Department of Health and Human Services
Indian Health Service
Services – 75-0390-0-1-551

CLINICAL SERVICES

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	Increase or Decrease
BA	$2,024,908,000	$2,090,642,000	$2,208,715,000	+$118,073,000
FTE	*7,596*	*8,538*	*8,538*	*0*

Total Budget – The total Clinical Services budget request of $2,208,715,000 and 8,538 FTE is an increase of $118,073,000 over the FY 2005 Enacted level of $2,090,642,000 and 8,538 FTE. The explanation of the request is described in the budget narratives that follow.

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Department of Health and Human Services
Indian Health Service
Services – 075-0390-0-1-551
HOSPITALS AND HEALTH CLINICS

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	$1,249,781,000	$1,289,418,000	$1,359,541,000	+$70,123,000
FTE	6,408	7,190	7,190	0
HIV-AIDS ($)	($2,628,000)	($2,678,000)	($2,791,000)	(+$113,000)
HIV-AIDS (FTE)	*(13)*	*(13)*	*(13)*	0
Activity: # Inpatient Admissions: 1/				
IHS Direct	43,004	43,004	43,606	+602
Tribal Direct	14,457	14,457	14,659	+202
Total Admissions	57,461	57,461	58,265	+804
# Outpatient Visits: 2/				
IHS Direct	4,492,783	4,492,783	4,555,682	+62,899
Tribal Direct	3,802,629	3,802,629	3,855,866	+53,237
Total Visits	8,295,412	8,295,412	8,411,548	+116,136

1/ Inpatient Admissions based on data trend from FY 2002
2/ Outpatient Visit based on estimated cost of current services compared to the budget request.

STATEMENT OF THE BUDGET REQUEST

The Hospitals and Health Clinics (H&HC) budget request of $1,359,541,000 funds predominantly the provision of direct, personal health care services to federally recognized American Indians and Alaska Natives (AI/AN).

PROGRAM DESCRIPTION

These funds are provided to 12 Area (regional) Offices which in turn provide resource distribution, program monitoring and evaluation activities, and technical support to over 240 Federal and Tribal operating units (local level) for more than 600 health care facilities providing care to 1.8 million American Indians and Alaska Natives predominantly in rural or isolated portions of the country. The Hospitals and Health Clinics budget supports essential personal health services including inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy, etc. In addition, the program includes public health initiatives targeting health conditions disproportionately affecting American Indians and Alaska Natives such as specialized

programs for diabetes, maternal and child health, youth services, communicable diseases including HIV/AIDS, tuberculosis, and hepatitis, and a continuing emphasis on women's and elder health and disease surveillance. Almost *one-half* of the H&HC budget is transferred to Tribal governments or Tribal organizations under P.L. 93-638 contracts or compacts which provide these individual and community health services.

PERFORMANCE ANALYSIS

The IHS budget request and related GPRA performance targets support the HHS Strategic Plan and specifically the plan's Strategic Objectives.

Objective 3.4 Eliminate racial and ethnic health disparities
Objective 3.6 Expand access to health services to American Indians and Alaska Natives

Given that the most recent analyses of mortality rates for AI/AN (1999-2001) show an overall increase in mortality compared to 1996-98 (while the US all race mortality dropped in a comparable time period), we have slowed, but we have not yet stopped the disparities from increasing. On an annual basis, the I/T/U programs have made incremental accomplishments in some areas. However, without significant increases in access to critical health care services, it is likely that the disparities in health status for AI/AN people as compared with the US all race population will continue to increase.

Diabetes -- The agency continues to make significant progress in addressing chronic diseases. A primary focus has been in the treatment and prevention of diabetes and its complications. Diabetes continues to be a growing problem in AI/AN communities with rates increasing rapidly in the majority of IHS Areas. The age at diagnosis is occurring younger, with no signs of decline in any IHS Area.

Supplemental funding, key Tribal involvement, collaboration with other Federal agencies and community emphasis have all contributed to the IHS achieving or exceeding the proposed goals for each diabetes GPRA element. Increased funding has allowed greater access to more sophisticated interventions. These include more effective pharmaceuticals, more aggressive screening for the secondary effects of diabetes, earlier intervention when complications are identified, and greater patient compliance with care regimens. The level and quality of services provided to over 100,000 diabetics throughout the IHS are audited annually to improve standardized care and patient outcomes. A wide range of IHS performance measures including foot care, eye care, end organ status, and adequacy of blood sugar control, have been incorporated into the National Committee for Quality Assurance/American Diabetes Association national performance diabetes care benchmarks.

There are six H&HC GPRA indicators that address the ongoing monitoring and treatment of diabetes in the AI/AN population. They were selected because of their proven benefits in reducing the morbidity and mortality associated with diabetes. These indicators are also located in the budget narrative dealing with the Special Diabetes Program for Indians (SDPI) since both H&C and SDPI fund diabetes related activities in IHS/Tribal hospitals

and clinics as well as in communities. Five of the six diabetes GPRA indicators were met in FY 2004.

Accreditation -- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care (AAAHC), and the Centers for Medicare and Medicaid Services (CMS) regularly conduct in-depth quality reviews of IHS and Tribal hospitals. The average accreditation grid scores are consistently at or above the average score for all U.S. hospitals. The most frequently cited area for improvement is physical plant safety and efficiency which is due to old, undersized facilities. The average age of IHS facilities is greater than 30 years. Fully 100 percent of IHS hospitals and health clinics met accreditation standards in FY 2004. (GPRA Indicator # 20)

Electronic Health Record -- To increase efficiency and enhance patient safety, the IHS continues to expand its electronic health record system since it began in FY 2004 at 7 sites, adding 25 additional sites in FY 2005. This system includes provider order entry for medications as well as lab and diagnostic imaging procedures, clinical reminders, and abnormal test notification to providers, all of which will serve to decrease medical errors and improve patient safety.

MedMarx Medication Error Reporting System -- MedMarx is an internet accessible medication error reporting system and quality improvement tool designed by United States Pharmacopoeia. Medication errors are monitored so that system problems can be recognized and changed, reducing the potential for patient harm. The IHS first pilot tested the MedMarx System in FY 2004. Its success produced clinical acceptance so that by fiscal year end, MedMarx was adopted at 55 sites in five IHS Areas. The IHS plans to implement MedMarx throughout the Indian health system as a part of a broader array of patient safety processes and systems to reduce adverse patient events. (GPRA Indicator # 21)

In conjunction with the GPRA measures described above, 11 other performance measures are directly related to the H&HC budget. These measures include pap and mammography screening, domestic violence screening, improving automated extraction of clinical performance measures and data quality, consumer satisfaction, immunization rates, community-based cardiovascular disease and obesity prevention, and reducing tobacco usage. Assessing performance data from the most current reported data demonstrates effective H&HC outcomes.

FY GPRA Data Reported	GPRA Measures Met	GPRA Measures Not Met	Total H&C GPRA Measures Reported
2004	14	5	19

Various services and outputs of the Hospitals and Health Clinics budget are reflected in these GPRA indicators.

Following are brief descriptions of other notable performance areas.

Emergency Preparedness -- The IHS' emergency preparedness arenas involve**:**

(1) planning and testing its continuity of operations plan (COOP) so that the agency can carry out its critical functions in any situation;
(2) building capacity in its public health infrastructure through linkages among its hospitals and clinics with local, county, Tribal and State agencies throughout the country;
(3) working with and expanding the capacity of local Tribal emergency medical systems (EMS);
(4) enhancing its ability to deploy Commissioned Officers for national emergencies; and
(5) preparing its hospitals and clinics to diagnose and treat victims of a bioterrorism or other mass casualty situation.

The Indian health system has participated in numerous local, regional, and national exercises to test its response capabilities and to enhance linkages with public safety elements at all levels. State programs have also supported the development of greater response capacity particularly in Alaska, New Mexico, and Maine. IHS continues efforts to assure that the needs of AI/AN communities are addressed by States which have received additional targeted funding for preparedness and response.

Managed Care at Work -- The IHS provides comprehensive services with $2,100 per person per year, a cost roughly 40 percent below that of most public and private health insurance plans. While continuing to increase collections from third party payers, the agency minimizes and avoids costs through negotiated rates for purchased services, medical products, and pharmaceuticals to maximize value from resources.

In FY 2004, the IHS and Tribes spent approximately $234 million on pharmaceuticals. Between FY 2000 and FY 2004, IHS and Tribal pharmaceutical costs increased an average of 17.2 percent per year. This rise is due to a variety of factors including the cost of new drug treatments for which no treatment has previously been available, the cost of new drug treatments that are more effective than previous lower cost treatments, new drugs that need to be added to existing regimens to improve outcomes, an increase in population served by IHS and Tribes, and aging of the population. To further manage growing pharmaceutical costs, the IHS uses limited formularies at the service sites, bulk purchasing agreements, and other cost containment approaches.

The agency has also taken great strides in addressing pharmaceutical services such as the analysis of factors leading to the steep rise in pharmaceutical costs and the implementation of interventions to assume greater control of these costs. The interventions initiated or enhanced to control costs include greater use of bulk purchasing methods through the Department of Veterans Affairs pharmaceutical prime vendor, increased use of a limited but more efficacious formulary, and education of providers about specific pharmacoeconomic strategies. This effort was enhanced by the provision of resources to expand IHS pharmacy residency activities. The residency programs now

operate in 11 communities and stimulate innovative thinking about the control of pharmaceutical costs and less expensive, but more effective approaches to patient care.

Health Promotion/Disease Prevention -- The IHS program continues to focus on increasing access to preventive and curative services for the underserved in Indian communities through a strategy targeting health programs reflecting community health status to provide the most effective services to the most people.

In recent years the diseases affecting American Indians and Alaska Natives have changed and required a change in service focus as the disease burden due to acute illness decreases and the chronic disease burden increases. Significant behavioral determinants often accompany chronic disease. Of particular concern are disease patterns that disrupt families and communities including accidents, suicides, homicides, family violence and chemical dependency. Prevention of these conditions requires a different set of precepts and disciplines, as they are less susceptible to traditional medical model interventions.

These prevention strategies are often difficult to maintain since the impact of the programs is often distant in time and community attention to these efforts may wane in the face of more immediate concerns (such as treatment for trauma associated with family violence).

In FY 2004, the agency continued the implementation of a major initiative on Health Promotion and Disease Prevention (HP/DP); this initiative was launched in FY 2003 by the Director in order to reduce health disparities. Although the IHS is the model health system in integrating individual and community health, increased emphasis is being focused on both clinical and community-based health promotion and disease prevention efforts. The main focus is on our collective ability to develop and implement programs that will prevent disease, not focusing exclusively on treatment of disease. Some of these strategies include:

- Traditional practices and values have a very strong role in promoting wellness.
- Models of effective implementation of such programs (e.g., promotion of breast feeding, and language and cultural training in early childhood and elementary settings) are being promoted.
- Best practices in clinical and community-based Health Promotion/Disease Prevention (HP/DP) interventions are being identified and disseminated.
- Engaging youth and families to address the burden of disease are strengthening our efforts. The agency is working closely with the national youth organizations to promote healthy lifestyles for AI/AN children and youth.
- The IHS HP/DP initiative is working with the Secretary's "Steps to a *HealthierUS"* initiative; Tribes are participating in both initiatives.
- Professional health experts, Federal leaders, Tribal leaders, and community leaders are engaged through the Health Promotion Task Force and Policy Advisory Committee to guide this initiative to eliminate health disparities.

- A Health Summit, "Healthier Indian Communities through Partnership and Prevention" was held in September 2004 and focused on eliminating health disparities; enhancing partnerships and collaboration as well as best practices.

FUNDING HISTORY – Funding for the Hospitals and Health Clinics during the last 5 years has been as follows:

Fiscal Year	Amount	FTE
2001	$1,084,173,000	6,953
2002	1,153,711,000	6,781
2003	1,188,540,000	6,672
2004	1,249,781,000	7,123
2005	1,289,418,000	7,190

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request of $1,359,541,000 and 7,190 FTE is a net increase of $70,123,000 over the FY 2005 Enacted level of $1,289,418,000 and 7,190 FTE. The increase will fund:

Pay Cost: + $20,537,000
The increase will fund federal and tribal pay cost increases which will assist the IHS in maintaining access to services for the IHS patient population. Provision of these funds is necessary to maintain the current I/T/U health system which works to eliminate disparities in health status between the American Indian and Alaska Native population and the rest of the U.S.

Inflation: + $15,961,000
The increase of $15,961,000 will enable the program to address the issues of increasing medical and inflation costs. Between FY 2000 and FY 2004, IHS and Tribal pharmaceutical costs increased an average of 17.2 percent per year. This increase will also help offset the rising costs of medical and other supplies.

Population Growth: + $18,200,000
The increase of $18,200,000 for population growth will enable hospitals and health clinics to fund the cost of the increasing AI/AN population and maintain the current level of health care services.

Staffing for New Facilities: +$18,480,000
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	$4,119,000	44	0
Idabel, OK Health Center	562,000	0	6
Coweta, OK Health Center	6,960,000	79	0
Red Mesa, AZ Health Center	3,171,000	36	0
Sisseton, SD Health Center	3,524,000	40	0
St. Paul, AK Health Center	144,000	1	0
Total	$18,480,000	200	6

IT Savings: -$1,707,000
The reduction reflects efficiencies gained from implementing information technology throughout IHS.

Administrative Savings: -$1,348,000

Department of Health and Human Services
Indian Health Service
Services – 75-0390-0-1-551
HOSPITALS & HEALTH CLINICS -- EPIDEMIOLOGY CENTERS

Authorizing Legislation: Program authorized by 25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001, and P.L. 102-573, Title II, Section 214.

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	Increase or Decrease
BA	$2,450,000	$4,915,000	$5,013,000	+$98,000
FTE	0	0	0	0

STATEMENT OF THE BUDGET

The FY 2006 budget of $5,013,000 for Epidemiology Centers is to continue support for up to 10 epidemiology centers providing public health and epidemiological services to multiple tribes in multiple IHS Areas.

PROGRAM DESCRIPTION

Epidemiology provides the foundation for all public health activities. Tribal governments and health facilities as well as IHS direct-service sites deliver public health services such as immunization and cancer prevention and control programs to American Indian and Alaska Native communities throughout the country. Efficient delivery of these services and development of effective interventions to improve health requires in-depth knowledge of the causes of illness and mortality among the population. Epidemiology Center staff collect, analyze, interpret, and disseminate health information critical to identifying diseases to target, suggesting strategies for successful interventions and testing the effectiveness of health interventions that have been implemented.

Congress in FY 1996 authorized the innovative IHS Tribal Epidemiology Center program. Initially, four Tribal Epidemiology Centers were selected following recommendations of an objective review panel and funded up to $155,000 each through cooperative agreements. In FY 2000, the four original centers and two new centers were funded for another five years. Three new centers were added in FY 2005 (includes a new center funded with non-recurring funds in FY 2004).

For fiscal year 2006, no new activities will be undertaken. IHS will continue to fund the IHS national coordinating center in Albuquerque and up to ten tribal epidemiology centers through cooperative agreements with American Indian or Alaska Native tribes and tribal organizations, such as Indian health boards.

PERFORMANCE ANALYSIS

The funding for epidemiology centers is not directly linked to any individual GPRA performance measure, but rather supports the entire set of clinical measures through improving data collection, monitoring, and analysis within the AI/AN communities where the epidemiology centers are located.

Operating from within tribal organizations such as regional health boards, the Epidemiology centers are uniquely positioned to be effective in disease surveillance and control programs, and also in assessing the effectiveness of public health programs. In addition, they fill gaps in data needed for GPRA reporting and monitoring of the Healthy People 2010 objectives. Some of the existing Epidemiology Centers have already developed innovative strategies to monitor the health status of tribes, including development of tribal health registries, and use of sophisticated record linkage computer software to correct existing state data sets for racial misclassification. These data are being collected by the national coordinating center at the IHS Division of Epidemiology Program to provide a more accurate national picture of Indian Health.

The existing Epidemiology Centers provide critical support to tribes who self-govern their health programs. Data generated locally and analyzed by Epidemiology Centers enable Tribes to evaluate tribal and community-specific health status data so that planning and decision-making can best meet the needs of their tribal membership. Because these data are used at the local level, immediate feedback is provided to the local data systems which will lead to improvements in Indian health data overall.

Epidemiology centers assist tribes in looking at the cost of health care for Indian people in order to improve the use of resources. In the future, in the expanding environment of tribally operated health programs, epidemiology centers will ultimately provide additional public health services such as disease control and prevention programs. Some existing centers provide additional assistance to tribal-participants in such areas as sexually transmitted disease control and cancer prevention. They also assist tribes in activities such as conducting Behavioral Risk Factor Surveys in order to establish baseline data for successfully evaluating intervention and prevention activities.

In FY 2006, this program continues to enhance the ability of the Indian health system to collect and manage data more effectively to better understand and develop the link between public health problems and behavior, socioeconomic conditions, and geography. The Tribal Epidemiology Program supports tribal communities by providing technical training in public health practice and prevention-oriented research and promoting public health career pathways for tribal members. Collaborative efforts to implement the Tribal Epidemiology Program will be coordinated with the National Institutes of Health and the Centers for Disease Control and Prevention (CDC) to optimize federal resource utilization, create stronger interagency partnerships, and prevent costly duplication of effort.

FUNDING HISTORY

FY 2000	$950,000
FY 2001	$1,450,000
FY 2002	$1,450,000
FY 2003	$1,450,000
FY 2004	$2,450,000
FY 2005	$4,915,000

RATIONALE FOR THE BUDGET

The FY 2006 budget of $5,013,000 is an increase of $98,000 over the FY 2005 enacted level of $4,915,000. Additional funding will cover the increases in costs using the FY 2006 Economic Assumptions.

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Indian Health Service
Services –75-039-0-1-551
DENTAL HEALTH

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	$104,513,000	$109,023,000	$119,489,000	+$10,466,000
FTE	760	850	850	0
Patients Treated	330,155	330,155	347,653	+17,498
Services Provided	2,499,834	2,499,834	2,632,325	+132,491

STATEMENT OF THE BUDGET REQUEST

The Dental Health budget request of $119,489,000 funds the provision of dental care to the American Indian and Alaska Native population.

PROGRAM DESCRIPTION

The purpose of the Dental Program is to raise the oral health status of the American Indian and Alaska Native (AI/AN) population to the highest possible level through the provision of high quality preventive and treatment services at both the community and clinic levels. The Program has been traditionally oriented toward preventive and basic care. More complex, rehabilitative care, although a legitimate need, is often deferred so that the basic services may be provided to more persons. Within the Schedule of Services, which is a service priority hierarchy used by the Dental Program, over 90 percent of services provided are basic and emergency care. Estimates of demand for treatment remain high; however, a continuing emphasis on community oral health promotion/disease prevention is essential to long-term improvement in the oral health of AI/AN people.

Services which alleviate pain or prevent disease are given a higher priority than those intended to contain or correct damage caused by disease. Thus, priority is given to services such as treating dental emergencies, procedures aimed towards preventing the onset of disease and services deemed necessary for routine diagnosis and treatment to control the early stages of disease. Procedures such as complex dental restorations, crown and bridge prosthetic devices, surgical extraction of teeth, and specialty care in the fields of orthodontics and periodontal surgery are not offered to most AI/AN people seeking treatment at IHS facilities.

PERFORMANCE ANALYSIS

The Indian Health Service Dental Program continues to emphasize the need for oral health promotion/disease prevention activities and increased access to care in our clinical-based and community-based programs.

