DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2007 Performance Budget Submission

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Facilities

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

	FY 2005 Actual	**FY 2006 Enacted**	**FY 2007 Request**	Increase or Decrease
BA	$388,574,000	$353,211,000	$347,287,000	($5,924,000)
FTE	1,281	1,312	1,354	+42

SUMMARY OF THE BUDGET REQUEST

The FY 2007 budget request of $347,287,000 and 1,354 FTE is a decrease of $5,924,000 and an increase of 42 FTE below the FY 2006 Enacted budget of $353,211,000 and 1,312 FTE.

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

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

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

	FY 2005 Actual	**FY 2006 Enacted**	**FY 2007 Request**	Increase or Decrease
BA	$49,204,000	$51,633,000	$52,668,000	+$1,035,000
FTE	0	0	0	0

STATEMENT OF THE BUDGET REQUEST

The budget request of $52,668,000 for Maintenance and Improvement (M&I) supports the maintenance and improvement of IHS and Tribal health care facilities.

PROGRAM DESCRIPTION

The IHS supports M&I activities in Federal-government owned buildings and where Tribally-owned space is used to provide health care services pursuant to contract or compact arrangements executed under the provisions of the Indian Self Determination and Education Assistance Act (P.L. 93-638). M&I funds are to support and enhance the delivery of health care and preventive health services and to safeguard interests in real property. Maintaining reliable and efficient buildings is increasingly challenging as existing facilities age and additional space is added into the real property inventory.

Specific M&I objectives include: (1) providing routine maintenance and repairs for facilities; (2) achieving compliance with buildings and grounds accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations or other applicable accreditation bodies; (3) providing improvements to facilities for enhanced patient care; (4) ensuring that health care facilities meet building codes and standards; and (5) ensuring compliance with executive orders and public laws relative to building requirements, e.g., energy conservation, seismic, environmental, handicapped accessibility, and security.

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

Funds in the M&I line item account are used primarily to maintain and improve health care facilities and are identified for allocation as routine maintenance and project funds. Staff quarters operation, maintenance, and improvement costs are primarily funded with rent collections called Quarters Return (QR) funds. M&I funds may be used in conjunction with QR funds at locations with few quarters or where QR funds are insufficient to ensure appropriate quarters maintenance.

Status of Facilities

The physical condition of IHS-owned and many Tribally-owned facilities is evaluated through annual general surveys conducted by local facility personnel and IHS Area engineers. In addition, comprehensive "Facility Condition Surveys" are conducted every 5 years by a team of engineers and architects or other specialists.

These surveys, together with routine observations by facilities personnel, identify deficiencies that are included in the Backlog of Essential Maintenance, Alterations, and Repair (BEMAR) database. The identified BEMAR for IHS and reporting Tribal facilities as of October 2005 was $429,187,000. The following table summarizes the BEMAR by category:

BEMAR 1/

PUBLIC LAW	
Life Safety Compliance	$21,525,000
General Safety	8,782,000
Environmental Compliance 2/	25,769,000
Handicapped Compliance	16,101,000
Energy Conservation	12,523,000
Seismic Mitigation 3/	77,048,000
Sub Total	**$161,748,000**
IMPROVEMENTS	
Patient Care	$33,138,000
Program Deficiencies	80,220,000
Sub Total	**$113,358,000**
MAINTENANCE & REPAIR 4/	
Architectural M&R	$12,258,000
Structural M&R	34,953,000
Mechanical M&R	53,534,000
Electrical M&R	19,266,000
Utilities M&R	6,836,000
Grounds M&R	18,868,000
Painting M&R	2,408,000
Roof M&R	5,958,000
Sub Total	**$154,081,000**
GRAND TOTAL	**$429,187,000**

1/ The FY 2006 M&I allocation will be distributed for routine maintenance and for projects; projects are intended to reduce identified BEMAR deficiencies.
2/ These types of projects include air quality improvement, asbestos remediation, lead-based paint, and contaminated soil remediation.

3/ The Earthquake Hazard Reduction Program Act required IHS to survey and estimate the cost associated with compliance to seismic construction standards. This survey was completed in the fall of 1998 and added $149,127,000 in seismic deficiencies. Since that time some seismic deficiencies have been corrected as part of larger projects, thus reducing the backlog.
4/ Staff quarters operation, maintenance, and improvement costs are funded through rents collected, called Quarters Return (QR) funds. The M&I funds may be used in conjunction with QR funds at locations where QR funds are insufficient to ensure appropriate quarters maintenance.

M&I Funds Distribution Method

The IHS M&I funds are distributed to four categories: routine maintenance, M&I projects, environmental compliance, and demolition:

Routine Maintenance Funds - Amounts are calculated using the IHS M&I distribution formula, which is based on the modified University of Oklahoma methodology to calculate routine maintenance costs. Routine M&I funds can be used to pay non-personnel costs for the following activities in IHS and Tribally-owned health care facilities: emergency repairs, preventive maintenance activities, maintenance supplies and materials, building service equipment replacement, upkeep activities, training, and local projects.

M&I Project Funds - IHS Area Facilities Engineers develop priority lists of larger projects to reduce the BEMAR. Although Tribes with tribally-owned facilities may take their individual shares of the M&I project pool funds, those in Areas with a Federal facility inventory M&I project pool funds may be restricted for Federal facilities to ensure that Federal stewardship responsibilities are maintained. Generally M&I projects in this category require levels of expertise, which may not be available at the local facility. Such projects accomplish major repairs and improvements of primary mechanical, electrical, and other building systems as well as public law compliance and program-related alterations. Program-related alteration projects include changes to existing facilities for more efficient utilization, for new patient care equipment, and to accommodate new treatment methodologies.

Environmental Compliance Funds - Many IHS and Tribal facilities were constructed before the existence of current environmental laws and regulations. Since IHS is required to comply with current Federal, State, and local environmental regulations, the use of environmental assessments to identify and evaluate potential environmental hazards is important. These assessments form the basis of the IHS facilities environmental remediation activities. The IHS has currently identified approximately $26 million in environmental compliance tasks and included them in the BEMAR database. Tribally-owned health care facilities receive assessments upon request by the Tribe.

Demolition Funds - The IHS has a number of Federally owned buildings that are vacant or obsolete and no longer needed. The number currently is estimated at 60 buildings. Many of these buildings are safety and security hazards. Demolition of these buildings reduces hazards and liability.

PERFORMANCE ANALYSIS

A total of $49,204,000 was appropriated in FY 2005 and approximately $6,200,000 in quarters return funds was collected and distributed; quarters return funds are used only to maintain staff quarters. Approximately $30 million, identified as M&I routine maintenance, was provided to the IHS Areas and Tribes for daily maintenance activities and local projects to maintain the current state of health care facilities; approximately $15 million, identified as M&I project, was provided to the IHS areas and Tribes for projects to reduce the Backlog of Essential Maintenance, Alterations and Repair (BEMAR) deficiencies and to improve healthcare facilities to meet changing healthcare delivery needs. In FY 2004 a national effort was initiated to execute a new cycle of Environmental Assessments, with emphasis on direct building and grounds related deficiencies with sufficient data to initiate projects to address pending environmental deficiencies. For environmental compliance, approximately $3 million was available, and approximately $500,000 for demolition. In conjunction with improved management practices, energy conservation measures, and projects, IHS reduced the energy related utility consumption for IHS managed facilities from 2,150,000 BTU/SM in 2004 to 2,066,000 BTU/SM in 2005.

Performance Goal	Results	Context
Ensure facility condition surveys are current (not over 5 years old)	These assessments are now a part of the IHS Director's Performance Contract with DHHS	These assessments supply data to the BEMAR, are used in the calculation of the FCI, and used in individual facility management/engineering plans

In the past IHS uses the Facility Condition Index (FCI) to measure the condition of facilities. The FCI is an industry accepted benchmark used to measure the relative condition of all IHS facilities. It provides a simple measure of a facility's condition. It is calculated by taking the total backlog of essential maintenance and repairs of the facilities (a.k.a. BEMAR) and dividing it by the total current replacement cost of the facilities. An FCI < 5 percent represents a facility in good condition, and FCI between 5 percent and 10 percent represents a facility in fair condition and an FCI > 10 percent represents a facility in poor condition. Completion of new replacement facilities in concert with M&I funding has reduced overall facility deficiencies resulting in an incremental improvement in the corresponding FY 2005 FCI ratio.

FY	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
FCI	26.05	26.57	25.53	22.26	21.07	19.72
CI	74	73	74	78	79	80

In 2005, Federal Real Property Council approved Condition Index (CI) as the measure of a constructed asset's condition at a specific point in time. CI is calculated as the ratio of Repair Needs to Plant Replacement Value [i.e., CI = (1 - $repair needs/$PRV) x 100)]. The CI is reported as a "percent condition" on a scale of 0 percent to 100 percent (positive whole numbers; for cases in which the calculation results in a negative number, the percentage should be reported as zero). The higher the CI, the better the condition the constructed asset is in. Based on the preliminary CI target levels set by the Department of Health and Human Services, facilities with a CI in the 65 to 84 range are in Fair condition. The IHS has transitioned to this measure.

