Department of Health and Human Services
Indian Health Service
Facilities – 75-0391-0-1-551

FACILITIES

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	Increase or Decrease
BA	**$391,350,000**	**$388,574,000**	**$315,668,000**	**-$72,906,000**
FTE	**1,263**	**1,412**	**1,412**	**0**

Total Budget – The total Facilities budget request of $315,668,000 and 1,412 FTE is a decrease of $72,906,000 below the FY 2005 enacted level of $388,574,000 and 1,412 FTE. The justification of each budget is described in the narratives that follow.

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Department of Health and Human Services
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MAINTENANCE AND IMPROVEMENT

Authorizing Legislation: Program authorized by 25 U.S.C. 13 (P.L. 67-85, the Snyder Act) and 42 U.S.C. 2001 (P. L. 83-568, the Indian Health Transfer Act).

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	Increase or Decrease
BA	$48,897,000	$49,204,000	$49,904,000	+$700,000
FTE	0	0	0	0

STATEMENT OF THE BUDGET REQUEST

The Maintenance and Improvement budget request of $49,904,000 supports the maintenance and improvement of IHS and Tribal health care facilities.

PROGRAM DESCRIPTION

The Indian Health Service (IHS) supports maintenance and improvement activities in Federal government owned buildings and where tribally owned space 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). The mission of the Maintenance and Improvement program is 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.

Specific Maintenance and Improvement (M&I) program objectives include: (1) providing routine maintenance and repairs for facilities; (2) achieving compliance with buildings and grounds accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) 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.

Facilities Engineering Plans (FEPs) establish annual M&I workload targets and helps determine the most prudent use of available resources. FEPs are prepared by IHS Areas, service units, and Tribal programs to identify, delineate, and plan facilities related activities and projects to be accomplished during the upcoming fiscal year for the M&I program.

Funds in the M&I account are used primarily to maintain and improve health care facilities. 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 engineers. In addition, comprehensive "Facility Condition Surveys" are conducted every 5 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 2004 is $482,956,000. The following table summarizes the BEMAR by category:

BEMAR 1/

PUBLIC LAW	
Life Safety Compliance	$38,336,000
General Safety	7,582,000
Environmental Compliance.2/	20,048,000
Handicapped Compliance	16,626,000
Energy Conservation	12,507,000
Seismic Mitigation.3/	99,274,000
Sub Total	**$194,373,000**
IMPROVEMENTS	
Patient Care	$33,049,000
Program Deficiencies	100,045,000
Sub Total	**$133,094,000**
MAINTENANCE & REPAIR 4/	
Architectural M&R	$10,124,000
Structural M&R	38,938,000
Mechanical M&R	51,230,000
Electrical M&R	22,983,000
Utilities M&R	6,926,000
Grounds M&R	18,333,000
Painting M&R	2,352,000
Roof M&R	4,603,000
Sub Total	**$155,489,000**
GRAND TOTAL 5/	**$482,956,000**

1/ The FY 2006 M&I allocation will be distributed for routine maintenance and for projects; projects are intended to reduce identified BEMAR deficiencies.

2/ Projects include air quality improvement, asbestos remediation, lead-based paint, 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 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.
5/ Decrease from last year due to new facilities coming on line and the accompanying disposal of old buildings; also, data validation removed extraneous data values.

M&I Funds Distribution Method

The IHS M&I funds are distributed to four subprograms, 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.

M&I Project Funds - IHS Area Facilities Engineers develop priority lists of larger projects to reduce the BEMAR, although some tribes take their individual shares. Generally M&I projects in this subprogram 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.

Environmental Compliance Funds - 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 $20 million in environmental compliance tasks and included them in the BEMAR database. Tribally owned health care facilities receive assessments upon request by the tribe.

Demolition Funds – The IHS has a number of buildings that are vacant or obsolete and no longer needed. The number currently is estimated at 10 – 15 buildings. Many of these buildings are safety and security hazards. Demolition of these buildings reduces hazards and liability.

PERFORMANCE ANALYSIS

A total of $48,897,000 was appropriated in FY 2004 and approximately $6,172,000 in quarters return funds was collected and distributed; quarters return funds are used only to maintain staff quarters. Approximately $30 million was provided to the IHS Areas and Tribes for daily maintenance activities and local projects to maintain the current state of health care facilities; approximately $15 million was provided to the IHS areas and tribes for projects to reduce the Backlog of Essential Maintenance, Alterations and Repair (BEMAR) deficiencies and to improve healthcare facilities to meet changing healthcare delivery needs. 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. For environmental compliance, approximately $3 million was available, and approximately $500,000 for demolition. In conjunction with improved management practices, energy conservation measures, and projects, IHS reduced the energy related utility consumption for IHS managed facilities from 2,233,000 BTU/SM in 2002 to 1,945,000 BTU/SM in 2004.

The IHS uses the Facility Condition Index (FCI) to measure the condition of facilities. FCI: The facility condition index is an industry accepted benchmark used to measure the relative condition of all IHS facilities. It provides a simple measure of a facility's condition. It is calculated by taking the total backlog of essential maintenance and repairs of the facilities (a.k.a. BEMAR) and dividing it by the total current replacement cost of the facilities. An FCI < 5% represents a facility in good condition, and FCI between 5% and 10% represents a facility in fair condition and an FCI >10% represents a facility in poor condition. New facilities completion has reduced the facility deficiencies and somewhat reduced the corresponding FCI ratio.

FY	**2000**	**2001**	**2002**	**2003**	**2004**
FCI	26.05	26.57	25.53	22.26	23.47

Also, below is a table which shows the increase in supported space (increasing Federal and tribally owned space, in square meters (sm), supported with M&I funds).

FY	**2001**	**2002**	**2003**	**2004**	**2005**
Sm	887,634	938,212	972,589	999,405	1,003,701

Steady State Condition

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 2 to 4 percent of current replacement value of supported buildings is required to maintain facilities in their current condition.

This amount would not render a net reduction in existing BEMAR and would not include improvements and alterations nor include staff and utilities operating costs.

The current (2004) replacement value, of all M&I eligible facilities, is approximately $2.249 billion.

Additionally, new Executive Orders supporting asset management and environmental management related to facilities will affect facilities operations.

FUNDING HISTORY – Funding for the Maintenance and Improvement program during the last 5 years has been as follows:

Fiscal Year	Amount	FTE
2001	$46,371,000	0
2002	$46,331,000	0
2003	$46,507,000	0
2004	$48,897,000	0
2005	$49,204,000	0

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request of $49,904,000 is an increase of $700,000 above the FY 2005 enacted level of $49,204,000. Additional funding will cover the increases in Maintenance and Improvement costs using the FY 2006 Economic Assumptions.

Department of Health and Human Services
Indian Health Service
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SANITATION FACILITIES CONSTRUCTION

Authorizing Legislation: U.S.C. 13 Snyder Act, PL 83-568, Transfer Act, 42 U.S.C. 2001, PL 86-121, Indian Sanitation Facilities Act; and Title III of PL 94-437, Indian Health Care Improvement Act, as amended.

	FY 2004 Enacted	FY 2005 Enacted	FY 2006 Estimate	Increase or Decrease
BA	$93,015,000	$91,767,000	$93,519,000	+$1,752,000
FTE	198	198	198	

STATEMENT OF THE BUDGET REQUEST

The Sanitation Facilities Construction budget request of $93,519,000 supports essential sanitation facilities including water supply, sewage, and solid waste disposal facilities to AI/AN homes and communities.

PROGRAM DESCRIPTION

The IHS SFC Program, an integral component of the IHS disease prevention activity, has carried out those authorities since 1960 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.

Support for the IHS' justification of SFC Program funding can be found in a PHS study entitled “Relationship of Environmental Factors to the Occurrence of Enteric Disease in Areas of Eastern Kentucky.” The data support the premise that the incidence of acute infections and diarrhea disease could be reduced significantly by selectively modifying environmental factors. The IHS physicians have stated that the Indian Sanitation Facilities Act has had a greater positive effect upon the health of AI/ANs than any other single piece of legislation.

A Report to Congress by the Comptroller General (dated March 11, 1974) noted that AI/AN families living in homes with satisfactory environmental conditions placed fewer demands on IHS' primary health care delivery system than families living in homes with unsatisfactory conditions. For example, those with satisfactory environmental conditions in their homes (e.g., safe piped water and adequate sewage disposal) required

approximately 25 percent of the health care services required by those with unsatisfactory environmental conditions.

The **four types** of sanitation facilities projects funded with 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.

