Inc.	$3,149,000	$27,000	$146,000	$793,000	$4,115,000
Kenalitze Indian Tribe	$1,870,000	$12,000	$132,000	$315,000	$2,329,000
Ketchikan Indian Community	$5,072,000	$131,000	$789,000	$1,599,000	$7,591,000
Knik Traditional Council	$58,000	$1,000	$8,000	$9,000	$76,000
Kodiak Area Native Association	$6,542,000	$88,000	$358,000	$1,122,000	$8,110,000
Maniilaq Association	$26,624,000	$920,000	$2,321,000	$7,633,000	$37,498,000
Metlakatla Indian Community	$5,926,000	$926,000	$383,000	$591,000	$7,826,000
Mount Sanford Tribal Consortium	$738,000	$1,000	$51,000	$172,000	$962,000
Native Village of Eklutna	$174,000	$1,000	$5,000	$19,000	$199,000
Norton Sound Health Corporation	$20,772,000	$733,000	$1,561,000	$3,978,000	$27,044,000
Seldovia Village Tribe	$1,210,000	$34,000	$43,000	$265,000	$1,552,000
Southcentral Foundation	$62,110,000	$1,260,000	$3,509,000	$11,216,000	$78,095,000
SouthEast Alaska Regional Health Corporation	$36,075,000	$1,327,000	$2,580,000	$5,615,000	$45,597,000
Tanana Chiefs Conference	$29,634,000	$643,000	$1,478,000	$3,367,000	$35,122,000
Yakutat Tlingit Tribe	$308,000	$8,000	$23,000	$71,000	$410,000
Yukon-Kuskokwim Health Corporation	$44,022,000	$1,855,000	$3,201,000	$11,179,000	$60,257,000
Arizona	**$32,759,000**	**$4,598,000**	**$1,304,000**	**$3,018,000**	**$41,679,000**
Gila River Indian Community	$32,759,000	$4,598,000	$1,304,000	$3,018,000	$41,679,000
California	**$46,316,000**	**$2,703,000**	**$1,959,000**	**$10,875,000**	**$61,853,000**
Consolidated Tribal Health Project, Inc.	$3,579,000	$307,000	$82,000	$909,000	$4,877,000
Hoopa Valley Tribe	$4,946,000	$222,000	$200,000	$934,000	$6,302,000
Indian Health Council, Inc.	$7,453,000	$470,000	$227,000	$1,612,000	$9,762,000
Karuk Tribe of California	$2,624,000	$615,000	$78,000	$1,016,000	$4,333,000
Northern Valley Indian Health, Inc.	$2,175,000	$528,000	$56,000	$533,000	$3,292,000
Redding Rancheria	$5,797,000	$101,000	$472,000	$1,633,000	$8,003,000
Riverside-San Bernardino County Indian Health, Inc.	$18,272,000	$362,000	$714,000	$3,872,000	$23,220,000
Susanville Indian Rancheria	$1,470,000	$98,000	$130,000	$366,000	$2,064,000
Connecticut	**$2,207,000**	**$32,000**	**$0**	**$31,000**	**$2,270,000**
Mohegan Tribe of Indians of Connecticut	$2,207,000	$32,000	$0	$31,000	$2,270,000
