Exhibit E-1

INDIAN HEALTH SERVICE
Federal Funds

General and Special Funds:

INDIAN HEALTH SERVICES

For expenses necessary to carry out the Act of August 5, 1954 (68 Stat. 674), the Indian Self-Determination Act, the Indian Health Care Improvement Act, and titles II and III of the Public Health Service Act with respect to the Indian Health Service, ~~$2,633,072,000,~~ *$2,732,298,000,* together with payments received during the fiscal year pursuant to 42 U.S.C. 238(b) for services furnished by the Indian Health Service: *Provided,* That funds made available to tribes and tribal organizations through contracts, grant agreements, or any other agreements or compacts authorized by the Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450), shall be deemed to be obligated at the time of the grant or contract award and thereafter shall remain available to the tribe or tribal organization without fiscal year limitation: *Provided further,* That up to $18,000,000 shall remain available until expended, for the Indian Catastrophic Health Emergency Fund: *Provided further,* That ~~$487,085,000~~ *$507,021,000* for contract medical care shall remain available for obligation until September 30, ~~2006~~ 2007: *Provided further,* That of the funds provided, up to $27,000,000 to remain available until expended, shall be used to carry out the loan repayment program under section 108 of the Indian Health Care Improvement Act: *Provided further,* That funds provided in this Act may be used for one-year contracts and grants which are to be performed in two fiscal years, so long as the total obligation is recorded in the year for which the funds are appropriated: *Provided further,* That the amounts collected by the Secretary of Health and Human Services under the authority of title IV of the Indian Health Care Improvement Act shall remain available until expended for the purpose of achieving compliance with the applicable conditions and requirements of titles XVIII and XIX of the Social Security Act (exclusive of planning, design, or construction of new facilities): *Provided further,* That funding contained herein, and in any earlier appropriations Acts for scholarship programs under the Indian Health Care Improvement Act (25 U.S.C. 1613) shall remain available until expended: *Provided*

further, That amounts received by tribes and tribal organizations under title IV of the Indian Health Care Improvement Act shall be reported and accounted for and available to the receiving tribes and tribal organizations until expended: *Provided further,* That, notwithstanding any other provision of law, of the amounts provided herein, not to exceed ~~$267,398,000~~ *$268,683,000* shall be for payments to tribes and tribal organizations for contract or grant support costs associated with contracts, grants, self-governance compacts or annual funding agreements between the Indian Health Service and a tribe or tribal organization pursuant to the Indian Self-Determination Act of 1975, as amended, prior to or during fiscal year ~~2005~~ 2006, of which not to exceed ~~$2,500,000~~ *$5,000,000* may be used for contract support costs associated with new or expanded self-determination contracts, grants, self-governance compacts or annual funding agreements: *Provided further,* That funds available for the Indian Health Care Improvement Fund may be used, as needed, to carry out activities typically funded under the Indian Health Facilities account. ~~*Provided further*, That of the amounts provided to the Indian Health Service, $15,000,000 is provided for alcohol control, enforcement, prevention, treatment, sobriety and wellness, and education in Alaska: *Provided further*, That none of the funds may be used for tribal courts or tribal ordinance programs or any program that is not directly related to alcohol control, enforcement, prevention, treatment, or sobriety: *Provided further*, That no more than 15 percent may be used by any entity receiving funding for administrative overhead including indirect costs.~~ [1/] *(Department of the Interior and Related Agencies Appropriations Act, 2005.)*

INDIAN HEALTH FACILITIES

For construction, repair, maintenance, improvement, and equipment of health and related auxiliary facilities, including quarters for personnel; preparation of plans, specifications, and drawings; acquisition of sites, purchase and erection of modular buildings, and purchases of trailers; and for provision of domestic and community sanitation facilities for Indians, as authorized by section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), the Indian Self-Determination Act, and the Indian Health Care Improvement Act, and for expenses necessary to carry out such Acts and titles II and III of the Public Health Service Act with respect to environmental health and facilities

support activities of the Indian Health Service, ~~$394,048,000~~ *$315,668,000*, to remain available until expended: *Provided*, That notwithstanding any other provision of law, funds appropriated for the planning, design, construction or renovation of health facilities for the benefit of an Indian tribe or tribes may be used to purchase land for sites to construct, improve, or enlarge health or related facilities: *Provided further,* That not to exceed $500,000 shall be used by the Indian Health Service to purchase TRANSAM equipment from the Department of Defense for distribution to the Indian Health Service and tribal facilities: *Provided further,* That none of the funds appropriated to the Indian Health Service may be used for sanitation facilities construction for new homes funded with grants by the housing programs of the United States Department of Housing and Urban Development: *Provided further,* That not to exceed $1,000,000 from this account and the ''Indian Health Services'' account shall be used by the Indian Health Service to obtain ambulances for the Indian Health Service and tribal facilities in conjunction with an existing interagency agreement between the Indian Health Service and the General Services Administration: ~~*Provided further*, That notwithstanding any other provision of law, funds appropriated for the planning, design, and construction of the replacement health care facility in Barrow, Alaska, may be used to purchase land up to approximately 8 hectares for a site upon which to construct the new health care facility:~~ [2/] *Provided further,* That not to exceed $500,000 shall be placed in a Demolition Fund, available until expended, to be used by the Indian Health Service for demolition of Federal buildings~~:~~ ~~*Provided further:* That up to $2,700,000 from unobligaeted balances may be used for the purchase of land at two sites for the construction of the northern and southern California Youth Regional Treatment Centers subject to advance approval from the House and Senate Committees on Appropriations~~. [3/] *(Department of the Interior and Related Agencies Appropriations Act, 2005.)*

ADMINISTRATIVE PROVISIONS, INDIAN HEALTH SERVICE

Appropriations in this Act to the Indian Health Service shall be available for services as authorized by 5 U.S.C. 3109 but at rates not to exceed the per diem rate equivalent to the maximum rate payable for senior-level positions under 5 U.S.C. 5376; hire of passenger motor vehicles and aircraft; purchase of medical equipment; purchase of reprints;

purchase, renovation and erection of modular buildings and renovation of existing facilities; payments for telephone service in private residences in the field, when authorized under regulations approved by the Secretary; and for uniforms or allowances therefor as authorized by 5 U.S.C. 5901–5902; and for expenses of attendance at meetings which are concerned with the functions or activities for which the appropriation is made or which will contribute to improved conduct, supervision, or management of those functions or activities.

In accordance with the provisions of the Indian Health Care Improvement Act, non-Indian patients may be extended health care at all tribally administered or Indian Health Service facilities, subject to charges, and the proceeds along with funds recovered under the Federal Medical Care Recovery Act (42 U.S.C. 2651–2653) shall be credited to the account of the facility providing the service and shall be available without fiscal year limitation. Notwithstanding any other law or regulation, funds transferred from the Department of Housing and Urban Development to the Indian Health Service shall be administered under Public Law 86–121 (the Indian Sanitation Facilities Act) and Public Law 93–638, as amended.

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

~~None of the funds made available to the Indian Health Service in this Act shall be used for any assessments or charges by the Department of Health and Human Services unless identified in the budget justification and provided in this Act, or approved by the House and Senate Committees on Appropriations through the reprogramming process. Personnel ceilings may not be imposed on the Indian Health Service nor may any action be taken to reduce the full time equivalent level of the Indian Health Service below the level in fiscal year 2002 adjusted upward for the staffing of new and expanded facilities, funding provided for staffing at the Lawton, Oklahoma hospital in fiscal years 2003 and 2004, critical positions not filled in fiscal year 2002, and staffing necessary to carry out the intent of Congress with regard to program increases.~~ [4/]

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

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

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

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

~~The Indian Health Service may purchase 8.5 acres of land for expansion of parking facilities at the W.W. Hastings hospital in Tahlequah, Oklahoma using third party collections subject to advance approval from the House and Senate Committees on Appropriations.~~ [5/]

~~Notwithstanding any other provision of law, the Tulsa and Oklahoma City Clinic demonstration projects shall be permanent programs under the direct care program of the Indian Health Service; shall be treated as service units and operating units in the allocation of resources and coordination of care; shall continue to meet the requirements~~

~~applicable to an Urban Indian organization under this title; and shall not be subject to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).~~ [6/]

The appropriation structure for the Indian Health Service may not be altered without advance ~~approval of~~ *notification to* the House and Senate Committees on Appropriations. *(Department of the Interior and Related Agencies Appropriations Act, 2005.)*

GENERAL PROVISIONS

Sec. 308. Notwithstanding any other provision of law, amounts appropriated to or earmarked in committee reports for the Bureau of Indian Affairs and the Indian Health Service by Public Laws 103-138, 103-332, 104-134, 104-208, 105-83, 105-277, 106-113, 106-291, 107-63, 108-7, 108-108, and *108-447* [7/] for payments to tribes and tribal organizations for contract support costs associated with self-determination or self-governance contracts, grants, compacts, or annual funding agreements with the Bureau of Indian Affairs or the Indian Health Service as funded by such Acts, are the total amounts available for fiscal years 1994 through ~~2004~~ *2005* [7/] for such purposes, except that, for the Bureau of Indian Affairs, tribes and tribal organizations may use their tribal allocations for unmet indirect costs of ongoing contracts, grants, self-governance compacts or annual funding agreements.

Exhibit E-2

Explanation of Language Changes

Language Provision	Explanation
1/ ~~*Provided further*, That of the amounts provided to the Indian Health Service, $15,000,000 is provided for alcohol control, enforcement, prevention, treatment, sobriety and wellness, and education in Alaska: *Provided further*, That none of the funds may be used for tribal courts or tribal ordinance programs or any program that is not directly related to alcohol control, enforcement, prevention, treatment, or sobriety: *Provided further,* That no more than 15 percent may be used by any entity receiving funding for administrative overhead including indirect costs.~~	Language restricts the Indian Health Service's ability to manage resources provided for Alcohol and Substance Abuse activities.
2/ ~~*Provided further*, That notwithstanding any other provision of law, funds appropriated for the planning, design, and construction of the replacement health care facility in Barrow, Alaska, may be used to purchase land up to approximately 8 hectares for a site upon which to construct the new health care facility:~~	Language refers to FY 2005 funding and is therefore not needed in FY 2006.
3/ ~~: *Provided further:* That up to $2,700,000 from unobligaeted balances may be used for the purchase of land at two sites for the construction of the northern and southern California Youth Regional Treatment Centers subject to advance approval from the House and Senate Committees on Appropriations.~~	Language refers to FY 2005 funding and is therefore not needed in FY 2006.
4/ ~~None of the funds made available to the Indian Health Service in this Act shall be used for any assessments or charges by the Department of Health and Human Services unless identified in the budget justification and provided in this Act, or approved by the House and Senate Committees on~~	Language restricts the Department's flexibility in managing overall resources and staffing of the Indian Health Service.

~~Appropriations through the reprogramming process. Personnel ceilings may not be imposed on the Indian Health Service nor may any action be taken to reduce the full time equivalent level of the Indian Health Service below the level in fiscal year 2002 adjusted upward for the staffing of new and expanded facilities, funding provided for staffing at the Lawton, Oklahoma hospital in fiscal years 2003 and 2004, critical positions not filled in fiscal year 2002, and staffing necessary to carry out the intent of Congress with regard to program increases.~~

5/ ~~The Indian Health Service may purchase 8.5 acres of land for expansion of parking facilities at the W.W. Hastings hospital in Tahlequah, Oklahoma using third party collections subject to advance approval from the House and Senate Committees on Appropriations.~~

Language refers to FY 2005 funding and is therefore not needed in FY 2006.

6/ ~~Notwithstanding any other provision of law, the Tulsa and Oklahoma City Clinic demonstration projects shall be permanent programs under the direct care program of the Indian Health Service; shall be treated as service units and operating units in the allocation of resources and coordination of care; shall continue to meet the requirements applicable to an Urban Indian organization under this title; and shall not be subject to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).~~

These 2 projects are covered by the Indian Health Care Improvement Act.

7/ Sec. 308. Notwithstanding any other provision of law, amounts appropriated to or earmarked in committee reports for the Bureau of Indian Affairs and the Indian Health Service by Public Laws 103-138, 103-332, 104-134, 104-208, 105-83, 105-277, 106-113, 106-291, 107-63, 108-7, 108-108, and *108-447* for payments to tribes and tribal organizations for contract support costs associated with self-

Limits payments for contract support costs in past years (FY 1994 through FY 2005) to the funds available in law and accompanying report language in those years for the Bureau of Indian Affairs and the Indian Health Service.

determination or self-governance contracts, grants, compacts, or annual funding agreements with the Bureau of Indian Affairs or the Indian Health Service as funded by such Acts, are the total amounts available for fiscal years 1994 through ~~2004~~ *2005* for such purposes, except that, for the Bureau of Indian Affairs, tribes and tribal organizations may use their tribal allocations for unmet indirect costs of ongoing contracts, grants, self-governance compacts or annual funding agreements.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
SERVICES

Amounts Available for Obligations

	2004 Actual	2005 Appropriation	2006 Appropriation
Appropriation:			
Appropriation (Services)	$2,561,932,000	$2,633,072,000	$2,732,298,000
Enacted Rescission	($31,568,000)	($36,580,000)	$0
Subtotal, Adjusted Appropriation . . .	$2,530,364,000	$2,596,492,000	$2,732,298,000
Special Diabetes Program for Indians. . .	$150,000,000	$150,000,000	$150,000,000
Subtotal, adjusted budget authority. .	$2,680,364,000	$2,746,492,000	$2,882,298,000
Offsetting Collections:			
Federal sources	404,000,000	405,000,000	407,000,000
Non-federal sources	412,000,000	416,000,000	423,000,000
Subtotal	$816,000,000	$821,000,000	$830,000,000
Unobligated Balance, Start of Year	300,000,000	233,000,000	233,000,000
Unobligated Balance End of Year	233,000,000	233,000,000	232,000,000
Unobligated Balance Lapsing	0	0	0
Total obligations	$3,563,364,000	$3,567,492,000	$3,713,298,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FACILITIES

Amounts Available for Obligations

	2004 Actual	2005 Appropriation	2006 Estimate
Appropriation.	396,232,000	394,048,000	315,668,000
Enacted Rescission.	(4,882,000)	(5,474,000)	0
Subtotal, Adjusted Appropriation . . .	391,350,000	388,574,000	315,668,000
Offsetting Collections:			
Federal sources	$4,000,000	$7,000,000	$7,000,000
Subtotal	$4,000,000	$7,000,000	$7,000,000
Unobligated balance, start of year	227,000,000	279,000,000	279,000,000
Unobligated balance end of year	279,000,000	279,000,000	279,000,000
Total Obligations.	343,350,000	395,574,000	322,668,000

INDIAN HEALTH SERVICE

Health Services

Summary of Changes

2005 Enacted	$2,596,492,000
Total estimated budget authority	$2,596,492,000
(Obligations)	($2,596,492,000)
2006 Estimate	$2,732,298,000
(Obligations)	($2,732,298,000)
Net Change	$135,806,000
(Obligations)	($135,806,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise (3 mos.)	--	N/A	--	$5,442,000
2 FY 2006 Pay Raise (9 mos.)	--	N/A	--	$10,715,000
3 Tribal Pay Cost	--	N/A	--	$28,133,000
4 Within Grade Increase	--	N/A	--	$9,930,000
5 One Day Less Pay	--	N/A	--	(2,243,000)
6 Increased Cost of Travel	--	27,552,000	--	$859,000
7 Increased Cost of Trans & Things	--	7,658,000	--	$154,000
8 Increased Cost of Printing	--	691,000	--	$13,000
9 Increased Cost of Rents, Comm., & Utilities	--	20,493,000	--	$407,000
10 Increased Cost of Health Care Provided Under Contracts & Grants	--	317,961,000	--	$12,400,000
11 Increased Cost of Supplies	--	87,412,000	--	$2,939,000
12 Increased Cost of Medical or other Equipment	--	8,104,000	--	$266,000
13 Increased Cost of Land & Structure	--	(86,000)	--	$0
14 Increased Cost of Grants	--	1,467,274,000	--	$35,183,000
15 Increased Cost of Insurance/Indemnities	--	394,000	--	$8,000
16 Increased Cost of Interest/Dividends	--	167,000	--	$2,000
16 Increased Cost of Service & Supply Fund	--	N/A	--	$723,000
17 Population Growth	--	N/A	--	$35,725,000
Subtotal Built-In	--	N/A	--	$140,656,000

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
B. Phasing-In of Staff and Operating Cost of New Fac:				
Piñon, AZ Health Center	--	N/A	92	$8,768,000
Idabel, OK Health Center	--	N/A	7	$649,000
Coweta, OK Health Center	--	N/A	121	$10,864,000
Red Mesa, AZ Health Center	--	N/A	50	$4,480,000
Sisseton, SD Health Center	--	N/A	55	$5,945,000
St. Paul, AK Health Center			1	$144,000
Subtotal Staffing	--	N/A	326	30,850,000
C. Program Increases:				
Contract Support Cost Increase	--	N/A	--	$5,000,000
TOTAL INCREASES	--	N/A	55	$176,506,000
A. Built-In:				
Absorption of Built-In Increases	--	N/A	--	($37,645,000)
Subtotal Built-In	--	N/A	--	($37,645,000)
IT Reduction	--	N/A	--	(1,707,000)
Admin Reduction	--	N/A	--	(1,348,000)
TOTAL DECREASES	--	N/A	--	($40,700,000)
NET CHANGE	--	N/A		$135,806,000

2005 Enacted	$2,090,642,000
Total estimated budget authority	$2,090,642,000
(Obligations)	($2,090,642,000)
2006 Estimate	$2,208,715,000
(Obligations)	$2,208,715,000
Net Change	$118,073,000
(Obligations)	($118,073,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise (3 mos.)	--	N/A	--	$4,835,000
2 FY 2006 Pay Raise (9 mos.)	--	N/A	--	9,491,000
3 Tribal Pay Cost	--	N/A	--	24,414,000
4 Within Grade Increase	--	N/A	--	8,745,000
5 One Day Less Pay	--	N/A	--	(1,988,000)
6 Increased Cost of Travel	--	25,368,000	--	815,000
7 Increased Cost of Trans & Things	--	6,900,000	--	139,000
8 Increased Cost of Printing	--	608,000	--	12,000
9 Increased Cost of Rents, Comm., & Utilities	--	19,937,000	--	397,000
10 Increased Cost of Health Care Provided Under Contracts & Grants	--	310,321,000	--	12,195,000
11 Increased Cost of Supplies	--	86,359,000	--	2,914,000
12 Increased Cost of Medical or other Equipment	--	7,152,000	--	241,000
13 Increased Cost of Land & Structure	--	(86,000)	--	0
14 Increased Cost of Grants	--	1,051,234,000	--	22,006,000
15 Increased Cost of Insurance/Indemnities	--	367,000	--	7,000
16 Increaded Cost of Interest/Dividends	--	102,000	--	2,000
17 Increased Cost of Service & Supply Fund	--	N/A	--	723,000
18 Population Growth	--	N/A	--	33,450,000
Subtotal Built-In	--	N/A	--	$118,398,000

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
B. Phasing-In of Staff and Operating Cost of New Fac:				
Piñon, AZ Health Center	--	N/A	76	$7,065,000
Idabel, OK Health Center	--	N/A	7	$649,000
Coweta, OK Health Center	--	N/A	110	$9,754,000
Red Mesa, AZ Health Center	--	N/A	46	$4,073,000
Sisseton, SD Health Center	--	N/A	51	$5,538,000
St. Paul, AK Health Center		N/A	1	$144,000
Subtotal Staffing	--	N/A	291	27,223,000
TOTAL INCREASES	--	N/A	291	$145,621,000
DECREASES:				
A. Built-In:				
Absorption of Built-In Increases	--	N/A	--	($24,493,000)
Subtotal Built-In	--	N/A	--	($24,493,000)
IT Reduction	--	N/A	--	(1,707,000)
Admin Reduction	--	N/A	--	(1,348,000)
TOTAL DECREASES	--	N/A	--	($27,548,000)
NET CHANGE	--	N/A	291	$118,073,000

Hospital and Health Clinics

2005 Enacted	$1,289,418,000
Total estimated budget authority	$1,289,418,000
(Obligations)	($1,289,418,000)
2006 Estimate	$1,359,541,000
(Obligations)	$1,359,541,000
Net Change	$70,123,000
(Obligations)	($70,123,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise at 3.5% (3 mos.)	--	N/A	--	$4,064,000
2 FY 2006 Pay Raise at 3.1 & 2.3% (9 mos.)	--	N/A	--	7,899,000
3 Tribal Pay Cost	--	N/A	--	18,764,000
4 Within Grade Increase	--	N/A	--	7,287,000
5 One Day Less Pay	--	N/A	--	(1,666,000)
6 Service and Supply Fund	--	N/A	--	723,000
7 Increased Cost of Travel	--	6,985,000	--	140,000
8 Increased Cost of Trans & Things	--	5,876,000	--	118,000
9 Increased Cost of Printing	--	591,000	--	12,000
10 Increased Cost of Rents, Comm., & Utilities	--	19,657,000	--	393,000
11 Increased Cost of Health Care Provided Under Contracts & Grants	--	82,287,000	--	3,328,000
12 Increased Cost of Supplies	--	68,530,000	--	2,248,000
13 Increased Cost of Medical or other Equipment	--	5,716,000	--	207,000
14 Increased Cost of Land & Structure	--	(86,000)	--	0
15 Increased Cost of Grants	--	610,487,000	--	9,507,000
16 Increased Cost of Insurance/Indemnities	--	351,000	--	7,000
17 Increased Cost of Interest/Dividends	--	58,000	--	1,000
19 Population Growth	--	N/A	--	20,631,000
Subtotal Built-In	--	NA	--	$73,663,000

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
B. Phasing-In of Staff and Operating Cost of New Fac:				
Piñon, AZ Health Center	--	N/A	44	$4,119,000
Idabel, OK Health Center	--	N/A	6	$562,000
Coweta, OK Health Center	--	N/A	79	$6,960,000
Red Mesa, AZ Health Center	--	N/A	36	$3,171,000
Sisseton, SD Health Center	--	N/A	40	$3,524,000
St. Paul, AK Health Center	--	N/A	1	$144,000
Subtotal Staffing	--	N/A	206	18,480,000
TOTAL INCREASES	--	N/A	206	$92,143,000
DECREASES:				
A. Built-In:				
Absorption of Built-In Increases	--	N/A	--	($18,965,000)
Subtotal Built-In	--	N/A	--	($18,965,000)
IT Reduction	--	N/A	--	(1,707,000)
Admin Reduction	--	NA	--	(1,348,000)
TOTAL DECREASES	--	N/A	--	($22,020,000)
NET CHANGE	--	N/A	206	$70,123,000

Dental Health

2005 Enacted	$109,023,000
Total estimated budget authority	$109,023,000
(Obligations)	($109,023,000)
2006 Estimate	$119,489,000
(Obligations)	($119,489,000)
Net Change	$10,466,000
(Obligations)	($10,466,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise at 3.5% (3 mos.)	--	N/A	--	$461,000
2 FY 2006 Pay Raise at 3.1 & 2.3% (9 mos.)	--	N/A	--	1,027,000
3 Tribal Pay Cost	--	N/A	--	1,343,000
4 Within Grade Increase	--	N/A	--	905,000
5 One Day Less Pay	--	N/A	--	(200,000)
6 Increased Cost of Travel	--	728,000	--	15,000
7 Increased Cost of Trans & Things	--	491,000	--	10,000
8 Increased Cost of Printing	--	13,000	--	0
9 Increased Cost of Rents, Comm., & Utilities	--	72,000	--	1,000
10 Increased Cost of Health Care Provided Under Contracts & Grants	--	2,892,000	--	234,000
11 Increased Cost of Supplies	--	3,719,000	--	138,000
12 Increased Cost of Medical or other Equipment	--	1,147,000	--	28,000
13 Increased Cost of Land & Structure	--	0	--	0
14 Increased Cost of Grants	--	42,599,000	--	670,000
15 Increased Cost of Insurance/Indemnities	--	0	--	0
16 Increased Cost of Interest/Dividends	--	1,000	--	0
17 Population Growth	--	N/A	--	1,744,000
Subtotal Built-In	--	N/A	--	$6,376,000

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
B. Phasing-In of Staff and Operating Cost of New Fac:				
Piñon, AZ Health Center	--	N/A	25	$2,177,000
Idabel, OK Health Center	--	N/A	1	$87,000
Coweta, OK Health Center	--	N/A	25	$2,124,000
Red Mesa, AZ Health Center	--	N/A	8	$679,000
Sisseton, SD Health Center	--	N/A	9	$765,000
St. Paul, AK Health Center	--	N/A	0	$0
Subtotal Staffing	--	N/A	68	5,832,000
TOTAL INCREASES	--	N/A	68	$12,208,000
DECREASES:				
A. Built-In:				
Absorption of Built-In Increases	--	N/A	--	($1,742,000)
Subtotal Built-In	--	N/A	--	($1,742,000)
TOTAL DECREASES	--	N/A	--	($1,742,000)
NET CHANGE	--	N/A	68	$10,466,000

2005 Enacted	$55,060,000
Total estimated budget authority	$55,060,000
(Obligations)	($55,060,000)
2006 Estimate	$59,328,000
(Obligations)	($59,328,000)
Net Change	$4,268,000
(Obligations)	($4,268,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise at 3.5% (3 mos.)	--	N/A	--	$217,000
2 FY 2006 Pay Raise at 3.1 & 2.3% (9 mos.)	--	N/A	--	374,000
3 Tribal Pay Cost	--	N/A	--	773,000
4 Within Grade Increase	--	N/A	--	367,000
5 One Day Less Pay	--	N/A	--	(81,000)
6 Increased Cost of Travel	--	272,000	--	5,000
7 Increased Cost of Trans & Things	--	395,000	--	8,000
8 Increased Cost of Printing	--	4,000	--	0
9 Increased Cost of Rents, Comm., & Utilities	--	19,000	--	0
10 Increased Cost of Health Care Provided Under Contracts & Grants	--	3,274,000	--	256,000
11 Increased Cost of Supplies	--	422,000	--	14,000
12 Increased Cost of Medical or other Equipment	--	75,000	--	1,000
13 Increased Cost of Land & Structure	--	0	--	0
14 Increased Cost of Grants	--	25,459,000	--	395,000
15 Increased Cost of Insurance/Indemnities	--	16,000	--	0
16 Population Growth	--	N/A	--	881,000
Subtotal Built-In	--	N/A	--	$3,210,000
B. Phasing-In of Staff and Operating Cost of New Fac:				
Piñon, AZ Health Center	--	N/A	7	$769,000
Idabel, OK Health Center	--	N/A	0	$0
Coweta, OK Health Center	--	N/A	6	$670,000
Red Mesa, AZ Health Center	--	N/A	2	$223,000
Sisseton, SD Health Center	--	N/A	2	$223,000
St. Paul, AK Health Center	--	N/A	0	$0
Subtotal Staffing	--	N/A	17	1,885,000
TOTAL INCREASES	--	N/A	8	$5,095,000
DECREASES:				
A. Built-In:				
Absorption of Built-In Increases	--	N/A	--	($827,000)
TOTAL DECREASES	--	N/A	--	($827,000)
NET CHANGE	--	N/A	8	$4,268,000

Alcohol & Substance Abuse

2005 Enacted	$139,073,000
Total estimated budget authority	$139,073,000
(Obligations)	($139,073,000)
2006 Estimate	$145,336,000
(Obligations)	($145,336,000)
Net Change	$6,263,000
(Obligations)	($6,263,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise at 3.5% (3 mos.)	--	N/A	--	$90,000
2 FY 2006 Pay Raise at 3.1 & 2.3% (9 mos.)	--	N/A	--	183,000
3 Tribal Pay Cost	--	N/A	--	3,534,000
4 Within Grade Increase	--	N/A	--	178,000
5 One Day Less Pay	--	N/A	--	(39,000)
6 Increased Cost of Travel	--	293,000	--	6,000
7 Increased Cost of Trans & Things	--	136,000	--	3,000
8 Increased Cost of Printing	--	0	--	0
9 Increased Cost of Rents, Comm., & Utilities	--	185,000	--	3,000
10 Increased Cost of Health Care Provided Under Contracts & Grants	--	7,790,000	--	245,000
11 Increased Cost of Supplies	--	354,000	--	7,000
12 Increased Cost of Medical or other Equipment	--	186,000	--	4,000
13 Increased Cost of Grants	--	119,637,000	--	1,818,000
14 Increased Cost of Insurance/Indemnities	--	0	--	0
15 Increased Cost of Interest/Dividends	--	0	--	0
16 Population Growth	--	N/A	--	2,225,000
Subtotal Built-In	--	N/A	--	$8,257,000
TOTAL INCREASES	--	N/A	--	$8,257,000
DECREASES:				
A. Built-In:				
Absorption of Built-In Increases	--	N/A	--	($1,994,000)
Subtotal Built-In	--	N/A	--	($1,994,000)
TOTAL DECREASES	--	N/A	--	($1,994,000)
NET CHANGE	--	N/A	--	$6,263,000

Contract Health Services

2005 Enacted	$498,068,000
Total estimated budget authority	$498,068,000
(Obligations)	($498,068,000)
2006 Estimate	$525,021,000
(Obligations)	($525,021,000)
Net Change	$26,953,000
(Obligations)	($26,953,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise at 3.5% (3 mos.)	--	N/A	--	$3,000
2 FY 2006 Pay Raise at 3.1 & 2.3% (9 mos.)	--	N/A	--	8,000
3 Within Grade Increase	--	N/A	--	8,000
4 One Day Less Pay	--	N/A	--	(2,000)
5 Increased Cost of Travel	--	17,090,000	--	649,000
6 Increased Cost of Trans & Things	--	2,000	--	0
7 Increased Cost of Rents, Comm., & Utilities	--	4,000	--	0
8 Increased Cost of Health Care Provided Under Contracts & Grants	--	214,078,000	--	8,132,000
9 Increased Cost of Supplies	--	13,334,000	--	507,000
10 Increased Cost of Medical or other Equipment	--	28,000	--	1,000
11 Increased Cost of Grants	--	253,052,000	--	9,616,000
12 Increased Cost of Insurance/Indemnities	--	0	--	0
13 Increased Cost of Interest/Dividends	--	43,000	--	1,000
14 Population Growth	--	N/A	--	7,969,000
Subtotal Built-In	--	N/A	--	$26,892,000
B. Phasing-In of Staff and Operating Cost of New Fac:				
Piñon, AZ Health Center	--	N/A	0	$0
Idabel, OK Health Center	--	N/A	0	$0
Coweta, OK Health Center	--	N/A	0	$0
Red Mesa, AZ Health Center	--	N/A	0	$0
Sisseton, SD Health Center	--	N/A	0	$1,026,000
St. Paul, AK Health Center	--	N/A	0	$0
Subtotal Staffing	--	N/A	0	1,026,000
TOTAL INCREASES	--	N/A	8	$27,918,000

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
DECREASES:				
A. Built-In:				
Absorption of Built-In Increases.	--	N/A	--	($965,000)
Subtotal Built-In.	--	N/A	--	($965,000)
TOTAL DECREASES.	--	N/A	--	($965,000)
NET CHANGE.	--	N/A	--	$26,953,000

Preventive Health

2005 Enacted	$110,381,000
Total estimated budget authority	$110,381,000
(Obligations)	($110,381,000)
2006 Estimate	$118,859,000
(Obligations)	$118,859,000
Net Change	$8,478,000
(Obligations)	($8,478,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise at 3.5% (3 mos.)	--	N/A	--	$225,000
2 FY 2006 Pay Raise at 3.1 & 2.3% (9 mos.)	--	N/A	--	460,000
3 Tribal Pay Cost	--	N/A	--	2,460,000
4 Within Grade Increase	--	N/A	--	445,000
5 One Day Less Pay	--	N/A	--	(96,000)
6 Increased Cost of Travel	--	232,000	--	5,000
7 Increased Cost of Trans & Things	--	617,000	--	12,000
8 Increased Cost of Printing	--	12,000	--	0
9 Increased Cost of Rents, Comm., & Utilities	--	68,000	--	1,000
10 Increased Cost of Health Care Provided Under Contracts & Grants	--	1,486,000	--	54,000
11 Increased Cost of Supplies	--	567,000	--	16,000
12 Increased Cost of Medical or other Equipment	--	575,000	--	17,000
13 Increased Cost of Land & Structure	--	0	--	0
14 Increased Cost of Grants	--	76,556,000	--	1,235,000
15 Increased Cost of Insurance/Indemnities	--	10,000	--	0
16 Population Growth	--	N/A	--	1,766,000
Subtotal Built-In	--	N/A	--	6,600,000
B. Phasing-In of Staff and Operating Cost of New Facilities:				
Piñon, AZ Health Center	--	N/A	16	$1,703,000
Idabel, OK Health Center	--	N/A	0	$0
Coweta, OK Health Center	--	N/A	11	$1,110,000
Red Mesa, AZ Health Center	--	N/A	4	$407,000
Sisseton, SD Health Center	--	N/A	4	$407,000
Subtotal Staffing	--	N/A	35	3,627,000
TOTAL INCREASES	--	N/A	35	$10,227,000
DECREASES:				
A. Absorption of Built-In Increases				
Subtotal Built-In	--	N/A	--	($1,749,000)
	--	N/A	--	($1,749,000)
TOTAL DECREASES	--	N/A	--	($1,749,000)
NET CHANGE	--	N/A	35	$8,478,000

Public Health Nursing

2005 Enacted	$45,015,000
Total estimated budget authority	$45,015,000
(Obligations)	($45,015,000)
2006 Estimate	$49,690,000
(Obligations)	$49,690,000
Net Change	$4,675,000
(Obligations)	($4,675,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise at 3.5% (3 mos.)	--	N/A	--	$198,000
2 FY 2006 Pay Raise at 3.1 & 2.3% (9 mos.)	--	N/A	--	408,000
3 Tribal Pay Cost	--	N/A	--	618,000
4 Within Grade Increase	--	N/A	--	393,000
5 One Day Less Pay	--	N/A	--	(85,000)
6 Increased Cost of Travel	--	139,000	--	3,000
7 Increased Cost of Trans & Things	--	571,000	--	11,000
8 Increased Cost of Printing	--	7,000	--	0
9 Increased Cost of Rents, Comm., & Utilities	--	28,000	--	1,000
10 Increased Cost of Health Care Provided Under Contracts & Grants	--	425,000	--	27,000
11 Increased Cost of Supplies	--	273,000	--	5,000
12 Increased Cost of Medical or other Equipment	--	300,000	--	6,000
13 Increased Cost of Land & Structure	--	0	--	0
14 Increased Cost of Grants	--	16,967,000	--	314,000
15 Increased Cost of Insurance/Indemnities	--	0	--	0
16 Increased Cost of Interest/Dividends	--	8,000	--	0
17 Population Growth	--	N/A	--	720,000
Subtotal Built-in	--	N/A		2,619,000
B. Phasing-In of Staff and Operating Cost of New Fac:				
Piñon, AZ Health Center	--	N/A	13	$1,342,000
Idabel, OK Health Center	--	N/A	0	$0
Coweta, OK Health Center	--	N/A	9	$888,000
Red Mesa, AZ Health Center	--	N/A	3	$296,000
Sisseton, SD Health Center	--	N/A	3	$296,000
St. Paul, AK Health Center	--	N/A	0	$0
Subtotal Staffing	--	N/A	28	2,822,000
TOTAL INCREASES	--	N/A	28	$5,441,000

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
DECREASES:				
A. Built-In:				
Absorption of Built-In Increases.	--	N/A	--	($766,000)
Subtotal Built-In.	--	N/A	--	($766,000)
TOTAL DECREASES.	--	N/A	--	($766,000)
NET CHANGE.	--	N/A	--	$4,675,000