As with other IHS activities, sanitation facilities projects are carried out cooperatively with the Indian people who are to be served by the facilities. Tribal involvement has been the keystone of the Sanitation Facilities Program since its inception in FY 1960. Projects are initiated only following receipt of a tribal request expressing willingness on their part to participate in carrying out the project and willingness to execute an agreement to assume ownership responsibilities, including operation and maintenance, for completed facilities.

One of three program delivery methods may be used to provide these services to Indian communities. The SFC program can be managed by the IHS directly (Direct Service), or it can be managed by a tribe that has elected to use Title I or Title V authorization under P.L. 93-638, the Indian Self-Determination and Education Assistance Act. The overall SFC Program goals, eligibility criteria, and project funding priorities remain the same, regardless of the program delivery methods chosen by a Tribe.

With completion of all projects approved through FY 2004, approximately 275,000 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.

Sanitation Facilities Needs

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 the end of FY 2004, the list of all documented projects totaled $1.861 billion with those projects considered economically feasible totaling $915 million. As of the end of FY 2004, there were over 150,000 AI/AN homes in need of sanitation facilities including over 36,000 AI/AN homes without potable water.

As proposed, 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.

PERFORMANCE ANALYSIS

The provision of sanitation facilities is a very important component of the overall effort required to achieve a reduction in infant mortality, a goal highlighted in Healthy People 2010 "The Year 2010 Objectives for the Nation." 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.

Currently, about 1 percent of all U.S. homes lack safe water in the home while about 12 percent (approximately 36,000) of all AI/AN homes lack safe water in the home.

For several years IHS has stated that 7.5% of AI/AN homes were without potable (safe and reliable) water. Based on end of year 2003 data, it is estimated that approximately 12% of AI/AN homes are without a safe and reliable water supply. This increase in the number of AI/AN homes lacking safe water is due to inflation, population growth, the age and condition of the existing infrastructure, high numbers of new and like new housing, and new environmental regulations including the new Arsenic and Surface Water Treatment rules promulgated by the Environmental Protection Agency. The new arsenic rule accounts for most of this increase because it has caused approximately 65 communities with nearly 13,000 homes to now be classified as deficiency level 4 for water as defined in 25 USC 1632. In order to meet the IHS strategic goal of raising the percent of AI/AN homes with safe water to 94% by 2010 a significantly larger increase in sanitation project and staff funding is required.

The SFC Program is a contributing factor in accomplishing the goals of the IHS Strategic Plan including: building healthy communities through disease prevention; achieving parity in access by attempting to increase the number of AI/AN homes with potable water to 94% by 2010; 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.

The SFC Program GPRA goal directly measures the impact of the program by counting the number of AI/AN homes served. The SFC Program has consistently met its GPRA goal. During FY 2006, the GPRA goal is to provide sanitation facilities projects to 20,000 Indian homes with water, sewage disposal, and/or solid waste facilities. During FY 2004, SFC served 24,928 homes with water, sewage disposal, and/or solid waste facilities compared with the GPRA goal to provide sanitation facilities projects to 18,150 Indian homes.

In FY 2005, of the $91,767,165 appropriated for sanitation facilities, $45,670,900 was used to address the backlog of existing homes. This included funding to serve solid waste needs (included in the solid waste funding was $490,300 to clean up open dumps

identified by an interagency task force, the members of which included the Bureau of Indian Affairs, the Environmental Protection Agency, the Department of Agriculture and others). The remainder of the FY 2005 appropriation was used to provide $45,115,665 for sanitation facilities for new/like-new Indian homes and $980,600 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 Environmental Protection Agency (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. The data is reported as east and west, excluding Alaska. The common measure was then applied using FY 2001 data. The IHS compared favorably in FY 2001 having provided 174 and 212 (east and west) services per million dollars compared with the BOR which provided 24 services per million dollars.

The Program Assessment Rating Tool (PART) is an OMB initiative performed on the SFC program in 2002. The PART rates a program's purpose, design, strategic planning, program management, and program results. The SFC program scored 80%, which was the second highest within the Department of Health and Human Services in 2004 and led to a rating of moderately effective. A major weakness of the SFC program is that it has not had an independent program review since 1974, and there has not been a recent benefit cost analysis on the value of sanitation facilities for AI/AN homes. The SFC program is working with Federal Occupational Health of the Department of Health and Human Services on an independent evaluation of the program to be completed in 2005. Additionally, a new GPRA measure along with a long term performance goal was developed. The new additional goal is for FY 2005, 20% of the homes served by the SFC Program funding, for the backlog of needs for existing homes (regular funds), will be at Deficiency Level 4 or above as defined by 25 USC 1632. The SFC Program beginning in FY 2004 shares a measure with the Dental program related to fluoridation.

FUNDING HISTORY – Funding for the Sanitation Facilities Construction program during the last 5 years has been as follows:

Fiscal Year	Amount	FTE
2001	$93,617,000	195
2002	$93,827,000	195
2003	$93,217,000	195
2004	$93,015,000	198
2005	$91,767000	198

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request of $$93,519,000 is an increase of $1,752,000 above the FY 2005 Enacted Budget of $91,676,000. The increase will fund construction inflation costs.

Number of Homes Benefited

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Budget
A. New/Like-New			
HUD...../1	5	200	200
BIA/HIP.....	112	300	300
Tribal/Other.....	2,431	3,300	3,300
Subtotal.....	2,548	3,800	3,800
B. Existing Indian Homes			
First Service.....	2,391	1,500	1,500
Upgraded/Emergency...	19,989	14,700	14,700
Subtotal.....	22,380	16,200	16,200
TOTAL...../2	24,928	20,000	20,000

1/ Sanitation facilities to be funded with HUD grants contributed by tribes to IHS projects.

2/ Construction projects are funded with IHS appropriated funds and contributions to serve these homes.

All Projects are budgeted to include full costs for pre-planning, design, construction costs, and associated overhead. The FY 2006 Sanitation Facilities Construction (SFC) portion of the appropriation will be allocated as follows:

1) $1,000,000 will be reserved at IHS Headquarters for special projects and for distribution to the 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 will be distributed to the Areas to address the Sanitation Deficiency System (SDS) priority list of needs.

2) Up to $47,000,000 of the total FY 2006 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 the Area's pro-rata share of remaining funds for serving such housing.

3) Up to $47,000,000 of the amount appropriated in FY 2006 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. 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 are able to fund the sanitation facilities necessary for the homes.

Department of Health and Human Services
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HEALTH CARE FACILITIES CONSTRUCTION

Authorizing Legislation: The Indian Health Service (IHS) is authorized to construct health care facilities by the Snyder Act, 25 U.S.C. 13; and the Indian Health Care Improvement Act, Public Law 94-437, as amended.

Projects [1]	FY 2004 Actual [2]	FY 2005 Enacted [3]	FY 2006 Estimate	Increase or Decrease
BA	$94,554,600	$88,596,800	$3,326,000	- $85,270,800
Planning Studies:				
Various Projects	0	986,100	0	N/A
Subtotal Plan. Stud.	**0**	**986,100**	**0**	**- 986,100**
Inpatient (Hospitals):				
Upper Santan, AZ – PIMC System – SE ACC	0	2,590,100	0	N/A
Komatke, AZ – PIMC System – SW ACC	0	1,354,400	0	N/A
Barrow, AK	0	2,958,300	0	N/A
Subtotal Inpatient	**0**	**6,902,800**	**0**	**- 6,902,800**
Outpatient (Health Centers):				
Piñon, AZ	19,335,800	0	0	N/A
Red Mesa, AZ	29,630,300	19,112,700	0	N/A
St. Paul, AK	6,439,700	0	0	N/A
Metlakatla, AK	9,091,600	0	0	N/A
Sisseton, SD	17,738,700	17,059,700	0	N/A
Clinton, OK	0	19,031,900	0	N/A
Eagle Butte, SD	2,765,500	4,930,500	0	N/A
Subtotal Outpatient	**85,001,600**	**60,134,800**	**0**	**- 60,134,800**
Staff Quarters:				
Bethel, AK	4,938,400	0	0	N/A
Zuni, NM	0	2,489,900	0	N/A
Wagner, SD	0	2,502,700	0	N/A
Ft. Belknap, MT	0	4,930,600	3,326,000	N/A
Subtotal Staff Qtrs,	**4,938,400**	**9,923,200**	**3,326,000**	**- 6,597,200**
Youth Regional Treatment Centers (YRTCs):				
Phoenix-NV Satellite	3,626,800	0	0	N/A
Central-Southern CA	0	0	0	N/A
Northern CA	0	0	0	N/A
Subtotal YRTCs	**3,626,800**	**0**	**0**	**0**
Joint Venture Construction Program (JVCP):				
Various Projects	0	4,733,300	0	N/A
Subtotal JVCP	**0**	**4,733,300**	**0**	**- 4,733,300**

Projects [1]	FY 2004 Actual [2]	FY 2005 Enacted [3]	FY 2006 Estimate	Increase or Decrease
Small Ambulatory Program (SAP):				
Various Projects	0	4,930,500	0	- 4,733,300
Subtotal SAP	**0**	**4,930,500**	**0**	**- 4,733,300**
Dental Facilities Program (DFP):				
Various Projects	987,700	986,100	0	- 986,100
Subtotal DFP	**987,700**	**986,100**	**0**	**- 986,100**

1 The Inpatient and Outpatient health care facilities, Staff Quarters, YRTCs, JVCP, SAP and DFP 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 PIMC SE ACC Inpatient project does not have a higher priority than the Central – Southern CA YRTC project.