Florida	**$7,294,000**	**$511,000**	**$207,000**	**$992,000**	**$9,004,000**
Seminole Tribe of Florida	$7,294,000	$511,000	$207,000	$992,000	$9,004,000
Kansas	**$2,249,000**	**$89,000**	**$5,000**	**$233,000**	**$2,576,000**
Prairie Band of Potawatomi Nation	$2,249,000	$89,000	$5,000	$233,000	$2,576,000
Idaho	**$13,837,000**	**$769,000**	**$915,000**	**$1,632,000**	**$17,153,000**
Coeur D'Alene Tribe	$5,220,000	$263,000	$532,000	$881,000	$6,896,000
Kootenai Tribe of Idaho	$564,000	$23,000	$58,000	$58,000	$703,000
Nez Perce Tribe	$8,053,000	$483,000	$325,000	$693,000	$9,554,000
Louisana	**$1,069,000**	**$107,000**	**$84,000**	**$119,000**	**$1,379,000**
Chitimacha Tribe of Louisana	$1,069,000	$107,000	$84,000	$119,000	$1,379,000
Maine	**$3,023,000**	**$171,000**	**$135,000**	**$737,000**	**$4,066,000**
Penobscot Indian Nation	$3,023,000	$171,000	$135,000	$737,000	$4,066,000
Massachusetts	**$654,000**	**$77,000**	**$164,000**	**$218,000**	**$1,113,000**
Wampanoag Tribe of Gay Head	$654,000	$77,000	$164,000	$218,000	$1,113,000
Michigan	**$20,970,000**	**$1,127,000**	**$917,000**	**$1,826,000**	**$24,840,000**
Grand Traverse Band of Ottawa and Chippewa Indians	$2,588,000	$187,000	$52,000	$418,000	$3,245,000
Keweenaw Bay Indian Community	$2,797,000	$216,000	$123,000	$381,000	$3,517,000
Little River Band of Ottawa Indians	$1,544,000	$63,000	$100,000	$170,000	$1,877,000
Sault Ste. Marie Tribe of Chippewa Indians	$14,041,000	$661,000	$642,000	$857,000	$16,201,000
Minnesota	**$16,354,000**	**$1,036,000**	**$551,000**	**$1,059,000**	**$19,000,000**
Bois Forte Band of Chippewa Indians	$2,357,000	$191,000	$64,000	$322,000	$2,934,000
Fond du Lac Band of Lake Superior Chippewa	$9,124,000	$482,000	$412,000	$429,000	$10,447,000
Mille Lacs Band of Ojibwe	$3,675,000	$315,000	$61,000	$234,000	$4,285,000
Shakopee Mdewakanton Sioux Community	$1,198,000	$48,000	$14,000	$74,000	$1,334,000
Mississippi	**$15,478,000**	**$1,064,000**	**$977,000**	**$1,764,000**	**$19,283,000**
Mississippi Band of Choctaw Indians	$15,478,000	$1,064,000	$977,000	$1,764,000	$19,283,000
Montana	**$18,811,000**	**$1,311,000**	**$1,641,000**	**$2,986,000**	**$24,749,000**
Chippewa Cree Tribe of the Rocky Boy's Reservation	$9,283,000	$720,000	$957,000	$1,779,000	$12,739,000