2005 Enacted	$12,429,000
Total estimated budget authority	$12,429,000
(Obligations)	($12,429,000)
2006 Estimate	$13,787,000
(Obligations)	($13,787,000)
Net Change	$1,358,000
(Obligations)	($1,358,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise at 3.5% (3 mos.)	--	N/A	--	$26,000
2 FY 2006 Pay Raise at 3.1 & 2.3% (9 mos.)	--	N/A	--	49,000
3 Tribal Pay Cost	--	N/A	--	268,000
4 Within Grade Increase	--	N/A	--	49,000
5 One Day Less Pay	--	N/A	--	(10,000)
6 Increased Cost of Travel	--	84,000	--	2,000
7 Increased Cost of Trans & Things	--	45,000	--	1,000
8 Increased Cost of Printing	--	5,000	--	0
9 Increased Cost of Rents, Comm., & Utilities	--	32,000	--	0
10 Increased Cost of Health Care Provided Under Contracts & Grants	--	257,000	--	9,000
11 Increased Cost of Supplies	--	237,000	--	9,000
12 Increased Cost of Medical or other Equipment	--	253,000	--	10,000
13 Increased Cost of Grants	--	7,747,000	--	133,000
14 Population Growth	--	N/A	--	199,000
Subtotal Built-In	--	8,660,000	--	$745,000
B. Phasing-In of Staff and Operating Cost of New Fac:				
Piñon, AZ Health Center	--	N/A	3	$361,000
Idabel, OK Health Center	--	N/A	0	$0
Coweta, OK Health Center	--	N/A	2	$222,000
Red Mesa, AZ Health Center	--	N/A	1	$111,000
Sisseton, SD Health Center	--	N/A	1	$111,000
St. Paul, AK Health Center	--	N/A	0	$0
Subtotal Staffing	--	N/A	7	805,000
TOTAL INCREASES	--	N/A	7	$1,550,000
DECREASES:				
A. Built-In:				
Absorption of Built-In Increases	--	N/A	--	($192,000)
Subtotal Built-In	--	N/A	--	($192,000)
TOTAL DECREASES	--	N/A	--	($192,000)
NET CHANGE	--	N/A	--	$1,358,000

Community Health Representative

2005 Enacted	$51,365,000
Total estimated budget authority	$51,365,000
(Obligations)	($51,365,000)
2006 Estimate	$53,737,000
(Obligations)	($53,737,000)
Net Change	$2,372,000
(Obligations)	($2,372,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise at 3.5% (3 mos.)	--	N/A	--	$1,000
2 FY 2006 Pay Raise at 3.1 & 2.3% (9 mos.)	--	N/A	--	3,000
3 Tribal Pay Cost	--	N/A	--	1,526,000
4 Within Grade Increase	--	N/A	--	3,000
5 One Day Less Pay	--	N/A	--	(1,000)
6 Increased Cost of Travel	--	9,000	--	0
7 Increased Cost of Trans & Things	--	1,000	--	0
8 Increased Cost of Rents, Comm., & Utilities	--	8,000	--	0
9 Increased Cost of Health Care Provided Under Contracts & Grants	--	804,000	--	18,000
10 Increased Cost of Supplies	--	57,000	--	2,000
11 Increased Cost of Medical or other Equipment	--	22,000	--	1,000
12 Increased Cost of Grants	--	50,270,000	--	764,000
13 Increased Cost of Insurance/Indemities	--	2,000	--	0
14 Population Growth	--	N/A	--	822,000
Subtotal Built-In	--	N/A	--	$3,139,000
TOTAL INCREASES	--	N/A	--	$3,139,000
DECREASES:				
A. Built-In:				
Absorption of Built-In Increases	--	N/A	--	($767,000)
Subtotal Built-In	--	N/A	--	($767,000)
TOTAL DECREASES	--	N/A	--	($767,000)
NET CHANGE	--	N/A	0	$2,372,000

Immunization

2005 Enacted	$1,572,000
Total estimated budget authority	$1,572,000
(Obligations)	($1,572,000)
2006 Estimate	$1,645,000
(Obligations)	($1,645,000)
Net Change	$73,000
(Obligations)	($73,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Tribal Pay Cost	--	N/A	--	$48,000
2 Increased Cost of Grants	--	1,572,000	--	$24,000
3 Population Growth	--	N/A	--	$25,000
Subtotal Built-In	--	1,572,000	--	$97,000
TOTAL INCREASES	--	N/A	--	$97,000
DECREASES:				
A. Built-In:				
Absorption of Built-In Increases	--	N/A	--	($24,000)
Subtotal Built-In	--	N/A	--	($24,000)
TOTAL DECREASES	--	N/A	--	($24,000)
NET CHANGE	--	N/A	--	$73,000

Other Services

2005 Enacted	$395,469,000
Total estimated budget authority	$395,469,000
(Obligations)	($395,469,000)
2006 Estimate	$404,724,000
(Obligations)	($404,724,000)
Net Change	$9,255,000
(Obligations)	($9,255,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise at 3.5% (3 mos.)	--	N/A	--	$382,000
2 FY 2006 Pay Raise at 3.1 & 2.3% (9 mos.)	--	N/A	--	$764,000
3 Tribal Pay Cost	--	N/A	--	$1,259,000
4 Within Grade Increase	--	N/A	--	740,000
5 One Day Less Pay	--	N/A	--	(159,000)
6 Increased Cost of Travel	--	1,952,000	--	39,000
7 Increased Cost of Trans & Things	--	141,000	--	3,000
8 Increased Cost of Printing	--	71,000	--	1,000
9 Increased Cost of Rents, Comm., & Utilities	--	488,000	--	9,000
10 Increased Cost of Health Care Provided Under Contracts & Grants	--	6,154,000	--	151,000
11 Increased Cost of Supplies	--	486,000	--	9,000
12 Increased Cost of Medical or other Equipment	--	377,000	--	8,000
13 Increased Cost of Land & Structure	--	0	--	0
14 Increased Cost of Grants	--	339,484,000	--	7,196,000
15 Increased Cost of Insurance/Indemnities	--	25,000	--	1,000
15 Population Growth	--	N/A	--	509,000
Subtotal Built-In	--	N/A	--	$10,912,000

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. CSC Increase				$5,000,000
Built-In Increases				$10,912,000
TOTAL INCREASES.	--	N/A	--	$15,912,000
DECREASES:				
B. Built-In:				
Absorption of Built-In Increases.	--	N/A	--	($11,403,000)
Subtotal Built-In.	--	N/A	--	($11,403,000)
TOTAL DECREASES.	--	N/A	--	($11,403,000)
NET CHANGE.	--	N/A	--	$4,509,000

Urban Health

2005 Enacted	$31,816,000
Total estimated budget authority	$31,816,000
(Obligations)	($31,816,000)
2006 Estimate	$33,233,000
(Obligations)	$33,233,000
Net Change	$1,417,000
(Obligations)	($1,417,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise at 3.5% (3 mos.)	--	N/A	--	$11,000
2 FY 2006 Pay Raise at 3.1 & 2.3% (9 mos.)	--	N/A	--	24,000
3 Tribal Pay Cost	--	N/A	--	804,000
4 Within Grade Increase	--	N/A	--	21,000
5 One Day Less Pay	--	N/A	--	(4,000)
6 Increased Cost of Travel	--	102,000	--	2,000
7 Increased Cost of Trans & Things	--	6,000	--	0
8 Increased Cost of Printing	--	0	--	0
9 Increased Cost of Rents, Comm., & Utilities	--	11,000	--	0
10 Increased Cost of Health Care Provided Under Contracts & Grants	--	2,321,000	--	54,000
11 Increased Cost of Supplies	--	5,000	--	0
12 Increased Cost of Equipment	--	23,000	--	1,000
12 Increased Cost of Grants	--	28,189,000	--	428,000
13 Population Growth	--	N/A	--	509,000
Subtotal Built-In	--	N/A	--	$1,850,000
TOTAL INCREASES	--	N/A	--	$1,850,000
DECREASES:				
A. Built-In:				
Absorption of Built-In Increases	--	N/A	--	($433,000)
Subtotal Built-In	--	N/A	--	($433,000)
TOTAL DECREASES	--	N/A	--	($433,000)
NET CHANGE	--	N/A	--	$1,417,000

Indian Health Professions

2005 Enacted	$30,392,000
Total estimated budget authority	$30,392,000
(Obligations)	($30,392,000)
2006 Estimate	$31,503,000
(Obligations)	($31,503,000)
Net Change	$1,111,000
(Obligations)	($1,111,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise at 3.5% (3 mos.)	--	N/A	--	$16,000
2 FY 2006 Pay Raise at 3.1 & 2.3% (9 mos.)	--	N/A	--	37,000
3 Within Grade Increase	--	N/A	--	35,000
4 One Day Less Pay	--	N/A	--	(7,000)
5 Increased Cost of Travel	--	114,000	--	2,000
6 Increased Cost of Trans & Things	--	0	--	0
7 Increased Cost of Printing	--	17,000	--	0
8 Increased Cost of Rents, Comm., & Utilities	--	79,000	--	1,000
9 Increased Cost of Health Care Provided Under Contracts & Grants	--	330,000	--	6,000
10 Increased Cost of Supplies	--	7,000	--	0
11 Increased Cost of Medical or other Equipment	--	4,000	--	0
12 Increased Cost of Grants	--	27,830,000	--	1,056,000
13 Increased Cost of Insurance/Indemnities	--	25,000	--	1,000
Subtotal Built-In	--	N/A	--	$1,147,000
TOTAL INCREASES	--	N/A	--	$1,147,000
DECREASES:				
A. Built-In:				
Absorption of Built-In Increases	--	N/A	--	($36,000)
Subtotal Built-In	--	N/A	--	($36,000)
TOTAL DECREASES	--	N/A	--	($36,000)
NET CHANGE	--	N/A	--	$1,111,000

Tribal Management

2005 Enacted	$2,343,000
Total estimated budget authority	$2,343,000
(Obligations)	($2,343,000)
2006 Estimate	$2,430,000
(Obligations)	($2,430,000)
Net Change	$87,000
(Obligations)	($87,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Increased Cost of Travel	--	4,000	--	0
2 Increased Cost of Trans & Things	--	1,000	--	0
3 Increased Cost of Printing	--	3,000	--	0
4 Increased Cost of Rents, Comm., & Utilities	--	11,000	--	0
5 Increased Cost of Health Care Provided Under Contracts & Grants	--	58,000	--	1,000
6 Increased Cost of Supplies	--	1,000	--	0
7 Increased Cost of Medical or other Equipment	--	0	--	0
8 Increased Cost of Grants	--	2,262,000	--	86,000
Subtotal Built-In	--	N/A	--	$87,000
TOTAL INCREASES	--	N/A	--	$87,000
DECREASES:				
A. Built-In:				
Absorption of Built-In Increases	--	N/A	--	$0
Subtotal Built-In	--	N/A	--	$0
TOTAL DECREASES	--	N/A	--	$0
NET CHANGE	--	N/A	--	$87,000

Direct Operations

2005 Enacted	$61,649,000
Total estimated budget authority	$61,649,000
(Obligations)	($61,649,000)
2006 Estimate	$63,123,000
(Obligations)	($63,123,000)
Net Change	$1,474,000
(Obligations)	($1,474,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise at 3.5% (3 mos.)	--	N/A	--	$348,000
2 FY 2006 Pay Raise at 3.1 & 2.3% (9 mos.)	--	N/A	--	688,000
3 Tribal Pay Cost	--	N/A	--	455,000
4 Within Grade Increase	--	N/A	--	669,000
5 One Day Less Pay	--	N/A	--	(145,000)
6 Increased Cost of Travel	--	1,588,000	--	32,000
7 Increased Cost of Trans & Things	--	131,000	--	3,000
8 Increased Cost of Printing	--	47,000	--	1,000
9 Increased Cost of Rents, Comm., & Utilities	--	387,000	--	8,000
10 Increased Cost of Health Care Provided Under Contracts & Grants	--	2,079,000	--	63,000
11 Increased Cost of Supplies	--	454,000	--	9,000
12 Increased Cost of Medical or other Equipment	--	345,000	--	7,000
13 Increased Cost of Grants	--	14,414,000	--	234,000
14 Increased Cost of Interest/Dividends	--	8,000	--	0
Subtotal Built-In	--	N/A	--	$2,372,000
TOTAL INCREASES	--	N/A	--	$2,372,000
DECREASES:				
A. Built-In:				
Absorption of Built-In Increases	--	N/A	--	($898,000)
Subtotal Built-In	--	N/A	--	($898,000)
TOTAL DECREASES	--	N/A	--	($898,000)
NET CHANGE	--	N/A	--	$1,474,000

Self Governance

2005 Enacted	$5,586,000
Total estimated budget authority	$5,586,000
(Obligations)	($5,586,000)
2006 Estimate	$5,752,000
(Obligations)	($5,752,000)
Net Change	$166,000
(Obligations)	($166,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise at 3.5% (3 mos.)	--	N/A	--	$7,000
2 FY 2006 Pay Raise at 3.1 & 2.3% (9 mos.)	--	N/A	--	15,000
3 Tribal Pay Cost	--	N/A	--	0
4 Within Grade Increase	--	N/A	--	15,000
5 One Day Less Pay	--	N/A	--	(3,000)
6 Increased Cost of Travel	--	144,000	--	3,000
7 Increased Cost of Printing	--	3,000	--	0
8 Increased Cost of Rents, Comm., & Utilities	--	0	--	0
9 Increased Cost of Health Care Provided Under Contracts & Grants	--	1,366,000	--	27,000
10 Increased Cost of Supplies	--	19,000	--	0
11 Increased Cost of Medical or other Equipment	--	5,000	--	0
12 Land & Structures		0		0
13 Increased Cost of Grants	--	3,106,000	--	118,000
14 Increased Cost of Interest/Dividends	--	49,000	--	0
Subtotal Built-In	--	N/A	--	$182,000
TOTAL INCREASES	--	N/A	--	$182,000
DECREASES:				
A. Built-In:				
Absorption of Built-In Increases	--	N/A	--	($16,000)
Subtotal Built-In	--	N/A	--	($16,000)
TOTAL DECREASES	--	N/A	--	($16,000)
NET CHANGE	--	N/A	--	$166,000

Contract Support Costs

2005 Enacted	$263,683,000
Total estimated budget authority	$263,683,000
(Obligations)	($263,683,000)
2006 Estimate	$268,683,000
(Obligations)	($268,683,000)
Net Change	$5,000,000
(Obligations)	($5,000,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Increased Cost of Health Care Provided Under Contracts & Grants	--	0	--	0
2 Increase Cost of Grants	--	263,683,000	--	$5,274,000
Subtotal Built-In	--	N/A	--	$5,274,000
TOTAL INCREASES	--	N/A	--	$5,274,000
DECREASES:				
A. Built-In:				
Absorption of Built-In Increases	--	N/A	--	($5,274,000)
Subtotal Built-In	--	N/A	--	($5,274,000)
B. Program Increases:				
Contract Support Cost Increase	--	N/A	--	$5,000,000
TOTAL INCREASES	--	N/A	--	$5,000,000
TOTAL DECREASES	--	N/A	--	($5,274,000)
NET CHANGE	--	N/A	--	$5,000,000

Indian Health Facilities

2005 Enacted	$388,574,000
Total estimated budget authority	$388,574,000
(Obligations)	($388,574,000)
2006 Estimate	$315,668,000
(Obligations)	$315,668,000
Net Change	($72,906,000)
(Obligations)	$72,906,000

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise at 3.5% (3 mos.)	--	N/A	--	$671,000
2 FY 2006 Pay Raise at 301 & 2.3% (9 mos.)	--	N/A	--	1,502,000
3 Within Grade Increase	--	N/A	--	1,375,000
4 One Day Less Pay	--	N/A	--	(301,000)
5 Tribal Pay	--	N/A	--	1,216,000
7 Increased Cost of Travel	--	2,673,000	--	53,000
8 Increased Cost of Trans & Things	--	2,328,000	--	47,000
9 Increased Cost of Printing	--	81,000	--	1,000
10 Increased Cost of Rents, Comm., & Utilities	--	10,766,000	--	226,000
11 Increased Cost of Health Care Provided Under Contracts & Grants	--	162,271,000	--	1,526,000
12 Increased Cost of Supplies	--	5,616,000	--	118,000
13 Increased Cost of Medical or other Equipment	--	1,709,000	--	234,000
14 Increased Cost of Land & Structure	--	7,453,000	--	166,000
15 Increased Cost of Grants	--	85,550,000	--	2,307,000
16 Increased Cost of Insurance/Indemnities	--	37,000	--	0
17 Increased Cost of Interests/Dividends	--	12,000	--	0
18 Population Growth	--	N/A	--	2,267,000
Subtotal Built-In	--	N/A	--	$11,408,000
B. Phasing-In of Staff and Operating Cost of New Fac:				
Piñon, AZ Health Center	--	N/A	6	$1,039,000
Idabel, OK Health Center	--	N/A	0	$35,000
Coweta, OK Health Center	--	N/A	6	$1,084,000
Red Mesa, AZ Health Center	--	N/A	7	$848,000
Sisseton, SD Health Center	--	N/A	7	$870,000
St. Paul, AK Health Center	--	N/A	1	$116,000
Subtotal Staffing	--	N/A	27	$3,992,000
TOTAL INCREASES	--	N/A	27	$15,400,000

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
DECREASES:				
A. Built-In:				
Absorption of Built-In Increases	--	N/A	--	($3,035,000)
Subtotal Built-In	--	N/A	--	($3,035,000)
B. 1 Base Reduction to Healthcare Facilities Construction	--	94,554,000	--	(85,271,000)
Subtotal Built-In	--	N/A	--	($85,271,000)
TOTAL DECREASES	--	N/A	--	($88,306,000)
NET CHANGE	--	N/A	27	($72,906,000)

Maintenance & Improvement

2005 Enacted…...	$49,204,000
Total estimated budget authority	$49,204,000
(Obligations)	($49,204,000)
2006 Estimate	$49,904,000
(Obligations)	$49,904,000
Net Change	$700,000
(Obligations)	($700,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Increased Cost of Travel	--	122 000	--	2,000
2 Increased Cost of Trans & Things	--	34 000	--	1,000
3 Increased Cost of Printing	--	3 000	--	0
4 Increased Cost of Rents, Comm., & Utilities	--	208 000	--	4,000
5 Increased Cost of Health Care Provided Under Contracts & Grants	--	9 362 000	--	181,000
6 Increased Cost of Supplies	--	3 148 000	--	68,000
7 Increased Cost of Equipment	--	359 000		7,000
8 Increased Cost of Land & Structure	--	7 306 000	--	146,000
9 Increased Cost of Grants	--	28 658 000	--	1,089,000
10 Increased Cost of Interest/Dividends	--		--	0
Subtotal Built-In	--	N/A	--	$1,498,000
TOTAL INCREASES	--	0	--	$1,498,000
DECREASE:				
A. Built-In:				
Absorption of Built-In Increases	--	N/A	--	($798,000)
Subtotal Built-In	--	N/A	--	($798,000)
TOTAL DECREASE	--	N/A	--	($798,000)
NET CHANGE	--	N/A	--	$700,000

2005 Enacted	$91,767,000
Total estimated budget authority	$91,767,000
(Obligations)	($91,767,000)
2006 Estimate	$93,519,000
(Obligations)	($93,519,000)
Net Change	$1,752,000
(Obligations)	($1,752,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise at 3.5% (3 mos.)	--	N/A	--	$0
2 FY 2006 CS&CO Pay Raise at 3.1 & 2.3% (9 mos.)	--	N/A	--	0
3 Within Grade Increase	--	N/A	--	0
4 One Day Less Pay	--	N/A	--	0
5 Increased Cost of Travel	--	169,000	--	3,000
6 Increased Cost of Trans & Things	--	0	--	0
7 Increased Cost of Printing	--	24,000	--	0
8 Increased Cost of Rents, Comm., & Utilities	--	45,000	--	2,000
9 Increased Cost of Health Care Provided Under Contracts & Grants	--	61,141,000	--	1,224,000
10 Increased Cost of Supplies	--	0	--	0
11 Increased Cost of Medical or other Equipment	--	0	--	0
12 Increased Cost of Land & Structure	--	0	--	0
13 Increased Cost of Grants	--	26,154,000	--	523,000
14 Interest/Dividends	--	0	--	0
Subtotal Built-In	--	N/A	--	$1,752,000
TOTAL INCREASES	--	N/A	--	$1,752,000
DECREASES:				
A. Built-In:				
Absorption of Built-In Increases	--	N/A	--	$0
Subtotal Built-In	--	N/A	--	$0
TOTAL DECREASE	--	N/A	--	$0
NET CHANGE	--	N/A	--	$1,752,000

Health Care Facilities Construction

2005 Enacted…...	$88,597,000
Total estimated budget authority.	$88,597,000
(Obligations)	($88,597,000)
2006 Estimate	$3,326,000
(Obligations)	($3,326,000)
Net Change	($85,271,000)
(Obligations)	($85,271,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
DECREASE:				
A. Built-In:				
1 Base Reduction to Healthcare Facilities Construction.	--	88,597,000	--	(3,326,000)
Subtotal Built-In.	--	N/A	--	($3,326,000)
TOTAL DECREASE.	--	N/A	--	($3,326,000)
NET CHANGE.	--	N/A	--	($85,271,000)

Facilities & Environmental Health Support

2005 Enacted…..	$141,669,000
Total estimated budget authority	$141,669,000
(Obligations)	($141,669,000)
2006 Estimate	$150,959,000
(Obligations)	($150,959,000)
Net Change	$9,290,000
(Obligations)	($9,290,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A.				
Built-In:				
1 Annualization of FY 2005 Pay Raise at 3.5% (3 mos.)	--	N/A	--	$671,000
2 FY 2006 Pay Raise at 3.1 & 2.3% (9 mos.)	--	N/A	--	$1,502,000
3 Within Grade Increase	--	N/A	--	$1,375,000
4 One Day Less Pay	--	N/A	--	-$301,000
5 Tribal Pay	--	N/A	--	$1,216,000
7 Increased Cost of Travel	--	2,382,000	--	$48,000
8 Increased Cost of Trans & Things	--	2,294,000	--	$46,000
9 Increased Cost of Printing	--	54,000	--	$1,000
10 Increased Cost of Rents, Comm., & Utilities	--	10,376,000	--	$217,000
11 Increased Cost of Health Care Provided Under Contracts & Grants	--	2,504,000	--	$109,000
12 Increased Cost of Supplies	--	2,403,000	--	$49,000
13 Increased Cost of Medical or other Equipment	--	1,709,000	--	$35,000
14 Increased Cost of Land & Structure	--	147,000	--	$3,000
15 Increased Cost of Grants	--	30,737,000	--	$297,000
16 Increased Cost of Insurance/Indemnities		37,000		$0
17 Increased Cost of Interest/Dividends	--	12,000	--	$0
18 Population Growth	--	N/A	--	$2,267,000
Subtotal Built-In	--	N/A	--	$7,535,000
B.				
Phasing-In of Staff and Operating Cost of New Fac:				
Piñon, AZ Health Center	--	N/A	6	$1,039,000
Idabel, OK Health Center	--	N/A	0	$35,000
Coweta, OK Health Center	--	N/A	6	$1,084,000
Red Mesa, AZ Health Center	--	N/A	7	$848,000
Sisseton, SD Health Center	--	N/A	7	$870,000
St. Paul, AK Health Center	--	N/A	1	$116,000
Subtotal Staffing	--	N/A	27	$3,992,000

TOTAL INCREASES.	--	N/A	15	$11,527,000

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
DECREASES:				
A.				
Built-In:				
Absorption of Built-In Increases.	--	N/A	--	($2,237,000)
Subtotal Built-In.	--	N/A	--	($2,237,000)
TOTAL DECREASES.	--	N/A	--	($2,237,000)
NET CHANGE.	--	N/A	15	$9,290,000

Facilities Health Support

2005 Enacted…..	$73,843,000
Total estimated budget authority	$73,843,000
(Obligations)	($73,843,000)
2006 Estimate	$79,348,000
(Obligations)	($79,348,000)
Net Change	$5,505,000
(Obligations)	($5,505,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise at 3.5% (3 mos.)	--	N/A	--	$349,000
2 FY 2006 Pay Raise at 3.1 & 2.3% (9 mos.)	--	N/A	--	783,000
3 Within Grade Increase	--	N/A	--	716,000
4 One Day Less Pay	--	N/A	--	(157,000)
5 Tribal Pay	--	N/A	--	634,000
6 Increased Cost of Travel	--	1,048,000	--	21,000
7 Increased Cost of Trans & Things	--	810,000	--	16,000
8 Increased Cost of Printing	--	8,000	--	0
9 Increased Cost of Rents, Comm., & Utilities	--	10,081,000	--	202,000
10 Increased Cost of Health Care				
11 Provided Under Contracts & Grants	--	1,580,000	--	58,000
12 Increased Cost of Supplies	--	1,779,000	--	37,000
13 Increased Cost of Medical or other Equipment	--	746,000	--	16,000
14 Increased Cost of Land & Structure	--	146,000	--	3,000
15 Increased Cost of Grants	--	13,837,000	--	137,000
16 Increased Cost of Insurance/Indemnities	--	23,000	--	0
17 Increased Cost of Interest/Dividends	--	11,000	--	0
Subtotal Built-In	--	N/A	--	$2,815,000
B. Phasing-In of Staff and Operating Cost of New Fac:				
Pinon, AZ Health Center	--	N/A	5	$948,000
Idabel, OK Health Center	--	N/A	0	35,000
Coweta, OK Health Center	--	N/A	6	1,084,000
Red Mesa, AZ Health Center	--	N/A	6	754,000
Sisseton, SD Health Center	--	N/A	6	776,000
St. Paul, AK Health Center	--	N/A	1	116,000
Subtotal Staffing	--	N/A	24	3,713,000
TOTAL INCREASES	--	N/A	24	$6,528,000

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
DECREASES:				
A. Built-In:				
Absorption of Built-In Inflation Increases. . .	--	N/A	--	($1,023,000)
Subtotal Built-In.	--	0	--	($1,023,000)
TOTAL DECREASES.	--	N/A	--	($1,023,000)
NET CHANGE.	--	N/A	24	$5,505,000

2005 Enacted…..	$56,329,000
Total estimated budget authority	$56,329,000
(Obligations)	($56,329,000)
2006 Estimate	$59,836,000
(Obligations)	($59,836,000)
Net Change	$3,507,000
(Obligations)	($3,507,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise at 3.5% (3 mos.)	--	N/A	--	$267,000
2 FY 2006 Pay Raise at 3.1 & 2.3% (9 mos.)	--	N/A	--	597,000
3 Within Grade Increase	--	N/A	--	547,000
4 One Day Less Pay	--	N/A	--	(120,000)
5 Tribal Pay	--	N/A	--	483,000
6 Increased Cost of Travel	--	802,000	--	16,000
7 Increased Cost of Trans & Things	--	1,404,000	--	28,000
8 Increased Cost of Printing	--	19,000	--	0
9 Increased Cost of Rents, Comm., & Utilities	--	263,000	--	7,000
10 Increased Cost of Health Care Provided Under Contracts & Grants	--	267,000	--	9,000
11 Increased Cost of Supplies	--	418,000	--	8,000
12 Increased Cost of Medical or other Equipment	--	717,000	--	14,000
13 Increased Cost of Land Structure		1,000		0
14 Increased Cost of Grants	--	16,468,000	--	157,000
15 Increased Cost of Insurance/Indemnities	--	14,000	--	0
16 Increased Cost of Interest/Dividends	--	1,000	--	0
17 Population growth	--	N/A	--	2,267,000
Subtotal Built-In	--	N/A	--	$4,280,000
B. Phasing-In of Staff and Operating Cost of New Fac:				
Piñon, AZ Health Center	--	N/A	1	$91,000
Idabel, OK Health Center	--	N/A	0	0
Coweta, OK Health Center	--	N/A	0	0
Red Mesa, AZ Health Center	--	N/A	1	$94,000
Sisseton, SD Health Center	--	N/A	1	$94,000
St. Paul, AK Health Center	--	N/A	0	$0
Subtotal Staffing			3	$279,000
TOTAL INCREASES	--	N/A	1	$4,559,000
DECREASES:				
A. Built-In:				
Absorption of Built-In Increases	--	N/A	--	($1,052,000)
Subtotal Built-In	--	N/A	--	($1,052,000)
TOTAL DECREASES	--	N/A	--	($1,052,000)
NET CHANGE	--	N/A	1	$3,507,000

2005 Enacted…..	$11,497,000
Total estimated budget authority	$11,497,000
(Obligations)	($11,497,000)
2006 Estimate	$11,775,000
(Obligations)	($11,775,000)
Net Change	$278,000
(Obligations)	($278,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Annualization of FY 2005 Pay Raise at 3.5% (3 mos.)	--	N/A	--	$55,000
2 FY 2006 Pay Raise at 3.1 & 2.3% (9 mos.)	--	N/A	--	122,000
3 Within Grade Increase	--	N/A	--	112,000
4 One Day Less Pay	--	N/A	--	(24,000)
5 Tribal Pay	--	N/A	--	99,000
6 Increased Cost of Travel	--	532,000	--	11,000
7 Increased Cost of Trans & Things	--	80,000	--	2,000
8 Increased Cost of Printing	--	27,000	--	1,000
9 Increased Cost of Rents, Comm., & Utilities	--	32,000	--	8,000
10 Increased Cost of Health Care Provided Under Contracts & Grants	--	657,000	--	42,000
11 Increased Cost of Supplies	--	206,000	--	4,000
12 Increased Cost of Medical or other Equipment	--	246,000	--	5,000
13 Increased Cost of Grants	--	432,000	--	3,000
Subtotal Built-In	--	N/A	--	$440,000
TOTAL INCREASES	--	0	--	$440,000
DECREASE:				
A. Built-In:				
Absorption of Built-In Increases	--	N/A	--	($162,000)
Subtotal Built-In	--	N/A	--	($162,000)
TOTAL DECREASE	--	N/A	--	($162,000)
NET CHANGE	--	N/A	--	$278,000

Equipment

2005 Enacted…..	$17,337,000
Total estimated budget authority	$17,337,000
(Obligations)	($17,337,000)
2006 Estimate	$17,960,000
(Obligations)	($17,960,000)
Net Change	$623,000
(Obligations)	($623,000)

	2005 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES:				
A. Built-In:				
1 Increased Cost of Trans & Things.	--	83,000	--	0
2 Increased Cost of Printing.	--		--	0
3 Increased Cost of Rents, Comm., & Utilities	--	137,000	--	3,000
Provided Under Contracts & Grants.	--	667,000	--	12,000
4 Increased Cost of Supplies.	--	65,000	--	1,000
5 Increased Cost of Equipment	--	5,043,000	--	192,000
6 Increased Cost of Land Structure	--	860,000	--	17,000
7 Increased Cost of Grants.	--	1,000	--	398,000
Subtotal Built-In.	--	N/A	--	$623,000
TOTAL INCREASES.	--	N/A	--	$623,000
DECREASE:				
A. Built-In:				
Absorption of Built-In Increases.	--	N/A	--	$0
Subtotal Built-In.	--	N/A	--	$0
TOTAL DECREASE.	--	N/A	--	$0
NET CHANGE.	--	N/A	--	$623,000

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

	2004 Actual		2005 Final Appropriation		2006 Estimate	
	FTE	Amount	FTE	Amount	FTE	Amount
SERVICES:						
Hospitals & Health Clinics	6,408	$1,249,781	7,190	$1,289,418	7,190	$1,359,541
Dental Services	760	104,513	850	109,023	850	119,489
Mental Health	253	53,294	317	55,060	317	59,328
Alcohol & Substance Abuse	174	138,250	180	139,073	180	145,336
Contract Health Services	1	479,070	1	498,068	1	525,021
Total Clinical Services	7,596	2,024,908	8,538	2,090,642	8,538	2,208,715
Public Health Nursing	252	42,581	317	45,015	317	49,690
Health Education	25	11,793	39	12,429	39	13,787
Comm.Health Reps.	4	50,996	4	51,365	4	53,737
Immunization AK	0	1,561	0	1,572	0	1,645
Total Preventive Health	281	106,931	360	110,381	360	118,859
Urban Health	9	31,619	11	31,816	11	33,233
Indian Health Professions	32	30,774	32	30,392	32	31,503
Tribal Management	0	2,376	0	2,343	0	2,430
Direct Operations	357	60,714	387	61,649	387	63,123
Self-Governance	8	5,644	8	5,586	8	5,752
Contract Support Costs	0	267,398	0	263,683	0	268,683
Total Services	8,283	2,530,364	9,336	2,596,492	9,336	2,732,298
FACILITIES:						
Maintenance & Improvement	0	48,897	0	49,204	0	49,904
Sanitation Facilities Constructi	183	93,015	198	91,767	198	93,519
Construction Facilities	0	94,554	0	88,597	0	3,326
Facil. & Envir. Hlth Supp.	1,065	137,803	1,214	141,669	1,214	150,959
Equipment	0	17,081	0	17,337	0	17,960
Total Facilities	1,248	$391,350	1,412	$388,574	1,412	$315,668
Total IHS	9,531	$2,921,714	10,748	$2,985,066	10,748	$3,047,966

HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
Budget Authority by Object
(Dollars in Thousands)

	FY 2005 Appropriation	FY 2006 Estimate	FY 2006 +/- FY 2005
Full-time equivalent employment.....	10,748	10,748	0
Full-time equivalent of overtime and holiday hours.....	425	425	0
Average SES salary.....	$146,167	$149,529	$3,362
Average GS grade.....	8.1	8.1	0
Average GS salary.....	$37,654	$38,520	$866
Personnel Compensation:			
Full-Time Permanent(11.0)…….	408,890	428,208	19,318
Other than Full-Time Permanent(11.3)…….	22,352	24,509	2,157
Other Personnel Comp.(11.5)……	37,285	37,824	539
Military Personnel Comp (11.7)…….	103,981	110,686	6,705
Special Personal Services Payments (11.8)……	222	224	2
Subtotal, Personnel Compensation...…….	572,730	601,451	28,721
Civilian Personnel Benefits(12.1)…….	120,274	122,315	2,041
Military Personnel Benefits (12.2)	44,882	47,823	2,941
Benefits to Former Personnel(13.0)…….	13,738	13,035	(703)
Subtotal, Pay Costs……	**751,624**	**784,624**	**33,000**
Travel(21.0)……	30,225	30,872	647
Transportation of Things(22.0)……	10,069	9,903	(166)
Rental Payments to GSA(23.1)…….	4,045	4,048	3
Rental Payments to Others(23.2)……..	2,168	2,135	(33)
Communications, Utilities and Miscellaneous Charges(23.3……	25,542	25,882	340
Printing and Reproduction(24.0)……..	772	762	(10)
Other Contractual Services:			
Advisory and Assistance Services(25.1)…….	4,328	4,301	(27)
Other Services(25.2)…….	120,032	125,106	5,074
Purchases from Govt. Accts.(25.3)……	46,088	46,989	901
Operation and Maintenance of Facilities(25.4)…..	19,852	8,662	(11,190)
Research and Development Contracts(25.5)…….	4	4	0
Medical Care(25.6)……	203,772	204,928	1,156
Operation and Maintenance of Equipment(25.7)…	4,555	4,531	(24)
Subsistence and Support of Persons(25.8)…….	2,146	2,154	8
Subtotal, Other Contractual Current.....…….	**400,777**	**396,675**	**(4,102)**
Supplies and Materials(26.0)……	93,036	94,608	1,572
Equipment (31.0)…….	19,602	15,554	(4,048)
Land & Structures (32.0)……	73,800	10,911	(62,889)
Investments & Loans (33.0)……..	0	0	0
Grants, Subsidies, & Constributions (41.0)…….	1,572,790	1,671,374	98,584
Insurance Claims & Indemnities (42.0)…….	431	433	2
Interest & Dividends (43.0)……	185	185	0
Subtotal Non-Pay Costs.....…….	**2,233,442**	**2,263,342**	**29,900**
Total Budget Authority by Object Class.....	**2,985,066**	**3,047,966**	**62,900**

FY 2006 BUDGET SUBMISSION
INDIAN HEALTH SERVICE
SALARIES AND EXPENSES

(Budget Authority Dollars in Thousands)

Object Class	FY 2005 Appropriation	FY 2006 Estimate	FY 2006 +/- FY 2005
Personnel Compensation:			
Full-Time Permanent(11.0)…….	408,890	428,208	19,318
Other than Full-Time Permanent(11.3)…….	22,352	24,509	2,157
Other Personnel Comp.(11.5)……	37,285	37,824	539
Military Personnel Comp. (11.7)……	103,981	110,686	6,705
Special Personnel Services Payments(11.8)	222	224	2
Subtotal, Personnel Compensation...……..	572,730	601,451	28,721
Civilian Personnel Benefits(12.1)…….	120,274	122,315	2,041
Millitary Personnel Benefits(12.2)	44,882	47,823	2,941
Benefits to Former Personnel(13.0)…….	13,738	13,035	(703)
Subtotal, Pay Costs …….	751,624	784,624	33,000
Travel(21.0)……	14,025	14,872	847
Transportation of Things(22.0)……	10,069	9,903	(166)
Rental Payments to Others(23.2)……..	2,168	2,135	(33)
Communications, Utilities and Miscellaneous Charges(23.3……	25,542	25,885	343
Printing and Reproduction(24.0)……..	772	762	(10)
Other Contractual Services:			
Advisory and Assistance Services(25.1)…….	4,328	4,301	(27)
Other Services(25.2)…….	120,032	125,106	5,074
Purchases from Govt. Accts.(25.3)……	46,088	46,989	901
Operation and Maintenance of Facilities(25.4)…..	19,852	8,662	(11,190)
Operation and Maintenance of Equipment(25.7)…	4,555	4,531	(24)
Subsistance and Support of Persons(25.8)…….	2,146	2,154	8
Subtotal, Other Contractual.....……..	197,001	191,743	(5,258)
Supplies and Materials(26.0)……	93,036	94,608	1,572
Subtotal, Non-Pay Costs……	342,613	339,908	(2,705)
Total Salaries & Expenses…….	1,094,237	1,124,532	30,295

Exhibit K

SIGNIFICANT ITEMS IN HOUSE, SENATE, AND CONFERENCE APPROPRIATIONS COMMITTEE REPORTS

2005 **House** Appropriations Committee Report Language (108-542)

Item

Distribution of funds – The Indian health care improvement fund money should be distributed in the same manner as in fiscal year 2003, which was the last year in which funds were appropriated for this program. (Page 131)

Action Taken or To Be Taken

The fiscal year 2005 Indian health care improvement funds are distributed by the same formula used in fiscal year 2003. However, the formula is applied using more recent data (user counts, costs, health status, local conditions, etc). The formula was developed with extensive tribal consultation consistent with the approach specified in section 1621 of the Indian Health Care Improvement Act. The qualifying threshold in FY 2005 remains the same – deficiency scores of 60% or less. Approximately $7.8 million is distributed among units scoring less than 40% deficiency. The balance, approximately $3.4 million is distributed to units scoring between 40% and 60% deficiency.