Steady State Condition

The Building Research Board of the National Academy of Sciences (NAS) (*Committing to the Cost of Ownership - Maintenance and Repair of Public Buildings, 1990*) has determined that approximately 2 to 4 percent of current replacement value of supported buildings is required to maintain facilities in their current condition. Due to facility type, facility use, and facility location the IHS would expect these percentages to be lower than the need for IHS's facilities.

The above percentages do not include estimated funds needed for a net reduction in existing BEMAR and would not include improvements and alterations nor operating costs which include staff and utilities.

The current (2005) replacement value, of all M&I eligible facilities, is approximately $2.18 billion.

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

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

Fiscal Year	Amount	FTE
2002	$46,331,000	0
2003	$49,507,000	0
2004	$48,897,000	0
2005	$49,204,000	0
2006	$51,633,000	0

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $52,668,000 is an increase of $1,035,000 over the FY 2006 Enacted budget of $51,633,000. The increase will provide:

Increased Costs of Delivering Health Care: +$1,035,000 to fund inflationary cost increases. Anticipated cost increases to programs funded within the Facilities Appropriation are associated with transportation, materials, labors, competitive markets for construction, etc. The increase will fund non-medical (2.1 percent) inflationary costs using the FY 2007 Economic Assumptions.

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

Authorizing Legislation: 25 U.S.C. 13 Snyder Act, P.L. 83-568, Transfer Act, 42 U.S.C. 2001, PL 86-121, Indian Sanitation Facilities Act; and Title III of P.L. 94-437, Indian Health Care Improvement Act, as amended.

	FY 2005 Actual	**FY 2006 Enacted**	**FY 2007 Request**	Increase or Decrease
BA	$91,767,000	$92,143,000	$94,003,000	+$1,860,000
FTE	199	199	199	

STATEMENT OF THE BUDGET REQUEST

The budget request of $94,003,000 for Sanitation Facilities Construction (SFC) supports essential sanitation facilities including water supply, sewage, and solid waste disposal facilities to AI/AN homes and communities.

Number of Homes Benefited			
	FY 2005 Actual	FY 2006 Estimate	FY 2007 Estimate
A. New/Like New			
HUD [1]	23	200	200
BIA/HIP	123	300	300
Tribal/Other	2,249	3,300	3,300
Subtotal	2,395	3,800	3,800
B. Existing Indian Homes			
First Service	2,029	1,500	1,800
Upgraded/Emergency	19,648	16,700	16,900
Subtotal	21,677	18,200	18,700
Total [2]	**24,072**	**22,000**	**22,500**

[1] Sanitation facilities to be funded with HUD grants contributed by Tribes to IHS projects.
[2] Construction projects are funded with IHS appropriated funds and contributions to serve these homes.

PROGRAM DESCRIPTION

Sanitation Facilities Construction (SFC) is an integral component of the IHS disease prevention activity, has carried out those authorities since 1959 using funds appropriated for SFC to provide potable water and waste disposal facilities for AI/AN people. As a result, the rates for infant mortality, the mortality rate for gastroenteritis and other environmentally related diseases have been dramatically reduced, by about 80 percent

since 1973. The IHS physicians and health professionals credit many of these health status improvements to IHS' provision of water supplies, sewage disposal facilities, development of solid waste sites, and provision of technical assistance to Indian water and sewer utility organizations.

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

A Report to Congress by the Comptroller General (dated March 11, 1974) noted that AI/AN families living in homes with satisfactory environmental conditions placed fewer demands on IHS' primary health care delivery system than families living in homes with unsatisfactory conditions. For example, those with satisfactory environmental conditions in their homes (e.g., safe piped water and adequate sewage disposal) required approximately 25 percent of the health care services required by those with unsatisfactory environmental conditions.

The four types of sanitation facilities projects funded through IHS are (1) projects to serve new or like-new housing, such as Indian homes being constructed or rehabilitated by the BIA-Home Improvement Program (HIP), Tribes, individual homeowners, or other nonprofit organizations, (2) projects to serve existing housing, (3) special projects (studies, training, or other needs related to sanitation facilities construction), and (4) emergency projects. Projects that serve new or like-new housing are funded based on a priority classification system. Projects that serve existing housing are annually prioritized with Tribal input in terms of health impact, cost effectiveness and other criteria, then funded in priority order.

Sanitation facilities projects are carried out cooperatively with the Indian people who are to be served by the facilities. Tribal involvement has been the keystone of the Sanitation Facilities Program since its inception in FY 1960. Receipt of a Tribal request to participate in carrying out the project and willingness to execute an agreement to assume ownership responsibilities, including operation and maintenance, for completed facilities is required before a project is initiated.

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

With completion of all projects approved through FY 2005, approximately 300,000 AI/AN homes will have been provided sanitation facilities since 1960. Experience shows that 60 to 70 percent of the actual construction is performed by Indian Tribes/firms.

Sanitation Facilities Needs

The Indian Health Care Improvement Act (Title III, Section 302(g) 1 and 2 of P.L. 94-437) directed the IHS to identify the universe of Indian sanitation facilities needs for existing Indian homes. As of the end of FY 2005, the list of all documented projects totaled over $2 billion with those projects considered economically feasible totaling $990 million. As of the end of FY 2005, there were over 140,000 AI/AN homes in need of sanitation facilities including over 38,000 AI/AN homes without potable water.

As proposed, the current backlog of projects would provide sanitation facilities to between 95 and 98 percent of all existing Indian homes. Also included in the backlog are projects intended to upgrade existing water supply and waste disposal facilities and projects to improve sanitation facilities operation and maintenance capabilities in Indian country. Maximum health benefits will be realized by addressing existing sanitation needs identified in the backlog and by providing sanitation facilities for new homes when they are constructed.

PERFORMANCE ANALYSIS

SFC is a contributing factor in accomplishing the goals of the IHS Strategic Plan including: building healthy communities through disease prevention; achieving parity in access by attempting to increase the number of AI/AN homes with potable water to 94 percent by 2010; providing compassionate quality health care through the provision of sanitation; and embracing innovation through prevention activities and increased partnerships with other federal agencies, states and Tribes. Safe drinking water supplies and adequate waste disposal facilities are essential preconditions for most health promotion and disease prevention efforts, as well as being a major factor in the quality of life of Indian people.

Prior to FY 2004 IHS, stated that 7.5 percent of AI/AN homes were without potable (safe and reliable) water. Based on end of year 2005 data, it is estimated that approximately 12 percent of AI/AN homes are without a safe and reliable water supply. This increase in the number of AI/AN homes lacking safe water is due to inflation, population growth, the age and condition of the existing infrastructure, high numbers of new and like new housing, and new environmental regulations including the new Arsenic and Surface Water Treatment rules promulgated by the Environmental Protection Agency. The new arsenic rule accounts for most of this increase because it has caused approximately 65 communities with nearly 13,000 homes to now be classified as deficiency level 4 for water as defined in 25 U.S.C. 1632.

Performance Goal		
During FY 2007, the GPRA goal is to fund sanitation facilities projects to serve 22,500 American Indian and Alaskan Native homes with water, sewage disposal, and/or solid waste facilities. For the backlog of needs for existing homes (regular funds), a minimum of 25% of the homes served by the Program funding will be at Deficiency Level 4 or above as defined by 25 USC 1632.	The SFC Program has consistently met its GPRA goal since GPRA inception.	The SFC Program GPRA goal directly measures the impact of the program by counting the number of AI/AN homes served. Deficiency Level 4 and 5 homes have the greatest health deficiencies. This measure combined with the existing GPRA goal will quantify the balance between cost effectiveness and health impact of the Program.

In FY 2005, of the $91,767,165 appropriated for sanitation facilities, $45,670,900 was used to address the backlog of existing homes. This included funding to serve solid waste needs (included in the solid waste funding was $490,300 to clean up open dumps identified by an interagency task force, the members of which included the Bureau of Indian Affairs, the Environmental Protection Agency, the Department of Agriculture and others). The remainder of the FY 2005 appropriation was used to provide $45,115,665 for sanitation facilities for new/like-new Indian homes and $980,600 for special projects, and emergency projects.

In cooperation with the Office of Management and Budget (OMB) a Common Measure was developed in 2002 with the Rural Utility Service (RUS), the Bureau of Reclamation (BOR), the Environmental Protection Agency (EPA), and the IHS to allow direct comparisons between rural water programs within the federal government. The Common Measures agreed upon were the number of connections and the population served per million dollars of total project cost. It was recognized that BOR and IHS are direct service programs to a specific population, and EPA and RUS are grant/loan programs that can leverage funding with both of these programs mostly providing strictly upgraded services. The IHS compared favorably in FY 2001 having provided 174 and 212 (east and west) services per million dollars compared with the BOR which provided 24 services per million dollars.