Confederated Salish and Kootenai Tribes of Flathead	$9,528,000	$591,000	$684,000	$1,207,000	$12,010,000
Nevada	**$18,277,000**	**$1,041,000**	**$1,185,000**	**$3,115,000**	**$23,618,000**
Duck Valley Shoshone-Paiute Tribe	$6,416,000	$536,000	$603,000	$1,386,000	$8,941,000
Duckwater Shoshone Tribe	$993,000	$34,000	$162,000	$558,000	$1,747,000
Ely Shoshone Tribe	$1,179,000	$50,000	$49,000	$260,000	$1,538,000
Las Vegas Paiute Tribe	$3,306,000	$107,000	$100,000	$251,000	$3,764,000
Washoe Tribe of Nevada and California	$4,488,000	$188,000	$191,000	$391,000	$5,258,000
Yerington Paiute Tribe of Nevada	$1,895,000	$126,000	$80,000	$269,000	$2,370,000
New York	**$6,946,000**	**$304,000**	**$187,000**	**$435,000**	**$7,872,000**
St. Regis Mohawk Tribe	$6,946,000	$304,000	$187,000	$435,000	$7,872,000
North Carolina	**$19,295,000**	**$1,472,000**	**$823,000**	**$3,522,000**	**$25,112,000**
Eastern Band of Cherokee Indians	$19,295,000	$1,472,000	$823,000	$3,522,000	$25,112,000
Oklahoma	**$279,917,000**	**$19,483,000**	**$11,941,000**	**$23,473,000**	**$334,814,000**
Absentee Shawnee Tribe of Oklahoma	$7,084,000	$204,000	$615,000	$546,000	$8,449,000
Cherokee Nation	$102,517,000	$7,213,000	$4,484,000	$4,586,000	$118,800,000
Chickasaw Nation	$42,671,000	$3,768,000	$1,784,000	$6,043,000	$54,266,000
Choctaw Nation of Oklahoma	$53,916,000	$5,252,000	$2,706,000	$5,141,000	$67,015,000
Citizen Potawatomi Nation	$10,772,000	$1,021,000	$675,000	$1,378,000	$13,846,000
Kaw Nation	$1,130,000	$79,000	$166,000	$191,000	$1,566,000
Kickapoo Tribe of Oklahoma	$6,087,000	$85,000	$115,000	$849,000	$7,136,000
Modoc Tribe of Oklahoma	$49,000	$63,000	$4,000	$16,000	$132,000
Muscogee (Creek) Nation	$38,066,000	$1,615,000	$1,019,000	$2,894,000	$43,594,000
Northeastern Tribal Health System	$6,397,000	$25,000	$113,000	$749,000	$7,284,000
Ponca Tribe of Oklahoma	$3,641,000	$56,000	$122,000	$388,000	$4,207,000
Sac and Fox Nation	$6,006,000	$59,000	$106,000	$442,000	$6,613,000
Wyandotte Nation	$1,581,000	$43,000	$32,000	$250,000	$1,906,000
Oregon	**$22,025,000**	**$990,000**	**$1,969,000**	**$6,040,000**	**$31,024,000**
Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians of Oregon	$1,606,000	$63,000	$176,000	$371,000	$2,216,000
Confederated Tribes of Grand Ronde	$5,923,000	$215,000	$430,000	$2,363,000	$8,931,000
Confederated Tribes of Siletz Indians of Oregon	$6,852,000	$188,000	$606,000	$1,243,000	$8,889,000
Confederated Tribes of the Umatilla Reservation	$5,925,000	$455,000	$566,000	$1,361,000	$8,307,000
Coquille Indian Tribe	$1,719,000	$69,000	$191,000	$702,000	$2,681,000
Washington	**$43,612,000**	**$3,078,000**	**$2,194,000**	**$9,592,000**	**$58,476,000**
Jamestown S'Klallam Indian Tribe	$878,000	$55,000	$69,000	$265,000	$1,267,000
Kalispel Tribe of Indians	$831,000	$134,000	$19,000	$59,000	$1,043,000
Lower Elwha Klallam Tribe	$1,656,000	$87,000	$78,000	$291,000	$2,112,000
Lummi Indian Nation	$7,258,000	$609,000	$220,000	$1,405,000	$9,492,000
Makah Indian Tribe	$3,398,000	$353,000	$265,000	$1,015,000	$5,031,000
Muckleshoot Indian Tribe	$5,330,000	$212,000	$152,000	$0	$5,694,000
Nisqually Indian Tribe	$1,893,000	$90,000	$96,000	$491,000	$2,570,000
Port Gamble S'Klallam Tribe	$1,982,000	$156,000	$109,000	$453,000	$2,700,000
Quinault Indian Nation	$4,822,000	$380,000	$171,000	$1,709,000	$7,082,000
Shoalwater Bay Indian Tribe	$1,725,000	$80,000	$222,000	$633,000	$2,660,000
Skokomish Indian Tribe	$1,843,000	$127,000	$100,000	$352,000	$2,422,000
Squaxin Island Indian Tribe	$2,945,000	$122,000	$152,000	$898,000	$4,117,000
Suquamish Tribe	$1,396,000	$58,000	$118,000	$492,000	$2,064,000
Swinomish Indian Tribal Community	$2,250,000	$185,000	$140,000	$645,000	$3,220,000
Tulalip Tribes of Washington	$5,405,000	$430,000	$283,000	$884,000	$7,002,000
Wisconsin	**$15,668,000**	**$865,000**	**$444,000**	**$729,000**	**$17,706,000**
Forest County Potawatomi Community	$1,709,000	$219,000	$198,000	$88,000	$2,214,000
Oneida Tribe of Indians of Wisconsin	$13,959,000	$646,000	$246,000	$641,000	$15,492,000
Grand Total	**$974,178,000**	**$71,031,000**	**$52,086,000**	**$136,911,000**	**$1,234,206,000**

