HOSPITALS AND HEALTH CLINICS

Indian Health Service Clinical Services	FY 1999 Enacted	FY 2000 Final Appropriation	FY 2001 Estimate	Increase or Decrease
Hospitals & Health Clinics				
A. Budget Authority	$947,198,000	$1,005,412,000	$1,084,190,000	+$78,778,000
B. (HIV/AIDS)	($2,366,000)	($2,462,000)	($2,575,000)	($0)
C. FTE	8,067	8,109	8,187	78
D. (HIV/AIDS)	(14)	(14)	(14)	(0)
E. Activity:				
Inpatient:				
# of Days	275,000	274,700	273,000	-1,700
Outpatient:				
# of Visits:				
Hospitals	3,650,000	3,750,000	3,832,500	+82,500
Free-Standing Clinics Visits	3,650,000	3,840,000	3,924,500	+84,500
Total, Visits	7,275,000	7,590,000	7,757,000	+$167,000

PURPOSE AND METHOD OF OPERATION

Mission Driven Program

The Hospitals and Health Clinics budget provides funding for health care essential to American Indians and Alaska Natives (AI/AN) and critical to the IHS mission. The mission of the agency is to elevate the health status of its service population to the highest possible level and eliminate disparities in health between AI/ANs and the general U.S. population. This element of the budget supports a full range of clinical, preventive, and rehabilitative services and is pivotal to realizing improved health for AI/ANs.

Scope of Services in Isolated Communities is Comprehensive

The Hospitals and Health Clinics budget supports essential services including inpatient care, routine and emergency ambulatory care, and support services including laboratory, pharmacy, nutrition, health education, medical records, physical therapy, nursing, etc. These services are generally unavailable from any other sources in the communities served through IHS. In addition, the program includes initiatives targeting special health conditions that affect AI/ANs such as specialized programs for diabetes, maternal and child health, youth services, communicable diseases, including AIDS, tuberculosis, and others, and a continuing emphasis on women's and elder health and epidemiology.

Other clinical services, e.g., dentistry and community services along with a number of health programs operated by the tribes, such as women, infants,

and children's programs, and behavioral health services, are often housed in the same facilities. This co-location of services in the hospital and clinic increases access and fosters a truly comprehensive community-oriented program.

Achieve Quality and Customer Satisfaction

The Hospitals and Health Clinics budget provides annual operating expenses for over 500 health care facilities providing inpatient care, routine and emergency ambulatory care and support services. The commitment of the IHS and tribal staff to the delivery of the highest quality of care possible is reflected in the continuing success in achieving and maintaining IHS and tribal-operated facility accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). The JCAHO and the Health Care Financing Administration (HCFA) regularly and periodically conduct in-depth reviews of the quality of care provided. They also review the status and safety of the facilities, adequacy and competency of staffing, and management of the service delivery components of the IHS.

These reviews are based upon the concept of continuous quality improvement in clinical programs. The IHS and the tribes fully embrace this concept and services are provided using the industry benchmarks for customer satisfaction. The average IHS and tribal hospital accreditation grid score has consistently been at or above the average score for all U.S. hospitals.

Performance Measures Demonstrate Effectiveness

This review process requires that the staffs of the health facility establish performance indicators and demonstrate routine monitoring, analysis, and intervention where the desired outcome is not achieved. The facility is granted accreditation based on the appropriateness of objectives established and met. The types of outcome measures monitored by the clinical facilities include the effectiveness of clinical programs, such as obstetrics and childcare.

The appropriateness of the services is measured a variety of ways: live births successfully managed; the Apgar scores of the infants (an objective measure of the infant's health at the end of labor and delivery); morbidity measures in the mother, such as preventable vaginal lacerations, etc.; and the hospital course of the mother and child as measured by morbidity and treatments utilized during the hospital stay. These measurements have demonstrated that the IHS operates a high quality program of services in its facilities. This is documented in the consistently high scores achieved by the IHS and tribal facilities undergoing JCAHO review. In fact when compared to HMO performance in the broader population, the IHS-funded programs are at the very top in most measures.