2 The FY 2004 Actual includes all rescissions, supplementals, reprogramming, and transfers.

3 The FY 2005 Enacted includes all rescissions.

STATEMENT OF THE BUDGET REQUEST

The $3,326,000 is being requested for the design and construction, including the initial equipment, of new staff quarters to support an existing health care facility that provides direct health care services for the American Indian and Alaska Native people, all pursuant to the existing program authorities. The budget includes a 1-year pause in new health care facilities construction starts in order to focus resources on fully staffing facilities that have been constructed and are opening in FYs 2005 and 2006.

PROGRAM DESCRIPTION

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 application of comprehensive priority system methodologies. Periodically, IHS Headquarters solicits proposals from the IHS Areas for urgently needed new or replacement health care facilities or essential staff quarters needs. The proposals are evaluated objectively and ranked according to need.

The objectives of the IHS Health Care Facilities Construction Program are to enhance IHS health care delivery capacity by providing for optimum availability of functional, well-maintained IHS and tribally operated health care facilities, and to provide staff housing at IHS health care delivery locations if no suitable housing alternative is available. 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, administer the Joint Venture Construction Program, provide construction funding for tribal small ambulatory care facilities under the Small Ambulatory Program, replace/provide new dental units under the Dental Facilities Program, and to assist non-IHS funded renovation projects.

To determine the locations where new and replacement facilities are most critically needed, the IHS has developed and is implementing comprehensive priority system methodologies for health care facilities and staff quarters construction. As needed, IHS

Headquarters solicits proposals from the IHS Areas for urgently needed new or replacement health care facilities, essential staff quarters projects, and replacement/new dental units. These proposals are evaluated and prioritized. Formal justification documents are prepared for those scoring highest. Once justified, projects are placed on the appropriate construction priority list and proposed for funding.

Health Care Facilities Construction Program

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 to construct new or replacement health care facilities. Based on the Phase I result, the IHS proceeded with Phase II of the methodology, using a more detailed analysis of the 28 highest ranked proposals. 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. As PJDs are approved, projects are added to the respective Health Facilities Construction Priority List.

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. The IHS began reviewing the need for quarters at each location where new or replacement health care facilities were being planned.

> Where quarters are required as part of a health care facility project, the IHS completes a PJDQ as a part of the PJD for the health care facility and the quarters need is included with the facilities construction project on the respective Health Care Facilities Construction Priority List.

The IHS is authorized to construct Youth Regional Treatment Centers (YRTCs) by Section 704 of the IHCIA, P.L. 94-437, as amended. One YRTC is to be constructed in each IHS Area except that two each are to be constructed in California and Alaska to provide substance abuse treatment to American Indian and Alaska Native youth.

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. 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. The costs of facility design and construction 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 authority for the current JVCP is Section 818(e) of the IHCIA, P.L. 94-437, as amended.

The IHS is authorized to provide construction funding to tribes or tribal organizations by 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.

Appropriations for IHS in FYs 1994-2004 included funding to replace and build new dental units under the IHS Dental Facilities Program..

The IHS is authorized to accept renovations and modernizations of any service facility through non-IHS funded sources and to assist by providing equipment and personnel by Section 305 of the IHCIA, P.L. 94-437, as amended.

In Year 2003, the Department of Health and Human Services (DHHS) instituted a capital facilities programming and project review process, including a non-information technology Capital Investment Review Board (CIRB). Documentation requirements and approval authorities are defined in the DHHS June 2003 CIRB policy statement, and in the DHHS April 2004 Facility Project Approval Agreement policy statement. On June 28, 2004, the CIRB met and reviewed all DHHS projects being considered for inclusion in the FY 2006 budget request, which exceed $10,000,000, include land purchase, or otherwise fell under the Board's authority.

PERFORMANCE ANALYSIS

Overview: The IHS Health Care Facilities Construction Program (HCFCP) has been evaluated under the Office of Management and Budget (OMB) Program Assessment Rating Tool (PART) process as part of the FY 2006 budget process, and received a score of 92 of possible 100, earning a rating of Effective. The HCFCP supports the IHS strategic goals No. 1 and No. 2, which deal with creating healthy communities and improving access to health care for American Indian and Alaska Native (AI/AN) people. By increasing the capacity of health care facilities to serve AI/AN communities, the HCFCP contributes to increasing access to critical health services that ultimately results in better health outcomes. These results have been documented by improvements in the rates of Years of Potential Life Lost at new facilities when they have been completed and staffed. This conceptual logic is the basis for a long-term performance goal for the PART review that has been conducted by OMB. The HCFCP has a single Government Performance and Results Act (GPRA) performance measure, which is unique in that it

significantly contributes to increasing access to health services as represented by most of the clinical GPRA performance measures as well as being used as performance metrics in the PART assessment of the HCFCP.

The IHS Health Care Facilities Construction Priority Lists target AI/AN communities with the highest relative need for resources and facilities processed under the HCFCP. By increasing the capacity of health care facilities to serve AI/AN communities, the HCFCP contributes to increasing access to critical health services that ultimately results in better health outcomes. These results have been documented by improvements in the rates of Years of Potential Life Lost at new facilities when they have been completed and staffed. This conceptual logic is the basis for a long-term performance goal for the PART review that has been conducted by OMB.

While the HCFCP has a single Government Performance and Results Act (GPRA) performance measure, it is uniquely responsible for that described below. The HCFCP significantly contributes to increasing access to health services as represented by most of the clinical GPRA performance measures as well as being used as performance metrics in the PART assessment of the HCFCP.

Program Performance: The IHS met the FY 2004 GPRA indicator by achieving the timely, phased construction activities for health care facilities as indicated below. This achievement will help enhance access to care for the AI/AN population.

Ft. Defiance, AZ: For this fully funded project, the replacement hospital was completed in June 2002 and opened for service on August 1, 2002. The replacement and additional staff quarters portion of the project was completed ahead of schedule on February 25, 2004. The project was completed in FY 2004.

Winnebago, NE: The replacement hospital portion of the project was completed in FY 2004. Renovation of the old structure continued for the Drug Dependency Unit (DDU) portion of the project until it was determined that the renovation of the old structure was no longer feasible. Method is being revised for providing the DDU.

Piñon, AZ: For this fully funded project, construction continued for the new health center and staff quarters project, with a scheduled 4th quarter FY 2005 project completion.

Red Mesa, AZ: For this fully funded project, funding is being used for construction. The project is scheduled for 2nd quarter FY 2006 completion.

Pawnee, OK: This fully funded project was completed in the 2nd quarter FY 2004.

St. Paul, AK: For this fully funded project, construction is proceeding and is scheduled for 2nd quarter FY 2006 completion.

Metlakatla, AK: For this fully funded project, construction is proceeding and is scheduled for 2nd quarter FY 2006 completion.

Sisseton, SD: For this fully funded project, the project is proceeding. The Tribe is developing the site for the IHS under a P.L. 93-638 Subpart J construction contract. The project is scheduled for 1st quarter FY 2007 completion.

Clinton, OK: For this fully funded project, the project is proceeding by the Tribe performing the design under a P.L. 93-638 Subpart J design contract. The project is scheduled for 1st quarter FY 2007 completion.

Eagle Butte, SD: Project is proceeding with arrangements being completed for design start and the inclusion of staff quarters into the project.

Bethel, AK: Project is fully funded. Provided funding is being used by the Yukon-Kuskokwim Health Corporation, through a design-build contract under an agreement with the IHS, to design and construct the staff quarters. The project is scheduled for a 2nd quarter FY 2005 completion.