Item

Reprogram increases – The Service should reprogram the increases included in the budget to cover partially pay cost increases so that there is an equitable distribution across all Federal and tribal programs. (Pages 131)

Action Taken or To Be Taken

The pay increase has been redistributed equitably between Federal and Tribal/Urban programs.

Item

Loan Repayment Program Funding – The fiscal year 2001 direction on the use of the loan repayment funding should continue to be followed in fiscal year 2005. (Page 131)

Action Taken or To Be Taken

In FY 2001, Congress provided an additional $5,000,000 for the loan repayment program. The referenced directions concerned that money and stated that the IHS should use it to fund loan repayment contracts, "with emphasis on critical shortage specialties such as pharmacists, dentists and podiatrists."

From FY 2001 through FY 2003, the IHS distributed that additional funding as follows:

Nurses	$937,500
Dentists	$1,959,270

Pharmacists	$1,580,056
Physician Assistants/Advanced Practice Nurses	$250,000
Podiatrists	$210,674
Physical Therapists	$62,500

For FY 2004 and FY 2005, physicians were added to the funded groups, making the fund distribution as follows:

Physicians	$49,705
Nurses	$981,674
Dentists	$1,988,200
Pharmacists	$1,441,445
Physician Assistants/Advanced Practice Nurses	$248,525
Podiatrists	$198,820
Rehabilitative Services	$62,131

Item

Joslin diabetes program – The Joslin diabetes program should be considered for funding using the special diabetes program funding in addition to the base funding of $1,500,000 for fiscal year 2005. (Page 131)

Action Taken or To Be Taken

IHS developed an extensive tribal consultation process in 2003 and 2004 for input on use of the Special Diabetes Program for Indians funding. Early in 2004, based on that input as well as programmatic input, the Director of IHS made his decisions on distribution of the SDPI funds for 2004-2008 which have been implemented. There are no additional SDPI funds for special projects such as the Joslin Vision Network project.

This program began in 1999 as a demonstration project to test the feasibility of clinical applications of the Joslin Vision Network (JVN) in Indian country. Recurring funding began in 2000 and in FY 2004 Congress continued IHS appropriations for this program that is now in its fourth year of clinical deployments. This program represents collaboration between the IHS and the Joslin Diabetes Center (JDC). Although the technology was developed at the JDC using DoD funding, this clinical program has been wholly developed and managed by the IHS as a global telemedicine program to increase access, quality, and cost efficiency for the purpose of achieving greater compliance with the diabetic retinopathy (DR) examination standard of care among American Indians and Alaska Natives. 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 with recommendations for management in the context of the patients overall medical status is returned to the remote site. In FY 04 fifteen additional IHS/JVN imaging sites were deployed bringing the total deployments to 21 across 10 states. With current funding levels, an additional 20 sites will be added in the next fiscal year.

Item

New health clinic planning funding – The funds for new health clinic planning and design are for facilities with newly approved program justification documents (PJDs). The Committee understands that there are two locations that potentially will have completed and approved PJDs within the next couple of months--San Carlos, Apache, AZ and Kayenta, AZ. The Committee urges the Service and the tribes to work together to complete these PJDs prior to conference consideration of this bill. (Page 133)

Action Taken or to be Taken

The Indian Health Service will use the funding provided to initiate planning and design of the San Carlos and Kayenta, Arizona projects.

Item

Ambulatory care facilities – The Service should issue a new solicitation for small ambulatory care facilities. There should be a cap of $2,000,000 for any one project and most, if not all, projects should be funded substantially below that level. (Page 133)

Action Taken or to be Taken

The IHS is revising the solicitation for the Small Ambulatory Program which will then be sent out for tribal comment before it is issued.

Item

Facilities priority system – The Service should continue to work on needed improvements to the facilities priority system so that the full range of need for facilities in Indian country is given appropriate consideration. (Page 134)

Action Taken or to be Taken

The IHS is in the process of addressing the issues related to developing a new priority system. In June 2004, the tribal consultation process commenced, with comments being received in October 2004. Eighty three tribal organizations presented 600 concerns, which are being addressed presently by the Facilities Appropriation Advisory Board (FAAB), an existing advisory group established by the IHS for advising the IHS in facilities matters and composed of tribal and IHS representatives from each of the IHS 12 Areas. The FAAB's recommendations will be considered in the development of the final proposed new system.

Item

Facilities funding – The methodology used to distribute facilities funding should address the fluctuating annual workload and maintain parity among IHS areas and tribes as the workload shifts. (Page 134)

Action Taken or to be Taken

The IHS continues to distribute facilities funding to address the fluctuating annual workload attempting to maintain parity among IHS Areas and Tribes as the workload shifts.

Item

Hospital in Tahlequah, Oklahoma – The Committee recommends bill language permitting the use of third party collections for the purchase of land for the IHS hospital in Tahlequah, Oklahoma subject to advance approval by the House and Senate Committees on Appropriations. The land will be used for a parking lot expansion at the W.W. Hastings hospital. (Page 134)

Action Taken or To Be Taken

With this Bill language IHS will continue to plan for expansion at the IHS hospital in Tahlequah, Oklahoma.

2005 **Senate** Appropriations Committee Report Language (108-341)

Item

Pay increase – The Committee expects that the pay increase will be distributed between Federal and tribal operations in the same manner as in past years. (Page 72)

Action Taken or To Be Taken

The pay increase has been redistributed equitably between Federal and Tribal/Urban programs.

Item

Epidemiology centers – The increase for epidemiology centers is intended to provide additional support to the seven existing centers, as well as to establish new centers in Service Areas that currently have none, such as Billings and California. (Page 72)

Action Taken or To Be Taken

Up to three new epidemiology centers will receive funding through competitive cooperative agreements, while existing epidemiology centers will receive increases to the base award amounts in addition to receiving direct assistance through assignment of senior health professionals.

Item

InPsych Programs – Within base funds, the InPsych programs at the University of Montana and the University of North Dakota are continued at $250,000 each, the InMed program at the University of North Dakota is funded at the current level of $750,000 and the RAIN program at the University of North Dakota is funded at $95,000 above the amounts distributed annually to the each of the participants in this grant program. (Page 72/73)

Action Taken or To Be Taken

These instructions will be followed. Planned FY 2005 distribution of these funds is as follows:

University of North Dakota InPsych Program	$250,000
University of Montana InPsych Program	$250,000
Oklahoma State University InPsych Program	$250,000
University of North Dakota InMed Program	$750,000
University of Arizona InMed Program	$307,263

Item

Alcohol abuse prevention and education -- …provided in the fiscal year 2005 budget is an amount of $16,000,000 for alcohol control, enforcement, prevention, treatment, sobriety and wellness, and education in Alaska to be distributed as follows:
(**a**) $2,000,000 shall be provided to the Alaska Federation of Natives to distribute to Alaska Native non-profit corporations within 30 days of receipt to operate the Village Public Safety Officer program, of which no more than 10 percent may be used for

administrative overhead, contract support, or indirect costs; (**b**) $5,000,000 to the Alaska Native Tribal Health Consortium, which shall be allocated for: (1) substance abuse and behavioral health counselors through the Counselor in Every Village Program; and (2) comprehensive substance abuse training programs for counselors and others delivering substance abuse services; (**c**) $9,000,000 to be divided as follows among Alaska Native regional organizations to provide substance abuse treatment and prevention programs: (1) $2,500,000 for Southcentral Foundation's Pathway Home; (2) $1,500,000 for Cook Inlet Tribal Council's substance abuse prevention and treatment programs; (3) $1,500,000 for Yukon Kuskokwim Health Corporation's Tundra Swan Inhalant Abuse Center; (4) $500,000 for the Southeast Alaska Regional Health Corporation's Deilee Hitt program; (5) $3,000,000 to be divided equitably among the remaining Alaska Native regional health organizations. (Page 73)

Action Taken or To Be Taken

(1) The funding amount has been modified by the Conference Report 108-792 as follows:

Modification 1: The conference agreement (page 1084) modified language, proposed by the Senate. The Modification provides $15,000,000 instead of $16,000,000. The distribution is modified to provide $8,000,000 to Alaska Native regional organizations with $2,000,000 (rather than $3,000,000) be divided among remaining organizations.

Alaska Native regional organizations (divide **$8,000,000** among):

1. Southcentral Foundation's Pathway Home	$2,500,000
2. Cook Inlet Tribal Council's ASA program	$1,500,000
3. Yukon Kuskokwim Health Corp's Tundra Swan Center	$1,500,000
4. Southeast Alaska Regional Health Corp's Deilee Hitt program	$500,000
5. Divided equitably among remaining AK Native Health Organizations	$**2,000,000**

Modification 2: Item (a) in the Senate report is revised as follows: $2,000,000 shall be provided as a direct lump sum payment to the State of Alaska Department of Public Safety.

Alaska Native Tribal Health Consortium	$5,000,000

(2) The IHS will distribute the funds as modified by the Conference agreement.

Item

Access Network – The Alaska Federal Health Care Access Network is funded at $2,500,000 for fiscal year 2005.

Action Taken

The Alaska Native Tribal Health Consortium (ANTHC), in support of the IHS mission, will fund and manage the continued development and growth of the Alaska Federal Health Care Access Network (AFHCAN). The AFHCAN system will continue the

development and deployment of telehealth solutions and support services (including training) to 200 sites in Alaska that provide health care to Native beneficiaries. ANTHC and AFHCAN will also continue efforts to offer these solutions and services to serve other IHS, native and tribal sites outside Alaska.

Item

PIMC – The $4,000,000 provided for the PIMC system is to be used to complete planning and begin design of the three ambulatory care centers associated with the project. To the extent that balances may be available from recently completed projects, the Committee expects that those funds, if needed, will be directed to both the PIMC and Barrow facilities to expedite the planning and design process. (Page 74)

Action Taken

The IHS is moving forward on the planning and design of the Southwest and Northeast satellite health care facilities of the replacement Phoenix Indian Medical Center System. IHS understands that if funds are available from recently completed projects they should be directed to both the PIMC project and the Barrow project for which partial funding was provided in FY 2005.

Item

Quarters Funding – In addition to the funds requested in the budget justification for staff quarters at Zuni, NM and Wagner, SD, the Committee has provided funds for staff quarters at Fort Belknap, MT, the next project on the priority list for quarters. Inasmuch as the project description for Fort Belknap was developed several years ago, the Committee expects the IHS to review and revise the proposal as necessary to address current requirements. (Page 74)

Action Taken

The IHS is reviewing and will revise the proposal as necessary to meet the current staff housing needs these quarters are intended to address.

Item

Facilities construction – The Committee understands that work is continuing on the development of a new priority system for facilities construction that will provide greater opportunities for tribes and better reflect their needs. The Committee hopes that the tribal consultation process moves forward in a timely manner so that future budget submissions can reflect the new system for funding facilities construction. (Page 74)

Action Taken or to be Taken

The IHS is in the process of addressing the issues related to developing a new priority system. In June 2004, the tribal consultation process commenced, with comments being received in October 2004. Eighty three tribal organizations presented 600 concerns, which are being addressed presently by the Facilities Appropriation Advisory Board

(FAAB), an existing advisory group established by the IHS for advising the IHS in facilities matters and composed of tribal and IHS representatives from each of the IHS 12 Areas. The FAAB recommendations will be considered in the development of the final proposed new system.

Item

Construction for drinking water system – . . . . the Committee strongly encourages the Service to continue to fund construction of a new drinking water system for the Shoshone-Bannock Tribes of the Fort Hall Reservation in Idaho at the highest level possible within the current IHS sanitation facilities construction priority list. (Page 74)

Action Taken or To Be Taken

IHS will continue to coordinate planning, funding and other activities to address the need for a safe and reliable water source for members of the Tribe residing on the Reservation. In FY 04, IHS funded over $1,000,000 in water projects for the Shoshone-Bannock Tribes of the Fort Hall Reservation off the IHS sanitation facilities construction priority list. Other sanitation needs for the Shoshone-Bannock Tribes of the Fort Hall Reservation remain on the IHS sanitation facilities construction priority list.

2005 **Conference** Appropriations Committee Report Language (108-792)

Item
Facilities – The funds provided for the Barrow, AK hospital are for land acquisition and planning. The total estimated cost of the facility is $125 million. (Page 1085)

Action Taken or To Be Taken

The IHS will utilize the FY 2005 funding to acquire land and continue planning the replacement Barrow, Alaska health facility project.

Item
Facilities – The Service should finalize the site selections for the northern and southern California youth regional treatment centers for alcohol and substance abuse and, after the sites are selected, include funds in the budget request for construction of these facilities. (Page 1085)

Action Taken or To Be Taken

The IHS will work to finalize site selections for these two facilities and to acquire the land for these projects.

Item
Facilities – The total estimated cost of the Fort Belknap, MT, staff quarters project is $8,300,000. The $5,000,000 provided for fiscal year 2005 should be used to construct staff quarters in Harlem, MT. Funding for staff quarters in Hayes, MT, should be included in the fiscal year 2006 budget request. (Page 1085)

Action Taken or To Be Taken

The IHS is reviewing and will revise the proposal as necessary to meet the current staff housing needs these quarters are intended to address.

Item
Facilities – The funds for new health clinic planning and design are to initiate design of the San Carlos, AZ, clinic and the Kayenta, AZ, clinic. The Service recently approved the program justification documents for these two facilities. (Page 1086)

Action Taken or To Be Taken

The Indian Health Service will use the funding provided to initiate planning and design at these two locations.

Item

Facilities – The Service should move quickly to issue a new solicitation for small ambulatory care facilities. There should be a 30-day tribal comment period prior to issuance of the final solicitation. (Page 1086)

Action Taken or To Be Taken

The IHS is revising the solicitation for the Small Ambulatory Program which will then be sent out for tribal comment before it is issued.

Item

Hospital in Tahlequah, Oklahoma - The conference agreement modifies language proposed by the House, permitting the use of third party collections for the purchase of land for expansion of the IHS hospital in Tahlequah, OK subject to advance approval by the House and Senate Committees on Appropriations.**(Was here) (Page 1086)

Action Taken or To Be Taken

With this Bill language IHS will continue to plan for expansion at the IHS hospital in Tahlequah, Oklahoma.

** The modification retains the original text and adds language authorizing permanent service unit status for the Tulsa and Oklahoma City pilot health programs.

Exhibit L

INDIAN HEALTH SERVICE
Authorizing Legislation
(Dollars in Thousands)

FILE: O:\DFM\BFPB\FY2006\CONG'L SUBM\Exhibit L	FY 2005		FY 2006	
	Amount Authorized	Enacted	Amount Authorized	Budget Request
1. Services Appropriation: 25 U.S.C. 13, Act and P.L. 83-568, Transfer Act, 42 U.S.C. 2001. Snyder Act, Title V, P.L. 94-437, Indian Health Care Improvement Act (IHCIA), as amended. Title I, Indian Health Manpower. Indian Self Determination and Education Assistance Act, P.L. 93-638, as amended, Sections 103(b)(2) and 103(e). Titles III & V, Self Governance Demonstration Program, Indian Self Determination Act, as amended. P.L. 100-472 Section 106(a)(2) A&B P.L. 106-260 Tribal Self Governance Amendment of 2000. Omnibus Consoldiated Appropriations Act, 2001, P.L. 106-554	$2,596,492	$2,596,492	$2,732,298	$2,732,298
2. Facilities Appropriation: Indian Sanitation Facilities Act P.L. 86-121, P.L. 101-512, Section 704 of the IHCIA P.L. 103-413, P.L. 102-573	388,574	388,574	315,668	315,668
3. Public and Private Collections: Economy Act 31 U.S.C. 686 Section 301, P.L. 94-437, Title V of IHCIA. Omnibus Consolidated Appropriations Act, 2001, P.L. 106-554	623,829	632,829	641,920	641,920
4. Special Diabetes Program for Indians: 111 STAT. 574 (P.L. 105-33) 114.2763A-525, (P.L. 106-554, Sec. 432)	$150,000	$150,000	$150,000	$150,000
Unfunded authorizations:	0	0	0	0
Total appropriations:	$3,758,895	$3,767,895	$3,839,886	$3,839,886
Total appropriations against Definite authorizations:	$3,758,895	$3,767,895	$3,839,886	$3,839,886

Exhibit M-1

INDIAN HEALTH SERVICE
Appropriation History Table
Services

FILE: O:\DFM\BFPB\FY2006\CONGL SUBM\Exhibit M

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1995	$1,653,305,000	$1,706,102,000	$1,715,052,000	$1,713,052,000
Reduction	-	-	-	($3,272,000)
Rescission	-	-	-	($2,688,000)
1996	$1,816,350,000	$1,725,792,000	-	$1,747,842,000
Rescission	-	-	-	($2,533,000)
1997	$1,894,593,000	$1,779,561,000	$1,800,836,000	$1,806,269,000
Supplemental	-	-	-	$1,000,000
1998	$1,835,465,000	$1,829,088,000	$1,958,235,000	$1,841,074,000
1999	$1,843,873,000	$1,932,953,000	$1,888,602,000	$1,950,322,000
Rescission	-	-	-	($1,942,000)
2000	$2,094,922,000	$2,085,407,000	$2,094,922,000	$2,078,967,000
Rescission	-	-	-	($4,794,000)
2001	$2,271,055,000	$2,106,178,000	$2,184,421,000	$2,240,658,000
Supplemental				$30,000,000
Rescission	-	-	-	($4,995,000)
2002	$2,387,014,000	$2,390,014,000	$2,388,614,000	$2,389,614,000
Rescission	-	-	-	($1,009,000)
2003	$2,513,668,000	$2,508,756,000	$2,466,280,000	$2,492,115,000
Rescission	-	-	-	($16,199,000)
2004	$2,502,393,000	$2,556,082,000	$2,546,524,000	$2,561,932,000
Rescission	-	-	-	($16,550,000)
Rescission	-	-	-	($15,018,000)
2005	$2,612,824,000	$2,627,918,000	$2,633,624,000	$2,632,667,000
Rescission				($15,638,000)
Rescission				($20,936,000)
2006	$2,732,298,000			

Exhibit M-2

INDIAN HEALTH SERVICE
Appropriation History Table
Facilities

FILE: O:\DFM\BFPB\FY2006\CONGL SUBM\Exhibit M

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1995	$167,079,000	$253,892,000	$253,767,000	$253,767,000
Reduction	-	-	-	($485,000)
Rescission	-	-	-	($300,000)
1996	$242,672,000	$236,975,000	-	$238,958,000
Rescission	-	-	-	($304,000)
1997	$275,251,000	$277,701,000	$251,957,000	$247,731,000
Supplemental	-	-	-	$2,000,000
1998	$286,535,000	$257,310,000	$168,401,000	$257,538,000
1999	$274,476,000	$313,175,000	$263,516,000	$289,465,000
Supplemental	-	-	-	$2,500,000
2000	$317,465,000	$312,478,000	$189,252,000	$318,580,000
Rescission	-	-	-	($2,025,000)
2001	$349,374,000	$336,423,000	$349,650,000	$363,904,000
Rescission	-	-	-	($801,000)
2002	$319,795,000	$369,795,000	$362,854,000	$369,487,000
2003	$370,475,000	$362,571,000	$391,865,000	$376,190,000
Rescission	-	-	-	($2,445,000)
2004	$387,269,000	$392,560,000	$391,188,000	$396,232,000
Rescission	-	-	-	($2,560,000)
Rescission	-	-	-	($2,322,000)
2005	$354,448,000	$405,453,000	$364,148,000	$394,453,000
Rescission				($2,343,000)
Rescission				($3,137,000)
2006	$315,668,000			

Exhibit P

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
FY 2006 Discretionary State/Formula Grants
($ in dollars)

CFDA Number/Program Name: 93:237; 93:442; 93:219 - Special Diabetes Program for Indians, and 93:954, 93:228, 93:193, 93:284, 93:933 - Other

STATE/MANDATORY	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Estimate	Difference +/- 2005
Alaska	$10,965,211	$10,965,211	$10,965,211	$0
Arizona	$22,390,121	$22,390,121	$22,390,121	$0
California	$11,043,152	$11,043,152	$11,043,152	$0
Colorado	$941,268	$941,268	$941,268	$0
Iowa	$518,266	$518,266	$518,266	$0
Idaho	$1,105,806	$1,105,806	$1,105,806	$0
Illinois	$201,393	$201,393	$201,393	$0
Kansas	$1,110,762	$1,110,762	$1,110,762	$0
Massachetts	$156,323	$156,323	$156,323	$0
Michigan	$2,563,163	$2,563,163	$2,563,163	$0
Minnesota	$5,084,178	$5,084,178	$5,084,178	$0
Mississippi	$404,000	$404,000	$404,000	$0
Montana	$6,924,426	$6,924,426	$6,924,426	$0
North Carolina	$1,175,894	$1,175,894	$1,175,894	$0
North Dakota	$2,973,997	$2,973,997	$2,973,997	$0
Nebraska	$1,668,467	$1,668,467	$1,668,467	$0
New Mexico	$9,220,445	$9,220,445	$9,220,445	$0
Nevada	$3,006,280	$3,006,280	$3,006,280	$0
New York	$816,323	$816,323	$816,323	$0
Oklahoma	$20,290,178	$20,290,178	$20,290,178	$0
Oregon	$2,646,635	$2,646,635	$2,646,635	$0
South Dakota	$7,223,197	$7,223,197	$7,223,197	$0
Tennessee	$11,092,932	$11,092,932	$11,092,932	$0
Texas	$423,320	$423,320	$423,320	$0
Utah	$1,739,063	$1,739,063	$1,739,063	$0
Washington	$6,093,509	$6,093,509	$6,093,509	$0
Wisconsin	$4,273,951	$4,273,951	$4,273,951	$0
Wyoming	$747,878	$747,878	$747,878	$0
Subtotal:	$136,800,138	$136,800,138	$136,800,138	$0
Indian Tribes	$33,565,743	$34,572,715	$35,609,896	$1,037,181

EXHIBIT Q

INDIAN HEALTH SERVICE
Detail of Full-Time Equivalent Employment (FTE)
By Headquarters, Area Office, and Service Unit

	FY 2004 Actual	FY 2005 Estimate	FY 2006 Estimate
Headquarters	395	420	420
Area Offices	1,116	1,138	1,138
Service Units	13,523	14,693	14,693
Total, FTEs	15,034	16,251	16,251

Average GS Grade

2001.....	8.2
2002.....	8.2
2003.....	8.1
2004.....	8.1
2005.....	8.1

EXHIBIT R

INDIAN HEALTH SERVICE
DETAIL OF PERMANENT POSITIONS

	2004 Actual	FY 2005 Estimate	2006 Estimate
ES-05	2	2	2
ES-04	3	3	3
ES-03	4	4	4
ES-02	5	5	5
ES-01	1	1	1
Subtotal	15	15	15
Total - ES Salaries	$2,118,364	$2,192,507	$2,242,934
GS/GM-15	381	418	418
GS/GM-14	398	437	437
GS/GM-13	352	386	386
GS-12	738	809	809
GS-11	1,282	1,406	1,406
GS-10	469	514	514
GS-9	1,481	1,624	1,624
GS-8	213	234	234
GS-7	829	909	909
GS-6	1,089	1,194	1,194
GS-5	1,855	2,035	2,035
GS-4	1,092	1,198	1,198
GS-3	253	277	277
GS-2	45	49	49
GS-1	1	1	1
Subtotal	10,478	11,492	11,492
Total - GS Salaries	$381,195,834	$432,726,942	$442,679,662
Assistant Surgeon General CO-08	5	5	5
Assistant Surgeon General CO-07	2	2	2
Director Grade CO-06	433	475	475
Senior Grade CO-05	623	683	683
Full Grade CO-04	545	598	598
Senior Assistant Grade CO-03	383	420	420
Assistant Grade CO-02	111	122	122
Junior Grade CO-01	16	16	16
Subtotal	2,118	2,321	2,321
Total - CO Salaries	$101,895,840	$115,559,465	$119,141,808
Ungraded	1,237	1,237	1,237
Total - Ungraded Salaries	$30,573,700	$31,490,911	$32,435,638
Average ES level	ES-03		
Average ES salary	141,224		
Average GS grade	8		
Average GS salary	36,381		

INDIAN HEALTH SERVICE
Budget and Performance Crosswalk
(Dollars in Thousands)

Performance Program Area	Budget Activity	FY 2004 Enacted	FY 2005 Appropriation	FY 2006
Treatment	Hospitals & Health Clinics	$1,249,781	$1,289,418	$1,359,541
	Dental Health	104,513	109,023	119,489
	Mental Health	53,294	55,060	59,328
	Alcohol & Substance Abuse	138,250	139,073	145,336
	Contract Health Services	479,070	498,068	525,021
	Urban Health	31,619	31,816	33,233
	Indian Health Professions	30,774	30,392	31,503
	Tribal Management	2,376	2,343	2,430
	Self Governance	5,644	5,586	5,752
	Contract Support Costs	267,398	263,683	268,683
	Medicare/Medicaid/Private Insurance Collections	534,010	537,905	545,632
	Direct Operations			63,123
	Special Diabetes	150,000	150,000	150,000
	Subtotal	3,046,729	3,112,367	3,309,071
Prevention	Public Health Nursing	42,581	45,015	49,690
	Health Education	11,793	12,429	13,787
	Community Health Representatives	50,996	51,365	53,737
	Immunization AK	1,561	1,572	1,645
	OEHE Support			471
	Environmental Health Support	19,561	19,715	21,541
	Subtotal	126,492	130,096	140,871
Capital Programming/ Infrastructure	Maintenance & Improvement	48,897	49,204	49,904
	Sanitation Facilities	93,015	91,767	93,519
	Health Care Facilities Construction	94,554	88,597	3,326
	Facilities Support	56,378	59,074	79,348
	Environmental Health Support	33,534	33,798	38,295
	OEHE Support	2,288	2,299	11,304
	Equipment	17,081	17,337	17,960
	Medicare/Medicaid/Private Insurance Collections	94,237	94,924	96,288
	Quarters	6,172	6,200	6,288
	Subtotal	446,156	443,200	396,232
Partnerships, Consultation, Core Functions, and Advocacy	Direct Operations	60,714	61,649	0
	Facilities Support	14,095	14,769	0
	Environmental Health Support	2,794	2,816	0
	OEHE Support	9,153	9,198	0
	Subtotal	86,756	88,432	0
IHS Total Program Level Funding		$3,706,133	$3,774,095	$3,846,174

Detail of Performance Analysis Table

Performance Measures	FY Targets	Actual Performance	Reference
Diabetes Group			
Indicator 1: Assure that the proportion of patients with diagnosed diabetes that have poor glycemic control does not increase [outcome]	FY06: maintain 05 level FY 05: maintain 04 level FY 04: establish the baseline of patients with diagnosed diabetes that have poor glycemic control. Prevalence of Diabetes FY 04: maintain database FY 03: maintain database FY 02: maintain database FY 01: maintain database FY 00: maintain database FY 99: establish baseline	FY06: FY 05: FY 04: 16/17%*** FY 03: database maintained FY 02: database maintained FY 01: database maintained FY 00: database maintained FY 99: baseline established	3 HP 2010 ***GPRA+ data
Indicator 2: Address the proportion of patients with diagnosed diabetes that have demonstrated glycemic control at the ideal level. [outcome]	Ideal Glycemic Control FY 06: maintain FY 05 level FY 05: maintain at FY 04 level* FY 04: +1% over FY 03 level FY 03: maintain at FY 02 level FY 02: improve from FY 01 1FY 01: improved from FY 00 FY 00: improved from FY 99 FY 99: 25% Good Glycemic Control FY 99: 38%	FY 06: FY 05: FY 04: 34/27%*** FY 03: 31*/28*** FY 02: 30%/25%*** FY 01: 29% ** FY 00: 26% FY 99: 24% FY 98: 22% FY 97: 25% FY 99: 35% FY 98: 35% FY 97: 25%	3, 5 HP 2010 * indicates revised FY 2005 measure. See Summary of Changes Table. * revised 1/05 ** revised 8/03 *** GPRA+ data

Performance Measures	FY Targets	Actual Performance	Reference
<u>Indicator 3:</u> Address the proportion of patients with diagnosed diabetes that have achieved blood pressure control. [outcome]	<u>Ideal Hypertension Control</u> FY 06: maintain FY 05 level FY 05: maintain at FY 04 level FY 04: +1% over FY 03 level FY 03: maintain at FY 02 level FY 02: maintain at FY 01 level FY 01: improve from FY 00 FY 00: improve from FY 99 FY 99: 41%	FY 06: FY 05: FY 04: 34/35%*** FY 03: 33/37% *** FY 02: 32%** /36%*** FY 01: 36%** FY 00: 35% FY 99: 36% FY 98: 38% FY 97: 27%	3, 5 HP 2010 *** GPRA+ data **revised 1/04 **revised 01/04
<u>Indicator 4:</u> Address the proportion of patients with diagnosed diabetes assessed for dyslipidemia. [outcome]	<u>LDL Cholesterol</u> FY 06: maintain FY 05 level FY 05: maintain at FY 04 level FY 04: +1% over FY 03 level FY 03: maintain at FY 02 level FY 02: improve from FY 01 FY 01: improve from FY 00 FY 00: improve from FY 99 FY 99: 32% <u>Total Cholesterol</u> FY 99: 82%	FY 06: FY 05: FY 04: 69%/53%*** FY 03: 65/48%*** FY 02: 64%/ 44%*** FY 01: 60% FY 00: 54% FY 99: 46% FY 98: 29% FY 99: 72% FY 98: 79% FY 97: 83%	3, 5 HP 2010 *** GPRA+ data

Performance Measures	FY Targets	Actual Performance	Reference
Indicator 5: Address the proportion of patients with diagnosed diabetes assessed for nephropathy. [outcome]	FY 06: maintain FY 05 level FY 05: maintain at FY 04 level FY 04: +1% over FY 03 level FY 03: maintain at FY 02 level FY 02: improve from FY 01 FY 01: improve from FY 00 FY 00: improve from FY 99 FY 99: 36%	FY 06: FY 05: FY 04: 63%/42%*** FY 03: 62/38%*** FY 02: 56%/35%*** FY 01: 54% FY 00: 41% FY 99: 36% FY 98: 33% FY 97: 36%	3, 5 HP 2010 ***GPRA+ data
Indicator 6: Address the proportion of patients with diagnosed diabetes who receive an annual diabetic retinal examination at designated sites. [outcome]	FY 06: maintain at 05 level FY 05: maintain at 04 level FY 04: +3% over FY 03 level FY 03: +3% over FY 02 level FY 02: no indicator	FY 06: FY 05: FY 04: 55%*** FY 03: 58%*** FY 02: 55%***	3, 5 HP2010 ***GPRA+ data

Performance Measures	FY Targets	Actual Performance	Reference
Cancer Screening Group			
Indicator 7: Address the proportion of eligible women patients who have had a Pap screen within the previous three years. [outcome]	Pap Screening FY 06: maintain FY 05 levels FY 05: maintain FY 04 level FY 04: maintain FY 03 level FY 03: maintain FY 02 level FY 02: +2% over FY 01 level FY 01: +3% over FY 00 level FY 00: +3% over FY 99 level FY 99: no indicator Cervical Cancer FY 99: determine incidence of cervical cancer	FY 06: FY 05: FY 04: 58%*** FY 03: 61%*** FY 02: 43.2% w/in 3 years (+1.3% over FY 2001)/62%*** FY 01: 21% w/in 1 year, 42% w/in 3 years FY 00: 12% w/in 1 year, 18% w/in 3 years FY 99: baseline not adequate FY 99: 8-10 per 100,000 based on 40% of AI/AN	3, 5 HP 2010 ***GPRA+ data
Indicator 8: Address the proportion of eligible women who have had mammography screening within the last 2 years. [outcome]	FY 06: maintain FY 05 level FY 05: maintain FY 04 level FY 04: maintain FY 03 level FY 03: maintain FY 02 level FY 02: +2% over FY 01 level FY 01: +2% over FY 00 level FY 00: +3% over FY 99 baseline FY 99: establish baseline	FY 06: FY 05: FY 04: 40%*** FY 03: 40%*** FY 02: 24.7% w/in 2 years (+3.7% over FY 2001)/42%*** FY 01: 21% w/in 2 years FY 00: 15% w/in 2 years FY 99: baseline not adequate	3, 5 HP 2010 ***GPRA+ data

Performance Measures	FY Targets	Actual Performance	Reference
<u>Indicator 9:</u> Address the proportion of eligible patients who have had appropriate colorectal cancer screening. [outcome]	FY 06: Establish baseline rate of appropriate colorectal cancer screening	FY 06:	3, 5 HP 2010

Performance Measures	FY Targets	Actual Performance	Reference
Alcohol and Substance Abuse Group			
Indicator 10: Assure quality and effectiveness of Youth Regional Treatment Centers. [outcome] [output 05/06]	RTC Accreditation: FY 06: achieve 100% accreditation FY 05: ensure 100% accreditation RTC Assessment Criteria FY 04: +2% over FY 03 for 4 criterion FY 03: +5% over FY 02 for 4 criterion FY 02: establish RTC baseline for 4 criterion Follow-up Rates FY 04: no indicator FY 03: no indicator FY 02: no indicator FY 01: FY 00 level or higher FY 00: 45% (+10% over FY 99 for 3 follow-ups by 12 months post discharge) FY 99: establish baseline Abstinence FY 04: no indicator FY 03: no indicator FY 02: no indictor FY 01: +5% over FY 00 FY 00: no indicator	FY 06: FY 05: FY 04: +2% over FY 03 FY 03: +4% over FY 02 for modifiable criteria FY 02: baseline established FY 03: no indicator FY 02: no indicator FY 01: 60% FY 00: 48% % -12 mos (+17%) FY 99: 40.9% FY 03: no indicator FY 02: no indicator FY 01: no reliable data source FY 00: no reliable data source	1, 3, 5