- During FY 2004, the IHS field staff exceeded the IHS objectives for the number of dental sealants placed on AI/AN children. While our FY 2004 objective was to maintain the number of dental sealants at FY 2003 levels, the Dental Program exceeded this goal by 17 percent. The placement of dental sealants is a Dental Program GPRA objective and addresses the Departments goals to *emphasize prevention programs (HHS Strategic Goal Objective 1.1).*
- Pilot projects in the IHS Aberdeen, Phoenix and Albuquerque Areas increased the numbers of community members receiving fluoridated water. One of the health benefits of fluoridated water includes a decrease in the formation of dental cavities. This project addresses the Departments goals to *emphasize prevention programs (HHS Strategic Goal Objective 1.1)* and will help to *decrease the oral health disparities (HHS Strategic Goal Objective 3.4)* experienced by AI/AN people.
- The Dental Program also utilized appropriated funds to assist dental provider volunteers in paying for their out-of-pocket expenses incurred when their services are offered to Indian Health Service dental programs. The funding increased the number of volunteers that provided dental services to Indian communities. During FY 2004, 104 volunteers participated in the program, treating 6,256 patients and providing 28,760 dental services. This project addressed the Department's goal *of increasing access to health care (HHS Strategic Goal Objective 3.6).*
- The Dental Program has placed an increased emphasis on the utilization of student externship programs, which has proven to be an effective recruitment tool for introducing employment options in the Indian Health Service. The student externship programs have also helped to increase access to oral health care services to AI/AN people. During FY 2004, there were 89 students that were placed at IHS Dental Program sites through the externship program. This project addressed the Department's goal of *increasing access to health care (HHS Strategic Goal Objective 3.6).*
- In recognition of the fact that improved oral health can lead to improvements in the medical condition of diabetics and people with other chronic, debilitating diseases, the Dental Program has developed periodontal oral health programs and funded denture fabrication, all with the intended outcome of improving the overall health status of the AI/AN people. This project addressed the *prevention* of diabetes through improved oral hygiene status and the improved ability for edentulous individuals to eat properly through the use of dentures, thus *improving their overall health status.* During FY 2004, there was a 1 percent increase in the number of diagnosed diabetic patients who received access to dental services. *(relates to HHS Strategic Goal Objective 3.4).*
- During FY 2004, the proportion of patients who obtained access to dental services was 24 percent, a 1 percent drop from FY 2003 levels. Dental vacancy rates contine to be a factor in achieving this performance indicator, which supports the

Department's goal of increasing access to health care (HHS Strategic Goal Objective 3.6).

All of these programs are directly associated with HHS goals and objectives, as well as Secretarial initiatives.

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

Fiscal Year	Amount	FTE
2001	$91,018,000	763
2002	$95,305,000	767
2003	$100,085,000	797
2004	$104,513,000	760
2005	$109,023,000	850

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request of $119,489,000 and 850 FTE is a net increase of $10,466,000 over the FY 2005 Enacted level of $109,023,000 and 850 FTE.

Pay Cost: +$2,001,000 – this will fund federal and tribal pay cost increases which will assist the IHS in maintaining access to services for the IHS patient population. Provision of these funds is necessary to maintain the current I/T/U health system which works to eliminate disparities in health status between the American Indian and Alaska Native population and the rest of the U.S.

Inflation: +$1,096,000 – this additional funding will cover the increases in dental and other costs using the FY 2006 Economic Assumptions.

Population Growth: +1,537,000 -- these resources will support the dental program's ability to provide dental services to the increasing AI/AN population.

Staffing for New Facilities: +$5,832,000
The increases 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	$2,177,000	25	0
Idabel, OK Health Center	87,000	1	1
Coweta, OK Health Center	2,124,000	25	0
Red Mesa, AZ Health Center	679,000	8	0
Sisseton, SD Health Center	765,000	9	0
St. Paul, AK Health Center	0	0	0
Total	5,832,000	68	1

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MENTAL HEALTH

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	$53,294,000	$55,060,000	$59,328,000	+$4,268,000
FTE	253	317	317	0
Client Contacts	204,560	204,560	211,515	+6,955

STATEMENT OF THE BUDGET REQUEST

The Mental Health budget request of $59,328,000 supports mental health and social service treatment, rehabilitation, and prevention services.

PROGRAM DESCRIPTION

The purpose of the Mental Health and Social Services (MH/SS) program is to raise the behavioral health status of the American Indian and Alaska Native (AI/AN) population to the highest possible level through the provision of high quality preventive and treatment services at both the community and clinic levels. The IHS MH/SS program is a community oriented clinical and preventive mental health service program that provides inpatient hospitalization, outpatient mental health and related services, crisis triage, case management, prevention programming and outreach services. It provides general executive direction, and management and administrative support, to 12 regional offices (Area Offices) that, in turn, provide resource distribution, program monitoring and evaluation activities, and technical support to IHS, tribal, and urban programs whose MH/SS staffs are responsible for the delivery of comprehensive mental health care to 1.8 million American Indians and Alaska Natives.

In a significant shift over the last several years, 80 percent of the overall MH/SS budget now goes directly to tribally operated programs via contracting and compacting, in accordance with P.L. 93-638. This trend of tribes taking responsibility for their own programs has shifted IHS MH/SS responsibilities from primarily direct service to supporting tribes delivering those services.

The most common MH/SS Program model is a tribally operated, acute crisis-oriented outpatient service staffed by one or more mental health professionals. Medical and clinical social work are usually provided by one or more social workers who provide family intervention for child abuse, suicide, domestic violence, parenting skills, and marital counseling, as well as discharge planning and support for hospitalized patients.

Partial hospitalization, transitional living, and child residential mental health programs are generally not provided. Inpatient services are provided under contract with local hospital psychiatric units. Other emergency and long term hospitalizations are provided through contracts by or with county and state mental hospitals. Such hospitals rarely offer culturally relevant services, such as traditional healers, in their programs.

Significant disparities (relative to the general population) exist across the spectrum of behavioral health problems.

Suicide: Compared with the general population, for which the highest suicide rate is found for individuals aged 74 and older, the highest suicide rate for American Indians and Alaska Natives is for individuals aged 15-34 (approximately 2.4 times the national rate or about 60 deaths per 100,000 population). The overall rate of suicide for American Indians and Alaska Natives is 20.2 per 100,000 or approximately 91 percent higher than the U.S. all-races rates which are 10.6 per 100,000.

Behaviorally Related Health Problems: Acute and chronic health conditions, many of which are behaviorally related, impact psychological well-being as well as are affected by behavioral health status. Seven of the top 10 Mortality and Morbidity problems are either directly related to or significantly impacted by behavior and behavioral/lifestyle choices. Individuals who experience chronic health problems are more likely than individuals without health problems to receive a diagnosis of depression and/or anxiety and to experience suicidal ideation. Liver disease, cancer, diabetes mellitus, heart disease, and cerebrovascular disease occur in significantly higher proportions in American Indian and Alaska Native communities as compared to the general population. Obesity is a growing and ominous problem as well. Given the high rates of physical and mental health problems, the negative health implications for American Indian and Alaska Native individuals, families, and communities are evident and pressing.

Violence and trauma related disorders are also reported at alarming rates in American Indian and Alaska Native communities: The rates of violence for every age group are higher among American Indians and Alaska Natives than that of the general population. The rate of violence for American Indian and Alaska Native youth aged 12-17 is 65 percent greater than the national rate for youth. Domestic violence and childhood sexual abuse are reported at alarming rates in Indian Country. The homicide mortality rate for American Indian and Alaska Native females ages 25 to 34 years is about 1.5 times that for the general population of females in this age group. Overcrowding in homes, lack of housing, and other socioeconomic issues are associated with high rates of abuse and neglect. The number of American Indian and Alaska Native families who are at or below the poverty level is 25.9 percent, a number significantly higher than for the general population.

Significant Programmatic Activities Include: The IHS MH/SS shifted strategic focus in FY 2004, after a detailed analysis of the continued trend toward tribal contracting and compacting services, funding patterns, statutory responsibilities, and national service

delivery across the treatment and prevention spectrum. The resulting focus areas reflect that change:

- Strategic Leadership
- Data Development
- Infrastructure Support
- Training and Convening
- Technical Support
- Collaborations
- Statutory Oversight
- Advocacy

Specific areas where these are operational include:

Suicide: To address these needs, the IHS Director created the IHS National Suicide Initiative in September 2003 to provide national leadership for the devastating impact of suicide on communities. The effort is directed at obtaining data that has previously been difficult to obtain and to develop recommendations.

Data Systems: Ongoing behavioral health data systems and software development are program priorities for IHS MH/SS to ultimately make completely electronic health care documentation and comprehensive national data collection a reality. Data collection, management and improvement efforts include expansion of the MH/SS system in I/T/U facilities including suicide, child abuse, and domestic violence in addition to other ongoing clinical information gathering and analysis. Two integrated behavioral health clinical documentation and data platforms were deployed recently, which provide direct patient care/medical record documentation, local data trending and analysis, and national reporting to the IHS centralized database. These platforms are available to all IHS and I/T/U programs free of charge.

Major Collaborations: Major partnerships currently exist with the Bureau of Indian Affairs (BIA), Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Disease Control and Prevention (CDC), Department of Justice (DOJ), and Administration for Children and Families (ACF). These partnerships often result in increased services to American Indian and Alaska Native communities working with the IHS, Tribes, and Urban Programs. IHS is the lead agency for the Memorandum of Understanding between the Department and Health and Human Services and Health Canada, signed in FY 2003, to promote program partnerships and collaborative efforts between the two countries over the next five years. Suicide, FAS/FAE, cross border issues, including care across borders were identified as primary areas for collaboration.

PERFORMANCE ANALYSIS

The MH/SS GPRA program performance goals were as follows for FY 2004:

Family Violence, Abuse, or Neglect Indicator: This indicator was to screen at least 15 percent of female patients ages 16-24 for domestic violence at health care facilities.

IHS did not meet this indicator in FY 2004. Only 4 percent of eligible patients were screened in FY 2004. The IHS will focus on additional training and screening tools during FY 2005. The indicator also directly supports HHS Strategic Plan Goals: 1.6; 3.4; 3.5; and 3.6.

Information Technology Development Group: This indicator was to improve the behavioral health data system by assuring at least 55 percent of the I/T/U programs will report minimum agreed-to behavioral health-related data to the national data warehouse. IHS did not meet this indicator in 2004. The FY 2004 performance measure was to improve the Behavioral Health (BH) Data System through a 5 percent increase in the number of the programs reporting minimum agreed-to behavioral health-related data to the national data warehouse. The actual number for FY 2004 represents a 2.3 percent increase. One reason for missing this target is that resources were devoted to implementing the new GUI interface at sites that were already submitting data to the national data warehouse. Nevertheless, the increase in sites using and exporting from 2002 to 2004 continues to be quite significant (33 percent).This indicator also directly supports HHS Strategic Plan Goals: 1.4; 3.4; and 5.5.

Suicide Prevention Indicator: This indicator is part of an expanding systematic effort at reducing the prevalence of suicide in the American Indian and Alaska Native population by collecting more accurate and comprehensive data. IHS met this indicator in 2004. In 2004 this indicator committed to implementing the national reporting plan to support national performance management of AI/AN suicide. The Suicide reporting form was deployed in the BH RPMS package in FY 2004, and Behavioral Health staffs with this package in all IHS Areas are now reporting this data. This indicator also directly supports HHS Strategic Plan Goals: 1.6; 3.4; 3.5; 3.6; 4.1; and 5.5.

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

Fiscal Year	Amount	FTE
2001	$45,018,000	297
2002	$47,142,000	285
2003	$50,626,000	287
2004	$53,294,000	253
2005	$55,060,000	317

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request of $59,328,000 and 317 FTE is a net increase of $4,268,000 over the FY 2005 Enacted level of $55,060,000 and 317 FTE.

Pay Cost: +$928,000
The increase will fund federal and tribal pay cost increases which will assist the IHS in maintaining access to services for the IHS patient population. Provision of these funds is

necessary to maintain the current I/T/U health system which works to eliminate disparities in health status between the American Indian and Alaska Native population and the rest of the U.S.

Inflation: +$679,000
This additional funding will cover the increases in medical and other costs using the FY 2006 Economic Assumptions.

Population Growth: +$776,000
These resources will support increased population growth and allow the mental health and social services programs to provide services to keep up with the increasing AI/AN population.

Staffing for New Facilities: +$1,885,000
The increases 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	$769,000	7	0
Idabel, OK Health Center	0	0	0
Coweta, OK Health Center	670,000	6	0
Red Mesa, AZ Health Center	223,000	2	0
Sisseton, SD Health Center	223,000	2	0
St. Paul, AK Health Center	0	0	0
Total	1,885,000	17	0

Department of Health and Human Services
Indian Health Service
Services –75-0390-0-1-551
ALCOHOL AND SUBSTANCE ABUSE

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 Enacted	FY 2005 Enacted	FY 2006 Estimate	Increase or Decrease
BA	$138,250,000	$139,073,000	$145,336,000	+$6,263,000
FTE	*174*	*180*	*180*	*0*
Services Provided:				
Outpatient Visit	663,936	663,936	673,231	+9,295
Inpatient Day	300,436	300,436	304,642	+4,206
Regl Treatment Ctr:				
Admission	4,415	4,415	4,477	+62
Aftercare Referrals	10,426	10,426	10,572	+146
Emergency Placement	469	469	476	+7

STATEMENT OF THE BUDGET REQUEST

The Alcohol and Substance Abuse budget request of $145,336,000 supports alcohol and other drug dependency treatments, rehabilitation, and prevention services. Ninety seven percent of these funds go directly to tribally contracted or compacted programs in accordance with tribal self governance provisions of P.L. 93-638.

PROGRAM DESCRIPTION

The purpose of the Alcohol and Substance Abuse Program (ASAP) is to raise the behavioral health status of the American Indian and Alaska Native (AI/AN) population to the highest possible level through the provision of high quality preventive and treatment services at both the community and clinic levels. ASAP funds tribally administered programs through contracts and compacts in accordance with P.L. 93-638. Ninety-seven percent of the budget goes directly to tribally administered programs. These programs provide alcohol and substance abuse treatment and prevention services within rural and urban communities, with a focus on holistic and culturally-based approaches. The ASAP exists as part of an integrated Behavioral Health Team (BHT) that works collaboratively to reduce the incidence of alcoholism and other drug dependencies in American Indian and Alaska Native communities.

Approximately 5 percent of the employees in IHS-funded ASAP are Federal staff with Tribal staff comprising 95 percent. The reported certified counselor and professional licensure rates continue at 85 percent.

Presently there are 12 operating Youth Regional Treatment Centers (YRTC). Nine centers are accredited by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF) and three are State Certified. Many of the approximately 300 tribal alcohol programs are State-licensed and/or certified. Alaska currently has two YRTC programs, and they are in the process of seeking funds to build an additional facility. In addition, there are more than a dozen American Indian and Alaska Native alcohol/substance abuse adult residential treatment facilities, including two serving pregnant women and/or women with children.

Significant disparities (relative to the general population) exist across the spectrum of substance abuse problems.

- In virtually every Healthy People 2010 target for substance abuse, the current status of Native Americans reveals great disparities. For example, ***Healthy People 2010*** target for cirrhosis deaths is 3.0 per 100,000. The current AI/AN rate is 22.6; for drug induced deaths the goal is 1.0 per 100,000 and the current AI/AN rate is 6.6.

- The latest data available to the IHS indicate that alcoholism mortality rates in some Tribal communities have increased significantly since 1992 to nearly 7 times the alcoholism death rate of the overall U.S. population. The American Indian and Alaska Native drug-related death rate is 18 percent higher than the rate for the overall U.S. population. The gap in services available between American Indians and Alaska Natives and the rest of the U.S. population continues to widen.

- Rates of current illicit drug use among the major racial/ethnic groups in 2001 were 7.2 percent for whites, 6.4 percent for Hispanics, and 7.4 percent for blacks. The rate was highest among American Indians/Alaska Natives (9.9 percent) and persons reporting more than one race (12.6 percent). Asians had the lowest rate (2.8 percent). Source: National Household Survey on Drug Abuse, 2001.

- Among youths aged 12 to 17, the rate of current illicit drug use was highest among American Indians/Alaska Natives (23.0 percent for combined 2000 and 2001 data).

<u>5 Year Strategic Plan</u>

In 2003, a landmark cooperative effort was completed. Consensus agreement was reached among IHS, tribes, and urban programs for spending plans and strategic goals to guide a more comprehensive and effective national response to the growing alcohol and substance abuse problems. IHS adopted the resulting spending recommendations and 5 Year Strategic Plan, without modification. The strategic plan goals are to:

- Improve Trending, Data, Research and Technology
- Develop Alternative Funding Sources
- Promote Community Education, Awareness and Prevention

- Foster Professional Development
- Implement a "Call to Action" and Leadership Development
- Develop Partnerships
- Provide Innovative Intervention, Treatment and Aftercare

Additionally, the National IHS Advisory Committee on Alcohol and Substance Abuse was established. Including representatives from federal, tribal, and urban programs nationally, the Committee assists the IHS to achieve its strategic goals and bring improved alcohol and substance abuse health care services to American Indian and Alaska Natives. Significant activities include:

- Data Systems -- Ongoing behavioral health data systems and software development are program priorities for IHS MH/SS to ultimately make completely electronic health care documentation and comprehensive national data collection a reality. Data collection, management and improvement efforts include expansion of the MH/SS system in I/T/U facilities including suicide, child abuse, and domestic violence in addition to other ongoing clinical information gathering and analysis. Two integrated behavioral health clinical documentation and data platforms were deployed recently, which provide direct patient care/medical record documentation, local data trending and analysis, and national reporting to the IHS centralized database. These platforms are available to all IHS and I/T/U programs free of charge. In addition, the ASAP is supporting two software enhancement projects that further integrate and coordinate assessment, treatment planning, and case management utilizing the American Society of Addiction Medicine (ASAM) Patient Placement Criteria and the CSAT Alcohol Severity Index (ASI). Systems are being tested at the 12 YRTCs.

- Collaborative Activities -- In FY 2004, the IHS Alcoholism and Substance Abuse Program (ASAP) collaborated with the Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), Bureau of Indian Affairs (BIA), Department of Housing and Urban Development, Department of Transportation, Administration on Aging, and the Department of Justice (DOJ). Multiple programs and collaborations are in place which bring together convergent interests and resources to support ASAP activities nationally. In addition, IHS is the lead agency for the Memorandum of Understanding between the Department of Health and Human Services and Health Canada, signed in FY 2003, to promote program partnerships and collaborative efforts between the two countries over the next five years. Suicide, FAS/FAE, cross border issues, including care across borders were identified as primary areas for collaboration.

PERFORMANCE ANALYSIS

The ASAP budget is an essential component to eliminating racial and ethnic disparities, which is HHS Strategic Objective 3.4. The progress made in improving mortality rates during the 1970s included alcohol-related deaths and deaths due to cirrhosis which declined very rapidly from the early 1970's into the mid 1980's. These large

improvements were brought about by increasing access to proven public health measures and greater access to care. However, this pace of improvement has stalled. Factors of significance are related to community economics, educational interventions, and personal health behaviors. Maintaining the ASAP services, with their emphasis on supporting the social, cultural, and spiritual values of communities, is an important part of promoting overall health and healthy life choices.

On an annual basis, the ASAP performance currently is measured through GPRA process indicators. As the new behavioral health data systems are implemented, other measures focused more on outcomes will be developed.

In FY 2004, the Alcohol and Substance Abuse budget contributed to the accomplishment of the following performance measures:

Youth Regional Treatment Centers: During FY 2004, the Youth Regional Treatment Centers that have been in operation for 18 months or more will achieve 100 percent accreditation either through CARF, or a comparable accreditation process. IHS met this indicator. Accreditation by JCAHO, CARF, or comparable state accrediting bodies ensures that the Youth Regional Treatment Centers met acceptable standards of treatment. This indicator has changed to focus on accreditation, as the components of the previous indicator are met and surpassed with accredited facilities. This indicator also directly supports HHS Strategic Plan Goals: 1.4; 3.4; 3.6; and 5.2.

Alcohol use screening: During FY 2004, establish the screening rate for alcohol use in women of childbearing age. IHS met this indicator. The intent of this indicator is a reduction in the incidence of Fetal Alcohol Spectrum Disorder (FASD). Surveillance conducted at two IHS Areas indicated FASD rates greatly exceed general population rates. Indian Health Service had implemented screening and case management protocols at the majority of our facilities and now actual screenings are baselined. IHS met this indicator. This indicator also directly supports HHS Strategic Plan Goals: 1.1; 1.4; and 3.4.

Behavioral Health Data System: During FY 2004, improve the behavioral health data system by assuring at least 55 percent of the I/T/U programs will report minimum agreed-to behavioral health-related data to the national data warehouse. IHS did not meet this indicator in 2004. The FY 2004 performance measure was to improve the Behavioral Health (BH) Data System through a 5 percent increase in the number of the programs reporting minimum agreed-to behavioral health-related data to the national data warehouse. The actual number for FY 2004 represents a 2.3 percent increase. One reason for missing this target is that resources were devoted to implementing the new GUI interface at sites that were already submitting data to the national data warehouse. Nevertheless, the increase in sites using and exporting from 2002 to 2004 continues to be quite significant (33 percent).This indicator also directly supports HHS Strategic Plan Goals: 1.4; 3.4; and 5.5.