Wadsworth, NV: This fully funded Phoenix-Nevada Satellite Youth Regional Treatment Center is proceeding under the design-build method, with a scheduled 2nd quarter FY 2007 completion.

Small Ambulatory Program: Twenty-one tribal projects have received awards under the Small Ambulatory Program (SAP) using funding provided in FY 2001, FY 2002, and FY 2003. For the FY 2001 SAP, tribes have received awards for nine projects, and six projects have been completed. For the FY 2002 SAP, tribes have received awards for eight projects, and five projects have been completed. For the FY 2003 SAP, tribes have received awards for four projects. Uncompleted projects are either in design or under construction by the tribes. The FY 2005 funding will allow for the selection and award of additional SAP projects.

Dental Facilities Program: Using FY 2004 funding, two additional projects are being processed for design and construction under this program, which will make a total of 29 projects being provided under this program since 1994. The FY 2005 funding will allow two additional dental units to be provided.

FUNDING HISTORY

Funding for the Health Care Facilities Construction program during the last five years has been as follows:

Fiscal Year	Amount	FTE
2001	$85,525,000	0
2002	$86,260,000	0
2003	$81,585,000	0
2004	$94,554,000	0
2005	$88,596,800	0

RATIONALE FOR THE BUDGET REQUEST

The request of $3,326,000 is a decrease of $85,270,800 from the $88,596,800 appropriated in FY 2005. The proposed resources will be used to complete additional staff quarters for the existing Fort Belknap, Montana health care facility complex. Consistent throughout HHS, the FY 2006 request for facilities funding focuses on maintenance of existing facilities. No funding is requested to initiate new projects.

Staff Quarters, Fort Belknap, MT: +$3,326,000

Funds in this request will be used to complete providing 29 staff quarters to support the Fort Belknap health care facility which is located in Harlem, MT, and at a satellite site in Hayes, MT. This project, which includes five replacement units, increases the total number of staff quarters from 16 to 40. The project will provide housing for 40 of 58 non-local health care professional personnel serving this health care facility complex. In addition to the 58 non-locals, the staffing level includes 49 locals, for a total of 107. Private sector housing is not available. The current choices for these employees are to live in house trailers or long commutes.

This project is a part of the IHS Health Care Facilities Construction Program (HCFCP), which has been evaluated under the Office of Management and Budget (OMB) Program Assessment Rating Tool (PART) process as part of the FY 2006 budget process.

Program: *Health Care Facilities Construction*

Rating: *Effective*

Agency: *Department of Health and Human Services*

Bureau: *Indian Health Service*

Program Type: *Capital Assets and Service Acquisition*

Program Summary:

The Indian Health Service's (IHS) Health Care Facilities Construction program designs and builds health care facilities and staff housing to provide health care services to the American Indian/Alaska Native (AI/AN) population.

The assessment found:

- The program purpose is clear and the design is free of major flaws that would limit the program's effectiveness. The program uses a comprehensive priority methodology system that identifies locations that have the highest need for a new or replacement health care facility.
- The program is developing facility-specific long-term and annual performance measures that will assess the role of new facilities in expanding access to critical health services that impact health outcomes.
- Independent evaluations are conducted on a regular basis or as needed to support program improvements and evaluate effectiveness. The program has maintained Joint Commission of Accreditation Healthcare Organizations (JCAHO) accreditation for all of its facilities. In addition, the program has sought evaluations to review all issues that drive space requirements, update design criteria and create an equipment planning process. This led to the adoption of the Health Systems Planning process in June 1999.
- The program collaborates and coordinates with related programs. IHS is a member of the Federal Facilities Council which produces practices documents for agencies to consider for their facilities programs. IHS is also a member of various national code committees that review proposed code changes related to hospital and clinic construction.

In response to these findings, the Administration will:

1. Continue construction of health care facilities currently in the process of being built. The 2006 Budget includes a one-year pause in new facilities construction.
2. Develop baselines and targets for new measures.

Key Performance Measures from Latest PART	*Year*	*Target*	*Actual*
Long-term Measure: Percent reduction of the YPLL rate within 7 years of opening the new facility	2010	-10%	
Long-term Measure: Percent increase in the proportion of diagnosed diabetics demonstrating ideal blood sugar control within 7 years of opening the new facility	2010	+10%	
Annual Efficiency Measure: Percent of scheduled construction phases completed on time	2003	100%	100%
	2004	100%	100%
	2005	100%	
	2006	100%	

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
94	89	3

INDIAN HEALTH CARE FACILITIES CONSTRUCTED SINCE FY 1980

PROJECT LOCATION	FISCAL YEAR COMPLETED	TOTAL $ APPROPRIATED
	Hospitals	
Bethel, AK	1980	34,100,000
Ada, OK	1980	14,374,000
Cherokee, NC	1981	10,341,000
Red Lake, MN	1981	9,566,000
Chinle, AZ	1982	19,758,000
Tahlequah, OK	1983	21,334,000
Browning, MT	1985	15,086,000
Kanakanak, AK	1987	16,578,000
Crownpoint, NM	1987	17,734,000
Sacaton, AZ	1988	15,765,000
Rosebud, SD	1989	20,000,000
Pine Ridge, SD	1993	27,090,000
Shiprock, NM	1995	53,591,364
Crow Agency, MT	1995	23,091,000
Kotzebue, AK	1995	62,483,000
Anchorage, AK	1997	167,915,000
Ft. Defiance, AZ [1]	2002	117,763,797
Winnebago, NE [2]	2004	47,857,000
Subtotal		$694,427,161
	Health Centers	
Cibecue, AZ	1980	750,000
Lodge Grass, MT	1982	1,485,000
Inscription House, AZ	1983	3,890,000
Ft. Duchesne, UT	1984	2,220,000
Tsaile, AZ	1984	3,856,000
Huerfano, NM	1984	3,304,000
Ft. Thompson, SD	1988	3,449,000
Wolf Point, MT	1990	3,654,000
Kyle, SD	1990	3,209,000
Toppenish, WA	1990	9,350,000
Ft. Hall, ID	1990	6,002,000
Sallisaw, OK	1992	4,265,000
Puyallup, WA	1993	8,472,000
Taos, NM	1993	5,765,000
Wagner, SD	1993	6,119,000
Belcourt, ND (OPD)	1994	19,449,000
Tohatchi, NM	1995	9,502,682
Stilwell, OK	1995	7,663,000
Ft. Belknap, MT [3]		18,885,000
Hays, MT	1997	
Harlem, MT	1998	
White Earth, MN	1998	13,462,000
Lame Deer, MT	1999	14,100,000
Hopi, AZ	2000	34,558,000
Parker, AZ	2001	21,641,000
Pawnee, OK	2004	19,327,147
Subtotal		$224,377,829

INDIAN HEALTH CARE FACILITIES CONSTRUCTED SINCE FY 1980

PROJECT LOCATION	FISCAL YEAR COMPLETED	TOTAL $ APPROPRIATED
Staff Quarters		
Chinle & Inscription House, AZ (design)		336,000
Inscription House, AZ (21)	1982	1,764,000
Chinle, AZ (161)	1983	12,236,000
Huerfano, NM (9) [4]	1983	
Ft. Duchesne, UT [4]	1984	
Crownpoint, NM (36)	1984	3,352,000
Tsaile, AZ (23)	1985	2,141,000
Ft. Thompson, SD (13)	1985	1,279,000
Kanakanak, AK (17)	1986	4,133,000
Browning, MT (26)	1987	2,470,000
Kyle, SD (24)	1987	1,615,000
Supai, AZ (2)	1990	246,000
Rosebud, SD (29 of 66)	1990	7,345,000
Neah Bay, WA (4)	1991	472,000
Dulce, NM (4)	1993	515,000
Barrow, AK (29)	1993	18,183,000
Rosebud, SD (remaining 37 units)	1993	7,695,000
Pine Ridge, SD (45)	1993	9,517,000
Kotzebue, AK (50)	1993	26,155,000
Belcourt, ND (21)	1997	3,912,000
Hopi, AZ (Polacca) (73) [5]	2001	4,995,000
Subtotal		$108,361,000
Youth Regional Treatment Centers		
Alaska - Fairbanks, AK	1993	1,466,000
Alaska – Mt. Edgecumbe, AK	1994	866,000
Phoenix – Sacaton, AZ	1994	2,357,000
Portland - Spokane, WA	1996	7,343,000
Aberdeen - Chief Gall, SD	1996	5,373,000
Subtotal		$ 17,405,000
Joint Venture Demonstration Projects		
Warm Springs, OR	1993	959,000
Poteau, OK	1994	700,000
Subtotal		$ 1,659,000
GRAND TOTAL		**$1,046,229,990**

[1] The replacement hospital opened on August 1, 2002, and the design-build staff quarters project was completed February 25, 2004. Project completion is pending FY 2005 completion of original scope, at which time the final cost shown in this table will be adjusted to actual expenditures.