Other outcome measures are utilized to assess the effectiveness of the outreach and prevention programs associated with the clinical services of the Agency, within are not normally measured by private industry. For example, demonstration that the outreach activities are effective and the clinical services are accessible found in the very low rate of out-of-hospital births among pregnant women served by the IHS despite the fact that the population in many locations is highly dispersed in remote

locations. There are many other outcome measures associated with maternal and child health, such as, the number of low birth weight deliveries which is very low in the IHS service population. Also, the immunization status of children in the service population in which the IHS service population is the only identified ethnic population with an immunization rate at or near the Healthy People 2000 target of 90 percent, the decline in deaths due to unintentional injury among children, etc. Many of these indicators are documented annually by the Agency publications, Trends in Indian Health, and the Regional Differences in Indian Health.

Training Crucial

This commitment requires regular and specialized training. Thus, the Hospitals and Health Clinics budget activity supports continuing medical education for a wide variety of the health professionals employed by the IHS and tribes. This includes specialized training in quality assurance and case management as well as discipline-specific training. The FY 1998 budget provided some advanced and specialized training for nurses in intensive care unit and operating room skills, nursing management, and the upgrading of Indian individuals from licensed practical nursing to registered nursing. The budget enabled IHS to support quality assurance training through JCAHO; residency training for IHS physicians; and continuing education of mid-level providers including physician assistants and nurse and pharmacy practitioners.

Managed Care at Work

The cost effectiveness of the Hospitals and Health Clinics activities is enhanced through an organized process of managed care. This approach to care is predicated on strategies of cost recovery and cost avoidance to provide the highest volume of services within a fixed budget. The success of this approach demonstrated by the increasing volume of third party recovery by IHS and tribal facilities (cost recovery).

Community Oriented Primary Care Attacks Changing Disease

The IHS program continues to focus on increasing access to preventive and curative services for the underserved in Indian communities. This is ordinarily dealt with by utilizing the concept of incrementally meeting the needs for clinical, preventive, and restorative care. In recent years the diseases manifest among AI/AN have changed such that there is less disease burden in the population from acute illness and more from chronic diseases with significant behavioral determinants.

Of particular concern are disease patterns that reflect disruptions in family and community strengths. This includes accidents, suicides, homicides, family violence and chemical dependency. Prevention of these chronic diseases requires a different set of precepts and disciplines since they are less susceptible to interventions of the traditional medical model.

New developments include community-based wellness centers, school and community based-adolescent clinics and community-based health screening services. In one case, published data suggests that the use of the

community wellness center reduces the dependence on medication and that participants require fewer medical visits than those who do not have access to wellness centers.

This emphasis on community oriented primary care is particularly well suited to the unique health needs of AI/AN people. The impressive accomplishments of the IHS have resulted from the broad community approach employing Public Health Nurses (PHNs), alcoholism workers, mental health workers, sanitarians, etc. These skills more directly address the effects of higher unemployment, lower socioeconomic status, and the complications of poor nutrition, sanitation, and housing found in many AI/AN communities.

Maintaining progress made

The overall strategy has paid dividends in the types of health and performance measures described above.

For example, although the number of pediatric visits has steadily increased, the number of well child visits has declined by 25 percent since 1993. This is critical since many of the prevention services that are essential in early life are not being provided. This includes not only immunizations, but nutritional counseling, parenting education and support and other preventive services that directly address diabetes, chemical abuse, and the issues of childhood and juvenile injuries and suicides. Similar declines in prevention services are documented in adult well care, well woman care (including cancer screening), and oral health. In addition, needed specialty medical services are being postponed or eliminated as demonstrated by the dramatic increase in deferred and disallowed contract health services for secondary and tertiary services.