FUNDING HISTORY – Funding for the Alcohol and Substance Abuse during the last 5 years has been as follows:

Fiscal Year	Amount	FTE
2001	$130,254,000	172
2002	$135,005,000	173
2003	$137,744,000	180
2004	$138,250,000	174
2005	$139,073,000	180

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request of $145,336,000 and 180 FTE is a net increase of $6,263,000 over the FY 2005 Enacted level of $139,073,000 and 180 FTE. The increase includes the following:

Pay Cost Increase: +$2,217,000
The request will fund federal and tribal pay costs which will assist the IHS in maintaining access to services for the IHS patient population. Provision of these funds is necessary to maintain the current I/T/U health system which works to eliminate disparities in health status between the American Indian and Alaska Native population and the rest of the U.S.

Inflation: +$2,086,000
This additional funding will cover the increases in medical and other costs using the FY 2006 Economic Assumptions.

Population Growth: +$1,960,000
These resources will support increased population growth and allow the ASA program to provide alcohol and substance abuse services to expand to meet the increasing AI/AN population.

Department of Health and Human Services
Indian Health Service
Services – 75-0390-01-551
CONTRACT HEALTH SERVICES

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	$479,070,000	$498,068,000	$525,021,000	+$26,953,000
FTE	1	1	1	0
Gen. Med & Surg. Hospitalization: ADPL	226	217	229	+12
Ambulatory Care: Outpatient Visits	495,711	497,899	505,717	+7,818
Patient & Escort Travel: One-Way Trips	36,637	36,782	37,410	+628
Dental Services	60,061	59,934	60,144	+210

STATEMENT OF THE BUDGET REQUEST

The Contract Health Service (CHS) budget request of $525,021,000 supplements health care resources available to eligible American Indian and Alaska Native people with the purchase of medical and health care services outside IHS direct care program. The CHS program supports the provision of care in IHS and tribally operated facilities by acquiring healthcare services that would otherwise not be available.

PROGRAM DESCRIPTION

The CHS program is administered through the 12 IHS Area Offices that consists of 155 IHS and tribally operated service units. The facilities include two major IHS operated medical centers and one tribally operated medical center. Not all tribes have access to IHS or tribally operated health care facilities and depend on CHS programs to provide all health care needs from the private sector.

The CHS program acquires basic health care services from private, local, and community health care providers that include hospital care, physician services, outpatient services, laboratory, dental, radiology, pharmacy, dental, and transportation services.
The CHS funds are used in situations where: **1**) no IHS direct care facility exists, **2**) the direct care element cannot provide the required emergency or specialty services, **3**) direct care element has an overflow of medical care workload, and **4**) supplements alternate resources.

The CHS program also includes a Catastrophic Health Emergency Fund (CHEF) in the amount of $18,000,000 that provides funds for high cost cases and catastrophic illnesses. Accessing CHEF requires meeting a threshold established in accordance with a Congressional mandate which is based on the annual change in the consumer price index (CPI). For FY 2005, the CPI based threshold equates to $24,700. Once the threshold and CHEF requirements are met, the CHEF program provides funding for over 667 high cost cases in amounts ranging from $500 to over $875,000. The fund is limited and depletes by the third quarter before the end of the fiscal year leaving many cases unfunded from the CHEF program and must be absorbed by local budgets.

The CHS program contracts with Blue Cross/Blue Shield of New Mexico as its fiscal intermediary (FI) agent to ensure that payments are made in accordance with the IHS payment policy and quality control requirements. The FI monitors data and processes payments and provides workload and financial data in support of IHS statistical and financial reports.

PERFORMANCE ANALYSIS

In FY 2004, the IHS CHS programs continued to maintain the same level of CHS procurement contracts. With the implementation of the Medicare Modernization Act (MMA) provision for Medicare-like rates in FY 2005 and FY 2006, the IHS will no longer be required to pay open market rates to hospitals that participate in Medicare programs. The IHS anticipates that these rates will reduce the cost of inpatient care by $8 million annually. The MMA Medicare like provisions will not be fully implemented in FY 2005 requiring CHS programs to continue to purchase health care services according to the IHS payment policy requirements.

The CHS program strives to attain the best prices available from the private providers and continues to negotiate contracts at the best rate possible.

For FY 2004, Aberdeen, Albuquerque, Bemidji, Billings, Navajo, Oklahoma, and Tucson Areas achieved their contracting goals at the IHS National GPRA goal set at 93%. Special efforts include orientation/education of IHS providers to funnel IHS patients to contracted facilities in the CHS referral process. Closer monitoring is achieved through weekly Managed Care and Resource Management Committee meetings that involve both the Area, Service Unit, and Tribal staff.

For FY 2004, Phoenix, Portland Areas reported below the 93% IHS National GPRA goal. The Phoenix Area has 28 hospital contracts and rate quote agreements, and shares 32 additional hospital contracts and rate quote agreements with Albuquerque, Navajo, and Tucson Areas. Many patients continue to be referred to non-contract facilities preventing the Area from meeting its GPRA target.

Strategies to Eliminate Barriers:

- Work to improve all service unit referral patterns and fully implement the MMA Medicare like rates and use contract hospitals.

- Service Units will refer or transfer patients only to hospitals that participate in the Medicare reimbursement program.
- Service Units will inform open market health care providers that the MMA Medicare liked rates will be applied.
- Fund ground and air ambulances to transfer eligible patients to contract hospitals.
- Service Units must transfer emergency admitted patients to Medicare hospitals as soon the patient is medically stable.

The greatest barrier to increased contracts has been attributed to the geographic locations of IHS facilities in relationship to contract facilities. By FY 2006 the IHS will have fully implemented the MMA Medicare like rates provision requiring private sector providers to provide care using medicare-like rates.

The CHS resources contributes to accomplishing other IHS GPRA performance goals that relate to diabetic patients and improving glycemic control, blood pressure and assessment of dyslipidemia and nephropathy; cancer screening for women through pap smears and mammography; immunizations for 19 to 35 month-old children; and vaccination for influenza and pneumococcal for 65 years and older.

FUNDING HISTORY – Funding for the Contract Health Services during the last 5 years has been as follows:

Fiscal Year	Amount	FTE
2001	$445,773,000	0
2002	$460,776,000	0
2003	$468,130,000	2
2004	$479,070,000	1
2005	$498,068,000	1

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request of $525,021,000 and 1 FTE is an increase of $26,953,000 over the FY 2005 Enacted budget of $498,068,000 and 1 FTE. The increase includes the following:

Inflation: +$18,906,000

The inflation amount of $18,906,000 will enable the CHS program to address the issues of inflation and the high costs of purchasing health care from the private sector. These increases will allow the CHS program to maintain a significant amount of its purchasing power in FY 2006. Because of the increased demand for CHS, the IHS will continue to adhere to the specific CHS guidelines to ensure that the most effective use of CHS dollars are attained. The CHS requirements and annual increases enhance the IHS' ability to provide needed health care services throughout the year.

Population Growth: +$7,021,000

The population growth funding of $7,021,000 will enable the CHS program to address the increasing AI/AN population. These increases will enhance the CHS' ability to maintain its purchasing power in FY 2006.

New Facilities: +$1,026,000

The new Sisseton outpatient facility replaces the old inpatient facility and will no longer provide inpatient or emergency care services. These funds will be used to purchase inpatient and emergency care services from the private sector that were previously provided at the inpatient facility. The following table displays the requested increase.

		FTE	
Facilities	Dollars	Federal	Tribal
Piñon, AZ Health Center	$0	0	0
Idabel, OK Health Center	0	0	0
Coweta, OK Health Center	0	0	0
Red Mesa, AZ Health Center	0	0	0
Sisseton, SD Health Center	1,026,000	0	0
St. Paul, AK Health Center	0	0	0
Total	$1,026,000	0	0

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Department of Health and Human Services
Indian Health Service
Services – 75-0390-0-1-551

PREVENTIVE HEALTH

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	Increase or Decrease
BA	$106,931,000	$110,381,000	$118,859,000	+$8,478
FTE	281	360	360	0

Total Budget – The total Preventive Health budget request of $118,859,000 and 360 FTE is an increase of $8,478,000 over the FY 2005 Enacted level of $110,381,000 and 360 FTE. The justification of each budget is described in the narratives that follow.

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Department of Health and Human Services
Indian Health Service
Services – 75-0390-0-1-551
PUBLIC HEALTH NURSING

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	$42,581,000	$45,015,000	$49,690,000	+$4,675,000
FTE	*252*	*317*	*317*	*0*
# of Patient Visits 1/	423,379	423,379	449,628	+26,249
# of Home Visits 1/	192,121	192,121	204,033	+11,912

1/ The PHN program implemented data assessment and improved documentation practices to improve PHN data quality in FY 2003 and 2004. This is actual Patient and Home Visits.

STATEMENT OF THE BUDGET REQUEST

The Public Health Nursing (PHN) budget request of $49,690,000 supports outreach activities including home visits, well-child examinations, immunizations, prenatal care, postpartum care, follow-up visits for skilled nursing services, and community screenings.

PROGRAM DESCRIPTION

The IHS PHN program integrates nursing practice and public health practice for individuals, families, and groups; thereby impacting the health of the community. Historically, the IHS PHN program has focused on secondary prevention, which are health intervention early in a disease process in order to prevent or delay complications; and tertiary disease prevention which are health intervention efforts intended to delay complications of advanced disease processes. It is the goal of the IHS PHN program to continue and increase primary prevention efforts by targeting health interventions for individuals, families, and groups before a disease process begins.

Prior performance measures have been based on the number of PHN visits in any setting and number of home visits, targeting populations at high risk for disease and poor accessibility to health care. For FY 2005, the PHN GPRA indicator logic was reviewed and revised to improve data quality, and will focus on overall PHN activities. The IHS PHN program is currently developing a new GPRA indicator for FY 2006. This new PHN performance measure will change the current efficiency indicator towards an outcome based indicator.

Because of the increasing user population, the Indian Health Service (IHS) Public Health Nursing (PHN) program faces unique challenges in providing services to a diverse population whose health care needs range from simple to complex nursing care in the home or other community settings. The *PHN is a major link to access health care* for many American Indians and Alaska Natives (AI/AN) who live in rural and isolated communities.

The threat of bioterrorism has also brought additional responsibilities for PHN Programs across the country. As a community-based program, PHN is integral to the emergency preparedness arena, through disease/health surveillance/education, and through collaboration with service unit, county, and state emergency preparedness programs.

PERFORMANCE ANALYSIS

The IHS PHN program continues to promote health and disease prevention activities with access to care through community-based programs.

During FY 2004, the IHS PHN program exceeded the IHS objective for maintaining public health nursing services at FY 2003 levels by 15,245 (4.2%); while increasing the proportion of home visits by 4,387 (2.7%).

In FY 2004 and FY 2005, the PHN programs developed activities that focus on measurable outcomes relating to the following department and agency prevention initiatives: Obesity (any age), Cardiovascular Disease Prevention in Women, Maternal Child Health (health of the prenatal and post partum patient and infant, including SIDS risk reduction), Tobacco Cessation, Domestic Abuse/Sexual Assault, and Immunizations – All Ages. These programs have measurable outcomes for intervention activities. These activities have been made possible through appropriation funding distributed in the form of competitive awards for IHS, Tribal and some Urban PHN programs. The 16 awards issued for FY 2004 emphasize departmental and agency goals of access to health care, health promotion, disease prevention, and advocacy in policy appropriate for the development and implementation of HP/DP activities.

In addition to the PHN GPRA Indicator, PHN program activity contributes to the IHS meeting 11 other GPRA Indicators: Diabetes; PAP Screening; Mammography Screening; Alcohol Screening; Childhood Immunization; Influenza and Pneumococcal Vaccination in adults; Cardiovascular Disease; Obesity; and Tobacco Use. These indicators address departmental and agency goals of health promotion and disease prevention.

Public Health Nursing is also striving to meet the Secretary's initiative of adopting information technology in health care by implementing a Public Health Nursing laptop-based software program. The PHN program has implemented data assessments and improved documentation practices in order to improve PHN data quality in FY 2003 and 2004.

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

Fiscal Year	Amount	FTE
2001	$36,114,000	289
2002	$37,781,000	279
2003	$39,875,000	288
2004	$42,581,000	252
2005	$45,015,000	317

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request of $49,690,000 and 317 FTE is an increase of $4,675,000 over the FY 2005 Enacted level of $45,015,000 and 317 FTE.

Pay Cost: +$852,000
The request will fund federal and tribal pay costs which will assist the IHS in maintaining access to services for the IHS patient population.

Inflation: +$367,000
This additional funding will cover the increases in medical and other costs using the FY 2006 Economic Assumptions. These increases will allow the PHN program to maintain the level of care of services and home visits at the prior FY workload levels.

Population Growth: +$634,000
The population growth funding of $634,000 will enable the PHN program to address the increasing AI/AN population and to provide outreach activities to more people.

Staffing for New Facilities: +$2,822,000
The request for phasing-in of staff and related costs for new facilities will allow IHS to expand provision of health care in those areas where existing capacity is most overextended. Funds are requested to staff the six 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	$1,342,000	13	0
Idabel, OK Health Center	0	0	0
Coweta, OK Health Center	888,000	9	0
Red Mesa, AZ Health Center	296,000	3	0
Sisseton, SD Health Center	296,000	3	0
St. Paul, AK Health Center	0	0	0
Total	$2,822,000	28	0

Department of Health and Human Services
Indian Health Service
Services –75-0390-0-1-551
HEALTH EDUCATION

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	$11,793,000	$12,429,000	13,787,000	+$1,358,000
FTE	*25*	*39*	*39*	*0*
Health Education Services Provided	588,947	588,947	626,640	+37,693

STATEMENT OF THE BUDGET REQUEST

The Health Education budget request of $13,787,000 will assist IHS facilities, Indian tribes, tribal organizations, and urban Indian organizations to develop comprehensive health education programs for American Indian and Alaska Natives.

PROGRAM DESCRIPTION

The Health Education Program:

(1) Communicates the importance and on-going need for comprehensive clinical and community health education programs;
(2) Ensures the provision of education to the client; working with hospitals, clinics and community education programs to integrate the IHS Patient Education Protocols and Code system;
(3) Provides technical assistance in comprehensive school health to schools that educate Native American children and youth from preschool to grade 12.
(4) Standardizes, coordinates and integrates education issues within the IHS including health literacy, professional education and training, as well as educational materials.

Comprehensive Health Education

The Health Education Program has identified these priorities that encompass the core practices of public health education - community health, school health, worksite health promotion, and patient education:

- To develop and strengthen a standardized, nationwide patient and health education program as evidenced by the integration of the IHS Patient Education Protocols into all IHS software packages including the PCC, PCC+ and the Electronic Health

Record; with the continued provision of ongoing training to I/T/U staff on the documentation and coding of patient and health education;

- To enhance the capacity of those schools that educate American Indian and Alaska Natives to respond to issues of youth health as evidenced by the development of a partnership in school nursing and comprehensive school health Memorandum of Agreement with the Bureau of Indians Office of Indian Education;

- Standardize professional education and training;

- To increase a concentrated focus on the area of literacy in health and patient education;

The Health Education program supports IHS, Tribal programs and federal facilities that provide technical assistance and training to Indian tribes, tribal organizations, and urban Indian organizations to develop comprehensive health education programs for Native Americans.

IHS statistics indicate a decline in the number of sites employing a full-time health educator; however, we are seeing a steady rise and increase in the health and patient education that is being provided to American Indian and Alaska Native clients. This is basically because in addition to services being provided by Health Educators, they are being provided by other clinical and community staff. This demonstrates the collaboration between the IHS Health Education Program and all IHS health disciplines and programs. All disciplines and programs are being trained to provide education services and a mechanism for tracking these services is in place.

To accomplish this renewed focus on education by all disciplines, all disciplines and programs are being trained to focus a more determined effort towards the continuation and ongoing need to provide education. A mechanism for the delivery and tracking of health and patient education has been developed and training is being provided to all health programs and disciplines.

PERFORMANCE ANALYSIS

During FY 2006, the IHS Health Education Program will continue collaboration to assist AI/AN communities to implement culturally sensitive community-directed cardiovascular disease prevention programs to attain improved cardiovascular disease health.

Other GPRA Indicators that the Health Education program supports are in the following areas:

- Nutrition and Exercise education
- HIV/AIDS education to prenatal clients
- Medication education
- Tobacco Cessation education/counseling

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

Fiscal Year	Amount	FTE
2001	$10,063,000	36
2002	$10,628,000	34
2003	$11,063,000	32
2004	$11,793,000	25
2005	$12,429,000	39

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request of $13,787,000 and 39 FTE is an increase of $1,358,000 over the FY 2005 Enacted level of $12,429,000. The increase includes the following:

Pay Cost Increase: +$214,000
The request will fund federal and tribal pay costs which will assist the IHS in maintaining access to services for the IHS patient population. Provision of these funds is necessary to maintain the current I/T/U health system which works to eliminate disparities in health status between the American Indian and Alaska Native population and the rest of the U.S.

Inflation: +$164,000
This additional funding will cover the increases in costs using the FY 2006 Economic Assumptions.

Population Growth: +$175,000
These funds will address increased services needed for the growing AI/AN population.

Staffing for New Facilities: +$805,000
The request for staffing and related costs for new facilities will allow IHS to expand provision of health care in those areas where existing capacity is most overextended. Funds are requested to staff the six 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	$361,000	3	0
Idabel, OK Health Center	0	0	0
Coweta, OK Health Center	222,000	2	0
Red Mesa, AZ Health Center	111,000	1	0
Sisseton, SD Health Center	111,000	1	0
St. Paul, AK Health Center	0	0	0
Total	$805,000	7	0

Department of Health and Human Services
Indian Health Service
Services – 75-0390-0-1-551
COMMUNITY HEALTH REPRESENTATIVES

Authorizing Legislation: Program authorized by 25 U.S.C. 13, Snyder Act, and P.L. 83-568, Transfer Act 42 U.S.C. 2001, and Indian Health Care Improvement Act Amendment Public Law (P.L.100-713).

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	Increase Or Decrease
BA	$50,996,000	$51,365,000	$53,737,000	+$2,372,000
FTE	*4*	*4*	*4*	*0*
Number of CHRs	1,500	1,500	1,500	0
# of Tribally Operated Services Provided	2,173,600	2,173,600	2,204,030	+30,430

STATEMENT OF THE BUDGET REQUEST

The Community Health Representatives (CHR) budget request of $53,737,000 funds Tribal CHR programs which provide quality health care outreach services as well as health promotion/disease prevention services, through the use of well-trained CHRs to AI/AN persons within their communities.

PROGRAM DESCRIPTION

The Community Health Representatives (CHR) Program was designed to bridge gaps between American Indian/Alaska Native (AI/AN) persons and resources by integrating basic medical knowledge about health promotion/disease prevention and local community knowledge in specially trained indigenous community members. The 264 CHR programs are administered and operated by the Tribes through contracts/compacts under the authority of the Indian Self-Determination and Education Assistance Act in order to implement the Indian Health Care Improvement Act as amended.

PERFORMANCE ANALYSIS

The CHR Program supports GPRA indicators including immunization rates for children and elders, blood pressure and glycemic control for diabetics, and injury prevention programs. To meet those indicators requires a collaborative effort on the part of CHRs, Public Health Nurses, Maternal and Child Health workers and Environmental Health specialists. IHS utilizes a multidisciplinary approach to maximize health resources to meet health care needs. The GPRA indicators above reflect cross-cutting strategies involving CHRs in the community and reveal only a limited snapshot of the critically important role CHRs serve in AI/AN communities. Across the scope of IHS' CHR programs, CHRs provide many links to effectively integrate efforts designed to positively

impact chronically underserved AI/AN communities, *thus supporting DHHS' goal to increase the use of effective health care services by medical providers*. At an individual level CHRs positively impact health-promoting behaviors, provide interagency coordination at the agency level and build community competence among AI/AN communities, all of which support DHHS goals.