An efficiency parameter was developed based on houses served per million dollars and was applied to Indian homes served from FY 2001 through FY 2005 by projects serving less than 200 houses per project (97% of the projects constructed). The results are presented below.

Deficiency Type	Houses Served per Million Dollars			
	High	Low	Average	2005
All regular and housing funds	290	192	227	290
Regular funds deficiency level 4 & 5 projects	81	72	74	74
Regular funds deficiency level 0 to 3	1005	522	756	957

Deficiency level 4 houses lack either adequate water or sewer service and deficiency level 5 houses lack both adequate water and sewer service.

In FY 2002, the SFC was reviewed through the Program Assessment Rating Tool (PART) process and received a score of 80 of possible 100, earning a rating of Moderately Effective. A major weakness of the SFC program is that it had not had an independent program review since 1974, and there has not been a recent benefit cost analysis on the value of sanitation facilities for AI/AN homes. As a result of the PART review the SFC program has worked with Federal Occupational Health of the Department of Health and Human Services on an independent evaluation of the program that was completed in July 2005. Based on this evaluation the SFC program has begun a strategic planning process to improve performance.

FY 2005, GPRA Measure 35: To provide sanitation facilities projects to serve 20,000 American Indian and Alaskan Native homes with water, sewage disposal, and/or solid waste facilities. **IHS exceeded this measure** by providing service to 24,072 homes in FY 2005. This significant increase in existing homes was the result of funding more projects to upgrade existing community sanitation facilities infrastructure.

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

Fiscal Year	Amount	FTE
2002	$93,827,000	198
2003	$93,217,000	183
2004	$93,015,000	183
2005	$91,767,000	199
2006	$92,143,000	199

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $94,003,000 and 199 FTE is an increase of $1,860,000 over the FY 2006 Enacted of $92,143,000 and 199 FTE. The increase will provide:

Increased Costs of Delivering Health Care: +$1,860,000 to fund inflationary cost increases. Anticipated cost increases to programs funded within the Facilities Appropriation are associated with transportation, materials, labors, competitive markets for construction, etc. The increase will fund non-medical (2.1 percent) inflationary costs using the FY 2007 Economic Assumptions.

All projects are budgeted to include full costs for pre-planning, design, construction costs, and associated overhead. The FY 2007 SFC portion of the appropriation will be allocated as follows:

1) $1,000,000 will be reserved at IHS Headquarters for special projects and for distribution to the Areas as needed to address water supply and waste disposal

emergencies caused by natural disasters or other unanticipated situations that require immediate attention to minimize potential threats to public health. Emergency and special funds remaining at the end of the fiscal year will be distributed to the Areas to address the Sanitation Deficiency System (SDS) priority list of needs.

2) Up to $47,000,000 of the total FY 2007 SFC appropriation will be reserved to serve new and like-new homes. Some of these funds may also be used for sanitation facilities for the individual homes of the disabled or sick with a physician referral indicating an immediate medical need for adequate sanitation facilities in their home. As needed, amounts to serve new and like-new homes will be established by Headquarters after reviewing Area requests. Priority will be given to projects intended to provide sanitation facilities for the first time to homes in categories B, C, and D (new homes and homes receiving major renovation bringing the homes up to like new condition) under the BIA Housing Improvement Program (HIP). (NOTE: Homes in BIA/HIP Category A are considered existing homes. Category A homes needing service will be included in the SDS.)

   The amount allocated to each Area for projects to serve other new/like-new homes will be the Area's pro-rata share of remaining funds for serving such housing.

3) Up to $47,000,000 of the amount appropriated in FY 2007 will be distributed to the Areas for prioritized projects to serve existing homes, based on a formula that considers, among other factors, the cost of facilities to serve existing homes that: (a) have not received sanitation facilities for the first time; or (b) are served by substandard sanitation facilities (water and/or sewer). Another distribution formula element is a weight factor that favors Areas with larger numbers of American Indian and Alaska Native (AI/AN) homes without water supply or sewer facilities, or without both. Up to $5,000,000 will be used for projects to clean up and replace open dumps on Indian lands pursuant to the Indian Lands Open Dump Cleanup Act of 1994.

The IHS appropriated funds will not be used to provide sanitation facilities for new homes funded with grants by the housing programs of the Department of Housing and Urban Development (DHUD). These DHUD housing grant programs for new homes are able to fund the sanitation facilities necessary for the homes.

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

HEALTH CARE FACILITIES CONSTRUCTION

Authorizing Legislation: Snyder Act, 25 U.S.C. 13; and the Indian Health Care Improvement Act, P.L. 94-437, as amended.

	FY 2005 Actual	**FY 2006 Enacted**	**FY 2007 Request**	Increase or Decrease
BA	$88,597,000	$37,779,000	$17,664,000	($20,115,000)
FTE	0	0	0	0

HEALTH CARE FACILITIES CONSTRUCTION PROJECTS

Projects [1]	FY 2005 Actual [2]	FY 2006 Enacted	FY 2007 Request	Increase or Decrease
BA	$88,597,000	$37,779,000	$17,664,000	-$20,115,000
Upper Santan, AZ – PIMC System–SE ACC	2,590,000	0	0	N/A
Komatke, AZ – PIMC System–SW ACC	1,354,000	7,882,000	17,664,000	9,782,000
Scottsdale, AZ – PIMC System NE ACC	0	0	N/A	N/A
Barrow, AK	2,958,000	7,882,000	0	-7,882,000
Subtotal Inpatient	**6,902,000**	**15,764,600**	**17,664,000**	**1,899,700**
Red Mesa, AZ	19,113,000	0	0	N/A
St. Paul, AK	0	0	0	N/A
Metlakatla, AK	0	0	0	N/A
Sisseton, SD	17,060,000	0	0	N/A
Clinton, OK	19,032,000	0	0	N/A
Eagle Butte, SD	4,931,000	0	0	N/A
Kayenta, AZ	431,000	3,821,000	0	-3,821,000
San Carlos, AZ	555,000	6,049,000	0	-6,049,000
Subtotal Outpatient	**61,122,000**	**9,870,000**	**0**	**-9,870,000**
Zuni, NM	2,490,000	0	0	N/A
Wagner, SD	2,503,000	0	0	N/A
Ft. Belknap, MT	4,931,000	3,277,000	0	-3,277,000
Subtotal Staff Qtrs	**9,924,000**	**3,277,000**	**0**	**-3,277,000**
Phoenix-NV Satellite	0	0	0	N/A
Central-Southern CA	0	0	0	N/A
Northern CA	0	0	0	N/A
Subtotal YRTCs	**0**	**0**	**0**	**0**
Various Projects	4,733,000	0	0	N/A
Subtotal JVCP	**4,733,000**	**0**	**0**	**0**
Various Projects	4,930,000	6,897,000	0	-6,897,000
Subtotal SAP	**4,930,000**	**6,897,000**	**0**	**-6,897,000**

Projects [1]	FY 2005 Actual [2]	FY 2006 Enacted	FY 2007 Request	Increase or Decrease
Various Projects	986,000	1,971,000	0	-1,971,000
Subtotal DFP	**986,000**	**1,971,000**	**0**	**-1,971,000**

1 The Inpatient and Outpatient health care facilities, Staff Quarters, YRTCs, JVCP, SAP and DFP projects are shown in priority order within their subcategory, but they are not prioritized against the other project categories that are listed. For example, the PIMC SE ACC Inpatient project does not have a higher priority than the Central – Southern CA YRTC project.

2 The FY 2005 Actual and the FY2006 Enacted include all rescissions.

STATEMENT OF THE BUDGET REQUEST

The budget request of $17,664,000 for Health Care Facilities Construction (HCFC) will fund the construction of a health facility, and the initial equipment, that provide direct health care services for the American Indian and Alaska Native people.

PROGRAM DESCRIPTION

Pursuant to the Indian Health Care Improvement Act (IHCIA), Public Law (P.L.) 94-437, as amended in 1992, the need for each health care facility and staff quarters construction project is assessed through a periodic application of comprehensive priority system methodologies. The proposals are evaluated objectively and ranked according to need.

The objectives of the IHS HCFC funds are to provide access to a modern health care delivery system by providing for optimum availability of functional, well-maintained IHS and Tribally operated health care facilities, and staff housing at IHS health care delivery locations if no suitable housing alternative is available. The IHS capital improvement program, funded through this budget activity, is authorized to construct health care facilities and staff quarters, renovate/construct Youth Regional Treatment Centers for substance abuse, Joint Venture Construction Projects, provide construction funding for Tribal small ambulatory care facilities projects, replace/provide new dental units, and to assist non-IHS funded renovation projects.