Indian Health Service
FY 2009 Self-Governance Funding Agreements
By Area

Area	Tribal User Pop	Program Tribal Shares	Area Tribal Shares	Headqtrs Tribal Shares	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
Alaska	117,492	388,412,000	13,346,000	12,099,000	24,359,000	63,831,000	502,047,000
Aberdeen	0	152,000	128,000	0	0	0	280,000
Bemidji	27,506	16,673,000	4,708,000	1,823,000	1,912,000	36,150,000	61,266,000
Billings	15,096	17,263,000	1,893,000	967,000	1,641,000	2,985,000	24,749,000
California	26,617	43,909,000	3,125,000	1,985,000	1,959,000	10,875,000	61,853,000
Nashville	38,310	55,602,000	5,851,000	2,012,000	2,703,000	8,503,000	74,671,000
Oklahoma	237,023	279,339,000	10,630,000	11,768,000	11,946,000	23,707,000	337,390,000
Phoenix	21,120	53,442,000	1,654,000	1,580,000	2,489,000	6,132,000	65,297,000
Portland	40,383	75,445,000	5,608,000	3,259,000	5,077,000	17,264,000	106,653,000
Total, IHS	523,547	930,237,000	46,943,000	35,493,000	52,086,000	169,447,000	1,234,206,000

Indian Health Service
Self-Governance
Fund Status Report --- FY 2009 Expenditure (Estimated)