CHRs typically supply social support services as well as health services to their communities. CHRs connect local/state/federal resources with community members – especially elders and children - needing assistance for energy costs, completing CMS eligibility forms, and assisting with tax returns. They help community members cope with stressors and promote positive health outcomes in a variety of ways which complement specialized services of medical providers. Such ancillary health services are not captured by GPRA indicators but add tremendous value to reaching the *DHHS Goal to improve economic and social development of distressed communities.*

CHRs contribute directly to the IHS Director's Prevention Initiative, by actively supporting building healthy communities. Below are only a few CHR projects and activities which contribute toward the journey to accomplish *DHHS and IHS Goals to expand access to health care services for AI/AN persons; expand community partnerships and build healthy communities; reduce tobacco and alcohol use among young people; effectively respond to bioterrorism and other public health challenges; emphasize prevention programs; and increase immunization rates:*

- Successful implementation of a demonstration project whereby tribal CHR Programs have productively arranged for patient transportation via a non-profit corporation and resulting in cost-savings to the federal government**;**
- Successful implementation of projects with CDC and National Heart, Lung and Blood Institute (NHBLI) regarding diabetes control and Cardiovascular Programs**;**
- Successful implementation of projects with CH SIDS Foundation to reduce the incidence of Sudden Infant Death Syndrome in AI/AN babies, additionally impacting goals to reduce tobacco and alcohol use among young mothers and fathers**;**
- Successful implementation of First Responder trainings for CHRs and community members for most of the 12 areas**;**
- Successful implementation of the cooperative grant agreement with the National Association of Community Health Representatives (NACHR), to provide improved health services delivery**,** outreach and health education to Native American persons;
- Provision of increased education and outreach services targeting prevention activities including injuries, diabetes, obesity, cardiovascular problems, exercise and lifestyle changes**;**
- Injury prevention activities to reduce the tremendous injury rates among AI/AN persons to include home assessments for elders and toddlers, child safety seat usage, safe cycling and helmet use classes, smoke detectors in homes, etc.;

- Increased activities in and awareness of local, county, regional, and Area Emergency Preparedness efforts and the important partnership role for CHRs in the tribal community to help affect those disaster plans.

CHR case finding and screening efforts provide appropriate referrals to health care providers, directly impacting access to prevention efforts and early identification of conditions which might otherwise go undetected and thus increase treatment, rehabilitation and emotional costs. CHRs provide these services as well as education and outreach; monitoring patient status; planning, development and implementation of specific projects. Besides indicators previously listed, projects typically address health issues over such diverse topics as:

Diabetes and associated Kidney problems	Cancer
FAS/FAE	Vision needs
Nutrition, lifestyle choices and obesity	Maternal and child health
Elder care	Alcohol/drug abuse prevention and referral
Domestic violence/Sexual assault	Tobacco cessation programs

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

Fiscal Year	Amount	FTE
2001	$48,061,000	0
2002	49,789,000	0
2003	50,774,000	3
2004	50,996,000	4
2005	51,365,000	4

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request of $53,737,000 and 4 FTE is an increase of $2,372,000 over the FY 2005 Enacted level of $51,365,000 and 4 FTE. The increase includes the following:

Pay Cost Increase: +$863,000 -- this will fund federal and tribal pay costs which will assist the IHS in maintaining access to services for the IHS patient population. Provision of these funds is necessary to maintain the current I/T/U health system which works to eliminate disparities in health status between the American Indian and Alaska Native population and the rest of the U.S.

Inflation: +$785,000 -- this additional funding will cover the increases in medical and other costs using the FY 2006 Economic Assumptions.

Population Growth: +$724,000 -- this funding will enable the CHR program to address the increased need for services resulting from the growing AI/AN population.

Department of Health and Human Services
Indian Health Service
Services –075-0390-0-1-551
HEPATITIS B AND HAEMOPHILUS IMMUNIZATION PROGRAMS (ALASKA)

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	$1,561,000	$1,572,000	$1,645,000	+$73,000
FTE	0	0	0	0
Services Provided:				
# Hepatitis Program patient visits for clinical care*	3400	3900	3900	0
# Chronic carriers surveyed	1350	1300	1300	0
Patients Immunized:				
# Hepatitis A/B**	8400	8400	8400	0
Hepatitis C patients followed	1300	1500	1700	+200
Studies evaluating need for Hepatitis A and Hepatitis B booster doses:				
Infants/Children	1000	1050	1050	0
Adults	1000	1000	1000	0
Non-Alcoholic Fatty Liver Registry patients***	230	350	450	+100
Autoimmune Hepatitis Registry Patients***	80	90	100	+10
Immunization Records Audited:				
# Trained in RPMS	120	120	120	0
# Health Aide Training	90	90	90	0
# Tribal Site Visits	5	5	5	0
3-27 month old Alaska Native immunization rates reported:	4,900	5,000	5,000	0
Purchase of Vaccine (Adult):				
Hepatitis A****	$50,000	$50,000	$50,000	0
Hepatitis B****	$50,000	$50,000	$45,000	-$5,000

STATEMENT OF THE BUDGET REQUEST

The FY 2006 budget request of $1,645,000 would maintain program activities of the Haemophilus Influenza type B Immunization and Viral Hepatitis Programs. These

activities include clinical care of chronic liver disease patients, consultation on immunization and hepatitis issues, follow-up of hepatitis B carriers, training and technical assistance for tribal health providers and Community Health Aides, consultation for the RPMS Immunization Package, patient and public education, immunization audits, vaccine-preventable disease surveillance, and coordination with the State of Alaska. Both programs seek outside grants to conduct critical research addressing health disparities.

The $1,645,000 includes $361,500 for tribal contracts with Yukon Kuskokwim Health Corporation and the Bristol Bay Health Corporation to cover 3.5 FTE (tribal) immunization coordinators. The remainder of the funds is used by the Alaska Native Tribal Health Consortium (ANTHC) to help cover 2.75 FTEs (tribal) for immunization consultants and the Hepatitis Program Director. Please note that resources from both IHS and other sources, such as the State of Alaska, support workload numbers.

PROGRAM DESCRIPTION

The Viral Hepatitis Program (Hepatitis B Program) and the Immunization (Haemophilus Influenza) Program are distinct programs of the ANTHC. The Viral Hepatitis Program provides IHS-and nation-wide and Alaska Native consultation and expertise on the treatment and prevention of hepatitis A, B, and C and treatment of liver disease. The program funds support training of providers and hepatitis specialty clinics throughout Alaska. The program also provides consultative services for providers nation-wide who care for AI/ANs, including web site materials and guidelines for provider, patient and public education, telephone and program consultation, future potential laboratory support and offers clinical preceptor ships for IHS/Tribal providers in the care of patients with chronic hepatitis B and C. The program operates through grants to conduct research to improve the prevention and treatment of hepatitis and other liver disease among AI/ANs.

Viral Hepatitis
A recent study published by the CDC in Hepatology demonstrated that Alaska Natives and American Indians have a disproportionate burden of liver disease and a higher mortality from liver disease than any other ethnic group in Alaska. The Liver Disease and Viral Hepatitis Program are shifting resources to meet the demand of increasing services and research needed in liver disease in Alaska Natives. We anticipate an increase in the number of patients seen in Hepatology clinics and in chronic liver disease registries. This is primarily due to an anticipated increase in the number of newly diagnosed Alaska Natives with hepatitis C and non-alcoholic liver disease (NAFLD). NAFLD is a result of the increasing incidence of obesity in Alaska Natives and is part of the metabolic syndrome caused by insulin resistance that is epidemic in Alaska Natives. Approximately 25% of persons with NAFLD will have progressive liver disease that can lead to cirrhosis of the liver and even hepatocellular carcinoma. We plan to provide increased clinic appointment slots for the increased number of patients by redesigning clinic flow and utilizing the help of Internal Medicine clinic nursing assistants. In addition, we plan to develop programs to build healthy Alaskan Native communities by integrating teaching of healthy life styles such as exercise, weight loss and abstaining

from alcohol in patients with liver disease that would decrease progression of liver diseases such as NAFLD and hepatitis B and C. We intend to apply for additional research grants to study the viral characteristics of hepatitis B to help identify chronically infected patients who might benefit from early antiviral therapy. We also plan to complete research projects on the long term immunogenicity of hepatitis B vaccine that study the anamnestic response to a booster dose in previously immunized persons. We plan to write a grant to study autoimmune liver disease in Alaska Native women, as they have recently been found to have the highest prevalence reported in the world. In FY 2006, we plan to apply for grants to study NAFLD in persons with adult onset diabetes to understand how significant liver disease contributes to morbidity and mortality in Alaska Natives with diabetes and design programs to reduce the progression of liver fibrosis in diabetics. We will also in FY 2006 plan to shift money from hepatitis A and B vaccine purchases to clinical and research services for NAFLD and hepatitis C by using 3rd party payers to purchase some of the vaccine needed for adults. Also, we anticipate there will be fewer adults (20%) who will need vaccination. By more efficient use of existing staff and acquisition of grants, we plan to increase research and clinical services to our patients.

Immunization (Hib) Program

Alaska Native children historically experienced some of the highest reported rates of vaccine-preventable diseases such as *Haemophilus influenzae* type b (Hib), *Streptococcus pneumoniae,* hepatitis B and hepatitis A. The Immunization (Hib) Program has developed and trained a network of regional immunization coordinators and educated tribal staff on immunizations and vaccine delivery to increase the level of immunization coverage in children. These efforts have achieved vaccine coverage levels of over 90% in Alaska Native 2 year olds and led to a >10 fold decrease in the above Hib, hepatitis A, and vaccine type *S. pneumoniae* In the past, State Public Health Nurses administered up to half of childhood vaccinations. Because of the current State fiscal crisis, the State Public Health Nursing program is anticipating major cuts in travel and itinerant nursing positions. This State fiscal crisis has led to new strains on the tribal organizations:

- More vaccine for villages is being shipped from tribal facilities.
- More vaccines are being stored in tribal pharmacies. This new challenge has led to several vaccine storage problems.
- Community health aides are responsible for administering a larger proportion of vaccines than ever before.

The Immunization Program is using program funding and traveling at the invitation of tribal corporations to provide increased training and direction for tribal programs, resulting in:

- Increased travel to tribal facilities to train staff and monitor vaccine storage.
- Increased training of Community Health Aides in vaccination.
- Increased collaboration with the State to develop standard storage guidelines.
- Increased technical assistance regarding refrigerators, thermometers etc.

In addition to the challenge of increased responsibility for vaccine delivery, there is a new national initiative to target adult vaccination. Vaccine-preventable disease, notably

Streptococcus pneumoniae occurs at a high rate in Alaska Native adults. The Immunization Program received grant funding from NIH to study adult pneumococcal disease, to evaluate current adult vaccination rates in Alaska Natives, and to develop new patient educational brochures and videos.

In addition to direct program activities, the Immunization Program consultant collaborates with Arctic Investigation Program – CDC to conduct surveillance for Hib and *S. pneumoniae* in Alaskans in order to develop the best vaccination strategy for Alaska Natives. We also monitor respiratory disease hospitalization in southwest Alaska to develop and monitor prevention strategies such as passive prophylaxis. Lastly, we serve on a national workgroup to update and revise the IHS computerized vaccine registry and provide consultation on IHS vaccine recommendations.

To address these new challenges, the Immunization Program has obtained outside grant funding through Native American Research Centers for Health, and is collaborating with partners including the State Immunization Program, Arctic Investigations Program-CDC, tribal pharmacists, tribal Community Health Aide programs. We do not expect increases from other sources in the current budget or FTEs beyond the current level.

PERFORMANCE ANALYSIS

The Hepatitis Program is directly linked to GPRA measures 24 and 25, which focus on childhood and adult immunization rates.

- The Immunization (Hib) Program has increased immunization delivery, immunization reporting and immunization rates among tribal corporations. Currently, 12 tribal corporations report 3-27 month immunization rates quarterly – this comprises over 90% of the Alaska Native user population for this age group.

- According to the 2001 National Immunization Survey, Alaska Native children have higher 2-year-old immunization rates than non-Alaska Natives and the U.S. general population. The 2-year old immunization rate among Alaska Natives monitored by the program was 85%, compared with the national average of 77%.

- There has been a 90% decrease in vaccine-type pneumococcal cases among Alaska Natives < 2 years old. Only 3 Hib disease cases have occurred in the past 3 years.

- Alaska Native elders (65+ years) have very high rates of pneumococcal vaccination (86%) compared with the national average (63%) according to a survey of 4 tribal regions.

- The Hepatitis Program has decreased the annual incidence of acute symptomatic hepatitis B infection from 215 per 100,000 prior to 1982, to < 2 per 100,000, more than a 100-fold decrease. In addition 1,300 Alaska Natives who are chronically infected with hepatitis B are monitored twice a year for cancer screening and development of active liver disease and cirrhosis so early intervention with antiviral

therapy or surgery for liver cancer can be performed. This represents an increase in visits from 3,400 to 3,900 per year.

- The Hepatitis Program is conducting studies on the immunogenicity, safety and long-term efficacy of hepatitis A and B vaccines in infants and adult with 1,050 patients enrolled, which is an increase of 250 patient visits over the previous reporting period.

- The Hepatitis Program monitors over 1,500 Alaska Natives with hepatitis C infection twice yearly for AFP testing to detect liver cancer early and perform liver function tests to identify potential treatment candidates. This represents an increase in the total number of patients followed per year by 500 and an increase in clinical evaluations of 1,000 per year.

- The Hepatitis B Program is currently developing an active program to diagnose, evaluate and counsel patients with non-alcoholic fatty liver (NAFLD). We anticipate a huge increase in number of patients with this condition as it is part of the metabolic syndrome which is a result of the epidemic of obesity in Alaska Natives.

GPRA Indicators:

Indicator 24: Increase the rates for all recommended immunizations for American Indian and Alaska Native children ages 3-27 months by 2% over FY 2003; and establish baseline rates for recommended immunizations for AI/AN children 19-35 months.

- The immunization rate for Alaska Native 3-27 month olds increased from 76.5% in FY03 to 77.5% in FY04
- 3 while reporting on 560 additional Alaska Native children. We have established a baseline rate for Alaska Native children 19-35 months of 82%.

Indicator 25: Increase overall influenza vaccination levels among diabetics and adults aged 65 years and older at FY 03 level.

- The FY2004 GPRA Influenza rate for Alaska Native adults aged 65 and older is 52.4% compared with the IHS average of 53.5%.

Indicator 26: Increase overall pneumococcal vaccination levels among AI/AN diabetics and elderly at FY 03 level.

- The FY2004 GPRA pneumococcal rate for Alaska Native adults aged 65 years and older is 85.7% compared with the IHS average of 67.1%.

At proposed levels of funding we will be able provide the same level of service and continue to augment our activities with grants and outside funding.

FUNDING HISTORY – Funding for the Hepatitis B and Haemophilus Immunization Program during the last 5 years has been as follows:

Fiscal Year	Amount	FTE
2001	$1,471,000	0
2002	$1,526,000	0
2003	$1,556,000	0
2004	$1,561,000	0
2005	$1,604,000	0

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request of $1,645,000 is an increase of $73,000 over the FY 2005 Enacted level of $1,572,000. The increase will provide for:

Pay Costs: +$27,000 for tribal pay increases
Inflation: +$24,000 for inflationary costs
Population Growth: +22,000 for increases in population

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Department of Health and Human Services
Indian Health Services
Services – 75-0390-0-1-551
URBAN INDIAN HEALTH

Authorizing Legislation: Title V, P.L. 94-437, Indian Health Care Improvement Act, as amended.

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	Increase or Decrease
BA	$31,619,000	$31,816,000	$33,233,000	+$1,417,000
FTE	9[1]	11	11	0

[1/] Includes 5 Albuquerque IHS Dental Clinic direct hires, 3 OUIHP HQE Staff, and 1 MOA at the Seattle Indian Health Board

Program Output Data

	FY 2003	FY 2004	FY 2005	FY 2006
Services Provided	**Actual**	**Estimate**	**Estimate**	**Estimate**
Medical	210,056	210,056	210,056	218,878
Dental	53,215	53,215	53,215	55,450
Outreach/Community Services	157,671	157,671	157,671	164,293
Other	252,599	252,599	252,599	263,208
Total	**673,541**	**673,541**	**673,541**	**701,829**

STATEMENT OF THE BUDGET REQUEST

The FY 2006 budget request of $33,233,000 for Urban Indian Health will assure that culturally appropriate and sensitive approaches of access to preventive and primary health care and alcohol and substance abuse services continue to reach targeted American Indian/Alaska Native (AI/AN) populations in urban areas throughout the United States. By reducing cultural and logistic barriers and increasing access to health care services for AI/ANs residing in urban areas, Title V funded Urban Indian Organizations (UIOs) contribute to the achievement of the two most critical HHS Strategic Plan Objectives relative to the health status of AI/AN people: Objectives 3.4-Eliminate racial and ethnic health disparities and 3.6-Increase access to health services for AI/ANs.

PROGRAM DESCRIPTION

The IHS addresses the nation's special responsibilities and legal obligations to elevate the health status and reduce the health disparities gap of AI/ANs residing in urban areas by funding, through contracts and grants, 34 urban Indian 501(c)(3) non-profit organizations providing health care services in 41 sites throughout the U.S. In addition to the 34 health programs, there are 10 Alcohol/Substance Abuse Programs funded with Urban Title V funds. Of those 10 programs, 8 are merged with an urban health program, with the remaining 2 operating as stand-alone programs. The organizations define their scopes of services based upon the documented and unmet needs of the urban AI/AN communities they serve and are governed by Boards of Directors of whom at least 51% are AI/AN.

Proposed Distribution of Urban Indian Health Program Funds - FY-2006

Operating Budget	IHS	$ 1,660,993
	Urban Coordinators/IHS Area Offices	83,900
Title V Contracts	34 Urban Health Programs and 10 Alcohol/Substance Abuse Programs	22,865,046
Title V Grants	34 Urban Indian Programs	7,584,941
Cooperative Agreement Grant	National Council of Urban Indian Health	412,640
Data Contract	Other Contractors	104,000
Direct Services	Albuquerque	521,480
Total		**$33,233,000**

The **Operating Budget** provides for the IHS in assuring the provisions of Title V are carried out and for providing central oversight of the programs and services authorized by Title V. Additionally, **Training and Technical Assistance Funds** are provided to the Area Urban Program Coordinators at 11 of the 12 IHS Area Offices. The Coordinators work to ensure contract/grant compliance, as well as compliance with statutes, and serve as the liaison between IHS and the Title V funded UIOs.

34 Contracts provide for health services, ranging from the provision of outreach and referral to limited or comprehensive ambulatory health care.

34 Grants provide for a variety of alcohol/substance abuse, mental health, immunization, and health promotion/disease prevention services.

10 Alcohol/Substance Abuse contracts/grants provide for an array of alcohol and substance abuse prevention, education, treatment, and rehabilitation services.

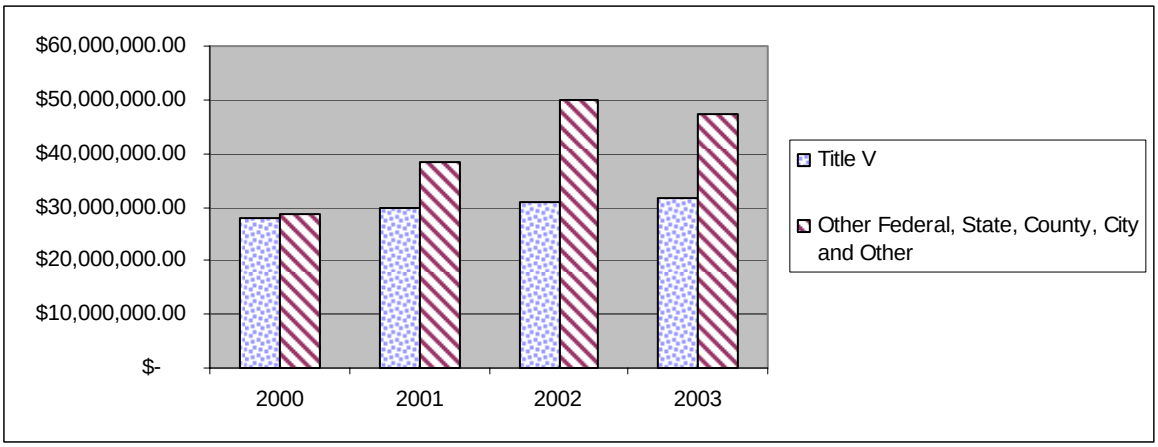
The **National Council of Urban Indian Health** operates under a Cooperative Agreement to support and develop quality accessible health care programs for all AI/ANs living in urban communities through advocacy, education, training and leadership development.

The IHS contracts with a Buy-Indian contractor responsible for the compilation of the **Urban Indian Health Program Common Reporting Requirements (UCRR) report** data submitted yearly by all UIO contractors/grantees. The UCRR provides information on activities conducted by the contractors/grantees and an accounting of the amounts and purposes for which Federal funds have been expended.