To determine the locations where new and replacement facilities are most critically needed, the IHS has developed and is implementing comprehensive priority system methodologies for health care facilities and staff quarters construction. As needed, IHS Headquarters solicits proposals from the IHS Areas for urgently needed new or replacement health care facilities, essential staff quarters projects, and replacement/new dental units. These proposals are evaluated and prioritized. Formal justification documents are prepared for those scoring highest. Once justified and approved, projects are placed on the appropriate construction priority list and proposed for funding. This system was last run for health care facilities in 1991.

During FY 1990, in consultation with the Tribes, the IHS revised its Health Facilities Construction Priority System (HFCPS) methodology. The HFCPS ranks proposals using

factors reflecting the total amount of space needed; age and condition of the existing facility, if any; degree of the isolation of population to be served in the proposed facility; and availability of alternate health care resources. There are three phases to the HFCPS. During FY 1991, Phase I of the methodology was applied to 149 IHS Area-generated proposals to construct new or replacement health care facilities. Based on the Phase I result, the IHS proceeded with Phase II of the methodology, using a more detailed analysis of the 28 highest ranked proposals. During FY 1992, the IHS consulted with Tribes about incorporating additional flexibility into the HFCPS in order to give consideration to new concepts, such as low acuity beds in health centers, as directed by the Congress in the FY 1992 Conference Report on IHS appropriations. Few Tribes urged the IHS to make changes to the HFCPS. In FY 1993, 23 of the 28 proposals considered in Phase II were advanced to Phase III. IHS Area Offices were asked to develop Program Justification Documents (PJDs) for each of the 23 proposed facilities. As PJDs are approved, projects are added to the respective Health Facilities Construction Priority List.

The IHS has two processes for reviewing the staff housing needs. Under the Quarters Construction Priority System methodology, the IHS reviews the need for additional quarters units at all existing health care facilities. Phases I and II of this methodology were last applied in 1991. As each Program Justification Document for Staff Quarters (PJDQ) is completed for these projects, the projects are added to the Quarters Construction Priority List. The second process responds to the Department of Health and Human Service office of the Inspector General report of April 17, 1990, regarding needed improvements for planning and construction of IHS staff housing. The IHS began reviewing the need for quarters at each location where new or replacement health care facilities were being planned.

The IHS is authorized to construct Youth Regional Treatment Centers (YRTCs) by Section 704 of the IHCIA, P.L. 94-437, as amended.

For the IHS Joint Venture Construction Program (JVCP), the Department of the Interior and Related Agencies Appropriations Act for FY 1991 (P.L. 101-512) authorized and partially funded a "joint venture demonstration program" to equip, supply, operate, and maintain up to three health centers. These health centers were to be selected on a competitive basis from those Tribal applicants agreeing to provide an appropriate facility for use as a health center for a minimum of 20 years, under a no cost lease. Beginning in FY 2003, Congressional language directed that staff quarters, if needed, were to be part of the health care facility under the Joint Venture Construction Program. The costs for facility design and construction and staff quarters, if any were to be borne by participating Tribes. The IHS was to be responsible for all costs associated with staffing,

initially equipping, and operating the facilities. The authority for the current JVCP is Section 818(e) of the IHCIA, P.L. 94-437, as amended.

The IHS is authorized to provide construction funding to Tribes or Tribal organizations by Section 306 of the IHCIA, P.L. 94-437, as amended. Funding may be awarded only to Tribes operating non-IHS outpatient facilities under the Indian Self-Determination and Education Assistance Act, P.L. 93-638, service contracts. This authorization is administered under the IHS Small Ambulatory Program.

Appropriations for IHS in FYs 1994-2005 included funding to replace and build new dental units under the IHS Dental Facilities Program.

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

In Year 2003, the Department of Health and Human Services (DHHS) instituted a capital facilities programming and project review process, including a non-information technology Capital Investment Review Board (CIRB). Documentation requirements and approval authorities are defined in the DHHS June 2003 CIRB policy statement, and in the DHHS April 2004 Facility Project Approval Agreement policy statement. On June 28, 2004, the CIRB met and reviewed all projects being considered for inclusion in the FY 2006 budget request, which exceed $10,000,000, include land purchase, or otherwise fell under the Board's authority. On June 29, 2005 the CIRB met and reviewed projects being considered for inclusion in the FY 2007 budget request.

PERFORMANCE ANALYSIS

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

Performance Goal		
During FY 2007, the GPRA goal is to improve access to healthcare facilities by the construction of the approved new health care facilities.	The Health Care Facilities Construction Program (HCFCP) did not meet the FY 2005 target. However, the program received a PART score of 92, one of the higher scores in the Department. Please see additional details in the Detail of Performance Analysis section.	The HCFCP Program provides infrastructure to increase access to healthcare services for American Indians and Alaska Natives.

FUNDING HISTORY – Funding for the Facility Planning and Construction program during the last 5 years has been as follows:

Fiscal Year	Amount
2002	$46,331,000
2003	$81,585,000
2004	$94,554,000
2005	$88,597,000
2006	$37,779,000

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $17,664,000 is a decrease of $20,115,000 from the FY 2006 Enacted budget of $37,779,000. The request will provide resources to be used for the following project. Consistent across the Department of Health and Human Services, no funds are requested in FY 2007 to initiate new construction.

PIMC, SW Ambulatory Care Center: +$17,664,000
Funds in this request will be used to complete the construction of this project, which received initial construction funding in 2006. This facility, to be located in Komatke, AZ, will provide basic ambulatory health care services, including dental care, eye care, digital imaging, OB/GYN, primary care, and laboratory services.

The proposed Southwest Ambulatory Center has been planned to provide 7,025 gross square meters (GSM) of space to support a modern and adequately staffed health care delivery system. It will serve a projected user population of 5,707 with 22,394 primary care provider visits and 44,721 outpatient visits. The facility will improve access to the health care services necessary to maintain and promote the health status and overall quality of life for the residents of the Southwest primary service area by providing services closer to the population to be served, and away from the overcrowded PIMC.

The proposed new IHS satellite health center will provide a full range of ambulatory care, as well as, comprehensive community health programs, which will address the curative and preventive health concerns for this area of the region. There is no need for staff quarters.

This facility is one of three centers that are part of the overall planning to relieve significant overcrowding at the facility for the PIMC in Phoenix, Arizona. Patient waiting times for all services will drop significantly. The typical patient must wait weeks or months for appointments for some health services and wait times to be examined by a health care professional are typically the entire day. Some health services are limited to a select demographic group. For example, current dental services are limited to children. Adults must obtain their dental care elsewhere which is usually outside the IHS system.

INDIAN HEALTH CARE FACILITIES CONSTRUCTED SINCE FY 1980

PROJECT LOCATION	FISCAL YEAR COMPLETED	TOTAL $ APPROPRIATED
Hospitals		
Bethel, AK	1980	34,100,000
Ada, OK	1980	14,374,000
Cherokee, NC	1981	10,341,000
Red Lake, MN	1981	9,566,000
Chinle, AZ	1982	19,758,000
Tahlequah, OK	1983	21,334,000
Browning, MT	1985	15,086,000
Kanakanak, AK	1987	16,578,000
Crownpoint, NM	1987	17,734,000
Sacaton, AZ	1988	15,765,000
Rosebud, SD	1989	20,000,000
Pine Ridge, SD	1993	27,090,000
Shiprock, NM	1995	53,591,364
Crow Agency, MT	1995	23,091,000
Kotzebue, AK	1995	62,483,000
Anchorage, AK	1997	167,915,000
Ft. Defiance, AZ [1]	2002	117,763,797
Winnebago, NE [2]	2004	47,857,000
Subtotal		$694,427,161
Health Centers		
Cibecue, AZ	1980	750,000
Lodge Grass, MT	1982	1,485,000
Inscription House, AZ	1983	3,890,000
Ft. Duchesne, UT	1984	2,220,000
Tsaile, AZ	1984	3,856,000
Huerfano, NM	1984	3,304,000
Ft. Thompson, SD	1988	3,449,000
Wolf Point, MT	1990	3,654,000
Kyle, SD	1990	3,209,000
Toppenish, WA	1990	9,350,000
Ft. Hall, ID	1990	6,002,000
Sallisaw, OK	1992	4,265,000
Puyallup, WA	1993	8,472,000
Taos, NM	1993	5,765,000
Wagner, SD	1993	6,119,000
Belcourt, ND (OPD)	1994	19,449,000
Tohatchi, NM	1995	9,502,682
Stilwell, OK	1995	7,663,000
Ft. Belknap, MT [3]		18,885,000
Hays, MT	1997	
Harlem, MT	1998	
White Earth, MN	1998	13,462,000
Lame Deer, MT	1999	14,100,000
Hopi, AZ	2000	34,558,000
Parker, AZ	2001	21,641,000
Pawnee, OK	2004	19,327,147
Pinon, AZ	2005	39,759,000
St. Paul, AK	2005	14,140,400
Subtotal		$278,277,229