[2] The replacement hospital opened April 10, 2004. Project completion is pending decision on best method for providing the Drug Dependency Unit (DDU) portion of the project. When the DDU is completed the final project cost shown in this table will be adjusted to actual expenditures.

[3] The Fort Belknap project was constructed at two sites, the main facility in Harlem and a satellite in Hays.

[4] These two projects were funded by the Chinle & Inscription House projects appropriations.

[5] This $4,995,000 was appropriated to help reduce the debt incurred by the Hopi Tribe in their providing of staff quarters to meet housing needs associated with the new health center; thereby, allowing reduced rental rates.

FY 2006 FUNDING STATUS
INDIAN HEALTH CARE FACILITIES CONSTRUCTION

FACILITY	($) [Rounded to hundreds] PRIOR TO FY 2006*	FY 2006 BUDGET REQUEST TOTAL ESTIMATE	TOTAL PROJECT ESTIMATE
Planning Studies	986,100	0	3,000,000
Inpatient Facilities (Section 301)			
PIMC System, AZ	224,400	0	1,225,000
SE ACC	2,590,100	0	40,752,000
SW ACC	1,354,400	0	20,933,000
NE ACC	0	0	42,225,000
Central – Hospital & ACC	0	0	431,287,000
Barrow, AK	3,078,300	0	125,524,524
Nome, AK	120,000	0	122,452,000
Whiteriver, AZ	0	0	146,866,000
Outpatient Facilities (Section 301)			
Ft. Yuma, AZ – On Hold	0	0	UNK
Pinon, AZ	39,759,000	0	39,759,000
Red Mesa, AZ	64,101,600	0	64,101,600
St. Paul, AK	14,140,400	0	14,140,400
Metlakatla, AK	20,010,600	0	20,010,600
Sisseton, SD	40,158,900	0	40,158,900
Clinton, OK	20,358,900	0	20,358,900
Dulce, NM (1)	0	0	NA
San Simon (Westside), AZ (1)	0	0	NA
Eagle Butte, SD	7,696,000	0	79,675,000
Kayenta, AZ	0	0	95,053,000
Quarters (Section 301)			
Bethel, AK	19,894,900	0	19,894,900
Zuni, NM	5,409,900	0	5,409,900
Wagner, SD	2,502,700	0	2,502,700
Ft. Belknap, MT	4,930,500	3,326,000	8,256,500
Youth Regional Treatment Centers (Section 704)			
Phoenix-Nevada Satellite YRTC	4,141,800	0	4,141,800
Central-Southern California YRTC	0	0	10,262,000
Northern California YRTC	0	0	10,875,000
Joint Venture Construction Program (Section 818e)	14,722,300	0	39,989,000
Small Ambulatory Program (Section 306)	29,876,000	0	95,000,000
Dental Facilities Program	11,463,100	0	25,000,000
Non-IHS Funds Renovation Projects (Section 305)	0	0	10,000,000

* All active projects are included.

(1) Tribes have Agreements to participate in the Joint Venture Construction Program for these projects.

(2) Section references are applicable sections of the Indian Health Care Improvement Act, P.L. 94-437, that authorize the Programs.

Department of Health and Human Services
Indian Health Service
Facilities – 75-0391-0-1-551

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

Program Authorization: Program authorized by 25 U.S.C. 13, Snyder Act, and P.L. 83-568 Transfer Act, 42 U.S.C. 2001.

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	Increase or Decrease
BA	$137,803,000	$141,669,000	$150,959,000	+$9,290,000
FTE	1,065	1,214	1,214	0

STATEMENT OF THE BUDGET REQUEST

The Facilities and Environmental Health Support budget request of $150,959,000 supports personnel who provide facilities and environmental health services throughout the IHS at the IHS Area, district, and service unit levels, and to pay operating costs associated with provision of those services and activities. The Facilities and Environmental Health Support (FEHS) account is separated into **three sub-activities** (Facility Support, Environmental Health Support, and Office of Environmental Health and Engineering (OEHE) Support) which provide support for the other activities within the facilities appropriation (e.g. Sanitation Facilities Construction).

PROGRAM DESCRIPTION

The Indian Health Facilities programs, managed at Indian Health Service (IHS) Headquarters by the Office of Environmental Health and Engineering (OEHE) and carried out by Area, field, and service unit staff, 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. Services are delivered directly by Federal or Tribal employees or by tribal contractors. In addition to staffing costs, funds appropriated for this activity are used to pay for utilities in IHS health care facilities, certain non-medical supplies and personal property, and biomedical equipment repair. This umbrella account is further managed and distributed through three categories: facilities support, environmental health support, and office of environmental health and engineering support. Currently, costs for permanent positions that constitute the Federal portion of this program are paid from this account. Costs for approximately 198 additional temporary and permanent sanitation facilities construction support personnel are paid from specific sanitation facilities project accounts. Also costs for positions in tribally contracted environmental health activities are included among the permanent positions paid from this account. Costs for health care facilities/staff quarters operation and maintenance personnel are paid from this account or from reimbursements.

The OEHE Headquarters staff includes components in Rockville, Dallas, and Seattle. The staff has management responsibility for IHS facilities and environmental health programs, provides direct technical services and support to Area personnel, and performs critical management functions. Headquarters OEHE management activities include 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 for both tribal and IHS personnel); long-range planning; meetings (with Members of Congress and their representatives, with tribes, and with other Federal agencies); realty services; and recruitment and retention. Also, OEHE Engineering Services staff located in Dallas, Texas and Seattle, Washington provide architectural, engineering, construction, contracting, and real property services to IHS and tribal health care facilities programs.

There are counterparts of most facilities and environmental health organizational elements in each IHS Area Office. **Staff of facilities and environmental health related programs in IHS Area Offices** vary in size depending on program scope; the number and size of IHS facilities served; the number, size, and complexity of construction projects; the number and location of Indian communities served; transportation considerations; and the method of providing technical services within the Area. 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.

Area personnel perform local management functions while devoting a predominance of time and effort to providing direct support to service unit, district office, and tribal contracted personnel. Typical of direct support functions are services performed by Area-based technical experts who visit IHS facilities and Indian communities to make institutional (hospital, school, restaurant, water supply) inspections, complete sanitation facilities construction survey work, train water/wastewater treatment plant operators or hospital maintenance personnel, survey real property including IHS staff quarters, perform epidemiological studies of injury occurrences, provide onsite construction inspection services, troubleshoot mechanical/electrical problems in IHS facilities.

The **management functions** performed by IHS Area personnel parallel those performed by Headquarters but are focused on Area and service unit needs and, therefore, are less broad in scope. They include Area policy development and implementation, quality assurance in Area/service unit operations (oversight), technical assistance (consultation and training), long-range planning, recruitment, and retention.

District Offices are opened when professional/technical services are needed at two or more IHS health care facilities or sanitation facilities construction projects, which are not large enough to individually merit full-time staff coverage, when the Area Office is too distant, or when the size of the service area is too large to provide suitable services, oversight, or technical assistance from the Area Office. Currently, IHS has

approximately 30 such offices staffed by engineers, environmental health officers, construction inspectors, land surveyors, environmental health and construction technicians, and support personnel. All provide direct program support services.

PERFORMANCE ANALYSIS

The performance analysis sections are contained within each sub-activity: Facilities Support, Environmental Health Support, and OEHE Support.

FUNDING HISTORY – Funding for the Facilities and Environmental Health Support program during the last 5 years has been as follows:

Fiscal Year	Amount	FTE
2001	$121,336,000	1,037
2002	$126,775,000	1,073
2003	$132,963,000	1,113
2004	$137,803,000	1,065
2005	$141,669,000	1,214

RATIONALE FOR THE BUDGET REQUEST

The budget request of $150,959,000 is an increase of $9,290,000 above the FY 2005 enacted level of $141,669,000.

Staffing for New Facilities: + 3,992,000
The increase will allow IHS to expand provision of health care in those areas where existing capacity is most overextended. The funds will staff 6 new facilities which will open in FY 2005 and FY 2006. The following table displays the requested increase.