$540,000 is administered by the Albuquerque Area IHS for the Albuquerque Indian Dental Center to provide dental services**.**

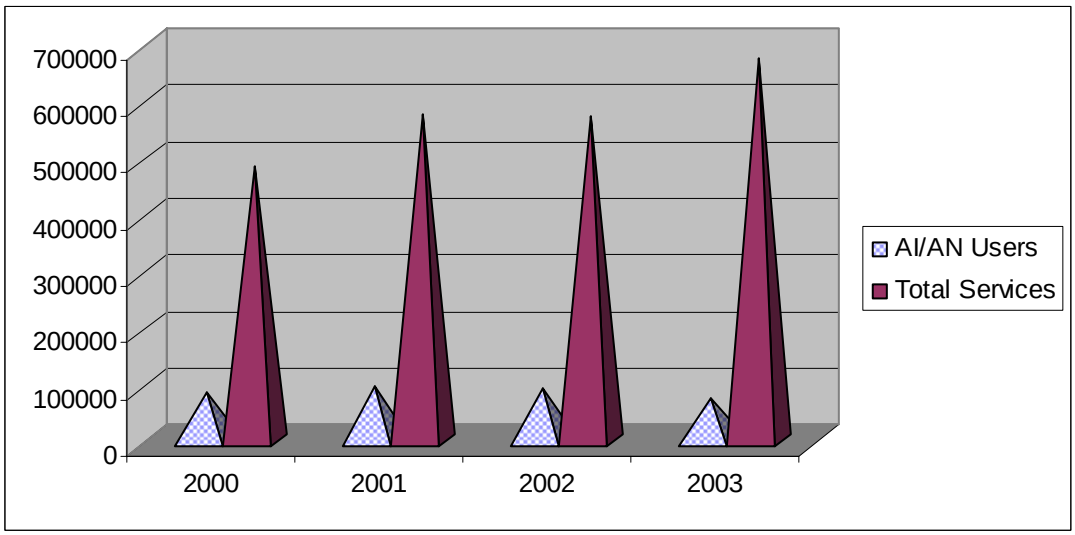
Geographic differences, funding resources and barriers to accessing existing community health providers and/or facilities vary by area. In order to meet the needs of the greatest number of AI/ANs living in urban areas, UIOs have used Title V resources to successfully leverage additional funding from other federal, state, county, city and private sources, as shown below in Chart 1:

Chart 1



While the majority (60+%) of AI/ANs now reside in urban areas, they represent a small percentage of the U.S. total urban population and are often times not included in the community health planning process. It is only the advocacy and partnership efforts of the UIOs that create inroads and access points to a system that is very challenging for the individual AI/AN to utilize. Although UIOs face different problems including, but not limited to, local health care infrastructures that are overburdened and State budget shortfalls/cutbacks, they provide a specific focus on the burden of disease within the AI/AN urban community where there are some of the greatest rates of disease of all ethnic groups. Although the number of AI/ANs served by UIOs from FY 2000-2003 has declined a small degree, the number of services provided to those users significantly increased over the same period of time, as indicated in Chart 2:

Chart 2



The Urban Indian Health Institute's recently published report, The Health Status of Urban American Indians and Alaska Natives, An Analysis of Select Vital Records and Census Data Sources, is intentionally limited to the U.S. counties served by the 34 Title V funded urban Indian organization contractors/grantees and found, *"SES* (Population Statistics and

Socioeconomic Status) *and health indicators from census and selected vital record sources demonstrating both progress toward better health among Indians living in UIHO* (urban Indian health organization) *areas, and also the existence and continuation of substantial health disparities when compared to the general population."*

PERFORMANCE ANALYSIS

The collection of data is integral to support the Urban Indian Health funding need and is necessary for the development of baselines and targets for new measures, as indicated by the findings of the OMB PART review of the Office of Urban Indian Health Programs. The program office has adopted specific annual and long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program.

FY 2004 Indicator 18: During FY 04, IHS developed a specific minimum data set as well as appropriate language for the urban Contracts and Grants. **IHS met this indicator** and surpassed it through the collective efforts of the Office of Urban Indian Health Programs' and the Indian Health Performance Evaluation System staffs in developing the urban Indian health care data mart within the IHS data warehouse and with the establishment of an urban Indian health data workgroup that continues its work toward the accomplishment of our FY 2005 and FY 2006 GPRA Indicators, as follows:

FY 2005 Indicator: During FY 05, IHS will have in place contract and grant requirements for all urban Indian programs to provide a specified data set in a standard format.

FY 2006 Indicator: During FY 06, IHS will establish baselines that capture, within the Indian health system, the health status and patient care data of AI/ANs residing in urban areas.

The successful accomplishment of these indicators will aid in the establishment of new IHS performance measures and will allow for a more notable Urban Indian Program contribution to the agency's long-term effort to derive GPRA performance data directly from automated information systems.

In addition, the program has adopted specific annual and long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program, in response to the OMB PART review. These **long-term performance measures** for the AI/AN population served by the UIOs are to: (**a**) decrease the Years of Potential Life Lost; (**b**) increase ideal blood sugar control for those diagnosed with diabetes based on the American Diabetes Association Guidelines; and (**c**) decrease obesity rates in children age 2-5 years.

The changes to improve IHS urban business processes, the adoption of specific performance measures and the building of infrastructure allow for more notable contribution to the agency's GRPA indicators that address **Data Quality Improvement, Consultation Process Improvement, Public Health Infrastructure** and **Advocacy,** as

well as contributing to the realization of the **IHS Strategic Goals** of: **Building Healthy Communities, Achieve Parity in Access by 2010** and to **Embrace Innovation**.

FUNDING HISTORY—Funding and FTE for Urban Indian Health during the last 5 years have been as follows:

Fiscal Year	Amount	FTE
2001	$29,843,000	5
2002	$30,947,000	5
2003	$31,528,000	6
2004	$31,619,000	9
2005	$31,816,000	11

RATIONALE FOR BUDGET REQUEST

The FY 2006 budget request of $33,233,000 and 11 FTE is an increase of $1,417,000 over the FY 2005 Enacted level of $31,816,000 and 11 FTE. The increase will provide:

Pay Costs: +$483,000 will fund federal and urban pay increases which will assist the IHS and the Title V funded urban Indian contractors and grantees in assuring that culturally appropriate and sensitive approaches of access to preventive and primary health care and alcohol and substance abuse services continue to reach targeted AI/AN populations in urban areas throughout the United States.

Inflation: +$485,000 will cover the increases in medical and other costs using the FY 2006 Economic Assumptions.

Population Growth: +$449,000 will allow Title V urban Indian organizations funds for the cost of the increasing AI/AN population and to maintain the current level of services.

Department of Health and Human Services
Indian Health Service
Services – 75-0390-0-1-551
INDIAN HEALTH PROFESSIONS

Authorizing Legislation: Indian Health Care Improvement Act, Pub.L. 94-437, as amended, Title I and section 217.

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	Increase or Decrease
BA	$30,774,000	$30,392,000	$31,503,000	+$1,111,000
FTE	32	32	32	0

STATEMENT OF THE BUDGET REQUEST

The Indian Health Professions budget request of $31,503,000 in FY 2006 supports scholarships, loan repayments, and recruitment and retention of health professionals.

PROGRAM DESCRIPTION

The purpose of this program is fourfold: (**1**) to enable American Indian and Alaska Native people (AI/AN) to enter the health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs; (**2**) to serve as a catalyst to the development of Indian communities by providing educational opportunities and enabling AI/AN health care professionals to further Indian self-determination in the delivery of health care; (**3**) to develop and maintain American Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental health field; and (**4**) to assist Indian health programs to recruit and retain qualified health professionals. To accomplish these purposes, funds will be distributed among several different programs as follows:

Proposed Distribution of Indian Health Professions Funds in FY 2006

Section	Title	Amount	Expected Outcome
103	Health Professions Preparatory Scholarship Program for Indians	$3,768,857	122 agreements, both new and continuing. Historically, we have been able to fund approximately 15% of the qualified applications.
104	Indian Health Professions Scholarship	$10,277,093	306 contracts, both new and continuing. Historically, we have been able to fund approximately 15% of the qualified applications.
105	Indian Health Service Extern Programs	$1,196,908	200 temporary clinical

			assignments
108	Indian Health Service Loan Repayment Program An increase of $1,244,202 is included in this program. These funds were reallocated from 3 less effective programs authorized by sections 102, 110 and 120, of the Indian Health Care Improvement Act.	$12,638,455	476 contracts in FY 2004. Another 298 people who are working at Indian health facilities were not funded because funds were not available.
112	Quentin N. Burdick American Indians into Nursing Program	$1,735,500	6 grants
114	INMED Program	$1,136,187	2 grants
217	American Indians into Psychology Program	$750,000	3 grants
TOTAL		**$31,503,000**	

PERFORMANCE ANALYSIS

The Indian Health Professions Program supports self-determination and access to health care through efforts to enable American Indians and Alaska Natives to enter health professions, and effective recruitment of health staff by providing scholarships, loan repayment, temporary employment, and health professions recruitment.

The Indian Health Professions budget supports several performance areas that indirectly support the entire set of GPRA measures by developing the IHS workforce, i.e., providers and other professional staff. The scholarship program had 428 participants in FY 2004. They were distributed among its three sections as follows:

Section 103[1]	37
Section 103P[2]	85
Section 104[3]	306

[1]Section 103 is comprised of people in preparatory programs, such as prenursing, prepharmacy, prephysical therapy, etc.
[2]Section 103P is comprised of people in premedicine and predentistry programs.
[3]Section 104 is comprised of people in health professions education programs such as medical school, dental school, pharmacy school, nursing school, etc.

In FY 2004 there were 791 people in the IHS loan repayment program, broken down as follows:

New awards[1]	242
Contract extensions[2]	234
New awards in FY 2003[3]	315

[1]All new contracts are for 2 years.
[2] Extensions can be made one year at a time after the first contract is completed.
[3]Initial contracts are for 2 years, so they do not appear in a count of awards made in a given year.

Health professionals provided temporary services to IHS facilities through direct employment into temporary positions, directly contracting with various facilities,

working with contract locum tenens companies, and volunteering their services for various periods of time.

The IHS has full time recruiters for physicians, nurses, and dentists. In addition, many health professional staff members assist in recruitment activities by visiting professional schools, attending professional meetings as IHS representatives, and acting as preceptors and mentors for health professional students who come to their facilities as part of their training. In addition to these activities, IHS efforts to address staffing shortfalls include, but are not limited to, the following:

- Establishing and maintaining a World Wide Web site that contains information regarding health professional needs at IHS, tribal, and urban Indian health facilities;
- Utilizing special pay and bonus authorities as much as possible;
- Establishing internship arrangements between IHS facilities and health profession training programs;
- Advertising in professional journals;
- Attending health fairs at colleges;
- Attending high school career days;
- Adding funds to the IHS Loan Repayment Program;
- Establishing special salary rates under the Title 38 authority;
- Sending direct mailings to practicing and student health professionals;
- Establishing seven Dental Clinical and Support Centers, whose activities include addressing the issues of recruitment and retention;
- Establishing workgroups of professionals to address the issues of recruitment and retention;
- Surveying current employees to see what attracted them to Indian health and what has made them stay on or may incline them toward leaving;
- Working with the National Health Service Corps to make Indian health facilities eligible to employ NHSC scholarship recipients;
- Encouraging high school and college students to enter the health professions;
- IHS Scholarship Programs;
- Tribal Matching Grants;
- Health Professions Recruitment and Retention Grants;
- Nursing Scholarship Program;
- Nursing Residency Program; and
- Advanced General Practice Residency Program for dentists

These programs all contribute to the IHS effort to recruit and retain compassionate, highly qualified health professionals. The more successful we are in these efforts, the healthier our communities become and the better access American Indian and Alaska Native people have to health care.

We still have many vacancies, as indicated by the following table.

Vacancy Rates for Selected Health Professions

1/2000 vs. 1/2004

Profession	Vacancy Rate 1/2000	Vacancy Rate 1/2004
Dentist	35%	24.0%
Nurse	11%	11.0%
Optometrist	14%	11.0%
Pharmacist	12%	6.5%
Physician	11%	11.0%

However, as the table also indicates, we are doing better overall than we were 4 years ago, even though we have more positions to fill. The scholarship and loan repayment programs have been major factors in this effort.

FUNDING HISTORY – Funding for Indian Health Professions during the last 5 years has been as follows:

Fiscal Year		FTE
2001	$30,386,000	20
2002	$31,165,000	21
2003	$35,373,000	24
2004	$30,774,000	31
2005	$30,392,000	32

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request of $31,503,000 and 32 FTE is an increase of $1,111,000 over the FY 2005 Enacted level of $30,392,000 and 32 FTE. The increase would provide for:

Pay Costs: +$44,000 for federal pay increases.

Inflation: +$1,067,000 in additional funding will cover the increases in medical and other costs using the FY 2006 Economic Assumptions.

Department of Health and Human Services
Indian Health Service
Services – 75-0390-01-551
TRIBAL MANAGEMENT

Authorizing Legislation: Indian Self-Determination and Education Assistance Act, Pub.L. 93-638, as amended, Section 103(b)(2) and 103(e); Pub.L. 100-472; Pub.L. 100-413.

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	Increase or Decrease
BA	$2,376,000	$2,343,000	$2,430,000	+$87,000
FTE	0	0	0	0

STATEMENT OF THE BUDGET REQUEST

The Tribal Management budget request of $2,430,000 funds grants to Tribes and Tribal organizations. The purpose of the program and grant awards is to assist Tribes and Tribal organizations in assuming all or part of existing IHS programs, services, functions, or activities. The IHS distributes the total appropriated amount into two parts; $2,330,000 is earmarked for grant awards and $100,000* is earmarked for program operations.

*Typically program operation costs are $60,000-$80,000 per fiscal year. Funds not used for program operations are distributed to supplement and/or award new grants.

PROGRAM DESCRIPTION

The Tribal Management Grant (TMG) Program is a competitive grant program that awards grants annually to Tribes and Tribal Organizations across the nation. The purpose of the TMG program is to assist Tribes and Tribal Organizations in assuming all or part of existing IHS programs, services, functions, and activities. Tribes and Tribal Organizations use TMG funding to enhance their management capabilities through a variety of projects including feasibility studies, Tribal-specific health plans, Tribal health program evaluations, and the development or improvement of Tribal health management structures such as establishing Tribal health boards and improving Tribal financial management systems.

PERFORMANCE ANALYSIS

The Tribal Management Grant (TMG) program's outcomes are consistent with the HHS Strategic Goal 5, "Improve the quality of health care services" as well as the IHS' Goal 3, "Provide compassionate, quality health care." The TMG program encourages Tribes and Tribal Organizations to be conscientious of the HHS and IHS goals and this is reflected in the projects undertaken in that Tribes and Tribal organizations continually work to improve the quality of care to their communities by achieving and maintaining, not only Federal standards/regulations but, applicable health care accreditations. A few examples

of these achievements include the establishment of and training for Tribal Health Boards which serve as a health advisory committee to Tribal councils as well as maintaining compliance by creating and implementing policies and procedures manuals in the areas of privacy, quality assurance, and medical records.

In Fiscal Year 2006, the TMG program anticipates awarding 20-30 new and continuation grants.

Fiscal Year	*Total Fund'g	*Prog. Oper.	*Grant Fund'g	**HMS Cont. Proj.	New Grant Awards				Total Grant Awards
					**HMS Projects	Plng Pro-jects	Eval-uation Projects	Feasi-bility Projects	
2002	$2,406	$92	$2,314	11	10	3	0	0	24
2003	$2,390	$63	$2,327	10	16	2	0	0	28
2004	$2,376	$81	$2,295	7	15	2	1	2	27
2005	$2,343	$100	$2,243	7	14	4	3	2	30
2006 Est.	$2,430	$100	$2,330	11					

*Dollar amounts are shown in thousands and rounded to nearest thousand
**Continuation projects are only Health Management Structure (HMS) projects – implementation of new management structures

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

Fiscal Year	Amount	FTE
2001	$2,406,000	0
2002	$2,406,000	0
2003	$2,390,000	0
2004	$2,376,000	0
2005	$2,343,000	0

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request of $2,430,000 is an increase of $87,000 above the FY 2005 Enacted level of $2,343,000. The increase of $87,000 will fund inflationary costs.

Department of Health and Human Services
Indian Health Service
Services – 75-0390-0-1-551
DIRECT OPERATION

Authorizing Legislation: Program authorized by 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	$60,714,000	$61,649,000	$63,123,000	+$1,474,000
FTE	357	387	387	0

STATEMENT OF THE BUDGET REQUEST

The Direct Operation's budget request of $63,123,000 in FY 2006 supports the IHS in carrying out its responsibility of providing leadership, oversight, executive direction and administrative support to 12 regional offices serving approximately 1.8 million American Indians and Alaska Natives across the U.S. The **budget funds Headquarters and 12 Area offices operations, and Tribal shares** (as indicated by the table below). The net increase would provide funds for personnel related pay cost and inflation.

(Dollars in Hundreds)

	FY 2004 Enacted	FY 2005 Enacted	FY 2006 Estimate
Headquarters (43%)	$26,107,020	$26,509,070	$27,142,890
Title I Contracts (non-add)	*1,786,819*	*1,8,13,621*	*1,840,825*
Title V Compacts (non-add)	*4,974,611*	*5,049,230*	*5,124,968*
Area Offices (12) (57%)	34,606,980	35,139,930	35,980,110
Title I Contracts (non-add)	*1,774,502*	*1,801,119*	*1,828,136*
Title V Compacts (non-add)	*6,885,417*	*6,988,698*	*7,093,528*
BA	**$60,714,000**	**$61,649,000**	**$63,123,000**
FTE	357	387	387
Headquarters	*202*	*217*	*217*
Area Offices (12)	*155*	*170*	*170*

PROGRAM DESCRIPTION

The Indian Health Service **Headquarters provides leadership, oversight, and executive direction to 12 regional offices** to ensure that comprehensive health care services are provided to American Indians and Alaska Natives. In addition, Headquarters **actively administers the Agency's accomplishment of the President's Management Agenda and HHS Secretarial priorities and initiatives**, while simultaneously maintaining the special Tribal-Federal relationship based in treaty and law.

The **Headquarters** operations are determined by statute and administrative requirements set forth by the Department of Health and Human Services, the Administration, the

Congress, and field operations (12 Area Offices, and 157 Service Units). Headquarters actively works with the Department to formulate and implement national health care priorities, goals, and objectives. The agency works with the Department to formulate a budget and necessary legislation. In addition, it responds to congressional inquiries, and interacts with other governmental entities to enhance and support health services for Indian people. The Headquarters also formulates policy and distributes resources, provides general program direction and oversight for IHS Areas and Service Units, provides technical expertise to all components of the Indian health system (I/T/U), maintains national statistics, identifies trends and projects future needs.

The **12 Area Offices** distribute resources, monitor and evaluate the full range of comprehensive health care and community oriented public health programs and provide technical support to IHS direct and tribally operated programs. They ensure the delivery of quality health care through the 157 Service Units and participate in the development and demonstration of alternative means and techniques of health services management and delivery to promote the optimal provision of health services to Indian people through the I/T/U.

PERFORMANCE ANALYSIS

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

Leadership and direction also includes specific focus on the PMA and Secretary's One Department initiative. The IHS will carry out and report on specific activities in the 5 government-wide objectives of the PMA. The Department tracks the performance of all HHS Operating Divisions by the use of a Management Scorecard which reflects the PMA objectives. For FY 2006, IHS activities will continue in the 5 objective areas: Strategic Management of Human Capital—performance contracts and workforce planning; Competitive Sourcing—Tribal self-determination; Improved Financial Performance—support the implementation timeline for the HHS Unified Financial Management System and continued audit improvements and fiscal monitoring; Expanded Electronic Government—support and implement current and planned e-Gov activities (e.g., e-grants, e-payroll, e-learning, e-travel, and e-OPF, automated position hiring and classification); and, Budget and Performance Integration—GPRA and OMB's Performance Assessment Rating Tool.

Significant activities include the establishment of performance plans that cascade throughout the agency and provide for performance accountability at all levels of the agency. This activity will be fully established in FY 2004 and refined in FY 2005 and FY 2006. Another activity is the complex planning and preparation of the implementation of the HHS Unified Financial Management System in the IHS in FY 2006. This system will substantially improve the management and accounting of

financial resources made available to the IHS. It will also enable the replacement of legacy support systems into a complete and comprehensive financial management system.

The Direct Operations budget contributes to the performance indicators that are included in the IHS Annual Performance Plan. The indicators address some of the administrative aspects of providing health care to American Indian and Alaska Native population. In addition, management improvements will be guided by the President's Management Agenda and the Secretary's One Department initiatives and goals.

Performance Plan FY 2006 -- The IHS FY 2006 Performance Plan complies with the requirements of the GPRA and the objectives contained in the President's Management Agenda (PMA), the One Department initiative of the Secretary of Health and Human Services (HHS), and the *HealthyPeople 2010* goals of achieving equivalent and improved health status for all Americans over the next decade. The long-term projected outcome of the FY 2006 Performance Plan has been enhanced (in FY 2004) to incorporate revisions to the IHS Strategic Plan and the new HHS Strategic Plan. For example, a roadmap table was developed that shows individual GPRA annual performance measures linked to specific long-term health outcome goals developed for the IHS Strategic Plan. The IHS and its stakeholders have always considered the GPRA and its requirements as a natural extension of the public health model the Agency has used effectively for almost a half century to make significant improvements in the health status of Indian people.