INDIAN HEALTH CARE FACILITIES CONSTRUCTED SINCE FY 1980

PROJECT LOCATION	FISCAL YEAR COMPLETED	TOTAL $ APPROPRIATED
Staff Quarters		
Chinle & Inscription House, AZ (design)		336,000
Inscription House, AZ (21)	1982	1,764,000
Chinle, AZ (161)	1983	12,236,000
Huerfano, NM (9) [4]	1983	
Ft. Duchesne, UT [4]	1984	
Crownpoint, NM (36)	1984	3,352,000
Tsaile, AZ (23)	1985	2,141,000
Ft. Thompson, SD (13)	1985	1,279,000
Kanakanak, AK (17)	1986	4,133,000
Browning, MT (26)	1987	2,470,000
Kyle, SD (24)	1987	1,615,000
Supai, AZ (2)	1990	246,000
Rosebud, SD (29 of 66)	1990	7,345,000
Neah Bay, WA (4)	1991	472,000
Dulce, NM (4)	1993	515,000
Barrow, AK (29)	1993	18,183,000
Rosebud, SD (remaining 37 units)	1993	7,695,000
Pine Ridge, SD (45)	1993	9,517,000
Kotzebue, AK (50)	1993	26,155,000
Belcourt, ND (21)	1997	3,912,000
Hopi, AZ (Polacca) (73) [5]	2001	4,995,000
Subtotal		$108,361,000
Youth Regional Treatment Centers		
Alaska - Fairbanks, AK	1993	1,466,000
Alaska – Mt. Edgecumbe, AK	1994	866,000
Phoenix – Sacaton, AZ	1994	2,357,000
Portland - Spokane, WA	1996	7,343,000
Aberdeen - Chief Gall, SD	1996	5,373,000
Subtotal		$ 17,405,000
Joint Venture Demonstration Projects		
Warm Springs, OR	1993	959,000
Poteau, OK	1994	700,000
Dulce, NM	2005	3,403,000
Idabel, OK	2005	2,272,500
Subtotal		$ 7,334,500

GRAND TOTAL **$1,105,804,890**

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

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

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

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

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

FY 2007 FUNDING STATUS
INDIAN HEALTH CARE FACILITIES CONSTRUCTION

FACILITY	($) [Rounded to hundreds]		
	PRIOR TO FY 2007*	FY 2007 BUDGET REQUEST TOTAL ESTIMATE	TOTAL PROJECT ESTIMATE
Planning Studies	986,100	0	3,000,000
Inpatient Facilities (Section 301)			
PIMC System, AZ	224,400	0	1,225,000
SE ACC	2,590,100	0	48,318,000
SW ACC	1,354,400	17,842,000	27,168,000
NE ACC	0	0	53,035,000
Central – Hospital & ACC	0	0	565,122,000
Barrow, AK	3,078,300	0	136,186,000
Nome, AK	120,000	0	132,675,000
Whiteriver, AZ	0	0	168,959,000
Outpatient Facilities (Section 301)			
Ft. Yuma, AZ – On Hold	0	0	UNK
Red Mesa, AZ	64,101,600	0	64,102,000
Metlakatla, AK	20,010,600	0	20,010,600
Sisseton, SD	40,158,900	0	40,159,000
Clinton, OK	20,358,900	0	20,359,000
Dulce, NM (1)	0	0	NA
San Simon (Westside), AZ (1)	0	0	NA
Eagle Butte, SD	7,696,000	0	97,351,000
Kayenta, AZ	4,357,000	0	108,626,000
San Carlos, AZ	6,665,000	0	115,960,000
Quarters (Section 301)			
Zuni, NM	5,409,900	0	5,409,900
Wagner, SD	2,502,700	0	2,502,700
Ft. Belknap, MT	8,241,000	0	8,241,000
Youth Regional Treatment Centers (Section 704)			
Phoenix-Nevada Satellite YRTC	4,141,800	0	4,141,800
Central-Southern California YRTC	0	0	12,492,000
Northern California YRTC	0	0	12,897,000
Joint Venture Construction Program (Section 818e)	14,722,300	0	39,989,000
Small Ambulatory Program (Section 306)	29,876,000	0	95,000,000
Dental Facilities Program	11,463,100	0	25,000,000
Non-IHS Funds Renovation Projects (Section 305)	0	0	10,000,000

* All active projects are included.

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

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

Present Health Care Facilities Priority Rankings

(January 2006)

Inpatient

Phoenix, AZ ***
Barrow, AK ***
Nome, AK
Whiteriver, AZ

Outpatient

Ft. Yuma, AZ (On-hold)
Red Mesa, AZ **
St. Paul, AK **
Sisseton, SD **
Eagle Butte, SD ***
Kayenta, AZ ***
San Carlos, AZ ***

Staff Quarters

Youth Regional Treatment Centers

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). Staffing fully funded. Project being kept on Priority List until construction completed per JVCP Agreement.

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

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

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

	FY 2005 Actual	FY 2006 Enacted	FY 2007 Request	Increase or Decrease
BA	$141,669,000	$150,709,000	$161,333,000	+$10,624,000
FTE	1,082	1,113	1,155	+42

STATEMENT OF THE BUDGET REQUEST

The Facilities and Environmental Health Support budget request of $161,333,000 supports personnel who provide facilities and environmental health services throughout the Indian Health Service (IHS) at the IHS Area, district, and service unit levels, and to pay operating costs associated with provision of those services and activities. The Facilities and Environmental Health Support (FEHS) account is separated into **three sub-activities** (Facility Support, Environmental Health Support, and Office of Environmental Health and Engineering (OEHE) Support) which provide support for the other activities within the facilities appropriation (e.g. Sanitation Facilities Construction).

PROGRAM DESCRIPTION

The Indian Health Facilities programs, managed at IHS Headquarters by the OEHE and carried out by Area, field, and service unit staff, provide an extensive array of real property, health care facilities and staff quarters construction, maintenance, and operation services, as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. Services are delivered directly by Federal or Tribal employees or by Tribal contractors. In addition to staffing costs, funds appropriated for this activity are used to pay for utilities in IHS health care facilities, certain non-medical supplies and personal property, and biomedical equipment repair. Approximately 198 additional temporary and permanent sanitation facilities construction support personnel costs are paid from specific sanitation facilities project accounts. Both Federal and Tribally contracted environmental health activities are included among the permanent positions paid from this account. Health care facilities/staff quarters operation and maintenance personnel costs are paid from this account or from reimbursements.

The OEHE Headquarters staff includes components in Rockville, Dallas, and Seattle. The staff has management responsibility for IHS facilities and environmental health programs, provides direct technical services and support to Area personnel, and performs critical management functions. Headquarters OEHE management activities include national policy development and implementation; budget formulation; project review and approval; congressional report preparation; quality assurance (internal control reviews,

Federal Managers Financial Integrity Act activities, and other oversight); technical assistance (consultation and training for both Tribal and IHS personnel); long-range planning; meetings (with Members of Congress and their representatives, with Tribes, and with other Federal agencies); realty services; and recruitment and retention. Also, OEHE Engineering Services staff located in Dallas, Texas and Seattle, Washington provide architectural, engineering, construction, contracting, and real property services to IHS and Tribal health care facilities programs.

There are counterparts of most facilities and environmental health organizational elements in each IHS Area Office. **Staff of facilities and environmental health related programs in IHS Area Offices** vary in size depending on program scope; the number and size of IHS facilities served; the number, size, and complexity of construction projects; the number and location of Indian communities served; transportation considerations; and the method of providing technical services within the Area. Area facilities and environmental health personnel include architects, engineers, environmental health officers, real property and staff quarters management specialists, biomedical technicians, facilities planners, injury prevention specialists, institutional environmental health officers, construction inspectors, utility operations consultants, draftspersons, and land surveyors.

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

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

District Offices provide professional/technical services when there are two or more IHS health care facilities or sanitation facilities construction projects, which are not large enough to individually merit full-time staff coverage, when the Area Office is too distant, or when the size of the service area is too large to provide suitable services, oversight, or technical assistance from the Area Office. Currently, IHS has approximately 30 such offices staffed by engineers, environmental health officers, construction inspectors, land surveyors, environmental health and construction technicians, and support personnel. All provide direct program support services.

PERFORMANCE ANALYSIS

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

Unintentional Injury Rates: Ensure injury mortality rates are no more than the previous year's rates.	This measure has been met every year data has been available.	The measure indicates the progress of the injury prevention program efforts.
Environmental Surveillance: Extend automated web-based environmental health reporting system to include collection of Tribal and federal environmental health priorities.	This surveillance measure has been met and exceeded every year.	The long range goal of DEHS is to identify priorities and target environmental health activities in communities. This measure is a step in the process of assessing environmental health concerns in communities.