These changes are unacceptable to the patients, the communities, and the professional staff. Therefore, the IHS budget request directly reflects the commitment to redressing these declines as a first priority.

ACCOMPLISHMENTS

Health Services

The accomplishment of the Hospitals and Clinics budget can be described in terms of both health services and health outcomes. In the area of health services, accomplishments can generally be characterized in terms of the provision of millions of basic primary care inpatient and outpatient medical services to more than 1.3 million AI/AN active users. An active user is an AI/AN who has received a medical service in an IHS or tribal facility during the last 3 years. Primary care is defined by the Institute of Medicine as the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large portion of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The provision of these services is critical to the prevention and amelioration of disease. It also engages patients in controlling their own health.

In the most recent year in which full year data are available, the IHS and tribal general hospitals admitted about 68,000 patients while an additional

21,000 patients were admitted to private hospitals under contract. There has been a gradual decline in admissions that is consistent with the declining inpatient admission rates experienced generally in the U.S. over the last decade in favor of other treatment modalities. It also reflects the IHS commitment to cost containment through expanded use of proven outpatient care disease management protocols rather than more costly hospitalizations.

The IHS and tribal hospital outpatient department and health clinics provided over 6 million outpatient services, a growth of 35 percent since 1990. The outpatient services were provided by a broad range of providers and illustrate efficient and effective mix of manpower. The hospitals and clinics budget also funds other types of patient and community services including health education, nutrition, and an array of health promotion and disease prevention programs that complement inpatient and outpatient services.

Performance Measures

The following performance indicators are included in the IHS FY 2001 Annual Performance Plan and are primarily dependent upon the activities funded within this budget line item for achievement. These indicators are sentinel indicators representative of some of the more significant health problems affecting AI/AN.

Indicator 1: To support planning for the treatment and prevention of diabetes during FY 2001, maintain Area age-specific diabetes prevalence rates and identify trends in the age-specific prevalence of diabetes (as a surrogate marker for diabetes incidence) for the AI/AN population.

Indicator 2: Reduce diabetic complications by demonstrating a continued trend in improved glycemic control in the proportion of I/T/U clients with diagnosed diabetes in FY 2001.

Indicator 3: Reduce diabetic complications by demonstrating a continued trend in improved blood pressure control in the proportion of I/T/U clients with diagnosed diabetes and hypertension who have achieved blood pressure control standards in FY 2001.

Indicator 4: Reduce diabetic complications by demonstrating a continued trend of improvement in assessing the proportion of I/T/U clients with diagnosed diabetes for dyslipidemia (i. e., cholesterol and triglyceride) in FY 2001.

Indicator 5: Reduce diabetic complications by demonstrating a continued trend of improvement in the proportion of I/T/U clients with diagnosed diabetes who have been assessed for nephropathy in FY 2001.

Indicator 6: Reduce cervical cancer mortality and morbidity by increasing the proportion of women in FY 2001 who have had a Pap screen in the previous year by 3 percent over the FY 2000 level.

Indicator 7: Reduce breast cancer mortality and morbidity by increasing the number of the AI/AN female population 40-69 years of age during FY 2001 who

have had screening mammography in the previous two years by 3 percent over the FY 2000 levels.

Indicator 8: Improve child and family health by increasing the proportion of AI/AN children served by IHS receiving a minimum of four well child visits by 27 months of age during FY 2001 by 3 percent over the FY 2000 level.

Indicator 10: Reduce the incidence of Fetal Alcohol Syndrome by increasing the proportion of I/T/U prenatal clinics utilizing a recognized screening and case management protocol(s) for pregnant substance abusing women by 10 percent over the FY 2000 level.

Indicator 17: To assure high quality health care, maintain 100 percent accreditation of all IHS hospitals and outpatient clinics during FY 2001.

Indicator 18: By the end of FY 2001, improve IHS-wide consumer satisfaction by 5 percent over the FY 2000 baseline level.