The Headquarters, through this activity, will continue to develop and expand its crosscutting collaborations and partnership with other Federal agencies and outside organizations to achieve common goals and objectives addressing health disparities of American Indian and Alaska Natives. The magnitude of health disparities and resources needed require crosscutting network, as well as challenges in meeting some GPRA performance measurements, and PMA objectives, such as (**a**) linking performance measurements to the budget and eventually to cost, and (**b**) Human Resources development, work life improvements, and recruitment and retention. Also, (**c**) the development and refinement of Information Technology Planning, Capital Planning, and Program Evaluation will continue as important challenges, as the environment changes in response to tribal contracting and compacting, changes in technology, and health care in the U.S.

The restructuring of its Headquarters' organization will demonstrate increased leadership and advocacy, while improving the Agency's responsibilities for oversight and accountability. It will be delayered and broader in capacity to be more responsive to Tribal governments, Indian organizations, HHS, and others who have an interest in the provision of comprehensive health care to American Indian and Alaska Natives. This new organization will enable it to more effectively meet the goals of the PMA and Secretary's One Department program and management initiatives.

FUNDING HISTORY – Funding for the Direct Operation during the last 5 years has been as follows:

Fiscal Year	Amount	FTE
2001	$52,946,000	1,629
2002	$55,323,000	1,483
2003	$55,312,000	334
2004	$60,714,000	357
2005	$61,649,000	387

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request of $63,123,000 and 387 FTE is an increase of $1,474,000 over the FY 2005 Enacted level of $61,649,000 and 387 FTE. The increase will provide:

Pay Cost: +$1.117 million for federal and tribal pay increases. The provision of these funds is necessary to maintain the current I/T/U health system which works to eliminate disparities in health status between the American Indian and Alaska Native population and the rest of the U.S.

Inflation: +$357,000 – The additional funding will cover the increases in costs using the FY 2006 Economic Assumptions.

Department of Health and Human Services
Indian Health Service
Services – 75-0390-01-551
SELF GOVERNANCE

Authorizing Legislation: Program authorized by Title V, Tribal Self-Governance, P.L. 93-638, Indian Self Determination and Education Assistance Act, as amended.

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	Increase or Decrease
BA	$5,644,000	$5,586,000	$5,752,000	+$166,000
FTE	8	8	8	0

STATEMENT OF THE BUDGET REQUEST

With this budget request of $5,752,000, the Office of Tribal Self-Governance will provide technical assistance to approximately 350 tribes and tribal organizations, fund up to 20 tribes with planning and negotiation grants, continue to fund the GPRA pilot projects, also provide the areas and headquarters programs any shortfall funding needs they may incur when providing tribal shares to any new tribes entering self-governance.

PROGRAM DESCRIPTION

In FY 1992, Indian Health Service (IHS) was instructed by Congress to initiate planning activities with tribal governments with approved Department of Interior self-governance compacts for the development of a Self-Governance Demonstration Project as authorized by P.L. 100-472. Through enactment of P.L. 102-573, the Indian Health Care Amendments of 1992, authority to fund the tribal self-governance demonstration projects (SGDP) was extended to IHS and the Office of Tribal Self-Governance was established. Through enactment of P.L. 106-260, the Tribal Self-Governance Amendments of 2000, permanent authority was given to Title V, Tribal Self-Governance. Since 1993, the IHS, in conjunction with Tribal representatives, has been engaged in a process to develop methodologies for identification of Tribal shares for all Tribes. Tribal shares are those funds historically held at the Headquarters and Area organizational levels of the IHS. **In FY 2006 approximately $1.022 billion will be transferred to support 102 compacts.**

In **FY 2006** the funding for Self-Governance of $5.75 million would provide: the Office of Tribal Self-Governance operating budget of $2.40 million and a reserve for any shortfalls of $3.35 million. The **reserve funds** are used (**1**) to ensure that funding of tribal shares under Self-Governance compacting does not adversely impact non-Self-Governance Tribes. These funds are provided directly to the Self-Governance Tribes or to Area Offices and/or Headquarters programs and the Office of Tribal Self-Governance so that Self-Governance Tribes may receive their full funding of tribal shares as provided for in P.L. 106-260, (**2**) for Self-Governance costs incurred as the result of special circumstances, and (**3**) to support special projects that enhance Self-Governance Activities.

PERFORMANCE ANALYSIS

The Self-Governance budget does not directly support any individual GPRA performance measure and has not been evaluated under the Program Assessment Rating Tool (PART) as it serves to support a system of care implemented at the local level by Tribal governments through their Compacts and Funding Agreements. In this way, the Self Governance budget indirectly supports many of the GPRA clinical measures through its support of tribal health care systems at the local level.

The Self Governance budget further supports accomplishments through:

- funding of Government Performance and Results Act (GPRA) pilot projects throughout the country to enhance GPRA data collection and performance;
- providing for the purchase of the Medical Education Technologies, Inc. Human Patient Simulator, adult and child, complete with maintenance agreement, Weapons of Mass Destruction training component and all other components for national Emergency Medical Services training purposes for all tribes and tribal organizations;
- providing resources for a Best Practices project to compile and document the successful outcomes of the Self-Governance tribes. Some examples of such are:
  - the development of the Ketchikan Indian Corporation health clinic so that pregnant mothers no longer have to fly 60 miles to deliver their babies;
  - the implementation and operation of the Northwest Indian Treatment Center;
  - the use of village members to serve as health aides;
  - the use of traditional medicine in the health system;
  - the Family Wellness Warriors Initiative and their collaboration with a faith-based organization to heal families of sexual and domestic abuse;
- supporting the Patient Administrative Management System, which will help with improved data collection for all tribes and tribal organizations.

Therefore, while OTSG does not directly control the assessment of these tribal programs and services it supports tribal efforts to pursue their local goals through special programs, advocacy, technical assistance and administrative support.

FUNDING HISTORY – Funding for the Self Governance during the last 5 years has been as follows:

Fiscal Year	Amount	FTE
2001	$9,803,000	8
2002	$9,876,000	8
2003	$5,553,000	8
2004	$5,644,000	8
2005	$5,586,000	8

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request of $5,752,000 and 8 FTE is an increase of $166,000 over the FY 2005 Enacted level of $5,586,000 and 8 FTE. The increase will fund:

Pay Cost: +$18,000 for federal pay increases
Inflation: +$148,000 for inflationary costs

Department of Health and Human Services
Indian Health Service
Services – 75-0390-01-551
CONTRACT SUPPORT COSTS

Authorizing Legislation: Indian Self-Determination and Education Assistance Act, Public Law 93-638, as amended, Section 106(a)(2) and (3).

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	Increase or Decrease
BA	$267,398,000	$263,683,000	$268,683,000	+$5,000,000
FTE	0	0	0	0

STATEMENT OF THE BUDGET REQUEST

The Indian Health Service (IHS) requests $268,683,000 in funding for contract support costs (CSC) which are required to be provided to Tribal governments and tribal organizations to assist in establishing and maintaining support systems (e.g., administrative and accounting systems) needed to administer self-determination agreements and to ensure compliance with the contract and prudent management. Five million ($5,000,000) of the requested amount will provide CSC support for new Indian self-determination contracts. Specifically, it is estimated that 18 - 20 tribal requests for CSC associated with the assumption of IHS programs will be funded from the $5,000,000 increase.

PROGRAM DESCRIPTION

The Indian Self-Determination and Education Assistance Act (ISDEAA) allows Tribes to assume operation of Federal programs and to receive not less than the amount of direct program funding that the Secretary would have otherwise provided for the direct operation of the program. The ISDEAA also provides that there be added to the program amount, CSC. CSC are defined in the ISDEAA as the reasonable costs for activities either not normally provided by the Secretary in his/her direct operation of the program, or were provided by the Secretary in support of the program from resources other than those under contract.

Specific elements of CSC include:

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

The IHS has had a CSC policy in existence since 1992 that governs the administration and allocation of CSC in the Agency. The policy was developed through extensive

consultation and participation of tribes. The original policy has been revised on several occasions, most recently September 1, 2004, based on the Agency's accumulated experiences and discussion with tribal leaders. The policy conforms to applicable OMB cost principles.

PERFORMANCE ANALYSIS

Funding appropriated for CSC increased significantly in fiscal years 1999 through 2002 but has actually decreased between fiscal years 2002 and 2005. The Congress and the Office of Management and Budget have requested that the IHS continue to review the soundness of its allocation policies concerning CSC and to take steps to assure that CSC provided to tribes are reasonable and do not duplicate other funding provided to tribes by the IHS under self-determination agreements. Consequently, the IHS established an element under the Government Performance and Results Act (GPRA) to provide specific technical assistance to tribes in the area of calculating CSC, and to review each tribal request that is submitted for CSC using a protocol to ensure that CSC that are approved are consistent throughout the IHS system and not duplicative of other funding provided to tribes.

The IHS has successfully addressed this GPRA indicator by providing wide spread technical assistance to tribes regarding the calculation of CSC as defined by requirements articulated in the Agency's CSC Policy (i.e., IHS CSC Circular 2004-03). In addition, the IHS has implemented, in the Agency's most recent CSC Circular, protocols, "Standards for the Review and Approval of Contract Support Costs in the Indian Health Service," to ensure the consistency, as well as non-duplication, of all types of costs approved as CSC in the IHS.

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

Fiscal Year	Amount	FTE
2001	$248,234,000	0
2002	$268,234,000	0
2003	$270,734,000	0
2004	$267,398,000	0
2005	$263,683,000	0

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request of $268,683,000 is an increase of $5,000,000 above the FY 2005 enacted budget of $263,683,000. The increase will cover the contract support costs of the estimated number of new contract requests IHS anticipates receiving in FY 2006.

Department of Health and Human Services
Indian Health Service
Services – 75-0390-01-551
CONTRACT SUPPORT COSTS

Authorizing Legislation: Indian Self-Determination and Education Assistance Act, Public Law 93-638, as amended, Section 106(a)(2) and (3).

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	Increase or Decrease
BA	$267,398,000	$263,683,000	$268,683,000	+$5,000,000
FTE	0	0	0	0

STATEMENT OF THE BUDGET REQUEST

The Indian Health Service (IHS) requests $268,683,000 in funding for contract support costs (CSC) which are required to be provided to Tribal governments and tribal organizations to assist in establishing and maintaining support systems (e.g., administrative and accounting systems) needed to administer self-determination agreements and to ensure compliance with the contract and prudent management. Five million ($5,000,000) of the requested amount will provide CSC support for new Indian self-determination contracts. Specifically, it is estimated that 18 - 20 tribal requests for CSC associated with the assumption of IHS programs will be funded from the $5,000,000 increase.

PROGRAM DESCRIPTION

The Indian Self-Determination and Education Assistance Act (ISDEAA) allows Tribes to assume operation of Federal programs and to receive not less than the amount of direct program funding that the Secretary would have otherwise provided for the direct operation of the program. The ISDEAA also provides that there be added to the program amount, CSC. CSC are defined in the ISDEAA as the reasonable costs for activities either not normally provided by the Secretary in his/her direct operation of the program, or were provided by the Secretary in support of the program from resources other than those under contract.

Specific elements of CSC include:

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

The IHS has had a CSC policy in existence since 1992 that governs the administration and allocation of CSC in the Agency. The policy was developed through extensive

consultation and participation of tribes. The original policy has been revised on several occasions, most recently September 1, 2004, based on the Agency's accumulated experiences and discussion with tribal leaders. The policy conforms to applicable OMB cost principles.

PERFORMANCE ANALYSIS

Funding appropriated for CSC increased significantly in fiscal years 1999 through 2002 but has actually decreased between fiscal years 2002 and 2005. The Congress and the Office of Management and Budget have requested that the IHS continue to review the soundness of its allocation policies concerning CSC and to take steps to assure that CSC provided to tribes are reasonable and do not duplicate other funding provided to tribes by the IHS under self-determination agreements. Consequently, the IHS established an element under the Government Performance and Results Act (GPRA) to provide specific technical assistance to tribes in the area of calculating CSC, and to review each tribal request that is submitted for CSC using a protocol to ensure that CSC that are approved are consistent throughout the IHS system and not duplicative of other funding provided to tribes.

The IHS has successfully addressed this GPRA indicator by providing wide spread technical assistance to tribes regarding the calculation of CSC as defined by requirements articulated in the Agency's CSC Policy (i.e., IHS CSC Circular 2004-03). In addition, the IHS has implemented, in the Agency's most recent CSC Circular, protocols, "Standards for the Review and Approval of Contract Support Costs in the Indian Health Service," to ensure the consistency, as well as non-duplication, of all types of costs approved as CSC in the IHS.

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

Fiscal Year	Amount	FTE
2001	$248,234,000	0
2002	$268,234,000	0
2003	$270,734,000	0
2004	$267,398,000	0
2005	$263,683,000	0

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget request of $268,683,000 is an increase of $5,000,000 above the FY 2005 enacted budget of $263,683,000. The increase will cover the contract support costs of the estimated number of new contract requests IHS anticipates receiving in FY 2006.

Department of Health and Human Services
Indian Health Service
Services – 75-0390-0-1-551
HIV/AIDS

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	$2,629,000	$2,678,000	$2,790,000	+112,000
FTE	0	0	0	0
Risk Assessment & Prevention Surveillance:				
1. HIV Surveillance Population-Based Res: Nat.Hist., Trans, Risk Factors	1,051,000	1,071,000	1,116,000	+45,000
Subtotal, Risk Assessment & Prevention Surveillance	**1,051,000**	**1,071,000**	**1,116,000**	**+45,000**
Information & Education/Prevention Services:				
1. High Risk or Infected Persons: a. Counseling, Testing & Partner Notification	237,000	241,000	251,000	+10,000
2. School & College Aged Youth a. Program Development & Training	237,000	241,000	251,000	+10,000
3. General Public & Special Programs a. Regional, State, & Local	867,000	884,000	921,000	+37,000
4. Health Care Workers & Providers a. Other Types of Training	237,000	241,000	251,000	+10,000
Subtotal – Information & Education/ Prevention Services (1-4)	**1,578,000**	**1,607,000**	**1,674,000**	**+$67,000**
TOTAL – IHS HIV-AIDS:	**$2,629,000**	**$2,678,000**	**$2,790,000**	**+$113,000**

STATEMENT OF THE BUDGET

The HIV/AIDS budget of $2,790,000 supports IHS and tribal HIV/AIDS programs. Funds support prevention activities within their respective communities, which includes counseling, testing, partner notification, outreach to children and youth, and training to health care providers in IHS and tribal health care facilities.

PROGRAM DESCRIPTION

The IHS HIV/AIDS budget supports hospitals/clinics that provide services to clients/ patients that have HIV/AIDS. The program performs the following:

1. Risk Assessment and Prevention Surveillance
2. Provision of HIV/AIDS information and education
3. Encouragement of counseling, testing and partner notification
4. HIV prevention education specific to children and youth

5. Training of health care providers in the latest HIV/AIDS treatment techniques
6. Reporting of HIV/AIDS surveillance data to CDC through State health departments

In addition, IHS HIV/AIDS Program depends largely on services from other agencies to carry out the needs of the American Indian and Alaska Native (AI/AN) in prevention of HIV/AIDS. The Department of Health and Human Services (DHHS) Secretary's Emergency Fund distributed through the Minority AIDS Initiative (MAI) has been instrumental in assisting IHS HIV/AIDS Program to use these funds to collaborate with other HHS agencies in providing training, and outreach to children and youth. Other funds have become available from Health Resources and Services Administration (HRSA) through grants that allow AI/AN organizations and Indian Urban Centers to apply. HRSA also has made funds available for the Indian Health Service through some of its outreach programs. In FY 2004, HRSA developed a collaborative effort with IHS to reduce health disparities in chronic and other diseases; increase the supply of health professionals available to provide health care in Indian country; and actively promote HIV/AIDS prevention and treatment within the AI/AN population.

One of the Minority AIDS Initiative goals was to improve the surveillance data reported to CDC from the Indian Health Service, tribally administered healthcare facilities and urban Indian centers and state health departments. The accomplishment from this initiative is that all states and territories now report HIV and AIDS to CDC that began in December 2002. Data will now include all those states that did not report HIV previously where there were significant numbers such as in Indian reservations and rural areas within the IHS (examples include Alaska, California, New York and the upper-Midwest states). The information will be published in the CDC Annual HIV/AIDS Surveillance Report.

With this accomplishment the MAI diverted the FY 2004-2005 funds to the HHS Secretary's initiative to test for HIV in those 140,000 people in the United States that do not know they are infected. Demonstration projects for implementation of Rapid HIV Testing began in September 2004. The HHS Secretary's goal is to reduce the number of new infections caused by HIV in the United States by emphasizing greater access to HIV testing and provision of prevention and care services for persons infected with HIV. All HHS agencies are required to participate in this initiative.

Another emphasis is to train classroom teachers in the use of HIV/AIDS curriculums for children and youth. The training of teachers includes Bureau of Indian Affairs Schools, and States that have significant numbers of AI/AN children that have children and youth in public schools (an example are AI/AN children and youth that live in rural areas instead of reservations and Indian children in urban/metropolitan areas).

Another initiative is to provide training to healthcare providers through the use of HRSA's AIDS Education Training Centers (AETC). The 2003-2004 MAI funding enables the IHS AIDS Program and HRSA to collaborate in providing direct training to healthcare providers. The training will include the latest treatment techniques for

HIV/AIDS clients/patients. This training is being provided to IHS, tribal and urban Indian centers throughout the United States. Training may be set-up at a central location within an IHS/tribal Area/ and IHS/tribal healthcare facility, or at an AIDS Education and Training Center that located in proximity to IHS/Tribal Areas.

The IHS/CDC DASH will provide training to classroom teachers in BIA schools this year. The HHS Secretary's MAI contributed $500,000 to this initiative. The CDC DASH provides, through an IAA with the BIA, an additional amount of approximately $200,000 to fund a contractor to work with BIA school teacher training in HIV/AIDS curriculums, but also work with developing HIV/AIDS curriculums that will be AI/AN specific. CDC provides funding in the form of grants to states that have significant numbers of AI/AN children in public schools.

PERFORMANCE ANALYSIS

The purpose of indicator 33 is to reduce the spread of HIV infections in American Indian and Alaska Native communities.

New HIV infection cases averaged 120 per year for males, but it is starting on another upward trend which is also happening on a national scale. The female HIV infection rate continues on an upward trend. The surveys of prenatal, sexually transmitted diseases (STD) and alcohol and drug abuse treatment programs have proven the presence of the virus in virtually all remote AI/AN communities.

The IHS did not meet this GPRA indicator in FY 2004. The indicator called for determining the percentage of high-risk sexually active persons who have been tested for HIV at an additional 10 sites. IHS was not able to meet this target because of difficulty in expanding the IDWeb project in FY 2004**.**

In FY 2005 this indicator will change to tracking HIV rates in pregnant women. This measure reflects the current CDC recommendations for screening pregnant women. (Indicator 33: Support screening for HIV infections in appropriate population groups)

RATIONALE FOR THE BUDGET

The FY 2006 budget of $2,790,000 is an increase of $112,000 over the FY 2005 Enacted budget of $2,678,000.

Department of Health and Human Services
Indian Health Service
Services – 75-0390-0-1-551
INFORMATION TECHNOLOGY INFRASTRUCTURE

Authorizing Legislation: Program authorized by 25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001, and P.L. 102-573, Title II, sector 214.

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	Increase or Decrease
BA	$64,623,000	$69,181,000	$67,474,000	-$1,707,000
FTE	0	0	0	0

1. UFMS and HHS Information Technology Enterprise Infrastructure funds will be shown on HHS' Department-wide Exhibit 53.
2. These budget amounts are primarily from Hospitals & Clinics.
3. IT FTEs are identified under Hospital & Clinics and other Sub-Activities

STATEMENT OF THE BUDGET

The Indian Health Service's budget for FY 2006 funding will support the adoption of information technology in health care, to reduce medical errors and improve health care quality, and modernize administrative functions consistent with HHS enterprise initiatives.

PROGRAM DESCRIPTION

Information technology (IT) is essential to effective health care delivery and efficient resource management in the Indian Health Service. Health care is information intensive and increasingly dependent on technology to assure that appropriate information is available whenever and wherever it is needed. IHS IT infrastructure includes people, computers, communications and security that support every aspect of the IHS mission. IHS IT is based on an architecture that incorporates government and industry standards for the collection, processing and transmission of information. IHS IT is managed as a strategic investment by senior management, fully integrated with the agency's programs, and critical to improving service delivery.