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $161,333,000 and 1,155 FTE is an increase of $10,624,000 and 42 over the FY 2006 Enacted budget of $150,709,000 and 1,113 FTE. The increase will provide for:

Pay Costs: +$3,116,000 to fund pay increases for Federal and Tribal employees. The activity represents the personnel that perform the facilities and environmental program, funding for pay cost is critical to maintain an appropriate level of funding to carry our programs.

Increased Costs of Delivering Health Care: +$828,000 to fund inflationary cost increases. Anticipated cost increases to programs funded within the Facilities Appropriation are associated with transportation, materials, laborers, competitive markets for construction, etc. The increase will fund non-medical (2.1 percent) inflationary costs using the FY 2007 Economic Assumptions.

Population Growth: +$2,389,000 for the increasing AI/AN population.

Staffing/Operating Cost Requirements for New Facilities: +$4,291,000 and 42 FTE will allow IHS to expand provision of health care at new facilities. The funds will staff 4 new facilities which will open in FY 2006 and FY 2007. The following table displays the requested increase.

		FTE	
Facilities	Amount	Federal	Tribal
Clinton, OK Health Center	$721,000	6	0
Red Mesa, AZ Health Center	$2,372,000	25	0
Sisseton, SD Health Center	$759,000	8	0
St. Paul, AK Health Center	$439,000	3	0
Total	$4,291,000	42	0

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

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT
FACILITIES SUPPORT

	FY 2005 Actual	FY 2006 Enacted	FY 2007 Budget	Increase or Decrease
BA	$73,843,000	$79, 985,000	$87,043,000	$7,058,000
FTE	566	594	632	38

STATEMENT OF THE BUDGET REQUEST

The Facilities Support request will fund personnel and operation costs at the Service Unit and Area levels[1].

PROGRAM DESCRIPTION

The personnel paid from this account operate and maintain health care facilities and staff quarters. Staff functions supported by this sub-activity include management, operation, and maintenance of real property, building systems, medical equipment technical support, and planning and construction management for new and replacement facilities projects. In addition, related Area and Service Unit operating costs, such as utilities, building operation supplies, facilities related personal property, and biomedical equipment repair and maintenance, are paid from this account.

The IHS is committed to ensuring that health care is provided in functional and safe structures. Because many IHS facilities are located in isolated and remote environments far from urban centers, the IHS builds and maintains residential quarters at those locations to house non-local health care personnel.

The IHS owns approximately 812,000 square meters of Federally-owned facilities (buildings and structures) and 786 hectares of Federal and trust land. The nature of space varies from sophisticated medical centers to residential units and utility plants (see following table). Facilities range in age from less than 1 year to more than 105 years. The average age of our health care facilities is 32 years.

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

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

Space Occupied by IHS and Tribal Health Care Programs				
Type of Facility	Federally Owned	Direct Federal Lease	GSA Assigned	Tribal
Hospitals and Health Centers	429,120 M^2	53,679 M^2	-0-	236,536 M^2*
Staff Quarters	247,739 M^2	0 M^2	-0-	306 M^2
Other	135,302 M^2	35,278 M^2	59,649 M^2	266,793 M^2
Total	812,161 M^2	88,957 M^2	59,649 M^2	503,635 M^2

(FY 2005 end of year)

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

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

- **Facilities Engineers** -- Area and Service Unit facilities engineers and staff are responsible for ensuring that IHS building systems are operated properly, facilities and grounds are maintained adequately, utilities are managed appropriately, environmental compliance requirements are met, and buildings are safe. The need for maintenance and improvement projects is determined at the Area level and identified in Area Facilities Engineering Plans.

- **Clinical Engineers --** The IHS has highly sophisticated medical equipment in its inventory. Skilled, specialized personnel are employed to maintain and service that equipment because the lives of patients and level of patient care depend on accurate calibration and safe operation. Clinical engineers and technicians perform this critically important function. Larger IHS facilities have clinical engineering personnel on-site, but most IHS and Tribal facilities depend on Area, district, or service unit-based clinical engineers and technicians who travel to several facility locations to repair and maintain biomedical equipment.

- **Realty Management** -- Area Realty Officers provide technical and management assistance for realty activities associated with direct-leased, GSA-assigned, and IHS-owned (and to some degree Tribally-owned) space. The program includes facility and land acquisitions and disposals, licensing/easement processing, use-permit issuance, quarters management and rent setting activities, lease administration, and budget functions. The program also helps Tribes and Tribal organizations acquire, administer, and/or manage excess federally owned and Tribally leased real property.

- **Facilities Planning and Construction** -- Some IHS Areas have facilities planning and construction-monitoring components that assist in the planning and construction management of new and replacement health care facility and staff quarters projects. The need for new facilities is determined by applying the IHS Health Facilities Construction and Quarters Construction Priority System methodologies. Area staffs develop initial proposals for new and replacement facilities, prepare Program Justification Documents, Program of Requirements Documents, and Project Summary Documents for projects. While construction is underway, Area facilities management staff may be supplemented with construction management personnel to oversee Federal interests in the construction of new and replacement facilities.

In addition, the functions of these facility and realty positions support new real property asset management requirements as required by Executive Order 13327, Real Property Asset Management; the President's Real Property Management Agenda Initiative; and HHS Program Management objectives. These management actions are to ensure management accountability, to ensure the efficient and economic use, to recognize the importance, and to respond to the current condition of Federal real property.

Operations Costs

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

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

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

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

PERFORMANCE ANALYSIS

In FY 2005, Facilities Support continued to provide Area offices, service units and certain Tribal healthcare entities with staff, utilities, program supplies and equipment to

maintain the healthcare buildings and grounds, and to service approximately $320,000,000 worth of medical equipment. Facilities supported include hospitals, health centers, staff quarters, health stations and school health clinics, and youth regional treatment centers. Energy related utility consumption fell from 2,150,000 BTU/SM in FY 2004 to 2,066,000 BTU/SM in FY 2005 overall, helping to stem the growth in the cost of utilities, which is primarily due to space increases and inflation. IHS will continue all of these functions in FY 2007.

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $87,043,000 and 632 FTE is an increase of $7,058,000 over the FY 2006 Appropriation of $79,985,000.

The increases will provide for:

Pay Costs: +$1,502,000 to fund pay increases for Federal and Tribal programs. This activity represents the personnel that perform the facilities and environmental program, funding for pay cost is critical to maintain an appropriate level of funding to carry our programs.

Increased Costs of Delivering Health Care: +**$556,000** to fund inflationary costs. Anticipated cost increases to programs funded within the Facilities Appropriation are associated with transportation, materials, laborers, competitive markets for construction, etc. The increase will fund non-medical (2.1 percent) inflationary costs using the FY 2007 Economic Assumptions.

Population Growth: +$1,147,000 to fund a 1.6 percent growth expected for AI/AN population and maintain the current level of services.

Staffing/Operating Cost Requirements for New Facilities: +$3,852,000 and 38 FTE will allow IHS to expand provision of health care at new facilities. The funds will staff 4 new facilities which will open in FY 2006 and FY 2007. The following table displays the requested increase.

		FTE	
Facilities	Dollars	Federal	Tribal
Clinton, OK Health Center	$392,000	3	0
Red Mesa, AZ Health Center	$2,262,000	24	0
Sisseton, SD Health Center	$759,000	8	0
St. Paul, AK Health Center	$439,000	3	0
Total	$3,852,000	38	0

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT
ENVIRONMENTAL HEALTH SUPPORT

	FY 2005 Actual	FY 2006 Enacted	FY 2007 Budget	Increase or Decrease
BA	$56,329,000	$57,410,000	$60,369,000	$2,959,000
FTE	438	441	445	4

STATEMENT OF THE BUDGET REQUEST

The request of $60,369,000 will fund the costs of personnel who accomplish environmental health services, injury prevention activities, and sanitation facilities construction activities, at the IHS Area, district, and service unit levels and to pay operating costs associated with provision of those services and activities.

PROGRAM DESCRIPTION

The Area, district and service unit environmental health staffs include engineers, environmental health officers, environmental health technicians, engineering aides, injury prevention specialists, and institutional environmental health officers. AI/AN's face hazards in their environment that contribute to their health status, including: communities in remote/isolated locations that expose residents to severe climatic conditions, hazardous geography, and extreme isolation; increased exposure to disease carrying insects and rodents; limited availability of housing and extensive use of sub-standard housing; unsanitary methods of sewage and garbage disposal; and unsafe water supply. Environmental factors coupled with economic deprivation have historically contributed to AI/AN experiencing disease and injury rates greater than those experienced by all other racial groups in the country. Developing solutions to the many environmental concerns affecting AI/AN requires knowledge and expertise possessed by a variety of professional and technical environmental health and skilled health specialists.