Indicator 20: Reduce the incidence of preventable diseases by increasing the proportion of AI/AN children who have completed all recommended immunizations for ages 0-27 months (as recommended by Advisory Committee on Immunization Practices) during FY 2001 by 2 percent over the FY 2000 rate.

Indicator 21: Reduce the incidence of preventable diseases, by increasing pneumococcal and influenza vaccination levels among adult diabetics and adults aged 65 years and older by 2 percent over the FY 2000 rates.

Indicator 22: Reduce injury-related hospitalizations for AI/AN people to no more than 70 per 10,000 people for FY 2001.

Indicator 25: Reduce childhood obesity rates by maintaining ongoing body mass index (BMI) assessments in AI/AN children 3-5 years old and/or 8-10 years old, for both intervention pilot sites and non-intervention comparison sites, as part of an overall assessment of the ongoing childhood obesity prevention project's **e**ffectiveness.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE
1996	$854,478,000	8,078
1997	$891,824,000	7,991
1998	$906,801,000	8,020
1999	$949,140,000	8,067
2000	$1,005,412,000	8,109

RATIONALE FOR BUDGET REQUEST

Total Request -- The request of $1,084,190,000 and 8,187 FTE is an increase of $78,778,000 and 78 FTE over the FY 2000 Appropriation of $1,005,412,000 and 8,109 FTE. The increase includes the following:

Current Services – Built-in Increases: +$40,085,000

The request of $40,085,000 is for current personnel related costs. These requests will partially fund the built-in increases associated with on-going operations. Included are funds for mandated increases such as pay raises, within grade increases and increasing benefits costs (e.g. Health Insurance). These funds will be shared with Title I and Title III tribes, as well as Federal programs.

It is extremely critical that the IHS maintain the FY 2000 level of service to prevent any further decline in primary health services. The IHS patient population continues to receive less access to health care than the general U.S. population. Maintaining the current I/T/U health system is necessary in eliminating disparities in health status between AI/ANs and the rest of the U.S. population.

Phasing-In of Staff for New Facilities: +$6,714,000 and +30 FTE

The request of $6,714,000 and 30 FTE provides for the phasing-in of staff and related costs for new facilities. The staffing of new facilities also contributes to the recruitment and retention of medical staff and promotes self-determination activities. The following table displays the requested increase.

Facilities:	**Dollars**	**FTE**	
Talihina, OK Hospital	$3,959,000	60	1/
Hopi,AZ Health Center	2,755,000	30	
Total	$6,714,000	30	

1/ Non-add – Tribally operated program.

Indian Health Care Improvement Fund: +$8,000,000

In FY 1999 the IHS developed a new model to estimate the full costs associated with providing health care for Indian people. The model uses an actuarial cost calculation to estimate the per capita cost to provide Indian people a health benefits package that is comparable to a mainstream employer sponsored benefits plan. In addition the model also estimates the costs of those public health services not provided by a typical employer sponsored benefits plan. This request will be used to begin to address those disparities that exist among tribes in the current distribution of the IHS budget.

Information Technology and Epi Centers - +7,000,000

See Tab.

Health Disparities - +$16,979,000 and 48 FTE

Diabetes: +$3,880,000

Diabetes was the most frequently identified health problem in the IHS Area I/T/U budget formulation workshops for FY 2001. Type 2 diabetes occurs at dramatically higher rates among AI/AN adults who are almost 3 times more likely to have diabetes than the general U.S. population. A recent alarming trend is the increase in prevalence of type 2 diabetes in young AI/AN's. Over a seven years period from 1991-1997, the prevalence of diabetes rose about 33% in children and adolescent AI/AN. Complications of diabetes lead too much higher incidence rates of blindness, vascular insufficiency leading to amputation, and End Stage Renal Disease (ESRD) than in the general U.S. population. Most recent data show that diabetes mortality is 4.3 times higher in the AI/AN population than in the U.S. population. There has been a 24 percent increase in the American Indian age-adjusted death rate since 1991-1993.