	Date	Vendor/Description	Obligation	Adjustment	Balance
1	10/1/08	Beginning Balance			$5,835,523
2	10/1/08	Congressional Increases/Decreases		142,000	5,977,523
3	10/1/08	Federal Pay Costs		26,000	6,003,523
4	10/1/08	Adjustment on rounding end of FY		477	6,004,000
5	Recurring	OTSG Office salary & benefits	1,684,477		4,319,523
6	Recurring	OTSG Office expenses, travel, etc.	214,731		4,104,792
7	10/1/08	Salish&Kootenai FA Neg 1995 User Pop	13,221		4,091,571
8	10/1/08	Choctaw 1995 Base Budget	21,058		4,070,513
9	10/1/08	Jamestown S'Klallam 1997 HQ TSA adj.	1,584		4,068,929
10	10/1/08	Mississipp Choctaw 1997 HQ TSA adj.	7,688		4,061,241
11	10/1/08	Penobscot 1997 HQ TSA adj	12,680		4,048,561
12	10/1/08	Cherokee Hastings Hosp. HQ TSA	718,185		3,330,376
13	10/1/08	Cherokee Hastings Hosp. Area TSA (Severance)	400,000		2,930,376
14	11/14/08	Trnfr to OKC for CW reimb for OCR members	1,399		2,928,977
15	1/11/09	TSGAC (Lummi) trvl/logistics/meetings	95,000		2,833,977
16	1/11/09	SGCE cont. agmt Lummi Tribe passthru	150,000		2,683,977
17	1/11/09	PAO - Jamestown Tech wkgp logistics	70,000		2,613,977
18	2/5/09	Blgs Reimb Salish&Kootenai trvl C. Lankford	2,186		2,611,791
19	2/12/09	BEM HQ Tribal Shares for Little River Band	29,641		2,582,150
20	3/31/09	GPRA Pilot Proj Mississippi Choctaw	42,000		2,540,150
21	3/31/09	GPRA Pilot Proj Rocky Boy	42,000		2,498,150
22	3/31/09	GPRA Pilot Proj Kaw	42,000		2,456,150
23	1/14/09	Planning Award Cowlitz PAO	50,000		2,406,150
24	1/14/09	Planning Award Reno-Sparks PHX	50,000		2,356,150
25	5/6/09	Trnfr to OKC for Cherokee add'l Severance	60,749		2,295,401
26	6/23/09	Trnf to PAO Lummi SGCETC Hlth Reform	100,000		2,195,401
27	6/29/09	Trnfr to OKC for Cherokee Prompt Pay owed	70,549		2,124,852
28	7/23/09	Trnfr to PHX reimb for trvl R. Tahsuda	3,408		2,121,444
29	8/11/09	Ambulances	500,000		1,621,444
30	8/13/09	Blgs for FI calculation error for Rocky Boy	65,000		1,556,444
31	8/13/09	Planning Award Taos Pueblo ALBQ	75,000		1,481,444
32	8/13/09	Negotiation Award Taos Pueblo ALBQ	30,000		1,451,444
33	8/13/09	Negotiation Award Cowlitz PAO	29,979		1,421,465
34	8/13/09	Negotiation Award Chickaloon AK	30,000		1,391,465
35	8/13/09	GPRA Project for Alaska Area FY 10	350,000		1,041,465
36	8/13/09	GPRA Project for Nashville Area FY 10	350,000		691,465
37	8/13/09	Blgs assist S&K with IT - EHR/RPMS issue.	150,000		541,465
38	8/21/09	Trnf to Albq for SG Trng cost of facility	2,076		539,389
39	8/20/09	Trnf to SGCETC thru Lummi exp at SG conf	31,839		507,550
40	8/21/09	SGCETC Agrmt FY 10	150,000		357,550
41	8/21/09	WIN Student	17,500		340,050
42	8/21/09	Copier	21,062		318,988
43	9/8/09	Dr Bloom - OTSG Staff retreat	5,329		313,659
44	9/10/09	Trnfr to PHX Area asst w/overpayment to DV	116,649		197,010
45	9/10/09	Awards	25,000		172,010
46	9/15/09	Balance to cover any add'l costs in OTSG ofc			172,010
		then bal would go to HQE	172,010		(0)
		Total spent to date:	6,004,000		

SIGNIFICANT ITEMS FOR INCLUSION IN
THE FY 2011 CONGRESSIONAL JUSTIFICATION

House Report 111-180

Item
Dental Health — The Committee is pleased to see progress in reducing the vacancy rate among dental professionals but is still concerned about the projected retirement rate of recognized specialty dentists. The increase provided is for the Headquarters Division of Oral Health, to be used by the Director of the Division of Oral Health with $1,000,000 to expand the dental residency program and $250,000 to expand the summer extern program. In addition, the Service is directed to further its dental health efforts by utilizing a portion of the health information technology funds provided within Hospitals and Health Clinics to refine and expedite the deployment schedule of the electronic dental record (EDR). The Service is strongly encouraged to make implementing the EDR a priority as it works to fully implement the overall electronic health record system. (page 145)

Action taken or to be taken
The $1,000,000 appropriation for the Division of Oral Health for the dental residency program will be utilized to sponsor the residency training of dentists in the dental specialties of greatest identified need. The funding will be used to train dentists in the specialties of oral and maxillofacial surgery and pediatric dentistry. It is anticipated that the funding will allow for the specialty training of a minimum of four dentists.

The $250,000 appropriation for the Division of Oral Health for the summer extern program will be utilized to expand the existing dental student summer externship program. The externship program has proven to be a vital and integral component to the Division of Oral Health's recruitment program. The summer externship program has the additional benefit of increasing access to oral health services for the American Indian and Alaska Native population. In previous fiscal years far more dental students have applied for the summer externship program than the Division of Oral Health has been able to fund. It is anticipated that the appropriation will allow for an additional 120 dental students to participate in the summer externship program.

The Indian Health Service has implemented EDR in 9 sites.