PROGRAM EMPHASIS AREAS

The **Division of Environmental Health Services** (DEHS) is a consultative public health advisor to Tribes. DEHS staff lead in the assessment and identification of environmental hazards and risk factors facing Tribal groups and partner with Tribal groups in the development of sound public health strategies to prevent or mitigate environmental hazards. Strategies employed by DEHS staff include: maintaining surveillance of disease and injury incidence in communities; investigation of disease and injury incidents; monitoring known environmental hazards in community facilities and institutions such as food service establishments, Head Start Centers, community water

supply systems, and health care facilities; and providing training, technical assistance and project funding to develop the capacity of Tribal governments to address their environmental health issues. DEHS is administered through three program emphasis areas: General Environmental Health, Injury Prevention, and Institutional Environmental Health.

General Environmental Health staff are the lead environmental health professionals providing environmental health services to Tribes in issues including water quality, waste disposal, hazardous materials management, food sanitation, community injury prevention, institutional environmental health, vector control, occupational safety and health and other environmental health issues. General Environmental Health staff are assigned at the Tribal, service unit, district, and area levels.

Staff and Tribal partners have used the Web-based Environmental Health Reporting System (WebEHRS) to collect community and facility environmental health data. The WebEHRS data is used for surveillance of environmental factors, monitoring community environmental health conditions, and assessing community public health priorities. Data provided by WebEHRS is used by environmental health staff to monitor workload and prioritize environmental health conditions in communities with Tribal governments. Expansion of the capacity of WebEHRS to track activities, projects, and priorities for Tribal and federal environmental health programs is a GPRA measure for IHS.

Injury Prevention Program staff take the lead in developing public health strategies to reduce the burden of injury experienced by AI/AN. AI/AN die from injuries and poisonings at a rate 2.6 times the U.S. All Races rate. Treatment of injury costs an estimated $350,000,000 per year in direct and contract health care costs to IHS. The IHS Injury Prevention Program has developed effective strategies and initiatives to reduce the burden of injury experienced by AI/AN, including: surveillance of community-based injuries; development of targeted prevention programs based on surveillance data; developing community coalitions to address their injury issues; developing the capacity of community coalition members through injury prevention practitioners training; funding competitively awarded grants to develop Tribal injury prevention infrastructure; and evaluation program initiatives. In FY 2005, through the "IHS Tribal Injury Prevention Cooperative Agreement Program", IHS awarded $1.4M to 32 community-based Tribal projects to develop Tribal injury prevention infrastructure and do direct prevention work in communities. DEHS plans to continue this effective prevention program and seek additional funds to expand funding opportunities to other Tribes.

The **Institutional Environmental Health** (IEH) officers are specialized staff who work on the unique environmental hazards and high risk populations associated with institutional environments found in health care, educational, childcare, correctional, and industrial facilities.

The IEH officers perform evaluations of institutions serving AI/AN populations using epidemiological approaches to assess environmental conditions and make recommendations to prevent or minimize harm. The IEH program has specific initiatives

for infection control, industrial hygiene, radiation protection, safety management, ergonomics, and life safety. IEH officers also provide assistance to facility managers in compliance with environmental health and safety management legislation and executive orders. IEH officers are key advisors to IHS and Tribal health care facilities seeking accreditation and/or certification. Maintaining accreditation ensures that IHS continues to have access to third party funding.

In 2003, the Institutional Environmental Health Program began implementation of a web-based occupational health incident reporting system, WebCident, in IHS healthcare facilities. WebCident is used to report injuries, illnesses, and other incidents experienced by visitors, patients, and employees at the facility. WebCident is used to prepare required OSHA logs, and identify hazardous conditions, high-risk occupations and practices, and develop appropriate targeted prevention strategies at facilities. DEHS plans to support the expansion of WebCident to all IHS and Tribal health care facilities, refine the program from feedback provided by users, and use data produced by WebCident to develop initiatives to reduce identified hazards and reduce Workers' Compensation claims to IHS.

- **Sanitation Facilities Construction** -- In accordance with P.L. 86-121, Indian Sanitation Facilities Act, IHS manages and provides professional engineering and services to construct over 374 projects annually, at a total cost of over $130 million, to provide essential sanitation facilities for AI/ANs. This work is a significant component of the comprehensive environmental health services provided by Area, district and service unit environmental health personnel. These services include management of staff, pre-planning consultation with Tribes and Tribal groups, coordination with other federal, state and local governmental entities, identifying supplemental funding outside of IHS, developing local policies and guidelines with Tribal consultation, developing agreements with Tribes and others for each project, providing project design and construction, assuring environmental and historical preservation procedures are followed, assisting Tribes where the Tribes provide construction management, and assisting Tribes with operation and maintenance of constructed facilities. All of these activities are more difficult due to the remote locations, diverse climatic and geologic conditions, and cultural considerations of Tribal communities. The Sanitation Facilities Construction program assures that its staff is highly qualified for its mission by requiring professional licensure of District Engineer and higher-level positions. Recent data indicates that of the 248 Commissioned Corps officer engineers employed by IHS, 73 percent are licensed compared to 20 percent of all U.S. engineers. 45 percent also have advanced degrees.

  In accordance with the Indian Health Care Improvement Act (Title III, Section 302(g) 1 and 2 of P.L. 94-437) the IHS annually updates its inventory of sanitation facilities deficiencies for existing Indian homes. This is carried out with extensive consultation with Tribes. The IHS also develops and updates an inventory of all open dump sites on Indian lands as required under the Indian Lands Open Dump Cleanup Act (P.L. 103-399). Both of these inventories are widely used by other governmental agencies in their evaluation and funding of sanitation projects.

Consistent with the 1994 Congressional earmark for "… tribal training on the operation and maintenance of sanitation facilities, $1,000,000 of these support funds will be used to provide for continued operation and maintenance training.

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

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

TRIBAL HEALTH PROGRAMS

The IHS Area, district and service unit environmental health personnel also train Tribal employees to provide environmental health services, under contract with IHS wherever a Tribe desires, provided that funds are available and other considerations make such arrangement practicable. As a result of training provided by IHS, Tribal environmental health personnel are better prepared to provide higher levels of service to the Indian people and to support the provision of direct patient care services. For example, some Tribes have chosen to contract for the provision of the full range of environmental health services as typically provided by the IHS direct delivery program.

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

Area, district and service unit environmental health personnel work with Tribes/Tribal organizations to encourage maximum participation in planning health services delivery

programs. Also, they provide technical assistance to the Tribal officials who carry out administrative/management responsibilities associated with operation of federally supported programs. Their support of self-determination for Tribal organizations will continue. However, the extent to which there is participation in the self-determination process depends on, and is determined by, the individual Tribes/Tribal organizations.

PERFORMANCE ANALYSIS

The IHS Environmental Health Services Program supports performance measures under the following Department and IHS categories:

IHS GPRA measure – The Division of Environmental Health Services has three measures, two Injury Prevention measures and one general environmental health measure. The measures are routinely met and exceeded.

IHS Long Range PART Objectives - An IHS Long-term Performance goal is to Decrease AI/AN population Years of Potential Life Lost by 2010. Injury represents 41percent of AI/AN YPLL. The next single health category, heart disease, represents 8 percent of the AI/AN YPLL. The IHS Injury Prevention Program initiatives, including the Tribal Injury Prevention Cooperative Agreement Program, are directly targeted at meeting this objective.

"One HHS": 10 Department-wide Management Objectives, Objective 10. DEHS has completed an extensive evaluation of the Area Injury Prevention Programs and presented the results to IHS management in FY 05. An External Evaluation of the Injury Prevention Training Program was conducted in 2002 with recommendations and findings implemented in 2003-2005. An external evaluation of the Institutional Environmental Health Training program was conducted in 2004, implementation of recommendations was started in 2005.

Secretary Leavitt's 500 Day Plan - Under "Transformation of Health Care System" and the vision of "Inequalities in health care are eliminated" with the Strategy of "Supporting community-based approaches to close the health care gap, particularly among racial and ethnic minority populations, including American Indians and Alaska Natives". The IHS Injury Prevention Program is committed to building community-based approaches to injury prevention through an extensive community practitioners' training program and $1.42M per year in Tribal capacity building cooperative agreement funding. This strategy continues to show results.

IHS Strategic Plan - The vision of the Environmental Health Services Program is, "Every American Indian and Alaska Native will live in a safe, healthy community". This is similar to the IHS Strategic Plan goal number 1, "Build Healthy Communities".

Healthy People 2010 (HP 2010) - Injury and Violence Prevention are grouped as one of the 10 leading health measures. Thirty-one objectives within HP 2010 relate to injury or unintentional injury prevention. There are two injury prevention GPRA measures which

relate to comprehensive community-based injury prevention efforts across IHS and Tribal settings. These have been met each year that data were available. In FY 2005, one of the injury measures changed to focus on development of a web-based data collection system to report injury prevention projects.