The Balanced Budget Act of 1997 created a $30 million grant program for the prevention and treatment of diabetes in AI/ANs. More than 300 new and innovative programs have been implemented as a result of these grant funds. Additional diabetes program funds would be used to implement successful "lessons learned" from these new programs in other Indian communities.

Although IHS has had an active clinical diabetes program for 20 years, the incidence of various complications has continued to increase. While progress has been made in reducing the rate of increase of blindness and amputations, these complications continue to occur at unacceptably high levels, and ESRD is escalating at a rapid rate. Increased primary prevention and expanded secondary prevention efforts are needed in addition to the existing clinic-based programs. Based on preliminary information from international and domestic literature reports, there are promising community-based primary and well documented secondary prevention efforts that have been inadequately utilized and evaluated in the U.S. and among AI/AN populations.

Currently I/T/U programs provide secondary and limited tertiary inpatient and outpatient treatment services to Indian beneficiaries with diabetes. In addition, some programs offer limited primary prevention services to those who are at high risk for acquiring diabetes. The IHS diabetes care services are consistent with services recommended by the American Diabetes Association and follow what is classified as current "best practices".

Ultimately, the anticipated outcome of this funding is a reduction in the mortality and morbidity of diabetes. In the short term, additional resources would be used to expand access to both ambulatory and inpatient diabetes services through a multidisciplinary approach. Ultimate use of the funds will be in accordance with local priorities, consistent with those developed during the budget formulation process.

Activities may include increased access to retinopathy, dialysis, nutrition, weight-loss, and foot-care programs. Promotion of the implementation of diabetes practice guidelines in I/T/U settings would be a major emphasis.

Funds may also be used to enhance data collection and tracking of diabetic patients as well as to continue "Diabetes Data" surveillance projects. Critical support for the RPMS/PCC to automate clinical feedback and data collection on diabetes will also be a top priority.

In addition, the funds may be used to provide training specific to diabetes prevention, expand the I/T drug formularies to include appropriate new diabetes drugs, increase diabetes teaching curricula and materials, ensure the availability of essential equipment such as HgA1C machines for tribes without the capability of on-site testing or other monitoring activities.

Recommended funding increases will support expanded prevention and treatment activities aimed at reducing complications of diabetes, reducing the prevalence of the disease, and increasing the educational and life-style tools, such as nutrition and physical fitness. Significant funding amounts are expected to support health promotion and disease prevention (HP/DP) community-based activities.

Cancer: +$970,000

Cancer was one of the top 10 most frequently identified health problems at the IHS I/T/U budget formulation workshops in FY 2001. Lung, breast, cervical, and other cancers are the leading causes of cancer mortality among AI/AN. We predict that lung cancer deaths among the heavily smoking tribes will rise too much higher levels within the next two decades. Five-year survival rates among American Indians and Alaska Natives with cancer are the poorest of all ethnic groups, due primarily to problems with late diagnosis and access to care.

The I/T/U health care system is heavily impacted by the treatment requirements associated with cancer. For example, in Aberdeen Area, malignant neoplasm's are the 14th leading cause for direct inpatient admissions, the 11th leading cause for contract health inpatient admissions, 19th leading cause for direct outpatient visits, and the 10th leading cause for contract health outpatient referrals. Neoplasm's rank as the 19th leading cause for CHS inpatient referrals for tribal programs.

The AI/AN cancer mortality rates have been increasing, while national rates are on the decline. Of special concern are the high rates of cervical, lung, and gastric cancer, and rising rates of breast and colorectal cancer. Fourteen Tribes now receive grants from the Centers for Disease Control and Prevention (CDC) for breast and cervical cancer screening, and others receive screening services from States through their CDC grants, but there are still many Tribes that do not have access to screening and treatment services.