Performance Measures	FY Targets	Actual Performance	Reference
Indicator 11: Address screening for alcohol use in appropriate female patients. [outcome]	Provide Alcohol Screening FY 06: increase screening over FY 05 FY 05: increase screening over FY 04: During FY 2004, establish the screening rate for alcohol use in women of childbearing age. Implement Screening Protocol FY 04: No indicator FY 03: Maintain FY 02 level FY 02: + 2% over FY 01 FY 01: + 10% over FY 00 FY 00: +5% over FY 99 FY 99: establish baseline	FY 06: FY 05: FY 04: baseline established FY 03: 95% FY 02: 90.5% (increase of 5.5% over FY 01) FY 01: 85% (decrease of 2.6%) FY 00: 87.6% (+9.2% over FY 99) FY 99: 78.4%	1, 3, 5 HP 2010

Performance Measures	FY Targets	Actual Performance	Reference
Oral Health Group			
Indicator 12: Address access to optimally fluoridated water for the AI/AN population. [outcome]	FY 06: increase by 1% FY 05: measure number of topical fluoride applications and number of patients receiving them* FY 04: 1% over FY 03 for pop. receiving fluor. water FY 03: 1% over FY 02 for pop. receiving fluor. water FY 02: 5% over FY 01 for AI/AN pop. receiving fluor. water FY 01: 10% over FY 00 for demo Areas 5% over FY 00 for other Areas FY 00: 15% over FY 99 for demo Areas FY 99: no indicator	FY 06: FY 05: FY 04: +0.1% FY 03: +0.37% FY 02: +1% for pop FY 01: 28% over FY 00 for demo Areas Same % FY 00 for other Areas FY 00: 18 systems in compliance (38% increase) FY 99: 13 systems in compliance for demo Areas or 2%	3 HP 2010 * indicates revised FY 2005 measure. See Summary of Changes Table.
Indicator 13: Address the proportion patients who obtain access to dental services. [efficiency]	FY 06: maintain at FY 05 level FY 05: maintain at FY 04 level FY 04: maintain at FY 03 level FY 03: maintain at FY 02 level FY 02: 1% over FY 01 FY 01: 27% FY 00: 23% FY 99: 21%	FY 06: FY 05: FY 04: 24%*** FY 03: 28.1/25%*** FY 02: 27.35% (+1% over FY 01) FY 01: 26.3% FY 00: 25.1% FY 99: 25.1% FY 98: 24.5% FY 97: 22%	3, 5 HP 2010 ***GPRA+ data

Performance Measures	FY Targets	Actual Performance	Reference
Indicator 14: Address the number of sealants placed per year in AI/AN children. [outcome]	Total Sealants Placed FY 06: maintain at FY 05 level FY 05: at FY 04 levels FY 04: at FY 03 level FY 03: at FY 02 level FY 02: +2.5% over FY 01 total sealants placed	FY06: FY 05: FY 04: 287,158 FY 03: 243,499 FY 02: 227,945 (+7.2% over FY 01) FY 01: 212,617	3, 5 HP 2010
Indicator 15: Address the proportion of patients diagnosed with diabetes who obtain access to dental services. [outcome]	FY 06: maintain at FY 05 level FY 05: maintain at FY 04 level FY 04: 1% increase over FY 03 FY 03: 2% increase over FY 02 FY 02: 2% increase over FY 01 FY 01: no indicator FY 00: no indicator FY 99: no indicator	FY 06: FY 05: FY 04: 37%*** FY 03: 36%*** FY 02: 36%*** FY 01: 32% FY 00: no indicator FY 99: no indicator	3, 5 HP 2010 ***GPRA+ data

Performance Measures	FY Targets	Actual Performance	Reference
Family Abuse, Violence, and Neglect Indicator			
Indicator 16: Address the proportion of women who are screened for domestic violence at health care facilities. [outcome]	Screening FY 06: increase over FY 05 level FY 05: maintain FY 04 level* FY 04: at least 15% screened FY 03: no indicator FY 02: no indicator FY 01: no indicator FY 00: no indicator FY 99: no indicator Staff Training FY 04: no indicator FY 03: 60% FY 02: 56% FY 01: no indicator FY 00: no indicator FY 99: no indicator Policies and Procedures FY 04: no indicator FY 03: 85% FY 02: 82% FY 01: 80% FY 00: 70% FY 99: 60% Data Code FY 04: no indicator FY 03: develop standard data code FY 02: no indicator FY 01: no indicator FY 00: no indicator FY 99: no indicator	FY 06: FY 05: FY 04: 4% screened FY 03: no indicator FY 02: no indicator FY 03: 60% FY 02: 70% FY 01: no indicator FY 00: 54% (baseline) FY 04: no indicator FY 03: 84% FY 02: 85% FY 01: 82% FY 00: 72% FY 99: 64% FY 04: no indicator FY 03: standard data code established FY 02: no indicator	1, 3 HP 2010 * indicates revised FY 2005 measure. See Summary of Changes Table

Performance Indicator	FY Targets	Actual Performance	Reference
<u>Indicator 17:</u> Expand the automated extraction of GPRA clinical performance measures and improve data quality. [efficiency05/06]	FY 06: continue the ongoing development and deployment of CIRS software application FY 05: add 2 new measures of automated data quality assessment FY 04: a. Implement quality training in all Areas b. +2 new measures to automated data quality assessment "package" FY 03: a. complete baseline of initial measures b. automate new measures c. distribute automated mapping tools to all I/T/Us FY 02: assess 5 sites for 5 performance measures FY 01: setup 5 sites for testing 5 performance measures FY 00: no indicator FY 99: no indicator	FY 06: FY 05: FY 04: implemented quality training in all Areas; added 2 new measures to automated quality assessment package FY 03: complete baseline of initial measures; new measures automated; automated mapping tools distributed to all I/T/U sites FY 02: 5 sites assessed for performance measures FY 01: 5 sites for testing 5 performance measures established	3, 5

Performance Indicator	FY Targets	Actual Performance	Reference
<u>Indicator 18:</u> Expand the Behavioral Health Data System by increasing use of appropriate software applications	<u>Expand MH/SS Use</u> FY 06: increase the number of sites using new integrated BH software application over the FY 05 level. FY 05: increase over FY 04* FY 04: +5% of programs report minimum data set use over FY 03 FY 03: +3% use over FY 02 FY 02: +5% use over FY 01 FY 01: +10% use over FY 00 FY 00: +10% use over FY 99 FY 99: 50% reported <u>Submit Minimum Data Set</u> FY 04: combined into above FY 03: 50% submit minimum data FY 02: no indicator	FY 06: FY 05: FY 04: 2.3% increase FY 03: 3% increase FY 02: 5% increase FY 01: +12.1% increase FY 00: +24.7% increase FY 99: 51% reported FY 98: 40-45% baseline est. FY 03: 50% FY 02: no accepted data set	3, 5 * indicates revised FY 2005 measure. See Summary of Changes Table

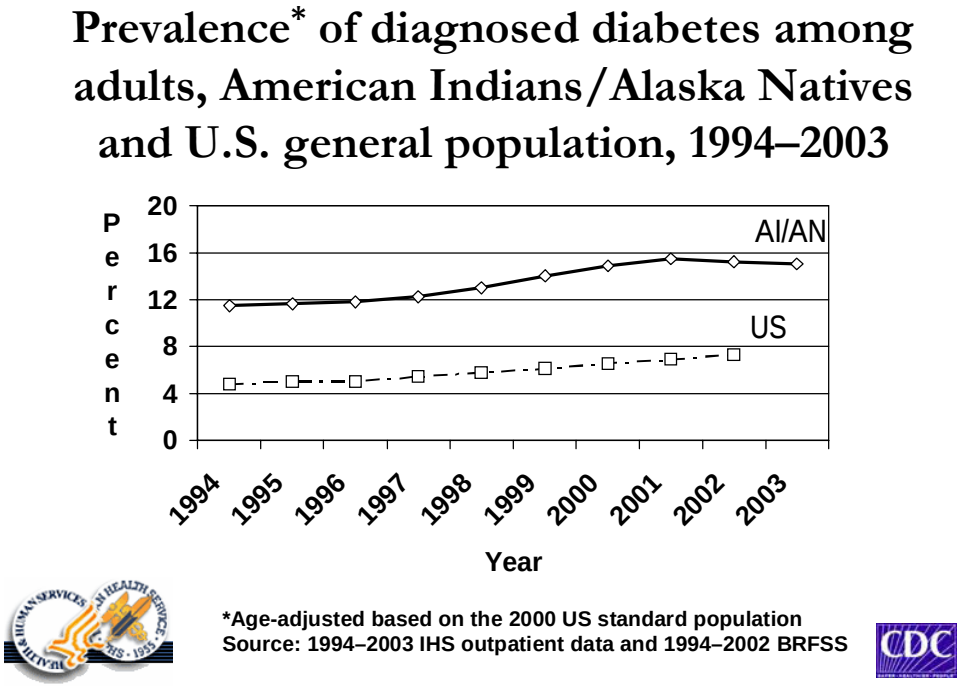
Performance Indicator	FY Targets	Actual Performance	Reference
Indicator 19: Expand Urban Indian Health Program capacity for securing mutually compatible automated information system that captures health status, and patient care data for the Indian health system.	I/T/U IT Enhancement FY 04: no indicator FY 03: no indicator Urban IT Enhancement FY 06: establish baseline FY 05: implement C&G language FY 04: develop language FY 03: +2 sites over FY 02 level FY 02: +2 sites over FY 01 level FY 01: implemented in 30% of urban programs FY 00: test in at least one site FY 99: develop specs and plan	FY 04: no indicator FY 06: FY 05: FY 04: minimum data set/language developed FY 03: 5 sites added FY 02: 2 sites added FY 01: 32% (11 of 34) urban programs FY 00: tested in several sites FY 99: accomplished 8/99	3, 5
Quality of Care Group			
Indicator 20: Maintain 100% accreditation of all IHS hospitals and outpatient clinics.	FY 06: 100% FY 05: 100% FY 04: 100% FY 03: 100% FY 02: 100% FY 01: 100% FY 00: 100% FY 99: 100%	FY 06: FY 05: FY 04: 100% FY 03: 100% FY 02: 100% FY 01: 100% FY 00: 100% FY 99: 100% FY 98: 100% (baseline)	3, 5

Performance Indicator	FY Targets	Actual Performance	Reference
Indicator 21: Address medication errors by developing a reporting system to reduce medication error. [outcome]	FY 06: establish and evaluate medical error reporting in 3 areas FY 05: all direct care facilities shall be using the NCCMERP nationally recognized medication error definition, and shall have a non-punitive multi-disciplinary medication error reporting system in place. FY 04: establish baseline data for medication error reporting for all IHS Areas b. pilot test standardized medication error reporting system in two additional areas FY 03: assess baseline and establish pilot sites FY 02: assess current systems for 3 elements	FY 06: FY 05: FY 04: baseline established and expanded Medmarx medication error reporting system into sites in 6 areas FY 03: baseline assessed and pilot sites established FY 02: 3 elements assessed	

Performance Indicator	FY Targets	Actual Performance	Reference
Indicator 22: Assess consumer satisfaction with the acceptability and accessibility of health care	FY 06: eliminated in FY 05 FY 05: eliminate FY 04: improve 3% over FY 03 FY 03: establish baseline FY 02: secure OMB clearance FY 01: secure OMB clearance FY 00: Federal clearance and establish baseline FY 99: develop instrument and protocol	 FY 04: survey not implemented FY 03: baseline established FY 02: OMB clearance secured FY 01: waiting final OMB approval FY 00: submitted but clearance not completed FY 99: instrument and protocol complete	3 5 * indicates revised FY 2005 measure. See Summary of Changes Table
Total Treatment Funding:	FY 06: $3,309,071,000 * FY 05: $3,112,367,000* FY 04: $3,046,729,000* *includes 85% of M/M and PI collections and Diabetes	HP: Chapter #: #: HHS Strategic Goal : PMA #	

Diabetes Group:

Indicator 1: **During FY 2006, assure that the proportion of patients with diagnosed diabetes that have poor glycemic control does not increase over FY 2005 level.**



Area age-specific diabetes prevalence rates have been prepared for the American Indian and Alaska Native population based on patients diagnosed with and treated for diabetes, and having at least one outpatient visit during FY 2004. This information is the contextual basis for our series of diabetic indicators.

Rationale: This indicator is directed at decreasing the percentage of patients with poor and very poor glycemic control.

Why is this Important? Reducing the number of patients with poor control will reduce the prevalence of diabetes complications. Some clinical studies have shown that a 1% decrease in the absolute A1C level translates into a:

- 14% decrease in total mortality,
- 21% decrease in diabetes-related deaths,
- 14% decrease in myocardial infarction,
- 40% decrease in eye disease,
- 43% decrease in amputations,
- and a 24% decrease in kidney failure.

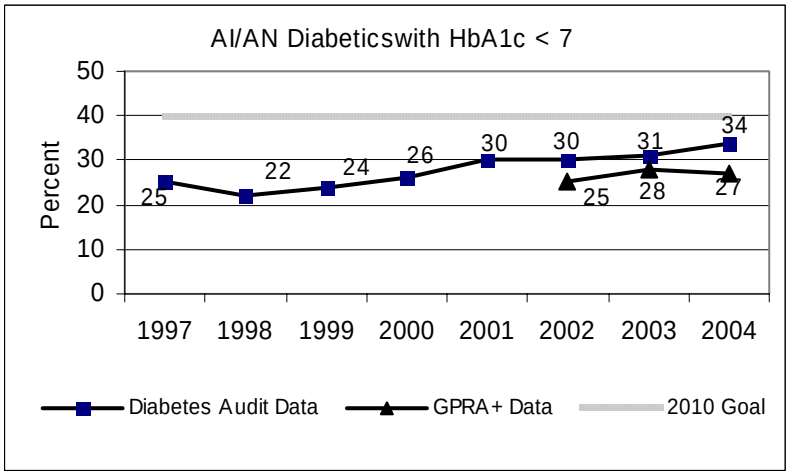
Reducing A1C levels can also save $800 in annual health care costs**.**

Approach: Glycemic control is measured with a test called the Hemoglobin A1C (HgbA1c) that measures the average blood sugar over the last 1-2 months. The IHS Diabetes Care and Outcomes Audit divides these control levels and identifies "Ideal"as a HgbA1c <7, based on national diabetes care standards.

Data Source: RPMS data from local RPMS databases, diabetes registries, yearly IHS Diabetes Care and Outcomes Audit.

Program Performance: IHS met this indicator in 2004. In 2004, the indicator was to establish the baseline of those in poor diabetic blood sugar control. In 2004, 17% of diabetic patients had poor glycemic control, according to GPRA+ data. The baseline GPRA+ numbers established for this indicator show that this percentage is unchanged from 2000. Maintaining this rate is a significant accomplishment, considering that between 2000 and 2004 the number of patients with diagnosed diabetes increased from 8% to 10% at the I/T/Us participating in the 2004 GPRA review.

<u>Indicator 2</u>: During FY 2006, maintain the proportion of patients with diagnosed diabetes that have demonstrated ideal glycemic control at the FY 2005 level.



<u>Rationale:</u> This indicator is directed at maintaining the percentage of diabetic patients with ideal blood sugar control.

Why is this important? Keeping blood sugar levels below 7 can slow or prevent the onset and progression of eye, kidney, and nerve disease caused by diabetes. Good blood sugar control also lowers the risk of heart attack and stroke.

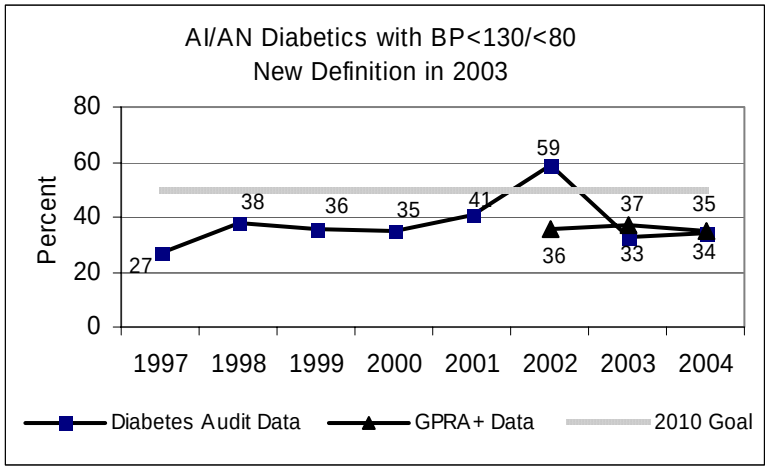
<u>Approach:</u> Glycemic control is measured with a test called the Hemoglobin A1C (HgbA1c) that measures the average blood sugar over the last 1-2 months. As stated earlier, “ideal” control is (<7%). The current guidelines recommend the use of HgbA1c cutoffs that determine control at the "Ideal" level.

<u>Data Source:</u> GPRA+ data from local RPMS databases, diabetes registries, yearly IHS Diabetes Care and Outcomes Audit.

<u>Program Performance</u>: IHS met this indicator in 2004 based on diabetic audit data. The FY 2004 Indicator was to increase the proportion of I/T/U clients with diagnosed diabetes who have achieved ideal glycemic control by 1% over the FY 2003 level. These results reflect meaningful agency accomplishment considering that:

- The prevalence of diabetics in the communities represented by this report has increased from 8% in 2000 to 10% in 2004.
- The number of patients being treated for diabetes in these same communities is 7% higher than the number treated in 2003 and 34% higher that in 2000.
- The number of patients in good control increased from 18,998 in 2003 to 19,743 in 2004.

<u>Indicator 3:</u> During FY 2006, maintain the proportion of patients with diagnosed diabetes who have achieved blood pressure control at the FY 2005 level.



<u>Rationale:</u> This indicator is directed at reducing complications of diabetes.

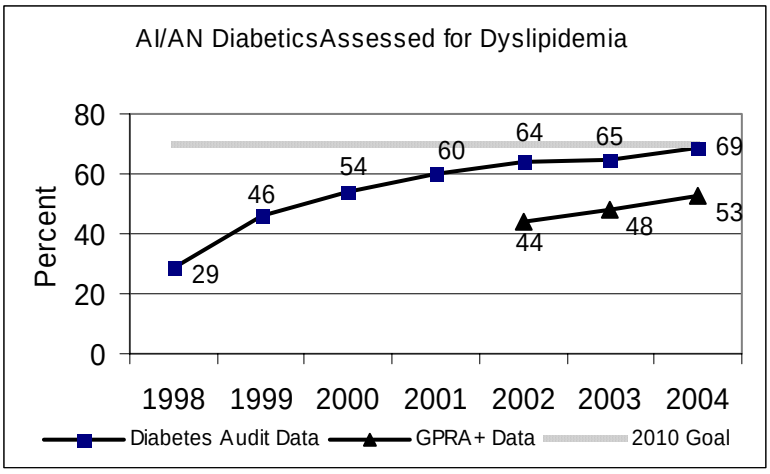
Why is this Important? A National Heart, Lung, and Blood Institute report indicates that the risk of heart disease and stroke doubles for every increase of 20 mm in systolic or 10 mm in diastolic pressure. Lower blood pressure levels in people with diabetes reduce the risk of heart disease and stroke by 33-50%. Blood pressure control also reduces the risk of eye, kidney, and nerve disease by one third.

<u>Approach</u>: National standards recommend that the ideal goal of diabetic blood pressure control should be 130/80. For the GPRA process, the "ideal" control is defined as <130/80, though this will change as clinical care guidelines are modified.

<u>Data Source</u>: GPRA+ data from local RPMS databases, diabetes registries and yearly IHS Diabetes Care and Outcome Audits.

<u>Program Performance:</u> IHS met this indicator in FY 2004 based on diabetic audit data. The FY 2004 indicator was to increase the proportion of I/T/U patients with diagnosed diabetes that have achieved blood pressure control by 1% over the FY 2003 level. The FY 2004 diabetic audit data showed that the proportion of patients in good control increased from 33% to 34%. GPRA+ data showed a drop in the percentage of patients who achieved good control from 37% in 2003 to 35% this year, which may be attributable to a change in the definition of good blood pressure control in GPRA+ software from <140/90.

Indicator 4: During FY 2006, maintain the proportion of patients with diagnosed diabetes assessed for dyslipidemia (LDL cholesterol) at the FY 2005 level.



Rationale: This indicator is directed at lowering serum LDL cholesterol.

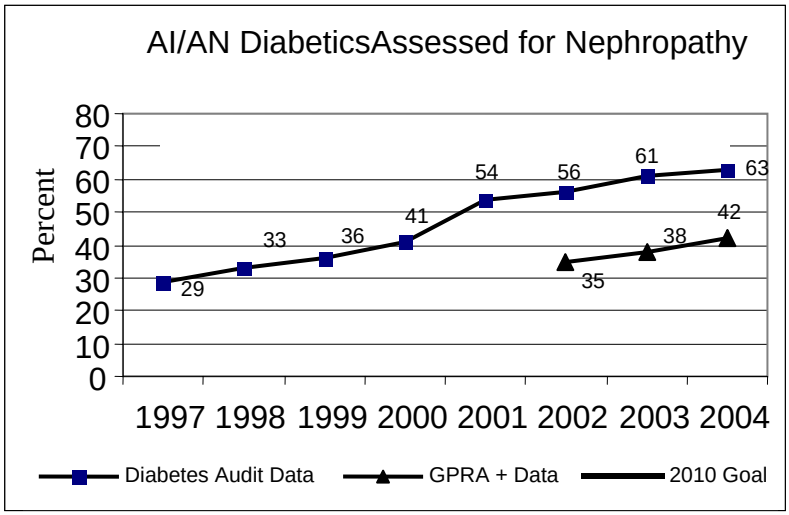
Why is this important? Low cholesterol levels help to protect diabetic patients from developing heart disease. Improved control of cholesterol levels reduces the risk of cardiovascular complications by 20-50%. National standards recommend that people with diabetes keep their cholesterol levels below 200 mg/dl, and their LDL cholesterol levels below 130 mg/dl and ideally below 100 mg/dl. Diabetic patients are especially prone to develop heart disease and therefore identification and treatment of elevated lipids in diabetic patients is extremely important. In addition, because persons with diabetes who experience a heart attack have an unusually high death rate either immediately or in the long term, a more intensive prevention strategy is warranted.

Approach: This indicator measures screening of LDL in diabetic patients. Trends over time for I/T/U facilities, service units, Areas and IHS-wide are constructed for selected indicators.

Data Source: GPRA+ data from local RPMS databases, diabetes registries, yearly IHS Diabetes Care and Outcomes Audit

Program Performance: **IHS met this indicator in FY 2004.** The FY2004 indicator was to increase the proportion of patients with diagnosed diabetes assessed for dyslipidemia by 1% over the FY 2003 level.The target of increasing the number of patients assessed for dyslipidemia was met and substantially exceeded according to both the diabetic audit and GPRA+ data.

Indicator 5: During FY 2006, maintain the proportion of patients with diagnosed diabetes assessed for nephropathy at the FY 2005 level.



Rationale: This indicator is directed at the assessment of microalbuminuria or proteinuria, measured in the urine with a urinalysis test.

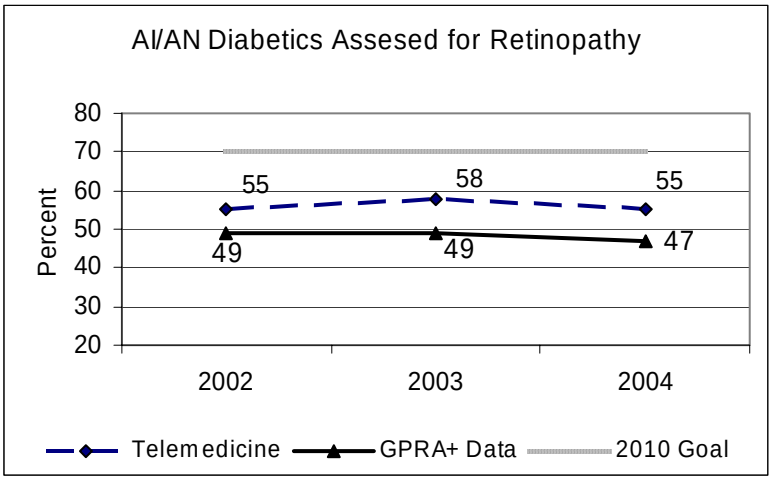
Why is this important? Diabetes can cause kidney disease by damaging the parts of the kidneys that filter out wastes. Diabetes is the leading cause of end stage renal disease (ESRD) of kidney failure, a growing problem in Indian communities. Early identification of at risk patients may help prevent or delay the need for dialysis or renal transplant. Microalbumin in the urine is an early sign of diabetic kidney disease. Proteinuria is also an independent predictor of cardiovascular disease, which is the number one killer of American Indian and Alaska Native adults.

Approach: The benefits of aggressive interventions to lower blood pressure in diabetics relative to kidney health have been well described in the literature and numerous practice guidelines and standards exist. A special sub-report of the IHS Diabetes Care and Outcomes Audit, called the Kidney Health Profile, generated annually, assesses screening and treatment for kidney health in a community. Each year's reported rate will be used to provide trend analysis.

Data Source: GPRA+ data from local RPMS systems, diabetes registries, yearly IHS Diabetes Care and Outcomes Audit.

Program Performance: IHS met this indicator in FY 2004. The FY 2004 indicator was to increase the proportion of patients with diagnosed diabetes assessed for nephropathy by 1% over the FY 2003 level. This goal was met and exceeded, with a 4% increase in the number of patients assessed based on GPRA+ data and a 2% increase according to the diabetic audit data.

Indicator 6: During FY 2006, maintain the proportion of patients with diagnosed diabetes who receive an annual retinal exam.



Rationale: The purpose of this indicator is to reduce the level of vision loss from diabetic retinopathy in the American Indian and Alaska Native population.

Why is this Important? Diabetes can affect sight by damaging the blood vessels inside the eye, a condition known as "diabetic retinopathy." Diabetic eye disease is a leading cause of blindness in the United States. Early detection of diabetic retinopathy (DR) is a fundamental part of the effort to reduce visual disability in diabetic patients. Clinical trials demonstrated that effective laser photocoagulation treatment of early DR could reduce vision loss by 90%.

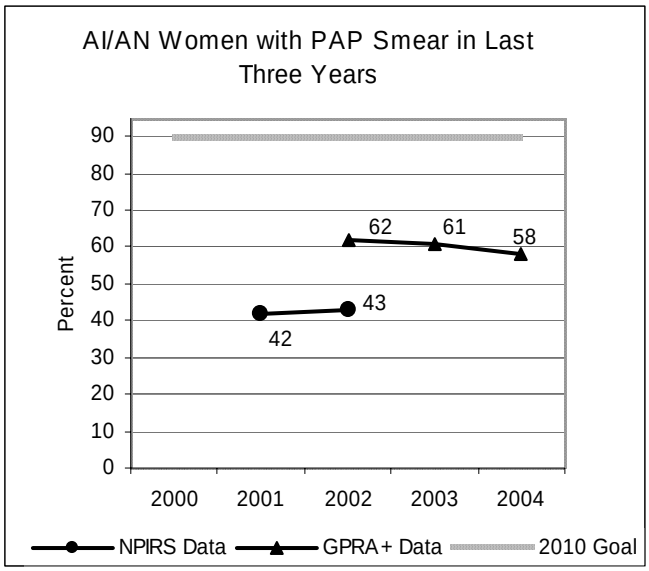
Approach: The IHS retinopathy screening rate has remained relatively unchanged since rates have been tracked. Some facilities have telemedicine projects in place designed to screen diabetics for diabetic retinopathy (pilot sites), and performance at these sites is being evaluated to determine the impact of this approach on screening rates. Pilot sites designated for FY 2004 are Phoenix Indian Medical Center, Tuba City Medical Center, Fairbanks Health Center, San Carlos Indian Hospital, Benewah Health Center, Hopi Health Care Center, Parker Indian Hospital, and Carl Albert Indian Health Facility.

Data Source: GPRA+ data from RPMS databases at selected pilot sites as well as all other facilities.

Program Performance: **IHS did not meet this indicator in FY 2004.** The FY 2004 indicator was to increase the proportion of patients with diagnosed diabetes who receive an annual diabetic retinal examination at designated sites by 3%. In FY 2003, the examination rate for pilot sites was 58%; in FY 2004, the rate dropped to 55%. Reasons for this drop include an increase in the size of the diabetic population as well as eye department staff decreases, or lack of staff increases. Adjusting for these variables, increases can be shown at all pilot sites except Parker, where the Tmed-DR program was minimally operational in 2004 due to staffing issues. Compared with the results of all sites participating in GPRA in FY 2004, the results at pilot sites are impressive. The rates for all sites dropped from 49% in FY 2003 to 47% in FY 2004.

Cancer Screening Group:

Indicator 7: During FY 2006, maintain the proportion of female patients ages 21 through 64 without a documented history of hysterectomy who have had a Pap screen within the previous three years at FY 2005 level.



Rationale: The purpose of this indicator is to reduce the mortality and morbidity of cervical cancer, which occurs at higher rates among American Indian and Alaska Native women than in the general U.S. population.

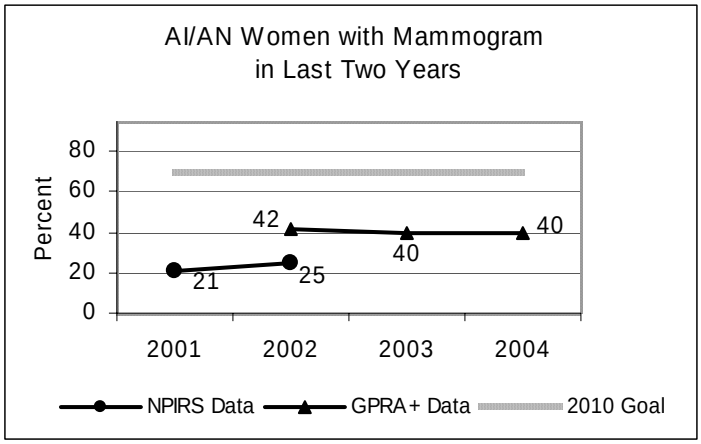
Why is this Important? American Indian women have a cervical cancer mortality rate of 4.4 (1999-2001) that exceeds the 2000 rate of 2.8 for U.S. all races. More than any other racial or ethnic group, American Indian women report having never had a Pap screen. Regular screening with a pap smear lowers the risk of developing invasive cervical cancer by detecting pre-cancerous cervical lesions that can be treated. If cervical cancer is detected early, the survival rate is almost 100 percent with appropriate treatment and follow- up.

Approach: The IHS Office of Public Health Support is responsible for overall coordination of efforts to achieve these indicators.

Data Source: GPRA+ data from RPMS.

Program Performance: IHS did not meet this indicator in FY 2004. The FY 2004 indicator was to maintain the proportion of eligible women patients who have had a Pap screen within the previous three years at the FY 2003 levels. In 2004 the Pap smear rate was 58%, a drop of 3% from the 61% rate reported in 2003. Some of this drop can be attributed to a change in the measure for a Pap test. Previously, all reported pelvic exams counted toward the Pap smear rate, but in 2004 only Pap smears were counted. Therefore, the 2004 rate is more accurate.

Indicator 8: During FY 2006, maintain the proportion of female patients ages 50-64 who have had mammography screening within the last 2 years at the FY 2005 level.



Rationale: The purpose of this indicator is to reduce the mortality and morbidity of breast cancer among American Indian and Alaska Native women.

Why is this Important? Biennial screening of women between the ages of 50 and 69 has been shown to be a cost effective way to decrease the breast cancer mortality rate. Breast cancer is the second leading cause of cancer death among U.S. women (lung cancer is first). Regular mammography screening can reduce breast cancer mortality by 20-30%. AI/AN women diagnosed with breast cancer have lower 5-year survival rates in comparison to whites, mainly because their cancers are less likely to be found in earlier stages.

Approach: Mammography screening is provided to American Indian and Alaska Native women directly by IHS facilities, by mobile mammography units supported either by CDC funds or through contract health arrangements with private radiology groups. The IHS Office of Public Health Support performs the overall coordination of this effort. Linkages with CDC and State screening programs are critical to success. CDC has funded the National Indian Women's Health Support Center to provide technical assistance to Tribal mammography programs.

Data Source: GPRA+ data from local RPMS database.

Program Performance: IHS met this indicator in FY 2004. This indicator called for maintaining the proportion of eligible women patients who have had mammography screening within the last 2 years at the FY 2003 rate.The 2004 mammogram rate remained unchanged from the 2003 rate of 40%. Because many tribal and urban facilities lack the equipment to perform mammograms on site, this rate is a difficult one to increase.

Indicator 9: During FY 2006, establish baseline rate of colorectal cancer screening for clinically appropriate patients aged 50 and over.

Rationale: The purpose of this indicator is to reduce the mortality and morbidity of colorectal cancer among American Indians and Alaska Natives.

Why is this Important? Colorectal cancers are the fourth most commonly diagnosed cancers in the United States, and are the second leading cause of cancer deaths, after lung cancer. Colorectal cancer rates among the Alaska Native population are well above the national average. Although colorectal cancer rates among American Indians are low compared to the overall US average, there is strong evidence that the number of colorectal cancer cases has been rising in recent years. Screening and preventative measures such as removal of polyps have been well proven to reduce the rates and lethality of colorectal cancer. Colorectal cancers have long asymptomatic periods during which they can be diagnosed and treated. Yearly screening has been shown to result in a 33.4 percent reduction in colorectal cancer mortality

Approach: Colorectal screening is provided to American Indian and Alaska Native patients directly by IHS facilities or through contract health arrangements with private radiology groups. IHS recognizes that 90% of colorectal cancer is preventable with appropriate screening interventions. Appropriate screening interventions will be based upon current colorectal cancer screening guidelines. IHS recognizes that the majority of sites will not be able to offer screening colonoscopy; however, current guidelines include stool guiaics as an appropriate screening mechanism. Local sites will have the option of establishing appropriate screening guidelines based upon nationally endorsed guidelines.

Data Source: GPRA+ reports from local RPMS database

Program Performance: No report for FY 04. New indicator for FY 06

Substance Abuse Treatment Group:

Indicator 10: During FY 2006, the Youth Regional Treatment Centers that have been in operation for 18 months or more will achieve 100% accreditation either through CARF, or a comparable accreditation process.

Rationale: This indicator is intended to evaluate Youth Regional Treatment Centers and ensure that these programs are appropriately managed.

Why is this Important? Successful completion of residential treatment can help reduce drug and alcohol use relapse in youths.

Approach: Accreditation by JCAHO, CARF, or comparable state accrediting bodies ensures that the Youth Regional Treatment Centers met acceptable standards of treatment care. This indicator has changed to focus on accreditation, as the components of the previous indicator are met and surpassed with accredited facilities.

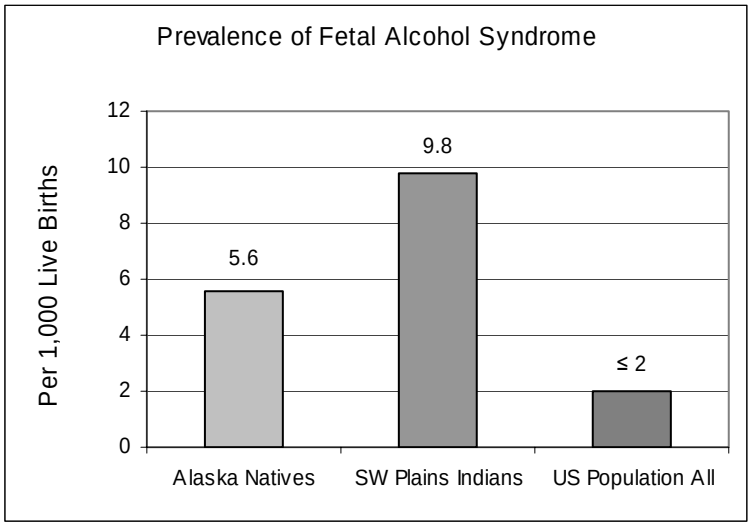
Data Source: Data for this indicator are collected from the YRTCs. The Division of Behavioral Health, Office of Public Health will be responsible for coordinating data collection from the Regional Treatment Centers.

Program Performance: IHS met this indicator in 2004. The FY 2004 performance measure was to show a 2% improvement over FY 2003 YRTC data for the following measures:

- Percent of youths who successfully completed alcohol/substance abuse treatment at IHS funded YRTCs. (70% in FY 2004 compared to 63% in FY 2003)
- Percent of youth (that completed treatment) who developed an aftercare plan with their appropriate aftercare agency (100% in FY 2004 compared to 99.6% in FY 2003)
- Percent of youth who have this after care plan communicated to the responsible follow-up agency; documentation of this communication must be in the youth YRTC record (100% in FY 2004 compared to 99.5% in FY 2003)
- Percent of YRTC programs that have a family week opportunity for youth that participate in the YRTCs (stable at 100% in FY 2003 and FY 2004)

These results are based on the eight YRTCs reporting data in both FY2004 and FY 2003. Completion of treatment, improvement in aftercare communication, established aftercare, and family week participation are known factors contributing to improved outcomes.