The Resource and Patient Management System (RPMS) is the IHS enterprise health information system. RPMS consists of more than 60 software applications and is used at approximately 400 IHS, tribal and urban (I/T/U) locations. IHS also maintains a centralized database of patient encounter and administrative data for statistical purposes, performance measurement for GPRA and accreditation, and public health and epidemiological studies. The IHS telecommunications infrastructure connects IHS, tribal, and urban facilities as part of the larger HHS telecommunications network. IHS participates in HHS enterprise-wide initiatives to improve IT infrastructure and works with the Department of Veterans Affairs and other federal partners to develop software and share technology resources. These collaborations are reflected in the IHS IT Architecture and five-year plan.

PERFORMANCE ANALYSIS

Noteworthy accomplishments for Information Technology include a PART score of Effective for RPMS, certification and accreditation of all major IHS IT systems, and adoption of Consolidated Health Informatics e-Gov standards in the IHS IT Architecture. Through improvements in IT systems and infrastructure, IHS continues to more effectively measure GPRA performance indicators and meet reporting requirements. The following performance indicators are included in the IHS FY 2006 Annual Performance Plan. These indicators address the development of improved automated data capabilities that support clinical care and performance measurement. Complete information is available in the Detail of Performance Analysis Section (Exhibit U).

Indicator 17 is designed to continue the automated extraction of GPRA clinical performance measures through ongoing development and deployment of CRS (clinical indicator reporting system) software. IHS met this indicator in FY 2004. The FY 2004 indicator was to expand the automated extraction of GPRA clinical performance measures and improve data quality by adding 2 new measures of automated data quality assessment to the GPRA software. The GPRA+ software included an additional 4 automated data quality indicators in FY 04; this software was successfully distributed to all 12 IHS areas. This enabled the IHS to report GPRA data on almost 1.2 million patients through the utilization of this electronic reporting system.

Indicator 18 was designed to improve the utilization of the Behavioral Health (BH) Data System through a 5% increase in the number of the programs reporting minimum agreed-to behavioral health-related data to the national data warehouse. Improving behavioral health outcomes relies on two important activities: data collection as close to point of care as possible, and data reporting in a standardized way that can be understood across the Indian health system. The behavioral health Interim Solution, deployed during FY 2003, helped address the need for incremental improvements in existing RPMS systems, as well as facilitated a standardized suicide data collection system within the RPMS package. During 2005, a new integrated behavioral health application will be developed and deployed to interested sites.

IHS did not meet this indicator in FY 2004. The actual number for FY 2004 represents a 2.3% increase. One reason for missing this target is that resources were devoted to implementing the new GUI interface at sites that were already submitting data to the national data warehouse. Nevertheless, the increase in sites using and exporting from 2002 to 2004 continues to be quite significant (33%).

Indicator 19 was designed to develop a specific minimum data set as well as appropriate language for the urban contracts and grants. IHS met this indicator in FY 2004. The data element sub workgroup developed data elements that constitute a minimum data set. In addition, draft language for inclusion in the Contracts and Grants has been completed.

The Urban Indian Health Program contributes to the attainment of the Healthy People 2010 goal of achieving equivalent and improved health status for all Americans by responding to the considerable health care need of the AI/AN people residing in urban areas.

IHS continues to improve its IT infrastructure to support Presidential, Secretarial and IHS goals and priorities. Compliance with E-Gov initiatives will dramatically improve the exchange of health care information. The Secretary's priority to accelerate the adoption of information technology in health care will reduce medical errors and improve health care quality. The IHS Electronic Health Record initiative, designed to support this accelerated adoption and deployment of electronic health information systems, will provide computer-based physician order entry, encounter documentation, access to medical literature and other essential capabilities. These initiatives, as well as increasingly affordable health care technologies such as telemedicine, require continuous improvement of IHS IT infrastructure.

FUNDING HISTORY -- Funding for the Information Technology during the last 5 years has been as follows:

Fiscal Year	Amount	FTE
2001	$51,998	0
2002	$56,498	0
2003	$58,187	0
2004	$64,623	0
2005	$69,181	0

RATIONALE FOR THE BUDGET

This budget of $67,474,000 will be used to support IHS enterprise health and administrative information technology infrastructure.

IHS's request includes funding to support the President's Management Agenda e-Gov initiatives and Departmental enterprise information technology initiatives identified through the HHS strategic planning process. Agency funds will be combined with resources in the Information Technology Security and Innovation Fund to promote collaboration in planning and project management and to achieve common goals such as secure and reliable communication and lower costs for the purchase and maintenance of hardware and software. The enterprise IT investments enable HHS programs to carry-out their missions more securely and at a lower cost.

The Resource and Patient Management System (RPMS) received a PART score of 88 and an "effective" rating. The score was based on findings that RPMS has a clear purpose, is supported by sound planning, makes an important contribution to health care, and has responsible program management. The review demonstrated results over a 20-year life cycle and showed that RPMS compares favorably with other information systems.

The PART also established that IHS has specific long-term performance measures for RPMS that focus on outcomes and meaningfully reflect the purpose of the program. These measures are to (1) Improve compliance with clinical practice guidelines for five chronic diseases (diabetes, asthma, cardiovascular disease, HIV/AIDS, and obesity) through the development and deployment of an electronic health record (EHR) to all I/T/U sites using RPMS by FY 2008; (2) Derive all national clinical performance measures electronically from RPMS by FY 2008; and (3) Improve treatment effectiveness in behavioral health services through development and deployment of enhanced automated behavioral health systems to all I/T/U sites using RPMS by FY 2008. Further details about RPMS milestones for these initiatives, as well as budget linkages, are available within the Exhibit 300.

Department of Health and Human Services
Indian Health Service
Services – 75-0390-0-1-551
PUBLIC AND PRIVATE COLLECTIONS

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

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Estimate
Medicare	$90,863,000	$91,784,000	$93,617,000
Tribal Medicare[1]	6,986,000	6,986,000	6,986,000
Tribal Medicare[2]	31,553,000	31,553,000	31,553,000
Subtotal	129,402,000	130,323,000	132,156,000
Medicaid	349,034,000	352,695,000	359,219,000
Tribal Medicaid[1]	22,217,000	22,217,000	22,217,000
Tribal Medicaid[2]	74,749,000	74,749,000	74,749,000
Subtotal	446,000,000	449,661,000	456,185,000
M/M Total	$575,402,000	$579,984,000	$588,341,000
Private Insurance	$52,845,000	$52,845,000	$53,579,000
TOTAL	**$628,247,000**	**$632,829,000**	**$641,920,000**
FTE	3,942	3,942	3,942

[1] Represents CMS tribal collection estimates.

[2] Represents tribal collection estimates from direct billing that began in FY 2002.

PROGRAM DESCRIPTION

The collection of third party revenue is essential to maintaining facility accreditation and standards of health care through the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) or the Accreditation Association for Ambulatory Health Care (AAAHC). These collections are a significant part of the IHS and tribal budgets, which support increased access to quality health care services for AI/AN people. Third party revenue represents over 50 percent of operating budgets at many facilities.

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

(Dollars in Thousands)

Type of Obligation	FY 2004 Actual	FY 2005 Estimate	FY 2006 Estimate
Personnel Benefits & Compensation	$265,368	$277,548	$288,332
Travel & Trans.	3,650	3,532	3,512
Trans. of Things	937	901	890
Comm./Util./Rent	8,549	8,254	8,182
Printing & Repro.	139	135	134
Other Contractual Services	90,119	87,179	86,562
Supplies	86,414	83,443	82,730
Equipment	13,216	12,751	12,638
Land & Structures	11,822	11,393	11,280
Grants	12,320	11,987	11,956
Insur./Indemnities	140	135	134
Interest/Dividends	68	66	65
Subtotal	492,742	497,324	506,415
Tribal Collections	$135,505	$135,505	$135,505
Total Collections	**$628,247**	**$632,829**	**$641,920**

Medicare/Medicaid

The FY 2006 Medicare/Medicaid (M/M) budget estimate includes an increase of $8,357,000. This increase assumes that increased collections will be achieved through improvements in our business billing and collection management practices. FY 2005 rates have not been established. Future IHS rate adjustments and projections will be completed following analysis of the FY 2003 hospital cost reports.

In FY 2005 and FY 2006, the IHS will continue to focus on strengthening business office policies and management practices including internal controls, patient benefits coordination, provider documentation training, certified procedural coding training, automated processing claims and information systems improvements. In FY 2005, we will focus on expanding current policies to strengthen internal controls and rewriting the business office operations manual to reflect new policies and procedures and improved business practices. The IHS plans to improve the processing of claims through a major rewrite of its third party billing package to ensure increased claims processing accuracy, HIPAA compliance and integration of the accounts receivable subsidiary. Continuing efforts to provide appropriate training for operations staff and managers focuses on a team approach to third party revenue management.

In FY 2005 and FY 2006, the IHS will continue working with Centers for Medicare and Medicaid Services (CMS) and the State Medicaid Offices to improve each hospital's capability to identify patients who are eligible to participate in Medicare and Medicaid programs. IHS will also continue to work with the CMS and the Tribes to resolve a number of third party reimbursement issues, including training and implementing key

provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003.

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

Private Third Party Collection

The FY 2006 Private Insurance budget estimate includes an increase of $734,000. This increase assumes that increased collections will be achieved through improvements in our business billing and collection management practices. During FY 2005 and in FY 2006, IHS will continue its efforts to enhance each health facility's capability to identify patients who have private insurance coverage and improve claims processing to increase private insurance billing and collections. Funds collected will be used by the local Service Units to improve services, including the purchase of medical supplies and equipment, and to improve local service unit business management practices.

Department of Health and Human Services
Indian Health Service
Services –75-0390-0-1-551
SPECIAL DIABETES PROGRAM FOR INDIANS

Authorizing Legislation: 111 STAT. 574, 1997 Balanced Budget Act (P.L. 105-33) and H.R. 4577, Consolidated Appropriation Act 2001 (P.L. 106-554).

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Estimate	Increase Or Decrease
BA	$150,000,000	$150,000,000	$150,000,000	0
FTE	*0*	*0*	*0*	*0*

The Balanced Budget Act of 1997 (P.L. 105-33) provided that $30 million per year appropriated to the Children's Health Insurance Program (CHIP) be transferred to Indian Health Service for diabetes prevention and treatment for five years ending in FY 2002 called the *Special Diabetes Program for Indians* grant program. An additional $70,000,000/year was provided under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 for FY 2001 and FY 2002, and $100,000,000 was provided for FY 2003. These funds support the Secretary's initiative to prevent diabetes and obesity, as well as a focus on healthier youth. The *Special Diabetes Program for Indians* grant was reauthorized in December 2002 (P.L 107-360) at $150 million per year, a $50 million per year increase, for five years (2004-2008).

STATEMENT OF THE BUDGET

The *Special Diabetes Program for Indians* budget of $150,000,000 is for the prevention and treatment of diabetes among American Indian and Alaska Natives.

American Indian and Alaska Native (AI/AN) communities suffer a disproportionately high rate of type 2 diabetes. Between 1997 and 2001, the prevalence of diabetes increased by 33% in all major regions served by the Indian Health Service. The highest rate of increase has occurred among AI/AN adolescents aged 15-19 years, with a 106% increase from 1990-2002. Diabetes mortality is 4.3 times higher in the AI/AN population than in the general U.S. population. Complications of diabetes lead to much higher incidence rates of blindness, vascular insufficiency leading to amputation, and End Stage Renal Disease (ESRD) than in the general U.S. population.

The initial *Special Diabetes Program for Indians (SDPI)* appropriation was authorized by Congress in 1997 in response to these alarming trends. It came in the wake of increasing public concern about the human and economic costs of diabetes in the U.S. and the growing prevalence among the AI/AN population. Congress directed the IHS to implement a grant process to distribute the funding of the *SDPI*. The *SDPI* was implemented according to legislative intent through a process that included formal tribal consultation, a methodology and process for distribution of the funds to eligible entities and a formal grant application and administrative process.

The *SDPI* reauthorization for $150 million for FY 2004-2008, directs the IHS to expand the program and implement a competitive grant program for eligible entities for the

implementation of specific interventions proven to prevent diabetes and reduce cardiovascular risk, the most compelling complication of diabetes. Funds will also be directed towards data improvement. In addition, distribution of funds to original *SDPI* grantees for the prevention and treatment of diabetes will continue.

PROGRAM DESCRIPTION

IHS Diabetes Program

The IHS Diabetes program provides leadership and programmatic administrative oversight to the *Special Diabetes Program for Indians* grant program. The mission is to develop, document, and sustain a public health effort to prevent and control diabetes in AI/ANs. This is accomplished by promoting collaborative strategies for the prevention of diabetes and its complications to over 1.5 million American Indians and Alaska Natives through its extensive diabetes network. The network consists of a national program office; Area Diabetes Consultants in each of the 12 IHS Areas; Model Diabetes programs in 23 sites; and local IHS, Tribal and Urban Indian diabetes grant programs in 318 AI/AN communities. This extensive diabetes network supports the *SDPI* grant programs by providing local administrative support, training and technical assistance and the dissemination of the latest scientific findings and best practices to the programs. Now the most comprehensive rural system of care for diabetes in the U.S., the IHS combines both clinical and public health approaches to address the problem of diabetes.

The IHS provides comprehensive diabetes surveillance, research translation, promotion of quality assurance and improvement activities, technical support, resource and "best practices" information and develop and distribute American Indian specific diabetes education materials. This program also serves as the key IHS contact and source of information for outside organizations and agencies working on diabetes and disparities related to diabetes.

The IHS used administrative funding to strengthen the diabetes infrastructure at the Headquarters and Area office levels to maintain and improve diabetes surveillance, technical assistance, provider networks, clinical monitoring and grant evaluation activities. Support for the Area Diabetes consultants, who serve a crucial role in coordinating these functions at the Area level, was also strengthened. Funding for the past 5 years has served to provide a much needed infrastructure within IHS and tribal administrations that enables continued development of diabetes programs to address treatment and prevention of diabetes.

Special Diabetes Program for Indians

SDPI funds originally provided "seed money" to over 300 new programs to begin or enhance diabetes prevention programs in Indian communities as well as to address diabetes treatment. The result has been the creation of innovative, culturally appropriate strategies that address diabetes. The *SDPI* funds have significantly enhanced diabetes care and education in AI/AN communities, as well as built a desperately needed infrastructure for diabetes programs. The IHS has continued to develop and operate the SDPI grant program with 318 IHS, Tribal and Urban Indian grant programs in 35 states.

Tribes and urban Indian organizations have had to make choices about how to best use their local *SDPI* funding because, while it is a significant increase in funding, it is not enough to address the entire problem of diabetes in AI/AN communities. A study published by the American Diabetes Association in 2003 on the economic burden of diabetes in the U.S. estimated that it costs $13,243 per year to care for one person with diabetes. Using current IHS diabetes prevalence figures, one would project a cost to the agency of $1.46 billion per year to care for those AI/AN who are diagnosed with diabetes today. These figures do not include those with undiagnosed diabetes or those in whom we could prevent the disease. The Indian health care system recognized from the start of this program that it would have to make careful choices about where to best invest these funds and knew these choices would best be made locally.

Targeted Demonstration Projects
In 2004 the IHS, in response to Congressional direction, developed and implemented a SDPI competitive Targeted Demonstration Project. The focus of the competitive Targeted Demonstration Project is on primary prevention of type 2 diabetes in those at risk for diabetes reduction of cardiovascular risk in AI/AN with type 2 diabetes. Sixty-six grants were awarded and this 5 year program was launched in November 2004

Primary Prevention of Type 2 Diabetes
The results of the Diabetes Prevention Program were issued in the Feb 7, 2002 issue of the New England Journal of Medicine (which included 171 AI participants) and showed conclusively that type 2 diabetes could actually be prevented or delayed through lifestyle changes (58 % reduction) or use of the medication metformin (31 % reduction). The DPP has provided a new road map for diabetes prevention. Many of our SDPI grant programs were working on diabetes prevention interventions prior to the publication of this study. Thus, the SDPI funds have provided the resources to build a much stronger diabetes infrastructure and launch diabetes prevention activities in AI/AN communities to translate these promising findings. In FY 2002, an overwhelming number of diabetes grant programs (96 %) reported they now use SDPI funds to support diabetes primary prevention activities.

To strengthen translation of DPP to the field, the competitive Diabetes Prevention (DP) Targeted Demonstration Project awardees will engage in a demonstration projects to specifically translate these results to AI/AN communities. The thirty six demonstration sites will translate the DPP at a local level in their respective AI/AN community.

Cardiovascular Risk Reduction
Individuals with diabetes are at risk for cardiovascular disease (CVD), and the incidence of CVD in AI/ANs now exceeds rates in the general population. The Strong Heart Study, a longitudinal cohort study of the risk factors for cardiovascular disease in American Indians, has demonstrated that diabetes is a major risk factor and accounts for the majority of risk for cardiovascular disease events in American Indians. The results of numerous clinical trials demonstrate that the risk of cardiovascular disease in individuals with diabetes can be reduced through control of blood pressure, reduction in cholesterol

levels, glycemic control, aspirin use, smoking cessation, physical activity and weight management. The competitive Cardiovascular Disease (CVD) Targeted Demonstration Project will provide funding to selected *SDPI* grantees for a demonstration project to aggressively and comprehensively implement and evaluate defined activities in the prevention of cardiovascular disease in people with diabetes. Thirty demonstration sites have been selected to address cardiovascular risk reduction.

SDPI Summary

The *SDPI* has brought tribes together over these past 8 years, working toward a common purpose and sharing information & lessons learned along the way. The IHS has shown through its public health evaluation activities that these programs have been very successful in improving diabetes care and outcomes, as well as the start of primary prevention efforts, on reservations and in urban clinics. Our evaluation of *SDPI* and diabetes clinical indicators suggests that population-level diabetes-related health is better among our AI/AN patients since the implementation of *SDPI*. The greatest benefit has likely been in the reduction in microvascular complications due to improvement in hyperglycemia. Further reducing microvascular and macrovascular complications will require continued efforts to improve glucose, blood pressure and cholesterol values. As a reflection of the global effect of quality of care and of resource allocation, these trends demonstrate the public health impact made possible when community, program, and congressional initiatives are focused on a common outcome.

Other Key aspects of the *Special Diabetes Program for Indians* include:

- **Tribal Consultation** A Tribal Leaders Diabetes Workgroup was established in 1998 to review the Area Tribal input and make recommendations on the administration and distribution of the diabetes funds. Based on their recommendations, funds were awarded through non-competitive grants for a five-year project term. An evaluation process was created for national and regional levels. Consultation has been completed for the new funding, $150 million per year from 2004 – 2008, authorized by P.L.107-360. Tribes provided input into the national distribution formula for the local, community-based grants, development of a competitive grant process for the Targeted Demonstration Projects, and strengthening of the IHS data system with these new funds.

- **Grant Program Evaluation** There are 286 SDPI grants representing 318 separate sites awarded each year. The CDC's *Framework for Public Health Evaluation*, which uses a mixed methods approach (both qualitative and quantitative methods), has been implemented and an analysis completed. A number of positive short term and intermediate term outcomes have been identified. In addition, the IHS in partnership with IT and the Epidemiology Centers, has improved the accuracy of baseline long-term measures (prevalence and mortality) and established a Diabetes Data Warehouse and "Data Mart" using RPMS data to measure accurately the long-term complications of diabetes.

- **Prevention Efforts** Prior to the *SDPI*, AI/AN communities had few resources to devote to primary prevention of diabetes. In 2002, an overwhelming number of diabetes grant programs (96%) reported that they now use funds to support diabetes primary prevention activities in their communities. The implementation of secondary prevention efforts – the prevention of complications such as kidney failure, amputations, heart disease and blindness – and tertiary prevention efforts to reduce morbidity and disability in those who already have complications from diabetes has also been a focus of *SDPI* activities. Improvement in the treatment for risk factors of cardiovascular disease, the detection and retardation of the progression of diabetic kidney disease, and the detection and treatment of diabetic eye disease have also been achieved since the implementation of *SDPI*.