This incremental request would provide comprehensive screening for early detection and treatment of disease, including breast, cervical and uterine cancers. Early identification, screening, and treatment compliance will be major priorities.

Ultimately, the anticipated outcome of additional funding is a reduction in the mortality rates for cancer. In the short term, expansion of

ambulatory, inpatient, diagnostic services and improving care and screening by a coordinated system to provide logistic support for referrals, track individual patients, and educate providers are the anticipated outcomes.

Elder Health: +$1,940,000

Elder care was identified by 8 of the 12 IHS Areas and the Urban Health Programs as a top health problem during the FY 2001 budget process. There is a demonstrated need to improve health care for approximately 100,000 elder American Indians and Alaska Natives population. The substantial growth of this population within the last decade has increased the need for more geriatric health services. The treatment and medication management unique to the elder patient population requires the development of specialized geriatric capacity within the I/T/U health care system. Increased health promotion and disease prevention initiatives are greatly needed for the care of American Indian/Alaska Native elders for they are the repositories of our cultural knowledge and wisdom to strengthen our families and communities.

Elder care accounts for 21 percent of ambulatory visits and 36 percent of hospital inpatient days. The growing number of the elder population thereby increases the need for inpatient and outpatient clinical services. The recommended funding would be used to increase access to basic primary and secondary tertiary care for the elderly and support training on the special health care needs of AI/AN elders.

Heart Disease: +$1,455,000

Heart Disease was identified by 8 of the 12 IHS Areas and the Urban Health Program as a top health problem in the FY 2001 budget process. Heart disease is the leading cause of mortality overall for American Indians and Alaska Natives. Despite the significant decline of over 50 percent in cardiovascular disease in the general US population since 1968, cardiovascular disease incidence appears to be significantly increasing in the American Indian/Alaska Native population. The recently published STRONG Heart Study data has revealed an incidence in the AI/AN population tested at almost two times the incidence in the general US population. In fact, between 1994 and 1996, about 22 percent of all deaths in the IHS service area were caused by diseases of the heart. In 1995, diseases of the heart caused about 32 percent of all deaths in the United States. The age-adjusted diseases of the heart death rate for the IHS service area population were 156.0. This is the rate adjusted for miscoding of Indian race on death certificates. The Indian rate is about 13 percent higher than the U.S. All Races rate of 138.3 in 1995. For ages 45 and older, the leading cause of death is diseases of the heart.

The I/T/U programs provide basic primary care and very few specialists are available. IHS nationwide currently employs only six cardiologists. Facilities for cardiac catheterization and surgery, or advanced diagnostic capability are not available within the IHS system. Consequently, the vast majority of advanced heart disease must be referred to specialists outside the IHS system, at considerable expense and, importantly, often without coordinated secondary and tertiary cardiology prevention activities for

these individuals. Most IHS beneficiaries live in rural areas, which makes access to specialty treatment difficult and adds to costs.

Currently the programs in all IHS Areas provide screening and basic treatment services for cardiovascular disease such as blood pressure monitoring, cholesterol screening, nutritional counseling for weight control, and medications for high blood pressure and cholesterol counts.

Ultimately, the anticipated outcome of additional funding is a reduction in the mortality rates for cardiovascular and cerebrovascular disease. In the short term, improved screening by the further development of a coordinated system to provide logistic support for referrals, track individual patients, and educate providers are the anticipated outcomes. New non-invasive and invasive cardiology services (at IHS as well as collaborating private/academic facilities) and medication costs will be supported.

Maternal and Child Health: +$2,912,000

Maternal and Child Health (MCH) was identified as a top health concern by 5 Areas in FY 2001 budget process. MCH services generate a large portion of the ambulatory workload in both our Federal and tribal facilities. The leading causes of direct and contract hospitalization for ages 15-44 is obstetrical deliveries and complications from pregnancy. In 1994-1996, the birth rate in the IHS service area was 24.1 per 1,000 versus 14.8 per 1,000 for U.S. All Races. Respiratory diseases are the leading cause of hospitalization for children ages 5 to 14.