Indicator 11: During FY 2006, increase the screening rate for alcohol use in females ages 15-44 over the FY 05 rate.



Rationale: The purpose of this indicator is a reduction in the incidence of Fetal Alcohol Syndrome (FAS).

Why is this Important? Heavy drinking during pregnancy can cause significant birth defects, including Fetal Alcohol Syndrome (FAS). FAS is the leading known, and preventable, cause of mental retardation. Rates of FAS are higher among American Indians and Alaska Natives than the general population. Studies have found alcohol consumption rates among AI/AN women of childbearing age to be higher than average. The US Preventative Services Task Force recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings. Screening with intervention has been shown to be effective in reducing alcohol misuse in pregnancy and to reduce the incidence of FAS.

Approach: The Division of Behavioral Health works with facilities to educate, establish and increase the rates of screening for alcohol use in this age cohort. In addition, RPMS Health Summary ensures that there is an automatic health care reminder for alcohol screening. This reminder is visible to the end health care provider at the time of the provider visit.

Data Source: RPMS data extraction

Program Performance: IHS met this indicator in FY2004. The FY 2004 indicator called for establishing a baseline screening rate for alcohol use in women of childbearing age.

Oral Health Group:

> **Indicator 12: During FY 2006, increase by 1% (1) the number of topical fluoride applications provided to American Indian and Alaska Native patients, with a maximum number of four applications per patient per year and (2) the number of American Indian and Alaska Native patients receiving at least one topical fluoride application above the FY 2005 levels.**

Rationale: Prevention of tooth decay improves nutritional health.

> **Why is this Important?** Fluoride application is an effective measure for reducing the prevalence of dental decay in all age groups.

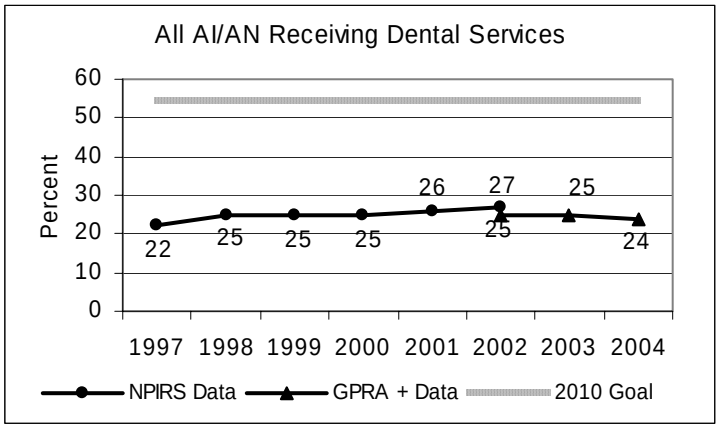
Approach: The effect on the tooth surface is essentially the same, regardless of whether the source is in the water or in topical applications. Area dental officers as a group have determined that tracking topical fluoride applications and the number of patients receiving these applications is a good alternative to measuring water fluoridation.

Date Sources: CRS data from local RPMS database

Program Performance: IHS did not meet this indicator in FY 2004. The FY 2004 indicator committed to a .5% increase in the number of American Indian and Alaska Native people benefiting from fluoridated drinking water. In FY 2004 an additional 1,713 individuals gained access to fluoridated water, an increase of 0.1%.

Significant progress has been made in most Areas with respect to water fluoridation, but the final objective of all the efforts, successful, consistent, monitored fluoridation on a widespread basis, has not yet occurred.

Indicator 13: During FY 2006, maintain the proportion of patients who obtain access to dental services at the FY 2005 level.



Rationale: This indicator is directed at improving the oral health status of the American Indian and Alaska Native population.

Why is this Important? This indicator is directed at improving the oral health status of the American Indian and Alaska Native population. Untreated tooth decay can cause abscesses and infections, pain, dysfunction and weight loss. Dental problems result in the loss of almost 2.5 million workdays each year. Access to dental care improves oral health as well as the overall health of AI/AN people.

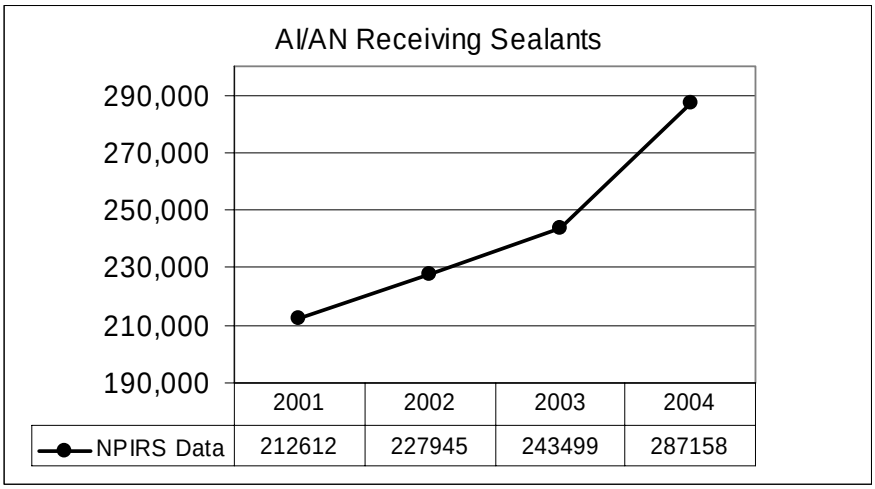
Approach: Access to dental services in FY 2006 will be maintained at 100% of the FY 2005 level through a combination of strategies that include:

- Increasing the I/T/U dental workforce.
- Increasing retention and productivity of dental providers.
- Updating and simplify the automated dental record keeping system.
- Expanding essential dental specialty services through contracts with the private sector.
- Targeting specific populations.

Data Source: IHS Dental Data System component of the RPMS; GPRA+ data from local RPMS.

Program Performance: **IHS did not meet this indicator in FY 2004.** The FY 2004 indicator called for maintaining the percent of patients who accessed dental services in 2004. In FY 2004 the percentage of patients obtaining access dropped by 1% to 24%. The key national factor contributing to this drop is the continued high vacancy rate in the dental program, which remains around 23%. Access to care, over recent years, seems closely tied to vacancy rates. A second factor is a substantial drop (9%) in the percentage of patients reported as accessing dental service in one Area. An investigation into this anomaly showed that that two reporting facilities had substantial data entry problems. These two facilities did have manual tallies available. If we take these into account, the indicator is met.

Indicator 14: During FY 2006, maintain the number of dental sealants placed per year in American Indian and Alaska Native patients at the FY 2005 level.



Rationale: The intent of this indicator is to reduce dental decay by increasing both the number of patients with dental sealants (the prevalence of sealants in the population) and the number of sealants per patient (the intensity of coverage per individual).

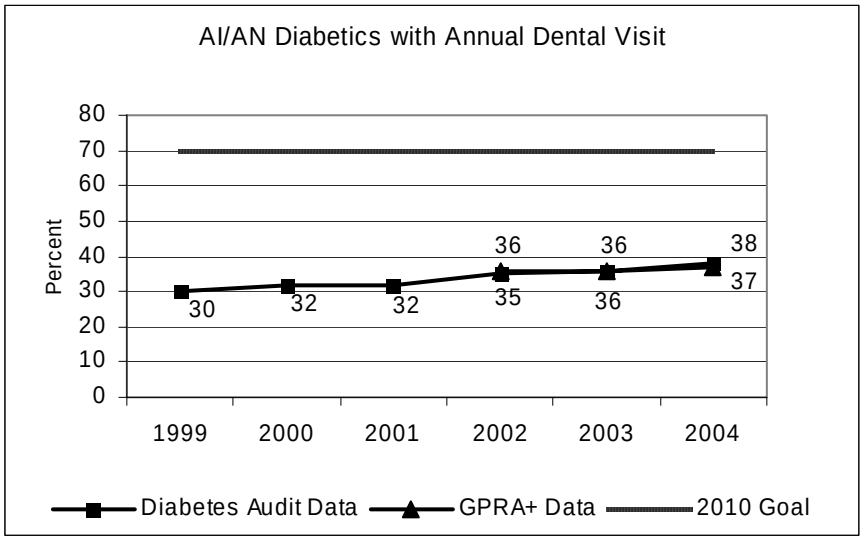
Why is this Important? Surveys of American Indian and Alaska Native children have consistently identified them as having significantly higher dental decay rates than the general U.S. population. Dental sealants, a recognized standard in preventive dental care, are an effective measure for reducing dental decay rates and can be effectively applied by dental auxiliaries at relatively low cost. Sealants reduce both the ravages and costs of treating dental decay.

Approach: Local dental clinics are responsible for implementing/maintaining effective and efficient sealant programs that are either school-based or school-linked and targeted for children ages 6-14 years (to coincide with the eruption of first and second permanent molar teeth). In order to maintain the number of sealants placed on the posterior teeth of Indian patients in FY 2006, an innovative approach will be required. One option involves the use of contract 4-handed dental sealant teams hired from the private sector. Dental Community Health Aides may be trained to assist dental hygienists and dental assistants in placing sealants. Additional portable equipment to be used in the schools is an efficient way to make use of lack of clinic space.

Data Source: NPIRS. In 2005, sealant data will be reported based on data collected at local facilities using CRS software.

Program Performance: **IHS met this indicator in FY 2004.** The FY 2004 indicator called for maintaining the number of dental sealants placed per year in American Indian and Alaska Native patients at the FY 2003 level As measured by NPIRS, the total number of sealants increased from 243,499 in 2003 to 287,158 in 2004.

Indicator 15: During FY 2006, maintain the proportion of patients diagnosed with diabetes who obtain access to dental services at the FY 2005 level.



Rationale: The purpose of this indicator is to improve both oral health status and diabetic control for American Indian and Alaska Native diabetics.

Why is this Important? Diabetics are at increased risk for destructive periodontal disease and subsequent tooth loss. All diabetic patients should receive a complete dental exam on an annual basis. In addition, untreated periodontitis in diabetics may complicate glycemic control. Access to both primary and secondary treatment and preventive services for diabetics can lessen periodontal disease progression and the subsequent effects on diabetes and overall health. Regular visits provide opportunities for prevention, early detection, and treatment.

Approach: Individual I/T/U hospitals and clinics provide access to care for diabetic patients in a wide variety of ways. At a minimum, a yearly examination provides an educational opportunity to enlighten the diabetic patient on their oral health status and proper home care to reduce periodontal disease and its effect on diabetic control. Those programs with additional time and resources can provide anything from extraction of teeth that are severely involved with periodontal disease to comprehensive periodontal therapy and dentures. The proposed FY 2006 IHS budget will support the capacity to maintain access at the FY 2005 level in the face of population growth and rising costs of treatment.

Data Source: GPRA+ from local RPMS databases; diabetes registries, yearly IHS Diabetes Care and Outcomes Audit.

Program Performance: IHS met this indicator in FY 2004. This indicator was to increase access to dental services at 1% over FY 2003 level. The diabetic audit data showed a 2% increase, and the GPRA+ data showed a 1% increase.

Family Violence, Abuse, or Neglect Indicator:

Indicator 16: During FY 2006, increase the screening rate of domestic violence in females ages 15 through 40 over the FY 2005 rate.

Rationale: This indicator is designed to help ascertain, evaluate and reduce the prevalence of family violence, abuse and neglect in American Indian and Alaska Native communities.

Why is this important? Rates of intimate partner violence are double for American Indian and Alaska Native people compared to whites, and 1½ times greater than U.S. all races. The health consequences of intimate partner violence are numerous. Women who experience domestic violence are more often victims of nonconsensual sex, have higher levels of smoking, chronic pain syndromes, depression, generalized anxiety, substance abuse, and Post-Traumatic Stress Disorder. Screening and appropriate referrals should help decrease the morbidity and mortality associated with intimate partner violence.

Approach: IHS has developed training materials that are specific for American Indian and Alaska Native communities. IHS has entered into a collaborative agreement with the Family Violence Prevention Fund as well as ACF, DHHS. This agreement facilitated the development of our teaching materials as well as the implementation and evaluation of a multifaceted systems approach to screening at clinical facilities throughout American Indian and Alaska Native communities.

Data Source: GPRA+ from local RPMS databases.

Program Performance: **IHS did not meet this indicator in FY 2004.** The FY 2004 indicator was to screen at least 15% of female patients ages 16-24 for domestic violence at health care facilities. Only 4% of eligible patients were screened in FY2004. The IHS will focus on additional training and screening tools during FY 2005.

Information Technology Development Group:

Indicator 17: During FY 2006, continue the automated extraction of GPRA clinical performance measures through ongoing development and deployment of CRS (clinical indicator reporting system) software.

Rationale: This indicator is designed to continue to improve passive extraction of GPRA clinical data from RPMS- IHS health information system.

Why is this Important? Increased local clinical data information results in improved quality of care.

Approach: IHS continues to develop GPRA+ software; this software will be renamed CRS (clinical information reporting system) in FY 05. Ongoing requirements development, as well as increased emphasis on clinical quality data improvement, will remain in place.

Data Source: CRS software application

Program Performance: **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.

Indicator 18: A new behavioral health clinical performance indicator will be developed for FY 2006 that utilizes the enhanced functionality in the IHS Integrated Behavioral Health (IBH) application and reflects patient outcomes. The IBH application will be deployed within the IHS Electronic Health Record by the end of FY 2005.

Rationale: The purpose of this indicator is to collect data in order to track and evaluate improvements in the behavioral health status of American Indian and Alaska Native people.

Why is this Important? Better BH data collection and analysis will improve planning, implementation and evaluation of mental health, alcohol and substance abuse, and social services efforts across I/T/U programs.

Approach: 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. Standardized data reporting can be achieved by providing a usable, provider-driven and provider friendly computerized application to I/T/U sites.

A key activity that began in FY 2002 was the design and implementation of an integrated Behavioral 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. By 2005, a new integrated behavioral health application will be developed and deployed to interested sites. Increased use of this application should result in increased quality of BH care to AI/AN communities using this system.

The IHS Indian Health Performance Evaluation System (IHPES) has also developed a national Mental Health SAS database.

Data Source: RPMS, the Mental Health Database, and appropriate surveys.

Program Performance: IHS did not meet this indicator in FY 2004. The FY 2004 performance measure was to improve 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. 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: During FY 2006, IHS will establish baseline participation in urban data sharing.

Rationale: The urban health programs are currently capturing data for the Urban Indian Health Program Common Reporting Requirement (UCRR).

Why is this Important? A minimum data set and a baseline measure of participation in urban data sharing will help address additional urban data needs, including GPRA reporting.

Approach: The urban program will facilitate a data workgroup to develop this minimum data set. This group will develop this minimum data set by during FY 04. Mandatory reporting on this data set will be included as part of the C&G language starting in FY 05.

Data Source: Review of Urban Program Contracts and Grants language

Program Performance: IHS met this indicator in FY 2004. The 2004 target was to develop a specific minimum data set as well as appropriate language for the urban C&G. The data elements 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.

Adequate health status and health services data are essential for the effective planning and management of any health care delivery system. Urban data must eventually reach parity with that collected by tribal and IHS facilities to allow for a more accurate portrayal of the needs and services available to American Indians and Alaska Natives (AI/AN) residing in urban areas, the existing disparities in health status that afflict them, and supporting local health program needs as well as provide data for the larger IHS requirements, including GPRA. The Urban Indian Health Programs support the considerable health care need of the AI/AN people residing in urban areas and to meet the Healthy People 2010 goal of achieving equivalent and improved health status for all Americans.

***Quality of Care Indicator Group*:**
The following indicators address the quality of health care provided in IHS settings from the perspectives of accreditation, medication errors, and consumer satisfaction.

> **Indicator 20: During FY 2006, maintain 100% accreditation of all IHS hospitals and outpatient clinics.**

Rationale: The accreditation of IHS hospitals and clinics represents the most objective and respected measure of health care quality.

> **Why is this Important?** Accreditation is essential for maximizing third-party collections, and contributes both directly and indirectly to improved clinical quality.

Approach: The local I/T/U multidisciplinary team approach to accreditation and ongoing quality management has been the mainstay of success in this important activity. Additional support and guidance from Areas and Headquarters staff will continue to support this indicator. This is one of the most demanding indicators to meet, given the growing clinical quality of care assessments that are required as well as issues related to health facilities maintenance, improvement, and renovation that are critical to accreditation. The accrediting body used for hospitals and some ambulatory health centers is the Joint Commission on the Accreditation of Health Care Organizations (JCAHO). However, there was an increase in the ambulatory health centers that obtained accreditation from the American Association of Ambulatory Health Centers (AAAHC).

Data Source: IHS compiled a database generated from accreditation reports submitted by IHS Area Quality Assurance coordinators.

Program Performance: IHS met this indicator in FY 2004. The FY 2004 indicator committed to maintaining 100% accreditation of all IHS hospitals and outpatient clinics and was achieved. During FY 2004, twenty-one IHS hospitals were evaluated by either JCAHO, CMS, or AAAHC. All twenty-one maintained full accreditation. In addition, sixteen ambulatory health centers participated in accreditation visits from JCAHO and AAAHC and all were accredited.

Indicator 21: During FY 2006, IHS will establish and evaluate a medical error reporting system at 3 areas.

Rationale: The intent of this indicator is to improve patient safety by establishing and evaluating a medical error reporting system within 3 areas.

Why is this Important? It is estimated that medical errors kill 48,000-98,000 Americans each year, and injure an additional one million. It is estimated that adverse drug reactions are between the fourth and sixth leading causes of death in the U.S. By developing a national medical error reporting system, which includes adverse reaction monitoring, IHS will be able to evaluate medical errors and develop appropriate interventions.

Approach: Initially, the IHS will rely on medication error reporting systems. It will then draw on national federal expertise to establish and evaluate all types of medical errors and reporting systems, including the VHA, DOD and AHRQ.

Data Source: In FY 2006, IHS will establish a national mechanism for medical error reporting, and evaluate its performance within 3 areas. Data will be obtained via direct contact with these 3 areas.

Program Performance: IHS met this indicator in FY 2004. The FY 2004 performance indicator was that the IHS would establish baseline data for medication error reporting for all IHS Areas and Pilot test standardized medication error reporting system in two additional Areas. Med Marx, the web based medication error reporting system, was pilot tested for one year at all of IHS and most tribal sites in the Phoenix and Albuquerque areas. Results of the pilot test were favorable and other areas were encouraged to adopt Med Marx or another standardized medication error reporting system. To date, 55 facilities in the Alaska, Aberdeen, Bemidji, Oklahoma, and Phoenix areas are using Med Marx.

The second part of the Medication Error Reporting indicator is related to assessing baseline data for reported errors. The Phoenix area was the pilot and established an area-wide baseline both prior to and after implementation of the Med Marx reporting system.

Indicator 22: Eliminated in FY 2005

Rationale: The intent of this indicator is to maintain consumer satisfaction.

Why is this Important? Assessing consumer satisfaction is fundamental to health care quality, and is one of the Institute of Medicines cornerstones of health care quality. Improved consumer satisfaction is also associated with higher consumer compliance levels with provider health recommendations, which can result in improved health outcomes.

Approach: In FY 1999, the IHS developed a comprehensive culturally sensitive consumer satisfaction survey instrument that was based on a tested and validated instrument from the private sector. Clearance was obtained in late FY 2002, and baseline data was obtained during FY 02. Additional assessments have been undertaken in FY 2003, with a follow-up survey to determine improvement scheduled to be completed in FY 2004.

The responsible parties for implementation are the local service sites with assistance from the IHS Area office staff. The local staff is part of the local quality assurance program and the aggregate staff will be part of the IHS epidemiology centers/program.

Data Source: IHS Consumer Satisfaction Survey

Program Performance: **IHS did not meet this indicator in FY 2004.** The FY 2004 indicator committed to improving customer satisfaction rates by 3% over the FY 2003 baseline. However, a follow-up survey was not conducted. Because Indicator 20 requires all IHS facilities to maintain accreditation, which includes a customer satisfaction component, Indicator 22 will be eliminated in FY 2005.

Prevention Indicators

Detail of Performance Analysis Table

Performance Measures	Targets	Actual Performance	Reference
Public Health Nursing Indicator			
Indicator 23: Address the number of public health nursing services (primary and secondary treatment and preventive services) provided by public health nursing. [efficiency]	Total Visits FY 06: Pending new indicator FY 05: maintain FY 04 levels FY 04: maintain FY 03 level FY 03: maintain FY 02 level FY 02: +2% over FY 01 FY 01: +3% over FY 00 FY 00: 7% over 97 or 363,033 FY 99: no indicator Home Visits FY 05: no indicator FY 04: maintain FY 03 level FY 03: +2% over FY 02 FY 02: +2% over FY 01 FY 01: +3% over FY 00 FY 00: 7% over 97 or 127,846 FY 99: no indicator	FY 06: FY 05: FY 04: 423,379*** FY 03:359,089 *** FY 02: 400,347/343,844*** FY 01: 383,436 (+3.1%) FY 00: 371,548 (9.5% over FY97) FY 99: 336,134 FY 97: 339,283 baseline FY 05: no indicator FY 04: 192,121*** FY 03: 160,650*** FY 02: 151,370/156263*** FY 01: 153,852 (+20%) FY 00: 127,873 (7% over 97) FY 99: 111,836 FY 97: 119,482 baseline	1, 3, 5 ***GPRA+ data
Immunization Group			

Performance Measures	Targets	Actual Performance	Reference
Indicator 24: Address rates for recommended immunizations for AI/AN children patients 19-35 months. [outcome 04]	FY 06: maintain baseline rates compared to FY 05 FY 05: maintain FY 04 level for children 19-35 months FY 04: +2% over FY 03 for children 3-27 months and establish baseline rates for 19-35 month old children FY 03: at FY 02 level FY 02: +1% over FY 01 level FY 01: +1% over FY 00 level FY 00: +2% over FY 99 level FY 99: 91%	FY 06: FY 05: FY 04: 81%; baseline established FY 03: 80% FY 02: 80% FY 01: 83% 12 of 12 Areas (-3%) FY 00: 86% 12 of 12 Areas (-3%) FY 99: 89% 12 of 12 Areas 87% 11 of 12 Areas FY 98: 88% (baseline 11 of 12 Areas)	7 1, 3 HP 2010
Indicator 25: Address influenza vaccination rates among non-institutionalized adult patients aged 65 years and older. [outcome]	Influenza FY 06: at FY 05 levels FY 05: at FY 04 levels FY 04: at FY 03 level FY 03: at FY 02 level FY 02: +1% over FY 01 level FY 01: +1% over FY 00 level FY 00: 65% FY 99: no indicator Pneumococcal FY 03: moved to # 25 below FY 02: no indicator FY 01: secure electronic baseline FY 00: 65% FY 99: no indicator	FY 06: FY 05: FY 04: 54%*** FY 03: 51% *** FY 02: 31%/51%*** FY 01: 34.8% FY 00: 30.7% FY 03: moved to # 25 below FY 02: no indicator FY 01: data not available FY 00: data source inadequate	1, 3, 5 HP 2010 ***GPRA+

Performance Measures	Targets	Actual Performance	Reference
Indicator 26: Address pneumococcal vaccination rates among non-institutionalized adult patients age 65 years and older. [outcome]	FY 06: maintain at FY 05 levels FY 05: maintain at FY 04 levels FY 04: maintain at FY 03 levels FY 03: maintain at FY 02 levels FY 02: no indicator FY 01: secure electronic baseline FY 00: 65% FY 99: no indicator	FY 06: FY 05: FY 04: 69%*** FY 03: 65%*** FY 02: 17%/ 64%*** FY 01: 11.2% FY 00: data source inadequate	1, 3, 5 HP 2010 ***GPRA+
Injury Prevention Group			
Indicator 27: Support community-based injury prevention programs.	Web Based Reporting: FY 06: implement web-based data collection system FY 05: maintain at FY04 level IP Intervention Projects FY 04: maintain at least 36 injury prevention projects. FY 03: implement at least 36 injury prevention projects. # of Comprehensive IP Programs FY 03: no indicator FY 02: maintain at least 25 sites* FY 01: no indicator FY 00: no indicator	FY 06: FY 05: FY 04: 37 injury prevention projects maintained FY 03: 36 injury prevention projects implemented FY 03: no indicator FY 02: 25 sites FY 01: 25 sites FY 00: baseline 25 sites	1, 3 .

Performance Measures	Targets	Actual Performance	Reference
Indicator 28: Address the number of unintentional injuries for AI/AN people. [outcome]	Deaths FY 06: maintain or reduce FY 2005 FY 05: maintain or reduce FY 04 FY 04: maintain or reduce FY 03 FY 03: maintain or reduce FY 02 rate FY 02: at FY 01 rate, or less FY 01: no indicator FY 00: no indicator FY 99: 93/100,000 (ICD-9) 95.84/100,000 (ICD-10) Hospitalizations FY 01: 70 per 10,000 FY 00: 71.5 per 10,000	FY 2006 FY 05: FY 04: Available December 2008 FY 03: Available December 2006 FY 02: 51.4/100,000 FY 01: 51.4/100,000 FY 00: 51.5/100,000 FY 99: 95.5/100,000 FY 96-98: 94.7/100,000 deaths FY 94-96: 92.6/100,000 deaths FY 92-94: 95.0/100,000 deaths FY 01: data not available FY 00: data not available FY 98: 72.5 /10,000 hosp. FY 96: 74.7/10,000 hosp.	1, 5 HP 2010

Performance Measures	Targets	Actual Performance	Reference
Suicide Prevention Indicator			
Indicator 29 Support suicide prevention by collecting comprehensive data on the incidence of suicidal behavior.	FY 06: establish baseline data FY 05: integrate the Behavioral Health suicide reporting tool into RPMS * FY 04: implement national reporting plan FY 03: + 5% over FY 02 level FY 02: + 10% over FY 01 level FY 01: 50% of I/T/Us implemented. FY 00: no indicator FY 99: no indicator	FY 06: FY 05: FY 04: national reporting plan implemented FY 03: increased by 30% FY 02: 22% of I/T/Us implemented (+10% over FY 01) FY 01: 12% of I/T/Us implemented FY 00: FY 99: FY 98: estimated 25%	3, 5 HP 2010 * indicates revised FY 2005 measure. See Summary of Changes Table
Developmental Prevention and Treatment			
Indicator 30: Support clinical and community-based cardiovascular disease prevention initiatives. [outcome]	FY 06: Increase # adult patients with lipid screening FY 05: baseline number of eligible patients screened for lipids FY 04: Evaluation implemented and 1 site added FY 03: Evaluation implemented and 1 site added FY 02: 3 sites implementing interventions FY 01: 3 sites with intervention plans FY 00: no indicator FY 99: no indicator	FY 06: FY 05: FY 04: evaluation implemented and two additional sites added FY 03: 4 sites implemented intervention plans FY 02: 3 sites implemented intervention plans FY 01: 3 sites with intervention plans	1, 3 HP 2010

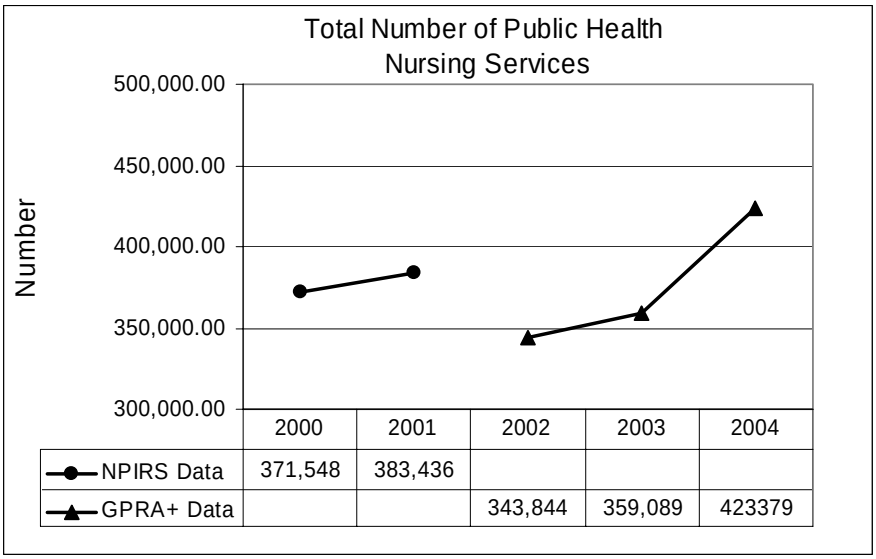
Performance Measures	Targets	Actual Performance	Reference
Indicator 31: Support clinical and community-based obesity prevention initiatives. [outcome]	BMI measured FY 06: decrease obesity rates in children, 2-5 years FY 05: increase % of patients with BMI measured FY 04: establish baseline BMI measures Develop Model Pilot Sites FY 03: implement a 3-element obesity prevent. /treat. plan FY 02: develop a 3-element obesity prevent treat. plan FY 01: implement obesity prevention program and monitor pilots and comparisons sites FY 00: establish five pilot sites FY 99: develop approach and baselines	FY 06: FY 05: FY 04: baseline BMI measures established FY 03: 3 element obesity prevention /treatment plan implemented FY 02: 3 element obesity prevent/ treatment plan developed FY 01: implementation and monitoring commenced at sites FY 00: pilot sites established FY 99: approach and baseline accomplished	1, 3 HP 2010

Performance Measures	Targets	Actual Performance	Reference
Indicator 32: Support local level initiatives directed at reducing tobacco usage. [outcome]	FY 06: Establish rates of tobacco using patients receiving tobacco cessation intervention Determine Screening Rates FY 05: maintain screening at FY 04 levels FY 04: establish baseline screening rates Pilot Test Strategies FY 03: develop 5-year tobacco control plan for IHS FY 02: commence all prescribed control activities in 5 sites FY 01: establish 5 tobacco control centers FY 00: establish baseline rates for tobacco usage FY 99: no indicator	FY 06: FY 05: FY 04: baseline tobacco screening rates established FY 03: 5 year tobacco control plan for IHS developed FY 02: commence all prescribed control activities in 5 sites FY 01: 7 tobacco control centers established FY 00: baseline rates established	1, 3 HP 2010
HIV/AIDS Group			
Indicator 33: Support screening for HIV infections in appropriate population groups. [outcome]	FY 06: increase screening rates for HIV in pregnancy FY 05: establish baseline rates for screening of HIV infection in pregnant women FY 04: +10 Sites FY 03: +5% over FY 02 FY 02: secure baseline in 3 new Areas FY 01: Establish baseline FY 00: no indicator FY 99: no indicator	FY 06: FY 05: FY 04: not met FY 03: .1 % over baseline FY 02: baseline in 3 areas FY 01: baseline for limited sites FY 00: no baseline	HP 2010

Performance Measures	Targets	Actual Performance	Reference
Environmental Surveillance Indicator			
Indicator 34: Implement automated web-based environmental health surveillance data collection system in tribal systems.	FY 06: 50% more environmental health programs above FY 2005 level will have reported the regionally appropriate environmental health priorities based on current community data FY 05: 12 environmental health programs will have reported the regionally appropriate environmental health priorities based on current community data into WebEHRS. FY 04: +15% over FY 03 level FY 03: +15% over FY 02 level FY 02: implement in at least 10 sites FY 01: 15% of communities assessed FY 00: develop surveillance protocol and plan FY 99: no indicator	FY 06: FY 05: FY 04: +15% over FY 03 level (26 sites added) FY 03: +116% over FY 02 level (implemented in 22 more sites) FY 02: implemented in 19 more sites FY 01: automated system distributed to all IHS field sites FY 00: protocol and plan partially completed FY 99: no surveillance systems in place	3, 4 * corrected 1/05 from 16% (+3 sites)
Total Prevention Funding :	FY 06: $140,871,000 FY 05: $130,096,000 FY 04: $126,492,000	HP: Chapter # #: HHS Strategic Goal : PMA#	

Public Health Nursing Indicator:

Indicator 23: During FY 2006, a new interim outcome indicator will be developed.



Rationale: The purpose of this current indicator is to improve the health status of American Indian and Alaska Native people through maintaining access to services associated with improved health outcomes.

Why is this Important? Public health nursing is a method of delivering services to outside of the I/T/U setting. Public health nurses provide health assessment, health promotion, disease prevention, and infectious disease management.

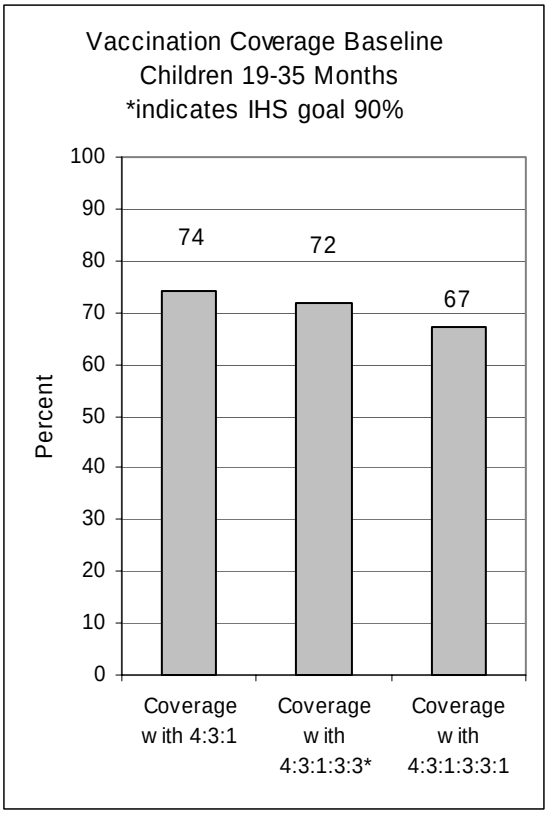
Approach: The population base for public health nursing services is the IHS user population residing within the official boundaries of the Area. However, in some service units, the user population is greater than the reported census population. In these cases, the Indian user population is used as an estimate of the service population to reflect PHN service to both stable communities and transient populations.

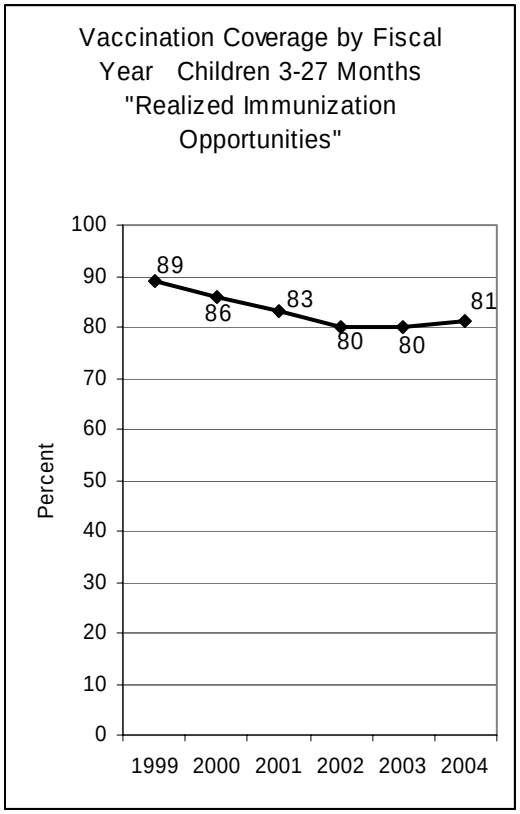
Data Sources: IHS PCC, GPRA+, and written reports submitted by Tribes using non-RPMS systems.

Program Performance: The IHS met this indicator in FY 2004. The FY 2004 indicator was to maintain the total number of public health nursing services provided to individuals in all settings and the total number of home visits at the 2003 workload levels. The total number of home visits reported in 2004 was 192,121 compared to 160,650 visits reported in 2003. The total number of visits in all settings was 423,379 in 2004, compared to 359,089 visits reported in 2003. It is important to note, though, that the number of facilities reporting in 2004 increased significantly.

Immunization Group:

Indicator 24: During FY 2006, maintain baseline rates for recommended immunizations for American Indian and Alaska Native children 19-35 months compared to FY 05.