Item
Indian Health Care Improvement Fund — The Committee recommends $45,543,000 for the Indian Health Care Improvement Fund, $30,543,000 above the fiscal year 2009 enacted level and the same as the budget request. The Service is directed to allocate the increased funding for the Fund to bring those units with the highest level of need up to at least 45 percent of need before allocating any additional funds to units with needs above 45 percent. (page 145)

Action taken or to be taken
The IHS will allocate FY 2011 appropriated funds among those IHS or Tribal sites for which current funding levels are measured below 45 percent of need (sites with the greatest needs). During FY 2010 the IHS, in consultation with Tribes, is evaluating the allocation formula. Statisticians and analysts from IHS and tribal operated programs are currently assessing measures, data definitions, collection/reporting, and alternative sources of data which may improve accuracy and precision of allocations. This stage will be completed in February 2010. In stage 2 to follow, we will consider whether to alter the structure of the allocation formula

itself. The evaluation will include a process for seeking input from Tribes through Tribal consultation. Changes to the formula that may be adopted during 2010 will be applied to FY 2011 funds.

Item
Urban Indian Health Program — The Committee recommends $43,139,000 for the urban health program, $6,950,000 above the fiscal year 2009 enacted level and $5,000,000 above the budget request. From within the increase provided, the Service is directed to conduct a new needs assessment of the urban Indian health program and the communities it serves. (page 145)

Action taken or to be taken
The Office of Urban Indian Health Programs is developing a $1,250,000 Request for Proposal to obtain a contractor to conduct a national needs assessment (2010-2011) of the Urban Indian Health Program including: (1) the communities it currently serves, and (2) determine where new programs must be established. The needs assessment will identify the urban AI/AN population including the health status, education, employment, transportation, and legal system issues. The assessment is expected to identify what health care services are needed by the urban AI/AN population and what services currently exist. Is the urban AI/AN population actually able to access currently available health care services or are there environmental barriers, i.e., lack of public transportation, or cultural barriers that are not conducive to using existing services. Ultimately the needs assessment will focus on availability, access, and utilization with the primary goal to determine how best to improve the health status of the urban AI/AN population.

Item
Indian Health Professions — The Committee recommends $40,743,000 for Indian health professions, $3,243,000 over the fiscal year 2009 enacted level and the same as the budget request. The Service is expected to use health professions program funding for loan repayment and scholarship programs to encourage increased recruitment and retention of health professionals. (page 145)

Action taken or to be taken
The IHS will use the Indian Health Professions funding for scholarships, loan repayment, externs, and the Indians Into Nursing, Indians Into Medicine, and Indians Into Psychology programs. These programs will assist the IHS in the recruitment and retention of health professionals. The majority of the funding will be used for loan repayment to immediately assist hospitals and clinics in recruiting health professionals to provide health care services to Indian communities.

Senate Report 111-38

Item
Indian Health Professions — Within the Indian Health Professions activity, the Committee notes that funds are continued for the Recruitment/Retention of American Indians into Nursing program; the Indians into Psychology program; and the Indians into Medicine program. (page 79)

Action taken or to be taken
These grant programs are part of the IHS recruitment activities to increase health professionals in Indian communities. The IHS plans to continue funding these grant programs at the current level.

Item
Indian Health Facilities — The Committee recommends $394,757,000 for Indian health facilities, an increase of $4,589,000 above the fiscal year 2009 nonemergency funding level and

the same amount as the budget request. Increases include an amount of $14,780,000 to meet escalating fixed costs such as pay and benefits, and $575,000 for facilities and environmental health support. Health facilities construction is funded at $29,234,000 and provides support for three ongoing projects: the Barrow, Alaska hospital; the Kayenta, Arizona health center; and the San Carlos, Arizona health center. In the fiscal year 2009 bill, the Service was instructed to prepare a new solicitation for both the Joint Venture Construction Program and the Small Ambulatory Grants Program. The Committee understands that the initial phase of this process is underway with a request to tribal leaders to inform the Service of their intent to apply for either program by July 1, 2009. (page 79)

Action taken or to be taken
A solicitation of interest in both programs was sent to all tribes nationwide on May 28, 2009. In response to this solicitation of interest, 63 tribes responded positively to receiving additional information regarding the Small Ambulatory Program (SAP) and 55 responded positively to the Joint Venture Construction Program (JVCP). Solicitation packages were prepared for both programs, per the directive.