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

The IHS Sanitation facilities program has two GPRA measures related to its construction activities participated in the Program Assessment Rating Tool (PART) during the 2005 budget cycle. Details of the results and the PART can be found in the section on the Sanitation Facilities Construction line item.

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $60,369,000 and 445 FTE is an increase of $2,959,000 over the FY 2006 Appropriation of $57,410,000.

The increases will provide for:

Pay Costs: +**$1,288,000** to fund pay cost increases for Federal and Tribal programs. This activity represents the personnel that perform the facilities and environmental program, funding for pay cost is critical to maintain an appropriate level of funding to carry our programs.

Increased Costs of Delivering Health Care: +$233,000 to fund inflation costs. Anticipated cost increases to programs funded within the Facilities Appropriation are associated with transportation, materials, laborers, competitive markets for construction, etc. The increase will fund non-medical (2.1 percent) inflationary costs using the FY 2007 Economic Assumptions.

Population Growth: +$1,000,000 to fund a projected 1.6 percent growth expected of the AI/AN population.

Staffing/Operating Cost Requirements for New Facilities: +$439,000 and 4 FTE will allow IHS to expand provision of health care in those areas where existing capacity is most overextended. The funds will staff 2 new facilities which will open in FY 2006 and FY 2007. The following table displays the requested increase.

		FTE	
Facilities	Amount	Federal	Tribal
Clinton, OK Health Center	$329,000	3	0
Red Mesa, AZ Health Center	110,000	1	0
Total	$439,000	4	0

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT
OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING SUPPORT

	FY 2005 Actual	FY 2006 Enacted	FY 2007 Budget	Increase or Decrease
BA	$11,497,000	$13,314,000	$13,921,000	$607,000
FTE	78	78	78	0

STATEMENT OF THE BUDGET REQUEST

The request of $13,921,000 will fund the Office of Environmental Health and Engineering Support which provides personnel, contracts, contractors, and operating costs for the Office of Environmental Health and Engineering (OEHE) Headquarters.

PROGRAM DESCRIPTION

Headquarters personnel have management responsibility for IHS facilities and environmental health programs, provide direct technical services and support to Area personnel, and perform critical management functions. Headquarters management activities includes national policy development and implementation, budget formulation, project review and approval, congressional report preparation, quality assurance (internal control reviews, Federal Managers Financial Integrity Act activities and other oversight), technical assistance (consultation and training), long range planning, meetings (with the Department of Health and Human Services, Members of Congress and their representatives, Tribes, and other Federal agencies), and recruitment and retention. Typical direct support functions performed by OEHE personnel who serve as project officers for health care facilities construction projects are: review and/or write technical justification documents, participate in design reviews and site surveys, conduct onsite inspections, and monitor project funding status, etc.

The OEHE Headquarters funded positions are in Rockville, Dallas, and Seattle. Headquarters personnel include engineers, environmental health officers, health facilities planners, realty management officers, and support personnel. In addition, Engineering Services staff located in Dallas and Seattle provide architectural, engineering, construction services, contracting services, and real property services. They provide direct services and support to other Headquarters Divisions and Area personnel in preparing project justifications, construction cost estimates and project designs, contracting for design and construction of new health care facilities and existing facility

improvements, conducting construction inspections and facility inspections, leasing space for IHS program operations, and providing management support.

In addition, these positions support new real property asset management requirements as required by Executive Order 13327, Real Property Asset Management; the President's Real Property Management Agenda Initiative; and HHS Program Management objectives. These actions are to ensure management accountability, to ensuring the efficient and economic use, recognizing the importance of the assets, and responding to the current condition of Federal real property.

PERFORMANCE ANALYSIS

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

RATIONALE FOR BUDGET REQUEST

The FY 2007 budget request of $13,314,000 and 78 FTE is an increase of $607,000 over the FY 2006 Appropriation of $13,921,000.

The increases will provide for:

Pay Costs: +$326,000 to fund pay cost increases for Federal and Tribal programs. This activity represents the personnel that perform the facilities and environmental program, funding for pay cost is critical to maintain an appropriate level of funding to carry our programs.

Increased Costs of Delivering Health Care: +$39,000 to fund inflationary costs. Anticipated cost increases to programs funded within the Facilities Appropriation are associated with transportation, materials, laborers, competitive markets for construction, etc. The increase will fund non-medical (2.1 percent) inflationary costs using the FY 2007 Economic Assumptions.

Population Growth: +$242,000 to fund a 1.6 percent growth expected of the increasing AI/AN population.

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

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

	FY 2005 Actual	**FY 2006 Enacted**	**FY 2007 Request**	Increase or Decrease
BA	$17,337,000	$20,947,000	$21,619,000	+$672,000
FTE				

STATEMENT OF THE BUDGET REQUEST

The Equipment budget request of $21,619,000 supports maintenance and replacement of biomedical equipment at IHS and Tribal health care facilities.

PROGRAM DESCRIPTION

The IHS and Tribal health programs manage laboratory, x-ray, and biomedical equipment valued at approximately $320 million. Accurate clinical diagnosis and effective therapeutic procedures depend in large part on health care providers using modern and effective medical equipment to assure the best possible health outcomes. The average life expectancy for today's medical device is approximately 6 years depending on the intensity of use, maintenance, and technical advances. Allocation of medical equipment funds is formula based.

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

PERFORMANCE ANALYSIS

In 2005, the medical equipment program distributed approximately $11 million to IHS and Tribal health programs to purchase new medical equipment, including replacement of existing equipment used in diagnosing and treatment of illnesses.

In FY 2005 Congress provided $5 million for equipment to Tribes or Tribal organizations that seek construction funding outside of full funding through IHS. In FY 2005, 31 awards were made to 22 Tribal organizations that funded and constructed clinics or clinic additions. Tribes plan on spending in excess of $85 million in construction projects using non-IHS funding sources to access these equipment funds. As a result, approximately 192,000 individual patients will be treated with updated medical equipment in these Tribally-funded construction projects.

Tribes funded for equipment in FY 2005 are as follows:

Cherokee Nation of Oklahoma	Klamath Tribes	Rocky Boy Health Board (2)
Chickasaw Nation (2)	Las Vegas Paiute	Santo Domingo Tribe
Choctaw Nation of Oklahoma (2)	Little Traverse	SEARHC
Gila River Indian Comm	Makah Tribal Council	Seldovia Village Tribe
Iowa Tribe of Oklahoma	Maniilaq Association (2)	St. Regis Mohawk Tribe
Jena Band of Choctaws	Muscogee (Creek) Nation (2)	Yukon Kuskokwim Hlth Corp. (2)
Kalispel Tribe	Norton Sound Health Corp. (4)	
Kodiak Area Native Assoc.	Reno Sparks Indian Colony	

*Some larger programs with multiple facilities applied for and were awarded more than one award due to multiple construction projects.

The remaining $1,219,000 in FY 2005 was used to purchase new and like new equipment from DOD through the TRANSAM program and to purchase ambulances for Tribal emergency medical services programs.

Support the health care programs and patient care by providing replacement medical equipment.	Continued 100 percent accreditation of hospitals and clinics across the Agency.	These funds support replacement medical equipment which affects meeting the environment of care standards for accreditation. By replacing older, outdated equipment with more modern equipment patient care and safety is maintained at the highest possible level ensuring accreditation.

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $21,619,000 is an increase of $672,000 over the FY 2006 Enacted budget of $21,619,000. The increase will provide:

Increased Costs of Delivering Health Care: +$672,000 to fund inflationary cost increases. Anticipated cost increases to equipment funded within the Facilities Appropriation are associated with transportation, materials, laborers, competitive markets for construction, etc. The increase will fund non-medical (2.1 percent) inflationary costs using the FY 2007 Economic Assumptions.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities – 75-0391-0-1-551
PERSONNEL QUARTERS / QUARTERS RETURN FUNDS

Authorizing Legislation: Program authorized by Public Law 98-473.

	FY 2005 Actual	**FY 2006 Enacted**	**FY 2007 Request**	Increase or Decrease
BA	$6,225,000	$6,288,000	$6,288,000	$0
FTE				

STATEMENT OF THE BUDGET REQUEST

The Quarters Return funds will support the operation, management, and general maintenance of personnel quarters at IHS health care facilities.

PROGRAM DESCRIPTION

Staff quarters' operation, maintenance, and improvement costs are funded with Quarters Return (QR) funds. An estimated $6,200,000 in QR funds will be collected from tenants of quarters during FY 2005. These funds will be used for the operation, management, and general maintenance of quarters, including temporary maintenance personnel services, security guard services, repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (stoves, water heaters, furnaces, etc.). In certain situations, M&I funds may be used, in conjunction with QR funds, to ensure adequate quarters maintenance; e.g., locations with few quarters where QR funds are not enough to pay for all required maintenance costs. These funds are distributed and used at the locality in which they are collected.

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $6,288,000 is the same as the FY 2006 Enacted budget of $6,288,000.