- **Best Practices Approach** Based upon Congressional direction, the IHS developed a consensus-based Indian health "best practices" approach to ensure dissemination of successful community based interventions to the SDPI grant programs. This was accomplished by convening best practices workgroups, consisting of experts from IHS, the tribes, urban Indian organizations, the IHS Model Diabetes Programs, and project coordinators from *SDPI* grant sites. The workgroups developed 14 Best Practice Model approaches for successful diabetes prevention, treatment and education practices in AI/AN communities based on findings from the latest diabetes scientific research, outcomes studies and their own successful experiences. The best practice models were used by applicants to identify strengths in diabetes resources and services in their communities, find gaps in diabetes services or programs, establish program priorities, find best practice models that could be applied within their own communities, and to begin a work plan to develop their own local best practice models. To assess use of the consensus-based Best Practice Models for AI/AN communities, IHS Area Chief Medical Officers and Area Diabetes Consultants completed assessments of Best Practice Model use with their review of each grant application. Data were then compiled. In 2002, elements of the Nutrition and Physical Fitness Best Practice Model approach were used by 72% of grant programs, the Diabetes Screening Best Practice Model approach was used by 64% of grant programs, and the Basic Diabetes Care and Education Best Practice Model approach was used by 63% of SDPI grantees.

- **Thirteen Best Practice Models** were developed to assist grant programs, including:

    - Basic diabetes care and education – A systems approach
    - Cardiovascular disease and diabetes – Screening, treatment, and follow-up
    - Community Advocacy – Winning support for your diabetes program
    - Eye care for people with diabetes – Screening, treatment, and follow-up
    - Foot care for people with diabetes – Screening, treatment, and follow-up
    - Kidney disease – Screening, prevention, treatment, and follow-up
    - Medications for diabetes care
    - Nutrition and physical fitness programs
    - Pregnancy and diabetes – Screening, management, and follow-up
    - School health – Nutrition and physical activity

- Diabetes screening programs
- Diabetes self-management education
- Type 2 diabetes in youth – Prevention and screening

The Best Practice Models will be updated in FY 2004 and 2005 to include diabetes and obesity prevention, CVD risk reduction, health care behavior change, communication, and depression.

- **CDC/National Diabetes Prevention Center** One million dollars of the BBA funds were allocated yearly to CDC Division of Diabetes for the development of a National Diabetes Prevention Center (NDPC) in Gallup, NM. The NDPC agreement was originally awarded to the University of New Mexico (UNM). In 2001, UNM redefined the NDPC's area of impact from that of a national perspective to a southwest regional focus and has worked primarily with the Zuni Pueblo and Navajo Nation as a UNM center solely for these southwestern tribes. The IHS and the CDC have worked collaboratively to expand the national focus of the NDPC through the dissemination of diabetes technical assistance resources and other diabetes data.

- **Tribal Management of Local Grant Programs** Eighty one percent (81%) of the *SDPI* grant recipients are Tribal programs. To responsibly manage a health program requires data that supports an assessment of the health needs of the population. To meet this need, Tribal programs were well represented in the IHS 2003 Diabetes Care and Outcomes Audit of AI/AN with diagnosed diabetes and will have the opportunity to participate in the 2004 audit. Data gathered by these audits provides Tribes with information to guide the management of their diabetes programs.

Collaborations and Partnerships The IHS has developed and built upon collaborations and partnerships with federal and private organizations as a result of the Special Diabetes Program for Indians. These include:

Obesity Prevention For 4 years the IHS coordinated an obesity prevention initiative targeting Head Start children (0-5 yrs), families, Head Start staff and AI communities. Four tribal Head Start pilot sites, in collaboration with their respective community health partners, have developed obesity and diabetes prevention interventions in their local communities.

Joslin Vision Network Teleophthalmology Project The JVN is a telemedicine system that uses low-level illumination and no pupil dilation to remotely diagnose diabetic retinopathy. The acquired retinal image is sent electronically to a reading center using existing IHS networks, and an analysis of the level of diabetic retinopathy is returned to the remote site. The IHS has deployed imaging sites at the Phoenix Indian Medical Center (PIMC), Sells PHS Indian Hospital, Tuba City Indian Medical Center, Parker Indian Hospital, Hopi Health Care Center, and the Chief Andrew Isaac Health Center in Fairbanks, Alaska.

In addition to the Joslin Vision Network, the IHS is partnering with the Joslin Diabetes Center to develop a web-based system that is based on the case management model that tracks diabetes care and education called the Comprehensive Diabetes Management Program (CDMP).

NIDDK/IHS/TLDC/AIHEC collaboration to Recruit AI/AN Students into Biomedical Science Research and Diabetes Careers In FY 2001, the IHS and NIDDK collaborated on a project to encourage young AI/AN students to consider careers in biomedical research and diabetes. This project also involves the CDC and the American Indian Higher Education Consortium (AIHEC), which represents the 34 tribal colleges around the country. This successful program is in its 3rd year of working to encourage young AIAN students to enter the sciences.

CDC National Diabetes Prevention Center IHS and CDC collaborations on projects with American Indian Research and Education Centers at the University of Nevada at Las Vegas and the University of New Mexico on the development of data software programs for collection and analysis, and support for development of Associate of Science curriculum in diabetes prevention.

The CDC provides diabetes epidemiologic support to the IHS with 1 full time position and close collaboration on projects of mutual concern.

Committee on Native American Child Health (CONACH) The IHS National Diabetes Program collaborated with the American Association of Pediatric's CONACH and Section on Endocrinology to develop a new clinical report “Prevention and Treatment of Type 2 Diabetes Mellitus in Children, With Special Emphasis on American Indians and Alaska Natives.

Collaboration and Partnership with Other Federal Agencies and Organizations
The IHS collaborates with a number of other federal agencies and organizations to promote the awareness of diabetes including the following: NIH, CDC, and the American Diabetes Association. A key partnership has been with the American Indian Higher Education Consortium to build tribal college and university capacity as well as working with the State Diabetes Control Programs to share skills, resources and training. The agency also works with the AI/AN Boys and Girls Clubs as well as the National Congress of American Indians (NCAI) to promote healthy lifestyles for children and youth aimed at reducing the risk for early onset of diabetes in youth.

PERFORMANCE ANALYSIS

The Indian Health Service currently has six diabetic performance measures within its annual Performance Budget. These measures track different aspects of diabetic care, such as blood sugar control. This extraordinary number of measures reflects the excessive diabetes disease burden in American Indian/Alaska Native communities. Two data sources, the chart review based audit of glycemic control in patients with diabetes and the entirely electronic health information system software application (GPRA+), combine to

provide reliable performance information. These two data sources have historically shown consistent improvement in our performance on the glycemic control measure. In addition, the diabetic audit of over 33,769 diabetic patients substantiates the electronic audit of over 116,456 diabetic patients.

IHS has been able to increase the proportion of its diabetic patients who maintain Ideal blood sugar control from 25 percent in FY 1997 to 34 percent in FY 2004 (up from 31% in 2003). This increase was achieved despite the fact that the total number of patients with diabetes the IHS served increased 45 percent during this period.

Hemoglobin A1c (A1c) is the name of the laboratory test that measures the average glucose level (sugar content) of a patient's blood during the preceding 3 months. It is the current "gold standard" for determining glycemic control in people with diabetes. A lower A1c percentage indicates better blood sugar control. Note that for each 1% drop in A1c, one would expect a:

- 14% decrease in total mortality
- 21% decrease in diabetes-related deaths
- 14% decrease in myocardial infarction
- 12% decrease in strokes
- 43% decrease in amputations
- 24% decrease in renal failure
- $800 reduction in health care costs per patient

Diabetes Performance Measure: Ideal Glycemic Control (A1c < 7.0)
FY 2006 Target: 34% for the IHS Diabetes Audit (Maintain FY 2005 Target)
In FY 2004 34% of AI/AN patients with diabetes achieved Ideal glycemic control by having an A1c less than 7.0% on the 2004 IHS Diabetes Audit, which is 3% above the rate of 31% in the 2003 IHS Diabetes Audit.

Diabetes Performance Measure: Poor Glycemic Control (A1c ≥ 10.0)
FY 2006 Target: ≤ 16% for the IHS Diabetes Audit (Maintain FY 2005 Target)
During FY 2004 a baseline was determined. 16% is the FY 2004 baseline (from the IHS Diabetes Audit) for the proportion of I/T/U clients with diagnosed diabetes who have poor glycemic control.

The Indian Health Service met all performance targets for FY 2004 from the IHS Diabetes Audit.

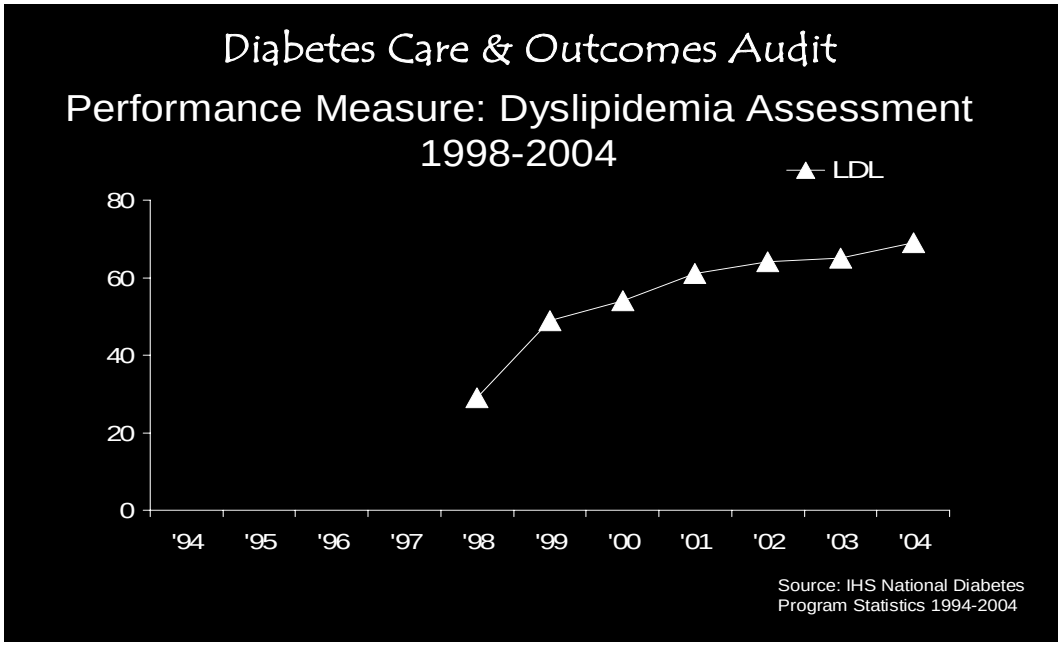
Diabetes Performance Measure: Blood Pressure Control
FY 2006 Target: 34% for the IHS Diabetes Audit (Maintain FY 2005 Target)
In FY 2004 34% of clients with diagnosed diabetes achieved blood pressure control standards of less than 130/80 in the 2004 IHS Diabetes Audit, which is 1% above the rate of 33% in the 2003 IHS Diabetes Audit.

Research has shown that coronary heart disease events, stroke, and kidney disease from diabetes can be reduced by lowering blood pressure to < 130/80 in persons with diabetes.

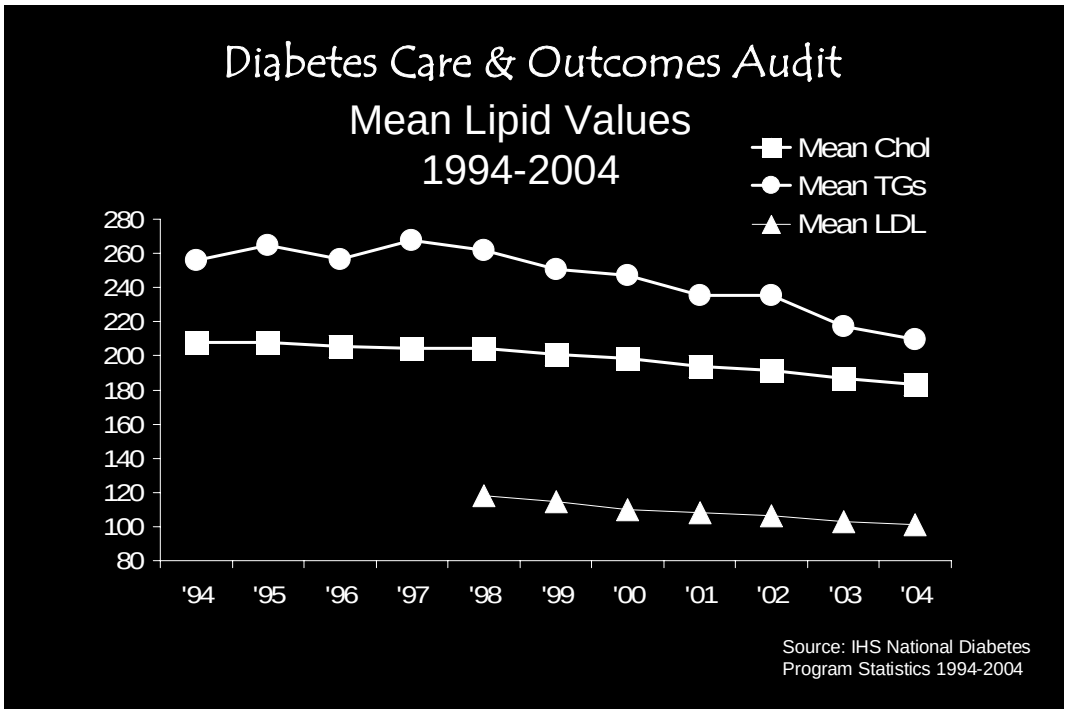
Diabetes Performance Measure: Dyslipidemia Assessment
FY 2006 Target: 65% for the IHS Diabetes Audit (Maintain FY 2005 Target)
In FY 2004 69% of clients with diagnosed diabetes were assessed for dyslipidemia by having a low-density lipoprotein (LDL) cholesterol level done. This is 4% greater than the level achieved in the 2003 IHS Diabetes Audit.

People with type 2 diabetes have higher rates of lipid (cholesterol and/or triglyceride) abnormalities and this contributes to higher rates of cardiovascular disease. Treatment of lipid abnormalities through drug therapy and lifestyle interventions has been shown to reduce cardiovascular disease and strokes in patients with type 2 diabetes. Lifestyle modifications include reduced saturated fat and cholesterol intake through Medical Nutrition Therapy, weight loss (if needed), and increased physical activity. Glycemic control can also improve lipid levels. Appropriate lipid management is aimed at lowering LDL cholesterol, raising high density lipoprotein (HDL) cholesterol, and lowering triglyceride levels.

The following slide illustrates the increasing percentage of clients with diabetes having an LDL checked on an annual basis.



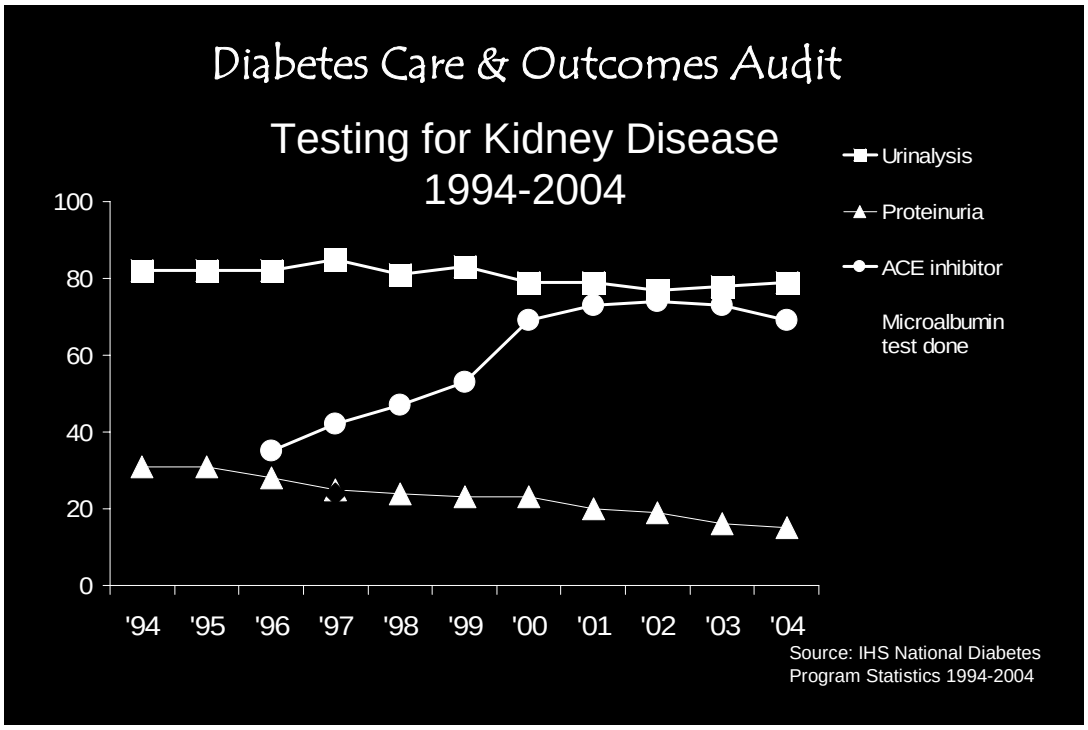
The next slide shows that the average LDL value for AI/AN's has decreased from 118 in 1998 to 101 in 2004. The current American Diabetes Association recommended target goal for LDL is < 100.



Diabetes Performance Measure: Nephropathy Assessment
FY 2006 Target: 63% for the IHS Diabetes Audit (Maintain FY 2005 Target)
In FY 2004 63% of clients with diagnosed diabetes were assessed for kidney disease by having a screening test for microalbuminuria done. This is an increase of 2% from the rate of 61% in the 2003 IHS Diabetes Audit.

The following chart from the Kidney Health Profile, a special sub-report of the IHS Diabetes Audit, assesses screening and treatment for kidney health. Protein in the urine or proteinuria is a marker for diabetic kidney disease.

Small amounts of protein the urine, known as microalbuminuria, occur very early in diabetic kidney disease and may indicate a point at which diabetic kidney disease is reversible. Medications called ACE inhibitors have been shown to reserve proteinuria and microalbuminuria, and to delay the progression of diabetic kidney disease. This slide shows that, since 1995, the prevalence of proteinuria in AI/AN communities has decreased (31% to 15%) as ACE inhibitor use has increased (35% to 69%). In addition, more diabetes programs are measuring microalbumin (18% to 63%) to try to find very early cases of diabetic kidney disease that might be reversible.



Diabetes Performance Measure: Diabetic Retinopathy
FY 2006 Target: 61% for designated Joslin Vision Network (JVN) pilot sites (Maintain FY 2004 Target)

During FY 2004 55% of clients with diagnosed diabetes received an annual diabetic retinal examination at designated sites. This was a decline of 3% from 58% in FY 2003 but a maintenance of the rate of 55% achieved in FY 2002.

Staffing pattern changes had an impact at 3 JVN sites in FY 2004. Loss of key staff impacted their ability to provide diabetic retinal exams by telemedicine. Staffing of the imaging position will be emphasized during site selection and orientation in an effort to mitigate this recurring risk.

The IHS improved the accuracy of baseline long-term outcomes measures of diabetes prevalence and mortality and established a Diabetes Data Warehouse—"Data Mart" using RPMS data to measure accurately the long-term complications of diabetes.

The programs and activities implemented by IHS provide a strong foundation and new beginning towards a diabetes-free future for AI/AN communities. However, the significant diabetes related health disparities that AI/AN already experience will worsen unless access to treatment services keeps up with the growing demand, and additional cost-effective preventive interventions are identified to reduce the disease burden of this epidemic.

The emphasis on diabetes care within the IHS Hospital and Health Clinics budget recognizes this role of diabetes as a major cofactor in morbidity and a leading cause of mortality among AI/AN people. Meeting these performance indicators will increase the percentage of AI/AN patients who have access to quality clinical care within the IHS system. And high quality clinical care is a recognized approach for the reduction of health care disparities associated with diabetes and other chronic diseases.

RATIONALE FOR THE BUDGET

The IHS *Special Diabetes Program for Indians* budget is for the base amount of $150,000,000 as provided in FY 2004 and 2005.

The IHS has demonstrated, through the SDPI, its ability to design, manage, and measure a complex, long-term project to address a chronic disease in partnership with tribes and other Indian organizations in a successful manner. What's more, IHS has shown that it can successfully work with these partners to help them progress from whatever their starting position – be it a fully functioning clinical diabetes program, a rudimentary community program, or no program at all – along a continuum of diabetes excellence so that all improve in some way. Significant infrastructure has been established where there was none. Basic programs have become centers of excellence. Innovation has become commonplace in these programs, and the sense of "tribal ownership" is now entrenched. By continuing to support this program, Congress is investing in a true collaboration between the tribes and the agency, one that has demonstrated positive outcomes and a proven track record that continues to show steady improvements, both quantitatively and qualitatively, from year to year.

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