In the IHS service areas, 4.5 percent AI/AN of all mothers drank alcohol during pregnancy versus 1.5 percent of U.S. mothers 20.4 percent smoked during pregnancy versus 13.9 percent of U.S. mothers. In the IHS service areas, 45.4 AI/AN births per 1,000 are to diabetic mothers versus 25.2 births per 1,000 in the U.S. all races. The overall AI/AN infant mortality rate continues to be higher than in the general population (9.3 per 1,000 versus 7.6 per 1,000). Postneonatal mortality rates in IHS service areas are 4.8 per 1,000 versus 2.7 per 1,000 for U.S. all races.

Currently the I/T/U programs provide services related to women’s health, infant, well child, adolescent, and other pediatric services, such as immunizations, prenatal care, nutrition services, etc. MCH services are needed to maintain and enhance opportunities for AI/AN children and youth to live healthier and happier lives. Indian youth have at a greater risk for serious mental health and substance abuse problems, suicide, increased gang activity, teen pregnancy, abuse and neglect, and developing chronic conditions due to physical inactivity, poor nutrition, and obesity than other youth in America.

To assure future good health and well being of Native American families and communities, a commitment to maternal and child health will involve the expansion of primary care services in the prevention, screening and treatment of childhood illnesses and those chronic diseases, which have their origins in the behaviors of children and mothers.

Domestic and Community Violence/Abuse: +$1,940,000

Domestic and Community Violence/Abuse was identified by 4 of the Areas and the Urban Indian Health Program as a top health problem during the FY 2001 budget process. Violence against women has been determined to be a major national health crisis by the American Medical Association, the Office for Victims of Crime, the Department of Justice, and the Centers for Disease Control and Prevention. The incidence and prevalence rates for child maltreatment and family violence have been difficult to determine for Indian Country, but according to a survey conducted by the National Indian Justice Center (1994), both IHS and BIA estimated that 34.4 percent of Indian children were at-risk of becoming victims of child abuse/neglect.

Consistent with the IHS Director's Initiative on Domestic Violence and Child Abuse, the IHS will continue to collaborate with other federal and national agencies to institute and expand intervention and prevention programs to address the prevalence of violence in AI/AN communities. In collaboration with the Family Violence Prevention Fund's 10 statewide training efforts, at least 20-30 IHS teams from hospitals and clinics have been trained on Improving the Health Care Response to Domestic Violence.

Every year, domestic violence results in almost 100,000 days of hospitalization, almost 30,000 ER visits, and almost 40,000 visits to a physician. Annual health care costs for treatment of injuries due to domestic violence are estimated to be between $5 billion and $10 billion. About 30-50 percent of all calls for law enforcement response and emergency room visits is related to domestic violence.

The increased in funding will establish baseline for need of community awareness activities aimed at domestic violence and decrease incidence and prevalence of domestic/community violence. Training will be expanded for all health care providers to improve the surveillance, reporting, intervention and treatment of victims of domestic and community violence and abuse.

Infectious Disease: +$970,000

Infectious Diseases, including Tuberculosis (TB), HIV, Sexually Transmitted Diseases (STD) and Hepatitis, were identified by four Areas and the Urban Indian Health Programs as a top health problem during the FY 2001 budget process. In addition, the Annual Performance Plan includes three performance indicators on preventing and monitoring infectious diseases, including childhood and adult immunizations (indicators 20 and 21), and HIV/AIDS (indicator 25).

Newly emerging infectious diseases, such as Hantavirus Pulmonary Syndrome and antimicrobial-resistant bacteria, disproportionately affect American Indians and Alaska Natives. In the past few months an alarming increase in antimicrobial resistant infections has been identified in multiple IHS Areas. Particularly worrisome, many of the patients involved have acquired infections in the community instead of in hospitals or nursing homes, the typical locations where these diseases are acquired. Clearly this is a problem which must be addressed rapidly and efficiently before we find

ourselves unwittingly returned to the pre-antibiotic era where an infected scratch could lead to death.