Rationale: The National Immunization Survey, which is used to estimate immunization coverage for each state and for the U.S., collects information on children 19-35 months. The Healthy People 2010 goal is 90% coverage with routine immunizations for children 19-35 months. We will continue to assess our performance using the 19-35 month cohort.

Why is this Important? Routine immunizations represent a cost-effective public health measure that significantly improves the health of children. Among all US children aged 19-35 months, vaccine coverage in 2003 reached an all-time high. National coverage levels are now over 90 percent for each vaccine recommended through age 35 months. National Immunization Survey statistics show that AI/AN children have vaccination rates that are below the national averages.

Approach: Through FY 2004, the IHS collected data on immunizations for children aged 3-27 months on a quarterly basis. The totals for the year do not represent individual children. The IHS determines the number of vaccination opportunities in FY 2004, and the number of vaccination opportunities that were realized. “Immunization opportunities” are the number of times that children were eligible to receive a vaccine. “Realized immunization opportunities” means the child received the required vaccination.

Data Source: Quarterly immunization reports on children 3-27 months old and an annual 2 year old immunization report based on IHS patient care records and public health nursing records of children who receive immunizations at an IHS facility. GPRA+ data will be used in future years.

Program Performance: IHS did not meet this indicator in FY 2004. The indicator called for 1) increasing coverage for children 3-27 months by 2% over 2003 and 2) establishing baseline rates for recommended immunizations for American Indian and Alaska Native children 19-35 months. Although a baseline rate was established for children 19-35 months, the coverage rate for 3-27 month old children was raised only by 1%, from 80% to 81%.

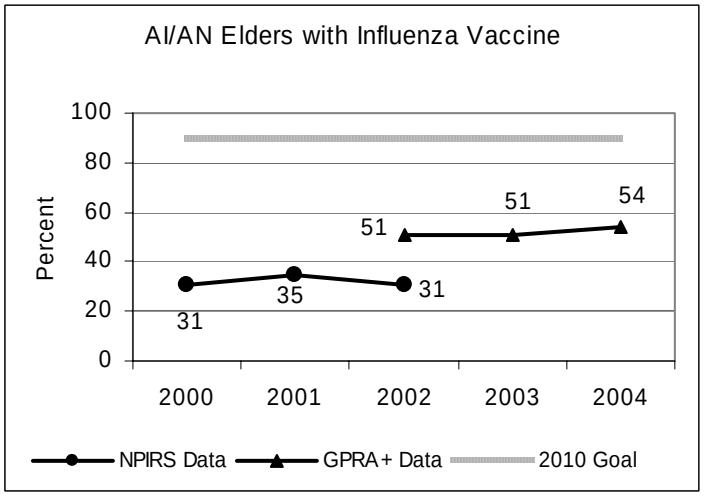
Challenges in meeting the FY 2004 indicator for children ages 3-27 months included:

- Vaccine shortages. There were extensive shortages for 6 of the routinely recommended childhood vaccinations in FY 2001 and FY 2002, including DTaP, some hepatitis B/Hib combination vaccines, and MMR. Shortages led to the suspension of routinely recommended doses in some states (such as the 4th DTaP), so that many children were not up-to-date with their vaccines. While the shortages were resolved in FY 2003, there may have been delays in catching children up that likely affected vaccine coverage levels for FY 2004.
- Vacancies in positions essential for the delivery, tracking, and reporting of immunizations (e.g. public health nurses, and medical records staff).
- The IHS immunization software package. This package is not fully utilized at many local facilities.
- An increasingly complex immunization schedule.
- Incomplete tracking due to multiple sources of health care, including non-IHS.

The IHS is working to address these challenges.

- The IHS is working with CDC and state immunization programs to prioritize limited vaccine supply to ensure the highest risk and most vulnerable children receive priority.
- Data-quality initiatives are ongoing and will likely result in lower immunization coverage levels initially. Improved data, however, will also allow IHS to identify low-performing areas to target for intervention.
- The IHS is addressing agency-wide recruitment and retention problems.
- A contract is in place to update the RPMS Immunization software package and to provide training in its use in all clinics.

Indicator 25: In FY 2006, maintain the FY 2005 rate for influenza vaccination levels among non-institutionalized adult patients age 65 years and older.



Rationale: The purpose of this indicator is to reduce morbidity and mortality due to influenza among adults.

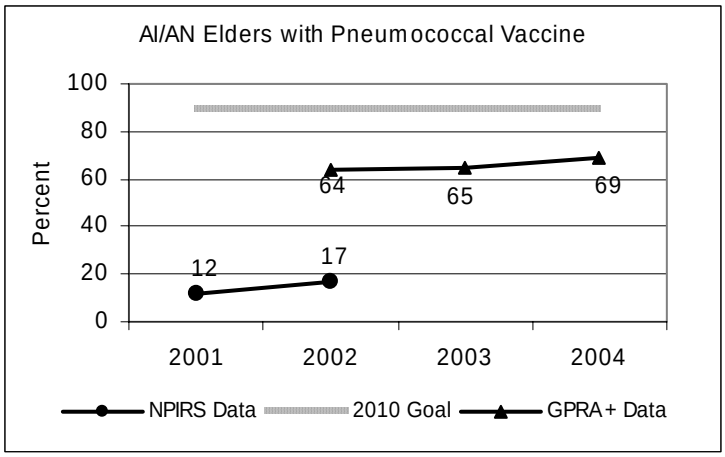
Why is this Important? Influenza is a highly contagious respiratory disease that can cause potentially life-threatening secondary infections. Elders who get influenza are also at increased risk of hospitalization and death from heart disease and stroke, and vaccination reduces that risk. In one study comparing vaccinated to non-vaccinated persons aged 65 and older over two influenza seasons, researchers found a 20% reduction in hospitalization for cardiovascular and cerebrovascular events in addition to a 30% reduced hospitalization for influenza and a 50% reduction in death from all causes.

Approach: IHS clinics are encouraged to provide influenza vaccine to adults 65 years of age during clinic visits and during mass immunization clinics. Educating patients is a part of the strategy to ensure influenza vaccine is provided. The proposed FY 2006 IHS budget will support the capacity for sites to continue existing strategies and maintain current immunization coverage levels in the face of population growth.

Data Source: GPRA+ from the RPMS database.

Program Performance: IHS met this indicator. This indicator was to maintain the percentage of adults 65 years old and older that receive influenza vaccine at the FY 2003 level. The target of maintaining the influenza vaccination rate was met and exceeded, with the percentage of eligible patients receiving influenza vaccine at 54%. This rate is 3% higher than the percentage reported last year and more than 20% higher than the percentage reported in 2000. Continued efforts must be made in order to reach the HP 2010 goal of a 90% immunization rate. Studies show that system interventions such as standing orders to administer vaccine increased rates by 39%, more than any other type of intervention.

<u>Indicator 26</u>: In FY 2006, maintain the FY 2005 rate for pneumococcal vaccination levels among non-institutionalized adult patients age 65 years and older.



<u>Rationale:</u> The purpose of this indicator is to reduce morbidity and mortality due to pneumococcal disease among adults.

Why is this Important? Elder health is an increasingly important issue as more and more of the population survives beyond the age of 65. Pneumococcal disease includes pneumonia, bacteremia, and meningitis. Pneumococcal disease has the highest death toll from a vaccine-preventable bacterial disease and patients over the age of 65 account for more than 51% of the deaths. Vaccination of the elderly against pneumococcal disease is one of the few medical interventions that has been found to improve health and save on medical costs.

<u>Approach:</u> IHS clinics are encouraged to provide pneumococcal vaccine to adults 65 years of age during clinic visits. The proposed FY 2006 IHS budget will support the capacity for sites to continue existing strategies and maintain current immunization coverage levels in the face of population growth.

<u>Data Source:</u> GPRA+ from the RPMS database.

<u>Program Performance:</u> IHS met this indicator in FY 2004. The indicator was to maintain the FY 2003 rate for pneumococcal vaccination levels among non-institutionalized adult patients age 65 years and older. In 2004 the percentage of patients receiving pneumococcal vaccinations rose 4% compared to the percentage reported in 2003.

Injury Prevention Group:

The following two indicators address the process and outcome of comprehensive community-based injury prevention efforts across I/T/U settings.

Indicator 27: During FY 2006, implement web-based data collection system to report injury prevention projects.

Rationale: The purpose of this indicator is to reduce injury rates in the American Indian and Alaska Native communities through the implementation of proven injury intervention strategies across I/T/U settings.

Why is this Important? Proven injury prevention interventions are projects that address a specific identified injury problem; employ a multiple-strategy approach; are based on a proven effective, evaluated injury prevention strategy; or are epidemiologically identified from local data and designed on a proven prevention approach. Examples of projects include Sleep Safe Project sites, national IHS Part II Injury Infrastructure Grants, and Injury Prevention Specialist Fellowship.

Approach: Since the mid-1980's IHS has developed the capacity of IHS staff and tribes to epidemiologically assess the injury hazards and risk factors in communities and develop intervention strategies. Injury intervention projects are underway through I/T/U settings to reduce the burden of injury experienced. This measure will report on the community specific initiatives underway throughout IHS.

Data Sources: Data to report on this indicator is compiled and reported by Area Injury Prevention Specialists.

Program Performance: IHS met this indicator in FY 2004. The FY 04 indicator committed to maintain at least 36 community-based, proven injury prevention intervention projects across I/T/U settings. IHS funded 37 Injury prevention cooperative agreement grantee projects in FY 04. In addition to these, each IHS Area has at least 1 to 5 injury prevention projects addressing a specific identified injury problem. At least thirteen Sleep Safe and Ride Safe projects were implemented as several I/T/U locations. The 2003-2004 Injury Prevention Specialist Fellowship program development projects implemented in FY 2004 involved community-based IP projects that addressed a specific identified injury project and designed on a proven prevention approach.

Indicator 28: During FY 2006, reduce deaths caused by unintentional injuries to no higher than the FY 2005 level.

Rationale: Injuries are a leading cause of hospitalization for American Indian and Alaska Native people. Annually, forty six percent (46%) of the Years of Potential Life Lost (YPLL) for American Indian and Alaska Native people are the result of injuries.

Why is this Important? Injuries are the number one cause of mortality for American Indian and Alaska Native people for ages 1-44 years and third for overall death rates. The single largest expenditure of contract medical care funds is for the treatment of injuries. The systematic implementation of prevention strategies through partnerships with tribes and outside agencies has demonstrated significant improvements in injury rates of American Indian and Alaska Native people.

Approach: The IHS has assigned an Injury Prevention Program Manager, who coordinates activities and resources with specially trained Injury Prevention Specialists at the Area, District, Service Unit and tribal levels. IHS maintains a broad base Injury Prevention program that includes a $1.475 million Infrastructure Grant Program, an internationally recognized training program, community-based epidemiologic assessment, and partnerships with other agencies to fund and implement proven intervention projects in communities.

Data Source: In its original form in the FY 1999 performance plan, this indicator targeted injury mortality as the performance measure. However, efforts to apply this approach in FY 2000 and FY 2001 revealed that the hospitalization data do not accurately reflect the number of unintentional injury cases that are hospitalized in IHS or tribal hospitals. Coding omissions have resulted in injury codes frequently not being noted.

Program Performance: No data is currently available to report on the 2004 indicator. IHS expects that we will be able to report on this indicator by 2008..

The FY 2002 indicator was met. The FY 2002 indicator committed to maintaining the rate of deaths due to unintentional injuries for American Indian and Alaska Natives at the FY 2001 level or less. In CY 2001, the age-adjusted mortality rate was 51.43 per 100,000. This is below the CY 2000 rate of 51.49 per 100,000.

Suicide Prevention Indicator:

Indicator 29: During FY 2006, establish baseline data on suicide using the RPMS suicide reporting tool.

Rationale: This indicator is part of an expanding systematic effort at reducing the prevalence of suicide in the American Indian and Alaska Native population. The suicide death rate for the American Indian and Alaska Native population has actually increased in the 1990s and is currently 72% greater than the national average.

Why is this Important? IHS has known that our data is incomplete, as many attempted suicides and completed suicides are not currently recorded in our data system. The Division of Behavioral Health, along with the Information Technology Support Center, has developed a comprehensive suicide data reporting system. A systematic assessment will be conducted to evaluate the impact of the deployed suicide surveillance plan.

Approach: Programs are responsible for implementing a national suicide reporting system. A suicide surveillance system is being encouraged for use at clinical facilities to assure that routine suicide screenings and case management are nationally consistent, but also tailored to the needs and resources of each site. This suicide surveillance instrument is integrated into the interim behavioral health software application, but will also be deployed into the general RPMS application. This will ensure that primary and emergency medicine providers can also enter data into this system.

Data Source: Local programs send reports to the national ITSC with identified data sources linked with RPMS as appropriate. Aggregated data is used to assess current rates. Effective deployment of the new interim behavioral health application ensures that the national suicide reporting system is being utilized appropriately.

Program Performance: 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. However, primary care physicians are not able to access this package. As a result IHS has changed the 05 Indicator to address this issue and deploy this form into the PCC and EHR to allow for comprehensive reporting.

Developmental Prevention and Treatment Group:

Indicator 30: During FY 2006, increase the number of patients ages 23 and older that receive blood cholesterol screening.

Rationale: Cardiovascular disease represents the single largest cause of death for American Indian and Alaska Native people above the age of 45.

Why is this Important? Screening for blood lipid levels can identify patients that are at high risk for cardiovascular disease. Appropriate screening and identification can help prevent cardiovascular disease development and complications.

Approach: This indicator focuses on evaluating screening and prevention for CV disease in adult patients.

Data Source: GPRA+ from local RPMS database

Program Performance: IHS met this indicator in 2004. During FY 2004, the four Tribal programs:

- continued to implement their Community Action Plan;
- did actual tracking of the Cardiovascular Disease Clinical Indicators selected by the three Tribes (lipids, cholesterol, body mass index, tobacco cessation rates, and exercise education) through GPRA+ software designed especially to track CVD; and
- assessed their communities through evaluating community knowledge, behaviors, and risks of CVD.

In addition, two more sites initiated culturally sensitive community-directed pilot cardiovascular disease prevention programs.

Activities for FY 2005 include the establishment of a baseline of the number of adult patients that received appropriate screening for blood lipids (which is also a HP 2010 goal.) This data will be evaluated by using the RPMS GPRA+ software application.

Indicator 31: During FY 2006, decrease the obesity rates in children, ages 2-5 years.

Rationale: This indicator is part of a comprehensive long-term effort to identify effective interventions to prevent and reduce obesity in American Indian and Alaska Native people.

Why is this Important? Obesity is a risk factor for high blood pressure, asthma, arthritis, coronary heart disease, stroke, colon cancer, post-menopausal breast cancer, endometrial cancer, gall bladder disease, and sleep apnea. Obesity is also a major risk factor for type 2 diabetes particularly among American Indians. Body Mass Index (BMI) is a simple measure of weight in relation to height. An estimated 65% of U.S adults aged 20 years and older are either overweight or obese, defined as having a body mass index (BMI) of 25 or more. Rates among American Indian and Alaska Native populations exceed the national averages.

Approach: The approach to this indicator includes an emphasis on decreasing childhood obesity through integrated community efforts, including involvement of WIC, Head Start, and local faith based initiatives.

Data Source: GPRA+ data from local RPMS databases

Program Performance: IHS met this indicator in FY 2004. This FY 2004 indicator was to establish baseline BMI measures.

Indicator 32: During 2006, establish the rates of tobacco-using patients that receive tobacco cessation intervention.

Rationale: Tobacco users who quit enjoy longer and healthier lives, on average, than those who do not. Even a long-time smoker can significantly reduce their risk of heart disease and other complications by quitting. Advice from a health care provider and group and individual cessation counseling can help smokers quit. Smoking cessation treatments, including nicotine replacement therapy and bupropion SR (e.g. Wellbutrin) have been found to be safe and effective.

Why is this Important? The use of tobacco represents the second largest cause of preventable deaths for American Indian and Alaska Native people. Smoking rates in many communities are almost twice the national average. Tobacco use contributes to the leading causes of mortality among American Indians and Alaska Natives. Lung cancer is the leading cause of cancer death among AI/ANs. Cardiovascular disease is the leading cause of death among AI/ANs, and tobacco use is an important risk factor for this disease.

Approach: In FY 2005, IHS will maintain these screening rates. In FY 2006, the rates of tobacco using patients that receive tobacco cessation intervention will be assessed.

Data Source: GPRA+ from local RPMS databases

Program Performance: **IHS met this indicator in FY 2004.** The 2004 indicator called for the IHS to establish rates of screening for tobacco use. Screening for tobacco use is essential to identifying patients at risk for complications of tobacco abuse. This indicator will eventually support tobacco cessation initiatives aimed at reducing tobacco usage in the AI/AN community. Because tobacco has a unique status among many American Indian and Alaska Native tribes as a sacred plant, any plan for control activities must have significant input from American Indian and Alaska Native community leaders.

HIV/AIDS Indicator:

Indicator 33: In FY 06, increase the screening rates for HIV in pregnancy.

Rationale: The purpose of this indicator is to reduce the spread of HIV infection in American Indian and Alaska Native communities. In 2005, this indicator will begin to track screening rates for HIV in pregnant women with the goal of eliminating HIV infections in children.

> **Why is this Important?** Identification of HIV in pregnancy can result in decreased transmission of HIV. Universal screening for HIV in pregnancy is recommended by the CDC as the most effective way to stop vertical transmission of HIV infections.. In 1995, the CDC reported that almost 90% of AIDS cases among children and virtually all new HIV infections among children in the United States were the result of perinatal transmission of HIV.

Approach: A baseline of HIV screening in pregnancy will be established in FY 05. RPMS will be used for documentation of screening and/ or patient education

Data Source: GPRA+ data from RPMS database

Program Performance: The IHS did not meet this indicator in FY 2004. The FY 2004 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.

Environmental Surveillance Indicator:

Indicator 34: By the end of FY 2006, 50% more environmental health programs above FY 2005 level will have reported the regionally appropriate environmental health priorities based on current community data (a total of 18 programs in FY 2006) into WebEHRS.

Rationale: This indicator is directed at reducing environmental threats to health by collecting community information for decision-making. Community environmental health status has traditionally been determined by completing environmental health surveys of individual facilities listed on the Facility Data System (FDS) inventory. Current changes in data collection methodology and technological advances will support more consistent assessment of community environmental health services by building a more comprehensive dataset to analyze and use to determine direction.

Why is this Important? Environmental health programs (federal and tribal) will begin using WebEHRS to track environmental health priorities identified through whatever means possible, e.g., community environmental health assessments, focus groups, environmental health advisory groups, etc. and will be able to determine whether the current activities are the appropriate best practices.

Approach: The Environmental Health Services program utilizes the Web-based Environmental Health Reporting System (WebEHRS) in conjunction with Tribal partners to collect community and facility information to be used for ongoing surveillance. At the regional level, this project is coordinated with the IHS Area Environmental Health Officers in partnership with the tribes and local IHS Environmental Health Services programs.

Data Source: Data is gathered using the current Web-based Environmental Health Reporting System (WebEHRS) developed in FY 2000 and implemented in IHS in FY 2001.

Program Performance: IHS met this indicator in FY 2004. The FY 2004 indicator committed to increasing the number of active tribal user accounts for the automated Web-based environmental surveillance system by 15% over the FY 2003 level for AI/AN tribes not currently receiving direct environmental health services. In FY 2004, 26 additional accounts, representing a 15 percent increase above the FY 2003 level, were added. There are approximately 70 tribal environmental health programs eligible to begin using the reporting system. Of those 70 tribal environmental health programs, 67 have begun using WebEHRS by the end of the reporting period.

The Division of Environmental Health developed and implemented WebEHRS, webehrs.hqe.ihs.gov, a web-based bottom up driven environmental health data and field support system. The data fields consist of environmental health related facilities and services found in American Indian and Alaskan Native communities. WebEHRS database is maintained on an IHS HQ-based server.

Capital Programming/Infrastructure Category

Performance Budget Integration

Detail of Performance Analysis Table

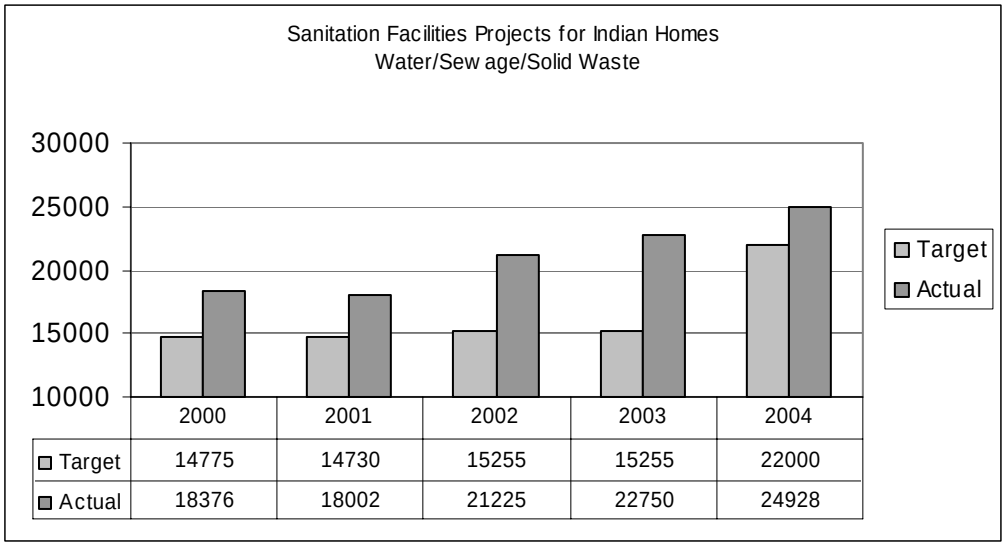
Performance Measures	Targets	Actual Performance	Reference
Capital Programming/Infrastructure Group			
Indicator 35: Provide sanitation facilities to new or like-new homes and existing Indian homes. [efficiency]	FY 06: 20,000 homes FY 05: 20,000 homes FY 04: 20,000 homes FY 03: 15,255 homes FY 02: 2,528 New/L. New 12,727 Existing Total 15,255 FY 01: 3,800 New/L. New 10,930 Existing Total 14,730 FY 00: 3,740 New/L. New 11,035 Existing Total 14,775 FY 99: 5,900 New/L. New 9,330 Existing Total 15,230	FY 06: FY 05: FY 04: 24,928 homes FY 03: 22,750 homes FY 02: 3,342 New/L. 17,883 Existing Total: 21,225 FY 01: 3,551 New/L. New 14,451 Existing Total 18,002 FY 00: 3,886 New/L. New 14,490 Existing Total 18,376 FY 99: 3,557 New/L. New 13,014 Existing Total 16,571	3 HP 2010
Indicator 35A: During FY 2006 20% of the homes served will be at Deficiency Level 4 or above as defined by 25 USC 1632	FY 06: 20% of homes at Deficiency Level 4 or above FY 05: no indicator	FY 06: FY 05: no indicator	

Performance Measures	Targets	Actual Performance	Reference
Indicator 36: Improve access to health care by construction of the approved new health care facilities. [efficiency]	FY 06: complete scheduled phase of construction of appropriated facilities FY 05: complete scheduled phase of construction of appropriated facilities* FY 04: complete scheduled phase of construction of appropriated facilities FY 03: complete scheduled phase of construction of appropriated facilities FY 02: complete scheduled phase of construction of appropriated facilities FY 01: complete scheduled phase of construction of appropriated facilities FY 00: complete scheduled phase of construction of appropriated facilities FY 99: complete scheduled phase of construction of appropriated facilities	FY 06: FY 05: FY 04: all scheduled phase of construction of appropriated facilities completed FY 03: phases for 12 of 12 projects completed on schedule FY 02: phases for 10 of 10 projects completed on schedule, plus phases for 2 projects not completed the previous year were completed FY 01: Phases for 5 of 7 projects completed on schedule, plus phase for one project not completed the previous year was completed. FY 00: phases for 5 of 6 projects completed on schedule FY 99: phases for ad projects completed on schedule	3 * indicates revised FY 2005 measure. See Summary of Changes Table.

Performance Measures	Targets	Actual Performance	Reference
Total Capital Programming/ Infrastructure Funding:	FY 06: 396,232,000 ** FY 05: $443,200,000** FY 04: $446,156,000** ** includes 15% of M/M and PI Collections and Quarters Collections	HP: Chapter # #: HHS Strategic Goal : PMA# .	

Capital Programming /Infrastructure Group:

Indicator 35: During FY 2006, provide sanitation facilities projects to 20,000 Indian homes with water, sewage disposal, and/or solid waste facilities.



	2000	2001	2002	2003	2004
Target	14775	14730	15255	15255	22000
Actual	18376	18002	21225	22750	24928

Rationale: This indicator directly supports improved environmental health for American Indian and Alaska Native people. The IHS Sanitation Facilities Construction Program has carried out those authorities since 1960 using funds appropriated for Sanitation Facilities Construction and contributed funds from Tribes and other Federal agencies to provide potable water and waste disposal facilities for AI/AN communities.

Why is this Important? This work is recognized as a significant factor in the rate reduction of infant mortality, gastroenteritis morbidity, and other environmentally related diseases by as much as 80 percent since 1973. American Indian and Alaska Native homes are twelve times more likely to be without clean water than homes in the broader U.S.

Approach: This program regularly updates the needs for sanitation facilities based on the Indian Health Care Improvement Amendments. End-of-year FY 2004 estimates reflect a cost of technically and economically feasible projects to correct the needs for existing homes at $915 million out of a total need of $1.861 billion. It is considered feasible to provide sanitation facilities for between 95 and 98 percent of all existing Indian homes.

Data Source: The SFC Sanitation Deficiency System (SDS), and Project Data System

Program Performance: IHS met this indicator in FY 2004. The FY 2004 performance measure to provide sanitation facilities to 22,000 homes was exceeded by service to 24,928 homes. These homes are served with water, sewer and solid waste facilities. This significant increase in existing homes was the result of funding more projects to upgrade existing community sanitation facilities infrastructure. IHS has received between $30 million to $100 million annually from outside contributors since 1996.

Indicator 35A: During FY 2006, 20% of the homes served by the Sanitation Facilities Construction Program funding, for the backlog of needs for existing homes will be at Deficiency Level 4 or above as defined by 25 USC 1632.

Rationale: This indicator directly supports improved environmental health for American Indian and Alaska Native people. The IHS Sanitation Facilities Construction Program has carried out those authorities since 1960 using funds appropriated for Sanitation Facilities Construction and contributed funds from Tribes and other Federal agencies to provide potable water and waste disposal facilities for American Indian and Alaska Native people.

Why is this Important? This work is recognized as a significant factor contributing to a reduction in the rates for infant mortality, gastroenteritis morbidity, and other environmentally related diseases by as much as 80 percent since 1973. American Indian and Alaska Native homes are still seven times more likely to be without clean water than homes in the broader U.S. with most of these homes located in geographically isolated areas.

Approach: This program regularly updates the needs for sanitation facilities based on the Indian Health Care Improvement Amendments (Title II, Section 302(g) 1 and 2 of P.L. 100-713).

Data Source: The SFC Sanitation Deficiency System (SDS), and Project Data System

Program Performance: **New indicator in FY 06**

<u>Indicator 36:</u> During FY 2006, increase the modern health care delivery system to improve access and efficiency of health care by assuring the timely phasing of construction of the following health care facilities:

a. Winnebago, NE – continue providing Drug Dependency Unit portion of project.

b. Phoenix Indian Medical Center (PIMC) System, SE Ambulatory Care Center (ACC), Upper Santan, AZ – complete planning and commence design of new satellite health center.

c. PIMC System, SW ACC, Komatke, AZ – complete planning and commence design of new satellite health center.

d. Barrow, AK – complete site acquisition and continue design of replacement hospital.

e. Red Mesa, AZ – complete construction of a new health center and supporting staff quarters.

f. St. Paul, AK – complete construction of replacement health center and supporting staff quarters.

g. Metlakatla, AK – complete construction of replacement health center and supporting staff quarters.

h. Sisseton, SD – continue construction of a replacement health center and supporting staff quarters.

i. Clinton, OK – continue construction of replacement health center.

j. Eagle Butte, SD – commence design of replacement health center.

k. Kayenta, AZ – prepare to commence design of replacement health center.

l. San Carlos, AZ – prepare to commence design of replacement health center.

m. Zuni, NM – complete design and construction of staff quarters supporting existing health care facility.

n. Wagner, SD – continue design and construction of staff quarters supporting existing health care facility.

o. Fort Belknap, MT – continue design and construction of staff quarters supporting existing health care facility in Harlem, MT, and satellite health care facility in Hays, MT.

p. Wadsworth, NV – continue construction of Phoenix-Nevada satellite Youth Regional Treatment Center (YRTC).

q. Central-Southern California – continue site acquisition for YRTC.

r. Northern California – continue site acquisition for YRTC.

s. Small Ambulatory Program (SAP) – until completed, continue to monitor tribal construction projects receiving FY 2001, FY 2002, and FY 2003

awards. Award competitively, selected tribally-owned FY 2005 SAP health center projects.

Rationale: This indicator supports the replacement of health care facilities to increase access to medical services supported by the IHS. These medical services are comparable to medical services available to the general population (appointments to see primary care physicians, nurses, dentists, etc.). Efficient space for health care delivery allows for more appointments, and for patients to see more health care providers in one trip. Although accessible is synonymous in this usage with obtainable health care services, the IHS can demonstrate that workloads have increased or services that are more comprehensive are provided in new facilities.

Why is this Important? Modern health care facilities help with the recruitment and retention of health care providers, which, in turn, can result in improved access and continuity of health care. Once a replacement facility has been completed and fully staffed, the IHS has experienced an average increase in patient visits of approximately 60% over the old facility. New health care facilities help contribute to improved quality of care.

Approach: The IHS uses the congressionally-directed Health Facilities Construction Priority System (HFCPS) methodology to identify inpatient and outpatient facilities project needs for placement on respective priority lists. Responding to Congressional language accompanying the FY 2000 appropriation, the IHS, in consultation with the tribes, is currently reviewing the HFCPS to revise as needed.

Through a two step process, the IHS applies the HFCPS methodology, evaluating the projected workload, existing facility age, isolation and existing space to determine the proposed projects to be considered during Phase III, during which a Program Justification Document (PJD) is prepared to justify the construction project. When the PJD is approved, the project is added to the bottom of the appropriate priority list.

Likewise, the Quarters Construction Priority System (QCPS) identifies staff quarters projects to support existing health care facilities. Staff quarters associated with replacement health care facilities are part of those projects and are not processed under the QCPS.

Data Source: Projects remain on the respective priority lists until they have been fully funded. Annually, the IHS updates its five-year planned construction budget for Health Care Facilities Construction, which is the basis for annual funding requests through the President to the Congress. The IHS Inpatient, Outpatient, Quarters and Youth Regional Treatment Centers Priority Lists show the priorities for proposed construction projects.

Program Performance: IHS met this indicator in 2004. The FY 2004 indicator was accomplished with the timely phased construction of the following health care facilities:

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

Red Mesa, AZ: Funding to date is being used for construction. If the final funding in the FY 2005 President's Request is appropriated, the project could be scheduled for 4th quarter FY 2006 completion.

Metlakatla, AK: For this fully funded project, construction is proceeding and is scheduled for 1st quarter FY 2006 completion.

Sisseton, SD: Project is proceeding on target. The Tribe is developing the site for IHS under a P.L. 93-638, Subpart "J," construction contract. Using funding appropriated in FY 2004 and requested in FY 2005, the project could be scheduled for 1st quarter FY 2007 completion.

In addition to the preceding four projects targeted for FY 2004, IHS also made progress on the following:

St. Paul, AK: For this fully funded project, construction is proceeding and is scheduled for 1st quarter FY 2006 completion.

Eagle Butte, SD: Project is proceeding, with arrangements being completed for design start.

Bethel, AK: Funding provided in FY 2004 is being used by the Yukon-Kuskokwin Health Corporation (YKHC), under a special agreement with the IHS, to continue the design-build of the staff quarters towards project completion. The YKHC plans to complete the project in the 2nd quarter FY 2005.

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

Dental Facilities Program: Two additional projects are being processed for design and construction under this program. As additional funding is appropriated, additional dental units are provided by the IHS.

Partnerships, Consultation, Core Functions, and Advocacy Indicators

Detail of Performance Analysis Table

Performance Measures	Targets	Actual Performance	Reference
Consultation Improvement Indicator			
Indicator 37: Improve the level of satisfaction with the processes for consultation and participation provided by the IHS, as measured by a survey of I/T/Us.	FY 06: eliminated FY 05: eliminated FY 04: 3% increase over FY 03 FY 03: establish baseline satisfaction rate* FY 02: secure OMB clearance for instrument and baseline FY 01: implement policy and submit instrument FY 00: revise policy and instrument FY 99: establish policy and collect baseline	FY 05: FY 04: not met FY 03: baseline rate established FY 02:secured clearance; no baseline FY 01: policy implemented and instrument submitted FY 00: revised policy proposed and instrument developed FY 99: policy established but baseline delayed	3 * indicates lack of adjustment in not meeting FY 02 measure. ** indicates revised FY 2005 measure. See Summary of Changes Table.
Administrative Efficiency, Effectiveness, and Accountability Group			
Indicator 38: Improve the level of Contract Health Service (CHS) procurement of inpatient and outpatient hospital services for routinely used providers under contracts or rate quote agreements at the IHS-wide reporting level.	FY 06: new indicator will be developed F.Y 05: no indicator in FY 05* (changes in CMS law ensure that rate quote agreements must be met) FY 04: +1% over FY 03 FY 03: +1% over FY 02 FY 02: 88% FY 01: 79% FY 00: no indicator FY 99: no indicator	FY 05: FY 04: 90% FY 03: 92% FY 02: 89% FY 01: 80% FY 00: no indicator FY 99: 86% FY 97: 74%	3, 8  * indicates revised FY 2005 measure. See Summary of Changes Table.

Performance Measures	Targets	Actual Performance	Reference
Indicator 39: Assure appropriate administrative and public health infrastructure is in place in response to agency reorganization and accountability requirements.	FY 06: completed in FY 05; no indicator in FY 06 FY 05: assess pub health infrastructure in additional 3 area offices FY 04: assess pub. health infrastructure in one additional Area Offices FY 03: assess pub. health infrastructure for HQ and 6 Areas FY 02: no indicator FY 01: no indicator FY 00: 1876 FTE or less FY 99: at least 10% under FY 97 level or 1876 FTE	FY 05: FY 04: PH infrastructure assessed for one additional Area Office FY 03: PH infrastructure assessed for HQ and 3 areas (not 6 areas) FY 02: no indicator FY 01: no indicator FY 00: 1,569 FTE FY 99: -22% (1,619 FTE) FY 97: 2085 FTE baseline	2 3 
Indicator 40: Increase the proportion of I/T/Us who have implemented Hospital and Clinic Compliance Plans to assure that claims meet the rules, regulations, and medical necessity guidance for Medicare and Medicaid payment.	FY06: no indicator FY 05: no indicator FY 04: no indicator FY 03: improve 10% over FY 02 baseline FY 02: no indicator FY 01: no indicator	FY 05: no indicator FY 04: no indicator FY 03: 100% compliance FY 02: no indicator FY 01: no indicator	3 

Performance Measures	Targets	Actual Performance	Reference
Indicator 41: Support Tribal Self-Determination through technical assistance	Technical Assistance FY 06: No indicator FY 05: No indicator FY 04: No indicator FY 03: 100% of new tribes FY 02: tribal approval of protocol FY 01: develop protocol Contract Support Cost Review FY 05: No indicator FY 04: No indicator FY 03: 100% use of protocol for new tribes FY 02: secure tribal acceptance FY 01: develop protocol FY 00: no indicator FY 99: no indicator	 FY 04: no indicator FY 03: 100% of new tribes FY 02: tribal approval FY 01: protocol developed FY 04: no indicator FY 03: 10/03 FY 02: tribal acceptance FY 01: protocol developed	3
Quality of Work Life and Staff Retention Group			

Performance Measures	Targets	Actual Performance	Reference
Indicator 42: Assess scholarship program for placement and efficiency [efficiency]	Placement Scholarship Recipients FY 06: Increase efficiency by placing recipients within 90 days of graduation FY 05: improve placement rate by 2% FY 04: Secure baseline rate for placement of scholarship recipients Nurse Retention FY 03: identify nurse retention problems and develop plan FY 02: no indicator FY 01: no indicator	 FY 06: FY 05 FY 04: baseline rate established FY 03: nurse retention assessed and plan developed FY 02: no indicator FY 01: no indicator	3 8 
Total Consultation, Partnerships, Core Functions, and Advocacy Funding:	FY 06: $0 FY 05: $88,432,000 FY 04: $86,756,000		

Partnerships, Consultation, Core Functions, and Advocacy Indicators

In an attempt to streamline our GPRA report, and decrease the number of GPRA indicators, this section will be eliminated by FY 2006. The above table illustrates that many of these indicators are completed by FY 2005, or have legal statutes that require compliance and achievement of these indicators.