The JVCP solicitation was sent by mail to all tribes that responded previously, and the application was also made available to all tribes via the IHS webpage.

Conference Report 111-316

Item
Dental Health. -The conference agreement provides $152,634,000 for dental health programs as proposed by the House, instead of $151,384,000 as proposed by the Senate. Of those funds, $1,000,000 is for the Headquarters Division of Oral Health to expand the dental residency program and $250,000 is to expand the summer extern program. In addition, the Service is directed to further its dental health efforts by utilizing a portion of the health information technology funds to refine and expedite the deployment schedule of the electronic dental record system. (page 73)

Action taken or to be taken
The $1,000,000 appropriation for the Division of Oral Health for the dental residency program will be utilized to sponsor the long term training of dentists in the dental specialties of greatest identified need. The funding will be used to train dentists in the specialties of oral and maxillofacial surgery and pediatric dentistry. It is anticipated that the funding will allow for the specialty training of a minimum of four dentists.

The $250,000 appropriation for the Division of Oral Health for the summer extern program will be utilized to expand the existing dental student summer externship program. The externship program has proven to be a vital and integral component to the Division of Oral Health's recruitment program. The summer externship program has the additional benefit of increasing access to oral health services for the American Indian and Alaska Native population. In previous fiscal years far more dental students have applied for the summer externship program than the Division of Oral Health has been able to fund. It is anticipated that the appropriation will allow for an additional 120 dental students to participate in the summer externship program.

The Indian Health Service has implemented EDR in 9 sites.

Item

Health Facilities Construction Projects - The conferees are concerned about the persistent backlog of Indian Health Service health facilities construction projects serving American Indians and Alaska Natives. The conferees believe that the joint venture program provides a cost-effective means to address this backlog and to increase access to health care services for American Indians and Alaska Natives. The conferees are aware that IHS is currently reviewing competitive applications from Tribes and Tribal organizations to participate in the 2010 joint venture program and encourage the Service to move forward with the process in an expeditious manner. (page 74)

Action taken or to be taken

A solicitation of interest in both programs was sent to all tribes nationwide on May 28, 2009. In response to this solicitation of interest, 63 tribes responded positively to receiving additional information regarding the Small Ambulatory Program (SAP) and 55 responded positively to the Joint Venture Construction Program (JVCP). Solicitation packages were prepared for both programs, per the directive.

The JVCP solicitation was sent by mail to all tribes that responded previously, and the application was also made available to all tribes via the IHS webpage.

Item

Suicide Prevention and Treatment Initiative - That $16,391,000 is provided for the methamphetamine and suicide prevention and treatment initiative and $10,000,000 is provided for the domestic violence prevention initiative and, notwithstanding any other provision of law, the amounts available under this proviso shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until expended. (pages 120-121)

Action taken or to be taken

IHS submitted the Report to Congress for the Methamphetamine and Suicide Prevention Initiative on November 20, 2009.

The Dear Tribal Leader Letter was mailed on December 16, 2009 providing the Director's decision on the allocation of funding for the Domestic Violence Prevention Initiative.

Item

Technology Activities - That $18,251,000 is provided for Headquarters operations and information technology activities and, notwithstanding any other provision of law, the amount available under this proviso shall be allocated at the discretion of the Director of the Indian Health Service. (page 120)

Action taken or to be taken

$16.251 million is being used to support the Office of Information Technology national work. This funding is allocated in 2010 to the national IT initiatives. These initiatives include our health information technology system, the national data warehouse, and distributed IT infrastructure throughout our 12 regions. The remaining $2 million is being used to increase IHS' capacity to perform government mandated and necessary administrative and management functions.