Previous successes in the elimination of TB may be in danger of being lost. Mortality due to TB among AI/ANs remains almost 200 percent higher than non-Indians. While most of the country has experienced declines in TB, the incidence of tuberculosis in Indians has risen in the past few years, primarily in tandem with the epidemic of diabetes. Patients with diabetes are much more likely to develop active TB which sustains the continuing cycle of TB transmission from generation to generation. Given the ever-increasing numbers of patients with diabetes, TB could re-emerge as a serious public health threat if left unchecked.

A comparison of the 1992-1994 Indian (IHS service area) age-adjusted death rates with U.S. all races population in 1993 reveals the disease burden on the AI/ANs associated with pneumonia and influenza to be 61 percent greater than among non-Indians. For example, in Navajo Area, upper respiratory ailments account for the largest proportion of ambulatory care visits and, pneumonia and influenza remain a significant cause of death since the mid-1970s, at twice the national rate. Other IHS areas report similar data on the impact of infectious diseases on the I/T health delivery system.

In the face of increasing sexually transmitted diseases among AI/ANs, there is a tremendous need to develop surveillance on the incidence and prevalence of HIV/AIDS infection rates to assure that prevention and treatment resource efforts are where needed, both on and off reservation. Access to appropriate levels of treatment is complicated for tribal members who are HIV positive by the limited scope of services available in the I/T/U health care system.

Although Hepatitis B screening and detection are improving, evidence suggests that Hepatitis C may be increasing among some groups of AI/ANs. A recent cluster of patients who died of Hepatitis B infections led to us finding a number of patients infected with Hepatitis C. In addition, although more accurate numbers are being gathered, the number of patients infected with Hepatitis C appears to be almost twice that of White populations in the U.S. A proportion of these patients will need expensive treatment as their infections progress.

Certain Indian tribes and Tribal Epidemiology Centers have established collaborative projects with IHS, State governments, and the Centers for Disease Control and Prevention (CDC) to develop infectious disease surveillance and control programs. For example, the Navajo Nation is a recipient of a CDC grant to evaluate the importance of infectious diseases to tribal members, as well as to develop some community-oriented infectious disease control projects. The Northwest Portland Area Epi Center has been an active collaborator with IHS in a major sexually transmitted disease control program aimed at preventing chlamydia infections.

Initial diagnosis of most infectious diseases is made in I/T/U facilities, or in contract medical laboratories. The screening, testing, and treatment of these diseases is expensive. Funding would allow staffing to screen for and detect these diseases before they reach advanced stages in order to stop the progression of the disease. In addition, funds will be used to

support and improve state and tribal-based surveillance and disease control programs needed to address many of these communicable diseases. Some funds specifically aimed at implementing surveillance of HIV/AIDS will involve establishing a team of IHS and CDC epidemiologists at the national Epidemiology Program to provide technical assistance to American Indian and Alaska Native communities throughout the U.S.

Emergency Medical Services: +$2,912,000

This request for emergency medical services will increase access to effective Emergency Medical Services (EMS) for Indian people by improving the capacity of IHS and tribal programs to provide hospital and pre-hospital EMS. The requested funds would be available to all Areas and would be used to expand the capacity of the existing 70 EMS programs which now serve Indian people. This includes the training of new emergency medical personnel as well as enhancing the skills of existing personnel and upgrading equipment. Funds will also be used to develop EMS capacity for 1 to 3 tribes that currently are without adequate EMS services. Presently an estimated 25 tribes have the need to develop EMS systems. This request directly supports the universal enhancement of tribal EMS programs from Basic Life Support to Advanced Life Support capabilities.