Indicator 37: Eliminated in FY 2006

Program Performance: The IHS did not meet this indicator in FY 2004. The FY 2004 indicator was to increase stakeholder satisfaction with the agency's consultation process by 3% over the FY 2003 baseline. However no follow-up survey has been conducted yet. IHS is currently in a joint partnership process with the Office of Intergovernmental Affairs in DHHS to review and revise both the DHHS and IHS tribal consultation policies. One of the items on the agenda for this group is how to evaluate and determine the effectiveness of DHHS and IHS consultation policies.

Indicator 38: IHS will develop a new indicator for FY 2006 that will move under the TREATMENT category. The Contract Health Service (CHS) procurement improvement indicator has been eliminated in FY 2005.

Program Performance: The IHS did not meet this indicator in FY 2004. The FY 2004 indicator was to improve the level of CHS procurement of inpatient and outpatient hospital services for routinely used providers by at least +1% over the FY 2003 level of the total dollars paid to contract providers or rate quote agreements at the IHS-wide reporting level. In 2004 the level dropped to 90% from 92% in FY 2003.

Indicator 39: Eliminated in FY 2006

Program Performance: The IHS met this indicator in FY 2004. The FY 2004 indicator committed to complete a systematic assessment of the public health infrastructure for Headquarters and one additional Area Office. Assessments have been completed for Headquarters and the Albuquerque, Tucson, and Navajo Area Offices. An assessment of Aberdeen Area Office is in progress.

Indicator 40: Eliminated effective FY 2004

Indicator 41: Eliminated effective FY 2004

The following scholarship indicator will move under TREATMENT category:

Managing Human Capital Indicator:

Indicator 42: During FY 2006, the IHS will increase its efficiency in placing Health Profession Scholarship recipients in Indian health settings within 90 days of graduation over the established FY 2004 baseline.

Rationale: The purpose of this indicator is to increase the efficiency in placing Health Profession Scholarship recipients in Indian health settings and increase access to critical health services for AI/AN people. The Indian Health Care Improvement Act (IHCIA), P.L. 94-437, as amended, authorizes IHS to conduct three interrelated scholarship programs to train the health professional personnel necessary to staff IHS, tribal, and urban health programs serving American Indians and Alaska Natives

Why is this Important? Increased efficiency in placing health profession scholarships recipients can and will help improve the health care delivery system at I/T/U facilities.

Approach: The IHS will utilize Area Office staff, IHS Headquarters health professionals, IHS website, mailings to tribes and urban facilities for announcement of students who will be completing their degree programs. Specific activities will include:

a. Identify a staff person at each Area Office to assume the responsibility of an IHS Area Scholarship Coordinator.
b. Provide IHS, Tribal, and urban recruiter's information on students who are graduating from their degree programs for recruitment purposes.
c. Maintain a comprehensive database to track students during their award year in order to provide information on students by date of graduation and health/allied health professions.

Data Source: During FY 2003, the IHS Scholarship program implemented a new data system to monitor the status of scholarship recipients and their placement in I/T/U settings. For FY 2004 a baseline rate for placing these recipients was established and the system will be used to monitor progress in improving the efficiency in placing them in succeeding years.

Program Performance: The IHS met this indicator in FY 2004. The FY 2004 indicator was to establish a baseline for the proportion of Health Professional Scholarship recipients that are placed in I/T/U programs within 90 days of graduation from their health/allied health discipline. For FY 2004 the baseline is 20%. In FY 2003-2004 we had 165 students graduate. Twenty-six students have been placed; four students went into deferment; and twenty-nine students graduated December 2004 and have not yet been placed. The reason for the low number of students not being placed within 90 days is licensing. A majority of students in the FY 2003-2004 year graduated in May 2004 and are waiting to take their boards.

INDIAN HEALTH SERVICE

SUMMARY OF FULL COST*

(Dollars in Millions)

Performance Program Area	FY 2004	FY 2005	FY 2006
TREATMENT	3,023.9	3,103.9	3,165.8
Measures 1-5	817.5	820.8	837.2
Measure 6	1.7	1.8	1.8
Measures 7-9	12.1	12.5	27.8
Measure 10	19.0	19.5	19.9
Measure 11	1.6	1.6	1.6
Measures 12-15	90.9	109	119.5
Measure 16	1.8	2.2	2.4
Measure 17-19	6.7	8.2	8.4
Measure 20	552.5	580	588.3
Measure 21	3.0	6.0	6.1
Measure 22	0.2	0	0.0
Measure 42	see below	see below	0.7
PREVENTION	126.5	132.2	135.3
Measure 23	43.1	45	49.7
Measure 24-26	7.9	8.6	9.0
Measure 27-28	38.6	40.5	42.0
Measure 29	26.0	28.0	28.5
Measure 30-31	2.7	3.3	3.4
Measure 32	1.5	1.5	1.5
Measure 33	3.0	3.6	3.7
Measure 34	0.2	0.2	0.2
CAPITAL PROGRAMMING/INFRASTRUCTURE	441.9	404.1	411.8
Measure 35	93	91.8	93.5
Measure 36	94.6	88.6	3.3
CONSULT., PARTNER., CORE FUNCT., ADV.	86.8	88.9	0
Measure 37	0.1	0.1	elim.
Measure 38	3.3	elim.	elim.
Measure 39	0.1	0.1	elim.
Measure 40	elim.	elim.	elim.
Measure 41	elim.	elim.	elim.
Measure 42	0.7	0.7	treatment
Full Cost Total	3,679.1	3,729.1	3,712.9

Allocation Methodology Explanation:

Specific measure calculations are either based on line item budget items, or calculated using peer reviewed published clinical costs, when available. If this cost data is not available, IHS used best estimates to arrive at full cost data.

Full cost data for the measures under each performance program are shown as non adds. The sum of full costs of performance measures may not equal the full cost of the performance area. This reflects the extent to which the program has elements that have no current performance measures.

EXHIBIT W

CHANGES AND IMPROVEMENTS OVER PREVIOUS YEARS

FY 2006 Performance Plan

The FY 2006 performance plan represents our ongoing effort to link annual performance indicators to the long-term health outcome goals from the recently revised IHS Strategic Plan. This plan and its performance targets are based on updates in baseline data and other data related issues, the ability to address key external factors influencing success, the level of attainment of related FY 2004 performance indicators, and the most current proposed funding level.

In FY 2006, the IHS has decreased the number of performance indicators from FY 2004 by 2, and has increased the number of efficiency measures to six. In addition, IHS has increased the number of outcome measures. Over half of our performance measures are either efficiency and/or outcome measures.

IHS has elected to eliminate all of its administrative indicators. Some of these indicators were scheduled for conclusion at the end of FY 2005. IHS desires to concentrate on outcome as opposed to process indicators. Elimination of these indicators is in alignment with the wishes of OMB to develop a more streamlined GPRA plan that will include sentinel indicators. These sentinel indicators should account for the majority of the proposed budget plan.

Revisions to FY 2005 Performance Plan

The table that follows summarizes the significant changes in content or magnitude to FY 2005 indicators originally submitted with the FY 2005 budget. Please note that some indicator numbers are not the same as they were in the FY 2005 Congressional Justification; IHS added a colorectal cancer screening indicator (#9) in FY 2006. As a result, Indicators 9 through 32 in the FY 2005 CJ are identified as indicators 10-33 in this FY 2006 submission. Indicators 34 through 42 are the same in all documents because #32 and 33 were combined.

Table of Changes to the FY 2005 IHS Performance Indicators

Original FY 2005 Indicator	Revised FY 2005 Indicator	Rationale for Change
Indicator 2: During FY 2005, maintain the proportion of patients with diagnosed diabetes that have demonstrated improved glycemic control (defined as ideal control) at the FY 2004 level.	**Indicator 2:** During FY 2005, maintain the proportion of patients with diagnosed diabetes that have demonstrated ideal glycemic control at the FY 2004 level.	**The language has been changed to clarify that this indicator tracks the number of patients in ideal control, not the number of patients who have improved and moved into ideal control.**
Indicator 12: During FY 2005,	**Indicator 12:** During FY	**Area dental officers as a group**

Original FY 2005 Indicator	Revised FY 2005 Indicator	Rationale for Change
increase the proportion of American Indian and Alaska Native population receiving optimally fluoridated water by .05% over FY 2004 for all IHS Areas.	2005, establish (1) the baseline number of topical fluoride applications provided to American Indian and Alaska Native patients, with a maximum of four applications per patient per year and (2) the baseline number of American Indian and Alaska Native patients receiving at least one topical fluoride application.	**have determined that tracking topical fluoride applications and the number of patients receiving these applications is a good alternative to measuring water fluoridation.**
Indicator 15: During FY 2005 the IHS will ensure that 15% of women between the ages of 15 and 40 are screened for domestic violence.	**Indicator 15:** During FY 2005, the IHS will maintain the screening rate for domestic violence in females ages 15 through 40 at the FY 2004 level.	**FY 2004 results highlighted a significant problem in documentation of domestic violence. The target for FY 2005 has been reduced; IHS will investigate ways to address these issues during FY 2005.**
Indicator 17: During FY 2005, improve the Behavioral Health (BH) Data System by assuring at least an additional 5% of the I/T/U programs will report minimum agreed-to behavioral health-related data to the national data warehouse.	**Indicator 17:** During FY 2005, expand the Behavioral Health (BH) Data System by increasing the number of sites using the RPMS Behavioral Health (BH) software application over the FY 2004 level.	**IHS did not meet the FY 2004 target. As a result, the target for FY 2005 has been reduced. The Behavioral Health Indicator will be changed in FY 2006 to provide a more meaningful measure.**
Indicator 20: During FY 2005, maintain 100% accreditation of all IHS hospitals and outpatient clinics.	**Indicator 20:** During FY 2005, maintain 100% accreditation of all IHS-operated hospitals and outpatient clinics.	**The language of this indicator has been changed to clarify that IHS will maintain accreditation of IHS-operated hospitals.**
Indicator 22: By the end of FY 2005, maintain consumer satisfaction rates at the FY 2004 level.	**Indicator 22:** Eliminated	**This indicator has been eliminated because it is subsumed by the accreditation indicator. The accreditation process includes assessment of customer satisfaction.**
Indicator 25: In FY 2005, maintain the FY 2004 rate for influenza vaccination levels among non-institutionalized adult patients age 65 years and older.	**Indicator 25:** On hold in FY 2005	**On hold due to nationwide influenza vaccine shortage.**
Indicator 29: During FY 2005, establish baseline data on suicide	**Indicator 29:** During FY 2005 integrate the Behavioral	**While the RPMS suicide reporting form is currently**

Original FY 2005 Indicator	Revised FY 2005 Indicator	Rationale for Change
from the new suicide reporting system.	Health suicide reporting tool into RPMS.	**deployed in the RPMS Behavioral Health System it is not currently deployed in the Patient Care Component (PCC) of RPMS. Primary Care Providers, including physicians and nurses, do not have access to the suicide reporting form in the Behavioral Health System. For suicide data to be comprehensive it must include data that is collected in the Primary Care environment as well as data from the Behavioral Health environment. The suicide reporting form will be deployed in the Patient Care Component of RPMS and the Electronic Health Record in FY 05**.
Indicator 30: During FY 2005, establish the number of adult patients that receive appropriate screening for blood lipids.	**Indicator 30:** During FY 2005, establish the number of patients ages 23 and older that receive blood cholesterol screening.	**The language of this indicator has been changed to clarify patient ages and specify the appropriate screening.**
Indicator 34: During FY 2005, the IHS will increase the number of active tribal user accounts for the automated Web-based environmental health surveillance system by 15% over the FY 2004 level for American Indian and Alaska Native tribes not currently receiving direct environmental health services.	**Indicator 34**: By the end of FY 2005, 12 environmental health programs will have reported the regionally appropriate environmental health priorities based on current community data into WebEHRS.	**Most of the known federal and tribal environmental health programs are using WebEHRS, it is appropriate to begin tracking all activities (not just surveys) related to defined environmental health priorities. Environmental health programs (federal and tribal) will begin using WebEHRS to track environmental health priorities identified through whatever means possible**
Indicator 35: During FY 2005, provide sanitation facilities projects to 22,000 Indian homes with water, sewage disposal, and/or solid waste facilities.	**Indicator 35:** During FY 2005, provide sanitation facilities projects to 20,000 Indian homes with water, sewage disposal, and/or solid waste facilities.	**The target for this indicator has been adjusted.**

Original FY 2005 Indicator	Revised FY 2005 Indicator	Rationale for Change
Indicator 36: During FY 2005, increase the modern health care delivery system to improve access and efficiency of health care by assuring the timely construction of the following health care facilities: a. Red Mesa, AZ – complete construction of a new health center, including supporting staff quarters. b. Sisseton, SD – complete construction of a replacement health center, including supporting staff quarters. c. Zuni, NM – complete design and construction of staff quarters project. d. Wagner, SD – deigns-build staff quarters project.	**Indicator 36**: During FY 2005, increase the modern health care delivery system to improve access and efficiency of health care by assuring the timely phasing of construction of the following health care facilities: a. Winnebago, NE – revise method of providing Drug Dependency Unit portion of project since renovation of old structure no longer considered feasible. b. Phoenix Indian Medical Center (PIMC) System , SE Ambulatory Care Center (ACC), Upper Santan, AZ – continue planning of this satellite health center. c. PIMC, SW ACC, Komatke, AZ – continue planning of this satellite health center. d. Barrow, AK – commence site acquisition and design of replacement hospital. e. Pinon, AZ – complete construction of new health center and supporting staff quarters. f. Red Mesa, AZ –continue construction of a new health center and supporting staff quarters. g. St. Paul, AK – continue construction of replacement health center and supporting staff quarters. h. Metlakatla, AK – continue construction of replacement health center and supporting staff quarters. i. Sisseton, SD –continue construction of replacement health center and supporting staff quarters. j. Clinton, OK – complete design and commence construction of replacement health center. k. Eagle Butte, SD – complete planning for replacement health center.	**Funds for additional projects have been appropriated since the original indicator was submitted. The indicator target has been modified to include these new construction projects.**

Original FY 2005 Indicator	Revised FY 2005 Indicator	Rationale for Change
	l. Kayenta, AZ – complete planning of replacement health center. m. San Carlos, AZ – complete planning of replacement health center. n. Bethel, AK – complete design-build of staff quarters supporting the existing health care facility. o. Zuni, NM –continue design and construction of staff quarters supporting existing health care facility. p. Wagner, SD – commence design and construction of staff quarters supporting existing health care facility. q. Ft. Belknap, MT – complete planning update of staff quarters supporting existing health care facility in Harlem MT, and satellite health care facility in Hays, MT, and commence design and construction of Harlem units. r. Wadsworth, NV – continue design and construction of Phoenix-Nevada satellite Youth Regional Treatment Center (YRTC). s. Central-Southern California - complete YRTC project planning and commence site acquisition t. Northern California - complete YRTC project planning and commence site acquisition u. Joint Venture Construction Program (JVCP) – negotiate JVCP Agreement and issue funding for initial equipment funding for tribally provided and owned health center. v. Small Ambulatory Program (SAP) – until completed, continue to monitor tribal construction projects receiving FY 2001, FY 2002, FY 2003 awards. With tribal consultation, update administration procedures and	

Original FY 2005 Indicator	Revised FY 2005 Indicator	Rationale for Change
	solicit FY 2005 SAP applications for tribally owned health center projects. w. Dental Facilities Program – using FY 2005 funding, provide additional dental units.	
Indicator 37: During FY 2005, the IHS will maintain stakeholder satisfaction with the agency's consultation process at the FY 2004 level	**Indicator 37:** Eliminated	**This indicator has been eliminated as part of the agency's effort to concentrate on outcome rather than process measures.**
Indicator 38: During the FY 2005 reporting period, the IHS will have improved the level of Contract Health Services (CHS) procurement of inpatient and outpatient hospital services for routinely used providers to at least 1% over the FY 2004 level of the total dollars paid to contract providers or rate quote agreements at the IHS-side reporting level.	**Indicator 38:** Eliminated	**This indicator has been eliminated for FY 2005 due to the Medicare Modernization Act that makes CHS negotiated contracts obsolete. A new indicator is to be developed to better measure CHS and its impact on the health of the AI/AN population.**

LINKAGE TO HHS AND IHS STRATEGIC PLANS

The IHS FY 2006 GPRA Performance Plan is a supportive and interdependent extension of the HHS Strategic Plan and the new IHS Strategic Plan. In the HHS/IHS Strategic Goal Crosswalk in this section, we have shown the relationship between the four broad Strategic Goals of the IHS Strategic Plan and the FY 2006 performance indicators. Every indicator selected for our performance plan directly or indirectly supports Objective 3.6 *Increase access to health services for American Indians and Alaska Natives* and Objective 3.4 *Eliminate racial and ethnic health disparities.* In addition, many IHS indicators address other components of the HHS plan and include:

1. Cardiovascular Disease Prevention Indicator 30 and Obesity Prevention Indicator 31 directly support HHS Objective 1.1 *Reduce behavioral and other factors that contribute to the development of chronic diseases.*
2. HIV Indicator 33 directly supports HHS Objective 1.2 *Reduce the incidence of sexually transmitted diseases and unintended pregnancies.*
3. Immunization Indicators 24-26 directly support HHS Objective 1.3 *Increase immunization rates among adults and children.*
4. Substance Abuse Indicators 10 and 11 directly support HHS Objective 1.4 *Reduce substance abuse.*
5. Tobacco Indicator 32 directly supports HHS Objective 1.5 *Reduce tobacco use, especially among youth.*
6. Injury Prevention Indicators 27 and 28 and Domestic Violence Indicator 16 directly support HHS Objective 1.6 *Reduce the incidence and consequences of injuries and violence.*
7. Medication Error Indicator 21 directly supports HHS Objective 5.1 *Reduce medication errors.*
8. Accreditation Indicator 20 directly supports HHS Objective 5.4 *Improve consumer and patient protections.*
9. IT Development Indicators 17 - 19 directly support HHS Objective 5.5 *Accelerate the development and use of an electronic health information infrastructure.*
10. Scholarship Placement Indicator 42 directly supports HHS Objective 8.2 *Improve the strategic management of human capital.*
11. IT Development Indicators 17 - 19 directly support HHS Objective 8.6 *Enhance the use of electronic commerce in service delivery and record keeping.*

In a similar vein, there is considerable consistency of focus between the new IHS Strategic Plan and the current version of the HHS Strategic Plan. While this is not surprising relative to health care specific areas that could fill pages, we would offer the following associations between objectives from **HHS Goal 8** ***Achieving Excellence in Management Practices*** and selected Action Performance Goals from the IHS Strategic Plan:

HHS Objective 8.2 Improve the Management of Human Capital

12. Increase the percentage of IHS Area and Headquarters staff meeting recommended training and experience standards for their respective positions.
13. Increase the relative annual amount of training provided to I/T/U staff by non-IHS resources.
14. Increase the number of I/T/U staff funded through IHS completing long-term training annually.
15. Increase the number of partnerships with universities or other organizations to help train Indian people.

HHS Objective 8.3 Enhance the Efficiency and Effectiveness of Competitive Sourcing

16. Increase the number and scope of negotiated contracts with health care providers.

HHS Objective 8.4 Improve Financial Management

17. Increase the percentage of I/T/U sites with a comprehensive IT system that allows for aggregation and export (sharing) of clinical, financial and administrative data.
18. Increase the percentage of I/T/U sites developing managerial cost accounting capacity.
19. Increase the percentage of I/T/U sites developing business plans with identified service/product lines.

HHS Objective 8.5 Enhance the use of Electronic Commerce in Service Delivery and Record Keeping

20. Increase the percentage of I/T/U sites with a comprehensive IT system that allows for aggregation and export (sharing) of clinical, financial and administrative data.
21. Increase the percentage of I/T/U site able to extract clinical data on lifestyle components (tobacco use, alcohol us, seat belts use, etc).

HHS Objective 8.6 Achieve Integration of Budget and Financial Performance Information

22. Increase the percentage of I/T/U sites with a comprehensive IT system that allows for aggregation and export (sharing) of clinical, financial and administrative data.

PARTNERSHIPS AND COORDINATION

The magnitude of American Indian and Alaska Native health disparities and the resource demands require the IHS to identify and collaborate with secondary available outside organizations that have the capacity, capability, and interest to assist in addressing these diverse health problems. Our resolve to develop this crosscutting network is evident by the number and diversity of collaborative activities that are currently in place and described in this section.

The IHS has continued to develop and expand its crosscutting collaborations and partnership with other agencies and organizations to achieve common goals and objectives addressing health disparities of American Indians and Alaska Natives.

Program Coordination By Partners Within DHHS:

HHS Office of Minority Health IAA

- This agreement provides funding from the Office of Minority Health to the Indian Health Service for "Closing the Health Gap Infant Mortality Initiative" for supplement to Tribal Epidemiology Centers Cooperative Agreements in seven existing Regions, two additional areas and for a National Project coordination
-

HHS Office of Women's Health

- conducting 11 surveys through Indian country to identify women's health issues

Administration for Children and Families/Head Start Bureau

- training and technical assistance to 177 Head Start grantees, including a full-time health and safety specialist position and a computerized data system for the IHS Head Start program.
- monitor and develop programs to address the 0-5 age group of American Indian and Alaska Native in prevention. This is an intervention program to address rising trends in obesity in this age group.
- co-sponsor pilot projects to improve the health care response to domestic violence. (Indicator 16)

Agency for Healthcare Research and Quality

- supporting work to strengthen health services research
- development of an Indian Primary Care Based Research Network
- incorporation of IHS data into the Healthcare Utilization Project and strengthening the research infrastructure of American Indian and Alaska Native organizations.
- support evaluation of medication errors in the Indian health system (Indicator 21)
- IHS-AHRQ Electronic Health Record development and evaluation

Centers for Disease Control and Prevention Umbrella Agreement

Annually develop a collaborative umbrella work plan that includes specific agreements with the following CDC entities:

- CDC/Agency for Toxic Substances and Disease Registry Tribal Liaison: strengthen inter-government response to tribal public health needs
- Division of Reproductive Health (DRH): reproductive related health problems in AI/AN including Sudden Death Syndrome (SIDS)
- Epidemiology/Preventive Medicine Training: hosts CDC Epidemic Intelligence Service (EIS) Officers for their two-year field epidemiology training experience and Preventive Medicine Residents (PMRs) for a one-year field training.
- CDC/National Center for Chronic Disease Prevention and Health Promotion-Chronic Disease Annual Work plan:
    - Division of Cancer Prevention and Control (DCPC):
        - provide technical assistance/guidance for capacity building with state health departments, IHS tribes and tribal organizations.
        - provides funds for colposcopy training and other IHS cancer control activities.
        - direct technical assistance and consultation to tribes and tribal organizations through the National Breast and Cervical Cancer Early Detection Program (Indicator 7-8)
    - Health Promotion Activities for Older Adults: technical assistance in the design, implementation and analysis of surveys for health promotion activities for older adults.
    - Behavioral Surveillance Branch (BSB): uses the CDC Behavioral Risk Factor Surveillance Survey (BRFSS).
    - Cardiovascular Health: technical assistance in the design, implementation, and evaluation of cardiovascular risk factor prevention and intervention programs. (Indicator 30)
    - Division of Oral Health: develop, implement and promote water fluoridation in American Indian and Alaska Native communities for dental disease prevention. (Indicator 12)
    - Division of Diabetes Translation (DDT): providing technical consultation and assistance on public health surveillance of diabetes to define the burden of diabetes and diabetes-related complications among the Native population. (Indicators 1-6)
    - Gallup National Diabetes Prevention Center: provide national leadership to plan, develop, implement and evaluate the National Diabetes Prevention Center. (Indicators 1-6).
    - Office on Smoking and Health (OSH)**:** develop, establish, and maintain a community-based program for the prevention and control of tobacco use, and related health problems among American Indian and Alaska Native populations. (Indicator 32)

- Division of Reproductive Health (DRH): address reproductive-related health problems in American Indian and Alaska Native, including Sudden Infant Death Syndrome, and to assist tribes in community health surveys.

- National Center for HIV, STD and TB Prevention (NCHSTP)
  - Division of Sexually Transmitted Disease Prevention: planning, development and implementation of sexually transmitted disease control programs between American Indian and Alaska Native.
  - Division of HIV/AIDS Prevention:
    - provide HIV prevention program activities for the implementation and evaluation of HIV prevention education for American Indian and Alaska Native children and youth in schools on reservations, rural areas, and urban metropolitan areas. (Indicator 33)

- National Center for Infectious Diseases (NCID)
  - Division of Viral and Rickettsial Diseases, Hepatitis Branch**:** epidemiologist to assist in the planning development, and implementation of hepatitis prevention and control programs between American Indian and Alaska Natives.
- National Center for Injury Prevention and Control (NCIPC): reduce unintentional and intentional injuries between American Indian and Alaska Natives. The CDC has assisted IHS with pilot injury surveillance projects (Indicators 27-28)
- National Immunization Program (NIP)**:** Vaccine-Preventable Disease Control - assists in the planning, development and implementation of vaccine-preventable disease control programs among American Indian and Alaska Natives. (Indicators 24-26)

In addition, collaborate on Injury Prevention activities:

National Center for Injury Prevention and Control of the CDC**.** Present briefings on injury issues to staff from the Senate Select Subcommittee on Indian Affairs.

Food and Drug Administration

- reduce patient and occupational exposures; to promote principles of radiation protection, and to allow the FDA to monitor radiation protection for conformance with existing agency and Federal policies.
- support in the evaluation and use of medical radiologic equipment.

Centers for Medicare and Medicaid Services

The collaboration with the Centers for Medicare and Medicaid Services (CMS) covers an array of issues that critically impact operational issues related to the Indian health care system and the provision of services by the IHS to its stakeholders.

- The IHS and CMS Joint Indian Health Steering Committee includes:

- Legislation Subcommittee: work on legislative issues, e.g., reauthorization of the Indian Health Care Improvement Act, using Medicare rates for CHS payments
- Operations Subcommittee: work on program policy and operation issues such as reimbursement policies, outreach and education, and data sharing and other policy guidance.
- Cost Reports Subcommittee: addresses short and long-range plans for development of hospital cost reports.
- the National Medical Education program (NMEP) Task Force, which ensures that beneficiaries receive accurate, reliable information about their benefits,

- Home Health Care workgroup to develop draft regulations to implement the Prospective Payment System.
- HHS Value-Based Purchasing Work Group that is part of the Quality Interagency Coordination Council. They have pursued the national goal to reduce the number of medical errors in health care environments and to build a safer health system nationally.
- Input into the Prospective Payment System Minimum Data Sets that include current cost reports.
- New Medicare and Medicaid reimbursement rates for the IHS and IHS-funded tribal facilities.
- guidance and proposed regulations exempting American Indian and Alaska Native from any cost sharing provisions under CHIP for eligible children.
- Medicare enrollment data to provide more accurate information for assessing outreach to Medicare beneficiaries that are American Indian and Alaska Native to establish an accurate database for IHS.

Health Resources and Services Administration

- support for the PHS Primary Care Policy Fellowship program
- provide HIV/AIDS education and training to health care providers that provide health care services to American Indian and Alaska Native people (Indicator 33)
- share software enabling IHS to receive occupational health, environmental assessment and health information management support services

National Institutes of Health

- collaborating academic research institutions, Indian tribes or Indian community based organizations.
- development of treatment regimens for individuals with diabetes who also suffer from periodontal disease. (Indicator 15)

conduct clinical research studies primarily in the areas of diabetes and digestive diseases

Substance Abuse and Mental Health Services Administration

- support several Native American collaborations addressing mental health and the "Indian Self Determination: Summit on Tribal Strategies to Reduce Alcohol, Substance Abuse and Violence."

Collaboration With Other Federal Agencies

Department of Interior/Bureau of Indian Affairs

- support several Native American collaborations addressing mental health, domestic violence abuse and neglect (Indicator 16)
- provide technical assistance and training for background checks of employees of tribal health programs.
- support of the IHS/BIA Annual Youth Conference reaching junior high and high school and college teens

Department of Justice

- support coordinated activities in mental health and community safety for American Indian and Alaska Native children, youth, and families.
- co-sponsor the "Indian Self Determination: Summit on Tribal Strategies to Reduce alcohol, Substance Abuse and Violence."

Department of Veterans Affairs

- collaborating with the VA on targeted data systems and credentialing
- develop an agreement targeting education and outreach of veteran beneficiaries who are underutilizing their benefits and services.
- develop care agreements and pharmaceutical supply agreements
- participates in the VA Pharmaceutical Prime Vendor Program

DATA VERIFICATION AND VALIDATION

Data Validation is the process for ensuring that data collected matches the intended area of performance.

Data Verification is the assessment of data completeness, accuracy, consistency and timeliness and related quality control practices.

The verification of clinically based performance indicators is supported by the IHS automated data system (RPMS), and/or the IHS Diabetes Care and Outcomes Audit.

For the Capital Programming/Infrastructure Indicators 35-36, the data are recorded at the local level where projects are conceptualized based on strict protocols and formulas. These data are compiled at the Area and Headquarters level and reviewed for accuracy and then compared against similar projects.

For indicators that survey our consumers (indicator 22), the required Paperwork Reduction Act clearance process effectively addresses both validation and verification process as required in submitting the instrument and collection protocol.

Data Sources to Describe the American Indian and Alaska Native Population

The IHS utilizes outside (non-IHS) and IHS data sources to manage its diverse programs and assess Indian health status. The two principal outside data sources are the Bureau of the Census and the Centers for Disease Control and Prevention, in particular, the National Center for Health Statistics (NCHS). The Census Bureau is the source of Indian population counts and social and economic data. However, reliable Indian census data at the county level are only available from the Decennial Census, once every 10 years. The IHS prepares American Indian and Alaska Native population estimates for years between the Censuses.

The NCHS provides IHS with natality and mortality files that contain all births and deaths for USA residents, including those identified as American Indian or Alaska Native. The NCHS obtains birth and death records from the State departments of health, based on information reported on official State birth and death certificates. The IHS receives these records with essentially the same basic demographic information as the records maintained by NCHS, but with names, addresses, and record identification numbers deleted as required by the Privacy Act. The NCHS does perform numerous edit checks and imputes values for non-responses. The IHS assigns IHS organizational (Area and service unit) identifiers to the birth and death records in setting up its Indian database. The IHS computer routines for accomplishing this have been thoroughly verified, and the results are continuously monitored. The IHS utilizes factors based on a National Death Index study to adjust Indian mortality rates for race miscoding. Because of significant time lags in obtaining mortality and natality data, IHS has chosen not to use mortality data for annual performance plan indicators except in one circumstance (unintentional injury mortality rates). The IHS will continue to use mortality data for tracking long-term trends in Indian health status and to make comparisons with other population groups.

IHS Health Information Data Systems

The IHS has its own clinical information systems to collect data on the services provided by IHS and tribal direct and contract programs. The software used by IHS facilities and most tribal facilities is the Resource and Patient Management System (RPMS). It is estimated that the national RPMS data set accounts for approximately 90 percent of the AI/AN user-population and clinical visits provided through the I/T/U facilities.

The local RPMS system supports a robust clinical and administrative data set. The PCC component (patient care component) of RPMS facilitates the collection, aggregation, display, and utilization of patient specific information. The PCC component includes many different software applications that are pertinent to the electronic retrieval of GPRA data, including lab, patient education, purpose of visit, and referral information.

IHS applies a series of edits at the facility and central database levels to detect and correct invalid data. At the central database level, additional edit checks are applied to ensure the validity of data sorts. Reports are also assessed for linearity (is the data consistent month to month) and completeness (how it compares to last year) prior to sending data for review and approval. Other data quality issues that cannot be detected by computer are identified through the monitoring for reasonableness that is performed in the field, and by Area and Headquarters health program staff.

Each facility that utilizes PCC has a facility-level database that contains the detailed PCC data collected at that site. A subset of the detailed PCC data (to meet the routine information needs of IHS Headquarters) is transmitted to the IHS central database. The local PCC data are the source of most of IHS' GPRA measures; these measures reflect clinical and prevention activities and morbidity and do not have the time lags described previously for mortality data.

The IHS has developed and deployed a clinical software application, GPRA+. This software monitors the IHS GPRA clinical indicators at a local level, and ensures standard data queries (through specified data logic and data fields) at individual sites. This software facilitates ongoing local feedback on GPRA indicators based upon site-specified times, locations, and providers. This application enables sites to track performance in a timelier manner, and implement appropriate responses to their results. The local results are aggregated into Area reports that are in turn aggregated into the national GPRA report that is submitted to Congress. In FY 04, IHS reported on almost 1.2 million patient records using this software application.

Defining current user population is also critical to our data systems. New user population data reflects a process of eliminating duplicate patients. In addition, IHS has established a 'clinical user population, similar to the VHA definition. This 'clinical user population' is based on the traditional user population definition; however, in addition, patients are included in this population if they have had two or more visits to a set of pre-defined clinics within the last 3 years. By using this specific population, we are able to evaluate clinical care for AI/AN patients who are using the I/T/U facilities as their 'medical home.'

IHS also supports an ongoing data quality integration project. This ensures that national clinical indicators, regardless of etiology, are developed in a similar manner, rely on specific data sets, and have well-defined data extract routines. The development of these processes supports our ongoing clinical quality improvement initiative.

Our information technology path is designed to increase quality data, as well as improve clinical care and health care outcomes. Ensuring quality data for GPRA and performance indicators remains a major focus of our information technology development path, as does developing point of care order and data entry through a graphical user interface.

In the course of preparing this proposed FY 2006 report, IHS identified issues that will be addressed in 2005 in order to further improve the quality of data for clinical indicators. Some of the actions that are planned include the following:

- Changing of GPRA+ to CRS. This modified software application, CRS (clinical information reporting system) will include current GPRA reports, as well as additional indicator reports. These additional reports will include the ability to run a HEDIS report, as well as other sophisticated data trends for clinical quality.
- Ongoing training for Area GPRA coordinators and local facilities. This training provides information and instructions about the software and will provide a forum to share best practices that have been identified during the analysis of the 2004 performance. In addition, coordinators discuss effective ways of using GPRA results to work with individual facilities.
- Ongoing encouragement of tribal facilities not running RPMS to either begin to use it or to develop or purchase software that is compatible with GPRA+. Require urban contractors to do the same though changes in contract and grant language

IHS Diabetes Care and Outcomes Audit

A final important data set that underpins the diabetes treatment indicators 1-6 is the IHS Diabetes Care and Outcomes Audit. Since 1986 a yearly medical record review to assess diabetes care has been conducted in more than 75% of the IHS and tribal facilities, representing care to over 100,000 American Indian and Alaska Native people with diabetes. The medical staffs at participating facilities are encouraged to maintain active diabetes registries using uniform definitions. Each registry is maintained in the IHS medical record system and includes information about individuals with diagnosed diabetes who have been seen at least once in the past three years. Each year a systematic random sample is drawn from each facility's registry, using a sample size sufficient to provide estimates of $\pm$10% of the true rates of adherence for that facility with a confidence of >90%.

The medical record review measures selected clinical interventions, performance measures, and intermediate outcomes using the uniform set of definitions. The Area diabetes consultants conduct chart reviews and other professional staff trained by them in accordance with written instructions and definitions provided by the IHS Diabetes Program. The abstracted data are entered into a microcomputer-based epidemiologic

software program. Summary reports are printed for immediate use by facility staff in their quality improvement and program planning activities. Regional and national rates are constructed for each item of the medical record review after data are aggregated from all participating sites.

During the period 1995-1999, approximately 150 sites submitted data to be compiled for the IHS total. Indian health facilities and tribally contracted facilities that do not provide direct patient services did not participate in the audit. Participation from each of the 12 IHS administrative regions varied by year and by federal or tribal management. All regions were represented in each year and approximately 2/3 of all the facilities contributed data in a given year. Tests of trend over the 3- year period were performed by the Mantel-Hanzel test except as noted in the text.