		FTE	
Facilities	Dollars	Federal	Tribal
Piñon, AZ Health Center	$1,039,000	6	0
Idabel, OK Health Center	35,000	0	0
Coweta, OK Health Center	1,084,000	6	0
Red Mesa, AZ Health Center	848,000	7	0
Sisseton, SD Health Center	870,000	7	0
St. Paul, AK Health Center	116,000	1	0
Total	$3,992,000	27	0

Inflation: +$805,000
Additional funding will cover the increases in costs using the FY 2006 Economic Assumptions.

Population Growth: + $1,997,000
The increase of $1,997,000 for population growth will fund the cost of the increasing AI/AN population and maintain the current level of services.

Department of Health and Human Services
Indian Health Service
Facilities –75-0391-0-1-551

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT
FACILITIES SUPPORT

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	Increase or Decrease
BA	$70,473,000	$73,843,000	$79,348,000	+$5,505,000
FTE	555	632	632	0

STATEMENT OF THE BUDGET REQUEST

Funding will pay personnel and operation costs at the Service Unit and Area levels[1].

PROGRAM DESCRIPTION

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, building systems, medical equipment technical support, and planning and construction management for new and replacement facilities projects. In addition, related Area and Service Unit operating costs, such as utilities, building operation supplies, facilities related personal property, and biomedical equipment repair and maintenance, are paid from this account.

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 builds and maintains residential quarters at those locations to house non-local health care personnel.

The IHS owns approximately 880,000 square meters of Federally-owned facilities (buildings and structures) and 770 hectares of Federal and trust land. The nature of space varies from sophisticated medical centers to residential units and utility plants (see following table). Facilities range in age from less than 1 year to more than 100 years. The average age of our health care facilities is 34 years. Many IHS facilities were built when medicine was practiced much differently than it is today and service populations were much smaller.

In addition to Federally-owned space, the IHS manages direct leased and GSA assigned space. The table on the following page shows the space occupied by IHS and Tribal Health Care Programs.

1/ Costs for these functions performed by P.L. 93-638 contractors at non-Federally-owned or previously Federally-owned facilities are funded from the Services appropriation.

Space Occupied by IHS and Tribal Health Care Programs				
Type of Facility	Federally Owned	Direct Federal Lease	GSA Assigned	Tribal
Hospitals and Health Centers	500 940 M^2	82 757 M^2	-0-	353 037 M^2*
Staff Quarters	256 973 M^2	0 M^2	-0-	306 M^2
Other	122 246 M^2	12 387 M^2	57 352 M^2	135 941 M^2
Total	880 159 M^2	95 144 M^2	57 352 M^2	489 284 M^2

*Tribal Space listed for Hospitals and Health Centers includes all space at locations where direct medical services are provided under P.L. 93-638 contracts in non-IHS owned buildings. Staffing and operations costs (including lease costs) are funded from the Services appropriation.

Staff Functions -- Four principal staff functions are funded at the Area and Service Unit levels through the Facilities Support sub-activity.

- **Facilities Engineers** -- 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 Engineers** -- The IHS has highly sophisticated medical equipment in its inventory. Skilled, 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 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 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.

Operations Costs

- Utility Costs -- Utility costs include heating and air conditioning expenses, fuel oil, natural gas, propane, water, sewer, and electricity for lighting and equipment operation.

- Building Operation Supplies and Equipment -- Funds for building operation supplies and equipment, including special tools to perform maintenance, heating and air conditioning supplies, etc.

- Biomedical Equipment and Repair -- The clinical engineering program provides technical service and support for biomedical equipment at IHS and tribal health care facilities. The program also administers service contracts for biomedical maintenance and repair where clinical engineering personnel are not available to perform this service.

- Leased Space -- The IHS continues to apply its Lease Priority System (LPS) methodology in order to plan/budget for Federally-funded IHS and tribal program space. The LPS improves lease management by establishing specific criteria for evaluating Federal and tribal health program space requests. **Most lease costs are paid from the Services appropriations**.

PERFORMANCE ANALYSIS

In FY 2005, Facilities Support continued to provide Area offices, service units and certain Tribal healthcare entities with staff, utilities, program supplies and equipment to maintain the healthcare buildings and grounds, and to service approximately $320,000,000 worth of medical equipment. Facilities supported include hospitals, health centers, staff quarters, health stations and school health clinics, and youth regional treatment centers. Energy related utility consumption fell from 2,233,000 BTU/SM in FY 2002 to 1,945,000 BTU/SM in FY 2004 overall, helping to stem the growth in the cost of utilities, which is primarily due to space increases and inflation. IHS will continue all of these functions in FY 2006.

FUNDING HISTORY – Funding for the Facilities Support program during the last 5 years has been as follows:

Fiscal Year	Amount	FTE
2001	$59,907,000	550
2002	$63,032,000	566
2003	$66,920,000	581
2004	$70,473,000	555
2005	$73,843,000	632

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request of $79,348,000 is an increase of $5,505,000 above the FY 2005 enacted level of $74,843,000.

Staffing for New Facilities: + 3,713,000
The increase will allow IHS to expand provision of health care in those areas where existing capacity is most overextended. The funds will staff 6 new facilities which will open in FY 2005 and FY 2006. The following table displays the requested increase.

		FTE	
Facilities	Dollars	Federal	Tribal
Piñon, AZ Health Center	$948,000	5	0
Idabel, OK Health Center	35,000	0	0
Coweta, OK Health Center	1,084,000	6	0
Red Mesa, AZ Health Center	754,000	6	0
Sisseton, SD Health Center	776,000	16	0
St. Paul, AK Health Center	116,000	1	0
Total	$3,713,000	24	0

Inflation: +$490,000
Additional funding will cover the increases in costs using the FY 2006 Economic Assumptions.

Department of Health and Human Services
Indian Health Service
Facilities – 75-0391-0-1-551

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT
ENVIRONMENTAL HEALTH SUPPORT

Authorizing Legislation: Program authorized by 25 U.S.C. 13, Snyder Act, and P.L. 83-568 Transfer Act, 42 U.S.C. 2001.

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	Increase or Decrease
BA	$55,889,000	$56,329,000	$59,836,000	+$3,507,000
FTE	433	488	488	0

STATEMENT OF THE BUDGET REQUEST

Funding will pay personnel who accomplish environmental health services, injury prevention activities, and sanitation facilities construction activities, at the IHS Area, district, and service unit levels and to pay operating costs associated with provision of those services and activities.

PROGRAM DESCRIPTION

Most American Indian and Alaska Native (AI/AN) people live in environments typified by severe climatic conditions, rough, often treacherous geography, extreme isolation, infestations of disease carrying insects and rodents, limited and sub-standard housing, unsanitary methods of sewage and garbage disposal, and unsafe water supplies. Such harsh environments, coupled with decades of economic deprivation and compounded by the lack of basic environmental essentials in many homes (such as running water and toilet facilities) historically have contributed significantly to the exceptionally high incidence of disease, injury, and early death among the AI/AN people.

Developing solutions to the many environmental concerns affecting AI/ANs requires knowledge and expertise possessed by a variety of professional and technical environmental health and skilled health specialists. The Area, district and service unit environmental health staffs include engineers, environmental health officers, environmental health technicians, engineering aides, injury prevention specialists, and institutional environmental health officers.

PROGRAM EMPHASIS AREAS

- **General Environmental Health** -- Concurrent with the provision of technical and consultative environmental health services, Area, district and service unit environmental health services staff provide a wide range of technical services to American Indian and Alaska Native communities including water quality, waste disposal, hazardous materials management, food sanitation, community injury prevention, institutional environmental health, vector control, and occupational safety and health. A critical component of this effort is the provision of technical assistance to the Tribes in developing environmental health program management capacity.

  In FY 2002, the Environmental Health Services program began utilizing the Web-based Environmental Health Reporting System (WebEHRS) in conjunction with Tribal partners to collect community and facility information to be used for ongoing surveillance. At the regional level, this project is coordinated with the IHS Area Environmental Health Officers in partnership with the tribes and local IHS Environmental Health Services programs. This collection and analysis of environmental health and epidemiological data may redesign the services and activities currently provided by and recommended by the Environmental Health Services program. Data analysis is necessary to establish baseline levels of community environmental health, evaluate the effectiveness of existing programs and to plan future programs to ensure that resources and activities are best targeted to most effectively reduce environmentally related disease and injury at the local level.

- **Injury Prevention** -- Injuries have a significant, adverse effect on AI/AN populations. Between 1996 and 1998, 5,277 AI/AN residing in the IHS service area, died from injuries (motor vehicle crashes, home fires, drowning, poisoning, suicide, homicide, etc.).

  On average, AI/ANs are dying at a rate 2.6 times the U.S. All Races rate for injuries and poisonings. The rates for Tucson, Aberdeen, and Navajo Areas were at least 3.5 times the U.S. All Races rate. The IHS estimates conservatively that almost $350,000,000 was spent in 2001 on acute care of injured Indian people; however, costly critically needed re-constructive surgeries, prosthetic devices, and rehabilitative services often cannot be provided. Frequently overlooked is the effect that injuries have on the injured person's family. Severe disabling injuries often affect the financial and social fabric of the family and the community, causing a "burden" unparalleled by other health problems.

  For many years the IHS has been aware of the significant drain on its health care resources that is caused by stabilizing, transporting, treating, and rehabilitating injury victims. In 1981, an Injury Prevention Program was initiated within the environmental health activity. Early efforts by Area, district, and service unit personnel at improved surveillance and targeted intervention were so encouraging that a formal injury prevention training program was established.

  One of the most important advancements in the field of injury prevention was dispelling the myth that injuries were a result of uncontrollable events. In fact, today it is known that injuries are predictable occurrences that can be successfully prevented with properly

targeted interventions. There is quantitative evidence that community-based prevention programs, patterned on the public health model, can reduce the incidence of severe injuries requiring hospitalization.

For instance, when Centers for Disease Control and Prevention personnel evaluated the effect of the Navajo Nation's motor vehicle safety belt law, they found that the number of severe injuries attributable to motor vehicle crashes was reduced by 28 percent. This reduction represents estimated savings to the Federal Government of more than $2,000,000 in direct care expenditures alone. An analysis of deaths among Alaska Natives in the Yukon River delta region indicated 30 percent reduction in drowning deaths. This reduction is attributed to a 5-year drowning prevention education effort sponsored by the Yukon Kuskokwim Health Corporation's Injury Prevention Program.

The IHS Five-Year Injury Prevention Strategic Plan identified the need for basic capacity building and investments in tribal and Federal infrastructures for the development of effective injury prevention programs. Since 1990, Congress has appropriated over $5.3 million to injury prevention programs and competitively based intervention projects. In 1997 the Director, IHS, supported a national demonstration grant announcement for basic public health infrastructure projects within tribes. Approximately $300,000 was awarded for 12 tribal project sites. In addition to these projects, literally hundreds of Indian communities and Alaska Native villages implemented proven injury prevention strategies associated with safe home and communities.

IHS has applied a community capacity building approach with the intent of developing the local public health capacity of tribes to significantly reduce injuries in their communities' settings. This systematic process includes training, core-funding base, partners, implementing interventions, and technical assistance as needed. These efforts have contributed to a 53 percent reduction in injury related deaths between 1972 and 1996. In FY 2000, IHS awarded approximately $1.475 million to tribes to establish comprehensive injury prevention programs and implement community-based intervention projects. These 25 programs are receiving $50,000 per year for 5 years to hire a full time injury prevention coordinator, form an injury prevention advisory group, conduct basic injury surveillance, form partnerships, and begin to implement strategies to target those at risk for injuries. In FY 2004, an additional 6 programs were funded at approximately $50,000 per year for two years to establish comprehensive injury prevention programs and 6 programs were funded at approximately $15,000 for two years to implement community-based intervention projects.

IHS has developed the leading injury prevention practitioner training program in the country. The IHS injury prevention training program is specifically designed to build the capacity of community-based practitioners to identify and effectively address the injury problems they face in their communities. Approximately 100 tribal and IHS personnel annually attend IHS Injury Prevention Practitioner courses. Since 1987, 68 of the students (48%) who have successfully completed the Injury Prevention Specialist Fellowship Program are American Indians or Alaska Natives. This program is a year-long course of study in advanced injury prevention.

- **Institutional Environmental Health** -- Institutional Environmental Health (IEH) officers, where available on IHS staffs, work with managers of health care, educational, childcare, and correctional facilities. Such institutions have diverse clientele but share many common problems (such as risks and hazards of new technologies). Emerging disease risks and hazards, stricter regular requirements and escalating costs resulting from claims for compensation for work related injuries sustained by health care workers make institutional environmental problems increasingly complex and challenging.

  The IEH officers are trained to anticipate, recognize, and evaluate potential hazards and recommend control procedures. Periodic, formal evaluations of institutions serving AI/AN populations using epidemiological approaches are performed in order to assess environmental conditions, identify those that may cause adverse health effects, and make recommendations to prevent or minimize harm. Among operational areas of interest to IEH officers are as follows: infection control, industrial hygiene, radiation protection, safety management, ergonomics and general environmental health conditions.

  Assistance is provided to institution managers/operators in developing appropriate programs for protecting clients and employees, and in complying with legislation and executive orders regarding environmental health and safety management issues. Advice is also offered regarding compliance with accreditation and/or certification standards. Maintaining accreditation ensures that IHS continues to have access to third-party funding.

  The Institutional Environmental Health Program began implementation of a web-based occupational health incident reporting system in IHS healthcare facilities. This reporting system replaces the IHS 516 form used to report injuries, illnesses, and other incidents. This web-based system will make collection, analysis, and reporting of all incidents required by OSHA and IHS much more efficient. In addition, quick problem identification, resulting from real-time data, remediation, and evaluation should reduce health hazards and costs associated with employee, patient, and visitor incidents.

- **Sanitation Facilities Construction** -- In accordance with P.L. 86-121, Indian Sanitation Facilities Act, the IHS manages and provides professional engineering and services to construct over 374 projects annually, at a total cost of over $130 million, to provide essential sanitation facilities for AI/ANs. This work is a significant component of the comprehensive environmental health services provided by Area, district and service unit environmental health personnel. These services include management of staff, pre-planning consultation with tribes and tribal groups, 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 and construction, assuring environmental and historical preservation procedures are followed, assisting tribes where the tribes provide construction management, and assisting tribes with operation and maintenance of constructed facilities. All of these activities are made more difficult due to the remote locations, the diverse climatic and geologic conditions, and cultural considerations where they work. The Sanitation Facilities Construction program assures that its staff is highly qualified for its mission by requiring professional licensure

of District Engineers and higher-level positions. Recent data indicates that of the 248 Commissioned Corps officer engineers employed by IHS 73 % are licensed compared to 20% of all U.S. engineers and 45% have advanced degrees.

In accordance with the Indian Health Care Improvement Act (Title III, Section 302(g) 1 and 2 of P.L. 94-437) the IHS annually updates its inventory of sanitation facilities deficiencies for existing Indian homes. This is carried out in considerable consultation with tribes. The IHS 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 evaluations and funding of sanitation projects.

Once a sanitation facility is built, the Indian family and/or community for which it was constructed assumes ownership, operation, and maintenance responsibilities including payment of associated costs. Therefore, a primary responsibility of IHS Area, district and service unit environmental health personnel is to provide technical assistance and guidance to Indian families and communities regarding the operation and maintenance of essential water supply and sewage disposal facilities.

Where appropriate, IHS environmental health personnel provide technical assistance to tribes and communities to create and manage sanitation facility operation and maintenance organizations. Among other areas, the IHS provides facility maintenance training and assistance with establishing ordinances and user fee schedules. The availability of technical assistance from IHS has contributed significantly to the ability of the small communities and rural families to keep their facilities in working condition. Sustained attention to proper operation and maintenance of these facilities, by tribes, communities, and individual homeowners, is an important contribution to continued strengthening of community infrastructure for AI/AN. In addition, it is necessary to protect the enormous preventive health investment made by the Federal Government on behalf of AI/AN. A portion of the work being done to upgrade the IHS databases is to be able to track and project the need for upgrades and replacement of existing facilities.

ACCOMPLISHMENTS

The FY 2004 accomplishments are as follows: (1) received approximately $80 million in SFC contributions from other Federal agencies, States, and Tribes. Combined with SFC appropriation, the total SFC program funded 469 projects in FY 2004; (2) the staff also assisted Tribes by providing engineering services to many other Tribes that independently funded their own projects; and (3) provided essential sanitation facilities to 24,928 homes which included 4,939 first service existing homes.

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.

The tribes have been an integral part of the sanitation facilities program for years. In recent years they have administered more than 50 percent of the project funds for the provision of sanitation facilities to AI/AN homes and communities. A Navajo tribal enterprise, the Navajo Engineering and Construction Authority, exemplifies this successful effort. It constructs virtually all sanitation facilities provided by the IHS on the Navajo Indian Reservation and employs approximately 350 Navajos on IHS funded construction projects.