Our diabetic indicators are reported using diabetic audit data for FY 2002. The successful development and deployment of our GPRA+ software enabled us to report GPRA+ data as well as diabetic audit data starting in FY 2003. We anticipate that future data will be reported using diabetic audit as well as GPRA+ reports. Our hope is the eventual synthesis of these two data sources into one report.

Performance Measurement Linkages with Budget

The FY 2006 budget includes budgetary links to performance by positing costs for achieving specific indicator goals. These projections must be cautiously evaluated. IHS is unable to evaluate costs for many of our performance measures. The vast majority of our clinical measures rely on interdisciplinary approaches to the delivery of care. Consequently, we are unable to designate specific costs for each separate activity at the current time.

A health care economist is essential to helping provide a more sophisticated review of current and proposed costs of achieving the GPRA performance indicators. IHS is in the process of negotiating a contract for this service; this expertise will be used to more effectively and accurately evaluate the potential and actual costs incurred in the provision of health care service delivery in the future. In the meantime, IHS has once again included full cost data within this budget submission. This *projected full cost data* should be viewed cautiously as noted above. Indian Health Service has utilized published peer reviewed cost data, when available, to estimate our Agencies performance costs.

Finally, **our GPRA indicators are representative of our programs, but not a comprehensive reflection of our program portfolio.** We are unable to present a full picture of our 'cradle to grave' integrated rural health care delivery system due to constraints on the number of indicators; however, the current FY 06 submission IS reflective of the priority problems and solutions confronting our patient population.

Our agency health care funding continues to be annually prioritized to the acute and chronic problems of greatest need and concern to our consumers. Health outcomes (i.e., mortality and morbidity) are well articulated annually in our publication *Trends in Indian Health* with 2-3 year old data. Our indicator set reflects these current and chronic problems.

Similarly, while performance targets for indicators addressing facilities construction are linked to funding levels in a linear way, this is often not the case for indicators addressing health care services when viewed through a one-year timeframe. In some cases, investments in the supportive infrastructure are the highest priority for long-term effectiveness but will do nothing in the short-run to increase access to services.

In addition, the American Indian and Alaska Native population increases approximately 1.6 percent annually. Thus, local service capacity increases in order to assure the same level of coverage each year for the majority of our clinical and prevention indicators. Medical inflation costs also continue to rise. The impact of these combined factors is reflected in our current GPRA indicator goals for most clinical and prevention related measures.

Cost Accounting

We prepare Medicare cost reports for all inpatient facilities, both direct federal and tribal. It is anticipated that we will continue to prepare a report for each inpatient facility each year. These cost reports determine our billing rates (both inpatient and outpatient) for Medicare and Medicaid with the exception of Medicare inpatient, which is paid via DRG.

Information Technology Planning

Information technology planning continues to be a cornerstone of our performance measurement linkage. Our health information system, and its planned expansion to include a graphical user interface at the majority of facilities by FY 2008, is critical to our performance measurement. Development of an appropriate Office of Information Technology Strategic Plan is now coupled with an emphasis on up to date practice management software. This helps ensure a smooth transition to a fully integrated performance measurement and outcome information technology solution.

Capital Planning

The maintenance deficiencies for health care facilities are captured and presented to Congress in the Backlog of Essential Maintenance, Alteration, and Repair for IHS and participating tribal facilities. Sanitation Facilities Construction needs are identified and reported to Congress through the Sanitation Deficiency System. Capital asset planning for health care facilities construction is done in accordance with the IHS Health Care Facilities Priority System Methodology and submitted to OMB through Circular A-11, Preparation of Budget Estimates, and Section III for reporting capital assets. These activities are represented in this performance budget by the two Capital Programming/Infrastructure Indicators.

Program Evaluation

IHS recognizes the growing importance of evaluation in supporting the IHS Mission, Goal and performance budgeting. The IHS evaluation process seeks to include American Indians and Alaska Natives as primary stakeholders in defining the purpose, design, and execution of evaluations. The IHS has worked with it stakeholders in identifying and implementing principles of responsive evaluation practice and setting evaluation priorities.

The purposes of IHS evaluation efforts are:

- to advise the Director of the IHS on policy formulation; to conduct and manage program planning, operations research, program evaluation, health services research, legislative affairs, and program statistics;
- to develop the long-range clinical program and financial plan for the IHS in collaboration with appropriate agency staff;
- to coordinate with HHS, Indian Tribes, and organizations on matters that involve planning, evaluation, research and legislation; and
- to develop and implement long-range goals, objectives, and priorities for all activities related to resource planning and allocation methodologies and models.

The Office of Public Health Support (OPHS) serves as the principal advisory office to the IHS on issues of national health policy and coordinates these four evaluation functions:

- *Health Program Evaluations*--Collect and analyze information useful for assisting IHS officials in determining the need for improving existing programs or creating new programs to address health needs;

- *Policy Analysis*--Conduct analyses when a change in the IHS health service delivery system must be considered, when issues emerge in an area where no policy currently exists, or when current policies are perceived as inappropriate or ineffective;
- *Health Services Research*--Undertake analyses of the organization, financing, administration, effects, and other aspects of the IHS; and
- *Special Studies and Activities*--Conduct studies and prepare special reports required by Congress in response to pending legislation or policies, often using a roundtable whenever an issue or a health problem requires immediate action and it is unclear what type of action should be taken.

The OPHS meets part of the IHS evaluation needs with two major types of short-term studies: policy or program assessments and evaluation study. The policy study contributes to IHS decision-making about budget, legislation, and program modifications and includes background information to support IHS projects. Evaluation studies are carried out at the program level, or area offices, and focus on specific program goals.

Summary of Select Evaluations Activities

Several evaluation projects funded since FY 04 have significant direct and/or indirect implications for IHS performance planning and are thus summarized below:

An Evaluation of Influenza and Pneumoccocal Vaccination coverage in Adults

This project is designed to help the IHS to evaluate the accuracy of the National data and to quantify the degree, if any, of under-estimation of influenza and Pneumoccocal vaccination coverage levels for each IHS Area. Once this is determined, the IHS and Area offices will be able to adjust the NPIRS-based rates and provide a more accurate measure of influenza and pneumoccocal coverage. This in turn will allow IHS to better identify possible barriers to immunization with influenza and pneumoccocal and develop strategies to improve coverage.

The Effects of Fluoridation on the Prevalence of Oral Disease in American Indian Youngsters

This project focuses on health program evaluation and health services research. It proposes an epidemiologic evaluation of the efficacy of water fluoridation in Indian Country. This evaluation will help identify the impact of water fluoridation on oral health.

Domestic Violence Pilot Project Evaluation

This project will strengthen the Indian, Tribal and Urban (I/T/U) facility responses to domestic violence through a “Health program Evaluation”. Recently funded IHS-ACF domestic violence pilot projects will be evaluated for efficacy. These results will be shared with other health care facilities throughout Indian country.

Cost Effectiveness of a Rural IHS Tele-medicine Consultation Service

Since 1999, an Indian Health Service Hospital, located in remote South Dakota, has been using a clinical tele-medicine program to deliver a wide range of clinical specialist's consultation and disease management services. This study will evaluate the economic impact of this method of care delivery.

Suicide Data Collection and Surveillance For Prevention Program

The purpose of this project is to reduce the high rate of suicide completions and attempts among youth and young adults on an American Indian Reservation by increasing the tribe's efforts to collect meaningful surveillance data to support the development of a comprehensive, evidence based on prevention program.

New Directions for Evaluation

The IHS is responding to dramatic changes taking place inside and outside the Government including greater involvement of tribal governments in the Indian health care system, technological innovations, the changing patterns of disease to more chronic conditions, and the transfer of many Federal programs and resources to individual States. IHS remains committed to comprehensively community-based, preventive, and culturally sensitive projects that empower tribes and communities to overcome health issues. IHS continues to embrace GPRA as a cornerstone of our ongoing commitment to clinical quality improvement. Indian Health Service anticipates the need for ongoing internal evaluation, as well as ongoing external evaluation, using external performance as a benchmark for specific measures (e.g. HEDIS).

Exhibit BB

Department of Health and Human Services

Indian Health Service

PART ASSESSMENTS

FY 2004-2005

1. **Federally-Administered Activities**
2. **Sanitation Facilities Construction Program**
3. **Resource and Patient Management System**
4. **Urban Indian Health Program**

Program: *IHS Federally-Administered Activities*

Agency: *Department of Health and Human Services*

Bureau: *Indian Health Services*

Rating: *Moderately Effective*

Program Type: *Direct Federal*

Last Assessed: *2 years ago*

Key Performance Measures from Latest PART	Year	Target	Actual
Annual Measure: Unintentional injury mortality rate in American Indian/Alaska Native population	1998		94.7
	1999	95.8	95.5
	2002	95.8	
	2004	95.8	

Recommended Follow-up Actions	Status
Include $25 million in the 2004 Budget to fund staffing and related operating costs for new facilities.	Completed
Support continuation of, and a $50 million increase in, annual mandatory funding for the Special Diabetes Program for Indians for demonstrated performance improvements.	Completed
Develop baselines and targets for new measures.	Action taken, but not completed

Update on Follow-up Actions:

The 2004 Budget included funding increases for contract health services and staffing and related operating costs for new facilities. In addition, the 2004 Budget included the $50 million increase in annual mandatory funding for the Special Diabetes program for Indians. The $25 million increase for contract health services was not enacted. The Administration is developing a long-term performance goal to decrease obesity rates in the American Indian/Alaska Native (AI/AN) population and an annual goal for decreasing obesity in AI/AN children. The long-term obesity goal is to be established in September 2008; the childhood obesity target will be set in December 2006.

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
1,698	1,793	1,887

Program: *IHS Sanitation Facilities Construction Program*

Agency: *Department of Health and Human Services*

Bureau: *Indian Health Services*

Rating: *Moderately Effective*

Program Type: *Capital Assets and Service Acquisition*

Last Assessed: *2 years ago*

Key Performance Measures from Latest PART	Year	Target	Actual
Long-term Measure: Percentage of American Indian/Alaska Native (AI/AN) homes with sanitation facilities	2000		92.5%
	2010	94%	
Long-term Measure: Percentage of Deficiency Level 4 or 5 AI/AN homes (as defined by U.S.C. 1632) provided with sanitation facilities			
Annual Measure: Number of new or like-new AI/AN homes and existing homes provided with sanitation facilities	2004	20000	24928
	2005	20000	
	2006	20000	

Recommended Follow-up Actions	Status
Propose a $20 million increase above the 2003 Budget so that the program can increase services to the most needy homes in its inventory which have higher construction costs.	Completed
Conduct an independent, comprehensive evaluation of the program.	Action taken, but not completed
Develop baselines and targets for new measures.	Action taken, but not completed

Update on Follow-up Actions:

The 2004 Budget included the increase for sanitation facilities construction, however the increase was not enacted. The program evaluation and final report is expected to be issued in 2005. The baseline for the long-term measure for the percentage of deficiency level 4 or 5 American Indian/Alaska Native (AI/AN) homes (as defined by U.S.C. 1632) provided with sanitation facilities is being established.

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
93	92	94

Program: *Resource and Patient Management System*

Rating: *Effective*

Program Type: *Capital Assets and Service Acquisition*

Agency: *Department of Health and Human Services*

Bureau: *Indian Health Service*

Last Assessed: *1 year ago*

Key Performance Measures from Latest PART	Year	Target	Actual
Long-term Measure: Develop comprehensive electronic health record (EHR) with clinical guidelines for select chronic diseases: Targets: FY 2003: Prototype EHR/Asthma; FY 2004: HIV/AIDS; FY 2005: Obesity; FY 2006: Cardiovascular; FY 2008: Comprehensive EHR			
Long-term Measure: Derive all clinical indicators from RPMS and integrate with EHR (Targets measured in indicators/Areas).	2004	37/12	37/12
	2005	37/12	
	2006	38/12	
	2008	39/EHR	
Annual Measure: Percent increase in IHS, Tribal and Urban programs that use the national behavioral health data reporting system	2001	10%	20%
	2002	5%	27.7%
	2003	5%	29.5%
	2004	5%	20%

Recommended Follow-up Actions	Status
Develop RPMS' capability to provide a valid cost accounting link to health outcomes by specific activity.	Action taken, but not completed
Ensure that Budget requests are explicitly tied to accomplishment of annual and long-term performance goals with a budget linkage to the specific activities of RPMS.	Action taken, but not completed

Update on Follow-up Actions:

The Indian Health Service will obtain full cost accounting functionality through the implementation of the Unified Financial Management System in September 2008.

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
34	36	37

Program: *Urban Indian Health Program*

Agency: *Department of Health and Human Services*

Bureau: *Indian Health Service*

Rating: *Adequate*

Program Type: *Block/Formula Grant*

Last Assessed: *1 year ago*

Key Performance Measures from Latest PART	Year	Target	Actual
Long-term Measure: Percent decrease in years of potential life lost	2010	10%	
Annual Efficiency Measure: Cost per service user in dollars per year	2003	$483	$571
	2002		$483
	2001		$359
	2000		$385
Annual Measure: Percent of diabetics with "ideal" blood sugar control	2003	35%	36%
	2004	35%	
	2005	35%	
	2006		

Recommended Follow-up Actions	Status
Establish a workgroup to address deficiencies identified by the assessment and make recommendations for developing a clear program purpose and restructuring the program to reduce duplication with other federal programs.	Action taken, but not completed
Develop baselines and targets for new measures.	Completed

Update on Follow-up Actions:

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
32	32	33

INDIAN HEALTH SERVICE

Federally Administered Activities

1.

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Develop long-term performance goal to decrease obesity rates in the AI/AN population.	09/01/06	Y	Breastfeeding in Workplace Policy is being reviewed by Curtis Kitto.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
The HHS Blueprint for action on breastfeeding and the GS's Call To Action To Prevent and Decrease Overweight and Obesity recommends breastfeeding be facilitated in the workplace by creating a breastfeeding friendly workplace; therefore IHS is developing a breastfeeding workplace policy to further pomote nursing in the workplace and act as a model for Indian programs.	09/30/05	IHS DCCS	Jean Charles-Azure and Judith Thierry

2.

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Develop an annual target for decreasing obesity in AI/AN children.	12/01/05	Y	Development and implementation of obesity prevention is dependent on available resources.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
Provide staff web training on HT WT standardization.	09/30/05	IHS DCCS	Jean Charles-Azure

Sanitation Facilities Construction

1.

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Conduct an independent, comprehensive evaluation of the program.	06/30/05	yes	Evaluation plan developed with DHHS Federal Occupation Health.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
Program evaluation completed with final report.	06/30/05	DHHS	Ronald Ferguson, P.E.

RPMS

1.

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Need for valid cost accounting link to the health outcomes by specific activity and respective funding sources between its patient-based clinical and administrative applications and financial and administrative applications.	09/30/08	yes	Integrated into UFMS deployment throughout DHHS
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
Ongoing involvement in UFMS integration.	09/30/05	DHHS	James Garvie

2.

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Resource needs presented in the Capital asset Plan and Business Case (Exhibit 300 for RPMS) need to be integrated into the IHS Budget justification.	09/01/05	yes	
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
Development of comprehensive Exhibit 300 including specific RPMS development.	completed	Indian Health Service	Theresa Cullen
Continued enhancements of Exhibit 300 to include additional specific RPMS development.	09/01/05	Indian Health Service	Theresa Cullen

3.

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Indian Health Service needs a budget linkage to the specific activities of RPMS.	09/01/05	yes	
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
Development of comprehensive 300 including specific rpms development.	completed	Indian Health Service	Theresa Cullen
Continued enhancements of Exhibit 300 to include additional specific RPMS development.	09/01/05	Indian Health Service	Theresa Cullen

Urban Indian Health Program

1.

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Establish a workgroup to address deficiencies identified by the assessment and make recommendations for developing a clear program purpose and restructuring the program to reduce duplication with other federal programs.	04/01/06	Y	Workgroup technical staff members identified, IHS Circular on workgroup out for comment. Currently developing recommendations to address program purpose and restructuring.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
Recommendation memo on Urban and Federal workgroup members to the Director IHS.	completed	IHS-Urban Indian Health	D. Exendine
Recommendation memo on program purpose and restructuring.	02/01/05	IHS-Urban Indian Health	D. Exendine
Recommendations submitted to Dr. Grimm.	04/01/05	IHS-Urban Indian Health	D. Exendine
Plan implementation for changes.	09/01/05	IHS-Urban Indian Health	D. Exendine
Rereview documents.	04/01/06	IHS-Urban Indian Health	D. Exendine

2.

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Develop baselines and targets for new measures.	09/01/05	Y	To be developed by the Urban workgroup.
Next Milestone	**Next Milestone Date**	**Lead Organization**	**Lead Official**
Discussion by workgroup.	06/01/05	IHS-Urban Indian Health	D. Exendine
Development of milestones and targets.	9/1/2005	IHS-Urban Indian Health	D. Exendine/new director

Exhibit DD

Measures and Results Summary Table

	Total Measures in Plan	Outcome Measures	Output Measures	Efficiency Measures	Results Reported	Results Met	Results Not Met
2001	38	13	22		37	25	12
2002	40	15	22	3	38	31	7
2003	41	17	21	3	38	31	7
2004	39	23	12	4	38	27	11
2005	37	22	9	6			
2006	37	24	7	6			

INDIAN HEALTH SERVICE
Reimbursements, Assessments, and Purchases

Reimbursement for Services Purchased within HHS

(in dollars)

	FY 2003 Actual	FY 2004 Actual	FY 2005 Estimate	FY 2006 Estimate
Service & Supply Fund	*$26,247,000	$26,179,857	$34,423,986	$39,294,782
Office of General Counsel	2,045,276	1,902,269	2,233,544	2,351,181
Unified Financial Mgmt System **	1,317,000	4,743,000	11,307,798	10,479,132
HHS Enterprise	1,774,000	1,441,000	1,441,000	1,441,000
TOTAL:	**$31,383,276**	**$34,266,126**	**$49,406,328**	**$53,566,095**
$ Change over prior year	($1,060,774)	$2,882,850	$15,168,186	$4,159,767
% Change over prior year	-3%	8%	31%	8%

NOTES:

1. * Does not include Supply Service Center
2. ** Does not include $3.0 million in FY 2004, $2.057 million in FY 2005, and $2.057 million in FY 2006 for Agency Specific amounts. FY'04 estimate for UFMS does not include the $3 million agency specific amount.

Description of Reimbursement for Services

Service and Supply Fund: The HHS Service and Supply Fund (SSF) is a revolving fund authorized under 42 U.S.C. 231. The SSF does not receive appropriated resources, but is funded entirely through charging HHS agencies, as well as other Federal agencies and departments, for usage of goods and services. Major services of the SSF include Human Resources Service (HRS) including Commissioned Personnel Service (CPS), Financial Management Service (FMS), Administrative Operations Service (AOS) and the Federal Occupational Health Service (FOHS).

The table below shows IHS' FY 2005 estimated usage and cost, as compared to total estimated usage for HHS customers and other Federal agencies.

- The Human Resources Services consist of payroll services, including automated personnel and payroll systems support and payroll processing.

- IHS receives Commissioned Personnel services that include active-duty payroll, health service payment management, personnel support, and recruitment for its PHS

Commissioned Corps active duty officers. CPS has been transferred from Service and Supply Fund to the Office of Public Health & Science, Office of the Secretary.

- The Financial Management Services consist of accounting services, including processing payment of authorized vendor invoices, preparation of IHS financial statements and other periodic fiscal reports, and audit liaison services for IHS' annual audited financial statements.

- The Administrative Operations services consist of the Service Supply Center, which provides pharmaceutical, medical and dental supplies to Federal health care facilities.

(in millions)

Major Service	Total Estimated Usage	IHS Estimated FY 2005 Usage	% Used by IHS
Human Resources	$63.4	$10.7	16.88%
Commissioned Personnel	20.9	6.4	30.62%
Financial Management	59.9	9.6	16.03%
Administrative Operations	91.4	1.8	1.97%
Federal Occupational Health	170.9	0.8	0.47%
Other	164.4	5.1	3.10%
Total	**$570.9**	**$39.44**	**6.03%**

Office of General Counsel: The agreement with the Office of General Counsel is to provide funding for legal services of licensed attorneys and paralegals to represent the Indian Health Service.

Unified Financial Management System: The UFMS is an initiative to integrate the Department's financial systems in order to reduce the resources and infrastructure needed to perform financial operations, reduce the number of information flows between the administrative and core financial systems, streamline both internal and external financial reporting and enable consolidated HHS financial reporting, and take advantage of advanced technical capabilities. All HHS Operating Divisions participate in the initiative are responsible for contributing to the cost.

HHS Enterprise Infrastructure: The Department is implementing improvements in its information technology enterprise infrastructure. These funds are 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.

Government-Wide Administrative Functions

(in dollars)

	FY 2003 Actual	FY 2004 Actual	FY 2005 Estimate	FY2006 Estimate
Tri-Council (CFOC,CIOC,PEC)	$65,356	$52,806	$49,876	$50,873
Federal Employment Services	24,850	25,758	26,273	26,799
President's Council on Bioethics	22,145	22,145	22,145	22,145
TOTAL:	**$112,351**	**$100,709**	**$98,294**	**$99,817**
$ Change over Prior Year	($42,841)	($11,642)	($2,415)	$1,523
% Change over Prior Year	-38.13%	-11.56%	-2.46%	1.53%

Description of Government-Wide Administrative Functions

Tri-Councils: Funding for these interagency management councils has been authorized through the Treasury / General Government Appropriations Act. Agencies each contribute to a central fund administered by the General Services Administration to fund the approved projects of each council.

Funds for the Chief Financial Officers Council (CFOC) support the Federal Audit Clearinghouse, the Joint Financial Management Improvement Program, and Grants Streamlining.

Funds for the Chief Information Officers Council (CIOC) support Program Management/ Capital Planning and Investment Management activities, the Federal Enterprise Architecture Program Management Office, and Human Capital and IT Workforce activities.

Funds for the Procurement Executives Council (PEC) support building of the Federal acquisition management information system (FAMIS), the Procurement Acquisition Career Management System and the posting of contract award documents on the Internet to promote transparency of Federal contracting activity.

Federal Employment Services: OPM provides various government-wide job recruitment activities, primarily the maintenance and enhancement of USAJOBS, a single website listing all Federal job openings. Public Law 104-52 authorizes OPM to charge fees to Federal agencies to cover the cost of providing these services.

President's Council on Bioethics: The Council was created November 2001 by Executive Order 12327 and its purpose is to advise the President on bioethical issues

related to advances in biomedical science and technology. It is composed of 17 leading scientists, doctors, ethicists, lawyers and theologians.

HHS-Wide Assessments

(in dollars)

	FY 2003 Actual	FY 2004 Actual	FY 2005 Estimate	FY 2006 Estimate
Quality of Worklife/Human Capital Initiative	$191,568	$14,571	$14,862	$15,159
Safety Mgmt Information	2,875	2,987	3,047	3,108
Safety, Health & Environmental Programs	9,755	18,213	18,577	18,949
Energy Program Review	11,686	16,999	17,339	17,686
IT Access for the Disabled	30,806	49,540	50,531	51,542
Media Outreach	2,548	2,498	2,548	2,548
Nat'l Rural Development Partnership	19,563	19,092	19,474	19,863
Federal Executive Board-Dallas	0	29,348	29,935	30,534
TOTAL:	**$268,801**	$153,248	$156,313	$159,440
$ Change over Prior Year		($115,553)	3,065	3,127
% Change over Prior Year		(43%)	2%	2%

Description of HHS-Wide Assessments

Quality of Worklife: The Quality of Work Life (QWL) Initiative was created to help HHS employees deal with the multitude of changes impacting the worksite. This initiative has three objectives: to improve employee satisfaction, strengthen workplace learning, and better manage ongoing change and transition. To meet these objectives, these funds support: the Work/Life Center at headquarters; the QWL Internet site on the HHS Home Page; an annual survey of HHS employees; the Department-wide Conference on Diversity and the Secretary's Conference on Family-Friendly Work Practices; activities of the HHS Union-Management Partnership Council; and consultation and skills training to human resource management professionals and change agents throughout HHS.

Safety Management Information System: The Safety Management Information System (SMIS) is a Department-wide, computerized accident and injury reporting and analysis system required by Department of Labor (DOL) regulations and Executive Order 12196. SMIS enables OPDIVs and STAFFDIVs to verify the accuracy of workers' compensation claims charged to HHS by DOL; it also assists in identifying deficiencies in the Department's accident prevention program and in focusing accident prevention efforts. SMIS interfaces with DOL's Federal Employee System and is available to OPDIVs and STAFFDIVs to download the DOL data.

Safety, Health and Environmental Management: The Safety, Health and Environmental Management funds enable the Department to continue conducting program evaluations and environmental compliance assessments of occupational safety and health, as required by pertinent laws, regulations and standards. CFR Title 29, Part 1960, requires the heads

of Federal agencies to provide safe healthful working environments for Federal employees; it also requires regularly scheduled safety program evaluation surveys. In order to ensure the effectiveness of these programs and conduct the required evaluations of them, the services of safety professionals are obtained through a contract or interagency agreement funded with these funds.

Energy Program Review: The National Energy Act of 1992 and Executive Order 12902, "Energy Efficiency and Water Conservation at Federal Facilities," mandate a myriad of requirements for energy and water conservation in HHS facilities. To do this, professional engineers and energy managers must be used to evaluate the status of OPDIV and STAFFDIV energy conservation programs, to assist in the development of stronger programs, and to ensure compliance with reporting requirements. The services of such professionals are obtained through a contract or interagency agreement support with these funds.

IT Access for the Disabled: Section 508 of the Rehabilitation Act Amendments of 1998 requires Federal agencies to ensure that individuals with disabilities have access to electronic and information technology (EIT) systems and equipment that is comparable to the access enjoyed by people without disabilities, unless doing so would pose an undue burden on the agency. These funds support the establishment of a baseline of compliance and vulnerabilities as well as the development of governance rules for Section 508 across HHS.

Media Outreach: These funds support Secretarial public affairs initiatives, including the production and distribution of: public service announcements (PSAs) and video news reports, for airing on radio and television; PSAs in Spanish; and media materials directed at disadvantaged and minority audiences. These funds also help defray the costs of media activities that cut across OPDIV lines, including: printed materials informing the public of major health and human services issues; contracts for services such as studio maintenance and camera crews; and charges incidental to satellite transmission.

National Rural Development Partnership: This Partnership (originally called the President's Rural Development Initiative) is managed by USDA's Rural Development Administration. It consists of 18 Federal departments and independent agencies, 37 State Rural Development Councils (SRDCs), and numerous non-governmental organizations. Under the Partnership, States develop SRDCs to support rural development through cooperation among Federal, State and local governments; the goal is to have SRDCs in all 50 States. This initiative also includes the National Rural Development Council (NRDC), a Federal-level interagency workgroup that addresses the policy and regulatory impediments to rural development raised by the SRDCs. HHS has been active in this initiative since its inception; staff from HRSA and IGA serve on the NRDC and on the executive board of the Partnership, while Regional Directors serve on the SRDCs as needed. These funds support both the SRDC and management of this initiative.

Federal Executive Board-Dallas: One new assessment has been added: the Federal Executive Board (FEB) office in Dallas-Forth Worth (DFW). The President's

Management Council has delegated responsibility for funding this FEB to HHS; therefore, this assessment will be used to provide an avenue for various Federal agencies in the DFW area to coordinate similar activities at the local level (e.g., promoting public service) and to be a forum for the exchange of information between Washington and the field.

The FEBs were established in 1961 by a Presidential Directive to improve coordination among Federal activities and programs outside of Washington DC. There are currently 28 FEBs across the country, in cities that are major centers of Federal activity. The operations of all FEBs are overseen by OPM. In 1996, the President's Management Council asked Federal agencies to fund the FEBs; HHS agreed to support the Dallas-Fort Worth FEB, including salaries and benefits for the Executive Director and Executive Assistant positions, plus office expenses. Currently, CMS is providing the Executive Assistant, and office support is provided by IGA. For several years, GSA covered the cost of the Executive Director; however, GSA has advised HHS that we must now reimburse GSA for this cost. This TAP covers the costs of the Executive Director position.

INDIAN HEALTH SERVICE
FY 2006 Moyer Cross-cutting Information
(Program Level in Thousands)

	FY 2004	FY 2005	FY 2006
AIDS			
HIV Surveillance	1,051	1,071	1,116
Information & Education/Prevention Services	2,962	3,002	3,082
Total, AIDS	4,014	4,074	4,198
Aging	n/a	n/a	n/a
Alzheimer's Disease	n/a	n/a	n/a
Cancer			
Cancer	15,352	15,352	15,352
Breast Cancer (Non-Add)	*14,269*	*14,269*	*14,269*
Total	15,352	15,352	15,352
Child Care	n/a	n/a	n/a
Diabetes			
Model Diabetes	7,700	7,700	7,700
Diabetes Grants	3,000	3,000	3,000
Periodontal Diabetes	300	300	300
Diabetes Funds (mandatory)	150,000	150,000	150,000
Total, Diabetes	161,000	161,000	161,000
Family Planning - Service Only	142,365	159,779	200,348
Homeless	n/a	n/a	n/a
Immunization - Services & Vaccine Purchases Only	1,561	1,572	1,645
Minority Health and Assistance			
Services	2,530,364	2,596,492	2,732,298
Facilities	391,350	388,574	315,668
Third Party Collection	601,426	634,870	634,870
Quarters	5,900	6,200	6,200
Diabetes (Mandatory)	150,000	150,000	150,000
Total, Minority Health and Assistance	3,679,040	3,776,136	3,839,036
Pediatric Aids	n/a	n/a	n/a
Rural Health	n/a	n/a	n/a
Substance Abuse	65,340	66,974	67,911
Women's Health			
Cancer	15,352	15,352	15,352
Breast Cancer (non-add)	*14,269*	*14,269*	*14,269*
Reproductive Health	128,990	128,990	128,990
Substance Abuse	1,981	1,981	1,981
Cross-cutting Categories	800	800	800
Total, Women's Health	147,123	147,123	147,123

FY 2006 Moyer Women's Health Table
INDIAN HEALTH SERVICE
(Dollars in thousands)

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Request
I. Cancer			
A. Breast cancer (including mammography & other services)	$14,269	$14,269	$14,269
B. Reproductive cancers			
1. Cervical			
2. Ovarian			
3. Vaginal, uterine & other			
C. Lung cancer			
D. Colorectal cancer	1,083	1,083	1,083
E. Other neoplasms			
Total, Cancer	15,352	15,352	15,352
II. Cardiovascular/pulmonary			
A. Blood diseases			
B. Heart disease			
C. Stroke			
D. Other cardiovascular diseases/disorders			
E. Pulmonary diseases			
F. Other Asthma			
G. Other			
Total, Cardiovascular/pulmonary			
III. Reproductive health			
A. Contraception			
B. Infertility			
C. Female reproductive physiology			
D. Hysterectomy			
E. Endometriosis/leiomyomas (fibroids)			
F. Pregnancy/pregnancy prevention/maternal health	128,740	128,740	128,740
G. Diseases related to DES exposure			
H. Other Female genital cutting			
I. Other	250	250	250
Total, Reproductive health	128,990	128,990	128,990
IV. Aging			
A. Menopause			
B. Harmone replacement therapy Menopausal hormone/non-hormone therapy			
C. Alzheimer's disease			
D. Malnutrition in the elderly			
E. Osteoarthritis			
F. Osteoporosis			
G. Women's Health Initiative			
Total, Aging			
V. Metabolism/endocrinology			
A. Diabetes			
B. Nutrition Obesity			
C. Obesity Hepatobiliary diseases			
D. Hepatobiliary d Thyroid diseases/conditions			
E. Thyroid diseas Other			
Total, Metabolism/endocrinology			
VI. Substance Abuse			
A. Etiology (unspecified)			
B. Epidemiology (unspecified)			
C. Prevention (unspecified)			
D. Treatment (unspecified)			
E. Alcohol	1,981	1,981	1,981
F. Illegal drugs			
G. Prescription drugs			

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Request
H. Tobacco products			
I. Other substances			
J. Co-occurring substance abuse & mental disorders			
Total, Substance Abuse	1,981	1,981	1,981
VII. Behavioral Studies/Programs			
A. Violence (incl. Domestic, abused women, spousal abuse)			
B. Behavior cha **Tobacco use cessation**			
Physical activity/nutrition (promoting			
C. Cultural/lifest **healthy behavior)**			
D. Women as ca **Other behavior change/risk modification**			
E. Other **Caregiving**			
F. **Other**			
Total, Behavioral Studies/Programs			
VIII. Mental Health			
A. Etiology (unspecified)			
B. Epidemiology (unspecified)			
C. Prevention (unspecified)			
D. Treatment (unspecified)			
E. Depression/mood disorders			
F. Suicide			
G. Schizorphreni Schizophrenia			
H. Anxiety disorders			
I. Eating disorders			
J. Psychosocial stress			
K. Post traumatic stress disorder (PTSD)			
L. Other mental disorders (excluding Alzheimer's)			
Total, Mental Health			
IX. Infectious Diseases			
A. AIDS/HIV			
B. Tuberculosis			
C. Sexually transmitted diseases (STD)			
D. Topical microbicides			
E. Toxic shock syndrome			
F. Tropical diseases			
G. Other			
Total, Infectious Diseases			
X. Immune Disorders			
A. Arthritis			
B. Lupus erythematosus			
C. Multiple schlerosis			
D. Myasthenia gravis			
E. Scleroderma			
F. Sjogren's syndrome			
G. Takayasu disease			
H. Other			
Total, Immune Disorders			
XI. Neurologic, muscular & bone			
A. Trauma research			
B. Muscular dystrophy			
C. Chronic pain conditions			
D. Temporomandibular disorders			
E. Fibromyalgia & eosinophilic myalgia			
F. Migraine			
G. Sleep disorders			
H. Paget's disease			
I. Other **Parkinson's Disease**			
J. Seizure disorders			
K. Other			
Total, Neurologic, muscular & bone			

	FY 2004 Actual	FY 2005 Enacted	FY 2006 Request
XII. Kidney and Urologic			
A. Urinary tract infections (cystitis, pyelonephritis)			
B. ESRD/transplantation			
C. Urinary incontinence			
D. Other			
Total, Kidney and Urologic			
XIII Ophthalmic, Otoloryngologic, and Oral Health			
A. Eye diseases & disorders			
B. Ear diseases & disorders			
C. Caries & perio Dental and oral health			
D. Other			
Total, Ophthalmic, Otoloryngologic, & Oral Health			
XIV Health effects of the environment			
A. Environmental estrogens			
B. Health effects of toxic exposure (exclude cancer)			
C. Toxicological research & testing program			
D. Chemical/biological warfare agents			
Total, Health effects of the environment			
XV. Cross-Cutting Categories and Special Initiatives			
A. Treatment, pre Treatment & prevention services			
B. Access to health care & financing			
C. Education & training for health care providers			
D. Health literacy & bi-lingual information			
E. Bilingual & cr Cultural influences			
F. Disability research & services			
G. Homelessness			
H. Chronic fatigue syndrome			
I. Breast feeding			
J. Organ donation			
K. Genetic services/counseling			
L. Unintentional injury			
M. Alternative & complementary therapies			
N. Health statistics & data collection			
O. Offices on Women's Health	800	800	800
Total, Cross-Cutting Categories	800	800	800
Total, IHS	$147,123	$147,123	$147,123

Present Health Care Facilities Priority Rankings

(January 2005)

Inpatient	**Outpatient**
Phoenix, AZ ***	Ft. Yuma, AZ (On-hold)
Barrow, AK ***	Pinon, AZ *
Nome, AK	Red Mesa, AZ **
Whiteriver, AZ	St. Paul, AK **
	Sisseton, SD **
	Clinton, OK **
	Dulce, NM ****
	San Simon, AZ (Westside) ****
	Eagle Butte, SD ***
	Kayenta, AZ ***
	San Carlos, AZ ***

Staff Quarters	**Youth Regional Treatment Centers**
Ft. Belknap, MT (29 units) ***	California, Central-Southern
	California, Northern

* Fully funded for design and construction. Partially funded for staffing.
** Fully funded for design and construction. Unfunded for staffing.
*** Partially funded.
**** Equipment fully funded under FY 2001 Joint Venture Construction Program (JVCP).

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