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.

PERFORMANCE ANALYSIS

The IHS Environmental Health Services Program supports Healthy People 2010 (HP 2010), the Indian Health Service Strategic Plan, and Government Performance and Results Act (GPRA) indicators. The vision of the Environmental Health Services Program is that every American Indian and Alaska Native will live in a safe, healthy community. This is similar to the IHS Strategic Plan goal number 1, “Build Healthy Communities”.

The Environmental Health GPRA indicator is routinely met and exceeded. This indicator is expected to change during 2005. It will commit each Area environmental health office to adding environmental health priorities into the system. This directly supports HP 2010 and the IHS Strategic Plan. The program emphasis areas (General Environmental Health, Injury Prevention, and Institutional Environmental Health) support five other HP 2010 focus areas.

Injury and Violence Prevention have been grouped as one of the 10 leading health indicators. Thirty-one objectives within HP 2010 relate to injury or unintentional injury prevention. There are two injury prevention GPRA indicators which relate to comprehensive community-based injury prevention efforts across I/T/U settings. These have been met each year that data were available. In FY 2005, one of the injury indicators will change to focusing on development of a web-based data collection system to report injury prevention projects.

The development of the web-based occupational incident data collection system supports HP 2010 Occupational Safety and Health focus area, as well as the environmental health focus area and the IHS Strategic Plan goals.

The IHS Environmental Health Services Program is concentrating on improving the data collection throughout the entire program so that we can focus our efforts where there is the greatest need. Also with improved data systems, we can measure which activities are the most effective in enhancing health and accomplishing goals set by communities.

The IHS Sanitation facilities program has two GPRA measures related to its construction activities and has already participated in the Performance Appraisal Rating Tool (PART) for the 2004 budget cycle. Details of the results and the PART can be found in the section on the Sanitation Facilities Construction line item.

FUNDING HISTORY – Funding for the Environmental Health Support program during the last 5 years has been as follows:

Fiscal Year	Amount	FTE
2001	$50,977,000	459
2002	$52,856,000	446
2003	$54,752,000	449
2004	$55,889,000	433
2005	$56,329,000	488

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request of $59,836,000 is an increase of $3,507,000 above the FY 2005 enacted level of $56,329,000.

Staffing for New Facilities: + 3,713,000
The increase will allow IHS to expand provision of health care in those areas where existing capacity is most overextended. The funds will staff 6 new facilities which will open in FY 2005 and FY 2006. The following table displays the requested increase.

		FTE	
Facilities	Dollars	Federal	Tribal
Piñon, AZ Health Center	$91,000	1	0
Idabel, OK Health Center	0	0	0
Coweta, OK Health Center	0	0	0
Red Mesa, AZ Health Center	94,000	1	0
Sisseton, SD Health Center	94,000	1	0
St. Paul, AK Health Center	0	0	0
Total	$279,000	3	0

Inflation: +$239,000
Additional funding will cover the increases in costs using the FY 2006 Economic Assumptions.

Population Growth: + $1,997,000
The increase of $1,997,000 for population growth will fund the cost of the increasing AI/AN population and maintain the current level of services.

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

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	Increase or Decrease
BA	$11,441,000	$11,497,000	$11,775,000	+$278,000
FTE	77	94	94	0

STATEMENT OF THE BUDGET REQUEST

The Office of Environmental Health and Engineering Support budget request of $11,775,000 funds personnel and operating costs for the Office of Environmental Health and Engineering (OEHE) Headquarters.

PROGRAM DESCRIPTION

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 Members of Congress and their representatives, with tribes, and with other Federal agencies), and recruitment and retention. Typical direct support functions performed by OEHE personnel who serve as project officers for health facilities construction projects are: review and/or write technical justification documents, participate in design reviews and site surveys, conduct onsite inspections, and monitor project funding status.

The OEHE Headquarters funded positions are in Rockville, Dallas, and Seattle. Headquarters personnel include engineers, sanitarians, health facilities planners, real property managers, and support personnel. In addition, Engineering Services staff located in Dallas and Seattle provides architectural, engineering, construction services, contracting services, and real property services. They provide direct services and support to other Headquarters Divisions and Area personnel in preparing project justifications, construction cost estimates, and project designs, contracting for design and construction of new health care facilities and existing facility improvements, conducting construction inspections and facility inspections; leasing space for IHS program operations; and providing management support.

PERFORMANCE ANALYSIS

In FY 2004, OEHE Support funded personnel who provided leadership and management, and carried out responsibilities for National policy development and implementation, budget formulation, congressional report preparation, health care facilities construction, and other national program related duties.

FUNDING HISTORY – Funding for the Office of Environmental Health and Engineering program during the last 5 years has been as follows:

Fiscal Year	Amount	FTE
2001	$10,432,000	86
2002	$10,877,000	83
2003	$11,251,000	83
2004	$11,441,000	77
2005	$11,497,000	94

RATIONALE FOR BUDGET REQUEST

The FY 2006 budget request for $11,775,000 is an increase of $278,000 above the FY 2005 enacted level of $11,497,000.

Inflation: +$76,000
Additional funding will cover the increases in costs using the FY 2006 Economic Assumptions.

Department of Health and Human Services
Indian Health Service
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EQUIPMENT

Authorizing Legislation: Program authorized by 25 U.S.C. 13 (P.L. 67-85, the Snyder Act) and 42 U.S.C. 2001 (P. L. 83-568, the Indian Health Transfer Act).

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	Increase or Decrease
BA	$17,081,000	$17,337,000	$17,960,000	+$623,000
FTE	0	0	0	0

STATEMENT OF THE BUDGET REQUEST

The Equipment budget request of $17,960,000 supports maintenance and replacement of biomedical equipment at IHS and Tribal health care facilities.

PROGRAM DESCRIPTION

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 6 years depending on the intensity of use, maintenance, and technical advances. Funds distribution is formula based.

This budget activity also funds equipment for replacement clinics built by Tribes using non-IHS funding sources, replacement of ambulances, and the transfer of available excess Department of Defense medical equipment to IHS and Tribal health programs.

PERFORMANCE ANALYSIS

In 2005, the medical equipment program distributed approximately $11,186,456 to IHS and Tribal healthcare programs to purchase new medical equipment, including replacement of existing equipment, used in diagnosing and treatment illnesses. For those Tribes building new and replacement health clinics using non-IHS funding sources, $4,930,500 was awarded to 37 Tribes. The remaining $1,219,000 was used to purchase new and like new equipment from DOD through the TRANSAM program and to purchase ambulances for Tribal emergency medical services programs.

FUNDING HISTORY – Funding for the Equipment program during the last 5 years has been as follows:

Fiscal Year	Amount	FTE
2001	$16,294,000	0
2002	$16,294,000	0
2003	$17,182,000	0
2004	$17,081,000	0
2005	$17,337,000	0

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request of $17,960,000 is an increase of $623,000 above the FY 2005 enacted level of $17,337,000. The additional funding will cover the increased costs of medical equipment using the FY 2006 Economic Assumptions.

Department of Health and Human Services
Indian Health Service
Facilities – 75-0391-0-1-551

PERSONNEL QUARTERS/QUARTERS RETURN FUNDS

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	Increase or Decrease
BA	$6,172,000	$6,200,000	$6,288,000	+$88,000
FTE	0	0	0	0

STATEMENT OF THE BUDGET REQUEST

Funding in the amount of $6,288,000 will provide funds for the operation, management, and general maintenance of personnel quarters at IHS health care facilities.

PROGRAM DESCRIPTION

Staff quarter's operation, maintenance, and improvement costs are funded with Quarters Return (QR) funds. Approximately $6,288,000 in QR funds will be collected from tenants of quarters during FY 2005. These funds will be used for the operation, management, and general maintenance of quarters, including temporary maintenance personnel, security guards, repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (stove, 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., location with few quarters where QR funds are not enough to pay for all required maintenance costs. These funds are distributed and used at the locality in which collected.

FUNDING HISTORY – Funding for the Personnel Quarters program during the last 5 years has been as follows:

Fiscal Year	Amount	FTE
2001	$5,500,000	0
2002	$5,700,000	0
2003	$5,900,000	0
2004	$6,172,000	0
2005	$6,200,000	0

RATIONALE FOR THE BUDGET REQUEST

The FY 2006budget request of $6,288,000 is an increase of $88,000 above FY 2005, representing an increase in collection of rentals of quarters.

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